Board of Governors

Regular Meeting

Friday, July 9, 2021
12:00 p.m. – 2:00 p.m.

Video Conference Call Only

Alameda, CA 94502

AGENDA

BOARD OF GOVERNORS
Regular Meeting
Friday, July 9, 2021
12:00 p.m. – 2:00 p.m.

Video Conference Call

Alameda, CA 94502

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

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

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

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. IT WOULD BE APPRECIATED 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. IF THAT IS NOT POSSIBLE, EVERY EFFORT WILL BE MADE TO ATTEMPT TO REVIEW E-COMMENTS DURING THE COURSE OF THE MEETING. TOWARDS THIS END, THE CHAIR OF THE BOARD WILL ENDEAVOR TO TAKE A BRIEF PAUSE BEFORE ACTION IS TAKEN ON ANY AGENDA ITEM TO ALLOW THE BOARD CLERK TO REVIEW E-COMMENTS, AND SHARE ANY E-COMMENTS RECEIVED DURING 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 9, 2021, at 12:00 p.m. in Alameda County, California, by Dr. Evan Seevak, Presiding Officer. This meeting 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 11, 2021 BOARD OF GOVERNORS MEETING MINUTES**

   b) **JULY 6, 2021 FINANCE COMMITTEE MEETING MINUTES**

   c) **2020 QUALITY IMPROVEMENT – PROGRAM EVALUATION**

   d) **2021 QUALITY IMPROVEMENT – PROGRAM DESCRIPTION**

   e) **2021 CULTURAL AND LINGUISTIC – PROGRAM DESCRIPTION**

6. **BOARD MEMBER REPORTS**

   a) **COMPLIANCE ADVISORY COMMITTEE**

   b) **FINANCE COMMITTEE**

   c) **STRATEGIC PLANNING COMMITTEE**

7. **CEO UPDATE**

8. **BOARD BUSINESS**

   a) **REVIEW AND APPROVE MAY 2021 MONTHLY FINANCIAL STATEMENTS**

   b) **REVIEW AND APPROVE RESOLUTION 2021-13 BOARD MEMBER (MARTY LYNCH) TO THE AT LARGE HEALTH SERVICES FOR SENIORS AND PERSONS WITH DISABILITIES MEMBER SEAT**

   c) **CALAIM PROGRESS REPORT: IN-LIEU OF SERVICES**

9. **STANDING COMMITTEE UPDATES**

   a) **PEER REVIEW AND CREDENTIALING COMMITTEE**

b) **PHARMACY AND THERAPEUTICS COMMITTEE**

c) **CONSUMER ADVISORY COMMITTEE**

10. STAFF UPDATES

11. UNFINISHED BUSINESS

a) **TELEHEALTH UTILIZATION SUMMARY**

b) **INTERPRETER SERVICES UTILIZATION AND COST REPORT UPDATE**

c) **VACCINATION RATES FOR MEMBERS NOT VACCINATED COMPARED TO HEALTH UTILIZATION**

d) **ENHANCED CARE MANAGEMENT – CASE MANAGEMENT AND WHOLE PERSON CARE SUMMARY OF REVENUE AND EXPENSE**

12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

13. PUBLIC COMMENT (NON-AGENDA ITEMS)

14. ADJOURNMENT

NOTICE TO THE PUBLIC

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

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

NOTICE TO THE PUBLIC

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

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

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

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

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

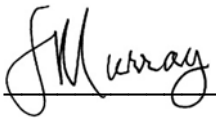
Public Input: If you are interested in addressing the Board, you may submit comments on any agenda item or on any item not on the agenda, in writing via mail to "Attn: Alliance Board," 1240 S. Loop Road, Alameda, CA 94502; or through e-comment at jmurray@alamedaalliance.org.

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.alamaedaalliance.org on July 2, 2021, by 12:00 p.m.



Clerk of the Board – Jeanette Murray

CONSENT CALENDAR

ALAMEDA Alliance FOR HEALTH

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

Board of Governors Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
BOARD OF GOVERNORS
REGULAR MEETING
June 11, 2021
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), Marty Lynch, Wilma Chan, Natalie Williams, Byron Lopez, Nicholas Peraino, Dr. Rollington Ferguson, David B. Vliet, Dr. Kelley Meade, Dr. Noha Aboelata, Aarondeep Basrai

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

Excused: Dr. Michael Marchiano

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
1. CALL TO ORDER			
Dr. Seevak	The regular board meeting was called to order by Dr. Seevak at 12:03 pm.	None	None
2. ROLL CALL			
Dr. Seevak	A telephonic roll call was taken of the Board Members, and a quorum was confirmed.	None	None
3. AGENDA APPROVAL OR MODIFICATIONS			
Dr. Seevak	Consent Calendar change a) The agenda should read "Review and Approve April 2021 Monthly Financials," not March 2021.	None	None
4. INTRODUCTIONS			
Dr. Seevak	None	None	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
5. CONSENT CALENDAR			
Dr. Seevak	Dr. Seevak presented the Consent Calendar. a) May 14, 2021, Board of Governors Meeting Minutes b) June 8, 2021, Finance Committee Meeting Minutes Motion to Approve June 11, 2021, Board of Governors Consent Calendar. A vote-by-roll call was taken, and the motion passed.	Motion to Approve June 11, 2021, Board of Governors Consent Calendar. Motion: R. Gebhart Second: M. Lynch Vote: Yes No opposed or abstained.	None
6. a. BOARD MEMBER REPORT – COMPLIANCE ADVISORY GROUP			
R. Gebhart	The Compliance Advisory Group was held telephonically on June 11, 2021, at 10:30 am. Rebecca introduced the three new members of the Compliance Advisory Group. a) Rebecca Gebhart, Chair b) Dr. Kelley Meade c) Dr. Noha Aboelata d) Byron Lopez Joint Audits: DMHC and DHCS Audit: • Virtual On-Site: April 13 – April 16, 2021 • Review Period: November 1, 2018 – October 31, 2020	Informational update to the Board of Governors. Vote not required.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	• The preliminary audit findings will be submitted from DHCS/DMHC separately to the plan within 90 days. • More details to come at the July Board meeting. Federal Audit: A PHI breach occurred with one of our providers in April of 2020. There was a lag in reporting until October 2020. The audit is being conducted by the U.S. Department of Health & Human Services, Office of Civil Rights. The plan issued the provider a corrective action plan (CAP). Our focus is on making sure the provider follows the CAP. More to discuss in the future. Question: How many members were involved? Answer: Approximately 2,300 persons were involved. Informational update to the Board of Governors. Vote not required.		
6. b. BOARD MEMBER REPORT – FINANCE COMMITTEE			
Dr. Ferguson	The Finance Committee was held telephonically on Tuesday, June 8, 2021. Dr. Ferguson updated the Board on the Finance Committee Meeting. Highlights: • TNE and MLR are good. The trend is down but the financial reserves remains at 543%. • There is a change in our loss prediction, and Gil will update in the Finance Report. • The State has moved to a calendar year. We should consider if we should move to a calendar year or stay at Fiscal Year.	Informational update to the Board of Governors. Vote not required.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Informational update to the Board of Governors. Vote not required.		
7. CEO UPDATE			
S. Coffin	Scott Coffin, Chief Executive Officer, presented the following updates: Executive Summary: • Medi-Cal enrollment trend month-after-month continues to decline, but enrollment continues to increase but will decline after the redetermination begins. We now have 284,191 members. • A new Dashboard is located on slide #244 in the packet, which contains the key operating metrics. Preliminary Fiscal Year 2022 Budget: • All 8 divisions pulled together to complete this budget. Medi-Cal Funding: • Governor Newsom's Fiscal Budget (May Revise) includes $300 million for Medi-Cal incentives and an additional $115 million in funding for In-Lieu Of Services. • Enhanced Home and Community Based Services (HCBS) funding was approved under the American Rescue Plan Act (ARPA) in March 2021. The HCBS program includes $3 billion in enhanced federal funding for navigation, transitions, infrastructure, and building provider capacity. The enhanced funding is available through March 2024. COVID-19 Vaccinations: • Approximately 47% of members (12 years and older) in Medi-Cal and Group Care are partially or fully vaccinated, about 10% higher than last	Informational update to the Board of Governors. Vote not required.	NONE:

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	month; 30% below the county average of 77%, and 11% below the statewide rate. • In May, the Alliance conducted a second round of mailings, robocalls, and postcards to over 151,000 Members (12 years and older) to encourage seeking the vaccine and supply a list of vaccination sites in Alameda County. HEDIS: • HEDIS ended today, and we have concluded with the process for 2020. Question: Do you think the low vaccination rate is due to low utilization? Is there a correlation between not getting a vaccine and not using the care? Answer: Our goal is to have as many Alliance Members vaccinated as Alameda County. We will continue to push to get people vaccinated. Question: Will the COVID-19 vaccine be a yearly vaccine. Answer: We will follow CDC recommendations. Informational update to the Board of Governors. Vote not required.		
8. a. BOARD BUSINESS – APRIL 2021 MONTHLY FINANCIAL STATEMENTS			
G. Riojas	Gil Riojas gave the following April 2021 Finance updates: Enrollment: • For the month ending April 30, 2021, the Alliance had an enrollment of 284,191 members, a net income of $6.9M, and the tangible net equity is 543%. • Our enrollment has increased by 2,554 members since March 2021.	Motion to Approve April 2021, Monthly Financial Statements. Motion: Dr. R. Ferguson Second: N. Peraino	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Net Operating Results: • For the month ending April 30, 2021, the actual net income was $6.9M, and the budgeted net income was $22,000. • The favorable variances were due to higher than anticipated revenue and lower than anticipated administrative expense. Revenue: • For the month ending April 30, 2021, the actual revenue was $95.3M vs. the budgeted revenue of $81.4M. Medical Expense: • For the month ending April 30, 2021, the actual medical expense was $91.8M vs. the budgeted medical expense of $73.9M. Medical Loss Ratio (MLR): • For the month ending April 30, 2021, the MLR was 96.4%, and the fiscal year-to-date of 95.9%. Administrative Expense: • For the month ending April 30, 2021, the actual administrative expense was $3.4M vs. the budgeted administrative expense of $7.5M. Other Income / (Expense): • As of April 30, 2021, our YTD interest income from investments is $554,000, and YTD claims interest expense is $284,000. Tangible Net Equity (TNE): • Tangible net equity results continue to remain healthy, and at the end of April 30, 2021, the TNE was reported at 543% of the required amount. Cash Position and Assets: • For the month ending April 30, 2021, the Alliance reported $273.4M in cash; $76.0M in uncommitted cash. Our current ratio is above the minimum required at 1.58 compared to the regulatory minimum of 1.0.	Vote: Yes No opposed or abstained.	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Motion to approve April 2021, Monthly Financial Statements as presented. A vote-by-roll call was taken, and the motion passed.		
8. b. BOARD BUSINESS – REVIEW AND APPROVE FY 2022 PRELIMINARY BUDGET			
G. Riojas	Gil presented the FY 2022 Preliminary Budget. Gil presented an in-depth FY2022 Preliminary Budget. Some topics discussed were: • The Budget Process • Budget Assumptions FY2022 compared to FY 2021 Forecast • Summary of Proposed Budget • Preliminary FY 2022 Budget Comparison to FY 2021 Forecast • Operating Performance: 2017 to 2022: Net Profit (Loss) Motion to approve the FY 2022 Preliminary Budget A vote-by-roll call was taken, and the motion passed.	Motion to Approve the FY 2022 Preliminary Budget Motion: Dr. K. Meade Second: M. Lynch Vote: Yes No opposed or abstained.	None
8. c. BOARD BUSINESS – REVIEW AND APPROVE RESOLUTION 2021-12 BOARD MEMBER SEAT			
S. Coffin	Scott Coffin introduced Resolution 2021-12 to appoint James Jackson to the Alameda Health System Member Seat. • The Board voted to appoint James Jackson to the Alameda Health System Member Seat. Motion to approve Resolution 2021-12 to appoint James Jackson to the Alameda Health System Member Seat. A vote-by-roll call was taken, and the motion passed.	Motion to approve Resolution 2021-12 to appoint James Jackson to the Alameda Health System Member Seat. Motion: W. Chan Second: M. Lynch Motion passed by roll call. Vote: Yes	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
		No opposed No abstained.	
8. d. BOARD BUSINESS – REVIEW AND APPROVE RESOLUTION 2021-10 BOARD MEMBER SEAT			
S. Coffin	Scott Coffin introduced Resolution 2021-10 to reappoint Board Member Natalie Williams to the Consumer Member Seat. Natalie Williams recused herself from the conversation and vote. • The Board voted to reappoint Board Member Natalie Williams to the Consumer Member Seat. Motion to approve Resolution 2021-10 to reappoint Board Member Natalie Williams to the Consumer Member Seat. A vote by roll call was taken, and the motion passed.	Motion to approve Resolution 2021-10 to reappoint Board Member Natalie Williams to the Consumer Member Seat. Motion: R. Gebhart Second: Dr. K. Meade Motion passed by roll call. Vote: Yes No opposed. 1 abstained (Natalie Williams).	None
8. e. BOARD BUSINESS – REVIEW AND APPROVE RESOLUTION 2021-11 CREATING COMPLIANCE ADVISORY COMMITTEE			
R. Gebhart	Rebecca Gebhart introduced Resolution 2021-11 Creating the Compliance Advisory Committee. • The Board voted to Create the Compliance Advisory Committee. Motion to approve Resolution 2021-11 Creating the Compliance Advisory Committee.	Motion to approve Resolution 2021-11 Creating the Compliance Advisory Committee. Motion: Dr. R. Ferguson	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	A vote by roll call was taken, and the motion passed.	Second: Dr N. Aboelata Motion passed by roll call. Vote: Yes No opposed. No abstained.	
8. f. BOARD BUSINESS – REVIEW AND APPROVE MEMBER NOMINATIONS TO THE COMPLIANCE ADVISORY COMMITTEE			
R. Gebhart	Rebecca Gebhart introduced Member Nominations to the Compliance Advisory Committee. • The Board voted to Nominate Members to the Compliance Advisory Committee. • The Members Nominations are Rebecca Gebhart, Chair, and Dr. Kelley Meade, Vice Chair, to the Compliance Advisory Committee, each for a term of two (2) years. Dr. Noha Aboelata and Byron Lopez are nominated as Members of the Compliance Advisory Committee, also serving two (2) year terms. Motion to approve Member Nominations to the Compliance Advisory Committee. A vote by roll call was taken, and the motion passed.	Motion to approve Member Nominations to the Compliance Advisory Committee. Motion: M. Lynch Second: W. Chan Motion passed by roll call. Vote: Yes No opposed or abstained.	None
8. g. BOARD BUSINESS – REVIEW AND APPROVE MEMBER NOMINATIONS TO THE EXECUTIVE COMMITTEE			
Dr. E. Seevak	Dr. Seevak introduced the Member Nominations to the Executive Committee.	Motion to approve Member Nominations	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	• The Board voted to Nominate Members to the Executive Committee. • The Members Nominations are Dr. Evan Seevak, Chair, and Rebecca Gebhart, Vice Chair, to the Executive Committee, each for a term of two (2) years. Marty Lynch, Dr. Rollington Ferguson, and David Vliet are nominated as Members of the Executive Committee, also serving two (2) year terms. Motion to approve the Member Nominations to the Executive Committee. A vote by roll call was taken, and the motion passed.	to the Executive Committee. Motion: N. Williams Second: A. Basrai Motion passed by roll call. Vote: Yes No opposed or abstained.	
8. h. BOARD BUSINESS – CALAIM IN-LIEU OF SERVICES – COST PRO-FORMA CY2022			
S. Coffin,	S. Coffin presented the CalAIM In-Lieu of Services – Cost Pro-Forma CY2022. The topics covered were: CalAIM Overview: • Background • Regulatory Filings • CalAIM – Phase One Launch • State funding for CalAIM services launching on January 1. 2022 • Financial Projections • Financial Risks • Key Objectives • Next Steps A board member commented: The Alliance staff and leadership are appreciated for working with all the CalAIM directives as this is a heavy lift. Also, ILOS is an incredible opportunity to address homelessness and other problems that lead to health disparities. Informational update to the Board of Governors.	Informational update to the Board of Governors. Vote not required.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Vote not required.		
9. a. STANDING COMMITTEE UPDATES – PEER REVIEW AND CREDENTIALING COMMITTEE			
Dr. S. O'Brien	The Peer Review and Credentialing Committee (PRCC) held telephonically on May 18, 2021. • There were twenty-three (23) initial providers approved. Additionally, thirty-two (32) providers were re-credentialed at this meeting. Informational update to the Board of Governors. Vote not required.	Informational update to the Board of Governors. Vote not required.	
9. b. STANDING COMMITTEE UPDATES – HEALTH CARE QUALITY COMMITTEE			
Dr. O'Brien	The Health Care Quality Committee (HCQC) was held telephonically on May 20, 2021. Dr. O'Brien gave the following updates: • Annual policy approvals. • Compliance Update. • QI Program and Evaluation Report. • Mental Health Report by Dr. Bhatt. Informational update to the Board of Governors. Vote not required.	Informational update to the Board of Governors. Vote not required.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
10. STAFF UPDATES			
S. Coffin	None	None	None
11. UNFINISHED BUSINESS			
S. Coffin	• TeleHealth Utilization Summary • Interpreter Services Utilization Summary Update. • Vaccination rates for members not vaccinated compared to health utilization. • Enhanced Care Management - Case Management and Whole Person Care summary of revenue and expense.	None	None
12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS			
S. Coffin	• None	None	None
13. PUBLIC COMMENTS (NON-AGENDA ITEMS)			
Dr. Seevak	• None	None	None
14. ADJOURNMENT			
Dr. Seevak	Dr. Seevak adjourned the meeting at 2:23 pm.	None	None

Respectfully Submitted By: Jeanette Murray
Executive Assistant to the Chief Executive Officer and Clerk of the Board

ALAMEDA Alliance FOR HEALTH

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

Finance Committee Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

July 6, 2021
8:00 am – 9:00 am

SUMMARY OF PROCEEDINGS

Meeting Conducted by Teleconference

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

Alliance Staff and other Board of Governor members on Conference Call: Scott Coffin, Tiffany Cheang, Richard Golfin III, Sasi Karaiyan, Dr. Steve O'Brien, Anastacia Swift, Carol van Oosterwijk, Ruth Watson, Matt Woodruff, Christine Corpus

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
CALL TO ORDER and INTRODUCTIONS			
Dr. Rollington Ferguson	Dr. Ferguson called the Finance Committee meeting to order at 8:00 am and Roll call was conducted.		
CONSENT CALENDAR			
Dr. Rollington Ferguson	Dr. Ferguson presented the Consent Calendar. June 8, 2021, Finance Committee Minutes were approved at the Board of Governors meeting June 11, 2021 and not presented today. There were no modifications to the Consent Calendar.	Motion to accept **Consent Calendar** Motion: Dr. Marchiano Seconded: N. Peraino Pass by Consent	
a.) CEO Update			
Scott Coffin	S. Coffin gave updates to the committee on the following: **Single Plan Model** –Last month, the Board of Governors approved a plan to proceed forward in conjunction with Alameda County in this effort. An impact assessment was initiated and included Alameda County Health Care Services Agency (HCSA), Alameda Health Systems (AHS), Community Health Center Network (CHCN), and the Alameda Alliance. We are currently conducting an	Informational update to the Finance Committee Vote not required	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	impact assessment to identify the benefits and opportunities as well as the risks and costs associated with changing the Medi-Cal delivery model from a two-plan model to a single-plan model. The final approval is required by the Alameda County Board of Supervisors no later than October 2021. The outcomes from the impact assessment will be presented to the County Board of Supervisors and the Alliance Board of Governors in the month of September. **COVID-19 Vaccination Progress Report** –Current vaccination rates among the Alliance's Medi-Cal and Group Care members (aged 12+) is currently 54%, including partially or fully vaccinated, or 122,292 members. This is a 7% increase over the previous month. Alameda County is 81% vaccinated and Statewide is currently just over 69%. **CalAIM** – *This will be a standing item on the agenda for the Finance Committee and Board Meeting, and each month a discussion will be facilitated to update the Board Members and Committee Members.* Update will be provided as a separate agenda item.		
b.) Review May 2021 Monthly Financial Statements			
Gil Riojas	**May 2021 Financial Statement Summary** **Enrollment:** Current enrollment is 286,757 and continues to trend upward, Total enrollment has increased by 2,566 members from April 2021, and 30,012 members since June 2020. As in previous months, increases are primarily in the Child, Adult, and Optional Expansion categories of aid, and include slight increases in the Duals category of aid. Total Enrollment continues to increase month over month, however; as previously discussed, the rate of increase has fallen from a high of 4,140 members in August 2020. While the rate of increase had been declining in previous months, we did see an uptick in the rate of increase for April and May, and could be an indication of a new stabilized rate of increase. We do anticipate the enrollment to peak and then assuming the Health Emergency ends, sometime in the early part of the year, it should begin to decline.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Net Income: For the month ending May 31, 2021, the Alliance reported a Net Income of $682,000 (versus budgeted Net Income of $1.8 million). For the year-to-date, the Alliance recorded a Net Loss of $3.0 million versus a budgeted Net Loss of $18.4 million. The unfavorable variance is attributed to higher than anticipated Medical Expense, and lower than anticipated Other Revenue. These were somewhat offset by higher than anticipated Revenue and lower than anticipated Administrative Expense. **Revenue:** For the month ending May 31, 2021, actual Revenue was $96.6 million vs. our budgeted amount of $81.2 million. Factors creating the favorable variance were mainly due to delay of pharmacy carve-out. We will see the variance for Revenue and Medical Expense for the rest of the fiscal year due to indefinite delay status of pharmacy carve-out. **Medical Expense:** Actual Medical Expenses for the month were $90.8 million vs. our budgeted amount of $73.8 million. For the year-to-date, actual Medical Expenses were $942.3 million versus budgeted $901.3 million. Drivers leading to the unfavorable variance can be seen on the tables on page 11, with the greatest variances coming from the pharmacy carve-out and Inpatient Hospital expenses. Further explanation on pages 11 and 12. **Medical Loss Ratio:** Our MLR ratio for this month was reported at 94.0%. Year-to-date MLR was at 95.7% vs our annual budgeted percentage 94.2%. As a reminder we want our MLR to be below 95%. **Administrative Expense:** Actual Administrative Expenses for the month ending May 31, 2021 were $5.1 million vs. our budgeted amount of $5.6 million. Our Administrative Expense represents 5.3% of our Revenue for the month, and 4.6% of Net Revenue for year-to-date. **Other Income / (Expense):** As of May 31, 2021, our YTD interest income from investments was $615,000. We continue to discuss strategy with our investment manager to see if there is a way to increase our return. YTD claims interest expense is $309,000.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	TangibleNet Equity (TNE): We reported a TNE of 556%, with an excess of $166.6 million. This remains a healthy number in terms of our reserves. **Cash and Cash Equivalents:** We reported $309.8 million in cash; $195.5 million is uncommitted. Our current ratio is above the minimum required at 1.74 compared to regulatory minimum of 1.0. **Capital Investments:** Fiscal year-to-date Capital Assets acquired less Capital Assets retired is ***negative*** $864,000 (net negative due to retirement of Trizetto software, $2 million). Our annual capital budget is $2.4 million. **Question:** Dr. Ferguson asked for clarification of the reporting of medical expenses excluding IBNP from the charts on page 11. G. Riojas explained the three columns of the chart and how they each reflect our medical expenses. **Question:** Dr. Ferguson asked regarding COVID-19 related costs compared to what we might see in a typical year for influenza. Had there been any changes in the flu over the last year and how does it compare? Has there been a financial impact? Dr. O'Brien answered that the Alliance has had almost no influenza hospitalizations over the last year and our PCPs indicated they saw very little influenza in their practices. Having said that, there isn't a clear favorable financial impact because while overall hospitalization are down, the length of stay and complexity of care needed has been up. The COVID-19 pandemic has had multiple different ramifications across healthcare and did change a variety of different dynamics. **Question:** Dr. Marchiano asked about the Alliance outreach efforts to increasing our vaccination rates amongst our members, and if we notice that one works better than another. M. Woodruff answered that the Alliance had a three-touch approach as each population has become eligible. We send letters, postcards, and utilize robocalls to communicate the member's eligibility and offer to schedule vaccine appointments. Our provider network CHCN has indicated that there is a marked increase in appointment requests following the postcard and robocall efforts. The letters do not seem to influence people to schedule. The biggest response has been a result of approval from S. Coffin in May to offer a $10 grocery gift card. Since offering the incentive we have seen	Motion to accept **May 2021, Financial Statements**	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	a large jump including over 700 calls to our call center specifically related to the gift card offering. Dr. Ferguson asked if one of the grocery stores would be willing to partner with the Alliance and "double down" on the offering. M. Woodruff answered that he would explore that option.	Motion: N. Peraino Seconded: Dr. Marchiano Motion Carried No opposed or abstained	
c.) CalAIM Progress Report: In-Lieu of Services			
Scott Coffin	S. Coffin gave an in-depth presentation to update the committee on the progress being made toward the January 1, 2022 implementation of In-Lieu of Services component of CalAIM.	Informational update to the Finance Committee. Vote not taken.	
Dr. Rollington Ferguson	Dr. Ferguson motioned to adjourn the meeting. The meeting adjourned at 8:59 am.	Motion to adjourn: Dr. Ferguson Seconded: N. Peraino No opposed or abstained.	

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

2020 Quality Improvement

Program Evaluation

ALAMEDA ALLIANCE FOR HEALTH
QUALITY IMPROVEMENT – PROGRAM EVALUATION 2020

ALAMEDA Alliance FOR HEALTH

2020
Quality Improvement Program Evaluation Signature Page

DocuSigned by:
Stephanie Wakefield
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Stephanie Wakefield, RN
Director of Quality

05/20/2021
Date

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Sanjay Bhatt
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Sanjay Bhatt, M.D.
Medical Director, QI
Vice Chair, Health Care Quality Committee

05/20/2021
Date

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

05/20/2021
Date

Scott Coffin
Chief Executive Officer

Date

Evan Seevak, M.D.
Board Chair

Date

ALAMEDA Alliance FOR HEALTH

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Introduction

Alameda Alliance for Health (Alliance) is a local, public, not-for-profit managed care health plan committed to making high-quality health care services accessible and affordable to County. 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 provider health care coverage to over 275,589 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 Services 2020 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, 2020 through December 31, 2020.

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.

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 2020 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. 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 care and 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: 2020 Trended Enrollment by Network and Aid Category

Current Membership by Network By Category of Aid							
Category of Aid	**Dec 2020**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	38,150	14%	8,844	8,501	374	13,958	6,473
Child	94,969	35%	9,292	8,661	28,902	31,790	16,324
SPD	26,339	10%	8,535	4,009	1,122	10,723	1,950
ACA OE	91,050	34%	15,063	31,096	1,129	32,984	10,778
Duals	19,127	7%	7,635	2,054	2	6,998	2,438
Medi-Cal	269,635		49,369	54,321	31,529	96,453	37,963
Group Care	5,954		2,568	919	-	2,467	-
Total	**275,589**	**100%**	**51,937**	**55,240**	**31,529**	**98,920**	**37,963**
Medi-Cal %	97.8%		95.1%	98.3%	100.0%	97.5%	100.0%
Group Care %	2.2%		4.9%	1.7%	0.0%	2.5%	0.0%
			18.8%	*20.0%*	*11.4%*	*35.9%*	*13.8%*
Network Distribution			**% Direct:**	**39%**		**% Delegated:**	**61%**

ALAMEDA Alliance FOR HEALTH

Table 2: 2020 Trended Categories of Aid, Distribution and Growth/Loss

Category of Aid Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Dec 2018	Dec 2019	Nov 2020	Dec 2020	Dec 2018	Dec 2019	Nov 2020	Dec 2020	Dec 2018 to Dec 2019	Dec 2019 to Dec 2020	Nov 2020 to Dec 2020
Adults	35,559	32,066	37,638	38,150	13.5%	12.9%	13.8%	13.8%	-9.8%	19.0%	1.4%
Child	95,322	89,056	94,620	94,969	36.1%	35.8%	34.6%	34.5%	-6.6%	6.6%	0.4%
SPD	26,006	25,687	26,314	26,339	9.8%	10.3%	9.6%	9.6%	-1.2%	2.5%	0.1%
ACA OE	85,345	78,154	89,752	91,050	32.3%	31.4%	32.8%	33.0%	-8.4%	16.5%	1.4%
Duals	16,072	17,776	18,990	19,127	6.1%	7.1%	6.9%	6.9%	10.6%	7.6%	0.7%
Medi-Cal Total	258,304	242,739	267,314	269,635	97.8%	97.6%	97.8%	97.8%	-6.0%	11.1%	0.9%
Group Care	5,886	6,092	5,982	5,954	2.2%	2.4%	2.2%	2.2%	3.5%	-2.3%	-0.5%
Total	264,190	248,831	273,296	275,589	100.0%	100.0%	100.0%	100.0%	-5.8%	10.8%	0.8%

Table 3: 2020 Trend Enrollment by Age Category

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Dec 2018	Dec 2019	Nov 2020	Dec 2020	Dec 2018	Dec 2019	Nov 2020	Dec 2020	Dec 2018 to Dec 2019	Dec 2019 to Dec 2020	Nov 2020 to Dec 2020
Under 19	98,122	91,641	97,068	97,399	37%	37%	36%	35%	-7%	6%	0%
19 - 44	84,866	78,271	91,897	93,280	32%	31%	34%	34%	-8%	19%	2%
45 - 64	57,340	54,210	57,413	57,679	22%	22%	21%	21%	-5%	6%	0%
65+	23,862	24,709	26,918	27,231	9%	10%	10%	10%	4%	10%	1%
Total	**264,190**	**248,831**	**273,296**	**275,589**	**100%**	**100%**	**100%**	**100%**	**-6%**	**11%**	**1%**

In December of 2020, the Alliance membership increased by 11% from December 2019 compared to a decrease in enrollment of 6% from December of 2018 to December of 2019. Total membership numbers increased by 11,399 from December 2018 to December 2020. The Alliance experienced membership growth in all age categories from 2019 to 2020. **6.0%** membership growth for ages under 19, **19%** growth (largest growth category) in the 19-44 age category, **6.0 %** growth for 45-64 age category and **10%** growth noted for 65+ age category. Percent of total distribution by age category decrease by **2%** for age category under age 19 (37% in 2018 down to 35% in 2020). Additionally, there was a **2%** increase in age category 19 – 44 (32% in 2018 to 34% in 2020). There was a 16.5% growth trend noted in ACA-OE aid category from December

2019 to December 2020. A likely driver of the noted increases in membership was the economic downturn related to the 2020 pandemic.

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

Table 4: 2020 Provider Network by Type, Enrollment and Percentage

PROVIDER NETWORK	PROVIDER TYPE	MEMBERS (ENROLLMENT)	% OF ENROLLMENT IN NETWORK
Direct-Contracted Network	Independent	51,937	19%
Alameda Health System (AHS)	Managed Care Organization	55,240	20%
Children First Medical Group (CFMG)	Medical Group	31,529	11%
Community Health Clinic Network (CHCN)	Medical Group	98,920	36%
Kaiser Permanente	HMO	37,963	14%
	TOTAL	**275,589**	**100%**

From 2018 to 2020, the percentage of members within each provider network has remained relatively steady.

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)
Health Centers (FQHCs and non-FQHCs)	67
Hospitals	17
Pharmacies/Pharmacy Benefit Manager (PBM)	Over 200
Skilled Nursing Facilities	64
Transportation Vendor	1 individual vendor with 380 individual transportation providers

Alliance members may choose from a network of over 590 primary care practitioners (PCPs), nearly 7000 specialists, 17 hospitals, 67 health centers, 64 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 16, 2020
- March 19, 2020
- May 21, 2020
- July 16, 2020
- September 17, 2020
- November 19, 2020

The 2019 QI Program Evaluation, the 2020 QI Program Description and the 2020 QI Work Plan were presented to the HCQC during the May 21, 2020 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 2020, 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.

2020 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. Job description expectations with assigned tasks and responsibilities remain unchanged regardless of the geographical location of staff member.

In 2020, as the result of onboarding of new senior and management level leadership, and qualified support staff the Health Care Services in 2019, the QI Department team was able to further mitigate gaps in both leadership and oversight of the QI program integrity. 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 for the Access to Care Manager due to employee resignation. Health Care Services continues to evaluate staff turn-over and strives to provide a positive work environment while creating a stable work force.

Through 2020, vendor partnerships were a part of the QI resource strategy. The Alliance discontinued its contractual relationship with Health Data Decisions (HDD). However, the 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 2020 SPH support the QI Department work with implementation, analysis, and reporting on the following surveys:

- Afterhours and Emergency Instruction Survey
- Health Information Form/Member Evaluation Tool (HIF-MET) Survey

- Health Risk Assessment (HRA) Survey
- Member Satisfaction Survey
- 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 2020 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 inlcuding 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, communitiy 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 within the Alliance membership through population data collection, analysis and segmentation.
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 create greater operational efficiencies.
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, and AMM.
7. Ensured timely Facilty Site Review (FSR/Medical Record Review (MRR) audits and Physical Accessibility Review Surveys (PARS).
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 intereprter 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 delegated providers around the implementation of a revised Delegate Corrective Action Plan (CAP) Process creating increased efficiencies for compliance from both direct and delegated providers.

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.

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), Whole Person and Health Homes Management Programns 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 concers.

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 Health Homes Management staff outreach to high risk members by telephone and communicate with Community-Based Care Management (CB-CMEs). When outreach attempts are successful, initial assessments are performed and care plans are developed. Members who agree to care are provided assistance 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 2020, the Provider Services department provided continued outreach to all PCP, Specialists and Ancillary provider offices via the use of fax blasts. In-person visits were conducted until Shelter-in-Place orders went into effect in March 2020 and subsequently resumed through alternative modalities of email, telephone, and mail.

Topics covered in the visits and fax blasts included but, were not limited to: use of the provider portal, the announcement of the Member Satisfaction update and reminders, Provider Satisfaction updates, Population Needs Assessment, Rx Safety Guidelines and updates, Gap-in Care report updates, Lactation Program Changes, DHCS Medi-Cal Rx updates, Immunizations, Stanford Cancer Network Program Partnership, Provider Appointment Availability Survey (PAAS) Update, Cultural Sensitivity Training for 2020, Initial Health Assessment (IHA) Update, Electronic submission of Prior Authorization notification, Timely Access Standards Reminders, Young Adult Expansion update, Provider Portal updates, Case Management Referral form distribution, Diabetes Prevention Program Benefit update, New Maternal Mental Health Program information, U.S. Preventative Services Task Force (USPSTF) A and B Recommendations Update, and several COVID-19 updates.

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 approximately 500 quarterly packets mailed to providers with updates as mentioned above. Additionally, 1,700 outreach occurrences conducted during the 2020 calendar year. The Provider Services department plans to continue our robust provider outreach and engagement strategies in 2021.

Member Outreach and Member Services

In 2020, the Alliance Member Services (MS) Department continued to have a strong focus on providing high-quality service. The Alliance received certification as a Center of Excellence for superior performance in the Alliance Member Services Call Center. The Center of Excellence recognition, awarded by BenchmarkPortal, is a high honor in the customer service and support industry.

The Alliance Member Services Team is committed to providing the highest levels of exceptional service to our members and providers. This award of excellence shows our dedication to deliver first-rate customer service and ensure that our members have access to the care and services they need to stay healthy.

As a committed safety-net partner, the Center of Excellence award is an example of our commitment to centering the needs of members and the larger Alameda County community. To become a Center of Excellence, the Alliance had to pass a thorough assessment that measures ongoing performance on key operating metrics. The key metrics were rated against the international BenchmarkPortal database – the largest in the world of contact center metrics. The outcome demonstrates the superior service the Alliance provides to members every day.

Our Alliance Team is greatly honored to receive the Certified Center of Excellence award during these challenging times. Our mission at the Alliance is to help our members live a healthy life by providing access to high-quality care and services that they need. Providing excellent customer service is just one of the many ways that we serve our community. This honor could not be achieved without the hard work of our dedicated staff.

Quarterly call center metrics are presented below in the Member Services blended (Ansafone and AAH call center) dashboard. The dashboard represents blended (Medi-Cal and Group Care) customer service results.

Table 6: 2020 Quarterly Call Center Metrics

ALLIANCE MEMBER SERVICES STAFF	Q1	Q2	Q3	Q4
Incoming Calls (MS)	30783	24743	29647	26869
Answered Calls (MS)	29112	24203	28236	25372
Abandoned Rate (MS)	5%	2%	5%	6%
Average Speed to Answer (ASA)	00:40	00:25	01:08	01:24
Calls Answered in 30 Seconds (All)	77%	88%	67%	61%
Average Talk Time	06:55	07:00	07:24	07:45
Calls Answered in 10 Minutes (goal: 100%)	100.0%	100.0%	100.0%	100.0%
Ansafone Call Center	**Q1**	**Q2**	**Q3**	**Q4**
Incoming Calls (AF)	9315	2903	7175	8759
Answered Calls (AF)	8358	2810	6589	8095
Abandoned Rate (AF)	10%	3%	8%	8%
Average Speed to Answer (ASA)	02:02	00:32	01:05	01:41
Calls Answered in 30 Seconds (AF)	48%	69%	64%	57%
Average Talk Time (ATT)	07:27	07:17	07:09	05:57
Recordings/Voicemails	**Q1**	**Q2**	**Q3**	**Q4**
Incoming Calls (R/V)	2837	1570	2172	2185
Answered Calls (R/V)	2837	1570	2172	2185
Abandoned Rate (R/V)	0.00%	0.00%	0.00%	0.00%
Calls Answered in 30 Seconds (R/V)	100%	100%	100%	100%
Blended Results	**Q1**	**Q2**	**Q3**	**Q4**
Incoming Calls (R/V)	42935	29216	38994	37813
Answered Calls (R/V)	40307	28583	36997	35652
Abandoned Rate (R/V)	6%	2%	5%	6%
Average Speed to Answer (ASA)	0:55	0:24	01:04	01:22
Calls Answered in 30 Seconds (R/V)	72%	86%	69%	63%

ALLIANCE MEMBER SERVICES STAFF	Q1	Q2	Q3	Q4
Average Talk Time (ATT)	6:32	6:39	6:55	6:53

Table 7: Member Services Call Volume 2020 Member Services Call Center Report

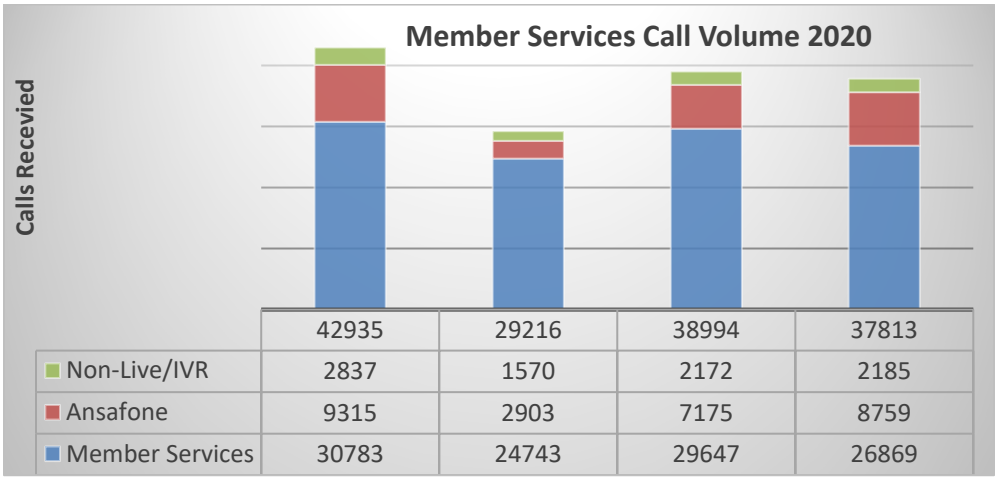
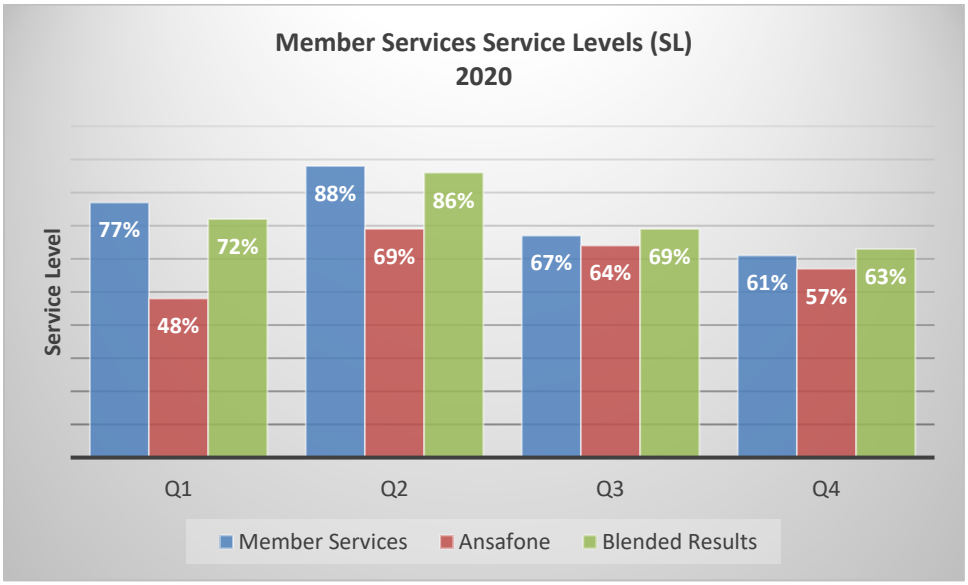


Table 8: Member Services Levels (SL) 2020 Member Services Call Center Report



In 2020, Member Services blended call center targeted metrics were not met for Q1 and Q4 for the abandonment rate of 5% or less. Staffing challenges due to unexpected/unplanned leave of absences (LOAs) and the pandemic impacted the team's ability to meet its service metrics. The MS Department reviewed and implemented various changes to improve service levels and meet metrics. The Member Services phone tree was redesigned to increase member satisfaction and decrease abandonment rates by allowing members to reach the right people, with the right skills

(bilingual in particular), at the right time. An automated edibility verification system implementation for January 2021 is planned that will allow members the self-serve option to check eligibility – real time without speaking to a live agent 24/7. In 2020 Member Services Leadership collaborated with HR to review the bilingual language assessment to increase the level of proficiency required to meet the quality standards to better service our members in this important area. Member Services is currently and will continue working with Compliance to review contractual performance guarantees to ensure quality measures have been met by our call overflow vendor. Through quality assurance process when service measures are not met by the vendor, Compliance will continue to issue corrective action plans. The Department continues to monitor and track call center operations to ensure compliance and quality standards are met. The plan will consolidate the external and internal call centers in 2021 to better service our membership.

Table 9: Abandonment Rate

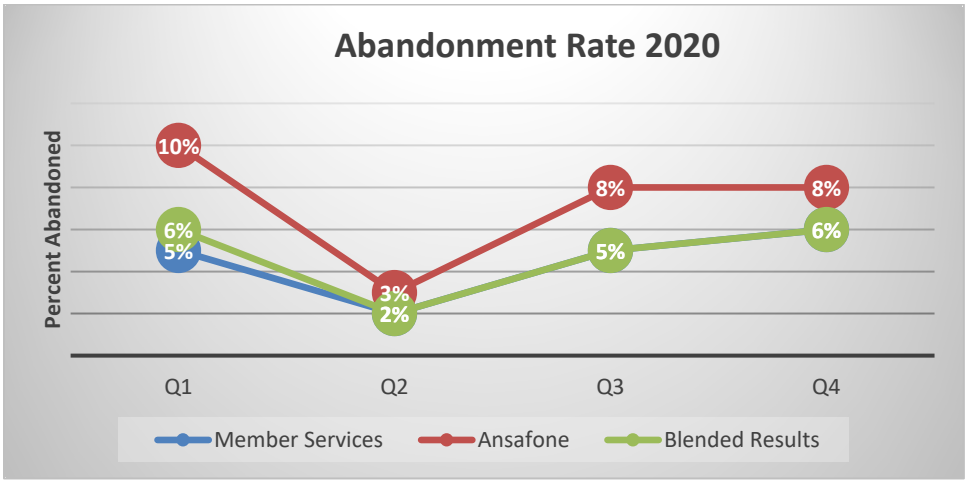
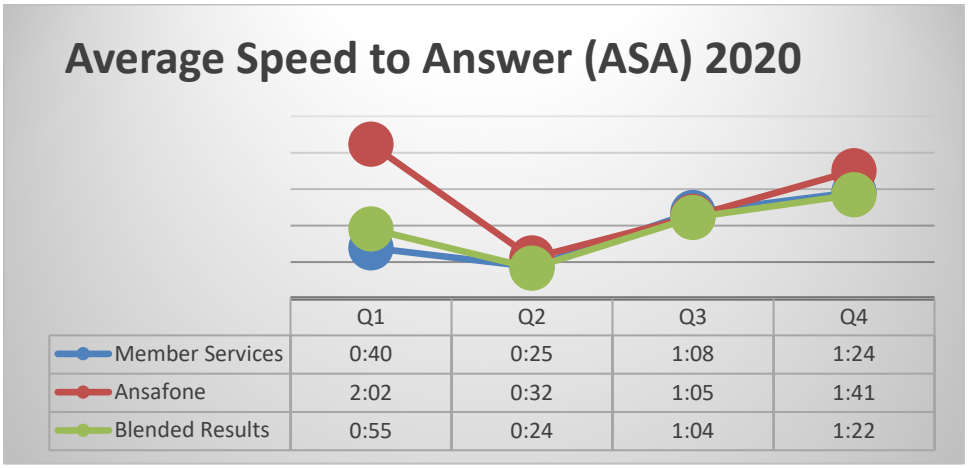


Table 10: Average Speed to Answer (ASA) 2020



	Q1	Q2	Q3	Q4
Member Services	0:40	0:25	1:08	1:24
Ansafone	2:02	0:32	1:05	1:41
Blended Results	0:55	0:24	1:04	1:22

Member Advisory Committee (MAC)

In 2020, 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 2020:

- March 19, 2020
- June 18, 2020
- September 17, 2020
- December 17, 2020

Some of the key topics discussed in 2020 included:

- Cultural and Linguistics Work Plan and Report
- Grievances & Appeals
- Communications & Outreach collateral, events and activities
- Health Education Report
- Timely Access Report
- Population Needs Assessment
- Pharmacy Updates
- COVID-19
- Questions & Answers for member concerns

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 2020, 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.

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 milliequivalence)

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 plans to send out educational mailings that is pertinent to members and providers. Mailing campaign may include:

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
6. Local alternative health services contracted with the Alliance (e.g. physical therapy, acupuncture, chiropractor, massage)

B. Opioids Stewardship Report

Alameda Alliance Ongoing Activities

Purpose of Report: To provide periodic updates regarding steps that AAH is taking to help combat the opioid epidemic.

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.

Table 11: 2019 Opioid/Benzodiazepine related ER Visits

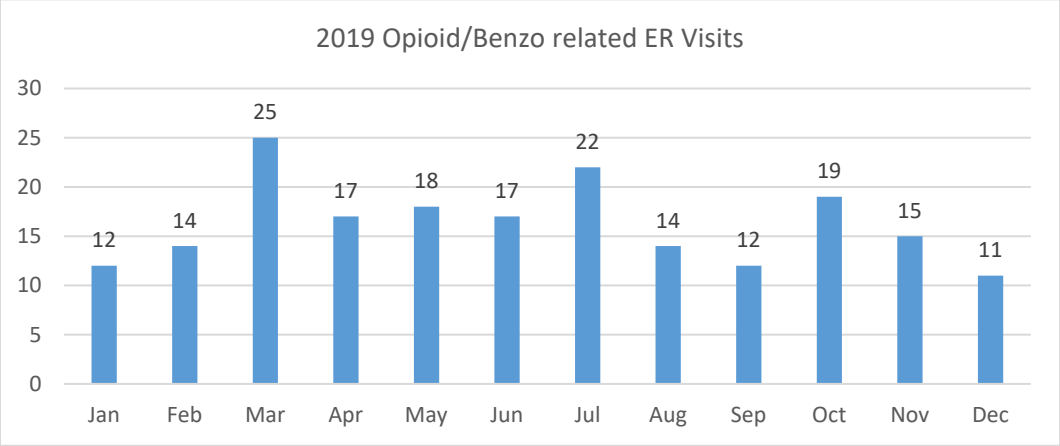
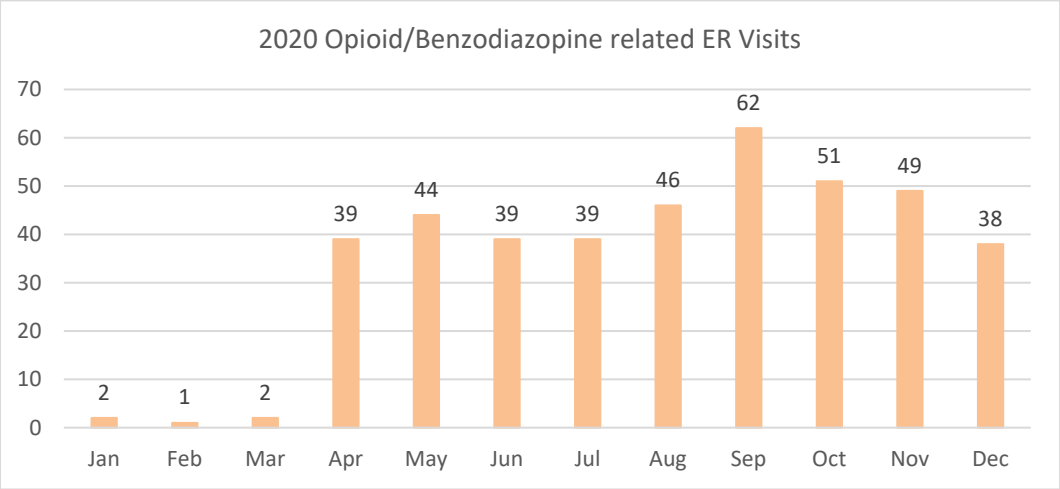


Table 12: 2020 Opioid/Benzodiazepine related ER Visits



Academic Detailing

- **Overview:** QI and Pharmacy Services to identify chronic users defined as greater than 3 months of use and prescribed **≥ 300 MME.** AAH will provide provider education for the providers of these chronic users which includes the following components:
- **Health education materials:** Three documents related to safety, alternative methods, and medications for pain management have been created and designed.
- **Network access maps for alternative resources:** Work with data analytics and C&O to create maps for providers and **members** we are focusing on for under academic detailing.
- **Members ≥ 300 MME data:** Pharmacy services working with PBM to collect most accurate data to identify members receiving ≥ 300 MME. QI gathering CURES reports and the most recent EMR notes per member.
- **Rising risk members:** members taking 50-89 MME for three consecutive months.
- **High risk members:** members taking ≥ 300 MME for three consecutive months.
    - Based on Quarter 4 (Sept – Dec 2020) MME data, we identified 78 risking risk members and 13 high risk members.

Risking risk members will receive:

- Rising risk cover letter
- Health education: Safety guide for patients and caregivers
- Health education: Treating pain without opioids

High risk members will receive:

- 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 your area

The Alliance will continue to improve our opioid stewardship program. Below are some changes the Alliance has implemented.

Pharmacy Safeguards – As of January 2020, AAH implemented additional safeguards to ensure appropriate opioid use.

Key Points include:

- SAOs have a 14-day limit on their initial start for opioid naïve patients
- Grandfathering chronic users 6 months prior to when program were started; chronic users defined as a cumulative day supply of greater or equal to 90 days' supply.
- All SAOs formulation will be limited for to maximum of 3 times daily dosing
- All cancer diagnosis, hospice/palliative care, and sickle cell anemia diagnosis will be exempted from quantity and fill restrictions for opioids
- Monthly reporting and tracking of >120, 200, 300, 400 MME members, providers
- Quarterly reporting of chronic users

Table 13: Pharmacy Safeguard Implementations

Pharmacy Safeguards

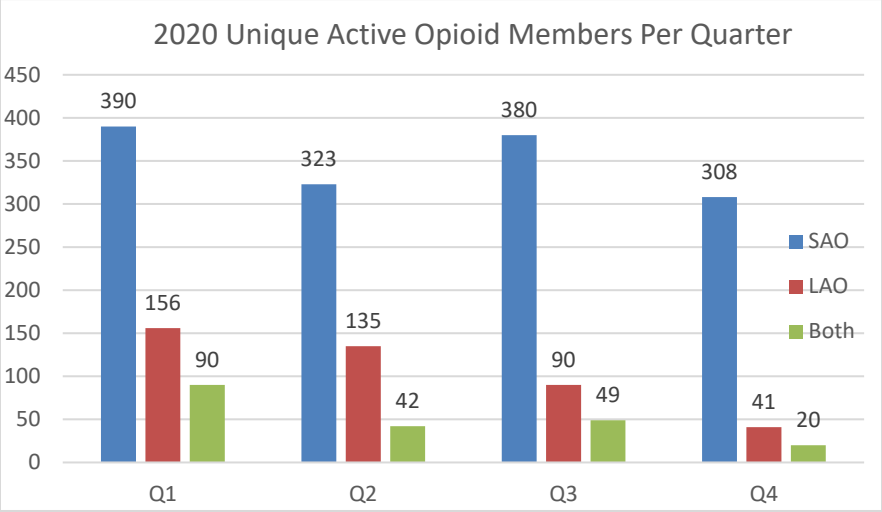
- PA: Prior Authorization
- LAO: Long Acting Opioid
- SAO: Short Acting Opioid

ACTION	ALLIANCE IMPLEMENTATION DATE				
Opioid Program Start		12/2017	06/2018	10/2019	01/2020
"New Start" SAO Limit	None	None	None	None	14
SAO QL per month	180	#180/30	#180/30	#90/30	#90/30
SAO Limited by	Drug	Drug	Drug	Total	Total
PA for all LAOs	No	Yes	Yes	Yes	Yes
LAO Increase limit	No	Yes	Yes	Yes	Yes
Cover Alprazolam	Yes	Yes	No	No	No
Cover Carisoprodol	Yes	Yes	No	No	No
Diazepam Limits	3/day	3/day	3/day	3/day	3/day
Lorazepam Limits	No	4/day	4/day	4/day	4/day
Clonazepam Limits	No	3/day	3/day	3/day	3/day

Below is a table that lists the number of members on short acting opioids (SAO) only, long acting opioids (LAO) only, and both short and long acting opioids in 2020. Short and long acting opioids had a general decrease in utilization and increase SAO utilization from Q2 to Q3 with a 17.6% (323 to 380 members).

Table 14: Members on SAO, LAO, and Both SAO and LAO for 2020

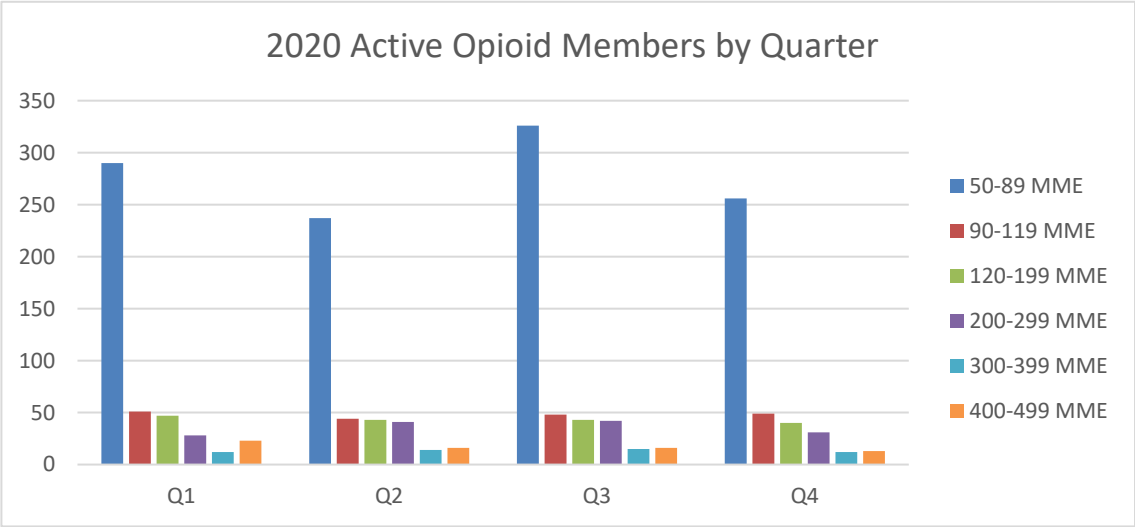
YEAR	SAO	LAO	BOTH
Q1	390	156	90
Q2	323	135	42
Q3	380	90	49
Q4	308	41	20



Below is a table that lists the number of members on greater than 50 MME opioids. Within 2020, this table shows a 13.2% (290 to 256 members from Q1 to Q4) decrease in members utilizing 50-89 MME, 4.1% (51 to 49 members) decrease in members utilizing 90-119 MME, 17.5% (47 to 40 members) decrease in members utilizing 120-199 MME, 133% (28 to 12 members) decrease in members utilizing 200-299 MME, no change for member utilizing 300-399 MME, and a 76.9% (23 to 13 members) decrease in members utilizing greater than 400 MME. There was also an increase in utilization from Q2 to Q3 for 50-89 MME and 90-119 MME.

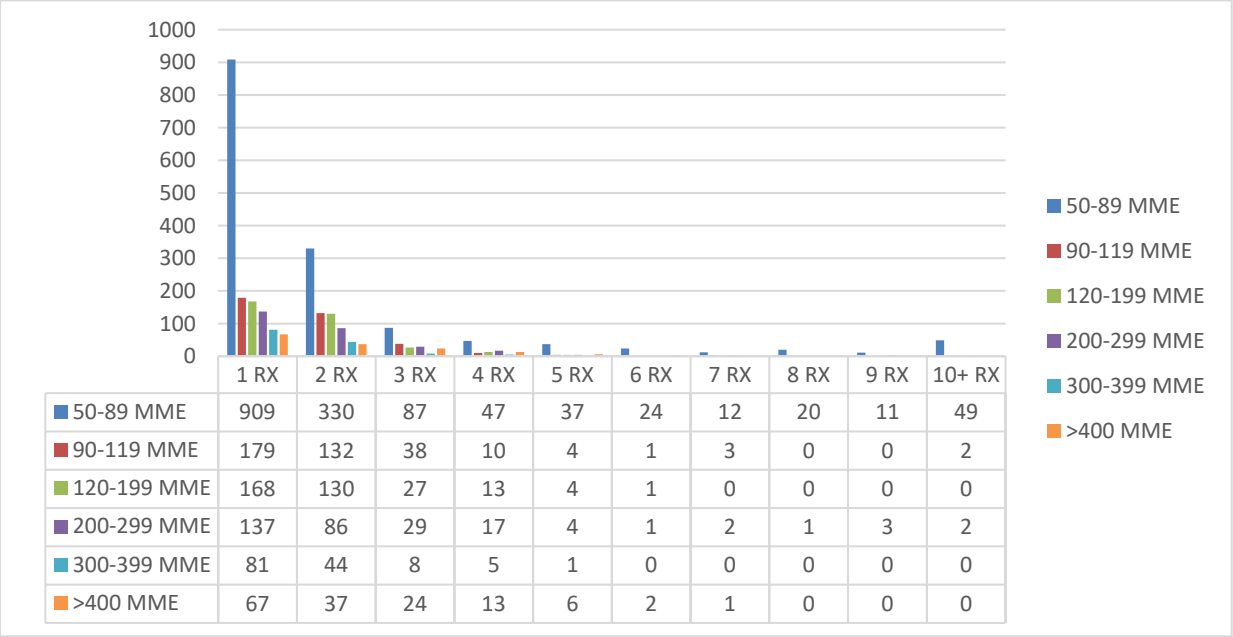
Table 15: Members per quarter on >50MME

MME (MORPHINE MILLIGRAM EQUIVALENTS)						
Month	**50-89**	**90-119**	**120-199**	**200-299**	**300-399**	**>400**
Q1	290	51	47	28	12	23
Q2	237	44	43	14	14	16
Q3	326	48	43	15	15	16
Q4	256	49	40	12	12	13



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 2020, 81 providers each wrote 1 prescription for 300-399 MME and 67 providers each wrote 1 prescription greater than 400 MME. In addition, 1 provider wrote 7 prescriptions greater than 400 MME.

Table 16: Frequency of provider opioid prescription count by MME



	1 RX	2 RX	3 RX	4 RX	5 RX	6 RX	7 RX	8 RX	9 RX	10+ RX
50-89 MME	909	330	87	47	37	24	12	20	11	49
90-119 MME	179	132	38	10	4	1	3	0	0	2
120-199 MME	168	130	27	13	4	1	0	0	0	0
200-299 MME	137	86	29	17	4	1	2	1	3	2
300-399 MME	81	44	8	5	1	0	0	0	0	0
>400 MME	67	37	24	13	6	2	1	0	0	0

Drug Recalls

The Pharmacy Department monitors all drug recalls. In 2020, pharmacy recall information is as below:

Table 17: 2020 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	21

In 2020, there were 78 recalls. Recalls were monitored for adversely affected members. The number of notifications where the PBM completed a claims data review were 21.

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.

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 an actual quality issues exists. PQI cases are classified as, **Quality of Access (QOA)**, **Quality of Care (QOC),** or **Quality of Service (QOS) Issues**. The Alliance QI Department investigates all PQIs referred as outlined in policy QI-104, Potential Quality Issues. PQIs may be submitted by members, practitioners, or internal staff. 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 closed by the review nurse. The QI Medical Director reviews all QOC cases, in addition to, any QOA or QOS case where the Quality Review Nurse 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).

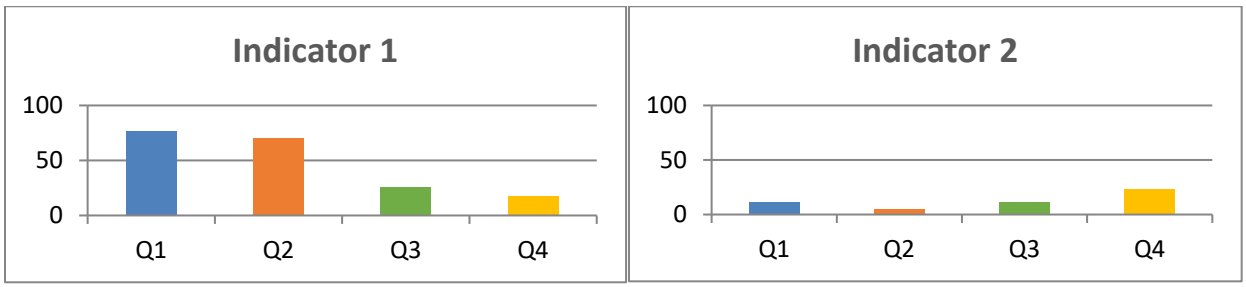
Table 18: Quality of Care (QOC) Issue Severity Level

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

Alameda Alliance for Health's Quality Department received 1,343 Potential Quality Issues (PQIs), during measurement year 2020, which is a 17.42% increase from 2019. Of the 1,343 PQIs received in 2020, 31.79%, or 427, of the PQIs were classified as a QOC. The quarterly frequencies are listed below:

Table 19: 2020 PQI Quarterly Frequencies

INDICATOR	Q1	Q2	Q3	Q4
Indicator 1: QOC PQIs	Denominator: **166** Numerator: **127** Rate: **76.51%**	Denominator: **137** Num: **97** Rate: **70.80%**	Denominator: **333** Numerator: **86** Rate: **25.82%**	Denominator: **707** Numerator: **117** Rate: 17.65%
Indicator 2: QOC PQIs leveled at severity C2-4	Denominator: **127** Numerator: **14** Rate: **11.02%**	Denominator: **97** Num: **5** Rate: **5.15%**	Denominator: **86** Numerator: **10** Rate: **11.63%**	Denominator: **117** Numerator: **28** Rate: **23.93%**



In 2020, the QI team continued its PQI PDSA (Plan-Do-Study-Act) improvement process.

In PDSA cycle 1, the QI Review Nurse Supervisor continued to conduct Exempt Grievances case audits via random sampling, to ensure that PQIs are not missed. QI Department management continues to provide oversight of exempt and standard grievances, reviews and investigates *clinical* referrals internal and external to the organization, and ensures that services and access related PQIs are addressed through vendor management and compliance oversight, and other existing channels.

PDSA cycle 2, addressed the technological support and improvement of the PQI application for the QI team. From 2017 through 2019, the team heavily relied on Microsoft Excel for tracking PQIs. In 2019, the QI Department began to collaborate with the IT department to develop a PQI application. In January of 2020, Quality Suite, an internally built PQI application was launched. The new PQI application is a more robust and responsive system allowing for improved reporting, documentation, tracking, and adjudication of PQIs.

PDSA cycle 3 began in August of 2020 the QI Department saw a dramatic increase of QOA referrals from Member Services and Grievance and Appeals due to a change in process to capture the depth and breadth of Access to Care complaints for PDSA performance improvement.

A full description of the PQI process is available 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 20: Inter-rater Reliability (IRR) 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 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 2020, 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. Mid-cycle, 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.

In March 3, 2020, DHCS issued All Plan Letter (APL) 20-006 Site Reviews: Facility Site Review and Medical Record Review. This outlines the revised FSR and MRR tools and standards which take effect on July 1,2020.

In April 24,2020, 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. DHCS encourages plans to explore alternatives to in-person site review and consider extensions to outstanding CAPs if alternatives to onsite verification are not feasible. In June 12, 2020, APL 20-011 was revised suspending requirements in APL 20-006 during COVID-19 pandemic and for an additional six months following the end of public health emergency.

In 2020, there were 74 site reviews. The total number and types of audits are detailed in the table below.

Table 21: 2020 Facility Site Reviews

TYPE	Q1	Q2	Q3	Q4	TOTAL
FSR/MRR: Full Scope	7	0	0	0	**7**
Initial FSR	1	0	2	3	**6**
Initial MRR	1	0	0	0	**1**
Initial FSR/MRR	0	0	0	0	**0**
MRR: Follow Up	1	0	0	0	**1**
FSR/MRR: Mid-cycle	3	0	0	0	**3**
FSR: Mid-cycle	1	0	0	0	**1**
Interim Monitoring	0	29	21	5	**55**
Periodic Annual	0	0	0	0	**0**
Periodic FSR	0	0	0	0	**0**
Periodic MRR	0	0	0	0	**0**
Total Reviews	14	29	23	8	74

In Q2, no onsite reviews were conducted due to COVID-10 pandemic. Interim Monitoring (IM), a provider self-assessment fax back form with required documented evidence that serves as an alternate to onsite review, includes, at a minimum, review of DHCS FSR critical elements. In 2020, a total of 55 IMs were issued. Two IM from 2020 remain open. In Q3 and Q4, five (5) initial site reviews were conducted for new providers and network provider site relocation. The virtual reviews were conducted via Webex.

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. All CAPs were compliant in Q1 and Q2. There were 2 CAPs in Q3 and 3 CAPs in Q4. Alliance allowed extension on CAP submission due to reduce office hours and staffing during public health emergency according to APL 20-011. CAP timeliness was not reported for Q3 and Q4. FSR staff continued to work with providers in getting CAP submission.

Table 22: Compliant and non-compliant FSR/MRR CAPs received in 2020

TYPE	Q1	Q2	Q3	Q4	TOTAL
Compliant CAPs (received within 45 calendar days)	9	1	not reported	not reported	**10**
Non-Compliant CAPs	9	0	not reported	not reported	**0**
Total CAPs Issued	**9**	**1**	**N/A**	**N/A**	**10**

In 2020, all CAPs were closed within 120 days of site review.

CAPs closed within 120 days of FSR in 2020

TYPE	Q1	Q2	Q3	Q4	TOTAL
CAPs closed within 120 days	9	1	2	3	**15**
CAPs not closed within 120 days	0	0	0	0	**0**
Total CAPs Issued	**9**	**1**	**2**	**3**	**15**

Per DHCS regulation, failed periodic reviews are reported to bi-annually. In 2020, the Alliance had no provider with non-passing scores below 80%.

Table 23: 2020 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	N/A	N/A	N/A

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.

In 2020, medical records at 11 sites were reviewed for the presence of an IHA. Table lists the results of these reviews. In April 24,2020, 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. DHCS encouraged plans to explore alternatives to in-person site review. There were no MRR conducted in Q2 to Q4 due to public health emergency. The compliance rate goal of 30% was exceeded in all Q1 audits. The 4 total non-compliant providers received re-education/training on IHA and IHEBA compliance.

Table 24: 2020 MRR Results

TYPE	Q1	Q2	Q3	Q4	TOTAL
# of MRRs with Compliant* IHAs	7 (64%)	N/A	N/A	N/A	7
# of MRRs with Non-Compliant IHAs (CAPs)	4	N/A	N/A	N/A	4
Total IHAs Audited via FSR	11	0	0	0	11

*Compliant = Per DHCS CAP guidelines, no CAP issued if MRR score is 90% or greater and 80% or greater on Pediatric/Adult Preventive section.

Peer Review and Credentialing Committee (PRCC)

In 2020, 33 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 was no site reviews conducted based on complaints in 2020. All grievances, complaints, and PQIs that required investigation were forwarded to this committee for review. In 2020, 54 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 2020, the PRCC granted one 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 25: Count of Practitioners Reviewed for Quality Issues at PRCC in 2020

PRCC DATE	PRC	NPDB	ATTESTATION	MALPRACTICE (PENDING/DISMISSED)	FSR	GRIEVANCE, COMPLIANTS, PQI	LICENSE ACTION	BOARD CERTIFICATION CAP	CAP	TOTAL
Jan		2				3		3	2	10
Feb		1		4		8			5	18
Mar						6		2	3	11
Apr		2		1		4	1		3	11
May						6		2	1	9
Jun						2		1	5	8
Jul	1		1			4		2	2	10
Aug No Committee Meeting										0
Sep		2				6		1	3	12
Oct		2		2				8		12
Nov	1					3		11		15
Dec				1		10		3	4	18
Total	**2**	**9**	**1**	**8**	**0**	**52**	**1**	**33**	**28**	**134**

Delegation Oversight

The Alliance conducts quarterly and annual delegation oversight in compliance with California Department of Health Care Services (DHCS), the California Department of Managed Health Care

(DMHC), and the National Committee for Quality Assurance (NCQA) regulations. Annual delegation oversight reviews were conducted in 2020.

Results from the 2020 reviews were reported to the Compliance Committee and/or Delegation Oversight Committee. The QI delegation audit results were also reported to the HCQC.

In addition to the annual oversight audits, the Alliance held quarterly Joint Operations Meetings with delegates. Additionally, the Alliance held regular Executive Team meetings with Community Health Center Network (CHCN) and Alameda Health Systems Leadership. The Alliance, as well as, the delegate contribute to the meeting agenda. The standard Leadership meeting agenda includes but, is not limited to, the following topics with updates: claims adjudication, information technology, provider relations, member services, quality activities concerns and progress, in addition to new and/or revised legislation, or DMHC, DHCS regulations. Weekly or biweekly Alliance and delegate calls were held to improve communication and information flow, provide bi-directional updates, and resolve any immediate mutual concerns. The Alliance places a high degree of importance on problem solving and communicating with delegates.

In 2020, the Alliance conducted Joint Operations Meetings (JOM) with the delegated groups to review their individual Access and Timely of Care survey results, in addition to, HEDIS rate performance specific to their group to identify opportunities for improvement, strategies for improvement of scores, and HEDIS timelines for reporting year 2020.

The following delegated groups were audited in 2020:

Table 26: 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	
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			X	X		
California Home Medical Equipment (CHME)			X	X														
Kaiser	X		X		X		X		X		X		X		X		X	
UCSF					X	X												

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
Physical Therapy PN					X	X												
Lucille Packard					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. 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 Population Health Program will be 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.

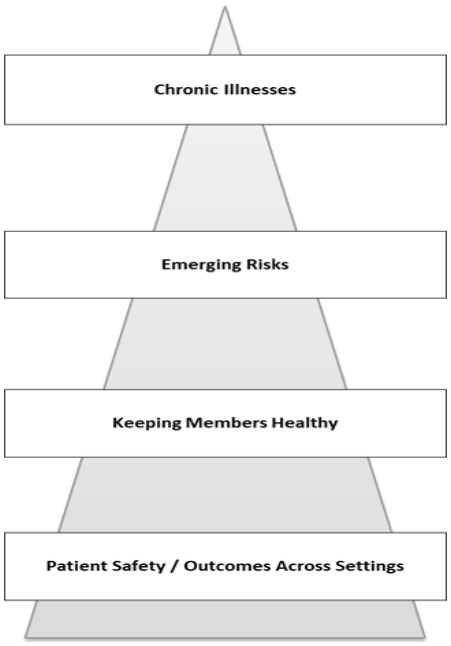
The framework of this strategy is designed to address the four focus areas of population health, as outlined by NCQA, while using Department of Health Care Services (DHCS) / Department of Managed Health Care (DMHC) required methods.

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



At least annually, the Alliance conducts a comprehensive analysis of the impact of its PHM strategy that includes the following: Quantitative results for relevant clinical/cost, utilization, and experience measures. Quantitative and qualitative analysis is conducted on the results. Comparison of results with established benchmarks are evaluated for evidence of program effectiveness and room for improvement. This analysis will be conducted by the Health Services Department in conjunction with Analytics, Member Services, Provider Services, Pharmacy, Quality, and Grievance & Appeals to support the Alliance's members and promote an effective Population Health Management Strategy. Additional information regarding the Plan's Population Health Strategy can be found in the Population Health Management Strategy Document.

Quality Improvement Projects

HEDIS Measure CDC: Improve the rate of HbA1c Testing in African American Men.

The Plan intended to adapt its pervious Quality Improvement Project and partner with additional providers during 2020. However, due to the pandemic providers were not willing to partner with the Plan on this initiative. In 2021, the Plan intends to revisit this initiative to improve the HbA1c testing in its African American diabetic male population.

HEDIS Measure AWC: Increase the Alameda Alliance overall rate of Adolescent Access to Primary Care

The Plan adapted its previous Quality Improvement Project and partnered with nine providers during 2020, to increase utilization of preventive care services for members 12-21 years of age

by offering a member incentive. A total of 441 gift cards were given to members between the ages of 12-21 at the completion of their well-child exam. The Plan recognizes that this is a challenging age group to engage to obtain preventive care services. The Plan intends to continue to adapt this strategy in 2021 to continue to improve the compliance rate for this age group.

Increasing rates of Tdap vaccines in pregnant women in the third trimester

The intent during 2020 was to expand the project to additional provider locations however, on February 20,2020, the Plan was notified that Alameda County Public Health Department had to shift its focus to COVID-19 activities. Additionally, on September 8, 2020, the principle project manager that the Plan worked with on the Tdap project accepted a temporary assignment with California's COVID-19 vaccine implementation project. As a result, the Plan is in the process of reevaluating this project and intends to revisit it in 2021.

Improve Compliance Rate for the African American Pediatric Population for W15 – DHCS Equity PIP

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." Additionally, this report confirms utilization rates for children in Medi-Cal have remained below 50 percent. As a result, Alameda Alliance for Health (Alliance), has decided to focus on increasing pediatric access through its Pediatric Care Coordination Pilot. 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 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.

During the development of the Pediatric Care Coordination Pilot, the Alliance identified that during 2018, only 45.92% of children who turned 15 months old received 6 or more well-child visits (W15). The Plan's performance rate for the W15 HEDIS measure is 20.31% below the 50th percentile.

During further analysis, the Alliance identified a disparity in access for Well-Child visits for the Plan's African American infant population compared to other ethnicities. For example, in 2018, 55.66% of the Plan's Chinese infant population received 6 or more Well-Child visits during the measurement year compared to 33.33% of the African American infant population. As a result, the Plan developed the following goal that by June 30, 2021, the percentage rate of 6 Well-Child visits within the first 15 months of life among African American infants, increase from 33.33% to 42.10%. However, on June 22, 2020, the Plan was notified by DHCS that due to COVID-19 public health crisis that the current PIP topic ended on June 30, 2020.

Improve Compliance Rate for Members Assigned to 5 Direct Providers for W34 – DHCS Priority PIP

The intervention will be focused on the HEDIS measure: W34 -- the percentage of members 3–6 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, important vaccinations and medications, as well as help answer any health-related questions patients and their families may have.

In the past two measurement years, MY2017 and MY2018, Alameda Alliance for Health (AAH)'s W34 hybrid rate was 79.27% and 73.84% respectively. In an effort to improve this rate and at the request of DHCS, AAH will conduct a W34 PIP.

W34 admin rates for direct providers within the AAH network will be the narrowed focus of this PIP. The MY2018 admin rate for AAH was 75.55% and for directs, it was 61.02%.

After looking at AAH MY2018 W34 admin data, we established a threshold to identify providers with patient panels greater than 60 and a compliance rate less than 70% to incorporate into this PIP. Based on this threshold, we identified the five providers. These five providers have the largest patient panels and the top five largest non-compliant populations in comparison to the rest of the AAH direct providers.

Specifically, the target population for this initiative will be members ages 3-6 assigned to five direct AAH providers:

1. Rhodora De La Cruz MD,
2. Susana Nolasco MD,
3. Merlin Tungol Venzon MD,
4. Washington Township Medical Foundation,
5. Ebrahim Ahmadi MD

As an initiative starting in 2019, AAH along with its providers are dedicated to access to care for children. The W34 measure specifically promotes the use of well-child visits for members between 3-6 years old. It has the potential to improve member health status and satisfaction by promoting preventative care including physical exams and vaccines. The W34 MY2018 admin rates for direct AAH providers demonstrate there is underutilization of preventative care among members 3-6 years old, and AAH will work to improve the rate for this measure.

Table 27: W34 Admin Rate per Direct AAH Provider for MY2018

Direct AAH Provider Name	False (Non-compliant)		True (Compliant)		Grand Total
	Number of Members	Percentage	Number of Members	Percentage	
Alameda Family Physician Medical Group, Inc.	2	50.00%	2	50.00%	4
California Cardiovascular Consultants	2	33.33%	4	66.67%	6
Castro Valley Pediatrics		0.00%	1	100.00%	1
Cuong Tat Vu, MD, Inc.	1	100.00%		0.00%	1
Davis Street Primary Care Clinic	15	34.09%	29	65.91%	44
De Hieu Le, MD	1	100.00%		0.00%	1
De La Cruz, Rhodora Cruz., MD	**79**	**32.64%**	**163**	**67.36%**	**242**
East Bay Pediatric Primary Care, Inc.	10	15.15%	56	84.85%	66
Ebrahim Ahmadi, M.D.	**30**	**48.39%**	**32**	**51.61%**	**62**
Express Medicine Urgent Care	1	100.00%		0.00%	1
Family Medicine Oakland	11	36.67%	19	63.33%	30
Ho Chao MD		0.00%	1	100.00%	1
Integrated Medical Associates	3	100.00%		0.00%	3
John Muir Health - Berkeley Center		0.00%	2	100.00%	2
La Loma Medical Group, Inc.	7	58.33%	5	41.67%	12
Lim, Mabel A., MD	5	83.33%	1	16.67%	6
Massen Medical, Inc.	5	100.00%		0.00%	5
Mintz Medical Corporation	1	100.00%		0.00%	1
Mission Primary Care	9	75.00%	3	25.00%	12
MOWRY MEDICAL GROUP, Inc.	1	100.00%		0.00%	1
Nolasco-Alonzo, Susana S., MD	**71**	**30.87%**	**159**	**69.13%**	**230**
Pacific Cardiology Associates	10	55.56%	8	44.44%	18

Direct AAH Provider Name	False (Non-compliant)		True (Compliant)		Grand Total
	Number of Members	Percentage	Number of Members	Percentage	
Phuong Duc Dang, MD	1	100.00%		0.00%	1
Piedmont Primary Care		0.00%	2	100.00%	2
Reen, Ranjit K., MD	1	100.00%		0.00%	1
Roots Community Health Center	22	73.33%	8	26.67%	30
Venzon, Merlin Tungol., MD	**70**	**43.75%**	**90**	**56.25%**	**160**
Washington Township Medical Foundation	**122**	**42.07%**	**168**	**57.93%**	**290**
West Coast Medicine and Cardiology, Inc.	1	100.00%		0.00%	1
Grand Total	481	38.98%	753	61.02%	1234

Table 28: W34 Admin Rate per Identified Direct AAH Provider for MY2018

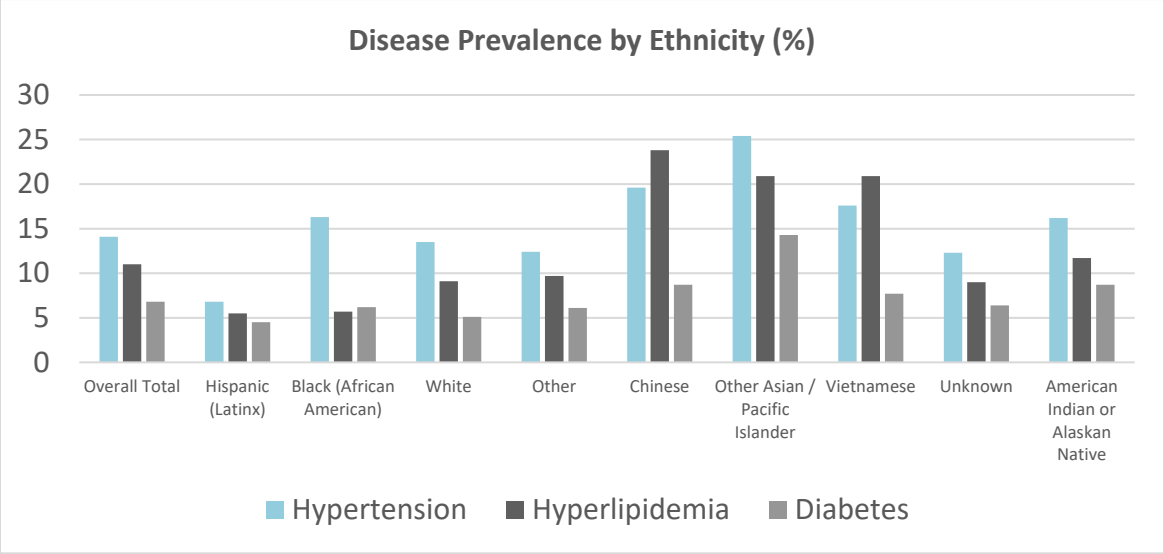
PCP Clinic	False (Non-compliant)		True (Compliant)		Grand Total
	Number of Members	Percentage	Number of Members	Percentage	
De La Cruz, Rhodora Cruz., MD	79	32.64%	163	67.36%	242
Ebrahim Ahmadi, M.D.	30	48.39%	32	51.61%	62
Nolasco-Alonzo, Susana S., MD	71	30.87%	159	69.13%	230
Venzon, Merlin Tungol., MD	70	43.75%	90	56.25%	160
Washington Township Medical Foundation	122	42.07%	168	57.93%	290
Total	**372**	**37.80%**	**612**	**62.20%**	**984**

As a result, the Plan developed the following goal that by June 30, 2021, increase the overall W34 admin rate from 62.20% to 66.46% for the group of five identified providers: (1) Rhodora De La Cruz MD, (2) Susana Nolasco MD, (3) Merlin Tungol Venzon MD, (4) Washington Township Medical Foundation, and (5) Ebrahim Ahmadi MD. However, on June 22, 2020, the Plan was notified by DHCS that due to COVID-19 public health crisis that the current PIP topic ended on June 30, 2020

Asian Health Services – BP Cuff Pilot

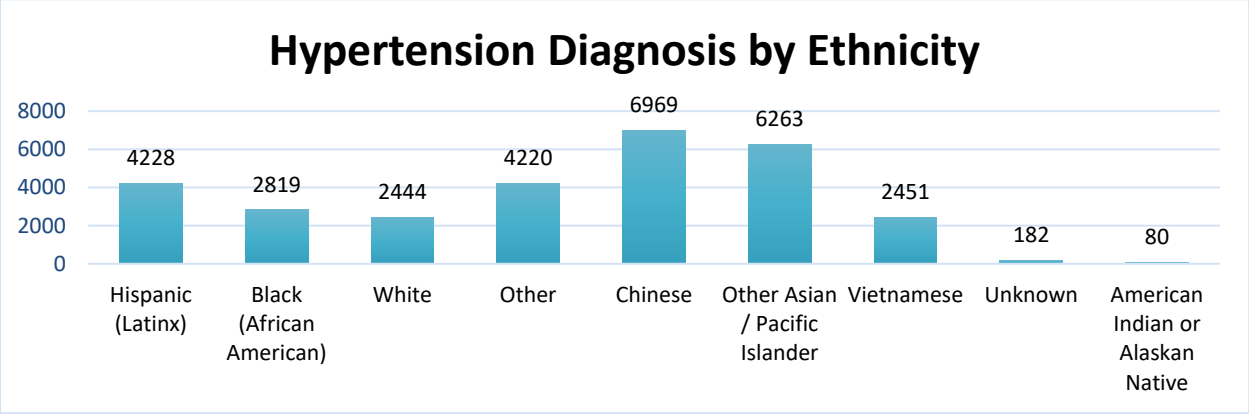
Through review of the Plan's Population Health data, it identified that Asian and Pacific Islander members were disproportionately affected by hypertension. Other Asian/Pacific Islander ethnic group had 80% greater prevalence of hypertension, 90% of hyperlipidemia, and 109% of diabetes than the total population. Chinese and Vietnamese ethnicities also had greater prevalence of these diseases. The Chinese ethnic group had the highest prevalence for hyperlipidemia (116% greater). This is a disparity focused initiative.]

Table 29:Disease Prevalence by Ethnicity (%)



The Alliance identified that hypertension has the highest prevalence in its Asian population. Through the review of the data, 15,683 Asian members were identified as being hypertensive. As a result, the Quality Improvement Department developed a quality improvement project to help improve at home BP monitoring of 150 Asian members assigned to Asian Health Services by offering a blood pressure cuff.

Table 30: Hypertension Diagnosis by Ethnicity



As a result, the Plan developed a pilot strategy to reach 150 Asian members with hypertension assigned to Asian Health Services was developed. The initial goal was to have the 150 members selected to participate in this project to have a controlled BP of <140/90 by December 31, 2020

In September, the pilot was initiated to improve BP control of 100 Asian members diagnosed with hypertension by providing digital BP cuffs for at home monitoring. The Plan partnered with Asian Health Services, which developed a scalable and sustainable workflow that allows the clinical team to identified Asian members who are hypertensive and have uncontrolled blood pressure and do not have an at home monitor. 54% of the members who participated in the pilot had their BP controlled by the last 2020 reading compared to 46% who had no change in compliance.

Improving Initial Health Assessment (IHA) Rates

The past 1 year of IHA rates is outlined below.

Table 31: 2019 IHA Rates

Q1 2019	Q2 2019	Q3 2019	Q4 2019
Denominator: 13,501 Numerator: 5,438 Rate: 40.28% Goal: 30% Gap to goal: Goal Met	Denominator: 13,714 Numerator: 5,444 Rate: 39.70% Goal:30% Gap to goal: Goal Met	Denominator:13,688 Numerator: 5,437 Rate: 30.72% Goal: 30% Gap to goal: Goal Met	Denominator: 12,647 Numerator: 4,626 Rate: 36.58% Goal: 30% Gap to goal: Goal Met

On average, an IHA is completed for 39.2% of new members (1/1/19 – 12/31/19); the table below identifies IHA completion rates by network.

Table 32: IHA Completion Rates among New Enrollees

Network	New Enrollees	With IHA Completed	IHA Compliant Rate
AHS	15,139	5,660	**37.4%**
ALLIANCE Excl. AHS	9,042	4,728	**52.3%**
CFMG	8,234	4,727	**57.4%**
CHCN	15,020	8,570	**57.1%**
KAISER	6,679	3,639	**54.4%**
ALL NETWORK	**54,114**	**27,324**	**50.5%**

In an effort 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, provider handbook, and P4P program
- Improve data sharing – by sharing gaps in care lists with our delegates and providers
- Incentivize IHA completion rates – by including IHA completion rates as an incentivized program
- Update claims codes – to ensure proper capture of IHA completion
- 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 2021.

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 2020, 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
- Pilot Program

The HCS strategy proposed leveraging “whole child wellness” integration through:

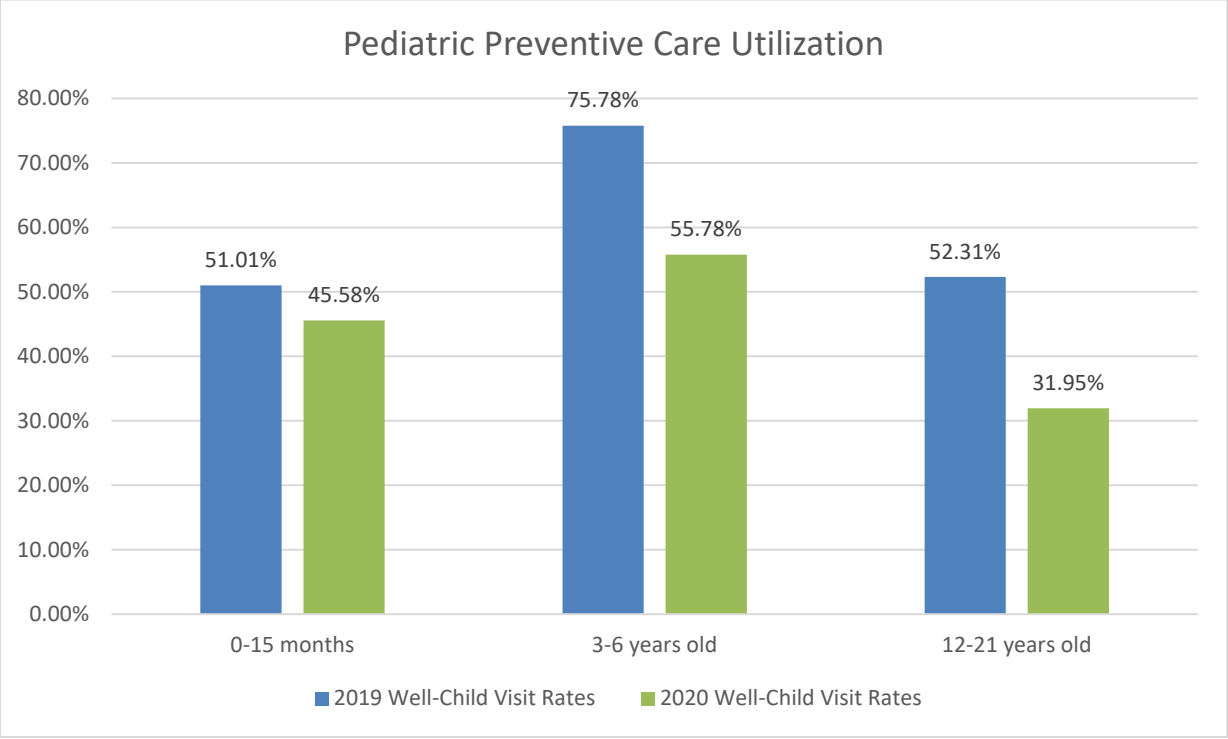
- Improved screening and referrals as part of Medi-Cal Early and Periodic Screening, and Diagnostic and Treatment (EPSDT) supplement benefit
- Reporting via data segmentation and visualization
- Member and provider incentives
- Community based program funding
- Provider P4P
- Health Education engagement
- QI Initiatives
- DHCS Performance Improvement Initiatives
- The Alliance collaborated with external stakeholder’s key to the success of this pediatric pilot
- Direct Providers
- Delegates

  - Alameda Health Services (8K Pediatric Members)
  - Children's First Medical Group (29K Pediatric Members)
  - 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 33: Pediatric Preventive Care Utilization



Based on the underutilization of preventive care service es, the Plan has 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

- W30 – Well-Child Visits in the first 30 months of life

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.

Table 34:: Medicaid Administrative HEDIS Rates

NCQA Acronym	Current Rate Method	Accred - MCAS - Both	Measure	Admin Final 2019	Admin Final 2020	Current Hybrid
CCS	H	Both	Cervical Cancer Screening	62.86%	58.32%	60.68%
CIS	H	Both	Combo 10	41.81%	46.81%	57.91%
CDC	H	MCAS	HbA1c Poor Control (>9.0%)	42.83%	42.87%	41.46%
CBP	H	Both	Controlling High Blood Pressure	22.49%	25.57%	51.34%
IMA	H	Both	Combination 2	50.51%	50.04%	51.09%
PPC	H	Both	Timeliness of Prenatal Care	76.47%	86.91%	92.01%
PPC	H	Both	Postpartum Care	77.75%	78.95%	83.68%
WCC	H	Both	BMI Percentile	37.66%	34.89%	70.83%
WCC	H	MCAS	Counseling for Nutrition	32.97%	35.09%	70.83%
WCC	H	MCAS	Counseling for Physical Activity	33.98%	33.23%	67.50%
AMM	A	Both	Effective Acute Phase Treatment	69.74%	72.83%	
AMM	A	MCAS	Effective Continuation Phase Treatment	54.94%	56.40%	
AMR	A	Both	Asthma Medication Ratio	59.93%	68.24%	
APM	A	Both	Metabolic Monitoring for Children and Adolescents on Antipsychotics Blood Glucose	67.86%	57.59%	
APM	A	Both	Metabolic Monitoring for Children and Adolescents on Antipsychotics Cholesterol	52.98%	36.65%	
APM	A	Both	Metabolic Monitoring for Children and Adolescents on Antipsychotics Blood Glocose and Cholesterol	52.38%	36.65%	
BCS	A	Both	Breast Cancer Screening	62.82%	56.19%	
CHL	A	Both	Chlamydia Screening in Women - Total	59.34%	59.09%	
SSD	A	Both	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.10%	76.29%	
WCV	A	MCAS	Child and Adolescent Well-Care Visit	0.00%	39.47%	
W30	A	MCAS	Well Child Visits in the First 15 Months	0.00%	45.64%	
W30	A	MCAS	Well Child Visits for age 15 Months- 30 Months	0.00%	69.34%	

Analysis Of HEDIS MEDICAID Managed Care Accountability Set (MCAS)

The above tables represent the Medicaid HEDIS measures for the DHCS' Managed Care Accountability Set. Of the trended measures (including individual sub measures), 12/19 measures met the Minimum Performance Level (MPL). The decline in HEDIS performance can be attributed to the decrease in members seeking services and the Plan's ability to obtain medical records during the pandemic.

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 2021 may include the following:

- BCS – Breast Cancer Screening
- CCS – Cervical Cancer Screening
- CDC – Comprehensive Diabetic Care
- CBP – Controlling High Blood Pressure
- WCC – BMI Percentile
- WCC – Counseling for Nutrition
- WCV – Well-Child Visits

Health Plan Accreditation

In September 2019, Alameda Alliance participated in the triennial reaccreditation survey for Health Plan Accreditation (HPA) sponsored by NCQA. NCQA HPA is a voluntary recognition program consisting of a triennial desktop review of program materials, policies and procedures and on-site file review. The standards evaluate Quality Improvement, Population Health Management, Network Management, Utilization Management, Credentialing, Rights and Responsibilities, and Member Connections. Annually, the score and award are reevaluated based on the fixed survey standards score and an annual reevaluation of audited HEDIS and CAHPS scores. NCQA grants the following decisions: Excellent (90-100 points), Commendable (80-89.99 points), Accredited (65-79.99 points), Provisional (55-64.99 points), and Denied (less than 54.99 points).

Table 35: Medicaid NCQA Accreditation Status Award

With a combined score of 86.14, Medicaid earned "Commendable" status, 48.99 Standards score, and 37.14 HEDIS + CAHPS score. Received CAP 2020 resurveyed 2/2021 on element UM 7B and passed with 100%.

Table 36: Group Care NCQA Accreditation Status Award

With a combined score of 41.66 for Standards, GroupCare earned "Accredited" status for the next year. The Alliance will have a resurvey in June 2020 to review elements that did not pass 80%, we will need a score of 42.5 for Standards to obtain our accredited status for 3 years. For GroupCare we also did not receive a passing score for the must pass element UM 7B. Resurvey of this element will also be conducted in June 2020. Received CAP 2020 resurveyed 2/2021 on element UM 7B and passed with 100%.

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 5.0 survey. 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 12/31/2020, the Alliance had a total of 275,589 members.

The breakdown of member enrollment by network is as follows:

- Alameda Health Systems (AHS) 20%
- Alliance 19%
- Community Health Center Network (CHCN) 36%
- Children First Medical Group (CFMG) 11%, Kaiser 14%

Table 37: Survey Response Rates by Line of Business

	Medi-Cal Adult	Medi-Cal Child	Commercial Adult
2020	14.7%	16.5%	23.5%
2019	21.3%	21.3%	28.3%
2018	20.9%	24.3%	27.9%

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 5.0 mean summary ratings for the Medicaid and Commercial samples that were submitted to NCQA in 2019 that provides for an aggregate or national summary. In respect to the QCAP scores, Red signifies that the current year 2020 score is significantly lower than the 2019 score, the 2018 score or benchmark score. Green indicates that the current year 2020 score is significantly higher than the2019 score, the 2018 score, or benchmark score.

Table 38:Medi-Cal Child Trended Survey Results

Summary Rate Scores: Medi-Cal Child				
Composite	**2020**	**Previous Year Comparison**	**2019**	**2018**
Getting Needed Care	81.0%	↓	83.5%	81.9%

Summary Rate Scores: Medi-Cal Child				
Composite	**2020**	**Previous Year Comparison**	**2019**	**2018**
Getting Care Quickly	82.0%	↓	85.4%	82.8%
How Well Doctors Communicate	92.7%	↓	93.7%	91.6%
Customer Service	84.0%	↓	86.1%	84.6%
Shared Decision Making	Removed from survey	N/A	78.4%	75.3%
Rating of Health Care (8-10)	87.3%	↓	89.8%	85.9%
Rating of Personal Doctor (8-10)	91.2%	↓	93.6%	89.6%
Rating of Specialist (8-10)	90.6%	↑	85.5%	86.3%
Rating of Health Plan (8-10)	87.5%	↓	88.9%	88.3%

Table 39:Medi-Cal Adult Trended Survey Results

Summary Rate Scores: Medi-Cal Adult				
Composite	**2020**	**Previous Year Comparison**	**2019**	**2018**
Getting Needed Care	82.6%	↑	76.0%	76.1%
Getting Care Quickly	71.7%	↓	74.5%	73.2%
How Well Doctors Communicate	95.7%	↑	88.4%	90.5%
Customer Service	88.8%	↑	80.7%	86.7%
Shared Decision Making	Removed from survey	N/A	78.7%	70.8%
Rating of Health Care (8-10)	75.4%	↑	73.6%	73.5%
Rating of Personal Doctor (8-10)	84.7%	↑	77.1%	80.3%
Rating of Specialist (8-10)	91.7%	↑	74.5%	77.8%
Rating of Health Plan (8-10)	78.4%	↑	73.4%	73.0%

Table 40:Commercial Adult Trended Survey Results

Summary Rate Scores: Commercial Adult				
Composite	**2020**	**Previous Year Comparison**	**2019**	**2018**
Getting Needed Care	65.6%	↓	72.8%	72.3%
Getting Care Quickly	68.7%	↓	70.9%	69.5%
How Well Doctors Communicate	90.0%	↑	87.6%	85.8%
Customer Service	80.3%	↓	82.8%	86.5%
Shared Decision Making	Removed from survey	N/A	84.3%	84.3%
Rating of Health Care (8-10)	66.1%	↓	68.2%	66.8%
Rating of Personal Doctor (8-10)	77.6%	↓	80.4%	73.3%
Rating of Specialist (8-10)	80.2%	↑	75.5%	75.9%
Rating of Health Plan (8-10)	68.5%	↑	64.5%	66.5%

Tables below contain trended survey results for the three (3) member populations and their delegate network compared to the Alliance.

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Table 41:Medi-Cal Child Trended Survey Results – Delegates

		AHS			Alliance			CFMG			CHCN			Kaiser 2019		
	2020 Plan Total	2020	2019	Year Over Year Trend	2020	2019	Year Over Year Trend	2020	2019	Year Over Year Trend	2020	2019	Year Over Year Trend	2020	2019	Year Over Year Trend
Total Respondents	**338**	**36**			**23**			**98**			**122**			**59**		
Getting Needed Care	**81.0%**	84.%	79.2%	↑	59.4	77.5%	↓	91.7%	82.6%	↑	73.7%	83.8%	↓	89.6	90.1%	↓
Getting Care Quickly	**82.0%**	77.1%	55.7%	↑	75.0	93.3%	↓	87.4%	89.3%	↓	74.4%	79.8%	↓	90.2	98.6%	↓
How Well Doctors Communicate	**92.7%**	90.1%	94.7%	↓	83.3	86.1%	↓	95.9%	93.8%	↑	90.3%	92.8%	↓	96.3	98.5%	↓
Rating of Health Care (8-10)	**87.3%**	94.1%	87.5%	↑	75.0%	100.0%	↓	95.0%	91.1%	↑	80.8%	87.0%	↓	89.5	93.9%	↓
Rating of Personal Doctor (8-10)	**91.2%**	100%	97.0%	↑	85.0%	100.0%	↓	96.2%	97.9%	↓	85.2%	88.1%	↓	90.7	94.7%	↓
Rating of Specialist (8-10)	**90.6%**	100%	75.0%	↑	80.0%	100.0%	↓	100%	91.3%	↑	84.2%	77.8%	↑	91.7	90.9%	↑
Rating of Health Plan (8-10)	**87.5%**	90.9%	97.2%	↓	76.2%	96.2%	↑	93.8%	88.8%	↑	79.7%	84.1%	↓	94.9	95.1%	↓

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Table 42:: Medi-Cal Adult Trended Survey Results – Delegates

		AHS			Alliance			CHCN				KAISER		
	2020 Total Plan	2020	2019	Year Over Year Trend	2020	2019	Year Over Year Trend	KAISER	2020	2019	Year Over Year Trend	2020	2019	Year Over Year Trend
Total Respondents	**193**	38			37				93			25		
Getting Needed Care	**82.6%**	88.3%	74.5%	↑	78.6%	81.9%	↓		82.7%	70.1%	↑	79.5%	90.0%	↓
Getting Care Quickly	**71.7%**	72.2%	69.5%	↑	79%	75.0%	↑		69.1%	75.2%	↓	70.3%	82.4%	↓
How Well Doctors Communicate	**95.7%**	98.1%	88.8%	↑	96.4%	82.9%	↑		95.3%	91.8%	↑	94.2%	93.2%	↑
Rating of Health Care (8-10)	**75.4%**	81.0%	67.6%	↑	95.8%	71.7%	↑		73.0%	75.6%	↓	80.0%	81.3%	↓
Rating of Personal Doctor (8-10)	**84.7%**	84.2%	70.6%	↑	73.9%	65.5%	↑		89.3%	85.9%	↑	79.2%	85.7%	↓

		AHS			Alliance			CHCN				KAISER		
	2020 Total Plan	2020	2019	Year Over Year Trend	2020	2019	Year Over Year Trend	KAISER	2020	2019	Year Over Year Trend	2020	2019	Year Over Year Trend
Rating of Specialist (8-10)	**91.7%**	90.9%	62.5%	↑	76.9%	67.9%	↑		93.8%	86.0%	↑	100%	63.6%	↑
Rating of Health Plan (8-10)	**78.4%**	80.0%	67.7%	↑	80.0%	71.0%	↑		78.0%	74.8%	↑	84.0%	91.6%	↓

Table 43: Commercial Adult Trended Survey Results – Delegated Network

		Alliance			CHCN			AHS		
	2020 Plan Total	2020	2019	Year Over Year Trend	2020	2019	Year Over Year Trend	2020	2019	Year Over Year Trend
Total Respondents	**241**	**90**			**121**			**30**		
Getting Needed Care	**65.6%**	59.8%	72.4%	↓	72.5%	71.8%	↑	52.8%	77.7%	↓
Getting Care Quickly	**68.7%**	63.5%	73.5%	↓	73.3%	71.2%	↑	68.9%	61.4%	↑
How Well Doctors Communicate	**90.0%**	86.9%	83.7%	↑	91.7%	90.8%	↑	93.5%	91.3%	↑
Rating of Health Care (8-10)	**66.1%**	62.5%	68.0%	↓	67.4%	65.6%	↑	75.0%	79.2%	↓
Rating of Personal Doctor (8-10)	**77.6%**	72.1%	73.2%	↓	81.9%	85.6%	↓	76.2%	88.9%	↓
Rating of Specialist (8-10)	**80.2%**	74.2%	70.0%	↑	89.4%	82.9%	↑	50%	81.8%	↓
Rating of Health Plan (8-10)	**68.5%**	66.3%	61.8%	↑	70.8%	67.5%	↑	65.5%	64.1%	↑

CAHPS Survey Analysis

The 2020 CAHPS survey results year-over-year trends show variation within the **Alliance** business lines. Across LOBs, the Medi-Cal Child population had the highest decrease 6 of seven measures, in composite summary rate scores in 2020. The Medi-Cal Adult population had the highest overall increase composite summary rate scores 6 of seven measures. Commercial Adult for the Alliance shows decrease in four (4) of seven measures.

Five (5) of the seven composite summary rate scores increased for **CFMG** for their Medi-Cal Child population in 2020. Six (6) of seven composite summary rate scores decrease for CHCN for their Medi-Cal Child population; however, five (5) of CHCN scores for their Medi-Cal Adult population increased and six (6) of seven composite scores increased for Commercial Adult .

Six out of seven composite summary rate scores decreased for **Kaiser** for their Medi-Cal Child population; five of seven composite rate scores for Adult Medi-Cal decreased, and four of the seven composite summary rate scores decreased for Commercial Adult.

AHS composite summary rate scores for their Medi-Cal Child population increased in five (5) of seven measures, while seven (7) of seven composite summary rate scores increased for their Medi-Cal Adult population and three (3) of seven measures increased for Commercial Adult.

Four of the seven composite summary rate scores decreased for their Commercial Adult population. Six out of seven composite summary rate scores increased for the Alliance network for their Medi-Cal Child population; however, six out of seven composite summary rate scores decreased for their Medi-Cal Adult population. Five of the seven composite summary rate scores increased for their Commercial Adult population.

Table 44: Composite Measures

Population	Top Measures	Bottom Measures
Medi-Cal Child	Rating of Specialist	Getting Needed Care
	Coordination of Care	Getting Care Quickly
	Rating of Health Plan	Customer Service
Medi-Cal Adult	How Well Doctors Communicate	Rating of Health Plan
	Rating of Health Care	Coordination of Care
	Rating of Specialist	Getting Care Quickly
Commercial Adult	Rating of Health Plan	How well Doctors Communicate
	Coordination of Care	Getting Care Quickly
	Rating of Personal Doctor	Rating of Specialist

Lastly, three composites - Rating of Health Plan, Rating of Health Care, and Rating of Personal Doctor – have been identified for all LOBs as key drivers of member satisfaction, as shown in the table below thus, providing opportunities for improvement.

Table 45: Composites and Key Drivers

Composite	Key Driver
Rating of Health Plan	Getting Quickly
	Getting Needed Care
Rating of Health Care	How Well Doctors Communicate
	Getting Needed Care
Rating of Personal Doctor	How Well Doctors Communicate
	Coordination of 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.

Quality Of Access

A. Standards and Provider Education

The Alliance has continued to educate providers on, monitor, and enforce the following standards**:**

Table 46:Primary Care Physician (PCP) Appointment

PRIMARY CARE PHYSICIAN (PCP) APPOINTMENT	
Appointment Type:	**Appointment Within:**
Non-Urgent Appointment	10 Business Days of Request
First OB/GYN Pre-natal Appointment	2 Weeks of Request
Urgent Appointment that *requires* PA	96 Hours of Request
Urgent Appointment that *does not* require PA	48 Hours of Request

Table 47: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
First OB/GYN Pre-natal Appointment	2 Weeks of Request
Urgent Appointment that *requires* PA	96 Hours of Request
Urgent Appointment that *does not* require PA	48 Hours of Request

Table 48: 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.

Table 49: Primary Care Physician (PCP) Appointment

PRIMARY CARE PHYSICIAN (PCP) APPOINTMENT	
Appointment Type:	**Measured By:**
Non-Urgent Appointment	PAAS, CG-CAHPS
First OB/GYN Pre-natal Appointment	First Prenatal, Confirmatory Survey
Urgent Appointment that *requires* PA	PAAS, CG-CAHPS
Urgent Appointment that *does not* require PA	PAAS, CG-CAHPS

Table 50: 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
First OB/GYN Pre-natal Appointment	First Prenatal, Confirmatory Survey
Urgent Appointment that *requires* PA	PAAS
Urgent Appointment that *does not* require PA	PAAS

Table 51: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 2020, the Alliance continued its cross functional quarterly meeting to review access issues and concerns.

In 2020, 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

The Alliance's annual Provider Appointment Availability Survey (PAAS) for MY2020 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 MY2020 in order 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 vast 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, Sacramento, San Francisco, Santa Clara, Solano, Marin, Madera, Monterey, San Mateo, Santa Cruz, and Sonoma.

Table 52:Compliance Rates by Appointment Type across All Provider Types

LOB	2019 Urgent Appt	2020 Urgent Appt	Routine Appt	Routine Appt
IHSS	65%	70%	72%	87%
MCL	68%	72%	75%	88%

Across all provider types, there was greater compliance with the routine appointment standard than with the urgent appointment standard, and this was evidenced for both LOBs – MCL and

IHSS for 2019 and 2020. When engaging in provider/delegate re-education around the timely access standards, the Alliance will 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 53:Overall Appointment Compliance Rates by Provider Type

LOB	Ancillary	PCPs	NPMH	Psychiatrists	Specialists
IHSS	94%	81%	85%	82%	63%
MCL	94%	87%	85%	84%	63%

In 2020 Ancillary Providers had the highest level of compliance for both LOBs across both appointment types (urgent appointment standard excluded for this provider type), followed by MCL PCPs, NPMH providers, and Psychiatrists, with Specialists having the lowest level of compliance for both LOBs. Results of the MY2019 PAAS also show Ancillary providers with the highest level of compliance, followed by PCPs, Psychiatrists, and NPMH providers, with Specialists again having the lowest level of compliance for both LOBs. When engaging in provider/delegate re-education around the timely access standards, the Alliance will increase its efforts on Specialists, given they had the lowest level of compliance across all provider types. This will be accomplished through targeted discussions with leadership staff during Joint Operations Meetings between the Alliance and its delegate leadership.

Table 54:Appointment Type by Provider Survey Type

Ancillary		
LOB	Urgent Appt	Routine Appt
IHSS	Not applicable	94%
MCL	Not applicable	94%

PCPs		
LOB	**Urgent Appt**	**Routine Appt**
IHSS	74%	88%
MCL	80%	93%
NPMH		
LOB	**Urgent Appt**	**Routine Appt**
IHSS	86%	84%
MCL	85%	84%
Psychiatrists		
LOB	**Urgent Appt**	**Routine Appt**
IHSS	67%	97%
MCL	71%	97%
Specialists		
LOB	**Urgent Appt**	**Routine Appt**
IHSS	54%	72%
MCL	53%	73%

All provider types had higher levels of compliance with the routine appointment standard than with the urgent appointment standard.

Table 55:Percentage of Ineligible Provider Types

MY	Psychiatrists	PCPs	Specialists	Ancillary	NPMH
2020	41%	17%	29%	36%	18%
2019	36%	31%	30%	29%	27%

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 MY2019 PAAS also show Psychiatrists as having the highest percentage of ineligible providers. Psychiatrists, PCPs, Specialists and NPMH providers showed a decrease in percentage of ineligible providers from MY2019 to MY2020. The Alliance will ensure continued collaboration with its Analytics and Provider Services Teams, as

well as with its delegate networks, to enhance accuracy of provider contact information, provider specialty, provider network status, and/or provider appointment availability, with the goal of decreasing the overall percentage of ineligible providers.

Table 56:Percentage of Non-Responsive Provider Types

MY	Psychiatrists	PCPs	Specialists	Ancillary	NPMH
2020	30%	6%	33%	12%	28%
2019	17%	8%	41%	15%	37%

Across all provider types, Specialists had the highest percentage of non-responsive providers, followed by Psychiatrists, NPMH providers, and Ancillary providers, with PCPs having the lowest percentages of non-responsive providers (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, showed improvement in compliance rates in either appointment types for both LOBs. NPMH providers had the biggest increase in compliance rates for the urgent appointment standard for both LOBs, followed by Psychiatrists. Psychiatrists had the biggest increase in compliance rates for the routine appointment standard for both LOBs.

Alameda Health System

For the PCP provider type, Alameda Health System still 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 increased their rate of compliance with both appointment standards for LOBs. For the Specialist provider types, CFMG providers demonstrated best practice by maintaining 100% compliance with both appointment standards for cardiology appointments. CFMG also showed significant improvements with endocrinology and gastroenterology routine appointments. However, CFMG providers lacked improvement with endocrinology and gastroenterology urgent appointments, providing opportunity for improvements.

CHCN

For the PCP and Ancillary provider types, CHCN providers demonstrated 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 urgent and routine cardiology appointments respectively, for both LOBs. For endocrinology appointments, CHCN providers showed a significant decrease in their rates of compliance for both appointment standards for both LOBs. For gastroenterology appointments, CHCN providers demonstrated a significant improvement with routine appointments, however, they showed a significant decrease in compliance with urgent appointments, providing opportunity for improvements.

ICP

For the PCP provider type, ICPs demonstrated a significant improvement with both appointment standards for both LOBs. For cardiology, ICPs demonstrated best practice by maintaining 100% compliance with the routine appointment standard for both LOBs. Additionally, for cardiology, ICPs increased their rate of compliance with the urgent appointment standard to 100% compliance for LOBs. For gastroenterology, ICPs demonstrated best practice by maintaining 100% compliance for both appointment standards for both LOBs. ICPs demonstrated 100% compliance with both Psychiatry appointment standards for both LOBs; a significant improvement from MY 2019 compliance rates. For the Adult NPMH provider type, ICPs demonstrated a significant improvement for both appointment standards for both LOBs for the Adult NPMH provider category but they did not participate in the Child NPMH provider category survey.

F. Provider-Focused Improvement Activities

As part of the Quality Improvement strategy for 2020, 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, in-office provider visits, and others as appropriate), with the goal of increasing the overall percentage of survey participation and compliance. Additionally, the Alliance will continue to conduct regularly scheduled and ad-hoc surveys/audits that assess provider compliance with timely access standards, issuing time-sensitive corrective action plans (CAPs) to all non-responsive and non-compliant providers. The Alliance will continue to discuss the importance of completion of the PAAS and other timely access surveys. Results and corrective actions needed for improvement are discussed with leadership staff during Joint Operations Meetings between the Alliance and its delegate leadership. The Alliance will also consider engaging in similar discussions with the larger provider groups in its network, especially those with low compliance rates and/or high rates of non-responsiveness. Lastly, the Alliance will continue to review other indicators of access and availability throughout the year and will engage in Plan-Do-Study-Act cycles, as appropriate.

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.

G. Best Practices

As part of the Quality Improvement strategy for 2021, during Joint Operations Meetings the Alliance will engage in discussions with delegate leadership whose providers have higher compliance rates, in an effort to learn about best practices that can be shared with other providers. The Alliance will share findings from the MY2020 PAAS within its Health Care Quality Committee (HCQC), which is comprised of leadership staff from several delegated networks, offering additional opportunities for discussion of best practices.

H. After Hours Survey

The Alliance contracted with SPH Analytics (SPH) to conduct the annual Provider After-Hours Survey for MY2020, which measures providers' compliance with the after-hours emergency instructions standard. The MY2020 After-Hours Survey was conducted from August to November 2020. SPH followed a phone-only protocol to administer the survey to the eligible provider population during closed office hours. A total of 350 Alliance providers and/or their staff were surveyed, and included 95 primary care physicians (PCPs), 211 specialists, and 44 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.

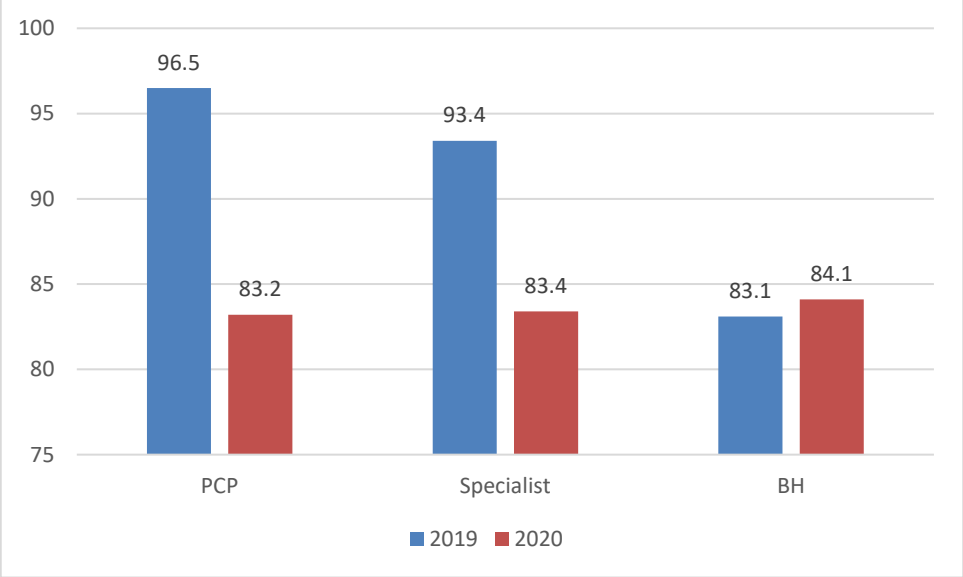
The table below presents the compliance rates for the providers surveyed in the After-Hours Survey:

Table 57:Compliance Rates for After Hours Survey

	Emergency Instructions		
Provider Type	**Total Compliant**	**Total Non-Compliant**	**Compliance Rate**
PCP	79	16	83.2%
Specialist	176	35	83.4%
BH	37	7	84.1%
Total	**292**	**58**	

A total of 58 providers (16 PCPs, 35 Specialists, 7 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 compliance rate, followed by Specialists, then PCP providers.

Table 58:After Hours Emergency Instruction and Access to Physician Compliance Rate Comparison (2019 v 2020)



The figure below presents the response rate across provider types:

Table 59: Response Rate by Provider Type

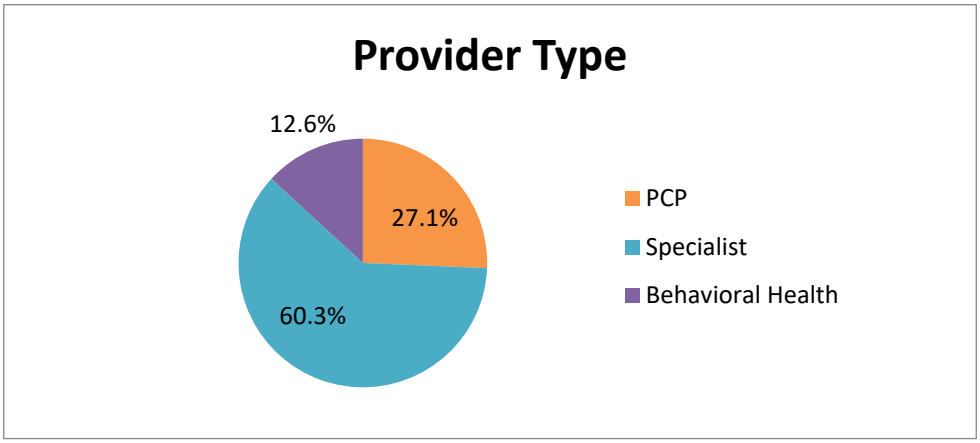
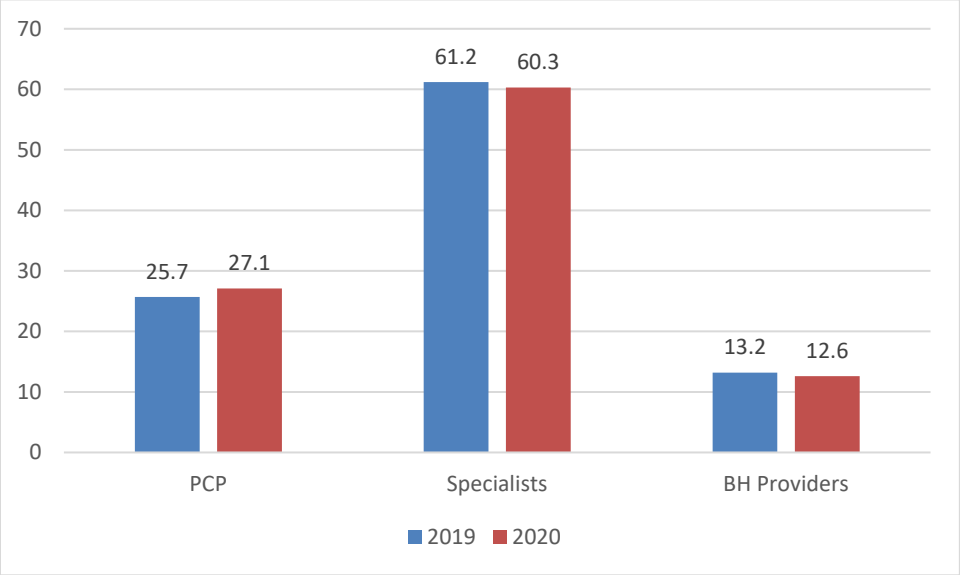


Table 60:After Hours Emergency Instruction and Access to Provider Survey Response Rate Comparison (2019 v 2020)



2020 results are not comparable to previous year's (2019) results due to a change in call script methodology. 2020 After Hours Emergency Response Rates for 2020 when compared to 2019 vary less than 1% year over year. However, Compliance Rates with After Hours Emergency Instruction year over year show significant decrease for PCPs at 13.3% and 10% decrease for Specialists in 2020 when compared to 2019. Additionally, the impact of the COVID PHE on After Hours Emergency Instruction compliance remains uncertain. Results of survey will be presented at Q2 Access and Availability Committee. Corrective Action Plans will be issued to all non-compliant and non-responsive providers.

I. First Prenatal Visit Survey

The Alliance conducted the annual First Prenatal Visit Survey for MY2020, which measures providers' compliance with the first prenatal visit standard. The survey was conducted in September - December of 2020 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 61: First Prenatal Visit Survey

Appointment Within 2 Weeks	75% Target Goal Met	Percent of Ineligibles	Precent of Non-Responsive
68.9%	No	51%	11.1%

The First Prenatal Visit 2020 survey results shows a compliance rate is 10 percentage points higher than the 2019 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 2021. 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.

J. Oncology Survey

The Alliance conducted the annual Oncology Survey for MY2019, which measures providers' compliance with the urgent and non-urgent appointment standards for specialists. The survey was conducted in June and July of 2019 and was administered to a random sample of eligible Alliance oncology providers. The table below shows results of the survey.

Table 62:Oncology Survey

Urgent Appt	75% Target Goal Met	Non-Urgent Appt	75% Target Goal Met	Percent of Ineligibles	Percent of Non-Responsive
86.7%	Yes	90%	Yes	3%	16%

The 2020 the compliance rate for non-urgent appointments decreased from 100% , as did the compliance rate for urgent appointments by 5 percentage points. Time-sensitive corrective action plans (CAPs) will be issued to all non-responding and non-compliant providers within Q2 2021. Additionally, the Alliance's QI Department will: continue: 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.

K. 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 2020, 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 2020. 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 2020 within each quarter.

Table 63:CG-CAHPS Survey Results 2020

Metric	Compliance Goal	Q1 2020	Q2 2020	Q3 2020	Q4 2020
In-Office Wait Time (Within 60 minutes)	80%	90.1%	91.1%	91.2%	92.4%
Call Return Time (Within 1 Business Day)	80%	79.0%	79.2%	77.6%	76.3%
Time To Answer Call (Within 10 minutes)	80%	79.0%	78.6%	79.4%	81.1%

The target compliance goal for each of the three metrics is 80%. In-office Wait Time compliance goals were met throughout 2020. Call Return Time and Time to Answer Call compliance rates trended slightly below the compliance goal of 80% ranging from 76.3% - 79.4%

The Alliance continues to follow its Escalation Process for Providers Non-Compliant with CG-CAHPS which involves: tracking and trending in the first quarter of non-compliance; sending a provider letter and discussions at Joint Operations Meetings with delegates for two consecutive quarters of non-compliance; and issuing corrective action plans (CAPs) and discussions with COOs/CFOs during three consecutive quarters of non-compliance.

Provider Satisfaction Survey Overview

The Alliance contracted with its NCQA certified vendor, SPH, to conduct a Provider Satisfaction Survey for measurement year 2020. 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 147 surveys were completed between October - December 2020 (87 mail, 34 internet, 26 phone).

The table below contains the survey response rates, survey respondents, and role of survey respondents for 2020 compared to 2019.

Table 64:Survey Response Rates: 2020 vs. 2019

	Mail/Internet	Phone
2020	15%	8%
2019	14.3%	28.6%

Table 65: Survey Respondents 2019 vs. 2018

	PCPs	BH Providers	SPCs
2019	58.0%	29.0%	27.8%
2018	32.9%	19.3%	56.0%

Year to Year Trend Comparisons

The table below contains the trended survey results across composites.

Table 66:Trended Survey Results Across Composites

Summary Rate Scores					
Composite / Attribute	**MY 2020 Result**	**Variance Compared to Previous Year**	**Variance Compared to SPH Commercial Benchmark BoB/ Aggregate**	**2019**	**2018**
Overall Satisfaction with the Alliance	**85%**	Significantly Higher	Significantly Higher	67.8%	81.1%
All Other Plans (Comparative Rating)	**56%**	Significantly Higher	Significantly Higher	43.8%	49.8%
Finance Issues	**45%**	Higher	Significantly Higher	36.2%	41.7%
Utilization and Quality Management	**51%**	Higher	Significantly Higher	48.2%	45.2%
Network/Coordination of Care	**39%**	Higher	Significantly Higher (Aggregate)	36.6%	40.9%
Pharmacy	**33%**	Lower	Significantly Higher (Aggregate)	34.1%	35.6%

Summary Rate Scores					
Composite / Attribute	**MY 2020 Result**	**Variance Compared to Previous Year**	**Variance Compared to SPH Commercial Benchmark BoB/ Aggregate**	**2019**	**2018**
Health Plan Call Center Staff	**54%**	Higher	Significantly Higher	44.5 %	52.8 %
Provider Relations	**62%**	Higher	Significantly Higher	57.3 %	53.5 %

The Alliance identified significant higher composite scores in 7 of 8 composites compared to 2019 scores. 8 of 8 composite scores are significantly higher than vendor commercial BoB and/or aggregate scores. Survey results indicate that the Alliance is performing above the 75th percentile in 7 of 8 composites and near the median in Network/Coordination of Care composite score.

SPH Alliance POWER List:

Promote and Leverage Strengths (Top 5 Listed)

1. The health plan's facilitation/support of appropriate clinical care for patients.
2. Procedures for obtaining pre-certification/referral/authorization information.
3. Timeliness of obtaining pre-certification/referral/authorization information.
4. Overall satisfaction with health plan's call center service.
5. Helpfulness of health plan call center staff in obtaining referrals for patients in your care.

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.

Grievances and Appeals

Alameda Alliance for Health reviews and investigates all grievance and appeal information submitted to the plan in an effort 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.

A **Grievance** is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. A grievance may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by the Alliance to make an authorization decision. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

A **Complaint** is the same as "grievance".

An **Appeal** refers to an appeal of any adverse decisions that are not about coverage.

An **UM Appeal** is defined as a review of an Adverse Benefit Determination. The state regulations do not explicitly define the term "Appeal", they do delineate specific requirements for types of Grievances that would fall under the new federal definition of Appeal. These types of Grievances involve the delay, modification, or denial of services based on medical necessity, or a determination that the requested service was not a covered benefit.

The Alliance's Grievance and Appeals (G&A) department monitors grievances (complaints) and appeals on a quarterly basis to identify issues affecting quality of care and service within the provider network. Providers exceeding the maximum amount of complaints are subject to disciplinary action.

A. Annual Grievance and Appeals Report – 2020

The quarterly grievance and appeals report is presented to the Health Care Quality Committee for systematic aggregation, evaluation of complaints, assessment of trends, and analysis for quality improvement. When trends are identified appropriate action will be taken to correct the problems. Grievance and Appeals are processed in accordance with DMHC regulations, DHCS APL 17-006 and NCQA Accreditation Standards.

Table 67: Standards/Benchmarks

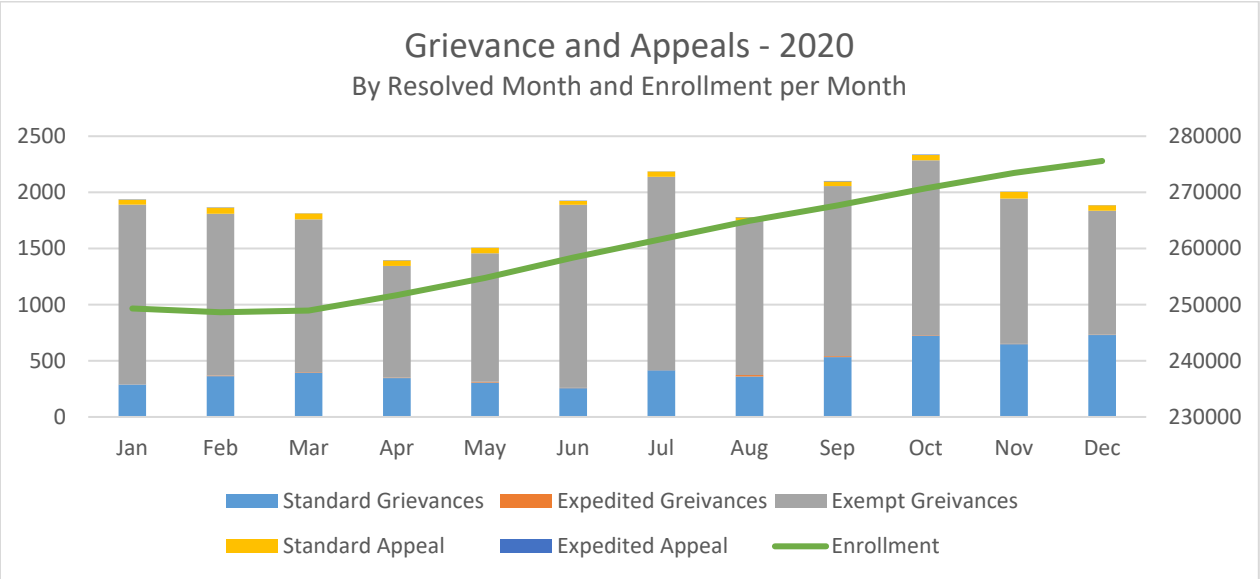
Case Type	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members
Standard Grievance	5,370	30 Calendar Days	95% compliance within standard	5,254	97.8%	
Expedited Grievance	61	72 Hours	95% compliance within standard	55	90.2%	

Case Type	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members
Exempt Grievance	16,731	Next Business Day	95% compliance within standard	16,705	99.8%	
Standard Appeal	553	30 Calendar Days	95% compliance within standard	552	99.8%	
Expedited Appeal	29	72 Hours	95% compliance within standard	28	96.6%	
2020 Total Cases:	22,744		95% compliance within standard	22,594	99.3%	7.28

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

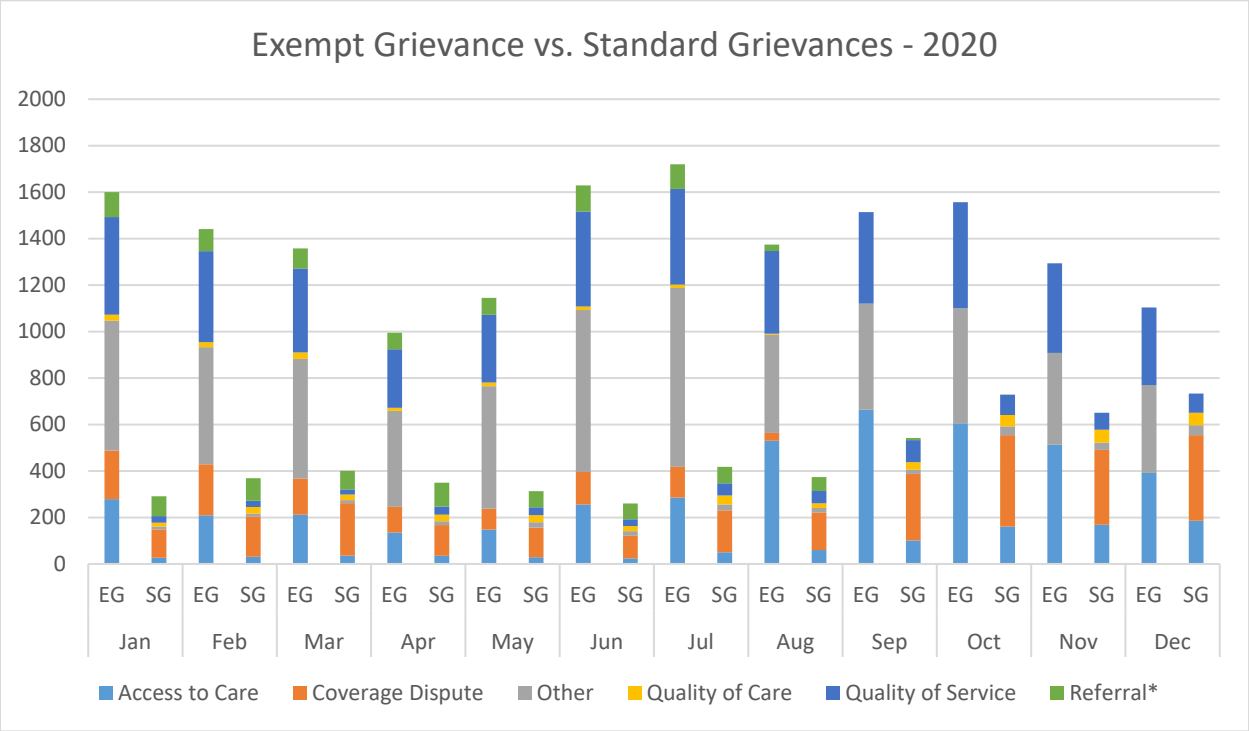
Our goal of 95% compliance rate within the expedited grievances turnaround time (72 hours) was not met. Four complaints with regard to Solara Medical Supplies and two cases with regard to medication.

Table 68: 2020 Grievance ad Appeals Tracking and Trending



There was an overall increase of standard grievances processed during the year, this was due to a change in process for grievances related to coverage disputes. In response to our DMHC Routine Follow-Up Survey, there was a finding that stated that coverage disputes were inappropriately handled as exempt grievance, complaints resolved by the next business day; therefore, exempt from written communication to the member. The Department's findings stated that these disputes should be handled as standard grievances. Starting August 2020, all coverage disputes were sent to the Grievance and Appeals Department to be resolved as standard grievances which requires a written acknowledgement and written resolution letter to be sent to the member.

Table 69:Exempt Grievance vs. Standard Grievances - 2020



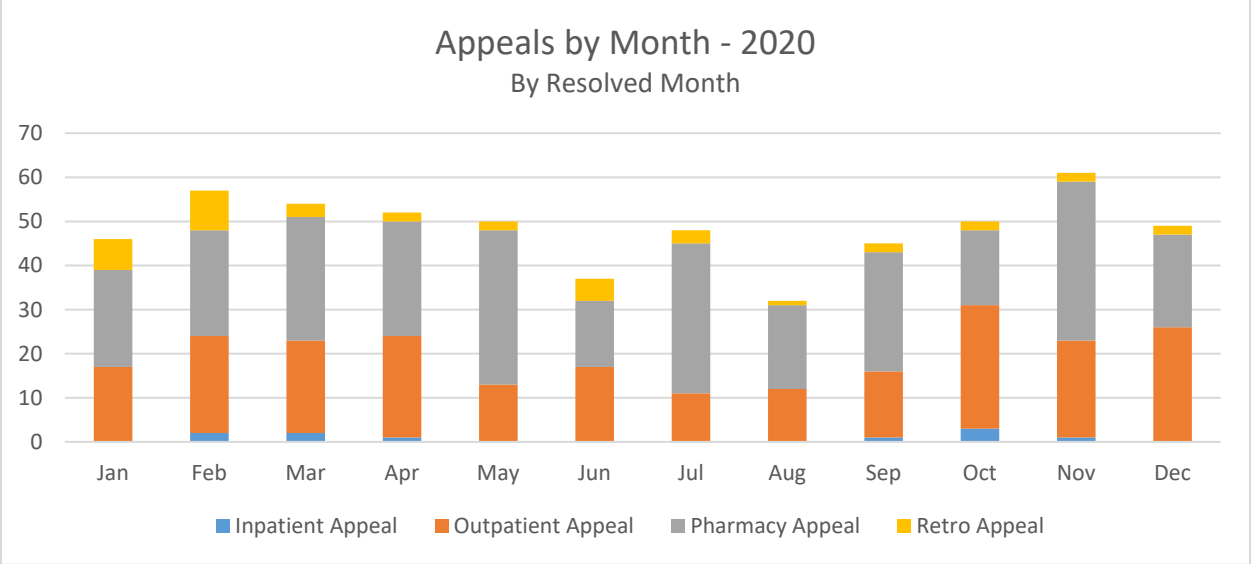
*Referral category was discontinued in August 2020, grievances related to referral are now rolled up into Access to Care.

- Process change for coverage disputes, all cases that fall under that category have to be forwarded to the G&A Department for written correspondence even if they could be resolved within the next business day, and examples include:
  - Member calling to ask for reimbursement of monies paid, we used to capture as exempt and refer them to the website to complete the reimbursement form.
  - Member calling with regards to being balanced billed, member services used to contacted the provider to bill the Alliance.

- Denied pharmacy services at point of sale, member services used to educate the member that they were either OON or the medication required a PA and close as an exempt grievance.

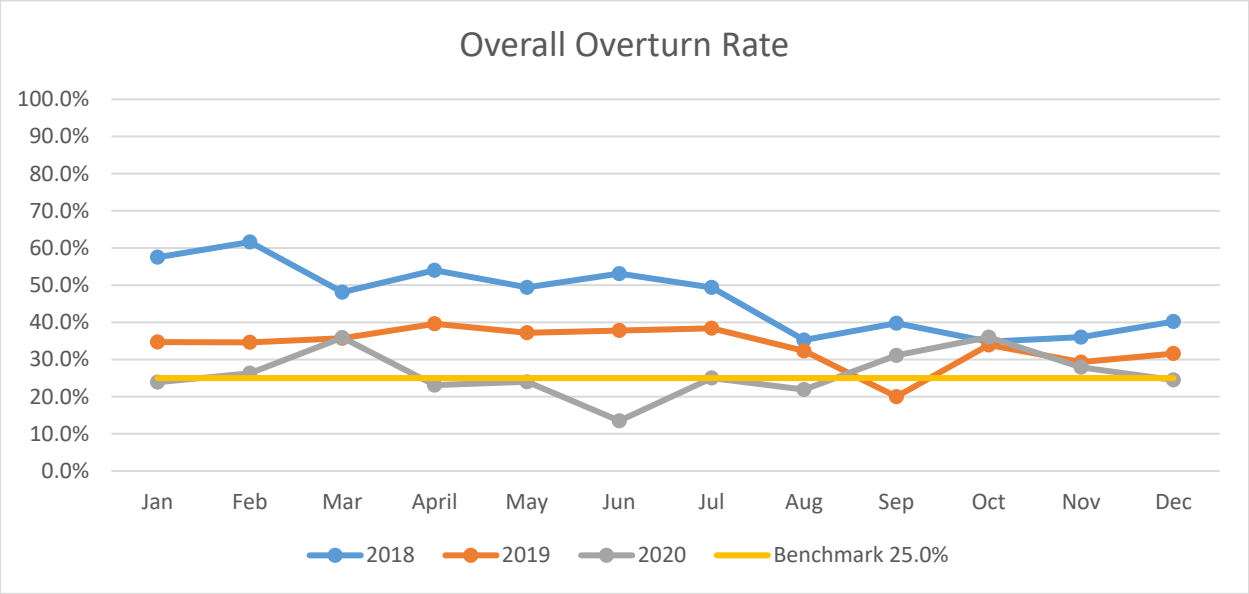
- IHSS Copays, we have had an increase of grievances related to IHSS members calling to complain about copays. The Alliance waived copays for IHSS members due to COVID-19, it was effective from 3/16 through 7/31, and members are upset that they now have to pay when they have not been paying since March. These complaints fall under coverage disputes and are being handled by the G&A Department.
- The appeals resolved in Q3 2020 experienced a decreased compared to the other quarters, this can be attributed to members not being able to get into their doctors office for routine appointments due to COVID-19.

Table 70: Appeals by Month - By Resolved Month



The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of 2020; we averaged 26.1%which was slightly over our goal.

Table 71:Overall Overturn Rate



Cultural And Linguistic Needs Of Members

The Alliance QI Department conducts a quarterly of the Alliance's membership 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 2020, the Alliance identified the following threshold languages.

Table 72:: 2020 Threshold Languages

Total by Plan	Threshold Languages		
Medi-Cal **269,862**	English	167,015	61.89%
	Spanish	53,819	19.94%
	Chinese	25,125	9.31%
	Vietnamese	8,471	3.14%

Total by Plan	Threshold Languages		
Group Care 5,954	English	3,547	59.57%
	Chinese	1,381	23.19%
	Spanish	294	4.94%

Table 73: Member Ethnicity – Medi-Cal

MEDI-CAL	Prior Year	YTD	% Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY ETHNICITY	Jan - Dec 2019	Jan - Dec 2020	% YTD Membership in Jan - Dec 2020 (minus) % of Membership in Jan - Dec 2019	Dec 2020	Dec 2020 %
Hispanic (Latino)	28.04%	28.30%	0.26%	76,720	28.43%
Other	17.52%	18.36%	0.83%	50,699	18.79%
Black (African American)	17.81%	17.51%	-0.30%	46,297	17.16%
Chinese	10.97%	10.76%	-0.20%	28,442	10.54%
Other Asian / Pacific Islander	10.73%	10.49%	-0.24%	28,247	10.47%
White	9.79%	9.43%	-0.36%	25,582	9.48%
Vietnamese	4.29%	4.19%	-0.10%	11,044	4.09%
Unknown	0.62%	0.75%	0.13%	2,227	0.83%
American Indian Or Alaskan Native	0.24%	0.23%	-0.02%	604	0.22%
Total Members				**269,862**	

Source: Alliance Monthly Membership Report December 2020

Medi-Cal Ethnicity Discussion: 2020 saw an overall increase in membership, but only slight changes in ethnicities as a percent of the Medi-Cal membership. Hispanic (Latino) members make up almost 30%, all Asian members combined make up over 25%, and Black (African American) members over17% of our Medi-Cal membership.

Table 74: Member Ethnicity – Group Care

GROUP CARE	Prior Year	YTD	% Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY ETHNICITY	Jan - Dec 2019	Jan - Dec 2020	% YTD Membership in Jan - Dec 2020 (minus) % of Membership in Jan - Dec 2019	Dec 2020	Dec 2020 %
Unknown	33.96%	31.10%	-2.86%	1,805	30.32%
Other Asian / Pacific Islander	26.48%	28.66%	2.18%	1,790	30.06%
Chinese	12.32%	13.09%	0.76%	759	12.75%
Black (African American)	11.80%	11.36%	-0.43%	671	11.27%
Other	6.94%	6.90%	-0.04%	393	6.60%
Hispanic (Latinx)	3.47%	3.71%	0.24%	227	3.81%
Vietnamese	2.97%	3.00%	0.04%	176	2.96%
White	1.94%	2.04%	0.10%	126	2.12%
American Indian Or Alaskan Native	0.11%	0.13%	0.01%	7	0.12%
Total Members				**5,954**	

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. The percent of Group Care members with unknown ethnicity continues to decline, although still higher than desired.

Table 75: Member and Provider Languages Spoken – Medi-Cal

MEDI-CAL	Prior Year	YTD	% Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY LANGUAGE	Jan - Dec 2019	Jan - Dec 2020	% YTD Membership in Jan - Dec 2020 (minus) % of Membership in Jan - Dec 2019	Dec 2020	Dec 2020 %
English	61.87%	61.42%	-0.45%	167,015	61.89%
Spanish	19.29%	19.89%	0.60%	53,819	19.94%
Chinese	9.73%	9.61%	-0.12%	25,125	9.31%
Unknown	3.48%	3.49%	0.01%	9,291	3.44%
Vietnamese	3.31%	3.24%	-0.07%	8,471	3.14%
Other Non-English	1.72%	1.74%	0.02%	4,543	1.68%
Farsi	0.60%	0.61%	0.00%	1,598	0.59%
Total Members				269,862	

Medi-Cal Language Discussion: Our Medi-Cal members are approximately 3/5 English-speaking, 1/5 Spanish-speaking, 1/10 Chinese-speaking 3/100 Vietnamese-speaking. There are no significant changes from last year.

Table 76: Member and Provider Languages Spoken – Group Care

GROUP CARE	Prior Year	YTD	% Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY LANGUAGE	Jan - Dec 2019	Jan - Dec 2020	% YTD Membership in Jan - Dec 2020 (minus) % of Membership in Jan - Dec 2019	Dec 2020	Dec 2020 %
English	60.55%	59.56%	-0.99%	3,547	59.57%
Chinese	22.31%	23.29%	0.98%	1,381	23.19%
Spanish	4.92%	4.94%	0.02%	294	4.94%
Unknown	4.20%	4.13%	-0.07%	243	4.08%
Vietnamese	3.64%	3.63%	-0.01%	214	3.59%
Other Non-English	2.79%	2.85%	0.06%	177	2.97%
Farsi	1.59%	1.59%	0.00%	98	1.65%
Total Members				5,954	

Group Care Language Discussion: Group Care members continue to speak predominately English 3/5 of the Group Care members, followed by Chinese-speaking (over1/5) and Spanish-speaking (1/20).

A. Practitioner Language Capacity

During 2020, 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 2020. Please note, multi-lingual providers are counted for each language spoken by the individual.

Table 77:MCAL Provider Network vs. Members Comparison of Identified Languages

	2019Q4			2020Q4			Change			
Language	PCPs	Members	Members per PCP	PCPs	Members	Members per PCP	# PCPs	% PCPs	# Members	% Members
English	503	122,728	243	519	137,496	264	16	3.2%	14,768	12%
Spanish	111	42,823	385	121	48,715	402	10	9.0%	5,892	14%
Chinese	68	22,367	328	68	23,110	339	0	0.0%	743	3%
Vietnamese	12	7,885	657	16	8,088	505	4	33.3%	203	3%
Arabic	7	2,062	294	6	2,203	367	-1	-14.3%	141	7%
Farsi	7	1,522	217	6	1,498	249	-1	-14.3%	-24	-2%
Total**	**890**	**209,727**		**910**	**231,656**		20	2.2%	21,929	10%

Source: Q4 2019 and Q4 2020 Provider Impact Reports

Table 78: MCAL PCPs & Members by Language

	2019Q4	2020Q4	Change
Language	Members per PCP	Members per PCP	Difference
English	243	264	Decline ↑21
Spanish	385	402	Decline ↑17
Chinese	328	339	Decline ↑21
Vietnamese	657	505	Improvement ↓152
Arabic	294	367	Decline ↑73
Farsi	217	249	Decline ↑32

* A number of PCPs do not have a primary language designated in the data we receive. Also, multi-lingual providers are counted for each language they speak.

The Alliance also identified and reviewed significant changes and trends related to provider language capacity. In 2020 the Plan experienced overall decline in Medi-Cal membership for all languages as well as a decline in PCPs speaking all languages except for Arabic. However, PCPs per member increased for Vietnamese. The plan will continue to monitor the decline to see if it persists and whether there are grievances that might require taking action.

Table 79:Group Care Provider Network vs. Members Comparison of Identified Languages

	2019Q4			2020Q4			Change			
Language	PCPs	Members	Members per PCP	PCPs	Members	Members per PCP	# PCPs	% PCPs	# Members	% Members
English	376	3,647	9	402	3,545	8	26	6.9%	-102	-3%
Chinese	59	1,407	23	60	1,383	23	1	1.7%	-24	-2%
Spanish	81	303	3	93	295	3	12	14.8%	-8	-3%
Vietnamese	10	224	22	14	215	15	4	40.0%	-9	-4%
Farsi	5	90	18	5	98	19	0	0.0%	8	9%
Arabic	7	15	2	6	9	1	-1	-14.3%	-6	-40%
Total**	**685**	**6,094**		**722**	**5,953**		37	5.4%	-141	-2%

Table 80: Group Care PCPs & Members by Language

	2019Q4	2020Q4	Change
Language	Members per PCP	Members per PCP	Difference
English	9	8	Improvement ↓ 1
Chinese	23	23	No change
Spanish	3	3	No change
Vietnamese	22	15	Improvement ↓ 7
Farsi	18	19	Decline ↑ 1
Arabic	2	1	Improvement ↓ 1

Our 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 25 members.

In addition, the Alliance continues to monitor provider language capacity levels and trends quarterly though the following:

- Review of provider and member spoken language capacity comparison
- 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. The Alliance has three

interpreter vendors to ensure coverage for both telephonic and in-person interpreters are available for all our members' health care needs. In 2020, the Alliance provided over 12,700 telephonic interpreter services. In addition, we completed just approximately 13,645 requests for interpreter services at the time of appointment. This represents over 99.5% fulfillment with prescheduled interpreter requests. The volume for in-person interpreters decreased from over 20,000 in 2019 due to COVID-19 reduction in in-person office visits.

Analysis Of 2020 Quality Program Evaluation and Effectiveness

The Alliance has identified the challenges and barriers to improvement throughout the 2020 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 will bring 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 2021.

Challenges and barriers to achieving objectives encountered within the 2020 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.
- Drop in health education program participation due to pandemic and move to virtual formats for classes.
- HEDIS measurement results impedes optimal strategic rapid cycle PDSA implementation for quality improvement activities
- Member Services call center "call abandonment" rate negatively impacted by staffing challenges

Program major accomplishments with objectives met for 2020 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
- Implementation of a revised provider CAP Process in which corrective action plans (CAPs) were revised to minimize administrative burden on provider offices to document corrective plan and resolution

- Increased Provider Satisfaction Survey scores in 2020 for five (5) of six (6) departments
- HCQC meetings held 6 times within 2020 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 most measures; above the MPL for all accountable HEDIS metrics
- Deployment of a Pediatric Care Coordination Pilot to promote access to care and EPSDT service utilization in partnership with direct, delegate, and CBOs.
- Improved targeted focus on direct and delegate provider education and outreach collaboration with Provider Services to improve access to care using gap in care reports
- Continued focus on health promotion and education that resulted in higher CAHPS scores
- Improved turn-around times and root cause analysis of PQIs
- Implementation of Phase I and Phase II of the PQI Application database
- Ongoing / successful performance improvement projects
- Robust Health Education and Cultural and Linguistic Programs
- Launched new on-demand telephonic and video interpreter capacity.
- In response to COVID-19 stay and home restrictions transitioned over half of interpreter services to video and telephonic.
- Moved Member Advisory Committee and member input to virtual formats to ensure continued member input into programs and services.
- Worked with community providers to move a majority of health education program offerings to virtual formats or 1:1 telephonic supports.
- Enhanced Disease Management Program
- Cost effective approach to quality and safety of care and services utilizing community resources such as:
    - Substance Abuse Disorder Program
    - Ongoing Performance Improvement Projects
- Alliance received certification as a Center of Excellence for superior performance in the Alliance Member Services Call Center.
- 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.
- QI Program was evaluated, discussed and approved by the HCQC Committee

The HCQC has evaluated the approved the overall effectiveness of the Alliance QI Program and the 2021 Work Plan and determined its progress in meeting safe, clinical practice, goals, based on an assessment of performance in all aspects of the QI Program. The committee determines no need to restructure or change the QI program for the subsequent 2020 year.

2021 Quality Improvement

Program Description

ALAMEDA ALLIANCE FOR HEALTH

QUALITY IMPROVEMENT PROGRAM DESCRIPTION 2021

ALAMEDA Alliance FOR HEALTH

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

2021 Quality Improvement Program Description Signature Page

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Date

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OVERVIEW

Alameda Alliance for Health is a public, not-for-profit managed care health plan committed to making high quality health care services accessible and affordable to lower-income people of Alameda County. Established in January 1996, the Alliance was created by and for Alameda County residents. The Alliance currently provides health care coverage to approximately 250,000 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 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 Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex. The Alliance does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Alliance QI program is committed to serving the healthcare needs of our culturally and linguistically diverse membership.

MISSION AND VISION

As its 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. The Alliance Vision is 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.

Goals of the QI program include, but are not limited 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. Perinatal, 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

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 survey 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 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 QI Program, Work Plan, annual 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 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 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 with regard to 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)
- 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
- 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. 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	
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			X	X		
Kaiser	X		X		X		X		X		X		X		X		X	
UCSF					X	X												
Physical Therapy PN					X	X												
Lucille Packard					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. Medical Director of Quality Improvement

The QI Medical Director is a board-certified physician trained in Emergency Medicine who holds a current unrestricted license to practice medicine in California. The QI 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 15 years of clinical experience, and 11 years of QI experience. The 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.
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 QI 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 degree in Public Administration in Health Care, with 22 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. Quality Improvement Manager

The Quality Improvement Manager is a non-clinical/licensed staff member who holds a Master's of Science degree in Quality Assurance in Healthcare and has 2 years of Health Plan experience and over 18 years of QI and operational management experience in IPAs and FQHCs. The QI Manger is responsible for the day-to-day management of the QI department, including but not limited to the HEDIS measures submissions, Physician Profiling (practice profiling) activities, Performance Improvement Projects, Potential Quality of Care data tracking and quality improvement initiatives. 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. The Quality Improvement Manager reports to the Sr. Director of Quality.

E. Access to Care Manager (Vacant)

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 is in compliance 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.

F. Quality Improvement Nurse Supervisor

The QI Nurse Supervisor is a Registered Nurse who holds an active license to practice in California and has 9 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.

G. 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.

H. 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 12 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.

I. 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.

J. 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.

K. Quality Program Coordinator (1)

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 consists of seventeen staff members. This includes: one Chief Analytics Officer, two Directors, one Manager, nine analysts, two Quality Specialists, one Business Administrator, and one Executive Assistant. They perform data analyses involving clinical, financial, provider and member data. 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 operational 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 a 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. 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. Case and Disease Management Services

The Case and Disease Management department oversees case management for high-risk members including those 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.

G. 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.

H. 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.

I. 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. Call abandonment data will be followed by QI in 2020 for noted improvement.

GRIEVANCE AND APPEALS

Alameda Alliance for Health reviews and investigates all grievance and appeal information submitted to the plan in an effort 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 2020.

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).Confirm
- 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.
- Business Objects: A data mining tool used by staff to create accurate member level reporting. Confirm
- 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 (Verscend).
- CAHPS 5.0 : 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. Confirm
- 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 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 2021 include the following:

- Childhood Immunizations: Combo 10
- Immunizations for Adolescents: Combo 2
- Well-Child Visits in the First 30 Months of Life
- Well-Child Visits in members 3-21 years of age
- Asthma Medication Ratio
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening in Women
- HbA1c Testing for Diabetics
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents

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

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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 byDHCS. 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)

The Alliance evaluates member experience periodically. The Consumer Assessment of Health Plan Survey (CAHPS) is conducted by 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 in order 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:

- Reviewing complaints and grievances and determining quality of care impact.
- Monitoring iatrogenic events such as, hospital-acquired infections reported on claims and reviewing encounter submissions.
- Reviewing concurrent inpatient admissions to evaluate and monitor the medical necessity and appropriateness of ongoing care and services. Safety issues may be identified during this review.
- Investigating reported and/or identified potential quality of care issues.
- Auditing Alliance internal processes/systems and delegated providers.

- Credentialing and re-credentialing review of malpractice, license suspension registries, loss of hospital privileges.
- Performing site review of provider offices for compliance with safety, infection control, emergency, and access standards.
- Monitoring operational compliance with local regulatory practices.
- Monitoring medication usage (e.g., monitoring number of rescue medications used by asthmatics).
- Partnering with the pharmacy benefit management company to notify members and providers of medication recalls and warnings.
- Reviewing hospital readmission reports.
- Improving continuity and coordination of care between practitioners.
- 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 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 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.

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.

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 through the use of 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 as a result 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 Population Health Program is used to:

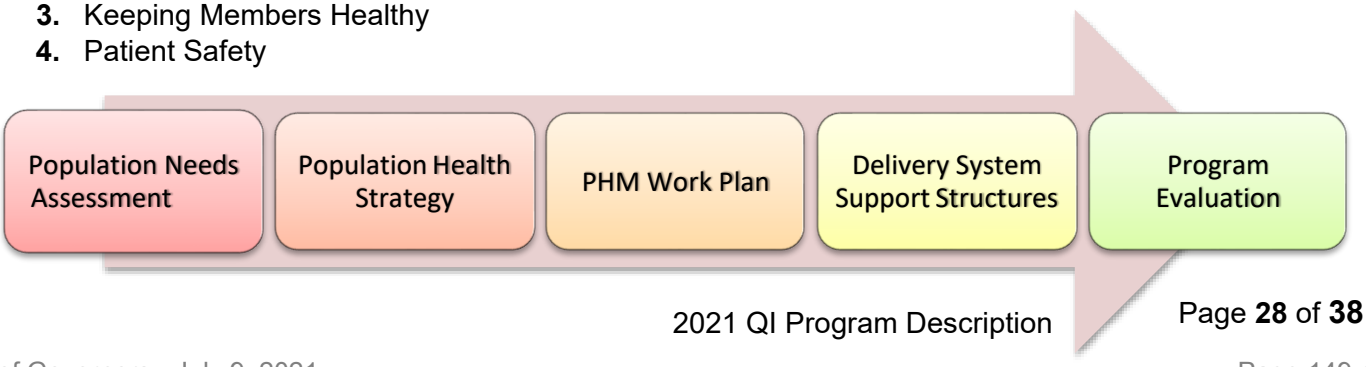
- Enhance Case Management Department and program
- Inform Quality Improvement Performance Projects
- Guide Health Education Materials and Programs
- Guide the Population Needs Assessment (PNA)

Additionally, the program may be used to better understand the patterns of cost, utilization and identify high-risk members with high-risk disease processes.

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:

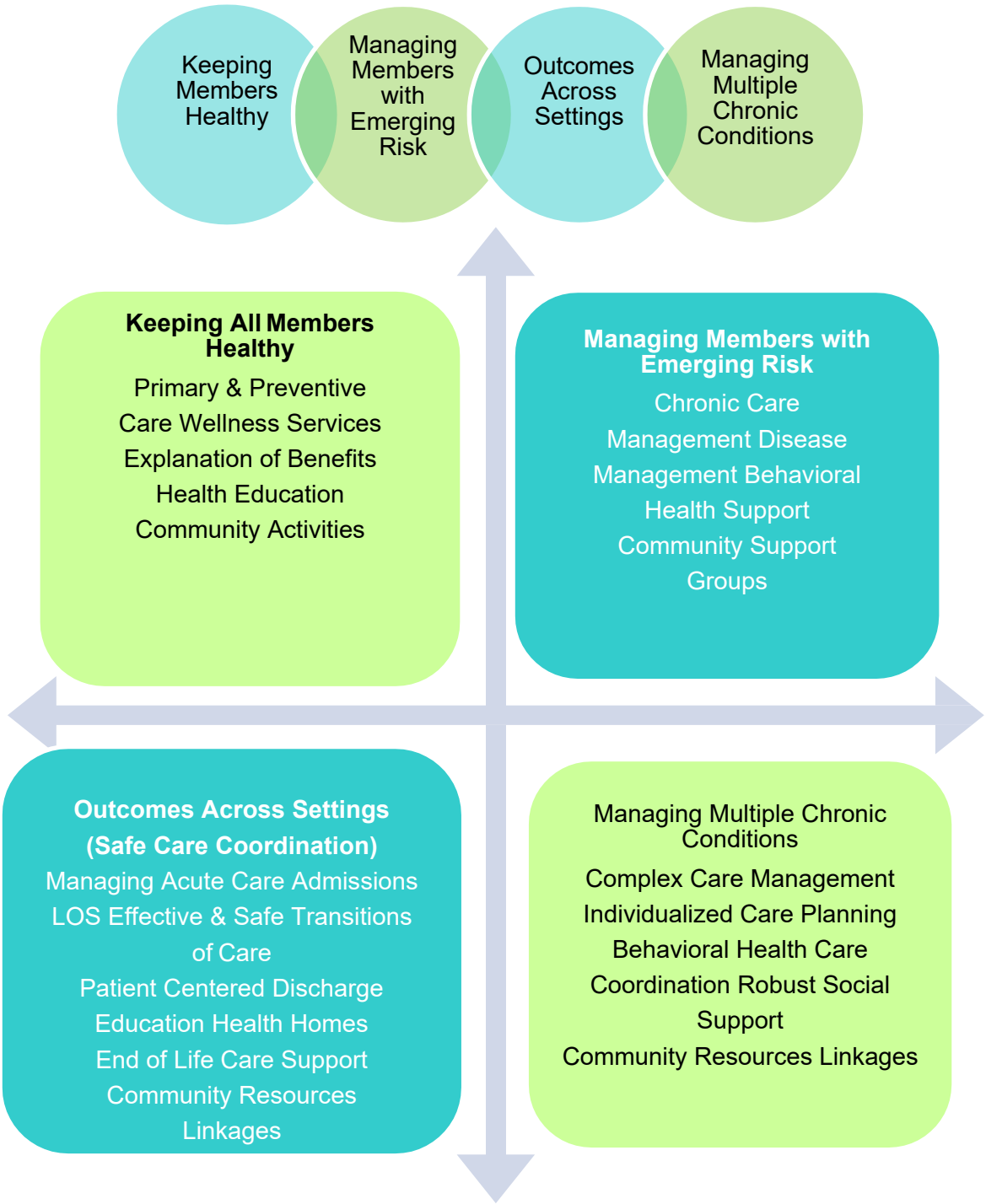
1. Members with Chronic Illness
2. Members with Emerging Risk
3. Keeping Members Healthy
4. Patient Safety



2. 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:

Figure 2: Four Areas of Focus



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.

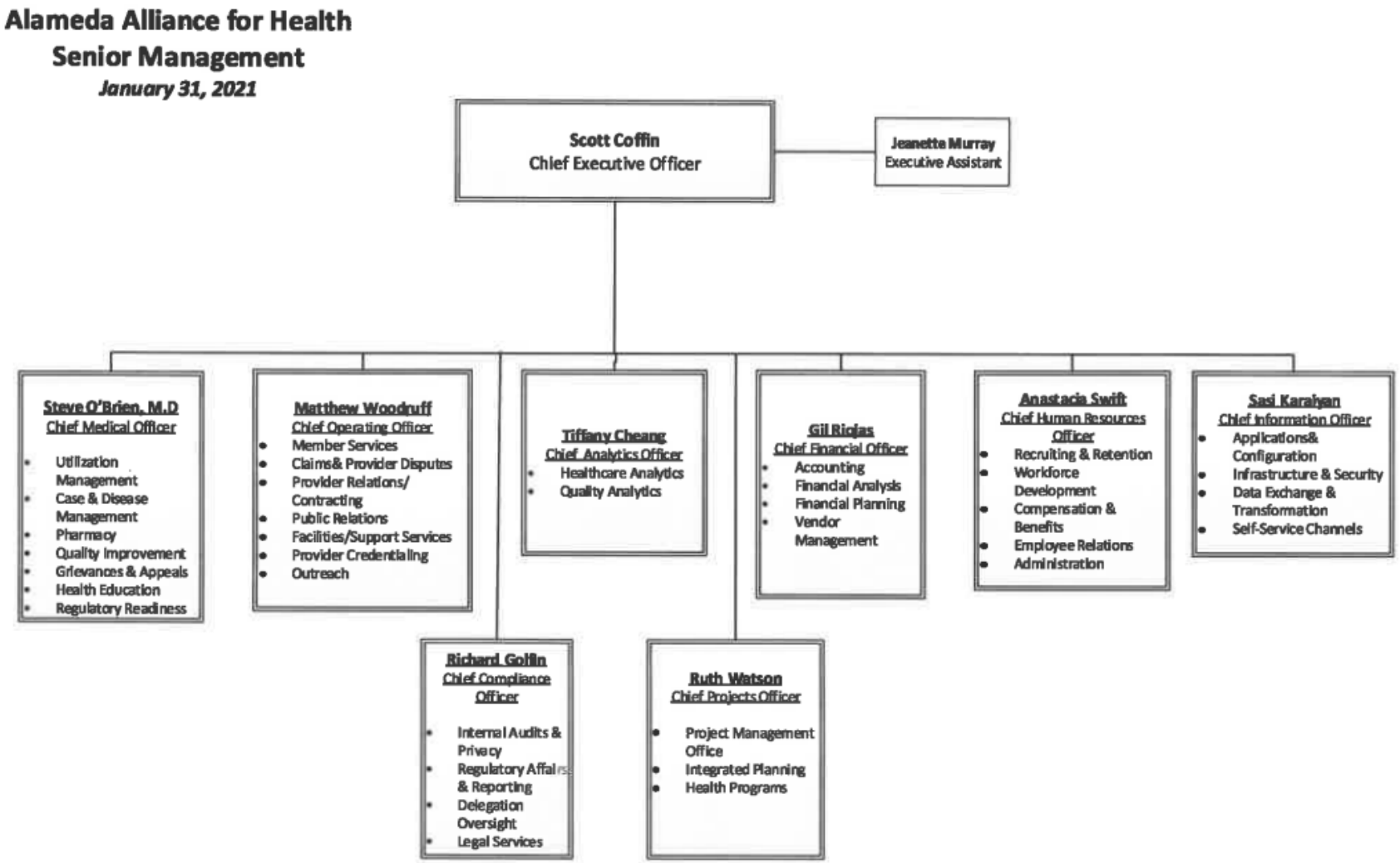
Committee members may not participate in the review of any case in which they have a direct professional, financial, or personal interest. It is each committee member's obligation to declare actual or potential conflicts of interest.

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.

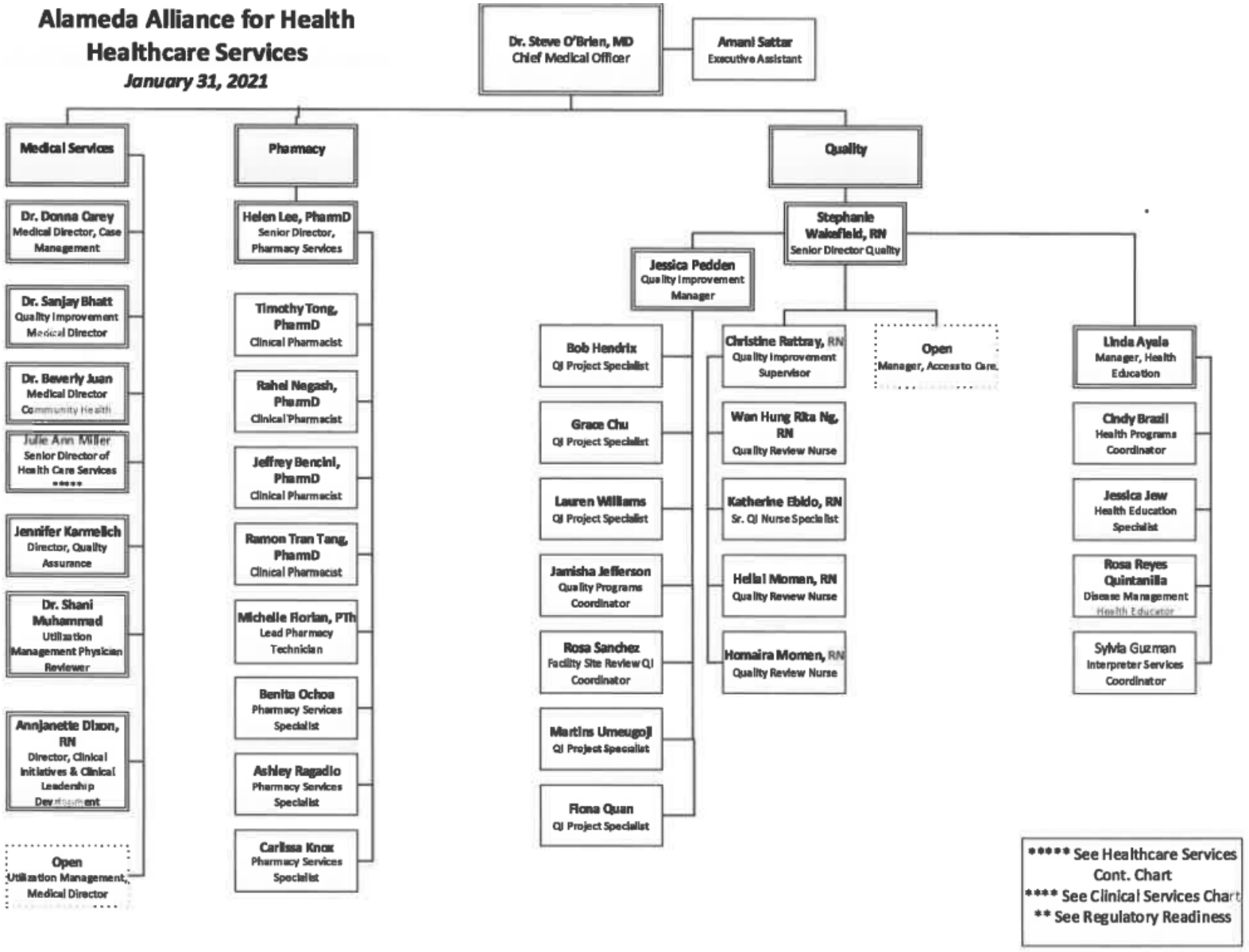
Organizational charts are as follows:

APPENDIX A

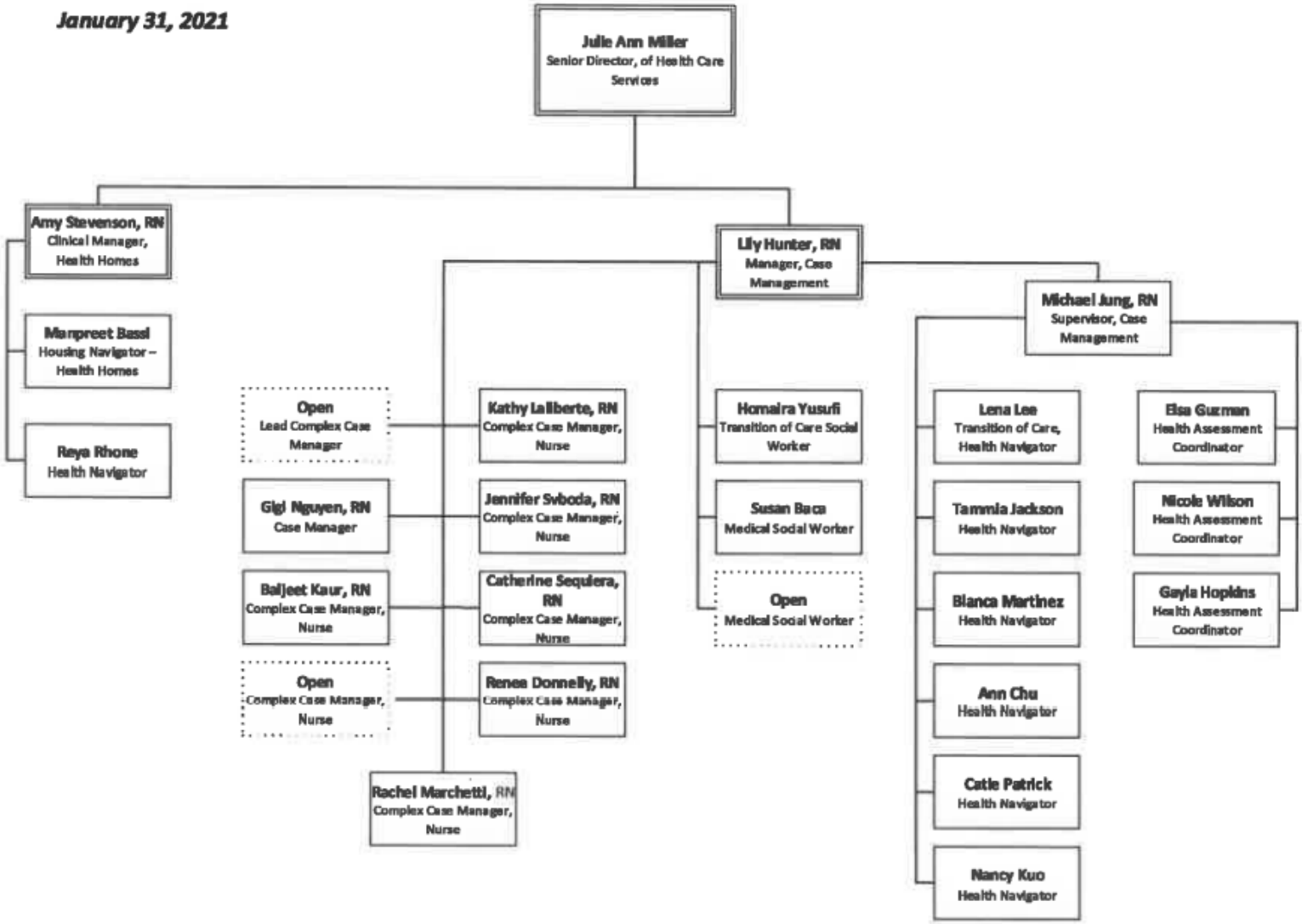
- Senior Management –



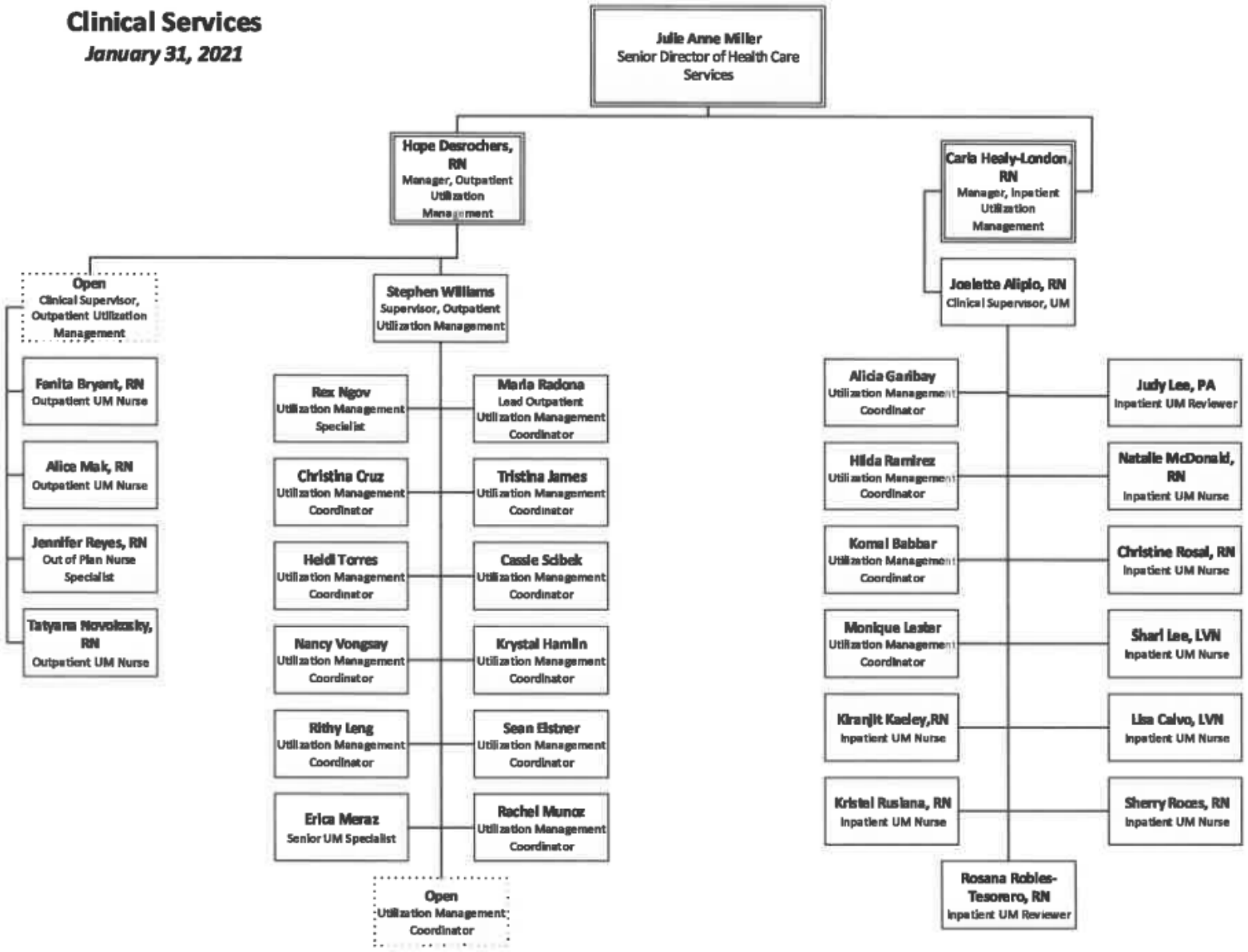
- Health Care Services –



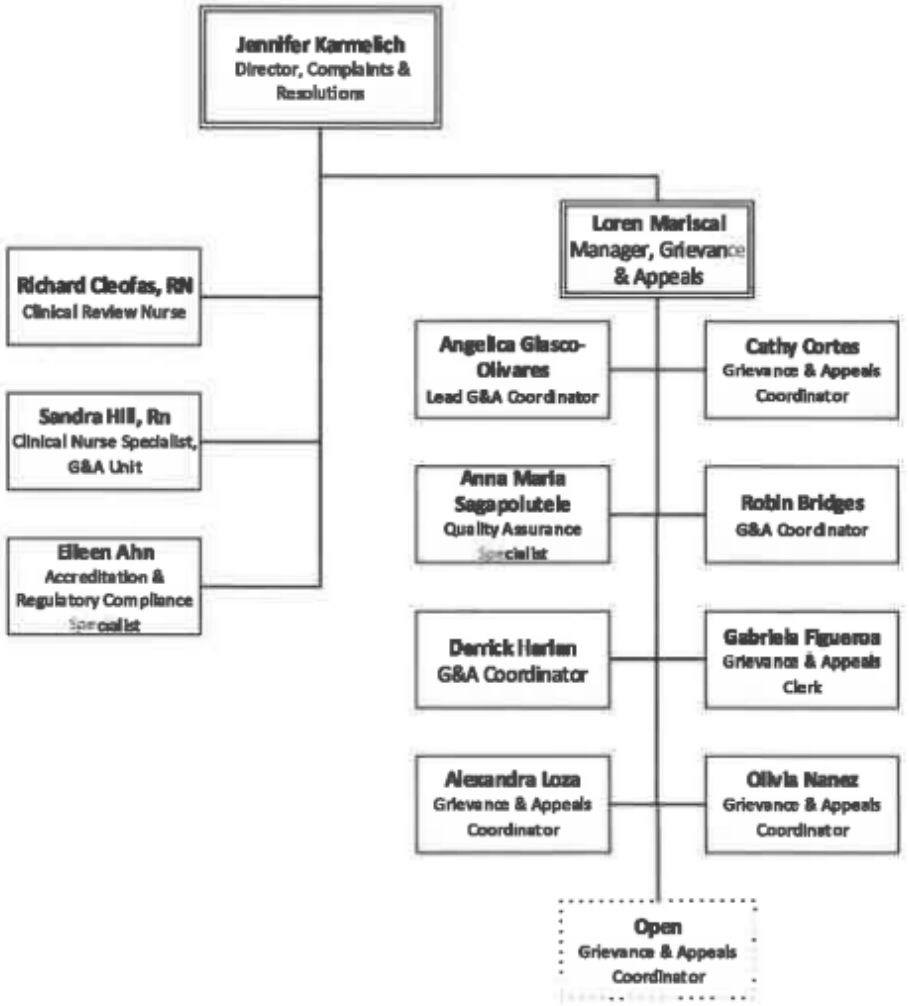
Alameda Alliance for Health
Health Care Services Cont.
January 31, 2021



Alameda Alliance for Health
Clinical Services
January 31, 2021

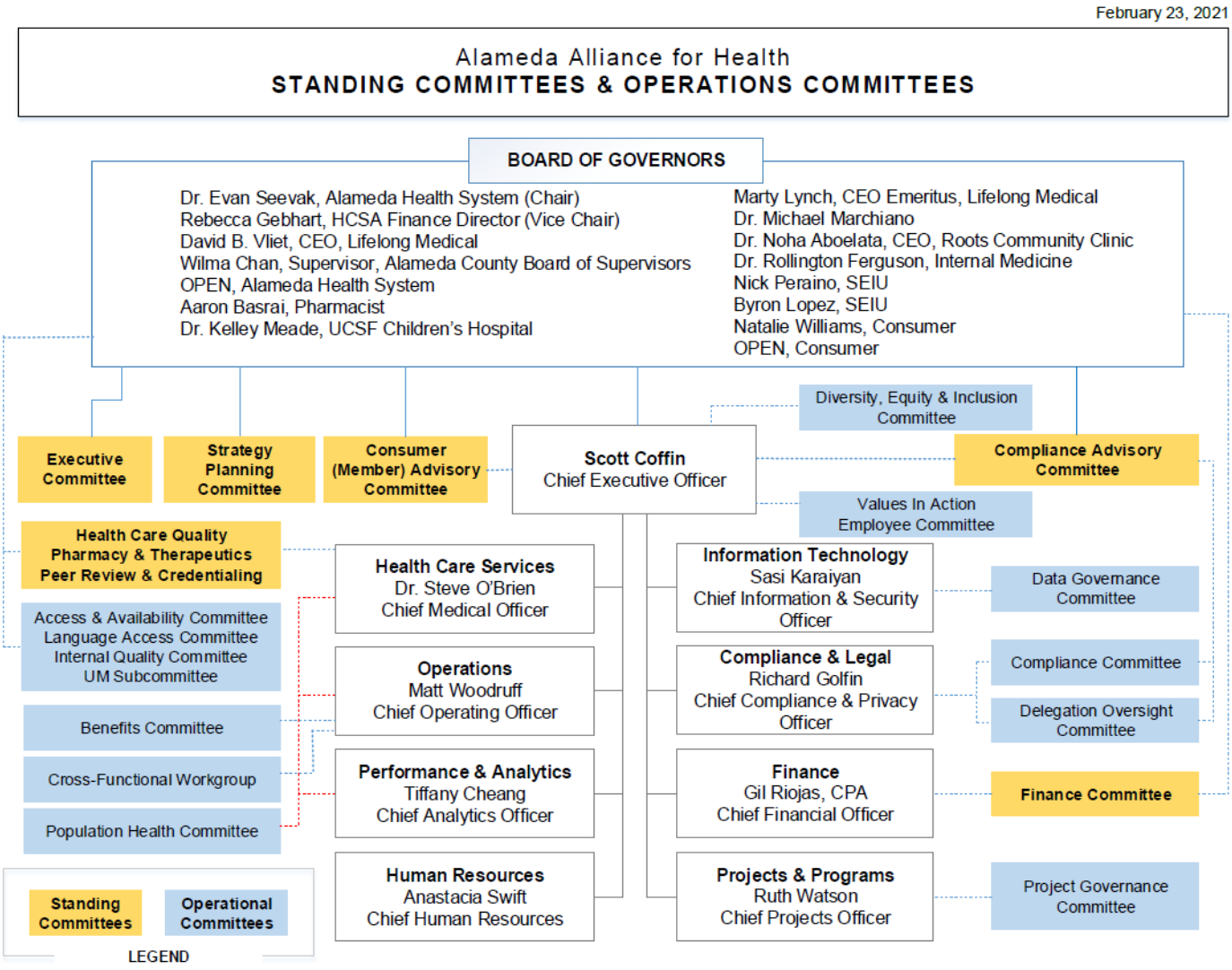


Alameda Alliance for Health
Regulatory Readiness
January 31, 2021



APPENDIX B

- ALAMEDA ALLIANCE COMMITTEES



ALAMEDA Alliance FOR HEALTH

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

2021 Cultural and Linguistic Program Description

Cultural and Linguistic Program Description

2021

2021 Cultural and Linguistic Services Program
Description Signature Page

Date 03/18/2021

DocuSigned by:
Sanjay Bhatt
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Sanjay Bhatt, M.D.
Medical Director, Quality Improvement
Vice Chair, Health Care Quality Committee

Date 03/18/2021

DocuSigned by:
Steve O'Brien
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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 2021

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 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 level of English proficiency, disability, age, immigrant and refugee status, sexual orientation, gender or gender identity.

Program objectives include:

- Comply with state and federal guidelines related to assessment of enrollees in order 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 health education materials are made available to members and providers and that these materials meet the literacy, cultural, linguistic, clinical and regulatory standards.

The Health Education Manager together with 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 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 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.

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 or 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 - Language Assistance Services
- CLS-008 Cultural and Linguistic Services Program - Enrollee Assessment
- CLS-009 Cultural and Linguistic Services Program – Contracted Providers
- CLS-010 Cultural and Linguistic Services Program - Staff Training
- CLS-011 Cultural and Linguistic Services Program – Compliance Monitoring

Alameda Alliance for Health
Cultural and Linguistic Services Program Work Plan
2021Appendix A

Program	**Member Cultural and Linguistic Assessment**		
Goal	Assess the cultural and linguistic needs of plan enrollees.		
Rationale	**Quarterly Alliance CLSS Reports:** From 2019 - 2020 there are no significant changes in demographics in the Alliance population, however the total membership increased by 12% from December 2019 – December 2020		
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 2021	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	**Quarterly Cultural and Linguistic Report Q4 2020:** 38% of members prefer to communicate with the plan in a non-English language. Of those, 85% speak threshold languages. **In 2020 overall fill rate for in-person interpreter services** was 99.7% and **coverage from July to December** for 24/7 telephonic interpreting was 98.6%%. **Use of telehealth visits due to COVID-19** – 37% of Initial Health Assessments from 2020 were conducted through telehealth visits, 21% for children, 48% for ages 19 – 44, 46% ages 45 – 64 and 43% ages 65 and over.		
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)
Expand promotion and use of telephonic and three-way video to support telehealth visits.		By December 31, 2021	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 2020 Provider Language Capacity report:** All ratios were stayed within the expected range. Highest ratio was Vietnamese (1:505) compared to 1:264 for English for Medi-Cal and Chinese (1:23) compared to 1:9 for English for Group Care. . **Quarterly Cultural and Linguistic Report Q4 2020:** 38% of members prefer to communicate with the placompn in a non-English language. Of those, 85% speak threshold languages. **Q1-Q3 2020 CG CAHPS Survey CAHPS Survey** adult responses to the question "Were you able to communicate with your doctor and clinic staff in your preferred language?" were 83.7% favorable for receiving a qualified interpreter through their doctor's office or health plan, child responses were 91.3% 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 2021	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

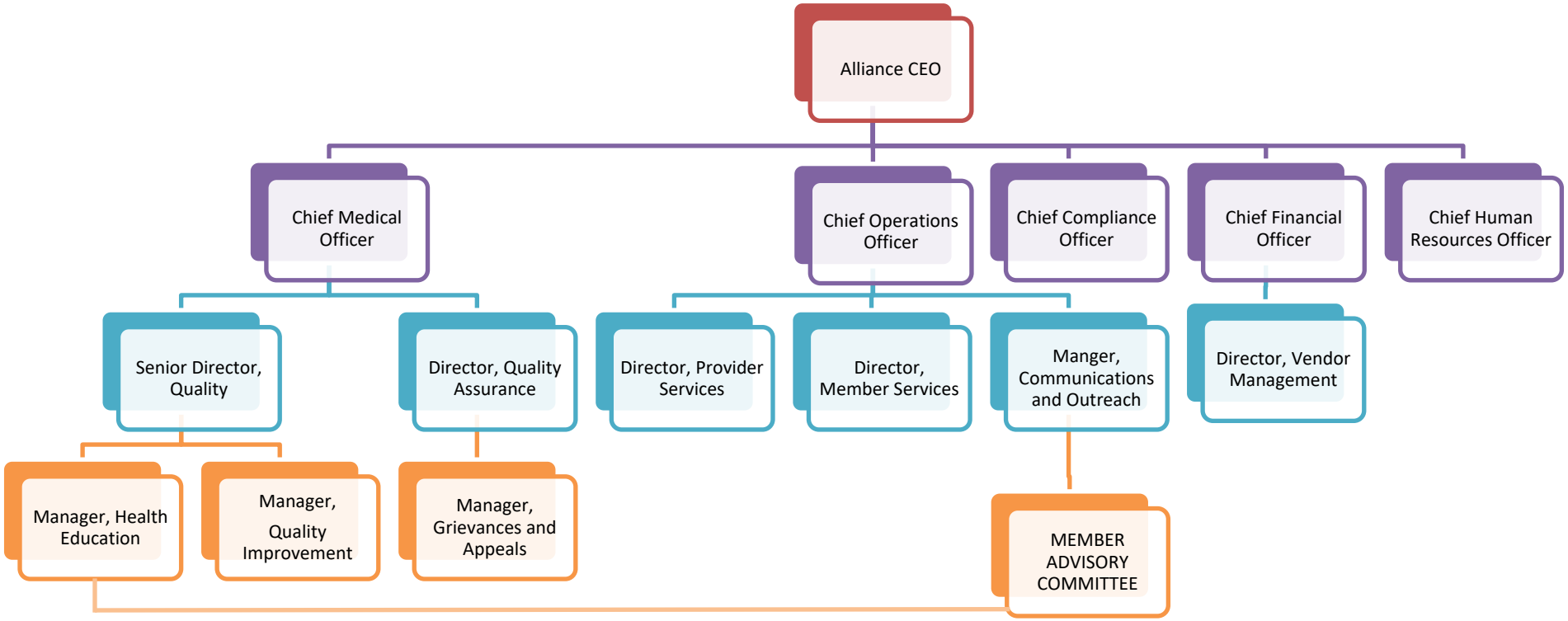
Program	**Staff and Provider Cultural Sensitivity Training**		
Goal	Ensure that all staff, providers and subcontractors are compliant with the cultural and linguistic program through cultural sensitivity training.		
Rationale	**Quarterly Cultural and Linguistic Report Q4 2019:** 38% of members prefer to communicate with the plan in a non-English language. Of those, 85% of members 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%.		
Lead Responsibility	Health Education Manager		
Performance Measure	Objective		
Compliance tracking of AAH staff participation in Cultural Sensitivity Training.	96% of Alliance staff (by July 30, 2021) 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 10/30/2020	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) and one traditional provider for the Member Advisory Committee.		By April 1, 2021	Health Education Manager & Manager, Communications and Outreach
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 2021.	Health Education Manager & Communications and Outreach Manager

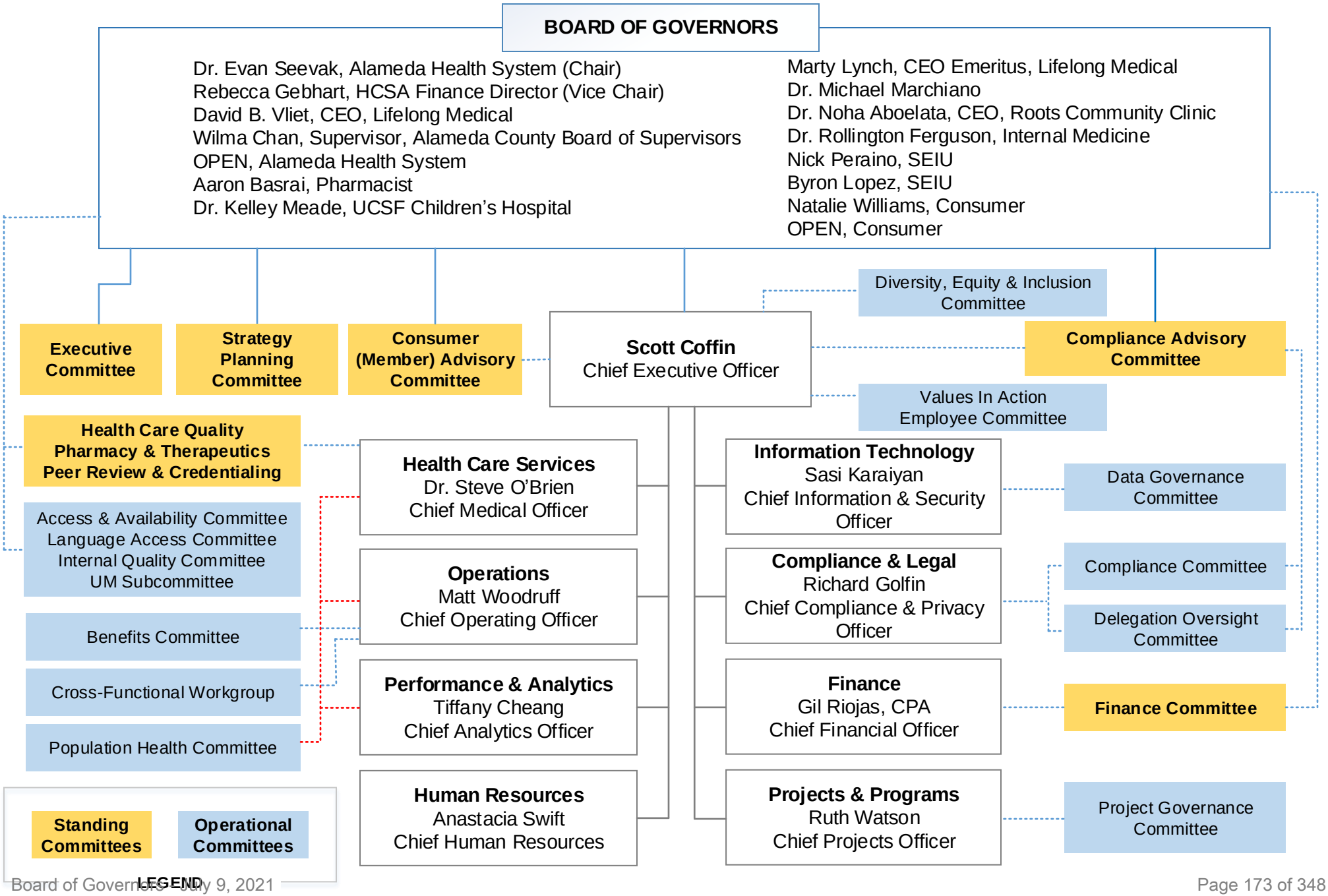
Program	**Monitoring of Cultural and Linguistic Services**		
Goal	**Monitor and continuously improve Alliance activities aimed at achieving cultural competence and reducing health care disparities.**		
Rationale	**AAH Grievances Related C&L and Discrimination/Sensitivity Report Q3 20:** Lack of Language Accessibility grievances averaged 32 per quarter with a range of 28 – 33.		
Rationale Category(s)	√ Contractual Topic ❒ GNA ❒ NCQA √ Quality Improvement		
Lead Responsibility	Health Education Manager		
Performance Measure	Objective		
CLSS Meeting Minutes	Meet regulatory compliance for monitoring quality of language assistance services.		
Supporting Activities		Timeline	Responsible Party(s)
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.		By end of January, April, July and October, 2021.	Manager, Grievances and Appeals; Health Education Manager
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.		October 31, 2021 – yearly renewal.	Executive Director, Human Resources; Health Education Manager; Director, Member Services
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.		Complete review once every three years for Alliance PCPs.	Senior Facility Site Review Nurse
Monitor contracts with interpreter services. Establish CAPs when necessary		Quarterly JOM meetings	Manager, Vendor Management; Health Education Manager
Monitor vendors delegated for language services for quality of language services provided using the C&L Audit Tool.		Yearly review according to Compliance schedule.	Compliance Director and Health Education Manager

Alameda Alliance for Health Organizational Chart
Cultural and Linguistic Services

APPENDIX B



Alameda Alliance for Health
STANDING COMMITTEES & OPERATIONS COMMITTEES



ALAMEDA Alliance FOR HEALTH

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

CEO Update

Scott Coffin

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

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

Date: **July 9, 2021**

Subject: **CEO Report**

- **Operational Performance:**
  - $682,000 net income reported in May 2021; Medi-Cal is reporting a net income of $895K, offset by a $213K net loss in Group Care for the month.
  - Net loss year-to-date is $3.0 million and forecast to end fiscal year 2021 at a $1.5 million net loss (Medi-Cal forecasts a $324K net income offset by a net loss of $1.8 million in Group Care)
  - Enrollment has exceeded 290,000, which is led by Medi-Cal enrollment; Medi-Cal enrollment is 284,000, representing 98% of total enrollment, and the Group Care enrollment remains steady at 6,000 Members per month
  - Regulatory operating metrics that did not meet thresholds included: 1) encounter data reporting for institutional claims 0-180 days, and 2) standard grievances turnaround time were 1% below the target. The encounter data clean-up is carried over from last month and was initially reported to the Board of Governors in May 2021; this metric is expected to resume to compliance in the month of August
  - Non-regulatory operating metrics that did not meet internal performance thresholds included 1) the Provider Disputes & Resolutions overturn rate is 8% above target, 2) Member Services inbound calls answered in 60 seconds or less is 26% below target, and 3) calls abandonment rate over by 9%. Corrective actions are being taken to reduce the provider overturn rate for disputes and to improve the response time in the Member Services call center

- **CalAIM Operational Readiness**
  - Whole Person Care Pilot (AC3) & Health Homes programs end 12/31/2021
  - Enhanced Care Management (ECM) benefits, In Lieu Of Services (ILOS), and Major Organ Transplants (MOT) benefits begin January 1, 2022
  - ECM and MOT are defined benefits and will be incorporated into the Medi-Cal base rates; ILOS is an optional service and is not a defined Medi-Cal benefit, and would be paid by health plans for 2+ years until the retrospective rate development process identifies the expenses (e.g., 2022 actual costs are identified in the 2025 rate development process)
  - CalAIM “Model of Care” submissions are due to the DHCS in 2021:

        - First submission delivered to DHCS on June 29, two days ahead of schedule; includes preliminary set of ILOS and approach to provider network development, and outlines the approach to transitioning the Members in Whole Person Care and Health Homes programs
        - Second submission is due to DHCS by September 1; includes the policies and procedures, and final selection of ILOS
        - Third submission is due to DHCS by October 1; includes the final provider network for all services – ECM, ILOS, MOT (e.g., subcontracting arrangements with Alameda County and community-based organizations)
    - Alameda Alliance and Alameda County Health Care Services Agency (HCSA) are negotiating a subcontracting arrangement for the administration of community-based organizations that deliver housing navigation, tenancy & sustaining services and coordinate housing deposits.
    - ECM, ILOS, and other data sharing is being managed in the Alameda County Social Health Information Exchange (SHIE), and the participating community-based organizations would update patient encounters in a timely manner (e.g., automated data exchange, manual entry)

- **Single Plan Model / County Organized Health System**
    - Countywide impact assessment being conducted to identify costs, benefits, risks, and opportunities to changing Alameda County's Medi-Cal delivery model into a single plan model; safety net partners include Alameda County HCSA, Community Health Center Network, Alameda Health System, and Alameda Alliance for Health
    - Target date to complete the assessment is September 2021, and a progress report will be presented to the Alameda County Board of Supervisors
    - DHCS to launch Medi-Cal procurement for two-plan counties in November 2021 and concludes by December 2023

- **COVID-19 Vaccinations**
    - Approximately 54% of members (12 years and older) in Medi-Cal and Group Care are partially or fully vaccinated, representing a total of 122,292 members in Group Care and Medi-Cal; approximately 7% higher than the previous month, representing an additional 15,000 members; Alameda County is approximately 81% vaccinated, and statewide the vaccination rate exceeds 69%
    - Fifty-four (54%) of the "Low and No Utilization" members are vaccinated, whereas sixty-one (61%) of the "Medium to High" Utilization members are vaccinated; based on members 12 years and older (approx. 230,000 members)

ALAMEDA Alliance FOR HEALTH

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

Operations Dashboard

OPERATIONS DASHBOARD

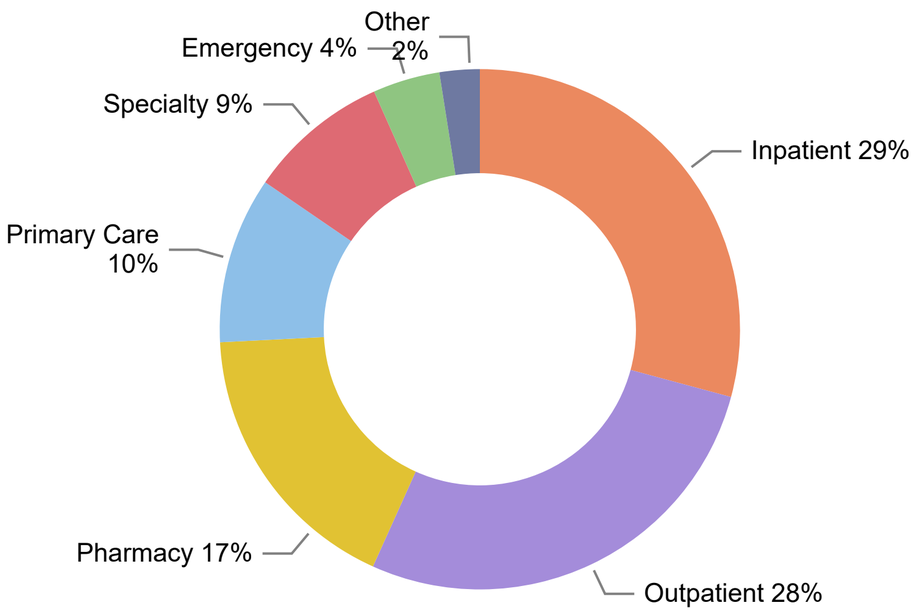
JULY 2021

Financials

Income & Expenses

Revenue	Medical Expense
$984.8M	**($942.3M)**
Other Income/(Exp.)	Admin Expense
$255.3K	**($45.7M)**
Net Income	Gross Margin %
($3.0M)	**4.3%**

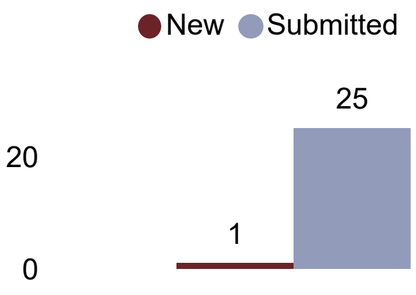
Medical Expenses



Liquid Reserves

MLR Net %	95.7%
TNE %	555.7%
TNE $	$203.1M

Reinsurance Cases



Balance Sheet

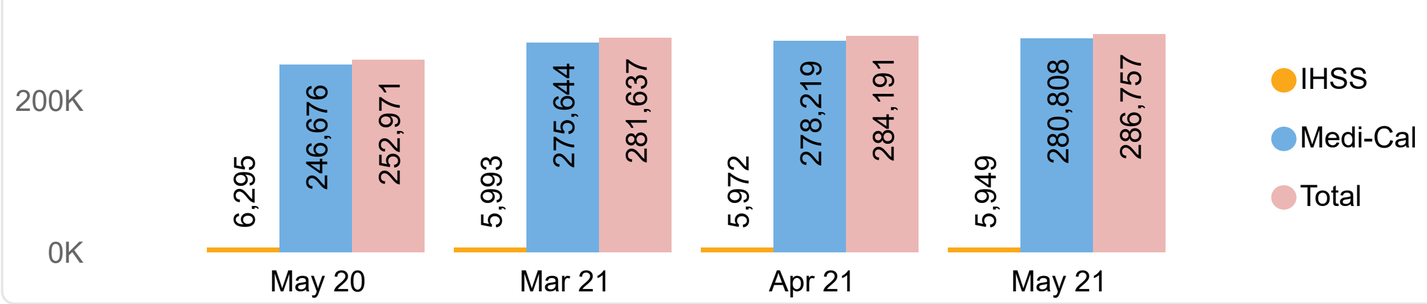
Cash Equivalents	$309.8M
Pass-Through Liabilities	$114.3M
Uncommitted Cash	$195.4M
Working Capital	$195.1M

Current Ratio %

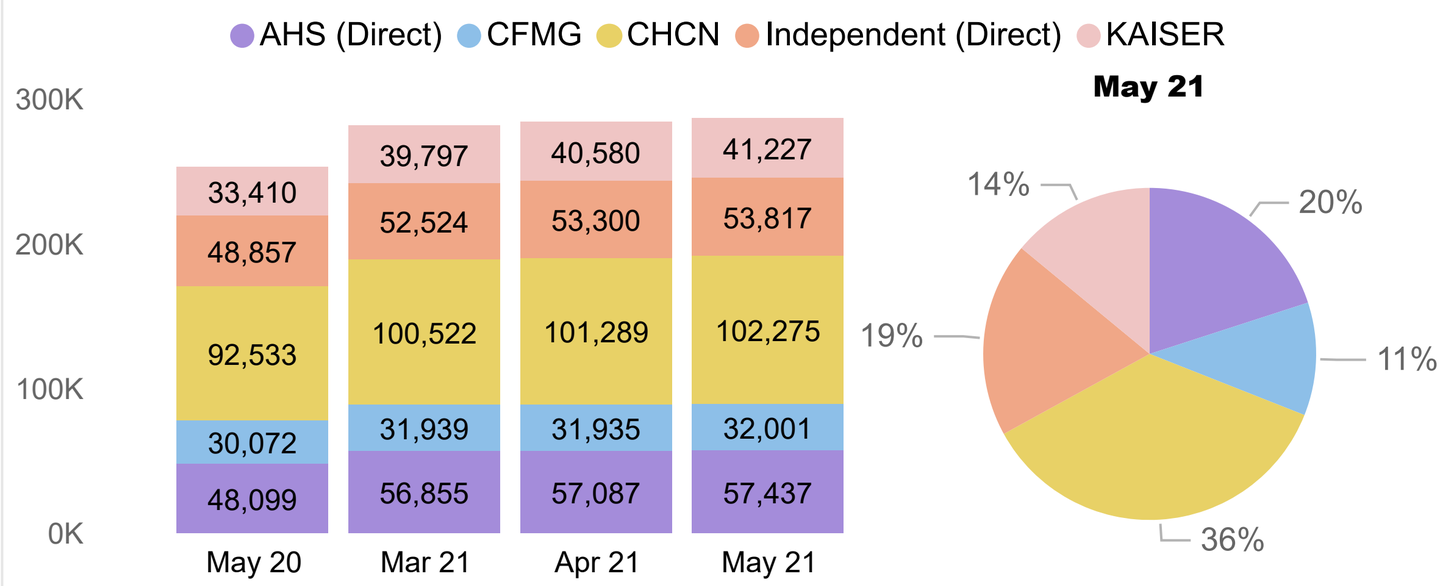
174.2%

Membership

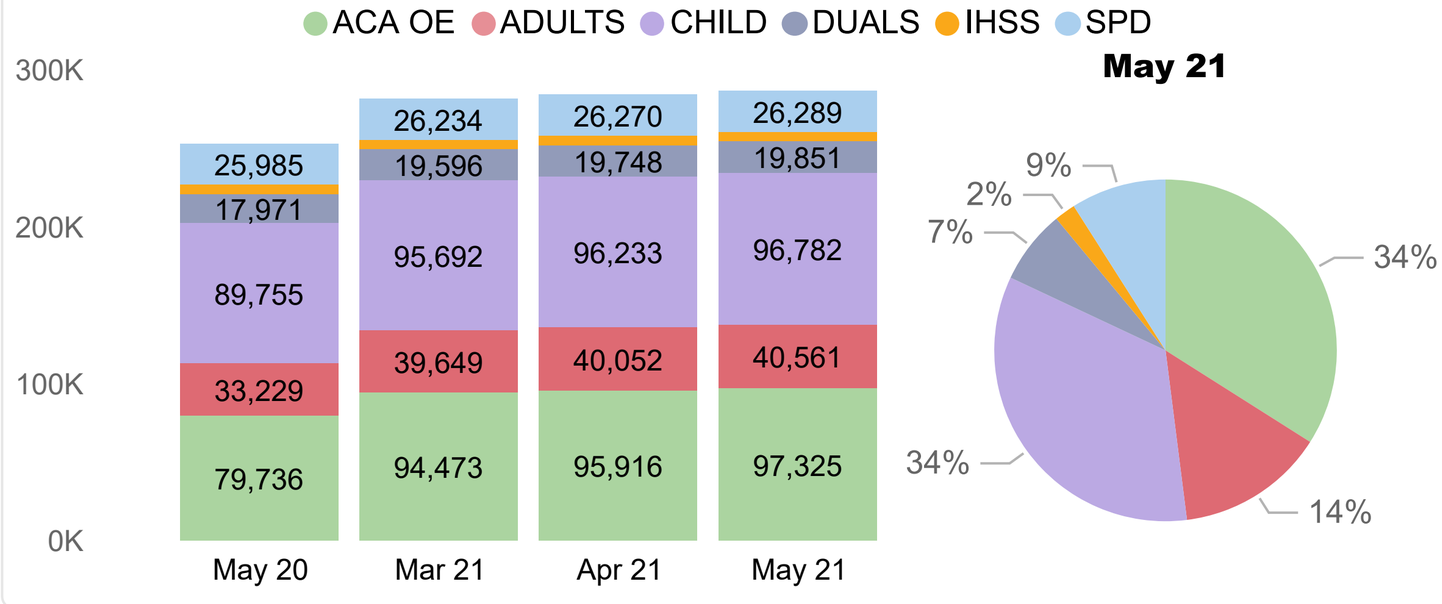
By Plan



By Network



By Category

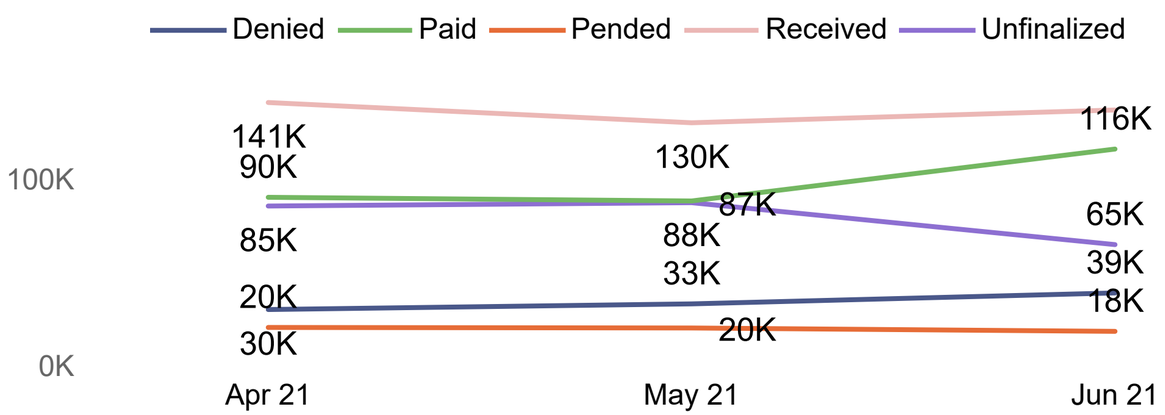


OPERATIONS DASHBOARD

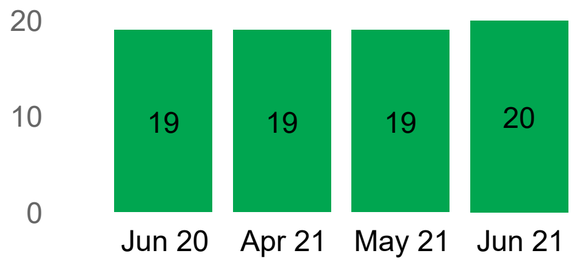
JULY 2021

Claims

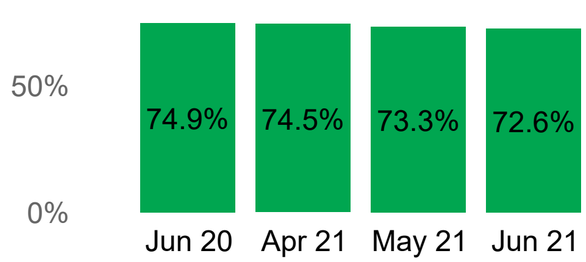
Claims Processing



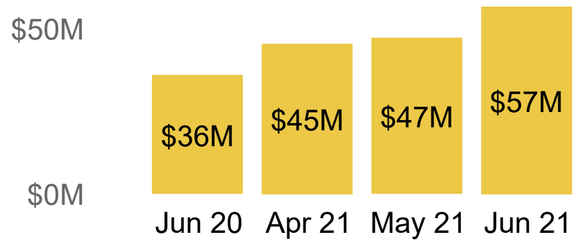
Average Payment TAT (Days)



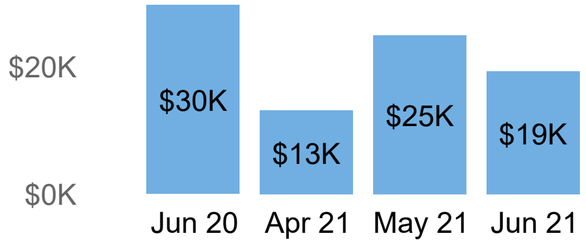
Auto Adjudication Rate (%)



Claims Paid (Dollars)

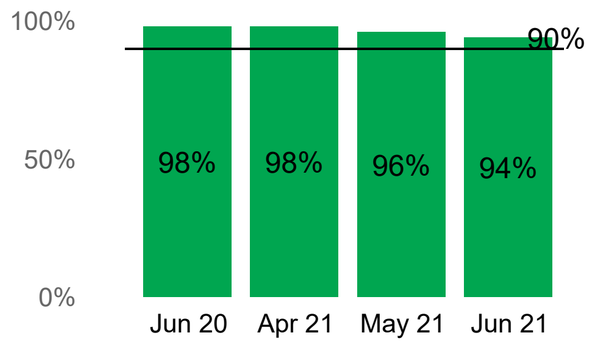


Interest Paid (Dollars)

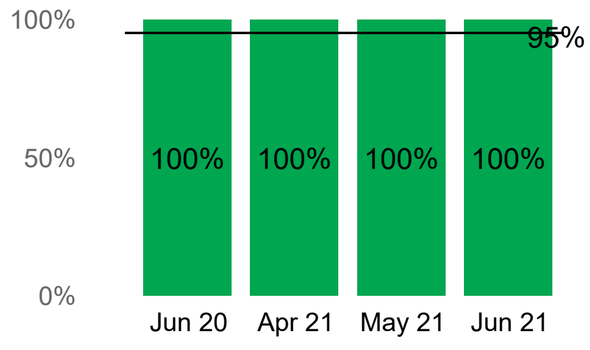


Claims Compliance

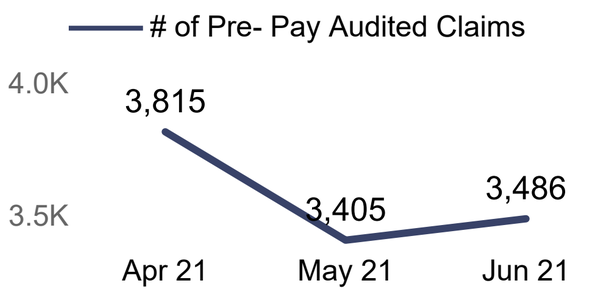
% Processed (30 Cal Days)



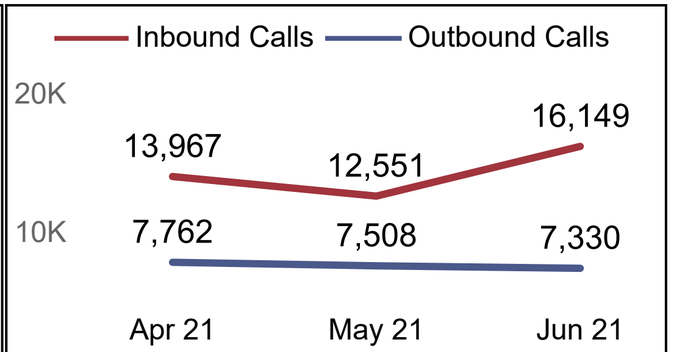
% Processed (45 Work Days)



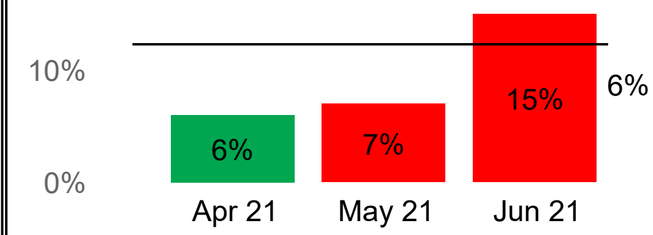
Claims Auditing



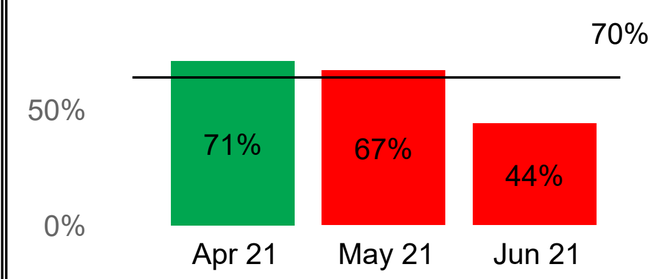
Member Services



Abandoned Call Rate %

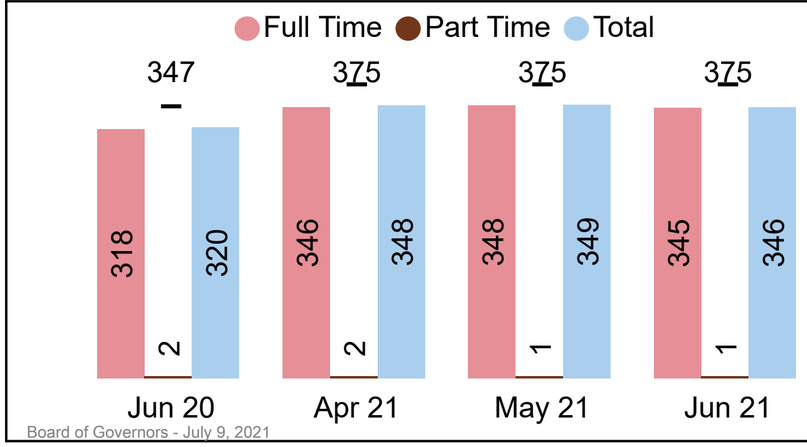


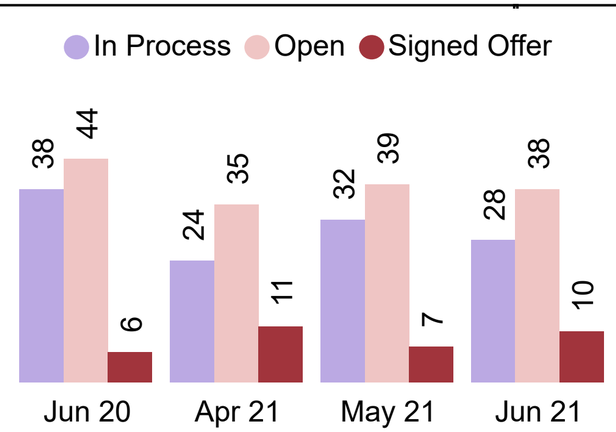
Calls Answered in 60 Seconds %



Average Call Times	Apr 21	May 21	Jun 21
Wait Time	00:54	01:04	02:23
Call Duration	06:33	06:09	06:23

Human Resources





Recruiting	Jun 20	Apr 21	May 21	Jun 21
New Hires	3	3	5	2
Separations	1	3	2	5
Temps / Seasonal	3	6	6	7

Current Vacancy

10%

OPERATIONS DASHBOARD

JULY 2021

Provider Services

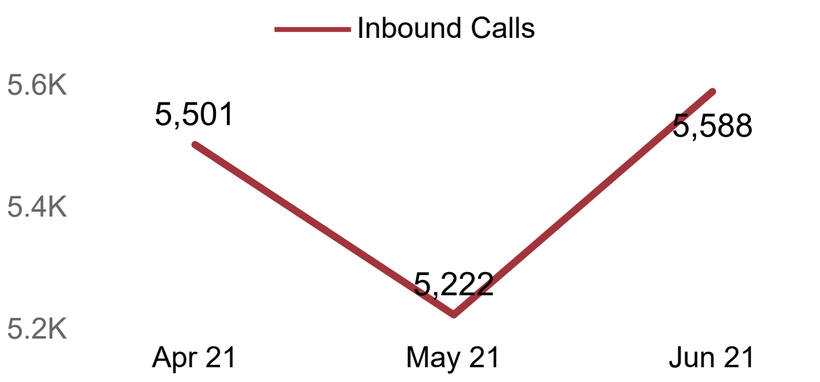
Provider Network

Primary Care Physician	694
Specialist	6,976
Hospital	17
Skilled Nursing Facility	65
Durable Medical Equipment	Capitated
Urgent Care	10
Health Centers (FQHCs and Non-FQHCs)	67
Transportation	380

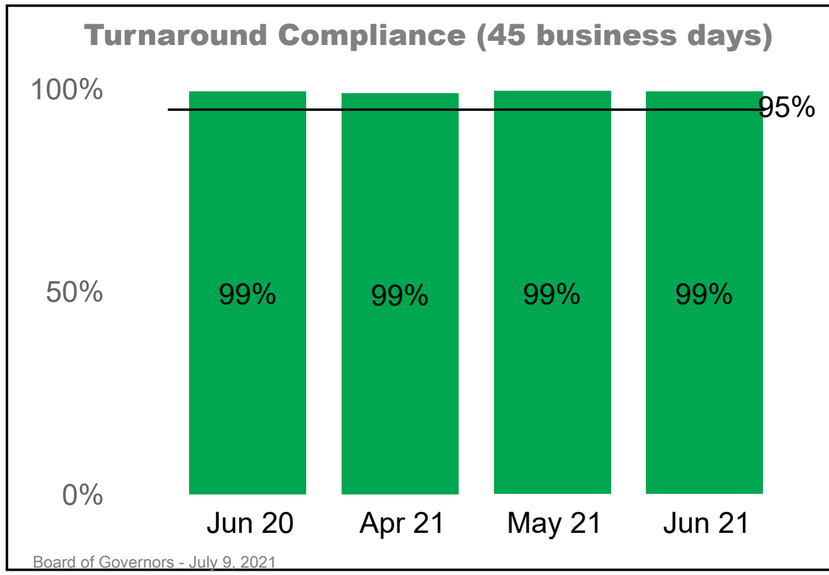
Provider Credentialing

1,416

Provider Call Center

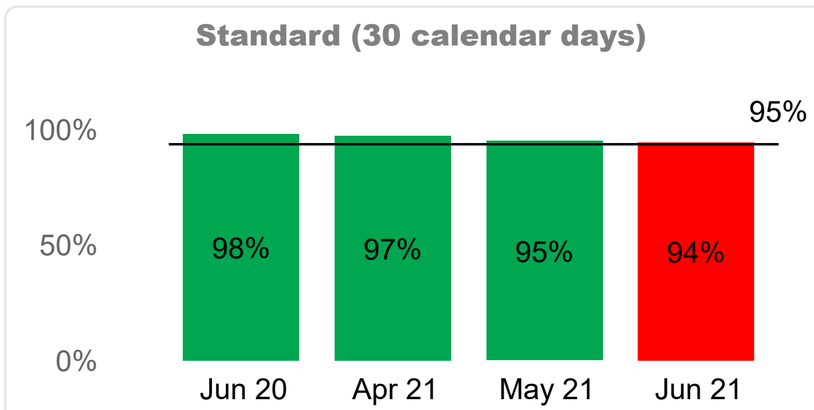


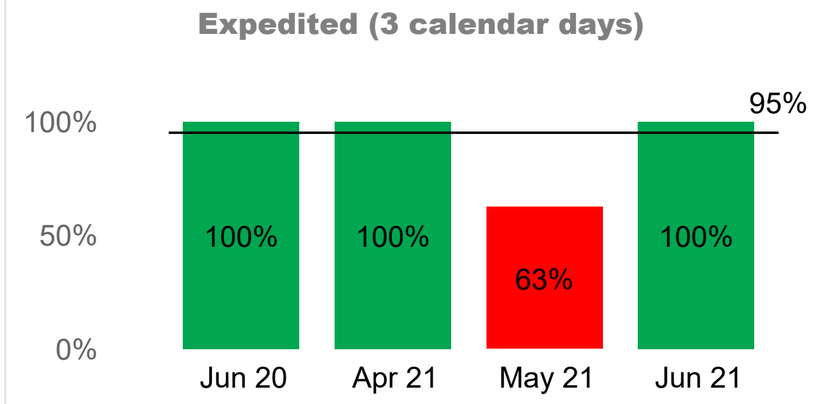
Provider Disputes & Resolutions



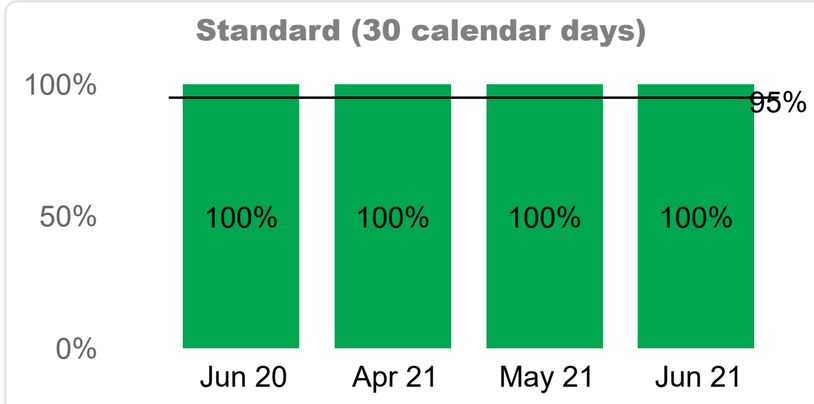
Compliance

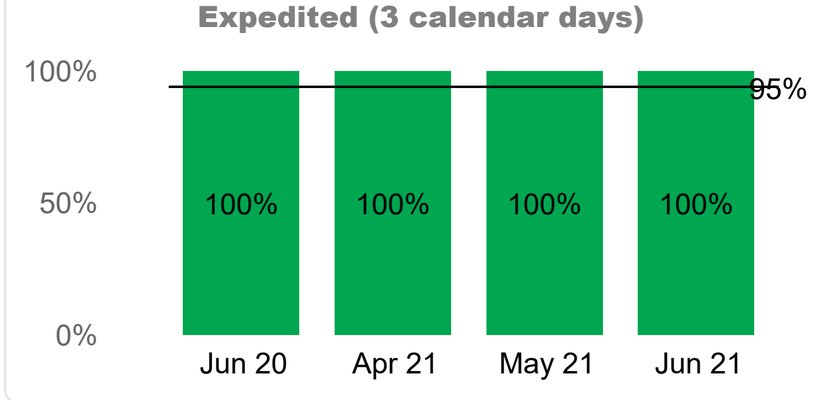
Member Grievances



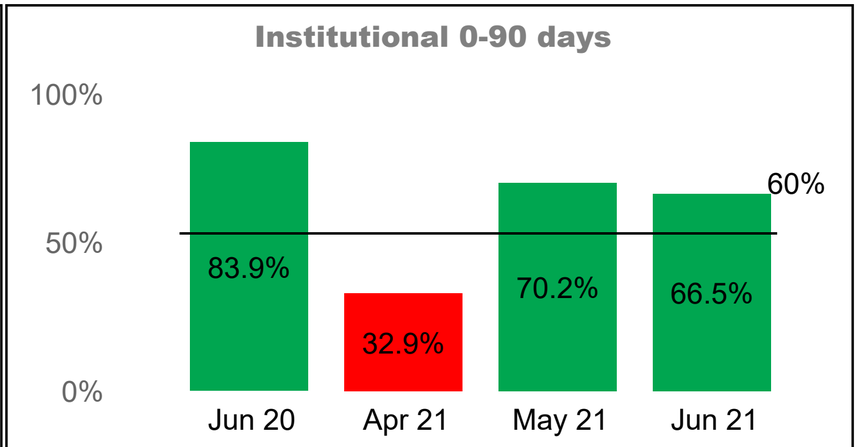


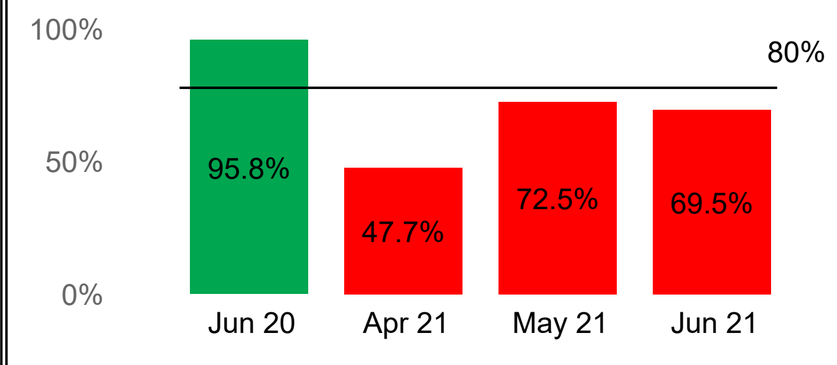
Member Appeals

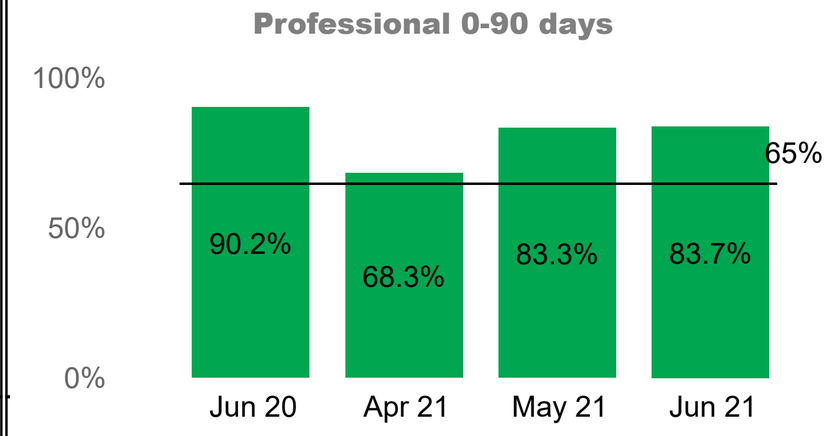


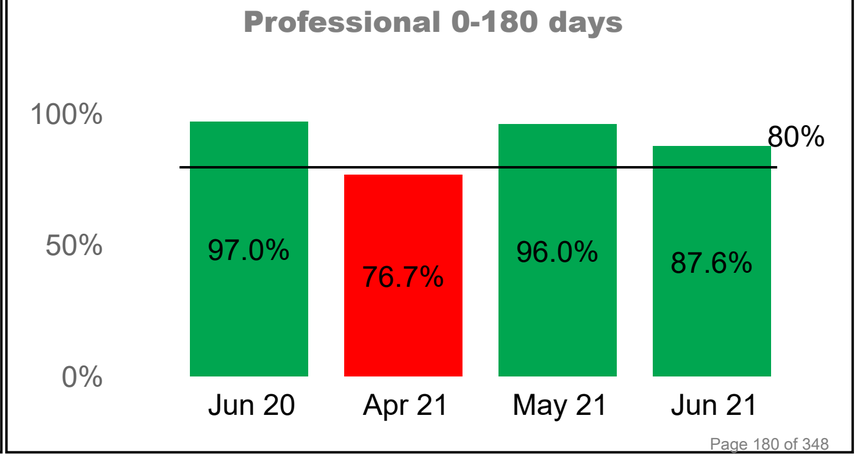


Encounter Data







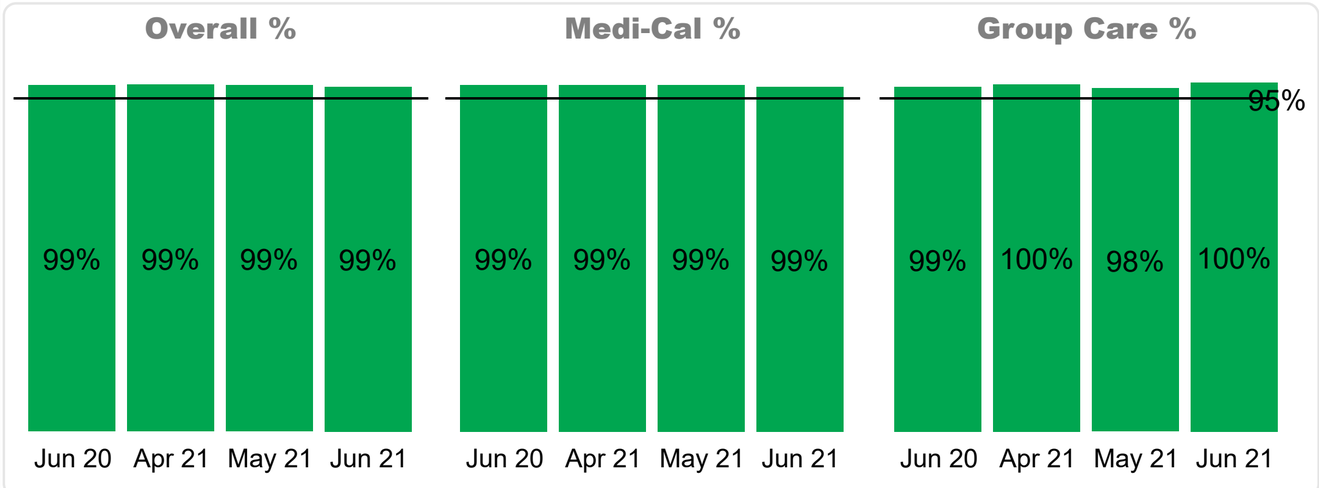


OPERATIONS DASHBOARD

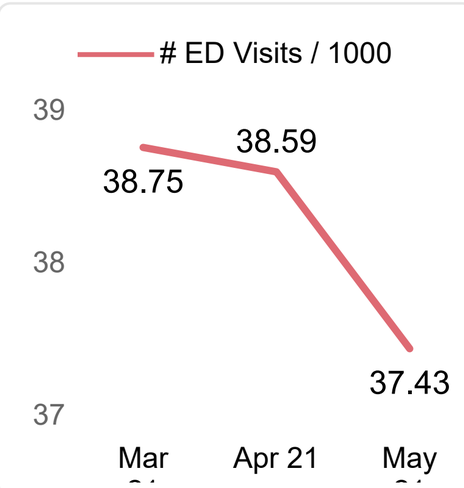
JULY 2021

Health Care Services

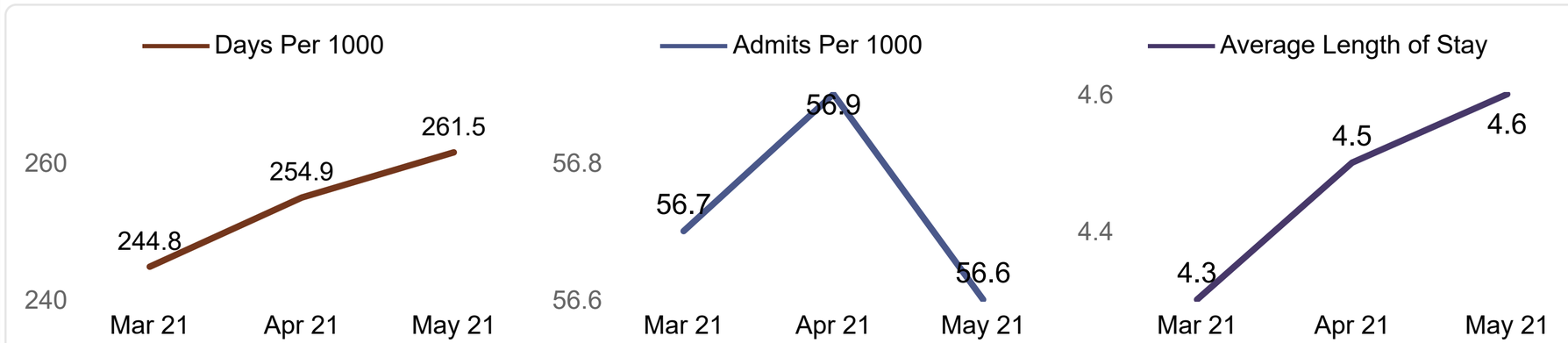
Authorization Turnaround



ED Utilization

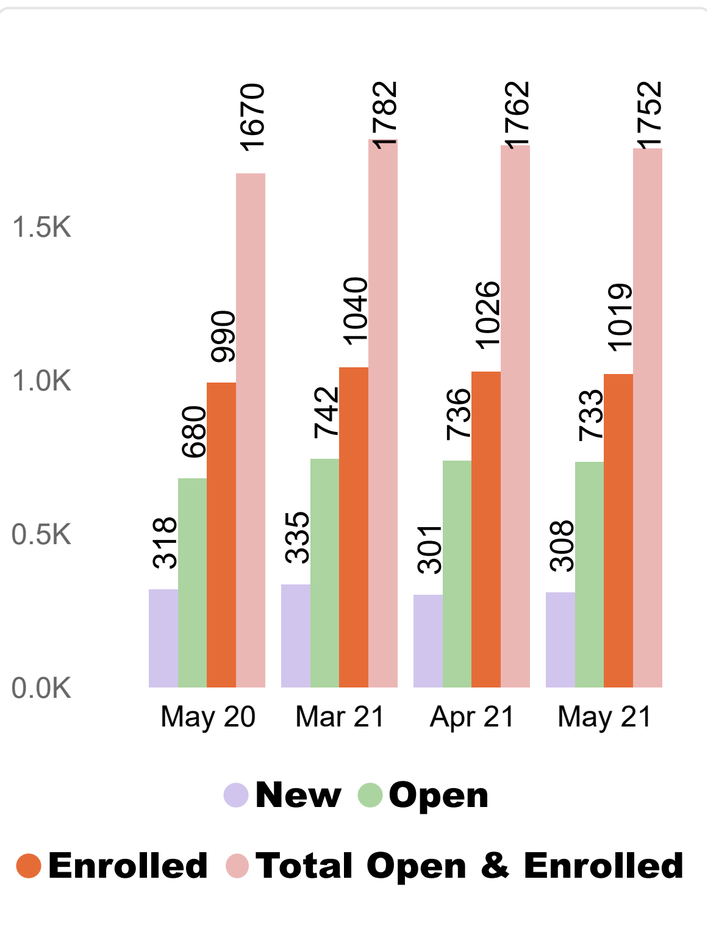


Inpatient Utilization

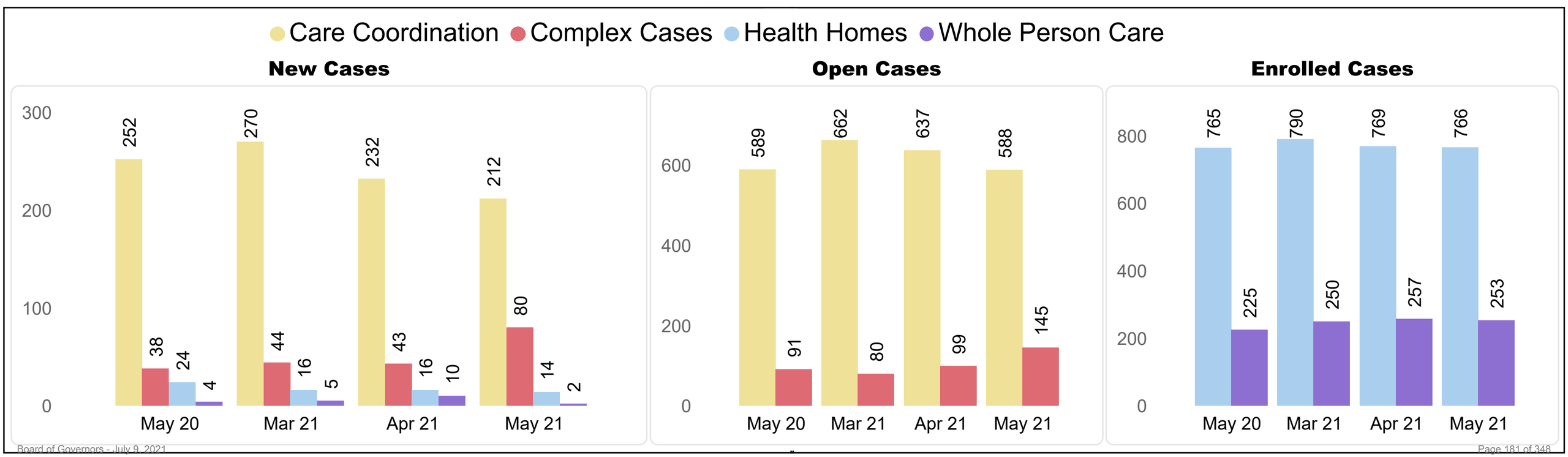


Case Management

Total Cases



Case Management



Technology (Business Availability)

Applications	Jun 20	Apr 21	May 21	Jun 21
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 20	Apr 21	May 21	Jun 21
Denial Rate Excluding Partial Denials (%)	3.4%	3.8%	3.5%	3.5%
Overall Denial Rate (%)	3.4%	3.8%	3.6%	3.6%
Partial Denial Rate (%)	0.1%	0.1%	0.1%	0.1%

Pharmacy Authorizations

Authorizations ▲	Jun 20	Apr 21	May 21	Jun 21
Approved Prior Authorizations	722	954	796	826
Closed Prior Authorizations	466	589	552	559
Denied Prior Authorizations	565	655	583	693
Total Prior Authorizations	1,753	2,198	1,931	2,078

Legislative Tracking

2021-2022 Legislative Tracking List

The following is a list of state bills currently tracked by the Public Affairs Department that have been introduced during the 2021-2022 Legislative Session that is of interest to and could have a direct impact on Alameda Alliance for Health and its membership.

Medi-Cal (Medicaid)

Bills in process in house of origin:

- **AB 852 (Wood – D) Nurse Practitioners: Scope of Practice: Practice without Standardized Procedures**
  - **Introduced:** 2/17/2021
  - **Status:** 6/3/21 Referred to Coms. on B., P. & E.D. and JUD.
  - **Summary:** This bill would refer to practice protocols, as defined, instead of individual protocols and would delete the requirement to obtain physician consultation in the case of acute decompensation of patient situation. The bill would revise the requirement to establish a referral plan, as described above, by requiring it to address the situation of a patient who is acutely decompensating in a manner that is not consistent with the progression of the disease and corresponding treatment plan.

- **AB 382 (Kamlager – D) Whole Child Model Program**
  - **Introduced:** 2/2/2021
  - **Status:** 6/24/21 Read third time. Passed. Ordered to the Assembly. (Ayes 39. Noes 0.). In Assembly. Ordered to Engrossing and Enrolling.
  - **Summary:** Current law authorizes the State Department of Health Care Services to establish a Whole Child Model (WCM) program, under which managed care plans served by a county-organized health system or Regional Health Authority in designated counties provide CCS services to Medi-Cal eligible CCS children and youth. Current law requires the department to establish a statewide WCM program stakeholder advisory group that includes specified persons, such as CCS case managers, to consult with that advisory group on the implementation of the WCM and to consider the advisory group's recommendations on prescribed matters. The existing law terminates the advisory group on December 31, 2021. This bill would instead terminate the advisory group on December 31, 2023.

- **SB 281 (Dodd – D) Medi-Cal: California Community Transitions Program**
  - **Introduced:** 2/1/2021
  - **Status:** 5/20/21 Referred to Com. on HEALTH.
  - **Summary:** Current law requires the State Department of Health Care Services to provide services consistent with the Money Follows the Person Rebalancing Demonstration for transitioning eligible individuals out of an inpatient facility who have not resided in the facility for at least 90 days, and to cease providing those services on January 1, 2024. Current law repeals these provisions on January 1, 2025. This bill would instead require the department to provide those services for individuals who have not resided in the facility for at least 60 days and would make conforming changes. The bill would extend the provision of those services to January 1, 2029, and would extend the repeal date of those provisions to January 1, 2030.

- **SB 365 (Caballero – D) E-consult Service**
  - **Introduced:** 2/17/2021
  - **Status:** 6/3/21 Referred to Com. on HEALTH.
  - **Summary:** Would make electronic consultation services reimbursable under the Medi-Cal program for enrolled providers, including FQHCs or RHCs. The bill would require the department to seek federal waivers and approvals to implement this provision and would condition the implementation of the bill's provisions on the department obtaining necessary federal approval of federal matching funds. The bill would make related findings and declarations.

Bills moved for action in second house:

- **AB 4 (Arambula – D) Medi-Cal: Eligibility**
  - **Introduced:** 12/8/2020
  - **Status:** 6/16/21 From committee: Do pass and re-refer to Com. on APPR. (Ayes 8. Noes 2.) (June 16). Re-referred to Com. on APPR.
  - **Summary:** Would, effective January 1, 2022, extend eligibility for full-scope Medi-Cal benefits to anyone regardless of age and who is otherwise eligible for those benefits but for their immigration status, pursuant to an eligibility and enrollment plan. The bill would delete the specified provisions regarding individuals who are under 25 years of age or 65 years of age or older and delaying implementation until the director makes the determination described above. The bill would require the eligibility and enrollment plan to ensure that an individual maintains continuity of care with respect to their primary care provider, as prescribed, would provide that an individual is not limited in their ability to select a different health care provider or Medi-Cal managed care health plan, and would require the department to provide monthly updates to the appropriate policy and fiscal committees of the Legislature on the status of the implementation of these provisions.

- **AB 32 (Aguilar-Curry – D) Telehealth**
  - **Introduced:** 12/7/2020
  - **Status:** 6/9/21 Referred to Com. on HEALTH.
  - **Summary:** Current law requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2021, to specify that coverage is provided for health care services appropriately delivered through telehealth on the same basis and to the same extent as in-person diagnosis, consultation, or treatment. Current law exempts Medi-Cal managed care plans that contract with the State Department of Health Care Services under the Medi-Cal program from these provisions and generally exempt county-organized health systems that provide services under the Medi-Cal program from Knox-Keene. This bill would delete the above-described references to contracts issued, amended, or renewed on or after January 1, 2021, would require these provisions to apply to the plan or insurer's contracted entity, as specified, and would delete the exemption for Medi-Cal managed care plans. The bill would subject county-organized health systems and their subcontractors that provide services under the Medi-Cal program to the above-described Knox-Keene requirements relative to telehealth.

- **AB 114 (Mainenschein – D) Medi-Cal Benefits: Rapid Whole Genome Sequencing**
  - **Introduced:** 12/17/2020
  - **Status:** 6/30/21 In committee: Hearing postponed by committee.
  - **Summary:** Would expand the Medi-Cal schedule of benefits to include rapid Whole Genome Sequencing, as specified, for any Medi-Cal beneficiary who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit. The bill would authorize the State

Department of Health Care Services to implement this provision by various means without taking regulatory action.

- **AB 369 (Kamlager – D) Medi-Cal Services: Persons Experiencing Homelessness**
  - **Introduced:** 2/1/2021
  - **Status:** 6/15/21 From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.
  - **Summary:** Would require the State Department of Health Care Services to implement a program of presumptive eligibility for persons experiencing homelessness, under which a person would receive full-scope Medi-Cal benefits without a share of cost. The bill would require the department to authorize an enrolled Medi-Cal provider to issue a temporary Medi-Cal benefits identification card to a person experiencing homelessness and would prohibit the department from requiring a person experiencing homelessness to present a valid California driver's license or identification card issued by the Department of Motor Vehicles to receive Medi-Cal services if the provider verifies the person's eligibility.

- **AB 470 (Carillo – D) Medi-Cal: Eligibility**
  - **Introduced:** 2/8/2021
  - **Status:** 6/30/21 From committee: Do pass and re-refer to Com. on APPR. (Ayes 10. Noes 0.) (June 30). Re-referred to Com. on APPR.
  - **Summary:** Would prohibit the use of resources, including property or other assets, to determine eligibility under the Medi-Cal program to the extent permitted by federal law, and would require the department to seek federal authority to disregard all resources as authorized by the flexibilities provided pursuant to federal law. The bill would authorize the State Department of Health Care Services to implement this prohibition by various means, including provider bulletins, without taking regulatory authority. By January 1, 2023, the bill would require the department to adopt, amend, or repeal regulations on the prohibition and to update its notices and forms to delete any reference to limitations on resources or assets.

- **AB 540 (Petrie-Norris – D) Program of All-Inclusive Care for the Elderly**
  - **Introduced:** 2/10/2021
  - **Status:** 6/16/21 Referred to Com. on HEALTH.
  - **Summary:** Current state law establishes the California Program of All-Inclusive Care for the Elderly (PACE program) to provide community-based, risk-based, and capitated long-term care services as optional services under the state's Medi-Cal State Plan, as specified. Current law authorizes the State Department of Health Care Services to enter into contracts with various entities for the purpose of implementing the PACE program and fully implementing the single-state agency responsibilities assumed by the department in those contracts, as specified. This bill would exempt a Medi-Cal beneficiary who is enrolled in a PACE organization with a contract with the department from mandatory or passive enrollment in a Medi-Cal managed care plan, and would require persons enrolled in a PACE plan to receive all Medicare and Medi-Cal services from the PACE program.

- **AB 586 (O'Donnell – D) Pupil Health: Mental Health Services: School Health Demonstration Project**
  - **Introduced:** 2/11/2021
  - **Status:** 6/23/21 From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on ED.
  - **Summary:** Would establish, within the State Department of Education, the School Health Demonstration Project, a pilot project, to be administered by the department, in consultation with

the State Department of Health Care Services, to expand comprehensive health and mental health services to public school pupils by providing training and support services to selected local educational agencies to secure ongoing Medi-Cal funding for those health and mental health services, as provided.

- **AB 1104 (Grayson – D) Air Ambulance Services**
  - **Introduced:** 2/18/2021
  - **Status:** 7/1/21 Read second time and amended. Re-referred to Com. on PUB. S.
  - **Summary:** Current law imposes a penalty of $4 until July 1, 2021, upon every conviction for a violation of the Vehicle Code or a local ordinance adopted pursuant to the Vehicle Code, other than a parking offense. The act requires the county or court that imposed the fine to transfer the revenues collected to the Treasurer for deposit into the Emergency Medical Air Transportation and Children's Coverage Fund. Current law requires the assessed penalty to continue to be collected, administered, and distributed until exhausted or until December 31, 2022, whichever occurs first. These provisions remain in effect until January 1, 2024, and are repealed effective January 1, 2025. This bill would extend the assessment of penalties pursuant to the above-described provisions until December 31, 2022, and would extend the collection and transfer of penalties until December 31, 2023.

- **AB 1132 (Wood – D) Medi-Cal**
  - **Introduced:** 2/18/2021
  - **Status:** 6/16/21 Referred to Coms. on HEALTH and PUB. S.
  - **Summary:** The Medi-Cal 2020 Demonstration Project Act requires the State Department of Health Care Services to implement specified components of a Medi-Cal demonstration project, including the Global Payment Program and the Whole Person Care pilot program, consistent with the Special Terms and Conditions approved by the federal Centers for Medicare and Medicaid Services. Pursuant to existing law, the department has created a multiyear initiative, the California Advancing and Innovating Medi-Cal (CalAIM) initiative, for purposes of building upon the outcomes of various Medi-Cal pilots and demonstration projects, including the Medi-Cal 2020 demonstration project. This bill would make specified portions of the CCI operative only through December 31, 2022, as specified, and would repeal its provisions on January 1, 2025

- **AB 1051 (Bennett D) Medi-Cal: specialty mental health services: foster youth.**
  - **Introduced:** 2/18/2021
  - **Status:** 6/28/21 From committee: Do pass and re-refer to Com. on HUMAN S. with recommendation: To Consent Calendar. (Ayes 11. Noes 0.) (June 23). Re-referred to Com. on HUMAN S.
  - **Summary:** Current law requires the State Department of Health Care Services to issue policy guidance concerning the conditions for, and exceptions to, presumptive transfer of responsibility for providing or arranging for specialty mental health services to a foster youth from the county of original jurisdiction to the county in which the foster youth resides, as prescribed. This bill would make those provisions for presumptive transfer inapplicable to a foster youth or probation-involved youth placed in a community treatment facility, group home, or a short-term residential therapeutic program (STRTP) outside of their county of original jurisdiction, as specified.

- **SB 56 (Durazno – D) Medi-Cal: Eligibility**
  - **Introduced:** 12/7/2020
  - **Status:** 6/23/21 Coauthors revised. From committee: Do pass and re-refer to Com. on APPR. (Ayes 11. Noes 3.) (June 22). Re-referred to Com. on APPR.

- **Summary:** Current law provides that Medi-Cal benefits for individuals who are 65 years of age or older, and who do not have satisfactory immigration statuses or are unable to establish satisfactory immigration statuses, will be prioritized in the Budget Act for the upcoming fiscal year if the Department of Finance projects a positive ending balance in the Special Fund for Economic Uncertainties for the upcoming fiscal year and each of the ensuing 3 fiscal years that exceeds the cost of providing those individuals with full-scope Medi-Cal benefits. This bill would, subject to an appropriation by the Legislature, and effective July 1, 2022, extend eligibility for full-scope Medi-Cal benefits to individuals who are 60 years of age or older, and who are otherwise eligible for those benefits but for their immigration status.

- **SB 242 (Newman – D) Health Care Provider Reimbursements**
  - **Introduced:** 1/21/2021
  - **Status:** 6/10/21 Referred to Com. on HEALTH.
  - **Summary:** Would require a health care service plan or health insurer to contract with its health care providers to reimburse, at a reasonable rate, their business expenses that are medically necessary to comply with a public health order to render treatment to patients, to protect health care workers, and to prevent the spread of diseases causing public health emergencies. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

- **SB 250 (Pan – D) Health Care Coverage**
  - **Introduced:** 1/25/2021
  - **Status:** 6/10/21 Referred to Com. on HEALTH.
  - **Summary:** Would authorize the Department of Managed Health Care and the Insurance Commissioner, as appropriate, to review a plan's or insurer's clinical criteria, guidelines, and utilization management policies to ensure compliance with existing law. If the criteria and guidelines are not in compliance with existing law, the bill would require the Director of the Department of Managed Health Care or the commissioner to issue a corrective action and send the matter to enforcement, if necessary. The bill would require each department, on or before July 1, 2022, to develop a methodology for a plan or insurer to report the number of prospective utilization review requests it denied in the preceding 12 months, as specified.

- **SB 256 (Pan – D) California Advancing and Innovating Medi-Cal**
  - **Introduced:** 1/26/2021
  - **Status:** 6/10/21 Referred to Com. on HEALTH.
  - **Summary:** Current federal law authorizes specified managed care entities that participate in a state's Medicaid program to cover, for enrollees, services or settings that are in lieu of services and settings otherwise covered under a state plan. This bill would establish the CalAIM initiative and would require the implementation of CalAIM to support stated goals of identifying and managing the risk and needs of Medi-Cal beneficiaries, transitioning and transforming the Medi-Cal program to a more consistent and seamless system, and improving quality outcomes. The bill would require the department to seek federal approval for the CalAIM initiative and would condition its implementation on receipt of any necessary federal approvals and availability of federal financial participation.

- **SB 293 (Limon – D) Medi-Cal: Specialty Mental Health Services**
  - **Introduced:** 2/1/2021
  - **Status:** 6/10/21 Referred to Com. on HEALTH.
  - **Summary:** Current law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals to receive

health care services, including specialty mental health services, and Early and Periodic Screening, Diagnostic, and Treatment services for an individual under 21 years of age. With respect to specialty mental health services provided under the Early and Periodic Screening, Diagnostic, and Treatment Program, on or after January 1, 2022, this bill would require the department to develop standard forms, including intake and assessment forms, relating to medical necessity criteria, mandatory screening and transition of care tools, and documentation requirements pursuant to specified terms and conditions, and, for purposes of implementing these provisions, would require the department to consult with representatives of identified organizations, including the County Behavioral Health Directors Association of California.

- **SB 316 (Eggman – D) Medi-Cal: Federally Qualified Health Centers and Rural Health Clinics**
  - **Introduced:** 2/4/2021
  - **Status:** 6/23/21 Coauthors revised. From committee: Do pass and re-refer to Com. on APPR. with recommendation: To consent calendar. (Ayes 15. Noes 0.) (June 22). Re-referred to Com. on APPR.
  - **Summary:** Current law provides that FQHC and RHC services are to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. “Visit” is defined as a face-to-face encounter between a patient of an FQHC or RHC and specified health care professionals, including a physician and marriage and family therapist. Under existing law, “physician,” for these purposes, includes, but is not limited to, a physician and surgeon, an osteopath, and a podiatrist. This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit or a dental visit, as defined. The bill would authorize an FQHC or RHC that currently includes the cost of a medical visit and a mental health visit that take place on the same day at a single location as a single visit for purposes of establishing the FQHC’s or RHC’s rate to apply for an adjustment to its per-visit rate, and after the department has approved that rate adjustment, to bill a medical visit and a mental health visit that take place on the same day at a single location as separate visits, in accordance with the bill.

- **SB 428 (Hurtado – D) Health Care Coverage: Adverse Childhood Experiences Screenings**
  - **Introduced:** 2/12/2021
  - **Status:** 6/10/21 Referred to Com. on HEALTH.
  - **Summary:** Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2022, to provide coverage for adverse childhood experiences screenings. 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 523 (Leyva – D) Health Care Coverage: Contraceptives**
  - **Introduced:** 2/10/2021
  - **Status:** 6/23/21 From committee: Do pass and re-refer to Com. on HEALTH. (Ayes 5. Noes 1.) (June 22). Re-referred to Com. on HEALTH.
  - **Summary:** Current law establishes health care coverage requirements for contraceptives, including, but not limited to, requiring a health care service plan, including a Medi-Cal managed care plan, or a health insurance policy issued, amended, renewed, or delivered on or after January 1, 2017, to cover up to a 12-month supply of federal Food and Drug Administration approved, self-administered hormonal contraceptives when dispensed at one time for an enrollee or insured by a provider or pharmacist, or at a location licensed or authorized to dispense drugs or supplies.

This bill, the Contraceptive Equity Act of 2021, would make various changes to expand coverage of contraceptives by a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on and after January 1, 2022, including requiring a health care service plan or health insurer to provide point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices, and products at in-network pharmacies without cost-sharing or medical management restrictions.

Bills left on suspense file that may be acted upon in January 2022

- **AB 368 (Bonta – D) Food Prescriptions**
  - **Introduced:** 2/1/2021
  - **Status:** 5/25/21 Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/28/2021) (May be acted upon Jan 2022)
  - **Summary:** Would require the State Department of Health Care Services to establish, no earlier than January 1, 2022, a pilot program for a 2-year period in the Counties of Alameda, Fresno, and San Bernardino to provide food prescriptions to eligible Medi-Cal beneficiaries, including individuals who have a specified chronic health condition, such as Type 2 diabetes and hypertension, when utilizing evidence-based practices that demonstrate the prevention, treatment, or reversal of those specified diseases. The bill would authorize the department, in consultation with stakeholders, to establish utilization controls, including the limitation on food prescriptions, and to enter into contracts for purposes of implementing the pilot program.

- **AB 77 (Petrie-Norris – D) Substance use Disorder Treatment Services**
  - **Introduced:** 12/7/2020
  - **Status:** 4/30/21 Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 3/25/2021) (May be acted upon Jan 2022).
  - **Summary:** This bill, commencing January 1, 2026, would require any substance use disorder treatment program to be licensed by the State Department of Health Care Services, except as specified. The bill would require the department, in administering these provisions, to issue licenses for a period of 2 years for substance use disorder treatment programs that meet the requirements in these provisions. The bill would require the department to issue a license to a substance use disorder program once various requirements have been met, including an onsite review. The bill would authorize the department to renew a license, as provided. The bill would prohibit providing substance use disorder treatment services to individuals without a license.

- **AB 112 (Holden – D) Medi-Cal Eligibility**
  - **Introduced:** 12/17/2020
  - **Status:** 5/25/21 Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/21/2021) (May be acted upon Jan 2022)
  - **Summary:** Current federal law prohibits a state from terminating Medi-Cal eligibility for an eligible juvenile if they are an inmate of a public institution, authorizes the suspension of Medicaid benefits to that eligible juvenile, and requires a state to conduct a redetermination of Medicaid eligibility or process an application for medical assistance under the Medicaid program for an eligible juvenile who is an inmate of a public institution. Under current state law, the suspension of Medi-Cal benefits to an inmate of a public institution who is a juvenile, as defined in federal law, ends when

the individual is no longer an eligible juvenile pursuant to federal law or one year from the date the individual becomes an inmate of a public institution, whichever is later. This bill would instead require the suspension of Medi-Cal benefits to an inmate of a public institution who is not a juvenile to end on the date they are no longer an inmate of a public institution or 3 years from the date they become an inmate of a public institution, whichever is sooner.

- **AB 265 (Petrie-Norris – D) Medi-Cal: Reimbursement Rates**
  - **Introduced:** 1/15/2021
  - **Status:** 5/25/21 Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/14/2021) (May be acted upon Jan 2022)
  - **Summary:** Current law requires the State Department of Health Care Services to develop, subject to federal approval, reimbursement rates for clinical or laboratory services according to specified standards, such as requiring that reimbursement to providers for those services not exceed the lowest of enumerated criteria, including 80% of the lowest maximum allowance established by the federal Medicare program for the same or similar services. This bill would delete provisions relating to the above-specified 80% standard and would make conforming changes.

- **AB 278 (Flora – R) Medi-Cal: Podiatric Services**
  - **Introduced:** 1/19/2021
  - **Status:** 5/25/21 Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/14/2021) (May be acted upon Jan 2022)
  - **Summary:** Current law requires a health care provider applying for enrollment as a Medi-Cal services provider or a current Medi-Cal services provider applying for continuing enrollment, or a current Medi-Cal services provider applying for enrollment at a new location or a change in location, to submit a complete application package. Under current law, a licensed physician and surgeon practicing as an individual physician practice or a licensed dentist practicing as an individual dentist practice, who is in good standing and enrolled as a Medi-Cal services provider, and who is changing the location of that individual practice within the same county, is eligible to file instead a change of location form in lieu of submitting a complete application package. This bill would make conforming changes to the provisions that govern applying to be a provider in the Medi-Cal program, or for a change of location by an existing provider, to include a doctor of podiatric medicine licensed by the California Board of Podiatric Medicine.

- **AB 521 (Mathis – R) Medi-Cal: Unrecovered Payments: Interest Rate**
  - **Introduced:** 2/10/2021
  - **Status:** 5/25/21 Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/21/2021) (May be acted upon Jan 2022)
  - **Summary:** Current law requires the Director of Health Care Services to establish administrative appeal processes to review grievances or complaints arising from the findings of an audit or examination. Under current law, if recovery of a disallowed payment has been made by the department, a provider who prevails in an appeal of that payment is entitled to interest at the rate equal to the monthly average received on investments in the Surplus Money Investment Fund, or simple interest at the rate of 7% per annum, whichever is higher. Under current law, with exceptions, interest at that same rate is assessed against any unrecovered overpayment due to the department. In the case of an assessment against any unrecovered overpayment due to the department, this bill would authorize the director to waive any or all of the interest or penalties owed by a provider, after taking into account specified factors, including the importance of the provider to the health care safety net in the community and the impact of the repayment amounts on the fiscal solvency of the provider.

- **AB 601 (Fong – R) Medi-Cal: Reimbursement**
  - **Introduced:** 2/11/2021
  - **Status:** 5/7/21 Failed Deadline pursuant to Rule 61(a)(3). (Last location was PRINT on 2/11/2021) (May be acted upon Jan 2022)
  - **Summary:** Current law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals to receive health care services, including clinical laboratory or laboratory services. The Medi-Cal program is, in part, governed by and funded pursuant to federal Medicaid program provisions. Current law requires the department to develop, subject to federal approval, reimbursement rates for clinical or laboratory services according to specified standards, such as requiring that reimbursement to providers for those services not exceed the lowest of enumerated criteria, including 80% of the lowest maximum allowance established by the federal Medicare Program for the same or similar services. This bill would make a technical, non-substantive change to these provisions.

- **AB 671 (Wood – D) Medi-Cal: Pharmacy Benefits**
  - **Introduced:** 2/12/2021
  - **Status:** 6/4/21 Failed Deadline pursuant to Rule 61(a)(8). (Last location was INACTIVE FILE on 5/27/2021)(May be acted upon Jan 2022)
  - **Summary:** This bill would authorize the department to provide disease management or similar payment to a pharmacy that the department has contracted with to dispense a specialty drug to Medi-Cal beneficiaries in an amount necessary to ensure beneficiary access, as determined by the department based on the results of the survey completed during the 2020 calendar year.

- **AB 822 (Rodriguez – D) Medi-Cal: Psychiatric Emergency Medical Conditions**
  - **Introduced:** 2/16/2021
  - **Status:** 5/25/21 Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/19/2021) (May be acted upon Jan 2022)
  - **Summary:** Current law requires the State Department of Health Care Services to implement managed mental health care for Medi-Cal beneficiaries through contracts with mental health plans. Under current law, mental health plans are responsible for providing specialty mental health services to enrollees, and Medi-Cal managed care plans deliver non-specialty mental health services to enrollees. Under existing law, emergency services and care, mental health benefits, substance use disorder benefits, and specialty mental health services are covered under the Medi-Cal program. This bill would specify that observation services for a psychiatric emergency medical condition, as defined, are covered under the Medi-Cal program, consistent with coverage under the above provisions and any other applicable law.

- **AB 848 (Calderon – D) Medi-Cal: Monthly Maintenance Amount: Personal and Incidental Needs**
  - **Introduced:** 2/17/2021
  - **Status:** 5/25/21 Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/19/2021) (May be acted upon Jan 2022)
  - **Summary:** Current law requires the State Department of Health Care Services to establish income levels for maintenance need at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. In calculating the income of a medically needy person in a medical institution or nursing facility, or a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly

organization, the required monthly maintenance amount includes an amount providing for personal and incidental needs in the amount of not less than $35 per month while a patient. Current law authorizes the department to increase, by regulation, this amount as necessitated by increasing costs of personal and incidental needs. This bill would increase the monthly maintenance amount for personal and incidental needs from $35 to $80 and would require the department to annually adjust that amount by the same percentage as the Consumer Price Index.

- **AB 862 (Chen – R) Medi-Cal: Emergency Medical Transportation Services**
  - **Introduced:** 2/17/2021
  - **Status:** 4/30/21 Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 2/25/2021) (May be acted upon Jan 2022).
  - **Summary:** The Medi-Cal Emergency Medical Transportation Reimbursement Act imposes a quality assurance fee for each emergency medical transport provided by an emergency medical transport provider subject to the fee in accordance with a prescribed methodology. Current law exempts an eligible provider from the quality assurance fee and add-on increase for the duration of any Medi-Cal managed care rating during which the program is implemented. Existing law requires each applicable Medi-Cal managed care health plan to satisfy a specified obligation for emergency medical transports and to provide payment to noncontract emergency medical transport providers and provides that this provision does not apply to an eligible provider who provides noncontract emergency medical transports to an enrollee of a Medi-Cal managed care plan during any Medi-Cal managed care rating period that the program is implemented. The bill would provide that during the entirety of any Medi-Cal managed care rating period for which the program is implemented, an eligible provider shall not be an emergency medical transport provider, as defined, who is subject to a quality assurance fee or eligible for the add-on increase and would provide that the program's provisions do not affect the application of the specified add-on to any payment to a nonpublic emergency medical transport provider.

- **AB 875 (Wood – D) Medi-Cal: Demonstration Project**
  - **Introduced:** 2/17/2021
  - **Status:** 5/25/21 Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/19/2021) (May be acted upon Jan 2022)
  - **Summary:** Current law authorizes the board of supervisors in each county to designate an entity or entities to assist county jail inmates to apply for a health insurance affordability program, as defined, consistent with federal requirements. Commencing January 1, 2023, this bill would instead require the board of supervisors, in consultation with the county sheriff, to designate an entity or entities to assist both county jail inmates and juvenile inmates with the application process. The bill would make conforming changes to provisions relating to the coordination duties of jail administrators. By creating new duties for local officials, including boards of supervisors and jail administrators, the bill would impose a state-mandated local program.

- **AB 935 (Maienschein – D) Telehealth: Mental Health**
  - **Introduced:** 2/17/2021
  - **Status:** 5/25/21 Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/19/2021) (May be acted upon Jan 2022)
  - **Summary:** Would require health care service plans and health insurers, including Medi-Cal managed care plans, by July 1, 2022, to provide access to a telehealth consultation program that meets specified criteria and provides providers who treat children and pregnant and certain postpartum persons with access to a mental health consultation program, as specified. The bill would require the consultation by a mental health clinician with expertise appropriate for pregnant, postpartum, and pediatric patients to be conducted by telephone or telehealth video, and to

include guidance on the range of evidence-based treatment options, screening tools, and referrals. The bill would add mental health consultations through this program to the Medi-Cal schedule of benefits.

- **AB 1131 (Wood – D) Health Information Network**
  - **Introduced:** 2/18/2021
  - **Status:** 5/25/21 Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/28/2021) (May be acted upon Jan 2022)
  - **Summary:** Would establish the statewide health information network (statewide HIN) governing board, an independent public entity not affiliated with an agency or department with specified membership, to provide the data infrastructure needed to meet California's health care access, equity, affordability, public health, and quality goals, as specified. The bill would require the governing board to issue a request for proposals to select an operating entity with specified minimum capabilities to support the electronic exchange of health information between and aggregate and integrate data from multiple sources within the State of California, among other responsibilities. The bill would require the statewide HIN to take specified actions with respect to reporting on and auditing the security and finances of the health information network.

- **AB 1050 (Gray – D) Medi-Cal: Application for Enrollment: Prescription Drugs**
  - **Introduced:** 2/18/2021
  - **Status:** 5/25/21 Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/12/2021) (May be acted upon Jan 2022)
  - **Summary:** The Telephone Consumer Protection Act, among other provisions, prohibits any person within the United States, or any person outside the United States if the recipient is within the United States, from making any call to any telephone number assigned to a paging service, cellular telephone service, specialized mobile radio service, or other radio common carrier service, or any service for which the called party is charged for the call, without the prior express consent of the called party, using an automatic telephone dialing system or an artificial or prerecorded voice. Under current case law, a text message is considered a call for purposes of those provisions. This bill would require the application for Medi-Cal enrollment to include a statement that if the applicant is approved for Medi-Cal benefits, the applicant agrees that the department, county welfare department, and a managed care organization or health care provider to which the applicant is assigned may communicate with them regarding appointment reminders or outreach efforts at no more than a 6th grade reading level through Free to End User text messaging unless the applicant opts out.

- **AB 1107 (Boerner Horvath – D)**
  - **Introduced:** 2/18/2021
  - **Status:** 4/30/21 Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 3/4/2021) (May be acted upon Jan 2022).
  - **Summary:** Would require a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2022, that offers coverage for emergency ground medical transportation services to include those services as in-network services and would require the plan or insurer to pay those services at the contracted rate pursuant to the plan contract or policy. Because a willful violation of the bill's requirements relative to a health care service plan would be a crime, the bill would impose a state-mandated local program.

- **AB 1160 (Rubio, Blanca – D) Medically Supportive Food**
  - **Introduced:** 2/18/2021

- **Status:** 4/30/21 Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 3/4/2021) (May be acted upon Jan 2022).
- **Summary:** Current law requires the State Department of Health Care Services to establish a Medically Tailored Meals Pilot Program to operate for a period of 4 years from the date the program is established, or until funding is no longer available, whichever date is earlier, in specified counties to provide medically tailored meal intervention services to Medi-Cal participants with prescribed health conditions, such as diabetes and renal disease. Effective for contract periods commencing on or after January 1, 2022, this bill would authorize Medi-Cal managed care plans to provide medically tailored meals to enrollees. The bill would authorize the department to implement this provision by various means, including a plan or provider bulletins, and would require the department to seek federal approvals. The bill would condition the implementation of this provision on the department obtaining federal approval and the availability of federal financial participation.

- **AB 1355 (Levine – D) Medi-Cal: Independent Medical Review System**
  - **Introduced:** 2/19/2021
  - **Status:** 4/30/21 Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 3/4/2021) (May be acted upon Jan 2022).
  - **Summary:** Would require the Department of Health Care Services to establish the Independent Medical Review System (IMRS) for the Medi-Cal program, commencing on January 1, 2022, which generally models the specified described requirements of the Knox-Keene Health Care Service Plan Act. The bill would provide that any Medi-Cal beneficiary grievance involving a disputed health care service is eligible for review under the IMRS 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. The bill would require information on the IMRS to be included in specified material, including the “myMedi-Cal: How to Get the Health Care You Need” publication and on the department’s internet website.

- **AB 1162 (Villapudua – D) Health Care Coverage: Claims Payments**
  - **Introduced:** 2/18/2021
  - **Status:** 5/25/21 Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/5/2021) (May be acted upon Jan 2022)
  - **Summary:** Would require a health care service plan or disability insurer that provides hospital, medical, or surgical coverage to provide access to medically necessary health care services to its enrollees or insureds that are displaced or otherwise affected by a state of emergency. The bill would allow the Department of Managed Health Care and the Department of Insurance to also suspend requirements for prior authorization during a state of emergency. The bill would authorize the respective departments to issue guidance to health care service plans and specified insurers regarding compliance with these provisions.

- **SB 508 (Stern – D) Mental Health Coverage: School-based Services**
  - **Introduced:** 2/10/2021
  - **Status:** 4/30/21 Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 2/25/2021) (May be acted upon Jan 2022).
  - **Summary:** Current law provides that specified services, including targeted case management services for children with an individual education plan or an individualized family service plan, provided by local educational agencies (LEAs), are covered Medi-Cal benefits and authorizes an LEA to bill for those services. Existing law requires the department to perform various activities

with respect to the billing option for services provided by LEAs. Current law authorizes a school district to require the parent or legal guardian of a pupil to keep current at the pupil's school of attendance certain emergency information. This bill would authorize an LEA to have an appropriate mental health professional provide brief initial interventions at a school campus when necessary for all referred pupils, including pupils with a health care service plan, health insurance, or coverage through a Medi-Cal managed care plan, but not those covered by a county mental health plan.

Other

Bills in process in house of origin:

- **AB 309 (Gabriel – D) Pupil Mental Health: Model Referral Protocols**
  - **Introduced:** 1/25/2021
  - **Status:** 6/30/21 In committee: Hearing postponed by committee.
  - **Summary:** Would require the State Department of Education to develop model referral protocols, as provided, for addressing pupil mental health concerns. The bill would require the department to consult with various entities in developing the protocols, including current classroom teachers, administrators, pupils, and parents. The bill would require the department to post the model referral protocols on its internet website. The bill would make these provisions contingent upon funds being appropriated for its purpose in the annual Budget Act or other legislation or state, federal, or private funds being allocated for this purpose.

- **AB 326 (Rivas, Luz – D) Health Care Service Plans: Consumer Participation Program**
  - **Introduced:** 1/26/2021
  - **Status:** 6/16/21 From committee: Do pass and re-refer to Com. on APPR. (Ayes 8. Noes 2.) (June 16). Re-referred to Com. on APPR.
  - **Summary:** Current law, until January 1, 2024, requires the Director of the Department of Managed Health Care to establish the Consumer Participation Program, which allows the director to award reasonable advocacy and witness fees to a person or organization that represents consumers and has made a substantial contribution on behalf of consumers to the adoption of a regulation or with regard to an order or decision impacting a significant number of enrollees. This bill would extend the operation of that program indefinitely.

- **AB 493 (Wood – D) Health Insurance**
  - **Introduced:** 2/8/2021
  - **Status:** 5/12/21 Referred to Com. on HEALTH.
  - **Summary:** Current law provides for the regulation of health insurers by the Department of Insurance. Current federal law, the Patient Protection and Affordable Care Act (PPACA), enacts various health care market reforms. Current law requires an individual or small group health insurance policy issued, amended, or renewed on or after January 1, 2017, to cover essential health benefits as prescribed, and provides that these provisions shall be implemented only to the extent essential health benefits are required pursuant to PPACA. This bill would delete the provision that conditions the implementation of that provision only to the extent essential health benefits are required pursuant to PPACA, and would make technical, non-substantive changes to that provision.

- **SB 40 (Hurtado – D) Health Care Workforce Development: California Medicine Scholars Program**

- **Introduced:** 12/7/2020
- **Status:** 6/28/21 From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
- **Summary:** Would, contingent upon an appropriation by the Legislature, as specified, create the California Medicine Scholars Program, a 5-year pilot program commencing January 1, 2023, and would require the Office of Statewide Health Planning and Development to establish and facilitate the pilot program. The bill would require the pilot program to establish a regional pipeline program for community college students to pursue premedical training and enter medical school, in an effort to address the shortage of primary care physicians in California and the widening disparities in access to care in vulnerable and underserved communities, including building a comprehensive statewide approach to increasing the number and representation of minority primary care physicians in the state.

- **AB 393 (Reyes – D) Early Childhood Development Act of 2020**
  - **Introduced:** 2/2/2021
  - **Status:** 5/20/21 In committee: Held under submission.
  - **Summary:** Would make additional legislative findings and declarations regarding childcare supportive services. This bill would require the State Department of Social Services to report on various topics related to early childhood supports in light of the COVID-19 pandemic by October 1, 2021.

- **AB 71 (Rivas – D) Homeless Funding: Bring California Home Act**
  - **Introduced:** 12/7/2020
  - **Status:** 6/3/21 Ordered to inactive file at the request of Assembly Member Luz Rivas.
  - **Summary:** The Personal Income Tax Law, in conformity with federal income tax law, generally defines gross income as income from whatever source derived, except as specifically excluded, and provides various exclusions from gross income. Current federal law, for purposes of determining a taxpayer's gross income for federal income taxation, requires that a person who is a United States shareholder of any controlled foreign corporation to include in their gross income the global intangible low-taxed income for that taxable year, as provided. This bill, for taxable years beginning on or after January 1, 2022, would include a taxpayer's global intangible low-taxed income in their gross income for purposes of the Personal Income Tax Law, in modified conformity with the above-described federal provisions.

Bills moved for action in second house:

- **AB 97 (Nazarian – D) Health Care Coverage: Insulin affordability**
  - **Introduced:** 12/8/2020
  - **Status:** 6/9/21 Referred to Com. on HEALTH.
  - **Summary:** Would prohibit a health care service plan contract or a health disability insurance policy, as specified, issued, amended, delivered, or renewed on or after January 1, 2022, from imposing a deductible on an insulin prescription 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 240 (Rodriguez – D) Local Health Department Workforce Assessment**
  - **Introduced:** 1/13/2021
  - **Status:** 6/21/21 Read second time and amended. Re-referred to Com. on APPR.

- **Summary:** This bill would require the State Department of Public Health to contract with an appropriate and qualified entity to conduct an evaluation of the adequacy of the local health department infrastructure and to make recommendations for future staffing, workforce needs, and resources, in order to accurately and adequately fund local public health. The bill would exempt the department from specific provisions relating to public contracting with regard to this requirement. The bill would require the department to report the findings and recommendations of the evaluation to the appropriate policy and fiscal committees of the Legislature on or before July 1, 2024. The bill would also require the department to convene an advisory group, composed of representatives from public, private, and tribal entities, as specified, to provide input on the selection of the entity that would conduct the evaluation.

- **AB 342 (Gipson – D) Health Care Coverage: Colorectal Cancer: Screening and Testing**
  - **Introduced:** 1/28/2021
  - **Status:** 6/22/21 From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.
  - **Summary:** Would require a health care service plan contract or a health insurance policy, except as specified, that is issued, amended, or renewed on or after January 1, 2022, to provide coverage for a colorectal cancer screening test, as specified. The bill would require the required colonoscopy for a positive result on a test or procedure to be provided without cost sharing, unless the underlying test or procedure was a colonoscopy, as specified. The bill would also provide that it does not require a health care service plan or health insurer to provide benefits for items or services delivered by an out-of-network provider and does not preclude a health care service plan or health insurer from imposing cost-sharing requirements for items or services that are delivered by an out-of-network provider.

- **AB 347 (Arambula – D) Health Care Coverage: Step Therapy**
  - **Introduced:** 1/28/2021
  - **Status:** 6/29/21 From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.
  - **Summary:** Would clarify that a health care service plan that provides coverage for prescription drugs may require step therapy, as defined, if there is more than one drug that is clinically appropriate for the treatment of a medical condition. The bill would require a health care service plan or health insurer to expeditiously grant a step therapy exception if the health care provider submits justification and supporting clinical documentation, if needed, that specified criteria are met. The bill would authorize an enrollee or insured or their designee, guardian, health care provider, or prescribing provider to file an internal appeal of a denial of an exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request, and would require a health care service plan or health insurer to designate a clinical peer to review those appeals.

- **AB 383 (Salas – D) Mental Health: Older Adults**
  - **Introduced:** 2/2/2021
  - **Status:** 6/21/21 Read second time and amended. Re-referred to Com. on HUMAN S.
  - **Summary:** Would establish within the State Department of Health Care Services an Older Adult Behavioral Health Services Administrator to oversee behavioral health services for older adults. The bill would require that position to be funded with administrative funds from the Mental Health Services Fund. The bill would prescribe the functions of the administrator and its responsibilities, including, but not limited to, developing outcomes and related indicators for older adults for the purpose of assessing the status of behavioral health services for older adults, monitoring the

quality of programs for those adults, and guiding decision making on how to improve those services. The bill would require the administrator to receive data from other state agencies and departments to implement these provisions, subject to existing state or federal confidentiality requirements. The bill would require the administrator to report to the entities that administer the MHSA on those outcomes and related indicators by July 1, 2022, and would require the report to be posted on the department's internet website.

- **AB 389 (Grayson – D) Ambulance Services**
  - **Introduced:** 2/2/2021
  - **Status:** 6/23/21 In committee: Hearing postponed by committee.
  - **Summary:** Would authorize a county to contract for emergency ambulance services with a fire protection district that is governed by the county's board of supervisors and provides those services, in whole or in part, through a written subcontract with a private ambulance service. The bill would authorize a fire protection district to enter a written subcontract with a private ambulance service for these purposes.

- **AB 457 (Santiago – D) Protection of Patient Choice in Telehealth Provider Act**
  - **Introduced:** 2/8/2021
  - **Status:** 6/28/21 Read second time and amended. Re-referred to Com. on APPR.
  - **Summary:** Current law provides for the licensure and regulation of various healing arts professions and vocations by boards within the Department of Consumer Affairs. Under current law, it is unlawful for healing arts licensees, except as specified, to offer, deliver, receive, or accept any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person, subject to certain exceptions. This bill would provide that the payment or receipt of consideration for internet-based advertising, appointment booking, or any service that provides information and resources to prospective patients of licensees does not constitute a referral of a patient if the internet-based service provider does not recommend, endorse, arrange for, or otherwise select a licensee for the prospective patient.

- **AB 1130 (Wood D) California Health Care Quality and Affordability Act**
  - **Introduced:** 2/18/2021
  - **Status:** 6/16/21 Referred to Coms. on HEALTH and JUD.
  - **Summary:** Current law establishes the Office of Statewide Health Planning and Development (OSHPD) to oversee various aspects of the health care market, including oversight of hospital facilities and community benefit plans. This bill would establish, within OSHPD, the Office of Health Care Affordability to analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs for consumers, set and enforce cost targets, and create a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers.

- **SB 17 (Pan – D) Office of Racial Equity**
  - **Introduced:** 12/7/2020
  - **Status:** 7/1/21 Read second time and amended. Re-referred to Com. on APPR.
  - **Status:** Would, until January 1, 2029, establish in state government an Office of Racial Equity, an independent public entity not affiliated with an agency or department, governed by a Racial Equity Advisory and Accountability Council. The bill would authorize the council to hire an executive director to organize, administer, and manage the operations of the office. The bill would task the office with coordinating, analyzing, developing, evaluating, and recommending strategies for advancing racial equity across state agencies, departments, and the office of the Governor.

The bill would require the office to develop a statewide Racial Equity Framework providing guidelines for inclusive policies and practices that reduce racial inequities, promote racial equity, address individual, institutional, and structural racism, and establish goals and strategies to advance racial equity and address structural racism and racial inequities.

- **SB 306 (Pan – D) Sexually Transmitted Disease: Testing**
  - **Introduced:** 12/7/2020
  - **Status:** 6/23/21 From committee: Do pass and re-refer to Com. on B. & P. (Ayes 12. Noes 2.) (June 22). Re-referred to Com. on B. & P. From committee with author's amendments. Read second time and amended. Re-referred to Com. on B. & P.
  - **Summary:** Current law authorizes a specified health care provider who diagnoses an STD, as specified, to prescribe, dispense, furnish, or otherwise provide prescription antibiotic drugs to that patient's sexual partner or partners without examination of that patient's partner or partners. The Pharmacy Law provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy. The Pharmacy Law requires a pharmacist to dispense a prescription in a container that, among other things, is correctly labeled with the name of the patient or patients. Current regulation requires a pharmacist to ensure that a patient receives written notice of their right to consult with a pharmacist when the patient or the patient's agent is not present. This bill would name the above practice "expedited partner therapy." The bill would require a health care provider to include "expedited partner therapy" or "EPT" on a prescription if the practitioner is unable to obtain the name of a patient's sexual partner, and would authorize a pharmacist to dispense an expedited partner therapy prescription and label the drug without an individual's name if the prescription includes "expedited partner therapy" or "EPT."

- **SB 221 (Wiener – D) Health Care Coverage: Timely Access to Care**
  - **Introduced:** 1/13/2021
  - **Status:** 6/28/21 From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
  - **Summary:** Would codify the regulations adopted by the Department of Managed Health Care and the Department of Insurance to provide timely access standards for health care service plans and insurers for non-emergency health care services. The bill would require both a health care service plan and a health insurer, including a Medi-Cal Managed Care Plan, to ensure that appointments with nonphysician mental health and substance use disorder providers are subject to the timely access requirements. The bill would additionally require a health care service plan and a health insurer, including a Medi-Cal Managed Care Plan, to ensure that an enrollee or insured that is undergoing a course of treatment for an ongoing mental health or substance use disorder condition is able to get a follow-up appointment with a nonphysician mental health care or substance use disorder provider within 10 business days of the prior appointment.

Bills left on suspense file that may be acted upon in January 2022

- **AB 95 (Low – D) Employees: Bereavement Leave**
  - **Introduced:** 12/7/2020
  - **Status:** 5/25/21 Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/21/2021) (May be acted upon Jan 2022)
  - **Summary:** Would enact the Bereavement Leave Act of 2021. The bill would require an employer with 25 or more employees to grant a request made by any employee to take up to 10 business days of unpaid bereavement leave upon the death of a spouse, child, parent, sibling, grandparent,

grandchild, or domestic partner, in accordance with certain procedures, and subject to certain exclusions. The bill would require an employer with fewer than 25 employees to grant a request by any employee to take up to 3 business days of leave, in accordance with these provisions. The bill would prohibit an employer from interfering with or restraining the exercise or attempt to exercise the employee's right to take this leave.

- **AB 93 (Garcia, Eduardo – D) Pandemics: Priority for medical treatment: food supply industry workers**
  - **Introduced:** 12/7/2020
  - **Status:** 4/30/21 Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 3/25/2021) (May be acted upon Jan 2022).
  - **Summary:** Would require the Legislative Analyst's Office to conduct a comprehensive review and analysis of issues related to the state's response to the COVID-19 pandemic, including, among others, whether local public health departments were sufficiently staffed and funded to handle specified pandemic-related responsibilities, and what specific measures of accountability the state applied to monitor and confirm that local public health departments were following state directives related to any dedicated COVID-19 funds allocated to counties. The bill would require the office to report to the Joint Legislative Audit Committee and the health committees of the Legislature by June 30, 2022. This bill contains other related provisions.

- **AB 454 (Rodriguez – D) Health Care Provider Emergency Payments**
  - **Introduced:** 2//2021
  - **Status:** 5/25/21 Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/12/2021) (May be acted upon Jan 2022)
  - **Summary:** This bill would authorize the Director of the Department of Managed Health Care or the Insurance Commissioner to require a health care service plan or health insurer to provide specified payments and support to a provider during and at least 60 days after the end of a declared state of emergency or other circumstance if two conditions occur, as specified.

- **AB 507 (Kalra – D) Health care Service Plans: Review of Rate Increases**
  - **Introduced:** 2/9/2021
  - **Status:** 5/7/21 Failed Deadline pursuant to Rule 61(a)(3). (Last location was PRINT on 2/9/2021) (May be acted upon Jan 2022).
  - **Summary:** The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Current law requires a health care service plan in the individual, small group, or large group markets to file rate information with the Department of Managed Health Care, as specified. Current law requires the information submitted to be made publicly available, except as specified, and requires the department and the health care service plan to make specified information, including a justification for an unreasonable rate increase, readily available to the public on their internet websites in plain language. This bill would make technical, non-substantive changes to those provisions.

- **AB 510 (Wood – D) Out-of-Network Health Care Benefits**
  - **Introduced:** 2/9/2021
  - **Status:** 5/7/21 Failed Deadline pursuant to Rule 61(a)(3). (Last location was PRINT on 2/9/2021) (May be acted upon Jan 2022).
  - **Summary:** Would authorize a noncontracting individual health professional, excluding specified professionals, to bill or collect the out-of-network cost-sharing amount directly from the enrollee or insured receiving services under a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2022, if the enrollee consents in writing or

electronically at least 72 hours in advance of care. The bill would require the consent to include a list of contracted providers at the facility who are able to provide the services and to be provided in the 15 most commonly used languages in the facility's geographic region.

- **AB 797 (Wicks – D) Health Care Coverage: Treatment for Infertility**
  - **Introduced:** 2/16/2021
  - **Status:** 4/30/21 Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 2/16/2021) (May be acted upon Jan 2022)
  - **Summary:** Would require every health care service plan contract or health insurance policy that is issued, amended, or renewed on or after January 1, 2022, to provide coverage for the treatment of infertility. The bill would revise the definition of infertility and would remove the exclusion of in vitro fertilization from coverage. The bill would delete the exemption for religiously affiliated employers, health care service plans, and health insurance policies from the requirements relating to coverage for the treatment of infertility, thereby imposing these requirements on these employers, plans, and policies.

- **AB 1400 (Kalra – D) Guaranteed Health Care for All**
  - **Introduced:** 2/19/2021
  - **Status:** 4/30/21 Failed Deadline pursuant to Rule 61(a)(2). (Last location was PRINT on 2/19/2021) (May be acted upon Jan 2022).
  - **Status:** This bill, the California Guaranteed Health Care for All Act, would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state.

- **SB 100 (Hurtado – D) Extended Foster Care Program Working Group**
  - **Introduced:** 12/29/2020
  - **Status:** 5/25/21 Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/20/2021) (May be acted upon Jan 2022)
  - **Summary:** Would require the State Department of Social Services to convene a working group to examine the extended foster care program and make recommendations for improvements to the program. The bill would require the working group to submit a report to the Legislature with the recommendations on or before July 1, 2022. The bill would require the working group to include representatives from specified state agencies and stakeholders. The bill would require the working group to evaluate and provide recommendations on the overall functioning of the extended foster care system, and on other specified components of the foster care system including higher education opportunities, job training, and employment opportunities for nonminor dependents, housing access, and access to health care and mental health services. The bill would require the recommendations to reflect a consensus of the working group, as specified.

ALAMEDA Alliance FOR HEALTH

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Board Business

Finance

Gil Riojas

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

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

Date: **July 9, 2021**

Subject: **Finance Report – May 2021**

Executive Summary

- For the month ended May 31, 2021, the Alliance had enrollment of 286,757 members, a Net Income of $682,000, and 556% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$96,603	$984,768
Medical Expense	90,818	942,327
Admin. Expense	5,122	45,725
Other Inc. / (Exp.)	19	255
Net Income	**$682**	**($3,028)**

Net Income by Program:

	Month	YTD
Medi-Cal	$895	($1,169)
Group Care	(213)	(1,859)
	$682	**($3,028)**

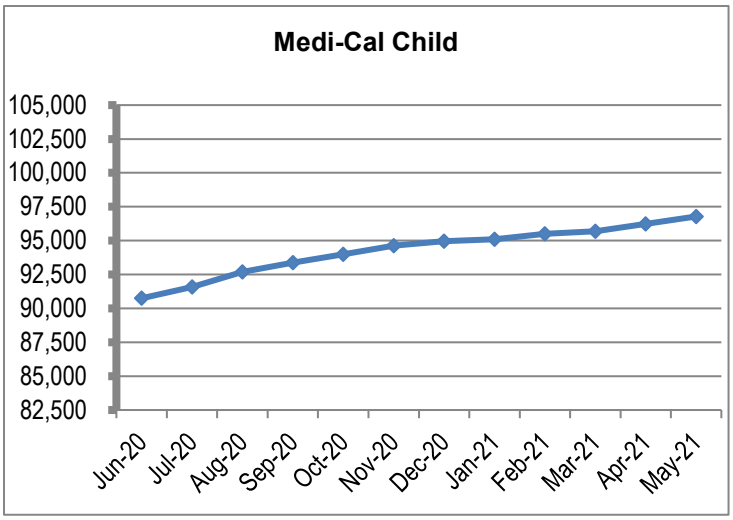
Enrollment

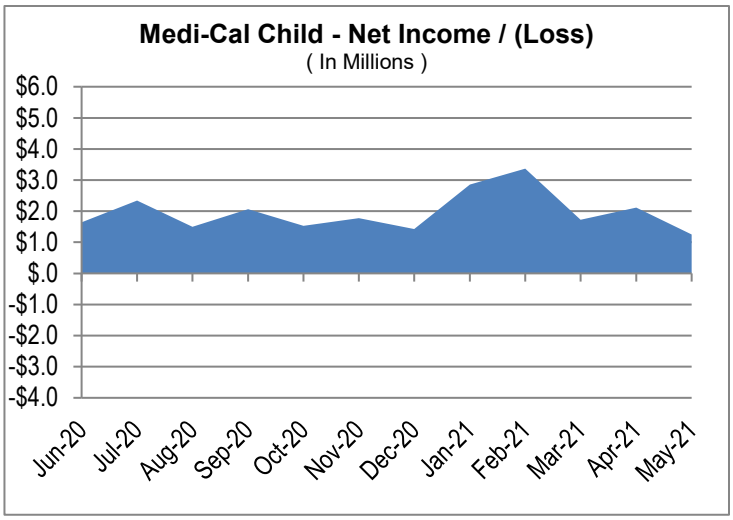
- Total enrollment increased by 2,566 members since April 2021.
- Total enrollment increased by 30,012 members since June 2020.

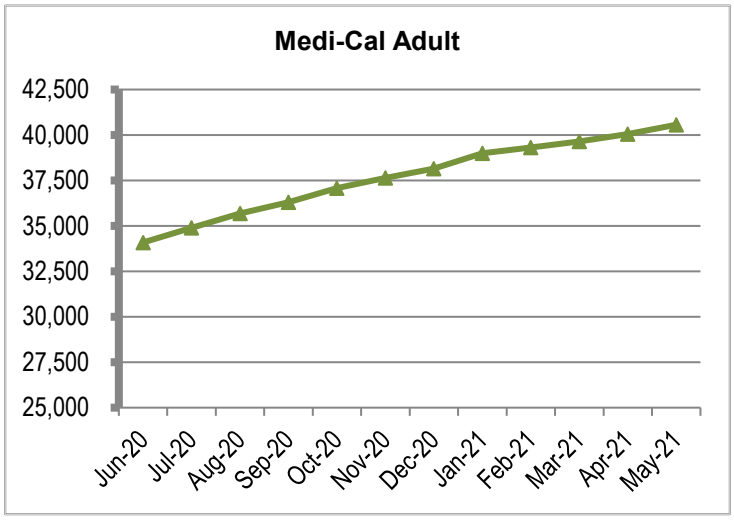
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

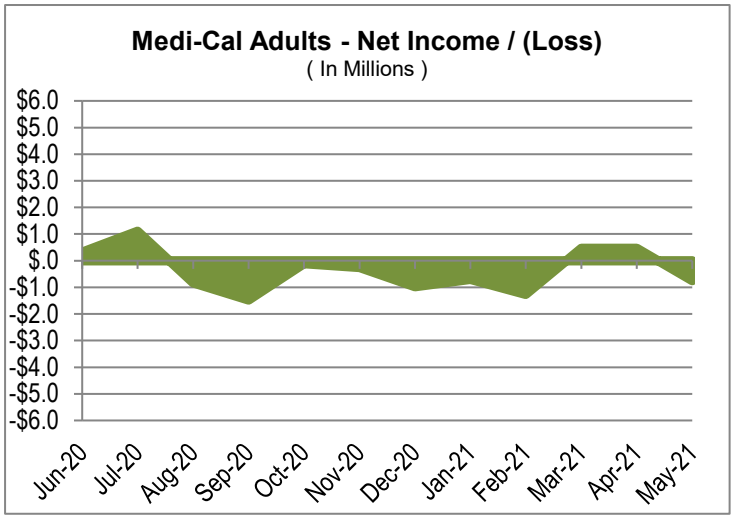
Enrollment					Member Months			
May-2021					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
40,561	40,508	53	0.1%	Adult	418,335	420,927	(2,592)	-0.6%
96,782	98,015	(1,233)	-1.3%	Child	1,040,531	1,051,434	(10,903)	-1.0%
26,289	26,329	(40)	-0.2%	SPD	288,660	289,077	(417)	-0.1%
19,851	19,616	235	1.2%	Duals	210,183	210,070	113	0.1%
97,325	96,332	993	1.0%	ACA OE	997,146	1,002,038	(4,892)	-0.5%
280,808	**280,800**	**8**	**0.0%**	**Medi-Cal Total**	**2,954,855**	**2,973,547**	**(18,692)**	**-0.6%**
5,949	6,009	(60)	-1.0%	Group Care	65,916	66,199	(283)	-0.4%
286,757	**286,809**	**(52)**	**0.0%**	**Total**	**3,020,771**	**3,039,746**	**(18,975)**	**-0.6%**

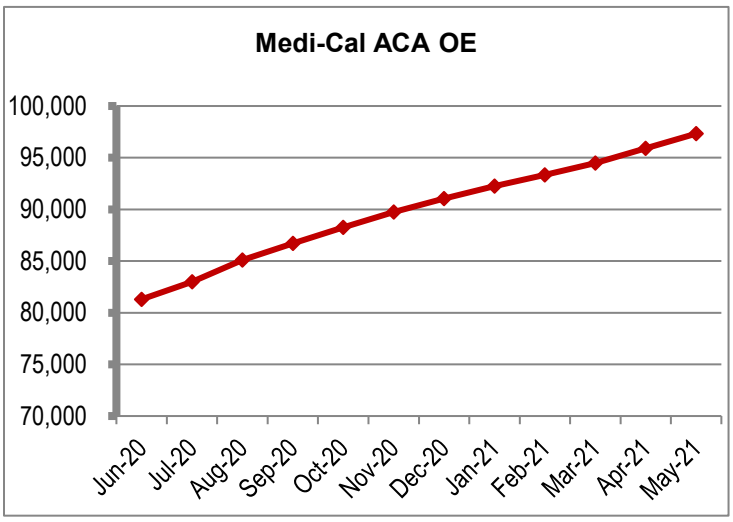
Enrollment and Profitability by Program and Category of Aid

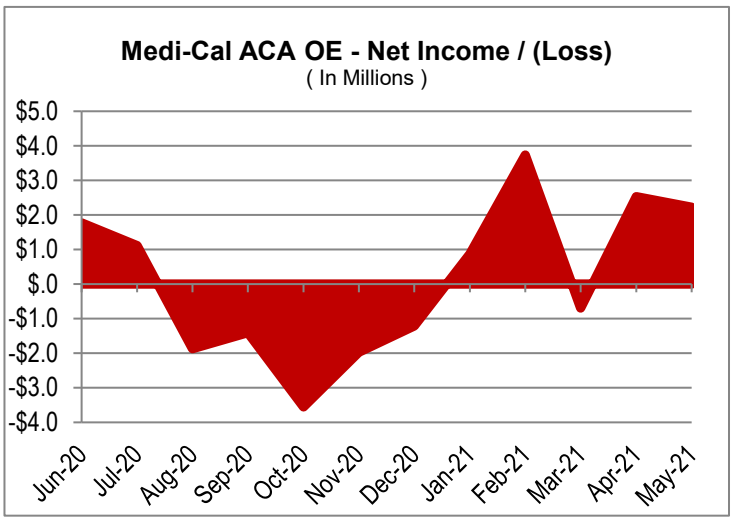




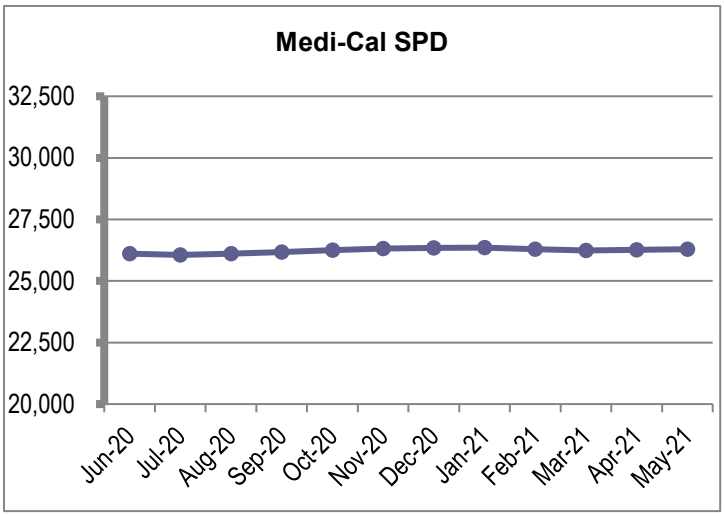


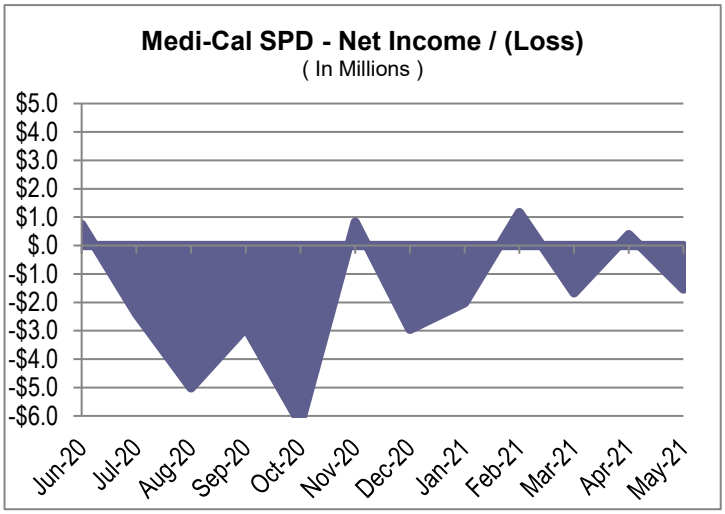


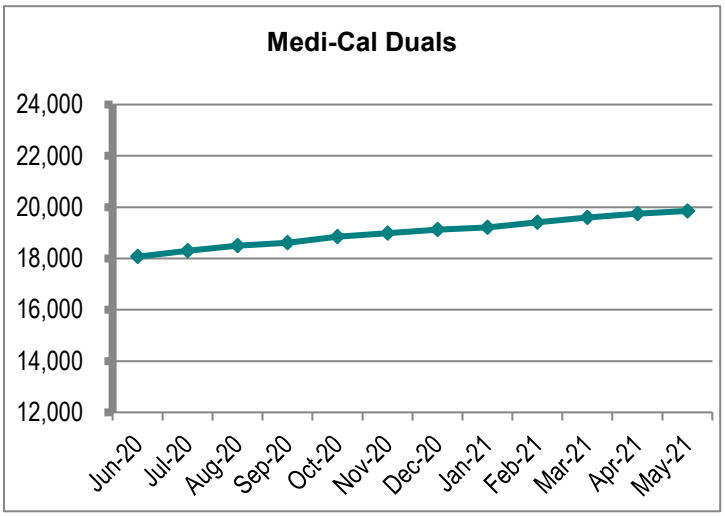


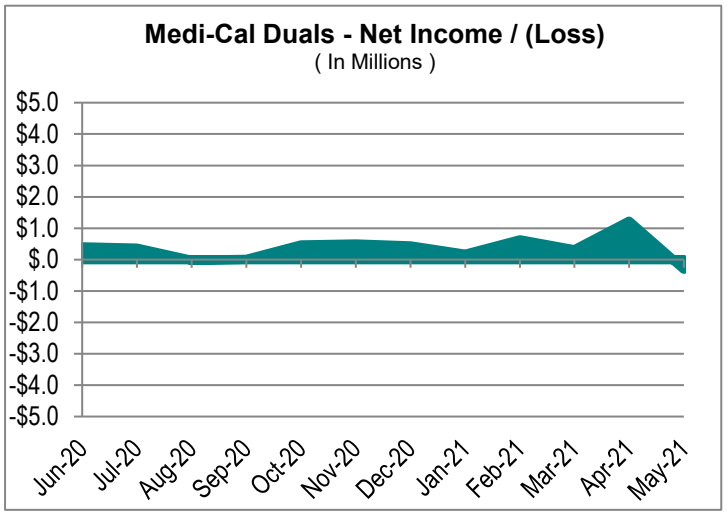


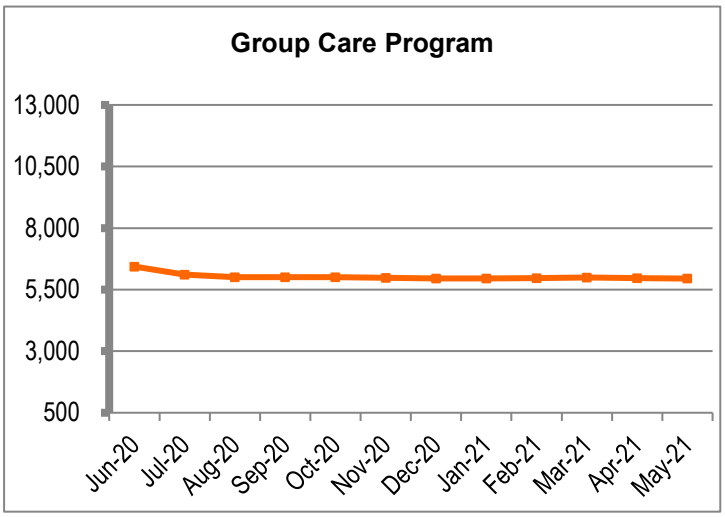
Enrollment and Profitability by Program and Category of Aid

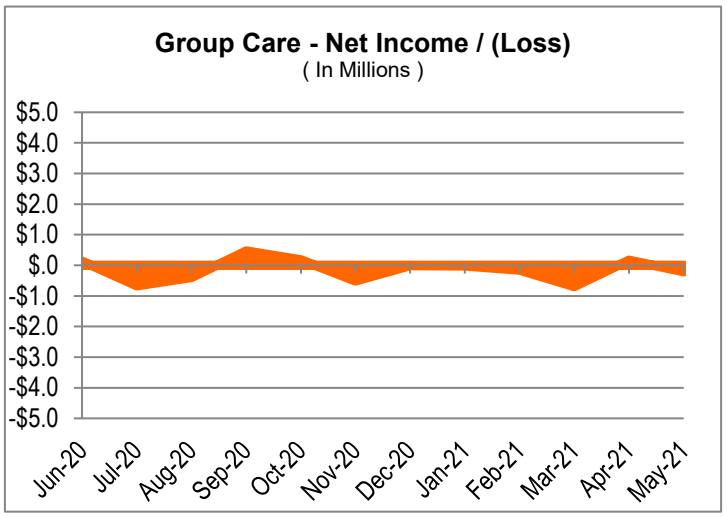




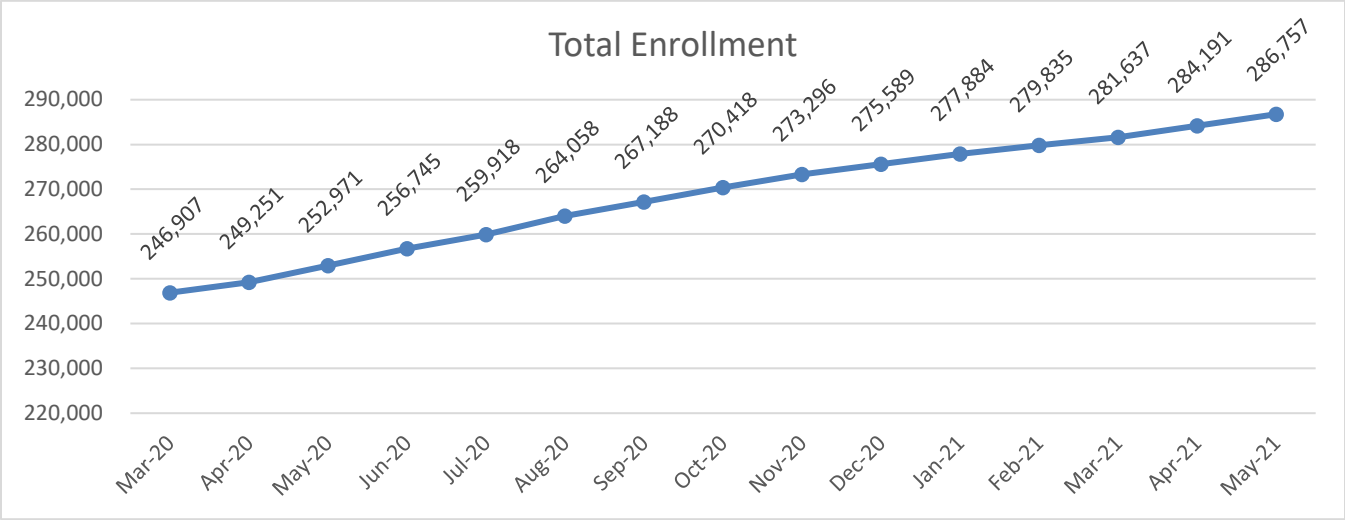


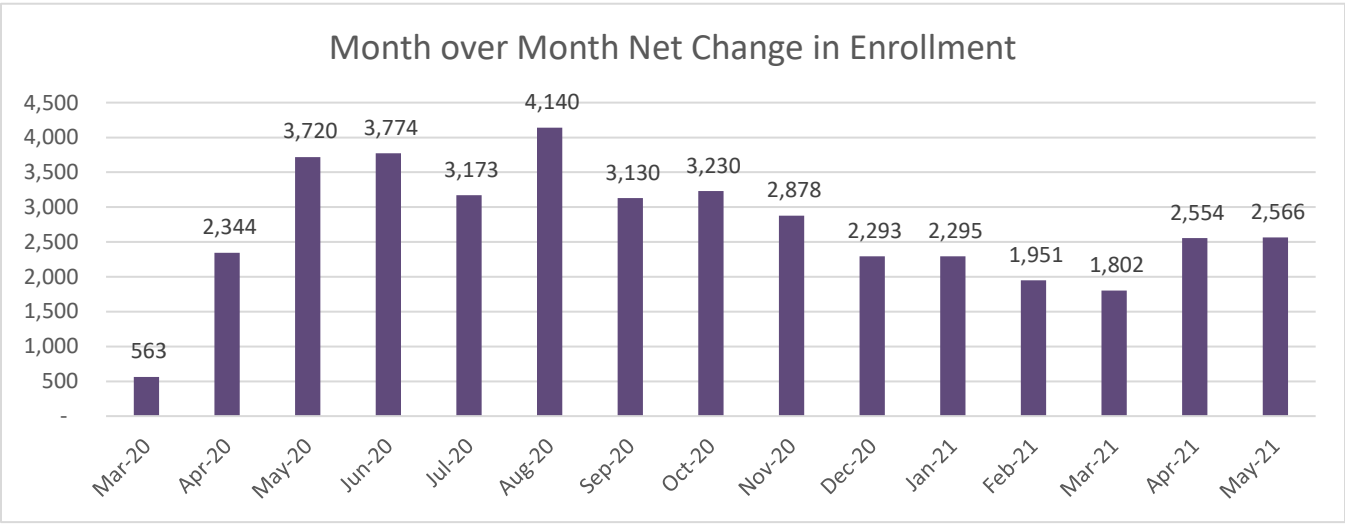






Net Change in Enrollment



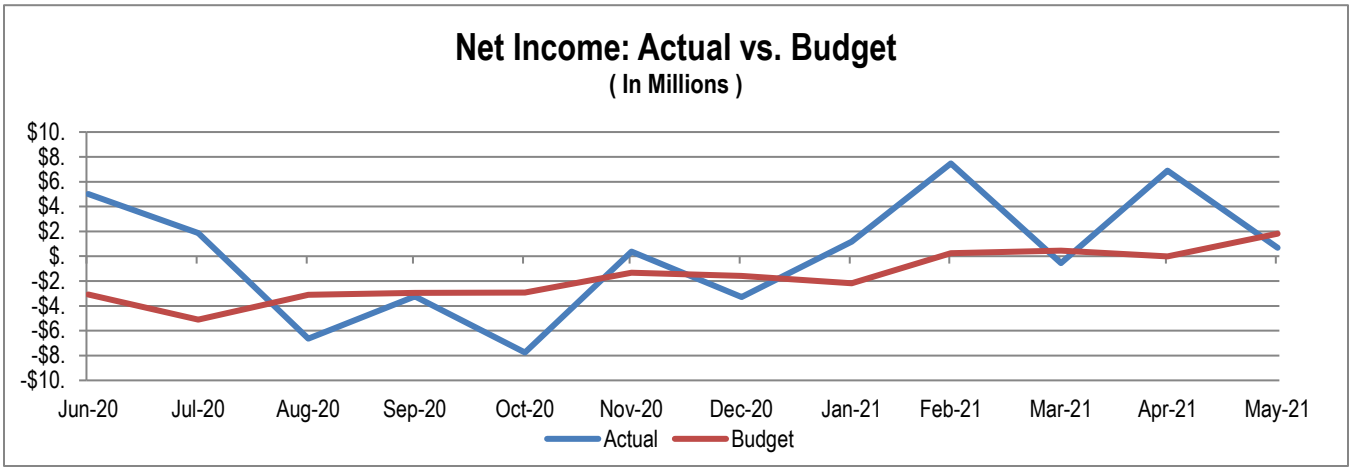


- Total Enrollment continues to increase however, the rate of increase has fallen from a high of 4,140 members in August 2020. The change in the rate of increase will impact our future forecast and enrollment projections for the remainder of the fiscal and calendar year.

Net Income

- For the month ended May 31, 2021:
  - Actual Net Income: $682,000.
  - Budgeted Net Income: $1.8 million.

- For the fiscal YTD ended May 31, 2021:
  - Actual Net Loss: $3.0 million.
  - Budgeted Net Loss: $18.4 million.

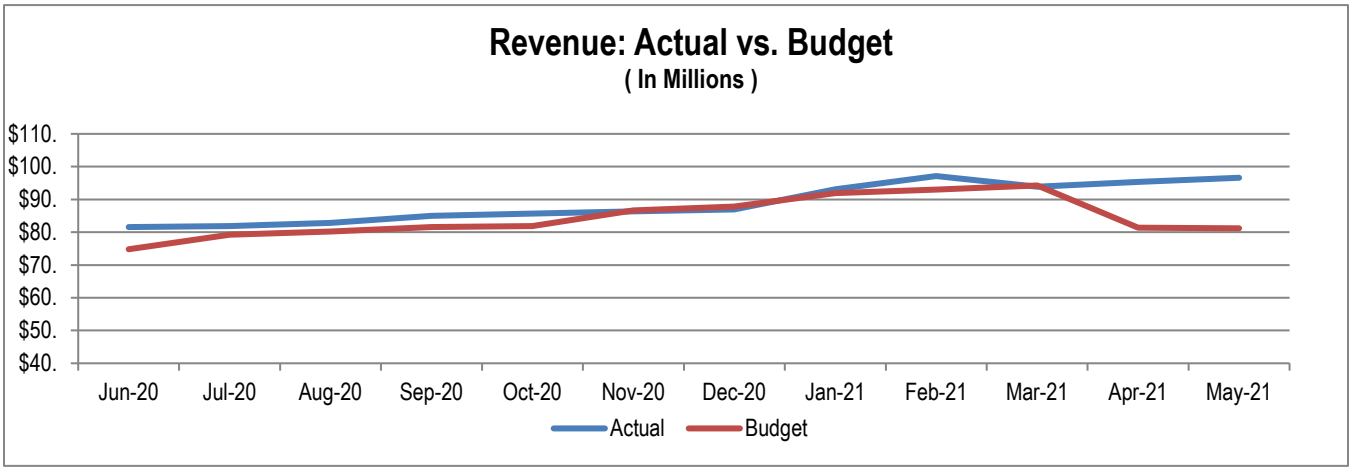


- The unfavorable variance of $1.1 million in the current month is due to:
  - Favorable $15.5 million higher than anticipated Revenue.
  - Unfavorable $17.1 million higher than anticipated Medical Expense.
  - Favorable $514,000 lower than anticipated Administrative Expense.
  - Unfavorable $33,000 Other Revenue.

Revenue

- For the month ended May 31, 2021:
  - Actual Revenue: $96.6 million.
  - Budgeted Revenue: $81.2 million.

- For the fiscal YTD ended May 31, 2021:
  - Actual Revenue: $984.8 million.
  - Budgeted Revenue: $951.7 million.

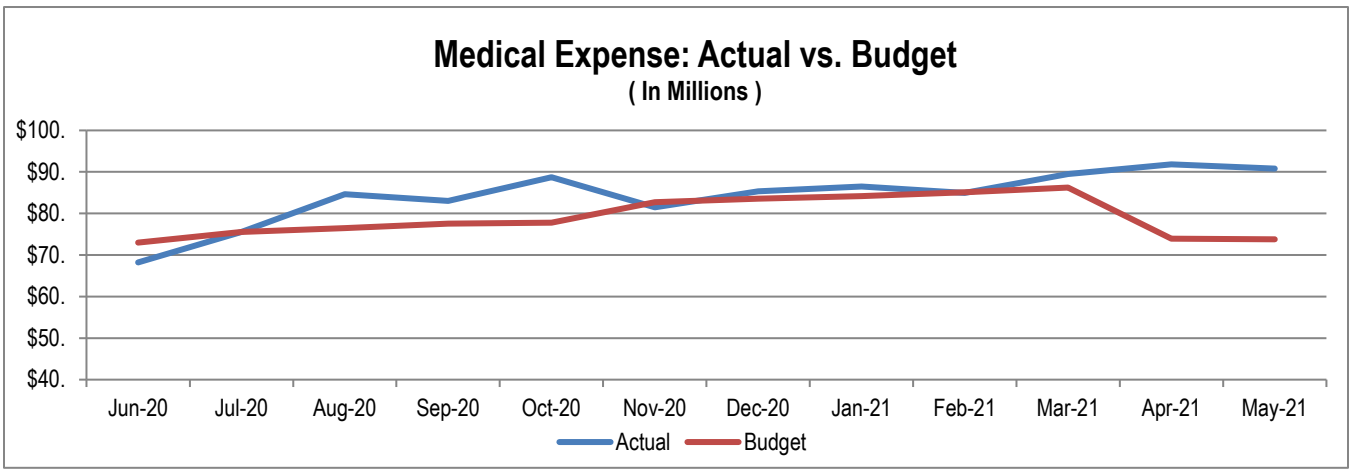


- For the month ended May 31, 2021, the favorable revenue variance of $15.5 million is mainly due to delay of Pharmacy Carve-out.

Medical Expense

- For the month ended May 31, 2021:
  - Actual Medical Expense: $90.8 million.
  - Budgeted Medical Expense: $73.8 million.

- For the fiscal YTD ended May 31, 2021:
  - Actual Medical Expense: $942.3 million.
  - Budgeted Medical Expense: $901.3 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 unpaid Medical Expenses for prior months by $3.7 million. Year-to-date, the estimate for prior years increased by $2.9 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)	
	Excluding IBNP Change	Change in IBNP	Reported		$	%
Capitated Medical Expense	$212,460,243	$0	$212,460,243	$211,258,449	($1,201,794)	-0.6%
Primary Care FFS	46,944,838	3,906	46,948,744	47,286,289	$341,451	0.7%
Specialty Care FFS	47,831,608	191,264	48,022,872	48,623,169	$791,561	1.6%
Outpatient FFS	87,007,464	418,053	87,425,517	85,383,288	($1,624,175)	-1.9%
Ancillary FFS	44,816,799	207,508	45,024,307	39,638,124	($5,178,675)	-13.1%
Pharmacy FFS	164,523,510	26,995	164,550,505	138,284,592	($26,238,917)	-19.0%
ER Services FFS	39,230,736	78,261	39,308,997	39,259,469	$28,734	0.1%
Inpatient Hospital & SNF FFS	273,111,660	1,976,458	275,088,118	267,048,081	($6,063,579)	-2.3%
Other Benefits & Services	20,701,999	0	20,701,999	22,870,234	$2,168,235	9.5%
Net Reinsurance	(121,052)	0	(121,052)	776,922	$897,974	115.6%
Provider Incentive	2,916,663	0	2,916,663	916,665	($1,999,998)	-218.2%
	$939,424,467	**$2,902,446**	**$942,326,913**	**$901,345,284**	**($38,079,183)**	**-4.2%**

Medical Expense - Actual vs. Budget (Per Member Per Month) Adjusted to Eliminate the Impact of Prior Year IBNP Estimates						
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Excluding IBNP Change	Change in IBNP	Reported		$	%
Capitated Medical Expense	$70.33	$0.00	$70.33	$69.50	($0.83)	-1.2%
Primary Care FFS	15.54	0.00	15.54	15.56	0.02	0.1%
Specialty Care FFS	15.83	0.06	15.90	16.00	0.16	1.0%
Outpatient FFS	28.80	0.14	28.94	28.09	(0.71)	-2.5%
Ancillary FFS	14.84	0.07	14.90	13.04	(1.80)	-13.8%
Pharmacy FFS	54.46	0.01	54.47	45.49	(8.97)	-19.7%
ER Services FFS	12.99	0.03	13.01	12.92	(0.07)	-0.6%
Inpatient Hospital & SNF FFS	90.41	0.65	91.07	87.85	(2.56)	-2.9%
Other Benefits & Services	6.85	0.00	6.85	7.52	0.67	8.9%
Net Reinsurance	(0.04)	0.00	(0.04)	0.26	0.30	115.7%
Provider Incentive	0.97	0.00	0.97	0.30	(0.66)	-220.2%
	$310.99	**$0.96**	**$311.95**	**$296.52**	**($14.47)**	**-4.9%**

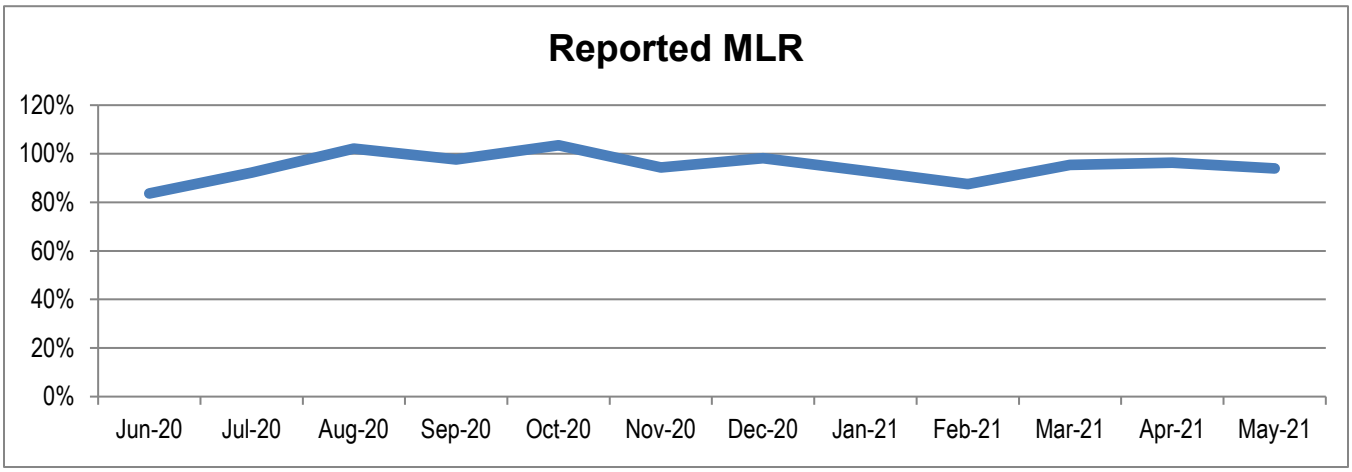
- Excluding the effect of prior year estimates for IBNP, year-to-date medical expense variance is $38.1 million unfavorable to budget. On a PMPM basis, medical expense is 4.9% unfavorable to budget.
    - Pharmacy Expense is significantly higher than budget driven by PBM expense. Financial responsibility for prescription drugs was scheduled to shift to DHCS beginning April 2021. This has been postponed and the Alliance continues to carry the expense which amounts to $21.0 million of the year-to-date variance. Non-PBM expense was unfavorable due to higher utilization partially offset by lower unit cost trends. Overall, all

populations are unfavorable except for the Child population which is favorable.

- Inpatient Expense is over budget due to higher-than-average COVID admissions in December 2020 and January 2021, along with admission increases in March through May 2021. This is partially offset by favorable utilization. The variance is driven by unfavorable acute care unit cost and utilization in the SPD Category of Aid, and to a lesser degree the Group Care population.
- Other Benefits & Services are under budget, primarily due to open positions in the Clinical Organization, unused paid time off, delayed hiring of consultants, delayed employee training and travel, lower Care Connect utilization, lower interpreter services utilization, delayed implementation of medical professional projects, a decrease in mailing services, and timing of member health education and incentives.
- Net Reinsurance is lower than budget due to the receipt of more recoveries than expected.
- Provider Incentive expense is over budget due to an addition of $2.0 million to the Measurement Year 2021 incentive pool.
- Ancillary Expense is above budget due to Home Heath, DME, Outpatient Therapy, Hospice, CBAS, Laboratory and Radiology and Ambulance expense offset by favorability in the other expense categories (Other Medical Professional and Non-Emergency Transportation). Overall utilization is unfavorable across all populations offset by favorable unit cost.
- Outpatient Expense is slightly over budget, driven by unfavorable utilization offset by favorable unit cost.
    - Behavioral Health: unfavorable due to higher utilization offset by favorable unit cost trends.
    - Lab & Radiology: unfavorable due to higher utilization offset by favorable unit cost trends.
    - Dialysis: favorable due to lower utilization offset by unfavorable unit cost trends.
    - Facility-Other: favorable due to lower utilization offset by unfavorable unit cost trends.
- Capitated Expense overall is on budget. Globally subcapitated expense is slightly over budget due to changes in PMPM rates.
- Emergency Room Expense is close to budget. Unfavorable unit cost was offset by favorable utilization across all COAs except for ACA OE and SPD populations (which had less favorable utilization and more unfavorable unit cost).
- Specialty Care is below budget due to favorable utilization. Expenses across all populations are favorable except for the SPD populations.
- Primary Care Expense is slightly under budget due to favorable utilization, partially offset by unfavorable unit cost across all populations except for Group Care members.

Medical Loss Ratio (MLR)

- The Medical Loss Ratio (total reported medical expense divided by operating revenue) was 94.0% for the month and 95.7% for the fiscal year-to-date.



Administrative Expense

- For the month ended May 31, 2021:
  - Actual Administrative Expense: $5.1 million.
  - Budgeted Administrative Expense: $5.6 million.

- For the fiscal YTD ended May 31, 2021:
  - Actual Administrative Expense: $45.7 million.
  - Budgeted Administrative Expense: $69.2 million.

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

Month					Year-to-Date			
Actual	Budget	Variance $	Variance %		Actual	Budget	Variance $	Variance %
$2,894,799	$3,059,244	$164,445	5.4%	Employee Expense	$29,822,406	$30,848,184	$1,025,779	3.3%
669,549	333,557	(335,992)	-100.7%	Medical Benefits Admin Expense	6,666,878	6,390,929	(275,949)	-4.3%
677,630	941,369	263,739	28.0%	Purchased & Professional Services	8,721,186	10,596,818	1,875,632	17.7%
880,181	1,301,716	421,535	32.4%	Other Admin Expense	514,068	21,366,187	20,852,119	97.6%
$5,122,159	$5,635,886	$513,727	9.1%	Total Administrative Expense	$45,724,538	$69,202,118	$23,477,581	33.9%

Favorable year-to-date variances include:
- Release of $10 million of remaining Sustainability Fund Reserves.
- Delayed timing of new project start dates in Consultants, Computer Support Services and Purchased Services.
- Savings in Building & Occupancy; a result of savings in Depreciation (delay of Capital Expense purchases).
- Savings in Licenses and Subscriptions resulting from the delay in new project starts.
- Savings in Printing / Postage Activities.

- Administrative expense represented 5.3% of net revenue for the month and 4.6% of net revenue year-to-date.

Other Income / (Expense)

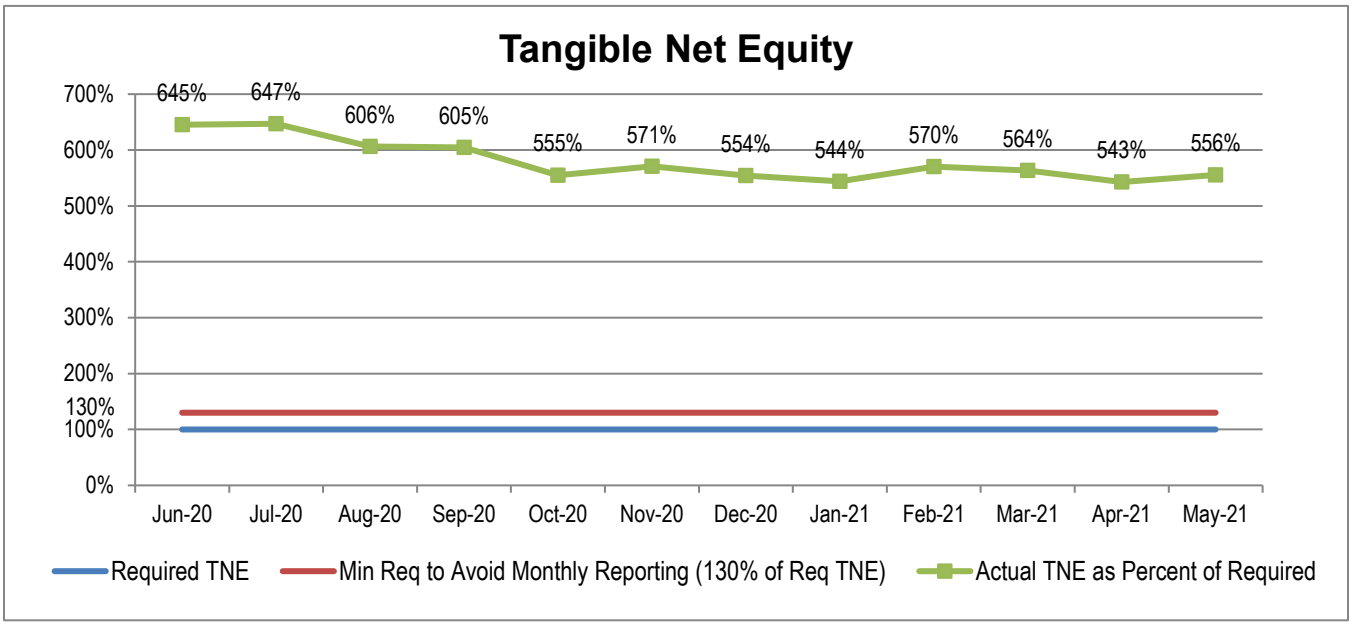
Other Income & Expense is comprised of investment income and claims interest.

- Fiscal year-to-date interest income from investments is $615,000.

- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims or recalculated interest on previously paid claims is $309,000.

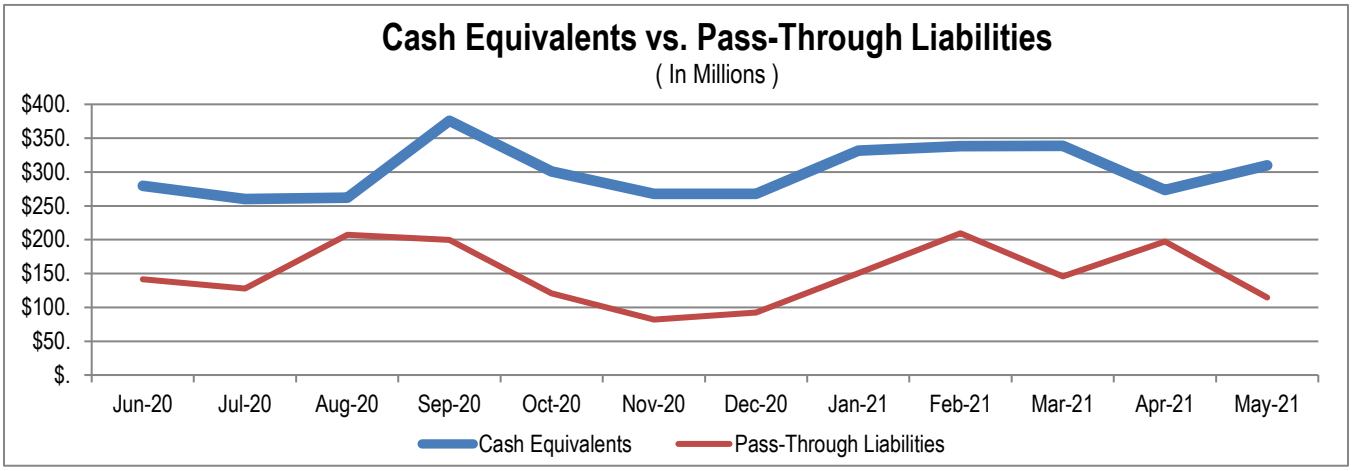
Tangible Net Equity (TNE)

- 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 $36.6 million
    - Actual TNE $203.1 million
    - Excess TNE $166.6 million
    - TNE as % of Required TNE 556%



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

- Key Metrics
  - Cash & Cash Equivalents $309.8 million
  - Pass-Through Liabilities $114.3 million
  - Uncommitted Cash $195.5 million
  - Working Capital $195.1 million
  - Current Ratio 1.74 (regulatory minimum is 1.0)



Capital Investment

- Fiscal year-to-date Capital Assets acquired less Capital Assets retired is negative $864,000 (net negative due to retirement of Trizetto software, $2 million).

- Annual capital budget: $2.4 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, 2021

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				MEMBERSHIP				
280,808	280,800	8	0.0%	1 - Medi-Cal	2,954,855	2,973,547	(18,692)	(0.6%)
5,949	6,009	(60)	(1.0%)	2 - Group Care	65,916	66,199	(283)	(0.4%)
286,757	**286,809**	**(52)**	**0.0%**	**3 - Total Member Months**	**3,020,771**	**3,039,746**	**(18,975)**	**(0.6%)**
				REVENUE				
$96,603,268	**$81,152,977**	**$15,450,291**	**19.0%**	**4 - TOTAL REVENUE**	**$984,767,708**	**$951,692,342**	**$33,075,366**	**3.5%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses:				
22,928,966	19,728,425	(3,200,541)	(16.2%)	5 - Capitated Medical Expense	212,460,248	211,258,448	(1,201,800)	(0.6%)
				Fee for Service Medical Expenses:				
20,086,035	23,529,457	3,443,422	14.6%	6 - Inpatient Hospital & SNF FFS Expense	275,088,118	267,048,074	(8,040,044)	(3.0%)
4,559,365	4,424,775	(134,590)	(3.0%)	7 - Primary Care Physician FFS Expense	46,948,745	47,286,290	337,545	0.7%
4,387,802	4,514,258	126,456	2.8%	8 - Specialty Care Physician Expense	48,022,868	48,623,167	600,299	1.2%
5,118,919	3,391,483	(1,727,436)	(50.9%)	9 - Ancillary Medical Expense	45,024,308	39,638,125	(5,386,183)	(13.6%)
8,085,546	7,742,177	(343,369)	(4.4%)	10 - Outpatient Medical Expense	87,425,516	85,383,287	(2,042,229)	(2.4%)
4,032,763	3,567,755	(465,008)	(13.0%)	11 - Emergency Expense	39,308,996	39,259,472	(49,524)	(0.1%)
17,516,537	4,478,477	(13,038,060)	(291.1%)	12 - Pharmacy Expense	164,550,507	138,284,596	(26,265,911)	(19.0%)
63,786,967	51,648,382	(12,138,585)	(23.5%)	13 - Total Fee for Service Expense	706,369,058	665,523,011	(40,846,047)	(6.1%)
1,872,255	2,160,674	288,419	13.3%	14 - Other Benefits & Services	20,701,994	22,870,234	2,168,239	9.5%
146,639	134,489	(12,150)	(9.0%)	15 - Reinsurance Expense	(121,052)	776,927	897,979	115.6%
2,083,333	83,334	(1,999,999)	(2,400.0%)	16 - Risk Pool Distribution	2,916,663	916,668	(1,999,995)	(218.2%)
90,818,160	**73,755,304**	**(17,062,856)**	**(23.1%)**	**17 - TOTAL MEDICAL EXPENSES**	**942,326,911**	**901,345,288**	**(40,981,624)**	**(4.5%)**
5,785,109	**7,397,674**	**(1,612,565)**	**(21.8%)**	**18 - GROSS MARGIN**	**42,440,797**	**50,347,054**	**(7,906,257)**	**(15.7%)**
				ADMINISTRATIVE EXPENSES				
2,894,798	3,059,243	164,445	5.4%	19 - Personnel Expense	29,822,406	30,848,185	1,025,778	3.3%
669,549	333,557	(335,993)	(100.7%)	20 - Benefits Administration Expense	6,666,878	6,390,929	(275,949)	(4.3%)
677,629	941,369	263,740	28.0%	21 - Purchased & Professional Services	8,721,185	10,596,817	1,875,632	17.7%
880,182	1,301,718	421,537	32.4%	22 - Other Administrative Expense	514,070	21,366,186	20,852,116	97.6%
5,122,159	**5,635,888**	**513,729**	**9.1%**	**23 -Total Administrative Expense**	**45,724,540**	**69,202,117**	**23,477,577**	**33.9%**
662,950	**1,761,786**	**(1,098,836)**	**(62.4%)**	**24 - NET OPERATING INCOME / (LOSS)**	**(3,283,743)**	**(18,855,063)**	**15,571,319**	**82.6%**
				OTHER INCOME / EXPENSE				
19,224	**51,986**	**(32,762)**	**(63.0%)**	**25 - Total Other Income / (Expense)**	**255,346**	**451,424**	**(196,078)**	**(43.4%)**
$682,173	**$1,813,772**	**($1,131,598)**	**(62.4%)**	**26 - NET INCOME / (LOSS)**	**($3,028,397)**	**($18,403,639)**	**$15,375,241**	**83.5%**
5.3%	6.9%	1.6%	23.7%	27 - Admin Exp % of Revenue	4.6%	7.3%	2.6%	36.1%

ALAMEDA ALLIANCE FOR HEALTH
SUMMARY BALANCE SHEET 2021
CURRENT MONTH VS. PRIOR MONTH
May 31, 2021

	May	April	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	$6,747,238	$25,092,923	($18,345,686)	-73.11%
Short-Term Investments	303,019,090	248,322,239	54,696,851	22.03%
Interest Receivable	9,582	3,455	6,127	177.34%
Other Receivables - Net	139,058,439	249,823,481	(110,765,041)	-44.34%
Prepaid Expenses	5,504,553	5,789,580	(285,027)	-4.92%
Prepaid Inventoried Items	4,971	3,971	1,000	25.19%
CalPERS Net Pension Asset	(832,801)	(832,801)	0	0.00%
Deferred CalPERS Outflow	4,303,523	4,303,523	0	0.00%
TOTAL CURRENT ASSETS	**457,814,595**	**532,506,370**	**(74,691,775)**	**-14.03%**
OTHER ASSETS:				
Restricted Assets	349,971	350,000	(29)	-0.01%
TOTAL OTHER ASSETS	**349,971**	**350,000**	**(29)**	**-0.01%**
PROPERTY AND EQUIPMENT:				
Land, Building & Improvements	9,751,302	9,751,302	0	0.00%
Furniture And Equipment	15,793,745	15,314,402	479,342	3.13%
Leasehold Improvement	927,440	927,440	0	0.00%
Construction in Process	63,615	63,615	0	0.00%
Internally-Developed Software	14,824,002	14,824,002	0	0.00%
Fixed Assets at Cost	41,360,103	40,880,761	479,342	1.17%
Less: Accumulated Depreciation	(33,637,990)	(33,489,899)	(148,092)	0.44%
NET PROPERTY AND EQUIPMENT	**7,722,113**	**7,390,862**	**331,251**	**4.48%**
TOTAL ASSETS	**$465,886,679**	**$540,247,232**	**($74,360,553)**	**-13.76%**
CURRENT LIABILITIES:				
Accounts Payable	$3,036,260	$3,259,911	($223,651)	-6.86%
Pass-Through Liabilities	114,334,306	197,393,888	(83,059,582)	-42.08%
Claims Payable	24,190,933	20,589,110	3,601,823	17.49%
IBNP Reserves	107,940,198	105,239,725	2,700,473	2.57%
Payroll Liabilities	4,593,237	4,738,360	(145,123)	-3.06%
CalPERS Deferred Inflow	1,627,670	1,627,670	0	0.00%
Risk Sharing	6,566,515	4,483,182	2,083,333	46.47%
Provider Grants/ New Health Program	451,143	451,143	0	0.00%
TOTAL CURRENT LIABILITIES	**262,740,262**	**337,782,988**	**(75,042,727)**	**-22.22%**
TOTAL LIABILITIES	**262,740,262**	**337,782,988**	**(75,042,727)**	**-22.22%**
NET WORTH:				
Contributed Capital	840,233	840,233	0	0.00%
Restricted & Unrestricted Funds	205,334,582	205,334,582	0	0.00%
Year-to Date Net Income / (Loss)	(3,028,397)	(3,710,571)	682,173	-18.38%
TOTAL NET WORTH	**203,146,418**	**202,464,244**	**682,173**	**0.34%**
TOTAL LIABILITIES AND NET WORTH	**$465,886,679**	**$540,247,232**	**($74,360,553)**	**-13.76%**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 5/31/2021

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received From:				
Capitation Received from State of CA	$207,316,369	$341,828,147	$538,619,808	$1,069,011,191
Commercial Premium Revenue	2,232,568	6,764,841	13,449,155	24,730,869
Other Income	290,839	941,587	2,106,967	4,192,660
Investment Income	38,791	103,564	254,679	558,985
Cash Paid To:				
Medical Expenses	(84,904,750)	(277,407,406)	(524,294,078)	(911,308,253)
Vendor & Employee Expenses	(5,083,755)	(6,968,578)	(21,901,125)	(43,900,097)
Interest Paid	0	0	0	0
Net Cash Provided By (Used In) Operating Activities	119,890,062	65,262,155	8,235,406	143,285,355
Cash Flows from Financing Activities:				
Purchases of Fixed Assets	(479,342)	1,406,863	1,226,995	863,854
Net Cash Provided By (Used In) Financing Activities	(479,342)	1,406,863	1,226,995	863,854
Cash Flows from Investing Activities:				
Changes in Investments	0	0	0	0
Restricted Cash	(83,059,553)	(95,165,977)	32,397,426	(114,057,966)
Net Cash Provided By (Used In) Investing Activities	(83,059,553)	(95,165,977)	32,397,426	(114,057,966)
Financial Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Net Change in Cash	**36,351,167**	**(28,496,959)**	**41,859,827**	**30,091,243**
Cash @ Beginning of Period	273,415,163	338,263,287	267,906,500	279,675,086
Subtotal	$309,766,330	$309,766,328	$309,766,327	$309,766,329
Rounding	(2)	0	1	(1)
Cash @ End of Period	**$309,766,328**	**$309,766,328**	**$309,766,328**	**$309,766,328**
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	$682,174	$7,018,403	$12,382,743	($3,028,398)
Depreciation	148,092	(18,771)	505,230	1,425,972
Net Change in Operating Assets & Liabilities:				
Premium & Other Receivables	110,758,915	61,843,970	(12,541,058)	108,729,982
Prepaid Expenses	284,027	(588,315)	(1,037,990)	(556,216)
Trade Payables	(223,651)	368,947	(202,571)	161,278
Claims payable & IBNP	8,385,629	6,691,865	18,524,094	43,850,055
Deferred Revenue	0	0	0	0
Accrued Interest	0	0	0	0
Other Liabilities	(145,123)	(10,053,945)	(9,395,040)	(7,297,319)
Subtotal	119,890,063	65,262,154	8,235,408	143,285,354
Rounding	(1)	1	(2)	1
Cash Flows from Operating Activities	**$119,890,062**	**$65,262,155**	**$8,235,406**	**$143,285,355**
Rounding Difference	(1)	1	(2)	1

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 5/31/2021

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$2,232,568	$6,764,841	$13,449,155	$24,730,869
Total	2,232,568	6,764,841	13,449,155	24,730,869
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	94,079,108	278,082,703	547,367,853	955,841,512
Allowance for Doubtful Accounts	0	0	0	0
Deferred Premium Revenue	0	0	0	0
Premium Receivable	113,237,261	63,745,444	(8,748,045)	113,169,679
Total	207,316,369	341,828,147	538,619,808	1,069,011,191
Investment & Other Income Cash Flows				
Other Revenue (Grants)	290,839	941,587	2,106,967	4,192,660
Interest Income	44,918	106,698	262,233	567,285
Interest Receivable	(6,127)	(3,134)	(7,554)	(8,300)
Total	329,630	1,045,151	2,361,646	4,751,645
Medical & Hospital Cash Flows				
Total Medical Expenses	(90,818,160)	(272,170,931)	(529,002,713)	(942,326,911)
Other Receivable	(2,472,219)	(1,898,340)	(3,785,459)	(4,431,397)
Claims Payable	3,601,823	6,286,638	5,993,065	9,586,333
IBNP Payable	2,700,473	(1,844,772)	10,031,030	33,848,823
Risk Share Payable	2,083,333	2,249,999	2,499,998	414,898
Health Program	0	(10,030,000)	(10,030,000)	(8,400,000)
Other Liabilities	0	0	1	1
Total	(84,904,750)	(277,407,406)	(524,294,078)	(911,308,253)
Administrative Cash Flows				
Total Administrative Expenses	(5,147,100)	(6,706,494)	(21,800,754)	(46,033,812)
Prepaid Expenses	284,027	(588,315)	(1,037,990)	(556,216)
CalPERS Pension Asset	0	0	0	0
CalPERS Deferred Outflow	0	0	0	0
Trade Accounts Payable	(223,651)	368,947	(202,571)	161,278
Other Accrued Liabilities	0	0	0	0
Payroll Liabilities	(145,123)	(23,945)	634,960	1,102,681
Depreciation Expense	148,092	(18,771)	505,230	1,425,972
Total	(5,083,755)	(6,968,578)	(21,901,125)	(43,900,097)
Interest Paid				
Debt Interest Expense	0	0	0	0
Total Cash Flows from Operating Activities	**119,890,062**	**65,262,155**	**8,235,406**	**143,285,355**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 5/31/2021

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Restricted Cash & Other Asset Cash Flows				
Provider Pass-Thru-Liabilities	(83,059,582)	(95,166,006)	32,397,397	(114,057,995)
Restricted Cash	29	29	29	29
	(83,059,553)	(95,165,977)	32,397,426	(114,057,966)
Fixed Asset Cash Flows				
Depreciation expense	148,092	(18,771)	505,230	1,425,972
Fixed Asset Acquisitions	(479,342)	1,406,863	1,226,995	863,854
Change in A/D	(148,092)	18,771	(505,230)	(1,425,972)
	(479,342)	1,406,863	1,226,995	863,854
Total Cash Flows from Investing Activities	**(83,538,895)**	**(93,759,114)**	**33,624,421**	**(113,194,112)**
Financing Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Total Cash Flows	**36,351,167**	**(28,496,959)**	**41,859,827**	**30,091,243**
Rounding	(2)	0	1	(1)
Cash @ Beginning of Period	273,415,163	338,263,287	267,906,500	279,675,086
Cash @ End of Period	**$309,766,328**	**$309,766,328**	**$309,766,328**	**$309,766,328**
Difference (rounding)	0	0	0	0

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 5/31/2021

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$682,174	$7,018,403	$12,382,743	($3,028,398)
Add back: Depreciation	148,092	(18,771)	505,230	1,425,972
Receivables				
Premiums Receivable	113,237,261	63,745,444	(8,748,045)	113,169,679
First Care Receivable	0	0	0	0
Family Care Receivable	0	0	0	0
Healthy Kids Receivable	0	0	0	0
Interest Receivable	(6,127)	(3,134)	(7,554)	(8,300)
Other Receivable	(2,472,219)	(1,898,340)	(3,785,459)	(4,431,397)
FQHC Receivable	0	0	0	0
Allowance for Doubtful Accounts	0	0	0	0
Total	110,758,915	61,843,970	(12,541,058)	108,729,982
Prepaid Expenses	284,027	(588,315)	(1,037,990)	(556,216)
Trade Payables	(223,651)	368,947	(202,571)	161,278
Claims Payable, IBNR & Risk Share				
IBNP	2,700,473	(1,844,772)	10,031,030	33,848,823
Claims Payable	3,601,823	6,286,638	5,993,065	9,586,333
Risk Share Payable	2,083,333	2,249,999	2,499,998	414,898
Other Liabilities	0	0	1	1
Total	8,385,629	6,691,865	18,524,094	43,850,055
Unearned Revenue				
Total	0	0	0	0
Other Liabilities				
Accrued Expenses	0	0	0	0
Payroll Liabilities	(145,123)	(23,945)	634,960	1,102,681
Health Program	0	(10,030,000)	(10,030,000)	(8,400,000)
Accrued Sub Debt Interest	0	0	0	0
Total Change in Other Liabilities	(145,123)	(10,053,945)	(9,395,040)	(7,297,319)
Cash Flows from Operating Activities	**$119,890,063**	**$65,262,154**	**$8,235,408**	**$143,285,354**
Difference (rounding)	1	(1)	2	(1)

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF MAY 2021

	Medi-Cal							
	Child	Adults*	SPD*	ACA OE	Duals	Medi-Cal Total	Group Care	Grand Total
Enrollment	96,782	40,561	26,289	97,325	19,851	280,808	5,949	286,757
Net Revenue	$11,552,038	$13,557,063	$27,949,062	$37,855,503	$3,457,036	$94,370,701	$2,232,567	$96,603,268
Medical Expense	$9,894,096	$13,557,447	$27,854,064	$33,656,567	$3,566,690	$88,528,863	$2,289,296	$90,818,160
Gross Margin	$1,657,942	($384)	$94,998	$4,198,935	($109,654)	$5,841,838	($56,729)	$5,785,109
Administrative Expense	$407,776	$744,449	$1,634,613	$1,981,998	$196,563	$4,965,399	$156,760	$5,122,159
Operating Income / (Expense)	$1,250,166	($744,833)	($1,539,614)	$2,216,937	($306,217)	$876,439	($213,489)	$662,950
Other Income / (Expense)	$2,849	($373)	$7,412	$8,077	$991	$18,955	$269	$19,224
Net Income / (Loss)	$1,253,015	($745,207)	($1,532,202)	$2,225,014	($305,226)	$895,394	($213,220)	$682,173
Revenue PMPM	$119.36	$334.24	$1,063.15	$388.96	$174.15	$336.07	$375.28	$336.88
Medical Expense PMPM	$102.23	$334.25	$1,059.53	$345.82	$179.67	$315.26	$384.82	$316.71
Gross Margin PMPM	$17.13	($0.01)	$3.61	$43.14	($5.52)	$20.80	($9.54)	$20.17
Administrative Expense PMPM	$4.21	$18.35	$62.18	$20.36	$9.90	$17.68	$26.35	$17.86
Operating Income / (Expense) PMPM	$12.92	($18.36)	($58.56)	$22.78	($15.43)	$3.12	($35.89)	$2.31
Other Income / (Expense) PMPM	$0.03	($0.01)	$0.28	$0.08	$0.05	$0.07	$0.05	$0.07
Net Income / (Loss) PMPM	$12.95	($18.37)	($58.28)	$22.86	($15.38)	$3.19	($35.84)	$2.38
Medical Loss Ratio	85.6%	100.0%	99.7%	88.9%	103.2%	93.8%	102.5%	94.0%
Gross Margin Ratio	14.4%	0.0%	0.3%	11.1%	-3.2%	6.2%	-2.5%	6.0%
Administrative Expense Ratio	3.5%	5.5%	5.8%	5.2%	5.7%	5.3%	7.0%	5.3%
Net Income Ratio	10.8%	-5.5%	-5.5%	5.9%	-8.8%	0.9%	-9.6%	0.7%

*** Effective January 2021 BCCTP members are included with SPDs. July 2020 - December 2020 BCCTP members were included with Adults.**

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE - MAY 2021

	Child	Adult*	Medi-Cal SPD*	ACA OE	Duals	Medi-Cal Total	Group Care	Grand Total
Member Months	1,040,531	418,335	288,660	997,146	210,183	2,954,855	65,916	3,020,771
Net Revenue	$127,148,283	$132,723,731	$294,658,176	$369,504,456	$36,001,964	$960,036,609	$24,731,099	$984,767,708
Medical Expense	$101,559,658	$130,917,154	$301,460,345	$352,587,813	$30,717,101	$917,242,071	$25,084,840	$942,326,911
Gross Margin	$25,588,625	$1,806,577	($6,802,169)	$16,916,643	$5,284,863	$42,794,538	($353,741)	$42,440,797
Administrative Expense	$3,670,470	$6,157,055	$15,661,335	$17,235,685	$1,491,891	$44,216,436	$1,508,104	$45,724,540
Operating Income / (Expense)	$21,918,155	($4,350,478)	($22,463,504)	($319,042)	$3,792,972	($1,421,898)	($1,861,846)	($3,283,743)
Other Income / (Expense)	$30,519	$38,566	$92,408	$99,403	($8,220)	$252,677	$2,669	$255,346
Net Income / (Loss)	$21,948,674	($4,311,911)	($22,371,096)	($219,640)	$3,784,752	($1,169,221)	($1,859,176)	($3,028,397)
Revenue PMPM	$122.20	$317.27	$1,020.78	$370.56	$171.29	$324.90	$375.19	$326.00
Medical Expense PMPM	$97.60	$312.95	$1,044.34	$353.60	$146.14	$310.42	$380.56	$311.95
Gross Margin PMPM	$24.59	$4.32	($23.56)	$16.97	$25.14	$14.48	($5.37)	$14.05
Administrative Expense PMPM	$3.53	$14.72	$54.26	$17.29	$7.10	$14.96	$22.88	$15.14
Operating Income / (Expense) PMPM	$21.06	($10.40)	($77.82)	($0.32)	$18.05	($0.48)	($28.25)	($1.09)
Other Income / (Expense) PMPM	$0.03	$0.09	$0.32	$0.10	($0.04)	$0.09	$0.04	$0.08
Net Income / (Loss) PMPM	$21.09	($10.31)	($77.50)	($0.22)	$18.01	($0.40)	($28.21)	($1.00)
Medical Loss Ratio	79.9%	98.6%	102.3%	95.4%	85.3%	95.5%	101.4%	95.7%
Gross Margin Ratio	20.1%	1.4%	-2.3%	4.6%	14.7%	4.5%	-1.4%	4.3%
Administrative Expense Ratio	2.9%	4.6%	5.3%	4.7%	4.1%	4.6%	6.1%	4.6%
Net Income Ratio	17.3%	-3.2%	-7.6%	-0.1%	10.5%	-0.1%	-7.5%	-0.3%

* Effective January 2021 BCCTP members are included with SPDs. July 2020 - December 2020 BCCTP members were included with Adults.

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED May 31, 2021

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSE SUMMARY				
$2,894,798	$3,059,243	$164,445	5.4%	Personnel Expenses	$29,822,406	$30,848,185	$1,025,778	3.3%
669,549	333,557	(335,993)	(100.7%)	Benefits Administration Expense	6,666,878	6,390,929	(275,949)	(4.3%)
677,629	941,369	263,740	28.0%	Purchased & Professional Services	8,721,185	10,596,817	1,875,632	17.7%
316,686	413,794	97,108	23.5%	Occupancy	3,861,218	4,280,796	419,579	9.8%
71,107	197,170	126,063	63.9%	Printing Postage & Promotion	(8,405,373)	10,423,786	18,829,160	180.6%
487,938	665,810	177,872	26.7%	Licenses Insurance & Fees	4,957,834	6,473,890	1,516,057	23.4%
4,451	24,945	20,494	82.2%	Supplies & Other Expenses	100,392	187,713	87,321	46.5%
2,227,360	2,576,645	349,284	13.6%	Total Other Administrative Expense	15,902,134	38,353,932	22,451,799	58.5%
$5,122,159	**$5,635,888**	**$513,729**	**9.1%**	**Total Administrative Expenses**	**$45,724,540**	**$69,202,117**	**$23,477,577**	**33.9%**

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ADMIN YTD 2021
06/21/21
REPORT #6

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED May 31, 2021

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
$1,913,422	$1,945,256	$31,834	1.6%	Salaries & Wages	$20,006,607	$19,852,209	($154,398)	(0.8%)
184,154	215,733	31,579	14.6%	Paid Time Off	1,918,860	2,115,226	196,366	9.3%
1,900	2,967	1,067	36.0%	Incentives	11,369	26,182	14,813	56.6%
0	0	0	0.0%	Severance Pay	7,605	7,605	0	0.0%
19,689	32,058	12,369	38.6%	Payroll Taxes	397,446	483,585	86,139	17.8%
20,018	7,220	(12,798)	(177.3%)	Overtime	226,400	155,443	(70,957)	(45.6%)
156,681	165,121	8,440	5.1%	CalPERS ER Match	1,584,324	1,631,137	46,814	2.9%
0	0	0	0.0%	Sick Leave Pay	4,097	4,097	0	0.0%
477,274	588,314	111,041	18.9%	Employee Benefits	4,860,999	5,469,315	608,315	11.1%
86	0	(86)	0.0%	Personal Floating Holiday	89,036	95,444	6,408	6.7%
3,019	12,422	9,402	75.7%	Employee Relations	37,579	148,935	111,355	74.8%
7,200	7,950	750	9.4%	Work from Home Stipend	48,690	52,590	3,900	7.4%
52	3,747	3,695	98.6%	Transportation Reimbursement	928	16,296	15,368	94.3%
0	14,469	14,469	100.0%	Travel & Lodging	(548)	70,241	70,790	100.8%
68,715	6,032	(62,683)	(1,039.2%)	Temporary Help Services	326,582	153,970	(172,612)	(112.1%)
36,276	48,917	12,641	25.8%	Staff Development/Training	149,876	351,946	202,070	57.4%
6,313	9,038	2,725	30.1%	Staff Recruitment/Advertising	152,556	213,963	61,407	28.7%
2,894,798	**3,059,243**	**164,445**	**5.4%**	**Total Employee Expenses**	**29,822,406**	**30,848,185**	**1,025,778**	**3.3%**
				Benefit Administration Expense				
402,837	85,908	(316,929)	(368.9%)	RX Administration Expense	3,910,376	3,630,874	(279,502)	(7.7%)
249,536	229,084	(20,453)	(8.9%)	Behavioral Hlth Administration Fees	2,574,519	2,567,470	(7,049)	(0.3%)
17,176	18,565	1,389	7.5%	Telemedicine Admin Fees	181,983	192,585	10,602	5.5%
669,549	**333,557**	**(335,993)**	**(100.7%)**	**Total Employee Expenses**	**6,666,878**	**6,390,929**	**(275,949)**	**(4.3%)**
				Purchased & Professional Services				
247,281	283,465	36,184	12.8%	Consulting Services	1,658,115	2,889,023	1,230,907	42.6%
252,523	496,974	244,451	49.2%	Computer Support Services	3,205,406	5,045,698	1,840,292	36.5%
8,750	8,750	0	0.0%	Professional Fees-Accounting	120,505	108,437	(12,068)	(11.1%)
0	100	100	100.0%	Professional Fees-Medical	0	700	700	100.0%
8,567	29,469	20,902	70.9%	Other Purchased Services	196,644	430,563	233,920	54.3%
3,784	10,284	6,500	63.2%	Maint.& Repair-Office Equipment	67,668	110,170	42,502	38.6%
25,337	8,050	(17,287)	(214.7%)	HMS Recovery Fees	340,988	217,171	(123,818)	(57.0%)
0	4,242	4,242	100.0%	MIS Software (Non-Capital)	1,500,000	309,692	(1,190,308)	(384.4%)
61,615	7,507	(54,108)	(720.7%)	Hardware (Non-Capital)	138,516	109,649	(28,867)	(26.3%)
7,873	14,195	6,322	44.5%	Provider Relations-Credentialing	129,730	136,441	6,712	4.9%
61,900	78,333	16,434	21.0%	Legal Fees	1,363,614	1,239,274	(124,339)	(10.0%)
677,629	**941,369**	**263,740**	**28.0%**	**Total Purchased & Professional Services**	**8,721,185**	**10,596,817**	**1,875,632**	**17.7%**
				Occupancy				
145,155	194,394	49,239	25.3%	Depreciation	1,679,834	1,914,648	234,814	12.3%
2,936	26,107	23,171	88.8%	Amortization	247,461	287,180	39,718	13.8%
67,855	67,855	0	0.0%	Building Lease	746,406	746,406	0	0.0%
5,255	2,002	(3,253)	(162.4%)	Leased and Rented Office Equipment	25,943	27,468	1,525	5.6%
11,677	13,625	1,948	14.3%	Utilities	129,664	140,866	11,202	8.0%
66,909	83,300	16,391	19.7%	Telephone	868,001	942,886	74,885	7.9%

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ADMIN YTD 2021
06/21/21
REPORT #6

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED May 31, 2021

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
$16,898	$26,510	$9,612	36.3%	Building Maintenance	$163,908	$221,343	$57,434	25.9%
316,686	**413,794**	**97,108**	**23.5%**	**Total Occupancy**	**3,861,218**	**4,280,796**	**419,579**	**9.8%**
				Printing Postage & Promotion				
15,463	37,703	22,241	59.0%	Postage	312,415	507,514	195,099	38.4%
4,250	3,250	(1,000)	(30.8%)	Design & Layout	59,825	36,100	(23,725)	(65.7%)
24,417	35,400	10,983	31.0%	Printing Services	548,537	636,537	87,999	13.8%
3,563	4,470	907	20.3%	Mailing Services	31,365	44,354	12,989	29.3%
2,386	2,483	98	3.9%	Courier/Delivery Service	29,997	26,804	(3,194)	(11.9%)
25	480	455	94.7%	Pre-Printed Materials and Publications	668	5,243	4,575	87.3%
0	1,250	1,250	100.0%	Promotional Products	32,713	33,221	508	1.5%
10,288	105,833	95,546	90.3%	Community Relations	(9,501,997)	9,055,738	18,557,735	204.9%
(17)	0	17	0.0%	Health Education-Member	(17)	0	17	0.0%
10,732	6,300	(4,432)	(70.4%)	Translation - Non-Clinical	81,120	78,275	(2,845)	(3.6%)
71,107	**197,170**	**126,063**	**63.9%**	**Total Printing Postage & Promotion**	**(8,405,373)**	**10,423,786**	**18,829,160**	**180.6%**
				Licenses Insurance & Fees				
0	0	0	0.0%	Regulatory Penalties	0	100,000	100,000	100.0%
21,072	20,700	(372)	(1.8%)	Bank Fees	221,635	213,967	(7,669)	(3.6%)
61,174	53,715	(7,458)	(13.9%)	Insurance	598,310	641,617	43,307	6.7%
337,435	517,229	179,795	34.8%	Licenses, Permits and Fees	3,426,330	4,746,144	1,319,813	27.8%
68,258	74,165	5,907	8.0%	Subscriptions & Dues	711,558	772,163	60,605	7.8%
487,938	**665,810**	**177,872**	**26.7%**	**Total Licenses Insurance & Postage**	**4,957,834**	**6,473,890**	**1,516,057**	**23.4%**
				Supplies & Other Expenses				
2,213	5,187	2,973	57.3%	Office and Other Supplies	21,821	39,877	18,056	45.3%
833	2,695	1,862	69.1%	Ergonomic Supplies	20,191	20,632	441	2.1%
879	11,013	10,134	92.0%	Commissary-Food & Beverage	6,171	56,365	50,194	89.1%
525	4,850	4,325	89.2%	Member Incentive Expense	34,475	53,350	18,875	35.4%
0	0	0	0.0%	Covid-19 IT Expenses	3,840	3,840	0	0.0%
0	1,200	1,200	100.0%	Covid-19 Non IT Expenses	13,894	13,649	(245)	(1.8%)
4,451	**24,945**	**20,494**	**82.2%**	**Total Supplies & Other Expense**	**100,392**	**187,713**	**87,321**	**46.5%**
$5,122,159	**$5,635,888**	**$513,729**	**9.1%**	**TOTAL ADMINISTRATIVE EXPENSE**	**$45,724,540**	**$69,202,117**	**$23,477,577**	**33.9%**

ALAMEDA ALLIANCE FOR HEALTH
CAPITAL SPENDING INCLUDING CONSTRUCTION-IN-PROCESS
ACTUAL VS. BUDGET
FOR THE FISCAL YEAR-TO-DATE ENDED MAY 31, 2021

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Computer Equipment (Laptop, Desktop, Tablets)	IT-FY21-01	$ 271,881	$ -	**$ 271,881**	$ 300,000	$ 28,119
	Display Monitors	IT-FY21-02	$ 30,302		**$ 30,302**	$ 40,000	$ 9,698
	Cisco Phones (Desk phone, Conference phone)	IT-FY21-03	$ -		**$ -**	$ 30,000	$ 30,000
	Audio / Video Equipment	IT-FY21-04	$ -		**$ -**	$ 60,000	$ 60,000
	APC UPS Batteries	IT-FY21-05	$ -		**$ -**	$ 20,000	$ 20,000
	IT Cage Supplies and Tools	IT-FY21-06	$ -		**$ -**	$ 10,000	$ 10,000
	Cisco Network Hardware (Switches, Routers, Firewalls, Wireless)	IT-FY21-07	$ 32,546		**$ 32,546**	$ 150,000	$ 117,454
	Cisco UCS Blade RAM	IT-FY21-08	$ -		**$ -**	$ 140,000	$ 140,000
	Pure Storage Shelf	IT-FY21-09	$ 24,232	$ 412,896	**$ 437,128**	$ 250,000	$ (187,128)
	Security Hardware	IT-FY21-10	$ -		**$ -**	$ 80,000	$ 80,000
	Call Center Hardware	IT-FY21-11	$ -		**$ -**	$ 40,000	$ 40,000
	Computer Components (Memory, Hard drives)	IT-FY21-16	$ -		**$ -**	$ 15,000	$ 15,000
	Network / AV Cabling	IT-FY21-18	$ -	$ 66,447	**$ 66,447**	$ 250,000	$ 183,553
	Carryover from FY20 / unplanned	IT-FY21-19	$ 163,751		**$ 163,751**	$ -	$ (163,751)
Hardware Subtotal			**$ 522,712**	**$ 479,342**	**$ 1,002,054**	**$ 1,385,000**	**$ 382,946**
2. Software:							
	Monitoring Software	AC-FY21-02	$ -		**$ -**	$ 60,000	$ 60,000
	Windows Server OS (3rd payment)	AC-FY21-03	$ -		**$ -**	$ 80,000	$ 80,000
	Adobe Acrobat Licenses	AC-FY21-04	$ -		**$ -**	$ 12,000	$ 12,000
	Carryover from FY20 / unplanned	AC-FY21-05	$ 28,232		**$ 28,232**	$ -	$ (28,232)
	Write off of Internally Developed Software (Trizetto)	NA	$ (2,000,000)		**$ (2,000,000)**	$ -	$ 2,000,000
Software Subtotal			**$ (1,971,768)**	**$ -**	**$ (1,971,768)**	**$ 152,000**	**$ 2,123,768**
3. Building Improvement:							
	Appliances over 1k new/replacement (all buildings/suites)	FA-FY21-01	$ -		**$ -**	$ 5,000	$ 5,000
	ACME Security: Readers, HID boxes, Cameras, Doors (planned/unplanned Maintenance repairs)	FA-FY21-02	$ -		**$ -**	$ 50,000	$ 50,000
	Seismic Improvements (Carryover from FY20)	FA-FY21-03	$ -		**$ -**	$ 150,000	$ 150,000
	HVAC: Replace VAV boxes, duct work, replace old equipment	FA-FY21-04	$ -		**$ -**	$ 65,000	$ 65,000
	Electrical work for projects, workstations requirement	FA-FY21-05	$ -		**$ -**	$ 20,000	$ 20,000
	Construction work for various projects	FA-FY21-06	$ -		**$ -**	$ 20,000	$ 20,000
	1240 Emergency Generator	FA-FY21-07	$ 63,615		**$ 63,615**	$ 318,000	$ 254,385

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
Building Improvement Subtotal			**$ 63,615**	**$ -**	**$ 63,615**	**$ 628,000**	**$ 564,385**
4. Furniture & Equipment:							
	Office desks, cabinets, shelving (all building/suites: new or replacement)	FA-FY21-19	$ 1,721		**$ 1,721**	$ 50,000	$ 48,279
	Ergonomic Equipment - Sit/Stand desks	FA-FY21-20	$ -		**$ -**	$ 40,000	$ 40,000
	Task Chairs: Various sizes, special order for Ergo/WC	FA-FY21-21	$ -		**$ -**	$ 50,000	$ 50,000
	Replace, reconfigure, re-design workstations	FA-FY21-22	$ 36,565		**$ 36,565**	$ 50,000	$ 13,435
Furniture & Equipment Subtotal			**$ 38,286**	**$ -**	**$ 38,286**	**$ 190,000**	**$ 151,714**
5. Leasehold Improvement:							
	Electrical work for projects, workstations requirement	FA-FY21-26	$ 3,090		**$ 3,090**	$ 20,000	$ 16,910
Leasehold Improvement Subtotal			**$ 3,090**	**$ -**	**$ 3,090**	**$ 20,000**	**$ 16,910**
6. Contingency:							
	Carryover from FY20 / Unplanned/ Contingency	FA-FY21-28	$ 870		**$ 870**	$ -	$ (870)
Contingency Subtotal			**$ 870**	**$ -**	**$ 870**	**$ -**	**$ (870)**
GRAND TOTAL			**$ (1,343,195)**	**$ 479,342**	**$ (863,854)**	**$ 2,375,000**	**$ 3,238,853**

7. Reconciliation to Balance Sheet:

Fixed Assets @ Cost -5/30/21	**$ 41,360,103**
Fixed Assets @ Cost - 6/30/20	**$ 42,223,957**
Fixed Assets Acquired YTD	**$ (863,854)**

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
SUMMARY - FISCAL YEAR 2021

TANGIBLE NET EQUITY (TNE)	Jul-20	Aug-20	QTR. END Sep-20	Oct-20	Nov-20	QTR. END Dec-20	Jan-21	Feb-21	QTR. END Mar-21	Apr-21	May-21
Current Month Net Income / (Loss)	$1,862,425	($6,647,096)	($3,237,699)	($7,755,478)	$366,707	($3,276,454)	$1,169,847	$7,470,948	($545,892)	$6,882,121	$682,173
YTD Net Income / (Loss)	$1,862,425	($4,784,670)	($8,022,369)	($15,777,847)	($15,411,141)	($18,687,595)	($17,517,747)	($10,046,800)	($10,592,692)	($3,710,571)	($3,028,397)
Actual TNE											
Net Assets	$208,037,240	$201,390,145	$198,152,445	$190,396,968	$190,763,674	$187,487,220	$188,657,068	$196,128,015	$195,582,123	$202,464,244	$203,146,418
Subordinated Debt & Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Actual TNE	**$208,037,240**	**$201,390,145**	**$198,152,445**	**$190,396,968**	**$190,763,674**	**$187,487,220**	**$188,657,068**	**$196,128,015**	**$195,582,123**	**$202,464,244**	**$203,146,418**
Increase/(Decrease) in Actual TNE	$1,862,425	($6,647,095)	($3,237,700)	($7,755,477)	$366,706	($3,276,454)	$1,169,848	$7,470,947	($545,892)	$6,882,121	$682,174
Required TNE[(1)]	**$32,152,830**	**$33,226,635**	**$32,768,500**	**$34,310,349**	**$33,421,093**	**$33,839,117**	**$34,693,839**	**$34,402,727**	**$34,699,152**	**$37,303,381**	**$36,557,671**
Min. Req'd to Avoid Monthly Reporting (130% of Required TNE)	$41,798,679	$43,194,626	$42,599,050	$44,603,454	$43,447,421	$43,990,852	$45,101,990	$44,723,545	$45,108,898	$48,494,395	$47,524,972
TNE Excess / (Deficiency)	$175,884,410	$168,163,510	$165,383,945	$156,086,619	$157,342,581	$153,648,103	$153,963,229	$161,725,288	$160,882,971	$165,160,863	$166,588,747
Actual TNE as a Multiple of Required	**6.47**	**6.06**	**6.05**	**5.55**	**5.71**	**5.54**	**5.44**	**5.70**	**5.64**	**5.43**	**5.56**

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

LIQUID TANGIBLE NET EQUITY											
Net Assets	$208,037,240	$201,390,145	$198,152,445	$190,396,968	$190,763,674	$187,487,220	$188,657,068	$196,128,015	$195,582,123	$202,464,244	$203,146,418
Fixed Assets at Net Book Value	(9,978,158)	(9,949,713)	(9,770,590)	(9,592,926)	(9,454,338)	(9,295,248)	(9,120,984)	(9,110,205)	(9,049,771)	(7,390,862)	(7,722,113)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(349,971)
Liquid TNE (Liquid Reserves)	**$197,709,082**	**$191,090,432**	**$188,031,855**	**$180,454,042**	**$180,959,336**	**$177,841,972**	**$179,186,084**	**$186,667,810**	**$186,182,352**	**$194,723,382**	**$195,074,334**
Liquid TNE as Multiple of Required	**6.15**	**5.75**	**5.74**	**5.26**	**5.41**	**5.26**	**5.16**	**5.43**	**5.37**	**5.22**	**5.34**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2021

	Actual Jul-20	Actual Aug-20	Actual Sep-20	Actual Oct-20	Actual Nov-20	Actual Dec-20	Actual Jan-21	Actual Feb-21	Actual Mar-21	Actual Apr-21	Actual May-21	Actual Jun-21	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	91,570	92,692	93,378	93,982	94,620	94,969	95,103	95,510	95,692	96,233	96,782		1,040,531
Adults*	34,909	35,689	36,302	37,072	37,640	38,152	38,994	39,315	39,649	40,052	40,561		418,335
SPD*	26,044	26,094	26,178	26,250	26,314	26,339	26,354	26,294	26,234	26,270	26,289		288,660
ACA OE	82,989	85,081	86,713	88,258	89,752	91,050	92,257	93,332	94,473	95,916	97,325		997,146
Duals	18,297	18,495	18,606	18,847	18,988	19,125	19,215	19,415	19,596	19,748	19,851		210,183
Medi-Cal Program	253,809	258,051	261,177	264,409	267,314	269,635	271,923	273,866	275,644	278,219	280,808		2,954,855
Group Care Program	6,109	6,007	6,011	6,009	5,982	5,954	5,961	5,969	5,993	5,972	5,949		65,916
Total	**259,918**	**264,058**	**267,188**	**270,418**	**273,296**	**275,589**	**277,884**	**279,835**	**281,637**	**284,191**	**286,757**		**3,020,771**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	825	1,122	686	604	638	349	134	407	182	541	549		6,037
Adults*	822	780	613	770	568	512	842	321	334	403	509		6,474
SPD*	(67)	50	84	72	64	25	15	(60)	(60)	36	19		178
ACA OE	1,693	2,092	1,632	1,545	1,494	1,298	1,207	1,075	1,141	1,443	1,409		16,029
Duals	228	198	111	241	141	137	90	200	181	152	103		1,782
Medi-Cal Program	3,501	4,242	3,126	3,232	2,905	2,321	2,288	1,943	1,778	2,575	2,589		30,500
Group Care Program	(328)	(102)	4	(2)	(27)	(28)	7	8	24	(21)	(23)		(488)
Total	**3,173**	**4,140**	**3,130**	**3,230**	**2,878**	**2,293**	**2,295**	**1,951**	**1,802**	**2,554**	**2,566**		**30,012**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	36.1%	35.9%	35.8%	35.5%	35.4%	35.2%	35.0%	34.9%	34.7%	34.6%	34.5%		35.2%
Adults % of Medi-Cal	13.8%	13.8%	13.9%	14.0%	14.1%	14.1%	14.3%	14.4%	14.4%	14.4%	14.4%		14.2%
SPD % of Medi-Cal	10.3%	10.1%	10.0%	9.9%	9.8%	9.8%	9.7%	9.6%	9.5%	9.4%	9.4%		9.8%
ACA OE % of Medi-Cal	32.7%	33.0%	33.2%	33.4%	33.6%	33.8%	33.9%	34.1%	34.3%	34.5%	34.7%		33.7%
Duals % of Medi-Cal	7.2%	7.2%	7.1%	7.1%	7.1%	7.1%	7.1%	7.1%	7.1%	7.1%	7.1%		7.1%
Medi-Cal Program % of Total	97.6%	97.7%	97.8%	97.8%	97.8%	97.8%	97.9%	97.9%	97.9%	97.9%	97.9%		97.8%
Group Care Program % of Total	2.4%	2.3%	2.2%	2.2%	2.2%	2.2%	2.1%	2.1%	2.1%	2.1%	2.1%		2.2%
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 2021

	Actual Jul-20	Actual Aug-20	Actual Sep-20	Actual Oct-20	Actual Nov-20	Actual Dec-20	Actual Jan-21	Actual Feb-21	Actual Mar-21	Actual Apr-21	Actual May-21	Actual Jun-21	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	50,199	51,057	51,527	51,397	52,073	51,937	52,336	52,451	52,524	53,300	53,817		572,618
Alameda Health System	50,193	51,312	52,596	53,607	54,283	55,240	55,847	56,285	56,855	57,087	57,437		600,742
	100,392	102,369	104,123	105,004	106,356	107,177	108,183	108,736	109,379	110,387	111,254		1,173,360
Delegated:													
CFMG	30,742	31,072	30,803	31,173	31,336	31,529	31,714	31,907	31,939	31,935	32,001		346,151
CHCN	94,144	95,194	96,219	97,528	98,274	98,920	99,414	100,003	100,522	101,289	102,275		1,083,782
Kaiser	34,640	35,423	36,043	36,713	37,330	37,963	38,573	39,189	39,797	40,580	41,227		417,478
Delegated Subtotal	159,526	161,689	163,065	165,414	166,940	168,412	169,701	171,099	172,258	173,804	175,503		1,847,411
Total	**259,918**	**264,058**	**267,188**	**270,418**	**273,296**	**275,589**	**277,884**	**279,835**	**281,637**	**284,191**	**286,757**		**3,020,771**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	1,402	1,977	1,754	881	1,352	821	1,006	553	643	1,008	867		12,264
Delegated:													
CFMG	317	330	(269)	370	163	193	185	193	32	(4)	66		1,576
CHCN	752	1,050	1,025	1,309	746	646	494	589	519	767	986		8,883
Kaiser	702	783	620	670	617	633	610	616	608	783	647		7,289
Delegated Subtotal	1,771	2,163	1,376	2,349	1,526	1,472	1,289	1,398	1,159	1,546	1,699		17,748
Total	**3,173**	**4,140**	**3,130**	**3,230**	**2,878**	**2,293**	**2,295**	**1,951**	**1,802**	**2,554**	**2,566**		**30,012**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	38.6%	38.8%	39.0%	38.8%	38.9%	38.9%	38.9%	38.9%	38.8%	38.8%	38.8%		38.8%
Delegated:													
CFMG	11.8%	11.8%	11.5%	11.5%	11.5%	11.4%	11.4%	11.4%	11.3%	11.2%	11.2%		11.5%
CHCN	36.2%	36.1%	36.0%	36.1%	36.0%	35.9%	35.8%	35.7%	35.7%	35.6%	35.7%		35.9%
Kaiser	13.3%	13.4%	13.5%	13.6%	13.7%	13.8%	13.9%	14.0%	14.1%	14.3%	14.4%		13.8%
Delegated Subtotal	61.4%	61.2%	61.0%	61.2%	61.1%	61.1%	61.1%	61.1%	61.2%	61.2%	61.2%		61.2%
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%**

* BCCTP included in Adults Category of Aid (COA) July - December 2020. BCCTP included in SPD COA January - June 2021.

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2021

	Budget Jul-20	Budget Aug-20	Budget Sep-20	Budget Oct-20	Budget Nov-20	Budget Dec-20	Budget Jan-21	Budget Feb-21	Budget Mar-21	Budget Apr-21	Budget May-21	Budget Jun-21	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	91,570	92,692	93,378	93,982	94,957	95,931	96,740	97,550	98,359	98,261	98,015	97,525	1,148,959
Adult	34,909	35,689	36,302	37,072	37,737	38,401	39,151	39,900	40,650	40,609	40,508	40,305	461,232
SPD	26,044	26,094	26,178	26,250	26,289	26,327	26,359	26,390	26,422	26,395	26,329	26,198	315,275
ACA OE	82,989	85,081	86,713	88,258	89,853	91,449	93,189	94,930	96,670	96,574	96,332	95,851	1,097,889
Duals	18,297	18,495	18,606	18,847	18,974	19,101	19,296	19,490	19,685	19,665	19,616	19,518	229,588
Medi-Cal Program	253,809	258,051	261,177	264,409	267,809	271,209	274,735	278,260	281,785	281,503	280,800	279,396	3,252,943
Group Care Program	6,109	6,007	6,011	6,009	6,009	6,009	6,009	6,009	6,009	6,009	6,009	6,009	72,208
Total	**259,918**	**264,058**	**267,188**	**270,418**	**273,818**	**277,218**	**280,744**	**284,269**	**287,794**	**287,512**	**286,809**	**285,405**	**3,325,151**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	2,358	1,122	686	604	975	975	809	809	809	(98)	(246)	(490)	8,313
Adult	2,399	780	613	770	665	665	750	750	750	(41)	(102)	(203)	7,795
SPD	1,130	50	84	72	39	39	32	32	32	(26)	(66)	(132)	1,284
ACA OE	4,247	2,092	1,632	1,545	1,595	1,595	1,741	1,741	1,741	(97)	(241)	(482)	17,109
Duals	1,279	198	111	241	127	127	195	195	195	(20)	(49)	(98)	2,500
Medi-Cal Program	11,413	4,242	3,126	3,232	3,400	3,400	3,525	3,525	3,525	(282)	(704)	(1,404)	37,000
Group Care Program	133	(102)	4	(2)	0	0	0	0	0	0	0	0	33
Total	**11,546**	**4,140**	**3,130**	**3,230**	**3,400**	**3,400**	**3,525**	**3,525**	**3,525**	**(282)**	**(704)**	**(1,404)**	**37,033**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	36.1%	35.9%	35.8%	35.5%	35.5%	35.4%	35.2%	35.1%	34.9%	34.9%	34.9%	34.9%	35.3%
Adult % of Medi-Cal	13.8%	13.8%	13.9%	14.0%	14.1%	14.2%	14.3%	14.3%	14.4%	14.4%	14.4%	14.4%	14.2%
SPD % of Medi-Cal	10.3%	10.1%	10.0%	9.9%	9.8%	9.7%	9.6%	9.5%	9.4%	9.4%	9.4%	9.4%	9.7%
ACA OE % of Medi-Cal	32.7%	33.0%	33.2%	33.4%	33.6%	33.7%	33.9%	34.1%	34.3%	34.3%	34.3%	34.3%	33.8%
Duals % of Medi-Cal	7.2%	7.2%	7.1%	7.1%	7.1%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.1%
Medi-Cal Program % of Total	97.6%	97.7%	97.8%	97.8%	97.8%	97.8%	97.9%	97.9%	97.9%	97.9%	97.9%	97.9%	97.8%
Group Care Program % of Total	2.4%	2.3%	2.2%	2.2%	2.2%	2.2%	2.1%	2.1%	2.1%	2.1%	2.1%	2.1%	2.2%
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 2021

	Budget Jul-20	Budget Aug-20	Budget Sep-20	Budget Oct-20	Budget Nov-20	Budget Dec-20	Budget Jan-21	Budget Feb-21	Budget Mar-21	Budget Apr-21	Budget May-21	Budget Jun-21	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted	100,392	102,369	104,123	105,004	106,384	107,763	109,255	110,746	112,237	112,129	111,857	111,315	1,293,574
Delegated:													
CFMG	30,742	31,072	30,803	31,173	31,498	31,822	32,099	32,376	32,652	32,620	32,538	32,376	381,771
CHCN	94,144	95,194	96,219	97,528	98,744	99,960	101,226	102,493	103,759	103,658	103,405	102,900	1,199,229
Kaiser	34,640	35,423	36,043	36,713	37,193	37,673	38,164	38,655	39,145	39,106	39,009	38,813	450,578
Delegated Subtotal	159,526	161,689	163,065	165,414	167,435	169,455	171,489	173,523	175,557	175,384	174,951	174,089	2,031,577
Total	**259,918**	**264,058**	**267,188**	**270,418**	**273,818**	**277,218**	**280,744**	**284,269**	**287,794**	**287,512**	**286,809**	**285,405**	**3,325,151**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	6,149	1,977	1,754	881	1,380	1,380	1,491	1,491	1,491	(109)	(272)	(542)	17,072
Delegated:													
CFMG	1,050	330	(269)	370	325	325	277	277	277	(33)	(82)	(163)	2,684
CHCN	2,365	1,050	1,025	1,309	1,216	1,216	1,266	1,266	1,266	(101)	(253)	(505)	11,121
Kaiser	1,982	783	620	670	480	480	491	491	491	(39)	(98)	(195)	6,155
Delegated Subtotal	5,397	2,163	1,376	2,349	2,021	2,021	2,034	2,034	2,034	(173)	(432)	(862)	19,960
Total	**11,546**	**4,140**	**3,130**	**3,230**	**3,400**	**3,400**	**3,525**	**3,525**	**3,525**	**(282)**	**(704)**	**(1,404)**	**37,033**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	38.6%	38.8%	39.0%	38.8%	38.9%	38.9%	38.9%	39.0%	39.0%	39.0%	39.0%	39.0%	38.9%
Delegated:													
CFMG	11.8%	11.8%	11.5%	11.5%	11.5%	11.5%	11.4%	11.4%	11.3%	11.3%	11.3%	11.3%	11.5%
CHCN	36.2%	36.1%	36.0%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%
Kaiser	13.3%	13.4%	13.5%	13.6%	13.6%	13.6%	13.6%	13.6%	13.6%	13.6%	13.6%	13.6%	13.6%
Delegated Subtotal	61.4%	61.2%	61.0%	61.2%	61.1%	61.1%	61.1%	61.0%	61.0%	61.0%	61.0%	61.0%	61.1%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2021

	Variance Jul-20	Variance Aug-20	Variance Sep-20	Variance Oct-20	Variance Nov-20	Variance Dec-20	Variance Jan-21	Variance Feb-21	Variance Mar-21	Variance Apr-21	Variance May-21	Variance Jun-21	Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	0	0	0	0	(337)	(962)	(1,637)	(2,040)	(2,667)	(2,028)	(1,233)		(10,903)
Adults*	0	0	0	0	(97)	(249)	(157)	(585)	(1,001)	(557)	53		(2,592)
SPD*	0	0	0	0	25	12	(5)	(96)	(188)	(125)	(40)		(417)
ACA OE	0	0	0	0	(101)	(399)	(932)	(1,598)	(2,197)	(658)	993		(4,892)
Duals	0	0	0	0	14	24	(81)	(75)	(89)	83	235		113
Medi-Cal Program	0	0	0	0	(495)	(1,574)	(2,812)	(4,394)	(6,141)	(3,284)	8		(18,692)
Group Care Program	0	0	0	0	(27)	(55)	(48)	(40)	(16)	(37)	(60)		(283)
Total	**0**	**0**	**0**	**0**	**(522)**	**(1,629)**	**(2,860)**	**(4,434)**	**(6,157)**	**(3,321)**	**(52)**		**(18,975)**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted	0	0	0	0	(28)	(586)	(1,072)	(2,010)	(2,858)	(1,742)	(603)		(8,898)
Delegated:													
CFMG	0	0	0	0	(162)	(293)	(385)	(469)	(713)	(685)	(537)		(3,244)
CHCN	0	0	0	0	(470)	(1,039)	(1,812)	(2,490)	(3,237)	(2,369)	(1,130)		(12,546)
Kaiser	0	0	0	0	137	290	409	534	652	1,474	2,218		5,714
Delegated Subtotal	0	0	0	0	(495)	(1,043)	(1,788)	(2,424)	(3,299)	(1,580)	552		(10,077)
Total	**0**	**0**	**0**	**0**	**(522)**	**(1,629)**	**(2,860)**	**(4,434)**	**(6,157)**	**(3,321)**	**(52)**		**(18,975)**

Notes:

Variance based on FY21 Preliminary Budget July 20 to October 20 and FY21 Final Budget November 20 to June 21.

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED May 31, 2021

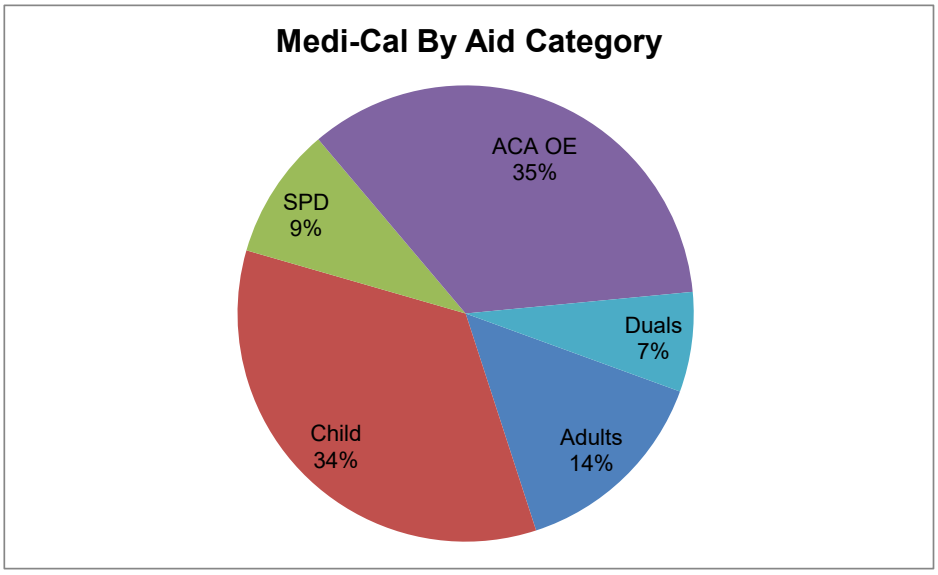
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES:				
$1,846,000	$1,837,417	($8,583)	(0.5%)	PCP-Capitation	$19,779,802	$19,775,335	($4,467)	0.0%
2,888,124	3,068,785	180,661	5.9%	PCP-Capitation - FQHC	30,834,080	31,923,747	1,089,667	3.4%
277,790	275,766	(2,024)	(0.7%)	Specialty-Capitation	3,010,377	3,007,026	(3,351)	(0.1%)
2,987,581	3,160,222	172,641	5.5%	Specialty-Capitation FQHC	31,685,390	32,761,147	1,075,757	3.3%
324,455	327,811	3,356	1.0%	Laboratory-Capitation	3,459,938	3,493,042	33,104	0.9%
911,072	917,788	6,716	0.7%	Transportation (Ambulance)-Cap	6,231,152	7,830,686	1,599,534	20.4%
211,177	273,266	62,089	22.7%	Vision Cap	2,247,381	2,679,978	432,597	16.1%
80,932	80,233	(699)	(0.9%)	CFMG Capitation	876,560	874,917	(1,643)	(0.2%)
150,857	159,927	9,070	5.7%	Anc IPA Admin Capitation FQHC	1,605,186	1,660,776	55,590	3.3%
11,408,304	7,945,764	(3,462,540)	(43.6%)	Kaiser Capitation	95,305,200	89,847,711	(5,457,489)	(6.1%)
643,366	708,822	65,456	9.2%	BHT Supplemental Expense	7,820,918	7,582,595	(238,323)	(3.1%)
8,562	0	(8,562)	0.0%	Hep-C Supplemental Expense	76,338	81,116	4,778	5.9%
653,705	400,223	(253,482)	(63.3%)	Maternity Supplemental Expense	3,703,004	3,725,917	22,913	0.6%
537,043	572,401	35,358	6.2%	DME - Cap	5,824,922	6,014,455	189,533	3.2%
22,928,966	**19,728,425**	**(3,200,541)**	**(16.2%)**	**5-TOTAL CAPITATED EXPENSES**	**212,460,248**	**211,258,448**	**(1,201,800)**	**(0.6%)**
				FEE FOR SERVICE MEDICAL EXPENSES:				
(1,371,232)	0	1,371,232	0.0%	IBNP-Inpatient Services	20,899,716	0	(20,899,716)	0.0%
(41,137)	0	41,137	0.0%	IBNP-Settlement (IP)	626,993	0	(626,993)	0.0%
(109,701)	0	109,701	0.0%	IBNP-Claims Fluctuation (IP)	1,671,979	0	(1,671,979)	0.0%
19,065,896	22,342,401	3,276,505	14.7%	Inpatient Hospitalization-FFS	220,027,795	255,157,067	35,129,272	13.8%
1,045,333	0	(1,045,333)	0.0%	IP OB - Mom & NB	12,345,041	0	(12,345,041)	0.0%
53,508	0	(53,508)	0.0%	IP Behavioral Health	1,446,780	0	(1,446,780)	0.0%
976,041	1,187,056	211,015	17.8%	IP - Long Term Care	10,730,155	11,891,007	1,160,852	9.8%
467,327	0	(467,327)	0.0%	IP - Facility Rehab FFS	7,339,658	0	(7,339,658)	0.0%
20,086,035	**23,529,457**	**3,443,422**	**14.6%**	**6-Inpatient Hospital & SNF FFS Expense**	**275,088,118**	**267,048,074**	**(8,040,044)**	**(3.0%)**
237,665	0	(237,665)	0.0%	IBNP-PCP	511,439	0	(511,439)	0.0%
7,131	0	(7,131)	0.0%	IBNP-Settlement (PCP)	15,344	0	(15,344)	0.0%
19,013	0	(19,013)	0.0%	IBNP-Claims Fluctuation (PCP)	40,916	0	(40,916)	0.0%
462	0	(462)	0.0%	Telemedicine FFS	10,080	0	(10,080)	0.0%
1,070,335	1,305,352	235,017	18.0%	Primary Care Non-Contracted FF	12,904,606	25,448,418	12,543,812	49.3%
94,522	79,974	(14,548)	(18.2%)	PCP FQHC FFS	664,072	868,170	204,098	23.5%
1,768,679	3,039,449	1,270,770	41.8%	Prop 56 Direct Payment Expenses	18,912,812	20,969,702	2,056,890	9.8%
76,625	0	(76,625)	0.0%	Prop 56-Trauma Expense	701,875	0	(701,875)	0.0%
101,531	0	(101,531)	0.0%	Prop 56-Dev. Screening Exp.	926,108	0	(926,108)	0.0%
634,414	0	(634,414)	0.0%	Prop 56-Fam. Planning Exp.	6,520,838	0	(6,520,838)	0.0%
548,988	0	(548,988)	0.0%	Prop 56-Value Based Purchasing	5,740,655	0	(5,740,655)	0.0%
4,559,365	**4,424,775**	**(134,590)**	**(3.0%)**	**7-Primary Care Physician FFS Expense**	**46,948,745**	**47,286,290**	**337,545**	**0.7%**
301,581	0	(301,581)	0.0%	IBNP-Specialist	1,623,636	0	(1,623,636)	0.0%
2,151,035	4,418,283	2,267,248	51.3%	Specialty Care-FFS	23,256,799	47,834,053	24,577,254	51.4%
140,227	0	(140,227)	0.0%	Anesthesiology - FFS	1,882,960	0	(1,882,960)	0.0%
567,740	0	(567,740)	0.0%	Spec Rad Therapy - FFS	7,457,329	0	(7,457,329)	0.0%
106,140	0	(106,140)	0.0%	Obstetrics-FFS	1,382,448	0	(1,382,448)	0.0%
257,186	0	(257,186)	0.0%	Spec IP Surgery - FFS	2,655,207	0	(2,655,207)	0.0%
453,669	0	(453,669)	0.0%	Spec OP Surgery - FFS	5,109,267	0	(5,109,267)	0.0%
340,490	0	(340,490)	0.0%	Spec IP Physician	4,126,191	0	(4,126,191)	0.0%
36,559	95,975	59,416	61.9%	SCP FQHC FFS	350,428	789,114	438,686	55.6%
9,048	0	(9,048)	0.0%	IBNP-Settlement (SCP)	48,708	0	(48,708)	0.0%
24,127	0	(24,127)	0.0%	IBNP-Claims Fluctuation (SCP)	129,894	0	(129,894)	0.0%
4,387,802	**4,514,258**	**126,456**	**2.8%**	**8-Specialty Care Physician Expense**	**48,022,868**	**48,623,167**	**600,299**	**1.2%**
441,124	0	(441,124)	0.0%	IBNP-Ancillary	2,121,272	0	(2,121,272)	0.0%
13,235	0	(13,235)	0.0%	IBNP Settlement (ANC)	63,638	0	(63,638)	0.0%
35,290	0	(35,290)	0.0%	IBNP Claims Fluctuation (ANC)	169,703	0	(169,703)	0.0%
250,365	0	(250,365)	0.0%	Acupuncture/Biofeedback	2,778,860	0	(2,778,860)	0.0%
106,631	0	(106,631)	0.0%	Hearing Devices	848,207	0	(848,207)	0.0%
17,271	0	(17,271)	0.0%	Imaging/MRI/CT Global	359,110	0	(359,110)	0.0%
45,431	0	(45,431)	0.0%	Vision FFS	459,219	0	(459,219)	0.0%
22,409	0	(22,409)	0.0%	Family Planning	228,910	0	(228,910)	0.0%
563,394	0	(563,394)	0.0%	Laboratory-FFS	4,924,537	0	(4,924,537)	0.0%
93,036	0	(93,036)	0.0%	ANC Therapist	1,091,406	0	(1,091,406)	0.0%
231,809	0	(231,809)	0.0%	Transportation (Ambulance)-FFS	3,020,678	0	(3,020,678)	0.0%
66,726	0	(66,726)	0.0%	Transportation (Other)-FFS	1,079,737	0	(1,079,737)	0.0%

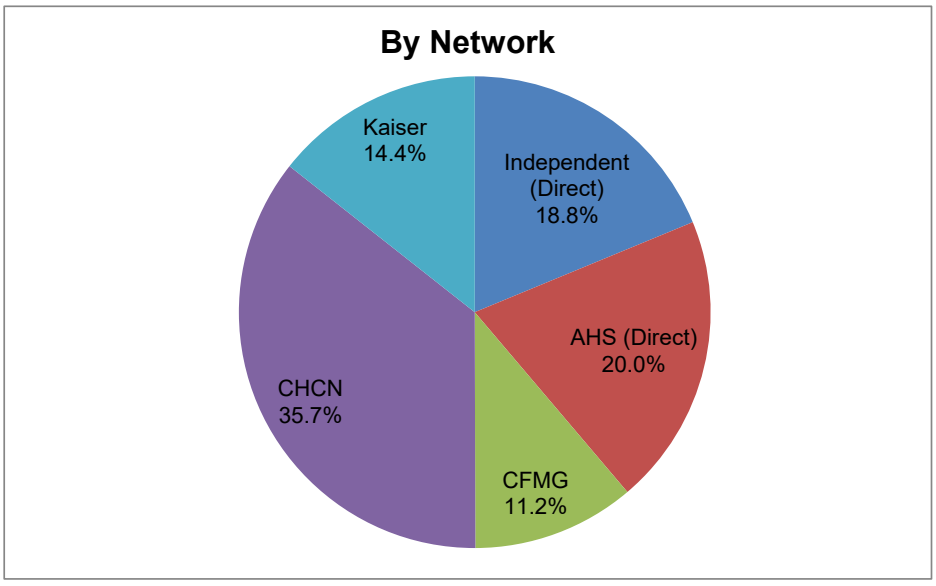
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED May 31, 2021

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
$468,924	$0	($468,924)	0.0%	Hospice	$4,831,170	$0	($4,831,170)	0.0%
702,028	0	(702,028)	0.0%	Home Health Services	7,308,500	0	(7,308,500)	0.0%
0	2,863,034	2,863,034	100.0%	Other Medical-FFS	0	33,704,479	33,704,479	100.0%
0	0	0	0.0%	Denials	3,885	0	(3,885)	0.0%
77,306	0	(77,306)	0.0%	HMS Medical Refunds	123,654	0	(123,654)	0.0%
0	0	0	0.0%	Refunds-Medical Payments	127	0	(127)	0.0%
281,912	0	(281,912)	0.0%	DME & Medical Supplies	3,706,483	0	(3,706,483)	0.0%
572,350	528,449	(43,901)	(8.3%)	GEMT Direct Payment Expense	6,124,078	5,933,646	(190,432)	(3.2%)
1,129,677	0	(1,129,677)	0.0%	Community Based Adult Services (CBAS)	5,781,136	0	(5,781,136)	0.0%
5,118,919	**3,391,483**	**(1,727,436)**	**(50.9%)**	**9-Ancillary Medical Expense**	**45,024,308**	**39,638,125**	**(5,386,183)**	**(13.6%)**
777,601	0	(777,601)	0.0%	IBNP-Outpatient	1,727,572	0	(1,727,572)	0.0%
23,329	0	(23,329)	0.0%	IBNP Settlement (OP)	51,830	0	(51,830)	0.0%
62,210	0	(62,210)	0.0%	IBNP Claims Fluctuation (OP)	138,208	0	(138,208)	0.0%
1,069,411	7,742,177	6,672,766	86.2%	Out-Patient FFS	11,941,138	85,383,287	73,442,149	86.0%
1,350,660	0	(1,350,660)	0.0%	OP Ambul Surgery - FFS	13,081,426	0	(13,081,426)	0.0%
726,077	0	(726,077)	0.0%	OP Fac Imaging Services-FFS	10,910,747	0	(10,910,747)	0.0%
3,028,052	0	(3,028,052)	0.0%	Behav Health - FFS	25,598,724	0	(25,598,724)	0.0%
450,299	0	(450,299)	0.0%	OP Facility - Lab FFS	4,879,770	0	(4,879,770)	0.0%
84,533	0	(84,533)	0.0%	OP Facility - Cardio FFS	1,006,624	0	(1,006,624)	0.0%
41,771	0	(41,771)	0.0%	OP Facility - PT/OT/ST FFS	385,579	0	(385,579)	0.0%
471,603	0	(471,603)	0.0%	OP Facility - Dialysis FFS	17,703,899	0	(17,703,899)	0.0%
8,085,546	**7,742,177**	**(343,369)**	**(4.4%)**	**10-Outpatient Medical Expense Medical Expense**	**87,425,516**	**85,383,287**	**(2,042,229)**	**(2.4%)**
460,687	0	(460,687)	0.0%	IBNP-Emergency	1,172,544	0	(1,172,544)	0.0%
13,821	0	(13,821)	0.0%	IBNP Settlement (ER)	35,180	0	(35,180)	0.0%
36,854	0	(36,854)	0.0%	IBNP Claims Fluctuation (ER)	93,798	0	(93,798)	0.0%
509,881	0	(509,881)	0.0%	Special ER Physician-FFS	5,734,980	0	(5,734,980)	0.0%
3,011,520	3,567,755	556,235	15.6%	ER-Facility	32,272,493	39,259,472	6,986,979	17.8%
4,032,763	**3,567,755**	**(465,008)**	**(13.0%)**	**11-Emergency Expense**	**39,308,996**	**39,259,472**	**(49,524)**	**(0.1%)**
1,585,428	0	(1,585,428)	0.0%	IBNP-Pharmacy	2,438,240	0	(2,438,240)	0.0%
47,564	0	(47,564)	0.0%	IBNP Settlement (RX)	73,150	0	(73,150)	0.0%
126,835	0	(126,835)	0.0%	IBNP Claims Fluctuation (RX)	195,063	0	(195,063)	0.0%
4,889,423	4,129,133	(760,290)	(18.4%)	RX - Non-PBM FFFS	47,994,423	44,731,060	(3,263,363)	(7.3%)
10,898,013	367,379	(10,530,634)	(2,866.4%)	Pharmacy-FFS	118,955,221	98,273,527	(20,681,694)	(21.0%)
(12,691)	0	12,691	0.0%	HMS RX Refunds	(385,597)	0	385,597	0.0%
(18,035)	(18,035)	0	0.0%	Pharmacy-Rebate	(4,719,993)	(4,719,991)	2	0.0%
17,516,537	**4,478,477**	**(13,038,060)**	**(291.1%)**	**12-Pharmacy Expense**	**164,550,507**	**138,284,596**	**(26,265,911)**	**(19.0%)**
63,786,967	**51,648,382**	**(12,138,585)**	**(23.5%)**	**13-TOTAL FFS MEDICAL EXPENSES**	**706,369,058**	**665,523,011**	**(40,846,047)**	**(6.1%)**
0	(39,655)	(39,655)	100.0%	Clinical Vacancy	0	(334,632)	(334,632)	100.0%
69,539	114,225	44,686	39.1%	Quality Analytics	753,359	1,042,238	288,878	27.7%
348,039	431,987	83,948	19.4%	Health Plan Services Department Total	3,984,733	4,461,138	476,405	10.7%
598,619	727,079	128,460	17.7%	Case & Disease Management Department Total	7,009,162	8,179,366	1,170,203	14.3%
297,707	242,386	(55,321)	(22.8%)	Medical Services Department Total	2,677,912	2,348,078	(329,834)	(14.0%)
448,510	514,732	66,222	12.9%	Quality Management Department Total	4,704,151	5,251,525	547,374	10.4%
99,389	129,992	30,603	23.5%	Pharmacy Services Department Total	1,244,100	1,501,443	257,343	17.1%
10,452	39,928	29,476	73.8%	Regulatory Readiness Total	328,577	421,079	92,502	22.0%
1,872,255	**2,160,674**	**288,419**	**13.3%**	**14-Other Benefits & Services**	**20,701,994**	**22,870,234**	**2,168,239**	**9.5%**
				Reinsurance Expense				
(314,778)	(384,705)	(69,927)	18.2%	Reinsurance Recoveries	(5,041,432)	(4,549,962)	491,470	(10.8%)
461,417	519,194	57,777	11.1%	Stop-Loss Expense	4,920,380	5,326,889	406,509	7.6%
146,639	**134,489**	**(12,150)**	**(9.0%)**	**15-Reinsurance Expense**	**(121,052)**	**776,927**	**897,979**	**115.6%**
				Preventive Health Services				
2,083,333	83,334	(1,999,999)	(2,400.0%)	Risk Sharing PCP	2,916,663	916,668	(1,999,995)	(218.2%)
2,083,333	**83,334**	**(1,999,999)**	**(2,400.0%)**	**16-Risk Pool Distribution**	**2,916,663**	**916,668**	**(1,999,995)**	**(218.2%)**
90,818,160	**73,755,304**	**(17,062,856)**	**(23.1%)**	**17-TOTAL MEDICAL EXPENSES**	**942,326,911**	**901,345,288**	**(40,981,624)**	**(4.5%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Current Membership by Network By Category of Aid							
Category of Aid	**May 2021**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	40,561	14%	9,154	8,953	542	14,721	7,191
Child	96,782	34%	9,652	8,703	29,222	32,034	17,171
SPD	26,289	9%	8,408	4,066	1,095	10,739	1,981
ACA OE	97,325	35%	16,178	32,645	1,140	35,135	12,227
Duals	19,851	7%	7,882	2,132	2	7,178	2,657
Medi-Cal	280,808		51,274	56,499	32,001	99,807	41,227
Group Care	5,949		2,543	938	-	2,468	-
Total	**286,757**	**100%**	**53,817**	**57,437**	**32,001**	**102,275**	**41,227**
Medi-Cal %	97.9%		95.3%	98.4%	100.0%	97.6%	100.0%
Group Care %	2.1%		4.7%	1.6%	0.0%	2.4%	0.0%
	Network Distribution		*18.8%*	*20.0%*	*11.2%*	*35.7%*	*14.4%*
			% Direct:	**39%**		**% Delegated:**	**61%**

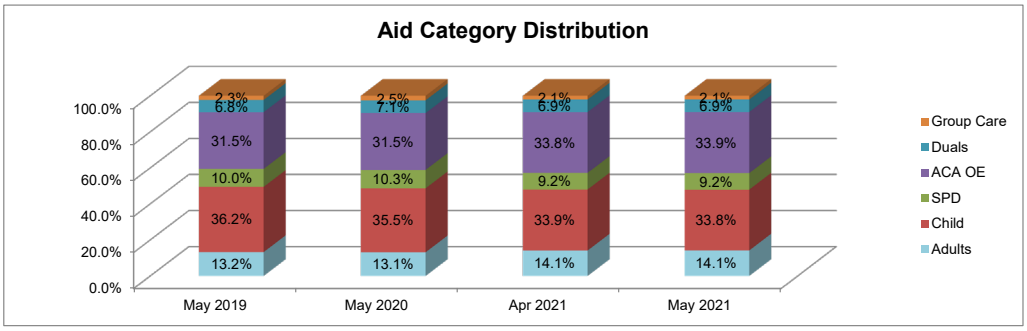




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

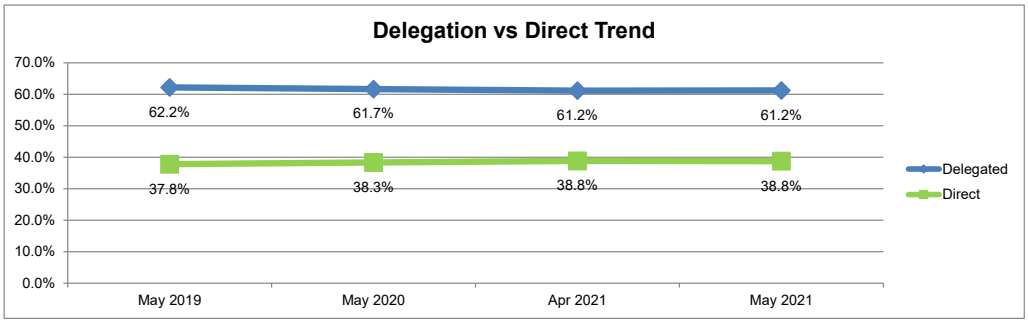
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	May 2019	May 2020	Apr 2021	May 2021	May 2019	May 2020	Apr 2021	May 2021	May 2019 to May 2020	May 2020 to May 2021	Apr 2021 to May 2021
Adults	34,120	33,229	40,052	40,561	13.2%	13.1%	14.1%	14.1%	-2.6%	22.1%	1.3%
Child	93,274	89,755	96,233	96,782	36.2%	35.5%	33.9%	33.8%	-3.8%	7.8%	0.6%
SPD	25,793	25,985	26,270	26,289	10.0%	10.3%	9.2%	9.2%	0.7%	1.2%	0.1%
ACA OE	81,174	79,736	95,916	97,325	31.5%	31.5%	33.8%	33.9%	-1.8%	22.1%	1.5%
Duals	17,487	17,971	19,748	19,851	6.8%	7.1%	6.9%	6.9%	2.8%	10.5%	0.5%
Medi-Cal Total	251,848	246,676	278,219	280,808	97.7%	97.5%	97.9%	97.9%	-2.1%	13.8%	0.9%
Group Care	5,933	6,295	5,972	5,949	2.3%	2.5%	2.1%	2.1%	6.1%	-5.5%	-0.4%
Total	**257,781**	**252,971**	**284,191**	**286,757**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**-1.9%**	**13.4%**	**0.9%**



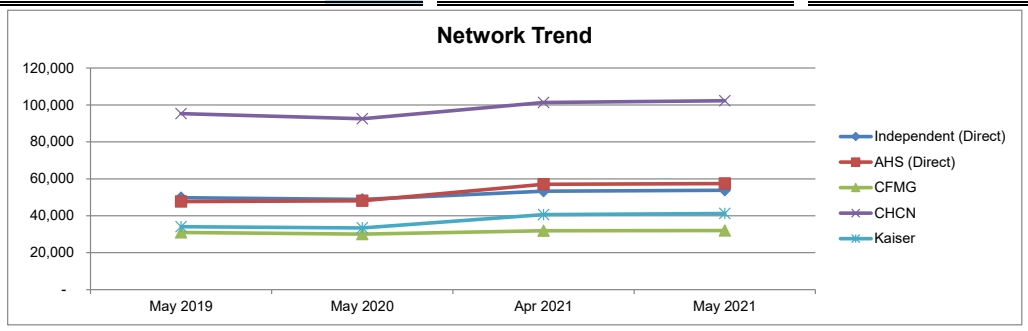
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	May 2019	May 2020	Apr 2021	May 2021	May 2019	May 2020	Apr 2021	May 2021	May 2019 to May 2020	May 2020 to May 2021	Apr 2021 to May 2021
Delegated	160,307	156,015	173,804	175,503	62.2%	61.7%	61.2%	61.2%	-2.7%	12.5%	1.0%
Direct	97,474	96,956	110,387	111,254	37.8%	38.3%	38.8%	38.8%	-0.5%	14.7%	0.8%
Total	**257,781**	**252,971**	**284,191**	**286,757**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**-1.9%**	**13.4%**	**0.9%**



Network Trend

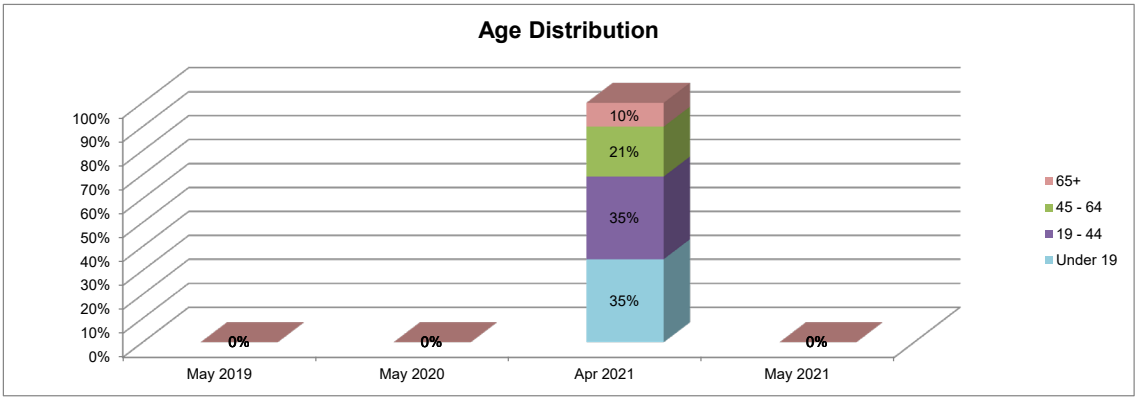
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	May 2019	May 2020	Apr 2021	May 2021	May 2019	May 2020	Apr 2021	May 2021	May 2019 to May 2020	May 2020 to May 2021	Apr 2021 to May 2021
Independent (Direct)	49,788	48,857	53,300	53,817	19.3%	19.3%	18.8%	18.8%	-1.9%	10.2%	1.0%
AHS (Direct)	47,686	48,099	57,087	57,437	18.5%	19.0%	20.1%	20.0%	0.9%	19.4%	0.6%
CFMG	30,944	30,072	31,935	32,001	12.0%	11.9%	11.2%	11.2%	-2.8%	6.4%	0.2%
CHCN	95,313	92,533	101,289	102,275	37.0%	36.6%	35.6%	35.7%	-2.9%	10.5%	1.0%
Kaiser	34,050	33,410	40,580	41,227	13.2%	13.2%	14.3%	14.4%	-1.9%	23.4%	1.6%
Total	**257,781**	**252,971**	**284,191**	**286,757**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**-1.9%**	**13.4%**	**0.9%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

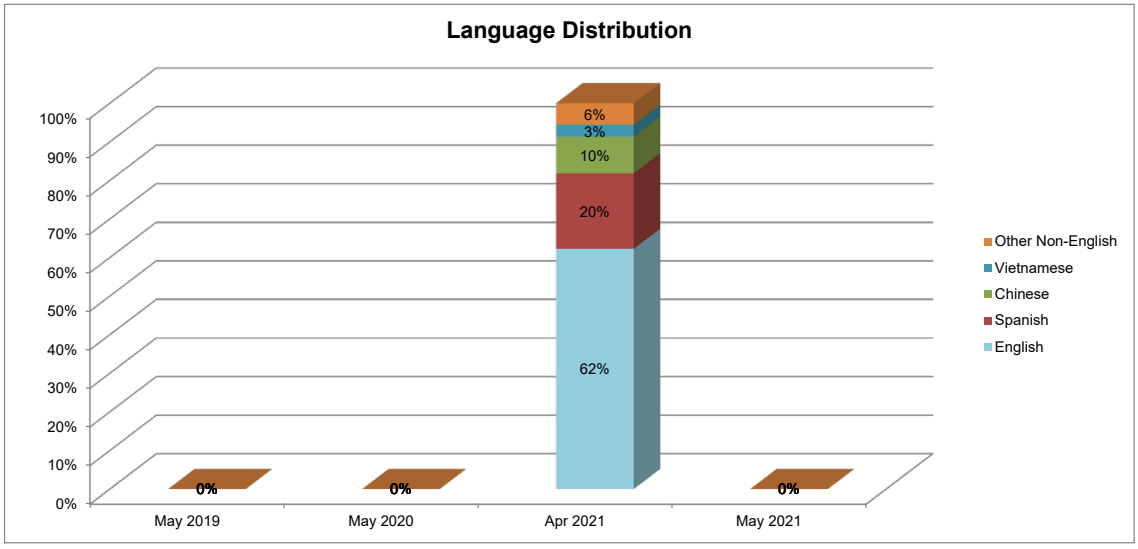
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	May 2019	May 2020	Apr 2021	May 2021	May 2019	May 2020	Apr 2021	May 2021	May 2019 to May 2020	May 2020 to May 2021	Apr 2021 to May 2021
Under 19	-	-	98,595	-	#DIV/0!	#DIV/0!	35%	#DIV/0!	0%	0%	-100%
19 - 44	-	-	98,096	-	#DIV/0!	#DIV/0!	35%	#DIV/0!	0%	0%	-100%
45 - 64	-	-	59,184	-	#DIV/0!	#DIV/0!	21%	#DIV/0!	0%	0%	-100%
65+	-	-	28,316	-	#DIV/0!	#DIV/0!	10%	#DIV/0!	0%	0%	-100%
Total	**-**	**-**	**284,191**	**-**	**#DIV/0!**	**#DIV/0!**	**100%**	**#DIV/0!**	**0%**	**0%**	**-100%**



Language Trend

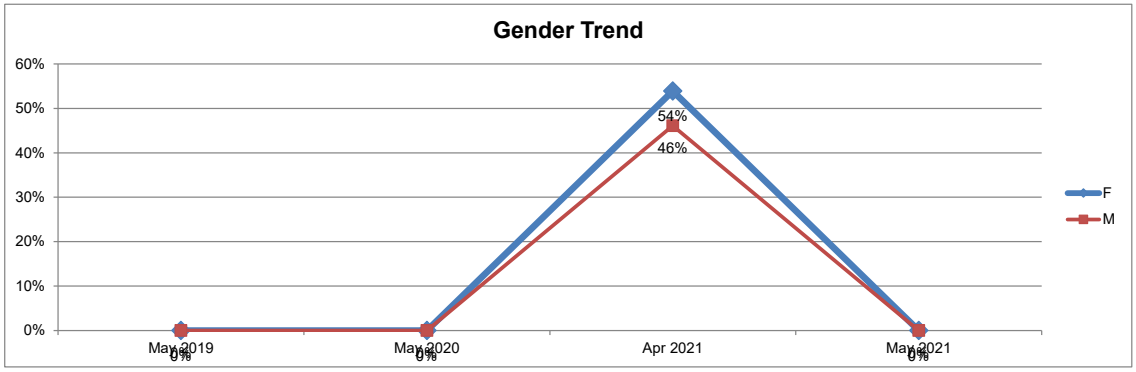
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	May 2019	May 2020	Apr 2021	May 2021	May 2019	May 2020	Apr 2021	May 2021	May 2019 to May 2020	May 2020 to May 2021	Apr 2021 to May 2021
English	-	-	176,931	-	#DIV/0!	#DIV/0!	62%	#DIV/0!	0%	0%	-100%
Spanish	-	-	55,588	-	#DIV/0!	#DIV/0!	20%	#DIV/0!	0%	0%	-100%
Chinese	-	-	27,029	-	#DIV/0!	#DIV/0!	10%	#DIV/0!	0%	0%	-100%
Vietnamese	-	-	8,790	-	#DIV/0!	#DIV/0!	3%	#DIV/0!	0%	0%	-100%
Other Non-English	-	-	15,853	-	#DIV/0!	#DIV/0!	6%	#DIV/0!	0%	0%	-100%
Total	**-**	**-**	**284,191**	**-**	**#DIV/0!**	**#DIV/0!**	**100%**	**#DIV/0!**	**0%**	**0%**	**-100%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

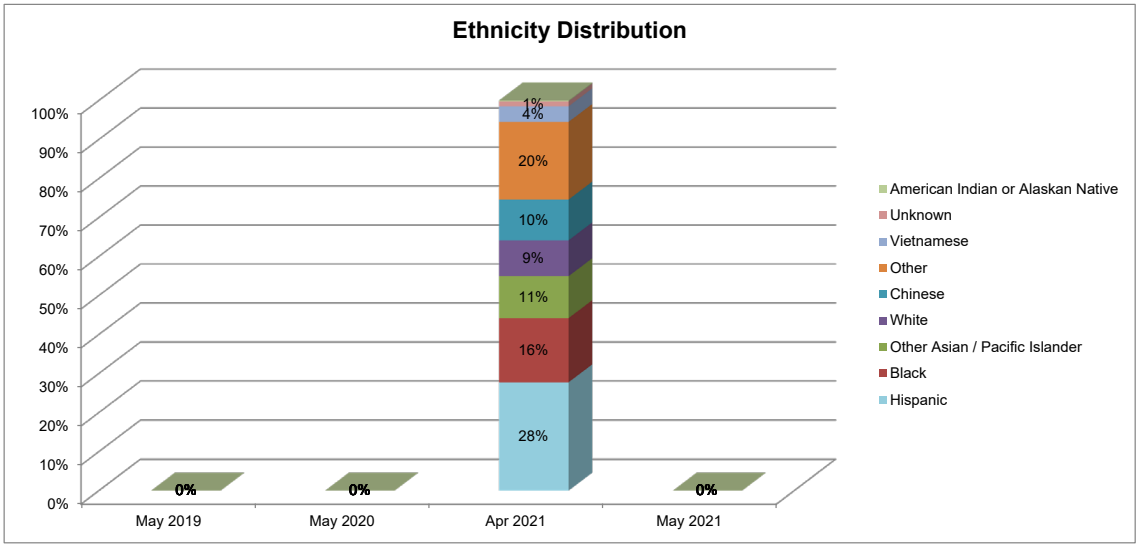
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	May 2019	May 2020	Apr 2021	May 2021	May 2019	May 2020	Apr 2021	May 2021	May 2019 to May 2020	May 2020 to May 2021	Apr 2021 to May 2021
F	-	-	153,186	-	#DIV/0!	#DIV/0!	54%	#DIV/0!	0%	0%	-100%
M	-	-	131,005	-	#DIV/0!	#DIV/0!	46%	#DIV/0!	0%	0%	-100%
Total	**-**	**-**	**284,191**	**-**	**#DIV/0!**	**#DIV/0!**	**100%**	**#DIV/0!**	**0%**	**0%**	**-100%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	May 2019	May 2020	Apr 2021	May 2021	May 2019	May 2020	Apr 2021	May 2021	May 2019 to May 2020	May 2020 to May 2021	Apr 2021 to May 2021
Hispanic	-	-	78,831	-	#DIV/0!	#DIV/0!	28%	#DIV/0!	0%	0%	-100%
Black	-	-	46,780	-	#DIV/0!	#DIV/0!	16%	#DIV/0!	0%	0%	-100%
Other Asian / Pacific Islander	-	-	30,527	-	#DIV/0!	#DIV/0!	11%	#DIV/0!	0%	0%	-100%
White	-	-	26,179	-	#DIV/0!	#DIV/0!	9%	#DIV/0!	0%	0%	-100%
Chinese	-	-	29,693	-	#DIV/0!	#DIV/0!	10%	#DIV/0!	0%	0%	-100%
Other	-	-	56,572	-	#DIV/0!	#DIV/0!	20%	#DIV/0!	0%	0%	-100%
Vietnamese	-	-	11,339	-	#DIV/0!	#DIV/0!	4%	#DIV/0!	0%	0%	-100%
Unknown	-	-	3,648	-	#DIV/0!	#DIV/0!	1%	#DIV/0!	0%	0%	-100%
American Indian or Alaskan Native	-	-	622	-	#DIV/0!	#DIV/0!	0%	#DIV/0!	0%	0%	-100%
Total	**-**	**-**	**284,191**	**-**	**#DIV/0!**	**#DIV/0!**	**100%**	**#DIV/0!**	**0%**	**0%**	**-100%**



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

Medi-Cal By City

City	May 2021	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	112,197	40%	12,819	26,951	13,963	46,681	11,783
Hayward	43,747	16%	8,925	9,428	4,875	12,908	7,611
Fremont	24,932	9%	9,651	3,845	816	6,554	4,066
San Leandro	25,116	9%	4,275	3,939	3,308	9,258	4,336
Union City	12,036	4%	4,419	1,817	376	3,116	2,308
Alameda	10,794	4%	2,048	1,725	1,625	3,730	1,666
Berkeley	9,931	4%	1,464	1,782	1,247	3,941	1,497
Livermore	8,501	3%	1,023	867	1,879	3,188	1,544
Newark	6,449	2%	1,741	2,047	195	1,240	1,226
Castro Valley	6,944	2%	1,336	1,144	1,071	1,988	1,405
San Lorenzo	5,951	2%	967	1,023	723	1,996	1,242
Pleasanton	4,527	2%	883	504	473	1,901	766
Dublin	4,775	2%	870	496	638	1,880	891
Emeryville	1,817	1%	303	367	293	546	308
Albany	1,738	1%	276	248	354	500	360
Piedmont	336	0%	52	80	26	89	89
Sunol	58	0%	9	14	7	14	14
Antioch	16	0%	2	5	4	4	1
Other	943	0%	211	217	128	273	114
Total	**280,808**	**100%**	**51,274**	**56,499**	**32,001**	**99,807**	**41,227**

Group Care By City

City	May 2021	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	2,017	34%	502	390	-	1,125	-
Hayward	668	11%	376	138	-	154	-
Fremont	638	11%	479	56	-	103	-
San Leandro	574	10%	228	89	-	257	-
Union City	324	5%	237	34	-	53	-
Alameda	283	5%	109	27	-	147	-
Berkeley	183	3%	52	14	-	117	-
Livermore	80	1%	31	1	-	48	-
Newark	136	2%	84	35	-	17	-
Castro Valley	184	3%	90	21	-	73	-
San Lorenzo	127	2%	55	18	-	54	-
Pleasanton	51	1%	27	1	-	23	-
Dublin	102	2%	40	11	-	51	-
Emeryville	29	0%	10	5	-	14	-
Albany	15	0%	3	3	-	9	-
Piedmont	15	0%	5	1	-	9	-
Sunol	-	0%	-	-	-	-	-
Antioch	26	0%	7	9	-	10	-
Other	497	8%	208	85	-	204	-
Total	**5,949**	**100%**	**2,543**	**938**	**-**	**2,468**	**-**

Total By City

City	May 2021	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	114,214	40%	13,321	27,341	13,963	47,806	11,783
Hayward	44,415	15%	9,301	9,566	4,875	13,062	7,611
Fremont	25,570	9%	10,130	3,901	816	6,657	4,066
San Leandro	25,690	9%	4,503	4,028	3,308	9,515	4,336
Union City	12,360	4%	4,656	1,851	376	3,169	2,308
Alameda	11,077	4%	2,157	1,752	1,625	3,877	1,666
Berkeley	10,114	4%	1,516	1,796	1,247	4,058	1,497
Livermore	8,581	3%	1,054	868	1,879	3,236	1,544
Newark	6,585	2%	1,825	2,082	195	1,257	1,226
Castro Valley	7,128	2%	1,426	1,165	1,071	2,061	1,405
San Lorenzo	6,078	2%	1,022	1,041	723	2,050	1,242
Pleasanton	4,578	2%	910	505	473	1,924	766
Dublin	4,877	2%	910	507	638	1,931	891
Emeryville	1,846	1%	313	372	293	560	308
Albany	1,753	1%	279	251	354	509	360
Piedmont	351	0%	57	81	26	98	89
Sunol	58	0%	9	14	7	14	14
Antioch	42	0%	9	14	4	14	1
Other	1,440	1%	419	302	128	477	114
Total	**286,757**	**100%**	**53,817**	**57,437**	**32,001**	**102,275**	**41,227**

Telehealth Utilization Summary

Interpreter Services Presentation

Care Management Program Presentation

Telehealth Utilization Summary

In Person vs Telehealth Visits

March 2020 - March 2021

In Person and Telehealth Visits

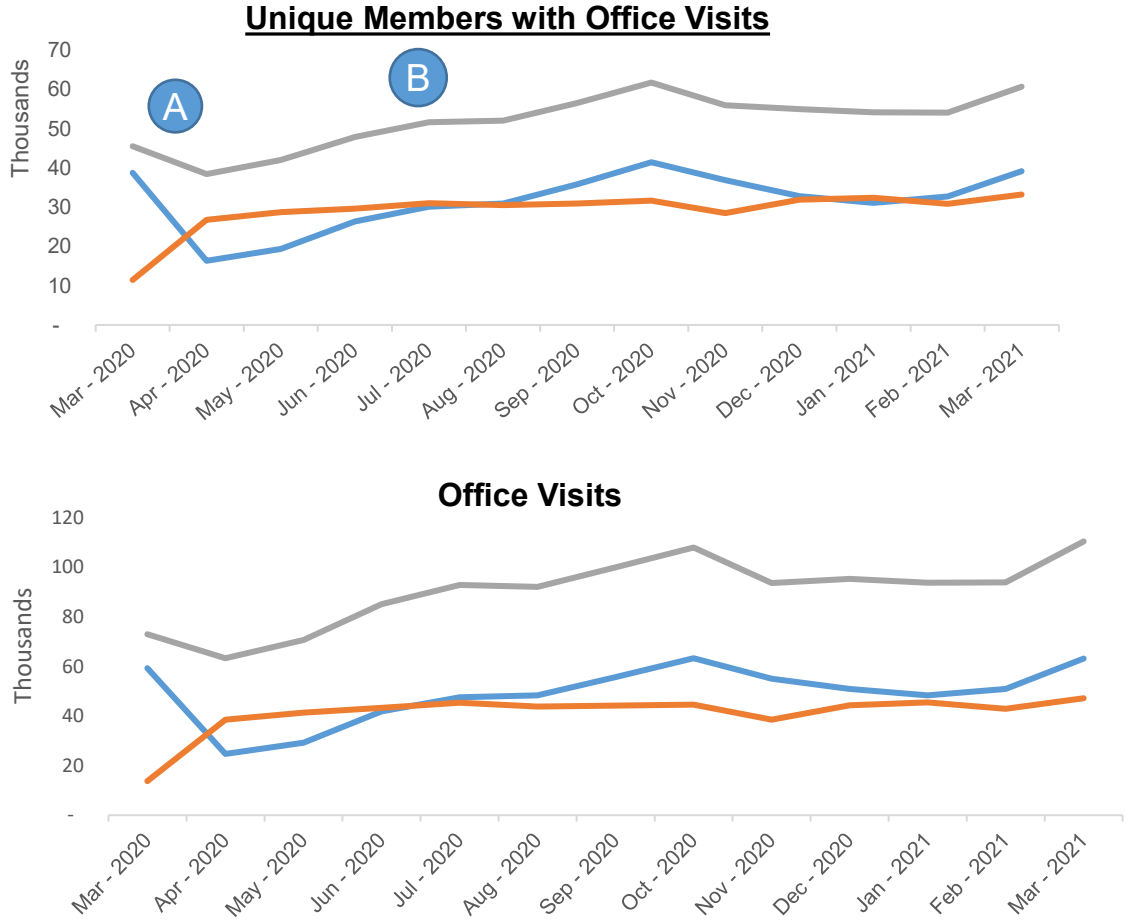
- Providers were reimbursed for Telehealth visits at the same contracted rates as an In Person visit.
- Data provided is for dates of service March 2020 – March 2021
- Telehealth vendor Teladoc averaged 24 visits per month. Average cost per month was approximately $17K.
- Telehealth data may be understated due to discrepancies in codes submitted on claims/encounters.

In Person vs Telehealth Office Visits: By Month Trend

In Person

Telehealth

Total



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Visits/Member

	Mar'20	Apr'20	May'20	Jun'20	Jul'20	Aug'20	Sep'20	Oct'20	Nov'20	Dec'20	Jan'21	Feb'21	Mar'21
All	1.6	1.6	1.7	1.8	1.8	1.8	1.8	1.7	1.7	1.7	1.7	1.7	1.8
In Person	1.5	1.5	1.5	1.6	1.6	1.6	1.6	1.5	1.5	1.6	1.5	1.6	1.6
Telehealth	1.2	1.4	1.4	1.5	1.5	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4

Key Observations –

A Significant drop in total office visits and unique members at the start of pandemic i.e. Mar – Apr 2020. Drop mostly due to In Person visits.

B Steady increase observed in both total unique members and their visits starting Apr 2020. Telehealth visits are used by ~60% of members in any given month.

C Visits/Member for both In Person and Telehealth has been consistent month over month (1-2 visits per month). Telehealth visits are used by ~60% of members in any given month.

In Person and Telehealth Visits by Delegate

Percentage of In Person and Telehealth Visits By Delegate

Delegates	Unique Members	% In Person	% Telehealth
AHS	27,617	68%	79%
Alliance	40,947	87%	57%
CFMG	19,435	87%	47%
CHCN	70,030	79%	83%
Kaiser	32,857	88%	67%

Visits per member by Delegate

	All	In Person	Telehealth
AHS	5.4	3.8	3.6
ALLIANCE	7.0	5.6	3.7
CFMG	3.4	2.4	2.8
CHCN	6.9	4.0	4.6
KAISER	5.6	3.7	3.6

Significant difference in In Person and TeleHealth usage as well as total visits/member by delegates was identified:

- CFMG has only 47% Telehealth visits compared to 83% in CHCN
- CHCN also has the highest visits per member for Telehealth i.e. 4.6 visits/ member
- On the other hand, Alliance has highest number of total visits per member primarily due to In Person visits/member

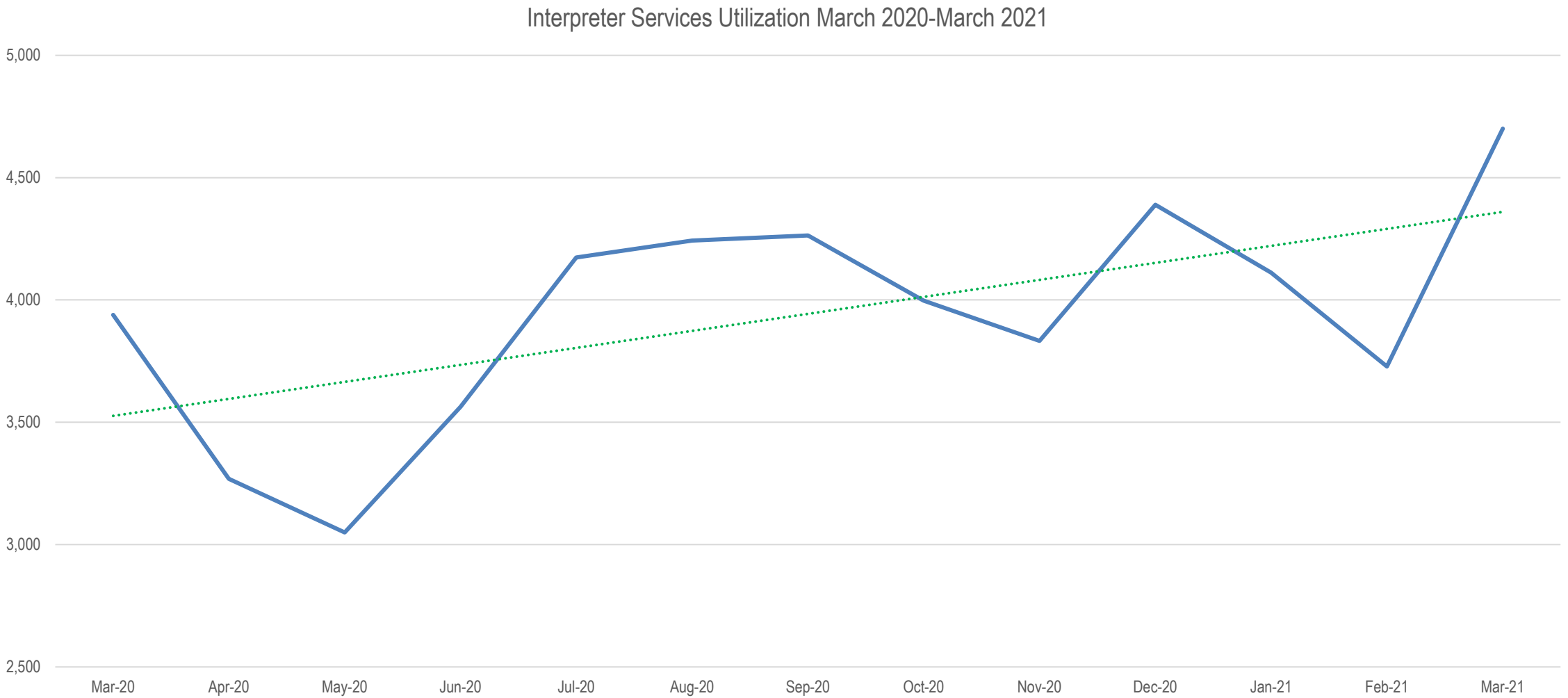
Note: The percentage utilization of In Person and Telehealth will not total 100%, as members can use both In Person and Telehealth visits

Interpreter Services Utilization and Cost Analysis

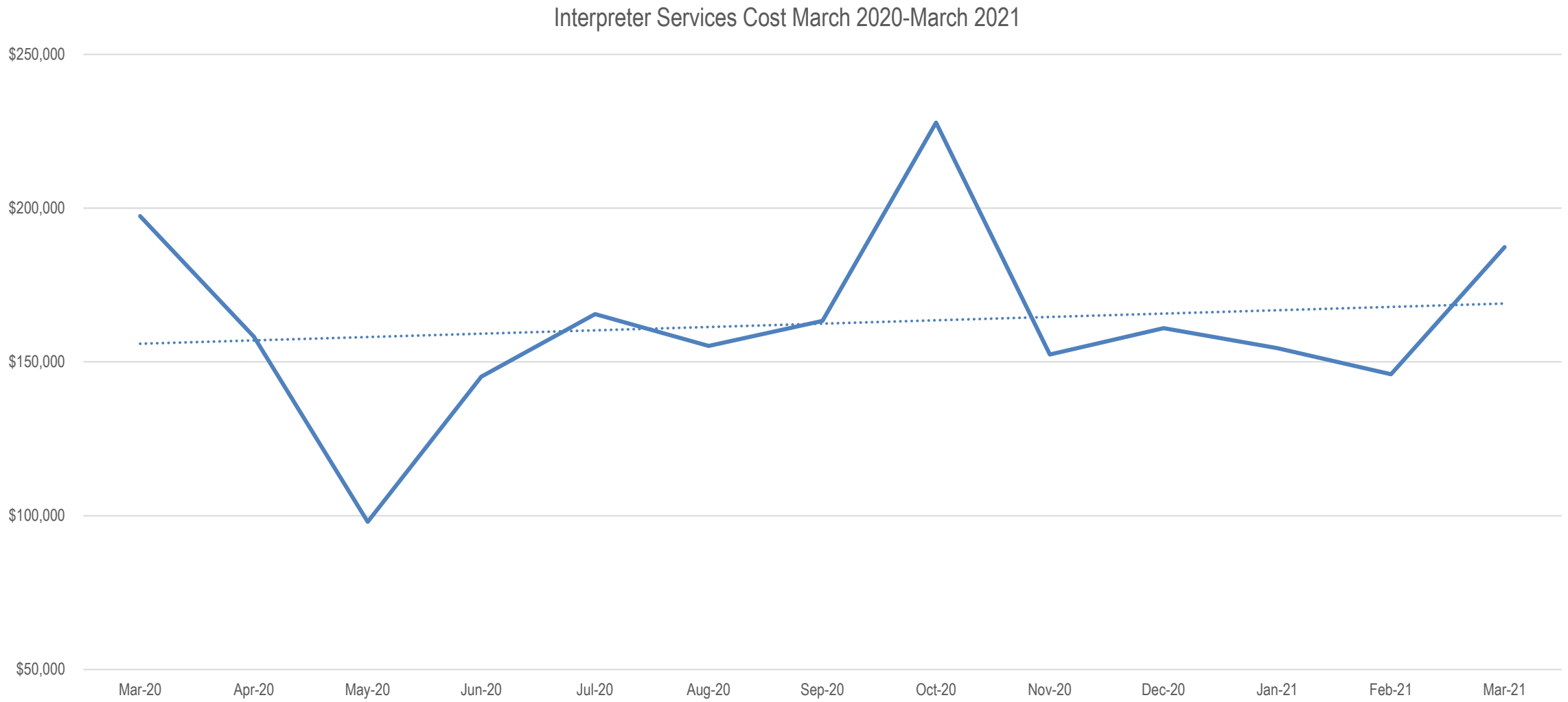
Interpreter Services Utilization and Cost Summary

- Utilization and cost data provided for March 2020 to March 2021.
- Both utilization and costs trends increased during the period.
- Monthly utilization averages 3,900 interpreter encounters per month.
- Average cost is $162K per month.
- Approximately 14K members utilized services over the most recent one-year period analyzed.
- Outpatient visits make up at least 16% of interpreter services.
- In 2020, 23% of adults and 28% of children surveyed reported needing medical services in a language other than English.
- 84% of adults and 91% of children reported they were able to communicate with their medical provider in their preferred language.

Interpreter Services Utilization



Interpreter Services Cost

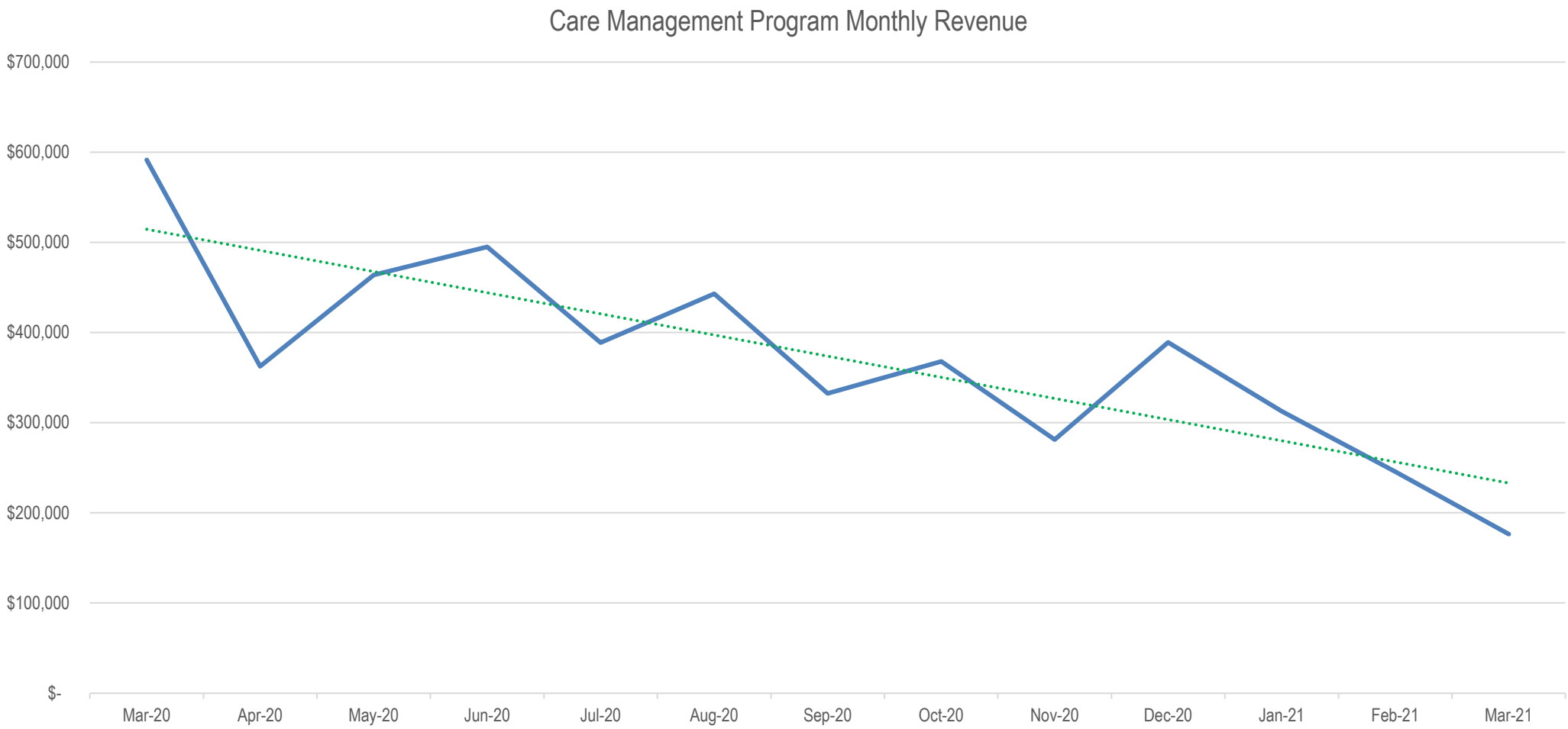


Care Management Programs Revenue and Expense Analysis

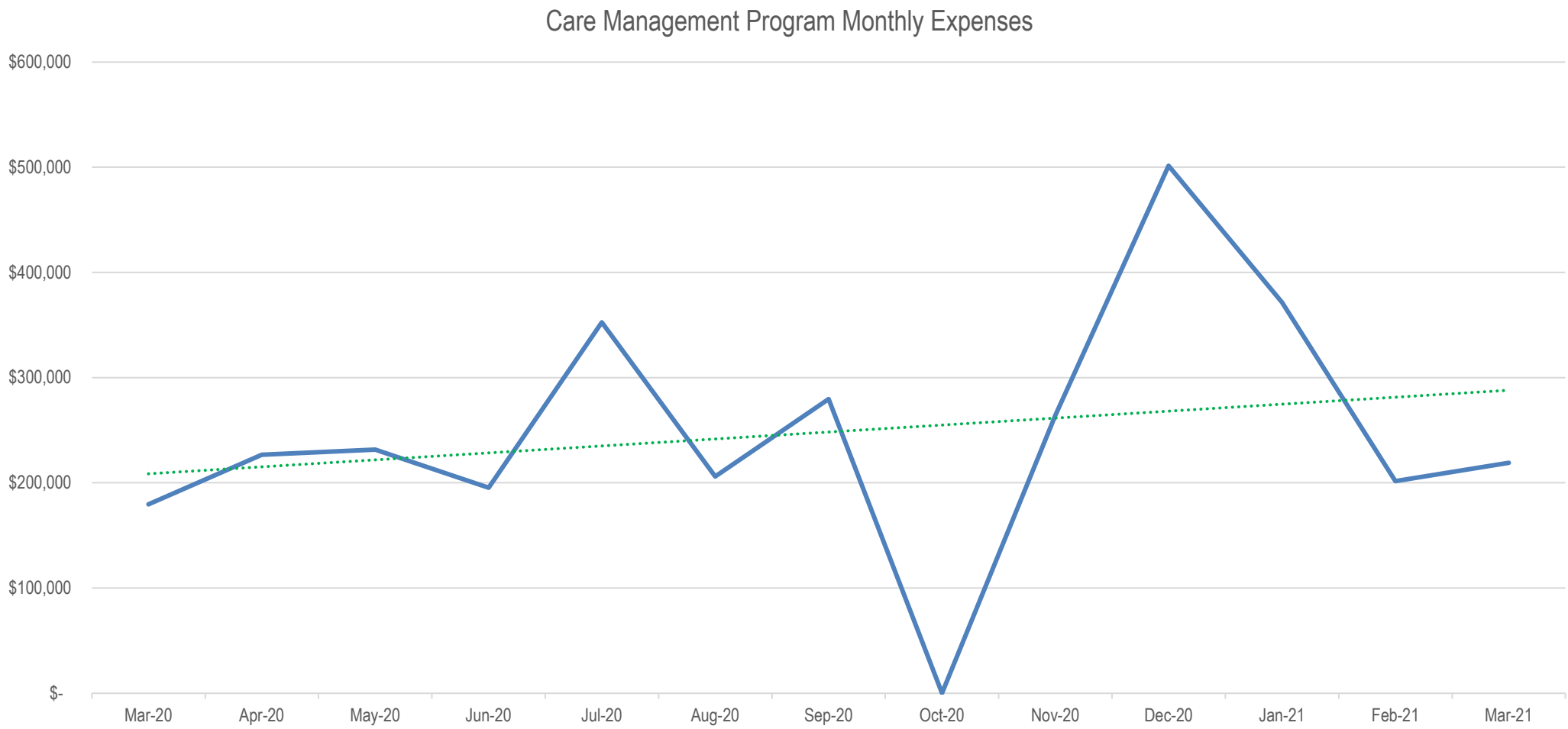
Care Management Programs Revenue and Expenses

- Care Management Programs include revenue and expense data from the current Whole Person Care (AC3) program and Health Home Program (HHP).
- Data provided for March 2020 to March 2021.
- Monthly revenue trends declined over the last twelve months as HHP rates from the State declined.
- Monthly expense trends increased month over month.
- Average monthly revenue is $373K and expense is $248K.
- Revenue amounts in excess of expense are used to offset current and future period rate and expense variances.
- Under CalAIM in CY2022, Enhanced Care Management funding and costs will supersede current AC3 and HHP funding and cost structure.

Care Management Program Revenue



Care Management Program Expenses



Resolutions

RESOLUTION NO. 2021-13

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH RECOMMENDING THAT THE ALAMEDA COUNTY BOARD OF SUPERVISORS REAPPOINT A MEMBER TO THE BOARD OF GOVERNORS OF ALAMEDA ALLIANCE FOR HEALTH

WHEREAS, the term for the “at large” subject knowledge expert on health services for seniors and persons with disabilities seat has expired, currently occupied by Mr. Marty Lynch, as a Member of the Alameda Alliance for Health (Alliance) Board of Governors; and

WHEREAS, pursuant to Section 3.F of the Alliance Bylaws, Marty Lynch has remained in service as no successor has been selected; and

WHEREAS, the Alliance Chief Executive Officer recommends that the Alliance Board of Governors reappoint Marty Lynch to the “at large” subject knowledge expert on health services for seniors and persons with disabilities seat pursuant to Section 3.D.8 of the Bylaws of the Alliance; and

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

WHEREAS, the Alliance Board of Governors desires to reappoint Marty Lynch to the “at large” subject knowledge expert on health services for seniors and persons with disabilities seat; and

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

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

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

SECTION 1. That the Alliance Board of Governors approves the Chief Executive Officer’s recommendation to reappoint Marty Lynch to the “at large” subject knowledge expert on health services for seniors and persons with disabilities seat on the Alliance Board of Governors, as created pursuant to Section 3.D.8 of the Bylaws of the Alliance.

SECTION 2. The Alliance Board of Governors hereby recommends that the Alameda County Board of Supervisors reappoint by majority vote Marty Lynch as the “at large” subject knowledge expert on health services for seniors and persons with disabilities member of the Alliance Board of Governors.

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

PASSED AND ADOPTED by the Board at a meeting held on the 9th day of July 2021.

_____
CHAIR, BOARD OF GOVERNORS

ATTEST:

_____
Secretary

ALAMEDA Alliance FOR HEALTH

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

CalAIM Progress Report

CalAIM Implementation Readiness

Progress Report

Presented to the Alameda Alliance Board of Governors

Scott Coffin, Chief Executive Officer

July 9th, 2021

Financial Projections

- **6 months of CalAIM revenues and expenses apply in FY2022 (January – June)**
  - ECM forecasts $8.0 million in revenue, and $7.8 million spent on case management services
  - MOT forecasts $1.8 million in revenue, and $1.7 million spent on medical services
- **Revised ILOS costs range from $18.75 to $21 million per year (11% contingency added)**
  - Approximately 1,200 Alliance Members were enrolled in Whole Person Care (AC3) housing services for the entire year based on 2020 actual experience
  - Assumes CBOs use the Alameda County Social Health Information Exchange (SHIE)

In Lieu Of Services Categories	Potential Annual Expense
Asthma Remediation	$150K
Home Modifications	$2.5M
Housing Navigation & Tenancy Sustaining	$7.5M
Housing Deposits & Other	$5.8M
Meals / Medically Tailored Meals	$1.8M
Recuperative Care / Respite	$1.0M
Totals	**$18.75M**

Progress Report

1. Continued modeling of ILOS cost projections $18.75 to $21 million per year (see slide #11)
2. DHCS announced allowable service restrictions on June 22nd for ILOS housing navigation, tenancy & sustaining, and deposits; limits the scope of services without changing the definition of the service (e.g. apply limitations to the duration of services, offer ILOS to specific populations or sub-populations, limit the service area "geography" in Alameda County)
3. Alameda Alliance submitted the first set of regulatory [Model of Care] documentation 2 days ahead of deadline on June 29th
4. Initiated the writing of the regulatory submissions due on September 1st & October 1st
5. DHCS released draft ILOS pricing guidance on July 1st and public comments are due by July 15th; included performance milestones that are tied to funding

Request to the DHCS

1) Minimize the $47M ILOS financial exposure until Medi-Cal base rates are adjusted; $18.75M per year to fund ILOS, total 2.5 years until rate development process starts to consider actual expenses (see slide #6)

2) Allocate at least $10 million in base rate funding in CY2022 to fund the WPC housing services; Alliance funds the remaining $8.75 to $11.0 million and avoids higher-cost services, and offsets the financial exposure

3) Partner with Alameda County to apply for PATH funding and Enhanced HCBS funding, and apply dollars in CY2023 and CY2024 to sustain the housing services

4) ILOS costs to be recognized by the DHCS in the Alliance's Medical Loss Ratio & Rate Development

Next Steps

1. Continue the contract negotiations with Alameda County HCSA for ILOS housing services, and identify ILOS service restrictions and limitations
2. 3-way meeting with DHCS, Alameda Alliance, and Alameda County HCSA on July 16th to address questions that relate to the funding, ILOS restrictions and limitations, and projected costs for housing services
3. Enterprise planning for operational readiness, preparing organization for implementation of ECM, ILOS, and MOT
4. Initiate drafting of the second and third deliverables for regulatory submission (see slide #7)
5. DHCS to publish managed care rates for ECM and ILOS in September; following rate confirmation the ILOS service categories proposed for the first phase on January 1, 2022, will be re-evaluated
6. Alameda County HCSA and Alameda Alliance to update the Board of Supervisors

Appendix

Reference slides from presentation at the June 9th Board of Governors meeting

Regulatory Filings

- First submission to DHCS by July 1st; includes preliminary set of ILOS and approach to provider network development, and outlines the approach to transitioning the Members in Whole Person Care and Health Homes programs
- Second submission is due to DHCS by September 1st; includes the policies and procedures, and final selection of ILOS
- Third submission is due to DHCS by October 1st; includes the final provider network for all services – ECM, ILOS, MOT (e.g. subcontracting arrangements with Alameda County and community-based organizations)

Enhanced Care Management
Populations of Focus

*Yellow highlight denotes the population transitions on January 1, 2022

1. Children or youth with complex physical, behavioral, developmental and oral health needs (i.e. California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode of psychosis)
2. Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless
3. High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits
4. Individuals at risk for institutionalization, eligible for long-term care
5. Nursing facility residents who want to transition to the community
6. Individuals at risk for institutionalization with Serious Mental Illness (SMI), children with Serious Emotional Disturbance (SED) or Substance Use Disorder (SUD) with co-occurring chronic health conditions
7. Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community

In Lieu Of Services

1. **Housing Transition Navigation Services**
2. **Housing Deposits**
3. **Housing Tenancy and Sustaining Services**
4. Short-term Post-Hospitalization Housing
5. **Recuperative Care (Medical Respite)**
6. Respite
7. Day Habilitation Programs
8. Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly & Adult and Adult Residential Facilities
9. Nursing Facility Transition to a Home
10. Personal Care (beyond In Home Services and Supports) and Homemaker Services
11. **Environmental Accessibility Adaptations (Home Modifications)**
12. **Meals/Medically Tailored Meals**
13. Sobering Centers
14. **Asthma Remediation**

LEGEND

Go-Live January 1, 2022

Phased Go-Live in CY2023

Major Organ Transplants

1. Kidney & cornea covered today by managed care health plans, and all other transplants are covered under the Medi-Cal “Fee for Service” system
2. Effective 1/1/2022, transplants for heart, liver & intestinal, lung, pancreas, and combined organs (e.g. heart/lung) administered by Alameda Alliance
3. Includes bone marrow transplants

ILOS Pro-Forma Costs (CY2022)

ILOS		Annual Expense	Percent
Asthma Remediation	$	150,000	1%
Home Modifications	$	2,500,000	13%
Housing Navigation & Tenancy Sustaining	**$**	**7,500,000**	**40%**
Housing Deposits & Other	**$**	**5,800,000**	**31%**
Meals / Medically Tailored Meals	$	1,800,000	10%
Recuperative Care / Respite	$	1,000,000	5%
Total	**$**	**18,750,000**	**100%**

Projected 12-month expenses for ILOS service paid to contracted providers

- Current projected ILOS expenses in CY2022 is $18.75M
- Alameda County HCSA proposed annual run rate of **$13.3 million** for the administration for housing services, or **71%** of the total annual expenses
- Alliance intends to execute a contract with Alameda County for a majority of the in-lieu of services

ALAMEDA Alliance FOR HEALTH

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Service you can trust.

Operations

Matt Woodruff

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

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

Date: **July 9, 2021**

Subject: **Operations Report**

Member Services

- 12-Month Trend Summary:

    - The Member Services Department received a thirty percent (30%) increase in calls in June 2021, totaling 16,149 compared to 11,356 in June 2020. Call volume pre-pandemic in June 2019 was 13,740, which is fifteen percent 15% lower than the current call volume.
    - June utilization for the member automated eligibility IVR system totaled nine hundred one (901).
    - The abandonment rate for June 2021 was fifteen percent (15%), compared to two percent (2%) in June 2020.
    - The Department's service level was forty-four percent (44%) in June 2021, compared to eighty-four percent (84%) in June 2020. The Department continues to recruit to fill open positions.
    - The average talk time (ATT) was six minutes and twenty-three seconds (06:23) for June 2021 compared to six minutes and thirty-one seconds (06:31) for June 2020.
    - The top five call reasons for June 2021 were: 1). Eligibility/Enrollment, 2). Change of PCP 3). Kaiser, 4). Benefits, 5). Correspondence/Follow-Up (COVID-19 vaccine incentive 646). The top five call reasons for June 2020 were: 1). Eligibility/Enrollment, 2). Kaiser, 3). Change of PCP, 4). Benefits, 5). ID Card Requests.
    - The Department continues to service members via multiple non-contact communication channels (telephonic, email, web-based requests) while honoring the 'shelter in place' order. The Department responded to 472 web-based requests in June 2021 compared to 498 in June 2020. The top three web reason requests for 2021 were: 1). ID Card Requests 2). Update Contact Information, 3). Change of PCP.

Claims

- 12-Month Trend Summary:

    - The Claims Department received 136,687 claims in June 2021 compared to 101,083 in June 2020.
    - The Auto Adjudication was 72.6% in June 2021 compared to 74.9% in June 2020.
    - Claims compliance for the 30-day turn-around time was 93.7% in June 2021 compared to 98.3% in June 2020. The 45-day turn-around time was 99.9% in June 2021 compared to 99.9% in June 2020.

- Monthly Analysis:

    - In June, we received a total of 136,687 claims in the HEALTHsuite system. This represents an increase of 5.3% from May and is lower, albeit by 35,604 claims, than the number of claims received in June 2020; the higher volume of received claims remains attributed to COVID-19 and COBA implementation.
    - We received 78% of claims via EDI and 22% of claims via paper.
    - During June, 99.9% of our claims were processed within 45 working days.
    - The Auto Adjudication rate was 72.6% for June.

Provider Services

- 12-Month Trend Summary:

    - The Provider Services Department's call volume in June 2021 was 5,588 calls compared to 6,281 calls in June 2020.
    - Provider Services continuously works to achieve first call resolution and reduction of the abandonment rates. Efforts to promote provider satisfaction is our first priority.
    - The Provider Services department completed 272 visits during June 2021.
    - The Provider Services department answered over 4,902 calls for June 2021 and made over 940 outbound calls.

Credentialing

- 12-Month Trend Summary:
    - At the Peer Review and Credentialing (PRCC) meeting held on June 15, 2021, there were seven (7) initial providers approved; zero (0) primary care providers, two (2) specialists, zero (0) ancillary providers, and five (5) midlevel providers. Additionally, thirty-six (36) providers were re-credentialed at this meeting; eight (8) primary care providers, nineteen (19) specialists, one (1) ancillary provider, and eight (8) midlevel providers.
    - For more information, please refer to the Credentialing charts and graphs located in the Operations supporting documentation.

Provider Dispute Resolution

- 12-Month Trend Summary:
    - In June 2021, the Provider Dispute Resolution (PDR) team received 658 PDRs versus 950 in June 2020.
    - The PDR team resolved 741 cases in June 2021 compared to 677 cases in June 2020.
    - In June 2021, the PDR team upheld 67% of cases versus 66% in June 2020.
    - The PDR team resolved 99.1% of cases within the compliance standard of 95% within 45 working days in June 2021 compared to 99% in June 2020.

- Monthly Analysis:
    - AAH received 658 PDRs in June 2021.
    - In June, 741 PDRs were resolved. Out of the 741 PDRs, 495 were upheld, and 246 were overturned.
    - The overturn rate for PDRs was 33% which did not meet our goal of 25% or less.
    - Below is a breakdown of the various causes for the 246 overturned PDRs. Please note that there were two primary areas that caused the Department to miss their goal of 25% or less. First were the system issues listed below represented a higher than normal percentage of overturned cases (representing 102% or 102 cases). Out of the 70 incorrect rates, 40 cases were due to DHCS Hospice rates published on 03/23/2021 were retro-back Hospice rates to 10/01/2020. The second, a larger than normal volume of overturns due to processor errors claims (representing 27% or 66 cases).

The combined rise in the volume of the two primary issues for overturned PDRs this month stopped us from achieving the goal of 25% or less.

- System Related Issues 41% (102 cases):
  - 15 cases: CES edit Update.
  - 5 cases: Incorrect member eligibility.
  - 12 cases: General configuration issues, like Not Covered, Modifier, Delegated.
  - 30 cases: Incorrect rate paid.
  - 40 cases: Incorrect Rate (DHCS published Hospice rates 03/23/2021 retro back to 10/01/2020)

- Authorization Related Issues 12% (29 cases):
  - 26 cases: Processor errors when auth on file.
  - 3 cases: UM Decisions/Med Nec Met

- Additional Documentation Provided 6% (15 cases):
  - 15 cases: Duplicate claim documentation that allows for claims to be adjusted.

- Claim Processing Errors 27% (66 cases)
  - 30 cases: Duplicate
  - 36 cases: Various Processor errors.

- 741 out of 734 cases were resolved within 45 working days resulting in a 99% compliance rate.
- The average turnaround time for resolving PDRs in June was 40 days.
- There were 1429 PDRs pending resolution as of 06/30/2021. with no cases older than 45 working days.

Community Relations and Outreach

- 12-Month Trend Summary:
  - In Quarter 4 (Q4) 2021, the Alliance completed 2,179 member orientation outreach calls and 529 member orientations by phone.
  - The C&O Department reached 531 people (100% identified as Alliance members) during outreach activities, compared to 909 individuals (100% self-identified as Alliance members) in Q4 2020.
  - The C&O Department spent a total of $0 in donations, fees, and/or sponsorships, compared to $0 in Q4 2020.

- The C&O Department reached members in 24 cities/unincorporated areas throughout Alameda County, Bay Area, and the U.S., compared to 24 cities in Q4 2020.

- Quarterly Analysis:

  - In Q4 2021, the C&O Department completed 2,179 member orientation outreach calls and 529 member orientations by phone, and two virtual community events.
  - Among the 535 people reached, 100% identified as Alliance members.
  - In Q4 2021, the C&O Department reached members in 24 locations throughout Alameda County, Bay Area, and the U.S.

- Monthly Analysis:

  - In June 2021, the C&O Department completed 633 member orientation outreach calls and 151 member orientations by phone, and 48 Alliance website inquiries.
  - Among the 151 people reached, 100% identified as Alliance members.
  - In June 2021, the C&O Department reached members in 24 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 2021
Incoming Calls (R/V)	16,149
Abandoned Rate (R/V)	15%
Answered Calls (R/V)	13,804
Average Speed to Answer (ASA)	02:23
Calls Answered in 30 Seconds (R/V)	44%
Average Talk Time (ATT)	06:23
Outbound Calls	7,330

Top 5 Call Reasons (Medi-Cal and Group Care) June 2021
Eligibility/Enrollment
Change of PCP
Kaiser
Benefits
Correspondence Questions/Follow up

Top 3 Web-Based Request Reasons (Medi-Cal and Group Care) June 2021
ID Card Request
Update Contact Info
Change of PCP

Claims Department
May 2021 Final and June 2021 Final

METRICS

Claims Compliance	May-21	Jun-21
90% of clean claims processed within 30 calendar days	96.0%	93.7%
95% of all claims processed within 45 working days	99.9%	99.9%

Claims Volume (Received)	May-21	Jun-21
Paper claims	25,605	29,904
EDI claims	104,242	106,783
Claim Volume Total	**129,847**	**136,687**

Percentage of Claims Volume by Submission Method	May-21	Jun-21
% Paper	19.72%	21.88%
% EDI	80.28%	78.12%

Claims Processed	May-21	Jun-21
HEALTHsuite Paid (original claims)	88,040	115,795
HEALTHsuite Denied (original claims)	33,016	38,867
HEALTHsuite Original Claims Sub-Total	**121,056**	**154,662**
HEALTHsuite Adjustments	1,617	1,512
HEALTHsuite Total	**122,673**	**156,174**

Claims Expense	May-21	Jun-21
Medical Claims Paid	$47,222,337	$56,686,287
Interest Paid	$24,941	$19,256

Auto Adjudication	May-21	Jun-21
Claims Auto Adjudicated	88,733	112,326
% Auto Adjudicated	73.3%	72.6%

Average Days from Receipt to Payment	May-21	Jun-21
HEALTHsuite	19	20

Pended Claim Age	May-21	Jun-21
0-29 calendar days		
HEALTHsuite	19,738	18,179
30-59 calendar days		
HEALTHsuite	386	139
Over 60 calendar days		
HEALTHsuite	0	3

Overall Denial Rate	May-21	Jun-21
Claims denied in HEALTHsuite	33,016	38,867
% Denied	26.9%	24.9%

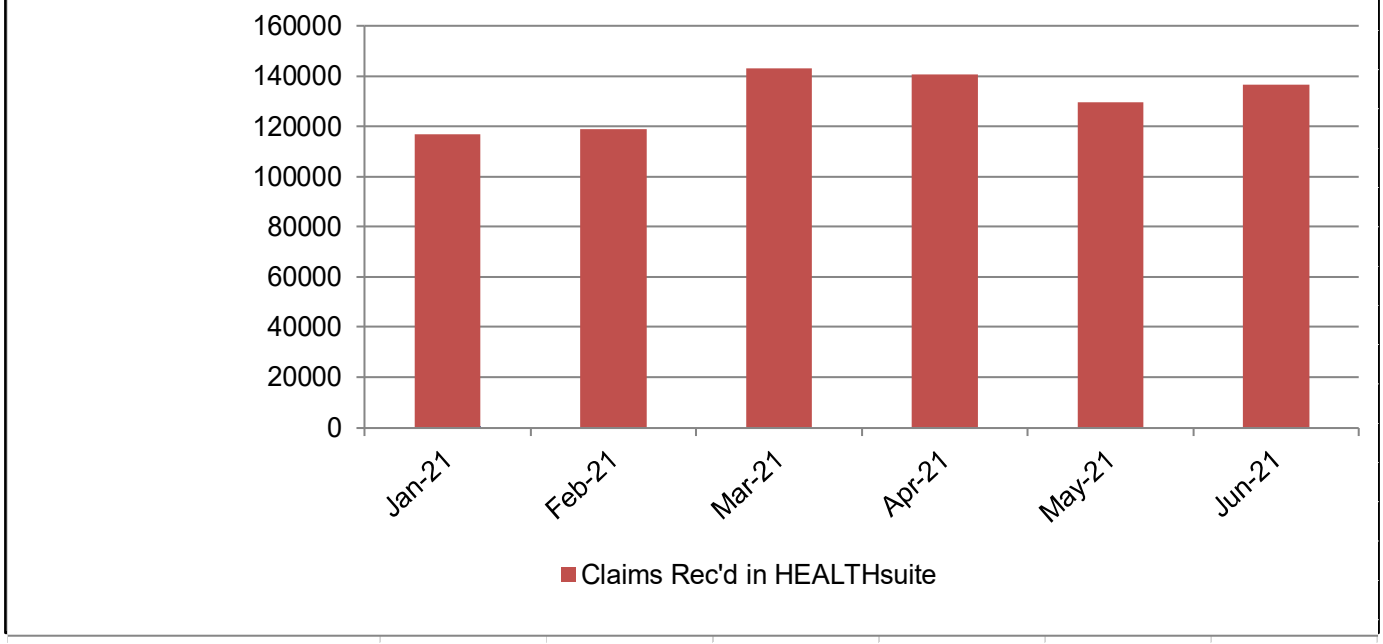
Claims Department
May 2021 Final and June 2021 Final

Jun-21

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	21%
Must Submit as a Paper Claim with Copy of Primary Payer EOB	13%
Duplicate Claim	13%
Non-Covered Benefit for this Plan	9%
Please Submit a Copy of Primary Payer Paper EOB	7%
% Total of all denials	**63%**

Claims Received By Month

Claims Received Through	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Claims Rec'd in HEALTHsuite	116,784	119,001	143,171	140,678	129,847	136,687



Provider Relations Dashboard June 2021

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	5343	4884	5816	5501	5222	5588						
Abandoned Calls	1060	756	815	788	729	686						
Answered Calls (PR)	4283	4128	5001	4713	4493	4902						
Recordings/Voicemails	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Incoming Calls (R/V)	611	533	511	464	414	462						
Abandoned Calls (R/V)												
Answered Calls (R/V)	611	533	511	464	414	462						
Outbound Calls	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Outbound Calls	881	689	1062	1048	933	940						
N/A												
Outbound Calls	881	689	1062	1048	933	940						
Totals	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Total Incoming, R/V, Outbound Calls	6835	6106	7389	7013	6569	6990						
Abandoned Calls	1060	756	815	788	729	686						
Total Answered Incoming, R/V, Outbound Calls	5775	5350	6574	6225	5840	6304						

Provider Relations Dashboard June 2021

Call Reasons (Medi-Cal and Group Care)

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	2.8%	3.9%	3.1%	3.0%	2.7%	3.5%						
Benefits	4.9%	3.4%	3.7%	3.1%	3.4%	2.8%						
Claims Inquiry	38.8%	36.8%	39.4%	38.1%	40.6%	40.4%						
Change of PCP	1.3%	3.6%	4.8%	4.1%	4.8%	5.3%						
Complaint/Grievance (includes PDR's)	3.5%	3.6%	3.8%	3.6%	2.8%	3.1%						
Contracts	0.5%	0.6%	0.3%	0.6%	0.5%	0.4%						
Correspondence Question/Followup	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%						
Demographic Change	0.1%	0.1%	0.1%	0.2%	0.1%	0.1%						
Eligibility - Call from Provider	25.0%	25.8%	24.3%	24.4%	25.1%	23.2%						
Exempt Grievance/ G&A	0.2%	0.2%	0.2%	0.0%	0.4%	0.4%						
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	2.0%	1.8%	1.3%	1.2%	1.1%	1.1%						
Kaiser	3.7%	0.2%	0.2%	0.4%	0.3%	0.3%						
Member bill	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%						
Mystery Shopper Call	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%						
Provider Portal Assistance	3.6%	4.3%	4.0%	3.9%	4.3%	4.1%						
Pharmacy	0.9%	0.9%	1.0%	1.1%	1.2%	0.7%						
Provider Network Info	0.2%	0.1%	0.2%	0.2%	0.3%	0.5%						
Transferred Call	0.2%	0.1%	0.1%	0.0%	0.0%	0.0%						
All Other Calls	12.3%	14.4%	13.6%	16.0%	12.7%	14.0%						
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	11	11	16	12	8	15						
Contracting/Credentialing	11	19	30	21	11	14						
Drop-ins	0	0	0	0	0	0						
JOM's	2	3	2	0	4	3						
New Provider Orientation	11	31	12	10	10	19						
Quarterly Visits	202	206	269	230	241	221						
UM Issues	2	2	3	0	1	0						
Total Field Visits	239	272	332	273	275	272	0	0	0	0	0	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS

Practitioners		AHP 399	PCP 361	SPEC 639	PCP/SPEC 17
AAH/AHS/CHCN Breakdown		AAH 429	AHS 201	CHCN 438	COMBINATION OF GROUPS 348
Facilities	**272**				

VENDOR SUMMARY
Credentialing Verification Organization, Symply CVO

	Number	Average Calendar Days in Process	Goal - Business Days	Goal - 98% Accuracy	Compliant
Initial Files in Process	11	33	25	Y	Y
Recred Files in Process	3	61	25	Y	Y
Expirables updated Insurance, License, DEA, Board Certifications					Y
Files currently in process	**14**				

CAQH Applications Processed in May 2021

Standard Providers and Allied Health	**Invoice not received**

June 2021 Peer Review and Credentialing Committee Approvals

Initial Credentialing	**Number**
PCP	0
SPEC	2
ANCILLARY	0
MIDLEVEL/AHP	5
	7
Recredentialing	
PCP	8
SPEC	19
ANCILLARY	1
MIDLEVEL/AHP	8
	36
TOTAL	**43**

June 2021 Facility Approvals

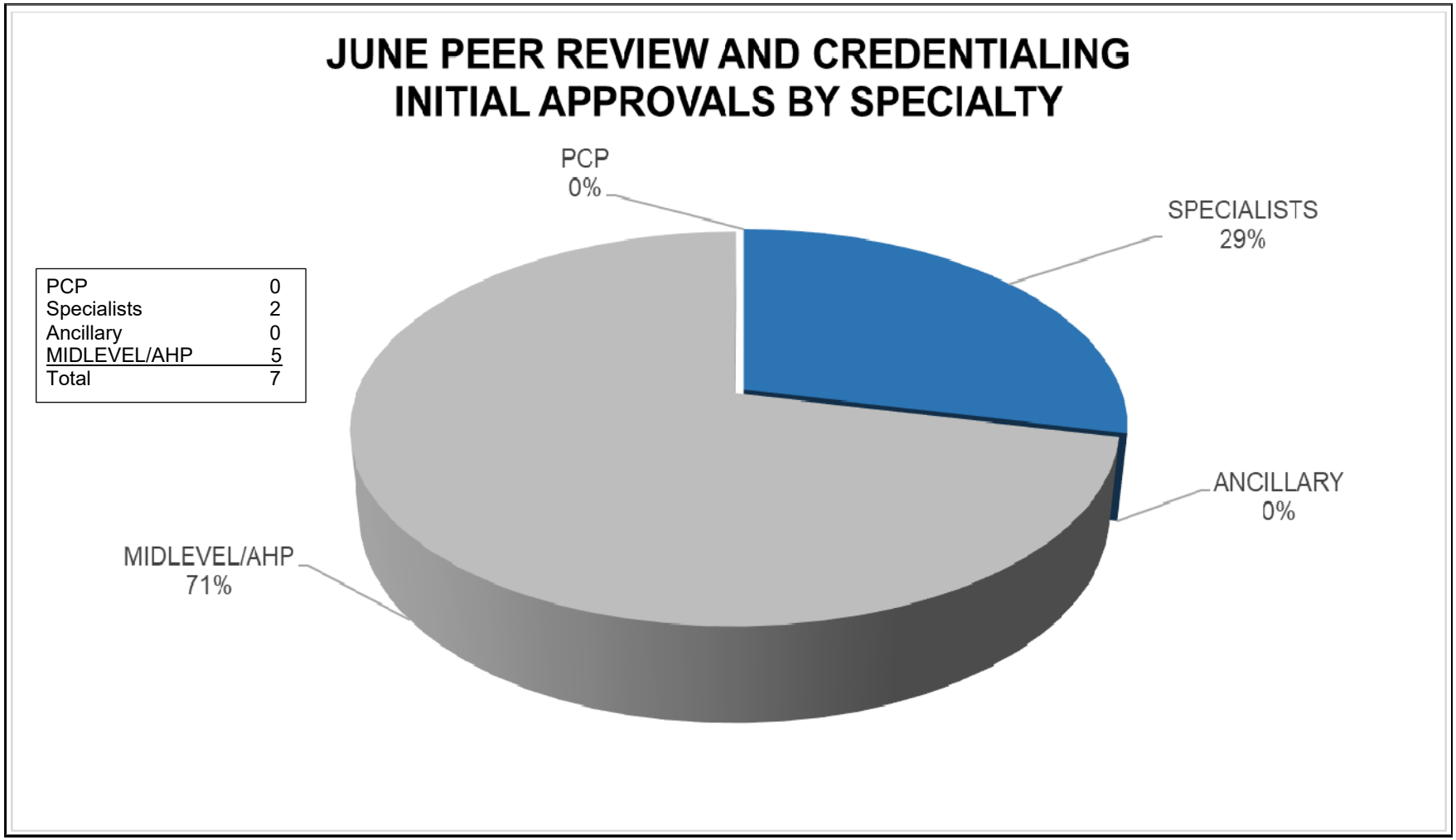
Initial Credentialing	2
Recredentialing	7
	9
Facility Files in Process	**42**

June 2021 Employee Metrics 3

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
Daniel	Brian	Allied Health	Initial	6/15/2021
Estoque	Ligaya	Allied Health	Initial	6/15/2021
Kim	Dayna	Specialist	Initial	6/15/2021
Krishnamurthy	Tarika	Allied Health	Initial	6/15/2021
Qureshi	Azam	Specialist	Initial	6/15/2021
Richardson	Megan	Allied Health	Initial	6/15/2021
Taylor	Briauna	Allied Health	Initial	6/15/2021
Bunker-Alberts	Michele	Allied Health	Recred	6/15/2021
Classen	Jerri	Allied Health	Recred	6/15/2021
Economou	Vasiliki	Specialist	Recred	6/15/2021
Gilani	Hussain	Specialist	Recred	6/15/2021
Hutton	Melissa	Allied Health	Recred	6/15/2021
Kalra	Jagjeet	Specialist	Recred	6/15/2021
Kellert	Brian	Specialist	Recred	6/15/2021
Lee	Eileen	Allied Health	Recred	6/15/2021
Lee	Scott	Specialist	Recred	6/15/2021
Lee	Yen-Chung	Specialist	Recred	6/15/2021
Lim	Mira	Specialist	Recred	6/15/2021
Liu	Benny	Specialist	Recred	6/15/2021
Mahal	Gurjeet	Allied Health	Recred	6/15/2021
Meadows	Journey	Allied Health	Recred	6/15/2021
Miller	Terina	Specialist	Recred	6/15/2021
Montang	Lisa	Primary Care Physician	Recred	6/15/2021
Narra	Kishore	Primary Care Physician and Specialist	Recred	6/15/2021
Nathan	Mark	Specialist	Recred	6/15/2021
Nathan	Sarah	Allied Health	Recred	6/15/2021
Odabaei	Golaun	Specialist	Recred	6/15/2021
Piatt	Bradford	Specialist	Recred	6/15/2021
Puccini	John	Allied Health	Recred	6/15/2021
Risgalla	Habib	Primary Care Physician	Recred	6/15/2021
Safaya	Rakesh	Specialist	Recred	6/15/2021
Seibert	Scott	Specialist	Recred	6/15/2021
Shrivastava	Ankita	Primary Care Physician	Recred	6/15/2021
Singh	Namita	Specialist	Recred	6/15/2021
Stanton	Jessica	Primary Care Physician	Recred	6/15/2021
Thompson	Joan	Ancillary	Recred	6/15/2021
Tran	Hanh	Specialist	Recred	6/15/2021
Upadhyay	Ajay	Specialist	Recred	6/15/2021
Van Gompel	Joshua	Specialist	Recred	6/15/2021
Wadhwani	Rita	Primary Care Physician	Recred	6/15/2021
West	Jeffrey	Specialist	Recred	6/15/2021
Win	Htay	Primary Care Physician	Recred	6/15/2021
Wu	Serena	Primary Care Physician	Recred	6/15/2021

JUNE PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY



PCP	0
Specialists	2
Ancillary	0
MIDLEVEL/AHP	5
Total	7

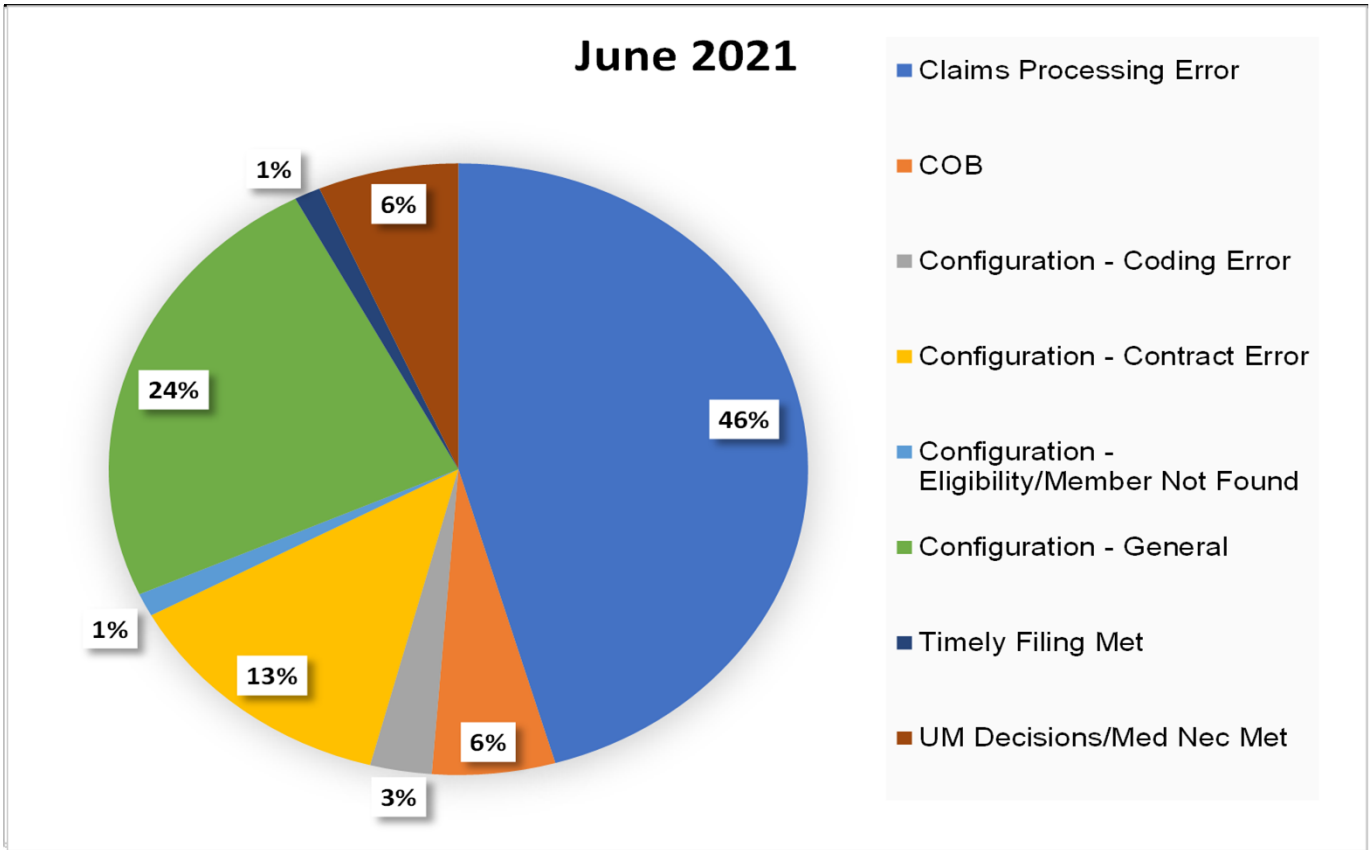
Provider Dispute Resolution
May 2021 June 2021

METRICS		
PDR Compliance	**May-21**	**Jun-21**
# of PDRs Resolved	593	741
# Resolved Within 45 Working Days	590	734
% of PDRs Resolved Within 45 Working Days	99.5%	99.1%
PDRs Received	**May-21**	**Jun-21**
# of PDRs Received	859	658
PDR Volume Total	**859**	**658**
PDRs Resolved	**May-21**	**Jun-21**
# of PDRs Upheld	422	495
% of PDRs Upheld	71%	67%
# of PDRs Overturned	171	246
% of PDRs Overturned	29%	33%
Total # of PDRs Resolved	**593**	**741**
Average Turnaround Time	**May-21**	**Jun-21**
Average # of Days to Resolve PDRs	39	40
Oldest Unresolved PDR in Days	42	44
Unresolved PDR Age	**May-21**	**Jun-21**
0-45 Working Days	1,482	1,429
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**1,482**	**1,429**

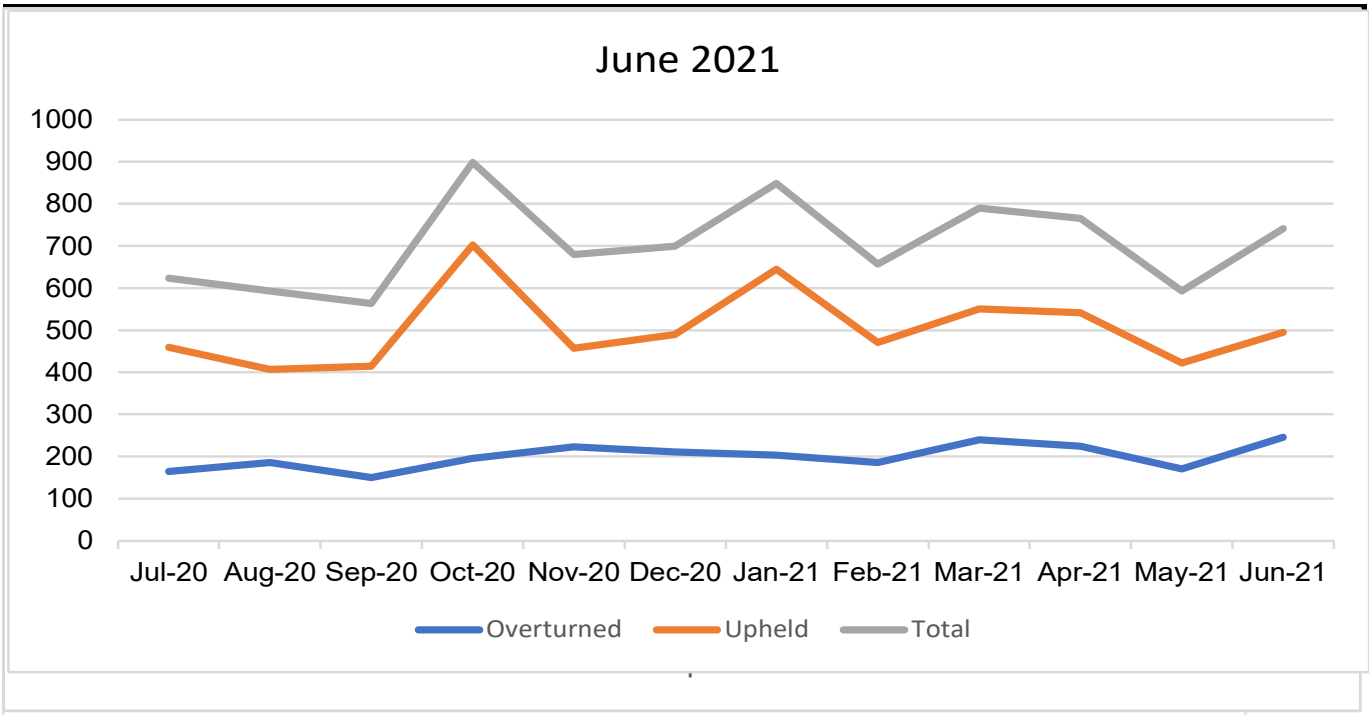
Provider Dispute Resolution
May 2021 June 2021

Jun-21

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

FY 2020 - 2021 | **4TH QUARTER (Q4) OUTREACH REPORT**

ALLIANCE IN THE COMMUNITY

FY 2020 - 2021 | 4TH QUARTER (Q4) OUTREACH REPORT

Between April 2021 and June 2021, the Alliance completed **2,179** member orientation outreach calls and conducted **529** member orientations (**24%** member participation rate). The Alliance also completed **2** virtual community events, and **109** Website Inquires in Q4.

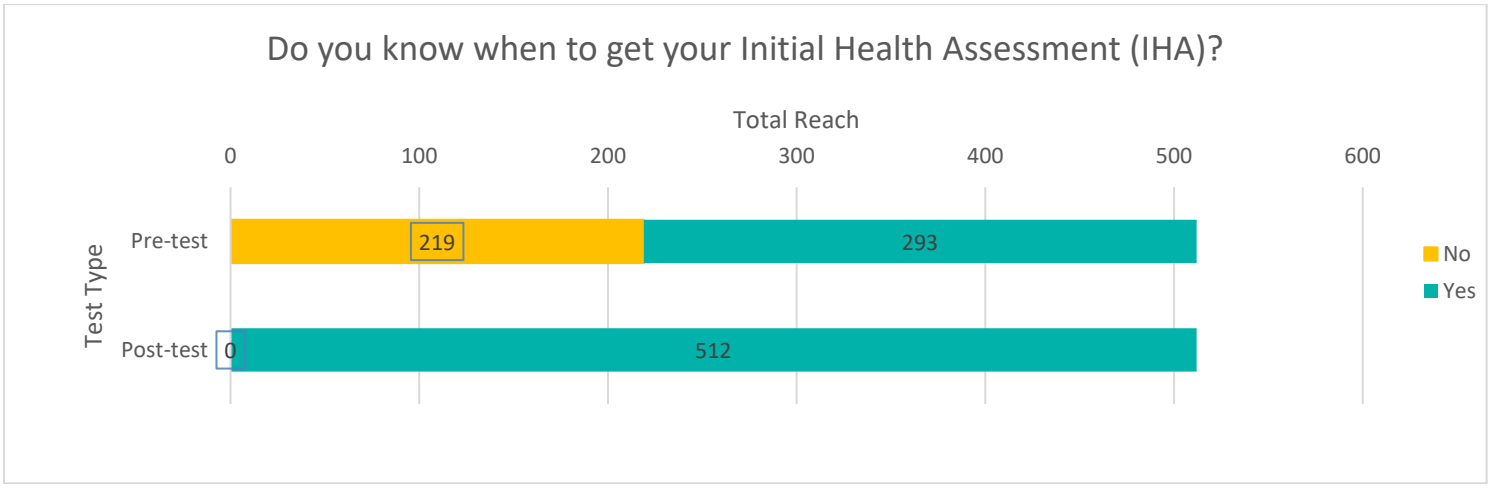
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **23,714** self-identified Alliance members have been reached during outreach activities.

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

On **Wednesday, March 18, 2020,** the Alliance began conducting member orientations by phone.

The Alliance Member Orientation (MO) program has been in place since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Assessment, by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between March 18, 2020 through June 30, 2021) – **3,938** members completed our MO program by phone.

After completing a MO **100%** of members who completed the post-test survey in Q4 FY 20-21 reported knowing when to get their IHA, compared to only **57.2%** 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 20-21\Q4\3. June 2021**

ALLIANCE IN THE COMMUNITY

FY 2020 - 2021 | 4TH QUARTER (Q4) OUTREACH REPORT

Q4 FY 2020-2021 TOTALS

2 VIRTUAL COMMUNITY EVENTS	**6** TOTAL REACHED AT VIRTUAL COMMUNITY EVENTS
0 MEMBER EDUCATION EVENTS	**0** TOTAL REACHED AT MEMBER EDUCATION EVENTS
529 MEMBER ORIENTATIONS	**529** TOTAL REACHED AT MEMBER ORIENTATIONS
0 MEETINGS/ PRESENTATIONS	**0** TOTAL REACHED AT MEETINGS/PRESENTATIONS
0 TOTAL INITIATED/INVITED EVENTS	**535** TOTAL MEMBERS REACHED AT EVENTS
531 TOTAL EVENTS	**535** TOTAL REACHED AT ALL EVENTS

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

TOTAL REACH 24 CITIES

**Cities represent the mailing addresses for members who completed a Member Orientation by phone. The italicized cities are outside of Alameda County. The following cities had <1% reach during Q4 2021: Boca Raton, Brooklyn, Carson, El Sobrante, Minneapolis, Richmond, Sacramento, San Francisco and Walnut Creek. The C&O Department started including these cities in the Q4 FY21 Outreach Report.*

$0

TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

** Includes refundable deposit.*

ALAMEDA Alliance FOR HEALTH

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

Compliance

Richard Golfin III

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

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

Date: **July 9, 2021**

Subject: **Compliance Division Report**

Compliance Activity Updates

- 2020 DHCS Kindred Focused Audit:
  On October 23, 2020, the DHCS sent notice to the Plan of a focused audit involving the Plan's delegate, CHCN, and Kindred facilities. On March 5, 2021, the DHCS issued the Final Report and Corrective Action Plan (CAP). The Plan submitted its CAP response and available supporting documents to DHCS on April 6, 2021. The Plan and CHCN continue to pursue milestones in its implementation of corrective measures as outlined in its CAP to the State.

- 2021 DMHC Full Medical Survey:
  On November 13, 2020, the DMHC sent notice to the Plan of the 2021 DMHC Routine Medical Survey beginning April 12, 2021. DMHC conducted virtual audit interviews on April 13, 2021, through April 16, 2021. The Plan has not received a preliminary audit report, which is typically due within 90-days from the last day of the audit. The last request for additional audit-related documentation was received on June 22, 2021.

- 2021 DHCS Routine Medical Survey:
  On January 13, 2021, the DHCS sent notice to the Plan of the 2021 DHCS Routine Medical Survey beginning April 12, 2021. The audit was conducted jointly with the DMHC from April 13, 2021, through April 23, 2021.The review period was June 1, 2019, through March 31, 2021, and covered the following:

  1) Utilization Management;
  2) Case Management & Care Coordination;
  3) Access & Availability;
  4) Member's Rights & Responsibilities;
  5) Quality Improvement System, and;
  6) Organization and Administration

  The Exit conference has been scheduled for July 20, 2021, from 10:30 –11:30 am. The Exit Conference involves the presentation of the DHCS medical audit preliminary findings for the audit period of June 1, 2019, through March 31, 2021. Three (3) days prior to the Exit Conference, the draft audit reports will be sent to the Plan. The Plan will have 15 calendar days from the date of the Exit Conference to provide mitigating information concerning the draft reports.

- 2021 Annual Network Certification:

  In order to demonstrate compliance with network adequacy requirements, the Plan annually submits its network for certification to the DHCS. The 2021 Annual Network Certification was submitted on April 30, 2021. Due to a change in network requirements, where time ***or*** distance must be met within the network, instead of time ***and*** distance, the Alternative Access Standards requests for the 2021 submission have reduced significantly from 290 requests in 2020, to 5 requests in 2021. DHCS completed its initial review of the Plan's submission and the Plan must provide supplemental documentation by Thursday July 8, 2021, which include signature pages for contracted hospitals, signature pages for mandatory provider types, and evidence of contracting efforts with out of network providers.

  The Plan is also required to submit a Subcontracted Network Certification (SNC) Readiness Plan in anticipation of the 2022 SNC. The MCP was required to include detailed responses as outlined in the Readiness Plan that describes the MCP's delegated structure and the monitoring and compliance processes that will be used in the 2022 SNC.

  - Phase 1: Plan of Action (POA) was submitted to DHCS in March 2020 which detailed the Plan's provider network, operational structure, subcontractors, and various internal processes.
  - Phase 2: Requires completion and submission of a SNC Readiness Plan which will expand on the POA submission and include additional information on overall provider network, list of all SNs, SN exemption requests and justifications, and monitoring and oversight methodologies as they pertain to network adequacy at the subcontractor level.

  The Plan successfully submitted its Readiness Plan on the due date, June 1, 2021.On June 29, 2021, the DHCS determined that the Plan's submission did not meet or fully answer one or more of the requirements outlined in the SNC Readiness Plan template and its attachment. The Plan is required to provide a response to DHCS on July 7, 2021.

- DMHC Measurement Year (MY) 2019 Network Corrective Action Plan:

  On February 26, 2021, the DMHC issued the MY 2019 Network Findings Report (Report). The Report evaluates compliance with the MY 2019 Timely Access Compliance Report Web Portal Instructions; the MY 2019 Provider Appointment Availability Survey (PAAS) Methodology; the instructions in the PAAS Contact List Template; the Raw Data Template and Results Template, and; network adequacy requirements under the Knox Keene Act. The DMHC identified nine (9) findings in the Report. The Plan's response was due within ninety (90) calendar days following the date of issuance, May 26, 2021, and the Plan successfully submitted its CAP response to the DMHC on May 26, 2021. The Plan is awaiting response from DMHC.

- OCR Limited Compliance Review:
  On February 26, 2021, the Plan notified the U.S. Department of Health and Human Services Office for Civil Rights (OCR) of a breach that occurred with the Plan's Business Associate. After notification of the breach, the Plan received a meeting request from an OCR investigator to discuss details of the incident. On March 3, 2021, the Plan met with an OCR investigator and was informed of their intent to conduct a Limited Compliance Review of HIPAA related activity. On May 26, 2021, the Plan received notice from OCR of its investigation on whether the Plan is in compliance with the applicable Federal Standards for Privacy of Individually Identifiable Health Information and/or the Security Standards for the Protection of Electronic Protected Health Information. Specifically, the OCR will investigate whether the Business Associate is in compliance with Plan Business Associate Contracts and applicable policies and procedures. The Plan submitted its response and supporting documents to the OCR on June 15, 2021.

Delegation Oversight Auditing Activities 2020

- The Plan conducts annual audits of its delegated entities to monitor compliance with regulatory and contractual requirements. The Plan has seven (7) delegates, and all seven (7) delegates were audited during the previous calendar year. In January 2021, the Plan issued preliminary audit reports to the three (3) delegates with open CAPs. The Plan issued a Final Audit Report and CAP to two (2) delegates in March 2021. The Compliance Department continues to work closely with delegates to review CAP responses; monitor implementation milestones, and; perform CAP verification.

Delegation Oversight Auditing Activities 2021

- The Plan conducts annual audits of its delegated entities to monitor compliance with regulatory and contractual requirements. The Plan has seven (7) delegates. On April 27, 2021, the Plan began its 2021 audit season by notifying its Pharmacy Benefits Manager, Perform Rx, of the Plan's intent to perform an annual delegation oversight audit for the Medi-Cal and IHSS lines of business. The audit review period is January 1, 2020, through December 31, 2020. There has been a small update to the schedule and the virtual onsite audit will now be conducted by the Plan's consultant, PillarRx, in collaboration with Plan staff from July 27 – 28, 2021.

- In collaboration with Bay Area and Northern California Medi-Cal Health Plans, Kaiser Foundation Health Plan received notice of the 2021 Joint Annual Delegation Oversight Audit. The audit review period is July 1, 2020, through May 31, 2021. Staff held an internal kick-off meeting on May 6, 2021, to discuss scope, timing, expectations and key dates. The Plan has received pre-audit documents for review. The virtual audit will be conducted from August 8, 2021 – September 10, 2021.

- The Plan is finalizing the 2021 Annual Delegation Audit Schedule.

Compliance

Supporting Documents

APL/PL IMPLEMENTATION TRACKING LIST						
#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
1	DMHC	21-001	1/5/2021	MODEL NOTICES; COMPLIANCE WITH SB 260	GROUP CARE	Section 1366.50, as amended in 2019, requires a health plan to inform enrollees who cease to be enrolled with the health plan that they may be eligible for reduced-cost coverage through the California Health Benefit Exchange (Covered California) or no-cost coverage through Medi-Cal. Section 1366.50 does not apply to Medi-Cal Managed Care products. Additionally, section 1366.50 requires health plans to provide Covered California with information regarding enrollees who cease to be covered by the health plan. That information includes enrollees' names, addresses, and other contact information.
2	DHCS	21-001	1/7/2021	2021-2022 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 2021-2022 Medi-Cal Eligibility Data System (MEDS/834) cutoff and processing schedule.
3	DHCS	21-002	2/25/2021	COST AVOIDANCE AND POST-PAYMENT RECOVERY FOR OTHER HEALTH COVERAGE	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide clarification and guidance to Medi-Cal managed care health plans (MCP) for cost avoidance and post-payment recovery requirements when an MCP member has other health coverage (OHC). In addition, the APL provides instructions on using the Department of Health Care Services' (DHCS) Medi-Cal Eligibility Record for processing claims, as well as reporting requirements.
4	DMHC	21-002	1/5/2021	IMPLEMENTATION OF SENATE BILL 855, MENTAL HEALTH AND SUBSTANCE USE DISORDER COVERAGE	GROUP CARE	This All Plan Letter (APL) provides guidance regarding implementation of this new legislation as well as filing and compliance requirements for all full service and certain specialized health care service plans (plan or plans).
5	DHCS	21-003	3/5/2021	MEDI-CAL NETWORK PROVIDER AND SUBCONTRACTOR TERMINATIONS	GROUP CARE	This All Plan Letter (APL) clarifies the obligations of Medi-Cal managed care health plans (MCPs) when terminating or initiating terminations of contractual relationships between MCPs, Network Providers, and Subcontractors. This APL also establishes MCPs' obligations to check exclusionary databases and terminate contracts with Network Providers and Subcontractors who have been suspended or excluded from participation in the Medi-Cal/Medicare programs.
6	DMHC	21-003	1/6/2021	TRANSFER OF ENROLLEES PER STATE PUBLIC HEALTH OFFICER ORDER	GROUP CARE	The State of California is experiencing a surge in COVID-19 positive cases and hospitalizations. This surge is causing many hospitals in the state to meet or exceed their usual capacity to serve patients, which can jeopardize the health and lives of the patients and staff. Accordingly, to provide care to all patients in need, it is imperative to maximize the capacity of hospitals in the state by allowing for expeditious transfer of patients from the most highly impacted hospitals to hospitals with more available capacity. This regional approach is central to an ethical and equitable response to the COVID-19 pandemic. Health plan prior authorization requirements for transfers between hospitals can cause unnecessary delays in effectuating such transfers.
7	DMHC	21-004	1/6/2021	TRANSFERS OF UNSTABLE OR DESTABILIZED ENROLLEES	GROUP CARE	This All Plan Letter reminds plans of their continuing obligations under Health and Safety Code section 1371.4 to cover emergency services and care provided to plan enrollees. Such coverage includes reimbursement for appropriate transfers of unstable enrollees between hospitals in conformance with the requirements of the federal Emergency Medical Treatment and Labor Act (EMTALA).
8	DHCS	21-005	4/15/2021	CALIFORNIA CHILDREN'S SERVICES WHOLD CHILD MODEL PROGRAM	MEDI-CAL	The purpose of this All Plan Letter is to provide direction and guidance to Medi-Cal managed care health plans (MCPs) participating in the California Children's Services (CCS) Whole Child Model (WCM) program. This APL conforms with CCS Numbered Letter (N.L.) 03-0421, which provides direction and guidance to county CCS programs on requirements pertaining to the WCM program. This APL supersedes APL 18-023.
9	DHCS	21-006	4/27/2021	NETWORK CERTIFICATION REQUIREMENTS	MEDI-CAL	This APL provides guidance to Medi-Cal managed care health plans (MCPs) on the Annual Network Certification (ANC) requirements pursuant to Title 42 of the Code of Federal Regulations (CFR) sections 438.68, 438.206, and 438.207, and Welfare and Institutions Code (WIC) section 14197.
10	DHCS	21-007	5/10/2021	THIRD PARTY TORT LIABILITY REPORTING REQUIREMENTS	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) on the updated process for submitting service and utilization information and copies of paid invoices/claims for covered services related to third party liability (TPL) torts to the Department of Health Care Services (DHCS).

APL/PL IMPLEMENTATION TRACKING LIST						
#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
11	DHCS	21-008	5/12/2021	TRIBAL FEDERALLY QUALIFIED HEALTH CENTER PROVIDERS	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding the implementation of the Tribal Federally Qualified Health Center (Tribal FQHC) provider type in Medi-Cal with an effective date of January 1, 2021. This APL also provides guidance regarding reimbursement requirements for Tribal FQHC provider types.
12	DMHC	21-010	3/4/2021	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).
13	DMHC	21-011	3/10/2021	NEW FEDERAL GUIDANCE REGARDING COVID-19 TESTING	MEDI-CAL & GROUP CARE	The federal Centers for Medicare & Medicaid Services (CMS) in conjunction with the Department of Labor and the Department of the Treasury, issued new guidance making it easier for enrollees to obtain diagnostic COVID-19 testing and clarifying when health plans must cover such testing for their enrollees.
14	DMHC	21-012	3/12/2021	COVID-19 VACCINE PRIORITIZATION FOR INDIVIDUALS WITH HIGH-RISK HEALTH CONDITIONS AND/OR DISABILITIES	MEDI-CAL & GROUP CARE	On February 12, 2021, the California Department of Public Health (CDPH) issued a Provider Bulletin regarding vaccine prioritization for individuals deemed to be at the very highest risk to get very sick from COVID-19 either because the individual has one or more enumerated severe health conditions and/or a developmental or other significant, high-risk disability. On March 11, 2021, the CDPH issued guidance to the public regarding how people at the very highest risk, as described in the Provider Bulletin, can gain access to COVID-19 vaccinations beginning March 15, 2021.
15	DMHC	21-013	4/1/2021	2021 ANNUAL ASSESSMENTS	MEDI-CAL & GROUP CARE	All Health Care Service Plans must file the Report of Enrollment Plan on or before May 15, 2021, as required by Health and Safety Code section 1356 and the California Code of Regulations, title 28, section 1300.84.6(a). The Report of Enrollment Plan is an online form to be filed electronically, via the Department's eFiling web portal.
16	DMHC	21-014	5/3/2021	COVID-19 VACCINATIONS FOR HOMEBOUND ENROLLEES; TRANSPORTATION ASSISTANCE TO OBTAIN COVID-19 VACCINES	GROUP CARE	This APL does not apply to Medi-Cal Managed Care Plans. The California Department of Health Care Services will be providing guidance to the managed care plans. This All Plan Letter applies to full-service commercial or Medicare Advantage health plans holding a restricted or limited license to the extent the plan is responsible for covering the administration of COVID-19 vaccinations for enrollees assigned to the plan.
17	DMHC	21-015	6/7/2021	BLOCK TRANSFER PORTAL UPDATES	MEDI-CAL	The Block Transfer team has updated the Block Transfer portal in an effort to streamline the Block Transfer filing submission process for Health Plans as well as the review process for the Department of Managed Health Care (Department).
18	DMHC	21-016	6/7/2021	CONTINUED COVERAGE OF COVID-19 DIAGNOSTIC TESTING	MEDI-CAL & GROUP CARE	On May 15, 2021, the DMHC's emergency regulation regarding COVID-19 testing expired. However, health plans must continue to cover certain COVID-19 testing for their enrollees pursuant to federal law.

ALAMEDA Alliance FOR HEALTH

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

Health Care Services

Steve O'Brien, MD

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

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

Date: **July 9, 2021**

Subject: **Health Care Services Report**

Utilization Management: Outpatient

- The new UM Medical Director, Dr. Rosalia Mendoza, is identifying opportunities to improve and standardize department processes, and she has begun to work with the team to improve processes.

- The team is working on a few areas to improve (policy clarifications, report development) that were identified during the DMHC/DHCS audit. Initial findings from the DHCS audit are expected to be received in July.

- Significant progress has been made in ongoing work on UM/Claims/Configuration collaboration and improved alignment. This standardization improves accuracy and timeliness of claims payment.

- Provider Portal prior authorization submissions: The UM team is receiving authorizations submitted online via the Provider Portal. The percentage of referrals being received via the Portal has increased to approximately 40%.

- UCSF PCP Pilot: the launching of our UCSF Primary Care pilot was effective 5/1/21. A maximum of 400 members may request transfer from Anthem Blue Cross to the Alliance for primary care services at UCSF, although less than 50 have currently enrolled. Members continue to receive all services at UCSF without a break in continuity. This pilot is being closely tracked to evaluate its outcomes.

- Stanford Oncology: our pilot with Stanford for Oncology services continues to be successful, with 73 members in the program as of the beginning of June. The partnership with Stanford gives AAH members access to clinical trials and full oncology care in the Stanford system.

Outpatient Authorization Denial Rates			
Denial Rate Type	**April 2021**	**May 2021**	**Jun 2021**
Overall Denial Rate	3.8%	3.6%	3.6%
Denial Rate Excluding Partial Denials	3.8%	3.5%	3.5%
Partial Denial Rate	0.0%	0.1%	0.1%
Turn Around Time Compliance			

Line of Business	April 2021	May 2021	June 2021
Overall	99%	99%	99%
Medi-Cal	99%	99%	99%
IHSS	100%	98%	100%
Benchmark	*95%*	*95%*	*95%*

Utilization Management: Inpatient

- COVID hospitalizations continue to remain quite low in acute hospitals and skilled nursing facilities, consistent with the community trends.

- DMHC/DHCS combined audit: The team is working on a few areas to improve (policy clarifications, report development) that were identified during the DMHC/DHCS audit. Initial findings from the DHCS audit are expected to be received in July and action plans will be developed about the findings.

- To assure effective communication and coordination of discharge efforts, weekly complex/long stay patient rounds continue with Sutter, AHS, Washington Hospital, Kindred and Kentfield hospitals, with a goal of removing barriers to discharge.

- Transitions of Care (TOC): The IP UM team is starting to take responsibility for post discharge care authorizations as part of the increased focus on discharge planning support to our hospitals.

- Partnerships in TOC continue with Alameda Health System (AHS). It is noted that the AHS Readmission rate for AAH members has been steadily decreasing since the launch of the TOC program with them.

- Partnership with denial management has launched with Alameda Health System to ensure accurate communication about denials, as well as appropriate and timely payment to our safety net partner.

Inpatient Med-Surg Utilization Total All Aid Categories **Actuals (excludes Maternity)**			
Metric	**March 2021**	**April 2021**	**May 2021**
Authorized LOS	4.4	4.6	4.4
Admits/1,000	48.2	48.4	48
Days/1,000	212.7	220.3	211.7

Pharmacy

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

Decisions	Number of PAs Processed
Approved	826
Denied	693
Closed	559
Total	**2078**

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

- Medications for diabetes, pain, acne, tear production, COPD and atopic dermatitis medications are top 10 drug categories for denials.

Rank	Drug Name	Common Use	Common Denial Reason
1	LIDOCAINE 5% PATCH	Pain	Criteria for approval not met
2	JANUVIA 50 MG TABLET	Diabetes	Criteria for approval not met
3	TRETINOIN 0.025% CREAM	Acne	Criteria for approval not met
4	JANUVIA 100 MG TABLET	Diabetes	Criteria for approval not met
5	JARDIANCE 10 MG TABLET	Diabetes	Criteria for approval not met
6	BUDESONIDE-FORMOTEROL 160-4.5	Chronic obstructive pulmonary disease (COPD)	Criteria for approval not met
7	PIMECROLIMUS 1% CREAM	Atopic dermatitis	Criteria for approval not met
8	JARDIANCE 25 MG TABLET	Diabetes	Criteria for approval not met
9	RESTASIS 0.05% EYE EMULSION	Tear production	Criteria for approval not met
10	JANUVIA 25 MG TABLET	Diabetes	Criteria for approval not met

- DHCS announced a further delay in MediCAL RX with no specific date for implementation.

- The State of California will take back drug coverage, rebate, utilization management and pharmacy provider network when they are ready. The plan pharmacy services are to maintain beneficiary care coordination, drug adherence, disease and medication management, physician administered drugs (PAD) and outpatient infusion drugs.

- Pharmacy services collaborates with other health care services teams for member on use of opioids and/or benzodiazepine.

- >300 morphine milligram equivalents (MME) users remain the same. There was an increase in utilization of 50 MME, 120 MME, decrease utilization in 90 MME, and 200 MME remains around the same. No drastic increase or decrease in any MME.

Q1 2021

MME	IHSS	MCAL	Total
January			**242**
50	5	132	137
90	1	30	31
120	3	23	26
200	1	29	30
300	1	6	7
400	0	11	11
February			**241**
50	2	135	137
90	5	24	29
120	0	26	26
200	0	32	32
300	1	4	5
400	0	12	12
March			**251**
50	5	138	143
90	1	26	27
120	1	33	34
200	0	31	31
300	1	4	5
400	0	11	11

- Pharmacy services, Quality, Health Education and Case Management work together to improve drug adherence in a program for 200 Black adults with asthma between 21 to 44 years of age under asthma medication possession rate 50% or below.

In the pilot, 6 of 12 members were able to be contacted and all 6 agreed to participate in the trial

- Pharmacy is leading initiatives on Outpatient Injectable medications with a focus on internal and external partnerships and biosimilar optimization. Between the months of July 2020-March 2021 the biosimilar utilization average has increased to 50%. Fiscal year savings $827k (7/20-3/21 Oncology ($462k), White Blood Cell Stimulator ($245k) and Immunology ($101k)

Case and Disease Management

- Population health-driven, disease-specific case management bundles continue development. CM Bundles are standard sets of actions developed to address the specific needs of members with significant diseases. Planning for Major Organ Transplant CM bundle has begun.

- The CM department continues its focused work on Oncology services in conjunction with Stanford and EpicCare, including using the CM Oncology bundle.

- Readmission reduction: CM is partnering with hospital partners at AHS and Sutter to focus on readmission reduction aligned with their readmission reduction goals. Standard work for Transitions of Care (TOC) has been developed to stabilize members after hospitalization to prevent re-admissions, currently at AHS and COVID discharges. The readmission rate at AHS has steadily declined since the initiation of the TOC program there.

- Clinical Initiatives: Health disparities have been identified in members with diabetes. A new UCSF/Project Open Hand research study provides 6 months of medically tailored meals to improve diabetes outcomes for interested and eligible members. The CM department is working on an initiative with Pharmacy on members with Asthma to improve adherence to Asthma medication recommendations.

- DMHC/DHCS combined audit: Initial findings from the DHCS audit are expected to be received in July and action plans will be developed based on the findings.

Health Homes Program (HHP) & Alameda County Care Connect (AC3)

- Enhanced Case Management (ECM): Planning continues with the AAH Project Management Office (PMO) to ensure a successful integration of HHP and AC3 into ECM. AAH CM and PMO are working closely with Alameda County HCS on the transition of AC3 members into ECM. Part One of the Model of Care and Transitions documents were submitted on June 30 and the team is working on the Part Two submission, due in September. MOC Part 2 will be developed along side our operationalization plan for the seven ILOS services selected to go live January 1, 2022

- In Lieu of Services (ILOS) are services not typically provided by managed health plans, to be provided in lieu of higher cost medical services. Working closely with the Project Office AAH/CM has finalized 7 services to be provided starting January 2022 (Phase 1). The ILOS selections are focused on services that will have the most impact on members to reduce unnecessary hospitalizations and ED visits.

Case Type	New Cases Opened in April 2021	Total Open Cases as of April 2021
Care Coordination	231	633
Complex Case Management	43	100
Transitions of Care	258	497

Grievances & Appeals

- Standard grievance resolution was 94.3%, which missed our goal of 95%. Standard grievance volumes have more than doubled in the last year and the high volume has stressed the current team and new positions have been authorized in the new budget. A plan to evaluate and address the volume is also underway.

- Total grievances resolved in June went over our goal of less than 1 complaint per 1,000 members at 6.13 complaints per 1,000 members.

- The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of June 2021; we met our goal at 18.5% overturn rate.

June 2021 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	1,014	30 Calendar Days	95% compliance within standard	957	94.3%	3.51
Expedited Grievance	1	72 Hours	95% compliance within standard	1	100.0%	0.003
Exempt Grievance	874	Next Business Day	95% compliance within standard	866	99.0%	3.02
Standard Appeal	53	30 Calendar Days	95% compliance within standard	53	100.0%	0.18
Expedited Appeal	1	72 Hours	95% compliance within standard	1	100.0%	0.003
Total Cases:	1,943		95% compliance within standard	1,878	97.6%	6.13

*Goal is to have less than 1 complaint (Grievance and Appeals) per 1,000 members (calculation: the sum of all unique grievances for the month divided by the sum of all enrollment for the month multiplied by 1000.)

Quality

- Substance Use Disorder Project
- In 2020 the Alliance partnered with our network providers and other local leaders to develop a Substance Use Disorder Program.
- 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 reports on 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 developed member facing education tools on the use of alternative methods to manage pain without opioid medication.

Alameda Alliance for Health

Manage Your Pain Without Opioids

Prescription Opioids – Pain Relievers

At Alameda Alliance for Health (Alliance), we are here to help you take charge of your health. You can use this guide to learn other ways to treat and manage your pain without opioids. Work with your doctor to find out which treatment is best for you.

Below are some options that may work better and have fewer risks and side effects.

Other Medicines

These can include:

- Pain relievers such as acetaminophen (Tylenol), ibuprofen (Advil, Motrin), or naproxen.
- Some anti-depressants and anti-seizures, which can also be used for nerve pain.

Talk Therapy

Seeing a therapist may help lower stress and anxiety that trigger pain. Talk therapy teaches techniques to change the way you think and behave.

Exercise

Exercise can make your body stronger and feel better.

The Alliance offers:

- Physical therapy.
- Occupational therapy.
- Water (aquatics) therapy.

Acupuncture

Acupuncture is a treatment where very thin needles are placed on certain points of your body. This may help with many types of pain.

Chiropractic Therapy

Chiropractors adjust the spine or other parts of the body. This may help with back and neck pain.

Nerve Stimulation

This device sends a mild electric current through nerves to block pain signals. One common device is called Transcutaneous Electrical Nerve Stimulation (TENS).

For help finding these services, please ask your doctor or call the Alliance Member Services Department at **1.510.747.4567**.

Questions? Please call Alliance Health Programs
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4577** • Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**
www.alamedaalliance.org

ALAMEDA Alliance FOR HEALTH

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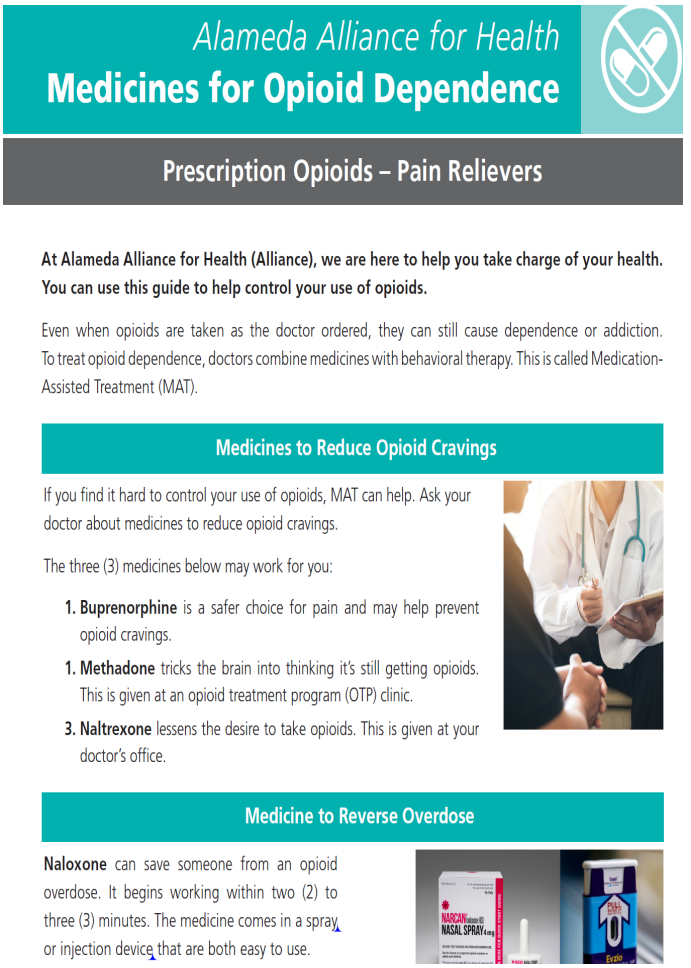


Alameda Alliance for Health

Medicines for Opioid Dependence

Prescription Opioids – Pain Relievers

At Alameda Alliance for Health (Alliance), we are here to help you take charge of your health. You can use this guide to help control your use of opioids.

Even when opioids are taken as the doctor ordered, they can still cause dependence or addiction. To treat opioid dependence, doctors combine medicines with behavioral therapy. This is called Medication-Assisted Treatment (MAT).

Medicines to Reduce Opioid Cravings

If you find it hard to control your use of opioids, MAT can help. Ask your doctor about medicines to reduce opioid cravings.

The three (3) medicines below may work for you:

1. **Buprenorphine** is a safer choice for pain and may help prevent opioid cravings.
1. **Methadone** tricks the brain into thinking it's still getting opioids. This is given at an opioid treatment program (OTP) clinic.
3. **Naltrexone** lessens the desire to take opioids. This is given at your doctor's office.

Medicine to Reverse Overdose

Naloxone can save someone from an opioid overdose. It begins working within two (2) to three (3) minutes. The medicine comes in a spray or injection device that are both easy to use.

- In Q4 2020, the Alliance identified members considered to be chronic or potentially chronic opioid users. Chronic users are defined as members with prescriptions of greater than 300 MME consecutively for a three (3) month period and potentially chronic opioid users are defined as members with prescriptions between 50 to 89 MME consecutively for a three (3) month period. The Alliance will address members using 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 related issues.

- In 2021, the Alliance plans to send Opioid educational mailings to both members and providers. Our mailing campaign may include:
    - 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.
    - Provider Opioid and Benzodiazepine Tapering Tools.
    - Opioid Safety guide for members and caregivers.
    - Non-opioid formulary alternatives.
    - Treatment for opioid dependence.
    - Local alternative health services contracted with the Alliance (e.g. physical therapy, acupuncture, chiropractor, massage).

ALAMEDA Alliance FOR HEALTH

June 21, 2021

Dear Valued Provider,

At Alameda Alliance for Health (Alliance), we appreciate you and the quality health care that you provide to our members. As you know, the Alliance is a local, public, not-for-profit managed care health plan committed to making high-quality health care services accessible and affordable to Alameda County residents.

In an effort to support our provider's focus on substance use disorder, chronic pain, and opioid and benzodiazepine usage, the Alliance has developed several provider materials for usage:

Provider Tools

- Opioid Tapering Tool
- Benzodiazepine Tapering Tool
- Non-Opioid Alternatives on the Alliance Formulary
- Opioid Dependence Treatment
- Maps of local alternative treating options

Member Tools

- Opioid Safety Guide

On a quarterly basis, we will mail a list of your patients who:

- Visit the Emergency Department for opioid and/or benzodiazepine overdose
- Concurrently utilize opioids and benzodiazepines
- Are defined as chronic opioid users
- Are defined as rising risk for substance use disorder (SUD)

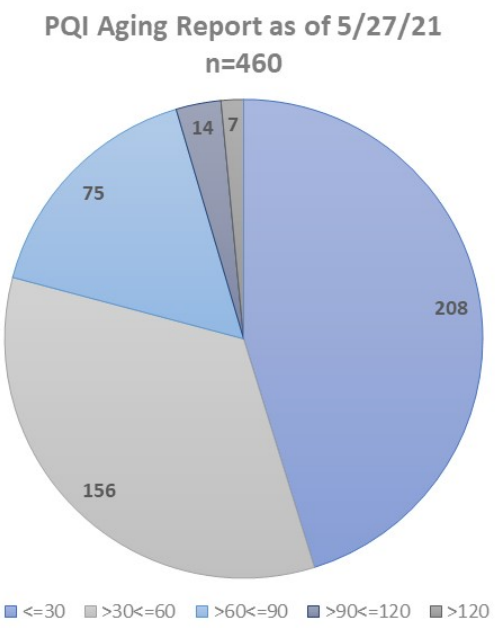
The following provider tools have also been included with this letter:

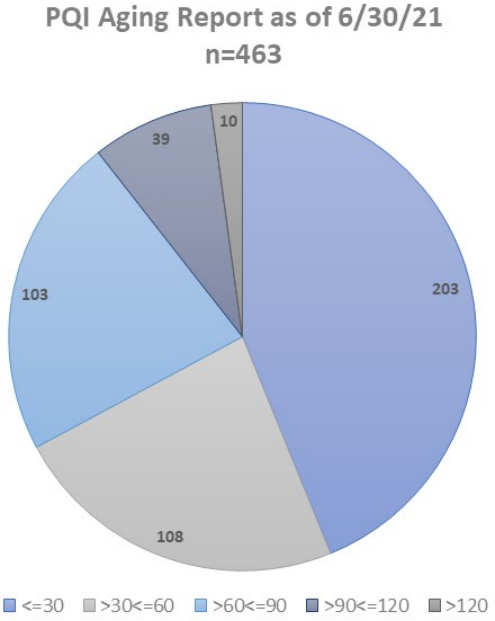
- Opioid Tapering Tool
- Benzodiazepine Tapering Tool

If you have any questions, or if you would like to request a copy of the other tools, please contact us using the information below.

As always, thank you for your continued partnership and for providing high-quality care to our members and community. Together, we are creating a healthier community for all.

- Potential Quality Issues (PQI) Aging Report
    - A PQI is defined as a suspected deviation from expected provider performance, clinical care or outcome of care that requires further investigation to determine whether an actual quality issue exists. Current PQI TAT is 120 days, which is calculated from the date of receipt to resolution by the QI team. TAT exceeding 120 days (slight increase from 7 to 10 from May to June 2021) are frequently related to timeliness of receipt of medical records from care or service providers.





ALAMEDA Alliance FOR HEALTH

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

Information Technology

Sasikumar Karaiyan

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

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

Date: **July 9, 2021**

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.

- Overall, we are continuing to perform activities to optimize the call center eco-system (applications, backend integration, configuration, and network).

    - The Call Center Application Environment upgrade:
        - Calabrio, Cisco Call Manager and Cisco Unity has been upgraded successfully.
        - 2 Ring and Cisco Unified Contact Center has been upgraded successfully.
    - Anticipating project phase closure by July 2021.

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. As part of this implementation, the Alliance shall enable and offer the following newly updated capabilities:

- **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 365 Business Voice can completely replace your business' existing phone system or internally integrate with our existing Cisco Voice Over Internet Protocol (VOIP).

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. This initiative is planned to start in August 2021 and complete before the end of Decembers 2021.

Multi-Factor Authentication (MFA) Rollout (Security)

- The Alliance has embarked on the Multi-Factor Authentication (MFA) rollout which is designed to increase security for Virtual Protocol Network (VPN) access to our network.

- Multi-Factor Authentication (MFA) is part of a comprehensive strategy to enhance security with more robust authentication methods to access the Alliance assets, data, and information. The Alliance migrated 35% of our staff to use Multi-Factor Authentication (MFA) and the remaining shall be completed before end of August 2021.

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

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

- The Alliance is in full motion on this Secure File Transfer Protocol (SFTP) Server Upgrade which is designed to expand its capabilities and provide redundancy for improved availability. In the month of June 2021, 8 Trading Partners have been migrated to the new Secure File Transfer Protocol (SFTP) Environment.

Encounter Data

- In the month of June 2021, the Alliance submitted 106 encounter files to the Department of Health Care Services (DHCS) with a total of 289,073 encounters.

- In June 2021, we completed our historic encounter data submission efforts by submitting 19K encounters to the Department of Healthcare Services (DHCS). Because of this effort, our lag time Key Performance Index (KPI) for the Institutional Encounters have been impacted and missed the established target. In July 2021, we will be back on track to meet our metric/KPI targets.

Enrollment

- The Medi-Cal Enrollment file for the month of June 2021 was received and processed on time.

- The Alliance redesigned the Primary Care Physician (PCP) auto assignment algorithm of member based on predetermined criteria such as distance, pay-for-performance, language, ethnicity, and provider availability.

HealthSuite

- A total of 154,662 claims were processed in the month of June 2021 out of which 112,326 claims auto adjudicated. This sets the auto-adjudication rate for this period to 72.6%.

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

TruCare

- A total of 9,486 authorizations were loaded and processed in the TruCare application.

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

Consumer and the Alliance Public Portal

- The provider and member consumer portal utilization for the month of May 2021 remains consistent with prior months.

- In the month of June 2021, the Alliance implemented a newer technology to translate and support our three threshold languages in our member portal – Chinese, Spanish and Vietnamese.

- As a part of the customer channel optimization, the Alliance is enhancing the Member and Provider portal to support new features and capabilities. The new features and capabilities include, Secure Communications, and Mobile Application on smartphones and Threshold Languages. The Mobile version of the member portal is estimated to go-live during August 2021.

Information Security

- 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 65.4k.

- Attempted information leaks detected and blocked at the firewall are lower from 20 to 18 for the month of **June 2021.**

- Network scans returned a value of 0, which is in line with previous month's data.

- Attempted User Privilege Gain is lower at 1 from a previous six-month average of 298.

Data Warehouse

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

- In the month of June 2021, the Alliance completed work on integrating Credentialing data into the Data Warehouse. The Authorization and Case Management are the remaining data domains to be added to the Data Warehouse which is expected to be completed before end of December 2021.

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 “Summary of Medical and Group Care member enrollment in the month of June 2021”.
- Summary of Primary Care Physician (PCP) Auto-assignment in the month of June 2021.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of June 2021”.
- The following tables 1-1 and 1-2 are supporting documents from the enrollment summary section.
- Table 1-1 Summary of Medical and Group Care Member enrollment in the month of June 2021”.

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
June	282,569	3,981	2,309	5,948	129	130

1. MC – Medical Member

2. GC – Group Care Member

Table 1-2 Summary of Primary Care Physician (PCP) Auto-Assignment
For the Month of June 2021

Auto-Assignments	Member Count
Auto-assignments MC	1,595
Auto-assignments Expansion	1,626
Auto-assignments GC	46
PCP Changes (PCP Change Tool) Total	2,454

TruCare

- See Table 2-1 “Summary of TruCare Authorizations for the month of June 2021”.
- There were 9,486 authorizations (total authorizations loaded in TruCare production) processed through the system.
- 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 2021

Transaction Type	Inbound EDI Auths	Failed PP-Already In TC	Failed PP-MNF	Failed PP-PNF	Failed PP-Procedure Code	Failed PP-Diagnosis Code	Misc	Total EDI Failure	New Auths Entered	Total Auths Loaded In TruCare
EDI-CHCN	5,297	147	0	18	4	43	43	255	0	5,042
Paper to EDI	1,258	0	0	0	0	0	0	0	0	1,258
Provider Portal	1,922	0	0	0	0	0	0	0	0	1,922
Manual Entry	0	0	0	0	0	0	0	0	1,264	1,264
Total										9,486

Key: PP=Pre-Processor; MNF=Member Not Found; PNF=Provider Not Found; TC=TruCare

Web Portal

- 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 2021

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	5,967	3,214	149,530	354
MCAL	72,603	2,048	5,600	740
IHSS	2,803	65	180	21
AAH Staff	175	46	769	3
Total	**81,548**	**5,373**	**156,079**	**1,118**

Table 3-2 Top Pages Viewed for the Month of May 2021

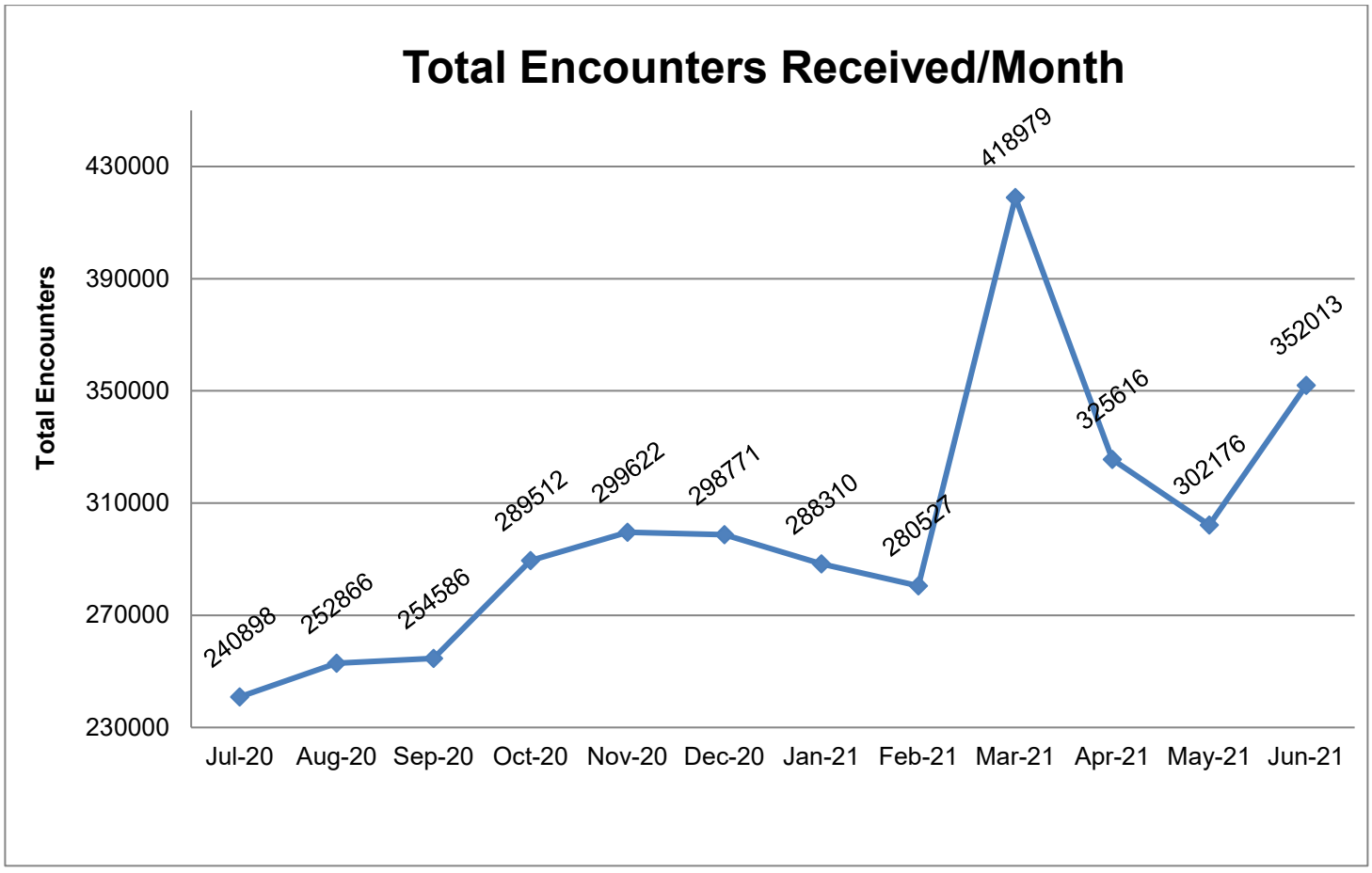
Top 25 Pages Viewed		
Category	**Page Name**	**May - 21**
Provider	Member Eligibility	625,045
Provider	Claim Status	161,150
Provider	Auth Search	7,963
Member My Care	Member Eligibility	2,608
Member Help Resources	Find a Doctor or Hospital	1,273
Member Help Resources	ID Card	1,228
Provider	Member Roster	1,023
Member Help Resources	Select or Change Your PCP	716
Member Home	GC ID Card	635
Provider	Provider Directory	597
Member My Care	My Claims Services	557
Member Help Resources	Request Kaiser as my Provider	537
Provider	Pharmacy	451
Provider - Home	Forms	398
Member My Care	Authorization	293
Member My Care	My Pharmacy Medication Benefits	283
Provider	Instruction Guide	225
Provider	Manual	152
Member Help Resources	Forms Resources	148
Member My Care	Member Benefits Materials	136
Member Help Resources	FAQs	134
Member Help Resources	Authorizations Referrals	131
Member My Care	My Pharmacy	126
Member Help Resources	Contact Us	95
Member My Care	Protected Health Information	76

Encounter Data From Trading Partners 2021

- AHS:
  June daily files (10,138 records) were received on time.
- Beacon:
  June monthly files (17,079 records) were received on time.
- CHCN:
  June weekly files (82,211 records) were received on time.
- CHME:
  June monthly file (4,700 records) were received on time.
- CFMG:
  June weekly files (8,129 records) were received on time.
- Docustream:
  June weekly files (1,218 records) were received on time.
- PerformRx:
  June monthly files (156,455 records) were received on time.
- Kaiser:
  June monthly files (60,081 records) were received on time.
  June monthly Kaiser Pharmacy files (21,176 records) were received on time.
- LogistiCare:
  June weekly files (15,473 records) were received on time.
- March Vision:
  June monthly file (3,306 records) were received on time.
- Quest Diagnostics:
  June weekly files (12,979 records) were received on time.
- Teladoc:
  June weekly files (12 records) were received on time.

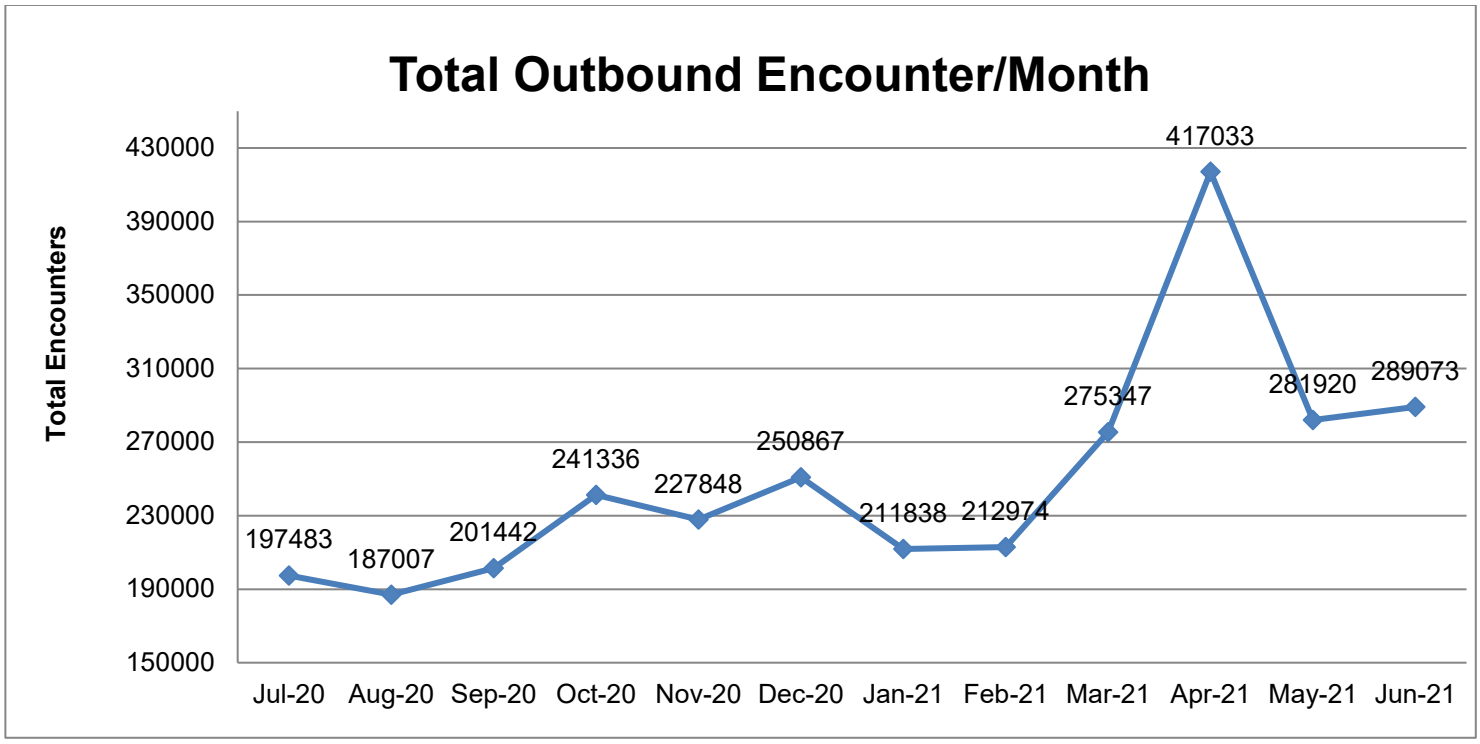
Trading Partner Encounter Inbound Submission History

Trading Partners	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
HealthSuite	107093	104293	111255	120149	111676	123248	116784	119001	143171	140678	129847	136687
AHS	10154	9353	849	12762	16814	8419	9404	9702	9326	11166	9074	10138
Beacon	11413	10193	20434	14637	12673	21326	15812	14616	13002	19247	14951	17079
CHCN	53049	64935	54812	65094	85984	66473	59612	62867	89453	69080	66260	82211
CHME	4344	4987	3832	5814	5152	4388	6143	6548	5776	5497	4885	4700
Claimsnet	6545	6608	8787	11018	6504	12819	7693	12059	10905	8835	10834	8129
Docustream	912	919	640	926	865	909	803	1160	935	1166	1445	1218
Kaiser	22508	26057	25829	29431	35590	29885	43639	25903	112545	39632	30039	60081
Logisticare	12865	10145	14821	11599	12665	15505	12603	14208	16924	12945	14399	15473
March Vision	1839	2568	2270	3012	2928	2361	3103	1917	2230	3156	3708	3306
Quest	10135	12783	11005	15047	8724	13406	12665	12515	14699	14203	16718	12979
Teladoc	41	25	52	23	47	32	49	31	13	11	16	12
Total	240898	252866	254586	289512	299622	298771	288310	280527	418979	325616	302176	352013



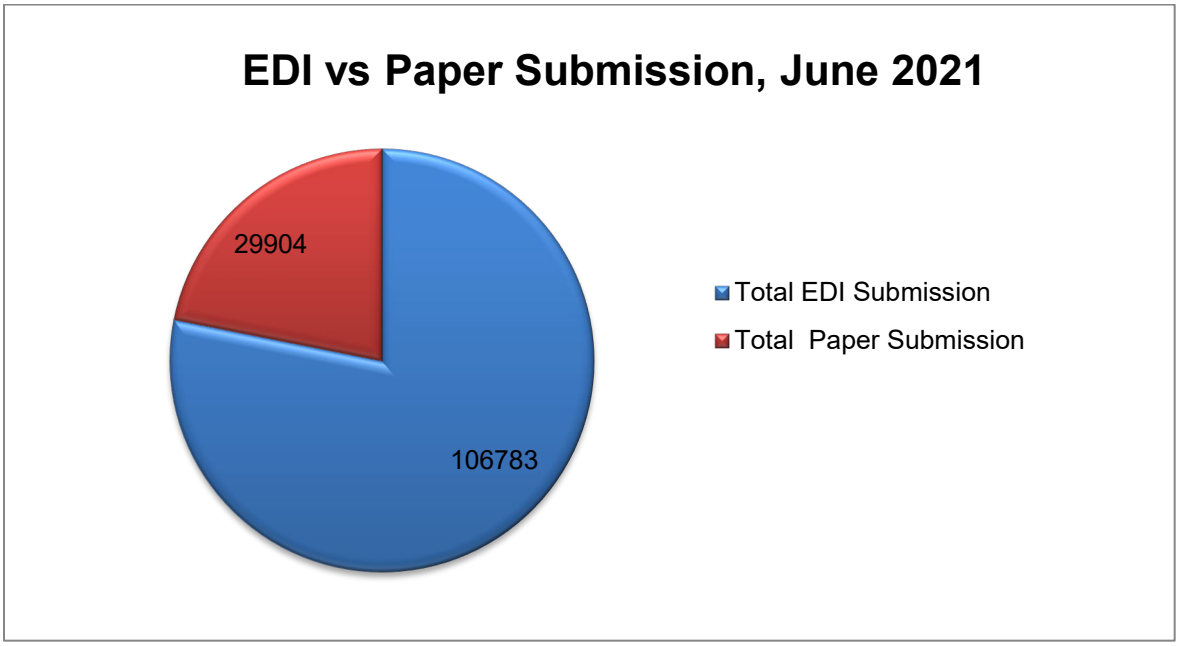
Outbound Encounter Submission

Trading Partners	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
HealthSuite	76561	73815	71394	97258	79162	100653	70368	81305	84220	216640	130885	128980
AHS	10662	8083	353	11922	15980	7909	8729	9089	8655	8812	10762	9912
Beacon	9507	7620	17466	13291	10580	16229	13315	11631	10171	14881	12347	11746
CHCN	43686	38537	52622	48065	50051	54860	41461	45137	64275	49446	48573	58519
CHME	4081	4663	3632	5232	4801	3696	5327	5508	5283	5136	4767	4586
Claimsnet	4792	6110	6611	7398	5707	8595	5160	8578	7964	6489	8110	5993
Docustream	799	812	609	849	969	807	764	1071	860	1070	1286	1016
Kaiser	21968	25720	25666	29031	35096	29087	42638	23810	59157	89295	29570	38443
Logisticare	14934	9924	11134	14600	12263	14773	12315	13881	16652	9705	17299	15178
March Vision	1121	1909	1687	2665	2470	2013	2655	1686	1930	2455	2850	2624
Quest	9331	9789	10236	11002	10743	12214	9085	11247	16169	13093	15455	12066
Teladoc	41	25	32	23	26	31	21	31	11	11	16	10
Total	197483	187007	201442	241336	227848	250867	211838	212974	275347	417033	281920	289073



HealthSuite Paper vs EDI Breakdown

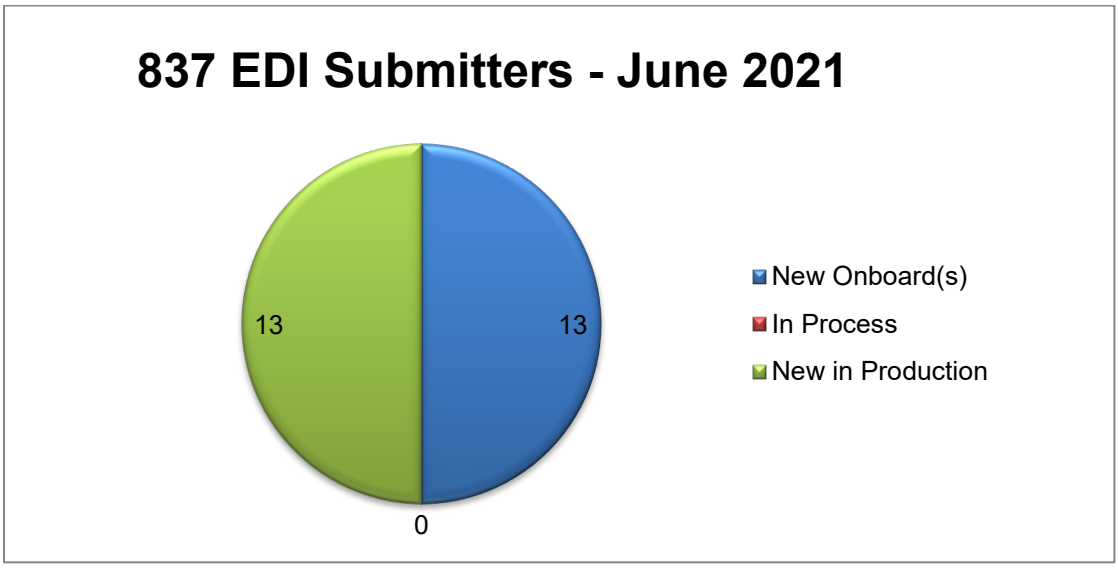
Period	Total EDI Submission	Total Paper Submission	Total Claims
21-Jun	106783	29904	136687

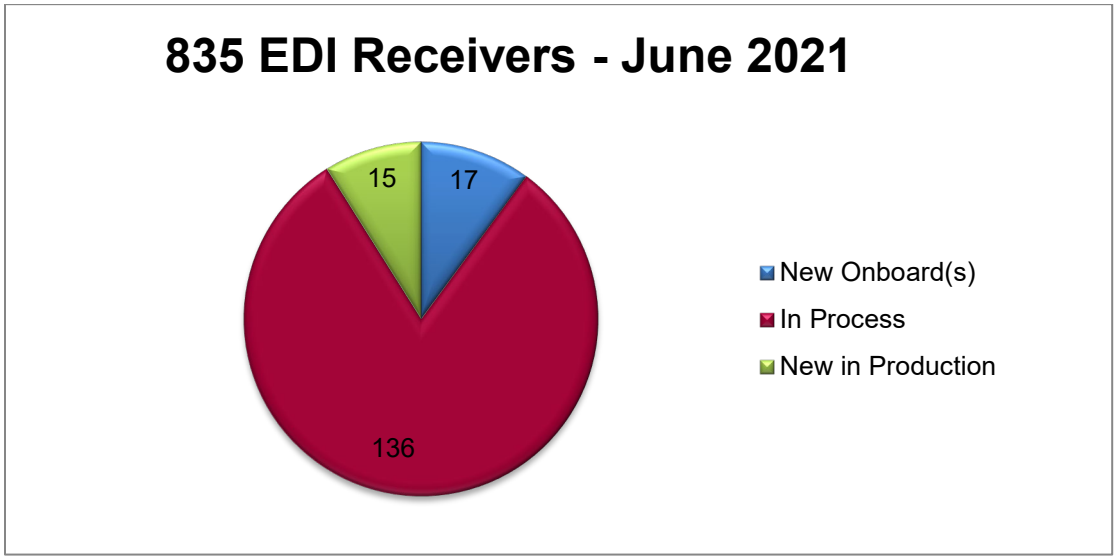


Onboarding EDI Providers - Updates

- June 2021 EDI Claims:
  - A total of 1143 new EDI submitters have been added since October 2015, with 13 added in June 2021.
  - The total number of EDI submitters is 1875 providers.
- June 2021 EDI Remittances (ERA):
  - A total of 305 new ERA receivers have been added since October 2015, with 15 added in June 2021.
  - The total number of ERA receivers is 344 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-20	11	0	11	1691	1	82	1	228
Aug-20	12	0	12	1703	0	82	0	228
Sep-20	8	0	8	1711	1	82	1	229
Oct-20	23	0	23	1734	7	86	3	232
Nov-20	15	0	15	1749	7	91	2	234
Dec-20	21	0	21	1770	42	91	42	276
Jan-21	15	0	15	1785	19	92	18	294
Feb-21	22	0	22	1807	14	101	5	299
Mar-21	20	2	18	1825	23	117	7	306
Apr-21	5	0	5	1830	20	126	11	317
May-21	32	0	32	1862	20	134	12	329
Jun-21	13	0	13	1875	17	136	15	344


837 EDI Submitters - June 2021
13
13
0
New Onboard(s)
In Process
New in Production


835 EDI Receivers - June 2021
15
17
136
New Onboard(s)
In Process
New in Production

EDSRF/Reconciliations

- EDSRF Submission: Below is the total number of encounter files that AAH submitted in the month of June 2021.

File Type	Jun-21
837 I Files	26
837 P Files	80
NCPDP	9
Total Files	115

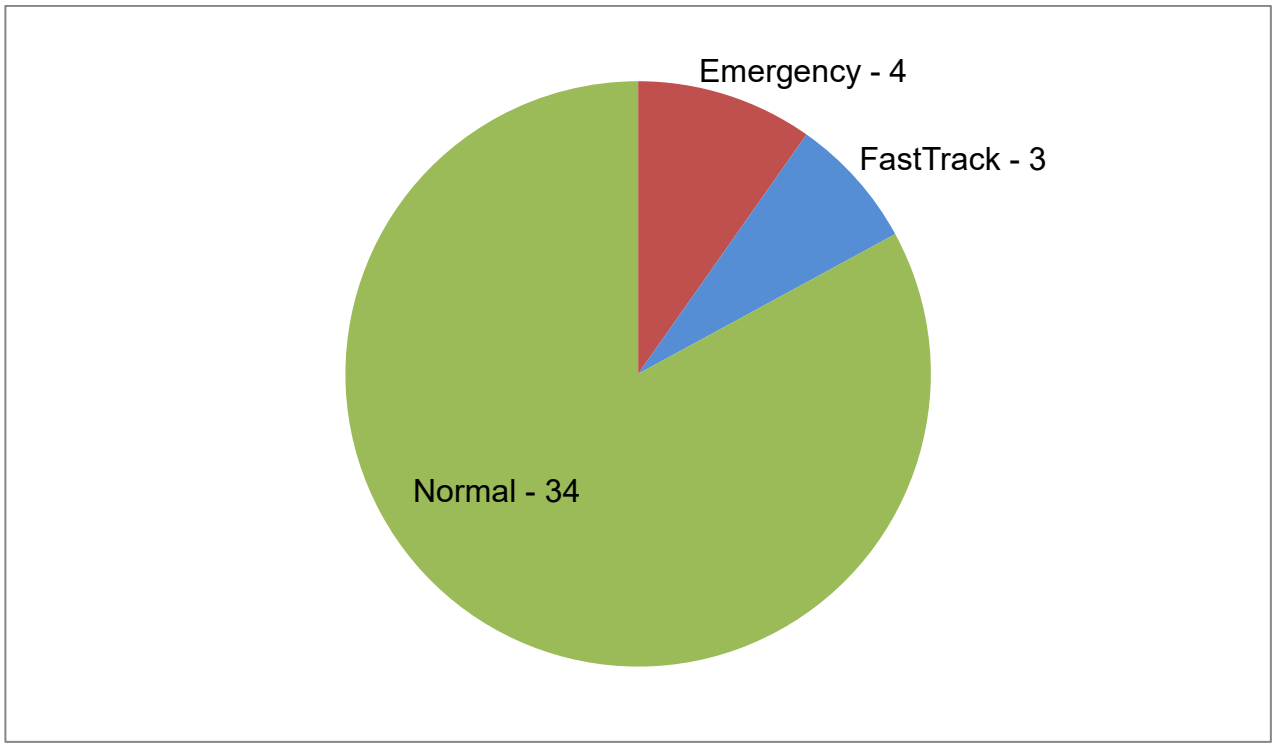
Lag-time Metrics/KPI's

AAH Encounters: Outbound 837	Jun-21	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	67%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	70%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	84%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	88%	80%

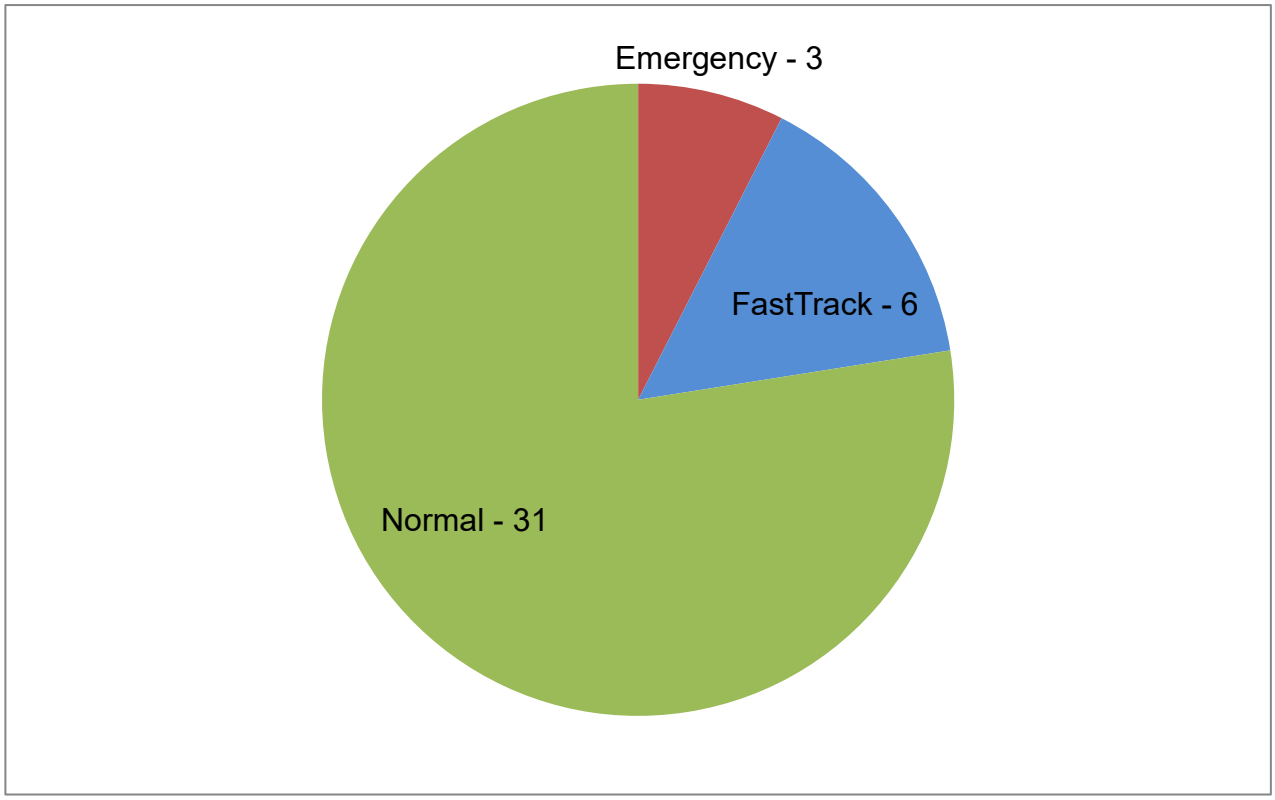
Change Management Key Performance Indicator (KPI)

- Change Request Submitted by Type in the month of June 2021 KPI – Overall Summary.
    - 2,238 Changes Submitted.
    - 2,097 Changes, Completed, and Closed.
    - 138 Active Changes.
    - 240 Changes Cancelled and Rejected.

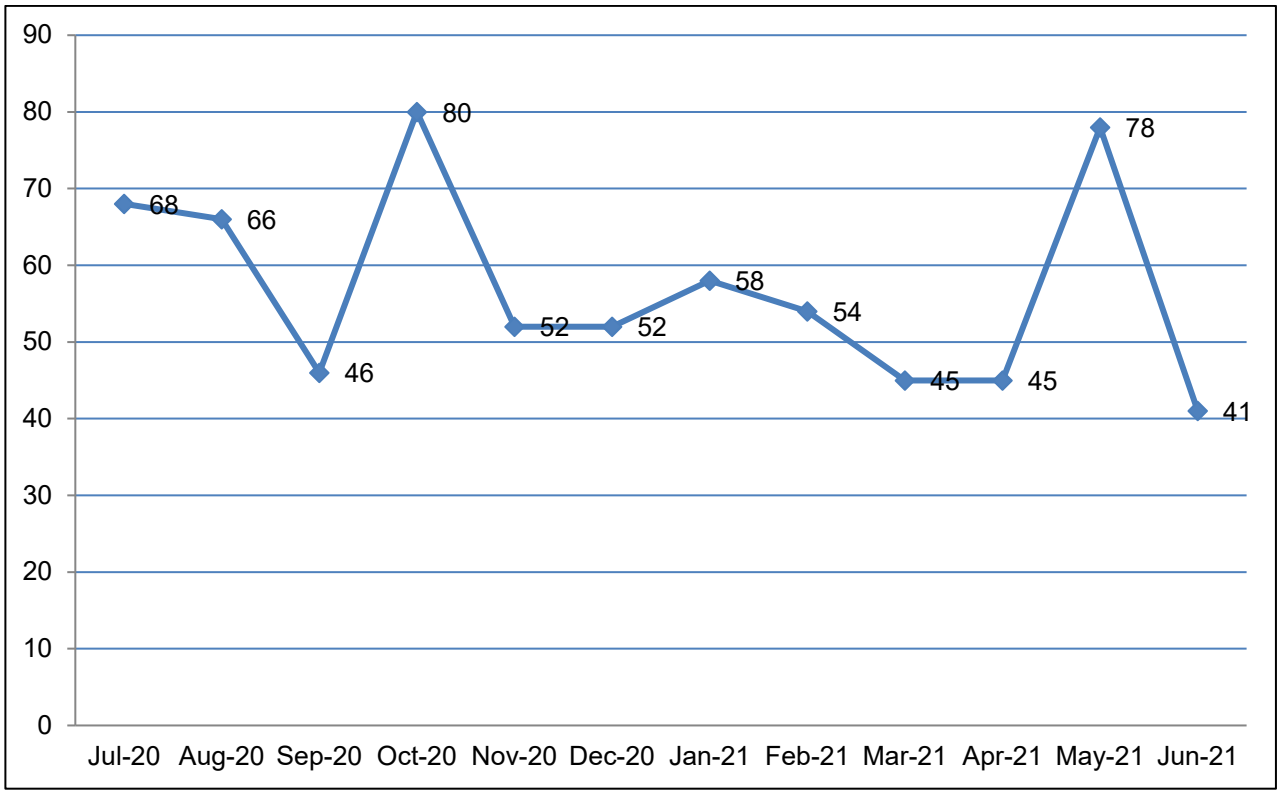
- 41 Change Requests Submitted/Logged in the month of June 2021



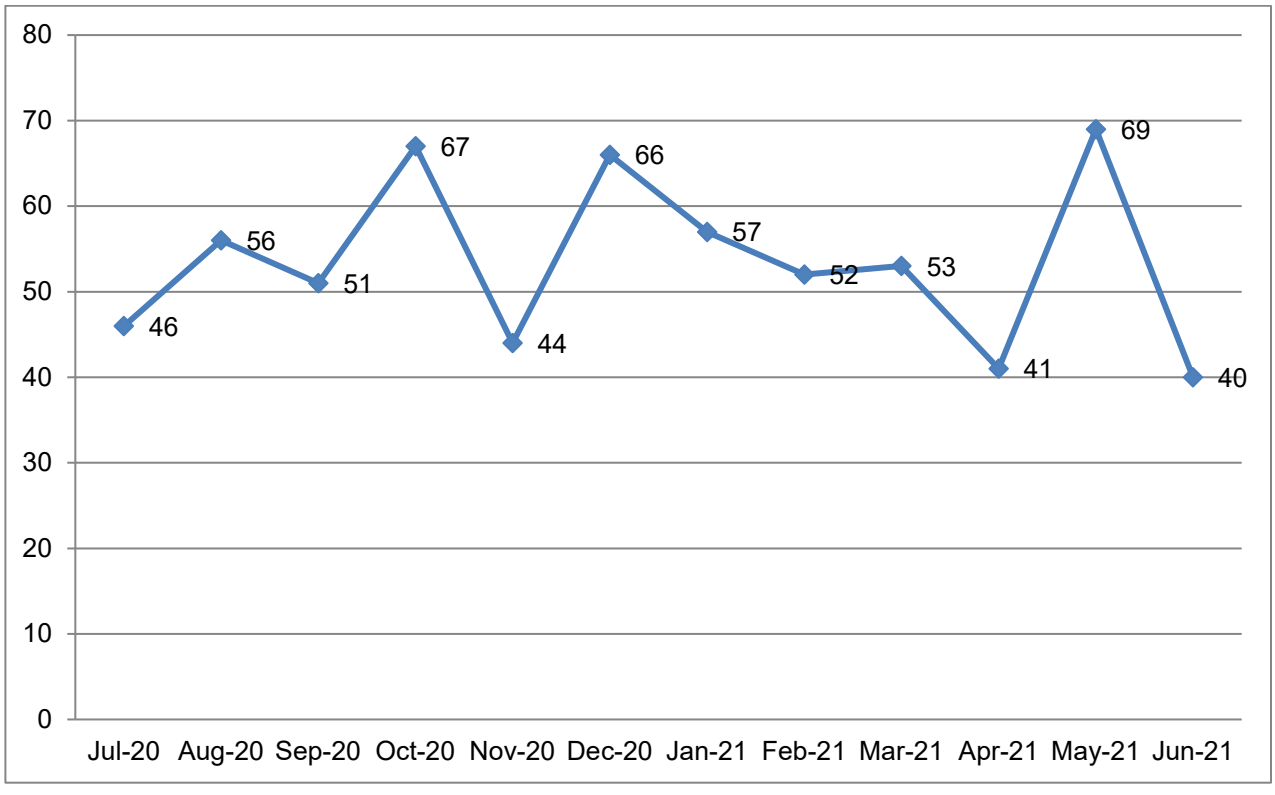
- 40 Change Requests Closed in the month of June 2021



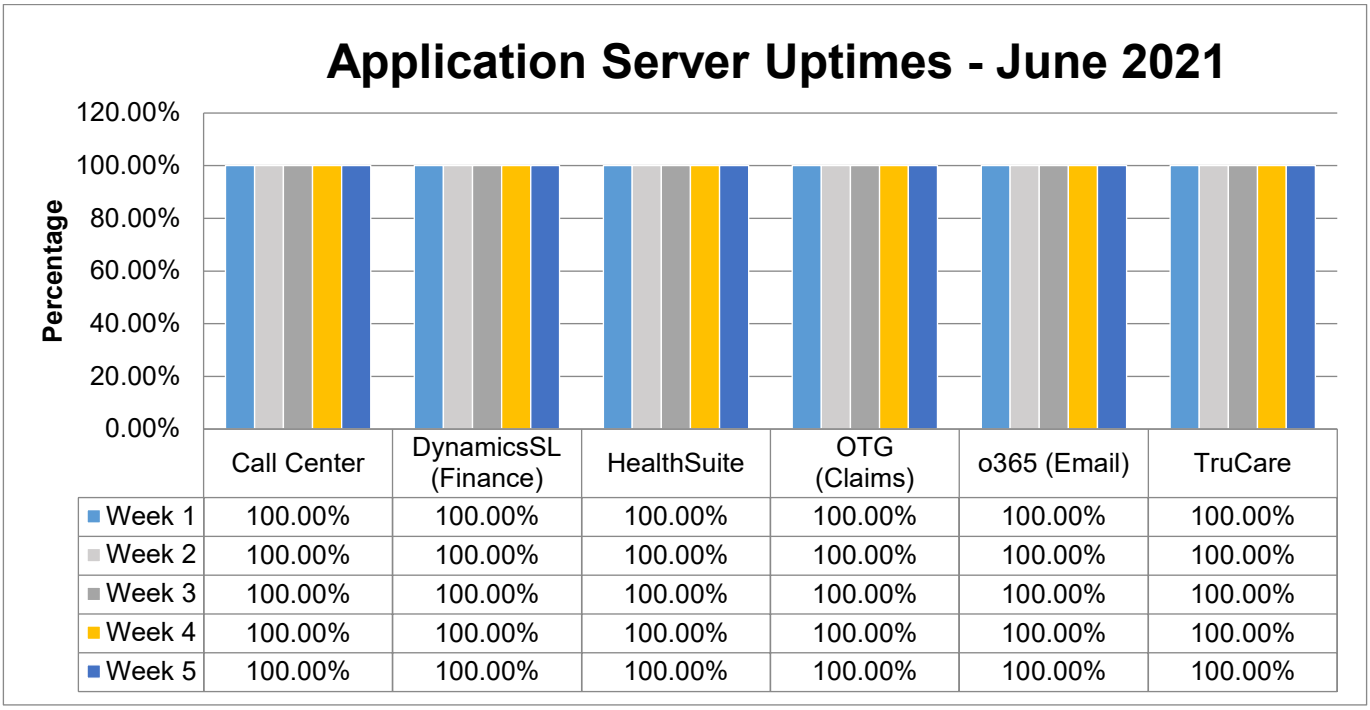
- Change Requests Submitted: Monthly Trend



- Change Requests Closed: Monthly Trend

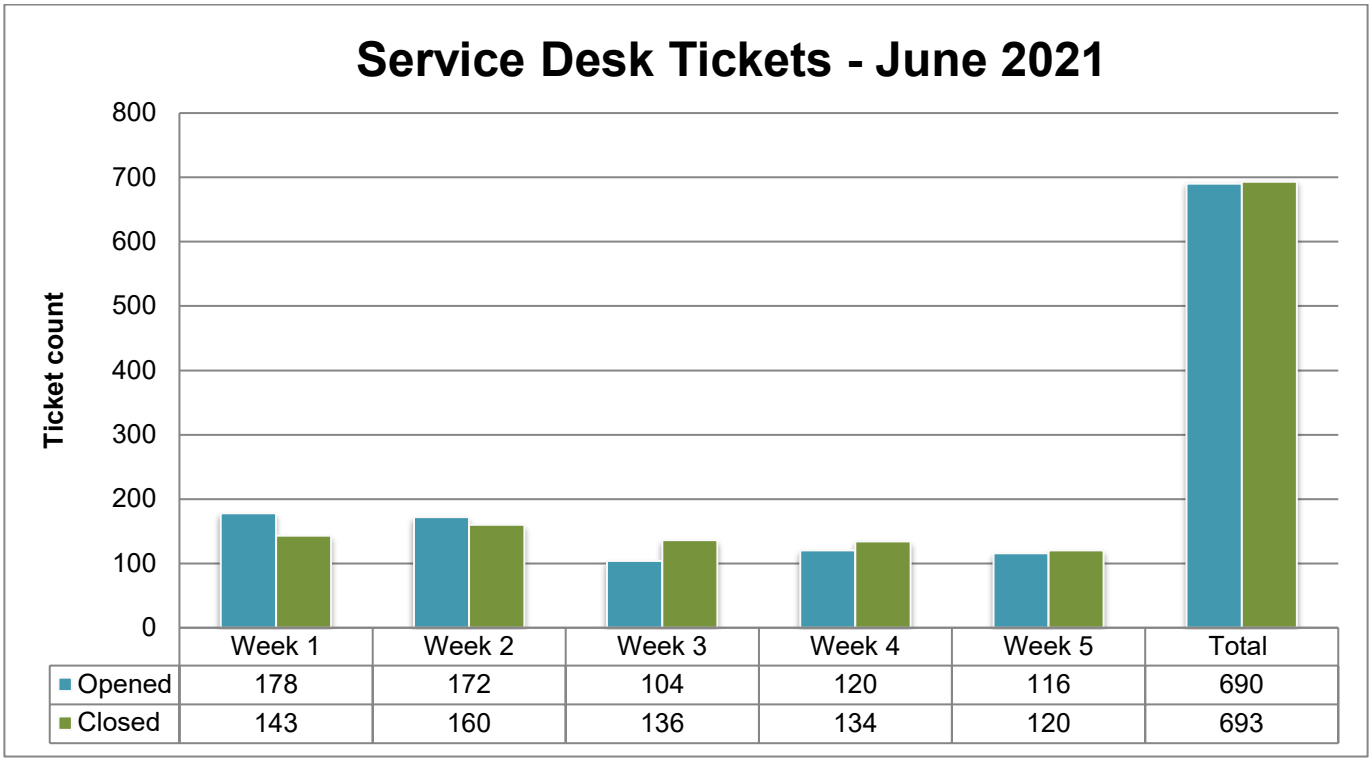


IT Stats: Infrastructure



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

- All mission critical applications are monitored and managed thoroughly.
- There were no outages experienced in the month of June 2021 despite supporting 97% of staff working remotely.

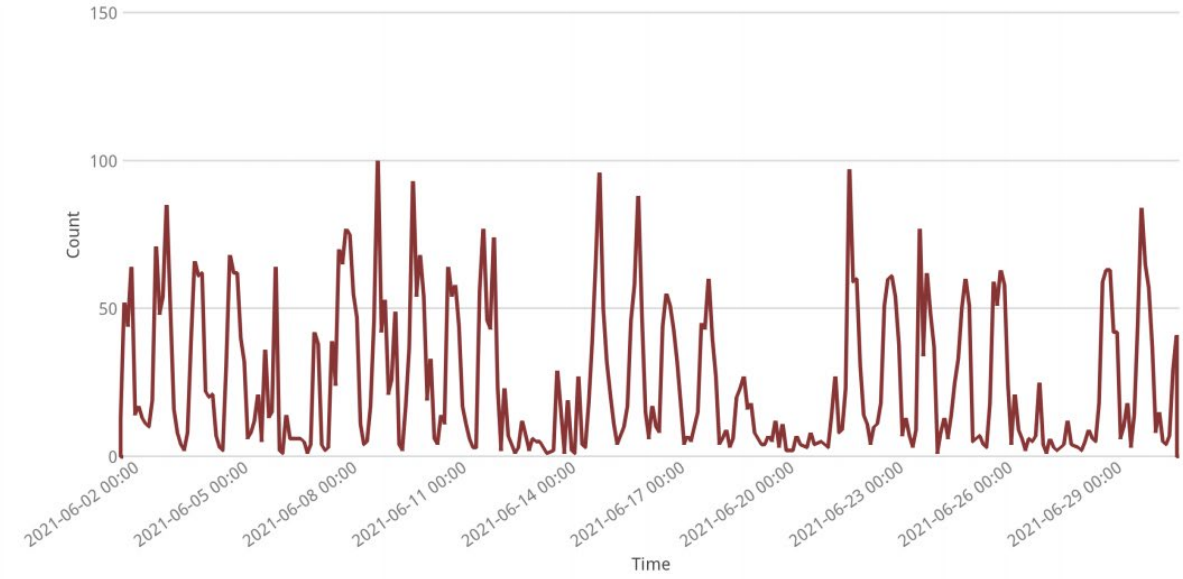


	Week 1	Week 2	Week 3	Week 4	Week 5	Total
Opened	178	172	104	120	116	690
Closed	143	160	136	134	120	693

- 690 Service Desk tickets were opened in the month of June 2021, which is 38% lower than the previous month and 693 Service Desk tickets were closed, which is 31.7% lower than the previous month.
    - The ticket count for the month of June 2021 is lower than the 3-month average of 1223.
    - This decrease is a result of the near completion of the Computer Standardization Project, low IT Service Desk staffing, and the slow summer months.

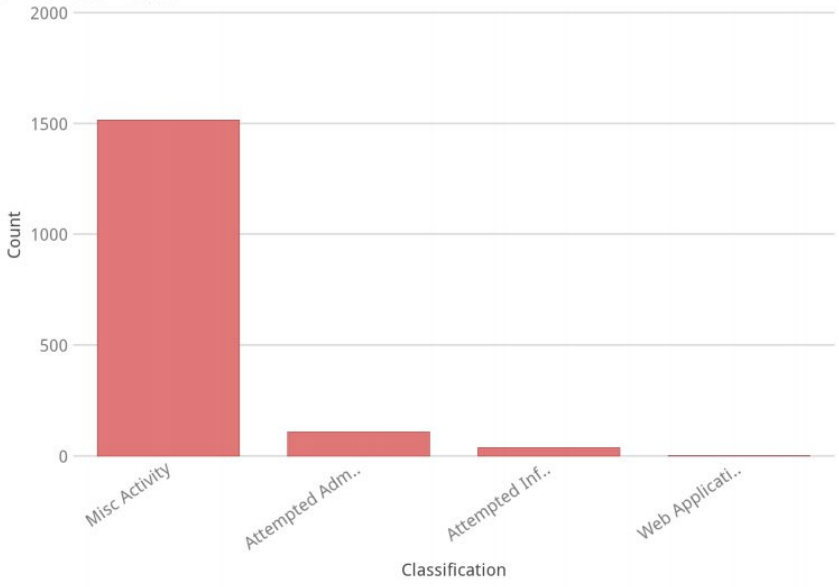
All Intrusion Events

Time Window: *2021-06-01 09:29:00 - 2021-06-30 09:29:00*



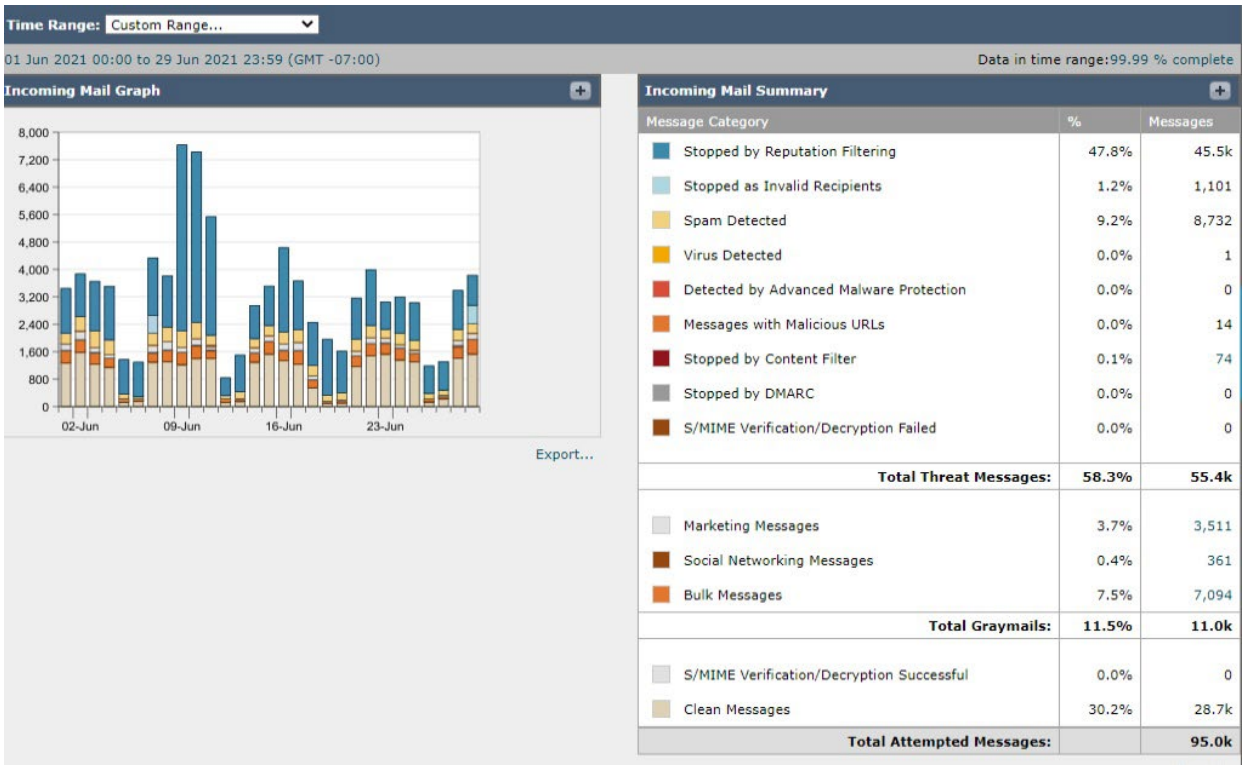
Dropped Intrusion Events

Time Window: *2021-06-01 09:30:00 - 2021-06-30 09:30:00*
Constraints: *Inline Result = dropped*



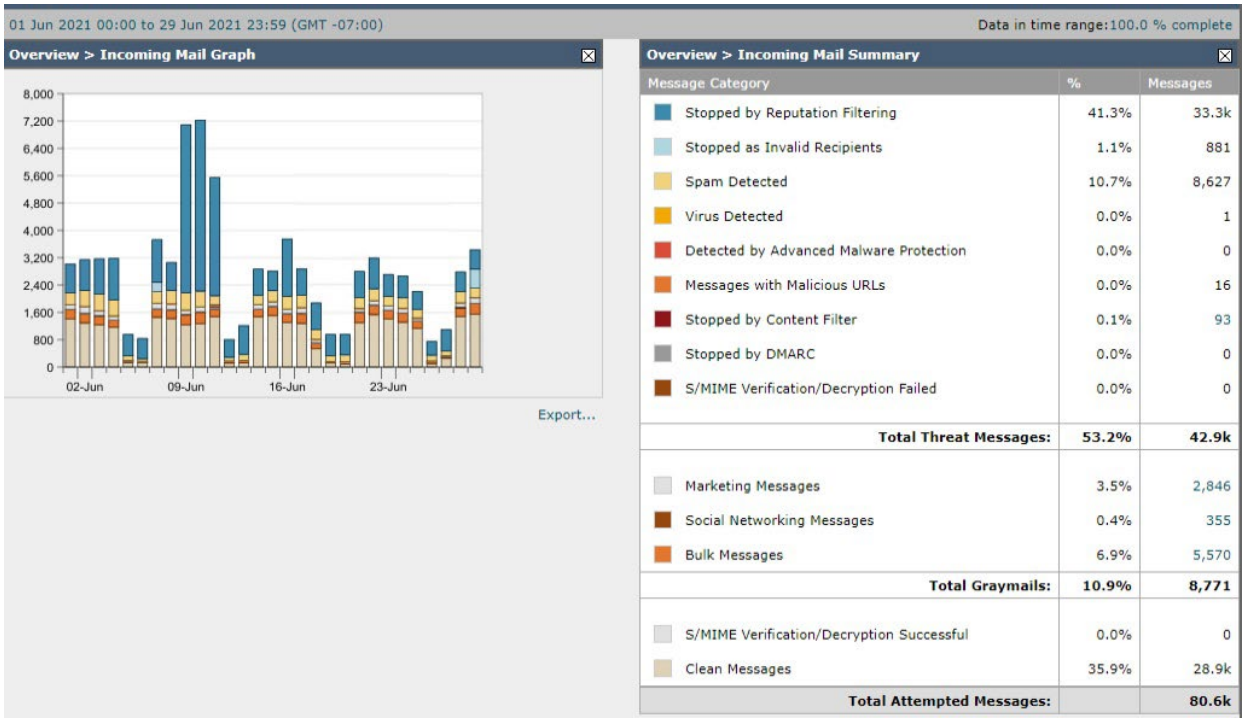
Classification	Count
Misc Activity	1,516
Attempted Administrator Privilege Gain	109
Attempted Information Leak	38
Web Application Attack	3

MX4



Message Category	%	Messages
Stopped by Reputation Filtering	47.8%	45.5k
Stopped as Invalid Recipients	1.2%	1,101
Spam Detected	9.2%	8,732
Virus Detected	0.0%	1
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.0%	14
Stopped by Content Filter	0.1%	74
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**58.3%**	**55.4k**
Marketing Messages	3.7%	3,511
Social Networking Messages	0.4%	361
Bulk Messages	7.5%	7,094
Total Graymails:	**11.5%**	**11.0k**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	30.2%	28.7k
Total Attempted Messages:		**95.0k**

MX9



Message Category	%	Messages
Stopped by Reputation Filtering	41.3%	33.3k
Stopped as Invalid Recipients	1.1%	881
Spam Detected	10.7%	8,627
Virus Detected	0.0%	1
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.0%	16
Stopped by Content Filter	0.1%	93
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**53.2%**	**42.9k**
Marketing Messages	3.5%	2,846
Social Networking Messages	0.4%	355
Bulk Messages	6.9%	5,570
Total Graymails:	**10.9%**	**8,771**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	35.9%	28.9k
Total Attempted Messages:		**80.6k**

Item / Date	Jun-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	***Jun-21***
Stopped By Reputation	322.6k	237.0k	129.0k	74.7k	68.9k	69.7k	43.8k	149k	60.7k	79.9k	65.4	***78.8k***
Invalid Recipients	50	612	2,582	1,120	883	153	62	242	384	1,776	99	***1,982***
Spam Detected	15.9k	16.9k	11.2k	15.4k	13.6k	13.2	8,650	30.2k	19.2k	19.2k	18	***17.4k***
Virus Detected	1	2	2	1	1	1	0	9	3	5	2	***2***
Advanced Malware	1	0	1	1	2	9	10	10	0	6	6	***0***
Malicious URLs	47	50	33	22	31	39	3	6	14	0	264	***30***
Content Filter	14	10	26	5	2	8	18	189	56	151	264	***167***
Marketing Messages	4,024	3,715	4,127	3,794	6,511	6,147	3,203	68	68	6,707	6,366	***6,357***
Attempted Admin Privilege Gain	2,573	33	1,865	314	285	84	42	160	89	96	95	***109***
Attempted User Privilege Gain	94	22	339	1,948	1,019	650	37	6	64	10	1	***0***
Attempted Information Leak	64	88	18	52	156	167	44	11	3	20	18	***38***
Potential Corp Policy Violation	19	59	210	0	0	0	0	0	0	0	0	***0***
Network Scans Detected	2	1	1	9	0	0	0	0	0	0	0	***0***
Web Application Attack	42	0	65	25	25	0	0	0	24	11	0	***3***
Attempted Denial of Service	0	0	0	0	11.2k	6,775	15,163	2,788	0	1	0	***0***
Misc. Attack	18	0	14	4,242	2,508	5,935	2,390	13,836	6,870	4,395	3,851	***1,516***

- 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 78.8k.

- Attempted information leaks detected and blocked at the firewall are higher from 18 to 38 for the month of **June 2021.**

- Network scans returned a value of 0, which is in line with previous month's data.

- Attempted User Privilege Gain is lower at 0 from a previous six-month average of 128.

Projects and Programs

Ruth Watson

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

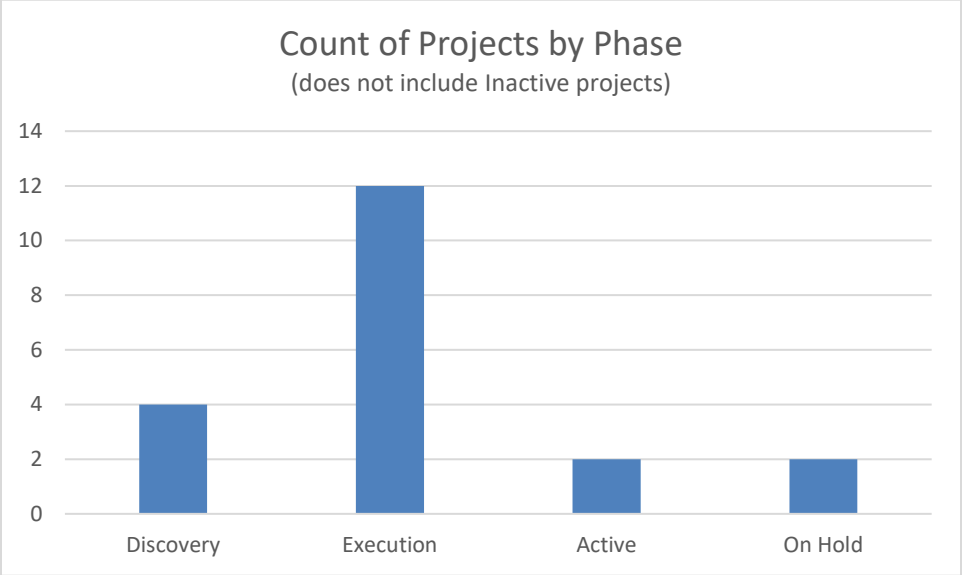
From: **Ruth Watson, Chief Projects and Programs Officer**

Date: **July 9, 2021**

Subject: **Projects & Programs Report**

Project Management Office

- 23 projects currently on the Alliance enterprise-wide portfolio
  - 18 active projects (discovery, initiation, planning, execution, warranty)
  - 2 project On Hold
  - 3 projects Inactive (**not included on the chart as Inactive is not a phase**)



- Project Portfolio Governance structure has been introduced and socialized at the leadership level
  - Project Governance Committee – comprised of department/division leadership (senior directors, directors, managers)
    - Meetings occur monthly; may occur more frequently, if needed
      - Reviewed projects and resource interdependencies
  - Portfolio Governance Committee – comprised of Senior Leadership Team
    - First meeting held on May 18, 2021
      - Reviewed Project Portfolio for 2021-2022
    - Next meeting: August 12, 2021

Integrated Planning

- CalAIM Enhanced Care Management (ECM) and In Lieu of Services (ILOS)
    - Core project team meeting twice per week; second meeting includes Alameda Care Connect (AC3) staff
    - Separate workgroup meetings with HCS, Provider Services, Member Services/Outreach & Communications, and Finance occur weekly; Analytics scheduled as needed
    - Model of Care (MOC) Part 1 was submitted to DHCS on June 30, 2021
        - Included responses to thirteen questions in the following areas:
            - ECM/ILOS provider capacity questions
            - WPC and HHP transition approach
            - Preliminary ILOS selections – seven (7) ILOS options are targeted for implementation on January 1, 2022
        - MOC Part 2 is due to DHCS on September 1, 2021
            - Will include the majority of ECM and ILOS Policies & Procedures
            - Final ILOS selections
        - MOC Part 3 is due to DHCS on October 1, 2021
            - Final ECM & ILOS Provider Capacity/Network
        - The MOC will be updated, as necessary, to account for the phased implementation of ECM target populations
    - Planning for completion of MOC Part 2 and preparation for Operational Readiness underway and will be done in parallel tracks
        - Planning meeting scheduled for July 13 with a Kick-Off meeting to occur the week of July 19
    - Listening sessions with community partners and stakeholders continue
        - Twelve (12) sessions completed through the end of June
        - Three (3) additional sessions are scheduled

- Behavioral Health Integration (BHI) Incentive Program – Department of Health Care (DHCS) pilot program commenced January 1, 2021, and continues through December 31, 2022
    - CY 2020 Baseline reports are due from grantees by June 30, 2021
        - The consolidated report must be submitted to DHCS by August 27
    - Quarterly milestone reports must be submitted to DHCS within 60 days from the end of the quarter; 2Q2021 report due to DHCS no later than August 27, 2021
        - Reports and supporting documentation are due from grantees by July 30
        - Reports to be reviewed and approved by Quality Improvement staff on August 13

Recruiting and Staffing

- Project Management Open position(s):
    - Sr. Technical Project Manager – recruitment underway
    - Technical Business Analyst – new employee, scheduled to start July 12

Projects and Programs

Supporting Documents

Project Descriptions

Key projects currently in-flight:

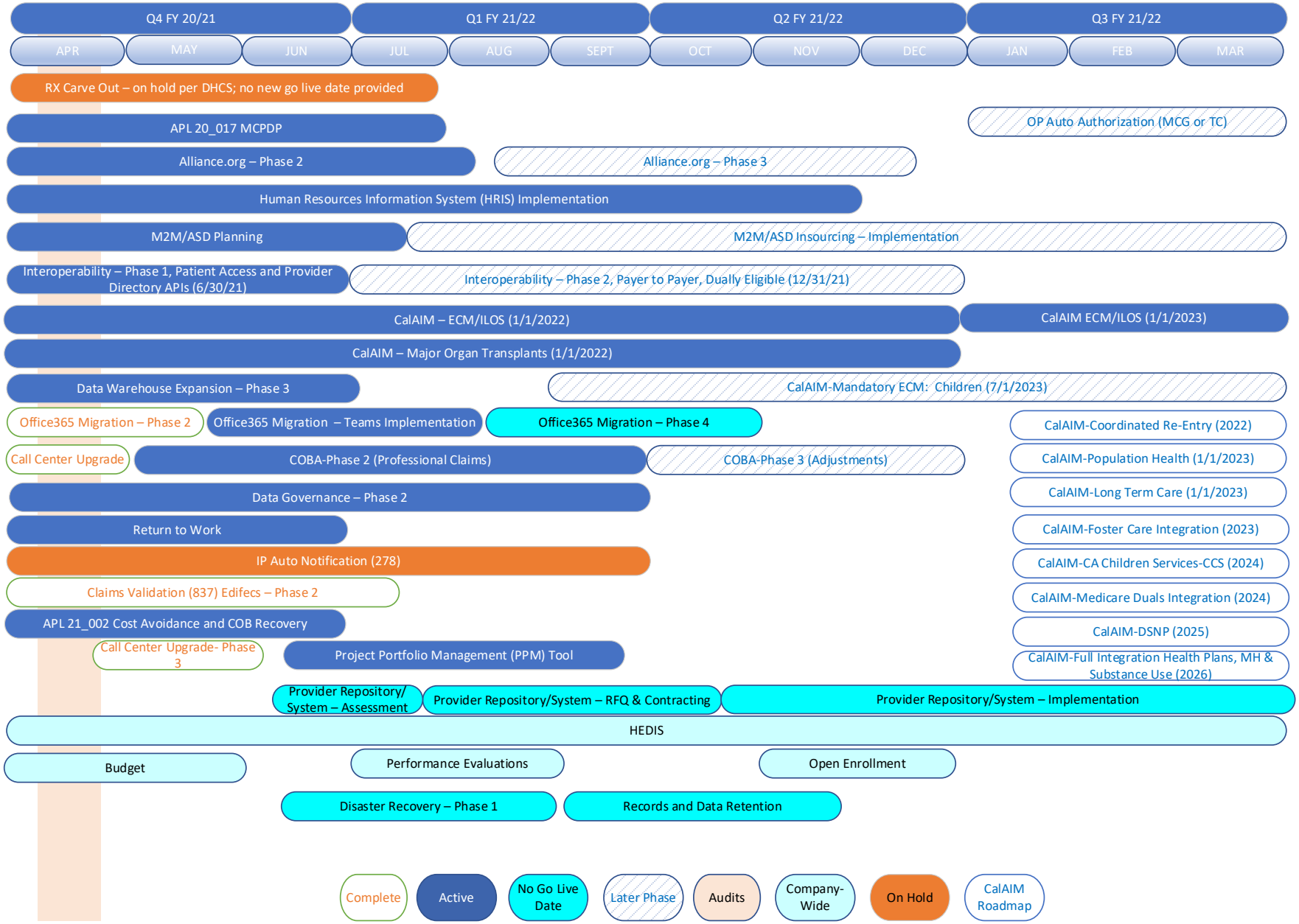
- California Advancing and Innovating Medi-Cal (CalAIM) – program to provide targeted and coordinated care for vulnerable populations with complex health needs
    - Enhanced Care Management (ECM) effective January 1, 2022 – ECM will target seven (7) specific populations of vulnerable and high-risk children and adults
        - Members currently receiving Whole Person Care (WPC) care management or Health Homes Program (HHP) services will transition into ECM
        - Model of Care Part 1 submitted to DHCS on June 30, 2021
        - Model of Care Part 2, due to DHCS on September 1, 2021, is being drafted
    - In Lieu of Services (ILOS) effective January 1, 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
        - Seven ILOS options have been selected for implementation on January 1, 2022
    - Major Organ Transplants (MOT) – currently not within the scope of many Medi-Cal managed care plans (MCPs); will be carved into all MCPs effective January 1, 2022.
        - Applicable to adults only; transplants for children will remain with California Children's Services
        - DHCS working to update "trailer bill legislation" to make Managed Medi-Cal rate protections applicable to contracted *and* non-contracted providers
            - Requires CMS approval
- Interoperability Phase 1 – regulatory mandate to implement the following:
    - Patient Access API – provide members with the ability to access their claims and encounter information, including cost, as well as a defined sub-set of their clinical information through third-party applications of their choice
    - Provider Directory API – requires payers to make provider directory information publicly available
    - Enforcement date is July 1, 2021
    - Engaged consultant services to provide Business Analysis support
- Return to Work – assessment of current state work environment and recommendations for future configurations (remote/onsite/hybrid)
- Human Resources Information System (HRIS) – replacement of current HRIS system; target go-live is October 2021
- Project Portfolio Management (PPM) Tool – vendor demonstrations are underway
- All Plan Letter (APL) 21-002 (formerly APL 20-010) Cost Avoidance, Other Health Coverage

    - New notification requirements between health plans and providers regarding other health coverage as required by DHCS; pending release of new APL
- APL 20-017 Managed Care Program Data Improvement
    - DHCS will require Managed Care Plans (MCPs) to report program data using new, standardized reporting formats
        - Additional requirements for data reporting related to grievances, appeals, monthly Medical Exemption Requests (MER) and other continuity of care requests, out-of-Network requests, and Primary Care Provider (PCP) assignments for all MCPs
        - MCPs are required to meet all requirements in this APL no later than July 1, 2021

Projects on Hold:

- Pharmacy Carve-out – transition of the pharmacy benefit for Medi-Cal members from managed care plans to the State; the Department of Health Care Services (DHCS) has further delayed the start with no new go-live date indicated
- In Patient (IP) Auto Notification (278 Data File) – pilot hospitals are not ready to start implementation

AAH Project Portfolio - Active + (updated 7/2/2021)



ALAMEDA Alliance FOR HEALTH

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

Analytics

Tiffany Cheang

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

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

Date: **July 9, 2021**

Subject: **Performance & Analytics Report**

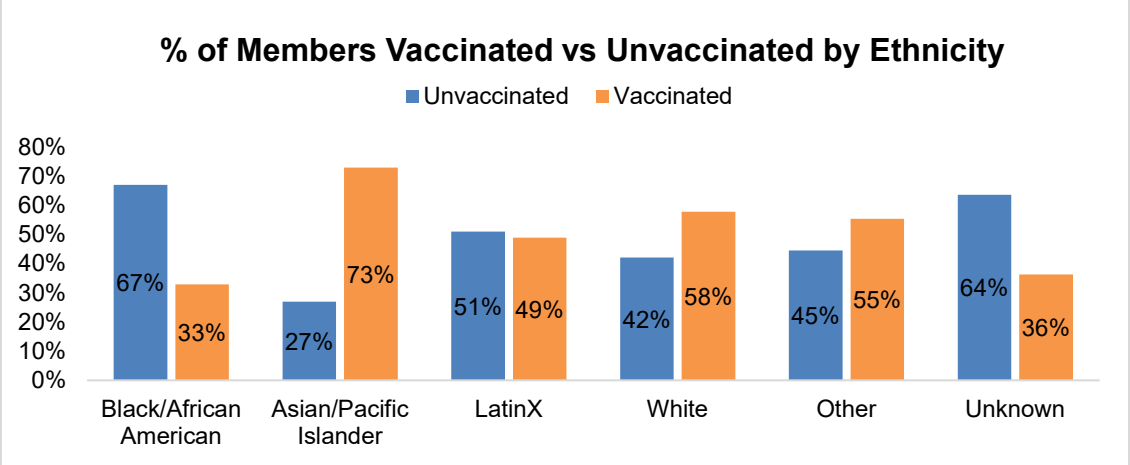
COVID-19 Vaccination Rate

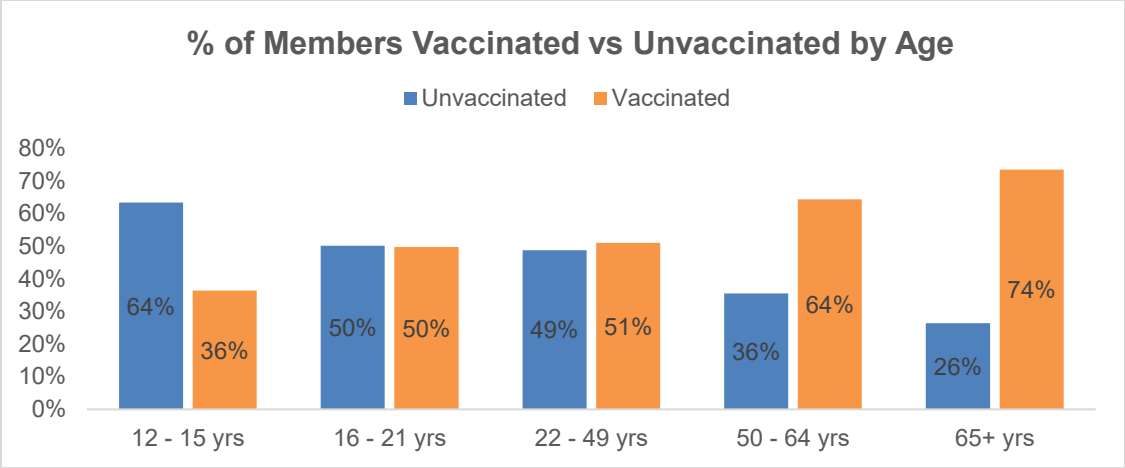
- The Alliance COVID-19 Vaccination rate is 54.0% for fully and partially vaccinated members aged 12 years and older.
  - 47.5% are fully vaccinated
  - 6.6% are partially vaccinated

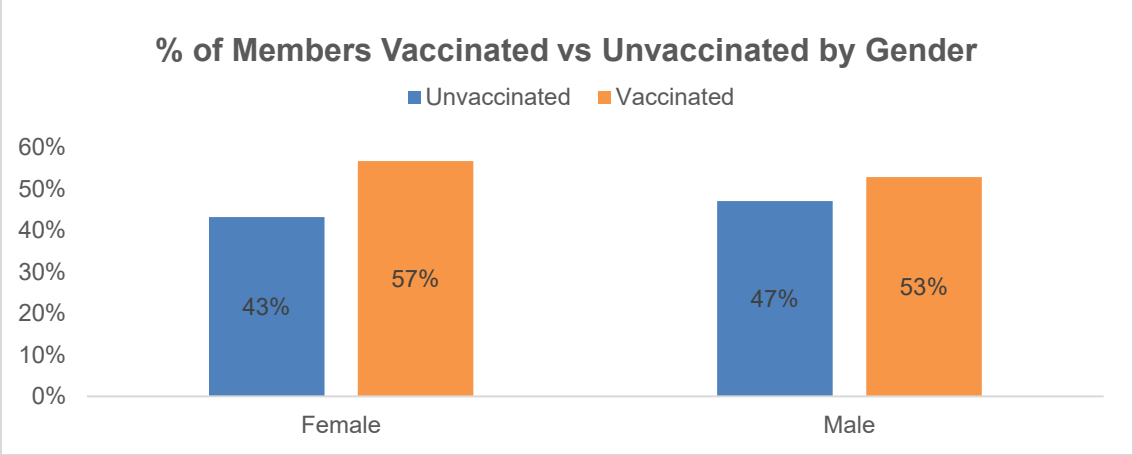
- A comparison of the Alliance's vaccinated (fully and partially) vs unvaccinated members results in the following:

- Utilization:
  - 54% of the Low and No Utilization members are vaccinated whereas 61% of the Medium to High Utilization members are vaccinated.

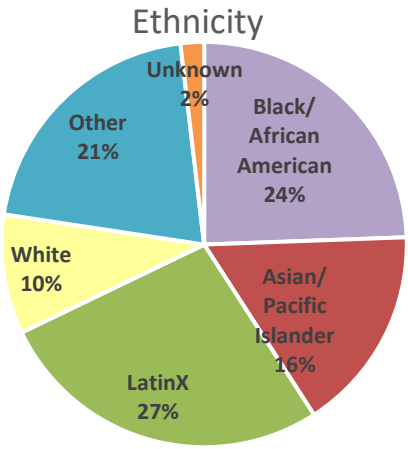
- Demographic Breakout:

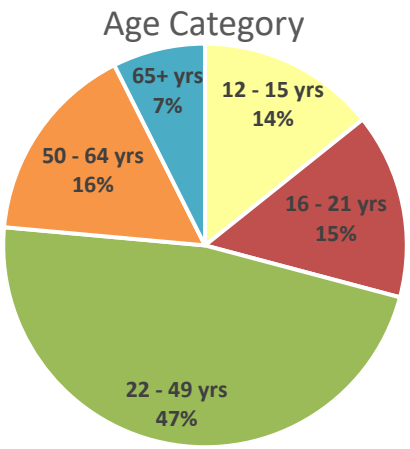






The following breakouts are based on the total **unvaccinated** population:





- 53% are Female and 47% are Male
- 50% are low utilizers and 42% have no utilization (compared to 60% and 30% for the vaccinated population)

Member Cost Analysis

- The Member Cost Analysis below is based on the following 12 month rolling periods:
    - Current reporting period: April 2020 – March 2021 dates of service
    - Prior reporting period: April 2019 – March 2020 dates of service
    (Note: Data excludes Kaiser membership data.)

- For the current reporting period, the top 8.1% of members account for 84.4% of total costs.

- In comparison, the Prior reporting period was lower at 7.7% of members accounting for 81.4% 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 increased to account for 60.6% of the members, with SPDs accounting for 28.0% and ACA OE's at 32.6%.
    - The percent of members with costs >= $30K slightly increased from 1.6% to 1.7%.
    - Of those members with costs >= $100K, the percentage of total members remained consistent at 0.4%.
        - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, increasing to 50.2%.

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

- However, the age distribution of the top 8.1% is more concentrated in the 45-66 year old category (41.0%) compared to the overall population (20.8%).

Analytics

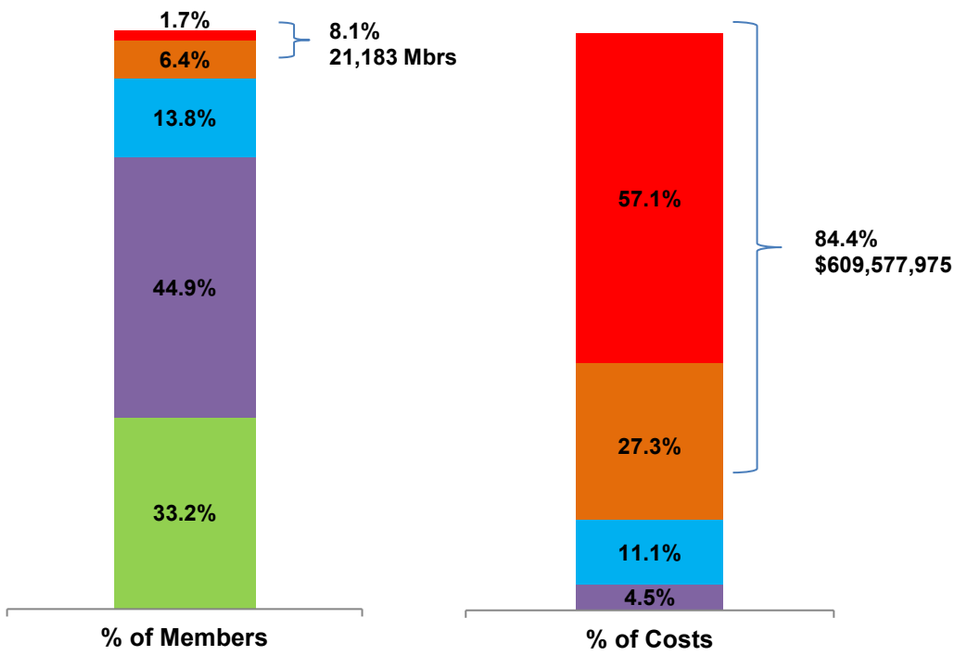
Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Apr 2020 - Mar 2021

Note: Data incomplete due to claims lag

Run Date: 06/28/2021

Member Cost Distribution



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	4,521	1.7%	$ 412,505,269	57.1%
$5K - $30K	16,662	6.4%	$ 197,072,706	27.3%
$1K - $5K	35,908	13.8%	$ 80,261,417	11.1%
< $1K	116,968	44.9%	$ 32,632,166	4.5%
$0	86,512	33.2%	$ -	0.0%
Totals	**260,571**	**100.0%**	**$ 722,471,558**	**100.0%**

Top 8.1% of Members = 84.4% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	1,072	0.4%	$ 226,103,675	31.3%
$75K to $100K	584	0.2%	$ 50,457,019	7.0%
$50K to $75K	1,114	0.4%	$ 68,380,363	9.5%
$40K to $50K	691	0.3%	$ 30,839,853	4.3%
$30K to $40K	1,060	0.4%	$ 36,724,359	5.1%
SubTotal	***4,521***	***1.7%***	***$ 412,505,269***	***57.1%***
$20K to $30K	2,139	0.8%	$ 52,238,576	7.2%
$10K to $20K	6,028	2.3%	$ 84,020,857	11.6%
$5K to $10K	8,495	3.3%	$ 60,813,273	8.4%
SubTotal	***16,662***	***6.4%***	***$ 197,072,706***	***27.3%***
Total	**21,183**	***8.1%***	**$ 609,577,975**	***84.4%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Mar 2021	241,539	$ 639,330,174
Dis-Enrolled During Year	19,032	$ 83,141,384
Totals	**260,571**	**$ 722,471,558**

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

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
8.1% of Members = 84.4% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Apr 2020 - Mar 2021
Note: Data incomplete due to claims lag
Run Date: 06/28/2021

8.1% of Members = 84.4% of Costs
28.0% of members are SPDs and account for 34.7% of costs.
32.6% of members are ACA OE and account for 30.8% of costs.
6.7% of members disenrolled as of Mar 2021 and account for 12.9% of costs.

Highest Cost Members; Cost Per Member >= $100K
39.7% of members are SPDs and account for 39.3% of costs.
28.4% of members are ACA OE and account for 28.6% of costs.
19.1% of members disenrolled as of Mar 2021 and account for 21.2% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	113	545	658	3.1%
MCAL	MCAL - ADULT	483	3,151	3,634	17.2%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	177	1,295	1,472	6.9%
	MCAL - ACA OE	1,427	5,482	6,909	32.6%
	MCAL - SPD	1,689	4,235	5,924	28.0%
	MCAL - DUALS	90	1,075	1,165	5.5%
Not Eligible	Not Eligible	542	879	1,421	6.7%
Total		**4,521**	**16,662**	**21,183**	**100.0%**

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	18	1.7%
MCAL	MCAL - ADULT	97	9.0%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	7	0.7%
	MCAL - ACA OE	304	28.4%
	MCAL - SPD	426	39.7%
	MCAL - DUALS	15	1.4%
Not Eligible	Not Eligible	205	19.1%
Total		**1,072**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 8,123,486	$ 6,044,611	$ 14,168,096	2.3%
MCAL	MCAL - ADULT	$ 38,056,017	$ 35,961,853	$ 74,017,870	12.1%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 8,896,089	$ 15,092,340	$ 23,988,428	3.9%
	MCAL - ACA OE	$ 124,759,001	$ 63,193,827	$ 187,952,828	30.8%
	MCAL - SPD	$ 159,179,108	$ 52,217,904	$ 211,397,012	34.7%
	MCAL - DUALS	$ 6,043,222	$ 13,360,618	$ 19,403,841	3.2%
Not Eligible	Not Eligible	$ 67,448,346	$ 11,201,554	$ 78,649,900	12.9%
Total		**$ 412,505,269**	**$ 197,072,706**	**$ 609,577,975**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 2,955,937	1.3%
MCAL	MCAL - ADULT	$ 18,434,356	8.2%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 1,109,643	0.5%
	MCAL - ACA OE	$ 64,560,537	28.6%
	MCAL - SPD	$ 88,944,986	39.3%
	MCAL - DUALS	$ 2,152,799	1.0%
Not Eligible	Not Eligible	$ 47,945,417	21.2%
Total		**$ 226,103,675**	**100.0%**

% of Total Costs By Service Type

Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs
$100K+	7%	0%	0%
$75K to $100K	6%	0%	1%
$50K to $75K	6%	0%	1%
$40K to $50K	7%	0%	1%
$30K to $40K	10%	1%	1%
$20K to $30K	8%	2%	1%
$10K to $20K	1%	0%	1%
$5K to $10K	0%	0%	0%
Total	**5%**	**0%**	**1%**

Breakout by Service Type/Location

Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
12%	57%	1%	14%	5%	3%	8%
16%	44%	2%	10%	5%	11%	12%
21%	39%	3%	7%	7%	9%	15%
17%	42%	6%	8%	6%	2%	19%
16%	41%	9%	9%	7%	1%	17%
18%	35%	11%	9%	7%	1%	18%
21%	33%	6%	12%	10%	2%	16%
25%	21%	8%	12%	13%	1%	19%
17%	**43%**	**4%**	**12%**	**7%**	**4%**	**13%**

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

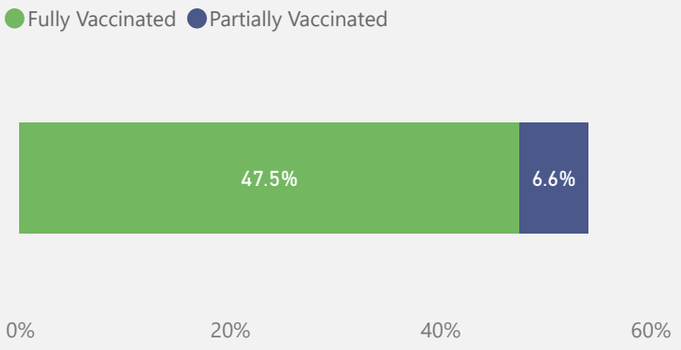
COVID-19 Vaccination Summary as % of Population Ages >= 12 Years

Data as of: 7/2/2021

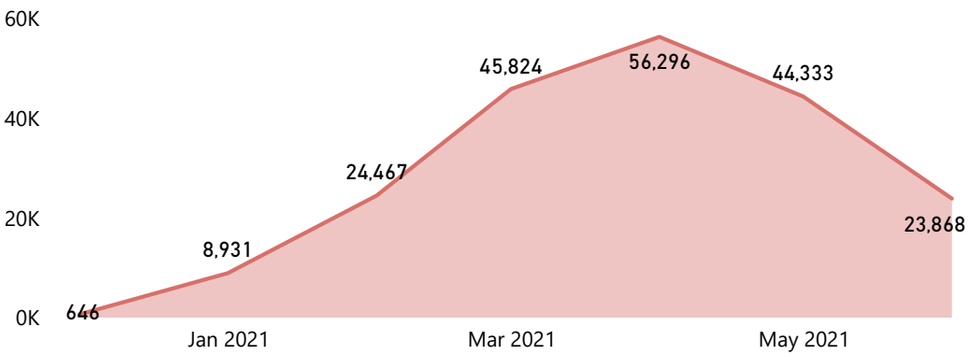
Members Fully Or Partially Vaccinated: 124,315

% Fully Or Partially Vaccinated: 54.0%

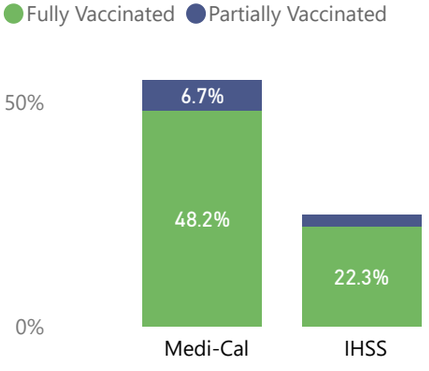
Breakout by Status



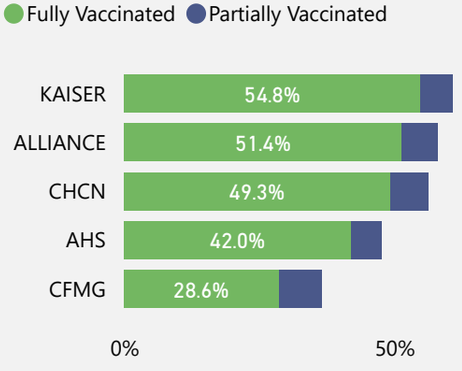
Monthly Trend



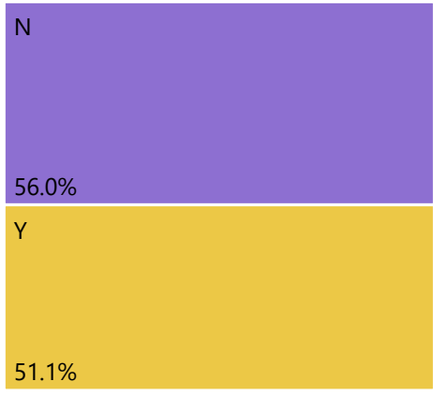
Medi-Cal vs IHSS



Network

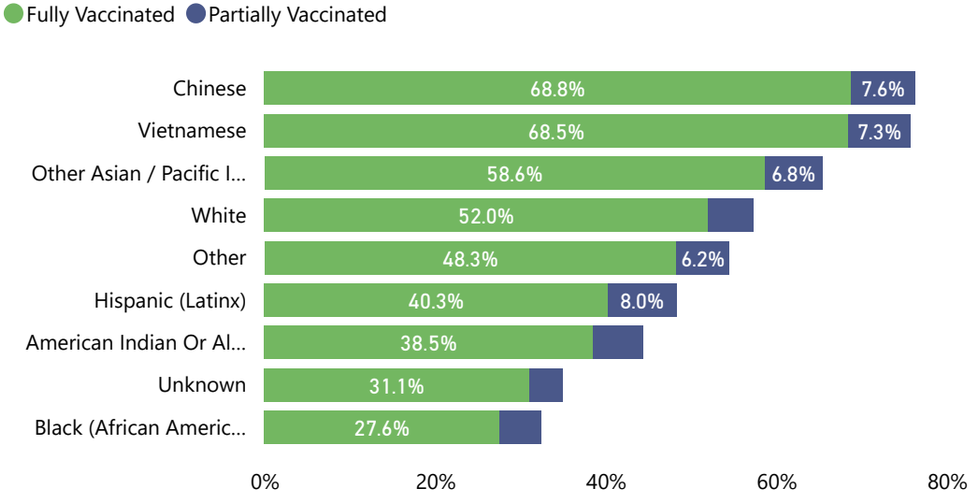


High Risk Zip Code

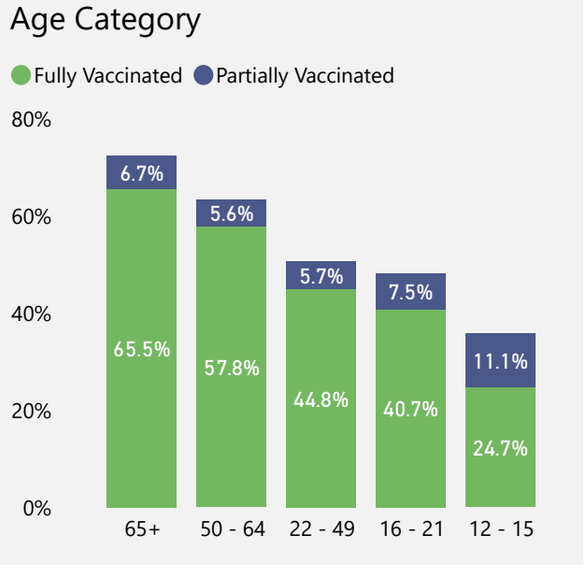


Top 15 Cities	Fully Vaccinated	Partially Vaccinated
ALAMEDA	57.9%	6.2%
ALBANY	64.1%	5.4%
BERKELEY	53.9%	5.5%
CASTRO VALLEY	51.8%	7.1%
DUBLIN	52.7%	6.5%
EMERYVILLE	43.6%	5.7%
FREMONT	54.0%	7.0%
HAYWARD	44.5%	6.8%
LIVERMORE	45.3%	6.0%
NEWARK	50.4%	6.2%
OAKLAND	43.0%	6.6%
PLEASANTON	54.3%	6.5%
SAN LEANDRO	50.9%	6.7%
SAN LORENZO	54.8%	6.1%
UNION CITY	52.9%	7.2%

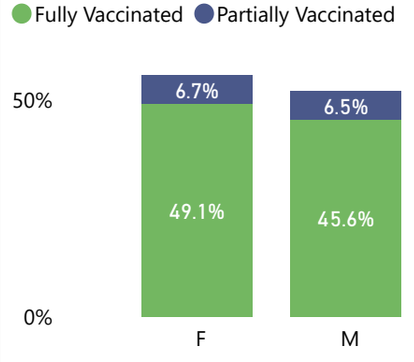
Ethnicity



Age Category



Gender



ALAMEDA Alliance FOR HEALTH

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

Human Resources

Anastacia Swift

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

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

Date: **July 9, 2021**

Subject: **Human Resources Report**

Staffing

- As of July 1, 2021, the Alliance had 345 full time employees and 1-part time employees.

- On July 1, 2021, the Alliance had 38 open positions in which 10 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 28 positions open to date. The Alliance is actively recruiting for the remaining 28 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	7	1	6
Operations	19	6	13
Healthcare Analytics	4	2	2
Information Technology	3	0	3
Finance	2	0	2
Compliance	1	0	1
Human Resources	0	0	0
Projects & Programs	2	1	1
Total	38	10	28

- Our current recruitment rate is 10%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in June 2021 included:
    - 5 years:
        - Snowvia Rodgers (Provider Relation)
        - Sherry Roces (Utilization Management)
        - Isabelle Liang (Member Services)
    - 6 years:
        - Yash Doshi (IT Data Exchange)
        - Tiana Rivas (Provider Relation)
        - Latrice Allen (Member Services)
        - Jeanette Murray (Executive)
    - 9 years:
        - Thuan Le (Claims)
        - Marcie Sperling-Bullock (Claims)
    - 10 years:
        - Eileen Ahn (Regulatory Readiness)
        - Elisea Toscano-Cochrane (Member Services)
    - 13 years:
        - Annie Wong (Healthcare Analytics)
    - 14 years:
        - Cindy Brazil (Quality Improvement)
    - 24 years:
        - Monina Malonzo Rayo (Claims)
    - 25 years:
        - Angie Vaziri (Member Services)