Board of Governors

Regular Meeting

Friday, June 11, 2021
12:00 p.m. – 2:00 p.m.

Conference Call Only

1240 South Loop Road, Alameda, CA 94502

AGENDA

BOARD OF GOVERNORS
Regular Meeting
Friday, June 11, 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 June11, 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) **MAY 14, 2021 BOARD OF GOVERNORS MEETING MINUTES**

   b) **JUNE 8, 2021 FINANCE COMMITTEE MEETING MINUTES**

   c) **2020 CASE MANAGEMENT & CARE COORDINATION, COMPLEX CASE MANAGEMENT & DISEASE MANAGEMENT PROGRAM EVALUATION**

   d) **2021 CASE MANAGEMENT & CARE COORDINATION, COMPLEX CASE MANAGEMENT & DISEASE MANAGEMENT PROGRAM DESCRIPTION**

   e) **2020 UTILIZATION MANAGEMENT PROGRAM EVALUATION**

   f) **2021 UTILIZATION MANAGEMENT PROGRAM DESCRIPTION**

6. **BOARD MEMBER REPORTS**

   a) **COMPLIANCE ADVISORY GROUP**

   b) **FINANCE COMMITTEE**

7. **CEO UPDATE**

8. **BOARD BUSINESS**

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

   b) **REVIEW AND APPROVE FY2022 PRELIMINARY BUDGET**

   c) **REVIEW AND APPROVE RESOLUTION 2021-12 BOARD MEMBER (JAMES JACKSON) ALAMEDA HEALTH SYSTEM MEMBER SEAT**

d) **REVIEW AND APPROVE RESOLUTION 2021-10 BOARD MEMBER (NATALIE WILLIAMS) CONSUMER MEMBER SEAT**

e) **REVIEW AND APPROVE RESOLUTION 2021-11 CREATING COMPLIANCE ADVISORY COMMITTEE**

f) **REVIEW AND APPROVE MEMBER NOMINATIONS TO THE STANDING COMPLIANCE ADVISORY COMMITTEE**

g) **REVIEW AND APPROVE MEMBER NOMINATIONS TO THE STANDING EXECUTIVE COMMITTEE**

h) **CALAIM / IN-LIEU OF SERVICES - COST PRO-FORMA CY2022**

9. **STANDING COMMITTEE UPDATES**

a) **PEER REVIEW AND CREDENTIALING COMMITTEE**

b) **HEALTH CARE QUALITY COMMITTEE**

10. **STAFF UPDATES**

11. **UNFINISHED BUSINESS**

12. **STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS**

13. **PUBLIC COMMENT (NON-AGENDA ITEMS)**

14. **ADJOURNMENT**

NOTICE TO THE PUBLIC

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

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

NOTICE TO THE PUBLIC

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

The Board meets regularly on the second Friday of each month. Due to 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.

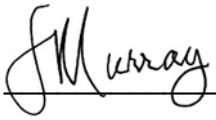
Public Input: If you are interested in addressing the Board, you may submit comments on any agenda item or on any item not on the agenda, in writing via mail to "Attn: Alliance Board," 1240 S. Loop Road, Alameda, CA 94502; or through e-comment at jmurray@alamedaalliance.org.

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 June 7, 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
May 14, 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, Dr. Michael Marchiano, David B. Vliet, Dr. Kelley Meade

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. Noha Aboelata, Aarondeep Basrai

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 12:00 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	None	None	None
4. INTRODUCTIONS			
Dr. Seevak	None	None	None
5. CONSENT CALENDAR			
Dr. Seevak	Dr. Seevak presented the Consent Calendar.	Motion to Approve	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	a) April 9, 2021, Board of Governors Meeting Minutes b) May 11, 2021, Finance Committee Meeting Minutes Motion to Approve May 14, 2021, Board of Governors Consent Calendar. A vote by roll call was taken, and the motion passed.	May 14, 2021, Board of Governors Consent Calendar. Motion: M. Lynch Second: David Vliet Vote: Yes No opposed or abstained.	
6. a. BOARD MEMBER REPORT – COMPLIANCE ADVISORY GROUP			
R. Gebhart and R. Golfin	The Compliance Advisory Group was held telephonically on May 14, 2021, at 10:30 am. Rebecca introduced Richard Golfin and the 2021 Joint DMHC & DHCS Medical Services Audit. Richard Golfin presented an overview of the Joint Audit Update. DMHC: • Virtual On-Site: April 13 – April 16, 2021 • Review Period: November 1, 2018 – October 31, 2020 DHCS: • Virtual On-Site: April 13 – April 23, 2021 • Review Period: June 1, 2019 – March 31, 2021 Scope: • Utilization Management • Case Management & Care Coordination • Access & Availability • Member's Rights & Responsibilities • Quality Improvement System • Organization and Administration	Informational update to the Board of Governors. Vote not required.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Initial Observations: • The below are plan observations, and the Plan already has another 394 requests from the agencies. Some of the below observations might be or might not be in the final report. ○ Notice of Action (NOA) letters at the Plan and its delegates were observed by auditors to have improved but require continued development. ○ System configuration for processing emergency & family planning claims should be revisited to capture all claim types for processing. ○ The Plan must expand its oversight of drivers at its transportation provider. ○ The Plan's grievance classification system may have issues with translating letters into the required threshold languages. ○ The Plan's fraud and privacy reporting mechanisms must be improved to routinely meet regulatory turnaround times. ○ The Plan's system for capturing Potential Quality Issues must be appropriately classified and clearly indicate MD Review. Next Steps: • Expect a Preliminary Audit Report within 90-days. • The Final Audit Report is issued 15-days after the Preliminary Report. • The Plan will have 30-days to submit its CAP response to the Final Audit Report. . Question: There are many moving parts and what is the outcome that we are hoping to achieve? Answer: The purpose of these reviews are to measure and compare the performance of a plan against its contract requirements, and this feedback is what will direct us in improving the care that we provide. Question: What is being utilized?		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Answer: The agencies will review several items in Utilization Management such as program description, policy and procedures, structure, etc. Compliance Dashboard: • 2018 DHCS Medical Services Audit is completed and closed. 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, May 11, 2021. Dr. Ferguson updated the Board on the Finance Committee Meeting. Highlights: • Membership increasing and TNE good. • The CFO will discuss the details in the Finance Report. Informational update to the Board of Governors. Vote not required.	Informational update to the Board of Governors. Vote not required.	None
7. CEO UPDATE			
S. Coffin, T. Cheang	Scott Coffin, Chief Executive Officer, presented the following updates: Executive Summary: • The Alliance turns 25 years in 2021, formed in 1996 by the Alameda County Board of Supervisors.	Informational update to the Board of Governors. Vote not required.	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP

	• We will be recognizing and celebrating a quarter of a century.
	
	Key Performance Metrics:
	
	• Page 132 and 133 of the Operations Dashboard. Several metrics have dropped into the red category, one is our encounter data, and the other was our provider disputes. By the end of June, these metrics should be back in the green status.
	
	Fiscal Year 2022 Budget:
	
	• Budget planning for Fiscal Year 2022 began in February.
	• Preliminary budget to be delivered to the Board of Governors during the first week in June.
	  ○ Final budget in December 2021 following the delivery of preliminary Medi-Cal rates from DHCS.
	  ○ DHCS to include the County Wide Averaging and risk adjustments due by mid-December from DHCS, and results will be included in the first quarter forecast.
	
	COVID-19 Vaccinations:
	
	• Approximately 37% of members (16 years and older) in Medi-Cal and Group Care are partially or fully vaccinated, compared to the statewide average of 49.1% who have received at least one dose.
	  ○ About 154,000 postcards will be mailed, followed up by a phone call in all four (4) threshold languages.
	
	Tiffany shared a COVID-19 slide and explained the information to the Board Members.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP

	• COVID-19 Vaccination Summary as % of Population Ages >= 16 Years. The shared information related to:
	  ○ Members Fully Vaccinated or At Least 1 Dose
	  ▪ Medi-Cal vs. IHSS Members
	  ▪ Network
	  ▪ Top 15 Cities and High-Risk Zip Code
	  ▪ Ethnicity
	  ▪ Age Category
	  ▪ Gender
	
	Comments: To reach a higher percentage of members vaccinated, we might think of doing something like giving out gift cards. Another idea is social media to reach the younger generation.
	
	There has been an uptake in appointments from the calling campaign, which seems to get a better response than the letters and postcards. As a standard approach, we will continue with the postcards and calls.
	
	Question: In the future, will the 12 to 15 be included on this dashboard?
	Answer: Yes, the children ages 12 to 15 will be included in the June report.
	
	Question: How are other Health Plans doing with vaccinations compared to the Alliance.
	
	Answer: We do not have this data on hand, but we will look and report back at the Board Meeting.
	
	Informational update to the Board of Governors.
	
	Vote not required.
			Question: How are other Health Plans doing with vaccinations compared to the Alliance.
			
			Answer: We do not have this data on hand, but we will look and report back at the Board Meeting.

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
8. a BOARD BUSINESS – MARCH 2021 MONTHLY FINANCIAL STATEMENTS			
G. Riojas	Gil Riojas gave the following March 31, 2021 Finance updates: Enrollment: • For the month ending March 31, 2021, the Alliance had an enrollment of 281,637 members, a net income of $7.5M, and the tangible net equity is 564%. • Our enrollment has increased by 1,802 members since February 2021. Net Operating Results: • For the month ending March 31, 2021, the actual net loss was $546,000, and the budgeted net income was $443,000. • The unfavorable variances were due to higher than anticipated medical expense, lower than anticipated revenue, and other revenue. Revenue: • For the month ending March 31, 2021, the actual revenue was $93.9M vs. the budgeted revenue of $94.3M. Medical Expense: • For the month ending March 31, 2021, the actual medical expense was $89.5M vs. the budgeted medical expense of $86.2M. Medical Loss Ratio (MLR): • For the month ending March 31, 2021, the MLR was 95.4%, and the fiscal year-to-date of 95.8%. Administrative Expense: • For the month ending March 31, 2021, the actual administrative expense was $4.9M vs. the budgeted administrative expense of $7.6M.	Motion to Approve March 2021, Monthly Financial Statements. Motion: N. Peraino Second: Dr. K. Meade Vote: Yes No opposed or abstained.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Other Income / (Expense): • As of March 31, 2021, our YTD interest income from investments is $512,000, and YTD claims interest expense is $241,000. Tangible Net Equity (TNE): • Tangible net equity results continue to remain healthy, and at the end of March 31, 2021, the TNE was reported at 564% of the required amount. Cash Position and Assets: • For the month ending March 31, 2021, the Alliance reported $338.6M in cash; $193.0M in uncommitted cash. Our current ratio is above the minimum required at 1.63 compared to the regulatory minimum of 1.0. Motion to approve March 31, 2021, Monthly Financial Statements as presented. A vote by roll call was taken, and the motion passed.		
8. b. BOARD BUSINESS – REVIEW AND APPROVE RESOLUTION 2021-06 BOARD MEMBER SEAT			
S. Coffin	Scott Coffin introduced Resolution 2021-06 to reappoint Board Member Dr. Michael Marchiano to the Alameda County Hospital Member Seat. Dr. Michael Marchiano Ferguson recused himself from participating in the discussion and vote. • The Board voted to reappoint Board Member Dr. Michael Marchiano to the Alameda County Hospital Member Seat. Motion to approve Resolution 2021-06 to reappoint Board Member Dr. Michael Marchiano to the Alameda County Hospital Member Seat. A vote by roll call was taken, and the motion passed.	Motion to approve Resolution 2021-06 to reappoint Board Member Dr. Michael Marchiano to the Alameda County Hospital Member Seat. Motion: S. Coffin Second: Dr. E. Seevak Motion passed by roll call. Vote: Yes No opposed.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
		1 abstained (Dr. M. Marchiano).	
8. c. BOARD BUSINESS – REVIEW AND APPROVE RESOLUTION 2021-07 BOARD MEMBER SEAT			
S. Coffin	Scott Coffin introduced Resolution 2021-07 to reappoint Board Member Dr. Rollington Ferguson to the Alameda County Physician Member Seat. Dr. Rollington Ferguson recused himself from participating in the discussion and vote. • The Board voted to reappoint Dr. Rollington Ferguson to the Alameda County Physician Member Seat. Motion to approve Resolution 2021-07 to reappoint Board Member Dr. Rollington Ferguson to the Alameda County Physician Member Seat. A vote by roll call was taken, and the motion passed.	Motion to approve Resolution 2021-07 to reappoint Board Member Dr. Rollington Ferguson to the Alameda County Physician Member Seat. Motion: Dr. E. Seevak Second: Dr. K. Meade Motion passed by roll call. Vote: Yes No opposed. 1 abstained (Dr. Rollington Ferguson).	None
8. d. BOARD BUSINESS – REVIEW AND APPROVE RESOLUTION 2021-08 BOARD MEMBER SEAT			
S. Coffin	Scott Coffin introduced Resolution 2021-08 to reappoint Board Member Aarondeep Basrai to the At Large Pharmacist Member Seat. Aarondeep Basrai Ferguson recused himself from participating in the discussion and vote.	Motion to approve Resolution 2021-08 to reappoint Board Member Aarondeep Basrai to the At Large	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	• The Board voted to reappoint Board Member Aarondeep Basrai to the At Large Pharmacist Member Seat. Motion to approve Resolution 2021-08 to reappoint Board Member Aarondeep Basrai to the At Large Pharmacist Member Seat. A vote by roll call was taken, and the motion passed.	Pharmacist Member Seat. Motion: Dr. E. Seevak Second: Dr. K. Meade Motion passed by roll call. Vote: Yes No opposed. 1 abstained Aarondeep Basrai).	
8. e. BOARD BUSINESS – REVIEW AND APPROVE RESOLUTION 2021-09 CREATING THE EXECUTIVE COMMITTEE			
S. Coffin	Scott Coffin introduced Resolution 2021-09 to Create the Executive Committee. Motion to approve Resolution 2021-09 to Create the Executive Committee A vote by roll call was taken, and the motion passed. Dr. Seevak brought forth the information that the Executive Committee consists of the Alliance Board of Governors Chair, Vice-Chair, Past Board Chair, Finance Committee Chair, Strategic Planning Committee Chair. Next month the Board will be voting on the membership.	Motion to approve Resolution 2021-09 to Create the Executive Committee Motion: Dr. E. Seevak Second: D. Vliet Motion passed by roll call. Vote: Yes No opposed or abstained.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
8. f. BOARD BUSINESS – PROVIDER SATISFACTION UPDATE			
M. Woodruff D. Crowder and S. Wakefield	Matt Woodruff, Darryl Crowder, and Stephanie Wakefield presented the Provider Satisfaction Update. The topics covered were: Provider Satisfaction Survey Overview • Provider Overview 2015-2020 • Survey Distribution & Response Rates • Provider Satisfaction Composite Score • Individual Questions Related to Interpreter Services • Provider Satisfaction Survey Results • Conclusions Question: What percentage of the Alliance's Members need interpreters? Answer: We will find out and bring that information back to the next Board Meeting. Question: The Alliance faxes and calls providers; do you also send e-mails to providers? Answer: E-mails are not as easy to obtain from the providers, but we can start making it a point to ask for them. Question: What was the Utilization rate of telehealth during COVID-19 and cost? Answer: We can run claims and have that information for you. Informational update to the Board of Governors. Vote not required.	Informational update to the Board of Governors. Vote not required.	Question: What percentage of the Alliance Members need interpreters? Answer: We will find out and bring that information back to the next Board Meeting. Question: What was the Utilization rate of Teladoc during COVID-19 and cost? Answer: We can run claims and have that information for you.

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
8. g. BOARD BUSINESS – CALAIM IMPLEMENTATION UPDATE FOR JANUARY 1, 2022			

S. Coffin, R. Watson, and Dr. O'Brien	S. Coffin, Ruth Watson, and Dr. Steve O'Brien presented the CalAIM Implementation Update for January 1, 2022.
	
	The topics covered were:
	
	CalAIM Overview:
	• Implementation Approach
	• Considerations & Opportunities
	• Progress Report
	• Deliverables & Timelines
	• Appendix
	  ○ CalAIM Timeline 2022
	  ○ Functional Roles
	  ○ Enhanced Care Management Populations of Focus
	  ○ In Lieu Of Services
	  ○ Major Organ Transplants
	
	At the June meeting, costs relating to these three services will be presented.
	
	Informational update to the Board of Governors.
	
	Vote not required.
		Informational update to the Board of Governors.
		
		Vote not required.
			None

8. h. BOARD BUSINESS – REAL ESTATE ACQUISITION			
Dr. R. Ferguson	Dr. Rollington Ferguson presented the Real Estate Acquisition. • The Alliance team is split into two separate buildings, and Dr. Ferguson would like to investigate purchasing a real estate location where the team can be in the same building. <u>Motion to discuss:</u> Scott and team to scout out real estate to acquire for the Alliance with the prospect of the future Alliance growth.	Informational update to the Board of Governors. Vote not required.	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Motion: Dr. Rollington Ferguson Second: N. Williams Discussion: • Due to the uncertainty of what it will be like after COVID-19, the Board felt it was hard to decide to purchase property at this time. However, the Raider's home next to the Alliance is for sale and the Board wanted to check into the sale price and size. • The Alliance is midway through a 20-week engagement with a firm that is working out the return to work details. We will know more next month after the budget and the decision on the number of new employees. The Board agreed that Scott would check into the cost and size of the Raiders building and any other properties, and bring recommendations back to the Board. It was decided that there was no motion needed, and Dr. Ferguson withdrew the motion.		The Board agreed that Scott would check into the cost and size of the Raiders Home for sale and any other properties and bring recommendations back to the Board.

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
9. a. STANDING COMMITTEE UPDATES – PEER REVIEW AND CREDENTIALING COMMITTEE			
Dr. Steve O'Brien	The Peer Review and Credentialing Committee (PRCC) held telephonically on April 20, 2021. Dr. Steve O'Brien gave the following updates: • There were ten (10) initial providers approved. Additionally, forty-seven (47) 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.	None
10. STAFF UPDATES			
S. Coffin	• Report on COVID-19 Vaccination, ages 12-15 • TeleHealth Utilization and Cost Report Update	None	2 updates
11. UNFINISHED BUSINESS			
S. Coffin	• None	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

June 8, 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, Matt Woodruff, Dr. Steve O'Brien, Tiffany Cheang, Richard Golfin III, Carol van Oosterwijk, Ruth Watson, Shulin Lin, 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. May 11, 2021, Finance Committee Minutes were approved at the Board of Governors meeting May 14, 2021, and not presented today. There were no modifications to the Consent Calendar.	Motion to accept **Consent Calendar** Motion: N. Peraino Seconded: Dr. Marchiano Pass by Consent	
a.) CEO Update			
Scott Coffin	S. Coffin gave updates to the committee on the following: **Budget Update** – Today we will be presenting the Preliminary Budget for Fiscal Year 2022. DHCS will be releasing Medi-Cal rates in mid-December, and a final budget will be presented to the Finance Committee and Board of Governors in December 2021.	Informational update to the Finance Committee Vote not required	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	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.* We are currently planning for the transition of the Whole Person Care Pilot, which is AC3 in Alameda County, as well as the Health Homes program. The Alliance is involved in both programs. The AC3 Program is managed by Alameda County Health Care Services Agency, and the Health Homes Program is managed by the Alliance. Both programs end on December 31, 2021. Some of the components of these programs will fall under CalAIM starting in January 2022. We are in the planning stages and plan to discuss the potential costs and financial risk for these services at the Board of Governors meeting on Friday, June 11. We are working with the Department of Health Care Services to understand how In Lieu of Services will be funded. We continue to track the deliverables of regulatory documents that must be filed in July, September, and October. There are no financial implications related to the submission of these documents; however, they do outline our commitments. We will therefore return to the committee in July to discuss the financial implications related to these submissions. **Question:** Dr. Ferguson asked how the Medi-Cal base rate will be established for the In Lieu of Services. Will we be paid prospectively or retrospectively? S. Coffin answered that the initial approach for these services is part of two (2) funding streams that were included in Governor Newsom's budget. One is a $300 million state-wide allocation to build capacity, the other is a $115 million one-time incentive for Medi-Cal base rates in calendar year 2022. Both funding sources are to be split among the participating counties, so it is unclear how much funding will be available to the Alliance in Calendar Year 2022 for the In Lieu of Services. In addition, because of the retrospective rate development process, our 2022 expenses will not likely be considered until the 2025 rate development process. G. Riojas added that we do not know yet whether In-Lieu of Services will be considered in the rate development process. Dr. Ferguson asked if there will be a limit placed in our budget for the unknown expense and exposure with these In Lieu of Services. S. Coffin answered that we do not currently have that defined in the budget but could include it in our discussion on Friday.	Recommend a proposed dollar allocation (or spending limit) for In-Lieu of Services expenses, by service category. If unable to prepare allocations by Friday, be prepared to discuss with full board; ILOS excluded from preliminary budget, and forecasted costs will be included in the final budget in December.	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
b.) Review April 2021 Monthly Financial Statements			
Gil Riojas	**<u>April 2021 Financial Statement Summary</u>** **Enrollment:** Current enrollment is 284,191 and continues to trend upward, Total enrollment has increased by 2,554 members from March 2021, and 27,446 members since June 2020. As in previous months, increases are primarily in the Child, Adult, and Optional Expansion categories of aid. Total Enrollment continues to increase month over month, however; as discussed last month, 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. **Net Income:** For the month ending April 30, 2021, the Alliance reported a Net Income of $6.9 million (versus budgeted Net Loss of 22,000). For the year-to-date, the Alliance recorded a Net Loss of $3.7 million versus a budgeted Net Loss of $20.2 million. The favorable variance is attributed to higher than anticipated revenue and significantly lower than anticipated Administrative Expense. These were somewhat offset by higher than anticipated Medical Expense. **Revenue:** For the month ending April 30, 2021, actual Revenue was $95.3 million vs. our budgeted amount of $81.4 million. Factors creating the favorable variance were mainly due to delay of the 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 $91.8 million vs. our budgeted amount of $73.9 million. For the year-to-date, actual Medical Expenses were $851.5 million versus budgeted $827.6 million. Drivers leading to the unfavorable variance can be seen on the tables on page 11, with the explanation on pages 11 and 12.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Medical Loss Ratio: Our MLR ratio for this month was reported at 96.4%. Year-to-date MLR was at 95.9% vs our annual budgeted percentage 94.2%. As a reminder, we want our Medical Loss Ratio to be lower and we are trying to stay in the 94-95% range. **Administrative Expense:** Actual Administrative Expenses for the month ending April 30, 2021 were ***negative*** $3.4 million vs. our budgeted amount of $7.5 million. This is due to the reversal of $10.0 million allocated to the Sustainability Fund. As a result, our Administrative Expense represents -3.5% of our Revenue for the month, and 4.6% of Net Revenue for year-to-date. **Other Income / (Expense):** As of April 30, 2021, our YTD interest income from investments was $554,000. 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 $284,000. **Tangible Net Equity (TNE):** We reported a TNE of 543%, with an excess of $165.2 million. This remains a healthy number in terms of our reserves. **Cash and Cash Equivalents:** We reported $273.4 million in cash; $76.0 million is uncommitted. Our current ratio is above the minimum required at 1.58 compared to regulatory minimum of 1.0. **Capital Investments:** Fiscal year-to-date Capital Assets acquired less Capital Assets retired is ***negative*** $1.3 million (net negative due to retirement of Trizetto software, $2 million). Our annual capital budget is $2.4 million. **Question:** N. Peraino asked if the pharmacy carve-out was part of “340B”. G. Riojas answered that yes, the 340B program is a component of the pharmacy carve out.	Motion to accept **April 2021, Financial Statements**	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Question: Dr. Ferguson commented that although very healthy, the overall trend for our TNE is down, and asked if there was an explanation. G. Riojas answered that from the beginning of the fiscal year to now, we have reported a year-to-date net loss. Additionally, the requirement was increased due to our consistent increase in Medical Expenses. As a reminder, the amount the state requires in TNE is based on a look-back period and our older months that had lower medical expenses have been replaced by newer months with higher medical expenses. This affects the TNE calculations.	Motion: N. Peraino Seconded: Dr. Marchiano Motion Carried No opposed or abstained	
c.) Review FY2022 Preliminary Budget			
Gil Riojas	G. Riojas gave a presentation for the Preliminary FY2022 budget for review to bring to the Board of Governors on Friday, June 11, 2021.	Informational update to the Finance Committee. Vote not taken.	
Dr. Rollington Ferguson	Dr. Ferguson motioned to adjourn the meeting. The meeting adjourned at 9:00 am.	Motion to adjourn: Dr. Ferguson Seconded: N. Peraino No opposed or abstained.	

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

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

2020

Case Management/Care Coordination,
Complex Case Management & Disease Management
2020 Program Evaluation

Signature Page

Date _____

Julie Anne Miller, LCSW
Senior Director, Health Care Services

Date _____

Sanjay Bhatt, M.D.
Director, Quality Improvement

Date _____

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

Date _____

Scott Coffin
Chief Executive Officer

Date _____

Evan Seevak, M.D.
Board Chair

2020
Case Management
Program Evaluation

Overview

Under the leadership and strategic direction established by Alameda Alliance for Health (The Alliance) Board of Directors and Quality Management Committee (QMC), senior management and the Health Care Quality Committee (HCQC), the Health Care Services 2020 Case Management Program was successfully implemented. This report serves as the annual evaluation of the effectiveness of the Case Management (CM) program activities, which include care coordination, care management, complex case management and disease management.

The processes and data reported covers activities conducted from January 1, 2020 through December 31, 2020.

Membership and Provider Network

The Alliance products include Medi-Cal Managed Care beneficiary's eligible thorough one of several Medi-Cal programs, e.g. TANF, SPD, Medi-Cal Expansion and Dually Eligible Medi-Cal members who do not participate in California's Coordinated Care Initiative (CCI). For dually eligible beneficiaries, Medicare remains the primary insurance and Medi-Cal benefits are coordinated with the Medicare provider.

Alliance Group Care is an employer-sponsored plan serviced by The Alliance which provides low-cost comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County. The Alliance provides services to IHSS workers through the commercial product, Group Care.

Figure 1 2020 Trended enrollment by network and age group

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%
		Network Distribution	*18.8%*	*20.0%*	*11.4%*	*35.9%*	*13.8%*
			% Direct:	39%		% Delegated:	61%

Age Category Trend				
	Members			
Age Category	Dec 2018	Dec 2019	Nov 2020	Dec 2020
Under 19	98,122	91,641	97,068	97,399
19 - 44	84,866	78,271	91,897	93,280
45 - 64	57,340	54,210	57,413	57,679
65+	23,862	24,709	26,918	27,231
Total	264,190	248,831	273,296	275,589

For 2020, The Alliance membership increased, as seen in Figure 1, to about 275 thousand members, from 248 thousand members in 2019. This trend is in alignment with the increase in Medi-Cal Enrollment in California in 2020.

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

Figure 2 Provider Network by Type and Enrollment

Provider Network	Provider Type	Members (Enrollment)	% of Enrollment in Network
Direct-Contracted Network	Independent	51,937	18.8%
Alameda Health System	Managed Care Organization	55,240	20%
Children First Medical Group	Medical Group	31,529	11.4%

Community Health Clinic Network	Medical Group	98,920	35.9%
Kaiser Permanente	HMO	37,963	13.8%
TOTAL		275,589	100%

The percentage of members within each network has been relatively steady from 2018 to 2020, varying by less than 1%

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

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

Delegation

The Alliance delegates CM activities to contracted health plan, provider groups, vendor networks and healthcare organizations that meet delegation agreement standards. The contractual agreements between The Alliance and delegated groups specify the responsibilities of both parties: the functions or activities that are delegated; the frequency of reporting on those functions and responsibilities; how performance is evaluated; and corrective action plan expectations, if applicable. The Alliance conducts a pre- contractual evaluation of delegated functions to assure capacity to meet standards and requirements.

The Alliance's Compliance Department is responsible for the oversight of delegated activities. The Compliance Department works with other respective departments to conduct the annual delegation oversight audits. When delegation occurs, The Alliance requires the delegated entity to comply with the NCQA standards and present quarterly reports of services provided to Alliance members. The Alliance's Compliance Department is responsible for the oversight of delegated activities and completes an annual performance evaluation of delegated case management operations. Results of the annual evaluation and any audit results are reviewed by the Compliance and Delegation Oversight Committee.

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

Figure 3 – 2020 the Alliance Delegated Network

2020 Alliance Delegated Network			
Provider Network/Delegate	**Provider Type**	**Delegated Activity- Care Coordination/CM**	**Delegated Activity- Complex Case Management**
Kaiser	HMO	Yes	Yes
CHCN	MCO	Yes	No
Beacon	MBHO	Yes	Yes

Delegation vs Direct Trend								
	Members				% of Total (ie.Distribution)			
Members	Dec 2018	Dec 2019	Nov 2020	Dec 2020	Dec 2018	Dec 2019	Nov 2020	Dec 2020
Delegated	163,165	154,621	166,940	168,412	61.8%	62.1%	61.1%	61.1%
Direct	101,025	94,210	106,356	107,177	38.2%	37.9%	38.9%	38.9%
Total	**264,190**	**248,831**	**273,296**	**275,589**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Overall, the network was sufficient to meet the needs of The Alliance membership and provider network through 2020. The organization had identified issues related to delegation oversight in 2019, so in 2020 there were continued improvements in the level of oversight, monitoring, reporting, and training of delegates.

Program Structure

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

Responsibility, Authority and Accountability/ Governing Committee

The Alameda County Board of Supervisors appoints the Board of Governors (BOG) of the Alliance, a 12-member body representing provider and community partner stakeholders. The BOG is the final decision-making authority for all aspects of The Alliance programs and is responsible for approving the Quality Improvement, Utilization Management and Case Management Programs. The Board of Governors delegates oversight of Quality and Utilization Management functions to The Alliance Chief Medical Officer (CMO) and the Health Care Quality Committee (HCQC) and provides the authority, direction,

guidance and resources to enable Alliance staff to carry out the Utilization Management and Case Management Programs. Utilization Management oversight is the responsibility of the HCQC. Utilization Management and Case Management activities are the responsibility of the Alliance Health Care Services staff under the direction of the Medical Director for Care Management and Special Programs and the Senior Director, Health Care Services in collaboration with the Alliance CMO.

Committee Structure

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

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

HCQC charters a sub-committee, the Utilization Management Committee (UMC) which meets at least once every 2 months (10 meetings in 2020,) serving as a forum for the Alliance to evaluate current CM activities, processes, and metrics. The UMC also evaluates the impact of CM programs on other key stakeholders within various departments and when needed and assesses and plans for the implementation of any needed changes.

The 2020 CM Program Evaluation and CM Program Description were developed and presented for documentation into the May 21, 2020 HCQC minutes for Board of Directors approval. The committee was chaired by the Chief Medical Officer with support of the Senior Director of Quality Management, external physicians, and key organizational staff.

In 2020 the UM Subcommittee of HCQC has continued to support the focus on CM activities, oversight for delegated CM activities, case management/care coordination, complex case management, transitions of care, population health, integration of behavioral health and medical as well as regulatory compliance.

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

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

During 2020 Dr. Aaron Chapman, a psychiatrist, and Medical Director of Alameda County Behavioral Health Care Services, actively participated in the HCQC meetings and provided clinical input ensuring policies and reports considered behavioral health implications.

Program Scope and Structure

The Alliance promotes case management services through multidisciplinary teams that address member specific medical conditions, behavioral, functional, and psychosocial issues whether in a single health care setting or during the member's transitions of care across the continuum of care. Case management activities are performed telephonically. The underlying premise of the program is that when an individual reaches the optimum level of wellness and functional capability, everyone benefits: the individuals being served, their support systems, the health care delivery systems, and the various payer sources.

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

Case Management Resources

The Alliance CM Department is staffed with physicians, nurses, social workers, and non-clinical support staff including clerical support and clinical support

coordinators. A full description of staff roles and responsibilities is provided in the 2020 CM Program Description.

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

In 2020, the leadership structure in the CM department was evaluated and revised to better meet the needs of the program and the staff:

- One of the two Managers positions was eliminated.
- A Supervisor of CM role was developed and hired.
- A Lead CM was hired.

The department was successful in hiring and retaining Complex Case Managers in 2020.

Delegated Case Management

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

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

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

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

In 2020, the CM staff conducted annual audits on the four (4) delegates. The threshold for CM audit compliance is 90%. For entities that do not meet the threshold, CM may require a corrective action plan which is tracked for compliance with the resolution of the deficiency. Entity audit results for 2020 were:

- Two (2) groups pass CM audit (≥ 90.0%), 1 failed with corrective actions required.

Figure 4 the Alliance Network – 2020 Annual Audit Score

Delegate	Provider Type	Delegated Activity- CM	2020 Audit Results	Corrective Action Required
Kaiser	HMO	X	Passed	None
CHCN	Medical Group	X	Passed	None
Beacon/College Health IPA (CHIPA)	Vendor-BH	X	Failed	Yes (2): No documentation of PCP collaboration and did not include review of clinical documentation

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

Recommend Actions/Next Steps

For 2021, there is an opportunity to continue to improve the oversight of delegated CM activities. The CM Department leadership continues to develop a robust level of delegate oversight and performance monitoring. The activities include dedicated staff, monitoring activities, performance management, delegate feedback and CM training.

Case Management Processes and Information Sources

Case Management Information Systems and Sources

The CM Department utilizes a clinical information system, TruCare, as the case management platform. TruCare is a member-centric application that automates the entire clinical, administrative, and technical components of case management into a single platform. The system supports case management with the use of algorithmic clinical intelligence and best practices to guide case managers through assessments, development of care plans, and ongoing management of members. The system includes assessment templates to drive consistency in the program. Care plans are generated within the system and are individualized for each member and include short and long-term goals, interventions, and barriers to goals. The clinical information system includes automated features that provide accurate documentation for each entry; record actions or interactions with members, caregivers, and providers; and create automatic date, time, and user stamps. To facilitate care planning and management, the clinical information system includes features to set prompts and reminders for next steps or follow-up contact.

Evidence-based clinical guidelines are available to support the Case Managers in conducting assessments, developing care plans, and managing care. The clinical practice guidelines are based on current published literature, current practice standards, and expert opinion. Whenever possible, guidelines are derived from nationally recognized sources. If a nationally recognized guideline is not available, the Alliance will involve board certified specialists in the development of the appropriate guidelines. Assessment questions were based on evidence-based guidelines from The National Guideline Clearinghouse (www.guideline.gov) until they were no longer available as of July 2018, as well as medical and behavioral healthcare specialty societies and/or Alliance Clinical Practice Guidelines, published on the AAH website.

In July 2019, the CM Department conducted a comprehensive review of the standard workflow hosted by a contractor certified in Lean Management. This included reviewing the functionality of the TruCare system. In 2020, Casenet, the corporate parent of TruCare continued to provide a collaborative effort along with CM leadership to optimize and improve the functionality of the TruCare system. Over the course of 2020, 3 separate upgrades to the system occurred. As 2020 ended, the work was not fully completed, and collaboration will continue into 2021.

The Alliance CM Department utilized the established evidence based clinical criteria as defined in the CM Program. Based on a review of member needs and utilization alternative criteria, the complex criteria is utilized to facilitate in assisting the given population to incorporate additional social determinants of health.

In 2020, CM Department collaborated with Senior Leadership to develop new criteria to align with the Population Health initiatives. The Disease Management Program was reviewed and enhanced in collaboration with Quality. The enhancements made were based on the Population Health initiatives, leading to a strengthening of the Disease Management Program in 2021.

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

Care Coordination and Case Management Processes

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

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

Basic Care Management

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

Care Coordination

Care coordination is provided by the Provider Group CM staff for members needing assistance in coordinating their health care services. This level of CM

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

Targeted Care Management

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

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

Complex Case Management

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

Complex Case Management is a collaborative process between the Primary and/or Specialty Care Providers, member and Care Manager, who provide assistance in planning, coordinating, and monitoring options and services to meet the member's health care needs.

Disease Management

The Alliance CM Disease Management (DM) program is integrated with the Quality Management Department and Population Health initiatives to provide interventions for members with targeted chronic illnesses. The Population Health initiative has identified target diagnoses affecting the Alliance membership at a disproportionate rate and/or with significant utilization. In 2020, the DM program worked on members with Asthma and Diabetes. Multiple approaches were taken to enhance the service, ranging from identification of members with the disease, ensuring standard work was employed related to the level of acuity of the member and their disease. The program worked with community partners: Asthma Start, for children with asthma, and a variety of community programs to provide services for members with diabetes.

Population Health Initiative

In 2020, the Population Health initiatives at the Alliance were strengthened and further integrated into ongoing Alliance work with members. A stratification of member acuity was developed, ranging from low-risk members who may need health promotion/education to the highest risk, most vulnerable members needing full wrap around Health Homes Program services. The CM interventions performed at each acuity level were identified, and the foci of CM work has been further targeted to the acuity level of the members.

Figure 5 Volume of CM cases in Population Health Target Diagnoses in 2020

Dx	Number with Disease State in the Last 12 Months	Care Coordination (Currently Enrolled)	Transitions of Care (Currently Enrolled)	Complex Case Management (Currently Enrolled)	Health Homes
CAD	5,052	42	27	29	182
CHF	2,952	39	37	38	190
Cervical Cancer	273	1	N/A	1	7
Lung Cancer	230	2	2	1	5
Emphysema	3,120	35	14	26	163
ESRD	767	10	13	11	34
Schizophrenia	2,829	14	10	10	68
Sickle Cell Disease	86	1	N/A	1	N/A
Hepatitis C	1,219	12	16	3	46
Tuberculosis	143	N/A	1	1	5
Substance Use Disease	7,700	47	52	27	236

Asthma	14,590	61	27	20	203
Breast Cancer	877	11	3	1	6
Hyperlipidemia	27,742	71	54	34	338
Hypertension	33,471	128	106	54	574
Diabetes	16,758	72	54	36	349
Obesity	20,223	56	30	25	242
Pregnancy	5,102	13	5	N/A	8
Gingivitis	1,479	2	3	N/A	13
Burns - 1st degree	346	1	1	N/A	4
Tobacco	10,692	58	48	26	226
Total Unique Members any DX	78,614	204	159	55	709

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

Specialty Programs

Transitions of Care

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

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

For 2021, the Transitions of Care Program plans to expand beyond the three (3) pilot hospitals and to incorporate further collaboration between Utilization

Management (UM) and Pharmacy to further meet the member's health care needs.

Case Management Processes

Health Risk Assessments

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

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

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

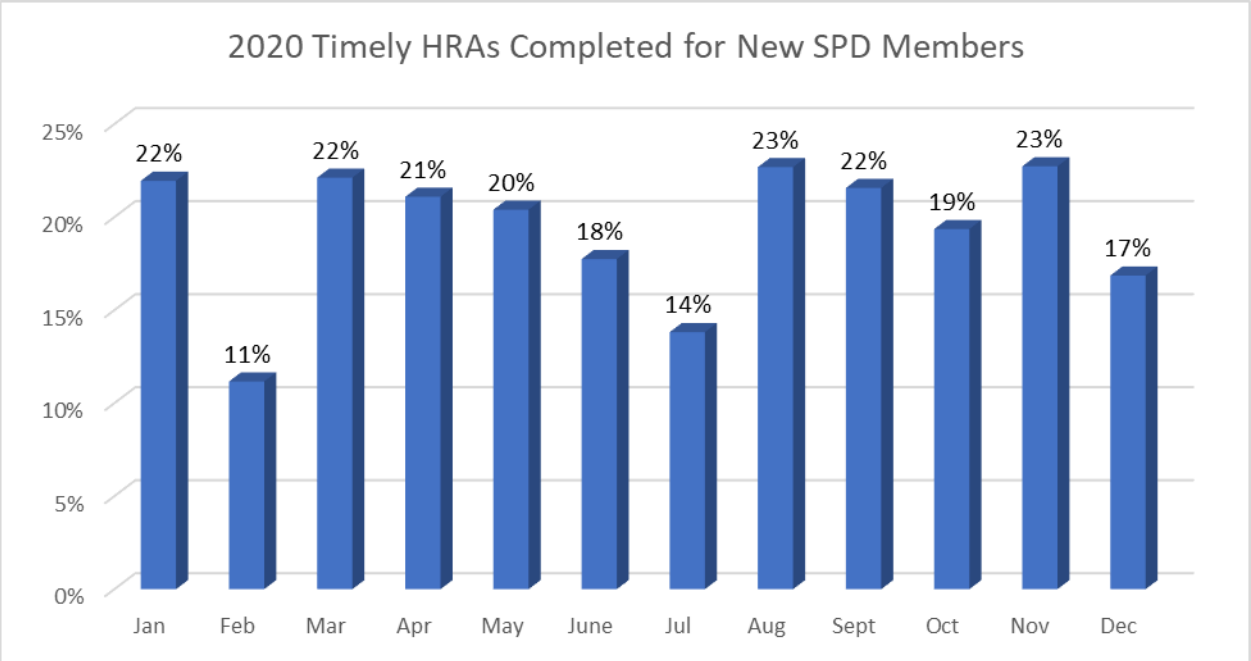
CM staff is responsible for ensuring the Member Care Plan is completed and shared as well as providing any community or health resources. For Members who completed the HRA with a final stratification of Low Risk, CM staff review the HRA responses to identify Member needs, i.e. resources for transportation,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

Member; a copy of the Care Plan is sent to the Primary Care Provider for care coordination.

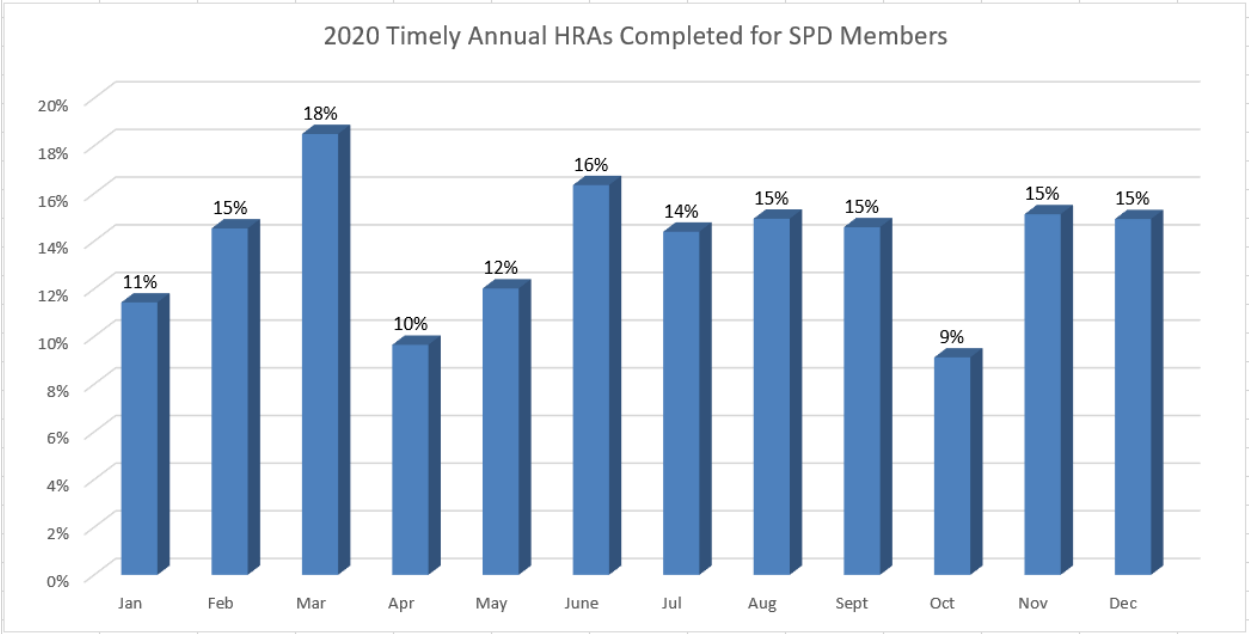
In 2020, the Alliance continues to contract with a vendor to make Interactive Voice Response (IVR) calls to members so that the Alliance can give members every opportunity to complete the HRA and have the results acted upon by the CM department.

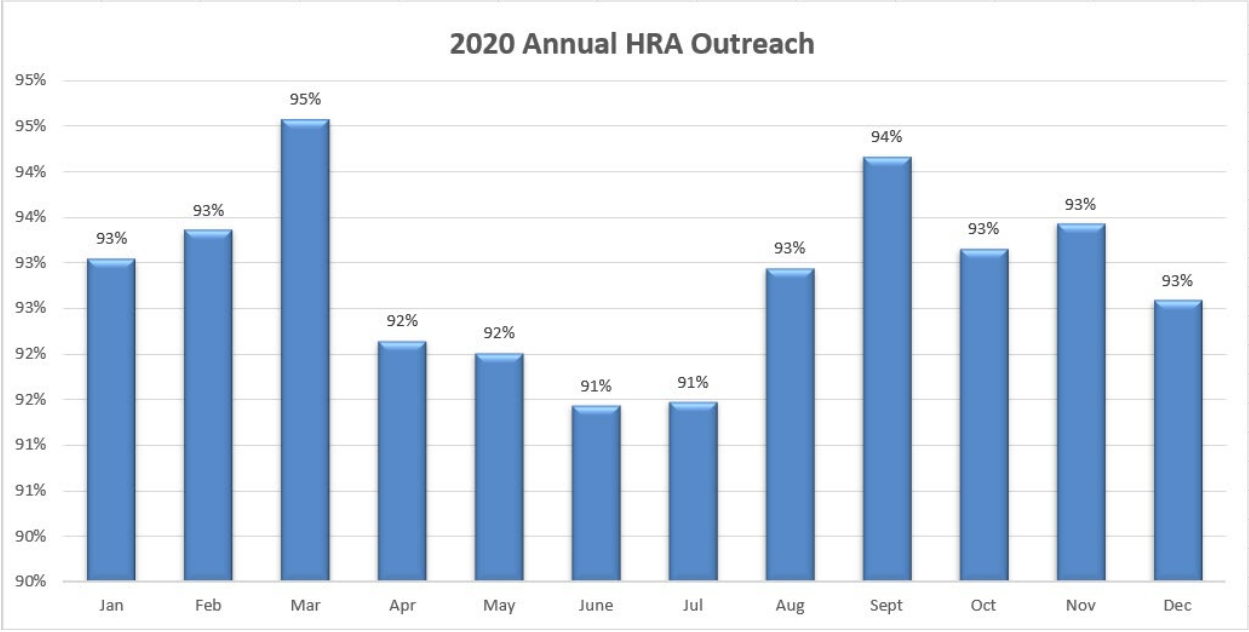
In collaboration with Healthcare Analytics, a HRA dashboard was created in 2018, to track compliance of outreach attempts and timely completion of the HRA for the SPD population, and this tracking continued in 2020.

New HRA completion for SPD Members



Annual HRA completion for SPD Members





The outreach rates for 2020 remained consistently above 90%, reflecting the engagement of the vendor to assist with the HRA process, to ensure that

members receive their HRAs timely, and were also responded to timely as well. The completion numbers increased in 2020, never going above 23%. Although this remains low, there will be further evaluation in 2021 to identify any opportunities for improvement.

CM Referral and Identification

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

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

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

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

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

The Alliance utilizes a predictive model application, CareAnalyzer, to aggregate utilization data and identify members who may be at risk and could benefit from CM interventions. Using CareAnalyzer, the HealthCare Analytics Department generates monthly reports using an established, proprietary algorithm which is shared with the CM Department. Staff review the data and prioritize outreach to the top 1% on the Population Health Report.

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

involvement with certain member situations, e.g. Appeals & Grievance Member Services, Compliance, and Leadership.

CM cases identified through the data sources or referral sources cited above are reviewed by the CM triage nurses, taking into consideration the known information about the case from claims history, medical records that may be on file for UM purposes, and member services call history. The triage nurse verifies member appropriateness for CCM and if appropriate opens a case in the CM information system and assigns a case manager. Members are deemed ineligible if the member is not on the Plan, has died or entered a hospice program, is in a long-term care facility or is receiving transplant services through a contracted center of excellence.

Predictive Model Application

As stated above, The Alliance utilizes a predictive model application, CareAnalyzer, to aggregate utilization data to identify members who may be at risk and could benefit from CM interventions. CareAnalyzer's unique analytic approach stems from the integration of The Johns Hopkins University ACG System, a comprehensive set of predictive modeling tools.

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

Figure 6 - 2020 Care Analyzer data for Disease Management and Care Management Services

Care Analyzer	01/2020	02/2020	03/2020	04/2020	05/2020	06/2020	07/2020	08/2020	09/2020	10/2020	11/2020	12/2020
Asthma	1064	884	1226	1416	726	819	1107	896	812	1041	7129	982
Diabetes (Excluding CCM)	3184	3110	5502	3768	2500	1101	6526	3452	3469	5503	4061	2883
CCM (Diabetes + Non-Diabetes)	686	700	723	737	651	480	567	547	524	541	535	559
Care Coordination MCAL/Medicare members	69	64	75	89	80	81	88	88	83	76	74	81
Percentage of CCM												
5%	34	35	36	37	33	24	28	27	26	27	27	28
3%	21	21	22	22	20	14	17	16	16	16	16	17
1%	7	7	7	7	7	5	6	5	5	5	5	6

Figure 6 above shows the number of members identified by CareAnalyzer algorithm for potential candidates for CCM services in 2020. The top volumes were in Diabetes, averaging about 3700 per month, followed by Asthma at around 1500 per month.

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

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

In early 2020, the logic to prioritize members who had a high RUB score or RRS predictive score was being used. However, leadership received feedback from the frontline staff that members identified by that logic were not in fact the most vulnerable members. CM continued to use the Care Analyzer report but instead of filtering the members based on RUB and RRS scores, the combination of co-morbidities (Diabetes, Renal Failure, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD)), inpatient admissions (greater than three (3)) and emergency room visits (greater than four (4)) in the prior six (6) months were used. If a member had any combination of three (3) of the above

filters, then the member would receive an outreach attempt from one of the Health Navigators.

With the changes made to filter the Population Health Report, in 2020, the case management team has been attempting to engage all the members who meet criteria as described above. (6.1% to 28.2%, depending on the month)

Transitions of Care

In November 2019, Transitions of Care program began was enhanced, piloting at 1 hospital system (containing 3 hospitals), with the plan for further expansion in 2020. The criteria for Transitions of Care is a discharge from an inpatient stay from one (1) of the three (3) hospitals. Continued collaboration is ongoing to prevent duplication of work by other Transitions of Care Programs.

There are two (2) reports used to create TOC referrals. The Admission, Transfer, Discharge (ADT) report is data sent from the hospital, and the TOC Discharge Report populated by Inpatient Utilization Management authorization closure. Upon discharge from the hospital, the members listed on the reports are then entered into the Clinical Information System as a referral. The referral source is listed as 'Internal Report'. Prior to CM staff assignment, the referrals are reviewed by a triage nurse to evaluate medical history and utilization history from various data sources including the hospital discharge summary. The triage nurse makes a recommendation during the assignment process as to which CM team member role is appropriate to receive the referral.

In 2020, CM validated the ADT Report, and retired the use of the TOC Discharge report. CM also collaborated with IT and automate referral entering into the system of record, TruCare. These optimizations have streamlined the referral process, saving many hours of manual entry.

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

Further planning regarding expansion of the TOC Program to more hospitals into 2021 is ongoing. The goal is to expand to include 25% more members into the TOC Program by the end of 2021.

The complex case management criteria was changed in 2019 to incorporate specific diagnoses, including mental health diagnoses as well as other complex psychosocial needs. The CM workflow includes every member enrolled in a

case management program to be evaluated for Complex Case Management (CCM). If the member meets criteria, CCM is offered to that individual (even if the member is first enrolled in the TOC Program).

Methodology:

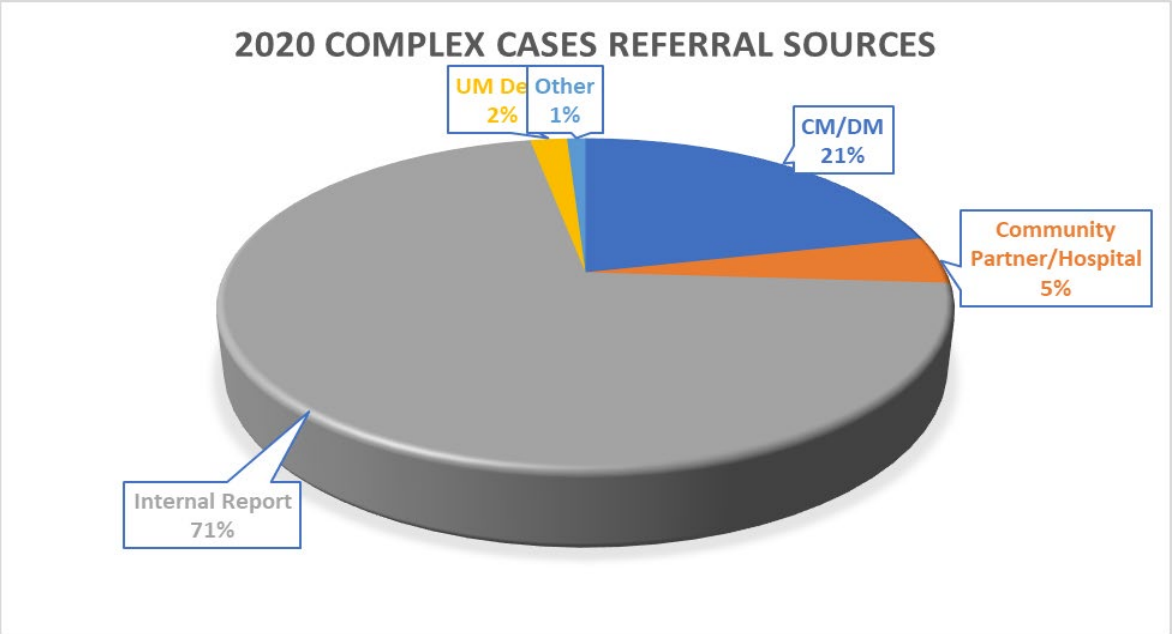
Using the Case Management Aging report, developed in 2018, CCM cases created in 2020 were pulled and separated based on sources. Seventy-one (71) percent (292 out of 411) of CCM cases came from an Internal Report. With the Transitions of Care (TOC) Program, the Internal Report category includes: ADT Feed, TOC Discharge Report and the Population Health Report.

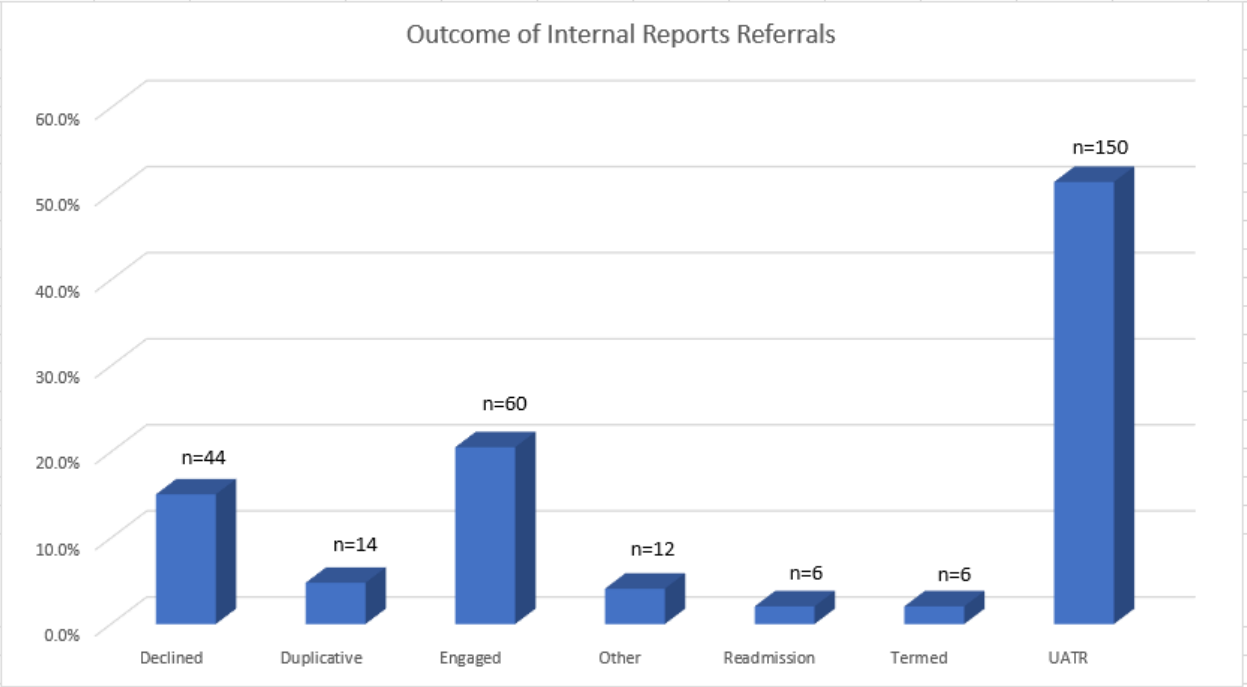
2020 Results:

Complex Case Management

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

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





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

- Overall for 2020, 71% of CCM cases were identified from the Internal Reports.
- CM/DM referral type is defined as CM department refers to other CM team members. For 2020, 21% of the referrals were these internal referrals.
- CM continued to have difficulty engaging members from the Internal Reports in the CCM program, with 20 % of potential cases successfully engaged in the program. (This is up from 7% in 2019.)
- The majority of cases identified through the internal reports were Unable to Reach, Engaged or Declined to be in the program.

Qualitative analysis:
The following provides a qualitative analysis of CCM and the Population Health Report derived from quantitative analysis of combined CCM Daily Aging and Population Health Reports, as well as feedback from, but not limited to, committee discussion and focus groups.

- There were members identified in the cost containment initiative but were not pulled from the Internal Reports.
- There were members identified in both cost containment initiative and Internal Reports but not successfully engaged.

In 2020, multiple initiatives were launched to improve the internal structure and processes. This included:

- Continued review and revision of the Population Health Report and the CM Daily Aging Report
- Department trainings to improve consistency in outreaching members, talking to members and documentation in the electronic system of record.

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

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

2021 Recommendations

- Continue to review and revise the Population Health Report
- Continue to identify, implement, and evaluate different avenues to attempt to improve member engagement.
- Findings will be collected and submitted as part of the 2021 CM program evaluation.

Figure 7 - 2020 CM Care Coordination Program by Referral Source

Care Coordination	202001	202002	202003	202004	202005	202006	202007	202008	202009	202010	202011	202012
AAH Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0
Behavioral Health Program	0	0	0	0	0	0	0	0	0	0	0	0
California Children's Services	0	0	0	0	0	1	0	0	0	1	1	0
CBAS/LTSS	0	0	0	0	0	0	0	0	0	0	0	0
CM/DM	44	51	38	34	52	47	70	48	52	64	45	45
Community Partner/Hospital	10	20	21	14	22	32	31	20	24	43	33	34
Compliance Dept	0	1	1	0	0	0	0	0	0	1	1	1
Grievance and Appeal	3	4	6	4	2	6	4	1	6	4	4	7
Health Education	0	0	0	0	0	0	0	0	0	0	0	2
Internal Report	12	12	2	18	23	33	24	10	10	16	17	11
Member Services	68	64	41	40	102	66	52	36	45	61	49	60
Nurse Advice Line	2	5	6	9	2	7	2	2	0	3	1	1
Other	3	4	3	2	4	6	2	2	9	1	3	6
PCP/Specialty Provider	0	2	2	0	0	1	0	0	0	2	0	1
Provider Services Dept	0	0	0	1	0	0	0	0	0	0	0	0
Self	11	16	3	8	6	8	7	11	9	7	8	12
UM Dept	66	59	52	49	53	35	47	57	72	53	35	43
Total	**219**	**238**	**175**	**179**	**266**	**242**	**239**	**187**	**227**	**256**	**197**	**223**

Analysis of 2020 show the top three referral sources for Care Coordination cases are:

1) Member Services at 684
2) UM Department at 621
3) CMDM at 590

CMDM referrals increased in 2020 as they were redefined as referrals made to a CM team member (internal referral). Referrals from PCP/Specialty Providers remain low and represent an opportunity to work with the Physicians/Physician Offices on the services for care coordination.

Figure 8 - 2020 CM Care Coordination Program by Active Cases

Care Coordination	202001	202002	202003	202004	202005	202006	202007	202008	202009	202010	202011	202012
ACTIVE CASES												
New Cases	259	268	218	201	253	253	267	195	244	251	206	236
Total Cases In Progress	634	635	606	525	562	619	622	549	561	585	547	553
Total Assessments Completed w/in 30 Days of Referral	0	1	1	1	6	5	5	2	5	14	5	4
Active Participation Rate % (Total Assessments Completed w/in 30 Days of Referral / Total Referrals)	n/a	0%	1%	1%	2%	2%	2%	1%	2%	5%	3%	2%

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

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

The Care Coordination Assessment was developed in Q4 of 2020. For the majority of 2020, the assessment contributing to the Active Participation Rate was the Social Worker Assessment. Development of the Social Worker Assessment began in 2019, completed and rolled out in early 2020.

Figure 9 - 2020 CM Care Coordination Program by Case Closure

Care Coordination	202001	202002	202003	202004	202005	202006	202007	202008	202009	202010	202011	202012
CASE CLOSURE BY CLOSURE REASONS												
Already in Program	5	5	12	7	7	8	8	3	8	6	5	6
Case still open	0	1	1	0	1	2	0	1	0	0	1	2
Completed Program	48	40	35	25	31	42	38	33	26	43	33	11
Condition stable with no further Case Management needs	41	44	41	39	45	53	46	64	53	57	42	48
Condition stable with no further Disease Management needs	1	0	0	2	3	5	0	2	0	0	0	0
Deceased	7	2	2	2	2	2	1	2	2	0	0	1
Declined Program	9	7	7	7	8	6	12	8	9	12	4	7
Duplicate member record	1	0	2	2	1	2	0	0	0	2	0	1
Duplicative Program	0	0	0	0	0	0	1	2	1	7	2	1
Escalate services to higher level program	9	8	11	10	14	12	13	9	10	5	8	7
Inappropriately identified for program	1	0	1	3	0	3	1	0	0	0	1	1
Lost Contact	39	21	22	23	17	32	32	23	24	24	28	11
Member/Caregiver refuses services	2	1	1	1	1	0	0	2	1	1	1	1
Member declines continued Case Management services	0	0	11	0	0	3	4	2	2	1	3	1
Member declines continued Disease Management services	0	0	0	2	1	0	0	0	0	0	0	0
Member Ineligible	10	12	10	8	5	7	7	8	10	9	7	3
Member non-compliant	0	1	0	0	0	0	1	0	0	0	0	0
Member transferred to Delegate/Other	9	6	5	8	4	1	6	3	9	5	4	7
Other	19	30	29	28	21	27	29	18	21	27	27	18
Readmission	1	1	3	1	1	3	2	4	2	2	4	4
Referred to Disease Management	0	0	0	0	0	1	0	0	0	0	0	0
Step down to lower level program	0	1	0	0	0	0	0	0	0	0	0	0
Termination of coverage	3	2	0	2	2	0	0	1	1	1	0	1
TruCare cleanup	0	0	1	0	0	0	0	0	1	0	0	1
Unable to contact member	63	65	88	46	33	55	67	47	47	42	60	48
Total	**268**	**247**	**282**	**216**	**197**	**264**	**268**	**232**	**227**	**244**	**230**	**180**

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

1) Unable to Contact at 661 members
2) Condition Stable with no further need for CM at 573 members
3) Completed Program at 405 members.

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

Plan for 2021

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

Complex Case Management

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

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

Figure 10 – 2020 Complex Case Management – Referrals by Source

Complex	202001	202002	202003	202004	202005	202006	202007	202008	202009	202010	202011	202012
CM/DM	1	0	5	7	11	10	4	3	10	8	13	16
Community Partner/Hospital	3	4	1	0	1	0	1	1	0	2	3	3
Grievance and Appeal	0	0	0	0	0	0	0	0	0	0	0	0
Internal Report	20	21	18	46	23	30	4	29	30	18	42	11
Member Services	1	0	0	0	1	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
PCP/Specialty Provider	0	0	0	0	0	0	0	0	0	0	0	0
Self	1	0	0	0	0	0	0	0	0	0	1	0
UM Dept	1	1	0	0	1	1	0	0	0	2	0	2
Total	**27**	**26**	**24**	**53**	**37**	**41**	**9**	**33**	**40**	**30**	**59**	**32**

For 2020, the top three referral sources were:

1) Internal Report (Care Analyzer and ADT Feed) at 292
2) CMDM (Internal referral) at 88
3) Community Partners/Hospitals at 19.

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

Figure 11 2020 CCM Active Cases and Case Assessments Rates

Complex	202001	202002	202003	202004	202005	202006	202007	202008	202009	202010	202011	202012
ACTIVE CASES												
New Cases	34	40	29	65	38	37	6	38	33	32	52	25
Total Cases In Progress	59	73	71	105	93	101	60	63	77	69	87	81
Total OptOut Assessments	0	0	0	0	0	0	0	0	0	0	0	2
Total Assessments Completed w/in 30 Days of Referral	13	15	11	23	16	19	5	3	12	29	36	35
Active Participation Rate % (Total Assessments Completed w/in 30 Days of Referral / Total Referrals)	48%	58%	46%	43%	43%	46%	56%	9%	30%	97%	61%	109%

Figure 11 above describes the 2020 Active case activities by the number of new cases, (429) the total open cases in program (939) and the number of cases in which the members was identified and referred but opted not to engage in the program, (2).

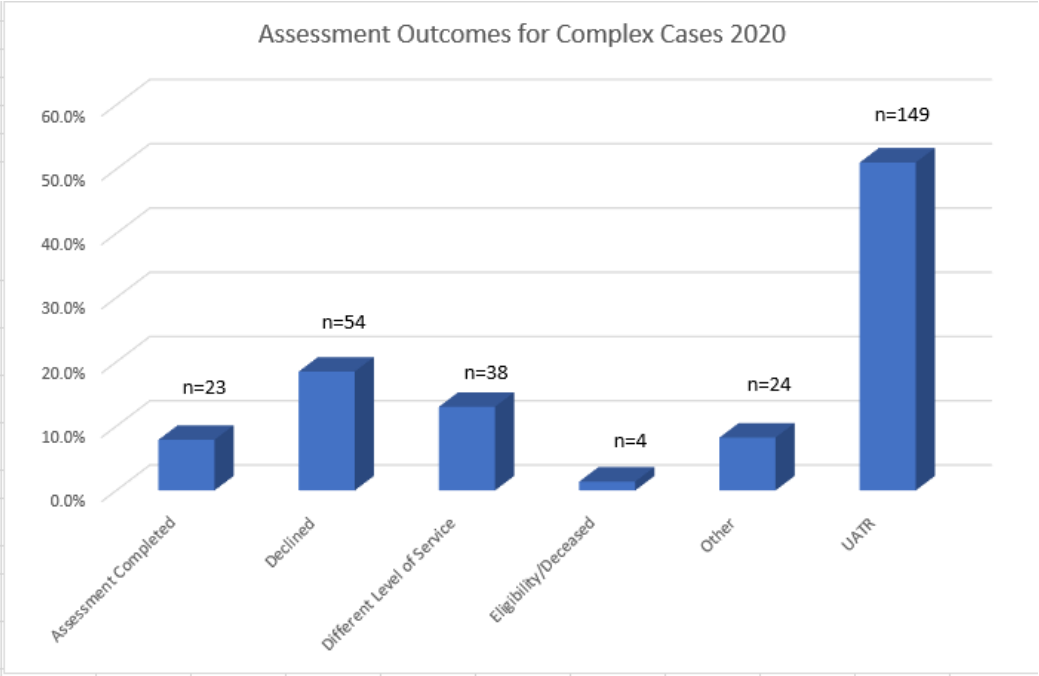
In addition, the data in Figure 11 monitors the number of assessments completed and the timeframe for completing the assessment. In this report the completion within the 30 days of referral was well below the 90% goal for the entire year at 53%.This value is created based on the total assessments completed within 30 days of referral and the number of referrals.

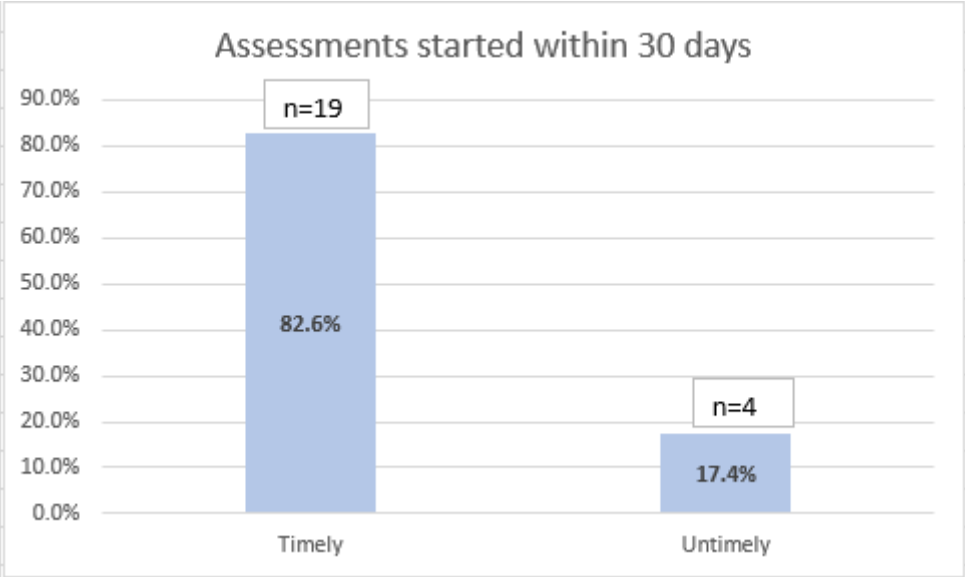
The current process is that the Case Manager attempts to begin the initial assessment in the first contact call. An initial assessment is performed as expeditiously as the Member's condition allows (and may be completed by multiple calls) but must be created within 30 calendar days and completed within 60 days from date of identification.

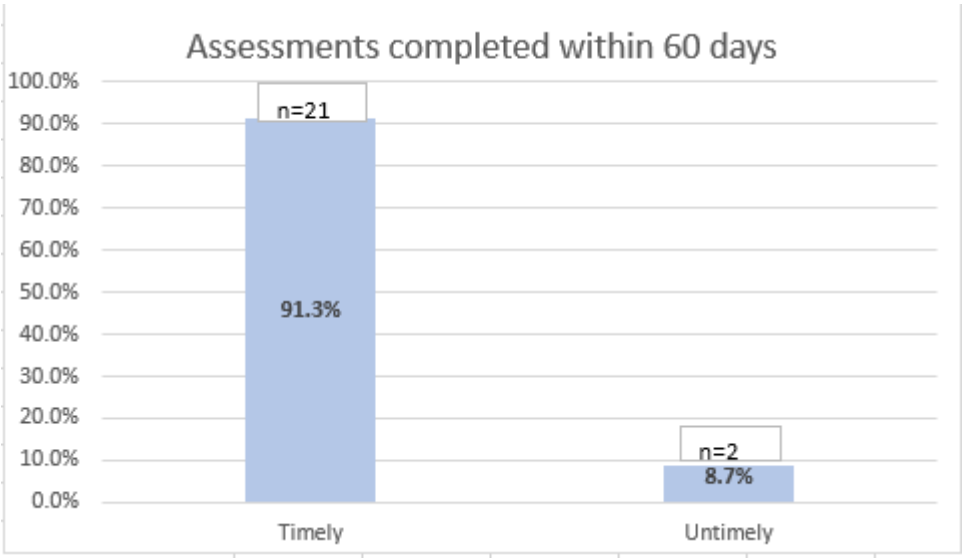
Further review of CCM case timeliness was done, using the Aging Report. The re-review revealed data integrity issues, such that cases less than 30 days were included in the report, and the report also included the members Declining CCM and Unable to Reach members. Because not all referrals lead to CCM consent and engagement, the Active Participation Rate needs to be refined.

Methodology for Data Validation:
Using the Daily Aging Report, all 292 cases referred and created in 2020 were pulled to identify the assessment status. CCM assessments completed were pulled and evaluated for timeliness.

2020 Results:







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

- Out of 23 assessments, 19 were started within 30 days and only four (4) was started after the 30-calendar day timeframe, at 86.2%.
- Out of 23 assessments, 21 were completed within 60 days and only two (2) were completed after the 60-calendar day timeframe, exceeding the goal at 91.3%.

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

- The assessments that were not started within 30 days were due to care coordination needs taking priority to starting the assessment, previously reported as another case, difficulty re-engaging the member.
- The two assessments that were not completed within 60 days were due to the cases were previously reported as other cases.

During 2020, CCM standard of work was created and staff were trained. Opportunities for process standardization and re-training staff have been identified.
There has been ongoing discussion regarding CCM cases and further refinement and system optimization for the system of record is warranted.

Plan for 2021:

- Review CCM standard of work by April 2021
- Create CCM competencies by May 2021.
- Continue to refine and optimize the system of record.

Interdisciplinary Care Team **(IDT)**

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

Methodology:

A new system was implemented in January of 2020 to review any case that had been open for 90 days or more, regardless of case type.
Using the Daily Aging Report, staff are notified of cases that are open at 60 days or more, to prepare to present the case at the next IDT meeting. Upon notification, all cases are logged within the Complex Case Log.
CM identified 22 CCM cases (open for at least 90 days) from the Complex Case Log (and validated with the Daily Aging Report).

2020 Results:

Complex Cases ≥ 90 days	Outcome of IDT	% of Timely IDT based on Report
0	No IDT	0%
19	Timely	86%
3	Untimely	14%

Every CCM case open for 90 days or more was presented at IDT meeting. Of the 3 cases that were not presented timely, this occurred early on in 2020, as the process was still new, and staff were being trained.
This led to 86% of timely IDT presentation (up from 19% in 2019).
The successful improved process will be continued throughout 2021.

Figure 12 - 2021 Complex Case Management Case Closures by Reason

Complex	202001	202002	202003	202004	202005	202006	202007	202008	202009	202010	202011	202012	Total
CASE CLOSURE BY CLOSURE REASONS													
Already in Program	0	0	0	0	0	1	0	3	6	0	0	2	12
Case still open	0	0	1	0	0	0	0	0	0	0	0	0	1
Completed Program	5	0	0	4	3	0	5	3	1	4	0	2	27
Condition stable with no further Case Management needs	1	2	0	0	1	2	1	0	3	3	4	2	19
Condition stable with no further Disease Management needs	0	0	0	0	0	0	1	0	0	0	0	0	1
Deceased	0	0	0	0	0	0	0	1	0	0	0	1	2
Declined Program	2	1	4	9	1	7	4	0	3	3	5	3	42
Duplicate member record	0	0	1	0	1	0	0	0	1	1	0	1	5
Duplicative Program	0	0	0	0	0	0	1	0	2	0	2	0	5
Escalate services to higher level program	0	0	2	2	3	3	2	3	2	1	1	0	19
Inappropriately identified for program	0	0	0	0	0	0	1	0	0	0	0	0	1
Lost Contact	2	4	3	1	2	6	2	4	2	2	4	4	36
Member/Caregiver refuses services	1	2	0	0	1	2	0	0	0	1	0	3	10
Member declines continued Case Management services	0	1	0	1	1	1	0	0	0	0	0	0	4
Member Ineligible	0	3	1	1	1	0	0	0	0	1	0	2	9
Member non-compliant	0	0	0	0	0	0	0	0	0	0	0	0	0
Member transferred to Delegate/Other	0	2	2	0	0	1	0	0	0	0	0	0	5
Other	1	3	1	8	3	3	4	2	7	1	1	1	35
Readmission	0	0	1	1	1	0	0	0	0	0	3	4	10
Step down to lower level program	1	1	0	1	0	0	1	0	0	0	0	0	4
Termination of coverage	0	0	0	0	0	1	0	0	0	0	0	0	1
TruCare cleanup	0	0	1	2	0	0	2	0	0	1	2	1	9
Unable to contact member	13	12	14	20	11	20	11	3	13	16	9	11	153
Total	26	31	31	50	29	47	35	19	40	34	31	37	410

As noted in Figure 12, the top three reasons for case closure in 2020 were:

1) Unable to Contact (153)
2) Member Declined the Program (42)
3) Lost Contact (36).

Recommended Interventions/Next Steps for 2021:

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

Performance Measures

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

Figure 13 – CM Performance Measures

	Goal	Measure	Measurement	Performance Goal	2020 Rate	Goal Met?
#1	Achieve and maintain high level of satisfaction with CM services.	Member Satisfaction Rates	High level of satisfaction with CM services	90%	93.3%	Yes
#2	Improve member outcomes	All-Cause readmission Rate	readmission rates for all causes for members in CCM with admission within 6 months of enrollment in CCM	Report in development	19.0%	NA
#3	Improve member outcomes	Emergency Room Visit Rate	ER rates for members enrolled in CCM	Report in development	Not Available	NA
#4	Achieve optimal member functioning.	Health Status	% of members in CCM responding that their health status improved because of CCM	90%	89%	No
#5	Use of Appropriate Health Care Services	Use of Services	Improvement in measures of office visits within Alliance Network	Report in development	Not Available	NA

Figure 13 captures the 2020 Performance Measures. Of the five measures, two had an established benchmark.

For 2020, CM continued to achieve the goal of achieving and maintaining high level of satisfaction with CM services at 93.3%

The overall all cause readmission rate was reported at 19.0%, but this is not specific to the CCM population. It is noted that most measures are not specific to members enrolled in CCM. With the assistance with the Analytics

department, a report is being developed to identify the readmission rate for members who are enrolled in CCM. This report will also include Emergency Room Visit Rates for members enrolled in CCM (Performance Measure #3).
The member surveys showed that 89% of members in CCM responded that their health status had improved because of CCM.
In collaboration with, Analytics a report is being developed to evaluate the use of appropriate Health Care Services by measuring office visits for members receiving CM services.

Assessing Members Experience with the CM Process

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

The goal of the Complex Case Management Program is to obtain a 90% or greater overall satisfaction with the CCM program.
Satisfactory results are defined as those that fall under the following categories:

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

In 2020, CM Department received a total of 4 surveys.

Figure 14 – 2020 Survey Results

	N	%	Sample Size	Goal Met?
Member Experience Criteria	Very Satisfied			
Time Spent with CM	3	100%	3	Y
CM Understands Concerns	3	100%	3	Y
Information to Manage Health	4	100%	4	Y
Overall Experience	4	100%	4	Y
Member Experience Criteria	Moderately Satisfied			
Time Spent with CM	1	100%	1	Y
Member Experience Criteria	Neutral			
CM Understands Concerns	1	100%	1	Y
Member Experience Criteria	Much Improved			
Better Manage Health Condition	1	100%	1	Y
Overall Health & Well-Being	2	100%	2	Y
Member Experience Criteria	Improved			
Better Manage Health Condition	2	100%	2	Y
Overall Health & Well-Being	1	100%	1	Y
Member Experience Criteria	Somewhat Improved			
Better Manage Health Condition	1	100%	1	Y
Overall Health & Well-Being	1	100%	1	Y
Member Experience Criteria	Always True			
Ability to Speak to CM	2	100%	2	Y
Member Experience Criteria	Always			
Ability to Speak to CM	2	100%	2	Y
Member Experience Criteria	Highly Likely			
Recommend CM Services	2	100%	2	Y
Member Experience Criteria	Likely			
Recommend CM Services	2	100%	2	Y

Of the four surveys returned, the combined satisfaction was 93.3%.

Another way to assess member experience is through review of the filed complaints against Case Management. A review of the 2020 Grievance data shows only one case identified as a member complaint about the CM process.

Figure 15 – 2020 Complaints Filed Regarding CM Process

Grievances Filed Against	Access to Care		Other		Quality of Service	Total
	Lack of Telephone Accessibility	Delay in Referral	Misc.	Discrimination / Sensitivity	Poor Provider / Staff Attitude	
Case Management	7	2	1	2	16	28

There was a total of 28 complaints for 2020. As there were 7 complaints related to Lack of Telephone Accessibility. This has created an opportunity for improvement, to evaluate the current phone answering process within the department of CM. There were 16 complaints with Quality of Service - Staff Attitude. Overall, customer service communication and member engagement training (and re-training if appropriate) is provided to all staff.

Recommended Interventions/Next Steps for 2021:

In 2021, there is an opportunity to ensure the CM Department:

- Review and revise the process on how CM initiates and collects the satisfaction survey to increase the response rate.
- Participates in the analysis of the data and development of activities aimed at improving the member experience with the CM processes.
- The phone answering process for CM to be reviewed and revised Spring 2021.
- Identifies CM performance measures, goals, and benchmarks.
- Collaborates with Health Care Analytics to ensure the performance measures can be captured and reported semi-annually.

Special Programs

Transitions of Care

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

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

In 2019, the Alliance revamped the existing TOC program. With the collaboration of IT, a new way of identifying members was created through a report called the Admission, Discharge, Transfer Feed sent from various hospitals. This report was validated against the TOC Discharge Report, which was based on authorization closures performed by the Inpatient UM Concurrent Review staff. The TOC pilot program continued in 2020 with Alameda Health Systems (containing 3 local hospitals). With the arrival COVID-19, the TOC program expanded to include any member discharged from any hospital with a diagnosis of COVID-19.

Figure 16 - 2020 Transitions of Care Referrals

Transitions of Care	202001	202002	202003	202004	202005	202006	202007	202008	202009	202010	202011	202012
CM/DM	4	22	24	20	21	21	27	17	32	27	19	25
Community Partner/Hospital	3	4	4	2	6	12	12	9	5	10	16	51
Health Education	0	0	0	0	0	0	0	0	1	0	0	0
Internal Report	122	125	167	122	134	156	198	161	195	150	171	173
Member Services	1	0	0	2	1	0	1	2	3	0	0	3
Nurse Advice Line	0	1	0	0	0	0	0	0	0	0	0	0
Other	0	0	1	5	2	4	5	3	1	1	0	2
Self	0	0	0	0	0	0	0	0	0	0	0	1
UM Dept	9	13	5	9	17	19	14	30	32	19	16	48
Total	**139**	**165**	**201**	**160**	**181**	**212**	**257**	**222**	**269**	**207**	**222**	**303**

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

1) Internal Report at 1,874
2) CM/DM at 259
3) UM Dept at 231

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

Figure 17 – 2020 Transitions of Care Active Cases

Transitions of Care	202001	202002	202003	202004	202005	202006	202007	202008	202009	202010	202011	202012
ACTIVE CASES												
New Cases	144	154	183	147	166	196	232	222	244	196	200	284
Total Cases In Progress	274	293	349	332	316	363	441	455	486	457	405	508
Total OptOut Assessments	1	0	1	0	0	0	0	0	0	0	0	1
Total Assessments Completed w/in 30 Days of Referral	126	152	212	150	155	200	269	243	287	212	170	288
Active Participation Rate % (Total Assessments Completed w/in 30 Days of Referral / Total Referrals)	91%	92%	105%	94%	86%	94%	105%	109%	107%	102%	77%	95%

The data noted in Figure 17 shows the increase in TOC cases throughout 2020. The Active Participation Rate is calculated from the total assessments completed within 30 days of referral and the total referrals.
Analysis of results showed that some referrals were declined because they were duplicate referrals, or the member was already enrolled in another CM program.
Further refinement is needed to understand the months where participation was over 100%. It may be that the Total Assessment Completed within 30 Days of Referral may not be an accurate depiction of active participation.

Figure 18 – Transitions of Care Case Closures

Transitions of Care	202001	202002	202003	202004	202005	202006	202007	202008	202009	202010	202011	202012
CASE CLOSURE BY CLOSURE REASONS												
Already in Program	4	0	1	1	2	3	1	2	1	2	2	2
Case still open	0	0	0	1	0	0	0	0	1	2	0	0
Completed Program	11	11	8	10	7	9	13	18	20	21	22	11
Condition stable with no further Case Management needs	4	4	7	12	15	11	18	28	29	28	18	24
Condition stable with no further Disease Management needs	0	0	0	1	1	1	0	1	2	2	0	0
Deceased	5	0	3	1	5	1	1	1	1	3	3	3
Declined Program	3	4	5	2	2	3	6	4	1	0	6	6
Duplicate member record	0	0	1	0	0	1	0	0	0	1	3	0
Duplicative Program	0	0	0	0	0	0	4	2	3	8	4	3
Escalate services to higher level program	2	3	4	6	5	10	11	6	8	7	6	5
Inappropriately identified for program	1	3	2	2	3	2	1	1	1	0	1	1
Lost Contact	11	10	15	29	15	15	25	21	18	32	20	14
Member/Caregiver refuses services	3	0	1	1	0	0	0	0	1	0	1	2
Member declines continued Case Management services	1	0	0	0	1	1	1	0	0	1	2	2
Member declines continued Disease Management services	0	0	0	0	0	1	0	0	0	1	0	1
Member Ineligible	1	4	1	3	2	2	1	2	1	6	5	2
Member non-compliant	0	0	0	0	0	1	0	0	0	0	0	0
Member transferred to Delegate/Other	1	0	5	4	3	1	3	2	1	2	1	4
Other	11	22	26	24	19	21	34	28	19	32	18	34
Readmission	8	15	11	14	20	17	14	21	37	23	14	27
Referred to Disease Management	1	0	0	0	0	0	0	0	0	0	0	0
Step down to lower level program	0	0	1	0	0	1	0	1	0	1	0	0
Termination of coverage	0	0	0	0	0	0	0	0	1	0	0	0
TruCare cleanup	0	0	0	0	3	0	0	0	2	0	0	0
Unable to contact member	68	51	73	71	46	53	75	75	78	80	55	65
Total	135	127	164	182	149	154	208	213	225	252	181	206

As noted in Figure 18, the top three (3) reasons for Case Closure in 2020 were:

1) Unable to Contact Member (790)
2) Other (288)
3) Lost Contact (225)

Continuity of Care

The CM Department collaborates with the UM Department and Member Services on the management of the continuity of care program. CM is responsible for assisting members who have been approved to see provider's outside of the network and need to be transitioned back in network after the Continuity of Care period has ended as well as members for whom Continuity of Care conditions have not been satisfied (ex. out of network provider not

accepting Medi-Cal rates.) CM is notified of the need to assist members back in network via a report developed by HealthCare Analytics which captures data from the UM authorization. Staff also provide assistance to members based on direct referrals into the care coordination program.

In 2019, UM took over the responsibility for assisting members who have exhausted a benefit or who are aging out of a benefit, i.e. California Children Services. The UM Department coordinates these services through the care coordination referral process and identifies members who are aging out of CCS eligibility to ensure that they transition to appropriate providers.

LONG TERM SERVICES AND SUPPORTS (LTSS)

The Alliance is responsible for ensuring Members who are eligible to receive LTSS services are identified and referred. In 2019, The CM Department worked in collaboration with the UM Department to ensure members were identified for Community Based Adult Services (CBAS), referred, and assessed appropriately and timely. In 2019 the CM Department had transitioned the responsibility for assessment, initial referral, re-assessments, and re-authorizations of services to the UM Department.

INTEGRATION OF MEDICAL AND BEHAVIORAL HEALTH

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

In 2020, the teams worked on efforts crossing the medical and behavioral health services which included:

- Enhancing CCM outreach to chronically ill
- Improve coordination of care by increasing clinical oversight and co-management with the medical management teams.
- Continued efforts toward improving communication between the primary care physician and behavioral health providers.
- Attendance by Beacon at the Interdisciplinary Care (IDT) Team meetings to collaborate, advise, refer, and provide additional insight into CCM cases.

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

HEALTH HOMES PROGRAM:

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

The primary program goal is to achieve improved health outcomes for eligible members by providing them additional supportive ("wrap around") care via the plan's network of CB-CME organizations. In 2020 Alameda Alliance simultaneously helped build and oversee the capacity of CB-CME's to address the needs of the population and orchestrate reporting of encounter data and program results.

Health Homes Patient Characteristics (enrollment criteria)

Eligibility Requirement	Criteria Details
1. Chronic condition criteria (*Must meet at least one of the above to be enrolled.)	· **At least two of the following**: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic renal (kidney) disease, dementia, substance use disorders; OR · **Hypertension and one of the following:** chronic obstructive pulmonary disease, diabetes, coronary artery disease, chronic or congestive heart failure; OR · **One of the following:** major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia); OR · **Asthma**
2. Acuity/Complexity criteria (*Must meet at least one of the above to be enrolled.)	· Has at least 3 or more of the HHP eligible chronic conditions; OR · At least one inpatient hospital stay in the last year: OR · Three or more emergency department visits in the last year; OR · Chronic homelessness.

Staff in 2020 included a Clinical Program Manager, a Health Navigator, a Housing Navigator, and hired a Physician Champion. Work also began on AAH CM team to become an internal CB-CME.
Two new SMI CB-CMEs (CHCN & BACS) were brought on board. Due to the COVID-19 response BACS was not fully implement the Health Homes program until the end of Q4.

Program Outcomes: As of 12/31/20, the program has served 1237 members at the 17 CB-CME sites in Alameda County:

CB-CME Site	Members Served in HHP in 2020
AHS Eastmont	40
AHS Highland	76
AHS Hayward	34
California Cardiovascular Consultants	108
CHCN Asian Health Services	85
CHCN Axis Community Center	36
CHCN La Clinica De La Raza	81
CHCN LifeLong Medical Care	234
CHCN Native America Health Center	45
CHCN Tiburcio Vasquez Health Center	98
CHCN TriCity Health Center	146
CHCN West Oakland Health Council	23
EBI	29
Family Bridges	36
Roots	109
Roots STOMP	14
Watson Wellness	43
Total Members Served	**1237**

Next Steps in 2021

Apply for AAH Health Homes CB-CME status
Continue to develop, train, and maintain AAH CB-CME workflows
Identify and contract with new CB-CMEs including SMI providers to expand network capacity.
Certify new CB-CMEs as appropriate members of our Health Homes network.
Continue to develop, train, and maintain AAH CB-CME network in preparation for CalAIM ECM/ILOS launch on January 1, 2022.

Coordination with Regulatory Compliance

The Alliance CM Department works closely with the Compliance Department in preparation for regulatory audits. In 2019, the department had participated in two follow up regulatory audits. Audits had identified the following key findings:

- The Plan did not follow the specified timeframes required for completion of the HRAs for newly enrolled SPD members. The Plan did not ensure that

HRAs were completed within 45 calendar days of enrollment for those identified by the risk stratification mechanism as higher risk and within 105 calendar days of enrollment for those identified as lower risk.

  - As a result, HRA tracking had been implemented in early 2019, and continued into 2020. HRAs were sent out within the required timeframes, and IVR calls were made to low-risk members to encourage them to complete and send in the HRA within the timeframe. Direct calls were made by CM staff on high-risk members to encourage them to complete and send in the HRA within the timeframe. A tracking log was kept to ensure that the required timelines were met.

- The plan had received a repeat finding in 2019 for monitoring CCM cases and presenting the cases to an Interdisciplinary Team if the CCM case remains open ≥ 90 days.
  - CM staff were provided additional training to assist with ensuring appropriate case closure and review. As 2019 came to a close, further refinement was warranted, resulting in the implementation of the CCM Log to track cases, which demonstrated better outcomes in 2020.

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

Recommended Interventions/Next Steps for 2020:

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

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

Conclusion

Overall, the 2020 CM Program continued to develop into an effective program maintaining compliance with regulatory and contractual requirements, monitoring of performance within the established benchmarks or goals, identifying opportunities for improvement and enhancing processes and

outcomes. The CM program activities have met the established targets. The Alliance leadership has played an active role in the CM Program structure by participating in various committee meetings, providing input and assistance in resolving barriers and developing effective approaches to achieve improvements. To ensure that AAH used a comprehensive approach to the CM program structure, practicing physicians provided input through the UM Committee and subcommittees.

CM Program Recommendations for 2021

As a result of internal performance monitoring performed in 2020, opportunities for improvement were identified and will be incorporated into the 2021 department goals. Highlights of opportunities for improvement based on the regulatory findings include:

- Redesign the CM program to focus on key CM activities, monitoring through the UM Committee and HCQC.
- Revise the CM staffing model to address operational needs.
- Ensure information systems are accurately reflective of reporting needs for compliance monitoring and oversight both internal and external.
- Identify appropriate performance measures and goals for CM and develop monitoring reports of performance toward the measures. This includes developing CM related activities to address improvement with the measures.
- Maintain the California Health Homes Program with community-based collaborations, including SMI.
- Apply for AAH Health Homes Internal CB-CME status.
- Work with the Alliance Project Management Office and all relevant Alliance departments to plan for the transition to CalAIM for the ECM, ILOS and Transplant services.
- Develop educational program for PCPs and Network Provider Groups on identification of members in need of CM/CCM, referral processes and engagement with CM team on management of ICPs and IDTs.
- Enhance reporting and analysis of CM activities focused on member experience with CM.
- Develop process for implementing activities addressing improved member experience with CM, including analysis of a member survey and member complaints.
- In collaboration with the Compliance Department, develop a department program focused on monitoring internal compliance and quality review of CM department operations.
- Collaborate with MS to obtain HRA data and information on program activities.

- Revise the continuity of care program to accurately reflect CM involvement and activities, including regulatory reporting and CCS age out program.
- Continue to enhance the Palliative Care Program in collaboration with Alameda Health Systems.
- Enhance delegation oversight activities for CM, Care Coordination, CCM, and TOC.
- Collaborate with Health Care Analytics on identifying enhancements to the predictive model algorithm to improve the identification of appropriate members for CCM.
- Continue internal auditing of cases for Care Coordination, CCM and TOC.

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

2021

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

2021 Program Description

Signature Page

Date _____

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Table of Contents

Summary of Changes from 2020 Program Description

- Progress on Optimization of TruCare
- Further Refinement of TOC process
- Planning for CalAIM
- Improvement Opportunities
- Grammatical, formatting changes

I. Background

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

The Alliance provides health care coverage to over 270,000 children and adults through the Medi-Cal and Group Care programs. Alliance Members choose from a network of over 1,700 doctors, 15 hospitals, 29 community health centers, and more than 200 pharmacies throughout Alameda County. Through active partnerships with healthcare providers and community partnerships, Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan Members.

The Alliance offers an array of care management services to support a collaborative patient and provider treatment process and to improve the health of the Member population.

Comprehensive case management is one such Alliance service offering that assists Members and providers in aligning effective healthcare services and appropriate community resources. The activities of the comprehensive case management program support Alliance Members and providers to attain the highest level of functioning available to the Member in relation to their overall health condition. The Alliance oversees and maintains the following case management services in the comprehensive case management program:

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

The comprehensive case management program description includes a discussion of program scope, objectives, structure and resources, population assessment, clinical information systems, care coordination and case management services, and individual program descriptions for each of the three case management services that comprise the comprehensive case management program.

II. Purpose and Scope

The purpose of the Alliance comprehensive case management program is to provide the case management process and structure to a Member who has complex health issues. Case management is defined by the Case Management Society of America as:

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

The Alliance promotes case management services through multidisciplinary teams that address Member specific medical conditions, behavioral, functional, and psychosocial issues in a single health care setting or during the Member's transitions of care across the continuum of care. Case management activities are performed telephonically. The underlying premise of the program is that when an individual reaches the optimum level of wellness and functional capability, everyone benefits: the individuals being served, their support systems, the health care delivery systems, and the various payer sources.

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

III. Goals and Objectives

A. Goals

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

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

B. Objectives

The comprehensive case management program is a supportive and dynamic resource that the Alliance uses to achieve these objectives as well as respond to the needs and standards of consumers, the healthcare provider community, regulatory and accrediting organizations.
The Health Care Quality Committee (HCQC) and Utilization Management Committee (UMC) are have authority and responsibility for the review and assessment of the CM program performance against objectives during the annual program evaluation, and if appropriate, provide recommendations for improvement activities or changes to objectives. The objectives of the comprehensive case management program are stated to support concrete measurements that assess effectiveness and progress toward the overall program goal of making high quality health care services accessible and affordable to the Alliance Membership. The objectives of the program include:

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

IV. Program Oversight and Staff Responsibility

A. Health Care Quality Committee (HCQC)

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

The HCQC provides the external physician involvement to oversee The Alliance QI and UM Programs. The HCQA includes a minimum of four (4) practicing physician representatives. The UM Committee include in its Membership physicians with active unrestricted licenses to practice in the State of California. The composition includes a practicing Medical Director Behavioral Health and/or a Behavioral Health Practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review, as needed.

The HCQC functional responsibilities for the CM Program include:

- Annual review and approval of the CM Program Description.
- Oversight and monitoring of the CM Program, including:
    - Define the strategies direction for population health.

- Define the goals and measures to the target population.
- Assist in identifying the target population along with programs/services to be provided.
- Recommend policy decisions.
- Oversight of interventions to the provision of the programs and services.
- Recommend necessary actions.

B. The Utilization Management Committee

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

UM Committee Structure

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

Authority and Responsibility

The HCQC is responsible for the overall direction and development of strategies to manage the UM program including but not limited to reviewing all recommendations and actions taken by the UM Committee.

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

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

UM Committee Membership

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

- The Alliance Chief Analytics Officer
- The Alliance Medical Directors, UM
- The Alliance Medical Director, CM
- The Alliance Medical Director, Quality Improvement
- The Alliance Senior Director, Quality Improvement

- The Alliance Senior Director, Pharmacy & Formulary
- The Alliance Senior Director, Health Care Services
- The Alliance Director, Compliance
- The Alliance Director, Member Services
- The Alliance Director of Provider Relations and Provider Contracting
- The Alliance Director, Quality Assurance
- The Alliance Manager, Healthcare Analytics
- The Alliance Managers, Case Management
- The Alliance Managers, Utilization Management
- The Alliance Manager, Grievance & Appeals

UMC Voting Privileges

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

UMC Quorum

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

UMC Meetings

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

UMC Minutes

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

UM Committee Functions

The UM Committee is a forum for facilitating clinical oversight and direction. The UMC purpose is to:

- Improve quality of care for the Alliance Members.
- Evaluate and trend enrollment data for medical and behavioral health services provided to Alliance Members and benchmarks for care management program utilization.
- Provide a feedback mechanism to drive quality improvement efforts.
- Increase cross functional collaboration and provide accountability across all departments in Medical Services.
- Provide mechanism for oversight of delegated CM functions, including review and

trend CM reports for delegated entities to identify improvement opportunities.

UM Committee responsibilities are to:

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

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

VII. Staff Resources

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

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

VII. Chief Medical Officer

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

VII. Medical Director

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

VII. Senior Director, Health Care Services

The Senior Director of Clinical Services, a licensed clinician, provides operational leadership to the Case and Disease Management programs and staff. The Senior Director provides guidance to the program design with a focus on analytics, operations, and regulatory adherence. The Senior Director also ensures the collaboration of the program with other internal and external stakeholders. The Senior Director provides leadership for case management accreditation and regulatory activities. The Senior Director works with the Manager to carry out program goals.

4. Manager, Case Management and Disease Management

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

5. Clinical Manager of Health Homes

The Clinical Manager of Health Homes is responsible the provision of daily oversight of components of the case management program, including programs between the Alliance and contracted Community Based Care Management Entities (CB-CMEs) for the Health Home Pilot and Alameda County's Whole Person Care initiative. Under the supervision of the Senior Director of Health Care Services, the scope of responsibilities of the Clinical Manager of Health Homes includes supervision and management of department staff; development of the operational plan; allocation and management of program resources; and accountability for the quality of care and services. The Manager reviews and evaluates the performance of the comprehensive case management program activities and presents regular reports to the UMC and HCQC.

6. Supervisor of Case Management and Disease Management

The Supervisor of Case and Disease Management provides daily oversight over the comprehensive case management program. Under the supervision of the Manager of Case Management and Disease Management, the scope of responsibilities of the Supervisor of Case

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

7. Lead Case Manager

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

8. Case Manager

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

9. Social Worker

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

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

10. Health Navigator

Under guidance from the Case Management Manager or the Clinical Manager, Health Homes, the Health Navigator supports clinical staff through the completion of components of case

management, disease management, and wellness/health maintenance programs. The Health Navigator provides the Member with individualized, patient-centered support and education to assist and guide the Member across the continuum of the healthcare delivery system. The Health Navigator works with the Case Manager to perform follow up case management activities and coordinate care and services for the Member with providers and community resources. The Health Navigator also coordinates care for Members not admitted to the complex case management program.

11. Health Risk Assessment Coordinator

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

V. Population and Member Needs Assessment

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

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

To effectively address Member needs, after the collection of Member population data, the CM Medical Director, Senior Director of Health Care Services, and Manager of Case Management and Disease Management analyze and review the data to determine any necessary updates to the processes and resources of the comprehensive case management program.

The information gathered in this process is used to further define and revise the program's structure and resources, including the following types of factors:

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

VI. Case Management Clinical Systems

VII. Clinical Information Systems

Delivery and documentation of case management services directly provided by Alliance staff is accomplished through a clinical information system. Alliance uses a Member-centric application that automates the entire clinical, administrative, and technical components of case management into a single platform. The system supports case management with the use of algorithmic clinical intelligence and best practices to guide Case Managers through assessments, development of care plans, and ongoing management of Members. The system includes assessment templates to drive consistency in the program. Care plans are generated within the system and are individualized for each Member and include short and long-term goals, interventions, and barriers to goals. The clinical information system includes automated features that provide accurate documentation for each entry; records actions or interactions with Members, care givers and providers; and automatic date, time, and user stamps. To facilitate care planning and management, the clinical information system includes features to set prompts and reminders for next steps or follow-up contact.

VII. Clinical Decision Support Tools

Evidence-based clinical guidelines are available to support the Case Managers in conducting assessments, developing care plans, and managing care. The clinical practice guidelines are based on current published literature, current practice standards, and expert opinion. Whenever possible, guidelines are derived from nationally recognized sources. If a nationally recognized guideline is not available, the Alliance will involve board certified specialists in the development of the appropriate guidelines. Clinical guidelines are reviewed and approved by the UMC and HCQC. *(Appendix B displays the list of clinical guidelines that support assessment and case management).*

VII. Care Coordination and Case Management Services

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

- **Health Risk Assessments** clinical processes are managed by the Alliance Care Management Department including High Risk HRAs and Care Planning, as well as Low Risk care plan development, with communication to Member and Provider.
- **Basic Case Management** for Low Risk level is provided by the Primary Care Physicians and their staff with a Network Provider Group's Care Management support. In the case of Direct Network Providers, the Alliance Case Management program provides Basic Case Management services.
- **Care Coordination/Service Coordination f**or Moderate Risk level is provided at the Provider Group level or The Alliance, supporting the PCP.
- **Specialty Programs** such as Transition of Care, Continuity of Care. Transitions of Care is provided by The Alliance Care Management staff for Members with a recent hospitalization. The level of management necessary is dependent upon the degree and complexity of illness or conditions to regain optimal health or improved functionality.
- **Complex Care Management** is provided by The Alliance Care Management staff for Members with conditions where the degree and complexity of illness or conditions is typically severe, the level of management necessary is typically intensive and the amount of resources required for Member to regain optimal health or improved functionality is typically extensive**.**

- **Health Homes/Alameda County Care Connect (AC3)** – Whole Person Care

In collaboration with Alameda County's Health Care Services Agency (the lead agency for the county's Whole Person Care Pilot – Alameda County Care Connect or AC3), the Alliance has developed and oversees a network of community-based care management teams providing in-person comprehensive multidisciplinary care coordination and care management for the Health Homes and AC3 target populations. The same network of teams also provides care for Members identified by the Alliance as high risk/high cost and/or meeting the Health Homes benefit criteria as defined by DHCS.

A. Health Risk Assessment

To ensure that the appropriate level and quality of care is delivered to newly enrolled, non-dual Seniors and Persons with Disabilities (SPD), the Alliance makes every effort to identify each Member's individual medical and resource needs. On July 11, 2017, Department of Health Care Services issued a new MMCD All Plan Letter for Requirements for Health Risk Assessments of MediCal Seniors and Persons with Disabilities. This revised MMCD APL supersedes the existing notification and clarifies the Plan's responsibilities for the early identification of Members who need early intervention and care planning to prevent adverse outcomes. The new guidance also requires development of a process for utilizing the standardized LTSS referral questions to identify and ensure the proper referral of Members who may qualify for and benefit from LTSS services. These questions are intended to assist in identifying Members who may qualify for and benefit from LTSS services. These questions are for referral purposes only and are not meant to be used in classifying high and low risk Members.

The Alliance utilizes a standardized HRA questionnaire to identify member care needs and provide early interventions for Members at higher risk for adverse outcomes. The questions are focused at medical care needs, community resource needs, the appropriate level of caregiver involvement, timely access to

primary and specialty care needs, identification of communication of care needs across providers as well as identifying any activities or services to optimize a Member's health status including a mental health screener. In addition to the standardized HRA questions, the DHCS LTSS questionnaire is completed to identify whether a beneficiary is experiencing risk factors that make them a candidate for LTSS services that will help keep them in their home and community.

The Alliance arranges for the assessment of every new SPD Member through a process that stratifies all new Members into an assigned risk category based on self-reported or available utilization data as either High Risk or Low Risk. Based on the results of the health risk stratification, the Alliance administers a Health Risk Assessment (HRA) survey to all newly enrolled SPD Members within:

- 45 days of enrollment identified as High Risk.
- 105 days of enrollment as Low Risk.

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

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

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

SPD Members are re-assessed annually in the month of their enrollment. All HRAs are reviewed for needs provided by a Social Worker, with member is identified as Low Risk or High-Risk Member.

For High Risk Members, the assigned Care Manager is responsible for ensuring the HRA is completed and the Care Plan updated accordingly. For Members identified as Low Risk Members, The Alliance uses utilization data to re-stratify Members. The Alliance follows the process outlined above for interventions based on the UTC Members. The CM team will create a standardized high-risk care plan and follow the communications activities to Member and PCP. For Members that are re-stratified from Low to High based on the annual re-assessment activities, a report will be sent to the CCM team for CM Nurse assignment, assessment, and development of a Care Plan. If the member continues to be stratified as Low Risk in the annual re-assessment, the member is provided a standardized care plan and informed of the availability of CM as needed.

B. Case Management

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

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

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

Care teams are assigned specific roles on the team to address the needs of the Members. The CM Nurse will serve as the medical lead for the team. The role of the CM Nurse is to ensure the CM assessments and follow-up is completed in a timely manner. The CM Nurse will communicate the outcomes of each assessment with the other team Members to ensure the team is knowledgeable on care needs and understands their role in the care plan. The teams are directed by defined workflows between the team Members. Communication is key to the effectiveness of the program. The team meets daily to discuss the needs and expectations for the day.

Extended Care Team Members are consultants to the core care team. As needed, the CM Nurse will coordinate care team discussions to address identified care needs. This may include medication reconciliation or adherence issues, behavioral health concerns, social determinates of health best managed using community resources, or health literacy issues.

Care teams also serve as sources to identify and refer Members to the CBCME programs. A full description of the program and The Alliance involvement with County Care Connect Programs is found in Section: VII.

1. Basic Case Management Services

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

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

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

- Initial Health Assessment (IHA)
- Initial Health Education Behavioral Assessment (IHEBA)
- Identification of appropriate providers and facilities (such as medical rehabilitation, and support services) to meet Member needs.
- Direct communication between the provider and Member, family and/or caregiver.
- Member, caregiver and/or family education, including healthy lifestyle changes when warranted.
- Coordination of carved out and out of plan services, and referral to appropriate community resources and other agencies.

2. Initial Health Assessment and Behavioral Risk Assessment

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

C. Care Navigation (Case Management/Care Coordination)

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

1. Case Management/Care Coordination

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

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

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

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

Once a Member is identified and referred for care coordination/case management, they are assigned to an Alliance lead Case Management unit to take responsibility for screening, referrals, care planning, and all other care coordination activities. Members are matched to the Case Management staff that is specialized based on the prominence of needs. Though there is one assigned "lead," the support and expertise of other units may be harnessed to provide collaboration and comprehensive, multidisciplinary care. This approach is most important for those Members who are multiply diagnosed with medical, functional, cognitive, and psychosocial conditions.

Alliance-based Health Navigators, Social Workers or Case Managers are responsible for the following services:

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

2. Targeted Case Management Services

The Alliance facilitates, and coordinates care for eligible Members (including the Medi-Cal SPD and Medi-Cal Expansion population) through targeted case management (TCM) services. Alliance staff follows preset guidelines and collaborates with primary care providers when necessary to determine

eligibility for TCM services. Members may be referred to receive TCM services through the Alliance or through the most appropriate contracted community partner.

Members eligible for TCM services have generally been identified as moderate or high risk and meet the following criteria:

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

Once a Member is identified and referred for TCM, they are assigned to an Alliance lead Case Management unit to take responsibility for screening, referrals, care planning, and all other care coordination activities. Members are matched to the Case Management unit that is specialized based on the prominence of medical or behavioral health needs. Though there is one assigned "lead," the support and expertise of other units may be harnessed to provide collaboration and comprehensive, multidisciplinary care. This approach is most important for those Members who are multiply diagnosed with medical, functional, cognitive, and psychosocial conditions.

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

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

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

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

For Members under age of twenty-one (21) not accepted for TCM services, the Alliance ensures Member access to services comparable to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) TCM services as well as California Children Services (CCS) for case management for Members with a qualified CCS condition.

D. Special Programs

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

- Transitions of Care
- Care Coordination for Members receiving continuity of care (CoC) with non-contracted providers.
- CCS Age Out Programs

1. Transitions of Care

Alliance Case Management staff maintains procedures to assist Members who were recently discharged from the hospital. Members are assigned to a Case Manager, Social Worker or Health Navigator to assist with short-term assistance with care coordination. Members, during program enrollment, will also be assessed for long-term care needs provided through Complex Case Management and Disease Management.

Once a Member is identified and referred for care coordination/case management, they are assigned to an Alliance lead Case Management unit to take responsibility for screening, referrals, care planning, and all other care coordination activities. Members are matched to the Case Management staff that is specialized based on the prominence of needs. Though there is one assigned "lead," the support and expertise of other units may be harnessed to provide collaboration and comprehensive, multidisciplinary care. This approach is most important for those Members who are multiply diagnosed with medical, functional, cognitive, and psychosocial conditions.

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

- Enrollment
- Evaluation of post-discharge needs in association with TOC bundle.
- All care coordination activities – including facilitating communication, referrals, treatment/service authorizations, etc.

- Maintenance of comprehensive, written records based upon evaluation.
- Clear documentation of service delivery, provider communications, Member interactions, etc.
- Periodic review of cases
- Case closure and evaluation as appropriate

2.Continuity of Care with Out-of-Network Providers

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

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

The Alliance's UM Department is responsible for the initial care determinations related to CoC situations. Once the CoC is approved, the Member is referred to Case Management for the identification of any care needs. One month prior to the termination of the CoC arrangement, CM staff contact the Member and treating Provider to ensure communication of the transition to all parties and identify any ongoing care needs. CM staff will also obtain any necessary information to share with the assigned PCP/Provider Group on the ongoing care coordination needs. Case Management staff are responsible for ensuring care is continued with out of network providers. The CM staff ensure the coordination of services with the Primary Care Providers and Specialists. A full description of the various CoC programs in found in the relevant UM Policies.

2. California Children Services/Age-Out Program

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

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

Referred children are screened for eligibility criteria and referred to a specialized contracted CCS provider. As the program is limited to providing services to children under the age of 21 years, The Alliance has developed a program to identify and provide care coordination of services for children on CCS who are nearing 21 years of age and aging out of pediatric health care services. As CCS children age

out of the system, staff will assist with the transitions to appropriate adult specialists in a collaborative manner to protect the individual and ensure age appropriate care is provided.

In 2019, the CCS age out program transitioned to UM, and the Case Managers assist with case management as needed.

E. Complex Case Management

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

- Case Management services
- Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team.
- Intense coordination of resources to ensure Member regains optimal health or improved functionality.

With Member and PCP input, development of care plans specific to individual needs and updating at least annually.

VIII. Case Management Program Description

A. Case Management

1. Identifying Members for Case Management

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

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

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

- Health Risk Assessments (HRA)
- Readmission Report
- Laboratory Results
- Opiate Utilization Report

Referral Sources

Individual Members may be referred by:

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

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

- Predictive modeling, e.g. Care Analyzer

The cases identified through the data sources or referral sources cited above are reviewed by the CM triage nurses, taking into consideration the known information about the case from claims history, medical records that may be on file for UM purposes, and Member services call history. The triage nurse verifies Member appropriateness for CM and if determined as appropriate then a case is opened in the care management information system and assigned to a Case Manager. Members are deemed ineligible if the Member is not in the Plan, has died or entered a hospice program, is in a long-term care facility or is receiving transplant services through a contracted center of excellence.

2. Case Management Process

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

A. Intake

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

B. Identification of Care Needs

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

C. Communication with Member

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

D. Coordination of Services

The PCP in collaboration with Alliance Case Management staff facilitate linkages between Members and community organizations to enhance access to community resources and ensure Members can utilize these resources. Utilization Management and Case Management staff coordinates access to community services, monitor service delivery, advocate for Member needs, and evaluate service outcomes.

E. Monitoring of PCP Services

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

F. Identification of Barriers to Care

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

G. Case Closure

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

- Goals met
- Interventions not successful/All resources exhausted
- Loss of eligibility
- Unable to establish or maintain contact with Member
- Member transferred to another setting and no longer require CCM
- Client refuses necessary psychosocial services and/or medical services
- Member declines CM
- Death of the Member
- Member not compliant with plan of care

- Determination by the Case Manager that the member is unable to appropriately and actively participate in the program

B. Targeted Case Management

1. Identifying Members for Targeted Case Management

Alliance Case Management staff facilitates services to Members eligible for targeted case management services to Regional Center of the East Bay (RCEB), community partner such as Community Based Adult Day Centers (CBAS) or other local government health program. The Alliance identifies Members that may be eligible for targeted case management services through admission review, concurrent review processes, provider referral, or at the request of the Member.

2. Targeted Case Management Process

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

A. Referral

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

B. Documented Assessment

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

C. Development of Comprehensive Service Plan

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

D. Coordination of Services

The TCM partner in collaboration with Alliance Case Management staff facilitate linkages between Members and community organizations to enhance access to community resources and ensure Members can utilize these resources. Utilization management and Case Management staff coordinates access to community services, monitor service delivery, advocate for Member needs, and evaluate service outcomes.

E. Crisis Assistance

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

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

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

G. Identification of Barriers to Care

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

H. Case Closure

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

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

IX. Complex Case Management Program Description

A. Identifying Members for Complex Case Management

1. Criteria

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

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

The criteria are subject to change at least annually but generally address Members with at least one of the following clinical features:

- Complex diagnoses such as End-Stage Renal Disease (ESRD),
- Chronic Heart Failure (CHF), and
- Chronic Obstructive Pulmonary Disease (COPD)
- High risk scores
- Multiple comorbidities
- Multiple Emergency Department (ED) visits in the previous six (6) months
- Multiple hospitalizations in the previous six (6) months
- Mental Health diagnosis
- Complex Psychosocial Needs (i.e. Homelessness)

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

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

2. Data Sources

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

- Claim and pharmacy data (CDPS and MRx) from the data warehouse and analyzed by the Health Care Analysts.

- Members are identified monthly from this data source Data from Admission, Transfer, Discharge (ADT) report, generated by various community hospitals
- UM data from preauthorization and concurrent review Data from purchasers (Medi-Cal and Commercial)

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

3. Referrals to Complex Case Management

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

A. Health Information Line referral

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

b. DM program referral

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

c. Hospital discharge planner referrals

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

d. UM referral

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

e. Member, caregiver, and practitioner referrals

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

f. Community-based referrals

The CM department may receive referrals for case management from community organizations/partners such as the Nurse Advice line contractor or CCS.

g. Behavioral health referrals

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

4. Date of Eligibility for Complex Case Management

Members identified or referred for Complex Case Management are reviewed for health plan enrollment and eligibility prior to beginning a general assessment. The Alliance considers a Member eligible for case management once a Member is provided a program overview and provides verbal or written consent to program enrollment. The encounter establishing eligibility is tracked in the Clinical Information System as a CCM Consent Note.

B. Complex Case Management Process

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

1. Referral & Screening

When a Member is identified, as described in Section IX.A ("Identifying Members for Complex Case Management") or a referral is received for case management, the CM staff enters the referral into the care management system and verifies Member health plan enrollment and eligibility. After health plan eligibility is confirmed the staff submits the referral. The Case Manager then screens and determines program eligibility in complex case management or other appropriate programs by performing the initial screening assessment with the oversight of the Associate Medical Director. If the Member does not meet criteria for complex case management, the Member may be referred to the other Alliance program for coordination of care, assistance in managing risk-factors, referral to community services or assistance in identifying a primary care practitioner. Appendix C & D contain the 2021 Case Management Criteria and Screening Checklist to assist clinical teams in consistency in assessment for CCM services.

2. Assessment of Health Status

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

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

At the time of the assessment, the Case Manager obtains consent to participate in the complex case management program and information about the Member's primary care practitioner, identifies short-term and long-term needs and initiates the care plan. If the Member declines complex case management services, the Member may be referred to the community services or assistance in identifying a primary care practitioner.

3. Documentation of Clinical History Including Medications

As part of the General Assessment, the Case Manager reviews and documents Member clinical history, including disease onset; key events such as acute phases; inpatient stays; treatment history; and current and past medications including schedules and dosages. All clinical documentation is collected and stored in a secure clinical information system and is organized in structured templates to facilitate efficient access and use of information.

4. Assessment of Activities of Daily Living

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

5. Assessment of Behavioral Health Status Including Cognitive Functions

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

6. Assessment of Social Determinants of Health

The Case Manager or Social Worker assesses for social determinants of health, which are economic and social conditions that affect a wide range of health, functioning and quality of life outcomes and risks that may affect a Member's ability to meet case management goals. As part of the assessment the following are being assessed by Case Managers or Social Workers:

- Current living situation, such as homelessness
- Issues related to obtaining or using medications.
- Transportation issues in meeting healthcare needs
- Overall financial concerns that impacts member's well-being

7. Assessment of Life-planning Activities

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

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

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

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

To ensure an appropriate care plan and healthcare needs are effectively met, Member visual and hearing needs, preferences or limitations are assessed by the Case Manager or Social Worker during the General Assessment. In the event Case Managers or Social Workers identify impairment, details such as use of hearing aids and eyeglasses, or any future known surgery will be provided to assist in the development of care planning.

10. Evaluation of Caregiver Resources and Involvement

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

11. Evaluation of Health Plan Benefits and Community Resources

The Intake Coordinator verifies Member health benefits, and the Case Manager or Social Worker assesses resources impacting care including caregiver, community, transportation, and financial resources. When indicated for the Member, the Case Manager or Social Worker accesses local, county, and state agencies as well as disease-specific organizations, and philanthropic groups to provide services such as community mental health, transportation, wellness organizations, palliative care programs, and nutritional support. United Way, Meals on Wheels and the American Cancer Society are examples of programs with available assistance.

12. Development of Individualized Person-Centered Case Management Plan

The Care Plan includes a personalized Person-Centered planning and treatment approach that is collaborative and responsive to meet Member specific health care needs. The Person-Centered approach involves the development of the care management plan with Member input regarding preferences and choices in treatments, services, and abilities. Working with the Member, the Case Manager or Social Worker establishes and documents a set of prioritized goals.

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

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

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

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

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

The Case Manager or Social Worker addresses the Member's beliefs and concerns about their condition and any perceived or real barriers to their treatment such as access, transportation, and financial barriers to obtaining treatment. Additionally, cultural, religious, and ethnic beliefs are assessed that may impact the condition being managed. Based on the assessment of these psychosocial issues, interventions may be modified. Examples of such issues include:

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

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

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

15. Development of Schedule for Follow-up and Communication

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

16. Development and Communication of Member Self-Management Plan

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

17. Process to Assess Progress

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

18. Case Closure

The Case Manager terminates case management services for Members based on established case closure guidelines. The criteria for case closure include:

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

19 Patient Safety

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

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

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

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

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

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

If the Member is contacted and declines to participate, the Member's wishes are respected. The CCM program is based on active participation. The Member may opt out of CCM services at any time during the process. Members who make the decision to opt out of CCM are offered the opportunity to enroll again into CCM upon request or by outreach from The Alliance upon a new triggering event.

21. Initial Assessment

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

The Case Manager or Social Worker may begin the initial assessment in the first contact call. An initial assessment is performed as expeditiously as the Member's condition requires (and may be completed by multiple calls), but always within 30 calendar days of the Member becoming eligible (i.e. date identified by triage nurse as eligible for complex case management or date identified from a report that Member meets CCM criteria).

22. Individualized Care Plan

Following the initial assessment, the Case Manager and/or Social Worker develops an Individualized Care Plan (ICP), consisting of goals and interventions. The Case Management staff incorporate information from the initial assessment, as well as other assessments such as Health Risk Assessments, Pharmacy profile, specialized assessments, such as PHQ-9 or PHQ-2, that may be included in the Initial Assessment, HRA and Health Information Form/Member Evaluation Tool.

The ICP is crucial to the success of care management activities. The ICP is a comprehensive, individualized, interdisciplinary action plan that includes varying types of goals such as clinical milestones, pain management, addressing care gaps, and Member self-management. The development and communication of the self-management goals refer to the instruction or materials provided to Members or their caregivers to help them manage their condition. These activities are suggested by the Member or the Member's primary caregiver in consultation with the care manager to support the Member's management of their condition, when appropriate. These are components of the care plan and do not require a separate plan. Member self-management activities include, but are not limited to:

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

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

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

Case Managers establish care plan goals with the following characteristics:

- Goals are relevant to the Member's condition with identified goals driving optimally coordinated care.
- Goals take into consideration the Member's or primary caregiver's goals and preferences, and desired level of involvement. These goals must be:
    - **Specific** - usually defining a maximum of four behaviors or measurable outcomes.
    - **Measurable** - so that it is easily understood when the goal is achieved.
    - **Achievable** - it does no good for the patient or for the manager to set unrealistic or unachievable goals. This is an invitation to frustration and disappointment for all involved parties.
    - **Relevant** - are the chosen goals the ones for which the greatest value can be achieved for the time, resources, energy expended?
    - **Time-dimensioned** - Is there a realistic timeframe in which the goal can be achieved?

- Goals are prioritized. A complex case may have many goals toward regaining optimal health or improved function, therefore each goal is prioritized against other goals for dependencies. The Alliance designates goals on a scale of 1 to 10. 1 = High, 10 = Low.
- Goals have specific time frames for re-evaluation. Members with complex health concerns require ongoing assessment and management. When establishing a goal, the Case Management staff sets a specific date for follow-up on progress toward that goal. Upon re-evaluation the goal may be on track, may require revision, or may no longer be appropriate due to changes in condition or circumstance. When a goal is retained as is or revised the Case Management staff establishes a next follow-up date in the case management system.
- Goals have identified resources to be utilized, including the appropriate level of care when applicable.
- Goals include documentation of any collaborative approaches to be used, including family participation, to achieve the goal. Goals have an assessment of barriers. Barriers may be assessed at the individual goal level (such as limited transportation to physical therapist) or at the case level (such as Member is in denial about prognosis).

Care plans assess the level of care settings, i.e. home health, custodial care, adult, or child day care. Case Managers or Social Workers determine the appropriate setting, education and training required, and community network resources required to achieve a desired level of functioning/independence. The Case Manager or Social Worker approves available add-on benefits and services for vulnerable Members such as disabled or those near end-of-life.

In some cases, a specialist, or multiple specialists, in lieu of the Member's PCP, best positioned to provide the most appropriate care. In these situations, the care manager discusses this option with the Member's PCP and the specialist(s) and arranges for a standing referral to the specialist(s). The care manager notifies the Member that he/she will have direct access to the managing specialist for a specific period.

23. Ongoing Management

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

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

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

When a top priority goal is achieved or eliminated, then other goals are evaluated and moved up to a higher priority.

The Case Management staff closes the case when criteria are met as defined in Section B.18 Case Closure. For Members that do not meet the closure criteria with 90 calendar days of enrollment, the Case Management staff will present the case to the Inter-Disciplinary Care Team (ICT) to identify the established goals are appropriate, and if additional goals are needed or referrals to additional services are warranted.

24. Case Management Integration

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

25. Inter-Disciplinary Care Teams

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

ICTs are held bi-weekly to discuss complex care planning as well as provide assistance and direction to the dedicated care teams.

X. Community Based Integration

The Alliance has collaborated with Alameda County Health Care Services Agency's Care Connect to implement the Health Home and Whole Person Care program. The purpose of the program is to build community infrastructure to improve integration, reduce unnecessary utilization of health services and improve health outcomes. The Whole Person Care infrastructure includes a community health record,

human infrastructure and housing navigation and supports. The goal of the collaboration is to ensure targeted Members and providers can access intensive, community-based care management services by Community Based Care Management Entities (CB-CME's) from anywhere in the care continuum, providing the "right care-right place-right time". The program outcomes focus of providing services that will:

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

The program activities focus on transitioning from a fragmented and siloed approach provided by various health delivery systems, county/community programs and heath plans to an integrated county-wide program focused on accessible shared health information, effective linkages to county resources, standardized approach to allocation of limited housing resources and access to high quality community case management services. The AC3 target population for Care Management includes:

- Literally homeless (HUD definition)
- High Utilizers of multiple crisis systems

The target population for the Health Homes program is based on the DHCS definition of eligibility (a combination of complex chronic illnesses, health care utilization, and other high risk factors like homelessness and mental illness)(see Appendix I California Health Homes Service Model)

The Alliance has dedicated clinical and non-clinical staff to participate in the planning and development of The Alliance activities for Health Homes and AC3. The Alliance is also committed to piloting a plan-based CB-CME with activities aligning to the HH/WPC programs in 2021. Staff works at developing mechanisms to identify Members and provide services to meet the overall goals. The processes are defined in CM Policies and Procedures.

XI. Disease Management

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

- Pediatric Asthma – Serves Members who are 5 to 11 years old and identified with asthma based on clinical, pharmacy, and utilization data or direct referral.

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

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

XII. Case Management Monitoring and Oversight

The Alliance utilizes several activities to monitor and oversight CM program activities and staff performance.

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

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

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

XIII. Program Effectiveness

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

A. Complex Case Management Performance Measurement

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

1. Achieve and maintain high levels of satisfaction with CM services.

Measure One - Member Satisfaction Rates

2. Improve Member outcomes

Measure Two - All-Cause Admission Rate

Measure Three – Emergency Room Visit Rate

3. Achieve optimal Member functioning.

Measure Four – Health Status Rate

4. Use of Appropriate Health Care Services

Measure Five – Use of Services (Primary Care)

A full description of the measures, goals, methodology and sources is available in Appendix E – 2021 Performance Measures.

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

1. Identifies a relevant process or outcome.

2. Uses valid methods that provide quantitative results.

3. Sets a performance goal.

4. Clearly identifies measure specifications.

5. Analyzes results.

6. Identifies opportunities for improvement, if applicable

7. Develops a plan for intervention and re-measurement.

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

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

B. Experience with Case Management

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

XIV. Annual Complex Case Management Program Evaluation

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

XV. Delegation of Case Management Activities

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

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

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

Alliance is also responsible for ensuring the delivery of quality, cost effective services. Through all delegated arrangements, oversight and evaluation are maintained through the following activities:

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

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

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

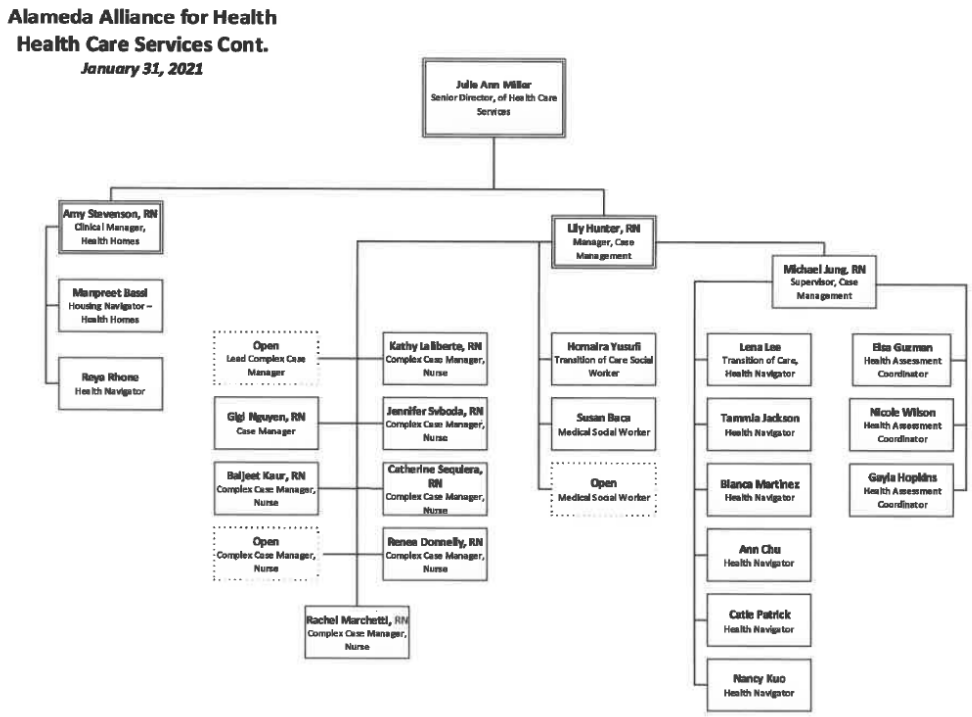
All delegation is conducted in accordance with Alliance's delegation policies and procedures, assuring consistent, thorough oversight and evaluation of delegated case management activities.

2021 Improvement Opportunities Summary:

- Continue to redesign the CM program to focus on key CM activities, monitoring through the UM Committee and HCQC.
- Ensure information systems reflect reporting needs for compliance monitoring and oversight, both internal and external.

- Continue to identify appropriate performance measures and goals for CM and develop monitoring reports for the measures.
- Maintain the Health Homes Program with community-based collaborations.
- Develop transition plan for enrolled Health Homes and Whole Person Care (AC3) in preparation for CalAIM Enhanced Care Management (ECM) and In Liew of Services (ILOS) launch on January 1, 2022.
- Apply for AAH CalAIM ECM status
- Develop a process for In Lieu of Services.
- Apply for AAH Health Homes Internal CB-CME status
- Develop educational program for PCPs and Network Provider Groups
- Enhance reporting and analysis of CM activities focused on member experience with CM.
- Collaborate with MS to obtain HRA data and information on program activities.
- Continue to enhance the Palliative Care Program
- Enhance delegation oversight activities for CM, Care Coordination, CCM, and TOC.
- Collaborate with Health Care Analytics on identifying enhancements to the predictive model algorithm to improve the identification of appropriate members for CCM.

APPENDIX A: Case Management Organization Chart



APPENDIX B: Clinical Care Guidelines

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Preventive Health Guidelines

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

- **Asymptomatic Healthy Adults**

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

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

- **Members Under 21 Years of Age**

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

- **Perinatal Services**

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

- **Immunizations**

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

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

Appendix C – 2021 Criteria for Case Management

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

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

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

a. The degree and complexity of the Member's illness is typically severe.
    1. Multiple specialties involved.
    2. Level of specialty management (tertiary providers)
    3. Primary diagnosis with complication(s)
    4. Higher levels of disease staging

b. The level of management necessary is typically intensive.
    1. Multiple services needing coordination.
    2. Frequency of care management contacts needed.
    3. Large number of external care coordination services

c. The amount of resources required for the Member to regain optimal health or improved functionality is typically extensive.
    1. Multiple hospitalizations in the past 6 months
    2. Multiple ED visits in the past 6 months
    3. High cost and utilization of pharmacy

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

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

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

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

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

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

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

Appendix D- REFERRAL TO COMPLEX CASE MANAGEMENT CHECK LIST

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

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

Complex Case Management Criteria

(any 3 of ANY of the following)

High Utilization:

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

At Risk Diagnoses:

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

Complex Medical/Psychosocial Needs:

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

Appendix E - 2020 CCM Performance Measures

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

Appendix F: HRA Questionnaire

ALAMEDA Alliance FOR HEALTH

Health Survey

Member Name: _____ Alliance Member ID#: _____

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

1. What is your preferred language:

   ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese
   ☐ Other: _____

2. Where do you live:

   ☐ Own home ☐ Temporary housing
   ☐ Rent ☐ Homeless
   ☐ Staying with friends/family ☐ Group home
   ☐ Assisted living ☐ Other: _____

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

3. In general, how would you describe your health?

   ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Decline to answer

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

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

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

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7. Do you need to see a doctor in the next 60 days? ☐ Yes ☐ No

8. Are you under the care of any specialists? ☐ Yes ☐ No

9. Are you pregnant? ☐ Yes ☐ No

   a. If you are pregnant, are you currently seeing a doctor for this pregnancy? ☐ Yes ☐ No

10. Do you have a condition that limits your activities or what you can do? ☐ Yes ☐ No

11. Do you have chronic pain? ☐ Yes ☐ No

12. Have you been to the Emergency Room (ER) two (2) or more times in the last 12 months? ☐ Yes ☐ No

13 Have you been admitted to the hospital in the past 12 months? ☐ Yes ☐ No

14 Have you been in a Skilled Nursing Facility (SNF) in the past 12 months? ☐ Yes ☐ No

15. Do you see a doctor regularly for a chronic condition? ☐ Yes ☐ No
If yes, check all that apply:

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

☐ Other: _____

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

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

Name of Medication	Dose (How Much)	How Often Taken

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

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

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

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

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

22.

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

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

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

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

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

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

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

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

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

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

Name of your helper: _____

What is your relationship to the helper: _____

May we contact your helper? ☐ Yes ☐ No

Phone number of helper: _____

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

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

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

Name: _____

Relationship: _____

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

a. Home Health Nurse ☐ Yes ☐ No

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

c. Home Care Worker ☐ Yes ☐ No

d. Social Worker ☐ Yes ☐ No

e. Adult Day Care Center ☐ Yes ☐ No

f. Help with Transportation ☐ Yes ☐ No

Other (please list): _____

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

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

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

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

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

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

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

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

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

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

This Health Survey is complete. Thank you!

Please return to:

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

If you have questions, please call:

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

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Appendix G Long-Term Services and Supports Referral Questions

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

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

• Tier 1 contains questions directly related to LTSS eligibility criteria and should trigger a follow-up assessment to determine if the beneficiary is eligible for LTSS services.

• Tier 2 contains questions that identify contributory risk factors, which would put a beneficiary at higher risk for needing LTSS services when combined with risk factors identified in Tier 1.
The headings in italics are not part of the questions but provide the intent of the questions.
Tier 1 LTSS Questions:

Long-Term Services and Supports Referral Questions *APL 17-013 Requirements for HRA for MediCal SPD
Activities of Daily Living Functional Limitations / Instrumental Activities of Daily Living Limitations / Functional Supports (Functional Capacity Risk Factor)
Question 1: Do you need help with any of these actions? (Yes/No to each individual action) a) Taking a bath or shower b) Going up stairs c) Eating d) Getting Dressed e) Brushing teeth, brushing hair, shaving f) Making meals or cooking g) Getting out of a bed or a chair h) Shopping and getting food i) Using the toilet j) Walking k) Washing dishes or clothes l) Writing checks or keeping track of money m) Getting a ride to the doctor or to see your friends n) Doing house or yard work o) Going out to visit family or friends p) Using the phone q) Keeping track of appointments If yes, are you getting all the help you need with these actions?
Housing Environment / Functional Supports (Social Determinants Risk Factor)
Question 2: Can you live safely and move easily around in your home? (Yes/No) If no, does the place where you live have: (Yes/No to each individual item) a) Good lighting b) Good heating c) Good cooling d) Rails for any stairs or ramps e) Hot water f) Indoor toilet g) A door to the outside that locks h) Stairs to get into your home or stairs inside your home i) Elevator j) Space to use a wheelchair k) Clear ways to exit your home

Long-Term Services and Supports Referral Questions *APL 17-013 Requirements for HRA for MediCal SPD
Low Health Literacy (Social Determinants Risk Factor)
Question 3: "I would like to ask you about how you think you are managing your health conditions" a) Do you need help taking your medicines? (Yes/No) b) Do you need help filling out health forms? (Yes/No) c) Do you need help answering questions during a doctor's visit? (Yes/No)
Caregiver Stress (Social Determinants Risk Factor)
Question 4: Do you have family Members or others willing and able to help you when you need it? (Yes/No) **Question 5:** Do you ever think your caregiver has a hard time giving you all the help you need? (Yes/No)
Abuse and Neglect (Social Determinants Risk Factor)
Question 6a: Are you afraid of anyone or is anyone hurting you? (Yes/No) **Question 6b:** Is anyone using your money without your ok? (Yes/No)
Cognitive Impairment (Functional Capacity, Medical Conditions, Behavioral Health Condition Risk Factor)
Question 7: Have you had any changes in thinking, remembering, or making decisions? (Yes/No) Tier 2 LTSS Questions:
Fall Risk (Functional Capacity Risk Factor)
Question 8a: Have you fallen in the last month? (yes/No) **Question 8b:** Are you afraid of falling? (Yes/No)
Financial Insecurity or Poverty (Social Determinants Risk Factor)
Question 9: Do you sometimes run out of money to pay for food, rent, bills, and medicine? (Yes/No)
Isolation (Social Determinants Risk Factor)
Question 10: Over the past month (30 days), how many days have you felt lonely? (Check one) ☐None – I never feel lonely ☐Less than 5 days ☐More than half the days (more than 15) ☐Most days – I always feel lonely

Appendix H – Disease Management Program Activities

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

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

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

DM Identification and Screening
Members are eligible for DM if they have a diagnosis of diabetes and are over 18 years of age or have a diagnosis of asthma and are between 5 and 12 years of age.
The Alliance informs practitioners about the DM programs through multiple methods, including but not limited to, Provider Services educational material, Alliance webpage, and Provider bulletins. The communication methods describe how to use disease management services and how the Alliance works with their patients enrolled in DM.

Training and/or targeted communications for key referral sources such as the CM department, UM department, Member Services, Hospital Discharge planners occur at least annually.
1. Members are identified for program eligibility through one of the following:
    a. Monthly report from HealthCare Analytics department utilizing claims, encounter, and pharmacy data. The report is further risk stratified into low, moderate, or high risk.
    b. Health Risk Assessment (HRA) for Medi-Cal Seniors and Persons with Disability (SPD). Members are identified as eligible with the appropriate age and diagnoses eligible for the DM program, and have a score calculated from HRA answers that may impact the member's health. The list of members meeting these criteria will be provided to the Intake Department for further processing.

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

Information needed for a DM referral includes:

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

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

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

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

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

DM Risk Stratification

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

a. High Risk Diabetes: Eligible age members with diagnosis of diabetes and other comorbidities and potentially significant risk factors, such as history of hospital or ER admission.

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

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

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

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

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

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

Enrollment

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

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

Assessment

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

2. Procedures for conducting assessments are addressed in *CM-001, CCM Identification, Screening, Assessment and Triage Policy*. Along with assessment questions regarding co-morbidities, cognitive deficits, psycho-social issues, depression, physical limitations and health behaviors, additional questions specific to the disease management condition have been added to the DM High Risk assessments.

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

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

DM Plan Development and Management

1. The steps in developing the Care Plan involve:
    a. Development of case management goals, including prioritized goals

b. Identification of barriers to meet the goals and complying with the plans

c. Development of schedules for follow-up and communication with members

d. Development and communication of member self-management plans

e. Assessment of progress against CCM plans and goals, and modifications as needed

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

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

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

DM Case Evaluation and Closure

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

2. High Risk Program enrollees will be evaluated for closure to DM services using *CM-003, Policy and Procedure, Complex Case Management Plan Evaluation and Closure Evaluation and Closure criteria.* CMs should aim to close the case within 6 months of enrollment allowing for 30 days of conducting the assessment.

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

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

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

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

Appendix I – California Health Homes Services Model

https://www/dhcs.ca.gov/services/Documents/MCQMD/HHP%20Documents/HHP_Program_Guide_11.01.19.pdf

A. Eligibility Criteria

1. Target Population

The HHP is intended to be an intensive set of services for a small subset of Members who require coordination at the highest levels. DHCS worked with a technical expert workgroup to design eligibility criteria that identify the highest-risk three to five percent of the Medi-Cal population who present the best opportunity for improved health outcomes through HHP services. These criteria include both 1) a select group of ICD-9/ICD-10 codes for each eligible chronic condition, and 2) a required high level of acuity/complexity.

2. HHP Eligibility Criteria and the Targeted Engagement List

Using administrative data, either DHCS or Medi-Cal managed care health plans (MCPs) will develop a Targeted Engagement List of Medi-Cal MCP Members who are eligible for the HHP based on the DHCS-developed eligibility criteria noted below. The list will be refreshed on a monthly or quarterly basis, using the most recent available data. The acuity/complexity level criteria will be implemented as part of a Targeted Engagement List process. The MCP will actively attempt to engage the Members on the Targeted Engagement List. (See Section II.G, Member Assignment, for more information on MCP activity to engage eligible Members.)

To be eligible for the HHP, a Member must meet the following eligibility criteria:

a. Have chronic conditions in at least one of the following categories (DHCS will select specific ICD 9/ICD 10 codes to further define these eligible conditions):

- At least two of the following: asthma, chronic obstructive pulmonary disease (COPD), diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, dementia, substance use disorders (SUD) **OR**
- Hypertension and one of the following: COPD, diabetes, coronary artery disease, chronic or congestive heart failure **OR**
- One of the following: major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia) **OR**
- Asthma and a risk of at least one of the following: diabetes, SUD, depression, obesity

b. Meet at least one of the following acuity/complexity criteria:

- A chronic condition predictive level above three based on a method to be determined by DHCS **OR**
- At least one inpatient stay in the last year **OR**
- Three or more Emergency Department (ED) visits in the last year **OR**
- Chronic homelessness

c. Have at least two separate claims for the eligible condition.

The Targeted Engagement List may include other criteria that are intended to ensure that HHP resources are targeted to Medi-Cal Members who present the best opportunity for improved health outcomes through HHP services.

The following exclusions will be applied either through MCP data analysis for individual Members or through assessment information gathered by the Community Based Care Management Entity (CB-CME):

- Members determined through further assessment to be sufficiently well managed through self-management or through another program, or the Member is otherwise determined to not fit the high-risk eligibility criteria
- Members whose condition management cannot be improved because the Member is uncooperative
- Members whose behavior or environment is unsafe for CB-CME staff
- Members determined to be more appropriate for an alternate care management program
- Chronic Renal Disease is an HHP eligible condition, but will not be included in the Targeted Engagement List. Members who have this condition may be referred for MCP approval.

2020
Utilization Management
Program Evaluation

2020 Utilization Management Program Evaluation

Signature Page

Date _____

Julie Anne Miller, LCSW
Senior Director, Health Care Services

Date _____

Sanjay Bhatt, M.D.
Director, Quality Improvement

Date _____

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

Date _____

Scott Coffin
Chief Executive Officer

Date _____

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

2020
Utilization Management (UM) Program Evaluation

Overview

Under the leadership and strategic direction established by Alameda Alliance for Health (the Alliance) Board of Directors and Quality Management Committee (QMC), senior management and the Health Care Quality Committee (HCQC), the Health Services 2020 Utilization Management Programs were successfully implemented. This report serves as the annual evaluation of the effectiveness of the program activities.

The processes and data reported covers activities conducted from January 1, 2020 through December 31, 2020.

Membership and Provider Network

The Alliance products include Medi-Cal Manage Care beneficiaries eligible thorough one of several Medi-Cal programs, e.g. Temporary Assistance for Needy Families (TANF), Seniors and Persons with Disabilities (SPD), Medi-Cal Expansion (MCE) and Dually Eligible Medi-Cal members who do not participate in California's Coordinated Care Initiative (CCI). For dually eligible beneficiaries, Medicare remains the primary insurance and Medi-Cal benefits are coordinated with the Medicare provider.

Alliance Group Care is an employer-sponsored plan services by the Alliance that provides low cost comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County. The Alliance provides services to IHSS workers through the commercial product, Group Care.

Figure 1. 2020 Trended Enrollment by Category of Aid and Age Groups:

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%**

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

Before 2020, the Alliance membership had been slowly declining over time with a total enrollment loss of 5.8% between 2018 and 2019. However, the 2020 pandemic and economic downturn correlated with an increase in enrollment in the Alliance, resulting in an overall increase of 10.8% by the end of 2020. The biggest jump in enrollment was in the Adult category (19% increase,) and ACA/Optional Expansion category (16.5%.) The percentage of Child members to total membership declined from 37% in 2018 to 35% in 2020. The percentage of younger adults (19-44) increased from 32% in 2018 to 34% in 2020. There has also been an increase in the percentage of adults over 65 from 9% to 10%. The economic downturn is a likely driver of the percentage increases in the adult and ACA/OE membership as adults lost employer-based health coverage.

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

Figure 2 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	Managed Care Organization	55,240	20%
Children First Medical Group	Medical Group	31,529	11%
Community Health Clinic Network	Medical Group	98,920	36%
Kaiser Permanente	HMO	37,963	14%
TOTAL		275,589	100%

The percentage of members within each network has been relatively steady from 2018 to 2020, varying by less than 1%.

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

- Ambulatory care
- Hospital care
- Emergency services
- Behavioral health (mental health and addiction medicine)
- Home health care
- Hospice
- Palliative Care
- Rehabilitation services

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

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

Figure 3 The Alliance Ancillary Network

The Alliance Ancillary Network	
Hospitals	16
Skilled Nursing Facilities	64
Health Centers (FQHCs and non-FQHCs)	75
Behavioral Health Network	1
DME Vendor	1 Capitated, 19 Non-Capitated
Transportation Vendor	1
Pharmacies/Pharmacy Benefit Manager (PBM)	Over 200

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

Delegation

The Alliance delegates UM activities to provider groups, networks and healthcare organizations that meet delegation standards. The contractual agreements between the Alliance and delegated groups specify the responsibilities of both parties; the functions or activities that are delegated; the frequency of reporting on those functions and responsibilities; how performance is evaluated; and corrective action plan expectations, if applicable. The Alliance conducts a pre-contractual evaluation of delegated functions to assure capacity to meet regulatory and accreditation standards and requirements. The Alliance's Compliance Department is responsible for the oversight of delegated activities. The Compliance Department works with the UM Department and other respective departments to conduct the annual delegation oversight audits. When delegation occurs, the Alliance requires the delegated entity to comply with regulatory, contractual and NCQA standards as well as submitted regular utilization reports, i.e. quarterly, semi-annual, and annual, to assess the delegate's performance. services provided to Alliance members. The Alliance has adopted the Industry Collaborative Efforts UM Reporting Templates as an acceptable format of reporting. The Alliance's Compliance Department is responsible for the oversight of delegated activities and completes an annual performance evaluation of all delegates. Results of the annual evaluation and any audit results are reviewed by the Compliance and Delegation Oversight Committee. The UM Department performs oversight audits of UM outpatient and inpatient activities as well as works with delegates on operational issues to ensure that members receive services from delegates that are in line with the Alliance's established policies and procedures.

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

Figure 4 – 2020 The Alliance Delegated Network

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

Overall, the network was sufficient to meet the needs of the Alliance membership and provider network throughout 2020. The organization clarifies issues related to delegated activities and responsibilities as needed. The issues have led to additional clarification in contractual documents as well as additional training to delegates on roles and expectations. In 2020, Joint Operation Meetings (JOMs) facilitated communication and operational alignment. These JOMs, which are collaborative meetings between the Alliance and Delegates/Vendors to address operations and performance outcomes are also used to identify joint opportunities for improvement. For 2021, there will continue to be opportunities to continue to improve the level of oversight, monitoring, reporting, and training of delegates.

UM Program Structure

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

Responsibility, Authority and Accountability/ Governing Committee

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

Committee Structure

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

Disabilities (SPD) and Chronic Conditions.

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

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

In 2020 the HCQC approved the UM Department 2019 Evaluation, 2020 Description, and UM 2020 Workplan on May 21, 2020, for Board of Directors approval. The committee was chaired by the Chief Medical Officer with support of the Senior Director of Quality Management, external physicians, and key organizational staff. The UM Committee had ten meetings in 2020.

In 2021 the UM Subcommittee of HCQC will continue to support the focus on UM activities, oversight for delegated UM activities, case management/care coordination, population health, integration of behavioral health and medical as well as regulatory compliance.

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

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

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

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

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

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

- Setting UM behavioral healthcare policies
- Reviewing UM behavioral healthcare cases, as needed
- Participating in the various UM Committees

- Evaluation of the overall effectiveness of the UM Program (Beacon)

Program Scope and Structure

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

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

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

Utilization Management Resources

The Alliance UM Department is staffed with physicians, nurses and non-clinical support staff including clerical support and clinical support coordinators. A full description of staff roles and responsibilities is provided in the 2020 UM Program Description.

The assignment of work to the team, whether working on site or remotely, for both clinical and non-clinical activities, is seamless to the process because it does not change the team member's job responsibilities or job description. In 2020, in response to the Covid 19 pandemic and public health requirements, the UM department transitioned to fully working from home. Staff were provided equipment, remote connectivity, and policies to follow to successfully work from home while maintaining full functionality and meeting regulatory requirements. The job descriptions with assigned tasks and responsibilities remained the same regardless of the geographical location of the team member.

In 2020, based on the established staffing ratios and roles, the UM Department hired for department roles. With the onboarding of new staff, the Health Care Services Department teams reviewed the current organization goals and restructured some clinical assignments in the Department to achieve those goals.

Delegated Utilization Management

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

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

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

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

In 2020, the UM staff conducted annual audits on the four (4) delegates. The threshold for UM audit compliance is 90%. For entities that do not meet the threshold, the UM staff may require a corrective action plan which is tracked for compliance with the resolution of the deficiency. Entity audit results for 2020 were:

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

Figure #5 The Alliance Network – 2020 Annual Audit Score

Delegate	Provider Type	Delegated Activity-UM	2020 Audit Results	Corrective Action Required
Kaiser	HMO	X	Deficiencies found, Corrective Action Plan Required	Yes: Case File-Timeliness Notification of Medical UM Decision Making.
CHCN	Medical Group	X	Deficiencies found, Corrective Action Plan Required	Yes: UM Program Involvement of BH practitioner Communication of urgent concurrent review decisions Documentation of discharge planning processes. Timeliness and notification of Medical UM Decision Making NOA: clear and concise

Delegate	Provider Type	Delegated Activity- UM	2020 Audit Results	Corrective Action Required
CFMG	Medical Group	X	Deficiencies found, Corrective Action Plan Required	Yes: NOA: appropriate reference to the benefit provision for denial and clear and concise language.
Beacon/College Health IPA (CHIPA)	MBHO	X	Deficiencies found, Corrective Action Plan Required	Yes: UM Program- Data collection re: collaboration between medical care and BH Children required to receive EPSDT screenings Documentation of eligibility criteria Continuity and coordination of care Timeliness of evaluation process

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

For 2020, the current UM delegates continue to meet the program's scope of activities. The individual issues of compliance to delegation requirements are addressed with the delegate through the Compliance Department. The UM team works collaboratively with the Compliance Department on identifying potential process improvement activities and monitoring corrective action plans. In 2020, the team:

- Collaborated with Senior Health Care Services Leadership and Compliance staff to resolve on-going corrective actions identified during regulatory audits.
- As part of the Grievance and Appeals process, in 2020 it was discovered our delegate, CHCN, was denying some authorizations to a contracted provider, UCSF, if the member did not meet tertiary or quaternary level of care. The Alliance did not have a process to require that members meet tertiary or quaternary level of care to access UCSF; the Alliance issued a cease and desist letter to CHCN to immediately stop the practice. The Alliance then went through a process to evaluate our network adequacy for tertiary/quaternary care and developed a policy to ensure that AAH members would be able to access tertiary/quaternary care appropriately. The policy was approved at HCQC in January of 2021, and an implementation plan is in development. It is expected that the policy will be enacted by the end of Q2 of 2021.

Recommend Actions/Next Steps

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

<u>Utilization Management Processes and Information Sources</u>

Utilization Management Decision Making

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

For 2020, the Alliance UM Department utilized the clinical criteria as defined in the UM Program. In 2020, the Alliance used the Milliman's CareWebQI® interactive software tools which integrate the MCG® guidelines into the core information system, TruCare, using the 24th Edition MCG® criteria. Upon review of member needs and the requirement to use alternative criteria as appropriate, there were no changes to the clinical criteria. In 2020 there were no requests from members, and no requests from providers for copies of the decision-making clinical criteria.

In 2020 the Alliance UM staff collaborated with Senior Leadership to ensure that Transportation processes continued to match the benefits defined in APL 17-010 for Non-Emergency Medical and Non-Medical Transportation and the requirement to provide non-medical transportation for Medi-Cal services that are not covered under the MCP contract. The Alliance monitors the performance of Logisticare's provision of this benefit by conducting operational meetings and JOMs, regular review of G&As, and performance metrics.

Consistency in Application of Criteria

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

Figure #6 Inter-rater Reliability Thresholds

Score	Action
High – 90%-100%	No action required
Medium – 61%-89%	Increased training and focus by Supervisors/ Managers
Low – Below 60%	Additional training provided on clinical decision-making. If staff fails the IRR test for the second time, a Corrective Action Plan is required with reports to the Senior Director of Health Services and the CMO. If staff fails to pass the IRR test a third time, the case will be escalated to Human Resources which may result in possible further disciplinary action.

The IRR process uses hypothetical UM cases. IRRs included a combination of acute and/or behavioral health IRRs provided by MCG in their IRR system and/or IRRs developed by the Alliance for targeted high-volume medical cases.

All new hire staff are trained and participate in the IRR process upon completion of their training. Results are tallied as they complete the process and corrective actions implemented as needed. When opportunities for improving the

consistency in applying criteria, UM staff addresses corrective actions through requiring global or individualized training or completing additional IRR case reviews.

For 2020, IRR testing was performed in Q3 for UM clinical staff and non-clinical staff to establish consistency in practice and outcomes for members. For the Outpatient nurses, 4 out of 5 criteria questions were passed on the initial attempt. On one question, three out of four nurses (3/4) failed the multi choice question by missing one clinical indicator. All nurses had an all-over final passing score, with a team average of 93%. For the Inpatient Nurses, four out of five criteria questions were passed on the initial attempt. One nurse required three attempts for one question to reach a passing score. The average Inpatient team score was 93%. The Medical Director IRR testing results showed that all Medical Directors scored at least 94% or higher.

Qualitative Analysis

Overall, the final scoring shows all team members passed the study for their respective areas. As a unit, the combined Inpatient team score was 93%, and the Outpatient team score was also 93%, indicating the UM staff are successfully able to apply clinical criteria appropriately for UM decision-making. To maintain a high level of consistency in the performance of UM, the threshold to pass IRR was increased to 90%.

In 2020, the Alliance also reviewed consistency in UM decision making activities for specific services. The AAH reviewed PET-CTs to determine if the requests were approved using the appropriate criteria and that the criteria were applied appropriately. The Alliance reviewed 46 PET CT requests and decisions made between 12/2019 and 11/2020. The review found 100% compliance with appropriate decision making. No issues were identified in that review.

Opportunities for Improvement

1. Continued staff education on appropriate use of system for MCG IRR modules.
2. Continued evaluation by managers of individual staff to ascertain the issues that required multiple attempts, with re-education as needed.
3. Share collective information with clinical staff for team education.

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

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

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

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

- Hospital services, including acute, long-term acute and acute rehabilitation.
- Skilled Nursing Facilities services
- Sub-Acute Facility services

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

1. Kindred long-term acute admissions that had denied services at some time during the stay. Findings were that the appropriate criteria were used, and the cases were adjudicated appropriately using the criteria. There were findings about opportunities for improved communication and frequency of reviewing once denials were issued. The Alliance is evaluating the opportunity to determine next steps.

Opportunities for Improvement

1. Develop schedule for continued review of the UM decision making for delegated services.
2. Share collective information with delegate's clinical staff for education.

UM Information Systems

The Alliance maintains a core information system, TruCare, that is utilized by both UM and case management. UM and CM staff identified opportunities to enhance the functionality of the system to assist in managing UM referrals and case management functions, and in 2019 a major initiative to optimize the TruCare platform had been launched. It was completed in 2020 and resulted in both optimization of the software itself and upgrade to version 8.0 in December 2020. These optimization and upgrades included staff training to ensure standard workflows are in use and staff is competent in the use of the software.

UM DETERMINATIONS

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

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

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

Referrals are tracked and reported by:

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

Denials are reported in relationship to:

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

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

- The performance goal for TAT is 95%.

Quality of NOA letters regarding all types of authorization requests are monitored to ensure clear and concise language, and that they are containing all regulatorily required content. In 2019 AAH received regulatory findings of deficits in outpatient NOA content and employed multiple strategies in 2020 to improve performance in this area. This included NOA template standardization, concurrent, (before sending out,) and retrospective review of the quality of the NOAs, feedback to all staff and MDs involved in the production of NOAs, training of all staff and MDs, and ongoing monitoring of the letters.

Usage of specialty referrals are monitored to ensure members have access to specialty services within or outside of the network.

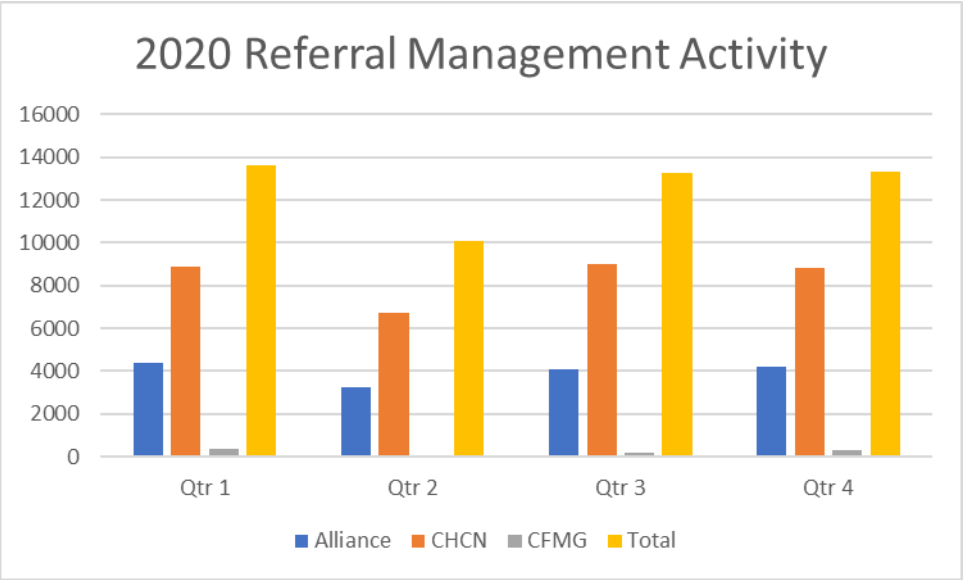
As discussed in a previous section, the Alliance manages two products, Medi-Cal and Commercial (Group Care). For the purpose of data analysis, as the commercial network, IHSS, represents only 2.2% of the total membership and 4.1% of the referral activities, the data is aggregated for reporting. In key areas where the activities are specific to a network, the report will denote the differences.

Utilization Management Referral Management Data

Quantitative Analysis

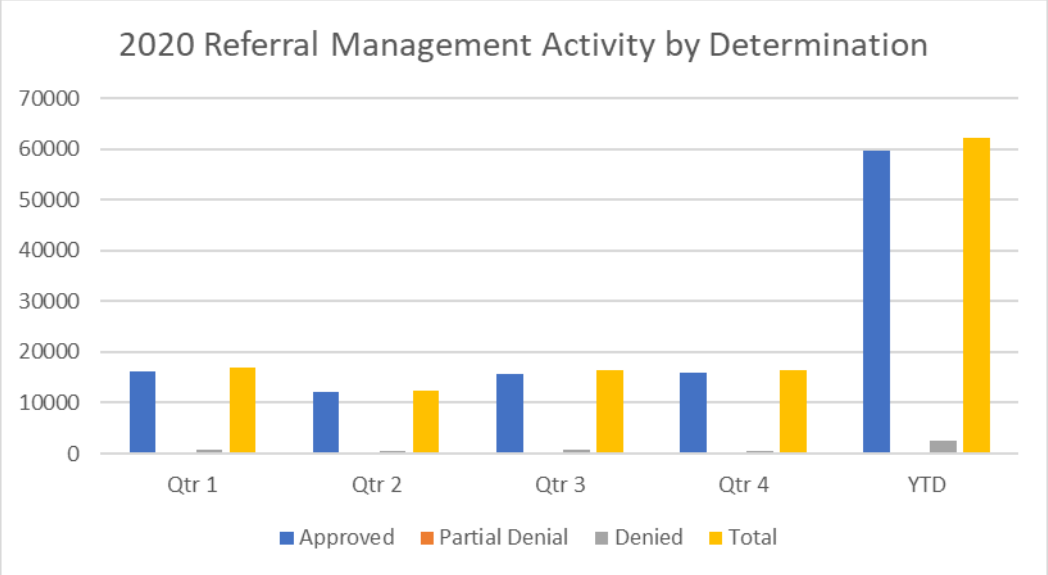
The data presented in Figures 7 – 11 represents key UM referral management functions by provider group, product, and UM determination.

Figure #7 2020 Referral Management Activity



Outpatient Referral Management data by quarter based on number of authorizations managed by the Alliance by date of service; Reporting period is January 1 through December 31, 2020 for all Delegates and all products.

Figure #9 2020 Referral Management Activity by Determination



Outpatient Referral Management data using the final determination, reported by quarter, based on number of authorizations managed by the Alliance by date of service; Reporting period is January 1 through December 31, 2020 for all Delegates and all products.

Figure #10 Comparisons of 2019 and 2020 Outpatient Referral Denial Rate

OP Denial Rates	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
2019	6.4%	7.6%	7.4%	7.1%	7.2%	8.4%	6.3%	6.5%	4.9%	4.8%	4.5%	3.7%	6.3%
2020	4.9%	4.6%	3.9%	3.9%	3.5%	3.8%	4.4%	4.4%	4.4%	3.7%	3.7%	3.3%	4.1%

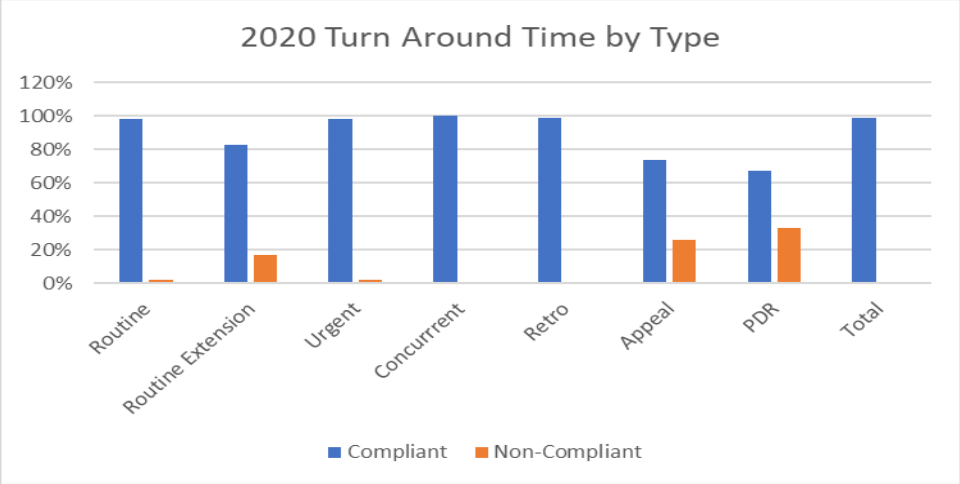
Outpatient Referral Management Denial Rate by month is based on number of authorizations by date of service through December 31, 2020 for all Delegates. The 2020 Year to Date (YTD) denial rate was 4.1%, which is a decrease of 2.2 percentage points from 2019. Most of this drop reflects the de-delegation of EviCore for OP Radiology in August of 2019, which was done because of excessive denials by EviCore, and appeals/overturns of those denials.

Referrals are also monitored to ensure staff process requests within the required timeframes or Turn-Around Times (TAT). The Compliance Department monitors turn-around time performance and reports it to the HCQA. The performance goal for TAT is 95%. For 2020, TAT performance was as follows:

Figure #11a 2020 Referral Management TAT Reports

2020 Performance Referral Management TAT						
	Q1	Q2	Q3	Q4	YTD	Goal
Overall	98%	99%	99%	99%	99%	95%
MediCal	98%	99%	99%	99%	99%	95%
Group	97%	99%	98%	98%	98%	95%

Figure#11b 2020 Referral Management TAT Reports



Qualitative Analysis

The overall referral volume managed by the network was affected by the Covid 19 pandemic in 2020. There was a significantly lower volume of referrals in the second quarter, at the start of the pandemic and social isolation. Over the course of the 3rd and 4th quarter, the membership began to increase, and telehealth capability expanded in the provider

network. There was a corresponding increase in the volume of referrals. The volume of referrals by network provider aligns with the volume of enrollment, with CHCN having the highest volume of referrals and the largest membership which includes adults, MCE and SPD members; CFMG having the lowest referrals and lowest membership which includes primarily children and adolescents.

The 2020 Year to Date (YTD) denial rate of 4.1% is below the established performance threshold of 5%. The decrease in the denial rate from 6.3% to 4.1% is attributable to the decrease in denials for radiology requests that had formerly been issued by our delegate, EviCore. EviCore was de-delegated for radiology because it had an unacceptably high denial and denial overturn rate. In 2020, a review of approved radiology procedures and inpatient cases at LTACH were done to evaluate performance in these areas. No issues were identified in the radiology reviews or the LTACH case reviews. UM will continue to analyze opportunities to further identify denial types to further understand the appropriateness of decision making.

Overall authorization Turnaround Time for 2020 for both Medi-Cal (99%) and Group Care (98%) met the established goal.

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

While the volume of referrals is reported in terms of product, ancillary network and determination, there is an additional opportunity to further assess the types of services by requested services and by type of authorizations, auto approved or clinical review. In 2021, the program will analyze opportunities to increase the number of requests that may appropriately be automatically authorized, thus improving throughput for members' care. This will also assist in validating an appropriate staffing ratio for the department.

Tracking of Unused Authorizations

The Alliance monitors the use of authorizations to ensure Members are accessing approved services and to identify potential specialty access concerns. An unused authorization report is run mid-cycle during the authorization period. A letter is sent out to members to remind them to use their approved authorization. Since the unused authorizations are based on claims sent in, there is a lag in knowing whether a given authorization was actually used or not.

Tracking of Specialty Care Authorizations

The Alliance had established a specialty referral tracking system to monitor specialty referrals requiring prior authorizations, including non-contracting providers, implemented in 2nd Qtr 2019, and was used in 1st Qtr 2020.

Specialty Referral Tracking April 2019 to March 2020								
	Approved/Partial Approved/Denied				% All TAT Met			
	ALLIANCE	CFMG	CHCN	ALL	ALLIANCE	CFMG	CHCN	
NUMBER OF AUTHS					Approved	Partial	Denied	All
Acupuncture	128	6	157	**291**	99.2%	100.0%	100.0%	**99.3%**
Chiropractic	85	1	1,932	**2,018**	98.2%	100.0%	100.0%	**98.8%**
Podiatry	827	161	511	**1,499**	98.7%	100.0%	95.7%	**98.5%**
Transplant Eval	132	-	134	**268**	98.5%	100.0%	100.0%	**98.6%**
Palliative Care	52	-	-	**63**	90.3%	N/A	100.0%	**90.5%**
Professional Services*								
Out of Network	502	131	3,068	3,703	95.6%	100.0%	94.2%	**95.1%**
In Network	1,311	2	1,600	2,913	98.5%	90.0%	95.2%	**98.3%**
Total	**1,813**	**133**	**4,668**	**6,616**	97.9%	95.5%	94.4%	**97.3%**
% Out of Network	**28%**	**98%**	**66%**	**56%**				

A different report was created in Q2 2020 using the PowerBI software to capture the full picture of specialty authorizations, and it is analyzed and reported regularly at UMC. It includes all Specialty Referrals that require authorization, by service type, in or out of network, approved/partially approved/denied, by determination reason, by network, by Provider, with TAT:

Qualitative Analysis

In reviewing the tracking outcomes for Specialty Referrals, it is noted that in particular there may be some underutilization of the Palliative Care benefit, as there are relatively few referrals. At the end of 2020, the Alliance began an engagement with a network partner, AHS, to enhance and extend the use of this benefit by our seriously ill members, and this will continue into 2021.

Recommendations/Next Steps for 2020:

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

TRANSPORTATION

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

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

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

Currently, the Alliance maintains four types of transportation:

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

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

QUANTITATIVE ANALYSIS

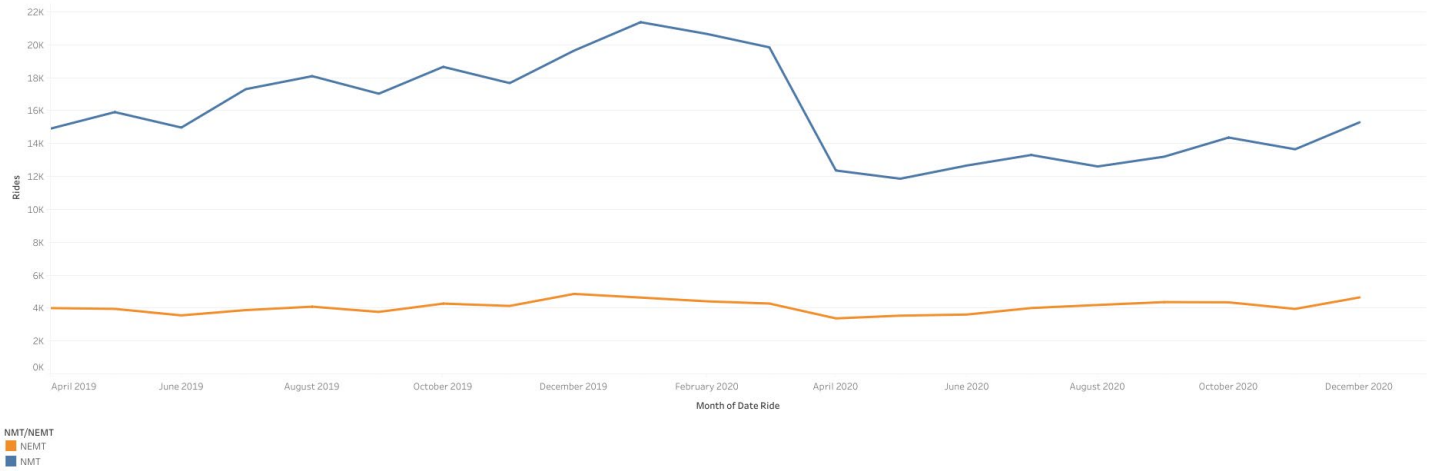
Figure#12 – 2020 Transportation Utilization

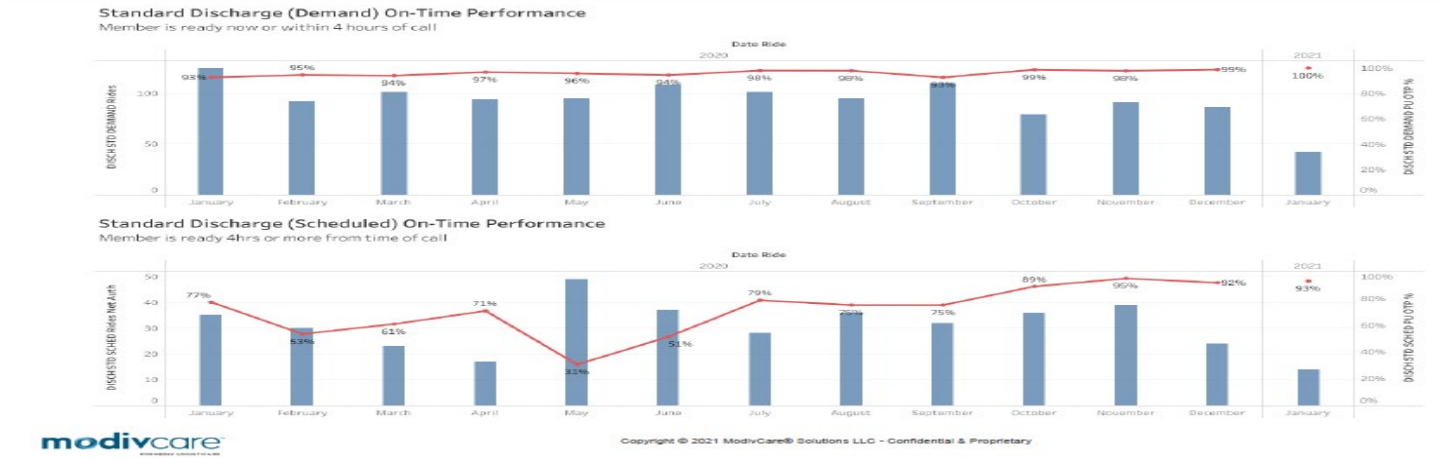
	Description		1st QTR Total	1st QTR Average	% of Total	2nd QTR Total	2nd QTR Average	% of Total	3rd QTR Total	3rd QTR Average	% of Total	4th QTR Total	4th QTR Average	% of Total	YTD	YTD Totals
Member	Members Served	Number of unique members utilizing transportation		2,236			1,311			1,558			1,660		1,691	1,691
Utilization	Gross Reservations	All Reservations taken including cancelled trips	75,082	25,027	100.0%	47,312	15,771	100.0%	51,554	17,185	100.0%	56,196	18,732	100.0%	230,144	230,144
	Utilization Rate	Transportation utilization rate (completed trips/total enrollment)		8.3%			5.2%			5.6%			5.7%		6.20%	
Call Center	Calls Received	Measures number of Reservations calls received	19,582	6,527		7,937	2,646		8,733	2,911		9,352	3,117		3,800	45,604

Timeliness	Average Hold Time	Average hold time should be less than 3 min for 90% of calls		01:17			00:55			00:51			00:50		00:58	
	Service Level	Goal: 80% of calls answered within 30 seconds		84.4%			82.8%			65.5%			89.0%		80.4%	
Quality Management	Complaints - Total	Measures the number of valid complaints Goal: 1% or less	336	112	0.4%	70	23	0.1%	96	32	0.2%	96	32	0.2%	598	598
	Complaint Percentage	Total complaint percentage based on gross reservations		0.45%			0.15%			0.19%			0.17%		0.3%	
	On Time Performance*	Goal: 90% on time for all legs		84.6%			85.2%			79.7%			83.2%		83.2%	
	Will Call On Time	Goal: 90% on time for Will Call Legs		97.1%			98.4%			97.6%			99.1%		98.0%	

NMT vs NEMT

NMT/NEMT	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20
NEMT	3,997	3,950	3,554	3,876	4,084	3,765	4,270	4,129	4,860	4,637	4,408	4,274	3,371	3,539	3,605	4,001	4,187	4,361	4,347	3,947	4,647
	21.15%	19.89%	19.19%	18.30%	18.41%	18.11%	18.62%	18.94%	19.83%	17.83%	17.59%	17.72%	21.43%	22.98%	22.16%	23.12%	24.93%	24.83%	23.23%	22.43%	23.31%
NMT	14,903	15,909	14,969	17,304	18,094	17,028	18,660	17,671	19,647	21,373	20,657	19,845	12,359	11,860	12,662	13,302	12,605	13,201	14,363	13,650	15,287
	78.85%	80.11%	80.81%	81.70%	81.59%	81.89%	81.38%	81.06%	80.17%	82.17%	82.41%	82.28%	78.57%	77.02%	77.84%	76.88%	75.07%	75.17%	76.77%	77.57%	76.69%





QUALITATIVE ANALYSIS

In 2020, the Alliance continued to ensure the provision of the transportation benefits, using Logisticare as the provider. Logisticare quality outcomes show that they are meeting the performance metrics for request response times and have a low rate of complaints. Complaints are monitored through the G&A process and reported at UMC for review and action as needed.

The amount of Ambulatory transport has a sustained increase since 2019, reflecting the increased use of the NMT benefit. However, the Covid 19 pandemic affected the use of the NEMT benefit starting in March of 2020 due to social distancing. The NMT transports remained steady over the year. Many of the NMT trips are for Dialysis, which is an ongoing clinical need, even during a pandemic. Work was done over the course of 2020 to ensure that members who needed transportation after leaving hospitals had timely responses, and improvement was made during the year.

Recommendations/Next Steps for 2021:
The Alliance UM Department will continue to monitor provision of the transportation benefit using criteria to allow appropriate members in need of non-medical transportation to access the transportation benefits and ensure timely responses to requests. AAH will ensure that vulnerable members receive transportation services to get to needed care.

Monitoring of Over/Under Utilization

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

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

The Alliance UM Department monitors, analyzes, and annually evaluates network performance against several relevant data types for each product line, Medi-Cal and Commercial. The UMC reviews quantitative and qualitative analysis of potential areas of under and over – utilization, identifying opportunities for improvement and implementation of a corrective action plan if necessary. The report is not inclusive of behavioral health activities.

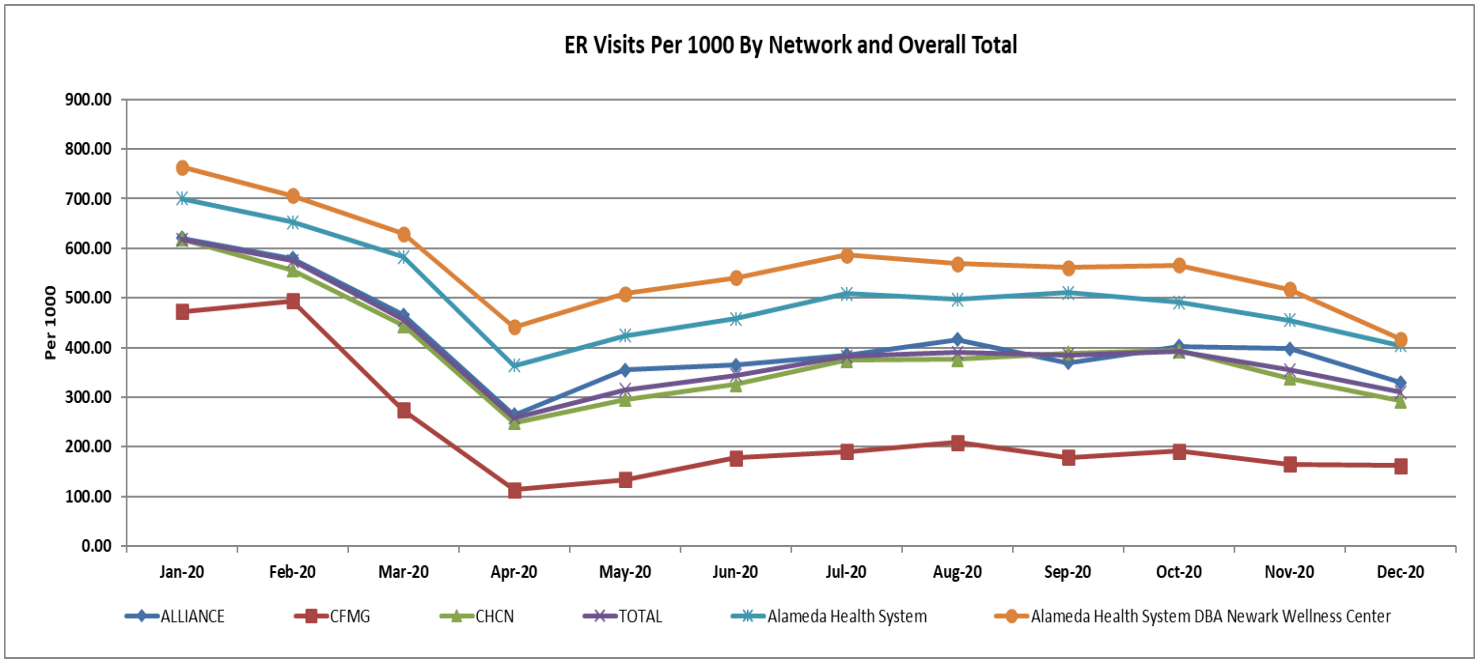
The UM Department has established monitoring activities to include:

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

Acute Hospitalization

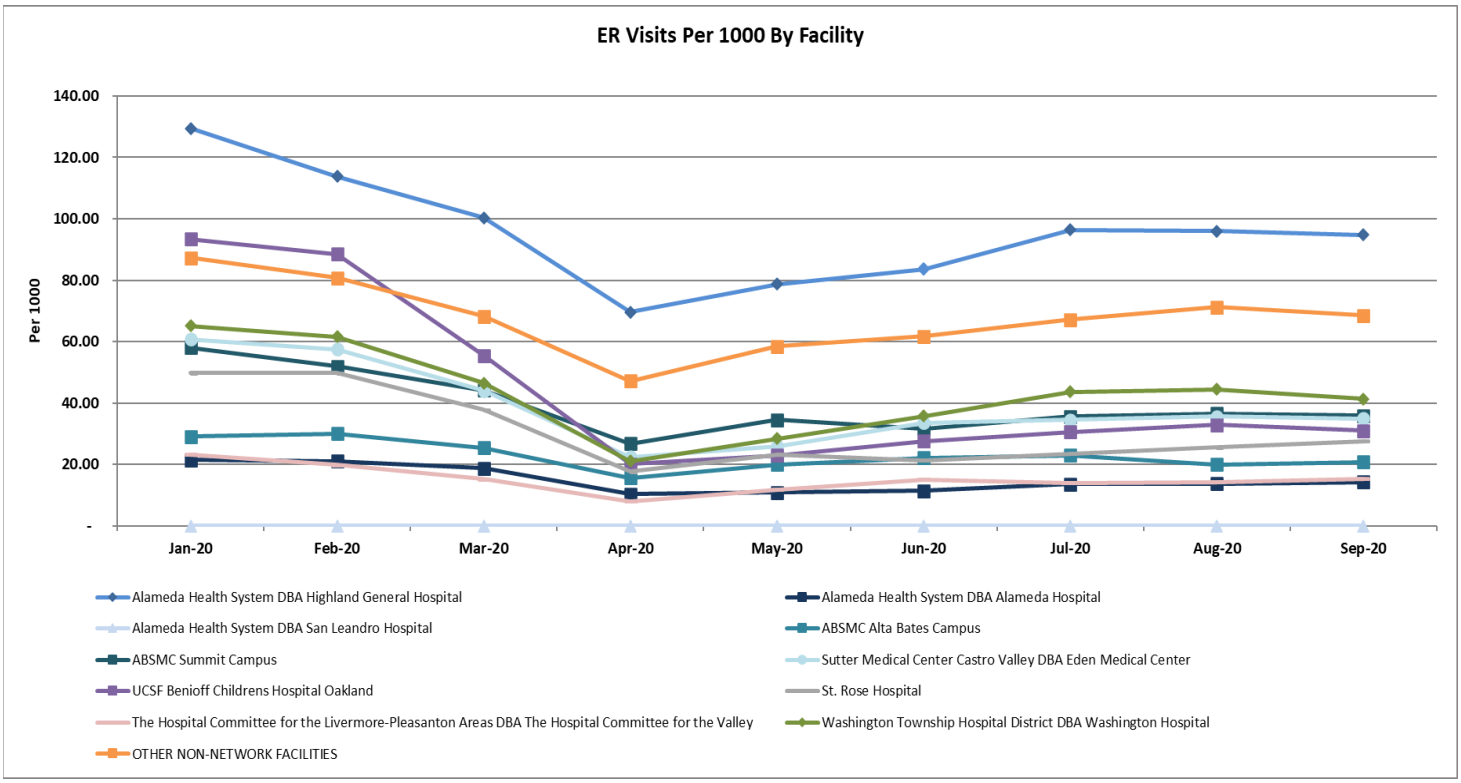
Emergency Room

Figure #13 depicts ER utilization by product from January to December 2020.



The data in Figure 13 show ER utilization across all products. There was a precipitous drop in ER visits in March/April, coinciding with the onset of the Covid 19 pandemic. There was a slow increase in volume over the next months, but the numbers stayed about 200 visits per 1000 less than before the pandemic, across the entire network.

Figure 14 depicts ER Utilization by Facility for 2020



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

Qualitative Analysis

The 2020 ER visit volume was affected by the Covid 19 pandemic, with a precipitous drop off in ER visits at the beginning of the pandemic in March/April. Volume slowly came back up across the rest of the year, but not up to the pre-pandemic volume. This pattern was seen in the number of visits by network and at all hospitals. Prior to the pandemic, the reporting data appeared to run parallel to the seasonality of ER utilization. In reviewing the CDC Flu Portal Dashboard for the 2019-2020 Flu Season, Influenza activity in the United States was at maximum in early December 2019 and tapered down until February 2020. This aligns with activity seen across all networks.

In reviewing ER visits by facilities, the top three centers for ER visits are 1) Highland General (Alameda Health Systems), 2) Other Non-network ERs, unspecified, and 3) UCSF Benioff Children's Hospital in Oakland. This the same pattern seen in 2019.

Hospitalization Measures

Concurrent/continued stay review for acute hospitalization focuses on:

- Facilitating timely and efficient provision of services
- Promoting adherence to established standards of care and identifying quality of care issues.
- Coordinating timely and efficient transfer to the most appropriate level of care
- Implementing proactive and effective discharge planning

- Identification of ongoing case management needs in the ambulatory setting

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

- Identifying a member's medical/psycho-social issues with potential need for post-hospital intervention
- Communicating to the attending physician and member regarding covered benefits for services needed post-discharge or upon transfer to a lower level of care.
- Assisting with locating appropriate placement for members with complex medical or psychosocial barriers to discharge.
- Referral to the Case Management department for coordination of care and follow up for the members.

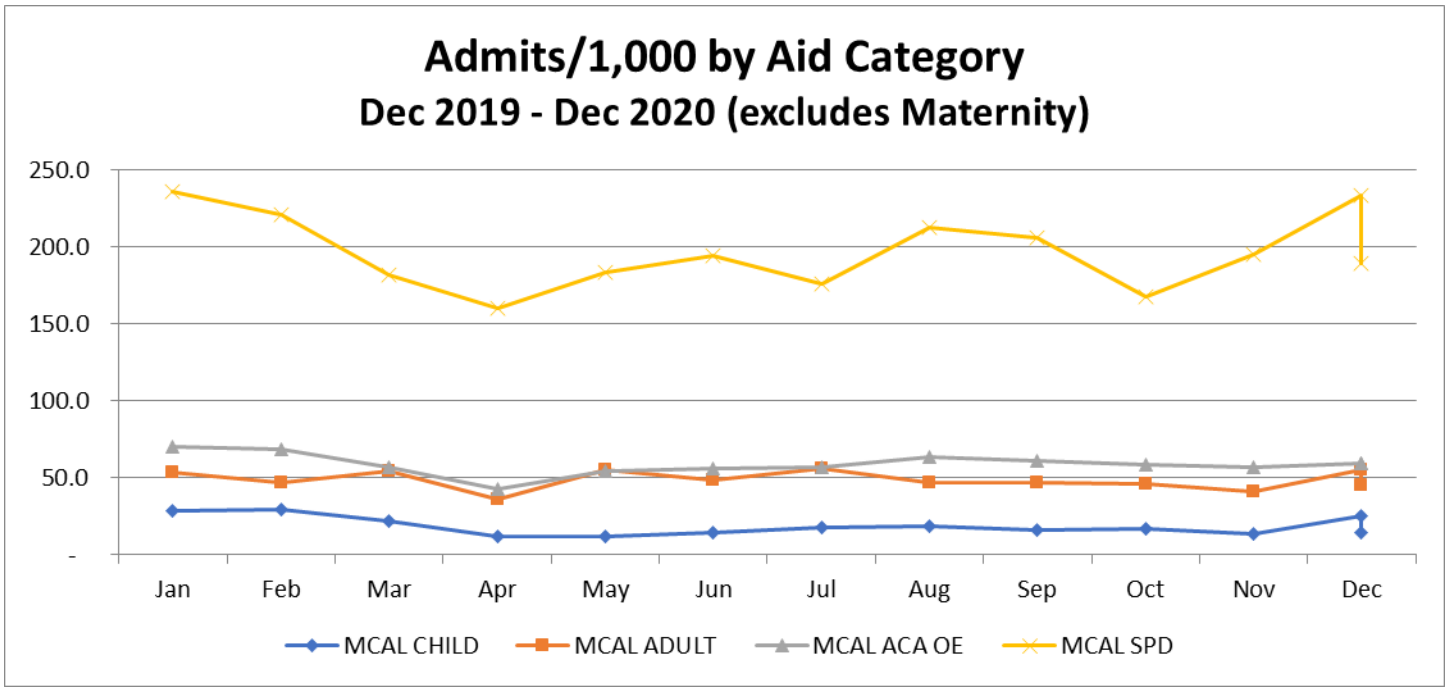
Quantitative Analysis

The Alliance has established benchmarks for inpatient admissions:

Figure #15– 2020 Hospitalization Targets

Inpatient Barometer All Products	
Metric	Target
Admits/1000	83.5
Bed Days/1000	295.7
Average Length of Stay (ALOS)	3.5

Figure #16 2020 Hospitalization admits per thousand by Aid Category.



The data above represents the 2020 performance for all lines of business in inpatient management by admits per thousand. Medi-Cal SPDs continue to have the highest admits per 1000 members while all other member aid categories remain relatively flat. This is as expected for the SPD population, who frequently have higher medical needs. There was a dip in admissions, similar to ED visits, in March and April, at the onset of the Covid 19 pandemic, and then a slow return to near normal levels.

Figure #17 **2020 Hospital bed days per thousand by Aid category**

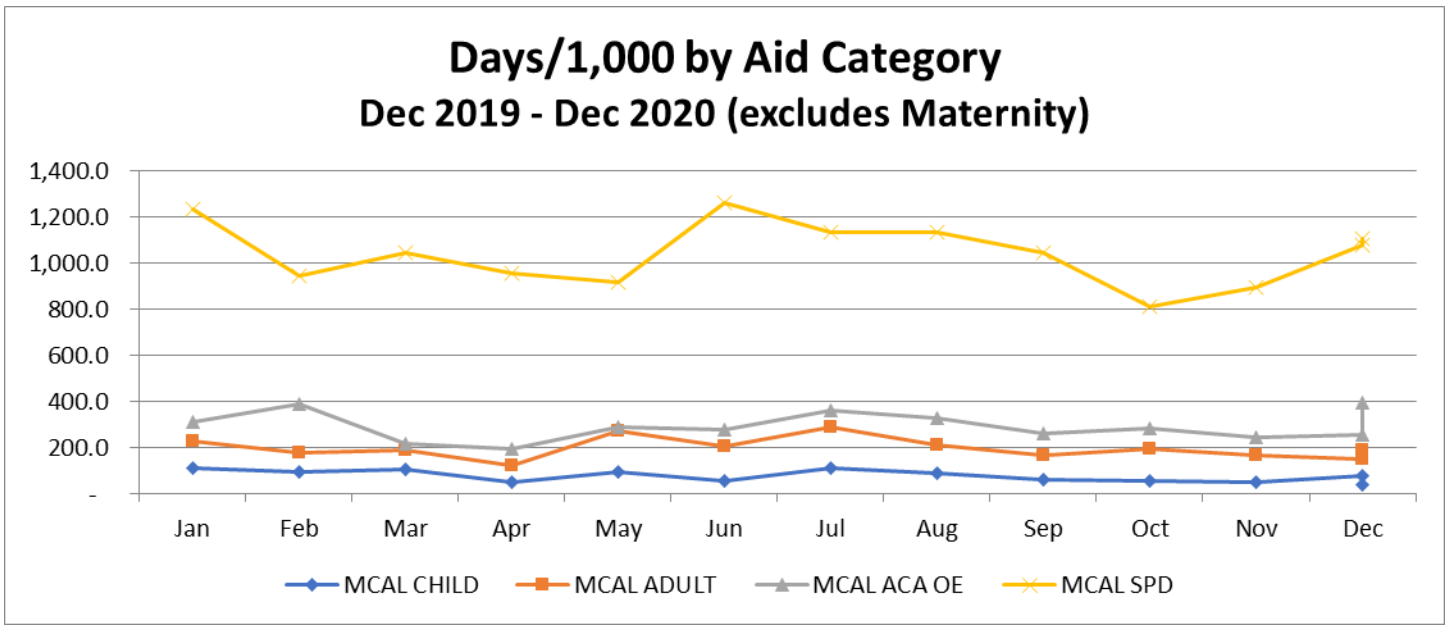
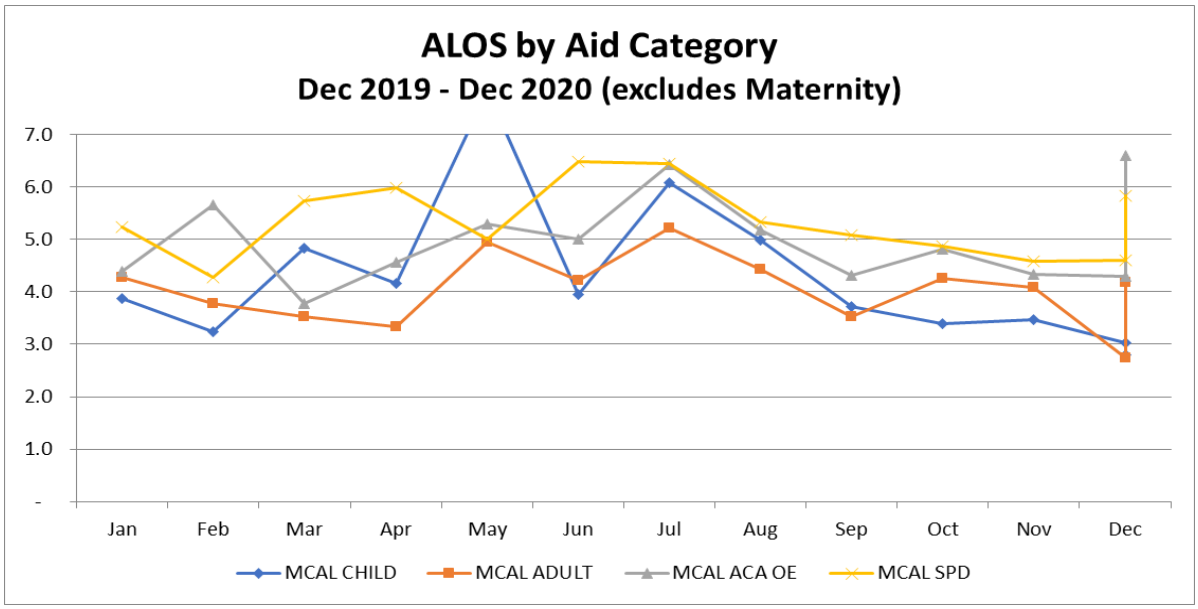


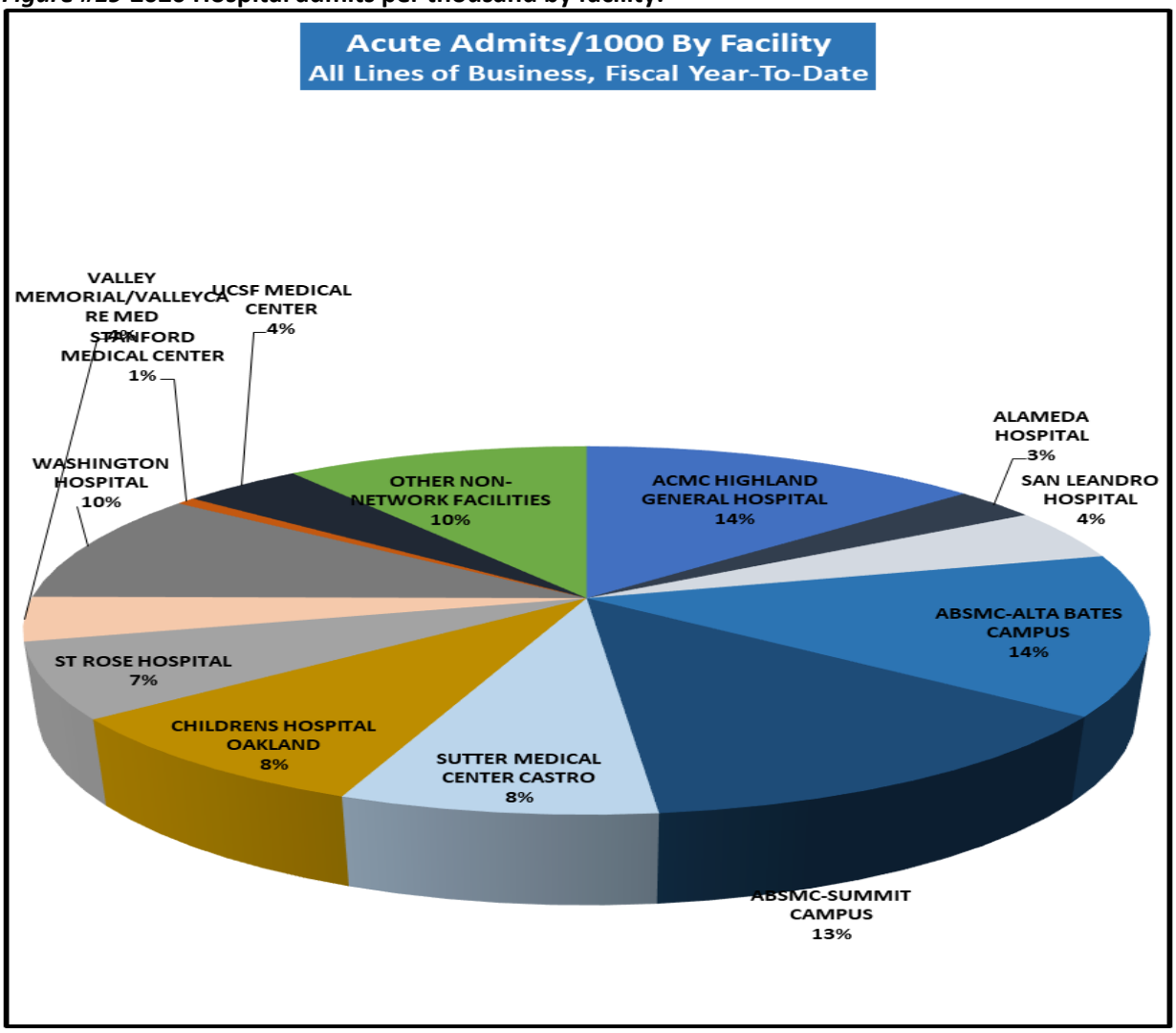
Figure #17 represents the 2020 performance for all lines of business in inpatient management by bed days per thousand. The data above again shows Medi-Cal SPDs as having the highest bed-days per 1000 members while all other member aid categories remain relatively flat. There is a reduction in bed days at the onset of the pandemic.

***Figure #18* 2020 Hospital average length of stay per thousand by Aid Category.**



The data above shows considerable variability, but Medi-Cal SPD and Medi-Cal Expansion (MCE) have the longest stays for inpatient hospitalizations, as is typical. The ALOS spike in May in the Child population is attributed to one child. The ALOS in 2020 was affected by patients admitted with Covid: Initially the patients admitted with Covid had long ALOS, but that LOS came down over the course of the year, though not to the typical ALOS. There were increasing admissions for Covid as the pandemic spread in the 2nd and 3rd quarters, with some reduction in Covid admissions toward the end of 2020.

Figure #19 **2020 Hospital admits per thousand by facility.**



There was some shifting of admissions to Sutter facilities (about 3%) from Alameda Health System facilities between 2019 and 2020.

Qualitative Analysis

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

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

Data provided to assess admissions by facilities, the top three hospitals are 1) ABSMC Facilities (Summit and Alta Bates), 2) Highland Hospital, and 3) Children's Hospital, Oakland. Two of the three hospitals also align with the ER utilization

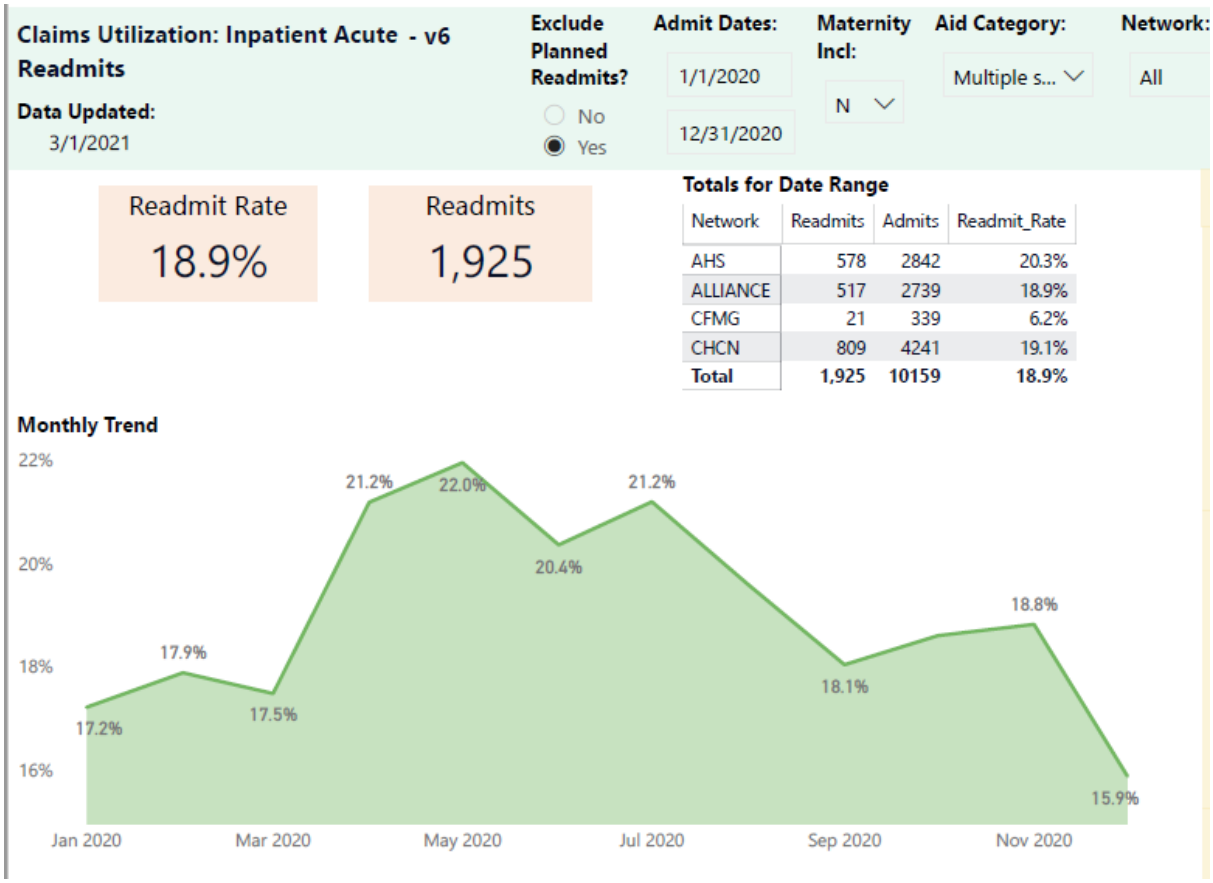
data by facilities as highly utilized facilities. Analysis of admissions and ALOS was complicated by the Covid 19 admissions over the course of 2020. Given the high number of admissions to Sutter facilities and Alameda Health System facilities, in 2020 the Alliance engaged both Sutter and Highland leadership and staff to develop strategies to support throughput and appropriate care transition program for Alliance members. Joint initiatives related to throughput, discharge options, and care coordination occurred throughout 2020.

Readmissions

All Cause Readmission rate, defined as readmission within 30 days of discharge, is trending above goal of 18%. The activities included early interventions prior to discharge and co-management with Case Management. There was an end of year trend going down, but this may represent a data lag instead of actual reduction. For 2020, the overall network readmission rate was 19%:

Quantitative Analysis

***Figure #20* - 2020 Hospital Readmission Overall and by Network**



Data identified in Figure 20 notes the overall readmission rates, and the rates per Network. The overall readmission rate represented by Health Plan total (19%) is above the goal of 18%, and the highest readmit rate is at AHS at 20.3%

Figure #21 2020 **Hospital readmission rates by Aid Category and Distribution of Aid Category**

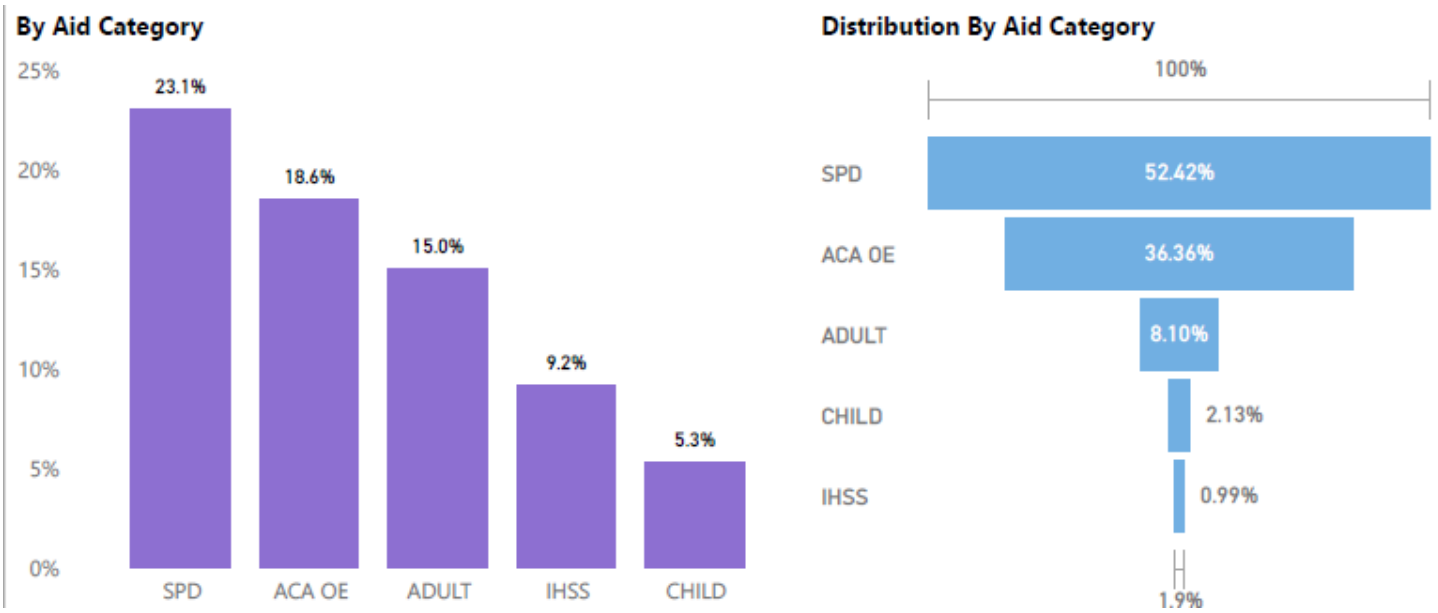
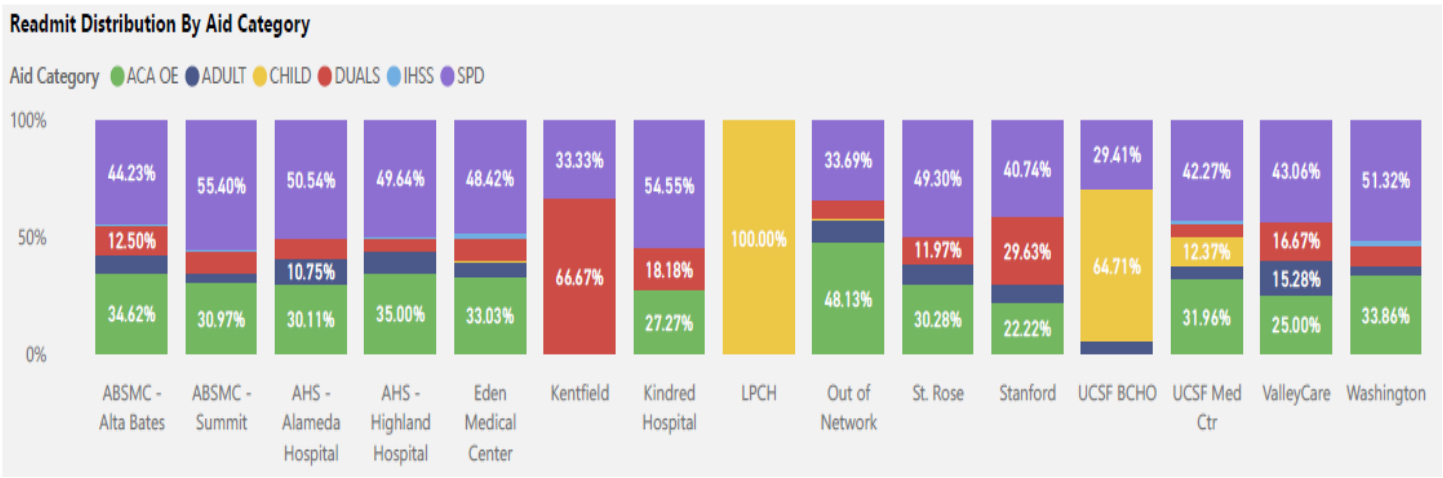


Figure #22 2020 **Readmit Distribution by Aid Category and Hospital**



Data in Figures 21 notes readmission rates by Aid category. As expected, the SPD members have both the highest readmit rate, and are the majority of all members readmitted. The overall health plan rate for SPD also exceeds the readmission goal rate of 18%. Members identified as non-SPD are consistently below the threshold rate. Figure 22 notes readmissions at hospitals, by Aid Category. Most non-specialty hospitals show the pattern of SPD members having the majority of readmissions.

Reduction in readmissions is the focus of the Transitions of Care (TOC) program. In 2020, the TOC program was launched as a pilot with Alameda Health Systems, reflecting both inpatient and outpatient coordination of services. The volume of TOC cases has steadily increased over 2020, and now includes members discharging out of AHS facilities and members discharging with a Covid 19 diagnosis. The Alliance has also been working with the Health Homes program and CHCN to standardize the elements of an effective TOC process.

Continuity of Care

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

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

a. The Alliance treated every exemption on the MER report as an automatic CoC request for the identified beneficiary.

Out of Network Services

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

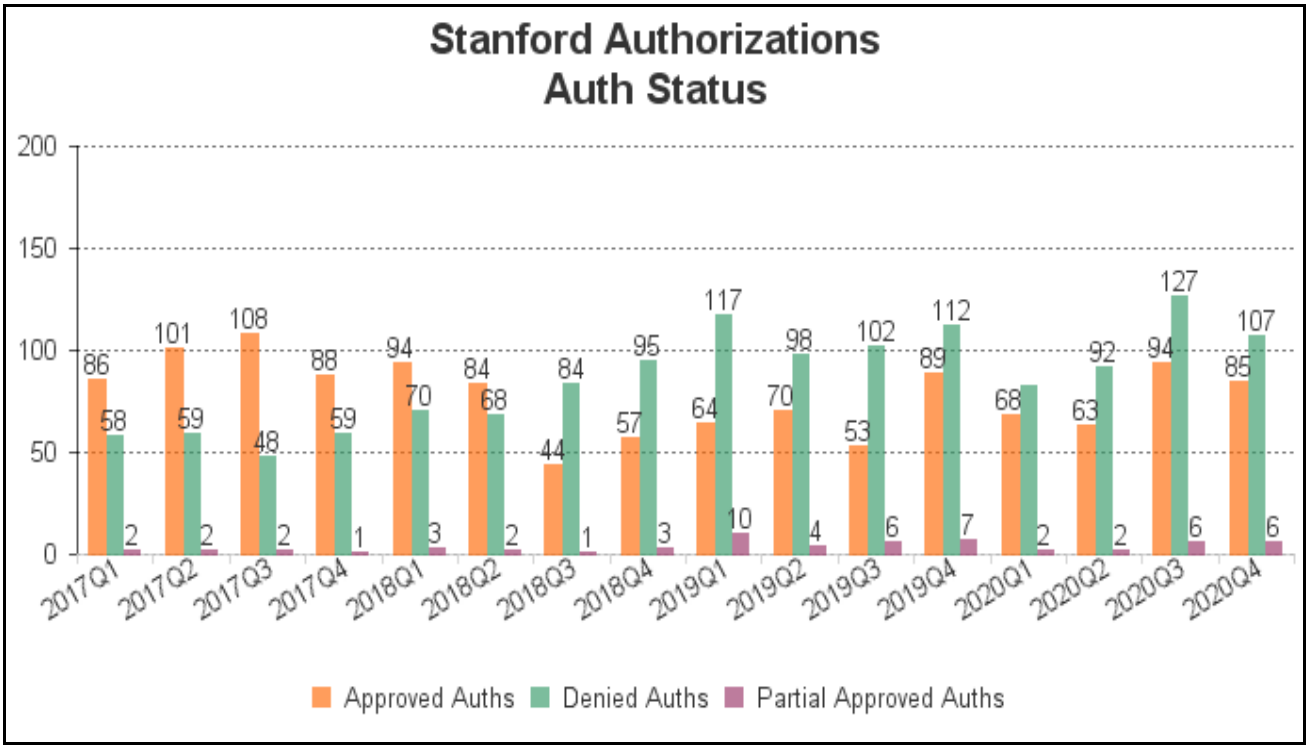
Figure 24 OON Requests (6 or more requests during the year.)

2020 Out of Network Requests			
Specialty Type	**Number Requested**	**Approved**	**% Approved**
General Acute Care Hospital	2176	1689	78%
Physical Medicine and Rehab	122	116	95%
Psychiatry	103	100	97%
Obstetrics and Gynecology	39	29	74%
Surgery-Plastic	36	28	78%
Neurology	35	33	94%
Gastroenterology	28	17	61%
Urology	25	19	76%
Cardiovascular Disease	23	15	65%
Rheumatology	22	14	64%
Surgery-General	20	17	85%
Oncology	13	11	85%
Podiatry	12	10	83%
Surgery-Neurological	8	4	50%

2020 Out of Network Requests			
Specialty Type	**Number Requested**	**Approved**	**% Approved**
Hematology	7	1	14%
Surgery-Orthopedic	6	6	100%

In 2020, the Alliance continued to focus on monitoring OON utilization at the highest requested OON provider, Stanford Hospital Systems. The monitoring included a review of each OON service request for medical necessity and the appropriateness to re-direct to an in-network provider.

Figure 24a OON UM Determinations – Stanford



Data in Figure 24a show the Authorizations requests to Stanford for OON services from Q1 2017 to Q4 2020. The data measures the number of OON referrals to Stanford by the authorization determination: approved, modified, or denied. The data over time shows demonstrates that the number of approved requests continued to decrease, and the number of denials continues to increase.

Quantitative Analysis

The chart in Figure #24a shows the continued trend of decreased approvals and increased denials at Stanford. In 2020 the Alliance launched an initiative with Stanford for oncology services to be provided within the network, to expand oncology services and access to clinical cancer trials for Alliance members.

The process for denials of OON requests is accompanied by confirmation of the requested service within the Alliance network and within time and distance requirements. OON request determinations are also routed to the AAH Case Management Department for assistance with care coordination. The Case Management department also assists the member obtaining the approved requested service within the network.

Pharmacy Utilization

The management and monitoring of Pharmacy utilization and activities is reported through the Pharmacy and Therapeutics Committee and HCQC. A full review of these activities can be found in the P&T Committee minutes.

Recommendations/Next Steps for 2021:

In 2020, the Alliance UM Department identified opportunities to improve the monitoring and the reporting of over/under utilization management activities, which included:

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

LONG TERM SERVICES AND SUPPORTS (LTSS)

The Alliance is responsible for ensuring Members who are eligible to receive LTSS services are identified and referred. In 2020, the UM Department took full responsibility for Community Based Adult Services (CBAS), to ensure that CBAS eligible members are identified, referred, and assessed appropriately and timely. The UM department Out of Plan RN provides assessment, re-assessments, and re-authorizations of services to the members.

Figure 25 - 2020 CBAS Enrollment by Facility by Delegate

CBAS Enrollment by Facility by Delegate					
Based on Active Approved Authorizations, excluding MediCal terminated members					
Run Date:	1/4/2021				
Number of Members					
Facility Name	**Alliance**	**IHSS**	**CHCN**	**Kaiser**	**Total**
Alzheimer Services of The East Bay	5	0	9	0	14
Family Bridges Inc.	81	0	201	1	283
Golden Castle Adult Day Health Care Center	4	0	0	0	4
Grace Adult Day Healthcare	12	0	0	0	12
Silicon Valley Adult Day Health Care	3	0	3	0	6
Total	105	0	213	1	319

As seen in the Figure 25, there were a total of 319 members receiving services through one of the five CBAS centers. The Center with the highest volume is Family Bridges, by a considerable margin. In 2020, the impact of the Covid 19 pandemic was felt in the CBAS centers. The CBAS Centers went to remote services and remained in telephonic communication with their members. The Alliance stayed in close contact with the centers to ensure that the services were provided, to problem solve with the CBAS Centers, and to ensure the continuous support for these vulnerable members.

BEHAVIORAL HEALTH

The Alliance provides access to mental health services for the Medi-Cal and Commercial membership in several ways:

- Basic mental health care needs are provided by Primary Care Providers
- Medi-Cal members with “mild to moderate” impairments in mental, emotional, or behavioral functioning are referred to the contracted behavioral health delegate, Beacon Health Strategies
- Medi-Cal members diagnosed with a severe persistent mental health is carved-out and managed by Alameda County Behavioral Health Care Services Department (ACBHCS).
- Commercial members access mental health benefits through the contracted BH delegate, Beacon Health Strategies.

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

The UM Department is also responsible for maintaining the relationship with ACBHCS to ensure eligible Medi-Cal members receive services through the Linked and Carve Out mental health programs. The focus of the activities is to ensure contracted providers continue to identify and refer members with serious persistent mental health conditions to the appropriate ACBHCS programs as well as facilitate coordination activities for co-existing medical and behavioral health disorders to assist with their treatment access and follow-up care.

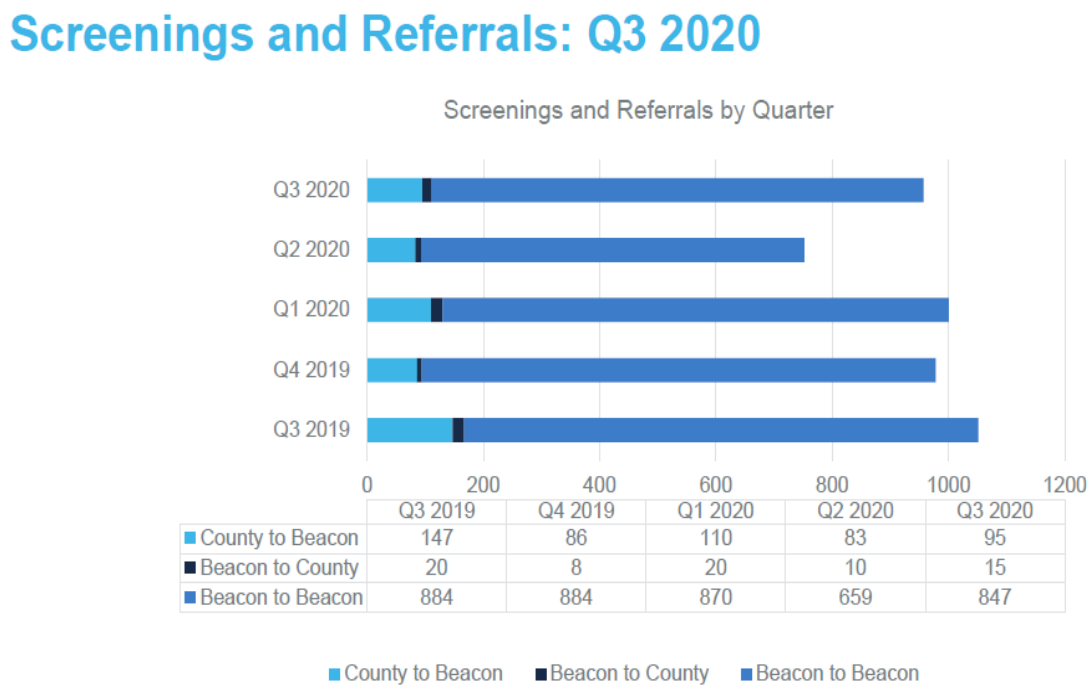
The Alliance contracts with Beacon to administer the applicable Medi-Cal for members with Mild/Moderate behavioral health needs and Commercial (IHSS) mental health benefits.

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

Figure #26– 2020 Beacon Health Strategies Agreement updated

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

Figure 26a-Q3 2019 to Q3 2020 Beacon Screening and Referral



	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020
County to Beacon	147	86	110	83	95
Beacon to County	20	8	20	10	15
Beacon to Beacon	884	884	870	659	847

Figure 26a reflects the integration between Beacon for mild to moderate BH and the Alameda County Behavioral Health for Severe Mental Illness, showing the referrals between the entities based on member acuity. The Alliance has developed multi-disciplinary team to analyze data and identify opportunities for collaboration between medical and

behavioral health. A full description of the program activities is defined in the Beacon Behavioral Health Program Evaluation and UM Program Description. The Beacon BH documents are reviewed at the Alliance HCQC.

Integration with Quality Improvement/Management

The UM Department collaborates with the Quality Management on reports which impact health services. In particular, the HEDIS reports are reviewed at UMC as part of the under-utilization trend monitoring.
The QM Department provides data to the UMC for analysis to use for quality improvement activities.

Assessing Members and Practitioners' Experience with the UM Process

Provider satisfaction survey that includes experience with the UM process results will be presented to HCQC in 2020. The Benchmark is a comparison of the Alliance outcomes to the other plans participating in in the 2020 SPH survey:

Figure #27 2020 Provider Satisfaction with Utilization Management

Provider Satisfaction with Utilization Management				
Question	**2018**	**2019**	**2020**	**Benchmark**
Access to UM Staff	41%	46%	**49%**	30%
Obtaining Pre-Auth Info	46%	45%	**55%**	32%
Timeliness of Pre-Auth Info	46%	48%	**54%**	32%
Facilitation of Care	46%	50%	**45%**	30%
Coverage of Prevention	53%	59%	**60%**	39%

As shown above in Figure #27, the overall scores from 2018 to 2020 are improving for access to UM staff, auth info, and coverage of prevention, with the 2020 scores placing AAH into the 95th percentile compared to other plans for these metrics. Care facilitation dropped somewhat and is in the 87th percentile. In all cases, the satisfaction rates are noted to be considerably higher than the benchmarks with other plans. Provider satisfaction likely improved in 2020 with the implementation of the Provider Portal for online authorization requests and feedback on authorization request status.

Figure #28 2020 Member Satisfaction with Utilization Management

	Member Satisfaction with Utilization Management			
CAHPS Question	**2018**	**2019**	**2020**	**Percentile Rank**
Getting Care Quickly	73%	**74.5%**	72%	<5% Percentile
Getting Needed Care	76%	**76%**	82.6%	47TH Percentile
Coordination of Care	83%	**70.4%**	80.3	14th Percentile

Member experience with the UM process is assessed using established survey Consumer Assessment of Healthcare Providers and Hospital Systems (CAHPS) which measure patient experience across health plans, providers, and health care facilities. UM utilizes three questions to assess patient experience with UM, 1) Getting Care Quickly, 2) Getting Needed Care and 3) Coordination of Care. The results will be presented in 2021 at HCQC, and a description of the full survey can be found in the Quality Program Description.

As identified in Figure #28, the trending shows Member satisfaction with Getting Care Quickly has hovered in the low 70% since 2018. Getting Needed Care improved significantly from 76% in 2018 to 82.6% 2020, improving from the 10th percentile to the 47th percentile. Member satisfaction with Coordination of Care decreased from 83% in 2018 to 80% in 2020, which was at the 14th percentile, showing improved performance in this metric. Overall, while member satisfaction shows approximately 67.4% of the surveyed members are satisfied with getting the care from their physicians, these are lower outcomes compared to other health plans. The continued high performance in Turn Around Time for authorizations and the high rates of approved Authorization requests suggests that the dissatisfaction with these metrics are more driven by provider services than UM processes per se. Member satisfaction will need to have increased focus in the future, in collaboration with Provider Services.

Recommended Interventions/Next Steps for 2021:

In 2021, there is an opportunity to ensure the UM Department participate in the analysis of the data and development of activities associated with the member and provider experience with the UM processes. While Provider Satisfaction is above the comparative benchmark and is over 50% for access to staff and auth info, and at or above 50% for care facilitation of care and preventive care coverage. However, Member experience is low compared to other health plans, and specific activities to address this will be required.

The continued lack of improvement with member satisfaction in 2020 will require a strategy with Provider Services to address this lack of improvement for Member experiences with the obtaining care.

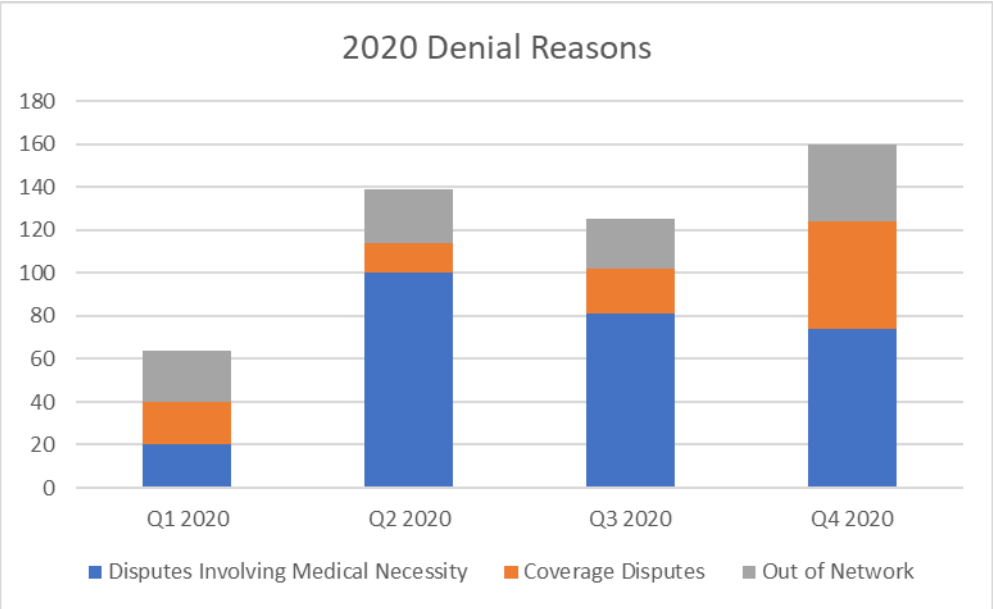
Analysis of Clinical Appeals

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

Clinical Appeals are investigated to determine if the initial UM determination was appropriate. The final appeal is resolved with determinations of upheld, overturn or withdraw (at the request of the member or member's authorized representative). Overturn appeal determinations are considered an opportunity to assess the UM process. The Alliance established a threshold of the overturn determination of 25%.

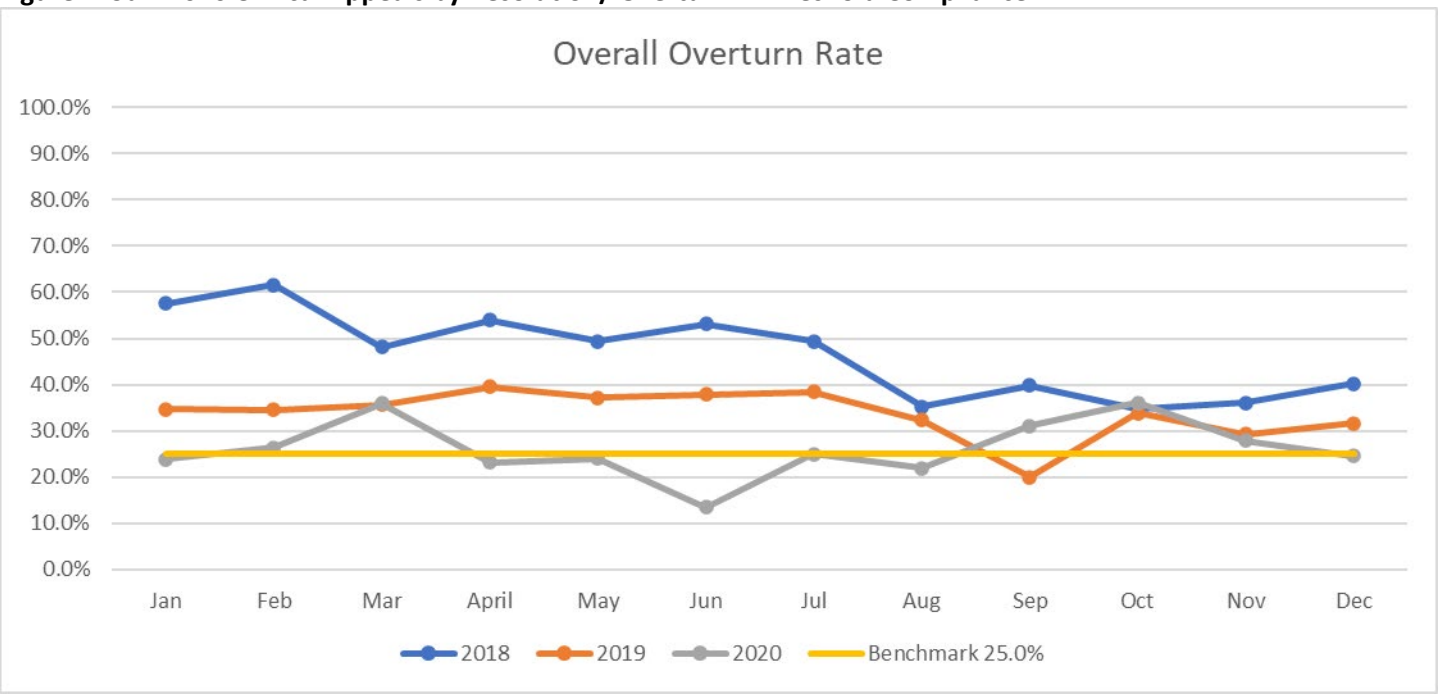
Quantitative Analysis

Figure #28 – 2020 Clinical Appeals



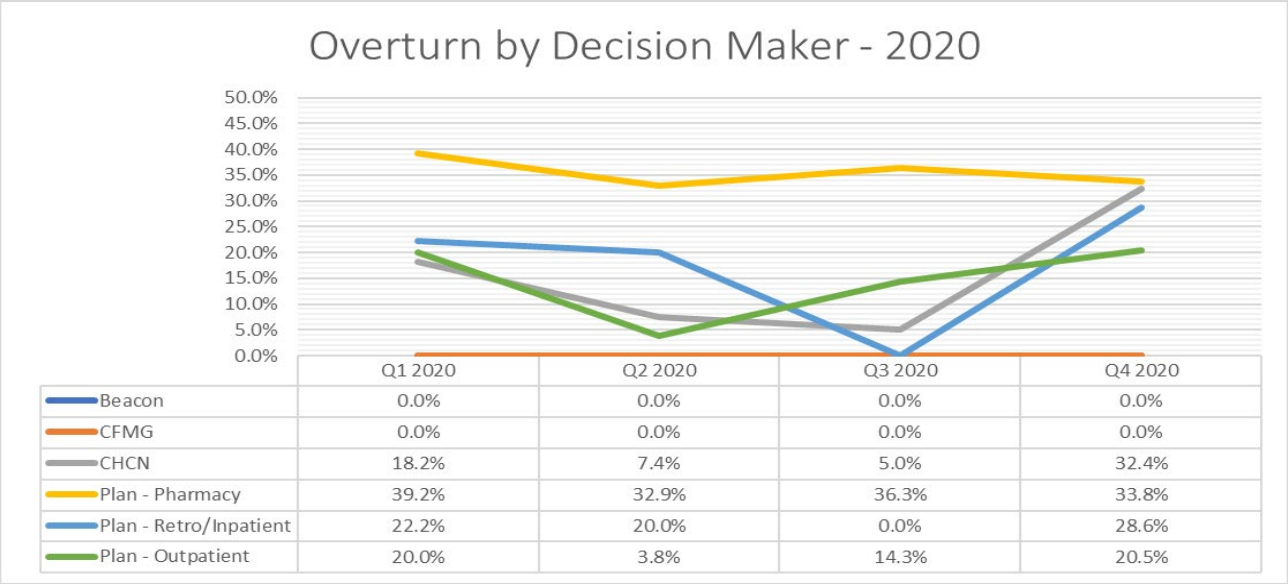
In Q4 2020, there were inconsistencies on how coverage disputes were captured, resulting in a higher number of denials based on coverage. G&A Department will research the issues and report on it in Q1 2021.

Figure #29a – 2020 Clinical Appeals by Resolution/ Overturn – Threshold Compliance



The Alliance ended the contractual relationship with the radiology vendor in 2019 and internalized the review of radiology authorizations. This was due to the high denial overturn rate that had been trending throughout 2018 and into Q1 2019. This change occurred on 8/1/2019, and since then there has been a significant decrease in the overturn rate. This coincided with a reduction in denials for Radiology at that time. Of note, in 2020 a review of PET-CT Alliance approved cases showed that the approvals were appropriate, supporting the appropriate adjudication of radiology cases. September 2019 was the first month in which the denial overturn rate was below the internal benchmark. In October 2019, the rate went back up. However, in 2020, the Alliance has continued to trend around the 25 % benchmark overturn rate.

Figure #29b – 2020 Clinical Appeals by Provider Group and Resolution



	Q1 2020	Q2 2020	Q3 2020	Q4 2020
Beacon	0.0%	0.0%	0.0%	0.0%
CFMG	0.0%	0.0%	0.0%	0.0%
CHCN	18.2%	7.4%	5.0%	32.4%
Plan - Pharmacy	39.2%	32.9%	36.3%	33.8%
Plan - Retro/Inpatient	22.2%	20.0%	0.0%	28.6%
Plan - Outpatient	20.0%	3.8%	14.3%	20.5%

- There is not enough data to identify any trends with Beacon or CFMG.
- CHCN had experienced a large increase in overturns in the 4th quarter, which can be attributed to a change in process on how CHCN was reviewing care being requested at a tertiary facility. CHCN was inappropriately denying authorizations to a tertiary facility as being out of network (OON), instead of for appropriateness for the level of care. CHCN was advised to stop using denial for OON to the contracted provider. A new policy and procedure were developed to outline the appropriate process for reviewing services requested at a tertiary and quaternary facility, which was adopted by CHCN.
- The Plan – Pharmacy appeals showed a decrease over the year, which can be attributed to weekly meetings that are being held between the Pharmacy Department and Grievance and Appeals Department to review overturned cases for quality improvement purposes.
- The Plan – Retro/Inpatient showed a significant increase in Q4 2020 compared to previous quarters.
- The Plan – Outpatient appeals were below the internal benchmark across 2020, so no action is required.

Recommended Interventions/Next Steps for 2021:

For 2021, the UM Department will collaborate with the Grievance and Appeals Department and HCQC to develop various grievance codes to aid in categorizing appeals as well as a series of standard reports to identify trends. In addition, there will be continued internal monitoring and oversight. Provide additional training to the UM staff on the retro process due to the increase of overturns on retro appeals.

Integration of medical and behavioral health

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

In 2020, the teams worked on efforts crossing the medical and behavioral health services which included:

- Involvement of Behavioral Health practitioners in the HCQC.
- HEDIS activities related to behavioral health measures.
- Enhancing CCM outreach to chronically ill
- Improve coordination of care by increasing clinical oversight and co-management with the medical management teams.
- Continued efforts toward improving communication between the primary care physician and behavioral health providers.

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

Coordination with Regulatory Compliance

The Alliance UM Department works closely with the Compliance Department in preparation for regulatory audits. In 2020, the department participated in follow up reviews and work from regulatory audits. As a result of the reviews, several internal workgroups met to identify activities targeted at resolving the identified UM related issues. The workgroups managed these activities via ongoing work-plans. The activities identified are on target for completion within the established timeframes. The activities include mechanisms for ongoing monitoring to mitigate further regulatory deficiencies.

Recommended Interventions/Next Steps for 2020:

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

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

Conclusion

Overall, the 2020 UM Program was effective in maintaining compliance with regulatory and contractual requirements, monitoring of performance within the established benchmarks or goals, identifying opportunities for improvement and enhancing processes and outcomes. The Covid 19 pandemic affected volume trends in multiple areas, but the Alliance maintained the required processes within the regulatory timelines, tracked the effect of the pandemic on members, and change processes to mitigate any potentially negative effects and meet the regulatory requirements of pandemic related APLs. The UM program activities have met most of the established targets, with a reduction in regulatory findings. The Alliance leadership has played an active role in the UM Program structure by participating in various committee meetings, providing input and assistance in resolving barriers and developing effective approaches to achieve improvements.

UM Program Recommendations for 2021

As a result of internal performance monitoring performed in 2020, opportunities for improvement were identified and will be incorporated into the 2021 department goals. Highlights of opportunities for improvement based on the regulatory findings include:

- Improve monitoring of network utilization (over/under), including out of network authorization requests with continued focus on the Stanford analysis.
- Continue monitoring of Specialty Referrals.
- Collaboration with the Alliance Compliance Department on the full implementation of the UM process for internal performance monitoring of UM decisions.
- Work with the Alliance Case Management Department and all relevant Alliance departments to plan for UM aspects of the transition to CalAIM for the ECM, ILOS and Transplant services in 2022.
- Strengthen programs around oversight of clinical decision making, both internally and for Delegates.
- Continue the care transition program in partnership with Highland Hospital and extend to other hospitals.
- Refine the ADT feed coming from contracted hospitals to enable automatic case creation in TruCare.
- Analyze the opportunity and implement the process to increase the number of authorizations that are appropriate for automatic approval.
- Improve reporting and analysis of grievance and appeals activities related to UM decision making and analysis for member and provider experience with UM.
- Continue implementation for tracking and intervening with unused Authorizations to ensure that members receive appropriate care and follow up.
- Work with AHS to improve the use of the Palliative Care benefit for members.
- Continue using the analysis of hospital data to work with hospital partners on individual hospital strategies for management of members for appropriate length of stay.
- Hardwire a standard process for policy review and revision that ensures UM processes maintain operational and regulatory compliance.

ALAMEDA Alliance FOR HEALTH

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

2021
Utilization Management
Program Description

2021 Utilization Management Program

Signature Page

Date _____

Julie Anne Miller, LCSW
Director, Health Care Services

Date _____

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Date _____

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Chief Medical Officer, Medical Management
Chair, Health Care Quality Committee

Date _____

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

- **<u>Changes in UM Program Description from 2020 Version</u>**
  - **Grammatical corrections**
  - **Pagination corrections**
  - **Addition/correction of relevant regulatory references**

Table of Contents

Introduction

Alameda Alliance for Health (the Alliance) is a public, not-for-profit managed care health plan committed to making high quality health care services accessible and affordable to lower-income people of Alameda County. Established in January 1996, the Alliance was created by and for Alameda County residents.

The Alliance provides health care coverage to over 250,000 children and adults through the Medi-Cal and Alliance Group Care programs. Alliance members choose from a network of over 1,700 doctors, 17 hospitals, 29 community health centers, and more than 190 pharmacies throughout Alameda County. The Alliance cares about the health of our community and reflects the community's cultural and linguistic diversity in the health plan's structure, operations, and services. In addition, many of the Alliance providers, employees, and Board of Governors (BOG) live in areas that we serve. The Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan members. Our members' optimal health is always our priority.

The Alliance's Utilization Management (UM) Program was established to provide basic and complex care management structures and key processes that enable the health plan to improve the health and health care of its members. The UM Program is a supportive and dynamic tool that the Alliance uses to achieve these objectives as well as respond to the needs and standards of consumers, the healthcare provider community, and regulatory and accrediting organizations. The UM Program is compliant with Health and Safety Code Sections 1363.5, 1367.01, 1368.1, 1374.16, 1374.72 and Title 28, CCR, Sections 1300.1300.67.2, 1300.70(b)(2)(H) & (c).

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

The annual evaluation of the effectiveness of UM processes was conducted and the recommendations were documented in the 2020 UM Program Evaluation. Based on those recommendations, the Alliance will continue its focus on the following areas for 2021:

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

- Strengthen internal oversight of UM processes.
- Strengthen oversight of delegates; and
- Continue to focus on activities to mitigate regulatory audit deficiencies related to UM activities.
- Secure staffing and resourcing to support these initiatives.

Section I. Program Objectives & Principles

The purpose of the Alliance UM Program is to objectively monitor and evaluate the appropriateness of utilization management services delivered to members of the Alliance. The UM Program serves Alliance members through the following objectives:

- Ensure that appropriate processes are used to review and approve the provision of medically necessary covered services.
- Provide continuity of care and coordination of medical services.
- Improve health outcomes; and
- Assure the effectiveness and efficiency of healthcare services.

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

- Appropriately licensed and qualified health care professionals with clinical care expertise make UM review determinations according to approved clinical review criteria.
- UM decisions are made on appropriateness of care and service, as well as existence of benefit coverage.
- Appropriate processes are used to review and approve provision of medically necessary covered services.
- Prior authorization requirements are not applied to emergency, family planning, preventive, or basic prenatal care, and sexually transmitted disease or HIV testing services.
- The Alliance does not financially reward clinicians or other individuals for issuing denials of coverage, care, or service.
- The Alliance does not encourage UM decisions that result in under-utilization of care to members.
- Members have the right to:
    - Participate with providers in making decisions about their individual health care, including the right to refuse treatment.
    - Discuss candidly with providers the appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
    - Receive written notification of a decision to deny, defer, or modify requests for prior authorization.
    - Request a second opinion from a qualified health professional at no cost to the member.
    - Voice grievances or appeals, either verbally or in writing, about the organization of the care received.

- Request a Medi-Cal state hearing, including information on the circumstances under which an expedited fair hearing is possible.
- Have access to, and where legally appropriate, receive copies of, amend or correct their medical record; and
- Receive information about how to access State resources for investigation and resolution of member complaints, including a description of the DHCS Medi-Cal Managed Care Ombudsman Program and its toll-free number, and the DMHC, Health Maintenance Organization (HMO) Consumer Service and its toll-free number

Section II. Program Structure

A. Program Authority and Accountability

1. Board of Governors

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

2. Committee Structure

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

Alliance committees meet on a regular basis and in accordance with Alliance Bylaws. Alliance Board meetings are open to the public, except for peer review activities, contracting issues, and other proprietary matters of business, which are held in closed session.

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

Quality Improvement Program.

The HCQC provides the external physician involvement to oversee the Alliance QI and UM Programs. The HCQA includes a minimum of four (4) practicing physician representatives. The UM Committee include in their membership physicians with active unrestricted licenses to practice in the State of California. The composition includes a practicing Medical Director Behavioral Health and/or a Behavioral Health Practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review, as needed.

The HCQC functional responsibilities for the UM Program include:

- Annual review and approval of the UM Program Description.
  Oversight and monitoring of the UM Program, including:
    - Recommend policy decisions.
    - Oversight of interventions to address over and under-utilization of health services.
    - Oversight of the integration of medical and behavioral health activities
    - Guide studies and improvement activities.
    - Review results of improvement activities, HEDIS measures, other studies and profiles and the results of audits; and
    - Recommend necessary actions.

B. Utilization Management Committee

The Utilization Management Committee (UMC) is a sub-committee of HCQC. The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The sub-committee is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

1. UM Committee Structure

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

2. Authority and Responsibility

The HCQC is responsible for the overall direction and development of strategies to manage the UM program including but not limited to reviewing all recommendations and actions taken by the UM Committee.

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

- Annual review and approval of the effectiveness of the UM Program
- Annual review and approval of the UM Program,
- UM Policies/Procedures,
- UM Criteria, and
- Other pertinent UM documents such as the UM Delegation Oversight Plan, UM Notice of Action Templates, and
- Case/ Care Management Program and Policies/ Procedures.

3. UM Committee Membership

The UMC is chaired by the Chief Medical Officer.

Members of the UM Committee include:

- The Alliance Chief Analytics Officer
- The Alliance Medical Directors, UM
- The Alliance Medical Director, CM
- The Alliance Medical Director, Quality Improvement
- The Alliance Senior Director, Quality Improvement
- The Alliance Senior Director, Pharmacy & Formulary
- The Alliance Senior Director, Health Care Services
- The Alliance Director, Compliance
- The Alliance Director, Member Services
- The Alliance Director of Provider Relations and Provider Contracting
- The Alliance Director, Quality Assurance
- The Alliance Manager, Healthcare Analytics
- The Alliance Managers, Case Management
- The Alliance Managers, Utilization Management
- The Alliance Manager, Grievance & Appeals

4. UMC Voting Privileges

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

5. UMC Quorum

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

6. UMC Meetings

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

7. UMC Minutes

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

8. UM Committee Functions

The UM Committee is a forum for facilitating clinical oversight and direction. The UMC purpose is to:

- Improve quality of care for the Alliance members.
- Evaluate and trend utilization data for medical and behavioral health services provided to Alliance members and benchmarks for over/under utilization. This includes in- network and out-of-network utilization data review to ensure services are accessible and available timely to members.
- Provide a feedback mechanism to drive quality improvement efforts in UM.
- Increase cross functional collaboration and provide accountability across all departments in Medical Services.
- Provide mechanism for oversight of delegated UM functions, including review and trend authorization and utilization reports for delegated entities to identify improvement opportunities.
- Identify behaviors, practices patterns and processes that may contribute to fraud, waste, and abuse with a goal to support the financial stability of our providers and network.

UM Committee responsibilities are to:

- Maintain the annual review and approval of the UM Program, UM Policies/Procedures, UM Criteria, and other pertinent UM documents such as the UM Delegation Oversight Plan, UM Notice of Action Templates, and Case/ Care Management Program and Policies/ Procedures.
- Participate in the utilization management/ continuing care programs aligned with the Program's quality agenda.
- Assist in monitoring for potential areas of over and underutilization and recommend appropriate actions when indicated.
- Review and analysis of utilization data for the identification of trends
- Recommend actions to the Quality Oversight Committee when opportunities for improvement are identified from review of utilization data including, but not limited to, Ambulatory Visits, Emergency Visits, Hospital Utilization Rates, Hospital Admission Rates, Average Length of Stay Rates, and Discharge Rates.
- Review information about New Medical Technologies from the Pharmacy & Therapeutics Committee including new applications of existing technologies for potential addition as a new medical benefit for Members.

Based on the decision of the UM Committee and recommendations through the appropriate Quality Committees, the approval of a new technology or new application of an existing technology by the HCQC shall be deemed to be the Alliance policy on coverage, and where the Alliance does not have the authority to modify the benefit package, the Chief Medical Officer shall notify, in writing, each payer for whom the Alliance manages benefits of its recommendation.

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

C. Program Oversight and Staff Responsibility

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

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

1. Chief Medical Officer

The Chief Medical Officer is a designated board-certified physician with responsibility for development, oversight, and implementation of the UM Program. The CMO holds a current unrestricted license to practice medicine in California. The CMO serves as the chair of the HCQC and UMC, and makes periodic reports of committee activities, UM Program activities and the annual program evaluation to the BOG. The CMO works collaboratively with Alliance network physicians to continuously improve the services that the UM Program provides to members and providers.

Any changes in the status of the CMO shall be reported to Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) within the required timeframe.

2. Medical Directors

The Medical Directors are licensed physicians with authority and responsibility for

providing professional judgment and decision-making regarding matters of UM. The Medical Directors hold current unrestricted license to practice medicine in California. Medical Directors responsibilities include but are not limited to the following:

- Ensure that medical decisions are rendered by and are not influenced by fiscal or administrative management considerations.
- The decision to deny services based on medical necessity is made only by Medical Directors.
- Ensure that the medical care provided meets the standards for acceptable medical care.
- Ensure that medical protocols and rules of conduct for plan medical personnel are followed.
- The initial reviewer must not review any appeal cases in which they were the decision maker for the authorization.
- Develop and implement medical policy.

The Alliance may also use external specialized physicians to provide specific expertise in conducting reviews. These physicians are currently licensed, and many have board certification in specific areas of medical expertise. The CMO is responsible for managing access and use of specialized physicians.

3. Senior Director, Health Care Services

The Senior Director, Health Care Services is a Licensed Clinical Social Worker and is responsible for overall UM Department operations, staff training, and coordination of services between departments. The Director's management responsibilities include:

- Develop and maintain the UM Program in collaboration with the CMO.
- Coordinate UM activities with the Quality Department and other Alliance units.
- Maintain compliance with the regulatory standards.
- Monitor utilization data for over and under-utilization.
- Coordinate interventions with the CMO to address under and over utilization concerns when appropriate.
- Monitor utilization data and activities for clinical and utilization studies; and maintain professional relationships with colleagues from other Medi-Cal Managed Care Plans, sharing information about requirements and successful evaluation strategies.
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision.
- Monitor documentation for adequacy.
- Available for UM staff on site or by telephone.

4. Pharmacy Services Senior Director

The Pharmacy Services Senior Director is a licensed pharmacist (Pharm.D.) responsible for coordinating daily operations and reviewing and managing pharmacy utilization reports to identify trends and patterns. The Director provides clinical expertise

relative to the Pharmacy, Quality and UM components of Alliance plan management including Member and Provider Services and Claims operations. The scope of responsibilities of the Pharmacy Services Director includes:

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

5. Utilization Review Clinicians

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

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

6. UM Coordinators

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

Roles and responsibilities include:

- Outpatient UM Coordinators
  - Ensure appropriate UM referral entries into the information system.
  - Process UM referrals approvals for selected requests identified as Auto Authorizations or Authorization in their Scope of Work that do not require clinical interpretation.
  - Complete intake functions with the use of established scripted guidelines and
  - Manage and complete UM Member and Provider communications.
  - Complete administrative denials, as defined in UM Policy 057 – Authorization Requests.
- Inpatient UM Coordinators:
  - monitor and collect facility admissions census data.
  - Complete data entry of initial cases.
  - Maintain member and provider communications.
  - Assist in requesting additional information as needed
  - Review of hospital referral to ensure appropriate case closure.
  - Approve inpatients services as defined in UM Policy UM-057 Authorization Requests.
- Ensuring the efficient processing for the authorization process and maintain documentation in support of the on-site and telephonic UM nurse staff.

Section III. Program Scope, Processes & Information Sources

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

A. Utilization Management Activities

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

- Services exempt from Prior Authorization means services for which the health plan cannot require advance approval.
- Pre-service Review means a formal process requiring a requesting health care provider to obtain advance approval to provide specific services or procedures. Preauthorization, Prior Authorization, and Pre-Certification are terms also used to describe Pre-service Review.
- Concurrent Review means a review for an extension of a previously approved, ongoing course of treatment over a period or number of treatments. Concurrent

reviews are typically associated with inpatient care, residential behavioral care, intensive outpatient behavioral health care, and ongoing ambulatory care.

- Post Service Review means the assessment of the appropriateness of medical services after the services have been provided. This is also called Retrospective Review.
- After Hours and Emergency Care

Emergency health care services are available and accessible within the service area 24 hours a day, seven days a week. The Alliance provides 24-hour access for members and providers to obtain timely authorization for medically necessary care, for circumstances where the member has received emergency services and care and is stabilized, but the treating provider believes that the member may not be discharged safely. A Physician is available 24 hours a day to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized Members in an emergency department, if necessary.

Emergency health care services are covered without prior approval:

- to screen and stabilize the member where a prudent layperson, acting reasonably would have believed an emergency medical condition existed.
- when there is an imminent and serious threat to health including, but not limited to, the potential loss of life, limb, or other major bodily function.
- when a delay in decision making would be detrimental to the member's life or health or could jeopardize the member's ability to regain maximum function.
- If an authorized representative, acting for the Alliance, has authorized the provision of emergency services.

A "Prudent Layperson" is a person who is without medical training, and who draws on his/her practical experience when deciding regarding whether emergency medical treatment is needed. A Prudent layperson is considered to have acted reasonably if other similarly situated laypersons would have believed that emergency medical treatment was necessary.

Other Alliance representatives who may direct members to emergency services include the Nurse Advice Line staff, and the Alliance nurse case manager or disease manager, an Alliance Member Services Representative or after-hours call answering service, or a contracted specialist. The Alliance will honor health plan coverage for services when directed by any Alliance staff member or delegated representative.

B. Communication Services for UM Process with Members and Providers

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

Director. Providers contact the UM Department directly at 510.747.4540. UM staff are available at least 8 hours per normal business day (excludes weekends and holidays). During scheduled business hours, the Alliance provides access to staff for members and practitioners seeking information about the UM process and the authorization of care. After hours calls are answered by a contracted vendor and non-emergency calls are returned the following business day. After Hour calls requiring clinical decision-making are transferred to a the Alliance on-call nurse for assistance. Staff identify themselves by name, title and as representatives of the Alliance when initiating or returning calls. HIPAA protocols are followed to ensure protection of privacy. Language assistance and TDD/TTY services are available as needed for members to communicate with the Alliance regarding the UM program.

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

C. Decision Support Tools

The appropriate use of criteria and guidelines require strong clinical assessment skills, sound professional medical judgment, and application of individual case information and local geographical practice patterns. Licensed nursing review staff apply professional judgment during all phases of decision-making regarding the Alliance members.

"Decision Support Tools" are intended for use by qualified licensed nursing review staff as references, resources, screening criteria, and guidelines with respect to the decisions regarding medical necessity of health care services, and not as a substitute for important professional judgment. The Medical Director evaluates cases that do not meet review criteria/guidelines and is responsible for authorization/denial determinations.

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

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

D. UM Review Criteria, Guidelines and Standards

The Alliance, Provider Groups and Vendors delegated for UM functions must utilize evidenced based nationally recognized criteria for UM decision making. UM criteria are

used to determine medical necessity in the Authorization Request review process.

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

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

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

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

Examples of regulations and guidelines are as follows:

- Regulations:
  - Code of Federal Regulations
  - California Health and Safety Code.
  - California Code of Regulations Title 22.
  - California Code of Regulations Title 28.
  - California Welfare and Institution Code

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

1. Application of UM Criteria

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

- Regulatory contractual requirements, such as DHCS regulations, Provider Manuals, All Plan Letters.
- Evidence based guidelines, such as MCG®, InterQual, ApolloMed, and UpToDate. Alliance specific guidelines

- UM Auto Authorization List as approved by the UM Committee.
- Other Utilization Management Committee Approved Criteria
- Pharmacy Therapeutics Committee Approved Criteria
- When none of the above criteria are applicable, consider the following and two (2) or more of the following criteria are applicable, then MCG® criteria are to be used as the first choice.
    - MCG® Guidelines
    - UpToDate.com

- National medical association guidelines, such as American Commission of Obstetrics and Gynecology (ACOG), American Association of Pediatrics (AAP), American Diabetes Association (ADA), World Professional Association for Transgender Health (WPATH).
- Definition of Medical Necessity (Product Line specific when the above criteria do not apply to a specific request for an UM decision).
- Other resources

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

2. Clinical Review Criteria

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

Additionally, the Alliance has a formal mechanism to evaluate and address new developments in technology and new applications of existing technology for inclusion in benefit plans to keep pace with changes and to ensure that members have equitable access to safe and effective care. The UMC reviews and approves all new coverage policies before implementation.

For the Medi-Cal line of business, the term “Medically Necessary” will include all Covered Services that are reasonable and necessary to protect life, prevent significant

illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. {Title 22, CCR, Section 51303(a)}. When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in Title 22, CCR, Section 51340 and 51340.1.

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

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

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

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

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

If criteria are requested, the organization makes them available:

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

E. Benefits

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

- Medi-Cal member benefits are developed by the State of California, DHCS and DHCS mandated benefits for Medi-Cal Members. DHCS benefits, available on the DHCS Web site, defined by, but not limited to:
  - Service requests for Medi-Cal beneficiaries.
  - Medi-Cal Manual of Criteria
  - Medi-Cal DME.
  - Medi-Cal Hospice
  - Medi-Cal Waivers.
  - Medi-Cal Linked and Carve Out Programs

- IHSS benefits are developed by Public Authority of Alameda County

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

1. Benefit Exclusions

Based on the specific contract requirements and applicable laws, some services are explicitly excluded from coverage. Per contract requirements, specific services may not be covered benefits, unless clinical indicators support medical necessity, as determined by the Medical Directors, in which case the medically needed services will be provided. Every attempt is made by the UM staff to identify additional community programs to provide wrap-around services to enhance the Alliance benefit package.

2. Transition to Other Care when Benefits End

The Alliance assists with, and/or ensures that practitioners assist with, a member's transition to other care, if necessary, when benefits end.

3. New Medical Technology Evaluation Assessment

The Alliance maintains a formal mechanism to evaluate and address new developments in technology and new applications of existing technology for inclusion in its benefits plan to keep pace with changes and to ensure that members have equitable access to safe and effective care. Evaluation of new technology is applied for medical and behavioral health procedures, pharmaceuticals, and devices. The UM Committee is responsible for evaluating and recommending coverage status for a new technology to the UM Committee or the Pharmacy and Therapeutics Committee, and to the Health Care Quality Committee. This includes evaluation of medical and behavioral health procedures, pharmaceuticals, and devices. Requests for evaluation of a new technology or a new application of an existing technology may come from a member, practitioner, organization, the Alliance's physician reviewers, or other staff.

The following are evaluated when considering new technology:

- Organizational reviews from appropriate government regulatory bodies, such as FDA or CMS.
- Relevant scientific information from peer-review literature, professional societies, and/or specialists and professionals who have expertise in the technology.

Based on the decision of the UM Committee, P&T Committee and recommendations through the appropriate Quality Committees, the approval of a new technology or new application of an existing technology by the Quality BOG Committee shall be deemed to be the Alliance's policy on coverage. When the Alliance does not have the authority

to modify the benefit package, the Chief Medical Officer shall notify, in writing, each payer for whom the Alliance manages benefits of its recommendation. A full description of the process is defined in UM policy and procedure.

4. Member Eligibility Verification

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

5. Determination Information Sources

UM clinical staff collects relevant clinical information from health care providers to make prospective, concurrent, and retrospective utilization review for medical necessity and health plan benefit coverage determinations. Clinical information is provided to the appropriate clinical reviewers to support the determination review process. Examples of relevant sources of patient clinical data and information used by clinical reviewers to make medical necessity and health plan benefit coverage determinations include the following:

- History and physical examinations.
- Clinical examinations.
- Treatment plans and progress notes.
- Diagnostic and laboratory testing results.
- Consultations and evaluations from other practitioners or providers.
- Office and hospital records.
- Physical therapy notes.
- On-site, telephonic and fax concurrent reviews from inpatient facilities.
- Information regarding benefits for services or procedures.
- Information regarding the local delivery system.
- Patient characteristics and information.
- Information from responsible family members; and
- Independent, unbiased, and evidenced based analyses of new, emerging, and controversial healthcare technologies.

F. UM Determinations

Qualified health professionals supervise review decisions, including service reductions. UM decisions based on medical necessity to deny or authorize an amount, duration, or scope that is less than requested shall be made by qualified physicians or appropriate health care professionals, who have appropriate clinical expertise in treating the condition and disease. Appropriate health care professionals at the Alliance are qualified physicians, qualified doctoral level behavioral health care professionals, and qualified pharmacists. The timeliness of UM decisions shall be commensurate with the seriousness and urgency of the request whether the request is routine or expedited and made in a timely manner and not unduly delayed for medical conditions requiring time sensitive

services. Appropriately licensed and qualified health care professionals with clinical care expertise make UM review determinations according to approved clinical review criteria. In addition to guidelines and criterion, patient records and conversations with appropriate practitioners are used in the decision-making process. Qualified health care professionals also supervise utilization review decisions. Under the supervision of a licensed medical professional, non-clinical staff collect administrative data or structured clinical data to administratively authorize cases that do not require clinical review.

Only a Medical Director, with a current license to practice without restriction in California, makes medical necessity denial determinations. A Medical Director is available to discuss UM denial determinations with providers. Providers are notified how to contact the Medical Director about determination processes in the denial letter.

In accordance with the DHCS contract, only qualified health care professionals supervise review decisions, including service reductions. A qualified physician will review all denials that are made based on medical necessity. Additionally, a qualified physician or pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the Plan Medical Director in collaboration with the Plan Pharmacy and Therapeutics committee (P&T Committee) or its equivalent.

UM decisions are not based on the outcome of individual authorization decisions or the number and type of non-authorization decisions rendered. UM staff involved in clinical and health plan benefit coverage determination processes are compensated solely based on overall performance and contracted salary and are not financially incentivized by the Alliance based on the outcome of clinical determinations.

Board certified physician advisors are available to the UM Program for consultation on clinical issues as well as consultation for potential denials. The UM Program maintains a list of board-certified physician specialists identified for consultation and documents their involvement in member authorization and appeal records when appropriate.

Decisions affecting care are communicated in writing to the provider and member in a timely manner, in accordance with regulatory guidelines for timeliness, and are not unduly delayed for medical conditions that require time-sensitive services. Reasons for decisions are clearly documented in the member/provider correspondence in easily understandable language. Notification must reference the benefit provision, guideline, protocol, or other similar criterion on which the denial decision is based. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based, upon request, must be included in the notification.

Providers are informed how to contact and speak with the Medical Director who made the decision. Notification communication includes appeal rights and procedures. Member notifications comply with appropriate contractual and regulatory guidance for each member's line of business. Member correspondence about authorization decisions includes a statement in each Alliance threshold language instructing the member how to obtain correspondence in their preferred language. Records, including Notice of Action

letters, meet contractual retention requirements. Members are informed that they may request copies of their medical records.

G. UM Referral Management and UM Review Processes

The scope of medical management services and activities includes utilization review determinations, referral management, discharge planning, complex case management, and UM documents.

1. Services Exempt from Prior Authorization

Exemptions from Prior Authorization services for members differ by product line and are listed in the member's benefit handbook, online at www.alamedaalliance.org and in the specific provider manuals. Exemptions include:

- Emergency Services, whether in or out of Alameda; except for care provided outside of the United States. Care provided in Canada or Mexico are covered.
- Urgent care, whether in or out of network
- Primary Care Visits
- Preventative Services
- Mental Health Care and Substance Use treatment
- Women's health services – a woman can go directly to any network provider for women's health care such as breast or pelvic exams. This includes care provided by a Certified Nurse Midwife/OB-GYN and Certified Nurse Practitioners
- Basic prenatal care – a woman can go directly to any network provider for basic pre-natal care.
- Family planning services, including counseling, pregnancy tests and procedures for the termination of pregnancy (abortion)
- Treatment for Sexually Transmitted Diseases includes testing, counseling, treatment and prevention.
- HIV testing and counseling
- Initial Mental Health Assessments
- Early and Periodic Screening, Diagnostic and Treatment

2. Auto-Authorization

- Services approved on the most recent copy of the Medical Management Auto Authorization Matrix.
- Direct - Services for which UM requests are not required, include but are not limited to:
  - Specialty visits, direct network
  - Preventive health diagnostic services, i.e. mammogram, colonoscopy

3. Services Requiring Prior Authorization

The Alliance develops, reviews, and approves at least annually, lists of auto authorizations. Any procedure, treatment, or service not on these lists requires prior

authorization. The Alliance communicates to all contracted health care practitioners the procedures, treatments, and services that require prior authorization and the procedures and timeframes necessary to obtain such prior authorization.

Authorization requirements for medical services are listed on the website, at www.alamedaalliance.org. Providers can also review the approved drug formulary at this website.

The services that currently require prior authorization include, but are not limited to:

- Non-emergency out of area care, outside of Alameda County
- Out of network care, for services not provided by a contracted network doctor.
- Inpatient Admissions, non-emergency/elective
- Inpatient Admission to Skilled Nursing Facility or Nursing Home
- Outpatient hospital services/surgery
- Outpatient facilities, non-hospital based, such as surgeries or sleep studies.
- Outpatient diagnostic and radiology services, minimally invasive or invasive such as CT Scans, MRIs, cardiac catheterization, PET
- Durable Medical Equipment, standard or customized; rental or purchased.
- Medical Supplies
- Prosthetics and Orthotics
- Podiatry services
- Home Health Care, including skilled nursing, nursing aides, rehabilitation therapies, and social workers.
- Transportation
- Transplant Services
- Experimental or Investigational Services
- Cancer Clinical Trials
- Medications not on the Alliance Approved Drug List and/or exceeding the monthly medication limit.
- All admissions to LTSS services - CBAS and Long-Term Care (LTC) facilities
- Acupuncture, greater than 4 visits per month.
- Chiropractic Services- See Prior Authorization grid for detail.
- Radiology Services (i.e. CT, MRI, PET)
- Second Opinions
- Select behavioral health services.

The Alliance also routinely analyzes past utilization patterns to determine whether it would be in the member's best interests to remove any of the listed services from the prior authorization requirement or add additional requirements. The Alliance makes any adjustments to this list by amending the Prior Authorization Policies, as appropriate.

4. Medical Director Responsibilities

The Medical Directors are responsible for providing clinical expertise to the UM staff and exercising sound professional judgment during review determinations regarding health care and health services.

The CMO and Medical Directors, with support of the UM Committee, have the authority, accountability, and responsibility for denial determinations. Physician review and determination is required for all final denial decisions based on medical necessity for requested medical services. The review of the denial of a pharmacy prior authorization for medical necessity, however, may be carried out by a qualified Physician or Pharmacist. For those contracted entities that are delegated UM responsibilities, the entity's Medical Director has the sole responsibility and authority to deny coverage; the Medical Director may also provide clarification of policy and procedure issues, and communicate with entity practitioners regarding referral issues, policies and procedures, etc.

5. Appropriate Professionals for UM Decision Process

The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. Only physicians, pharmacist, or doctoral level behavioral health specialists can make decisions/determinations for denial or modification of care based on medical necessity.

6. Timeliness Standards

The Alliance maintains established timeliness standards for UM determinations for routine and urgent Authorization Requests in compliance with Regulatory Standards for each Product Line as described in corresponding Policies/Procedures. The timeliness of UM decisions shall be commensurate with the seriousness and urgency of the request whether the request is routine or expedited. Time sensitive requests cannot be delayed waiting for medical information. Response to requests must meet required regulatory timeframes.

7. Utilization Review Processes

The UM Program includes the following utilization review processes:

Prospective Review

Prospective (pre-service) review is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted prior to the delivery of a health care service or supply to a member. A prospective review decision is based on the collection of medical information available to the health care provider prior to the time the service or supply is provided.

Concurrent Review

Concurrent review is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted during a member's ongoing stay in a facility or course of outpatient treatment. The frequency of review is based on the member's medical condition with respect to applicable care guidelines.

Retrospective Review

Retrospective (post-service) review is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted after the health care service or supply is provided to a member.

The Alliance does not accept non-emergent/urgent services that required prior authorization after the date of service. There are a few exceptions which a retrospective request will be considered by the Medical Director, if they are submitted within 30 calendar days of the date of service:

- Requests due to member eligibility issues
- Provision of inpatient services where the facility is unable to confirm enrollment with the Alliance.
- Services rendered in an urgent and emergent situation.

The Alliance maintains instructions for the authorization process on the website and provider training which is available to contracted and non-contracted providers. For non-contracted facilities, the Alliance maintains a 24-hour UM contact notification process on the California DMHC website. The Alliance maintains a full list of conditions eligible for retrospective review by the Department and is reviewed annually for any changes.

8. Outpatient Referral Management

Alliance network physicians are the primary care managers for member healthcare services. Based on the member's assignment, referrals may be managed by the Alliance or a delegated Provider Group.

Network Primary Care Physicians (PCPs) may process in-network specialist and facility referrals directly to members as "direct referrals" without administrative pre-authorization from the UM Program or the Provider Group. These referrals are primarily for routine outpatient and diagnostic services and are tracked by the UM Program using claim and encounter data. For services identified as requiring prior authorization, PCPs must submit and coordinate prior authorization for several services that require prior authorization, such as DME, home health and certain radiology services. All elective inpatient surgeries and non-contracted provider referrals require prior authorization.

The UM Program clinical information system tracks all authorized, denied, deferred, and modified service requests and includes timeliness records. These processes are outlined in the Provider Manual and in internal policies and procedures.

Practitioners and providers send referrals and requests for prior authorization of services to the UM Department by mail, fax and/or telephone, based on the urgency of the requested service. Request must include the following information for the requested service:

- Member demographic information (name, date of birth, etc.)

- Provider demographic information (Referring and Referred to)
- Requested service/procedure, including specific CPT/HCPCS Codes
- Member diagnosis (ICD-10 Code and description)
- Pertinent medical history and treatment
- Location where service(s) will be performed.
- Clinical indications necessitating service or referral *(See Section: Minimum Clinical Information for Review of UM Requests for Authorization)*

Requests for services are reviewed in accordance with approved UM criteria and the member's benefit structure. When decisions on coverage are based on medical necessity, relevant clinical information is obtained and consultation with the treating practitioner occurs, as necessary.

Requests for Authorization determinations related to Medi-Cal and IHSS Product Lines are defined differently as follows**:**

- Pre-Service Determinations for Medi-Cal and IHSS are defined in the following terms:
    - Approval - the determination to provide a service.
    - Modification – the determination to either approve less than what was requested or to approve something else in place of what was requested.
    - Denial - a determination to not provide the request service.
    - Delay – when a determination cannot be made, and additional time is required to obtain relevant clinical information.
    - Termination- to not extend an extension of a previously authorized service (e.g. PT visits, SNF days, etc.) (NOTE: must give 10 calendar days' notice of terminations)

UM staff receive requests for authorization of outpatient services and elective procedures prior to admission to ensure that admission to a healthcare facility is appropriate/medically necessary. Non-Clinical UM staff may approve services which can be auto-authorized, within their scope when the specific elements of the policy are met. Clinical UM staff will review services that require prior authorization based on medical necessity. The medical necessity clinical review is based on the severity and complexity of the individual case, unless there are questions regarding the medical necessity of services.

Should the UM staff question the medical necessity of services to be rendered, or appropriateness of the level of care for service based on review criteria and guidelines, the Medical Director will be consulted for case review. The Medical Director, or physician designee, will contact the attending physician to discuss the case, if necessary.

Should the Medical Director or physician designee determine that proposed services are not medically necessary or indicated, a denial determination may be made by the Medical Director. Denial notification and communication will be made in accordance with current regulatory timeliness standards and denial notification requirements, as established by regulators, including the DHCS and Department of Managed Health Care (DMHC) and national accrediting organizations, such as NCQA.

9. Second Opinion

The Alliance members may request a second opinion from any qualified primary care provider or specialist within the same medical group. If a qualified specialist is not available within medical group, a referral is provided within the Alliance's network. If the qualified specialist is not available in the Alliance network, staff will assist the medical group to identify an out-of-network specialist. The second opinion from a qualified health professional will be provided at no cost to the member. The Alliance provides a second opinion from a qualified health care professional when a member or a practitioner requests it for reasons that include, but are not limited to, the following:

- The member questions the reasonableness or necessity of recommended surgical procedures.
- The member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including but not limited to, a serious chronic condition.
- The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and requests consultation, or the member requests an additional diagnosis.
- The treatment plan in progress is not improving the medical condition of the member within an appropriate period given the diagnosis and plans of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment.
- The member has attempted to follow the practitioner's advice or consulted with the initial practitioner concerning serious concerns about the diagnosis or plan of care.

The Alliance educates its members and practitioners of the availability of second opinions in annual member publications. Policies regarding second opinions are available to the public upon request. Member rights related to second opinions include:

- To be provided with the names of two physicians who are qualified to give a second opinion.
- To obtain a second opinion within 30 calendar days, or if the medical need is emergent or urgent, to obtain an opinion within a timeframe that is appropriate to the member's condition and that does not exceed 72 hours
- To see the second opinion report

10. Standing Referrals

The Alliance maintains process to provide enrollees a standing referral to a specialist. The procedure shall provide for a standing referral if the PCP, in consultation with both the specialist, if any, and the Alliance Medical Director (or designee), determines that the enrollee has a condition or disease that requires continuing specialized medical care from the specialist or Specialty Care Center, (SCC).

The Alliance may require the PCP to submit a treatment plan during care or prior to the referral from the enrollee as determined by the Medical Director:

- If a treatment plan is necessary in the course of care and is approved by the Alliance, in consultation with the PCP, specialist, and enrollee, a standing referral shall be made in accordance with the treatment plan.
- A treatment plan may be deemed unnecessary if the Alliance approves a current standing referral to a specialist.
- The treatment plan may limit the number of visits to the specialist, limit the period of time during which visits are authorized, or required that the specialist provide the PCP with regular reports on the care and treatment provided to the enrollee.

The Alliance maintains guidelines for standing referral requests for enrollees that required specialized medical care over a period and who have a life-threatening, degenerative, or disabling condition, to a specialist or SCC that has expertise in treating the condition or disease for having specialist coordinate he enrollee's health care. Standing referral to a specialist or SCC are provided within the Alliance's network to participating providers, unless there is no specialist or SCC within the Alliance's network that is appropriate to provide treatment to enrollee, as determined by the PCP in consultation with the Medical Director and as documented in the treatment plan.

11. Concurrent/Continued Stay Review (Acute, Skilled, Rehabilitation)

The Alliance provides telephonic UM services and on-site UM at a sub-set of network hospitals. Appropriate inpatient medical management is ensured through consistent and coordinated Concurrent Review of members, irrespective of the presence or utilization of a contracted hospitalist. Concurrent/Continued Stay Review is a process coordinated by the UM staff during a member's course of hospitalization, which may include acute hospital, skilled nursing, and acute rehabilitation facilities, to assess the medical necessity and appropriateness of continuation at the requested level of care. Concurrent/Continued Stay review also involves the telephonic or on-site medical record review that occurs after admission if no pre-admission review has occurred.

Additional objectives of continued stay review are to:

- Ensure that services are provided in a timely and efficient manner.
- Ensure that established standards of quality care are met.
- Implement timely and efficient transfer to lower levels of care when clinically indicated and appropriate.
- Implement effective and safe discharge planning.
- Identify cases appropriate for Case Management and Transitions of Care Services

The Concurrent Review Procedure shall be followed throughout the member's hospitalization, utilizing approved criteria and guidelines. Telephonic, facsimile reviews or on-site are coordinated by the UM staff daily, or on cyclic intervals based on individual case requirements. In the event a scheduled review date falls on a weekend or holiday, the UM staff will coordinate a Concurrent Review on the work day prior to the scheduled review date, or not later than the first work day after the holiday or weekend.

Continued hospital care and/or ancillary services, that do not meet continued stay criteria is referred to the Medical Director, or physician designee, to evaluate and consult with the attending physician, as appropriate. When the Medical Director decides that the case does not meet criteria for continued stay based on medical necessity or appropriateness, the attending physician will be contacted, and discharge planning discussed. When an acceptable discharge plan is mutually agreed upon by the attending physician and the UM Medical Director, a Notice of Action (NOA) letter may be issued immediately by fax or via overnight Certified Mail to the attending physician, hospital and the member, if the member disagrees with the discharge plan.

12. Transition of Care and Discharge Planning

Transition of Care and Discharge Planning management are components of the UM process that assess necessary services and resources available to facilitate member discharge and/or transition to the appropriate level of care. Discharge Planning refers to activities related to planning the discharge of a member out of an inpatient medical facility. Transition of Care refers to activities related to movement of a member from a clinical setting to a home or community setting.

Discharge planning begins as early as possible during an inpatient admission, and is designed to identify and initiate cost effective, quality-driven treatment intervention for post-hospital care needs. It is a cooperative effort between the attending physicians, hospital discharge planner, UM staff, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of medical/psycho-social issues with potential need for post-hospital intervention
- Development of an individual care plan involving an appropriate multi-disciplinary team and family members involved in the member’s care.
- Communication to the attending physician and member, when appropriate, to suggest alternate health care resources.
- Communication to attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization.
- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge Planning staff, and UM staff.
- Referral to Transitions of Care programs or Home Health Programs within or outside of AAH programs.

The UM staff obtains medical record information and identifies the need for discharge to a lower level of care based on discharge review criteria/guidelines. If the attending physician orders discharge to a lower level of care, the UM staff assists the hospital UM/Discharge Planner in coordinating post-hospital care needs. The same process is

utilized for continued stay approval or denial determinations by the UM Medical Director, as previously noted in the Concurrent Review Process.

UM Review Clinicians work with facility discharge planners, attending physicians and ancillary and community service providers to assist in making necessary arrangements for member post- discharge needs. The UM Review Clinicians integrate with the Case Management Population Health driven initiatives by identifying, referring, communicating, and making recommendations that will help meet members' needs and address medical and psychosocial issues that result in hospitalization.

For SPD members, UM Review Clinicians are responsible for ensuring discharge planning is in place ensuring that necessary care, services, and supports are in place in the community for the SPD beneficiary once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the patient and/or caregiver. Minimum criteria for discharge planning activities includes:

A. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, durable medical equipment (DME), and other services received.
B. Documentation of pre-discharge factors, including an understanding of the medical condition by the SPD beneficiary or a representative of the SPD beneficiary as applicable, physical, and mental function, financial resources, and social supports.
C. Services needed after discharge, type of placement preferred by the SPD beneficiary/representative of the SPD beneficiary and hospital/institution, type of placement agreed to by the SPD beneficiary/representative of the SPD beneficiary, specific agency/home recommended by the hospital, specific agency/home agreed to by the SPD beneficiary/representative of the SPD beneficiary, and pre-discharge counseling recommended.
D. Summary of the nature and outcome SPD beneficiary/representative of the SPD beneficiary involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital/institution.

13. Denial Notifications

Adverse Benefit Determination letters or/and Notice of Action (NOA) letters for denials are provided to members and their practitioners in compliance with the member's regulatory appeal requirements. All potential denials and/or modifications of service are discussed with the appropriate Medical Director, who makes the final determination.

Services that are denied, modified, delayed shall contain the following elements:

- Clear, concise, and easily understandable explanation of the reason for denial in the Notice of Action (NOA) or adverse determination letter
- Reference to the specific benefit, guideline, protocol, or other similar criterion on

which the denial decision is based.
- Statement that members can obtain a copy of the actual benefit, guideline, protocol, or other similar criterion on which the decision was based.
- Member Rights
- Appeal Rights and Process

In addition to the above for ongoing services that are terminated for all members, the NOA shall include:

- Agreement to an alternative treatment plan by attending practitioner for hospital concurrent decisions and by the PCP for Ambulatory Concurrent decisions
- In addition to the above for Medi-Cal members:
- Citation to the criteria used to support the decision (Medi-Cal only)
- Information about the member's State Hearing rights and process
- "Aid Paid Pending" process, as applicable for Medi-Cal, must also be included.

In addition, All UM NOA correspondences for pre-service and concurrent denials, modifications, and adverse decisions sent to the Requesting Practitioner shall include a name and phone number for contacting the Peer Reviewer to allow for the Requesting Practitioner to request a reconsider of the UM Determination

14. Peer to Peer Review (Discussing a Denial with a Peer Reviewer)

All UM Notice of Action correspondences for pre-service and concurrent denials, (including modifications, terminations, and adverse decisions) sent to the Requesting Practitioner shall include a name and phone number for contacting the Peer Reviewer to allow the Requesting Practitioner the opportunity to discuss issues or concerns regarding the decision. If a denial is being considered by the Peer Reviewer, a practitioner can discuss the decision by calling or writing to supply additional information for discussion with the Peer Reviewer. The Peer Reviewer will make himself/herself available for discussion of the denial decision within one business day of the receipt of the provider telephone call or written request. If the discussion does not result in a fully reversed denial determination, the practitioner can initiate an expedited or standard appeal, as appropriate.

15. Required Internal Reporting for UM Staff

- Potentially fraudulent or abusive practices identified to The Compliance Department
- Potential under and over utilization to the UM Manager
- Coordination of care for results or facilitation to the UM Manager
- Opportunities for improvement to the UM Manager
- Breaches of adherence to confidentiality and HIPAA policies to the Alliance's designated Compliance staff member
- Potential quality issues identified through UM activities to the Quality Improvement Department
- Barriers to accessibility and availability of UM services to their UM Manager

16. UM Documents

In addition to this program description, other documents important in communicating UM policies and procedures include:

- The Provider Manual, available on the Alliance web site and on a CD, provides an overview of operational aspects of the relationship between the Alliance, providers, and members. Information about the Alliance's UM Program, referral and tracking procedures, processes, and timeframes necessary to obtain prior authorization are included in the manual. In addition, the Provider Manual describes how providers may obtain a copy of the clinical guidelines used to make medical determinations.

- The Provider Bulletin is a periodic newsletter distributed to all contracted provider sites and delegated groups on topics relevant to the provider community and may include UM policies, procedures, and activities.
- The Member Alert is a periodic newsletter distributed to members in all lines of business. Each issue covers different topics of interest and importance to members about their health may include information about UM policies and procedures.

- Evidence of Coverage (EOC) documents are distributed to members based on their product line. Members have the right to submit a complaint or grievance about any plan action. The Evidence of Coverage document directs members to call the Member Service phone number to initiate complaints or grievances involving UM issues and actions. Member complaints or grievances are documented in the data system and forwarded to the UM unit for follow-up response. The Alliance Grievance and Appeal unit coordinates with the UM unit on appropriate responses to member complaints or grievances.

These documents, or summaries of the documents, are available upon request to providers, members, and community partners. In addition, the UM Program information is available on the Alliance website.

H. Continuity of Care for Medical and Behavioral Health Services

Continuity of care can be defined as the lack of interruption in the care provided to members when circumstances dictate a change in the member's insurance coverage, geographic location, entity, or provider assignment.

The Alliance must provide continuity of care with an out-of-network provider when:

- The Alliance can determine that the beneficiary has an existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a

provider).
    - An existing relationship means the beneficiary has seen an out-of-network primary care provider (PCP) or specialist at least once during the 12 months prior to the date of his or her initial enrollment in the Alliance for a non-emergency visit, unless otherwise specified by regulation.
- The provider is willing to accept the higher of the Alliance's contract rates or Medi-Cal FFS rates.
- The provider meets the applicable professional standards and has no disqualifying quality of care issues (a quality of care issue means the Alliance can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other MediCal beneficiaries);
- The provider is a California State Plan approved provider; and
- The provider supplies the Alliance with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, if it is allowable under federal and state privacy laws and regulations.

The Alliance is not required to provide continuity of care for services not covered by Medi-Cal. In addition, provider continuity of care protections does not extend to the following providers: durable medical equipment, transportation, other ancillary services, and carved-out services.

The UM staff works with the member and the member's current treating physician and/or PCP to assist the member in continuity of care. Every effort is made to maintain continuity of care for the member during the transition process. If the current treating physician is not affiliated with any of the existing Provider Groups, (PGs,) or with the member's PG selection, the UM staff works with the PGs to make arrangements with the physician to continue care of the member until the treatment is completed or the member can be safely transitioned to a physician within the PG. The UM staff notifies each PG of its membership qualifying for continuity of care assistance.

When members are identified as possibly benefiting from coordination of care, both within and outside of the network, the case is referred to Case Management for further intervention. The Case Management actively engages in activity that monitors and assesses continuity and coordination of clinical care. Individual registered nurses work closely with the Member, the physicians and any other associated healthcare delivery organization involved in the case, to provide timely, quality-based care meeting the needs of the individual member.

Continuity of care is also evaluated when members are referred from primary care physicians and specialists, including behavioral health specialists, or when a member is transferred or admitted to another level of care, such as a transfer or admittance to a skilled nursing facility (SNF), rehabilitation, chemical dependency, or mental health facility, where member follow through is a risk.

The Alliance documents all requests for assistance with continuity of care and is responsible for monitoring and oversight of the activities. A full description of the various programs is listed in the applicable policies and procedures.

1. *New Enrollees*

The Alliance recognizes that a strong doctor-patient relationship, particularly for members with serious medical conditions, may enhance the healing process. Maintaining continuity of care as new enrollees change physicians and health plans are an important aspect of this relationship. Each newly enrolled Medi-Cal member are placed in a transition group for up to 30 days, during which time they select their Alliance, PG, and PCP.

For a newly enrolled SPD members, the Alliance must honor any active MediCal FFS Treatment Authorization Requests (TARs) for up to 60 days or until a new assessment is completed by the Alliance. A new assessment is considered completed by the Alliance if the beneficiary has been seen by an Alliance -contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. The FFS TAR must be honored as outlined above without a request by the beneficiary or the Provider.

2. ***Terminated Practitioners (Both PCPs and Specialists)***

The Alliance's contracts with delegates establish a mechanism to continue appropriate and timely care for members whose physicians are terminating from the PG. This process includes notification from practitioners of intent to terminate, in accordance with the laws applicable to the line of business. Members under current care, and those with approved prior authorizations, not yet utilized, are identified, so that their care can be managed and coordinated with the receiving entity or with the Alliance physicians. Members, such as those undergoing cancer treatments of chemotherapy or radiation therapy, that are dialysis-dependent, awaiting transplants, in late-term pregnancies, have pending surgeries, or those awaiting transfer or admittance to a skilled nursing facility (SNF), rehabilitation, chemical dependency, or mental health facility, and any other members who might have their ongoing care negatively impacted by the termination of the group are identified.

The Alliance will notify members affected by the termination of a practitioner or practice group in general, family, or internal medicine of pediatrics, at least 30 calendar days prior to the effective termination date, and help them select a new practitioner.

For members undergoing active treatment for a chronic or acute medical condition, care may be continued through the current period of active treatment or up to 90 calendar days, whichever is less.

3. ***Pregnant and Post- Partum Members***

Pregnant and post-partum Medi-Cal beneficiaries who are assigned a mandatory aid code and are transitioning from Medi-Cal FFS into the Alliance have the right to request out-of-network provider continuity of care for up to 12 months in accordance with the Alliance contracts and the general requirements listed in the regulatory guidance. This requirement is applicable to any existing Medi-Cal FFS provider relationship that is

allowed under the general requirements of regulatory guidance.

For Alliance Group Care, continuation of care extends through the postpartum period for members in their second or third trimester of pregnancy.

4. ***Medical Exemption Requests***

A Medical Exemption Request (MER) is a request for temporary exemption from enrollment into the Alliance only until the Medi-Cal beneficiary's medical condition has stabilized to a level that would enable the beneficiary to transfer to an Alliance provider of the same specialty without deleterious medical effects. A MER is a temporary exemption from the Alliance enrollment that only applies to beneficiaries transitioning from Medi-Cal FFS to the Alliance. A MER should only be used to preserve continuity of care with a Medi-Cal FFS provider under the circumstances described above in this paragraph. The Alliance is required to consider MERs that have been denied as an automatic continuity of care request to allow the beneficiary to complete a course of treatment with a Medi-Cal FFS provider in accordance with the most recent regulatory guidance.

5. ***Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder***

The Alliance is responsible for providing Early and Periodic Screening, Diagnosis, and Treatment services for beneficiaries ages 0 to 21. Effective September 15, 2014, the services include medically necessary Behavioral Health Treatment (BHT) services such as Applied Behavioral Analysis and other evidence-based behavioral intervention services that develop or restore, to the maximum extent practicable, the functioning of beneficiaries diagnosed with Autism Spectrum Disorder (ASD). In accordance with the requirements listed in the most recent DHCS All Plan Letter, the Alliance must provide continued access to out-of-network BHT providers (continuity of care) for up to 12 months.

I. Behavioral Health Management

The provision of behavioral health and substance use services are applied to Alliance members according to their benefit. Group Care members receive a comprehensive benefit for all behavioral health services. In 2021, the Alliance is implementing the requirements of All Plan Letter (APL) 21-002 – Implementation of SB 855, Mental Health and Substance Use Disorder Coverage for the Group Care Line of Business. Medi-Cal members receive services for mild to moderate behavioral health services. The provision of treatment for moderate to severe behavioral health services for Medi-Cal members is managed under a Memorandum of Understanding with Alameda County Behavioral Health Care Services, as described below.

The Alliance ensures services are provided in a culturally and linguistically appropriate manner.

1. Alameda County Behavioral Health Care Services (ACBHCS)

Specialty behavioral health services for Medi-Cal members excluded from the Alliance contract with DHCS are coordinated under a Memorandum of Understanding executed with ACBHCS. This is a carve-out arrangement for specialty behavioral health management with the State of California directly overseeing and reimbursing the behavioral health services provided to Medi-Cal members.

The referral procedure for Alliance members includes:

- Alliance Primary Care Providers (PCPs) render outpatient behavioral health and substance abuse services within their scope of practice.
- PCPs refer the members to ACBHCS for evaluation and coordination of medically necessary specialty behavioral health services by the Access Team, including inpatient psychiatric care.
- PCPs refer members to qualified Medi-Cal providers for the provision of services not covered by ACBHCS.

2. Behavioral Health

The Alliance contracts with a Managed Behavioral Health Organization (MBHO) NCQA accredited delegate for the provision of behavioral health and substance abuse services not covered through ACBHCS, and for behavioral health and substance abuse services benefits for of all other lines of business. The Alliance delegates behavioral health utilization management activities and the maintenance of the provider network for behavioral health and substance abuse services.

All services are based on a member's benefit plan and the functions delegated to the MBHO by the Alliance. The scope of the program covers behavioral health treatment that may be beyond the customary scope of practice of a primary care physician. Care settings include home and office bases services, free-standing and hospital-based programs, residential treatment programs and facility based acute care treatment units. The MBHO uses information provided by the Alliance to determine member-specific benefit coverage, including plan-specific Evidence of Coverage documents, web-based member eligibility verification systems and direct download of member eligibility information via 834 files exchanges. Medical necessity is determined by applying level of care criteria, while the clinical appropriateness of services are evaluated using Clinical Practice Guidelines. Member specific clinical information is obtained from the member and/or family member or other legal representative, behavioral health medical providers (through verbal case review and/or submission of medical records). Program processes include triage and referral; prospective; concurrent; post-service review and care coordination. Services include education to members and providers, coordination of care with primary care physicians, linkage and coordination with state and community agencies.

The Alliance reviews and approves the MBHO's LOC criteria through the HCQC. The Alliance reviews the criteria to ensure its clinical criteria for both medical and behavioral health services are aligned. MBHO's Level of Care criteria (LOC), as adopted by the UMC, were developed from the comparison of national, scientific and evidence-based

criteria sets, including but not limited to those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA) and American Academy of Child and Adolescent Psychiatry (AACAP), Substance Abuse and Mental Health Services Administration (SAMHSA), and the American Society of Addiction Medicine (ASAM.)

The MBHO uses the LOC criteria as guidelines, not absolute standards, and considers them in conjunction with other indications of a member's needs, strengths, and treatment history in determining the best placement for a member. LOC criteria are applied to determine appropriate care for all members. In general, members will only be certified if they meet the specific medical necessity criteria for a particular LOC. However, the individual's needs and characteristics of the local service delivery system are taken into consideration prior to the making of UM decisions.

3. Alameda Alliance Triage and Referral

The Alliance arranges for triage and screening services available by telephone to members 24 hours per day, 7 days per week. The Alliance ensures that the telephone triage or screening services are provided in a timely manner appropriate for the requesting member's condition.

The Alliance is contingent on its contracted provider network to provide triage services to its members. Primary care providers and mental health care providers provide triage and screening services 24 hours a day, 7 days a week for medical and behavioral health care services.

For cases when the providers are unable to meet the time-elapsed standards, the Plan provides members the Plan's nurse advice line to call as an alternative triage and screening service arrangement. Providers who are unable to provide triage and screening services are required to inform members about the Alliance's nurse advice line information.

4. Monitoring Over and Under Utilization of Medical and Behavioral Health Services

The CMO or its physician designee monitors patterns of over and under-utilization.

Data is reviewed at the UMC and HCQC and when a pattern of under or over utilization is identified an analysis of barriers is conducted and potential interventions are identified. Data is then re-evaluated to determine the efficacy of the interventions.

When a concern over potential over or under-utilization for a specific member is identified, the clinical team including the Primary Care Physician, under the direction of the UM Medical Director, develops a plan to address the utilization issue which may include referral to Behavioral Health Case Management and/or the Alliance's Case Management or Disease Management programs, physician peer to peer with the inpatient attending physician, referral to the Alameda county mental health authority for additional services and supports.

5. Behavioral Health Integration

Members may contact their appropriate behavioral health organization directly or be referred by the PCP and/or health care professional. The Alliance maintains procedures for providers to coordinate care and services for members in need of behavioral health services including, but not limited to, all medical necessary services across the behavioral health provider network.

The Alliance uses a variety of mechanisms that ensure behavioral health services and management processes are actively integrated into the UM Program and include:

- A behavioral healthcare practitioner, who is a behavioral healthcare physician or a doctoral-level behavioral health practitioner, is involved in quarterly HCQC meetings to support, advise and coordinate behavioral healthcare aspects into UM Program policies, procedures and processes.
- There are regular care coordination rounds, in which the staff attending rounds evaluates topics such as access, availability, health management systems, practice guidelines, clinical and service quality improvement activities, member satisfaction, continuity and coordination of care and member's rights and responsibilities.
- The Alliance routinely receives clinical reports from its Behavioral Health provider network which are reviewed by the Chief Medical Officer, the Director of Health Care Services, the Senior Director of Quality Improvement, and the Director, Compliance, or designees.
- The Alliance participates in quarterly operational meetings with the Behavioral Health provider network delegate to review and coordinate administrative, clinical, and operational activities.

J. Pharmacy Management

The Alliance ensures the provision of pharmacy management to a pharmacy benefit manager (PBM), PerformRx. The PBM possesses service level guarantees that manages pharmacy services under the delegated arrangement and maintains clinical policies and procedures that are revised at least annually. The Alliance delegates some of its pharmacy utilization management activities to the pharmacy benefit management company. The PBM supports full prior authorization review services, including confirmation of denials for weekends/holidays/emergency. The PBM provides support to the Alliance's Pharmacy and Therapeutic Committee activities including formulary management, guideline development and trend reviews related to pharmacy services. The Pharmacy and Therapeutics Committee meets quarterly and provides oversight for evidence-based, clinically appropriate pharmacy guideline criteria. Guidelines are developed in conjunction with review of peer-reviewed literature and with consideration for such factors as safety, efficacy and cost effectiveness, with the input and evaluation of external clinical specialists appropriate to the subject matter.

The PBM receives and processes medication prior authorization requests for medications

filled through network retail and specialty pharmacies. The PBM's Prior Authorization Department is comprised of certified technicians and clinical pharmacists who conduct reviews and approve requests that meet prior authorization criteria. All requests that the PBM cannot approve per their protocol are forwarded to Alliance for the final determination. All pharmacy PA requests must be processed, and a decision rendered within the regulatory requirement. Pharmacy UM decision monitoring is reported through the UM Committee.

K. Linked and Carved Out Services

For linked and carved out services the Alliance provides linkages with community programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions, receive wrap-around services that enhance their medical benefits. These linkages are established through special programs, such as the Alliance Community Liaisons, and specific program Memoranda of Understanding (MOU) with other community agencies and programs, such as the California Children's Services, Alameda County Behavioral Health Care Services, and the Regional Center of the East Bay (RCEB). The UM staff and delegated entity practitioners are responsible for identification of such cases, and coordination of referral to appropriate State agencies and specialist care when the benefit coverage of the member dictates. The UM Department coordinates activities with the Case Management Department to assist members with the transition to other care, if necessary, when benefits end. This may include informing the member about ways to obtain continued care through other sources, such as community resources.

A full description of program the identification and referral process as well as the care coordination activities is maintained in the UM department policies and procedures.

Transportation Services

Transportation services are covered benefits. Transportation benefits include:

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

Benefits are administered based on the guidance of the Alliance product line. Those products include:

- MediCal
- IHSS

For the administration of the benefit:

- For Members enrolled with Kaiser, the Alliance delegates the responsibility for the provision of transportation services to the contracted Plan Partner.

- For the administration of MediCal Direct and IHSS, the Alliance is responsible for the provision of transportation services.

The Alliance contracts with a vendor, Modivcare, formerly Logisticare, to provide the various modes of transportation. The vendor's UM Department is delegated for the utilization review process to determine medical necessity when required; the vendor is not delegated for potential denials. All potential denials are referred to the Alliance UM Medical Director for final determination. Utilization review is performed using the transportation guidance for the product, and as needed, a Physician Certification Statement (PCS). A full description of the process is defined the most recent policies on transportation services.

C. Transportation Access to Early and Periodic Screening, Diagnostic and Treatment Services

The Alliance is responsible for the provision of medical and non-medical transportation to eligible children under the age of 21 to access Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. The Alliance is required to provide appointment scheduling assistance and necessary transportation, including non-emergency medical transportation and non-medical transportation, to and from medical appointments for the medically necessary covered services. The Alliance is not responsible for providing non-medical transportation to and from the services that are carved-out, including dental services. DHCS All Plan Letter 19-010 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment of Services for MediCal Members Under the Age of 21, August 14, 2019.

Section IV. Special Programs

A. Long Term Services and Supports

The UM program includes oversight of the UM clinical decision-making review and authorizations for access to Long Term Service and Support benefits including Long Term Care (LTC) and Community Based Adult Services (CBAS). LTSS is responsible for the programmatic management of the LTSS programs. The Alliance administers the LTC and CBAS program elements as defined by the most recent DHCS contract, MMCD letter, or APL.

1. Long Term Care

The Long-Term Care (LTC) UM activities includes long term skilled care authorizations for the following facilities: skilled nursing, intermediate care, sub-acute care, intermediate care; developmentally disabled, intermediate care–developmentally disabled—habilitative, and intermediate care–developmentally disabled—nursing, residential care facilities, board and care, and assisted living facilities. LTC excludes Institutes for Mental Disease and special behavioral health treatment programs. Authorizations are provided based on member's meeting criteria the eligibility and nursing facility admission criteria.

For Medi-Cal members: Long Term Care (LTC) services for eligible MediCal members. The Alliance is responsible for the provision of LTC services for the month of admission plus the following month. The UM Department is responsible for providing

the following activities:

- If a Member requires LTC in the facility for longer than the regulatory timeframe for admission, the Alliance shall submit a disenrollment request for the member to DHCS, for approval.
- The Alliance shall provide all Medically Necessary Covered Services to the Member until the disenrollment is effective. For these Members, an approved disenrollment request will become effective the first day of the eligible month, provided Contractor submitted the disenrollment request at least 30 calendar days prior in the appropriate timeframe. If the Alliance submitted the disenrollment request less than 30 calendar days prior to that date, disenrollment will be effective the first day of the month that begins at least 30 calendar days after submission of the disenrollment request. Prior to the disenrollment effective date, the Alliance shall ensure the Member's orderly transfer from the Alliance's Provider to the Medi-Cal Fee-For-Service program. This includes notifying the Member and his or her family or guardian of the disenrollment; assuring the appropriate transfer of medical records or copies from the Alliance's Provider to the Medi-Cal fee-for-service provider; assuring that continuity of care is not interrupted; and, completion of all administrative work necessary to assure a smooth transfer of responsibility for the health care of the Members.
- Admission to a nursing facility of a MediCal Member who has elected hospice services does not affect the Member's eligibility for Enrollment. Hospice services are Covered Services under and are not long-term care services regardless of the Member's expected or actual length of stay in a nursing facility.

2. CBAS

The Alliance administers the CBAS program elements as defined by the most recent DHCS contract, MMCD letter, or APL. The Alliance maintains procedures, processes, and mechanisms for administering assessments and re-assessments for CBAS services. For providers delegated to perform the CBAS assessments, the Alliance provides the necessary delegation oversight and monitoring activities. The Alliance develops mechanisms to generate and distribute the required reports to the identified DHCS departments.

D. Palliative Care

Palliative Care Services are provided to members per the requirements of the latest All Plan Letter Palliative care services may be delivered at the hospital, as part of the inpatient care treatment plan, or authorized and delivered in primary care, specialty care clinics, by home health teams, or by hospice entities. The Alliance offers a network of palliative care services to its members through various provider types.

The Alliance, as part of its palliative care network development, contracts with hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and /or training in palliative care. The Alliance may also contract with different types of providers

depending on local provider qualifications and the need to reflect the diversity of their membership. Community-Based Adult Services (CBAS) facilities may be considered as a palliative care partner for facilitating advance care planning or palliative care referrals. The Alliance utilizes qualified providers for palliative care based on setting and needs of the members if the provider complies with the existing Medi-Cal requirements.

The Alliance ensures that palliative care provided in a member's home complies with existing Medi-Cal requirements for in-home providers, services, and authorization, such as physician assessments and care plans.

The Alliance informs and educates its providers regarding availability of the palliative care benefit through its website and education materials.

The Alliance identifies members eligible for palliative care by the following:

- Screening for palliative care eligibility in Complex Case Management referrals
- Referrals from network providers, including through case management, concurrent review, and the general authorization process.
- Analysis of member data

Palliative care services follow the general authorization process is outlined in the UM policy and procedures. Through the authorization review and decision process, the type of palliative care (including the location where palliative care services can be delivered) will be determined based on medical necessity. Referral and care coordination for palliative services will be provided to the member within the timely access standard requirements. Alliance's network providers receive instructions of the referral and authorization process for palliative care through the Alliance's provider educational materials and via the Alliance's website.

Section V. Quality Improvement Integration

The UM Program includes a wide variety of quality assurance activities to support positive member outcomes and continuous quality improvement. The CMO guides these activities in collaboration with the Senior Director of Health Care Services, the Administrative Director of Quality and the Director of Accreditation, and oversight of the HCQC. Performance results are analyzed and reviewed with opportunities for improvement identified for intervention and performance management. The following quality activities are included in the UM Program:

- Monitoring Under and Over Utilization, including Out of Network and Provider Capacity monitoring.
- Monitoring of Member Experience with the UM process.
- Monitoring UM Appeals for UM Decision Making.
- Potential quality issue referrals.
- Provider Preventable Condition identification and referral.
- Inter-rater reliability assessments.
- Delegation oversight including Corrective Action Plan completion and process

improvements if audit findings occur.

The UM data sources, and information used for quality monitoring and improvement activities include the following:

- Claims and encounter data.
- Medical records.
- Medical utilization data.
- Behavioral Health utilization data.
- Pharmacy utilization data.
- Appeal, denial, and grievance information.
- Internally developed data and reports.
- Audit findings; and
- Other clinical or administrative data.

A. Monitoring Over and Under Utilization

The Alliance regularly monitors member service utilization using industry standard utilization measures. Medi-Cal contracts require that plans report rates to detect over and under-utilization. Rates for these measures vary based on the relative health of each population. For instance, usage rates for Non-SPD Medi-Cal members tend to be significantly lower than those for SPD Medi-Cal and IHSS members because the former populations are generally younger and healthier. Monitoring reports include changes in membership totals for each line of business in the last 12 months. National and regional benchmarks are not available for every line of business. In the absence of such benchmarks, the Alliance closely monitors monthly, quarterly, and annual data for significant changes and trends, reports the results quarterly to the UMC and HCQC, and acts when indicated.

UM data elements are reviewed to assess over/under utilization of services for either medical and/or behavioral health include but are not limited to the following:

- Ambulatory Services – e.g. Outpatient encounters per enrollee per year primary care visits, specialist visits, preventive health care.
- Out of Network Specialty Referrals, e.g. specialists, behavioral health care.
- Acute Hospital Services
    - Emergency room visit rates.
    - Hospital admit rates.
    - Bed days rates.
    - Length of Stay.
    - Re-admission rates.
- Behavioral health utilization data.
- Pharmacy utilization rates.

- HEDIS measures for use of services
- Complaint reports (Grievance & Appeals) that reflect barriers for access to care or delivery of care.

Because of these clinical data analyses, the Alliance identifies opportunities for improvement through root cause analysis, action plans and the continuous improvement cycle ensure the actions taken are improving performance. When appropriate, feedback is provided to both entities and individual practitioners allowing their input into the improvement activities. The Alliance continues to monitor the action plans to ensure the activities improvements in the care delivery process.

B. Experience with Utilization Management

Annually Alliance members and providers are surveyed to assess their experience with the plan's utilization management processes and services. Data is collected and analyzed to identify improvement opportunities. For identified opportunities, Alliance takes actions designed to improve the experience based on the data.

1. Member

Alliance uses survey data to assess the member experience with the UM process. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is administered by mail to Alliance Medi-Cal members. Among the composite measures are member ratings for: 1) Getting Needed Care – member experience when attempting to get care, tests or treatments; 2) Getting Care Quickly – member experience when receiving care; and 3) Rating the Health Plan. The CAHPS summary rate results are compared to Medicaid benchmarks. The UM department participates on the member satisfaction team.

2. Provider

Annually, the Alliance surveys its providers for their experience with the plan's utilization management processes and services. A vendor employed by the plan contacts a sample of network providers by mail and/or internet. Among the survey questions, six (6) questions ask providers to rate the plan on:

- Access to knowledgeable UM staff.
- Procedures for obtaining prior authorization information.
- Timeliness for obtaining prior authorization information.
- The Plan's facilitation/support of appropriate clinical care for patients.
- Degree to which the Plan covers and encourages preventive care and wellness. Alliance provider survey responses are benchmarked against other Medi-Cal/Medicaid plans that use the same vendor's survey.

Alliance conducts quantitative and qualitative analysis to identify areas for improvement. Outcomes of the assessments are presented to the UMC and HCQC to assist in identifying opportunities for improvement. If the analysis indicates that there are opportunities to improve experience with UM, Alliance UM Department participates

on the provider satisfaction team. Activities identified to improve the member and provider experience with UM are used to update the following years UM Program.

C. Grievances and Appeals

The Alliance maintains an effective member grievance and appeals (G&A) process that follows all regulatory, contractual and accreditation requirements. G&A is managed within Health Care Services, and complaints identified with clinical service needs are supported by UM Nurses and Physicians. Trending data for clinical appeals and fair hearings is reported to the UMC for the identification and recommendations of opportunities to improve the UM experience for members and providers. On a quarterly basis, the UM Department will review and analyze grievance data. The evaluation is reported to the UMC.

Appeal decisions are made by a practitioner who was not involved in the initial decision unless the case is overturned. A same-or similar specialist review is required for all appeals of medical necessity decisions. The details of the appeal process are outlined in the Alliance Appeals Policy and Procedure.

D. Potential Quality of Care/ Provider Preventable Reportable Conditions

At any time during an UM review, staff identify a condition or situation that appears to deviate from the professional standard of care or identified by regulatory guidance as a Potential Quality of Care or Provider Preventable Reportable Condition, are referred to the Quality Improvement Department to be evaluated per policy and procedure.

E. UM Delegation Activities

The Alliance delegates UM activities to provider groups, vendor networks and healthcare organizations that meet delegation agreement standards. The contractual agreements between the Alliance and delegated groups specify: the responsibilities of both parties; the functions or activities that are delegated; the frequency of reporting on those functions and responsibilities to the Alliance; how performance is evaluated; and corrective action plan expectations, if applicable. The Alliance conducts a pre- contractual evaluation of delegated functions to assure capacity to meet standards and requirements. The Alliance's Compliance Department is responsible for the oversight of delegated activities. The Compliance Department will work with other respective departments to conduct the annual delegation oversight audits. Delegate work plans, reports and evaluations are reviewed by the Alliance and the finding are summarized at HCQC and Compliance Committee meetings, as appropriate. The Compliance Department in conjunction with each respective department monitors the delegated functions of each delegate through reports and annual oversight audits.

As part of delegation responsibilities, delegated providers must:

- Develop, enact, and monitor a UM Program description that addresses all State, Federal, health plan and accreditation requirements.
- Provide encounter information and access to medical records pertaining to

Alliance members.

- Submit at least quarterly reports, annual evaluations, and program descriptions and work plans; and
- Cooperate with annual audits and complete any corrective actions necessary by the Alliance.
- Participate in performance improvement activities.

F. Inter-Rater Reliability Testing

Inter-Rater Reliability (IRR) Testing is a method used at the Alliance to assess the degree of agreement among personnel who make utilization management decisions. It provides a score of how much homogeneity or consensus there is in responses to utilization management cases. The purpose is for the Alliance to provide consistency and accuracy of review criteria applied by all reviewers - physicians and non-physicians and to act on improvement opportunities identified through this testing. This report provides an analysis of the Alliance's testing for each year and fulfills regulatory, contractual and accreditation requirements associated with ensuring the consistency in applying UM criteria and acting on identified improvement opportunities.

IRR testing is conducted following the Alliance internal policy (QI-133 Inter-Rater Reliability—Testing for Clinical Decision Making) for UM, QM and Pharmacy staff that participates in the Health Services medical necessity decision making process. IRR test results are collated and reviewed by management.

Reports on IRR test results are reviewed and approved by the HCQC. The IRR process and reports are reviewed for delegated entities during the annual auditing process.

G. UM Department – Internal Quality Review

To ensure the oversight of the internal UM process, Alliance UM Department conducts ongoing auditing and monitoring of key operational areas to ensure compliance with all federal, state, regulatory, contractual and accreditation standards. Alliance UM Department has implemented a monitoring program for the early identification of potential compliance risks. In addition, the program includes an opportunity to provide quality oversight of the current UM processes. This is accomplished by internal monitoring of UM authorization files on a routine and/or periodic basis.

1. UM File Review

UM will complete file reviews using a defined methodology for the file selection. Files will be assessed to ensure compliance using the regulatory and accreditation requirements as well as to identify opportunities for process improvement. The process outcomes will also be utilized for staff performance. Elements of the review include, but are not limited to, ensuring the appropriate medical information is obtained, use of criteria, application of clinical decision making, and appropriate referral to physician

reviewers as needed. For cases that are denied or modified, the file will assess the NOA requirements for communication to the member and provider.

2. Audit of Authorization Processing Turn-Around-Time (TAT)

An authorization aging report is used to monitor TATs for authorizations. Any opened authorization without a final determination will appear in this report. The UM Manager or designee will work this report daily to ensure all authorization determinations are compliant with UM will complete file reviews using a defined methodology for the file selection. Files will be assessed to ensure compliance using the regulatory and accreditation requirements as well as to identify opportunities for process improvement.

H. Annual UM Workplan

Each year, the Alliance establishes objectives and priorities and outlines a strategic UM Workplan for the coming year. The UM Workplan incorporates anticipated timeframes, responsible parties, and status of activities. The UM Workplan is submitted to the UM Committee for approval annually. See Attachment B – 2021 UM Workplan.

I. Annual UM Evaluation

Members of the UM Program management team annually evaluate and update the UM Program to ensure the overall effectiveness of UM Program objectives, structure, scope. and processes. The evaluation includes, at a minimum:

- Review of changes in staffing, reorganization, structure, or scope of the program.
- Resources allocated to support the program.
- Review of completed and ongoing UM work plan activities.
- Assessment of performance indicators.
- Review of delegated arrangement activities; and
- Recommendations for program revisions and modifications

The UM Program management team presents a written program evaluation to the UMC and HCQC. The UMC and HCQC reviews and approves the UM Program evaluation on an annual basis. The review and revision of the UM program description may be conducted more frequently as deemed appropriate by the UMC, HCQC, CMO, CEO, or BOG.

The HCQC's recommendations for revision are incorporated into the UM Program description, as appropriate, which is reviewed and approved by the BOG and submitted to DHCS on an annual basis.

UM Program Recommendations for 2021

As a result of internal performance monitoring performed in 2020, opportunities for improvement were identified and will be incorporated into the 2021 department goals. Highlights of opportunities for improvement based on the regulatory findings include:

- Improve monitoring of network utilization (over/under), including out of network authorization requests particularly focus on the Stanford analysis.
- Improve monitoring of Specialty Referrals.
- Collaboration with the Alliance Compliance Department on the full implementation of the UM process for internal performance monitoring of UM decisions.
- Strengthen programs around oversight of clinical decision making, both internally and for Delegates.
- Continue the care transition program in partnership with Highland Hospital and expansion to other hospitals.
- Develop and refine the ADT feed coming from contracted hospitals to enhance communication, coordination of care, and automation of UM Case creation in TruCare.
- Analyze the opportunity and implement the process to increase the number of authorizations that are appropriate for automatic approval.
- Improve reporting and analysis of grievance and appeals activities related to UM decision making and analysis for member and provider experience with UM.
- Continue implementation for tracking and intervening with unused Authorizations to ensure that members receive appropriate care and follow up.
- Continue to monitor and enhance the use of the Palliative Care benefit for members in collaboration with outside partners.
- Refine processes for the Stanford Oncology program, including streamlining authorizations and coordination with Case Management.
- Continue the analysis of hospital data and develop an individual hospital strategy for management of members for appropriate length of stay.
- Hardwire the standardized work and training for the UM department staff to ensure regulatory compliance.
- Hardwire a standard process for policy review and revision that ensures UM processes maintain operational and regulatory compliance.

Attachment A

2019 The Alliance Delegated Network or Vendor Relationships

Delegate	Provider Type		Delegated Activity - UM	Delegated Activity – Grievance and Appeals	Exceptions
Kaiser	HMO		X	X	
Alameda Health System	Delivery System		X	NA	
CHCN	Medical Group		X	NA	
CFMG	Medical Group		X	NA	
California Home Medical Equipment (CHME)	Vendor DME		X*	NA	* Not delegated for denials
Beacon/College Health IPA (CHIPA)	MBHO		X	NA	
Logisticare	Vendor - Transportation		NA	NA	* Not delegated for denials
March Vision	Vendor – Vision Services		NA	NA	

Attachment B – 2021 UM Work Plan

See attached document.

ALAMEDA Alliance FOR HEALTH

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CEO Update

Scott Coffin

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

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

Date: **June 11, 2021**

Subject: **CEO Report**

- **Operational Performance**
  - Net income reported in April 2021 of $6.9 million; Medi-Cal reporting a net income of $6.7M, and Group Care a net income of $168K for the month.
  - Net loss year-to-date is $3.5 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 reached a new record of 284,191; growth in Medi-Cal continues to increase each month, and Group Care remains steady at 5,900 to 6,100 Members per month; Medi-Cal increase month-over-month is declining, averaging 2,150 per month since January
  - Regulatory operating metrics that did not meet thresholds included: 1) encounter data reporting for institutional claims 0-180 days, and 2) exempt grievances turnaround time were 32% below the target (5 of 8 grievances processed correctly, and 3 grievances were related to accessing specialty medications, and were processed one day late). The encounter data clean-up is carried over from last month, and was reported to the Board of Governors in May 2021
  - Non-regulatory operating metrics that did not meet internal performance thresholds included 1) Provider Disputes, 2) Member Services inbound calls answered in 30 seconds or less is 3% below target, 3) calls abandonment rate over by 1%. 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

- **Preliminary Fiscal Year 2021-2022 Budget**
  - Preliminary fiscal year 2021-2022 budget (July 1, 2021 to June 30, 2022) forecasts a $10.6 million net income
    - Medi-Cal enrollment is projected to decrease by 28,000 prior to June 2022, and Group Care enrollment remains at approximately 6,000
    - Preliminary rates for Enhanced Care Management (ECM) services were received on May 28, and have been included in the preliminary budget
    - Medi-Cal In-Lieu Of Services (ILOS) revenues and expenses are excluded in the preliminary budget pending confirmation from the

DHCS on reimbursements, and the estimates will be included in the final budget
        - Major Organ Transplants rates have not been released by the DHCS and will be included in the final budget
        - Other factors impacting the final budget for fiscal year 2022 include the timing for the pharmacy carve-out, decision by the DHCS on the risk corridor for Medi-Cal services, and enhanced HCBS funding and state budget allocations to support the transition of the Whole Person Care Pilot (AC3)
    - Alliance's final budget will be presented to the Finance Committee and Board of Governors in December 2021 following the delivery of preliminary Medi-Cal rates from DHCS

- **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 (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, and the DHCS is proposing to align the CalAIM services (e.g., housing navigation, tenancy & sustaining services, and deposits) as a supplemental source of funding to the counties. The HCBS funds are applied for by the county, and DHCS routes the payments through the managed care health plans; 85% of the funds must be allocated to direct services, and 15% is to pay for administrative expenses
    - Projects for Assistance in Transition from Homelessness (PATH) grant funding is available to county-based public health agencies, purposed to support community-based outreach, mental health and substance abuse referral and treatment, and to sustain a defined group of housing services for adults who are homeless or at risk of homelessness

- **CalAIM**
    - Whole Person Care Pilot (AC3) & Health Homes programs end 12/31/2021
    - Enhanced Care Management (ECM) & 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 to DHCS by July 1; 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 to 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)

- **COVID-19 Vaccinations**
    - Approximately 47% of members (12 years and older) in Medi-Cal and Group Care are partially or fully vaccinated, approximately 10% higher than last month; 30% below the county average of 77%, and 11% below the statewide rate
    - In the month of May, the Alliance conducted a second round of mailings, robocalls and post cards to over 151,000 Members (12 years and older) to encourage seeking the vaccine, and to supply a list of vaccination sites in Alameda County
    - See COVID-19 dashboard on page 249

- **HEDIS**
    - HEDIS rates are on schedule to be finalized prior to the June 15 deadline
    - Approximately 91% of the 3,960 records were retrieved virtually this year, and the projected AQFS score for measurement year 2020 is between 50% to 60%; approximately seven (7) HEDIS measures held to a minimum level are below the standard, including:
        - Cervical Cancer Screening
        - Comprehensive Diabetes Care – HbA1c Poor Control
        - Controlling High Blood Pressure
        - Weight Assessment and Counseling – BMI

        - Weight Assessment and Counseling – Counseling for Nutrition
        - Breast Cancer Screening
        - Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

    - DHCS is waiving sanctions and penalties for measurement year 2020, and announced that enforcement will apply to measurement year 2021 for HEDIS measures below the minimum performance level
    - Pay-for-Performance (P4P) quality incentive payments, for measurement year 2020, are scheduled for September 2021

ALAMEDA Alliance FOR HEALTH

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Operations Dashboard

OPERATIONS DASHBOARD

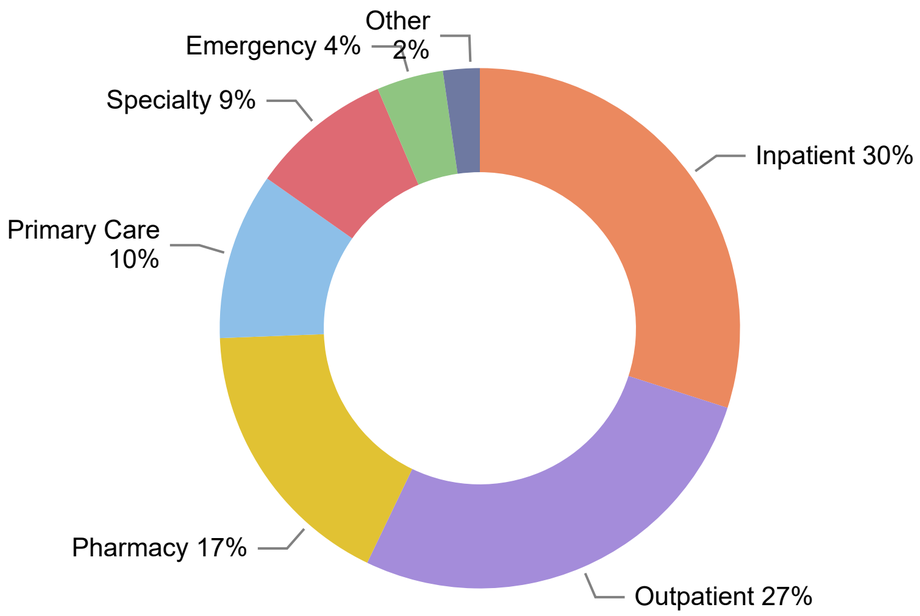
JUNE 2021

Financials

Income & Expenses

Revenue	Medical Expense
$888.2M	**($851.5M)**
Other Income/(Exp.)	Admin Expense
$236.1K	**($40.6M)**
Net Income	Gross Margin %
($3.7M)	**4.1%**

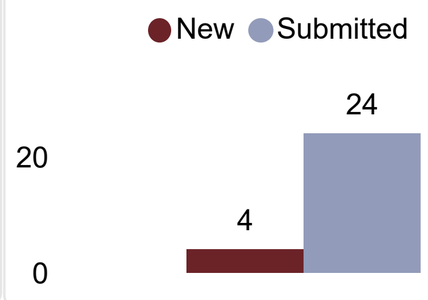
Medical Expenses



Liquid Reserves

MLR Net %	95.9%
TNE %	542.8%
TNE $	$202.5M

Reinsurance Cases



Balance Sheet

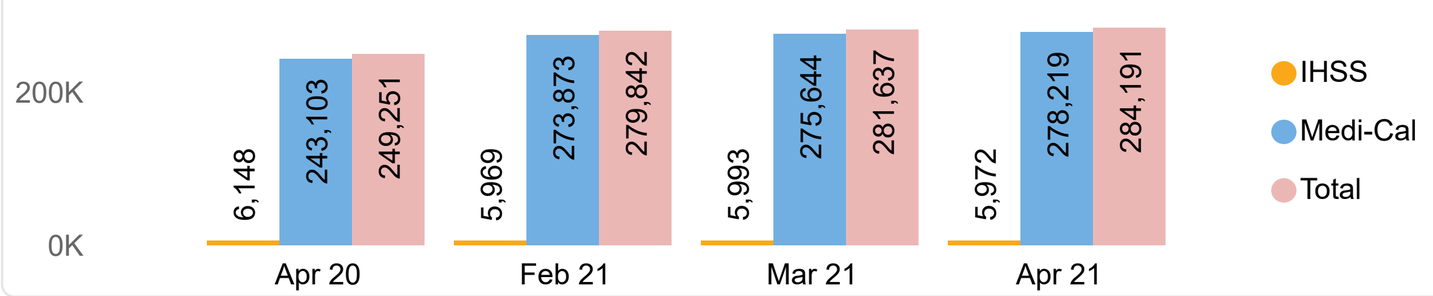
Cash Equivalents	$273.4M
Pass-Through Liabilities	$197.4M
Uncommitted Cash	$76.0M
Working Capital	$194.7M

Current Ratio %

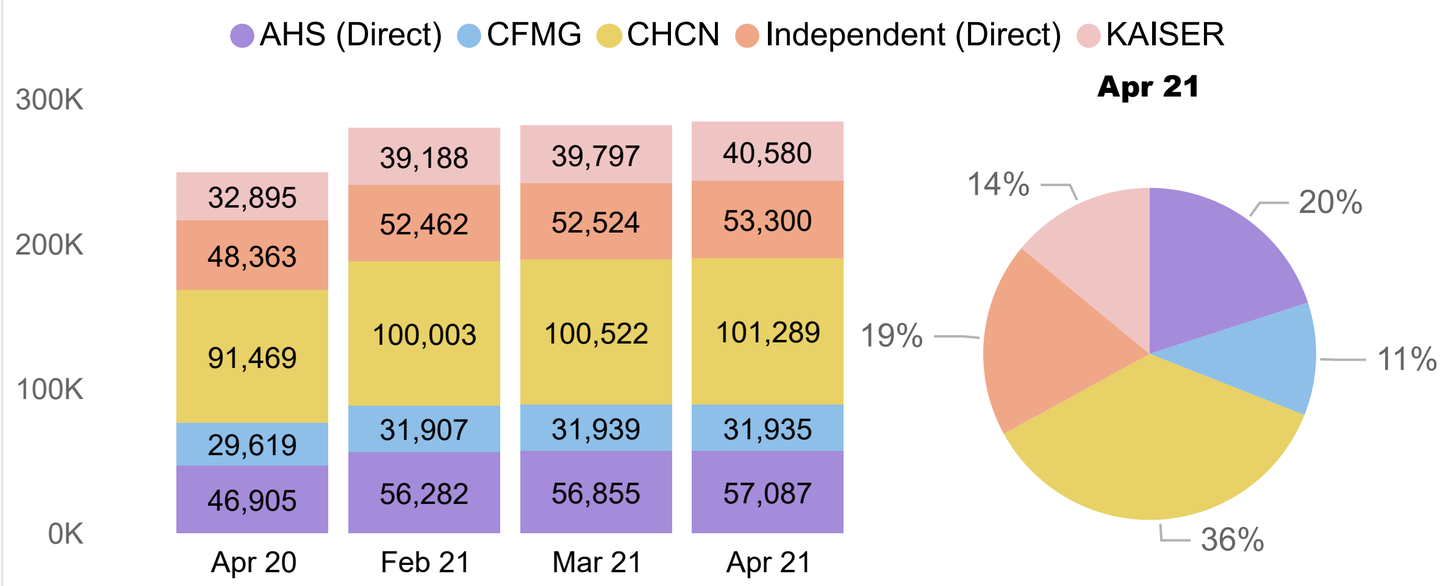
157.6%

Membership

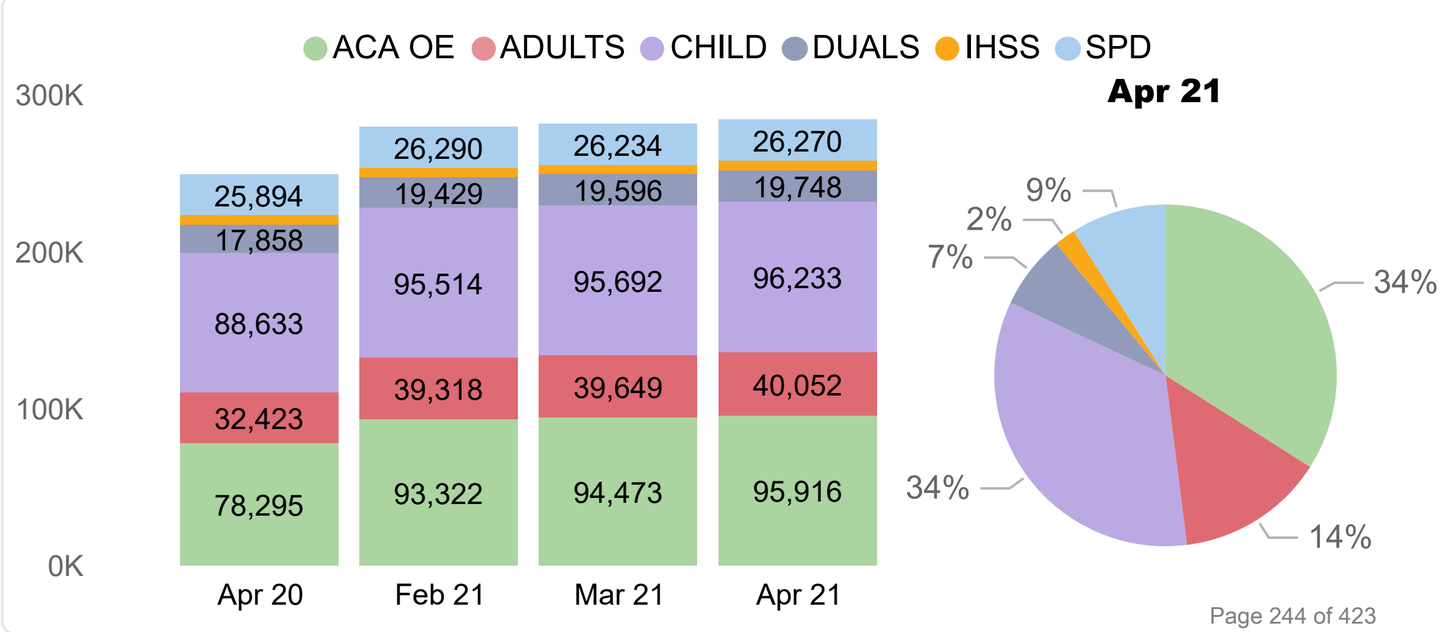
By Plan



By Network



By Category

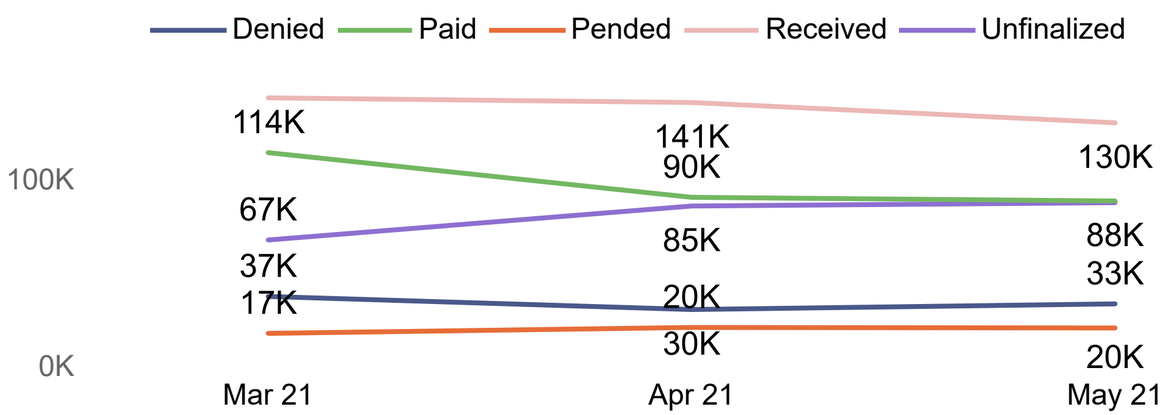


OPERATIONS DASHBOARD

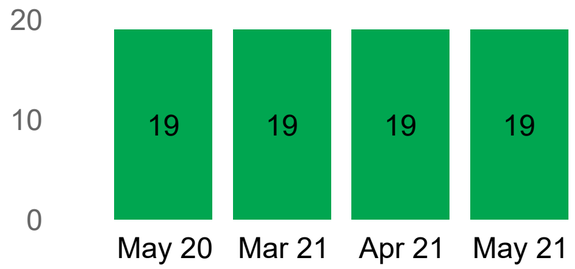
JUNE 2021

Claims

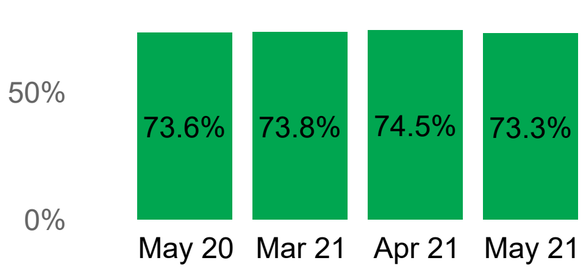
Claims Processing



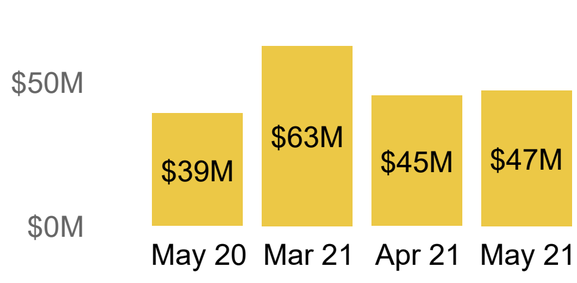
Average Payment TAT (Days)



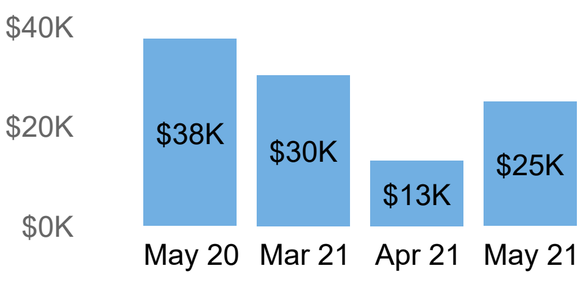
Auto Adjudication Rate (%)



Claims Paid (Dollars)

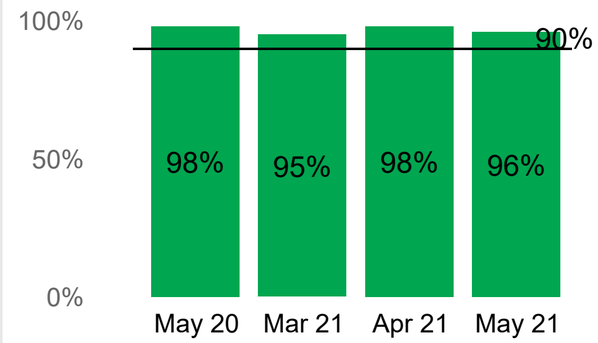


Interest Paid (Dollars)

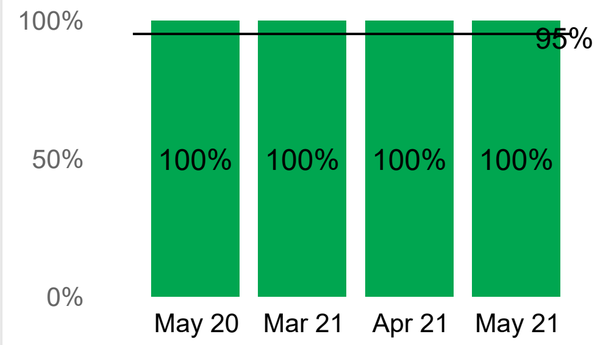


Claims Compliance

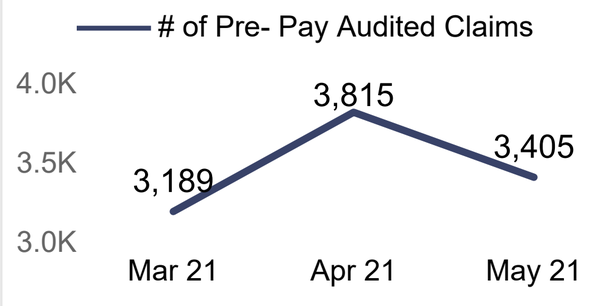
% Processed (30 Cal Days)



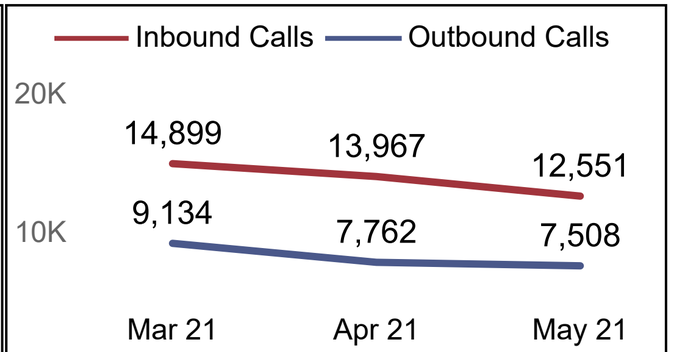
% Processed (45 Work Days)



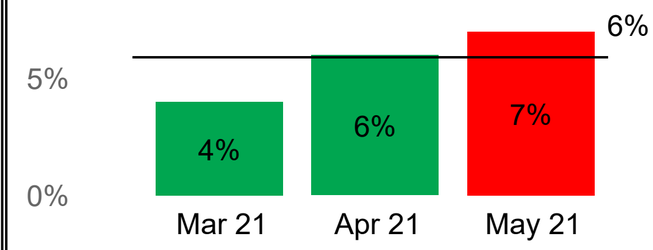
Claims Auditing



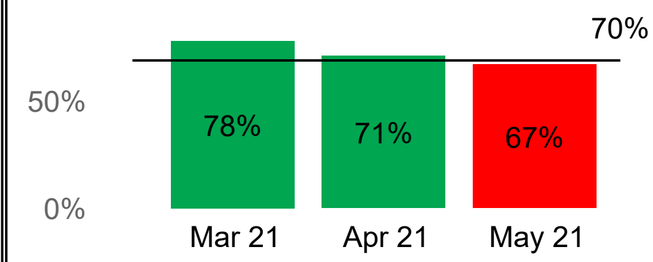
Member Services



Abandoned Call Rate %

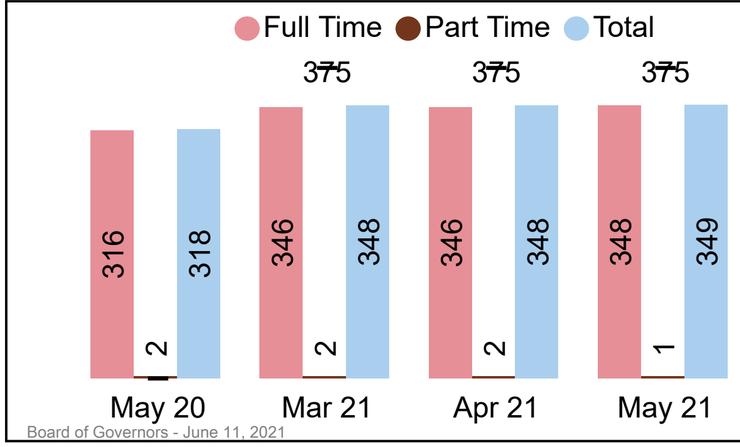


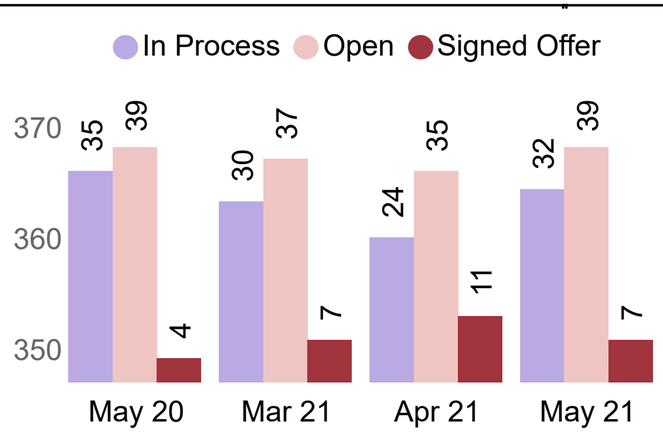
Calls Answered in 60 Seconds %



Average Call Times	Mar 21	Apr 21	May 21
Wait Time	00:37	00:54	01:04
Call Duration	06:26	06:33	06:09

Human Resources





Recruiting	May 20	Mar 21	Apr 21	May 21
New Hires	3	8	3	5
Separations	4	0	3	2
Temps / Seasonal	4	7	6	6

Current Vacancy

10%

OPERATIONS DASHBOARD

JUNE 2021

Provider Services

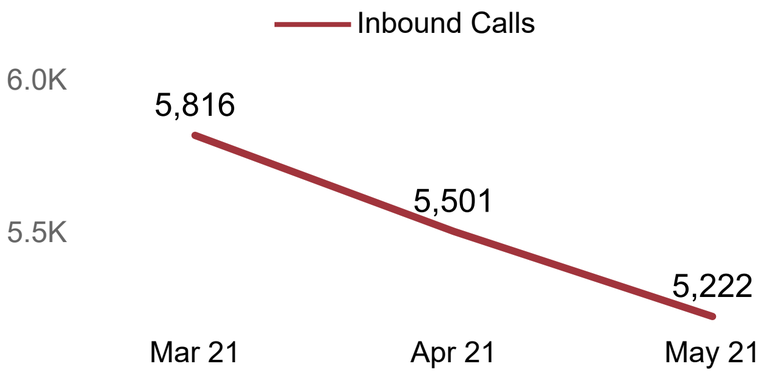
Provider Network

Primary Care Physician	694
Specialist	6,973
Hospital	17
Skilled Nursing Facility	65
Durable Medical Equipment	Capitated
Urgent Care	10
Health Centers (FQHCs and Non-FQHCs)	67
Transportation	380

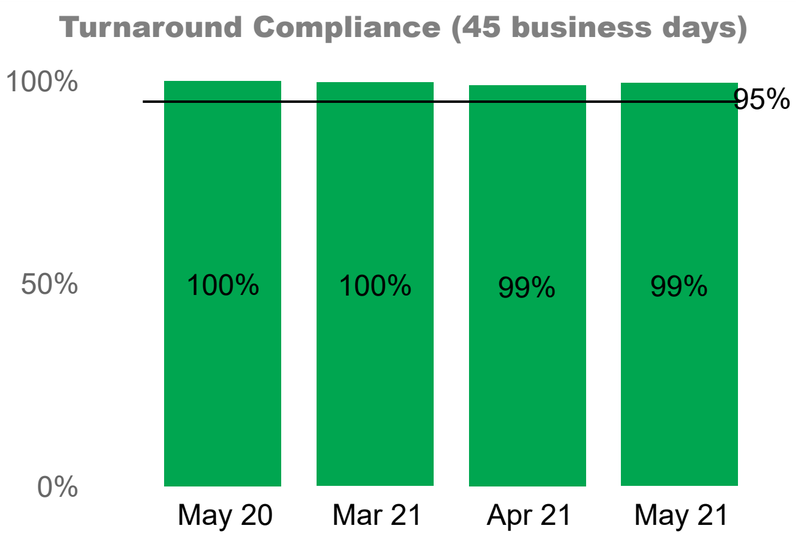
Provider Credentialing

1,447

Provider Call Center

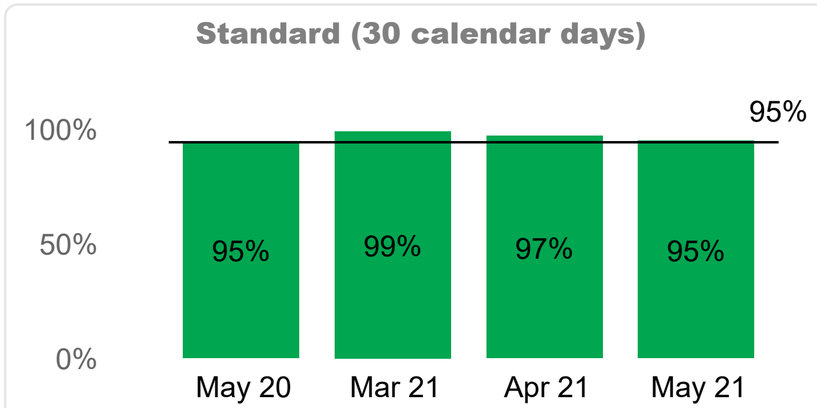


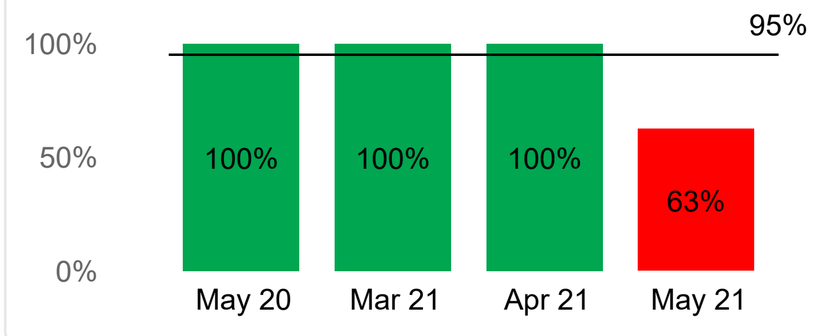
Provider Disputes & Resolutions



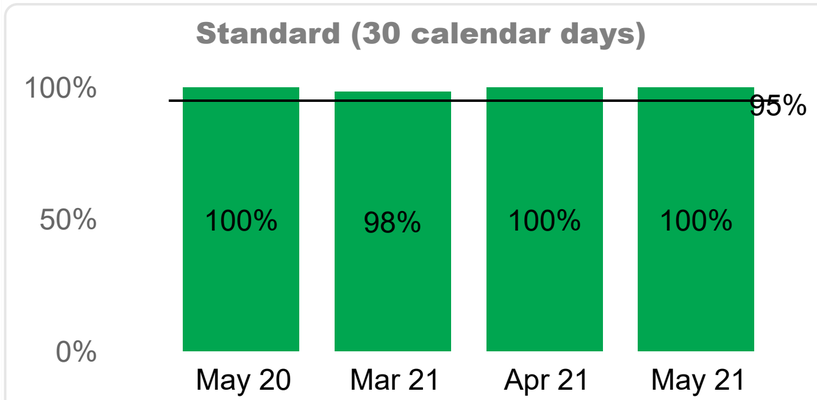
Compliance

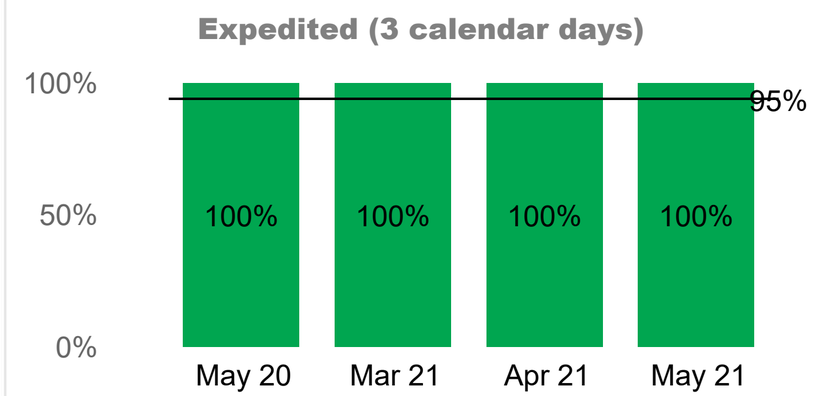
Member Grievances



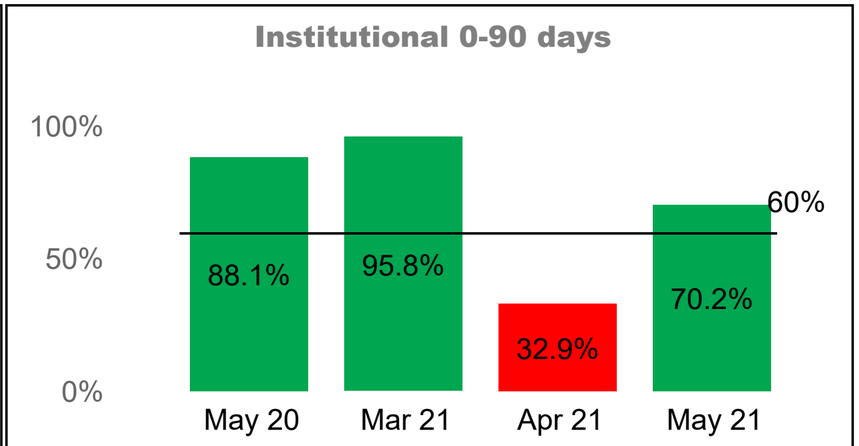


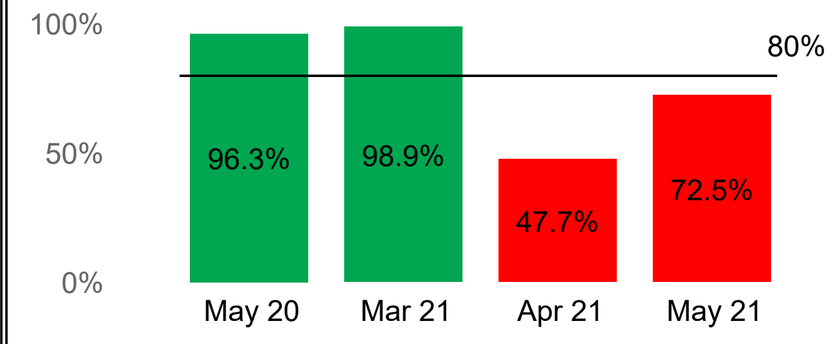
Member Appeals

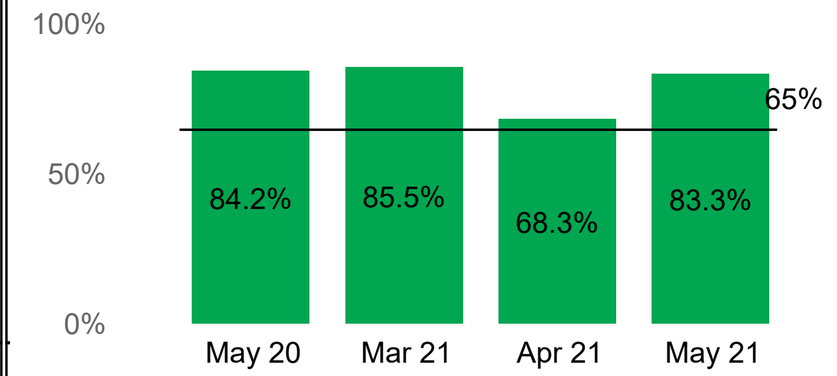


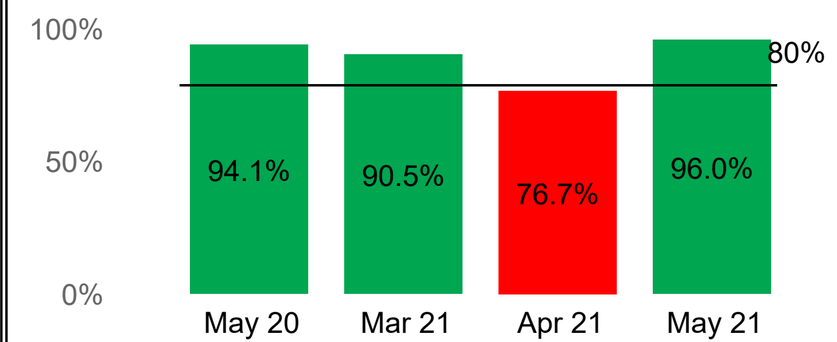


Encounter Data







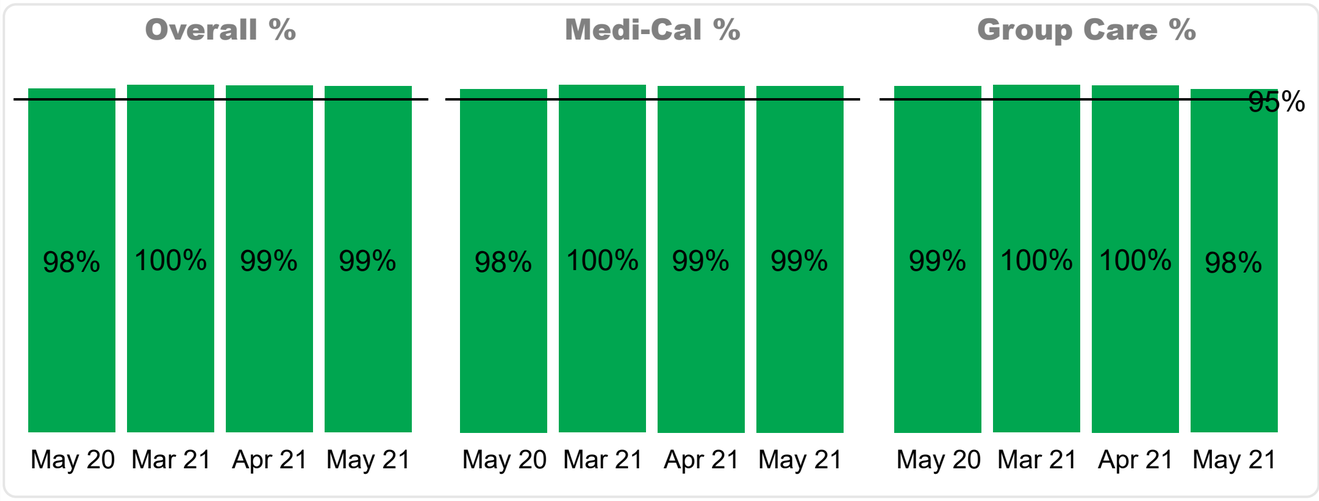


OPERATIONS DASHBOARD

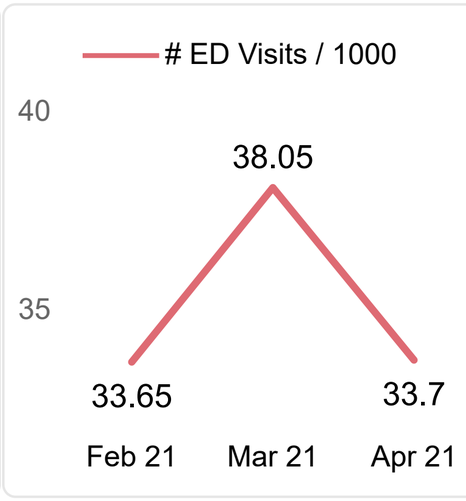
JUNE 2021

Health Care Services

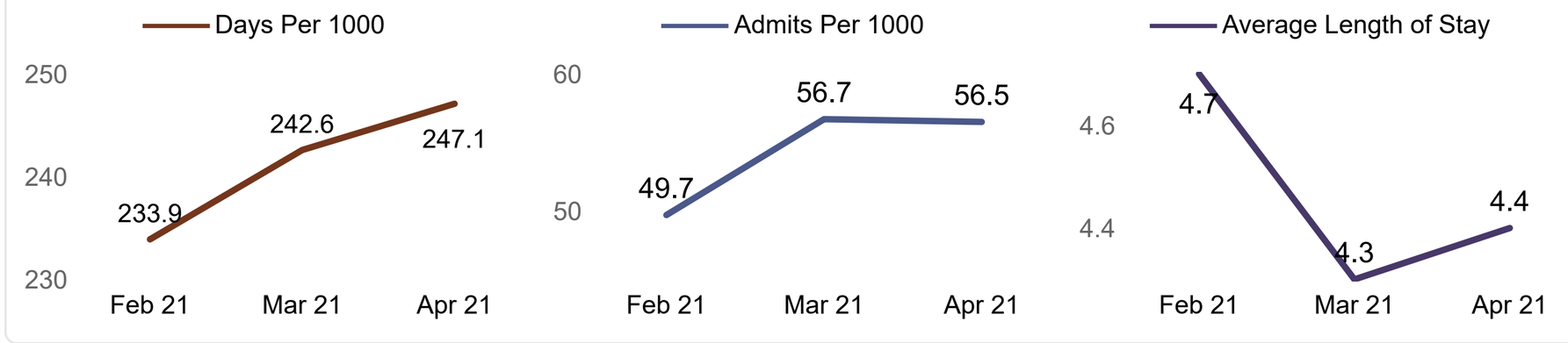
Authorization Turnaround



ED Utilization

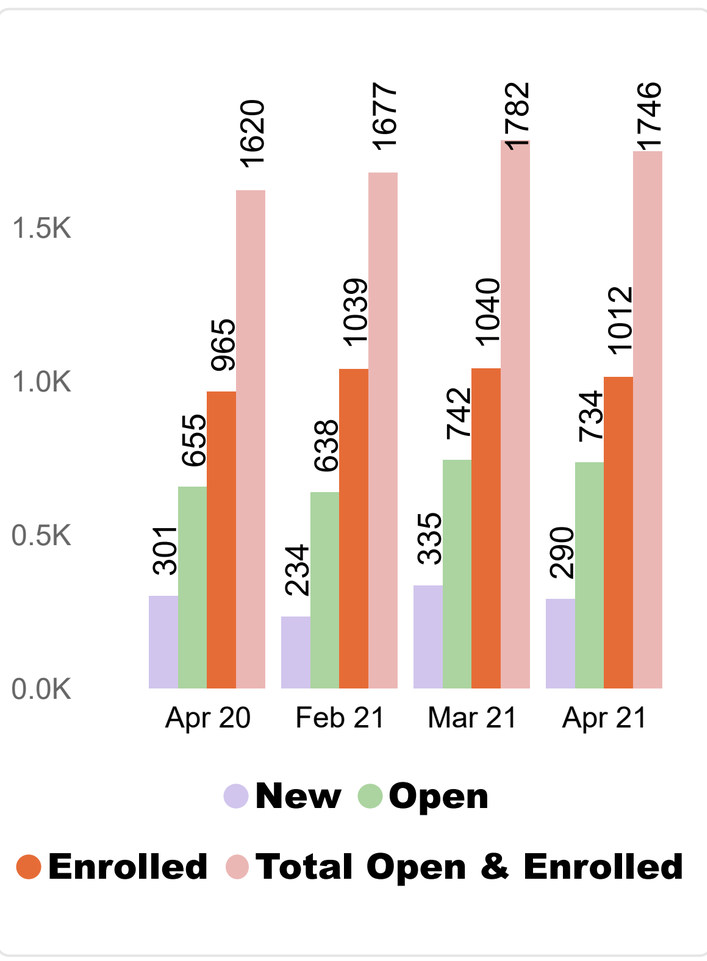


Inpatient Utilization

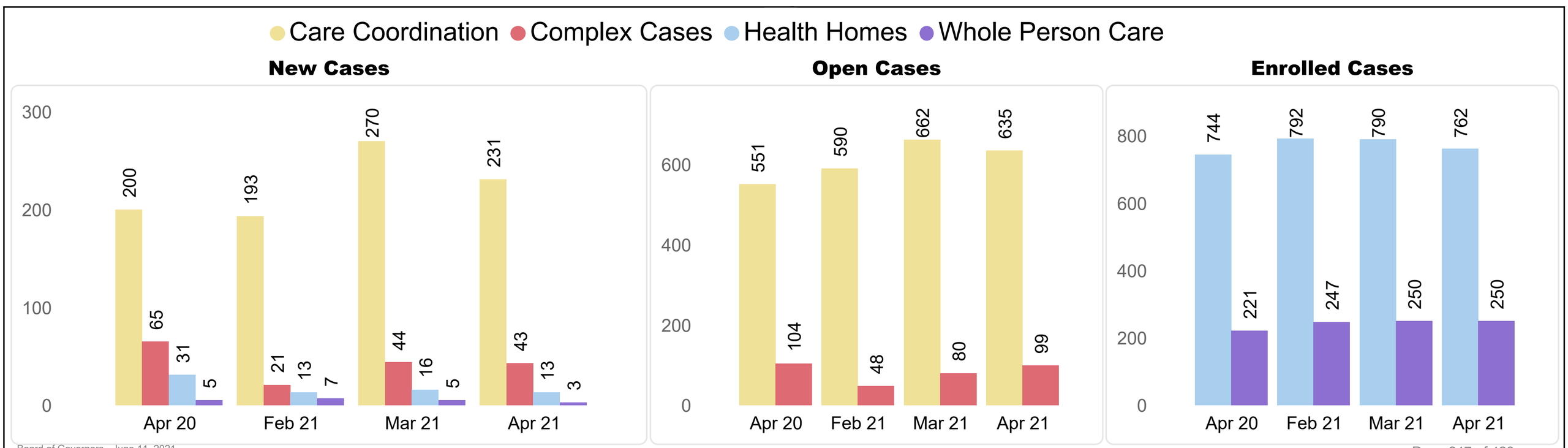


Case Management

Total Cases



Case Management



Technology (Business Availability)

Applications	May 20	Mar 21	Apr 21	May 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	May 20	Mar 21	Apr 21	May 21
Denial Rate Excluding Partial Denials (%)	3.1%	3.8%	3.2%	3.0%
Overall Denial Rate (%)	3.3%	3.8%	3.3%	3.1%
Partial Denial Rate (%)	0.1%	0.0%	0.1%	0.1%

Pharmacy Authorizations

Authorizations ▲	May 20	Mar 21	Apr 21	May 21
Approved Prior Authorizations	641	861	954	796
Closed Prior Authorizations	458	638	589	552
Denied Prior Authorizations	503	771	655	583
Total Prior Authorizations	1,602	2,270	2,198	1,931

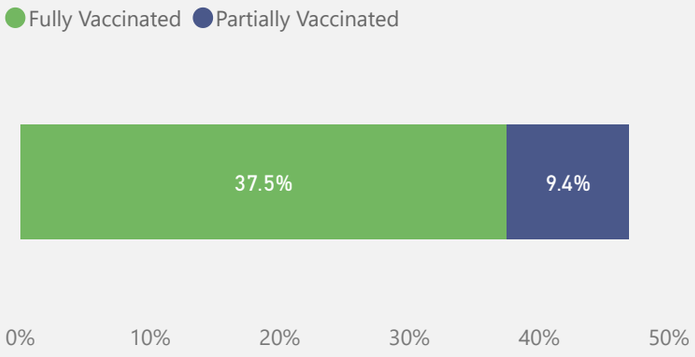
COVID-19 Vaccination Summary as % of Population Ages >= 12 Years

Data as of: 5/26/2021

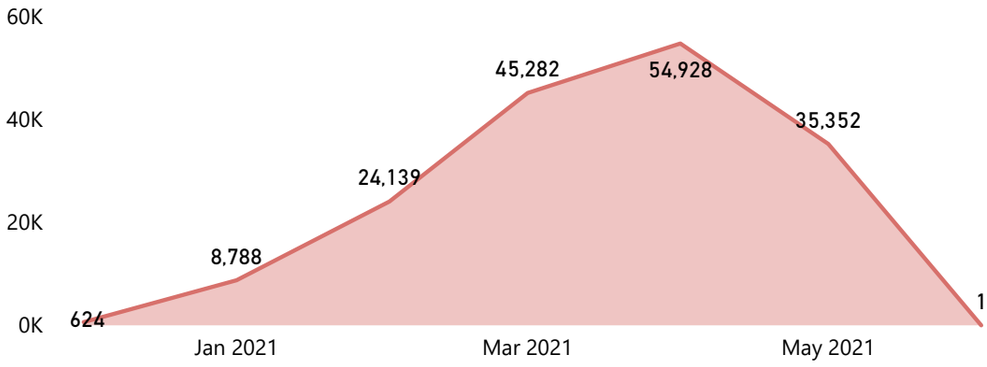
Members Fully Or Partially Vaccinated: 107,029

% Fully Or Partially Vaccinated: 46.8%

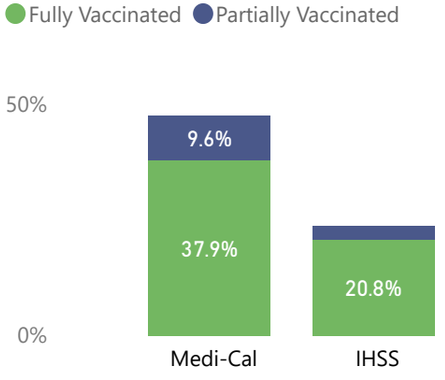
Breakout by Status



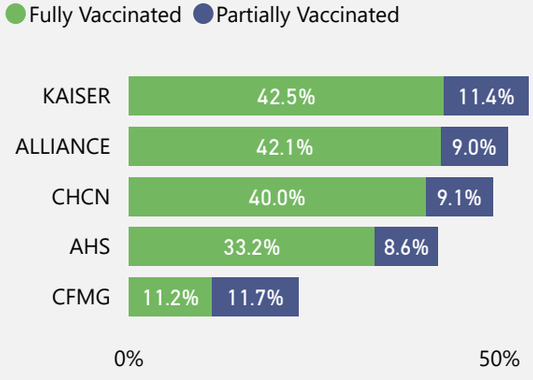
Monthly Trend



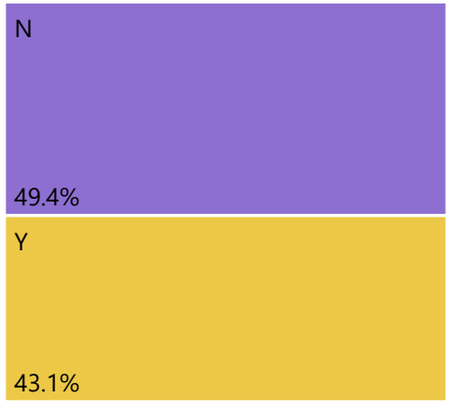
Medi-Cal vs IHSS



Network

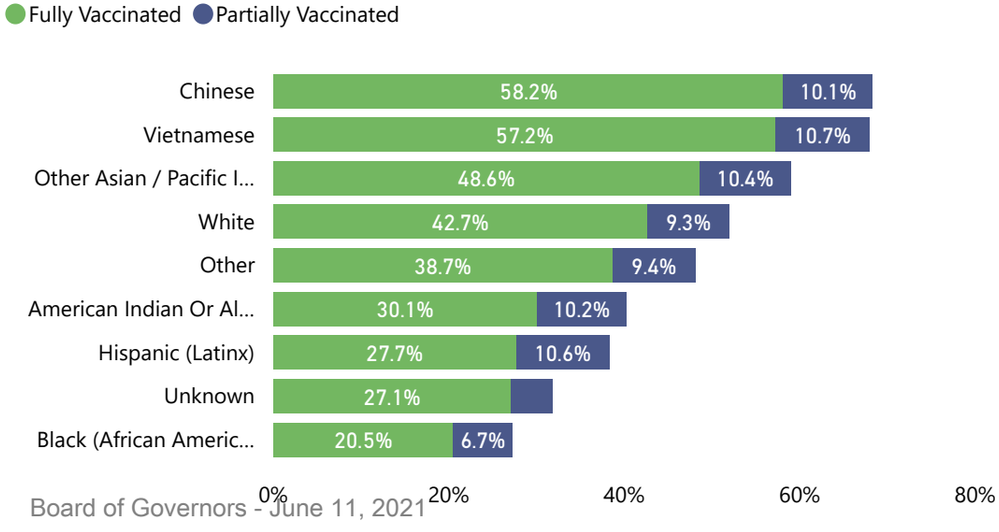


High Risk Zip Code

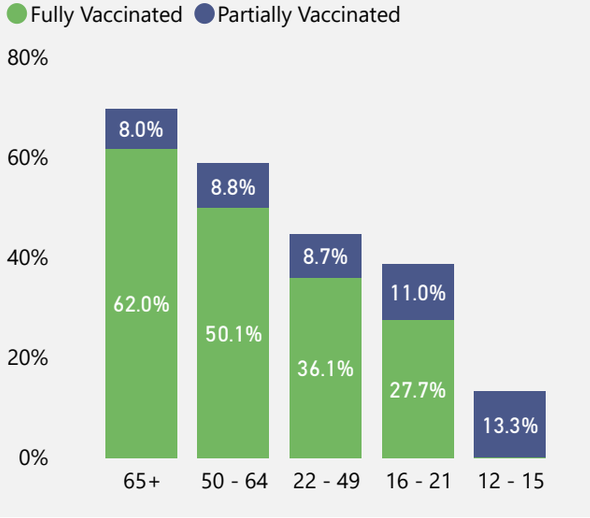


Top 15 Cities	Fully Vaccinated	Partially Vaccinated
ALAMEDA	46.9%	10.2%
ALBANY	52.5%	11.4%
BERKELEY	44.4%	9.9%
CASTRO VALLEY	41.5%	9.2%
DUBLIN	44.2%	10.2%
EMERYVILLE	36.1%	7.5%
FREMONT	42.8%	10.5%
HAYWARD	34.0%	9.4%
LIVERMORE	35.6%	10.0%
NEWARK	38.5%	10.7%
OAKLAND	33.5%	8.9%
PLEASANTON	43.7%	11.0%
SAN LEANDRO	40.9%	9.1%
SAN LORENZO	44.3%	9.1%
UNION CITY	42.4%	10.2%

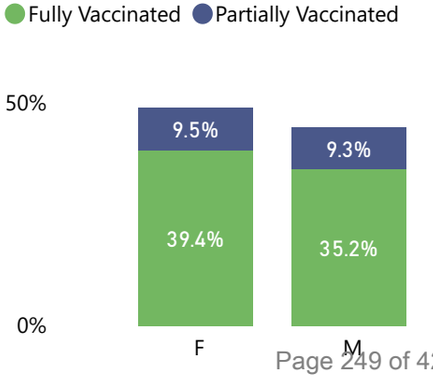
Ethnicity



Age Category



Gender



ALAMEDA Alliance FOR HEALTH

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

Legislative Tracking List

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.

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- **AB 382 (Kamlager – D) Whole Child Model Program**
  - **Introduced:** 2/2/2021
  - **Status:** 5/19/21 Referred to Com. on HEALTH.
  - **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:** 6/2/21 In Senate. Read first time. To Com. on RLS. for assignment.
  - **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:** 6/2/21 In Senate. Read first time. To Com. on RLS. for assignment.
  - **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 exempts 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:** 5/28/21 In Senate. Read first time. To Com. on RLS. for assignment.
  - **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:** 5/28/21 In Senate. Read first time. To Com. on RLS. for assignment.
  - **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:** 5/28/21 In Senate. Read first time. To Com. on RLS. for assignment.
  - **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:** 6/3/21 In Senate. Read first time. To Com. on RLS. for assignment.
  - **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:** 6/2/21 In Senate. Read first time. To Com. on RLS. for assignment.
  - **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:** 6/2/21 In Senate. Read first time. To Com. on RLS. for assignment.
  - **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:** 6/2/21 In Senate. Read first time. To Com. on RLS. for assignment.
  - **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:** 5/28/21 Read third time. Passed. Ordered to the Senate. (Ayes 77. Noes 0.) In Senate. Read first time. To Com. on RLS. for assignment.
  - **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:** 6/2/21 Read third time. Passed. (Ayes 29. Noes 7.) Ordered to the Assembly. In Assembly. Read first time. Held at Desk.
  - **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 three fiscal years that exceed the cost of providing those individuals 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 65 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:** 6/2/21 In Assembly. Read first time. Held at Desk.
  - **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:** 6/2/21 In Assembly. Read first time. Held at Desk.
  - **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:** 6/2/21 In Assembly. Read first time. Held at Desk.
  - **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:** 6/2/21 In Assembly. Read first time. Held at Desk.
  - **Summary:** Current law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, 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:** 6/2/21 In Assembly. Read first time. Held at Desk.
  - **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)**
  - **Introduced:** 2/12/2021
  - **Status:** 6/2/21 In Assembly. Read first time. Held at Desk.
  - **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:** 6/2/21 In Assembly. Read first time. Held at Desk.
  - **Summary:** 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.

- **AB 671 (Wood – D) Medi-Cal: Pharmacy Benefits**
  - **Introduced:** 2/12/2021
  - **Status:** 5/27/21 Ordered to inactive file at the request of Assembly Member Wood.
  - **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.

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 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 any 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:** 6/3/21 Referred to Com. on ED.
  - **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 and administrators. 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:** 5/19/21 Referred to Com. on HEALTH.
  - **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:** 6/3/21 Referred to Com. on HEALTH.
  - **Summary:** Would 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. The bill would require the office to contract with a managing agency for the pilot program, as specified.

- **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:** 5/28/21 In Senate. Read first time. To Com. on RLS. for assignment.
  - **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:** 5/28/21 In Senate. Read first time. To Com. on RLS. for assignment.
  - **Summary:** 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:** 5/28/21 In Senate. Read first time. To Com. on RLS. for assignment.
  - **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 examination and laboratory test, as specified. The bill would require the coverage to include additional colorectal cancer screening examinations as listed by the United States Preventive Services Task Force as a recommended screening strategy and at least at the frequency established pursuant to regulations issued by the federal Centers for Medicare and Medicaid Services for the Medicare program if the individual is at high risk for colorectal cancer. The bill would prohibit a health care service plan contract or a health insurance policy from imposing cost sharing on an individual who is between 50 and 75 years of age for colonoscopies conducted for specified purposes.

- **AB 347 (Arambula – D) Health Care Coverage: Step Therapy**
  - **Introduced:** 1/28/2021
  - **Status:** 6/3/21 In Senate. Read first time. To Com. on RLS. for assignment.
  - **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 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, primary care physician, or health care provider to file an appeal of a prior authorization or the denial of a 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:** 5/28/21 In Senate. Read first time. To Com. on RLS. for assignment.
  - **Summary:** Would establish within the State Department of Health Care Services an Older Adult Mental Health Services Administrator to oversee mental 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 outcome and related indicators for older adults for the purpose of assessing the status of mental health services for older adults, monitoring the quality of programs for those adults, and guiding decision making on how to improve those services.

- **AB 389 (Grayson – D) Ambulance Services**
  - **Introduced:** 2/2/2021
  - **Status:** 6/3/21 In Senate. Read first time. To Com. on RLS. for assignment.
  - **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:** 5/28/21 In Senate. Read first time. To Com. on RLS. for assignment.
  - **Summary:** Would enact the Protection of Patient Choice in Telehealth Provider Act, which would require a health care service plan and a health insurer to arrange for the provision of a service via telehealth to an enrollee or an insured through a third-party corporate telehealth provider, as defined, only if specified notice conditions are met and the enrollee or insured, once notified as specified, elects to receive the service via telehealth through a third-party corporate telehealth provider. For an enrollee or insured that is currently receiving specialty telehealth services for a mental or behavioral health condition, the bill would require that the enrollee or insured be given the option of continuing to receive that service with the contracting individual health professional, a contracting clinic, or a contracting health facility.

- **AB 1130 (Wood D) California Health Care Quality and Affordability Act**
  - **Introduced:** 2/18/2021
  - **Status:** 6/3/21 Read third time. Passed. Ordered to the Senate.
  - **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.

- **AB 1130 (Wood D) California Health Care Quality and Affordability Act**
  - **Introduced:** 2/18/2021
  - **Status:** 6/3/21 Read third time. Passed. Ordered to the Senate.
  - **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:** 6/2/21 Read third time. Passed. (Ayes 31. Noes 6.) Ordered to the Assembly. In Assembly. Read first time. Held at Desk.
  - **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:** 6/2/21 Read third time. Passed. (Ayes 31. Noes 7.) Ordered to the Assembly. In Assembly. Read first time. Held at Desk.
  - **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. 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:** 6/2/21 In Assembly. Read first time. Held at Desk.
  - **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 nonemergency 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.

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Board Business

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Finance

Gil Riojas

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

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

Date: **June 11, 2021**

Subject: **Finance Report – April 2021**

Executive Summary

- For the month ended April 30, 2021, the Alliance had enrollment of 284,191 members, a Net Income of $6.9 million, and 543% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$95,306	$888,164
Medical Expense	91,829	851,509
Admin. Expense	(3,380)	40,602
Other Inc. / (Exp.)	25	236
Net Income	$6,882	($3,711)

Net Income by Program:

	Month	YTD
Medi-Cal	$6,714	($2,065)
Group Care	168	(1,646)
	$6,882	($3,711)

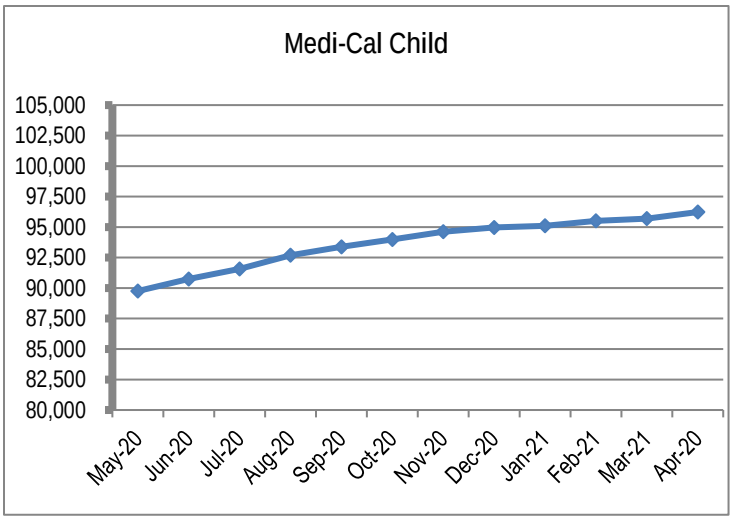
Enrollment

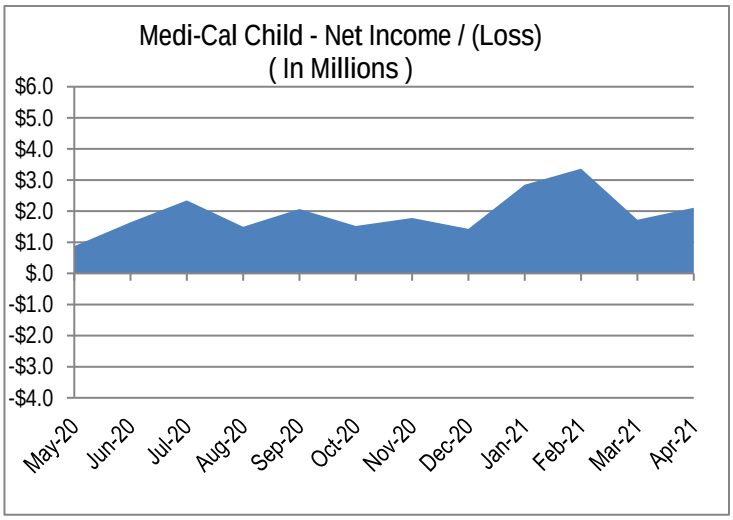
- Total enrollment increased by 2,554 members since March 2021.
- Total enrollment increased by 27,446 members since June 2020.

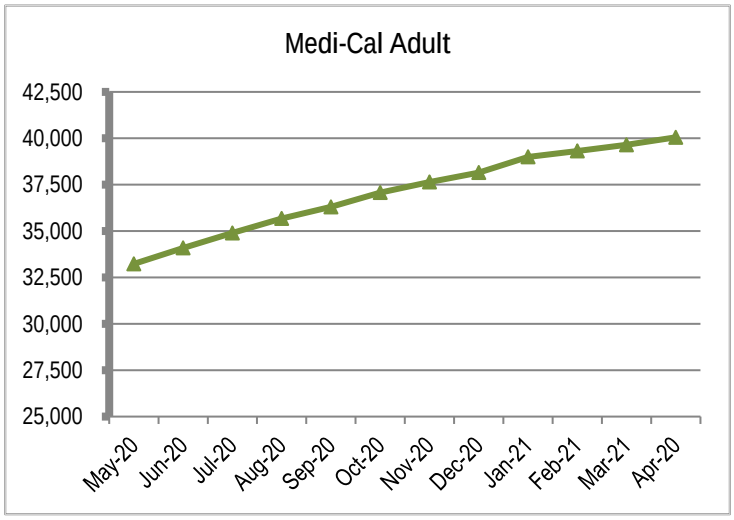
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

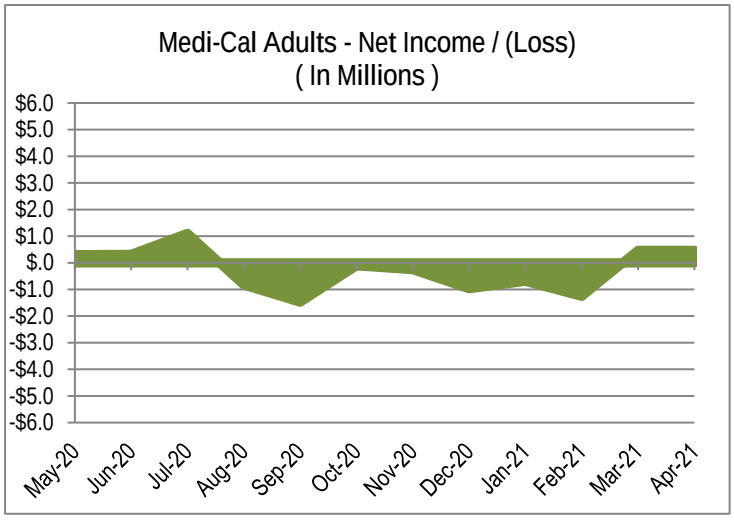
Enrollment					Member Months			
April-2021					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
40,052	40,609	(557)	-1.4%	Adult	377,774	380,419	(2,645)	-0.7%
96,233	98,261	(2,028)	-2.1%	Child	943,749	953,419	(9,670)	-1.0%
26,270	26,395	(125)	-0.5%	SPD	262,371	262,748	(377)	-0.1%
19,748	19,665	83	0.4%	Duals	190,332	190,455	(123)	-0.1%
95,916	96,574	(658)	-0.7%	ACA OE	899,821	905,706	(5,885)	-0.6%
278,219	281,503	(3,284)	-1.2%	Medi-Cal Total	2,674,047	2,692,748	(18,701)	-0.7%
5,972	6,009	(37)	-0.6%	Group Care	59,967	60,190	(223)	-0.4%
284,191	287,512	(3,321)	-1.2%	Total	2,734,014	2,752,938	(18,924)	-0.7%

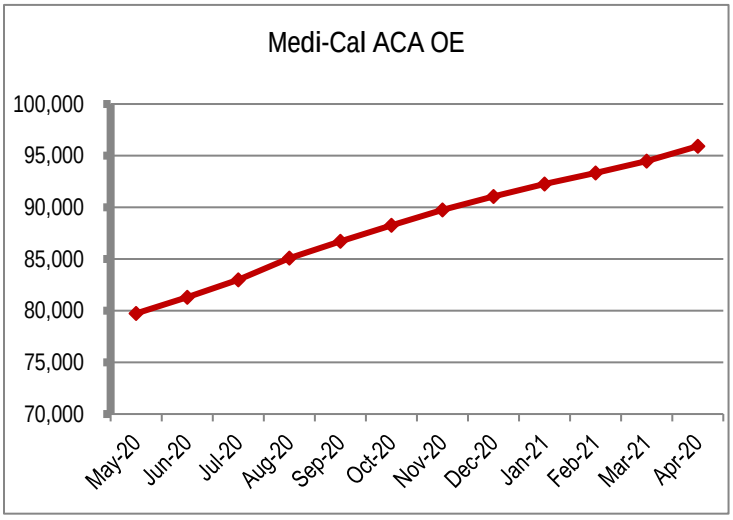
Enrollment and Profitability by Program and Category of Aid

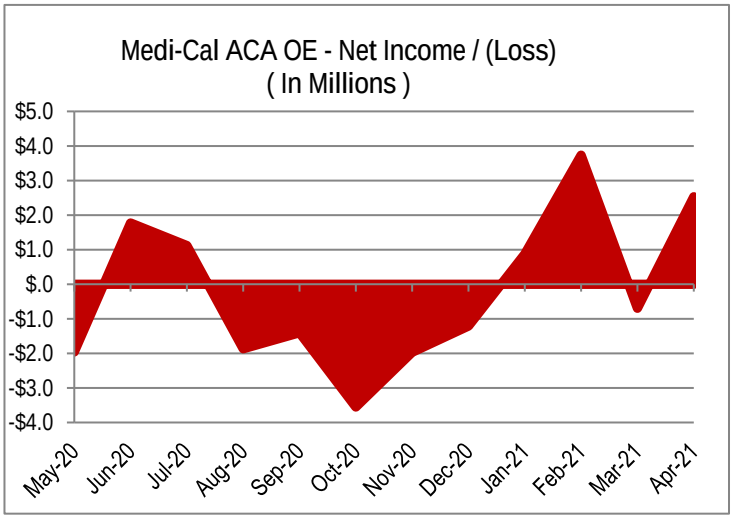




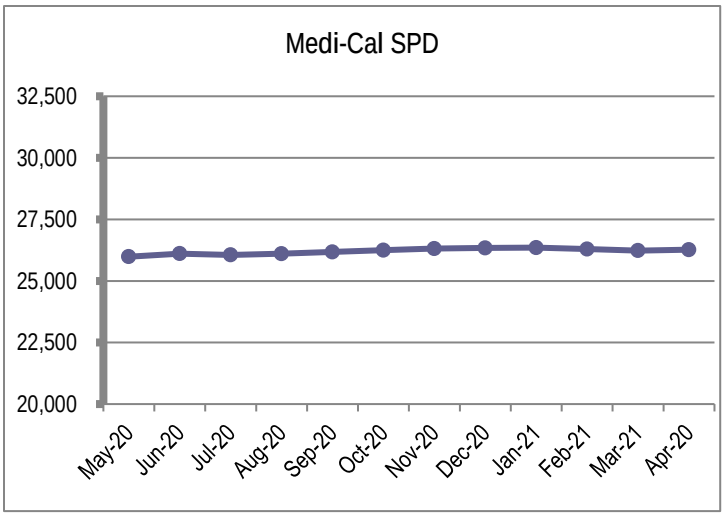


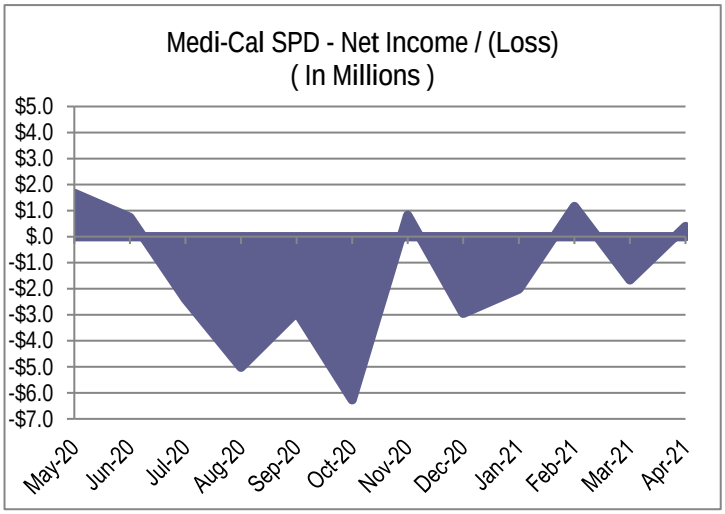


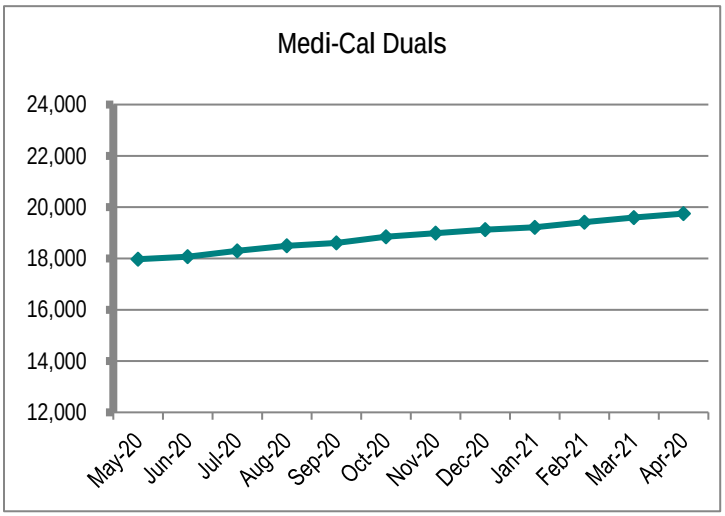


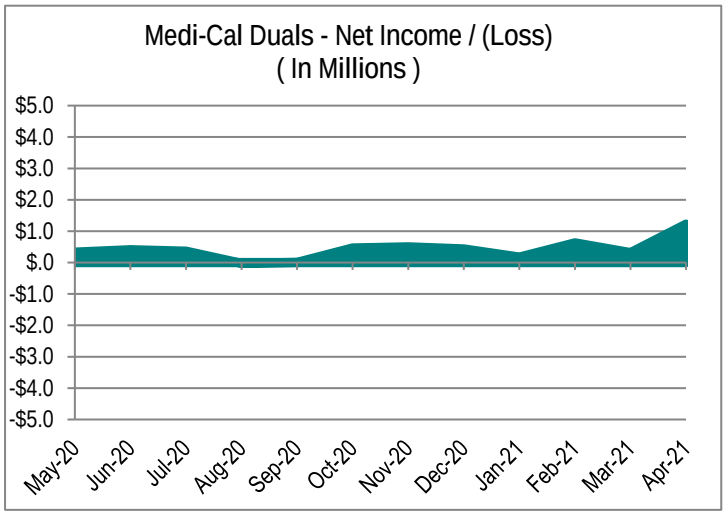


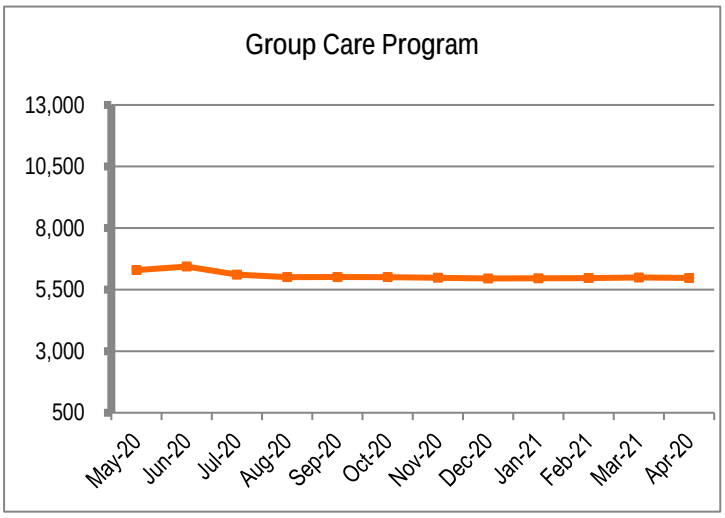
Enrollment and Profitability by Program and Category of Aid

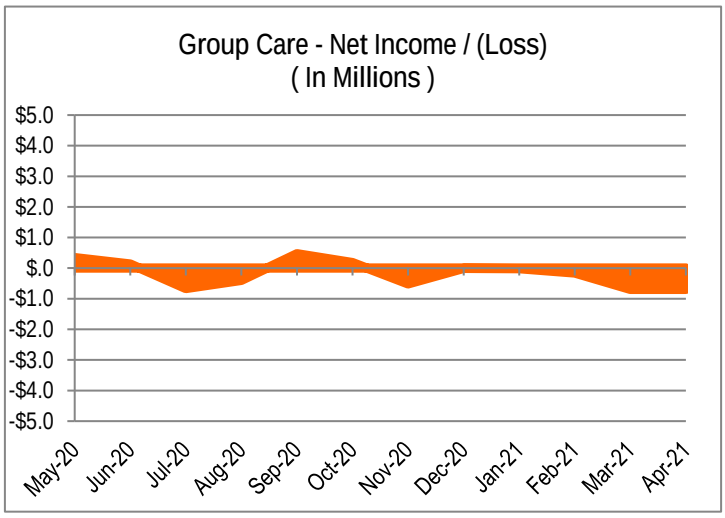




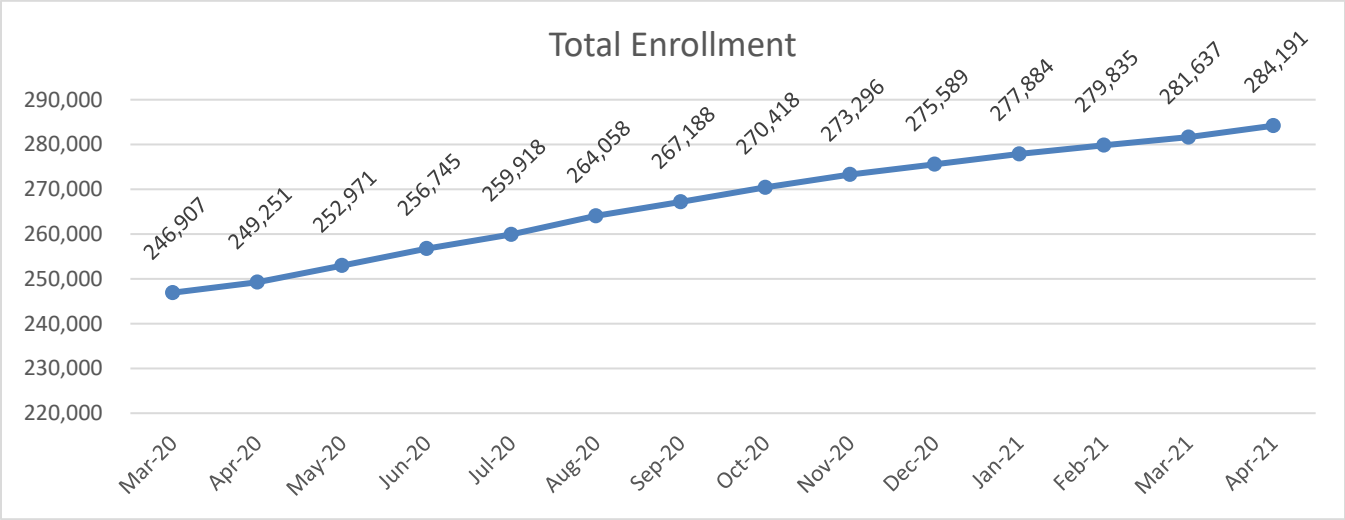


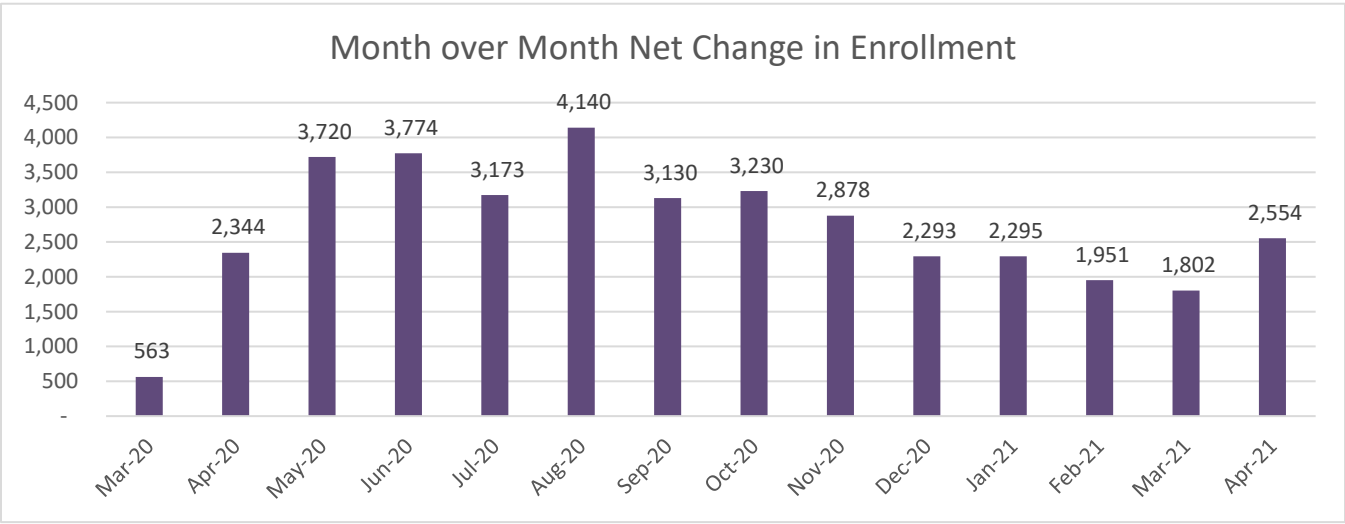






Net Change in Enrollment



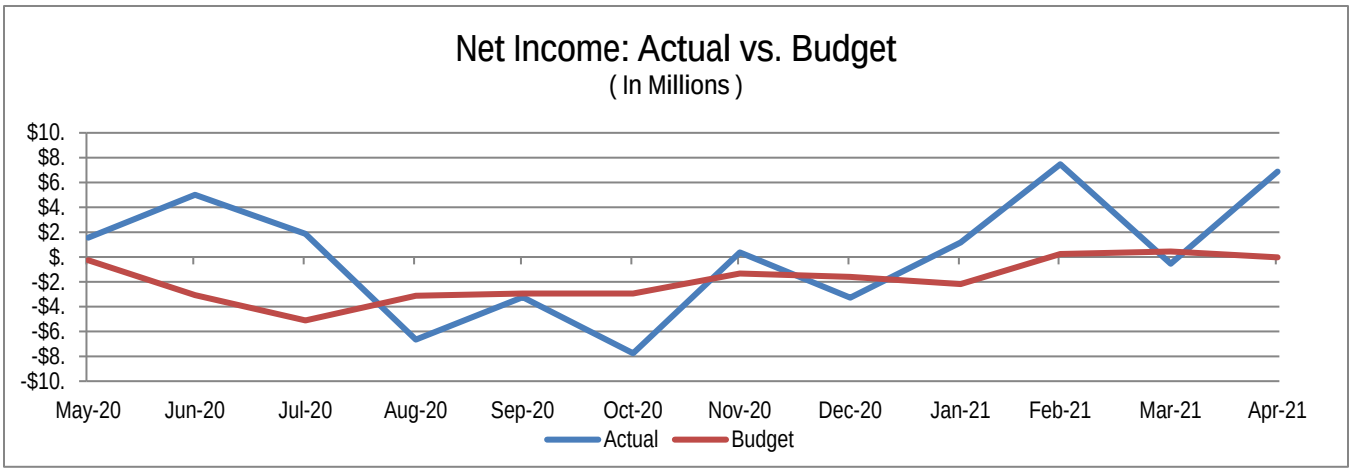


- Total Enrollment continues to increase month over month, however; as discussed last month, the rate of increase has fallen from a high of 4,140 members in August 2020. The change in the rate of increase will impact our future forecast and enrollment projections for the remainder of the fiscal and calendar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

Net Income

- For the month ended April 30, 2021:
  - Actual Net Income: $6.9 million.
  - Budgeted Net Loss: $22,000.

- For the fiscal YTD ended April 30, 2021:
  - Actual Net Loss: $3.7 million.
  - Budgeted Net Loss: $20.2 million.

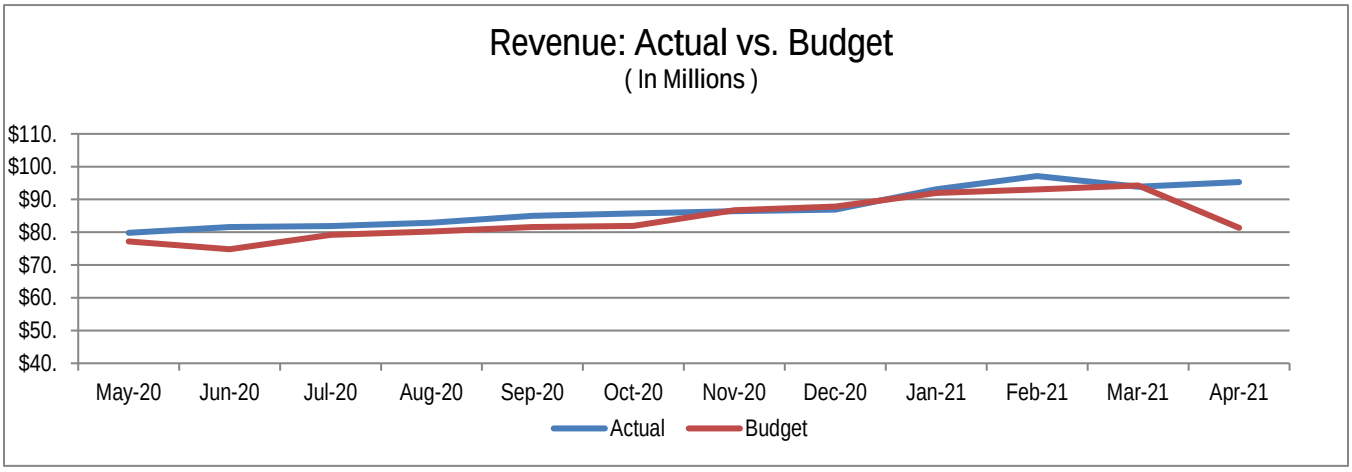


- The favorable variance of $6.9 million in the current month is due to:
  - Favorable $14.0 million higher than anticipated Revenue.
  - Favorable $10.9 million lower than anticipated Administrative Expense.
  - Unfavorable $17.9 million higher than anticipated Medical Expense.
  - Unfavorable $28,000 lower than anticipated Other Revenue.

Revenue

- For the month ended April 30, 2021:
  - Actual Revenue: $95.3 million.
  - Budgeted Revenue: $81.4 million.

- For the fiscal YTD ended April 30, 2021:
  - Actual Revenue: $888.2 million.
  - Budgeted Revenue: $870.5 million.

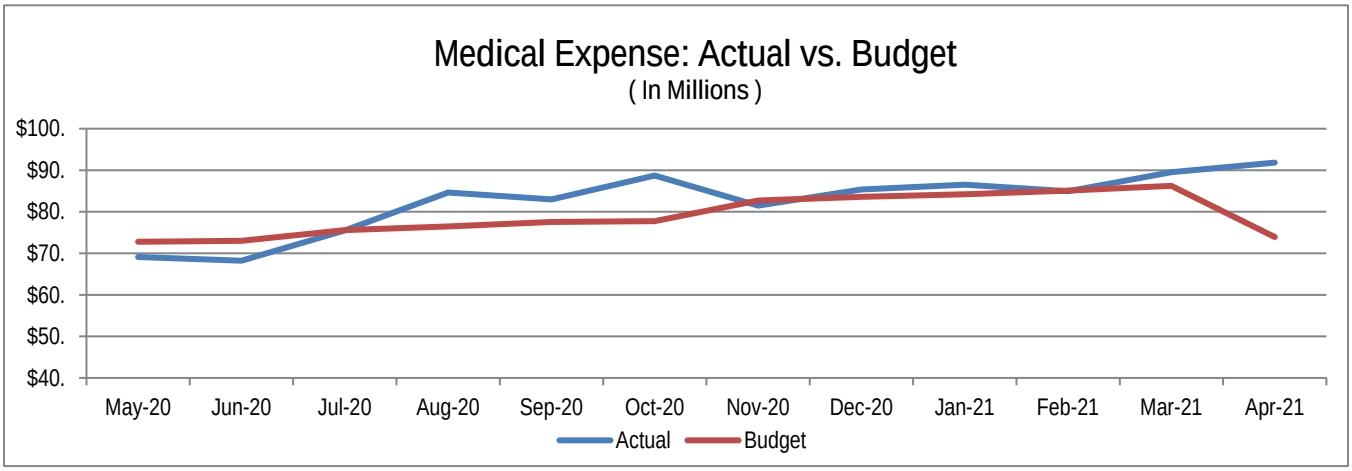


- For the month ended April 30, 2021, the favorable revenue variance of $14.0 million is mainly due to delay of pharmacy carve-out.

Medical Expense

- For the month ended April 30, 2021:
  - Actual Medical Expense: $91.8 million.
  - Budgeted Medical Expense: $73.9 million.

- For the fiscal YTD ended April 30, 2021:
  - Actual Medical Expense: $851.5 million.
  - Budgeted Medical Expense: $827.6 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 April, updates to Fee-For-Service (FFS) decreased the estimate for unpaid Medical Expenses for prior months by $733,000. Year-to-date, the estimate for prior years increased by $2.5 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	$189,531,275	$0	$189,531,275	$191,530,023	$1,998,748	1.0%
Primary Care FFS	42,387,263	2,116	42,389,379	42,861,515	$474,251	1.1%
Specialty Care FFS	43,485,791	149,279	43,635,070	44,108,910	$623,119	1.4%
Outpatient FFS	78,955,868	384,103	79,339,971	77,641,112	($1,314,756)	-1.7%
Ancillary FFS	39,740,769	164,620	39,905,389	36,246,641	($3,494,127)	-9.6%
Pharmacy FFS	147,017,999	15,969	147,033,968	133,806,117	($13,211,883)	-9.9%
ER Services FFS	35,201,652	74,582	35,276,234	35,691,714	$490,062	1.4%
Inpatient Hospital & SNF FFS	253,254,703	1,747,380	255,002,083	243,518,624	($9,736,079)	-4.0%
Other Benefits & Services	18,829,744	0	18,829,744	20,709,560	$1,879,816	9.1%
Net Reinsurance	(267,691)	0	(267,691)	642,435	$910,126	141.7%
Provider Incentive	833,330	0	833,330	833,332	$2	0.0%
	$848,970,704	$2,538,048	$851,508,752	$827,589,983	($21,380,721)	-2.6%

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	$69.32	$0.00	$69.32	$69.57	$0.25	0.4%
Primary Care FFS	15.50	0.00	15.50	15.57	0.07	0.4%
Specialty Care FFS	15.91	0.05	15.96	16.02	0.12	0.7%
Outpatient FFS	28.88	0.14	29.02	28.20	(0.68)	-2.4%
Ancillary FFS	14.54	0.06	14.60	13.17	(1.37)	-10.4%
Pharmacy FFS	53.77	0.01	53.78	48.60	(5.17)	-10.6%
ER Services FFS	12.88	0.03	12.90	12.96	0.09	0.7%
Inpatient Hospital & SNF FFS	92.63	0.64	93.27	88.46	(4.17)	-4.7%
Other Benefits & Services	6.89	0.00	6.89	7.52	0.64	8.4%
Net Reinsurance	(0.10)	0.00	(0.10)	0.23	0.33	142.0%
Provider Incentive	0.30	0.00	0.30	0.30	(0.00)	-0.7%
	$310.52	$0.93	$311.45	$300.62	($9.90)	-3.3%

- Excluding the effect of prior year estimates for IBNP, year-to-date medical expense variance is $21.4 million unfavorable to budget. On a PMPM basis, medical expense is 3.3% 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

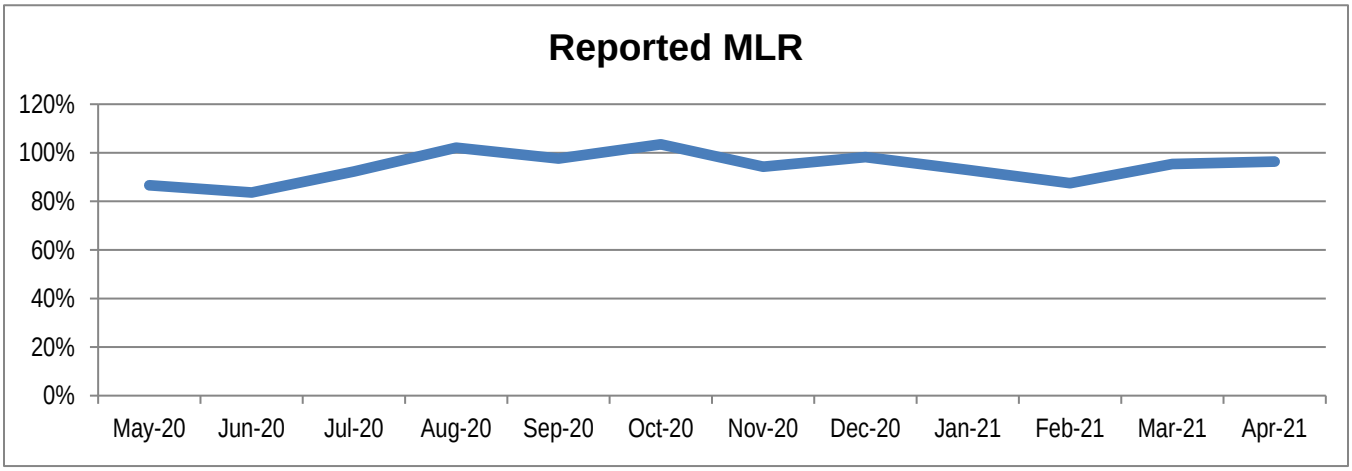
Alliance continues to carry the expense. This contributed to $11.0 million of the variance. Non-PBM expense was unfavorable due to higher utilization offset by lower unit cost trends. Overall, all populations are unfavorable except for the Child and Dual populations which are favorable.

- Inpatient Expense is over budget due to higher than average COVID admissions in December 2020 and January 2021 along with admission increases in March and April 2021. This is partially offset by favorable utilization. The variance is largely driven by the ACA OE and SPD Categories 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, 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 due to Stanford Non-Emergent admissions.
- Ancillary Expense is above budget due to Home Heath, DME, Outpatient Therapy, Hospice, Laboratory and Radiology and Ambulance expense offset by favorability in the other expense categories (Other Medical Professional, CBAS 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 unfavorable utilization offset by favorable unit cost trends.
    - Lab & Radiology: unfavorable due to unfavorable utilization offset by favorable unit cost trends.
    - Dialysis: unfavorable due to unfavorable utilization offset by favorable unit cost trends.
    - Facility-Other: favorable due to favorable utilization offset by unfavorable unit cost trends.
- Capitated Expense is under budget primarily because the transportation capitation PMPM rate is variable and based on trip cost and utilization levels that are year-to-date lower than anticipated when budgeted.
- Emergency Room Expense is lower than planned, due to favorable utilization, offset by unfavorable unit cost across all COAs except for ACA OE and SPD populations (which has 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 ACA OE and 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 96.4% for the month and 95.9% for the fiscal year-to-date.



Administrative Expense

- For the month ended April 30, 2021:
  - Actual Administrative Expense: negative $3.4 million. (Due to reversal of $10.0 million allocated to the Sustainability Fund)
  - Budgeted Administrative Expense: $7.5 million.

- For the fiscal YTD ended April 30, 2021:
  - Actual Administrative Expense: $40.6 million.
  - Budgeted Administrative Expense: $63.6 million.

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

Month					Year-to-Date			
Actual	Budget	Variance $	Variance %		Actual	Budget	Variance $	Variance %
$2,852,123	$3,009,753	$157,630	5.2%	Employee Expense	$26,927,608	$27,788,941	$861,334	3.1%
702,894	336,221	(366,673)	-109.1%	Medical Benefits Admin Expense	5,997,328	6,057,372	60,044	1.0%
2,135,651	1,165,385	(970,266)	-83.3%	Purchased & Professional Services	8,043,557	9,655,449	1,611,892	16.7%
(9,070,777)	2,999,109	12,069,886	402.4%	Other Admin Expense	(366,113)	20,064,469	20,430,582	101.8%
($3,380,109)	$7,510,468	$10,890,577	145.0%	Total Administrative Expense	$40,602,380	$63,566,231	$22,963,852	36.1%

Favorable variances include:
  - Release of the $10 million 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.
  - Savings in Software Expense.

- Administrative expense represented -3.5% 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.

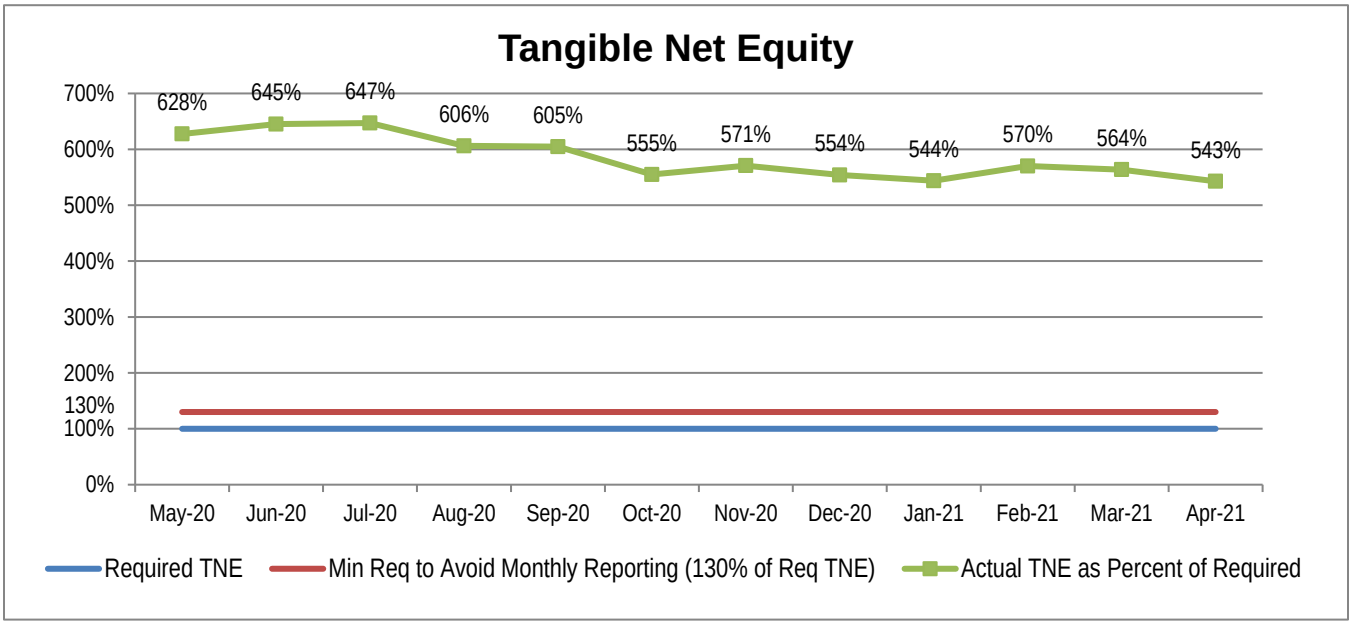
- Fiscal year-to-date interest income from investments is $554,000.

- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims or recalculated interest on previously paid claims is $284,000.

Tangible Net Equity (TNE)

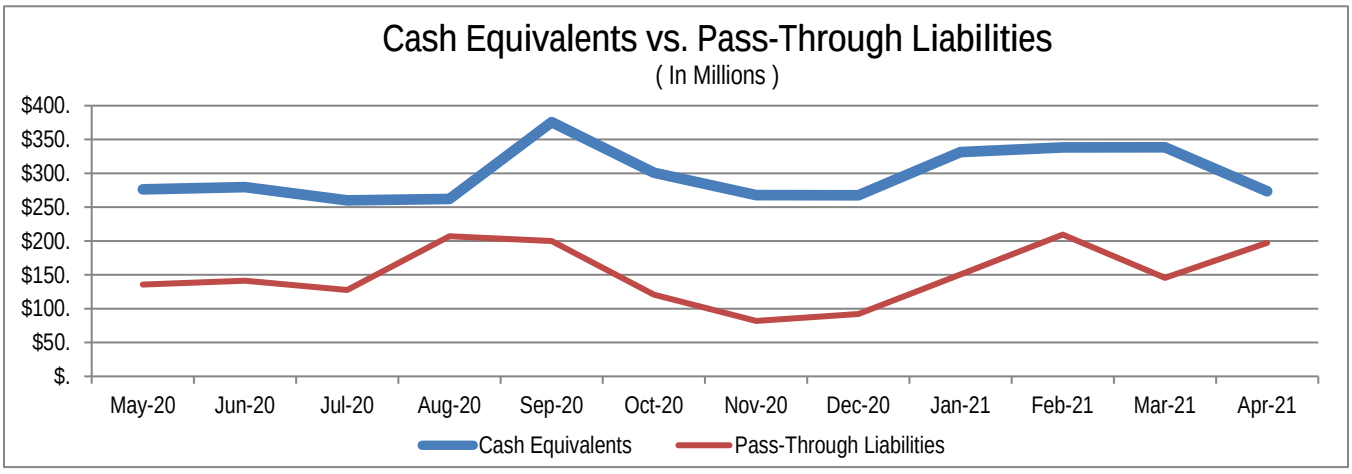
- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to consumers. TNE is a calculation of a company's total tangible assets minus the company's total liabilities. The Alliance exceeds DMHC's required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

  - Required TNE $37.3 million
  - Actual TNE $202.5 million
  - Excess TNE $165.2 million
  - TNE as % of Required TNE 543%



- 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 $273.4 million
  - Pass-Through Liabilities $197.4 million
  - Uncommitted Cash $76.0 million
  - Working Capital $194.7 million
  - Current Ratio 1.58 (regulatory minimum is 1.0)



Capital Investment

- Fiscal year-to-date Capital Assets acquired less Capital Assets retired is negative $1.3 million (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 April 30, 2021

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				MEMBERSHIP				
278,219	281,503	(3,284)	(1.2%)	1 - Medi-Cal	2,674,047	2,692,747	(18,700)	(0.7%)
5,972	6,009	(37)	(0.6%)	2 - Group Care	59,967	60,190	(223)	(0.4%)
284,191	**287,512**	**(3,321)**	**(1.2%)**	**3 - Total Member Months**	**2,734,014**	**2,752,937**	**(18,923)**	**(0.7%)**
				REVENUE				
$95,306,180	**$81,350,563**	**$13,955,616**	**17.2%**	**4 - TOTAL REVENUE**	**$888,164,440**	**$870,539,364**	**$17,625,075**	**2.0%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses:				
19,813,260	19,777,191	(36,069)	(0.2%)	5 - Capitated Medical Expense	189,531,281	191,530,023	1,998,742	1.0%
				Fee for Service Medical Expenses:				
27,089,226	23,571,145	(3,518,081)	(14.9%)	6 - Inpatient Hospital & SNF FFS Expense	255,002,083	243,518,617	(11,483,466)	(4.7%)
4,484,001	4,433,926	(50,075)	(1.1%)	7 - Primary Care Physician FFS Expense	42,389,380	42,861,515	472,135	1.1%
4,687,918	4,516,253	(171,665)	(3.8%)	8 - Specialty Care Physician Expense	43,635,066	44,108,909	473,843	1.1%
4,557,460	3,399,917	(1,157,543)	(34.0%)	9 - Ancillary Medical Expense	39,905,389	36,246,642	(3,658,747)	(10.1%)
8,754,484	7,775,364	(979,120)	(12.6%)	10 - Outpatient Medical Expense	79,339,970	77,641,110	(1,698,860)	(2.2%)
4,058,158	3,580,227	(477,931)	(13.3%)	11 - Emergency Expense	35,276,233	35,691,717	415,484	1.2%
16,369,969	4,479,361	(11,890,608)	(265.5%)	12 - Pharmacy Expense	147,033,970	133,806,119	(13,227,851)	(9.9%)
70,001,216	51,756,193	(18,245,023)	(35.3%)	13 - Total Fee for Service Expense	642,582,091	613,874,629	(28,707,462)	(4.7%)
1,857,346	2,163,587	306,241	14.2%	14 - Other Benefits & Services	18,829,740	20,709,560	1,879,820	9.1%
73,568	134,402	60,834	45.3%	15 - Reinsurance Expense	(267,691)	642,438	910,129	141.7%
83,333	83,333	0	0.0%	16 - Risk Pool Distribution	833,330	833,334	4	0.0%
91,828,723	**73,914,706**	**(17,914,017)**	**(24.2%)**	**17 - TOTAL MEDICAL EXPENSES**	**851,508,752**	**827,589,984**	**(23,918,768)**	**(2.9%)**
3,477,457	**7,435,857**	**(3,958,400)**	**(53.2%)**	**18 - GROSS MARGIN**	**36,655,688**	**42,949,380**	**(6,293,692)**	**(14.7%)**
				ADMINISTRATIVE EXPENSES				
2,852,124	3,009,754	157,630	5.2%	19 - Personnel Expense	26,927,608	27,788,941	861,333	3.1%
702,894	336,221	(366,673)	(109.1%)	20 - Benefits Administration Expense	5,997,329	6,057,372	60,043	1.0%
2,135,650	1,165,385	(970,265)	(83.3%)	21 - Purchased & Professional Services	8,043,556	9,655,448	1,611,892	16.7%
(9,070,777)	2,999,110	12,069,887	402.4%	22 - Other Administrative Expense	(366,112)	20,064,468	20,430,580	101.8%
(3,380,108)	**7,510,471**	**10,890,579**	**145.0%**	**23 -Total Administrative Expense**	**40,602,381**	**63,566,229**	**22,963,848**	**36.1%**
6,857,565	**(74,613)**	**6,932,179**	**9,290.8%**	**24 - NET OPERATING INCOME / (LOSS)**	**(3,946,693)**	**(20,616,849)**	**16,670,156**	**80.9%**
				OTHER INCOME / EXPENSE				
24,556	**52,295**	**(27,739)**	**(53.0%)**	**25 - Total Other Income / (Expense)**	**236,122**	**399,438**	**(163,316)**	**(40.9%)**
$6,882,121	**($22,318)**	**$6,904,440**	**30,936.0%**	**26 - NET INCOME / (LOSS)**	**($3,710,571)**	**($20,217,411)**	**$16,506,840**	**81.6%**
-3.5%	9.2%	12.8%	138.4%	27 - Admin Exp % of Revenue	4.6%	7.3%	2.7%	37.4%

ALAMEDA ALLIANCE FOR HEALTH
SUMMARY BALANCE SHEET 2021
CURRENT MONTH VS. PRIOR MONTH
April 30, 2021

	April	March	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	$25,092,923	$21,101,161	$3,991,762	18.92%
Short-Term Investments	248,322,239	317,516,632	(69,194,393)	-21.79%
Interest Receivable	3,455	7,294	(3,839)	-52.63%
Other Receivables - Net	249,823,481	135,122,876	114,700,604	84.89%
Prepaid Expenses	5,789,580	5,135,147	654,432	12.74%
Prepaid Inventoried Items	3,971	3,971	0	0.00%
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	**532,506,370**	**482,357,804**	**50,148,566**	**10.40%**
OTHER ASSETS:				
Restricted Assets	350,000	350,000	0	0.00%
TOTAL OTHER ASSETS	**350,000**	**350,000**	**0**	**0.00%**
PROPERTY AND EQUIPMENT:				
Land, Building & Improvements	9,751,302	9,751,302	0	0.00%
Furniture And Equipment	15,314,402	15,314,402	0	0.00%
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	16,824,002	(2,000,000)	-11.89%
Fixed Assets at Cost	40,880,761	42,880,761	(2,000,000)	-4.66%
Less: Accumulated Depreciation	(33,489,899)	(33,830,989)	341,091	-1.01%
NET PROPERTY AND EQUIPMENT	**7,390,862**	**9,049,771**	**(1,658,909)**	**-18.33%**
TOTAL ASSETS	**$540,247,232**	**$491,757,575**	**$48,489,657**	**9.86%**
CURRENT LIABILITIES:				
Accounts Payable	$3,259,911	$2,293,126	$966,784	42.16%
Pass-Through Liabilities	197,393,888	145,633,975	51,759,912	35.54%
Claims Payable	20,589,110	29,798,389	(9,209,279)	-30.91%
IBNP Reserves	105,239,725	97,516,068	7,723,657	7.92%
Payroll Liabilities	4,738,360	4,425,233	313,128	7.08%
CalPERS Deferred Inflow	1,627,670	1,627,670	0	0.00%
Risk Sharing	4,483,182	4,399,849	83,333	1.89%
Provider Grants/ New Health Program	451,143	10,481,143	(10,030,000)	-95.70%
TOTAL CURRENT LIABILITIES	**337,782,988**	**296,175,452**	**41,607,536**	**14.05%**
TOTAL LIABILITIES	**337,782,988**	**296,175,452**	**41,607,536**	**14.05%**
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)	(3,710,571)	(10,592,692)	6,882,121	-64.97%
TOTAL NET WORTH	**202,464,244**	**195,582,123**	**6,882,121**	**3.52%**
TOTAL LIABILITIES AND NET WORTH	**$540,247,232**	**$491,757,575**	**$48,489,657**	**9.86%**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 4/30/2021

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received From:				
Capitation Received from State of CA	($22,978,334)	$164,803,371	$414,039,633	$861,694,822
Commercial Premium Revenue	2,292,574	6,757,744	13,473,370	22,498,302
Other Income	467,792	906,603	2,113,745	3,901,821
Investment Income	41,968	114,319	288,709	520,195
Cash Paid To:				
Medical Expenses	(102,437,925)	(273,146,657)	(515,081,071)	(826,403,505)
Vendor & Employee Expenses	3,651,382	(5,983,343)	(20,751,400)	(38,816,342)
Interest Paid	0	0	0	0
Net Cash Provided By (Used In) Operating Activities	(118,962,543)	(106,547,963)	(105,917,014)	23,395,293
Cash Flows from Financing Activities:				
Purchases of Fixed Assets	2,000,000	1,723,174	1,670,128	1,343,196
Net Cash Provided By (Used In) Financing Activities	2,000,000	1,723,174	1,670,128	1,343,196
Cash Flows from Investing Activities:				
Changes in Investments	0	0	0	0
Restricted Cash	51,759,912	46,829,606	76,613,597	(30,998,413)
Net Cash Provided By (Used In) Investing Activities	51,759,912	46,829,606	76,613,597	(30,998,413)
Financial Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Net Change in Cash	**(65,202,631)**	**(57,995,183)**	**(27,633,289)**	**(6,259,924)**
Cash @ Beginning of Period	338,617,793	331,410,346	301,048,452	279,675,085
Subtotal	$273,415,162	$273,415,163	$273,415,163	$273,415,161
Rounding	0	(1)	(1)	1
Cash @ End of Period	**$273,415,162**	**$273,415,162**	**$273,415,162**	**$273,415,162**
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	$6,882,121	$13,807,176	$12,067,277	($3,710,571)
Depreciation	(341,091)	6,948	531,936	1,277,880
Net Change in Operating Assets & Liabilities:				
Premium & Other Receivables	(114,696,765)	(113,816,119)	(124,900,929)	(2,028,931)
Prepaid Expenses	(654,432)	(620,448)	(1,524,353)	(840,242)
Trade Payables	966,784	439,474	641,709	384,929
Claims payable & IBNP	(1,402,288)	3,150,687	16,401,466	35,464,425
Deferred Revenue	0	0	0	0
Accrued Interest	0	0	0	0
Other Liabilities	(9,716,872)	(9,515,682)	(9,134,120)	(7,152,196)
Subtotal	(118,962,543)	(106,547,964)	(105,917,014)	23,395,294
Rounding	0	1	0	(1)
Cash Flows from Operating Activities	**($118,962,543)**	**($106,547,963)**	**($105,917,014)**	**$23,395,293**
Rounding Difference	0	1	0	(1)

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 4/30/2021

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$2,292,574	$6,757,744	$13,473,370	$22,498,302
Total	2,292,574	6,757,744	13,473,370	22,498,302
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	92,545,356	278,647,266	537,140,064	861,762,403
Allowance for Doubtful Accounts	0	0	0	0
Deferred Premium Revenue	0	0	0	0
Premium Receivable	(115,523,690)	(113,843,895)	(123,100,431)	(67,581)
Total	(22,978,334)	164,803,371	414,039,633	861,694,822
Investment & Other Income Cash Flows				
Other Revenue (Grants)	467,792	906,603	2,113,745	3,901,821
Interest Income	38,129	112,666	290,772	522,367
Interest Receivable	3,839	1,653	(2,063)	(2,172)
Total	509,760	1,020,922	2,402,454	4,422,016
Medical & Hospital Cash Flows				
Total Medical Expenses	(91,828,723)	(266,293,467)	(519,654,102)	(851,508,752)
Other Receivable	823,086	26,123	(1,798,435)	(1,959,178)
Claims Payable	(9,209,279)	5,560,269	2,677,662	5,984,510
IBNP Payable	7,723,657	(2,659,582)	13,223,806	31,148,350
Risk Share Payable	83,333	249,999	499,998	(1,668,435)
Health Program	(10,030,000)	(10,030,000)	(10,030,000)	(8,400,000)
Other Liabilities	1	1	0	0
Total	(102,437,925)	(273,146,657)	(515,081,071)	(826,403,505)
Administrative Cash Flows				
Total Administrative Expenses	3,366,993	(6,323,635)	(21,296,572)	(40,886,713)
Prepaid Expenses	(654,432)	(620,448)	(1,524,353)	(840,242)
CalPERS Pension Asset	0	0	0	0
CalPERS Deferred Outflow	0	0	0	0
Trade Accounts Payable	966,784	439,474	641,709	384,929
Other Accrued Liabilities	0	0	0	0
Payroll Liabilities	313,128	514,318	895,880	1,247,804
Depreciation Expense	(341,091)	6,948	531,936	1,277,880
Total	3,651,382	(5,983,343)	(20,751,400)	(38,816,342)
Interest Paid				
Debt Interest Expense	0	0	0	0
Total Cash Flows from Operating Activities	**(118,962,543)**	**(106,547,963)**	**(105,917,014)**	**23,395,293**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 4/30/2021

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Restricted Cash & Other Asset Cash Flows				
Provider Pass-Thru-Liabilities	51,759,912	46,829,606	76,613,597	(30,998,413)
Restricted Cash	0	0	0	0
	51,759,912	46,829,606	76,613,597	(30,998,413)
Fixed Asset Cash Flows				
Depreciation expense	(341,091)	6,948	531,936	1,277,880
Fixed Asset Acquisitions	2,000,000	1,723,174	1,670,128	1,343,196
Change in A/D	341,091	(6,948)	(531,936)	(1,277,880)
	2,000,000	1,723,174	1,670,128	1,343,196
Total Cash Flows from Investing Activities	**53,759,912**	**48,552,780**	**78,283,725**	**(29,655,217)**
Financing Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Total Cash Flows	**(65,202,631)**	**(57,995,183)**	**(27,633,289)**	**(6,259,924)**
Rounding	0	(1)	(1)	1
Cash @ Beginning of Period	338,617,793	331,410,346	301,048,452	279,675,085
Cash @ End of Period	**$273,415,162**	**$273,415,162**	**$273,415,162**	**$273,415,162**
Difference (rounding)	0	0	0	0

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 4/30/2021

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$6,882,121	$13,807,176	$12,067,277	($3,710,571)
Add back: Depreciation	(341,091)	6,948	531,936	1,277,880
Receivables				
Premiums Receivable	(115,523,690)	(113,843,895)	(123,100,431)	(67,581)
First Care Receivable	0	0	0	0
Family Care Receivable	0	0	0	0
Healthy Kids Receivable	0	0	0	0
Interest Receivable	3,839	1,653	(2,063)	(2,172)
Other Receivable	823,086	26,123	(1,798,435)	(1,959,178)
FQHC Receivable	0	0	0	0
Allowance for Doubtful Accounts	0	0	0	0
Total	(114,696,765)	(113,816,119)	(124,900,929)	(2,028,931)
Prepaid Expenses	(654,432)	(620,448)	(1,524,353)	(840,242)
Trade Payables	966,784	439,474	641,709	384,929
Claims Payable, IBNR & Risk Share				
IBNP	7,723,657	(2,659,582)	13,223,806	31,148,350
Claims Payable	(9,209,279)	5,560,269	2,677,662	5,984,510
Risk Share Payable	83,333	249,999	499,998	(1,668,435)
Other Liabilities	1	1	0	0
Total	(1,402,288)	3,150,687	16,401,466	35,464,425
Unearned Revenue				
Total	0	0	0	0
Other Liabilities				
Accrued Expenses	0	0	0	0
Payroll Liabilities	313,128	514,318	895,880	1,247,804
Health Program	(10,030,000)	(10,030,000)	(10,030,000)	(8,400,000)
Accrued Sub Debt Interest	0	0	0	0
Total Change in Other Liabilities	(9,716,872)	(9,515,682)	(9,134,120)	(7,152,196)
Cash Flows from Operating Activities	**($118,962,543)**	**($106,547,964)**	**($105,917,014)**	**$23,395,294**
Difference (rounding)	0	(1)	0	1

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF APRIL 2021

	Child	Adults*	Medi-Cal SPD*	ACA OE	Duals	Medi-Cal Total	Group Care	Grand Total
Enrollment	96,233	40,052	26,270	95,916	19,748	278,219	5,972	284,191
Net Revenue	$12,368,783	$13,081,558	$27,978,365	$36,104,760	$3,479,983	$93,013,449	$2,292,731	$95,306,180
Medical Expense	$10,391,850	$13,092,848	$28,836,469	$34,882,633	$2,387,890	$89,591,690	$2,237,033	$91,828,723
Gross Margin	$1,976,933	($11,289)	($858,105)	$1,222,127	$1,092,094	$3,421,760	$55,697	$3,477,457
Administrative Expense	($132,623)	($472,292)	($1,237,127)	($1,295,231)	($131,200)	($3,268,473)	($111,636)	($3,380,108)
Operating Income / (Expense)	$2,109,555	$461,003	$379,022	$2,517,358	$1,223,294	$6,690,232	$167,333	$6,857,565
Other Income / (Expense)	$1,678	$2,197	$9,015	$11,258	($151)	$23,997	$559	$24,556
Net Income / (Loss)	$2,111,233	$463,200	$388,037	$2,528,616	$1,223,143	$6,714,229	$167,892	$6,882,121
Revenue PMPM	$128.53	$326.61	$1,065.03	$376.42	$176.22	$334.32	$383.91	$335.36
Medical Expense PMPM	$107.99	$326.90	$1,097.70	$363.68	$120.92	$322.02	$374.59	$323.12
Gross Margin PMPM	$20.54	($0.28)	($32.66)	$12.74	$55.30	$12.30	$9.33	$12.24
Administrative Expense PMPM	($1.38)	($11.79)	($47.09)	($13.50)	($6.64)	($11.75)	($18.69)	($11.89)
Operating Income / (Expense) PMPM	$21.92	$11.51	$14.43	$26.25	$61.95	$24.05	$28.02	$24.13
Other Income / (Expense) PMPM	$0.02	$0.05	$0.34	$0.12	($0.01)	$0.09	$0.09	$0.09
Net Income / (Loss) PMPM	$21.94	$11.56	$14.77	$26.36	$61.94	$24.13	$28.11	$24.22
Medical Loss Ratio	84.0%	100.1%	103.1%	96.6%	68.6%	96.3%	97.6%	96.4%
Gross Margin Ratio	16.0%	-0.1%	-3.1%	3.4%	31.4%	3.7%	2.4%	3.6%
Administrative Expense Ratio	-1.1%	-3.6%	-4.4%	-3.6%	-3.8%	-3.5%	-4.9%	-3.5%
Net Income Ratio	17.1%	3.5%	1.4%	7.0%	35.1%	7.2%	7.3%	7.2%

*** 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 - APRIL 2021

	Child	Adult*	Medi-Cal SPD*	ACA OE	Duals	Medi-Cal Total	Group Care	Grand Total
Member Months	943,749	377,774	262,371	899,821	190,332	2,674,047	59,967	2,734,014
Net Revenue	$115,596,245	$119,166,669	$266,709,114	$331,648,953	$32,544,928	$865,665,908	$22,498,532	$888,164,440
Medical Expense	$91,665,562	$117,359,708	$273,606,281	$318,931,245	$27,150,411	$828,713,208	$22,795,544	$851,508,752
Gross Margin	$23,930,682	$1,806,961	($6,897,168)	$12,717,708	$5,394,517	$36,952,700	($297,012)	$36,655,688
Administrative Expense	$3,262,694	$5,412,605	$14,026,722	$15,253,687	$1,295,328	$39,251,036	$1,351,345	$40,602,381
Operating Income / (Expense)	$20,667,989	($3,605,644)	($20,923,890)	($2,535,979)	$4,099,189	($2,298,336)	($1,648,357)	($3,946,693)
Other Income / (Expense)	$27,670	$38,940	$84,996	$91,326	($9,211)	$233,721	$2,401	$236,122
Net Income / (Loss)	$20,695,659	($3,566,705)	($20,838,894)	($2,444,653)	$4,089,978	($2,064,615)	($1,645,956)	($3,710,571)
Revenue PMPM	$122.49	$315.44	$1,016.53	$368.57	$170.99	$323.73	$375.18	$324.86
Medical Expense PMPM	$97.13	$310.66	$1,042.82	$354.44	$142.65	$309.91	$380.13	$311.45
Gross Margin PMPM	$25.36	$4.78	($26.29)	$14.13	$28.34	$13.82	($4.95)	$13.41
Administrative Expense PMPM	$3.46	$14.33	$53.46	$16.95	$6.81	$14.68	$22.53	$14.85
Operating Income / (Expense) PMPM	$21.90	($9.54)	($79.75)	($2.82)	$21.54	($0.86)	($27.49)	($1.44)
Other Income / (Expense) PMPM	$0.03	$0.10	$0.32	$0.10	($0.05)	$0.09	$0.04	$0.09
Net Income / (Loss) PMPM	$21.93	($9.44)	($79.43)	($2.72)	$21.49	($0.77)	($27.45)	($1.36)
Medical Loss Ratio	79.3%	98.5%	102.6%	96.2%	83.4%	95.7%	101.3%	95.9%
Gross Margin Ratio	20.7%	1.5%	-2.6%	3.8%	16.6%	4.3%	-1.3%	4.1%
Administrative Expense Ratio	2.8%	4.5%	5.3%	4.6%	4.0%	4.5%	6.0%	4.6%
Net Income Ratio	17.9%	-3.0%	-7.8%	-0.7%	12.6%	-0.2%	-7.3%	-0.4%

* 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 April 30, 2021

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSE SUMMARY				
$2,852,124	$3,009,754	$157,630	5.2%	Personnel Expenses	$26,927,608	$27,788,941	$861,333	3.1%
702,894	336,221	(366,673)	(109.1%)	Benefits Administration Expense	5,997,329	6,057,372	60,043	1.0%
2,135,650	1,165,385	(970,265)	(83.3%)	Purchased & Professional Services	8,043,556	9,655,448	1,611,892	16.7%
317,602	398,844	81,243	20.4%	Occupancy	3,544,532	3,867,003	322,471	8.3%
(9,922,196)	1,922,504	11,844,700	616.1%	Printing Postage & Promotion	(8,476,480)	10,226,617	18,703,096	182.9%
505,722	652,236	146,514	22.5%	Licenses Insurance & Fees	4,469,895	5,808,080	1,338,185	23.0%
28,096	25,526	(2,570)	(10.1%)	Supplies & Other Expenses	95,941	162,768	66,827	41.1%
(6,232,233)	4,500,716	10,732,949	238.5%	Total Other Administrative Expense	13,674,773	35,777,288	22,102,515	61.8%
($3,380,108)	**$7,510,471**	**$10,890,579**	**145.0%**	**Total Administrative Expenses**	**$40,602,381**	**$63,566,229**	**$22,963,848**	**36.1%**

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ADMIN YTD 2021
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ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED April 30, 2021

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
$1,899,851	$1,920,003	$20,152	1.0%	Salaries & Wages	$18,093,185	$17,906,953	($186,232)	(1.0%)
184,977	211,634	26,657	12.6%	Paid Time Off	1,734,706	1,899,493	164,787	8.7%
0	2,967	2,967	100.0%	Incentives	9,469	23,215	13,746	59.2%
0	0	0	0.0%	Severance Pay	7,605	7,605	0	0.0%
30,009	31,831	1,823	5.7%	Payroll Taxes	377,757	451,527	73,770	16.3%
25,907	7,080	(18,827)	(265.9%)	Overtime	206,383	148,223	(58,159)	(39.2%)
160,579	162,878	2,299	1.4%	CalPERS ER Match	1,427,643	1,466,016	38,373	2.6%
0	0	0	0.0%	Sick Leave Pay	4,097	4,097	0	0.0%
453,676	579,309	125,633	21.7%	Employee Benefits	4,383,725	4,881,000	497,275	10.2%
281	0	(281)	0.0%	Personal Floating Holiday	88,950	95,444	6,493	6.8%
400	15,285	14,886	97.4%	Employee Relations	34,560	136,513	101,953	74.7%
7,230	7,800	570	7.3%	Work from Home Stipend	41,490	44,640	3,150	7.1%
0	3,397	3,397	100.0%	Transportation Reimbursement	876	12,550	11,673	93.0%
16	9,329	9,313	99.8%	Travel & Lodging	(548)	55,772	56,321	101.0%
56,328	6,032	(50,296)	(833.8%)	Temporary Help Services	257,867	147,938	(109,929)	(74.3%)
26,510	43,170	16,660	38.6%	Staff Development/Training	113,600	303,029	189,429	62.5%
6,359	9,038	2,678	29.6%	Staff Recruitment/Advertising	146,243	204,926	58,683	28.6%
2,852,124	**3,009,754**	**157,630**	**5.2%**	**Total Employee Expenses**	**26,927,608**	**27,788,941**	**861,333**	**3.1%**
				Benefit Administration Expense				
440,707	86,393	(354,314)	(410.1%)	RX Administration Expense	3,507,539	3,544,966	37,426	1.1%
245,140	231,296	(13,844)	(6.0%)	Behavioral Hlth Administration Fees	2,324,982	2,338,386	13,404	0.6%
17,047	18,532	1,486	8.0%	Telemedicine Admin Fees	164,807	174,020	9,213	5.3%
702,894	**336,221**	**(366,673)**	**(109.1%)**	**Total Employee Expenses**	**5,997,329**	**6,057,372**	**60,043**	**1.0%**
				Purchased & Professional Services				
227,620	389,665	162,045	41.6%	Consulting Services	1,410,834	2,605,558	1,194,723	45.9%
314,911	517,016	202,105	39.1%	Computer Support Services	2,952,883	4,548,724	1,595,841	35.1%
8,750	8,750	0	0.0%	Professional Fees-Accounting	111,755	99,687	(12,068)	(12.1%)
0	100	100	100.0%	Professional Fees-Medical	0	600	600	100.0%
3,685	127,243	123,557	97.1%	Other Purchased Services	188,077	401,095	213,018	53.1%
5,255	10,284	5,030	48.9%	Maint.& Repair-Office Equipment	63,884	99,886	36,002	36.0%
26,059	8,050	(18,009)	(223.7%)	HMS Recovery Fees	315,652	209,121	(106,531)	(50.9%)
1,500,000	4,242	(1,495,758)	(35,263.4%)	MIS Software (Non-Capital)	1,500,000	305,450	(1,194,550)	(391.1%)
1,223	7,507	6,285	83.7%	Hardware (Non-Capital)	76,901	102,141	25,241	24.7%
9,573	14,195	4,622	32.6%	Provider Relations-Credentialing	121,857	122,246	389	0.3%
38,575	78,333	39,758	50.8%	Legal Fees	1,301,714	1,160,941	(140,773)	(12.1%)
2,135,650	**1,165,385**	**(970,265)**	**(83.3%)**	**Total Purchased & Professional Services**	**8,043,556**	**9,655,448**	**1,611,892**	**16.7%**
				Occupancy				
149,351	190,407	41,056	21.6%	Depreciation	1,534,678	1,720,254	185,576	10.8%
9,558	26,107	16,549	63.4%	Amortization	244,525	261,073	16,547	6.3%
67,855	67,855	0	0.0%	Building Lease	678,551	678,551	0	0.0%
375	2,002	1,627	81.3%	Leased and Rented Office Equipment	20,689	25,466	4,777	18.8%
13,058	11,427	(1,631)	(14.3%)	Utilities	117,987	127,241	9,253	7.3%
71,350	83,300	11,950	14.3%	Telephone	801,092	859,586	58,494	6.8%

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ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED April 30, 2021

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
$6,054	$17,746	$11,692	65.9%	Building Maintenance	$147,010	$194,833	$47,823	24.5%
317,602	**398,844**	**81,243**	**20.4%**	**Total Occupancy**	**3,544,532**	**3,867,003**	**322,471**	**8.3%**
				Printing Postage & Promotion				
29,719	79,203	49,484	62.5%	Postage	296,952	469,811	172,859	36.8%
3,060	3,250	190	5.8%	Design & Layout	55,575	32,850	(22,725)	(69.2%)
40,248	120,485	80,237	66.6%	Printing Services	524,121	601,137	77,016	12.8%
3,012	4,470	1,458	32.6%	Mailing Services	27,801	39,884	12,083	30.3%
4,559	2,482	(2,076)	(83.6%)	Courier/Delivery Service	27,612	24,320	(3,292)	(13.5%)
8	480	472	98.3%	Pre-Printed Materials and Publications	642	4,763	4,121	86.5%
5,344	0	(5,344)	0.0%	Promotional Products	32,713	31,971	(742)	(2.3%)
(10,018,766)	1,705,833	11,724,599	687.3%	Community Relations	(9,512,285)	8,949,905	18,462,189	206.3%
10,619	6,300	(4,319)	(68.6%)	Translation - Non-Clinical	70,388	71,975	1,587	2.2%
(9,922,196)	**1,922,504**	**11,844,700**	**616.1%**	**Total Printing Postage & Promotion**	**(8,476,480)**	**10,226,617**	**18,703,096**	**182.9%**
				Licenses Insurance & Fees				
0	0	0	0.0%	Regulatory Penalties	0	100,000	100,000	100.0%
21,607	20,700	(907)	(4.4%)	Bank Fees	200,563	193,267	(7,297)	(3.8%)
61,174	53,715	(7,458)	(13.9%)	Insurance	537,136	587,902	50,766	8.6%
349,902	491,911	142,009	28.9%	Licenses, Permits and Fees	3,088,895	4,228,914	1,140,019	27.0%
73,040	85,910	12,870	15.0%	Subscriptions & Dues	643,301	697,998	54,697	7.8%
505,722	**652,236**	**146,514**	**22.5%**	**Total Licenses Insurance & Postage**	**4,469,895**	**5,808,080**	**1,338,185**	**23.0%**
				Supplies & Other Expenses				
3,026	4,787	1,761	36.8%	Office and Other Supplies	19,608	34,690	15,083	43.5%
17,126	2,695	(14,431)	(535.5%)	Ergonomic Supplies	19,357	17,937	(1,421)	(7.9%)
132	11,994	11,863	98.9%	Commissary-Food & Beverage	5,292	45,352	40,060	88.3%
4,850	4,850	0	0.0%	Member Incentive Expense	33,950	48,500	14,550	30.0%
0	0	0	0.0%	Covid-19 IT Expenses	3,840	3,840	0	0.0%
2,962	1,200	(1,762)	(146.9%)	Covid-19 Non IT Expenses	13,894	12,449	(1,445)	(11.6%)
28,096	**25,526**	**(2,570)**	**(10.1%)**	**Total Supplies & Other Expense**	**95,941**	**162,768**	**66,827**	**41.1%**
($3,380,108)	**$7,510,471**	**$10,890,579**	**145.0%**	**TOTAL ADMINISTRATIVE EXPENSE**	**$40,602,381**	**$63,566,229**	**$22,963,848**	**36.1%**

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ALAMEDA ALLIANCE FOR HEALTH
CAPITAL SPENDING INCLUDING CONSTRUCTION-IN-PROCESS
ACTUAL VS. BUDGET
FOR THE FISCAL YEAR-TO-DATE ENDED APRIL 30, 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		**$ 24,232**	$ 250,000	$ 225,768
	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	$ -		**$ -**	$ 250,000	$ 250,000
	Carryover from FY20 / unplanned	IT-FY21-19	$ 163,751		**$ 163,751**	$ -	$ (163,751)
Hardware Subtotal			**$ 522,712**	**$ -**	**$ 522,712**	**$ 1,385,000**	**$ 862,288**
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			**$ 28,232**	**$ (2,000,000)**	**$ (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, shelvings (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			**$ 656,805**	**$ (2,000,000)**	**$ (1,343,196)**	**$ 2,375,000**	**$ 3,718,195**

7. Reconciliation to Balance Sheet:

Fixed Assets @ Cost -4/30/21	**$ 40,880,761**
Fixed Assets @ Cost - 6/30/20	**$ 42,223,957**
Fixed Assets Acquired YTD	**$ (1,343,196)**

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
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
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)
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
Subordinated Debt & Interest	$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**
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
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**
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
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
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**

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
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)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$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**
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**

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			943,749
Adults*	34,909	35,689	36,302	37,072	37,640	38,152	38,994	39,315	39,649	40,052			377,774
SPD*	26,044	26,094	26,178	26,250	26,314	26,339	26,354	26,294	26,234	26,270			262,371
ACA OE	82,989	85,081	86,713	88,258	89,752	91,050	92,257	93,332	94,473	95,916			899,821
Duals	18,297	18,495	18,606	18,847	18,988	19,125	19,215	19,415	19,596	19,748			190,332
Medi-Cal Program	253,809	258,051	261,177	264,409	267,314	269,635	271,923	273,866	275,644	278,219			2,674,047
Group Care Program	6,109	6,007	6,011	6,009	5,982	5,954	5,961	5,969	5,993	5,972			59,967
Total	**259,918**	**264,058**	**267,188**	**270,418**	**273,296**	**275,589**	**277,884**	**279,835**	**281,637**	**284,191**			**2,734,014**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	825	1,122	686	604	638	349	134	407	182	541			5,488
Adults*	822	780	613	770	568	512	842	321	334	403			5,965
SPD*	(67)	50	84	72	64	25	15	(60)	(60)	36			159
ACA OE	1,693	2,092	1,632	1,545	1,494	1,298	1,207	1,075	1,141	1,443			14,620
Duals	228	198	111	241	141	137	90	200	181	152			1,679
Medi-Cal Program	3,501	4,242	3,126	3,232	2,905	2,321	2,288	1,943	1,778	2,575			27,911
Group Care Program	(328)	(102)	4	(2)	(27)	(28)	7	8	24	(21)			(465)
Total	**3,173**	**4,140**	**3,130**	**3,230**	**2,878**	**2,293**	**2,295**	**1,951**	**1,802**	**2,554**			**27,446**
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%			35.3%
Adults % of Medi-Cal	13.8%	13.8%	13.9%	14.0%	14.1%	14.1%	14.3%	14.4%	14.4%	14.4%			14.1%
SPD % of Medi-Cal	10.3%	10.1%	10.0%	9.9%	9.8%	9.8%	9.7%	9.6%	9.5%	9.4%			9.8%
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%			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%
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%			97.8%
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%			2.2%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**			**100.0%**

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

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

	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			518,801
Alameda Health System	50,193	51,312	52,596	53,607	54,283	55,240	55,847	56,285	56,855	57,087			543,305
	100,392	102,369	104,123	105,004	106,356	107,177	108,183	108,736	109,379	110,387			1,062,106
Delegated:													
CFMG	30,742	31,072	30,803	31,173	31,336	31,529	31,714	31,907	31,939	31,935			314,150
CHCN	94,144	95,194	96,219	97,528	98,274	98,920	99,414	100,003	100,522	101,289			981,507
Kaiser	34,640	35,423	36,043	36,713	37,330	37,963	38,573	39,189	39,797	40,580			376,251
Delegated Subtotal	159,526	161,689	163,065	165,414	166,940	168,412	169,701	171,099	172,258	173,804			1,671,908
Total	**259,918**	**264,058**	**267,188**	**270,418**	**273,296**	**275,589**	**277,884**	**279,835**	**281,637**	**284,191**			**2,734,014**
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			11,397
Delegated:													
CFMG	317	330	(269)	370	163	193	185	193	32	(4)			1,510
CHCN	752	1,050	1,025	1,309	746	646	494	589	519	767			7,897
Kaiser	702	783	620	670	617	633	610	616	608	783			6,642
Delegated Subtotal	1,771	2,163	1,376	2,349	1,526	1,472	1,289	1,398	1,159	1,546			16,049
Total	**3,173**	**4,140**	**3,130**	**3,230**	**2,878**	**2,293**	**2,295**	**1,951**	**1,802**	**2,554**			**27,446**
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%
Delegated:													
CFMG	11.8%	11.8%	11.5%	11.5%	11.5%	11.4%	11.4%	11.4%	11.3%	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%			35.9%
Kaiser	13.3%	13.4%	13.5%	13.6%	13.7%	13.8%	13.9%	14.0%	14.1%	14.3%			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%
Total	**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)			(9,670)
Adults*	0	0	0	0	(97)	(249)	(157)	(585)	(1,001)	(557)			(2,645)
SPD*	0	0	0	0	25	12	(5)	(96)	(188)	(125)			(377)
ACA OE	0	0	0	0	(101)	(399)	(932)	(1,598)	(2,197)	(658)			(5,885)
Duals	0	0	0	0	14	24	(81)	(75)	(89)	83			(123)
Medi-Cal Program	0	0	0	0	(495)	(1,574)	(2,812)	(4,394)	(6,141)	(3,284)			(18,701)
Group Care Program	0	0	0	0	(27)	(55)	(48)	(40)	(16)	(37)			(223)
Total	**0**	**0**	**0**	**0**	**(522)**	**(1,629)**	**(2,860)**	**(4,434)**	**(6,157)**	**(3,321)**			**(18,924)**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted	0	0	0	0	(28)	(586)	(1,072)	(2,010)	(2,858)	(1,742)			(8,295)
Delegated:													
CFMG	0	0	0	0	(162)	(293)	(385)	(469)	(713)	(685)			(2,707)
CHCN	0	0	0	0	(470)	(1,039)	(1,812)	(2,490)	(3,237)	(2,369)			(11,417)
Kaiser	0	0	0	0	137	290	409	534	652	1,474			3,495
Delegated Subtotal	0	0	0	0	(495)	(1,043)	(1,788)	(2,424)	(3,299)	(1,580)			(10,628)
Total	**0**	**0**	**0**	**0**	**(522)**	**(1,629)**	**(2,860)**	**(4,434)**	**(6,157)**	**(3,321)**			**(18,923)**

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 April 30, 2021

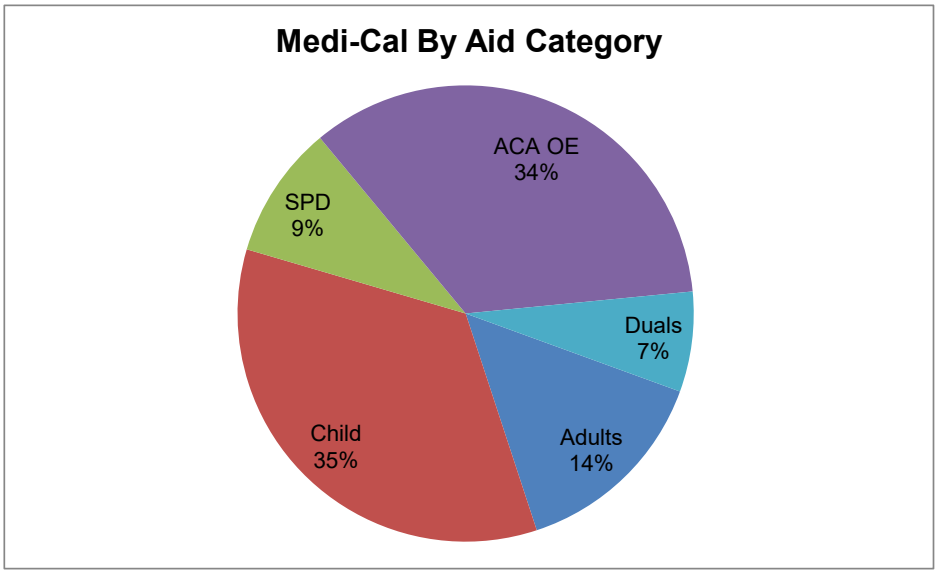
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES:				
$1,842,056	$1,841,890	($166)	0.0%	PCP-Capitation	$17,933,803	$17,937,918	$4,115	0.0%
2,865,453	3,076,245	210,792	6.9%	PCP-Capitation - FQHC	27,945,956	28,854,962	909,006	3.2%
277,805	276,458	(1,347)	(0.5%)	Specialty-Capitation	2,732,587	2,731,260	(1,327)	0.0%
2,959,547	3,167,921	208,374	6.6%	Specialty-Capitation FQHC	28,697,809	29,600,925	903,116	3.1%
322,180	328,612	6,432	2.0%	Laboratory-Capitation	3,135,483	3,165,231	29,748	0.9%
671,205	920,040	248,835	27.0%	Transportation (Ambulance)-Cap	5,320,080	6,912,898	1,592,818	23.0%
209,871	273,951	64,080	23.4%	Vision Cap	2,036,204	2,406,712	370,508	15.4%
80,934	80,435	(499)	(0.6%)	CFMG Capitation	795,628	794,684	(944)	(0.1%)
149,555	160,316	10,761	6.7%	Anc IPA Admin Capitation FQHC	1,454,329	1,500,849	46,520	3.1%
8,630,425	7,965,678	(664,747)	(8.3%)	Kaiser Capitation	83,896,896	81,901,947	(1,994,949)	(2.4%)
954,350	710,599	(243,751)	(34.3%)	BHT Supplemental Expense	7,177,552	6,873,773	(303,779)	(4.4%)
8,562	0	(8,562)	0.0%	Hep-C Supplemental Expense	67,777	81,116	13,339	16.4%
305,628	401,227	95,599	23.8%	Maternity Supplemental Expense	3,049,299	3,325,694	276,395	8.3%
535,688	573,819	38,131	6.6%	DME - Cap	5,287,879	5,442,054	154,175	2.8%
19,813,260	**19,777,191**	**(36,069)**	**(0.2%)**	**5-TOTAL CAPITATED EXPENSES**	**189,531,281**	**191,530,023**	**1,998,742**	**1.0%**
				FEE FOR SERVICE MEDICAL EXPENSES:				
4,287,236	0	(4,287,236)	0.0%	IBNP-Inpatient Services	22,270,948	0	(22,270,948)	0.0%
128,619	0	(128,619)	0.0%	IBNP-Settlement (IP)	668,130	0	(668,130)	0.0%
342,978	0	(342,978)	0.0%	IBNP-Claims Fluctuation (IP)	1,781,680	0	(1,781,680)	0.0%
19,892,550	22,384,642	2,492,092	11.1%	Inpatient Hospitalization-FFS	200,961,899	232,814,666	31,852,767	13.7%
971,008	0	(971,008)	0.0%	IP OB - Mom & NB	11,299,708	0	(11,299,708)	0.0%
81,637	0	(81,637)	0.0%	IP Behavioral Health	1,393,272	0	(1,393,272)	0.0%
1,013,805	1,186,503	172,698	14.6%	IP - Long Term Care	9,754,114	10,703,951	949,837	8.9%
371,394	0	(371,394)	0.0%	IP - Facility Rehab FFS	6,872,331	0	(6,872,331)	0.0%
27,089,226	**23,571,145**	**(3,518,081)**	**(14.9%)**	**6-Inpatient Hospital & SNF FFS Expense**	**255,002,083**	**243,518,617**	**(11,483,466)**	**(4.7%)**
181,616	0	(181,616)	0.0%	IBNP-PCP	273,774	0	(273,774)	0.0%
5,449	0	(5,449)	0.0%	IBNP-Settlement (PCP)	8,213	0	(8,213)	0.0%
14,531	0	(14,531)	0.0%	IBNP-Claims Fluctuation (PCP)	21,903	0	(21,903)	0.0%
672	0	(672)	0.0%	Telemedicine FFS	9,618	0	(9,618)	0.0%
1,138,688	1,306,798	168,110	12.9%	Primary Care Non-Contracted FF	11,834,271	24,143,066	12,308,795	51.0%
41,021	80,062	39,041	48.8%	PCP FQHC FFS	569,550	788,196	218,646	27.7%
1,752,482	3,047,066	1,294,584	42.5%	Prop 56 Direct Payment Expenses	17,144,133	17,930,253	786,120	4.4%
76,079	0	(76,079)	0.0%	Prop 56-Trauma Expense	625,250	0	(625,250)	0.0%
100,948	0	(100,948)	0.0%	Prop 56-Dev. Screening Exp.	824,577	0	(824,577)	0.0%
628,615	0	(628,615)	0.0%	Prop 56-Fam. Planning Exp.	5,886,425	0	(5,886,425)	0.0%
543,900	0	(543,900)	0.0%	Prop 56-Value Based Purchasing	5,191,667	0	(5,191,667)	0.0%
4,484,001	**4,433,926**	**(50,075)**	**(1.1%)**	**7-Primary Care Physician FFS Expense**	**42,389,380**	**42,861,515**	**472,135**	**1.1%**
449,953	0	(449,953)	0.0%	IBNP-Specialist	1,322,055	0	(1,322,055)	0.0%
2,315,431	4,420,229	2,104,798	47.6%	Specialty Care-FFS	21,105,764	43,415,770	22,310,006	51.4%
96,945	0	(96,945)	0.0%	Anesthesiology - FFS	1,742,734	0	(1,742,734)	0.0%
623,046	0	(623,046)	0.0%	Spec Rad Therapy - FFS	6,889,589	0	(6,889,589)	0.0%
118,868	0	(118,868)	0.0%	Obstetrics-FFS	1,276,308	0	(1,276,308)	0.0%
212,976	0	(212,976)	0.0%	Spec IP Surgery - FFS	2,398,020	0	(2,398,020)	0.0%
472,458	0	(472,458)	0.0%	Spec OP Surgery - FFS	4,655,598	0	(4,655,598)	0.0%
315,988	0	(315,988)	0.0%	Spec IP Physician	3,785,701	0	(3,785,701)	0.0%
32,758	96,024	63,266	65.9%	SCP FQHC FFS	313,869	693,139	379,270	54.7%
13,498	0	(13,498)	0.0%	IBNP-Settlement (SCP)	39,660	0	(39,660)	0.0%
35,997	0	(35,997)	0.0%	IBNP-Claims Fluctuation (SCP)	105,767	0	(105,767)	0.0%
4,687,918	**4,516,253**	**(171,665)**	**(3.8%)**	**8-Specialty Care Physician Expense**	**43,635,066**	**44,108,909**	**473,843**	**1.1%**
843,358	0	(843,358)	0.0%	IBNP-Ancillary	1,680,148	0	(1,680,148)	0.0%
25,301	0	(25,301)	0.0%	IBNP Settlement (ANC)	50,403	0	(50,403)	0.0%
67,468	0	(67,468)	0.0%	IBNP Claims Fluctuation (ANC)	134,413	0	(134,413)	0.0%
259,446	0	(259,446)	0.0%	Acupuncture/Biofeedback	2,528,495	0	(2,528,495)	0.0%
94,957	0	(94,957)	0.0%	Hearing Devices	741,576	0	(741,576)	0.0%
21,553	0	(21,553)	0.0%	Imaging/MRI/CT Global	341,838	0	(341,838)	0.0%
54,129	0	(54,129)	0.0%	Vision FFS	413,787	0	(413,787)	0.0%
17,054	0	(17,054)	0.0%	Family Planning	206,501	0	(206,501)	0.0%
674,206	0	(674,206)	0.0%	Laboratory-FFS	4,361,143	0	(4,361,143)	0.0%
101,668	0	(101,668)	0.0%	ANC Therapist	998,370	0	(998,370)	0.0%
259,173	0	(259,173)	0.0%	Transportation (Ambulance)-FFS	2,788,869	0	(2,788,869)	0.0%
53,608	0	(53,608)	0.0%	Transportation (Other)-FFS	1,013,010	0	(1,013,010)	0.0%

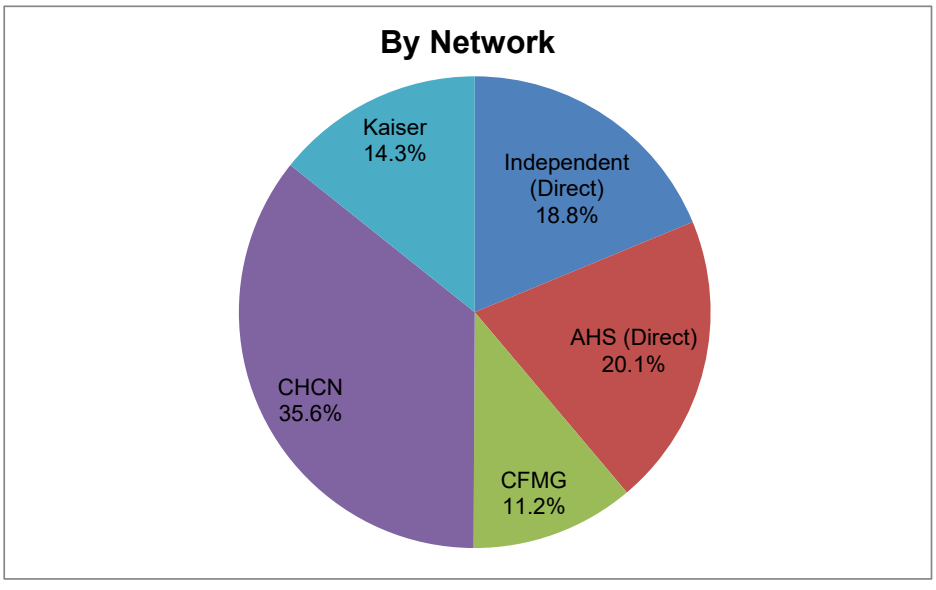
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED April 30, 2021

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
$282,501	$0	($282,501)	0.0%	Hospice	$4,362,246	$0	($4,362,246)	0.0%
631,516	0	(631,516)	0.0%	Home Health Services	6,606,472	0	(6,606,472)	0.0%
0	2,870,144	2,870,144	100.0%	Other Medical-FFS	0	30,841,445	30,841,445	100.0%
0	0	0	0.0%	Denials	3,885	0	(3,885)	0.0%
84,751	0	(84,751)	0.0%	HMS Medical Refunds	46,348	0	(46,348)	0.0%
1,100	0	(1,100)	0.0%	Refunds-Medical Payments	127	0	(127)	0.0%
460,088	0	(460,088)	0.0%	DME & Medical Supplies	3,424,571	0	(3,424,571)	0.0%
566,323	529,773	(36,550)	(6.9%)	GEMT Direct Payment Expense	5,551,728	5,405,197	(146,531)	(2.7%)
59,258	0	(59,258)	0.0%	Community Based Adult Services (CBAS)	4,651,460	0	(4,651,460)	0.0%
4,557,460	**3,399,917**	**(1,157,543)**	**(34.0%)**	**9-Ancillary Medical Expense**	**39,905,389**	**36,246,642**	**(3,658,747)**	**(10.1%)**
122,510	0	(122,510)	0.0%	IBNP-Outpatient	949,971	0	(949,971)	0.0%
3,676	0	(3,676)	0.0%	IBNP Settlement (OP)	28,501	0	(28,501)	0.0%
9,802	0	(9,802)	0.0%	IBNP Claims Fluctuation (OP)	75,998	0	(75,998)	0.0%
1,107,169	7,775,364	6,668,195	85.8%	Out-Patient FFS	10,871,727	77,641,110	66,769,383	86.0%
1,289,244	0	(1,289,244)	0.0%	OP Ambul Surgery - FFS	11,730,766	0	(11,730,766)	0.0%
574,005	0	(574,005)	0.0%	OP Fac Imaging Services-FFS	10,184,670	0	(10,184,670)	0.0%
2,606,812	0	(2,606,812)	0.0%	Behav Health - FFS	22,570,671	0	(22,570,671)	0.0%
473,876	0	(473,876)	0.0%	OP Facility - Lab FFS	4,429,472	0	(4,429,472)	0.0%
107,197	0	(107,197)	0.0%	OP Facility - Cardio FFS	922,090	0	(922,090)	0.0%
42,265	0	(42,265)	0.0%	OP Facility - PT/OT/ST FFS	343,808	0	(343,808)	0.0%
2,417,927	0	(2,417,927)	0.0%	OP Facility - Dialysis FFS	17,232,296	0	(17,232,296)	0.0%
8,754,484	**7,775,364**	**(979,120)**	**(12.6%)**	**10-Outpatient Medical Expense Medical Expense**	**79,339,970**	**77,641,110**	**(1,698,860)**	**(2.2%)**
713,443	0	(713,443)	0.0%	IBNP-Emergency	711,857	0	(711,857)	0.0%
21,404	0	(21,404)	0.0%	IBNP Settlement (ER)	21,359	0	(21,359)	0.0%
57,075	0	(57,075)	0.0%	IBNP Claims Fluctuation (ER)	56,944	0	(56,944)	0.0%
501,141	0	(501,141)	0.0%	Special ER Physician-FFS	5,225,100	0	(5,225,100)	0.0%
2,765,094	3,580,227	815,133	22.8%	ER-Facility	29,260,973	35,691,717	6,430,744	18.0%
4,058,158	**3,580,227**	**(477,931)**	**(13.3%)**	**11-Emergency Expense**	**35,276,233**	**35,691,717**	**415,484**	**1.2%**
360,128	0	(360,128)	0.0%	IBNP-Pharmacy	852,812	0	(852,812)	0.0%
10,804	0	(10,804)	0.0%	IBNP Settlement (RX)	25,586	0	(25,586)	0.0%
28,811	0	(28,811)	0.0%	IBNP Claims Fluctuation (RX)	68,228	0	(68,228)	0.0%
4,815,495	4,130,593	(684,902)	(16.6%)	RX - Non-PBM FFFS	43,105,000	40,601,927	(2,503,073)	(6.2%)
11,251,591	366,773	(10,884,818)	(2,967.7%)	Pharmacy-FFS	108,057,208	97,906,148	(10,151,060)	(10.4%)
(78,855)	0	78,855	0.0%	HMS RX Refunds	(372,906)	0	372,906	0.0%
(18,005)	(18,005)	0	0.0%	Pharmacy-Rebate	(4,701,958)	(4,701,956)	2	0.0%
16,369,969	**4,479,361**	**(11,890,608)**	**(265.5%)**	**12-Pharmacy Expense**	**147,033,970**	**133,806,119**	**(13,227,851)**	**(9.9%)**
70,001,216	**51,756,193**	**(18,245,023)**	**(35.3%)**	**13-TOTAL FFS MEDICAL EXPENSES**	**642,582,091**	**613,874,629**	**(28,707,462)**	**(4.7%)**
0	(39,664)	(39,664)	100.0%	Clinical Vacancy	0	(294,977)	(294,977)	100.0%
71,974	116,350	44,377	38.1%	Quality Analytics	683,820	928,012	244,192	26.3%
383,735	431,587	47,852	11.1%	Health Plan Services Department Total	3,636,694	4,029,151	392,457	9.7%
595,611	727,279	131,668	18.1%	Case & Disease Management Department Total	6,410,543	7,452,287	1,041,743	14.0%
211,434	242,541	31,107	12.8%	Medical Services Department Total	2,380,205	2,105,693	(274,513)	(13.0%)
462,456	512,524	50,068	9.8%	Quality Management Department Total	4,255,641	4,736,793	481,152	10.2%
105,426	131,542	26,116	19.9%	Pharmacy Services Department Total	1,144,711	1,371,451	226,740	16.5%
26,711	41,428	14,717	35.5%	Regulatory Readiness Total	318,126	381,151	63,026	16.5%
1,857,346	**2,163,587**	**306,241**	**14.2%**	**14-Other Benefits & Services**	**18,829,740**	**20,709,560**	**1,879,820**	**9.1%**
				Reinsurance Expense				
(384,882)	(384,881)	1	0.0%	Reinsurance Recoveries	(4,726,654)	(4,165,257)	561,397	(13.5%)
458,450	519,283	60,833	11.7%	Stop-Loss Expense	4,458,963	4,807,695	348,732	7.3%
73,568	**134,402**	**60,834**	**45.3%**	**15-Reinsurance Expense**	**(267,691)**	**642,438**	**910,129**	**141.7%**
				Preventive Health Services				
83,333	83,333	0	0.0%	Risk Sharing PCP	833,330	833,334	4	0.0%
83,333	**83,333**	**0**	**0.0%**	**16-Risk Pool Distribution**	**833,330**	**833,334**	**4**	**0.0%**
91,828,723	**73,914,706**	**(17,914,017)**	**(24.2%)**	**17-TOTAL MEDICAL EXPENSES**	**851,508,752**	**827,589,984**	**(23,918,768)**	**(2.9%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Current Membership by Network By Category of Aid							
Category of Aid	**Apr 2021**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	40,052	14%	9,088	8,855	509	14,564	7,036
Child	96,233	35%	9,535	8,662	29,183	31,867	16,986
SPD	26,270	9%	8,442	4,040	1,097	10,730	1,961
ACA OE	95,916	34%	15,823	32,470	1,144	34,508	11,971
Duals	19,748	7%	7,851	2,115	2	7,154	2,626
Medi-Cal	278,219		50,739	56,142	31,935	98,823	40,580
Group Care	5,972		2,561	945	-	2,466	-
Total	**284,191**	**100%**	**53,300**	**57,087**	**31,935**	**101,289**	**40,580**
Medi-Cal %	97.9%		95.2%	98.3%	100.0%	97.6%	100.0%
Group Care %	2.1%		4.8%	1.7%	0.0%	2.4%	0.0%
	Network Distribution		*18.8%*	*20.1%*	*11.2%*	*35.6%*	*14.3%*
			% Direct:	**39%**		**% Delegated:**	**61%**

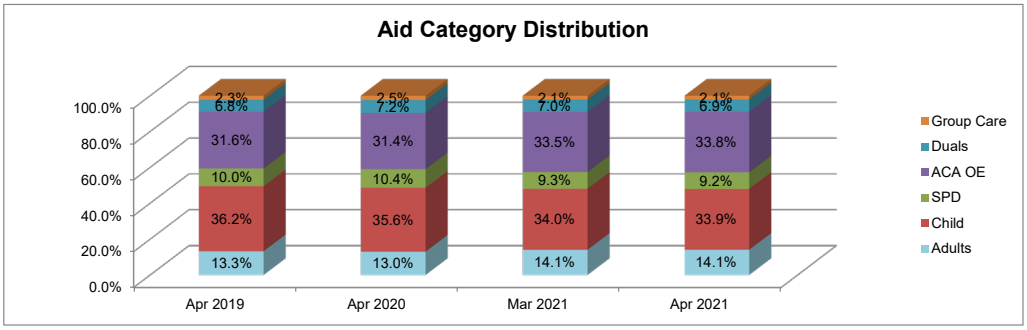




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

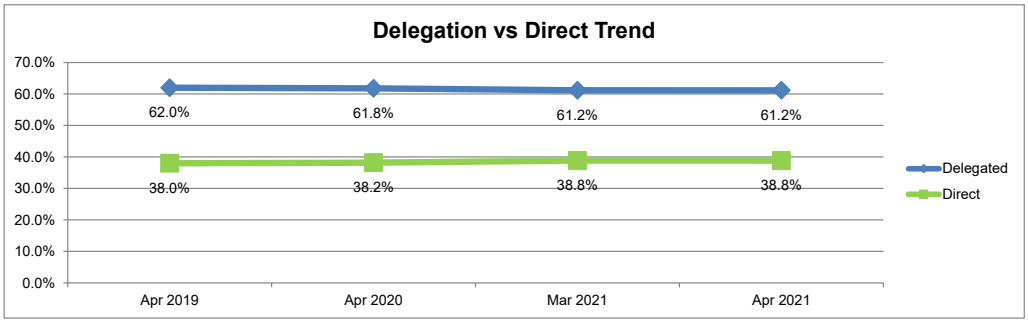
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Apr 2019	Apr 2020	Mar 2021	Apr 2021	Apr 2019	Apr 2020	Mar 2021	Apr 2021	Apr 2019 to Apr 2020	Apr 2020 to Apr 2021	Mar 2021 to Apr 2021
Adults	34,331	32,423	39,649	40,052	13.3%	13.0%	14.1%	14.1%	-5.6%	23.5%	1.0%
Child	93,615	88,633	95,692	96,233	36.2%	35.6%	34.0%	33.9%	-5.3%	8.6%	0.6%
SPD	25,787	25,894	26,234	26,270	10.0%	10.4%	9.3%	9.2%	0.4%	1.5%	0.1%
ACA OE	81,813	78,295	94,473	95,916	31.6%	31.4%	33.5%	33.8%	-4.3%	22.5%	1.5%
Duals	17,481	17,858	19,596	19,748	6.8%	7.2%	7.0%	6.9%	2.2%	10.6%	0.8%
Medi-Cal Total	253,027	243,103	275,644	278,219	97.7%	97.5%	97.9%	97.9%	-3.9%	14.4%	0.9%
Group Care	5,910	6,148	5,993	5,972	2.3%	2.5%	2.1%	2.1%	4.0%	-2.9%	-0.4%
Total	**258,937**	**249,251**	**281,637**	**284,191**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**-3.7%**	**14.0%**	**0.9%**



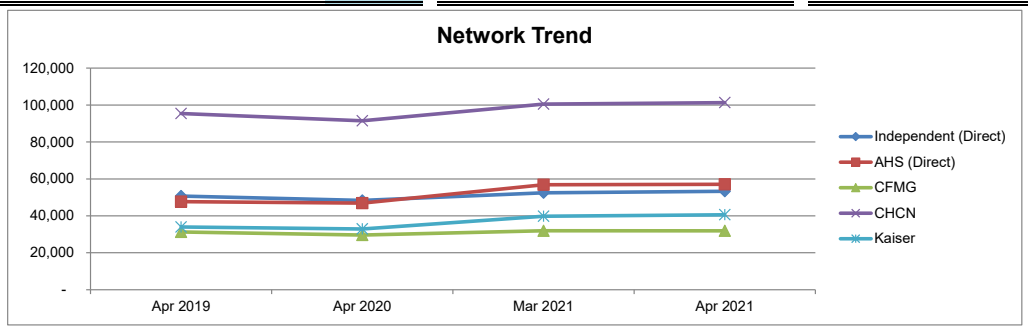
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Apr 2019	Apr 2020	Mar 2021	Apr 2021	Apr 2019	Apr 2020	Mar 2021	Apr 2021	Apr 2019 to Apr 2020	Apr 2020 to Apr 2021	Mar 2021 to Apr 2021
Delegated	160,549	153,983	172,258	173,804	62.0%	61.8%	61.2%	61.2%	-4.1%	12.9%	0.9%
Direct	98,388	95,268	109,379	110,387	38.0%	38.2%	38.8%	38.8%	-3.2%	15.9%	0.9%
Total	**258,937**	**249,251**	**281,637**	**284,191**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**-3.7%**	**14.0%**	**0.9%**



Network Trend

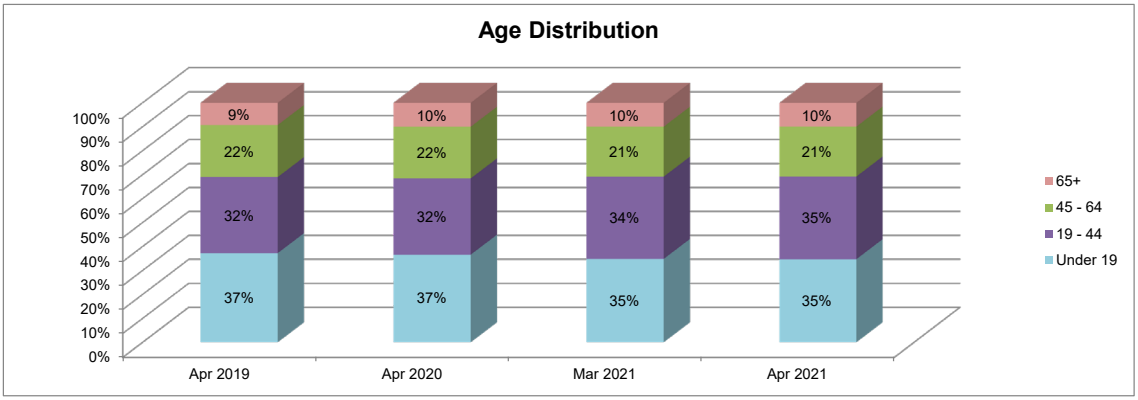
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Apr 2019	Apr 2020	Mar 2021	Apr 2021	Apr 2019	Apr 2020	Mar 2021	Apr 2021	Apr 2019 to Apr 2020	Apr 2020 to Apr 2021	Mar 2021 to Apr 2021
Independent (Direct)	50,735	48,363	52,524	53,300	19.6%	19.4%	18.6%	18.8%	-4.7%	10.2%	1.5%
AHS (Direct)	47,653	46,905	56,855	57,087	18.4%	18.8%	20.2%	20.1%	-1.6%	21.7%	0.4%
CFMG	31,252	29,619	31,939	31,935	12.1%	11.9%	11.3%	11.2%	-5.2%	7.8%	0.0%
CHCN	95,361	91,469	100,522	101,289	36.8%	36.7%	35.7%	35.6%	-4.1%	10.7%	0.8%
Kaiser	33,936	32,895	39,797	40,580	13.1%	13.2%	14.1%	14.3%	-3.1%	23.4%	2.0%
Total	**258,937**	**249,251**	**281,637**	**284,191**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**-3.7%**	**14.0%**	**0.9%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

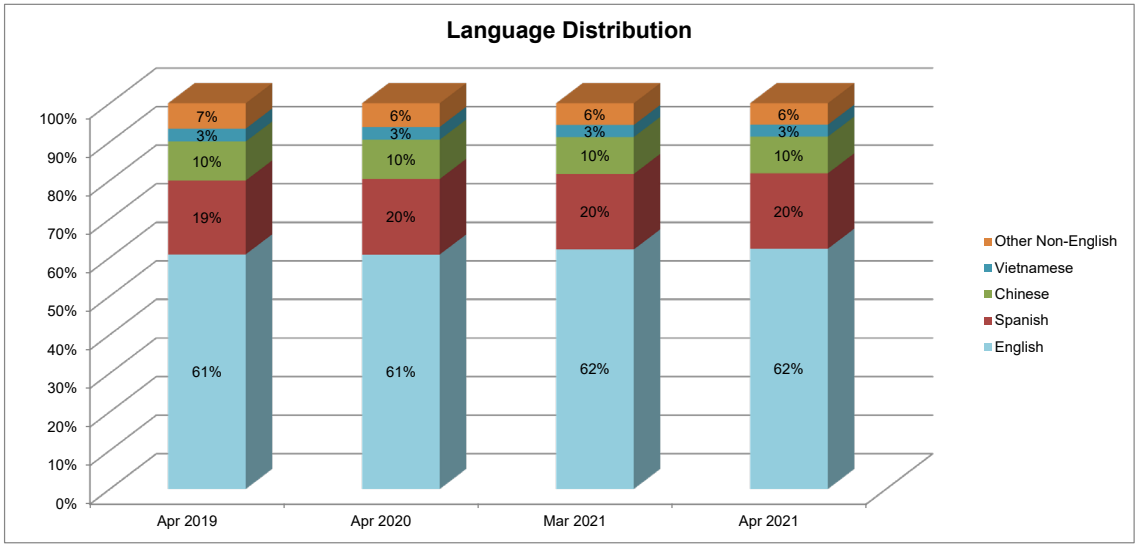
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Apr 2019	Apr 2020	Mar 2021	Apr 2021	Apr 2019	Apr 2020	Mar 2021	Apr 2021	Apr 2019 to Apr 2020	Apr 2020 to Apr 2021	Mar 2021 to Apr 2021
Under 19	96,382	91,177	98,054	98,595	37%	37%	35%	35%	-5%	8%	1%
19 - 44	82,257	79,413	96,750	98,096	32%	32%	34%	35%	-3%	24%	1%
45 - 64	56,248	53,750	58,732	59,184	22%	22%	21%	21%	-4%	10%	1%
65+	24,050	24,911	28,101	28,316	9%	10%	10%	10%	4%	14%	1%
Total	**258,937**	**249,251**	**281,637**	**284,191**	**100%**	**100%**	**100%**	**100%**	**-4%**	**14%**	**1%**



Language Trend

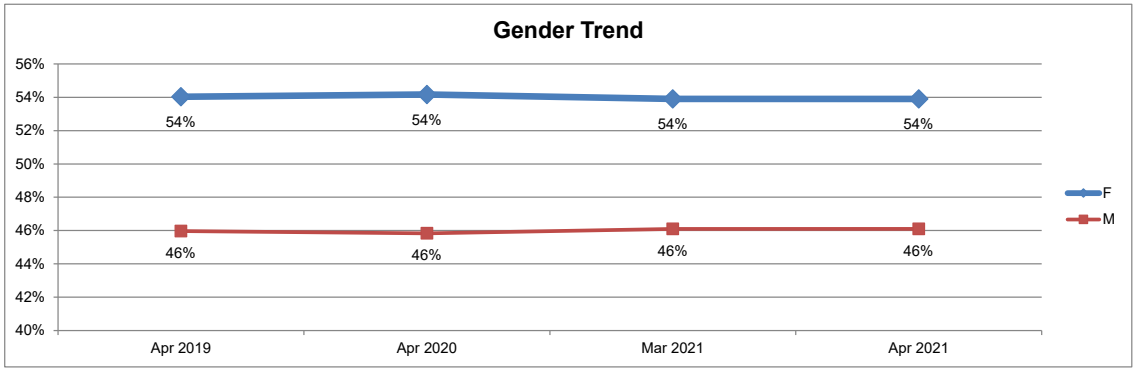
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Apr 2019	Apr 2020	Mar 2021	Apr 2021	Apr 2019	Apr 2020	Mar 2021	Apr 2021	Apr 2019 to Apr 2020	Apr 2020 to Apr 2021	Mar 2021 to Apr 2021
English	157,438	151,454	174,804	176,931	61%	61%	62%	62%	-4%	17%	1%
Spanish	49,619	48,853	55,172	55,588	19%	20%	20%	20%	-2%	14%	1%
Chinese	26,131	25,363	26,957	27,029	10%	10%	10%	10%	-3%	7%	0%
Vietnamese	8,699	8,285	8,791	8,790	3%	3%	3%	3%	-5%	6%	0%
Other Non-English	17,050	15,296	15,913	15,853	7%	6%	6%	6%	-10%	4%	0%
Total	**258,937**	**249,251**	**281,637**	**284,191**	**100%**	**100%**	**100%**	**100%**	**-4%**	**14%**	**1%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

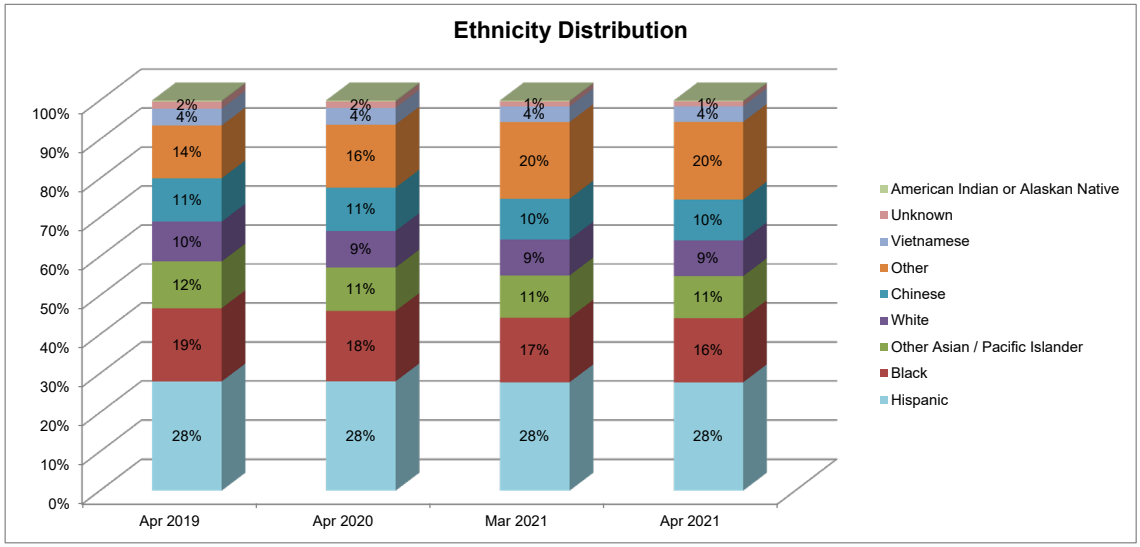
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Apr 2019	Apr 2020	Mar 2021	Apr 2021	Apr 2019	Apr 2020	Mar 2021	Apr 2021	Apr 2019 to Apr 2020	Apr 2020 to Apr 2021	Mar 2021 to Apr 2021
F	139,906	135,011	151,807	153,186	54%	54%	54%	54%	-3%	13%	1%
M	119,031	114,240	129,830	131,005	46%	46%	46%	46%	-4%	15%	1%
Total	**258,937**	**249,251**	**281,637**	**284,191**	**100%**	**100%**	**100%**	**100%**	**-4%**	**14%**	**1%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Apr 2019	Apr 2020	Mar 2021	Apr 2021	Apr 2019	Apr 2020	Mar 2021	Apr 2021	Apr 2019 to Apr 2020	Apr 2020 to Apr 2021	Mar 2021 to Apr 2021
Hispanic	72,383	69,755	78,149	78,831	28%	28%	28%	28%	-4%	13%	1%
Black	48,646	44,971	46,663	46,780	19%	18%	17%	16%	-8%	4%	0%
Other Asian / Pacific Islander	30,981	27,749	30,465	30,527	12%	11%	11%	11%	-10%	10%	0%
White	26,448	23,355	25,931	26,179	10%	9%	9%	9%	-12%	12%	1%
Chinese	28,806	27,754	29,519	29,693	11%	11%	10%	10%	-4%	7%	1%
Other	35,013	40,272	55,311	56,572	14%	16%	20%	20%	15%	40%	2%
Vietnamese	11,175	10,741	11,298	11,339	4%	4%	4%	4%	-4%	6%	0%
Unknown	4,816	4,076	3,680	3,648	2%	2%	1%	1%	-15%	-11%	-1%
American Indian or Alaskan Native	669	578	621	622	0%	0%	0%	0%	-14%	8%	0%
Total	**258,937**	**249,251**	**281,637**	**284,191**	**100%**	**100%**	**100%**	**100%**	**-4%**	**14%**	**1%**



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

Medi-Cal By City

City	Apr 2021	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	111,466	40%	12,615	26,793	13,992	46,480	11,586
Hayward	43,283	16%	8,873	9,352	4,858	12,705	7,495
Fremont	24,620	9%	9,558	3,793	818	6,458	3,993
San Leandro	24,907	9%	4,267	3,900	3,286	9,160	4,294
Union City	11,929	4%	4,397	1,812	370	3,079	2,271
Alameda	10,680	4%	2,019	1,692	1,620	3,711	1,638
Berkeley	9,773	4%	1,408	1,806	1,243	3,848	1,468
Livermore	8,405	3%	1,002	883	1,865	3,127	1,528
Newark	6,438	2%	1,735	2,043	198	1,244	1,218
Castro Valley	6,867	2%	1,328	1,130	1,053	1,974	1,382
San Lorenzo	5,900	2%	965	998	720	1,998	1,219
Pleasanton	4,468	2%	894	502	471	1,838	763
Dublin	4,745	2%	860	512	641	1,853	879
Emeryville	1,813	1%	303	379	298	526	307
Albany	1,716	1%	272	251	355	491	347
Piedmont	338	0%	47	79	31	89	92
Sunol	57	0%	8	14	7	14	14
Antioch	15	0%	7	3	-	-	5
Other	799	0%	181	200	109	228	81
Total	**278,219**	**100%**	**50,739**	**56,142**	**31,935**	**98,823**	**40,580**

Group Care By City

City	Apr 2021	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	2,029	34%	510	392	-	1,127	-
Hayward	669	11%	380	135	-	154	-
Fremont	638	11%	481	54	-	103	-
San Leandro	575	10%	227	91	-	257	-
Union City	328	5%	234	40	-	54	-
Alameda	282	5%	107	27	-	148	-
Berkeley	181	3%	51	15	-	115	-
Livermore	82	1%	31	2	-	49	-
Newark	136	2%	83	36	-	17	-
Castro Valley	189	3%	93	23	-	73	-
San Lorenzo	126	2%	56	15	-	55	-
Pleasanton	52	1%	27	2	-	23	-
Dublin	103	2%	42	10	-	51	-
Emeryville	28	0%	10	5	-	13	-
Albany	14	0%	4	2	-	8	-
Piedmont	15	0%	5	1	-	9	-
Sunol	-	0%	-	-	-	-	-
Antioch	27	0%	8	8	-	11	-
Other	498	8%	212	87	-	199	-
Total	**5,972**	**100%**	**2,561**	**945**	**-**	**2,466**	**-**

Total By City

City	Apr 2021	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	113,495	40%	13,125	27,185	13,992	47,607	11,586
Hayward	43,952	15%	9,253	9,487	4,858	12,859	7,495
Fremont	25,258	9%	10,039	3,847	818	6,561	3,993
San Leandro	25,482	9%	4,494	3,991	3,286	9,417	4,294
Union City	12,257	4%	4,631	1,852	370	3,133	2,271
Alameda	10,962	4%	2,126	1,719	1,620	3,859	1,638
Berkeley	9,954	4%	1,459	1,821	1,243	3,963	1,468
Livermore	8,487	3%	1,033	885	1,865	3,176	1,528
Newark	6,574	2%	1,818	2,079	198	1,261	1,218
Castro Valley	7,056	2%	1,421	1,153	1,053	2,047	1,382
San Lorenzo	6,026	2%	1,021	1,013	720	2,053	1,219
Pleasanton	4,520	2%	921	504	471	1,861	763
Dublin	4,848	2%	902	522	641	1,904	879
Emeryville	1,841	1%	313	384	298	539	307
Albany	1,730	1%	276	253	355	499	347
Piedmont	353	0%	52	80	31	98	92
Sunol	57	0%	8	14	7	14	14
Antioch	42	0%	15	11	-	11	5
Other	1,297	0%	393	287	109	427	81
Total	**284,191**	**100%**	**53,300**	**57,087**	**31,935**	**101,289**	**40,580**

FY 2022 Preliminary Budget

Presented to the Alameda Alliance Board of Governors

June 11th, 2021

Budget Process

- Preliminary budget presented to Finance Committee on June 8th and the Board of Governors on June 11.
- Draft Enhanced Care Management Rates received May 28th.
- DHCS has communicated that CY 2022 partial rates will be delivered in September. Final rates will be delivered in December.
- Final budget presented to Board of Governors in December.

Budget Assumptions FY 2022

FY 2022 Budget Compared to FY 2021 Forecast

Revenue:

- 98% of Revenue for Medi-Cal, 2% for Group Care.

Staffing:

- Staffing includes 403 full-time equivalent employees by June 30, 2022.
- There are 36 new positions budgeted. The new positions are in: Operations (14), Health Care Services (11), Programs & Projects (4), Human Resources (3), Information Technology (2), Performance Analytics (1) and Finance (1).
- Several of the new positions will be offset by the release of temporary employees.
- Year-end headcount includes 20 positions for new projects: The largest ones are Mental Health Insourcing (10), CalAIM Enhanced Care Management, Major Organ Transplants and In Lieu of Services (7). The remaining three distributed among several projects.

Enrollment:

- Medi-Cal membership increases through December, driven primarily by the reduction in redetermination activity. Disenrollments are anticipated to begin in January 2022, with the end of the Public Health Emergency.
- Group Care enrollment remains steady at approximately 6,000.

Budget Assumptions FY 2022 (con't)

FY 2022 Budget Compared to FY 2021 Forecast

Medical Expense:

- Medical loss ratio is 92.0%, a decrease of 4.0%.
- Underlying utilization trend is 0.5%; unit cost trend is 0.6%.

Reimbursement Rates:

- Medi-Cal base rates assumed to decrease by 1.8% on a per member/per month basis, equating to a decrease of $20.8M in revenue.
- Pharmacy is carved out of Medi-Cal beginning in January 2022, resulting in reduced revenue of $72.2 million.
- Estimated increased Revenue of $8.2 million is included for Enhanced Care Management; $1.8 million is included for Major Organ Transplants. These CalAIM initiatives are scheduled for January 2022.
- In Lieu of Service rates are undefined and pending further information from DHCS.
- Group Care rates do not change.

Hospital & Provider Rates (Alliance to the Providers):

- Hospital contract rates increase by $10.2 million in the year.
- Professional capitation rates increase by $11.8 million in the year, excluding changes for the Pharmacy carve-out and CalAIM.

Summary of Proposed Budget to the Board of Governors

FY 2022 Budget

- Year-end membership is 260,000 in Medi-Cal and Group Care, approximately 28,000 members lower (primarily Medi-Cal). Decrease due to the resumption of disenrollments.
- Revenue is $1.1 billion, $12.1 million higher as compared to FY 2021.
- Medical expenses are $1.0 billion, $28.7 million lower. This is comprised of the carve-out of pharmacy services, offset by CalAIM, contract changes, increasing medical trends and member month volume changes.
- $4.2 million in medical and operational expense savings are included in the net results.
- Administrative expenses are 7.5% of revenue, $28.4 million higher. Led by labor ($12.2 million) and purchased and professional services ($4.3 million). The release of the $10.3 million Sustainability Fund in FY 2021 is also a material driver of the variance.
- Tangible Net Equity of 574%, or $165.2 million above required by June 2022.
- Net Income is $10.7 million. Medi-Cal is $10.4 million Net Income; Group Care is $300,000.

PRELIMINARY BUDGET FY 2022

June 11, 2021

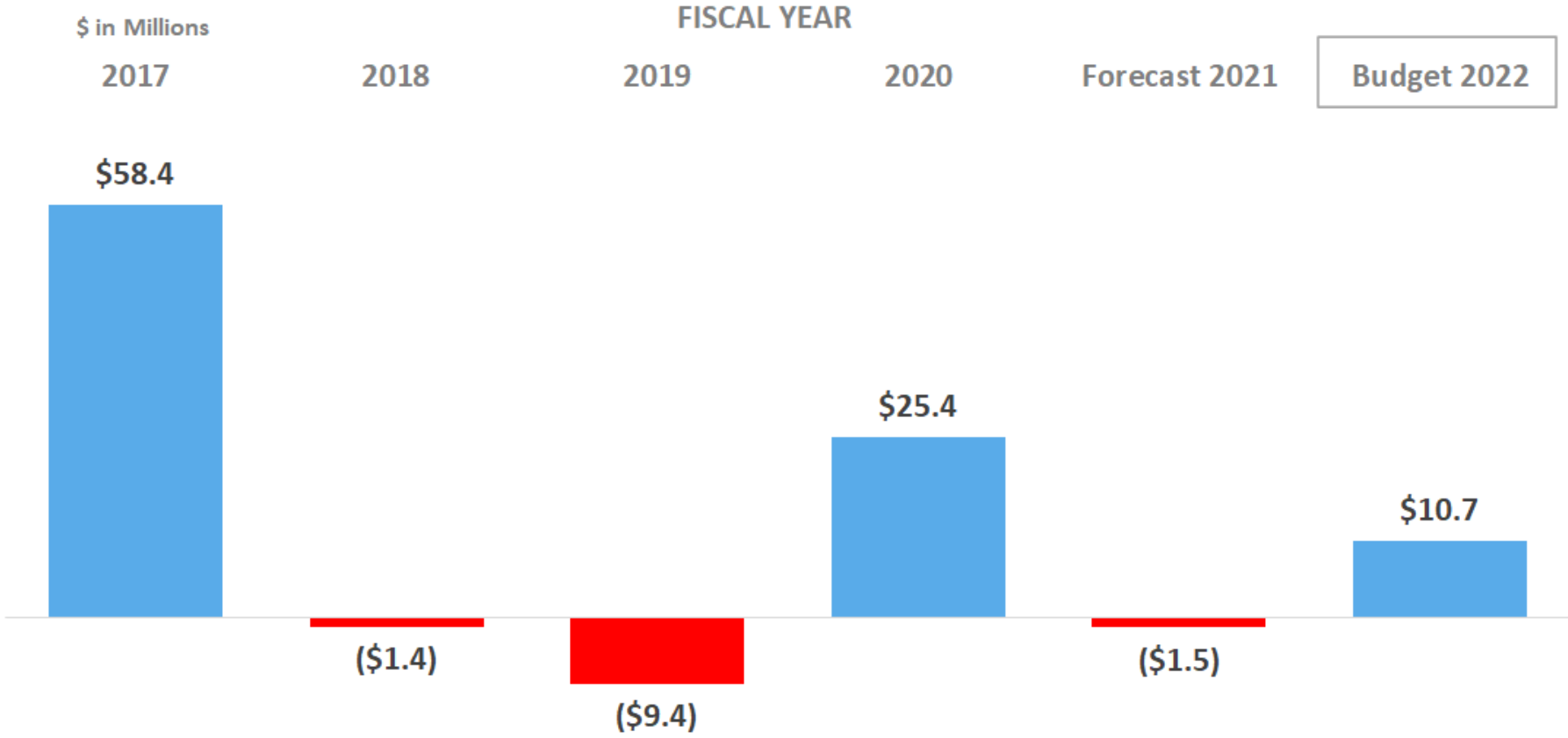
Medical And Operational Savings Initiatives:

- Third Party Liability and Coordination of Benefits recoupment: $2.5 million.
- Increased use of Biosimilar Medications: $720,000.
- Increased alignment of Prior Authorizations in claims and care management systems: $624,000.
- Reduction of Inpatient Readmissions: $360,000.

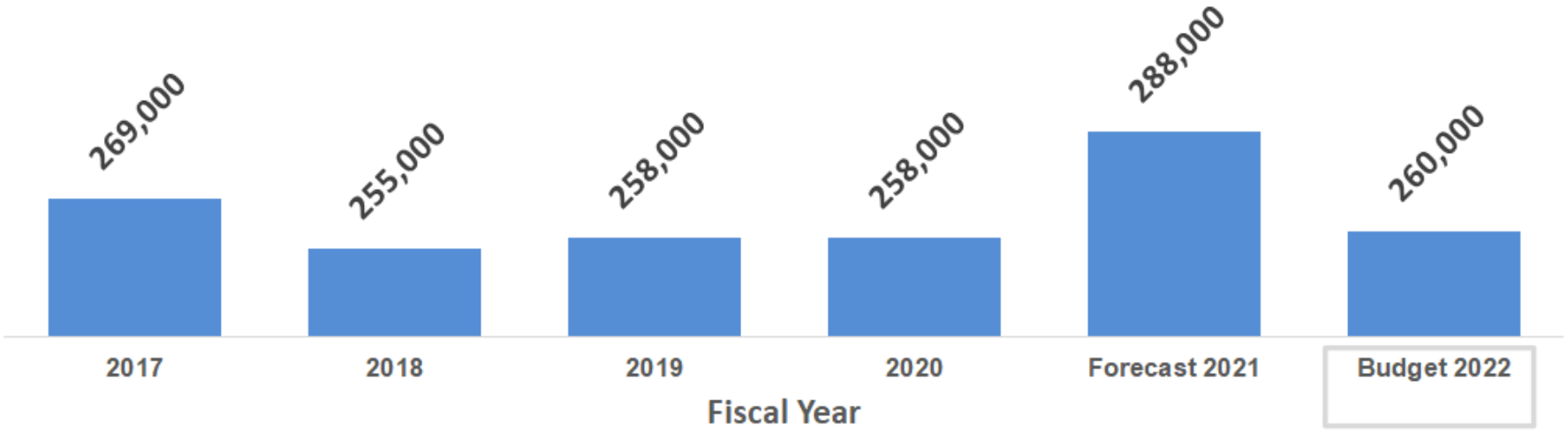
Preliminary FY 2022 Budget Comparison to FY 2021 Forecast

$ in Thousands	FY 2022 Budget			FY 2021 Forecast			Variance F/(U)		
	Medi-Cal	Group Care	Total	Medi-Cal	Group Care	Total	Medi-Cal	Group Care	Total
Enrollment at Year-End	*254,071*	*5,942*	*260,013*	*282,251*	*5,939*	*288,190*	*(28,180)*	*3*	*(28,177)*
Member Months	*3,295,409*	*71,295*	*3,366,704*	*3,236,700*	*71,860*	*3,308,560*	*58,709*	*(565)*	*58,144*
Revenues	$1,066,629	$26,657	$1,093,286	$1,054,197	$26,945	$1,081,143	$12,432	($288)	$12,144
Medical Expense	976,615	23,677	1,000,292	1,002,026	26,988	1,029,014	25,412	3,310	28,722
Gross Margin	**90,014**	**2,980**	**92,994**	**52,171**	**(42)**	**52,129**	**37,843**	**3,022**	**40,866**
Administrative Expense	79,720	2,680	82,400	52,166	1,794	53,960	(27,554)	(886)	(28,440)
Operating Margin	**10,294**	**300**	**10,594**	**5**	**(1,836)**	**(1,831)**	**10,289**	**2,136**	**12,425**
Other Income / (Expense)	102	3	105	319	5	324	(218)	(2)	(219)
Net Income / (Loss)	**$10,396**	**$303**	**$10,699**	**$324**	**($1,831)**	**($1,507)**	**$10,072**	**$2,134**	**$12,206**
Administrative Expense % of Revenue	**7.5%**	**10.1%**	**7.5%**	**4.9%**	**6.7%**	**5.0%**	**-2.5%**	**-3.4%**	**-2.5%**
Medical Loss Ratio	**91.6%**	**88.8%**	**91.5%**	**95.1%**	**100.2%**	**95.2%**	**3.5%**	**11.3%**	**3.7%**
TNE at Year-End			**$200,098**			**$199,908**			**$190**
TNE Percent of Required at Year-End			**573.9%**			**541.7%**			**32.2%**

Operating Performance: 2017 to 2022: Net Profit (Loss)

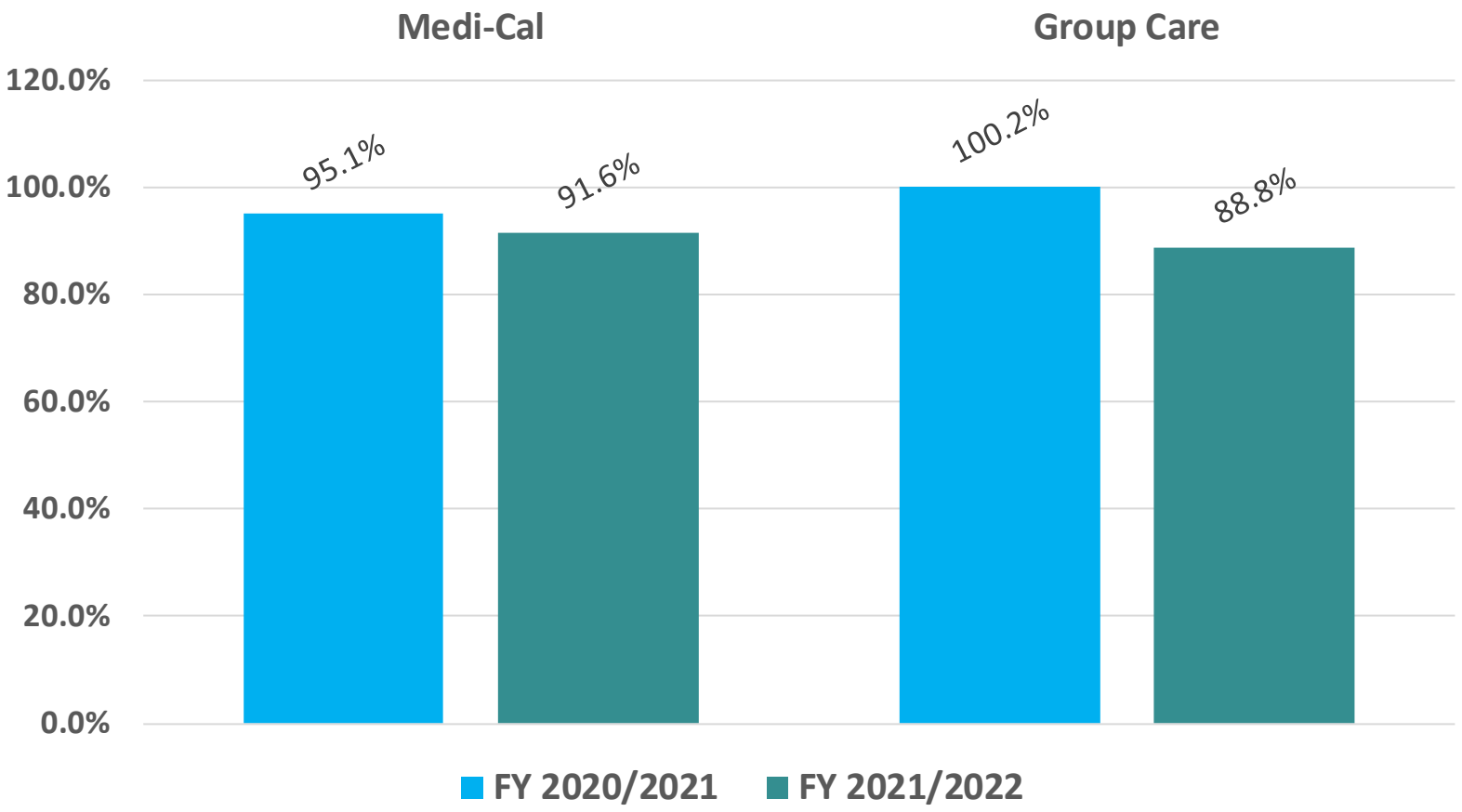


Enrollment Year End: 2017 to 2022



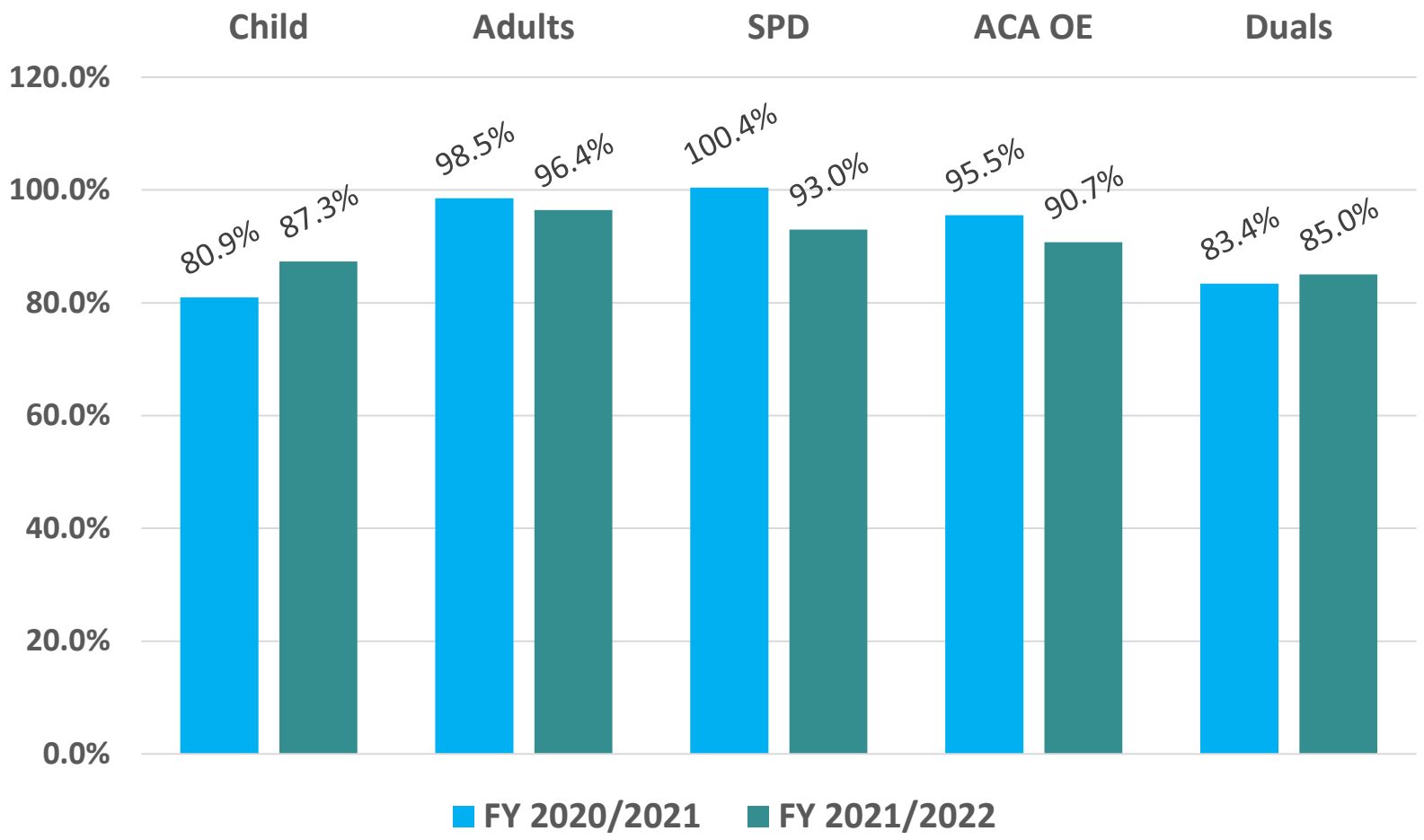
Medical Loss Ratio by Line of Business

FY 2022 Budget Compared to FY 2021 Forecast

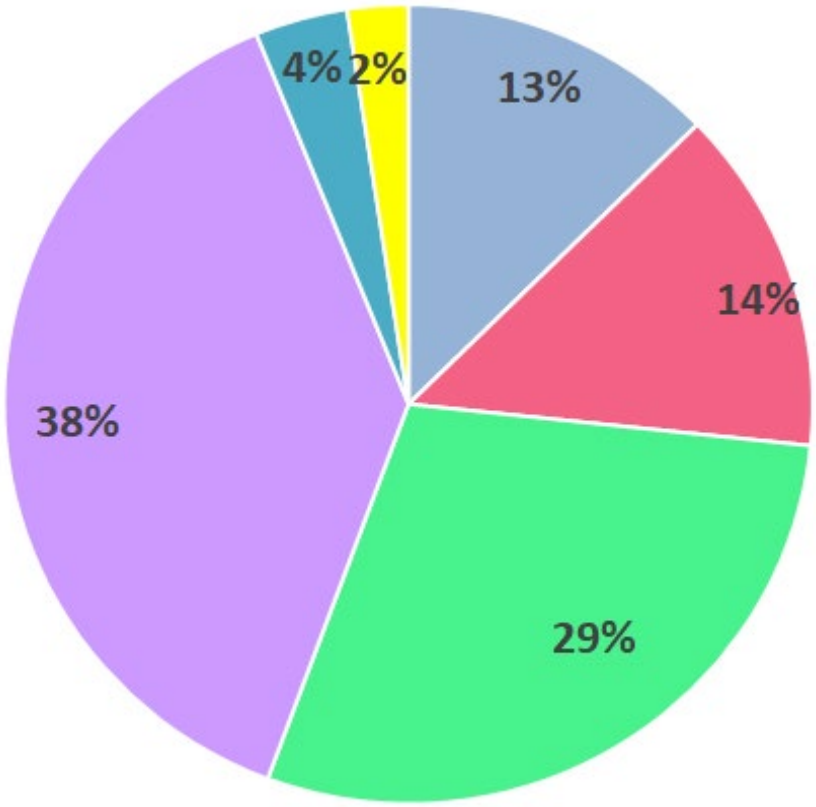


Medi-Cal Loss Ratio by Category of Aid

FY 2022 Budget Compared to FY 2021 Forecast



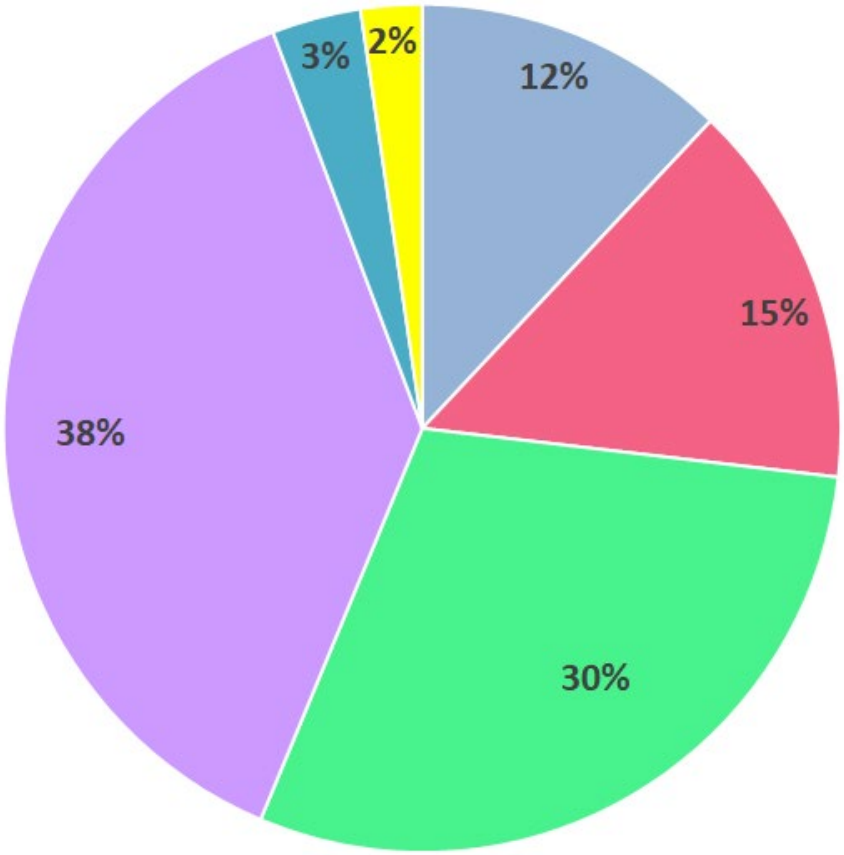
FY 2022 Revenue by Aid Category & Group Care



MEDI-CAL

Child	13%
Adults	14%
SPD	29%
ACA OE	38%
Duals	4%
Group Care	2%

FY 2022 Medical Expense by Aid Category & Group Care



MEDI-CAL

Child	12%
Adults	15%
SPD	30%
ACA OE	38%
Duals	3%
Group Care	2%

FY 2022 Administrative Expenses

FY 2022 Budget Compared to FY 2021 Forecast

Addition of $28.4 million in Administrative Expenses:

• Employee expense increases	($12.2) million
• Member benefits administration	($0.3) million
• Purchased and professional services	($4.3) million
• Technology infrastructure & licensing	($1.4) million
• Supplies, postage, and other expenses	($10.2) million
Total	**($28.4) million**

FY 2022 Capital Expenditures

Full Year budget of $1.4 million in capitalized purchases for Information Technology and Facilities. This is a reduction of $1.1 million from FY 2021.

- Information Technology: $710,000
  - Hardware: $560,000
    - Network hardware and cabling: $400,000
    - Voice Infrastructure: $100,000
    - Backup Hardware: $60,000
  - Software: $150,000
    - Monitoring and Access Management Software: $80,000
    - Disaster Recovery and Patch Management: $70,000
- Facilities: $706,000
  - Emergency Generator for 1240 Building: $361,000
  - EV Charging Stations: $70,000
  - Building Improvements: $150,000
  - Workplace Improvements: $125,000

Due to the change in AAH's Capital Expenditure policy, $552,000 has been moved from Capital Expense to Operating Expense. These costs are for items which are below the new $5,000 limit and include laptops, monitors, phones, appliances, electrical and furniture.

Administrative and Clinical Expenses by Line of Business

FY 2022 Budget

$ In Thousands

	Administrative Departments			Clinical Departments			Total
	Medi-Cal	Group Care	Total	Medi-Cal	Group Care	Total	
Employee Related Expense	$43,514	$1,408	$44,922	$17,279	$560	$17,839	62,761
Member Benefits Administration	$7,267	$274	$7,542	$1,782	$0	$1,782	9,324
Purchased & Professional Services	$15,204	$522	$15,725	$3,557	$170	$3,728	19,453
Other	$13,735	$476	$14,211	$2,101	$68	$2,169	16,380
Total	**$79,720**	**$2,680**	**$82,400**	**$24,719**	**$799**	**$25,518**	**$107,918**

Staffing: Administrative and Clinical FTEs

FY 2022 Budget Compared to FY 2021 Forecast

Administrative FTEs	FY21 YE Actual	Hire in FY22	FY22 YE Budget
Administrative Vacancy	(29.6)	(2.7)	(32.3)
Operations	3.0	0.0	3.0
Executive	2.0	0.0	2.0
Finance	23.0	0.0	23.0
Healthcare Analytics	13.0	1.0	14.0
Claims	39.0	2.0	41.0
Information Technology	4.0	(2.0)	2.0
IT Infrastructure	13.0	0.0	13.0
IT Applications	21.0	(6.0)	15.0
IT Development	15.0	0.0	15.0
IT Data Exchange	8.0	0.0	8.0
IT- Ops and Quality Apps Mgt	0.0	8.0	8.0
Member Services	55.0	4.3	59.2
Provider Relations	26.0	5.0	31.0
Credentialing	3.0	2.0	5.0
Health Plan Operations	1.0	0.0	1.0
Human Resources	8.0	5.0	13.0
Vendor Management	4.0	1.0	5.0
Legal	4.0	0.0	4.0
Facilities	5.0	2.0	7.0
Community Relations	8.0	2.0	10.0
Privacy and SIU	0.0	7.0	7.0
Regulatory Compliance	18.5	(8.5)	10.0
Delegation Oversight and G&A	12.0	1.0	13.0
Projects & Programs	10.0	4.0	14.0
Total Administrative FTEs	**265.8**	**25.1**	**290.9**

Clinical FTEs	FY21 YE Actual	Hire in FY22	FY22 YE Budget
Clinical Vacancy	(3.4)	(0.0)	(3.5)
Quality Analytics	6.0	0.0	6.0
Utilization Management	40.9	(2.5)	38.4
Disease Mgmt. / Care Mgmt.	28.0	1.0	29.0
Medical Services	7.0	(1.0)	6.0
Quality Management	21.0	1.0	22.0
HCS Behavioral Health	0.0	3.0	3.0
Pharmacy Services	9.5	(0.5)	9.0
Regulatory Readiness	2.0	0.0	2.0
Total Clinical FTEs	**110.9**	**1.0**	**111.9**

Total FTEs	**376.7**	**26.1**	**402.8**

**FTE = Full-Time Equivalent Personnel working approximately 2,080 hours per year. Includes Temporary Employees.*

Resolutions

RESOLUTION NO. 2021-12

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

WHEREAS, The Alameda Alliance for Health (Alliance) Board of Governors currently has an unfilled vacancy.

WHEREAS, the Chief Executive Officer (CEO) of Alameda Health System (AHS) has recommended a nominee to fill the vacant seat pursuant to Section 3.D.7 of the Alliance Bylaws; and

WHEREAS, pursuant to Section 3.C of the Alliance Bylaws the CEO of the Alliance recommends that the Alliance Board of Governors appoint the AHS CEO's nominee to fill the vacant seat; and

WHEREAS, pursuant to Sections 3.C and 3.J.2 of the Alliance Bylaws, the Alliance Board of Governors has reviewed the nominee recommendation; and

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

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

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

SECTION 1. That the Alliance Board of Governors approves James Jackson, the recommendation and nomination of the CEO of AHS, to fill the Alameda Health System seat on the Alliance Board of Governors, as created pursuant to Section 3.D.7 of the Alliance Bylaws.

SECTION 2. The Alliance Board of Governors hereby recommends that the Alameda County Board of Supervisors adopt a resolution by majority vote appointing James Jackson as a member in the Alameda Health System seat of the Alliance Board of Governors.

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

PASSED AND ADOPTED by the Board at a meeting held on the 11th day of June, 2021.

_____
CHAIR, BOARD OF GOVERNORS

ATTEST:

_____
Secretary

RESOLUTION NO. 2021-10

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, Natalie William's initial one (1) year term as an Alameda Alliance for Health (Alliance) Board of Governors member in a consumer member seat will expire on July 29, 2021; and

WHEREAS, the Alliance Chief Executive Officer recommends that the Alliance Board of Governors reappoint Natalie Williams to a consumer member seat pursuant to Section 3.D.5 of the Alliance Bylaws; 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 Natalie Williams to a consumer member 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 a 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 Natalie Williams to a consumer member seat on the Alliance Board of Governors, as created pursuant to Section 3.D.5 of the Bylaws of the Alliance.

SECTION 2. The Alliance Board of Governors hereby recommends that the Alameda County Board of Supervisors reappoint by majority vote Natalie Williams as a consumer member of the Alliance Board of Governors.

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

PASSED AND ADOPTED by the Board at a meeting held on the 11th day of June 2021.

_____
CHAIR, BOARD OF GOVERNORS

ATTEST:

_____
Secretary

RESOLUTION NO. 2021-11

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH TO AMEND RESOLUTION 2017-04 BY MAKING AD HOC COMPLIANCE ADVISORY GROUP INTO A STANDING COMPLIANCE ADVISORY COMMITTEE

WHEREAS, the Alameda Alliance for Health (Alliance) Board of Governors has adopted bylaws which allow for the creation by way of resolution of both standing committees and ad hoc advisory groups, to carry out the purposes of the Board of Governors; and

WHEREAS, the Board of Governors on November 10, 2017 passed Resolution No. 2017-04 creating an ad hoc Compliance Advisory Group to advise the Board of Governors on compliance and regulatory matters; and

WHEREAS, the Board of Governors has decided that a standing Compliance Advisory Committee is needed to take up all compliance-related issues and make recommendations to the Board of Governors on the Alliance's compliance program and relatable subject matter, including but not limited to oversight of regulatory findings related to the Alliance's operations; and

WHEREAS, the Board of Governors has determined that the ad hoc Compliance Advisory Group shall become the standing Compliance Advisory Committee; and

WHEREAS, Section 7.A.1 of the Bylaws requires that the frequency, composition, compensation, terms, and nomination of members of standing committees shall be as set forth by resolution; and

WHEREAS, Section 7.A.3 of the Bylaws requires that the standing Compliance Advisory Committee must include two (2) or more members of the Board of Governors in its membership; and

WHEREAS, Section 7.C.1 of the Bylaws requires that the Chair and Vice Chair of the standing Compliance Advisory Committee shall be Board of Governors members selected and approved by the Board of Governors; and

WHEREAS, Section 7.C.1 of the Bylaws requires that the Alliance Chief Compliance Officer shall serve, ex officio, as a voting member and be counted toward determining whether a quorum is present at each standing Compliance Advisory Committee meeting.

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

SECTION 1. The ad hoc Compliance Advisory Group established pursuant to Resolution No. 2017-04 shall become the standing Compliance Advisory Committee pursuant to this Resolution No. 2021-11.

SECTION 2. The standing Compliance Advisory Committee shall meet on at least 11 times per year on the second Friday of the month from 10:30 a.m. to 11:30 a.m. at the Alliance Headquarters, located at 1240 S. Loop Rd, Alameda CA 94502, or shall meet by teleconference if deemed necessary.

SECTION 3. The standing Compliance Advisory Committee members shall be recommended to the Board of Governors and shall be approved by majority vote of the Board of Governors.

SECTION 4. Appointments to the standing Compliance Advisory Committee shall be for a term of two (2) years, and members may be reappointed to additional terms by Board of Governors approval.

SECTION 5. The Compliance Advisory Committee Chair and Vice Chair shall be members of the Board of Governors selected and approved by the Board of Governors.

SECTION 6. The voting membership of the standing Compliance Advisory Committee shall be as follows:

Two (2) or more Members of the Board of Governors
Chief Compliance Officer serving ex officio

SECTION 7. The meetings of the standing Compliance Advisory Committee shall be conducted according to Roberts Rules of Order to the extent adopted by the Board of Governors; under no circumstance shall the Committee be bound by all provisions of Roberts Rules of Order.

SECTION 8. Members of the standing Compliance Advisory Committee shall not receive compensation.

SECTION 9. The Alliance Secretary shall certify the adoption of this resolution.

PASSED AND ADOPTED by the Board of Governors at a meeting held on the 11th day of June, 2021.

_____
CHAIR, BOARD OF GOVERNORS

ATTEST:

_____
Secretary

ALAMEDA Alliance FOR HEALTH

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Staff Reports

TO: Alameda Alliance for Health Board of Governors

FROM: Rebecca Gebhart, Alameda Alliance Board of Governors

DATE: June 11, 2021

SUBJECT: Member Nominations to the Standing Compliance Advisory Committee

RECOMMENDED ACTION

1. To approve a motion to nominate 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.

DISCUSSION

In November 2017, the Alameda Alliance for Health (Alliance) Board of Governors (Board) created an ad-hoc Compliance Advisory Group via-Resolution 2017-04.[1]

On March 3, 2021, the Alameda County Board of Supervisors approved revisions to the Alliance Bylaws allowing for the creation of a standing Compliance Advisory Committee to discuss compliance related matters to be reported to the Board. With Board approval of Resolution 2021-11, the standing Compliance Advisory Committee will replace the ad-hoc Compliance Advisory Group.

Resolution 2021-11 provides for composition of the Compliance Advisory Committee which will consist of two (2) or more Board Members approved by a majority of the Board. Additionally, section 7.C.1 of the Bylaws requires that the Alliance Chief Compliance Officer serve, ex officio, as a voting member of the Committee and shall be counted towards determining whether a quorum is present.

FISCAL IMPACT

This action will not have a fiscal impact.

ATTACHMENTS

N/A

[1] Resolution 2017-04 A resolution of the Alameda Alliance for Health Creating an Ad Hoc Compliance Advisory Group passed and adopted at the November 10, 2017 Board of Governors Regular Meeting

TO: Alameda Alliance for Health Board of Governors

FROM: Dr. Evan Seevak, Chair, Alameda Alliance Board of Governors

DATE: June 11, 2021

SUBJECT: Member Nominations to the Standing Executive Committee

RECOMMENDED ACTION

1. To approve a motion to nominate 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.

DISCUSSION

The Alameda Alliance for Health (Alliance) Board of Governors (Board) approved Resolution No. 2021-09 on May 14, 2021. Resolution No. 2021-09 provides for composition of the Executive Committee which will consist of five (5) Board members recommended to the Board and approved by a majority of the Board. These five (5) members shall be voting members of the Executive Committee. The Chair and Vice Chair of the Committee shall be selected and approved by the Board. Appointments to the Committee shall be for a term of two (2) years and Committee members may be reappointed to additional terms with the Board's approval.

The Chief Executive Officer of the Alliance shall serve ex officio as a non-voting member of the Committee and shall not be counted towards a quorum.

FISCAL IMPACT

This action will not have a fiscal impact.

ATTACHMENTS

N/A

CalAIM

FY2022 Cost Pro-Forma

Presented to the Alameda Alliance Board of Governors

June 11th, 2021

Agenda

- Background
- Regulatory Filings
- CalAIM - Phase One Launch
- State funding for CalAIM services launching on January 1, 2022
- Financial Projections
- Financials Risks
- Key Objectives
- Next Steps

Background

- **Whole Person Care and Health Homes programs are ending on December 31, 2021**
  - Unique opportunity to continue the services that have been created through the Whole Person Care and Health Homes Pilots; reaching the hardest to serve, unstably housed, neediest people in Alameda County
  - 1115 Waiver authorizes funding for the Whole Person Care "AC3" pilot, administered by Alameda County Health Care Services Agency (HCSA)
    - AC3 administers the housing services through a network of eleven (11) Community-Based Organizations
    - Alameda Alliance administers care management services as a subcontractor of HCSA
  - DHCS has identified four (4) counties with high populations being served in the Whole Person Care pilots: Contra Costa, Alameda, San Mateo and Santa Clara
  - $300 million allocated in Governor Newsom's state budget to build ECM/ILOS infrastructure & capacity (allocated for January to June 2022)
- **New Medi-Cal services begin on January 1st, 2022**
  - Enhanced Care Management (ECM) benefit
  - In-Lieu of Services (ILOS)
  - Major Organ Transplants (MOT) benefit

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)

CalAIM – Phase One Launch

- **100% of Alliance Members enrolled in Whole Person Care (care management bundle) and Health Homes programs will be transitioned into ECM services on 1/1/2022**
- **On January 1, 2022, eligibility criteria is currently proposed to be applied to Medi-Cal members for ECM, ILOS and MOT**
  - ECM eligibility criteria defined by the DHCS, includes adults with 5 or more ED visits in 6 months and/or 2 or more hospital inpatient/skilled nursing stays in 6 months (high utilizer only); additional criteria provided by DHCS for homeless, severely mental ill and substance use for ECM only
  - For housing services, the Alliance is proposing to use Johns Hopkins ACG risk-scoring to identify Members with highest risk; Alameda County HCSA communicated concerns about the results of the risk stratification, 25% of members reaching eligibility for housing services
  - MOT eligibility criteria is defined by the medical necessity of the Member, and includes all adults (children continue to be served through the CCS program based on eligibility)

State Funding

- **Enhanced Care Management (ECM) Services**
  - DHCS pays a specific capitated rate to the Alliance (defined benefit)
  - Preliminary rates were received on May 28th, final rates in August
  - Approx. $16 million in calendar year 2022 (50% paid in FY2022)
- **In-Lieu of Services (ILOS)**
  - DHCS is not paying a capitated rate for ILOS (optional service)
  - Financial savings from ILOS are expected to offset costs that would otherwise be incurred by the Alliance
  - One-time funding of $115 million in FY2022 state budget, actual dollar allocation to Alameda Alliance unknown
- **Major Organ Transplants (MOT)**
  - DHCS blends the MOT rate into the existing Medi-Cal base rates, paid by category of aid (defined benefit)
  - DHCS to deliver preliminary rates in December

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
- ILOS expenses exclude potential savings that could be offset by these services, and there may be opportunities for Alameda County HCSA to pursue funding through ARPA/enhanced Home-and-Community Based Services (HCBS) made available via ARPA; potential costs may reach $18.75M
  - 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 are using the Alameda County Social Health Information Exchange (SHIE)

In Lieu Of Services Categories	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**

Financial Risks

- Governor Newsom's budget includes $115 million in ILOS funding across all counties in fiscal year 2022, and $300 million for building capacity – actual dollar allocations to Alameda County currently undefined
- ILOS is an optional service, and relies on justification as a cost-effective substitute and medically necessary; limited experience within managed care to "follow the patient" and justify outcomes
- Retrospective rate development process may not recognize ILOS expenses for 2.5 years (e.g. actual costs in calendar year 2022 are factored into the rate process in 2025); total financial impact is undefined by DHCS at this time. Future year utilization and costs factors must be consistent with federal Medicaid rate setting requirements.
- Actual costs for ILOS could reach nearly $20 million per year, potentially impacting the financial reserves until the rate process begins to factor the actual costs

Key Objectives

- Finalize the list of In-Lieu Of Services for phase one - 1/1/2022
  - Seven (7) ILOS are identified for Phase One (see Appendix)
- DHCS to affirm an adjustment related to ILOS costs being factored into the rate development cycle for CY2022
- Reach agreement with Alameda County HCSA on populations of focus (Eligible Members) and the scope of services and costs for housing navigation, tenancy sustaining and other transition services

Next Steps

- Resume negotiations with Alameda County HCSA on housing services
- 3-way meeting with DHCS & Alameda County HCSA, requesting guidance from the state on transitions and costs for services from Whole Person Care “AC3” program (e.g. low risk, high risk)
- Draft the first regulatory submission and circulate to safety-net partners for comment
- Continue building the provider network
- Kickoff operational readiness (e.g. development of policies, regulatory reporting requirements, provider training resources & tools, internal workflows, changes to care management and claims systems)
- Coordinate activities with Alameda County HCSA & community-based organizations

Appendix

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

*Yellow highlight denotes services being launched in the first phase on January 1, 2022

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

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Operations

Matt Woodruff

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

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

Date: **June 11, 2021**

Subject: **Operations Report**

Member Services

- 12-Month Trend Summary:

    - The Member Services Department received a twenty-nine percent (29%) increase in calls in May 2021, totaling 12,551 compared to 8,966 in May 2020. Call volume pre-pandemic in May 2019 was 14,962, which is sixteen percent 16% higher than the current call volume.
    - May utilization for the member automated eligibility IVR system totaled five hundred ninety (590).
    - The abandonment rate for May 2021 was seven percent (7%), compared to two percent (2%) in May 2020.
    - The Department's service level was sixty-seven percent (67%) in May 2021, compared to eighty-seven percent (87%) in May 2020. The Department continues to recruit to fill open positions.
    - The average talk time (ATT) was six minutes and nine seconds (06:09) for May 2021 compared to six minutes and thirty-nine seconds (06:39) for May 2020.
    - The top five call reasons for May 2021 were: 1). Eligibility/Enrollment, 2). Change of PCP 3). Kaiser, 4). Benefits, 5). ID Card Request. The fifth call reason in May 2020 was 5) Pharmacy. The first and fourth call reasons were the same for 2020 and 2021. Kaiser was second and Change of PCP was third in 2020.
    - 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 495 web-based requests in May 2021 compared to 410 in May 2020. The top three web reason requests for 2021 were: 1). ID Card Requests 2). Change of PCP 3). Update contact information.

Claims

- 12-Month Trend Summary:

    - The Claims Department received 129,847 claims in May 2021 compared to 89,063 in May 2020.
    - The Auto Adjudication was 73.3% in May 2021 compared to 73.6% in May 2020.
    - Claims compliance for the 30-day turn-around time was 96.0% in May 2021 compared to 98.1% in April 2020. The 45-day turn-around time was 99.9% in May 2021 compared to 100% in May 2020.

- Monthly Analysis:

    - In the month of May, we received a total of 129,847 claims in the HEALTHsuite system. This represents a decrease of 7.7% from April and is higher than the number of claims received in May 2020 by 40,784 claims. The higher volume of received claims remains attributed to COVID-19 and COBA implementation.
    - We received 80% of claims via EDI and 20% of claims via paper.
    - During the month of May, 99.9% of our claims were processed within 45 working days.
    - The Auto Adjudication rate was 73.3% for the month of May.

Provider Services

- 12-Month Trend Summary:

    - The Provider Services Department's call volume in May 2021 was 5,222 calls compared to 5,740 calls in May 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 275 virtual visits during May 2021
    - The Provider Services department answered over 4,493 calls for May 2021 and made over 933 outbound calls.

Credentialing

- 12-Month Trend Summary:

    - At the Peer Review and Credentialing (PRCC) meeting held on May 18, 2021, there were twenty-three (23) initial providers approved; three (3) primary care provider, four (4) specialists, one (1) ancillary providers, and fifteen (15) midlevel providers. Additionally, thirty-two (32) providers were re-credentialed at this meeting; six (6) primary care providers, fifteen (15) specialists, one (1) ancillary provider, and ten (10) 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 May 2021, the Provider Dispute Resolution (PDR) team received 859 PDRs versus 808 in May 2020.
    - The PDR team resolved 593 cases in May 2021 compared to 603 cases in May 2020.
    - In May 2021, the PDR team upheld 71% of cases versus 67% in May 2020.
    - The PDR team resolved 99.5% of cases within the compliance standard of 95% within 45 working days in May 2021 compared to 100% in May 2020.

- Monthly Analysis:

    - AAH received 859 PDRs in May 2021.
    - In the month of May, 593 PDRs were resolved. Out of the 593 PDRs, 422 were upheld, and 171 were overturned.
    - The overturn rate for PDRs was 29% which did not meet our goal of 25% or less.
    - Below is a breakdown of the various causes for the 171 overturned PDRs. Please note that there were two primary areas that caused the Department to miss its goal of 25% or less. First, were the system issues listed below that represented a higher than normal percentage of overturned cases (representing 32% or 55 cases), and second, a larger than normal volume of overturns due to processor errors on duplicate claims (representing 22% or 37 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 32% (55 cases):
  - 8 cases: CES edit Update.
  - 2 cases: Incorrect member eligibility.
  - 29 cases: General configuration issues, like Not Covered, Modifier, Delegated.
  - 16 cases: Incorrect rate paid.

- Authorization Related Issues 16% (27 cases):
  - 10 cases: Processor errors when auth on file.
  - 17 cases: UM Decisions/Med Nec Met

- Additional Documentation Provided 18% (31 cases):
  - 31 cases: Duplicate claim documentation that allows for claims to be adjusted.

- Claim Processing Errors 34% (58 cases)
  - 37 cases: Duplicate
  - 21 cases: Various Processor errors.

- 590 out of 593 cases were resolved within 45 working days resulting in a 99.5% compliance rate.
- The average turn-around time for resolving PDRs in May was 39 days.
- There were 1482 PDRs pending resolution as of 05/31/2021, with no cases older than 45 working days.

Community Relations and Outreach

- 12-Month Trend Summary:
  - In May 2021, the Alliance completed 630 member orientation outreach calls and 161 member orientations by phone. The Alliance also reached 3 people during a virtual community presentation.
  - The C&O Department reached 164 people (99% identified as Alliance members) during outreach activities, compared to 278 individuals who all identified as Alliance members in May 2020.
  - The C&O Department reached members in 16 cities/unincorporated areas throughout Alameda County, Bay Area, and the U.S., compared to 0 reported cities in May 2020.

- Monthly Analysis:

    - In May 2021, the C&O Department completed 630 member orientation outreach calls and 161 member orientations by phone, and 27 Alliance website inquiries. The Alliance also reached 3 people during a virtual community presentation.
    - Among the 164 people reached, 99% identified as Alliance members.
    - In May 2021, the C&O Department reached members in 16 locations throughout Alameda County, the Bay Area, and the U.S.
    - Please see attached **Addendum A**.

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	May 2021
Incoming Calls (R/V)	12,551
Abandoned Rate (R/V)	7%
Answered Calls (R/V)	11,726
Average Speed to Answer (ASA)	01:04
Calls Answered in 30 Seconds (R/V)	67%
Average Talk Time (ATT)	06:09
Outbound Calls	7,508

Top 5 Call Reasons (Medi-Cal and Group Care) May 2021
Eligibility/Enrollment
Change of PCP
Kaiser
Benefits
ID Card Request

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

Claims Department
April 2021 Final and May 2021 Final

METRICS

Claims Compliance	Apr-21	May-21
90% of clean claims processed within 30 calendar days	98.3%	96.0%
95% of all claims processed within 45 working days	99.9%	99.9%

Claims Volume (Received)	Apr-21	May-21
Paper claims	26,546	25,605
EDI claims	114,132	104,242
Claim Volume Total	**140,678**	**129,847**

Percentage of Claims Volume by Submission Method	Apr-21	May-21
% Paper	18.87%	19.72%
% EDI	81.13%	80.28%

Claims Processed	Apr-21	May-21
HEALTHsuite Paid (original claims)	89,994	88,040
HEALTHsuite Denied (original claims)	29,988	33,016
HEALTHsuite Original Claims Sub-Total	**119,982**	**121,056**
HEALTHsuite Adjustments	848	1,617
HEALTHsuite Total	**120,830**	**122,673**

Claims Expense	Apr-21	May-21
Medical Claims Paid	$45,400,241	$47,222,337
Interest Paid	$13,115	$24,941

Auto Adjudication	Apr-21	May-21
Claims Auto Adjudicated	89,387	88,733
% Auto Adjudicated	74.5%	73.3%

Average Days from Receipt to Payment	Apr-21	May-21
HEALTHsuite	19	19

Pended Claim Age	Apr-21	May-21
0-29 calendar days		
HEALTHsuite	19,959	19,738
30-59 calendar days		
HEALTHsuite	448	386
Over 60 calendar days		
HEALTHsuite	5	0

Overall Denial Rate	Apr-21	May-21
Claims denied in HEALTHsuite	29,988	33,016
% Denied	24.8%	26.9%

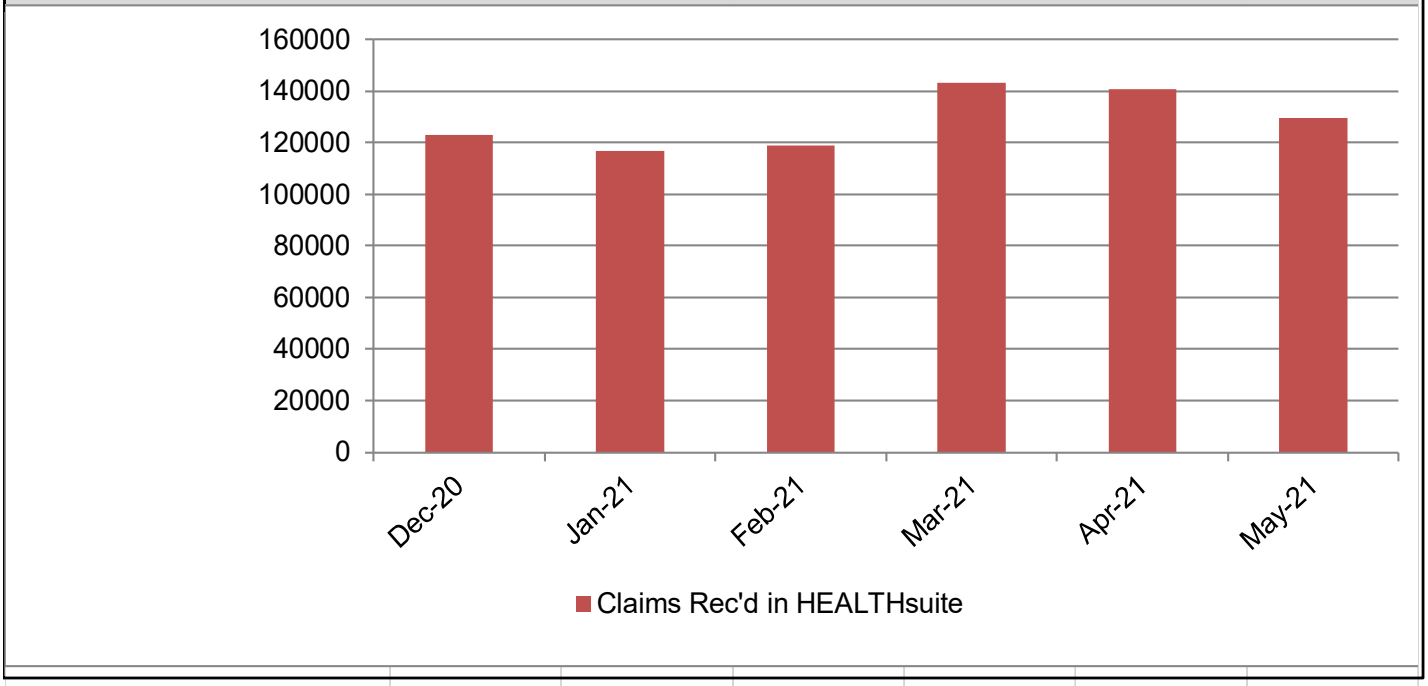
Claims Department
April 2021 Final and May 2021 Final

May-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	12%
Duplicate Claim	11%
Non-Covered Benefit for this Plan	8%
Please Submit a Copy of Primary Payer Paper EOB	8%
% Total of all denials	**60%**

Claims Received By Month

Claims Received Through	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Claims Rec'd in HEALTHsuite	123,248	116,784	119,001	143,171	140,678	129,847



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

Provider Relations Dashboard May 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%							
Benefits	4.9%	3.4%	3.7%	3.1%	3.4%							
Claims Inquiry	38.8%	36.8%	39.4%	38.1%	40.6%							
Change of PCP	1.3%	3.6%	4.8%	4.1%	4.8%							
Complaint/Grievance (includes PDR's)	3.5%	3.6%	3.8%	3.6%	2.8%							
Contracts	0.5%	0.6%	0.3%	0.6%	0.5%							
Correspondence Question/Followup	0.0%	0.0%	0.0%	0.0%	0.0%							
Demographic Change	0.1%	0.1%	0.1%	0.2%	0.1%							
Eligibility - Call from Provider	25.0%	25.8%	24.3%	24.4%	25.1%							
Exempt Grievance/ G&A	0.2%	0.2%	0.2%	0.0%	0.4%							
General Inquiry/Non member	0.0%	0.0%	0.0%	0.0%	0.0%							
Health Education	0.0%	0.0%	0.0%	0.0%	0.0%							
Intrepreter Services Request	2.0%	1.8%	1.3%	1.2%	1.1%							
Kaiser	3.7%	0.2%	0.2%	0.4%	0.3%							
Member bill	0.0%	0.0%	0.0%	0.0%	0.0%							
Mystery Shopper Call	0.0%	0.0%	0.0%	0.0%	0.0%							
Provider Portal Assistance	3.6%	4.3%	4.0%	3.9%	4.3%							
Pharmacy	0.9%	0.9%	1.0%	1.1%	1.2%							
Provider Network Info	0.2%	0.1%	0.2%	0.2%	0.3%							
Transferred Call	0.2%	0.1%	0.1%	0.0%	0.0%							
All Other Calls	12.3%	14.4%	13.6%	16.0%	12.7%							
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Field Visit Activity Details

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Claims Issues	11	11	16	12	8							
Contracting/Credentialing	11	19	30	21	11							
Drop-ins	0	0	0	0	0							
JOM's	2	3	2	0	4							
New Provider Orientation	11	31	12	10	10							
Quarterly Visits	202	206	269	230	241							
UM Issues	2	2	3	0	1							
Total Field Visits	239	272	332	273	275	0	0	0	0	0	0	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS

Practitioners		AHP 413	PCP 368	SPEC 649	PCP/SPEC 17
AAH/AHS/CHCN Breakdown		AAH 451	AHS 206	CHCN 441	COMBINATION OF GROUPS 349
Facilities	**271**				

VENDOR SUMMARY
Credentialing Verification Organization, Symply CVO

	Number	Average Calendar Days in Process	Goal - Business Days	Goal - 98% Accuracy	Compliant
Initial Files in Process	16	34	25	Y	Y
Recred Files in Process	26	42	25	Y	Y
Expirables updated Insurance, License, DEA, Board Certifications					Y
Files currently in process	**42**				

CAQH Applications Processed in May 2021

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

May 2021 Peer Review and Credentialing Committee Approvals

Initial Credentialing	**Number**
PCP	3
SPEC	4
ANCILLARY	1
MIDLEVEL/AHP	15
	23
Recredentialing	
PCP	6
SPEC	15
ANCILLARY	1
MIDLEVEL/AHP	10
	32
TOTAL	**55**

May 2021 Facility Approvals

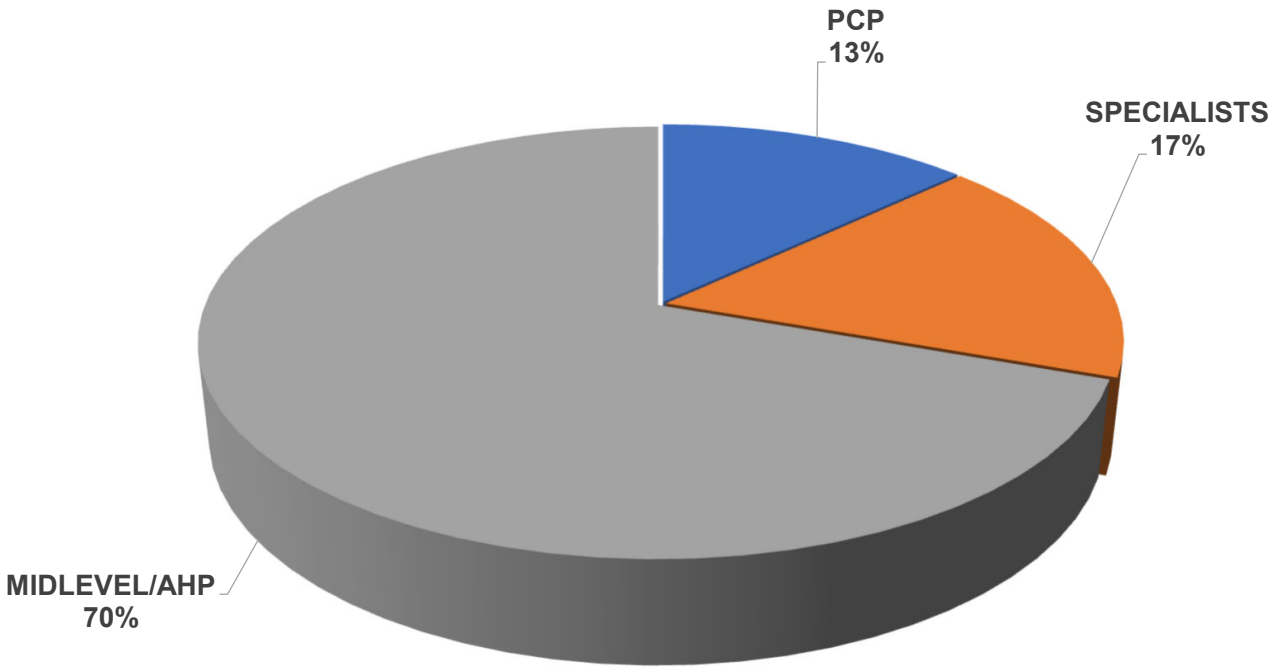
Initial Credentialing	2
Recredentialing	5
	7
Facility Files in Process	**36**

May 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
Agarwal	Nikhil	Specialist	Initial	5/18/2021
Anuforo	Sylvanus	Allied Health	Initial	5/18/2021
Buriel	Milissa	Allied Health	Initial	5/18/2021
Chhina	Jaspreet	Allied Health	Initial	5/18/2021
Cuffaro	Taylor	Allied Health	Initial	5/18/2021
Elmi	Eman	Specialist	Initial	5/18/2021
Flores	Laravic	Primary Care Physician	Initial	5/18/2021
Garg	Sachin	Primary Care Physician	Initial	5/18/2021
Hudson	Mollie	Allied Health	Initial	5/18/2021
Kaneko	Kentaro	Allied Health	Initial	5/18/2021
Keeton	Victoria	Allied Health	Initial	5/18/2021
Li	Yan	Allied Health	Initial	5/18/2021
Liu	Jessica	Primary Care Physician	Initial	5/18/2021
Luna	Lauren	Allied Health	Initial	5/18/2021
Ni	Huan	Allied Health	Initial	5/18/2021
Quan	Tiffany	Allied Health	Initial	5/18/2021
Sachkar	Nicole	Allied Health	Initial	5/18/2021
Tran	Janet	Allied Health	Initial	5/18/2021
Tsou	Gee Yen	Allied Health	Initial	5/18/2021
Walsh	Jason	Allied Health	Initial	5/18/2021
Wong	Nang	Ancillary	Initial	5/18/2021
Wright	Francis	Specialist	Initial	5/18/2021
Yalom	Eve	Specialist	Initial	5/18/2021
Allen	Melissa	Allied Health	Recred	5/18/2021
Anand	Shwetha	Specialist	Recred	5/18/2021
Birenbaum	Emily	Primary Care Physician	Recred	5/18/2021
Braddock	Jennifer	Allied Health	Recred	5/18/2021
Cahill	Elizabeth	Specialist	Recred	5/18/2021
Chawla	Varun	Specialist	Recred	5/18/2021
Che	Qi	Specialist	Recred	5/18/2021
Chow	Diane	Specialist	Recred	5/18/2021
Cowden	Katy	Allied Health	Recred	5/18/2021
Erasmus	Desmond	Specialist	Recred	5/18/2021
Gordon	Danielle	Allied Health	Recred	5/18/2021
Irani	Adil	Specialist	Recred	5/18/2021
Jung	Jesse	Specialist	Recred	5/18/2021
Kelly	Irene	Primary Care Physician	Recred	5/18/2021
Khetrapal	Rabin	Primary Care Physician	Recred	5/18/2021
Lieu	Macy	Allied Health	Recred	5/18/2021
Lin	Jiin-Tarng	Primary Care Physician	Recred	5/18/2021
Lobo	Kristin	Primary Care Physician	Recred	5/18/2021
Mahawar	Suresh	Specialist	Recred	5/18/2021
Pascal	Steven	Specialist	Recred	5/18/2021
Patel	Krishna	Allied Health	Recred	5/18/2021
Reddy	Thirupathi	Specialist	Recred	5/18/2021
Sachwitz	Drew	Allied Health	Recred	5/18/2021
Stewart	Kelley	Allied Health	Recred	5/18/2021
Tannura	Laila	Allied Health	Recred	5/18/2021
Thomas	Rahitha	Allied Health	Recred	5/18/2021
Wang	Aiqun	Ancillary	Recred	5/18/2021
Wang	Michael	Specialist	Recred	5/18/2021
Wong	Clifford	Specialist	Recred	5/18/2021
Yee	John	Specialist	Recred	5/18/2021
Yee	Stephen	Primary Care Physician	Recred	5/18/2021
Young	Robyn	Specialist	Recred	5/18/2021

MAY PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY

PCP	3
Specialists	4
Ancillary	0
MIDLEVEL/AHP	16
Total	23



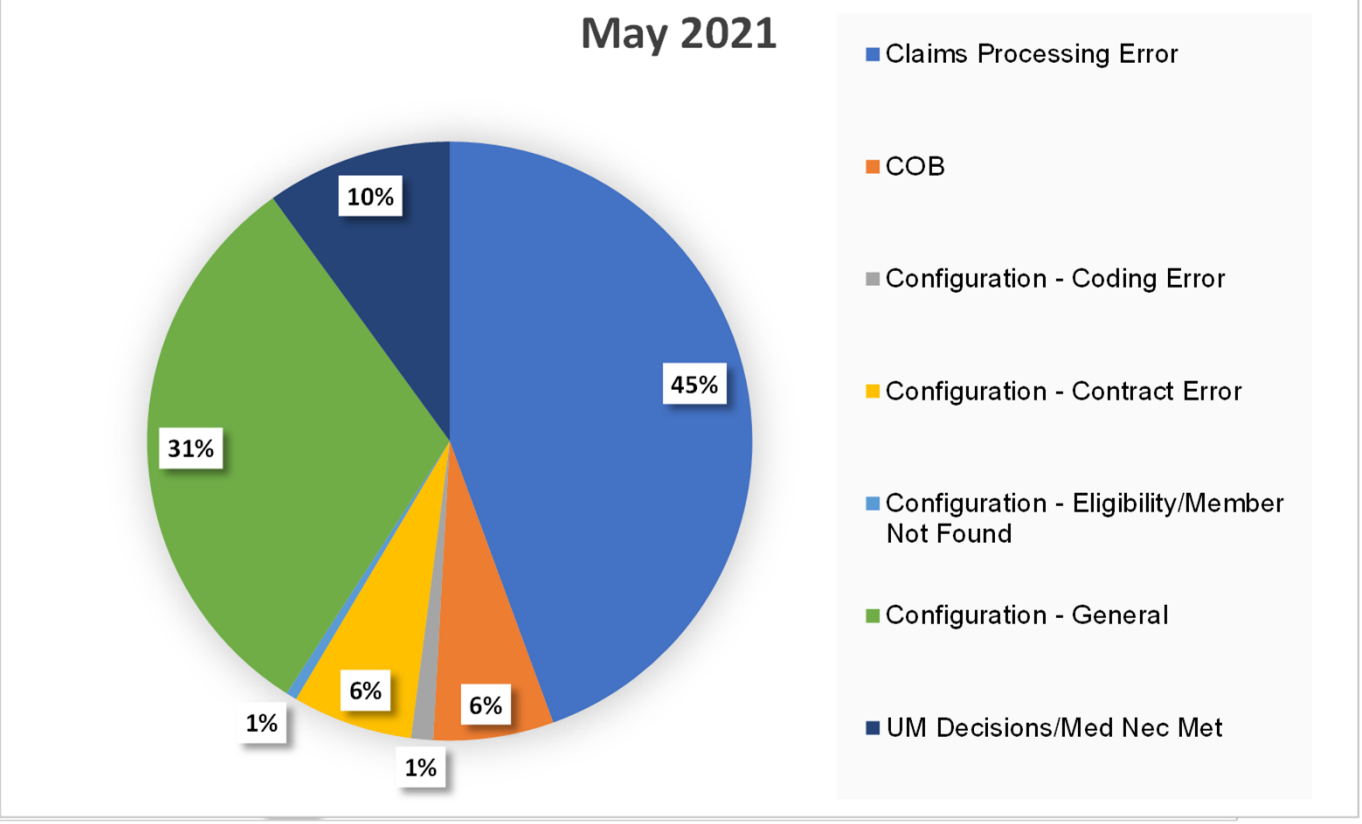
Provider Dispute Resolution
April 2021 and May 2021

METRICS		
PDR Compliance	**Apr-21**	**May-21**
# of PDRs Resolved	766	593
# Resolved Within 45 Working Days	758	590
% of PDRs Resolved Within 45 Working Days	99.0%	99.5%
PDRs Received	**Apr-21**	**May-21**
# of PDRs Received	784	859
PDR Volume Total	**784**	**859**
PDRs Resolved	**Apr-21**	**May-21**
# of PDRs Upheld	541	422
% of PDRs Upheld	71%	71%
# of PDRs Overturned	225	171
% of PDRs Overturned	29%	29%
Total # of PDRs Resolved	**766**	**593**
Average Turnaround Time	**Apr-21**	**May-21**
Average # of Days to Resolve PDRs	42	39
Oldest Unresolved PDR in Days	44	42
Unresolved PDR Age	**Apr-21**	**May-21**
0-45 Working Days	1,228	1,482
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**1,228**	**1,482**

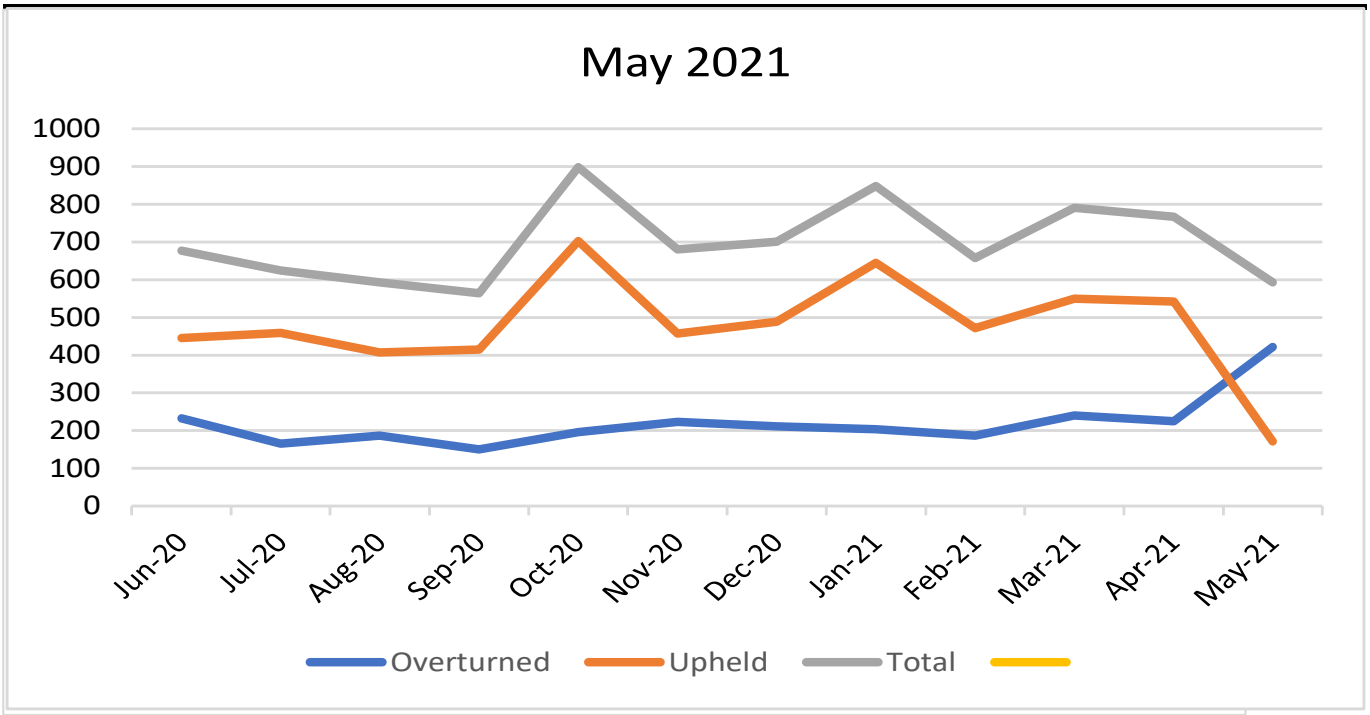
Provider Dispute Resolution
April 2021 and May 2021

May-21

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

FY 2020-2021 | **MAY 2021 OUTREACH REPORT**

ALLIANCE IN THE COMMUNITY

FY 2020-2021 | MAY 2021 OUTREACH REPORT

During May 2021, the Alliance completed **630** member orientation outreach calls and conducted **161** member orientations (**26%** member participation rate). In addition, in May 2021, the Outreach team completed **27** Alliance website inquiries, and reached **3** people at a virtual community presentation.

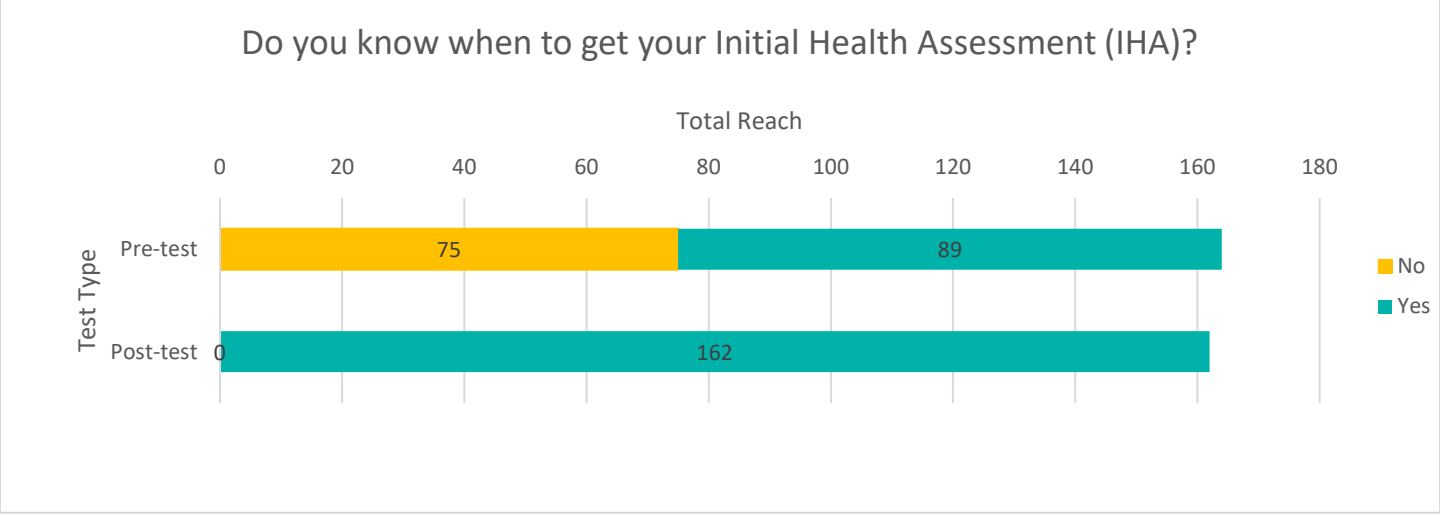
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **23,035** self-identified Alliance members have been reached during outreach activities.

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

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

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 May 1, through May 31, 2021 (20 working days) – **161** net new members completed a MO by phone.

After completing a MO **100%** of members who completed the post-test survey in May 2021 reported knowing when to get their IHA, compared to only **54%** 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\2. May 2021**

ALLIANCE IN THE COMMUNITY

FY 2020-2021 | MAY 2021 OUTREACH REPORT

FY 2019-2020 MAY 2020 TOTALS

- **4** COMMUNITY EVENTS
- **7** MEMBER EDUCATION EVENTS
- **19** MEMBER ORIENTATIONS
- **2** MEETINGS/ PRESENTATIONS/ COMMUNITY TRAINING
- **32** TOTAL INITIATED/ INVITED EVENTS
- **0** TOTAL COMPLETED **EVENTS**

0 CITIES

- **0** TOTAL REACHED AT COMMUNITY EVENTS
- **0** TOTAL REACHED AT MEMBER EDUCATION EVENTS
- **278** TOTAL REACHED AT MEMBER ORIENTATIONS
- **0** TOTAL REACHED AT MEETINGS/PRESENTATIONS
- TOTAL REACHED AT COMMUNITY TRAINING
- **278** MEMBERS REACHED AT ALL EVENTS
- **278** **TOTAL REACHED AT ALL EVENTS**

$0.00 TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

FY 2020-2021 MAY 2021 TOTALS

- **0** COMMUNITY EVENTS
- **0** MEMBER EDUCATION EVENTS
- **0** MEMBER ORIENTATIONS
- **1** MEETINGS/ PRESENTATIONS
- **0** COMMUNITY TRAINING
- **0** TOTAL INITIATED/ INVITED EVENTS
- **0** TOTAL COMPLETED **EVENTS**

16 CITIES*

Alameda
Albany
Berkeley
Castro Valley
Dublin
El Sobrante
Fremont
Hayward
Livermore
Newark
Oakland
Pleasanton
Sacramento
San Leandro
San Lorenzo
Union City

- **0** TOTAL REACHED AT COMMUNITY EVENTS
- **0** TOTAL REACHED AT MEMBER EDUCATION EVENTS
- **161** TOTAL REACHED AT MEMBER ORIENTATIONS
- **3** TOTAL REACHED AT MEETINGS/PRESENTATIONS
- **0** COMMUNITY TRAINING
- **162** MEMBERS REACHED AT ALL EVENTS
- **164** **TOTAL REACHED AT ALL EVENTS**

$0.00 TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

**Cities represent the mailing address designations for members who completed a member orientation by phone. The italicized cities are outside of Alameda County. The C&O Department started including these cities in the Q4 FY21 Outreach Report.*

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: **June 11, 2021**

Subject: **Compliance 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 continues to meet 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, 2021DMHC conducted their virtual audit interview 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.

- *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:

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

  - The Plan has not received a preliminary audit report, which is typically due within 90-days from the last day of the audit.

- 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. The Plan has not received any feedback from DHCS regarding its submission.

- New to the Calendar Year 2021, the Plan will be required to certify its provider networks at the subcontractor level through a process called the Subcontracted Network Certification (SNC). DHCS has created a phased approach to implementing these requirements:
  - 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, which included the Network Overview and Structure; Subcontracted Network Information; SN Certification Exceptions, and; details of monitoring, oversight, and compliance methodologies, alongside processes that will be used to determine compliance with network adequacy standards for the 2022 SNC.

- 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.

- 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 Covered Entity is in compliance with Plan Business Associate Contracts or other Arrangements. The Plan is required to submit responses to the OCR within 20 days of the notice, by June 15, 2021.

- Joint Regulatory Inquiry (DHCS, DMHC) – Lags Medical Center*:*
    - On May 26, 2021, the Plan received notice that Lags Spine and Sportscare Medical Center (LAGS) is under investigation for fraud against the Medi-Cal program. As a result, the Department of Health Care Services (DHCS) is placing select NPIs associated with LAGS under the following: A payment suspension pursuant to W&I Code section 14107.11 and 42 CFR section 455.23, effective May 4, 2021; and a temporary suspension and deactivation pursuant to W&I Code section 14043.36, effective May 19, 2021. The Plan is prohibited from reimbursing LAGS for services provided to Medi-Cal members. To the extent that LAGS submits claims for reimbursement, the MCP may adjudicate those claims, but must withhold payment for all approved claims until further notice from DHCS. In October 2020, LAGS informed the Plan it was temporarily closing the only site located within the Plan's service area. The Plan terminated its contract with LAGS on May 27, 2021, with an effective date of May 4, 2021. There was no impact to Plan members as part of the termination.

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. The virtual onsite audit will be conducted by the Plan's consultant, PillarRx, in collaboration with Plan staff from June 22 – 23, 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.

Pre-audit documents are due to participating health plans on June 23, 2021. Staff held an internal kick-off meeting on May 6, 2021, to discuss scope, timing, expectations, and key dates. The virtual onsite audit will be conducted from August 8, 2021 – September 10, 2021.

- The 2021 Annual Delegation Audit Schedule is being finalized and will be submitted to the Delegation Oversight Committee for approval on June 22, 2021.

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.

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: **June 11, 2021**

Subject: **Health Care Services Report**

Utilization Management: Outpatient

- The new UM Medical Director, Dr. Rosalia Mendoza, is being oriented and trained to work at AAH, and she has already begun to work with the team to improve processes.

- The team is working on a few areas to improve identified during the DMHC/DHCS audit.

- Significant progress has been made on UM/Claims/Configuration collaboration and improved alignment. This standardization improves the 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 is approximately 35%.

- Notice of Action letters: The UM team continues the ongoing work to build out the NOA letter templates to drive standardization and efficiency.

- UCSF PCP Pilot: The launching of our UCSF PCP pilot was effective 5/1/21. A maximum of 400 members will be transitioning from Anthem Blue Cross to the Alliance for services, and members are currently being added to the Alliance as they request. Members continue to receive all services at UCSF without a break in continuity. The prior authorization process for the pilot is being mirrored to our current processes with UCSF for specialty services.

- Stanford Oncology: Our pilot with Stanford for Oncology services continues to be successful, with a total of 72 members in the program. 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	**March 2021**	**April 2021**	**May 2021**
Overall Denial Rate	3.8%	3.3%	3.1%
Denial Rate Excluding Partial Denials	3.8%	3.3%	3.1%
Partial Denial Rate	0.0%	0.0%	0.0%

Turn Around Time Compliance			
Line of Business	**March 2021**	**April 2021**	**May 2021**
Overall	100%	99%	99%
Medi-Cal	100%	99%	99%
IHSS	100%	100%	98%
Benchmark	*95%*	*95%*	*95%*

Utilization Management: Inpatient

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

- UM Inpatient Manager (Carla HealyLondon), Senior Director HCS (Julie Anne Miller) and UM Medical Director presented successfully during the DMHC/DHCS audits.

- To assure effective communication and coordination of discharge efforts, weekly complex/long stay patient rounds continue with Sutter, AHS, Washington, and Kindred 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

Inpatient Utilization Total All Aid Categories **Actuals (excludes Maternity)**			
Metric	**February 2021**	**March 2021**	**April 2021**
Authorized LOS	4.7	4.3	4.4
Admits/1,000	49.7	56.7	56.5
Days/1,000	233.9	242.6	247.1

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	796
Denied	583
Closed	552
Total	**1931**

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

- Medications for diabetes, pain, acne, attention deficit hyperactivity disorder, tear production, and peptic ulcers 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	TRETINOIN 0.05% CREAM	Acne	Criteria for approval not met
3	RESTASIS 0.05% EYE EMULSION	Tear production	Criteria for approval not met
4	JANUVIA 50 MG TABLET	Diabetes	Criteria for approval not met
5	JARDIANCE 10 MG TABLET	Diabetes	Criteria for approval not met
6	JANUVIA 100 MG TABLET	Diabetes	Criteria for approval not met
7	TRETINOIN 0.025% CREAM	Acne	Criteria for approval not met
8	OMEGA-3 ETHYL ESTERS 1 GM CAP	Cholesterol	Criteria for approval not met
9	CLINDAMYCIN PHOSP 1% LOTION	Acne	Criteria for approval not met
10	ATOVAQUONE-PROGUANIL 250-100	Malaria	Criteria for approval not met

- DHCS lengthens pharmacy carve-out transition with no specific date.

- Post carve-out, the State of California will take back many pharmacy responsibilities including drug coverage, rebate, utilization management and pharmacy provider network.

- AAH is to maintain beneficiary care coordination, drug adherence, disease, and medication management, in authorization, denial & appeals of physician-administered drugs (PAD) and outpatient infusion drugs. The pharmacy team has worked closely with Project Management, IT, and other departments to prepare for the transition.

- Pharmacy services collaborates with other health care services teams for member on use of opioids and/or benzodiazepine, transitions of care, education on active smokers and asthma medication starters.

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

- Quality improvement and cost containment initiatives continue with the focus on effective formulary management, coordination of benefit & collaboration with Quality and case management to improve drug adherence, disease medication management, and generic utilization.

- Pharmacy is also leading initiatives on PAD focused internal and external partnership, biosimilar optimization, vaccination and channel management, and infusion strategy.

Case and Disease Management

- Population health-driven, disease-specific case management bundles continue development with the expansion of the oncology bundle. Early research and planning for Major Organ Transplant CM bundle has begun.

- 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.

- 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.

- The CM department continues its focused work on Oncology services in conjunction with Stanford and EpicCare.

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. PMO is leading a series of listening/input sessions for key stakeholders. Model of Care and Transitions documents due are June 30, 2021, and the team is collaborating to complete the submission timely.

- In Lieu of Services: In Lieu of Services (ILOS) are services not typically provided by managed health plans in lieu of higher cost medical services. CM is working with Project Management Office on planned community and stake holder listening sessions through June. Determination of ILOS categories for launch January 2022 will be completed soon to complete the Model of Care document by its due date. Working closely with the Project Office, we are finalizing a list of up to 7 services to be provided starting January, 2022 (Phase 1). The ILOS selection is focused on maintaining continu

Case Type	New Cases Opened in April 2021	Total Open Cases As of April 2021
Care Coordination	231	635
Complex Case Management	43	99
Transitions of Care	258	497

Grievances & Appeals

- Total grievances resolved in May went over our goal of less than 1 complaint per 1,000 members at 6.00 complaints per 1,000 members.

- The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of May 2021; we did meet our goal at 8% overturn rate.

- 3 expedited grievances related to access to specialty medication were not able to be resolved within the required 3-day period. All 3 were resolved on the 4th day.

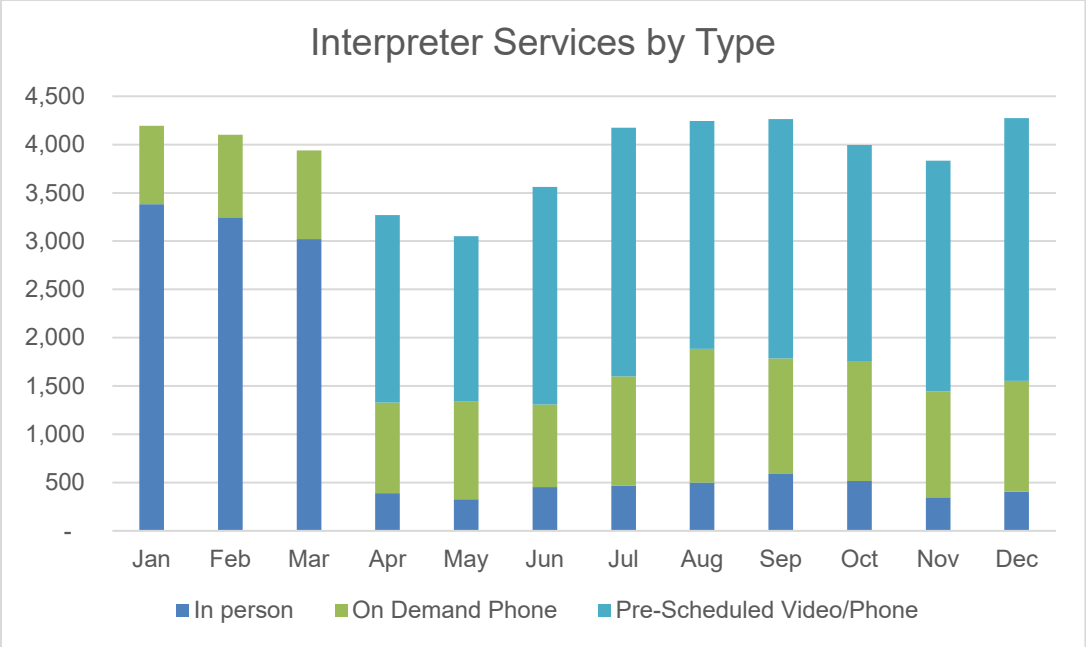
May 2021 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	764	30 Calendar Days	95% compliance within standard	725	94.8%	2.66

Expedited Grievance	8	72 Hours	95% compliance within standard	5	62.5%	0.02
Exempt Grievance	970	Next Business Day	95% compliance within standard	970	100.0%	3.37
Standard Appeal	55	30 Calendar Days	95% compliance within standard	55	100.0%	0.19
Expedited Appeal	2	72 Hours	95% compliance within standard	2	100.0%	0.006
Total Cases:	1,799		95% compliance within standard	1,757	97.6%	6.00

Quality

- The Alliance covered interpreters for 46,904 member encounters in 2020, including telephonic, in person and video interpretation. Stay at Home orders had a significant impact on how we deliver interpreter services starting in April of 2020 moving us from primarily in-person to primarily telephonic and video. One significant benefit of most telephonic interpretation services is that it is On Demand and does not require pre-scheduling.

- Service Type by Month, 2020



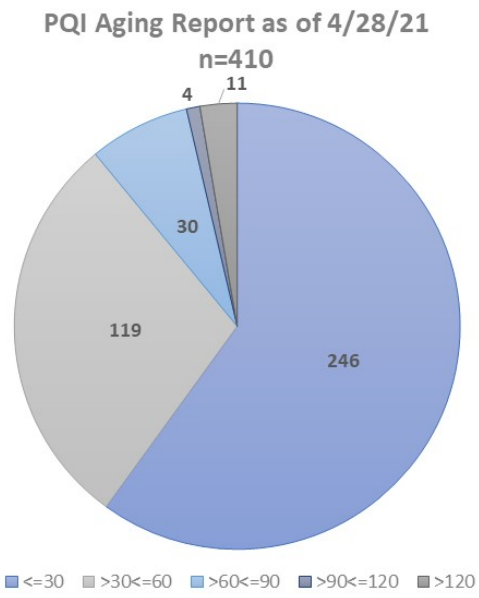
- CG CAHPS Survey 2020 Language Access Questions:
    - Member satisfaction with interpreter services has risen substantially.
    - The CG-CAHPS is a member satisfaction survey sent to approximately 2,000 randomly selected members from claims for ambulatory outpatient visits each month. Of those who responded to the CG-CAHPS survey in 2020, 23% of adult surveys responded that they need an interpreter, and 28% of the child surveys..
    - Favorable response rate for interpreter availability among those who needed an interpreter was 83.7% for Adults and 91.4% for children.
    - Responses 2 & 3 are counted as “Favorable” responses.

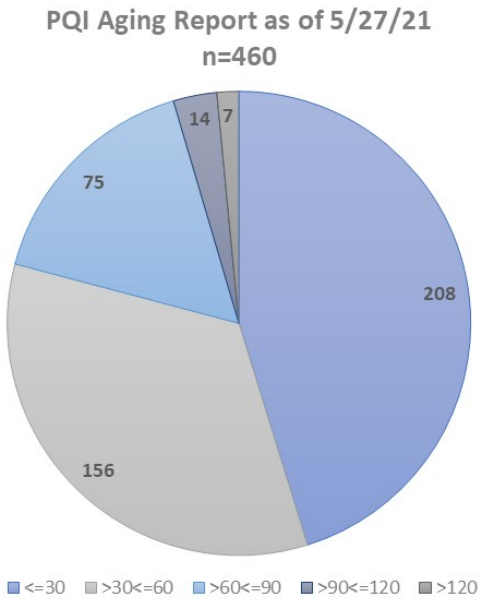
Favorable Response Rate	Q1	Q2	Q3	Q4	Total
Adult	83.8%	84.0%	83.2%	83.6%	**83.7%**
Child	90.1%	90.6%	93.6%	92.6%	**91.4%**

- Next Steps.
    - The internal Cultural and Linguistic Committee will discuss the creation of an objective for this measurement.
    - Continue to expand On Demand interpreter service availability

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. The current PQI TAT is 120 days, which is calculated from the receipt of the PQI by QI to the resolution date.





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 & Security Officer**

Date: **June 11, 2021**

Subject: **Information Technology Report**

Call Center System Availability

- AAH phone systems and call center applications performed at 100% availability during the month of May 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 June 2021.

Office 365 Project

Phase 3 of the Office 365 project will soon kick-off, focusing on the deployment of Microsoft Teams enterprise-wide. One of our goals is to move away from silo operated platform to a consolidated shared services platform which will allow the 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).

Multi-Factor Authentication Rollout (Security)

- The Alliance has embarked on the Multi-Factor Authentication (MFA) rollout designed to increase security for Virtual Protocol Network (VPN) access to our network. The 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 30% of our staff to MFA, and the remaining shall be completed before the end of August 2021.

Encounter Data

- In the month of May, the Alliance submitted 111 encounter files to the Department of Health Care Services (DHCS) with a total of 281,920 encounters.

- As part of encounter data quality process improvement, the Alliance resubmitted is working with UCSF, Sutter, and Kaiser, and submitted 40K replacement/void encounters that were not meeting DHCS encounter data submission standards. Encounter quality monitoring and fixing data errors is an ongoing effort. Our goal is to continue to keep the encounter data quality at high standards and ensure our delegates are submitting 90% of the encounters.

Enrollment

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

HealthSuite

- A total of 121,056 claims were processed in the month of May, of which 88,733 claims auto adjudicated. This sets the auto-adjudication rate for this period to 73.3%.

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

TruCare

- A total of 9,043 authorizations were loaded and processed in the TruCare application.

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

Web Portal

- The provider and member consumer portal utilization for the month of April remains consistent with prior months. Additionally, there is an increase in the medical authorization submission using the Provider portal.

- 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 provider and member portals are estimated to go-live during June and July of 2021, respectively.

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 **May.**

- Network scans returned a value of 0, which is in line with the 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.

- In the month of May 2021, the Alliance completed work on integrating Kaiser and PerformRx historical pharmacy, Admission, Discharge, and Transfer (ADT) data into the Data Warehouse. The Credentialing, Authorization, and Case Management are the remaining data domains to be added to the Data Warehouse, which is expected to be completed before the 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 May 2021”.
- Summary of Primary Care Physician (PCP) Auto-assignment in the month of May 2021.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of May 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 May 2021”.

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
May	280,774	4,589	2,180	5,949	112	133

1. MC – Medical Member

2. GC – Group Care Member

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

Auto-Assignments	Member Count
Auto-assignments MC	1,346
Auto-assignments Expansion	1,314
Auto-assignments GC	42
PCP Changes (PCP Change Tool) Total	2,282

TruCare

- See Table 2-1 “Summary of TruCare Authorizations for the month of May 2021”.
- There were 9,043 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 May 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	4,877	156	0	39	6	25	68	272	0	4,605
Paper to EDI	1,275	0	0	0	0	0	0	0	0	1,275
Provider Portal	1,812	0	0	0	0	0	0	0	0	1,812
Manual Entry	0	0	0	0	0	0	0	0	1,351	1,351
Total										9,043

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 April 2021

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	5,586	3,158	149,629	362
MCAL	71,868	2,254	5,184	797
IHSS	2,782	70	139	24
AAH Staff	172	44	715	2
Total	**80,408**	**5,526**	**155,667**	**1,185**

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

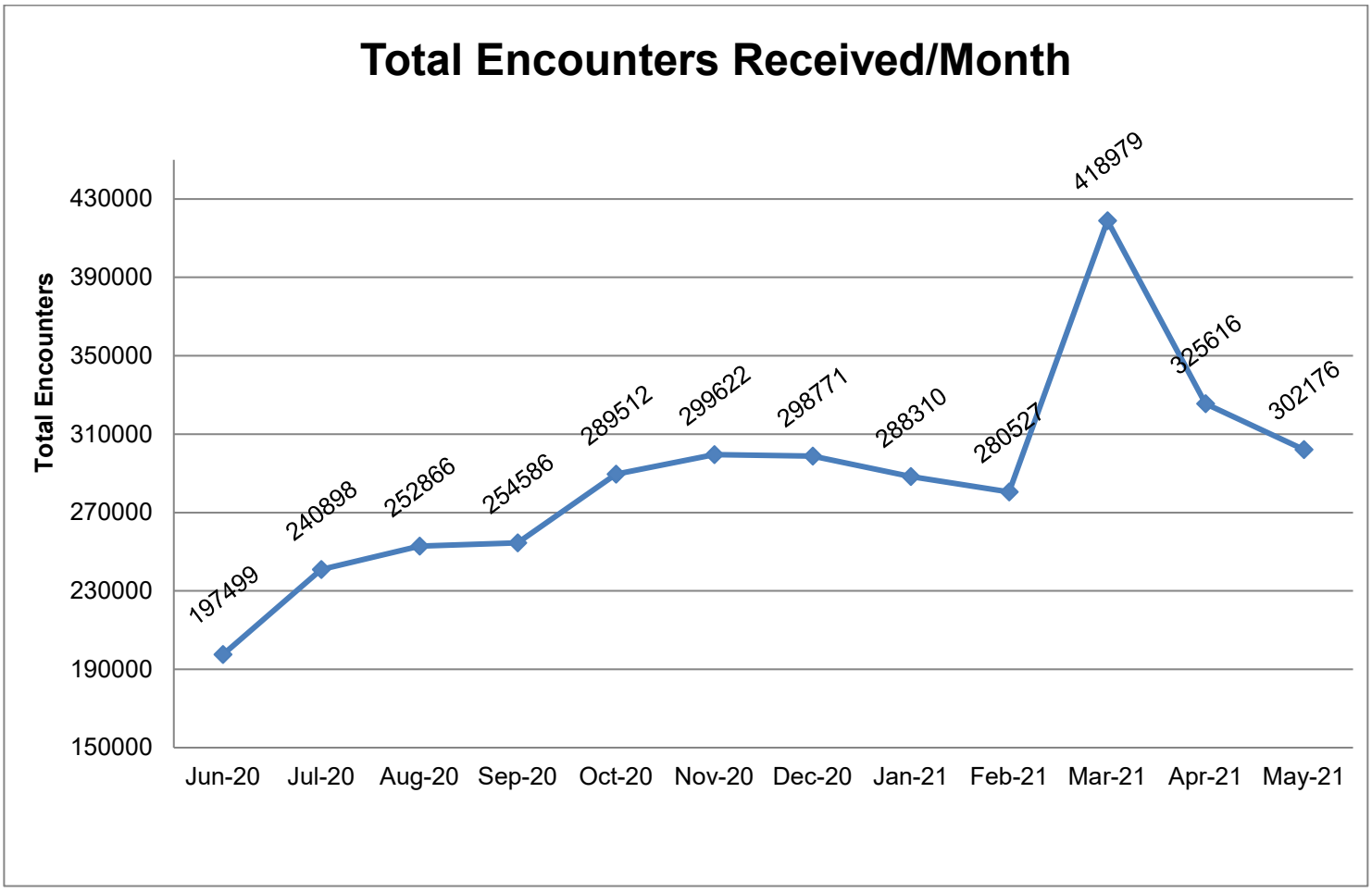
Top 25 Pages Viewed		
Category	**Page Name**	**April - 21**
Provider	Member Eligibility	644,175
Provider	Claim Status	161,962
Provider	Auth Submit	5,572
Member My Care	Member Eligibility	2,953
Provider	Auth Search	2,098
Member Help Resources	Find a Doctor or Hospital	1,629
Member Help Resources	ID Card	1,430
Provider	Member Roster	1,038
Member Help Resources	Select or Change Your PCP	980
Member Home	MC ID Card	764
Member My Care	My Claims Services	693
Member Help Resources	Request Kaiser as my Provider	650
Provider	Provider Directory	629
Member My Care	Authorization	357
Provider - Home 2019	Forms	350
Member My Care	My Pharmacy Medication Benefits	332
Provider	Instruction Guide	266
Provider	Pharmacy	237
Member Help Resources	FAQs	184
Member My Care	Member Benefits Materials	178
Provider	Manual	169
Member Help Resources	Authorizations Referrals	165
Member Help Resources	Forms Resources	150
Member My Care	My Pharmacy Argus	144
Member Help Resources	Contact Us	132

Encounter Data From Trading Partners 2021

- AHS:
  May daily files (9,074 records) were received on time.
- Beacon:
  May monthly files (14,951 records) were received on time.
- CHCN:
  May weekly files (66,260 records) were received on time.
- CHME:
  May monthly file (4,885 records) were received on time.
- CFMG:
  May weekly files (10834 records) were received on time.
- Docustream:
  May weekly files (1,445 records) were received on time.
- PerformRx:
  May monthly files (162,414 records) were received on time.
- Kaiser:
  May monthly files (30,039 records) were received on time.
  May monthly Kaiser Pharmacy files (21,376 records) were received on time.
- LogistiCare:
  May weekly files (14,399 records) were received on time.
- March Vision:
  May monthly file (3,708 records) were received on time.
- Quest Diagnostics:
  May weekly files (16,718 records) were received on time.
- Teladoc:
  May weekly files (16 records) were received on time.

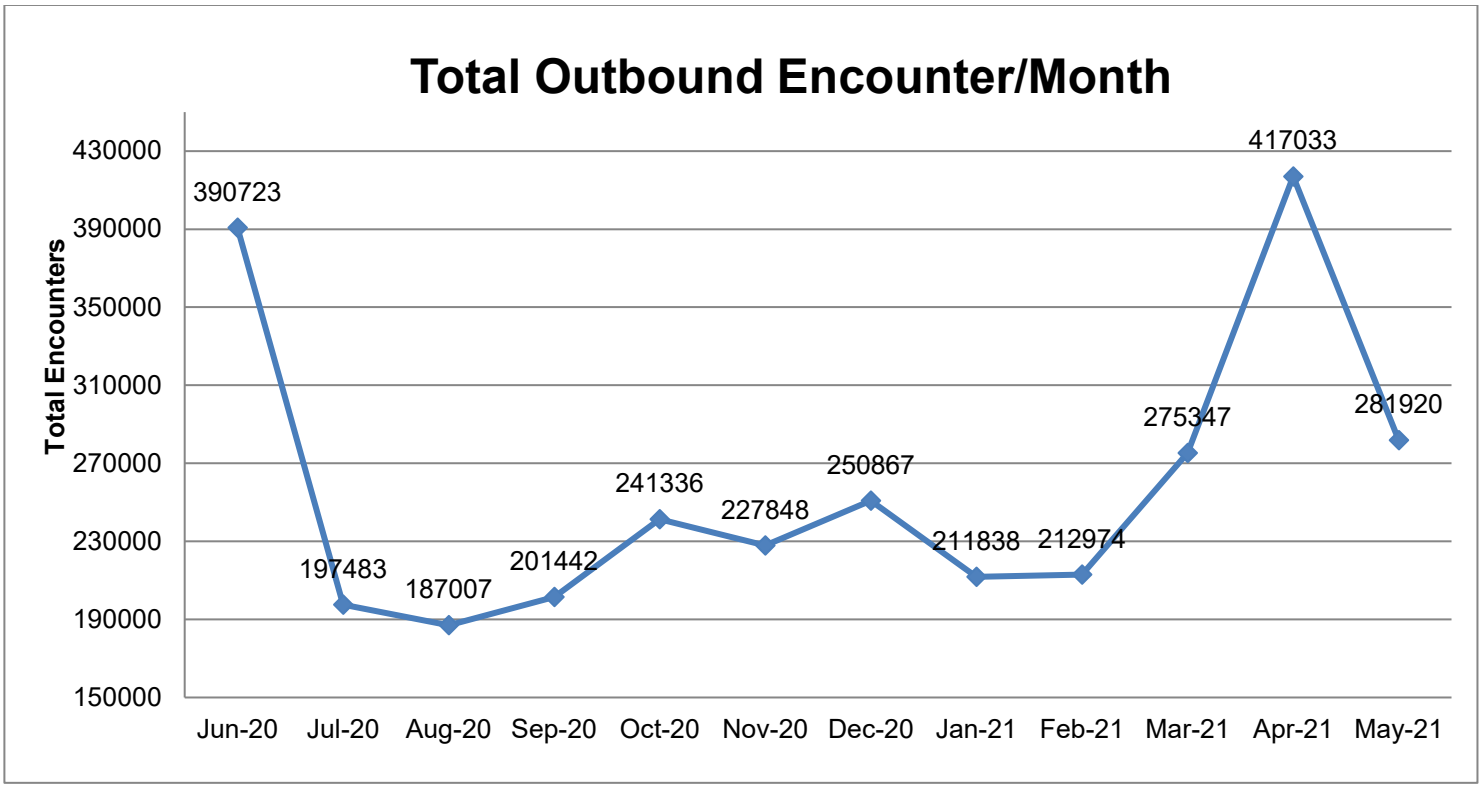
Trading Partner Encounter Inbound Submission History

Trading Partners	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
HealthSuite	95735	107093	104293	111255	120149	111676	123248	116784	119001	143171	140678	129847
AHS	7129	10154	9353	849	12762	16814	8419	9404	9702	9326	11166	9074
Beacon	9612	11413	10193	20434	14637	12673	21326	15812	14616	13002	19247	14951
CHCN	73144	53049	64935	54812	65094	85984	66473	59612	62867	89453	69080	66260
CHME	4903	4344	4987	3832	5814	5152	4388	6143	6548	5776	5497	4885
Claimsnet	6154	6545	6608	8787	11018	6504	12819	7693	12059	10905	8835	10834
Docustream	822	912	919	640	926	865	909	803	1160	935	1166	1445
Kaiser	19364	22508	26057	25829	29431	35590	29885	43639	25903	112545	39632	30039
Logisticare	10857	12865	10145	14821	11599	12665	15505	12603	14208	16924	12945	14399
March Vision	1336	1839	2568	2270	3012	2928	2361	3103	1917	2230	3156	3708
Quest	6809	10135	12783	11005	15047	8724	13406	12665	12515	14699	14203	16718
Teladoc		41	25	52	23	47	32	49	31	13	11	16
Total	197499	240898	252866	254586	289512	299622	298771	288310	280527	418979	325616	302176



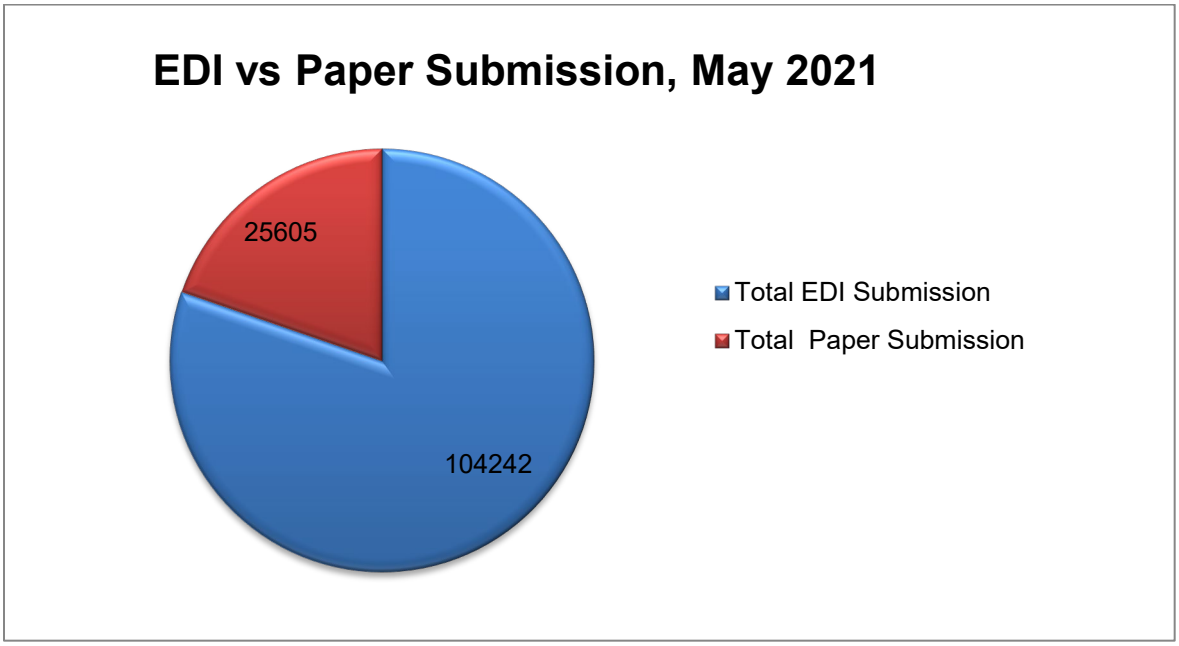
Outbound Encounter Submission

Trading Partners	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
HealthSuite	60932	76561	73815	71394	97258	79162	100653	70368	81305	84220	216640	130885
AHS	6727	10662	8083	353	11922	15980	7909	8729	9089	8655	8812	10762
Beacon	7377	9507	7620	17466	13291	10580	16229	13315	11631	10171	14881	12347
CHCN	270473	43686	38537	52622	48065	50051	54860	41461	45137	64275	49446	48573
CHME	4640	4081	4663	3632	5232	4801	3696	5327	5508	5283	5136	4767
Claimsnet	5643	4792	6110	6611	7398	5707	8595	5160	8578	7964	6489	8110
Docustream	720	799	812	609	849	969	807	764	1071	860	1070	1286
Kaiser	15545	21968	25720	25666	29031	35096	29087	42638	23810	59157	89295	29570
Logisticare	10438	14934	9924	11134	14600	12263	14773	12315	13881	16652	9705	17299
March Vision	803	1121	1909	1687	2665	2470	2013	2655	1686	1930	2455	2850
Quest	7425	9331	9789	10236	11002	10743	12214	9085	11247	16169	13093	15455
Teladoc		41	25	32	23	26	31	21	31	11	11	16
Total	390723	197483	187007	201442	241336	227848	250867	211838	212974	275347	417033	281920



HealthSuite Paper vs EDI Breakdown

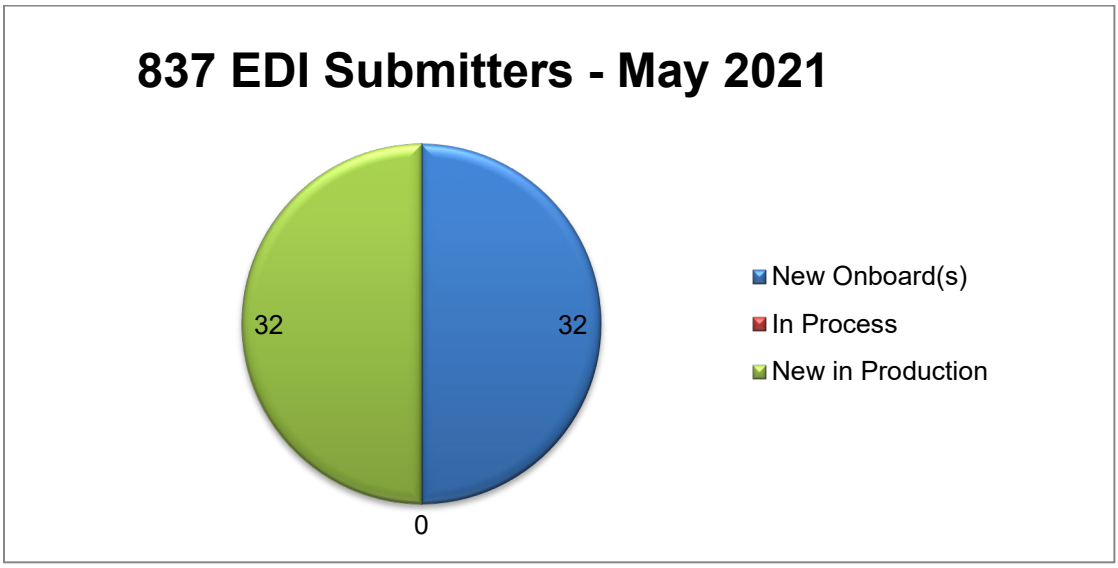
Period	Total EDI Submission	Total Paper Submission	Total Claims
21-May	104242	25605	129847

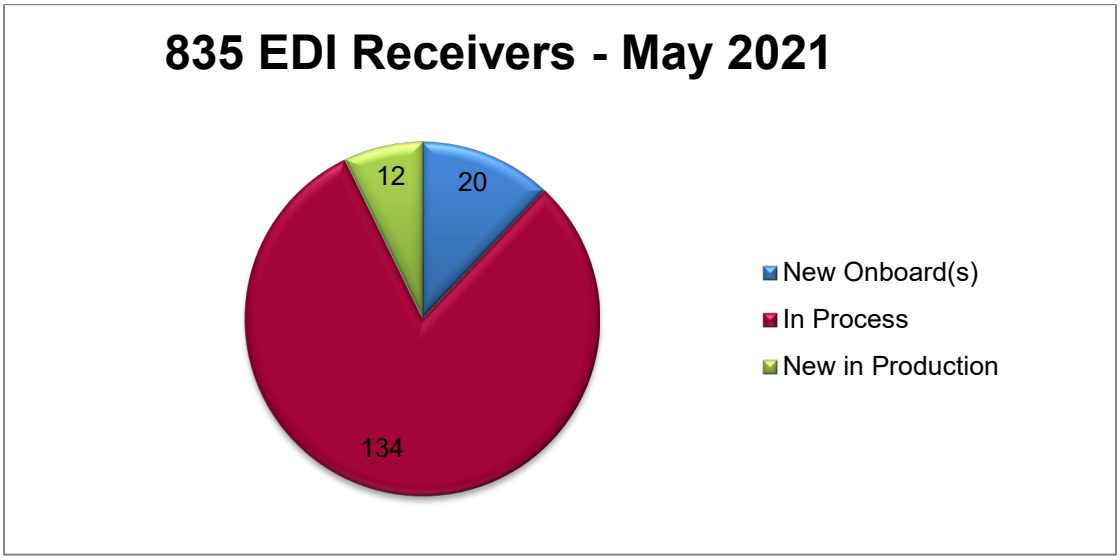


Onboarding EDI Providers - Updates

- May 2021 EDI Claims:
  - A total of 1130 new EDI submitters have been added since October 2015, with 32 added in May 2021.
  - The total number of EDI submitters is 1862 providers.
- May 2021 EDI Remittances (ERA):
  - A total of 290 new ERA receivers have been added since October 2015, with 12 added in May 2021.
  - The total number of ERA receivers is 329 providers.

	837				835			
	New On Boards	In Process	New In Production	Total in Production	New On Boards	In Process	New In Production	Total in Production
Jun-20	17	0	17	1680	2	82	1	227
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


837 EDI Submitters - May 2021
32
32
0
New Onboard(s)
In Process
New in Production


835 EDI Receivers - May 2021
12
20
134
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 May 2021.

File Type	May-21
837 I Files	20
837 P Files	91
NCPDP	9
Total Files	120

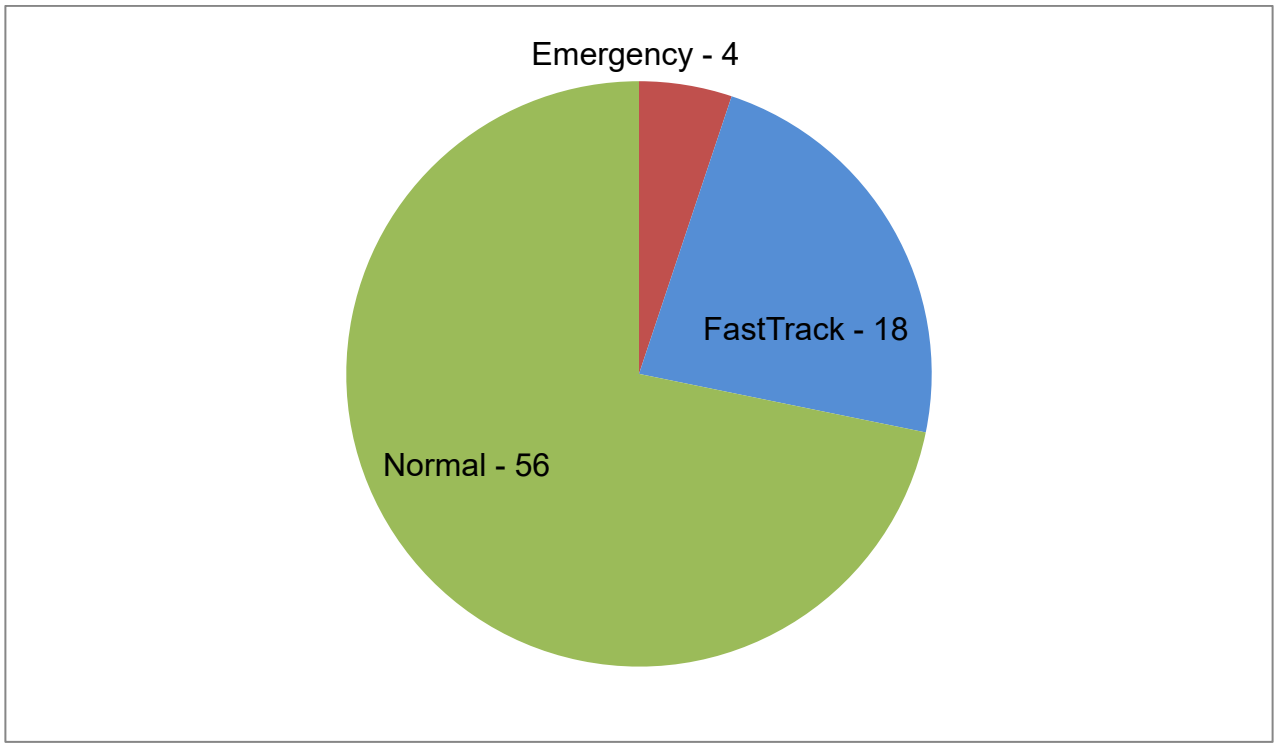
Lag-time Metrics/KPI's

AAH Encounters: Outbound 837	May-21	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	70%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	73%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	83%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	96%	80%

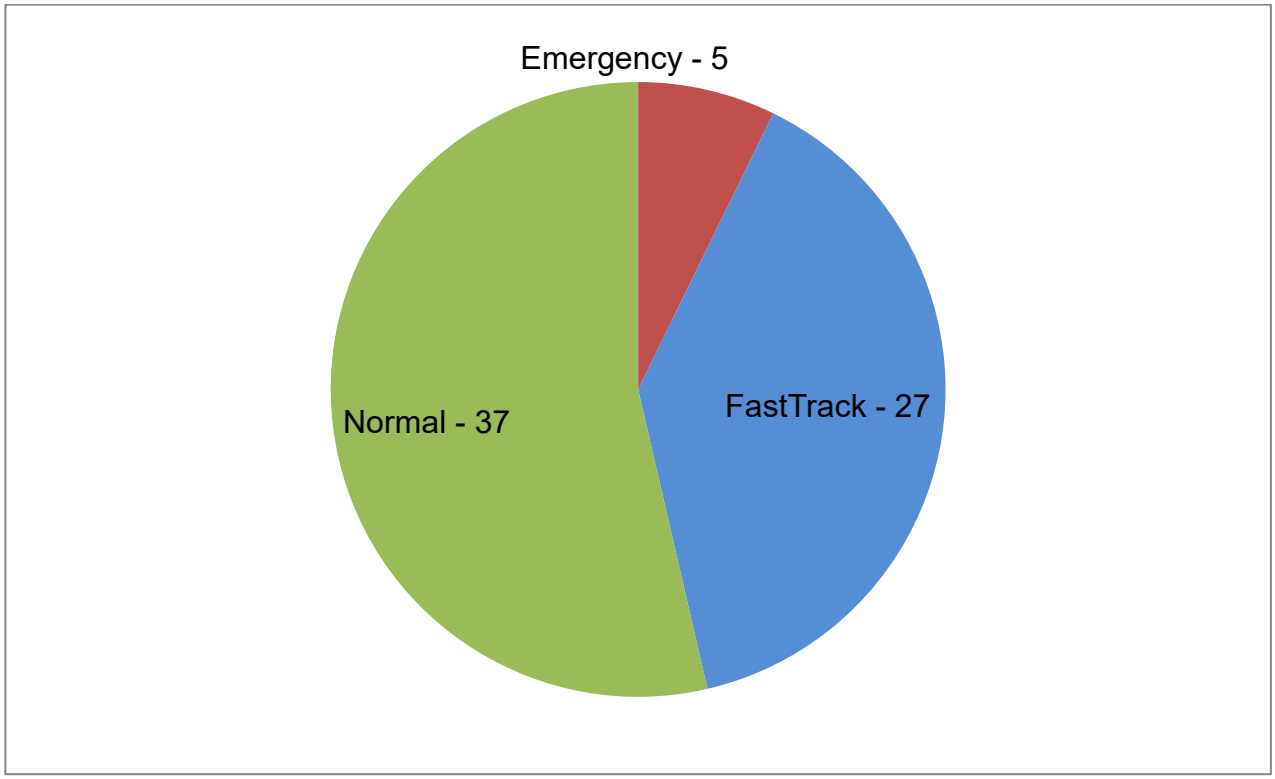
Change Management Key Performance Indicator (KPI)

- Change Request Submitted by Type in the month of May 2021 KPI – Overall Summary.
    - 2,198 Changes Submitted.
    - 2,063 Changes, Completed, and Closed.
    - 132 Active Changes.
    - 235 Changes Cancelled and Rejected.

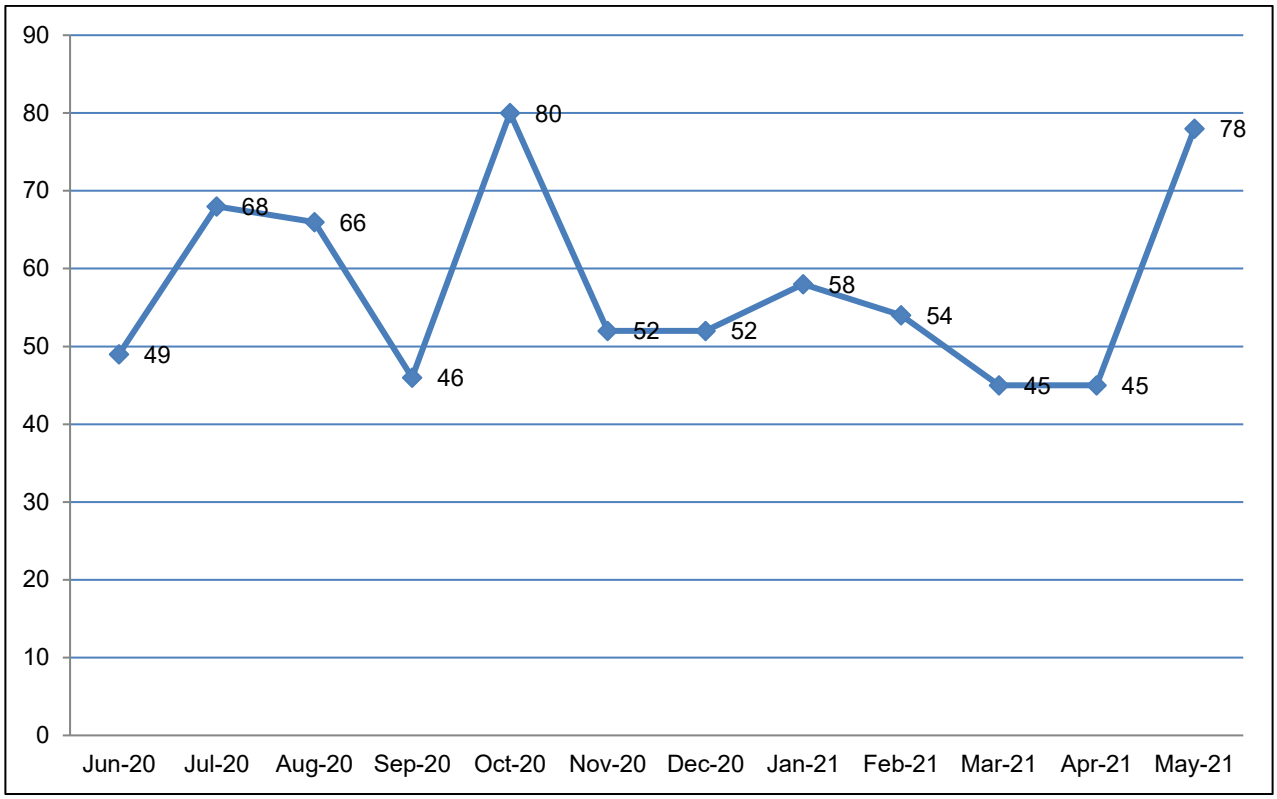
- 78 Change Requests Submitted/Logged in the month of May 2021



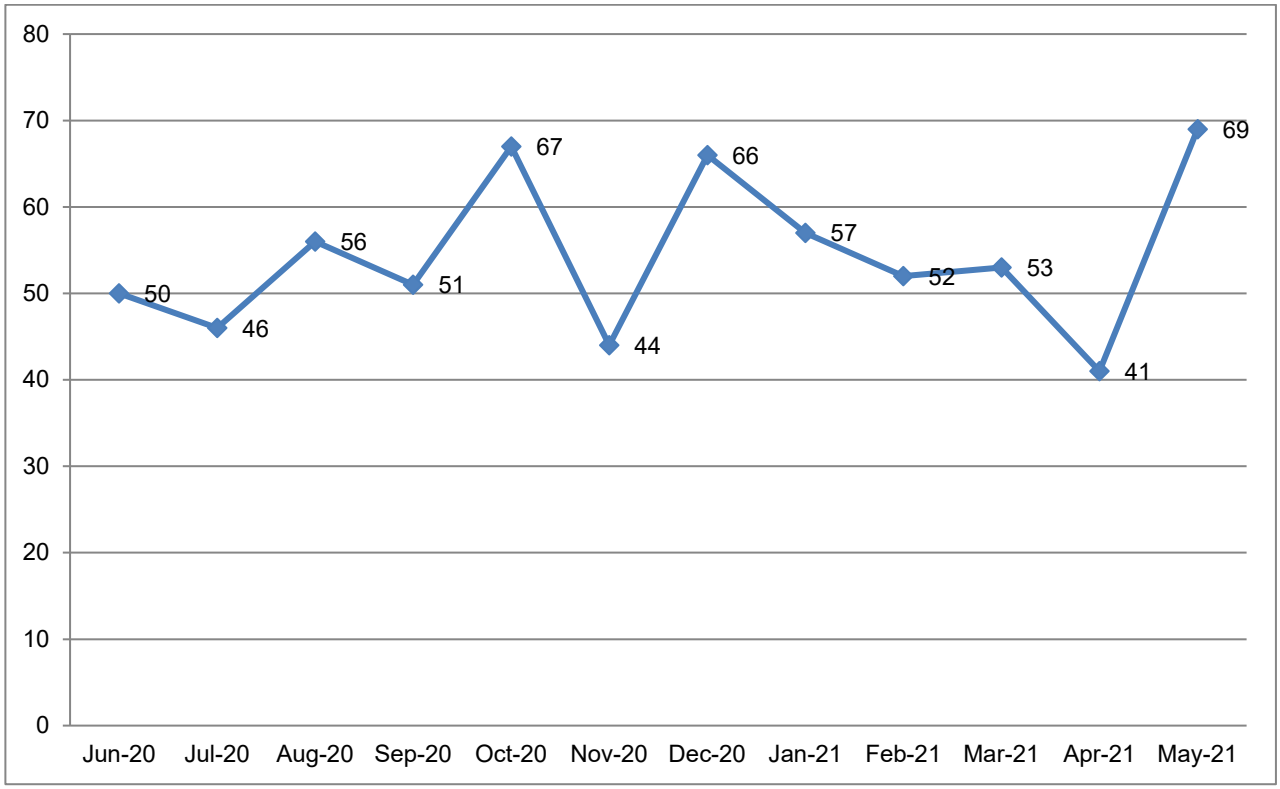
- 69 Change Requests Closed in the month of May 2021



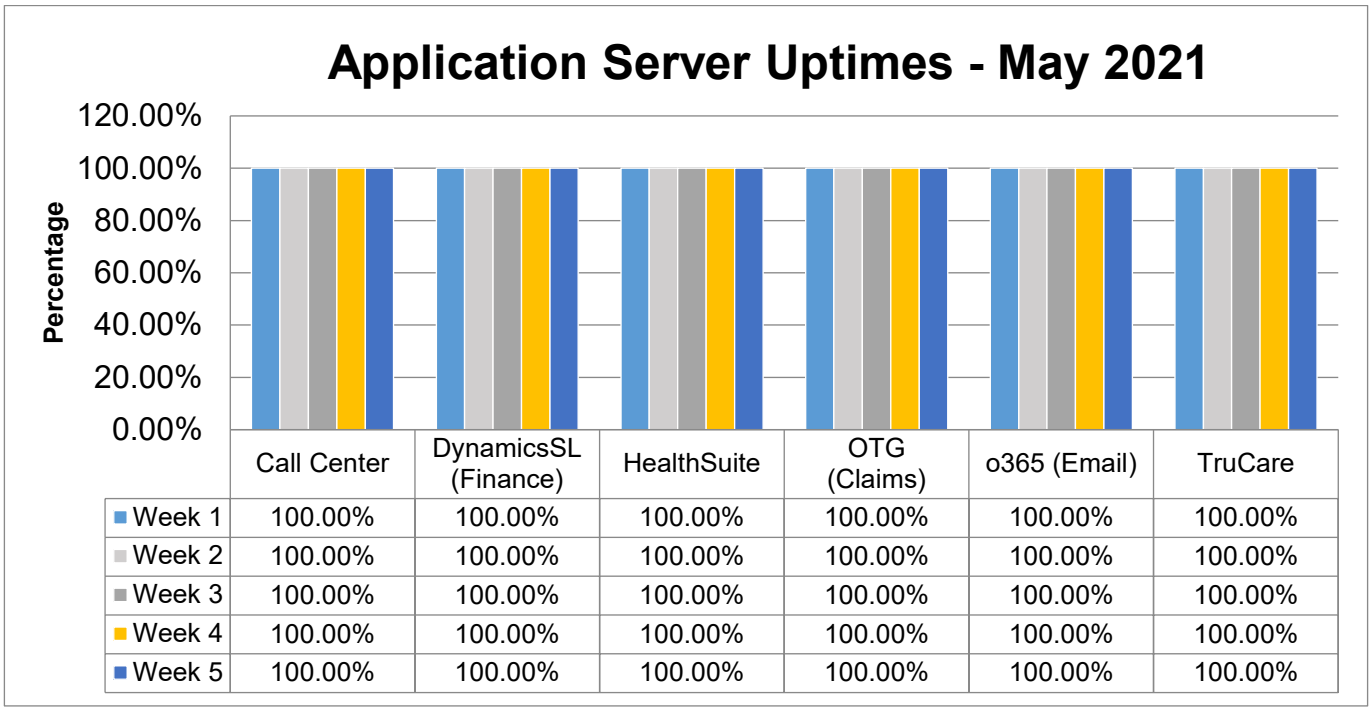
- Change Requests Submitted: Monthly Trend



- Change Requests Closed: Monthly Trend

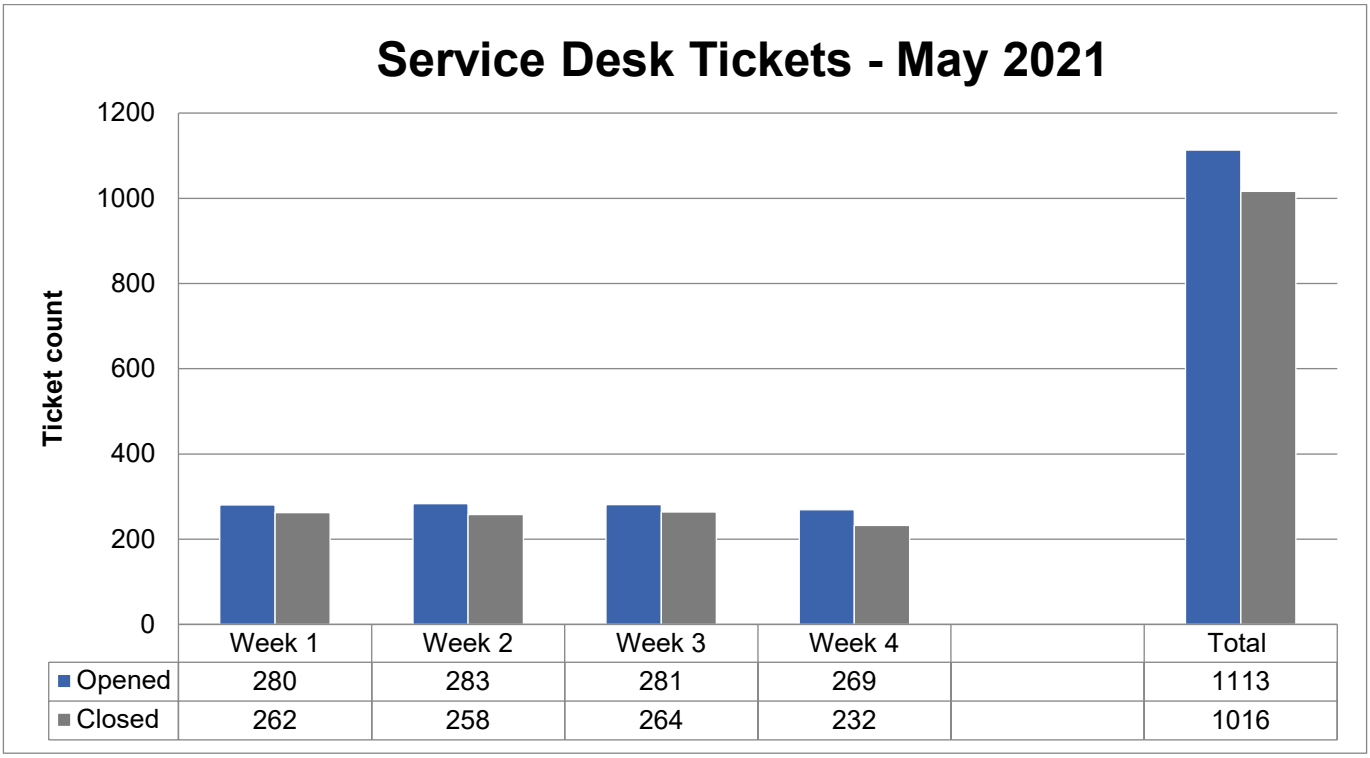


IT Stats: Infrastructure



	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%

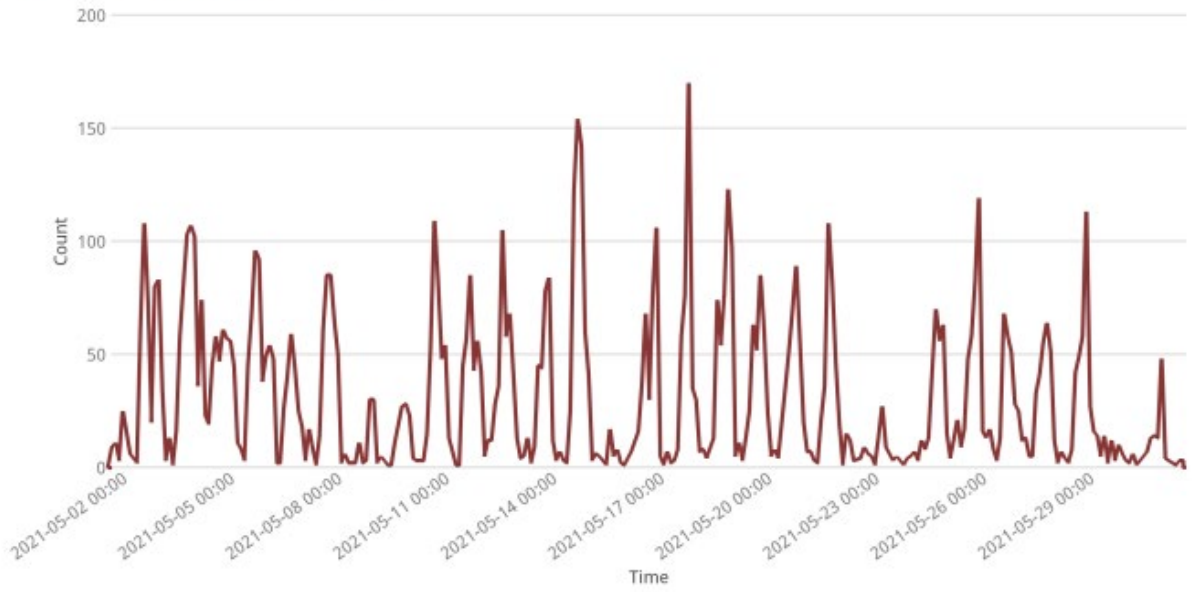
- All mission critical applications are monitored and managed thoroughly.
- There were no outages experienced in the month of **May** despite supporting 97% of staff working remotely.



- 1113 Service Desk tickets were opened in the month of **May**, which is 28.8% lower than the previous month and 1016 Service Desk tickets were closed, which is 32.9% lower than the previous month.
    - The ticket count for the month of May has leveled off in comparison to the month of April which spiked due to the number of tickets entered for password resets.

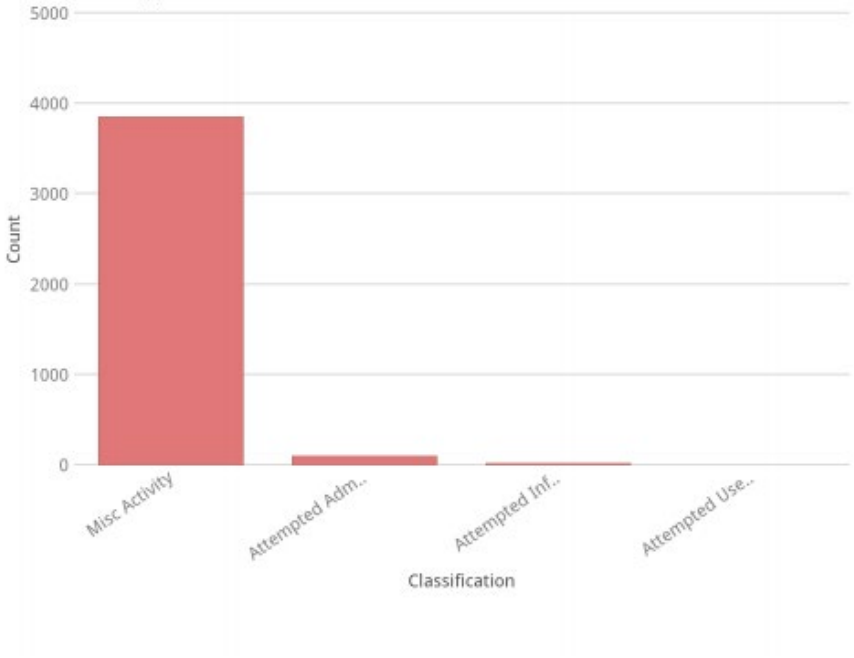
All Intrusion Events

Time Window: *2021-05-01 09:29:00 - 2021-05-31 09:29:00*



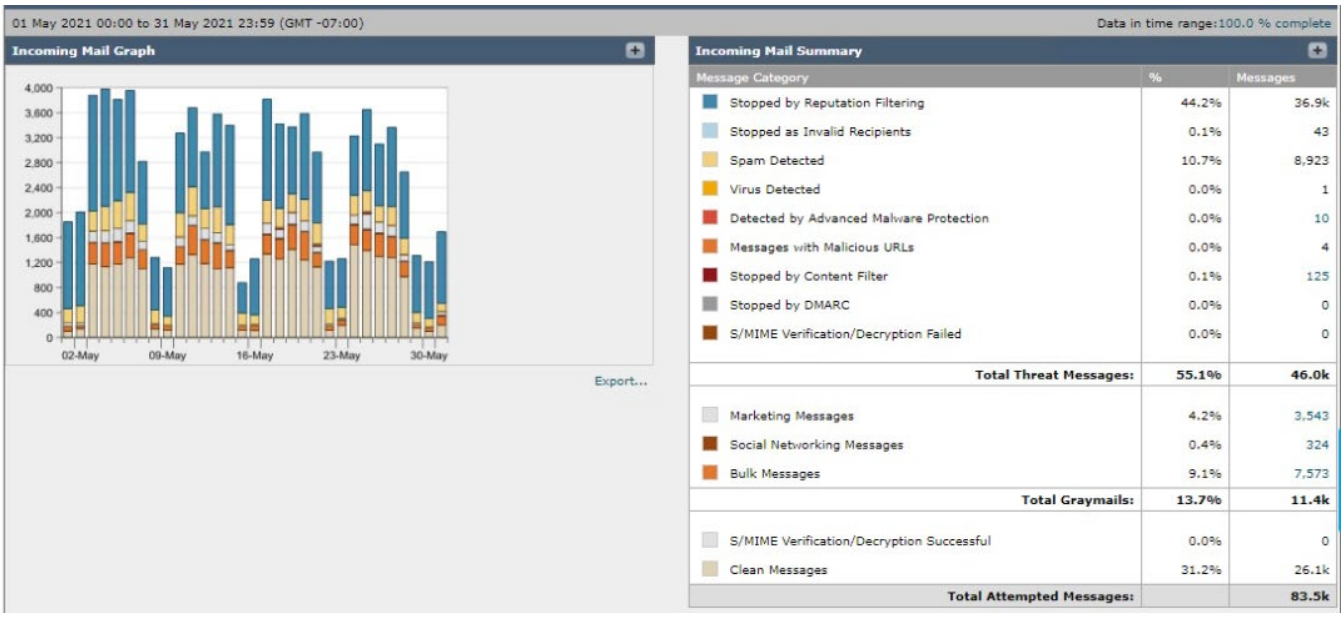
Dropped Intrusion Events

Time Window: *2021-05-01 09:30:00 - 2021-05-31 09:30:00*
Constraints: *Inline Result = dropped*

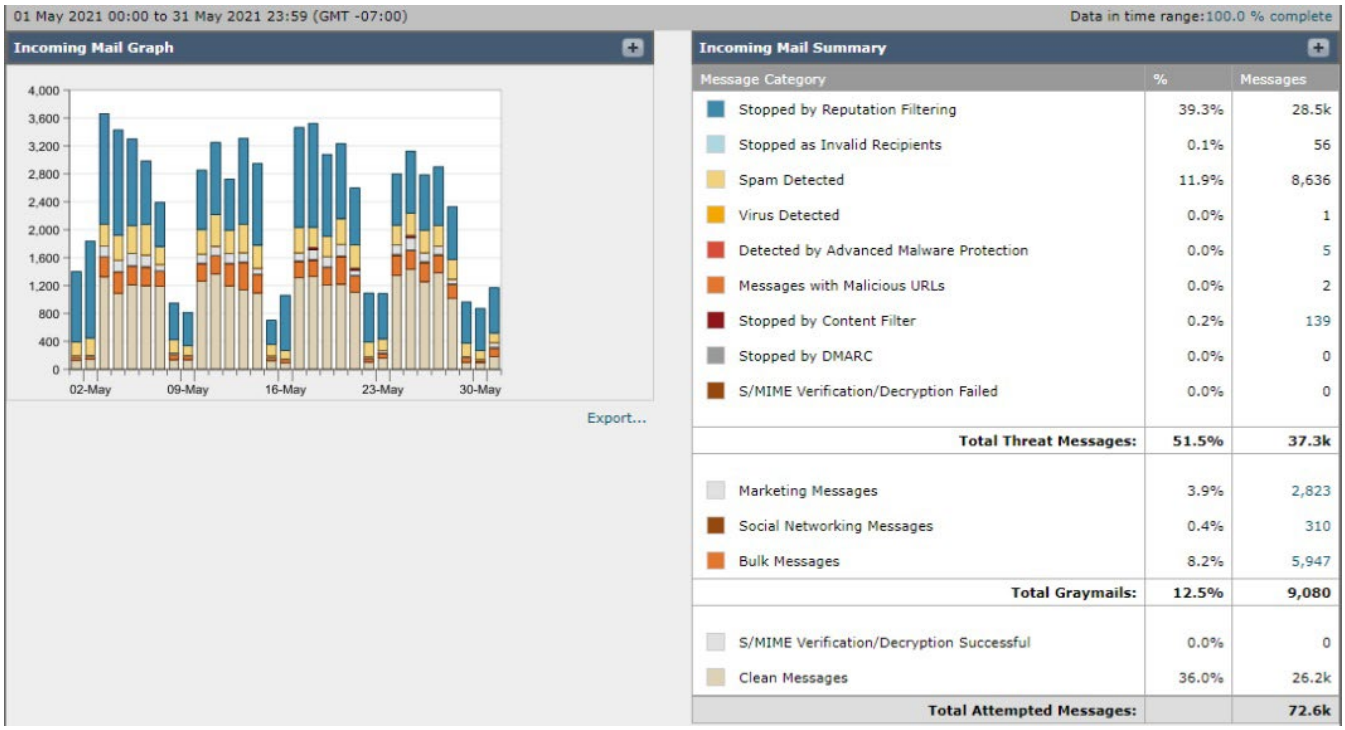


Classification	Count
Misc Activity	3,851
Attempted Administrator Privilege Gain	95
Attempted Information Leak	18
Attempted User Privilege Gain	1

MX4


01 May 2021 00:00 to 31 May 2021 23:59 (GMT -07:00)
Data in time range:100.0 % complete
Incoming Mail Graph
4,000
3,600
3,200
2,800
2,400
2,000
1,600
1,200
800
400
0
02-May
09-May
16-May
23-May
30-May
Export...
Incoming Mail Summary
Message Category | % | Messages
Stopped by Reputation Filtering | 44.2% | 36.9k
Stopped as Invalid Recipients | 0.1% | 43
Spam Detected | 10.7% | 8,923
Virus Detected | 0.0% | 1
Detected by Advanced Malware Protection | 0.0% | 10
Messages with Malicious URLs | 0.0% | 4
Stopped by Content Filter | 0.1% | 125
Stopped by DMARC | 0.0% | 0
S/MIME Verification/Decryption Failed | 0.0% | 0
Total Threat Messages: | 55.1% | 46.0k
Marketing Messages | 4.2% | 3,543
Social Networking Messages | 0.4% | 324
Bulk Messages | 9.1% | 7,573
Total Graymails: | 13.7% | 11.4k
S/MIME Verification/Decryption Successful | 0.0% | 0
Clean Messages | 31.2% | 26.1k
Total Attempted Messages: | | 83.5k

MX9


01 May 2021 00:00 to 31 May 2021 23:59 (GMT -07:00)
Data in time range:100.0 % complete
Incoming Mail Graph
4,000
3,600
3,200
2,800
2,400
2,000
1,600
1,200
800
400
0
02-May
09-May
16-May
23-May
30-May
Export...
Incoming Mail Summary
Message Category | % | Messages
Stopped by Reputation Filtering | 39.3% | 28.5k
Stopped as Invalid Recipients | 0.1% | 56
Spam Detected | 11.9% | 8,636
Virus Detected | 0.0% | 1
Detected by Advanced Malware Protection | 0.0% | 5
Messages with Malicious URLs | 0.0% | 2
Stopped by Content Filter | 0.2% | 139
Stopped by DMARC | 0.0% | 0
S/MIME Verification/Decryption Failed | 0.0% | 0
Total Threat Messages: | 51.5% | 37.3k
Marketing Messages | 3.9% | 2,823
Social Networking Messages | 0.4% | 310
Bulk Messages | 8.2% | 5,947
Total Graymails: | 12.5% | 9,080
S/MIME Verification/Decryption Successful | 0.0% | 0
Clean Messages | 36.0% | 26.2k
Total Attempted Messages: | | 72.6k

Item / Date	May-20	Jun-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	***May-21***
Stopped By Reputation	278.0k	322.6k	237.0k	129.0k	74.7k	68.9k	69.7k	43.8k	149k	60.7k	79.9k	***65.4***
Invalid Recipients	55	50	612	2,582	1,120	883	153	62	242	384	1,776	***99***
Spam Detected	17.1k	15.9k	16.9k	11.2k	15.4k	13.6k	13.2	8,650	30.2k	19.2k	19.2k	***18***
Virus Detected	3	1	2	2	1	1	1	0	9	3	5	***2***
Advanced Malware	0	1	0	1	1	2	9	10	10	0	6	***6***
Malicious URLs	43	47	50	33	22	31	39	3	6	14	0	***264***
Content Filter	23	14	10	26	5	2	8	18	189	56	151	***264***
Marketing Messages	3,834	4,024	3,715	4,127	3,794	6,511	6,147	3,203	68	68	6,707	***6,366***
Attempted Admin Privilege Gain	1,292	2,573	33	1,865	314	285	84	42	160	89	96	***95***
Attempted User Privilege Gain	23	94	22	339	1,948	1,019	650	37	6	64	10	***1***
Attempted Information Leak	48	64	88	18	52	156	167	44	11	3	20	***18***
Potential Corp Policy Violation	32	19	59	210	0	0	0	0	0	0	0	***0***
Network Scans Detected	2	2	1	1	9	0	0	0	0	0	0	***0***
Web Application Attack	124	42	0	65	25	25	0	0	0	24	11	***0***
Attempted Denial of Service	0	0	0	0	0	11.2k	6,775	15,163	2,788	0	1	***0***
Misc. Attack	56	18	0	14	4,242	2,508	5,935	2,390	13,836	6,870	4,395	***3,851***

- 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 **May.**

- 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.

Projects and Programs

Ruth Watson

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

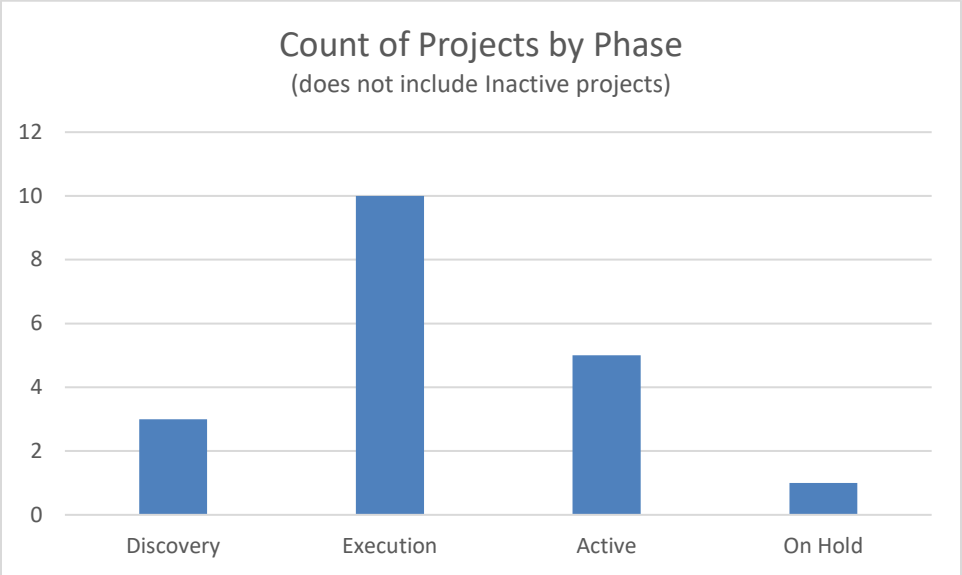
From: **Ruth Watson, Chief Projects and Programs Officer**

Date: **June 11, 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)
  - 1 project On Hold
  - 4 projects Inactive (**not included on 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)
    - Responsibilities include:
      - Prioritization of the portfolio
      - Review new business cases
      - Resolution of issues escalated by any given project steering committee
    - Meetings occur monthly; may occur more frequently, if needed
  - Portfolio Governance Committee – comprised of Senior Leadership Team
    - Responsibilities include:
      - Oversight, funding and approval body

        - Ensure alignment of recommended projects to strategic goals
        - Serves as the final level for resolution of escalated issues
    - First meeting held on May 18, 2021

Integrated Planning

- Behavioral Health Integration (BHI) Incentive Program – Department of Health Care (DHCS) pilot program commenced January 1, 2021 and continues through December 31, 2022
    - Quarterly milestone reports must be submitted to DHCS within 60 days from the end of the quarter; 1Q2021 report due to DHCS no later than May 28, 2021
        - Reports and supporting documentation reviewed and approved by Quality Improvement staff on May 14
        - Completed Quarterly Milestone Report, including invoice in the amount of $281,150, and submitted to Compliance for review and approval on May 18
        - Report and invoice submitted to DHCS by Compliance on May 28

- 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
    - DHCS revised the Model of Care (MOC) deliverables and timelines and presented to Managed Care Plans (MCPs) during technical assistance meeting on May 25
    - MOC now has three separate submissions
        - Template Submission #1, due to DHCS by July 1, 2021
            - Focus is on the following areas:
                - Initial ECM/ILOS provider capacity questions
                - WPC and HHP transition
                - Preliminary ILOS selections
        - Template Submission #2, due to DHCS September 1, 2021
            - MCPs must submit the majority of ECM/ILOS Policies & Procedures
            - Final ILOS selections
        - Template Submission #3
            - Final ECM & ILOS Provider Capacity/Network
        - The MOC will be updated, as necessary, to account for the phased implementation of ECM target populations
    - Listening sessions with community partners and stakeholders continue
        - Ten sessions completed through June 2
        - Four additional sessions are scheduled
        - Level of interest for the two town hall sessions previously scheduled for May 20 and May 26 was very low

        - May 20 session re-scheduled for July 16; registration information is posted on the Alameda Alliance website
        - May 26 session was canceled
- Integrated Planning Grid – manual process to analyze resource information for portfolio projects and department activities originally gathered from each senior leader
    - Consolidated information into two views – division view and project view
    - Division view sent to department heads (senior directors, directors, managers) to update the information, as needed
    - Procurement process for a Project Portfolio Management (PPM) tool to assist in resource planning commencing soon
- Project Portfolio budgeting – continued to meet with Finance to confirm project level budgeting in order to track the cost of portfolio projects

Recruiting and Staffing

- Project Management Open position(s):
    - Sr. Technical Project Manager – recruitment underway
    - Technical Business Analyst – recruitment underway

Projects and Programs

Supporting Documents

Project Descriptions

Key projects currently in-flight:

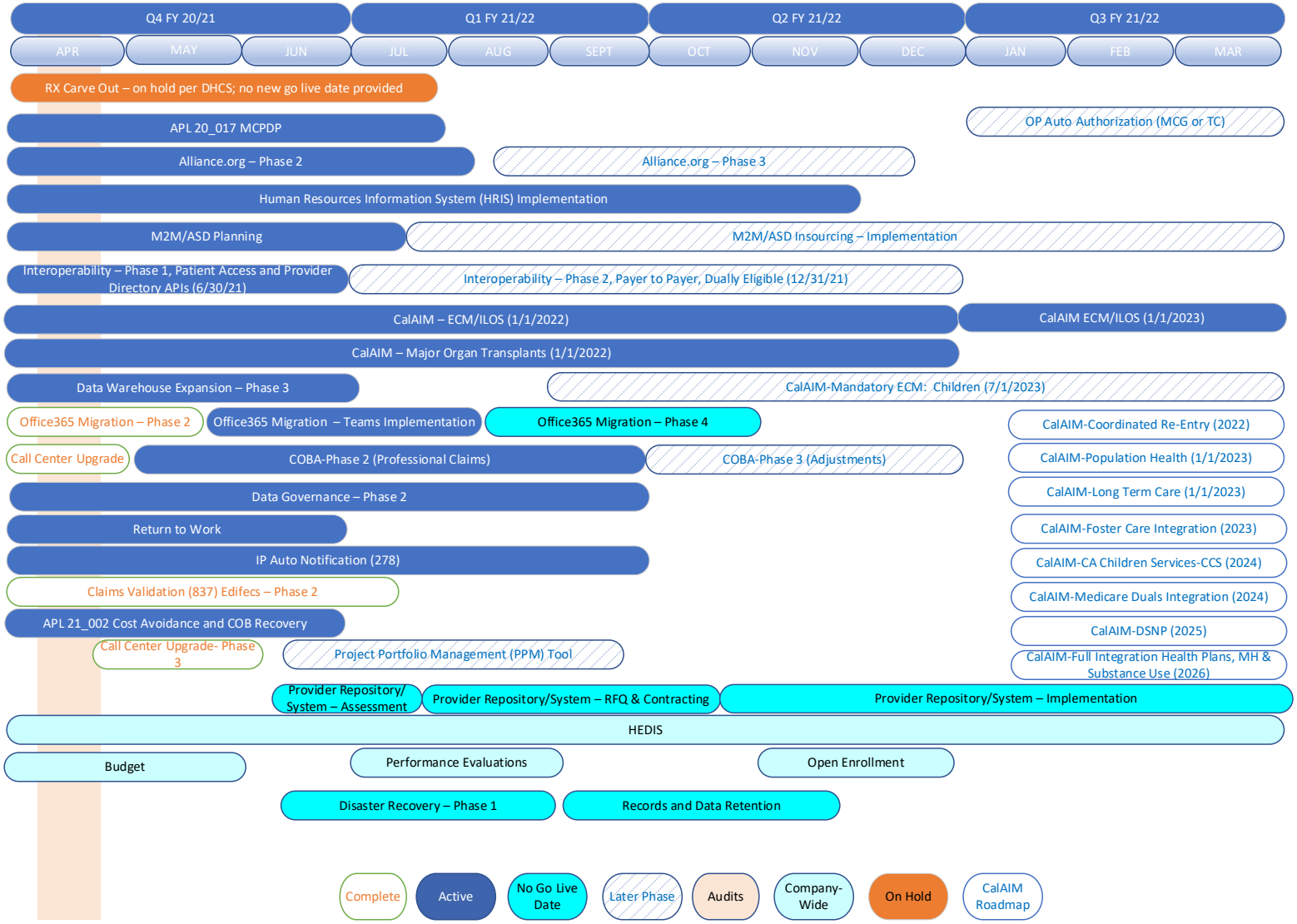
- California Advancing and Innovating Medi-Cal (CalAIM) – program to provide targeted and coordinated care for vulnerable populations with complex health needs
    - Enhanced Care Management (ECM) effective January 1, 2022 – ECM will target seven specific populations of vulnerable and high-risk children and adults
        - Members currently receiving Whole Person Care (WPC) and/or Health Homes Program (HHP) services will transition into ECM
        - Final DHCS templates have been received
        - Model of Care draft is in process
        - Weekly meetings to include AC3 started March 2021
    - 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
        - Assessing current capabilities & capacity with current providers
        - Developing draft Member eligibility criteria and service offerings
        - Weekly meetings to include AC3 started March 2021
    - 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
        - Assessing Transplant network
- 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
- 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

AAH Project Portfolio - Active + (updated 6/4/2021)



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: **June 11, 2021**

Subject: **Performance & Analytics Report**

COVID-19 Vaccination Rate

- The Alliance COVID-19 Vaccination rate is 46.8% for fully and partially vaccinated members aged 12 years and older.
    - 37.5% are fully vaccinated
    - 9.4% are partially vaccinated

Member Cost Analysis

- The Member Cost Analysis below is based on the following 12 month rolling periods:
    - Current reporting period: March 2020 – Feb 2021 dates of service
    - Prior reporting period: March 2019 – Feb 2020 dates of service
    - (Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 8.0% of members account for 84.3% of total costs.

- In comparison, the Prior reporting period was slightly lower at 7.8% of members accounting for 81.3% of total costs.

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

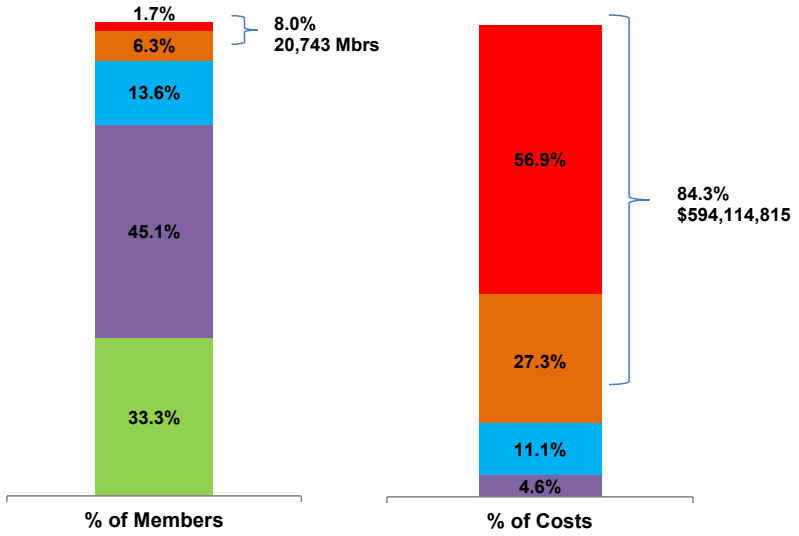
    - The SPD (non duals) and ACA OE categories of aid increased to account for 60.5% of the members, with SPDs accounting for 28.1% and ACA OE's at 32.4%.
    - The percent of members with costs >= $30K slightly increased from 1.6% to 1.7%.
    - Of those members with costs >= $100K, the percentage of total members remained consistent at 0.4%.
        - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, increasing to 50.8%.

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

- However, the age distribution of the top 8.0% is more concentrated in the 45-66 year old category (40.9%) compared to the overall population (20.8%).

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Mar 2020 - Feb 2021
Note: Data incomplete due to claims lag
Run Date: 05/28/2021

Member Cost Distribution



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	4,433	1.7%	$ 401,467,204	56.9%
$5K - $30K	16,310	6.3%	$ 192,647,611	27.3%
$1K - $5K	35,274	13.6%	$ 78,439,884	11.1%
< $1K	117,048	45.1%	$ 32,418,694	4.6%
$0	86,378	33.3%	$ -	0.0%
Totals	**259,443**	**100.0%**	**$ 704,973,393**	**100.0%**

Top 8.0% of Members = 84.3% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	1,019	0.4%	$ 216,740,662	30.7%
$75K to $100K	584	0.2%	$ 50,344,423	7.1%
$50K to $75K	1,116	0.4%	$ 68,574,392	9.7%
$40K to $50K	647	0.2%	$ 28,805,003	4.1%
$30K to $40K	1,067	0.4%	$ 37,002,724	5.2%
SubTotal	***4,433***	***1.7%***	***$ 401,467,204***	***56.9%***
$20K to $30K	2,102	0.8%	$ 51,236,356	7.3%
$10K to $20K	5,909	2.3%	$ 81,999,050	11.6%
$5K to $10K	8,299	3.2%	$ 59,412,205	8.4%
SubTotal	***16,310***	***6.3%***	***$ 192,647,611***	***27.3%***
Total	**20,743**	***8.0%***	**$ 594,114,815**	***84.3%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Feb 2021	240,321	$ 623,761,771
Dis-Enrolled During Year	19,122	$ 81,211,622
Totals	**259,443**	**$ 704,973,393**

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
8.0% of Members = 84.3% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Mar 2020 - Feb 2021
Note: Data incomplete due to claims lag
Run Date: 05/28/2021

8.0% of Members = 84.3% of Costs
28.1% of members are SPDs and account for 34.4% of costs.
32.4% of members are ACA OE and account for 31.2% of costs.
6.9% of members disenrolled as of Feb 2021 and account for 12.9% of costs.

Highest Cost Members; Cost Per Member >= $100K
38.8% of members are SPDs and account for 37.9% of costs.
29.3% of members are ACA OE and account for 29.7% of costs.
19.2% of members disenrolled as of Feb 2021 and account for 21.3% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	106	543	649	3.1%
MCAL	MCAL - ADULT	465	3,088	3,553	17.1%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	176	1,269	1,445	7.0%
	MCAL - ACA OE	1,396	5,318	6,714	32.4%
	MCAL - SPD	1,671	4,155	5,826	28.1%
	MCAL - DUALS	85	1,044	1,129	5.4%
Not Eligible	Not Eligible	534	893	1,427	6.9%
Total		**4,433**	**16,310**	**20,743**	**100.0%**

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	18	1.8%
MCAL	MCAL - ADULT	89	8.7%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	8	0.8%
	MCAL - ACA OE	299	29.3%
	MCAL - SPD	395	38.8%
	MCAL - DUALS	14	1.4%
Not Eligible	Not Eligible	196	19.2%
Total		**1,019**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 8,347,016	$ 5,924,343	$ 14,271,359	2.4%
MCAL	MCAL - ADULT	$ 36,022,375	$ 35,269,120	$ 71,291,495	12.0%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 9,207,704	$ 14,520,897	$ 23,728,601	4.0%
	MCAL - ACA OE	$ 123,940,169	$ 61,283,511	$ 185,223,680	31.2%
	MCAL - SPD	$ 152,944,083	$ 51,185,238	$ 204,129,322	34.4%
	MCAL - DUALS	$ 5,657,892	$ 12,972,501	$ 18,630,394	3.1%
Not Eligible	Not Eligible	$ 65,347,963	$ 11,492,001	$ 76,839,964	12.9%
Total		**$ 401,467,204**	**$ 192,647,611**	**$ 594,114,815**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 3,444,712	1.6%
MCAL	MCAL - ADULT	$ 17,045,323	7.9%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 1,543,187	0.7%
	MCAL - ACA OE	$ 64,392,545	29.7%
	MCAL - SPD	$ 82,190,998	37.9%
	MCAL - DUALS	$ 2,029,390	0.9%
Not Eligible	Not Eligible	$ 46,094,507	21.3%
Total		**$ 216,740,662**	**100.0%**

% of Total Costs By Service Type

Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	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)
$100K+	7%	0%	0%	12%	58%	1%	14%	5%	2%	7%
$75K to $100K	6%	0%	1%	17%	44%	3%	11%	5%	9%	12%
$50K to $75K	6%	0%	1%	20%	39%	2%	7%	7%	10%	15%
$40K to $50K	7%	0%	1%	16%	43%	5%	9%	6%	2%	18%
$30K to $40K	9%	1%	1%	17%	41%	9%	8%	6%	2%	17%
$20K to $30K	8%	2%	1%	19%	35%	11%	9%	7%	1%	17%
$10K to $20K	1%	0%	1%	21%	34%	6%	12%	9%	2%	16%
$5K to $10K	0%	0%	0%	25%	21%	8%	12%	13%	1%	19%
Total	**5%**	**0%**	**1%**	**17%**	**44%**	**4%**	**11%**	**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

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: **June 11, 2021**

Subject: **Human Resources Report**

Staffing

- As of June 1, 2021, the Alliance had 348 full time employees and 1-part time employees.

- On June 1, 2021, the Alliance had 39 open positions in which 7 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 32 positions open to date. The Alliance is actively recruiting for the remaining 32 positions and several of these positions are in the interviewing or job offer stage.

- Summary of open positions by department:

Department	Open Positions June 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	8	2	6
Operations	19	4	15
Healthcare Analytics	3	0	3
Information Technology	3	0	3
Finance	0	0	0
Compliance	4	1	3
Human Resources	0	0	0
Projects & Programs	2	0	2
Total	39	7	32

- Our current recruitment rate is 10%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in May 2021 included:
    - 5 years:
        - Aracely Melendez (Claims)
        - Riandria Hollie (Claims)
    - 6 years:
        - Scott Coffin (Executive)
        - Thomas Garrahan (Provider Relation)
    - 8 years:
        - Michelle Lewis (Community Relations)
        - Alicia Garibay (Utilization Management)
        - Josephine Camarena (Member Services)
    - 9 years:
        - Linda Ayala (Quality Improvement)
        - Brian Butcher (IT Infrastructure)
    - 13 years:
        - Cecilia Gomez (Provider Relation)
        - Saudia Lacy (Member Services)
    - 18 years:
        - Nancy Kuo (Case & Disease Management)