
# Board of Governors

## Regular Meeting

**Friday, October 8, 2021**
**12:00 p.m. – 2:00 p.m.**

**Video Conference Only**

**1240 South Loop Road, Alameda, CA 94502**

# AGENDA

BOARD OF GOVERNORS
Regular Meeting
Friday, October 8, 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

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

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

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

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

1. **CALL TO ORDER**

   *(A regular meeting of the Alameda Alliance for Health Board of Governors will be called to order on October 8, 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) **SEPTEMBER 10, 2021 BOARD OF GOVERNORS MEETING MINUTES**

   b) **OCTOBER 5, 2021 FINANCE COMMITTEE MEETING MINUTES**

6. **BOARD MEMBER REPORTS**

   a) **COMPLIANCE ADVISORY COMMITTEE**

   b) **FINANCE COMMITTEE**

7. **CEO UPDATE**

8. **BOARD BUSINESS**

   a) **REVIEW AND APPROVE MOSS ADAMS FISCAL YEAR 2021 AUDIT RESULTS**

   b) **REVIEW AND APPROVE AUGUST 2021 MONTHLY FINANCIAL STATEMENTS**

   c) **REVIEW AND APPROVE RESOLUTION 2021-14 ALAMEDA ALLIANCE FOR HEALTH AMENDING THE ALLOWABLE MEMBERSHIP TO ITS STRATEGIC PLANNING COMMITTEE**

   d) **REVIEW AND APPROVE MEMBER NOMINATIONS TO THE STRATEGIC PLANNING COMMITTEE**

   e) **CALAIM PROGRESS REPORT**

   f) **VACCINATION INCENTIVE PROGRAM UPDATE**

   g) **SINGLE PLAN MODEL UPDATE**

## 9. STANDING COMMITTEE UPDATES

### a) PEER REVIEW AND CREDENTIALING COMMITTEE

### b) HEALTH CARE QUALITY COMMITTEE

### c) PHARMACY & THERAPEUTICS COMMITTEE

### d) MEMBER ADVISORY COMMITTEE

## 10. STAFF UPDATES

## 11. UNFINISHED BUSINESS

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

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

## 14. ADJOURNMENT

**NOTICE TO THE PUBLIC**

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

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

**NOTICE TO THE PUBLIC**

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

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

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

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

**Additions and Deletions to the Agenda:** Additions to the agenda are limited by California Government Code Section 54954.2 and confined to items that arise after the posting of the Agenda and must be acted upon prior to the next Board meeting. For special meeting agendas, only those items listed on the published

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

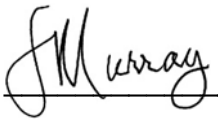
**Public Input:** If you are interested in addressing the Board, you may submit comments on any agenda item or on any item not on the agenda, in writing via mail to "Attn: Alliance Board," 1240 S. Loop Road, Alameda, CA 94502; or through e-comment at jmurray@alamedaalliance.org. You may also provide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

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

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

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

I hereby certify that the agenda for the Board of Governors was posted on the Alameda Alliance for Health's web page at www.alamaedaalliance.org on October 4, 2021, by 12:00 p.m.



_____Clerk of the Board – Jeanette Murray


# CONSENT CALENDAR

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
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# Board of Governors Meeting Minutes

**ALAMEDA ALLIANCE FOR HEALTH**
**BOARD OF GOVERNORS**
**REGULAR MEETING**
**September 10, 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. Kelley Meade, Dr. Noha Aboelata, Aarondeep Basrai, Dr. Michael Marchiano, James Jackson

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

**Excused:** David Vliet

| 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 12:01 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 |

| AGENDA ITEM SPEAKER | DISCUSSION HIGHLIGHTS | ACTION | FOLLOW UP |
|---|---|---|---|
| **4. INTRODUCTIONS** | | | |
| Dr. Seevak | None | None | None |
| **5. CONSENT CALENDAR** | | | |
| Dr. Seevak | Dr. Seevak presented the September 10, 2021, Consent Calendar.<br><br>a) July 9, 2021, Board of Governors Meeting Minutes<br><br>b) September 7, 2021, Finance Committee Meeting Minutes<br><br>Motion to Approve September 10, 2021, Board of Governors Consent Calendar.<br><br>A roll call vote was taken, and the motion passed. | Motion to Approve September 10, 2021, Board of Governors Consent Calendar.<br><br>Motion: Dr. Aboelata<br>Second: M. Lynch<br><br>Vote: Yes<br><br>No opposed or abstained. | None |
| **6. a. BOARD MEMBER REPORT – COMPLIANCE ADVISORY COMMITTEE** | | | |
| R. Gebhart | The Compliance Advisory Committee was held telephonically on September 10, 2021, at 10:30 am.<br><br>Brain Lopez and Dr. Aboelata attended the Compliance Advisory Committee meeting.<br><br>Informational:<br>• The revalidation project is completed and closed.<br>• Kindred Focus Audit – findings and milestones are being addressed.<br><br>DHCS / DMHC 2021 Audit:<br>• We have not received the DMHC Audit findings yet.<br>• We have received the DHCS Audit findings, and there we 33 findings for a 2-years lookback. | Informational update to the Board of Governors.<br><br>Vote not required. | None |

| AGENDA ITEM SPEAKER | DISCUSSION HIGHLIGHTS | ACTION | FOLLOW UP |
|---|---|---|---|
| | • Staff presented the findings in 3 different ways:<br>  ○ Self-Identified findings.<br>  ○ Repeat findings .<br>  ○ Risk findings (categorized by high risk, medium risk, low risk).<br>• Definition of Risk Findings:<br>  ○ High risk is a significant effort is required to remediate.<br>  ○ Medium risk is PnPs may require updated, and training involved.<br>  ○ Low risk is no update to PnPs, limited impact on providers and members, and no or very little training required.<br>• Rebecca discussed the four self-findings that the Alliance identified and the DHCS identified.<br>• Repeat findings were discussed in depth.<br><br>Informational update to the Board of Governors.<br><br>Vote not required. | | |
| **6. b. BOARD MEMBER REPORT – FINANCE COMMITTEE** | | | |
| Dr. Ferguson | The Finance Committee was held telephonically on Tuesday, September 7, 2021.<br><br>Dr. Ferguson updated the Board on the Finance Committee Meeting.<br><br>Highlights:<br>• The Committee focused on the June end of the year totals.<br>• Membership was up over 32,000 over the last year.<br>• The Alliance had projected a Fiscal YTD net loss of $15.4M, but our actual net loss was $1.6M.<br>• Projected administrative expenses of $75.5M for the fiscal year. Actual reported administrative expense was $53.3M for the fiscal year.<br>• Our medical expense for the year was budgeted at $973.0M, and the actual was $1.0 billion.<br>• MLR 95.2%. | Informational update to the Board of Governors.<br><br>Vote not required. | None |

| AGENDA ITEM SPEAKER | DISCUSSION HIGHLIGHTS | ACTION | FOLLOW UP |
|---|---|---|---|
| | • TNE 560%.<br>• $329,000 claims interest expense for the year.<br>• The Committee would like to tighten up on the predictability of numbers.<br><br>Informational update to the Board of Governors.<br><br>Vote not required. | | |
| **6. c. BOARD MEMBER REPORT – STRATEGIC PLANNING COMMITTEE** | | | |
| S. Coffin | The Strategic Planning Committee was held telephonically on August 9, 2021.<br><br>Scott Coffin updated the Board on the Strategic Planning Committee Meeting. The four members are David Vliet, Dr. Meade, Dr. Seevak, and Marty Lynch.<br><br>Highlights:<br>• Bobbie Wunsch, Pacific Health Consulting Group, has been engaged and is the lead consultant to guide us through the planning.<br>• The Strategic Plan is in two parts, a 3-year and 10-year plan view, and the work will conclude by the end of December 2021.<br>• The Senior Executive Team, Alliance Staff, Alliance Focus Group, and Members Advisory Committee are engaged.<br>• Twelve community leaders are involved for a comprehensive strategic view.<br>• The Mission, Vision, and Values are being revised and edited to our current needs.<br>• Updates will be announced at a Board Meeting in the future.<br><br>Informational update to the Board of Governors.<br><br>Vote not required. | Informational update to the Board of Governors.<br><br>Vote not required. | None |
| **7. CEO UPDATE** | | | |
| S. Coffin | Scott Coffin, Chief Executive Officer, presented the following updates: | | None |

| AGENDA ITEM SPEAKER | DISCUSSION HIGHLIGHTS | ACTION | FOLLOW UP |
|---|---|---|---|
| | Executive Summary:<br><br>Operational Report:<br>• The enrollment each month is increasing, but the contrary to this is Governor Newsom issued executive orders suspending the redeterminations that presumably will be rescinded in 2022. An enrollment reduction will occur at that time.<br><br>Operations Dashboard – Key Performance Metrics:<br>• One regulatory metric below standards is standard grievances turnaround time. Remediation is taking place to restore compliance.<br>• The internal non-regulatory metrics that are below standards also are to be restored and within our target range.<br>• The Alliance's final budget for fiscal year 2021/2022 will be presented at the December 2021 Board Meeting for Board approval.<br><br>Question: Do we know the number of dis-enrollments after the suspension, and are there any programs in CalAIM to offset the dis-enrollments?<br><br>Answer: The Alliance is working with Alameda County Social Services Agency on the enrollment analysis for Medi-Cal to help us understand how many Medi-Cal Members will potentially be dis-enrolled. We are also analyzing all the changes with CalAIM next year that will add Members. The Board will be updated on this in the future.<br><br>Question: What will happen with the older undocumented population becoming available for Medi-Cal? Can this be included in a report? Also, the potential impact in Alameda County on older applicants as the asset test is eliminated.<br><br>Answer: We are working with Alameda County to analyze these two subjects and report to the Board the findings at a future date. | Informational update to the Board of Governors.<br><br>Vote not required. | |

| AGENDA ITEM SPEAKER | DISCUSSION HIGHLIGHTS | ACTION | FOLLOW UP |
|---|---|---|---|
| | Informational update to the Board of Governors.<br><br>Vote not required. | | |
| **8. a. BOARD BUSINESS – REVIEW AND APPROVE JUNE 2021 MONTHLY FINANCIAL STATEMENTS** | | | |
| G. Riojas | Gil Riojas gave the following June 2021 Finance updates:<br><br>These totals are pre-audit numbers. Moss Adams will be presenting the year-end audit at the October Board Meeting.<br><br>Enrollment:<br>• For the month ending June 30, 2021, the Alliance had an enrollment of 288,554 members, a net income of $1.4M, and the tangible net equity is 560%.<br>• Our enrollment has increased by 1,797 members since May 2021.<br><br>Net Operating Results:<br>• For the month ending June 30, 2021, the actual net income was $1.4M, and the budgeted net income was $3.0M.<br>• The unfavorable variances were due to higher than anticipated medical expense, administrative expense, and other revenue.<br><br>Revenue:<br>• For the month ending June 30, 2021, the actual revenue was $90.8M vs. the budgeted revenue of $80.9M.<br><br>Medical Expense:<br>• For the month ending June 30, 2021, the actual medical expense was $81.8M vs. the budgeted medical expense of $71.7M.<br><br>Medical Loss Ratio (MLR):<br>• For the month ending June 30, 2021, the MLR was 90.1%, and the fiscal year-to-date of 95.2%. | Motion to Approve June 2021, Monthly Financial Statements.<br><br>Motion: Dr. Ferguson<br>Second: Dr. Meade<br><br>Vote: Yes<br><br>No opposed or abstained. | None |

| AGENDA ITEM SPEAKER | DISCUSSION HIGHLIGHTS | ACTION | FOLLOW UP |
|---|---|---|---|
| | Administrative Expense:<br>• For the month ending June 30, 2021, the actual administrative expense was $7.6M vs. the budgeted administrative expense of $6.3M.<br><br>Other Income / (Expense):<br>• As of June 30, 2021, our YTD interest income from investments is $649,000, and YTD claims interest expense is $329,000.<br><br>Tangible Net Equity (TNE):<br>• Tangible net equity results continue to remain healthy, and at the end of June 30, 2021, the TNE was reported at 560% of the required amount.<br><br>Cash Position and Assets:<br>• For the month ending June 30, 2021, the Alliance reported $301.0M in cash; $206.2M in uncommitted cash. Our current ratio is above the minimum required at 1.80 compared to the regulatory minimum of 1.0.<br><br>Question: Are video visits captured in the primary care category?<br><br>Answer: The visits are captured under the appropriate category of services and part of medical expenses.<br><br>Motion to approve June 2021, Monthly Financial Statements as presented.<br><br>A roll call vote was taken, and the motion passed. | | |
| **8. b. BOARD BUSINESS – REVIEW AND APPROVE JULY 2021 MONTHLY FINANCIAL STATEMENTS** | | | |
| G. Riojas | Gil Riojas gave the following July 2021 Finance updates:<br><br>Enrollment: | Motion to Approve July 2021, Monthly Financial Statements.<br><br>Motion: N. Williams | None |

| AGENDA ITEM SPEAKER | DISCUSSION HIGHLIGHTS | ACTION | FOLLOW UP |
|---|---|---|---|
| | • For the month ending July 31, 2021, the Alliance had an enrollment of 290,091 members, a net income of $2.6M, and the tangible net equity is 558%.<br>• Our enrollment has increased by 1,537 members since June 2021.<br><br>Net Operating Results:<br>• For the month ending July 31, 2021, the actual net income was $2.6M, and the budgeted net income was $1.4M.<br>• The favorable variances were due to higher than anticipated revenue and lower than anticipated administrative expense.<br><br>Revenue:<br>• For the month ending July 31, 2021, the actual revenue was $97.3M vs. the budgeted revenue of $97.2M.<br><br>Medical Expense:<br>• For the month ending July 31, 2021, the actual medical expense was $89.8M.<br><br>Medical Loss Ratio (MLR):<br>• For the month ending July 31, 2021, the MLR was 92.4%.<br><br>Administrative Expense:<br>• For the month ending July 31, 2021, the actual administrative expense was $4.8M vs. the budgeted administrative expense of $6.2M.<br><br>Other Income / (Expense):<br>• As of July 31, 2021, our YTD interest income from investments is $22,000, and YTD claims interest expense is $16,000.<br><br>Tangible Net Equity (TNE):<br>• Tangible net equity results continue to remain healthy, and at the end of July 31, 2021, the TNE was reported at 558% of the required amount. | Second: Dr. Meade<br><br>Vote: Yes<br><br>No opposed or abstained. | |

| AGENDA ITEM SPEAKER | DISCUSSION HIGHLIGHTS | ACTION | FOLLOW UP |
|---|---|---|---|
| | Cash Position and Assets:<br>• For the month ending July 31, 2021, the Alliance reported $281.0M in cash; $204.0M in uncommitted cash. Our current ratio is above the minimum required at 1.90 compared to the regulatory minimum of 1.0.<br><br>Question: After dis-enrollment of the auto determinations, will the State pay for the services rendered during this time?<br><br>Answer: We have been talking to the State about this issue, and they are not planning on retroactively collecting revenue for this time.<br><br>Question: Are the delays in hiring from waiting to hire or challenges in hiring.<br><br>Answer: No, there were no delays in hiring.<br><br>Motion to approve July 2021, Monthly Financial Statements as presented.<br><br>A roll call vote was taken, and the motion passed. | | |
| **8. c. BOARD BUSINESS – CALAIM PROGRESS UPDATE** | | | |
| S. Coffin | Scott Coffin presented the CalAIM Progress Report Update.<br><br>Each month there will be an update to the Board of the key activities of CalAIM in preparation for the January 2022 deadline.<br><br>• CalAIM Model of Care #2 document was successfully submitted to the DHCS. The next submission is due October 1. All submission terms have been met with a combined effort of our County Safety Net partners. | Informational update to the Board of Governors.<br><br>Vote not required. | None |

| AGENDA ITEM SPEAKER | DISCUSSION HIGHLIGHTS | ACTION | FOLLOW UP |
|---|---|---|---|
| | • DHCS to release final rates for ILOS and transplants by September 30. We will be revising ILOS rates and cost projections and report back to the Board in November.<br>• Operational readiness phase initiated and continues over the next four months.<br>• Meeting held with DHCS, Alameda County HCSA, and Alameda Alliance in med-July.<br>• Go live ECM, ILOS, and major organ transplants by January 1, 2022.<br><br>Informational update to the Board of Governors.<br><br>Vote not required. | | |
| **8. d. COVID-19 VACCINATIONS AND INCENTIVE PROGRESS REPORT** | | | |
| S. Coffin | Scott Coffin presented the COVID-19 Vaccinations and Incentives progress report.<br><br>Purpose to update on vaccinations to Medi-Cal and Group Care line of business and the new vaccine program.<br><br>• Vacated Medi-Cal Members: 144,651.<br>• Group Care Members: 3,971.<br>• California Department of Health Care Services allocated over $300M in budget to incentivize vaccination.<br>• Alliance sent in a proposal that was accepted, but we have not yet received the allocated amount.<br>• Outreach will include member texting, social media, billboards, mobile vaccination clinics, and coordination with faith-based organizations.<br><br>Question: Will Group Care providers be mandated to be vaccinated since working with a vulnerable population?<br><br>Answer: Not at this moment, but we will look into this. | Informational update to the Board of Governors.<br><br>Vote not required. | |

| AGENDA ITEM SPEAKER | DISCUSSION HIGHLIGHTS | ACTION | FOLLOW UP |
|---|---|---|---|
| | Comment: Going into the community, such as the churches, is a way to help people to get their vaccination.<br><br>Informational update to the Board of Governors.<br><br>Vote not required. | | |
| **9. a. STANDING COMMITTEE UPDATES – PEER REVIEW AND CREDENTIALING COMMITTEE** | | | |
| Dr. O'Brien | The Peer Review and Credentialing Committee (PRCC) was held telephonically on July 20, 2021.<br><br>Dr. O'Brien gave the following Committee update:<br><br>• There were seventeen (17) initial providers approved. Additionally, thirty-four (34) providers were re-credentialed at this meeting.<br><br>Informational update to the Board of Governors.<br><br>Vote not required. | Informational update to the Board of Governors.<br><br>Vote not required. | |
| **9. b. STANDING COMMITTEE UPDATES – HEALTH CARE QUALITY COMMITTEE** | | | |
| Dr. O'Brien | The Health Care Quality Committee was held telephonically on July 15, 2021.<br><br>Dr. O'Brien gave the following Committee updates:<br><br>• P & Ps were reviewed.<br>• Alameda County First 5 presented a pilot coordination Pediatric Care Project in which the Alliance was involved. This pilot is being expanded to a more extensive program this year, and we will be partnering with them.<br>• Dr. Miller, CMO from CHCN, gave a presentation on HEDIS.<br>• ECM, ILOS update.<br>• Pharmacy update.<br>• Behavior Health insourcing update. | Informational update to the Board of Governors.<br><br>Vote not required. | None |

| AGENDA ITEM SPEAKER | DISCUSSION HIGHLIGHTS | ACTION | FOLLOW UP |
|---|---|---|---|
| | Informational update to the Board of Governors.<br><br>Vote not required. | | |
| **10. STAFF UPDATES** | | | |
| S. Coffin | None | None | None |
| **11. UNFINISHED BUSINESS** | | | |
| S. Coffin | None | None | None |
| **12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS** | | | |
| S. Coffin | Update on Claims Interest Analysis and Remediations | None | Update |
| **13. PUBLIC COMMENTS (NON-AGENDA ITEMS)** | | | |
| S. Coffin | Comment: Look into acquiring a building that would accommodate all the needs of the Alliance in the same building. The Board recommends that Scott assign someone to look into this issue. Discussion to be addressed next month. | None | Comment |
| **14. CLOSED SESSION** | | | |
| Dr. Seevak | Dr. Seevak announced a Closed Session at 1:45 pm.<br><br>All Guests and Staff departed from the conference line. The Board of Governors and Scott Coffin remained for the Closed Session pursuant to the following:<br>• Discussion and Deliberation regarding Trade Secrets (Health & Safety Code Section 32106). | Closed Session Discussion. | None |
| **15 ADJOURNMENT** | | | |
| Dr. Seevak | Dr. Seevak adjourned the meeting at 2:00 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**

**October 5, 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, Gil Riojas
**Committee Members absent:** Nick Peraino

**Board of Governor members on Conference Call:** James Jackson

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

| AGENDA ITEM SPEAKER | DISCUSSION HIGHLIGHTS | ACTION | FOLLOW UP |
|---|---|---|---|
| **CALL TO ORDER and INTRODUCTIONS** | | | |
| **Dr. Rollington Ferguson** | Dr. Ferguson called the Finance Committee meeting to order at 8:00 am and Roll Call was conducted. | | |
| **CONSENT CALENDAR** | | | |
| **Dr. Rollington Ferguson** | Dr. Ferguson presented the Consent Calendar.<br><br>July 6, 2021, Finance Committee Minutes were approved at the Board of Governors meeting July 9, 2021 and not presented today. | There were no modifications to the Consent Calendar, and no items to approve. | |
| **a.) CEO Update** | | | |
| **Scott Coffin** | Scott Coffin provided the following information in accordance with Assembly Bill (AB) 361:<br><br>Good morning to members of the Finance Committee. | Informational update to the Finance Committee<br><br>Vote not required | |

| AGENDA ITEM SPEAKER | DISCUSSION HIGHLIGHTS | ACTION | FOLLOW UP |
|---|---|---|---|
| | The Board recognizes that there is a proclaimed state of emergency at both the State and the local Alameda County level, and there are recommended measures to promote social distancing in place. The Board shall therefore conduct its meetings via teleconference in accordance with AB 361 for the duration of the proclaimed state of emergency.<br><br>In further compliance with AB361, the following statement will be added to agendas: “State or local officials continue to impose or recommend measures to promote social distancing.”<br><br>Additionally, the public must be provided a reasonable time to provide comment during each agenda item, and as such, agendas will be revised to reflect the following suggested language: “DURING EACH AGENDA ITEM, YOU WILL BE PROVIDED A REASONABLE AMOUNT OF TIME TO PROVIDE PUBLIC COMMENT. THE BOARD WOULD APPRECIATE, HOWEVER, IF COMMUNICATIONS OF PUBLIC COMMENTS RELATED TO ITEMS ON THE AGENDA, OR ITEMS NOT ON THE AGENDA, ARE PROVIDED PRIOR TO THE COMMENCEMENT OF THE MEETING.”<br><br>Scott Coffin then provided updates to the committee on the following:<br><br>**COVID-19 Vaccine Response** – On September 21st, the Department of Health Care Services (DHCS) identified the potential available pool of incentive funding for COVID-19 vaccination outreach. The total incentive pool is approximately $6.0 million. A second tranche for member incentives is expected to be announced by the DHCS in the coming weeks, and we forecast a potential pool of $1.5 to $2.0 million dollars. The outreach campaign started in October and lasts until February 28, 2022. Three payments will be made by the DHCS to the Alliance, the first in October, and two more payments, in January and March.<br><br>Alameda Alliance submitted a proposal to DHCS on August 30th, partnering with Alameda County Public Health and clinic leaders on the vaccination outreach strategy and implementation.<br><br>Approximately 80% of funding is based on outcome measures, driven through a combination of member and provider incentives | | |

| AGENDA ITEM SPEAKER | DISCUSSION HIGHLIGHTS | ACTION | FOLLOW UP |
|---|---|---|---|
| | Outreach includes member texting, social media, billboards, mobile vaccination clinics, and coordination with primary care physicians and faith-based organizations.<br><br>The current vaccination rate for Alameda County is 91%, and the Alliance's vaccination rate for Medi-Cal enrollees is 67%. Our goal is to bridge this gap and increase the rate of vaccines by at least 7-10%.<br><br>**CalAIM** – The DHCS released the first phase of rates and incentives for the CalAIM initiatives that begin on January 1st, 2022. The two benefits include "enhanced care management" and major organ transplants, and the third is an optional service referred to as Community Supports, formerly referred to as In Lieu Of Services. In addition to base rates, the DHCS identified a total of $14.7 million dollars as a potential incentive pool to be earned if certain measures are met. The incentive funding is tied to building capacity in our system to deliver these services, and the DHCS will be issuing guidance on the scoring system and payment intervals. The first payment from the DHCS, related to CalAIM incentives, will be paid by the DHCS by February 2022.<br><br>**Final Budget FY2022** – The final budget is being prepared for delivery to the Board in December, and the first quarter forecast is scheduled for December. The final budget will include several adjustments in our administrative expenses, related to the CalAIM operational readiness, forecasted revenues and expenses. The final budget will also include cost adjustments associated with the insourcing of mental health services, currently scheduled for October 2022. To avoid duplicative work, we will be combining the first quarter forecast into the final budget and delivering the entire package in December. The second quarter forecast would be in March 2022.<br><br>**Single Plan Model** – The Alameda County Board of Supervisors approved a new Ordinance that establishes a single health plan to serve Medi-Cal managed care beneficiaries in Alameda County. If approved by the DHCS and DMHC, the transition to a "Single Plan Model" would occur on January 1, 2024. The Alliance has funded the impact assessment in fiscal year 2022 totaling $90,000 with Pacific Health Consulting Group. The Alliance's Board of Governors approved to file a letter of intent in April 2021, and the DHCS approved the letter of intent on August 31st. At this time there are no further costs identified in fiscal year 2022 related to the Single Plan Model. The DHCS has indicated that a new timeline will be issued in October or November. | | |

| AGENDA ITEM SPEAKER | DISCUSSION HIGHLIGHTS | ACTION | FOLLOW UP |
|---|---|---|---|
| | | | |
| **b.) Review and Approve Moss Adams Fiscal Year 2021 Audit Results** | | | |
| **Chris Pritchard**<br>**Rianne Suico** | Following a comprehensive presentation explaining their audit process and results, Moss Adams issued the Alliance an Unmodified Opinion which is Combined financial statements are presented fairly and in accordance with generally accepted accounting principles. This is the highest level of assurance that can be issued from the audit firm.<br><br>The composition of assets were confirmed (cash and cash equivalents, premiums receivable, investments, reinsurance, capital assets) and noted that the Financial Statements are free of material misstatements. In addition, we tested the investments to make sure that Management has recorded them at their fair market value as required by the Accounting Standards.<br><br>Liabilities and net position balance were confirmed (accounts payable, accrued expenses, claims payable, payable to other governmental agencies and hospital fee, net position, etc.) and were consistent.<br><br>The Accounting estimates are reasonable, no audit adjustments, no issues discussed prior to our retention as auditors, no disagreements with management and there were no adjustments or issues completing work. In final, there is no awareness of any instances of fraud or noncompliance with your applicable loss and regulations. | Informational update to the Finance Committee<br><br>Vote not required | |
| **c.) Review and approve August 2021 Monthly Financial Statements** | | | |
| **Gil Riojas** | **<u>August 2021 Financial Statement Summary</u>**<br><br>**Enrollment:**<br>Current enrollment is 291,207 and continues to trend upward, Total enrollment has increased by 1,116 members from July 2021, and 2,653 members since June 2021. Consistent increases were primarily in the Child, Adult, and Optional Expansion categories of aid, and include slight increases in the Duals category of aid, with SPD and Group Care remaining relatively flat. | | |

| AGENDA ITEM SPEAKER | DISCUSSION HIGHLIGHTS | ACTION | FOLLOW UP |
|---|---|---|---|
| | Total Enrollment continues to increase month over month, however; as previously discussed, the rate of increase has fallen from a high of 4,140 members in August 2020.<br><br>**Net Income:**<br>For the month ending August 31, 2021, the Alliance reported a Net Income of $1.5 million (versus budgeted Net Income of $1.3 million). For the year-to-date, the Alliance recorded a Net Income of $4.1 million versus a budgeted Net Income of $2.6 million. The favorable variance is largely attributed to higher than anticipated Revenue and lower than anticipated Administrative Expense. These were somewhat offset by higher than anticipated Medical Expense.<br><br>**Revenue:**<br>For the month ending August 31, 2021, actual Revenue was $98.1 million vs. our budgeted amount of $97.4 million. Favorable Revenue variance is mainly due to Behavioral Health supplemental revenue.<br><br>**Medical Expense:**<br>Actual Medical Expenses for the month were $91.4 million vs. our budgeted amount of $89.8 million. For the year-to-date, actual Medical Expenses were $181.2 million versus budgeted $179.5 million. Drivers leading to the unfavorable variance can be seen on the tables on page #11, with the greatest variances coming from the pharmacy carve-out and Inpatient Hospital expenses.<br><br>**Medical Loss Ratio:**<br>Our MLR ratio for this month was reported at 93.2%. Year-to-date MLR was at 92.8% vs our annual budgeted percentage 91.6%.<br><br>**Administrative Expense:**<br>Actual Administrative Expenses for the month ending August 31, 2021 were $5.2 million vs. our budgeted amount of $6.3 million. Our Administrative Expense represents 5.3% of our Revenue for the month, and 5.1% of Net Revenue for year-to-date. Reasons for the favorable month-end variances, as well as the favorable year-to-date variances are outlined on page 13 of the presentation.<br><br>**Other Income / (Expense):** | | |

| AGENDA ITEM SPEAKER | DISCUSSION HIGHLIGHTS | ACTION | FOLLOW UP |
|---|---|---|---|
| | As of August 31, 2021, our YTD interest income from investments was $54,000.<br><br>YTD claims interest expense is $72,000.<br>**TangibleNet Equity (TNE):**<br>We reported a TNE of 564%, with an excess of $172.4 million. This remains a healthy number in terms of our reserves.<br><br>**Cash and Cash Equivalents:**<br>We reported $298.8 million in cash; $155.9 million is uncommitted. Our current ratio is above the minimum required at 1.69 compared to regulatory minimum of 1.0.<br><br>**Capital Investments:**<br>No Capital Assets have been purchased year-to-date. Our annual capital budget is $1.4 million.<br><br>**Question:** Dr. Ferguson asked for clarification of the FY2021 Claims Liability trend. Gil Riojas provided an explanation attributing the impact of COVID to our Incurred But Not Paid estimate. He further explained how this information is used to monitor and adjust our IBNP calculations. We ultimately reduced the impact of COVID while conducting monthly retrospective reviews of IBNP estimates.<br><br>**Question:** Dr. Ferguson asked for a follow-up about the Investment Strategy. Gil Riojas answered that this information is currently being gathered and will be presented at the November Finance Committee and Board of Governors meetings. | Motion to accept **August 2021 Financial Statements**<br><br>Motion: J. Jackson<br>Seconded: Dr. Marchiano<br><br>Motion Carried<br><br>No opposed or abstained | |
| **ADJOURNMENT** | | | |
| **Dr. Rollington Ferguson** | Dr. Ferguson motioned to adjourn the meeting.<br><br>The meeting adjourned at 8:52 am. | Motion to adjourn: G. Riojas<br>Seconded: J. Jackson<br><br>No opposed or abstained. | |

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

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# CEO Update

## Scott Coffin

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

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

**Date:** **October 8, 2021**

**Subject:** **CEO Report**

- **Operational Performance**
  - $1.5 million net income reported in August 2021, and year-to-date $4.1 million net income.
  - Enrollment has exceeded 294,000 and the Medi-Cal enrollment continues to increase 1,000-1,500 per month.
  - Final budget for fiscal year 2021/2022, including the first quarter forecast, to be presented to the Board of Governors for approval in December

  - Key Performance Metrics:

    - Expedited Grievances turnaround time (3 calendar days) did not meet regulatory metrics for the month of September, resulting in a 50% score, 45% below the compliance minimum. A total of two (2) expedited grievances were received, and one of those grievances was resolved outside of the allowable time. All other regulatory operating metrics were met.

    - Non-regulatory operating metrics that did not meet internal performance thresholds included: 1) Member Services inbound calls answered in 30 seconds or less is 31% below target, 2) calls abandonment rate is over the target by 10%. 3) Vacancy rates for unfilled staffing positions is 2% above the internal target. Inbound call volumes have returned to pre-pandemic levels, averaging 15,000 or more calls per month; additional 40,000+ Medi-Cal members have enrolled since March 2020. Corrective actions are being implemented to improve the experience in our Member Services call center.

- **Medi-Cal Rx**
  - The administration of pharmacy services transitions to the State of California on January 1, 2022.
  - Medi-Cal physician-administered drugs and outpatient infusion drugs will be administered by the Alameda Alliance Pharmacy Department.

- Medi-Cal beneficiary notification letters will be mailed by the DHCS and Alameda Alliance.
- Alameda Alliance continues to administer all pharmacy services for Group Care Members, and the covered services and benefits related to pharmaceuticals do not change.

- **CalAIM Operational Readiness**
  - Whole Person Care Pilot (WPC/AC3) & Health Homes programs (HHP) end 12/31/2021
  - Enhanced Care Management (ECM) benefits, Community Supports (formerly "In Lieu Of Services"), and Major Organ Transplants (MOT) benefits begin January 1, 2022
  - The DHCS delivered rates and incentive dollars for ECM and MOT benefits and for Community Supports at the end of September. A financial analysis is underway to forecast the annualized revenue and expenses related to these services for calendar year 2022. A revised proforma will be distributed to the Board of Governors before the end of October, and the financial results will be included in the final budget.
  - CalAIM "Model of Care" submissions are due to the DHCS in 2021:
    - First submission delivered to DHCS on June 29, two days ahead of schedule; includes a 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 was delivered to DHCS on September 1, and the third model of care submission was delivered to the DHCS on October 1; includes the transition of WPC and HHP members, provider network for ECM and ILOS, and member notification materials.
    - Alameda Alliance submitted the provider network to DHCS for the Major Organ Transplant services on September 2
  - 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, coordination of housing deposits, and asthma remediation.
    - Alameda County HCSA, Alameda Alliance, and DHCS are meeting on October 25 to review the reimbursements for services under the Community Supports in calendar year 2022.
  - ALL IN "Recipe4Health" program is currently contracted with the Alameda Alliance and is transitioning services into the CalAIM Community Supports on January 1, 2022.

        - Alameda County ALL IN, Alameda Alliance, and DHCS are meeting on October 27 to review the reimbursements for services under the Community Supports in calendar year 2022.

- **Single Plan Model / County Organized Health System**
    - The California Department of Health Care Services (DHCS) delivered a conditional approval to the Alameda County Health Care Services Agency on August 31, 2021.
    - Presentation to the Alameda County Board of Supervisor's Health Committee on September 13, 2021.
    - County ordinance to be presented for approval by the Board of Supervisors in the month of September; a new local ordinance is required to establish Alameda Alliance as the single health authority for Alameda County.
    - DHCS to issue a revised timeline and required approvals in calendar years 2021 and 2022 related to changing the Medi-Cal delivery model from a two-plan to a single plan model.

- **COVID-19 Vaccinations**
    - Approximately 66% of members (12 years and older) in Medi-Cal and Group Care are partially or fully vaccinated; approximately 78,237 of the eligible members in Group Care and Medi-Cal remain unvaccinated
    - Alameda County vaccination rate exceeds 91% for all populations, includes residents ages 12 and older with at least one dose
    - The California Department of Health Care Services (DHCS) is funding $350 million to increase vaccination rates for Medi-Cal beneficiaries on a statewide basis. The vaccination outreach campaign starts in October and finishes on February 28, 2022
    - Alameda Alliance was awarded $6 million in the first tranche and a second tranche of $2.4 million for member incentives; in order to retain 100% of the $8.4 million incentive dollars, the Alliance must reach an 85% vaccination rate, representing a 19% gain over the current vaccine rate.
    - Includes a combination of outreach efforts designed to increase the vaccination rates, including member and provider incentives, social media, texting, live calls, health education materials, and funding for mobile & pop-up vaccination clinics; partnerships with county agencies, safety-net providers, and faith-based organizations are included in the proposal.

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# Operations Dashboard

# OPERATIONS DASHBOARD

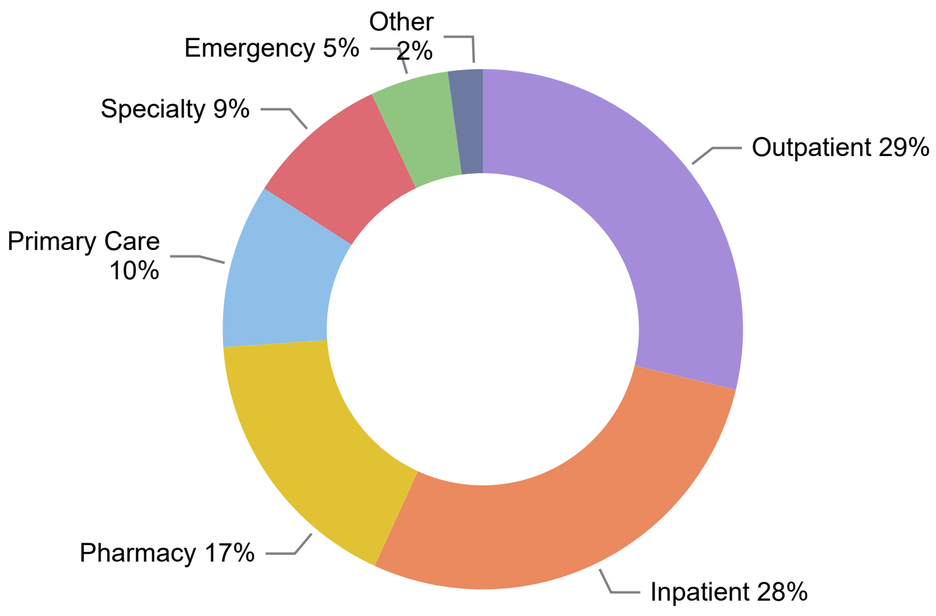
**OCTOBER 2021**
10/6/2021 9:38:55 AM

## Financials

### Income & Expenses

| | |
|---|---|
| Revenue | Medical Expense |
| **$195.4M** | **($181.2M)** |
| Other Income/(Exp.) | Admin Expense |
| **($16.2K)** | **($10.0M)** |
| Net Income | Gross Margin % |
| **$4.1M** | **7.2%** |

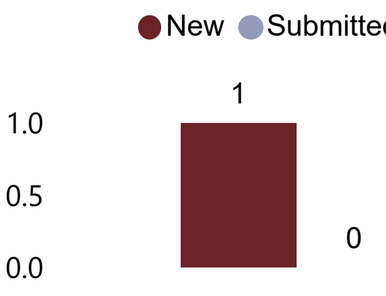
### Medical Expenses




### Liquid Reserves

| | |
|---|---|
| MLR Net % | **92.8%** |
| TNE % | **564.2%** |
| TNE $ | **$209.5M** |

### Reinsurance Cases



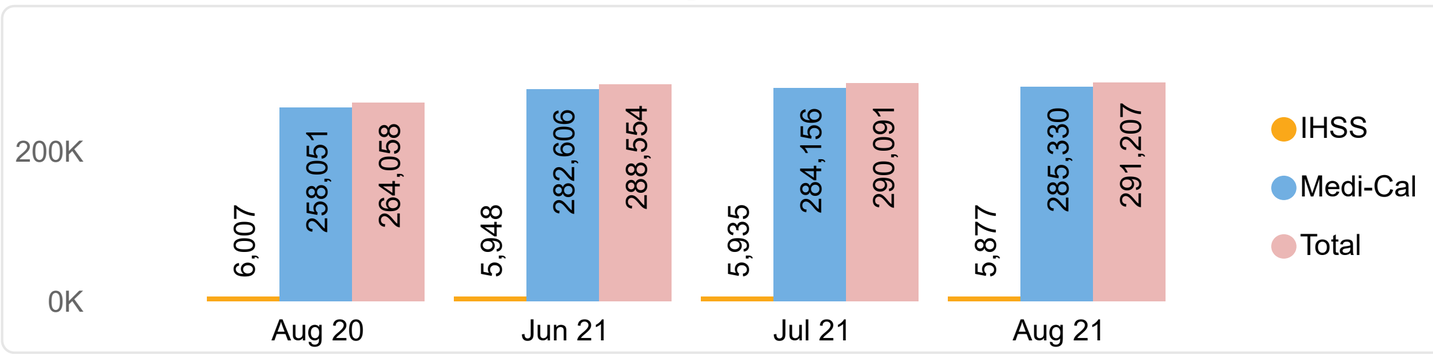

### Balance Sheet

| | |
|---|---|
| Cash Equivalents | **$298.8M** |
| Pass-Through Liabilities | **$142.9M** |
| Uncommitted Cash | **$155.9M** |
| Working Capital | **$203.1M** |

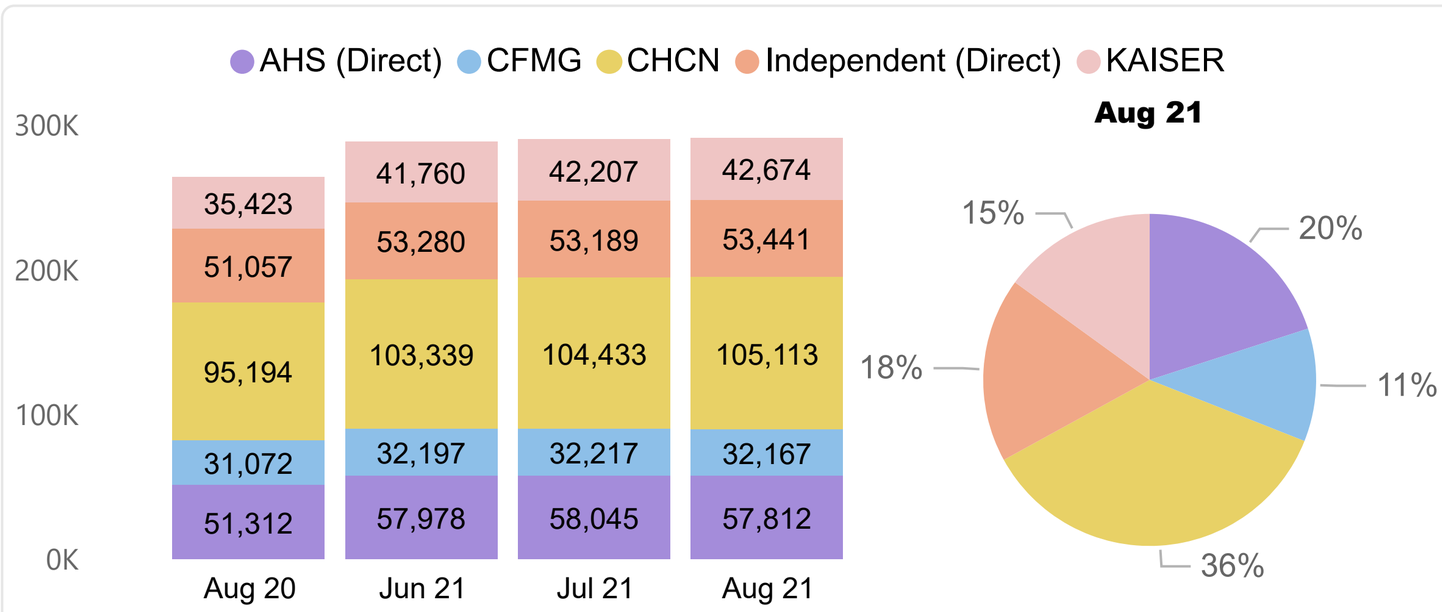
Current Ratio %
**169.2%**

## Membership

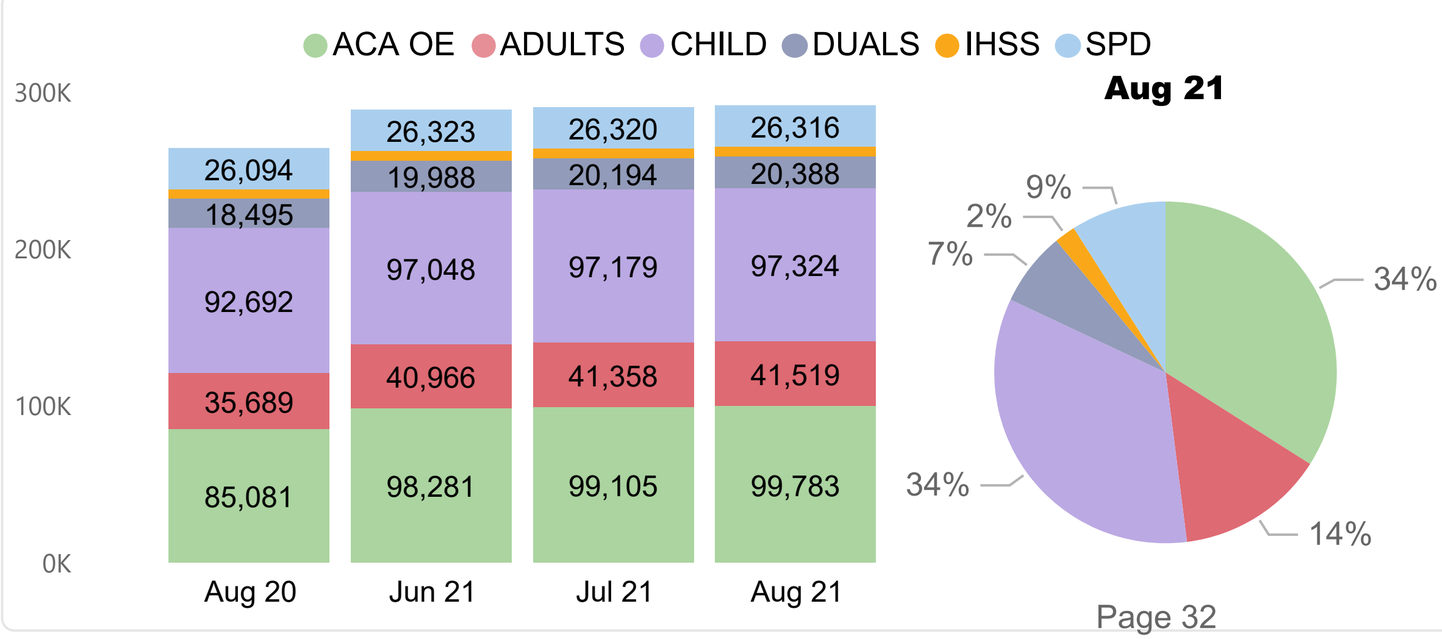
### By Plan




### By Network




### By Category

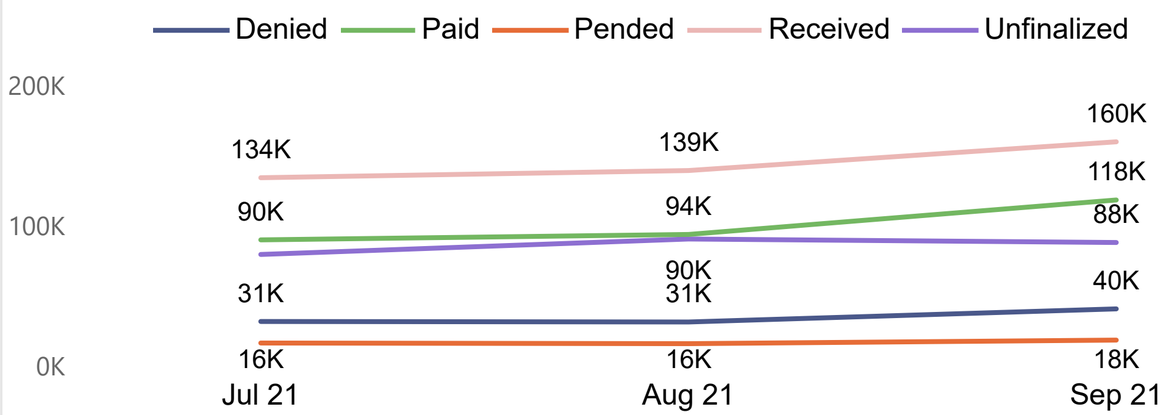


# OPERATIONS DASHBOARD

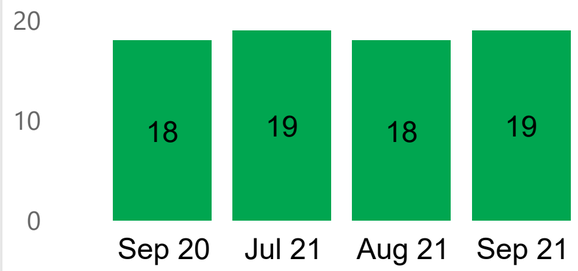
**OCTOBER 2021**
10/6/2021 9:38:55 AM

## Claims

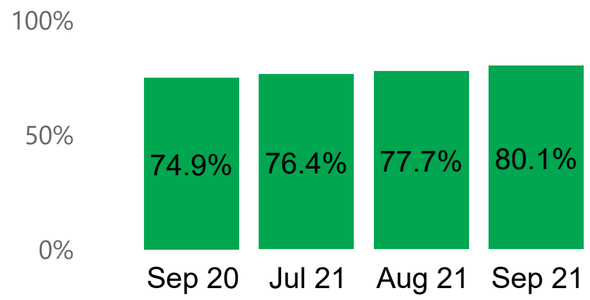
### Claims Processing



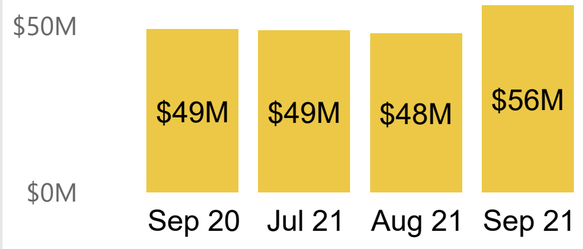

### Average Payment TAT (Days)



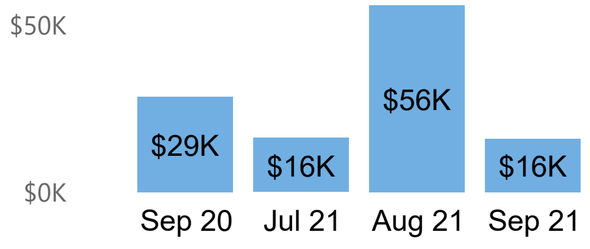

### Auto Adjudication Rate (%)




### Claims Paid (Dollars)

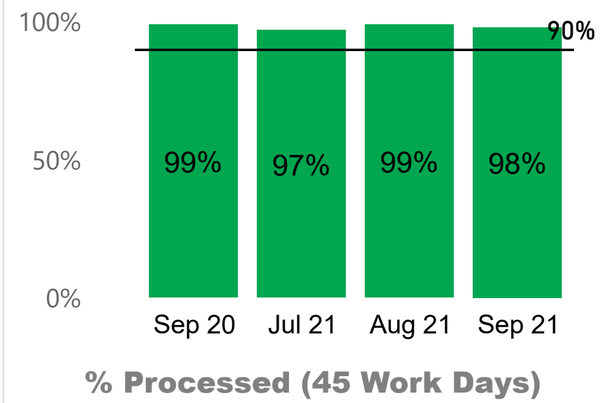



### Interest Paid (Dollars)

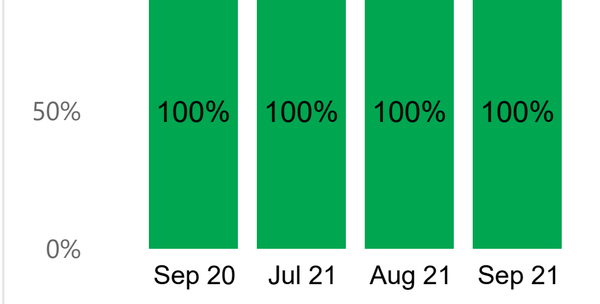



### Claims Compliance

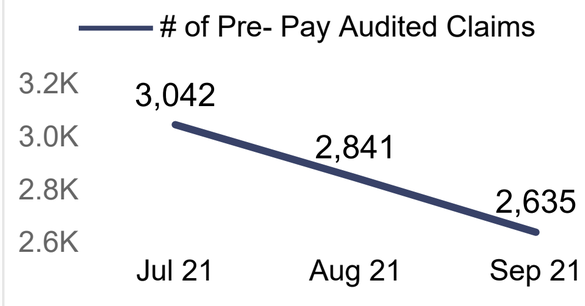
#### % Processed (30 Cal Days)



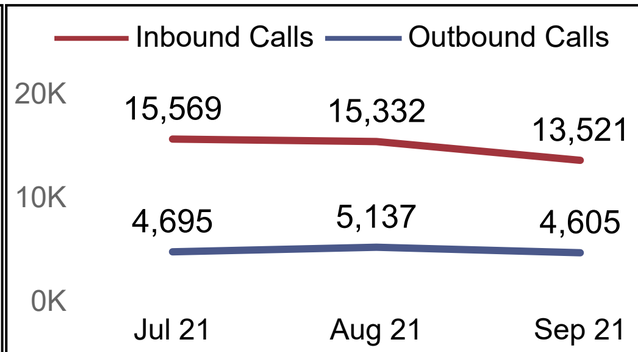

#### % Processed (45 Work Days)



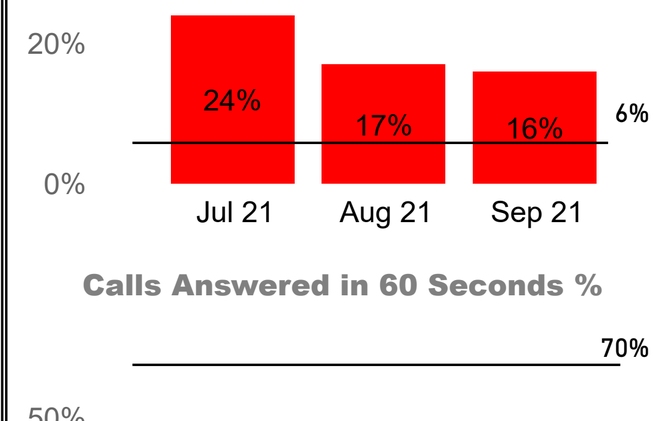

### Claims Auditing



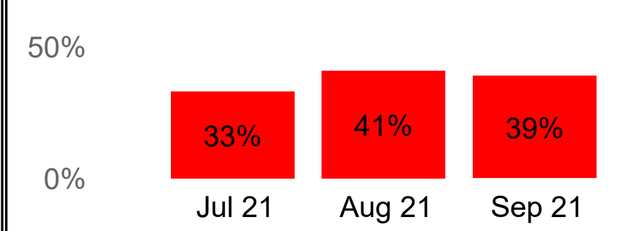

## Member Services




### Abandoned Call Rate %

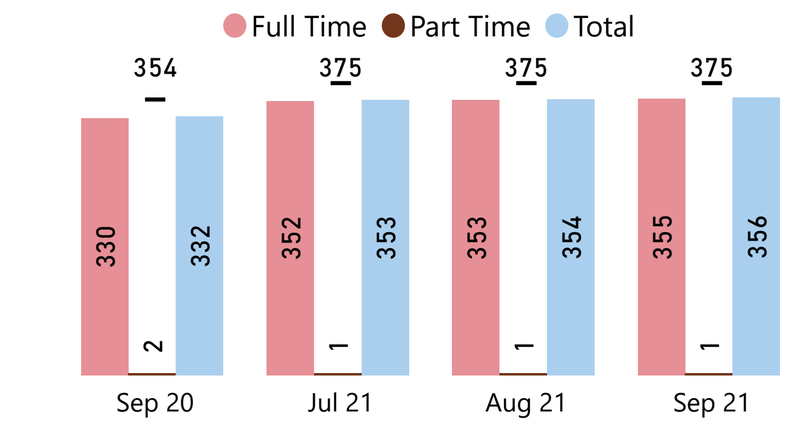


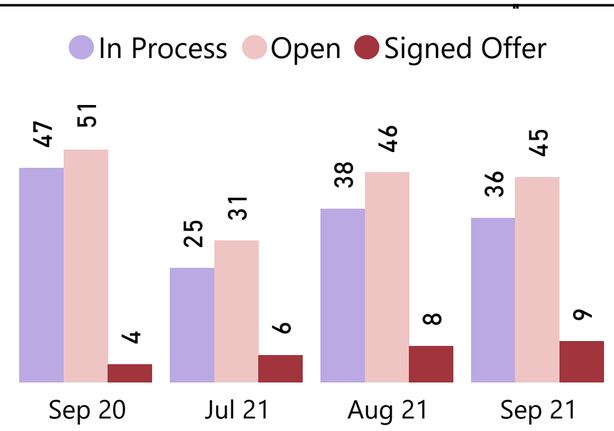

### Calls Answered in 60 Seconds %




| Average Call Times | Jul 21 | Aug 21 | Sep 21 |
|---|---|---|---|
| Wait Time | 04:35 | 03:48 | 03:33 |
| Call Duration | 07:57 | 07:15 | 06:18 |

## Human Resources




| Recruiting | Sep 20 | Jul 21 | Aug 21 | Sep 21 |
|---|---|---|---|---|
| New Hires | 8 | 7 | 5 | 3 |
| Separations | 5 | 2 | 2 | 2 |
| Temps / Seasonal | 3 | 14 | 13 | 13 |

Current Vacancy
12%

# OPERATIONS DASHBOARD

**OCTOBER 2021**
10/6/2021 9:38:55 AM

## Provider Services

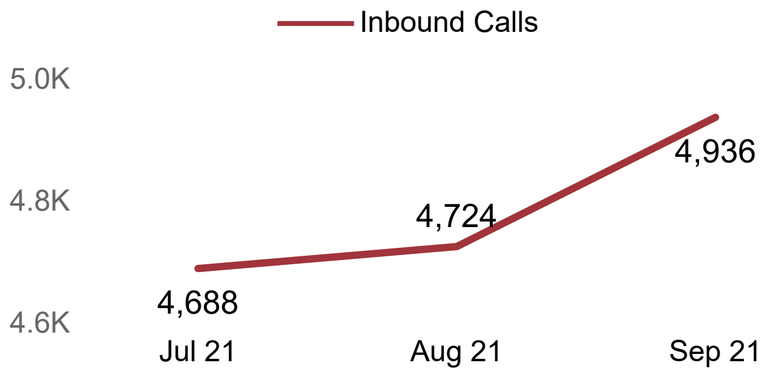
### Provider Network

| | |
|---|---|
| Primary Care Physician | 705 |
| Specialist | 7,232 |
| Hospital | 17 |
| Skilled Nursing Facility | 65 |
| Durable Medical Equipment | Capitated |
| Urgent Care | 9 |
| Health Centers (FQHCs and Non-FQHCs) | 68 |

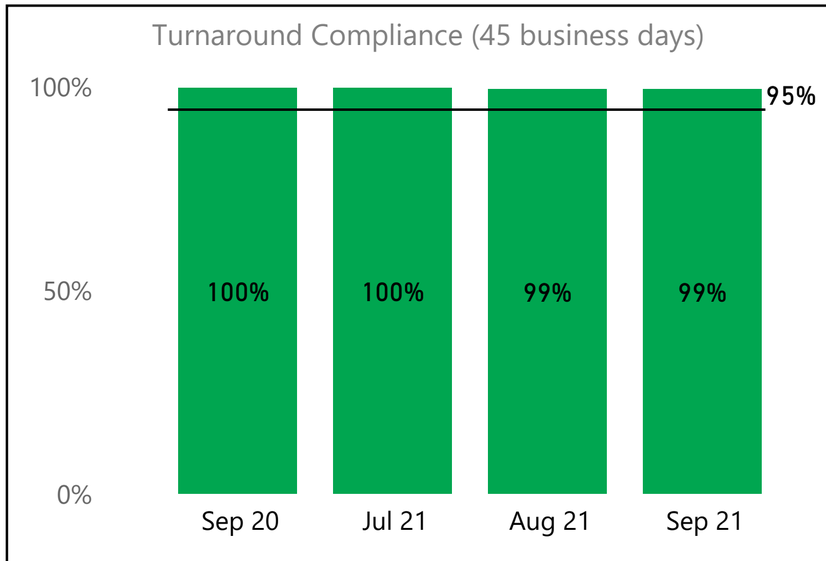
### Provider Credentialing

1,405

### Provider Call Center

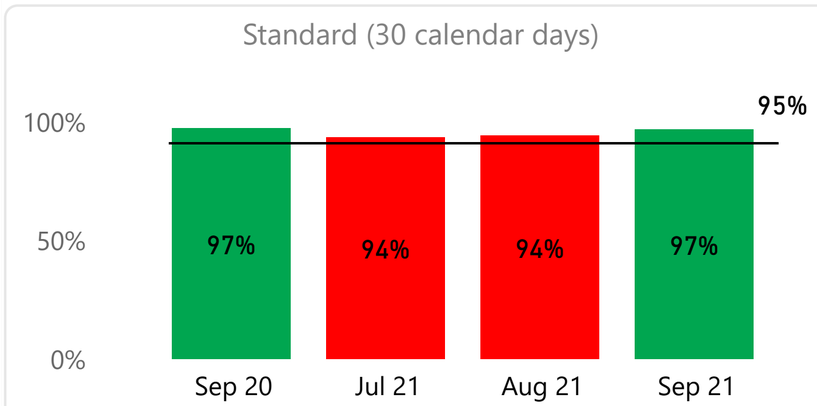


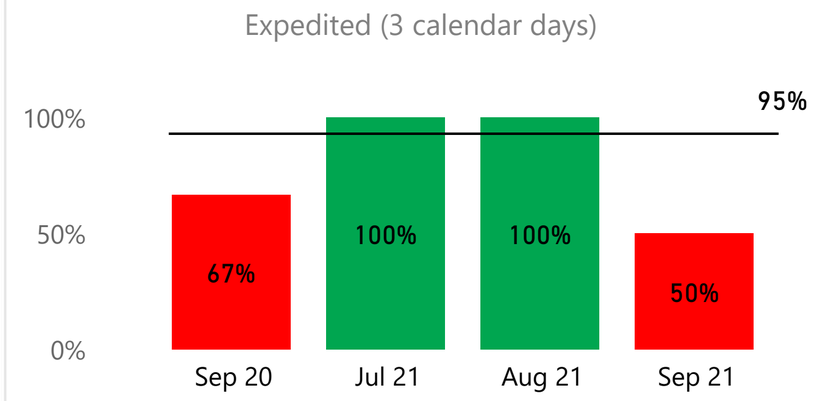

## Provider Disputes & Resolutions



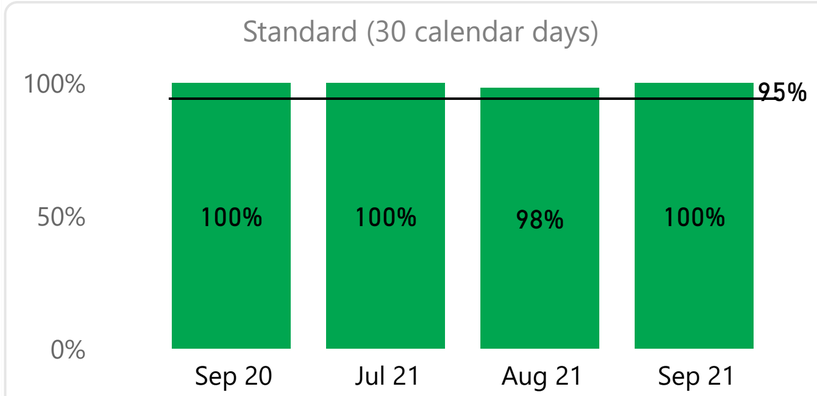

## Compliance

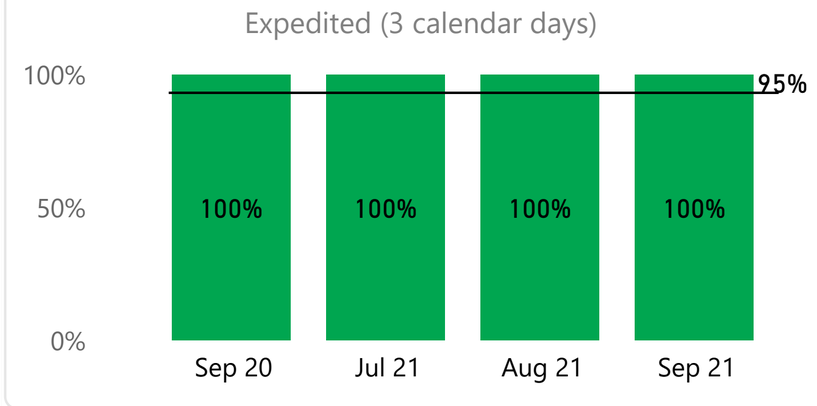
### Member Grievances



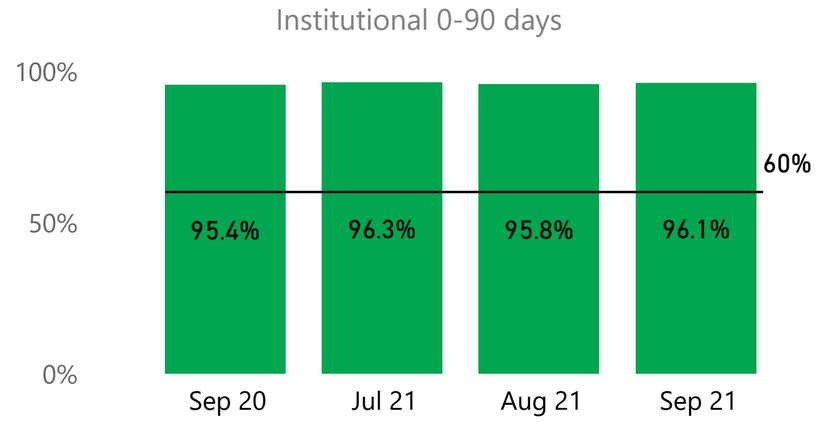



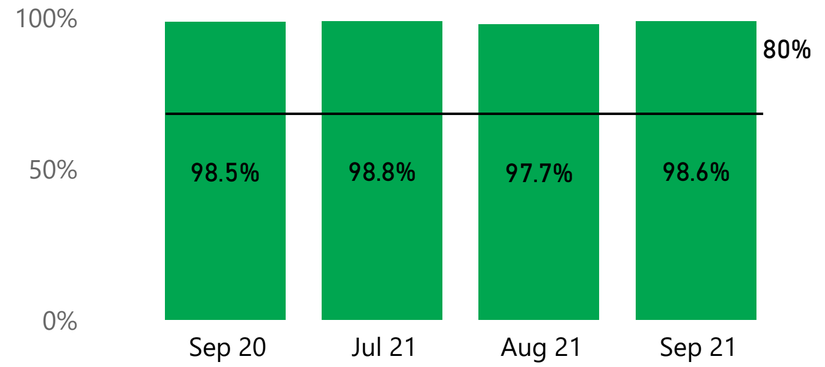

### Member Appeals

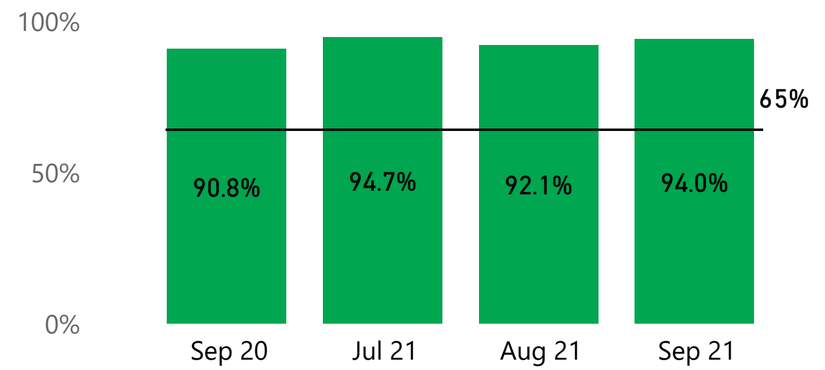


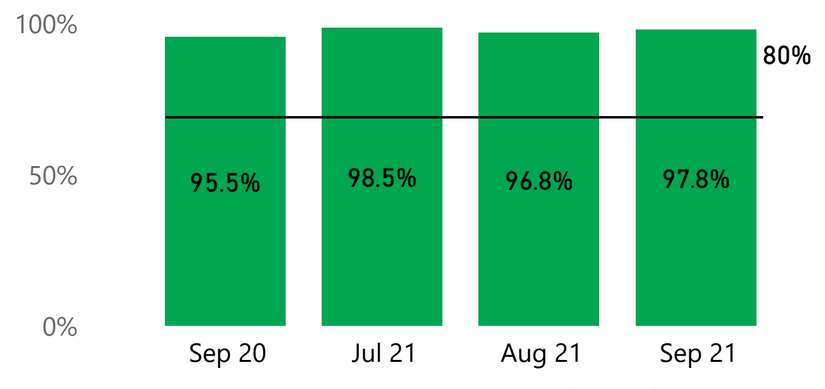




## Encounter Data



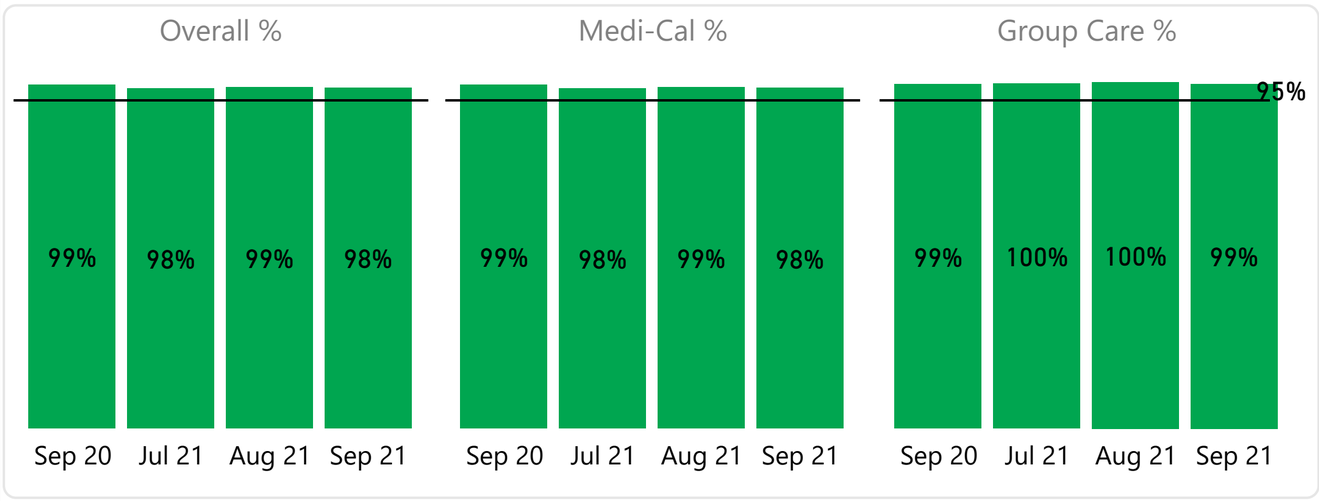



# OPERATIONS DASHBOARD

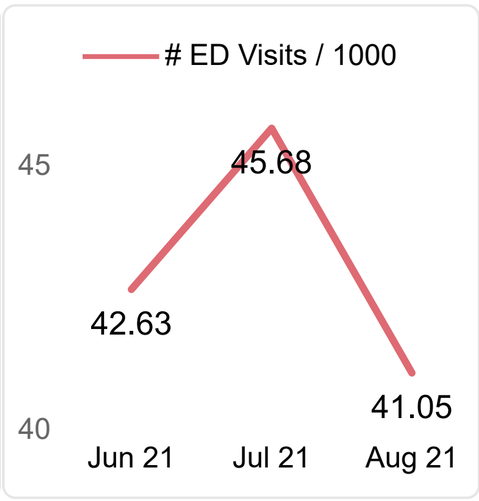
**OCTOBER 2021**
10/6/2021 9:38:55 AM

## Health Care Services

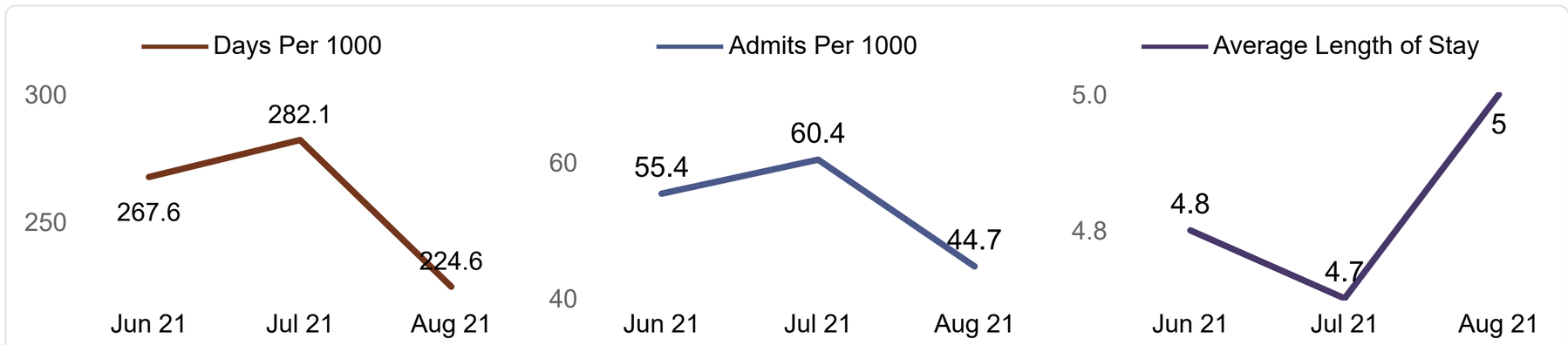
### Authorization Turnaround




### ED Utilization

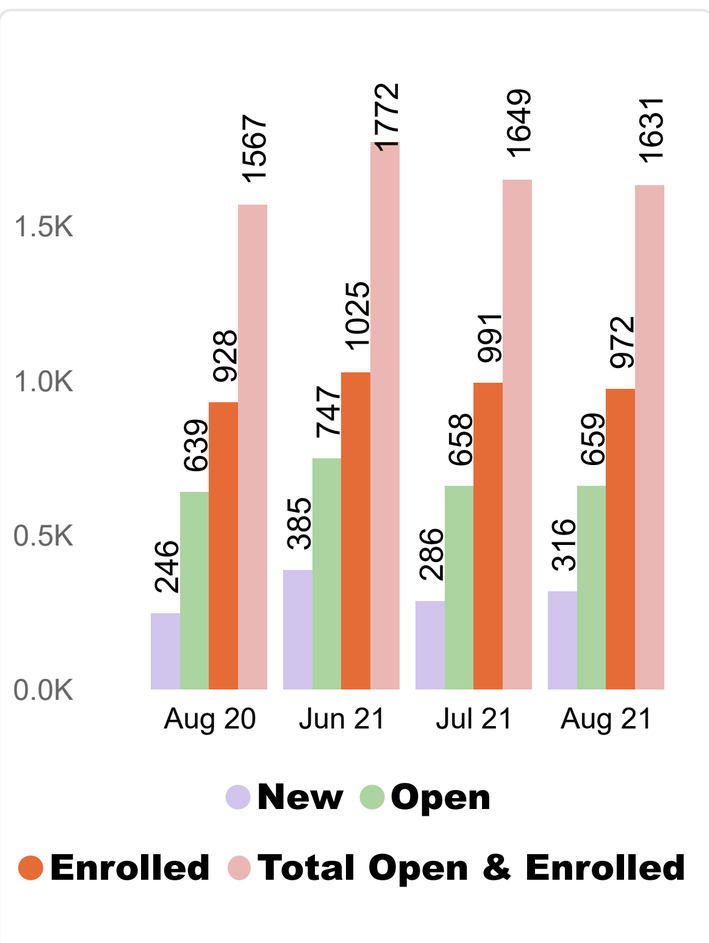



### Inpatient Utilization

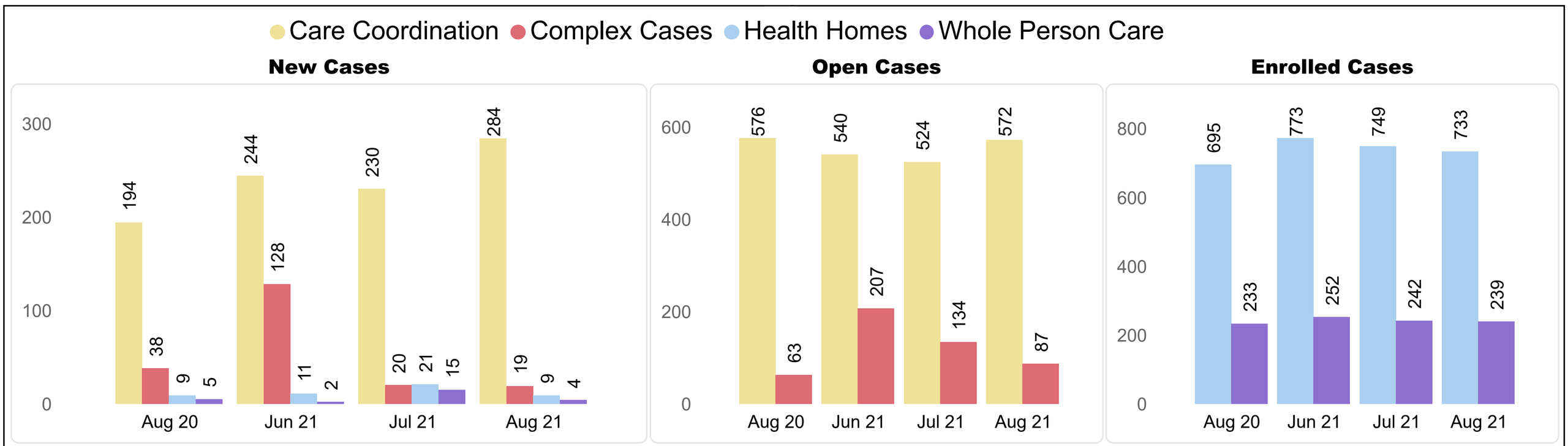



## Case Management

### Total Cases




## Case Management



## Technology (Business Availability)

| Applications | Sep 20 | Jul 21 | Aug 21 | Sep 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 | Sep 20 | Jul 21 | Aug 21 | Sep 21 |
|---|---|---|---|---|
| Denial Rate Excluding Partial Denials (%) | 4.0% | 4.0% | 4.0% | 3.4% |
| Overall Denial Rate (%) | 4.2% | 4.2% | 4.3% | 3.5% |
| Partial Denial Rate (%) | 0.2% | 0.2% | 0.3% | 0.1% |

## Pharmacy Authorizations

| Authorizations ▲ | Sep 20 | Jul 21 | Aug 21 | Sep 21 |
|---|---|---|---|---|
| Approved Prior Authorizations | 743 | 713 | 756 | 808 |
| Closed Prior Authorizations | 501 | 643 | 656 | 672 |
| Denied Prior Authorizations | 596 | 635 | 572 | 624 |
| Total Prior Authorizations | 1,840 | 1,991 | 1,984 | 2,104 |

# EXECUTIVE DASHBOARD
## OCTOBER 2021

ALAMEDA Alliance FOR HEALTH

THE ALLIANCE EXECUTIVE DASHBOARD PROVIDES A HIGH LEVEL OVERVIEW OF KEY PERFORMANCE MEASURES AND INDICATORS.

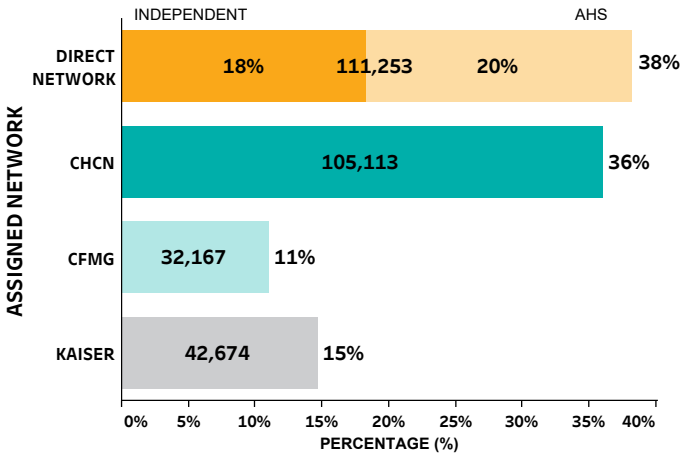
### MEMBERSHIP**

**291,207**

**TOTAL MEMBERSHIP**

**IHSS** 5,877 **MEDI-CAL** 285,330

### DISTRIBUTION OF ALL MEMBERSHIP BY ASSIGNED NETWORK**



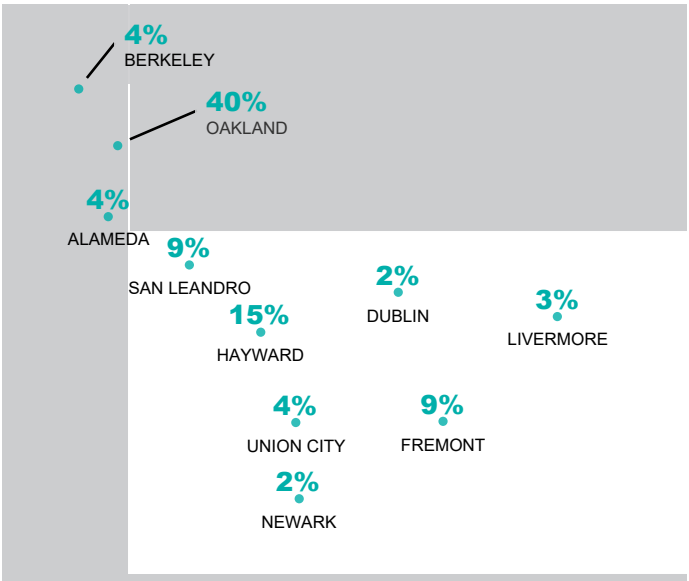

### DISTRIBUTION OF MEMBERSHIP BY CITY**

**92%**

OF ALLIANCE MEMBERS LIVE IN **10 CITIES** AND THE REMAINING **8%** LIVE IN THE OTHER ALAMEDA COUNTY CITIES AND UNINCORPORATED AREAS

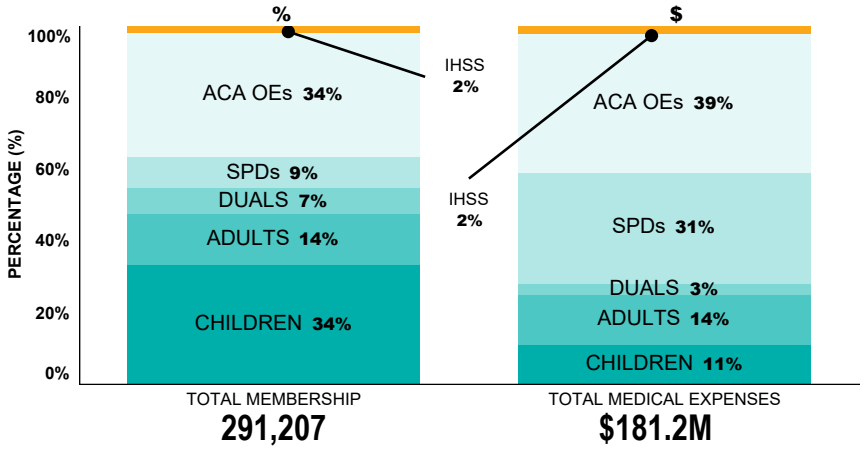
**TEN CITIES**

- ALAMEDA
- BERKELEY
- DUBLIN
- FREMONT
- HAYWARD
- LIVERMORE
- NEWARK
- OAKLAND
- SAN LEANDRO
- UNION CITY



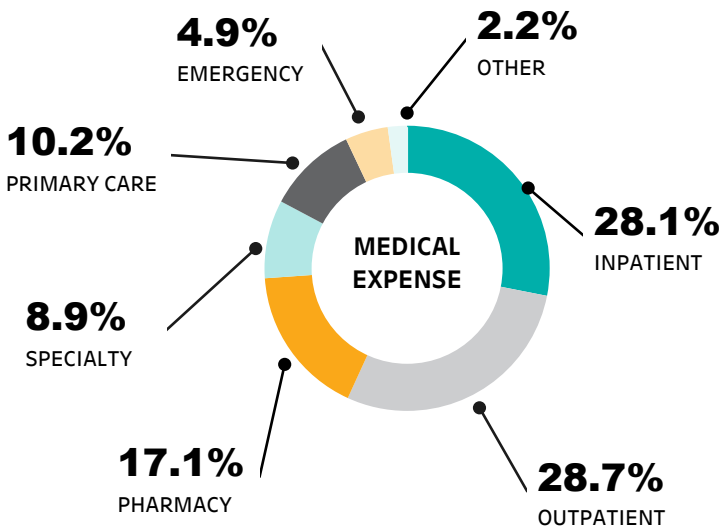

** KPIs REPORTING 2 MONTH LAG
**** KPIs REPORTING 4 MONTH LAG

### DISTRIBUTION OF MEDICAL EXPENSE BY MEMBERSHIP CATEGORY**




### REVENUE & EXPENSES**

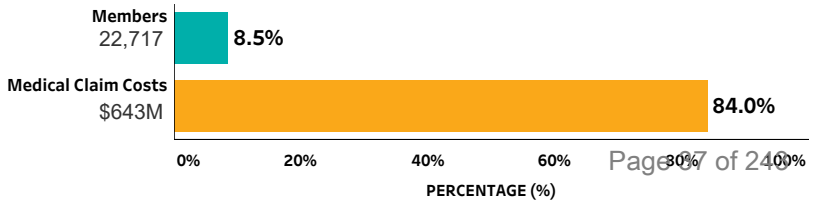
| | AUGUST 2021 | FISCAL YTD |
|---|---|---|
| REVENUE | $98.1M | $195.4M |
| MEDICAL EXPENSE | ($91.4M) | ($181.2M) |
| ADMIN EXPENSE | ($5.2M) | ($10.0M) |
| OTHER | ($27K) | ($16K) |
| **NET INCOME** | **$1.5M** | **$4.1M** |




### TANGIBLE NET EQUITY**

**564%** **$210M**

### HIGH UTILIZER DISTRIBUTION****



## UTILIZATION**

**4,623**
INPATIENT BED DAYS

**8,439**
EMERGENCY ROOM VISITS

**5.0 DAYS**
AVERAGE LENGTH OF STAY

## CASE AND DISEASE MANAGEMENT**

| | NEW CASES | OPEN CASES |
|---|---|---|
| CARE COORDINATION | 284 | 572 |
| COMPLEX CASE MANAGEMENT | 19 | 87 |
| **Total** | 303 | 659 |

| | NEW CASES | ENROLLED |
|---|---|---|
| HEALTH HOMES | 9 | 733 |
| WHOLE PERSON CARE (AC3) | 4 | 239 |
| **Total** | 13 | 972 |

**TOTAL CASE MANAGEMENT**

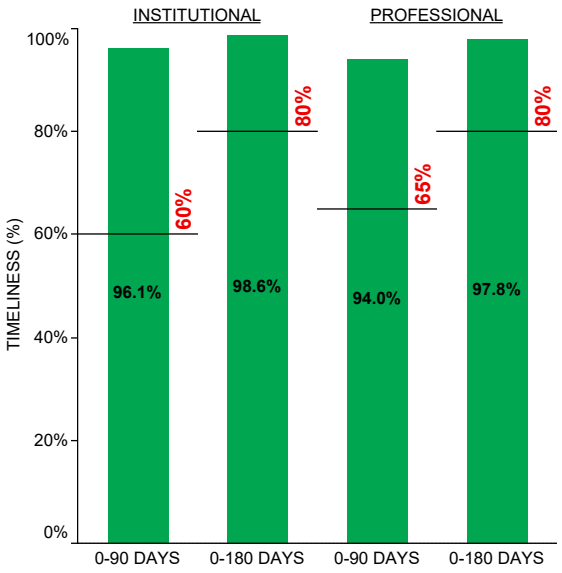
**316**
TOTAL NEW CASES

**1,631**
TOTAL OPEN CASES & ENROLLED

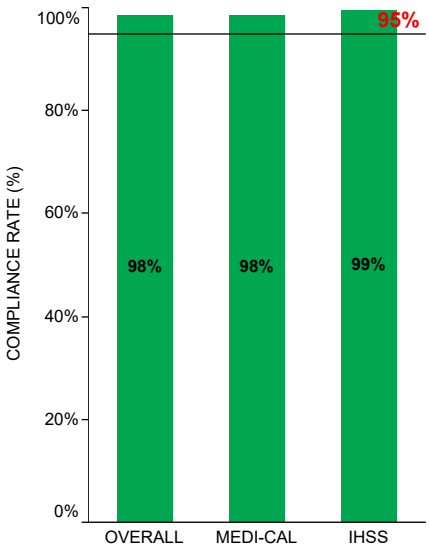
## REGULATORY COMPLIANCE

ALL REGULATORY COMPLIANCE MEASURES ARE IN COMPLIANCE.

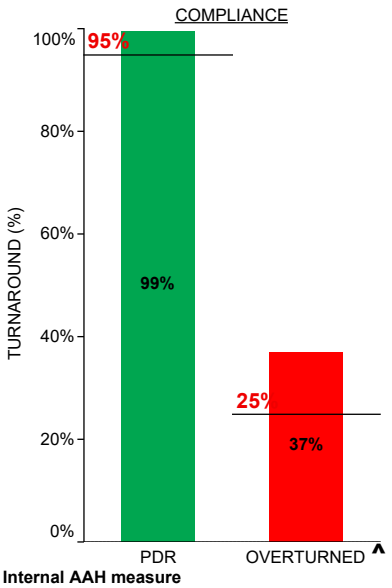
### ENCOUNTER DATA




### MEDICAL AUTHORIZATIONS




### PROVIDER DISPUTES & RESOLUTIONS




^ For Internal AAH measure

## CALL CENTER

**13,521**
CALLS RECEIVED

**39%**
ANSWERED IN 60 SECONDS

**16%**
CALLS ABANDONED

## CLAIMS

**158,547**
PROCESSED CLAIMS

**80.1%**
AUTO ADJUDICATED

**19 DAYS**
PROCESSED PAYMENTS

## STAFF & RECRUITING

**356**
TOTAL EMPLOYEES

**3**
HIRED IN THE LAST 30 DAYS

**12%**
CURRENT VACANCY

ALAMEDA Alliance FOR HEALTH

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

# Legislative Tracking

## 2021-2022 Legislative Tracking List

The following is a list of state bills currently tracked by the Public Affairs Department that have been introduced during the 2021-2022 Legislative Session that is of interest to and could have a direct impact on Alameda Alliance for Health and its membership. September 10th was the last day for each house to pass bills and October 10th will be the last day for the Governor to sign or veto bills passed by the legislature.

### Medi-Cal (Medicaid)

***Bills approved by the governor:***

- **AB 382 (Kamlager – D) Whole Child Model Program**
  - **Introduced:** 2/2/2021
  - **Status:** 7/9/21 Approved by the Governor. Chaptered by Secretary of State - Chapter 51, Statutes of 2021.
  - **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.

- **AB 361 (Rivas – D) Open Meeting: Local Agencies: Teleconferences**
  - **Introduced:** 2/1/2021
  - **Status:** 9/16/21 Chaptered by Secretary of State - Chapter 165, Statutes of 2021.
  - **Summary:** Would, until January 1, 2024, authorize a local agency to use teleconferencing without complying with the teleconferencing requirements imposed by the Ralph M. Brown Act when a legislative body of a local agency holds a meeting during a declared state of emergency, as that term is defined when state or local health officials have imposed or recommended measures to promote social distancing, during a proclaimed state of emergency held for the purpose of determining, by majority vote, whether meeting in person would present imminent risks to the health or safety of attendees, and during a proclaimed state of emergency when the legislative body has determined that meeting in person would present imminent risks to the health or safety of attendees, as provided.

***Bills sent to the Governor's desk:***

- **SB 365 (Caballero – D) E-consult Service**
  - **Introduced:** 2/17/2021
  - **Status:** 9/9/21 Enrolled and presented to the Governor at 1 p.m.
  - **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.

- **AB 369 (Kamlager – D) Medi-Cal Services: Persons Experiencing Homelessness**
  - **Introduced:** 2/1/2021
  - **Status:** 9/10/21 Enrolled and presented to the Governor at 4 p.m.
  - **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 532 (Wood – D) Health Care: Fair Billing Practices**
  - **Introduced:** 2/1/2021
  - **Status:** 9/15/21 Enrolled and presented to the Governor at 5 p.m.
  - **Summary:** Current law requires a hospital, as defined, to maintain an understandable written policy regarding discount payments for financially qualified patients as well as a written charity care policy, and requires a hospital to negotiate the terms of a discount payment plan with an eligible patient, as specified. Current law requires each hospital to provide patients with written notice about the availability of the hospital's discount payment and charity care policies, including information about eligibility and contact information for a hospital employee or office from which the patient may obtain further information about the policies. This bill would additionally require the written patient notice to include the internet address of a specified health consumer assistance entity and information regarding Covered California and Medi-Cal presumptive eligibility.

- **AB 1104 (Grayson – D) Air Ambulance Services**
  - **Introduced:** 2/18/2021
  - **Status:** 9/10/21 Enrolled and presented to the Governor at 4 p.m.
  - **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.

- **SB 48 (Limon – D) Medi-Cal: Annual Cognitive Health Assessment**
  - **Introduced:** 1/28/2021
  - **Status:** 9/17/21 Enrolled and presented to the Governor at 1:30 p.m.
  - **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 pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Subject to an appropriation by the

Legislature for this purpose, this bill would expand the schedule of benefits to include an annual cognitive health assessment for Medi-Cal beneficiaries who are 65 years of age or older if they are otherwise ineligible for a similar assessment as part of an annual wellness visit under the Medicare Program.

- **SB 242 (Newman – D) Health Care Provider Reimbursements**
  - **Introduced:** 1/21/2021
  - **Status:** 9/17/21 Enrolled and presented to the Governor at 1:30 p.m.
  - **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 428 (Hurtado – D) Health Care Coverage: Adverse Childhood Experiences Screenings**
  - **Introduced:** 2/12/2021
  - **Status:** 9/17/21 Enrolled and presented to the Governor at 1:30 p.m.
  - **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 510 (Pan – D) Health Care Coverage: COVID-19 cost sharing**
  - **Introduced:** 2/17/2021
  - **Status:** 9/17/21 Enrolled and presented to the Governor at 1:30 p.m.
  - **Summary:** Would require a health care service plan contract or a disability insurance policy that provides coverage for hospital, medical, or surgical benefits, excluding a specialized health care service plan contract or health insurance policy, to cover the costs for COVID-19 diagnostic and screening testing and health care services related to the testing for COVID-19, or a future disease when declared a public health emergency by the Governor of the State of California, and would prohibit that contract or policy from imposing cost sharing or prior authorization requirements for that coverage. The bill would also require a contract or policy to cover without cost sharing or prior authorization an item, service, or immunization intended to prevent or mitigate COVID-19, or a future disease when declared a public health emergency by the Governor of the State of California, that is recommended by the United States Preventive Services Task Force or the federal Centers for Disease Control and Prevention, as specified.

***2-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 4 (Arambula – D) Medi-Cal: Eligibility**
  - **Introduced:** 12/8/2020
  - **Status:** 8/27/21 Failed Deadline pursuant to Rule 61(a)(12). (Last location was APPR. SUSPENSE FILE on 7/5/2021) (May be acted upon Jan 2022)
  - **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:** 7/14/21 Failed Deadline pursuant to Rule 61(a)(11). (Last location was HEALTH on 6/9/2021) (May be acted upon Jan 2022)
  - **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:** 8/27/21 Failed Deadline pursuant to Rule 61(a)(12). (Last location was APPR. on 6/16/2021) (May be acted upon Jan 2022)
  - **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 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).

Updated 10/5/2021

- **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 470 (Carillo – D) Medi-Cal: Eligibility**
- **Introduced:** 2/8/2021
- **Status:** 8/27/21 Failed Deadline pursuant to Rule 61(a)(12). (Last location was APPR. SUSPENSE FILE on 7/15/2021) (May be acted upon Jan 2022)
- **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 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 540 (Petrie-Norris – D) Program of All-Inclusive Care for the Elderly**
  - **Introduced:** 2/10/2021
  - **Status:** 8/27/21 Failed Deadline pursuant to Rule 61(a)(12). (Last location was APPR. SUSPENSE FILE on 7/15/2021) (May be acted upon Jan 2022)
  - **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:** 7/14/21 Failed Deadline pursuant to Rule 61(a)(11). (Last location was ED. on 6/9/2021) (May be acted upon Jan 2022)
- **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 601 (Fong – R) Medi-Cal: Reimbursement**
  - **Introduced:** 2/11/2021
  - **Status:** 5/7/21 Failed Deadline pursuant to Rule 61(a)(3). (Last location was PRINT on 2/11/2021) (May be acted upon Jan 2022)
  - **Summary:** Current law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals to receive health care services, including clinical laboratory or laboratory services. The Medi-Cal program is, in part, governed by and funded pursuant to federal Medicaid program provisions. Current law requires the department to develop, subject to federal approval, reimbursement rates for clinical or laboratory services according to specified standards, such as requiring that reimbursement to providers for those services not exceed the lowest of enumerated criteria, including 80% of the lowest maximum allowance established by the federal Medicare Program for the same or similar services. This bill would make a technical, non-substantive change to these provisions.

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

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

- **AB 848 (Calderon – D) Medi-Cal: Monthly Maintenance Amount: Personal and Incidental Needs**
  - **Introduced:** 2/17/2021
  - **Status:** 5/25/21 Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/19/2021) (May be acted upon Jan 2022)

Updated 10/5/2021

- **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 852 (Wood – D) Nurse Practitioners: Scope of Practice: Practice without Standardized Procedures**
  - **Introduced:** 2/17/2021
  - **Status:** 7/14/21 Failed Deadline pursuant to Rule 61(a)(11). (Last location was B., P. & E.D. on 6/3/2021) (May be acted upon Jan 2022)
  - **Summary:** This bill would refer to practice protocols, as defined, instead of individual protocols and would delete the requirement to obtain physician consultation in the case of acute decompensation of patient situation. The bill would revise the requirement to establish a referral plan, as described above, by requiring it to address the situation of a patient who is acutely decompensating in a manner that is not consistent with the progression of the disease and corresponding treatment plan.

- **AB 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)

Updated 10/5/2021

- **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 1132 (Wood – D) Medi-Cal**
  - **Introduced:** 2/18/2021
  - **Status:** 7/14/21 Failed Deadline pursuant to Rule 61(a)(11). (Last location was HEALTH on 6/16/2021) (May be acted upon Jan 2022)
  - **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.

Updated 10/5/2021

- **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 1051 (Bennett D) Medi-Cal: specialty mental health services: foster youth.**
  - **Introduced:** 2/18/2021
  - **Status:** 9/10/21 Failed Deadline pursuant to Rule 61(a)(15). (Last location was INACTIVE FILE on 9/1/2021) (May be acted upon Jan 2022)
  - **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.

- **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 56 (Durazno – D) Medi-Cal: Eligibility**
  - **Introduced:** 12/7/2020
  - **Status:** 8/27/21 Failed Deadline pursuant to Rule 61(a)(12). (Last location was APPR. on 6/22/2021) (May be acted upon Jan 2022)
  - **Summary:** Current law provides that Medi-Cal benefits for individuals who are 65 years of age or older, and who do not have satisfactory immigration statuses or are unable to establish satisfactory immigration statuses, will be prioritized in the Budget Act for the upcoming fiscal year if the Department of Finance projects a positive ending balance in the Special Fund for Economic Uncertainties for the upcoming fiscal year and each of the ensuing 3 fiscal years that exceeds the cost of providing those individuals with full-scope Medi-Cal benefits. This bill would, subject to an appropriation by the Legislature, and effective July 1, 2022, extend eligibility for full-scope Medi-Cal benefits to individuals who are 60 years of age or older, and who are otherwise eligible for those benefits but for their immigration status.

Updated 10/5/2021

- **SB 250 (Pan – D) Health Care Coverage**
  - **Introduced:** 1/25/2021
  - **Status:** 7/14/21 Failed Deadline pursuant to Rule 61(a)(11). (Last location was HEALTH on 6/10/2021) (May be acted upon Jan 2022)
  - **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:** 7/14/21 Failed Deadline pursuant to Rule 61(a)(11). (Last location was HEALTH on 6/10/2021) (May be acted upon Jan 2022)
  - **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 281 (Dodd – D) Medi-Cal: California Community Transitions Program**
  - **Introduced:** 2/1/2021
  - **Status:** 7/6/21 July 6 set for first hearing canceled at the request of author.
  - **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 293 (Limon – D) Medi-Cal: Specialty Mental Health Services**
  - **Introduced:** 2/1/2021
  - **Status:** 8/27/21 Failed Deadline pursuant to Rule 61(a)(12). (Last location was APPR. on 7/6/2021) (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 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:** 9/10/21 Failed Deadline pursuant to Rule 61(a)(15). (Last location was INACTIVE FILE on 9/9/2021) (May be acted upon Jan 2022)
  - **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 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.

- **SB 523 (Leyva – D) Health Care Coverage: Contraceptives**
  - **Introduced:** 2/10/2021
  - **Status:** 8/27/21 Failed Deadline pursuant to Rule 61(a)(12). (Last location was APPR. SUSPENSE FILE on 8/19/2021) (May be acted upon Jan 2022)
  - **Summary:** Current law establishes health care coverage requirements for contraceptives, including, but not limited to, requiring a health care service plan, including a Medi-Cal managed care plan, or a health insurance policy issued, amended, renewed, or delivered on or after January 1, 2017, to cover up to a 12-month supply of federal Food and Drug Administration approved, self-administered hormonal contraceptives when dispensed at one time for an enrollee or insured by a provider or pharmacist, or at a location licensed or authorized to dispense drugs or supplies.

Updated 10/5/2021

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.

**Other**

***Bills approved by the governor:***

- **AB 342 (Gipson – D) Health Care Coverage: Colorectal Cancer: Screening and Testing**
  - **Introduced:** 1/28/2021
  - **Status:** 10/1/21 Signed by the Governor
  - **Summary:** Would require a health care service plan contract or a health insurance policy, except as specified, that is issued, amended, or renewed on or after January 1, 2022, to provide coverage for a colorectal cancer screening test, as specified. The bill would require the required colonoscopy for a positive result on a test or procedure to be provided without cost sharing, unless the underlying test or procedure was a colonoscopy, as specified. The bill would also provide that it does not require a health care service plan or health insurer to provide benefits for items or services delivered by an out-of-network provider and does not preclude a health care service plan or health insurer from imposing cost-sharing requirements for items or services that are delivered by an out-of-network provider.

- **AB 457 (Santiago – D) Protection of Patient Choice in Telehealth Provider Act**
  - **Introduced:** 2/8/2021
  - **Status:** 10/1/21 Signed by the Governor
  - **Summary:** Current law provides for the licensure and regulation of various healing arts professions and vocations by boards within the Department of Consumer Affairs. Under current law, it is unlawful for healing arts licensees, except as specified, to offer, deliver, receive, or accept any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person, subject to certain exceptions. This bill would provide that the payment or receipt of consideration for internet-based advertising, appointment booking, or any service that provides information and resources to prospective patients of licensees does not constitute a referral of a patient if the internet-based service provider does not recommend, endorse, arrange for, or otherwise select a licensee for the prospective patient.

- **AB 644 (Waldron – R) California MAT Re-entry Incentive Program**
  - **Introduced:** 2/12/2021
  - **Status:** 7/9/21 Approved by the Governor. Chaptered by Secretary of State
  - **Summary:** Current law, contingent upon the appropriation of specified federal grant funds to the State Department of Health Care Services, establishes the California MAT Re-Entry Incentive Program, which makes a person released from prison on parole, with specified exceptions, eligible for a 30-day reduction in the period of parole for every six months of treatment, up to a maximum 90-day reduction. To receive the reduction to the period of parole, existing law requires that the parolee successfully participate in a substance abuse treatment program that employs a multifaceted approach to treatment, including medically assisted therapy (MAT), as specified, and to have been enrolled in, or successfully participated in, an institutional substance abuse program.

Updated 10/5/2021

This bill would, instead of requiring the person to have participated in an institutional substance abuse program, require the person to have been enrolled in, or successfully participated in, a post-release substance abuse program.

***Bills sent to the Governor's desk:***

- **AB 309 (Gabriel – D) Pupil Mental Health: Model Referral Protocols**
  - **Introduced:** 1/25/2021
  - **Status:** 9/17/21 Enrolled and presented to the Governor at 3 p.m.
  - **Summary:** Would require the State Department of Education to develop model referral protocols, as provided, for addressing pupil mental health concerns. The bill would require the department to consult with various entities in developing the protocols, including current classroom teachers, administrators, pupils, and parents. The bill would require the department to post the model referral protocols on its internet website. The bill would make these provisions contingent upon funds being appropriated for its purpose in the annual Budget Act or other legislation, or state, federal, or private funds being allocated for this purpose.

- **AB 326 (Rivas, Luz – D) Health Care Service Plans: Consumer Participation Program**
  - **Introduced:** 1/26/2021
  - **Status:** 9/17/21 Enrolled and presented to the Governor at 3 p.m.
  - **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 347 (Arambula – D) Health Care Coverage: Step Therapy**
  - **Introduced:** 1/28/2021
  - **Status:** 9/17/21 Enrolled and presented to the Governor at 3 p.m.
  - **Summary:** Would clarify that a health care service plan that provides coverage for prescription drugs may require step therapy, as defined, if there is more than one drug that is clinically appropriate for the treatment of a medical condition. The bill would require a health care service plan or health insurer to expeditiously grant a step therapy exception if the health care provider submits justification and supporting clinical documentation, if needed, that specified criteria are met. The bill would authorize an enrollee or insured or their designee, guardian, health care provider, or prescribing provider to file an internal appeal of a denial of an exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request, and would require a health care service plan or health insurer to designate a clinical peer to review those appeals.

- **AB 389 (Grayson – D) Ambulance Services**
  - **Introduced:** 2/2/2021
  - **Status:** 9/17/21 Enrolled and presented to the Governor at 3 p.m.
  - **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.

Updated 10/5/2021

- **AB 1064 (Fong – R) Pharmacy Practice: Vaccines: Independent Initiation and Administration**
  - **Introduced:** 2/18/2021
  - **Status:** 9/10/21 Enrolled and presented to the Governor at 4 p.m.
  - **Summary:** Current law provides additional authority for the pharmacist to independently initiate and administer any COVID-19 vaccines approved or authorized by the federal Food and Drug Administration (FDA), or vaccines listed on the routine immunization schedules recommended by the federal Advisory Committee on Immunization Practices (ACIP), in compliance with individual ACIP vaccine recommendations, and published by the federal Centers for Disease Control and Prevention (CDC) for persons 3 years of age and older. This bill would recast this provision to instead authorize a pharmacist to independently initiate and administer any vaccine that has been approved or authorized by the FDA and received an ACIP individual vaccine recommendation published by the CDC for persons 3 years of age and older.

- **SB 306 (Pan – D) Sexually Transmitted Disease: Testing**
  - **Introduced:** 12/7/2020
  - **Status:** 9/17/21 Enrolled and presented to the Governor at 1:30 p.m.
  - **Summary:** Current law authorizes a specified health care provider who diagnoses an STD, as specified, to prescribe, dispense, furnish, or otherwise provide prescription antibiotic drugs to that patient's sexual partner or partners without examination of that patient's partner or partners. The Pharmacy Law provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy. The Pharmacy Law requires a pharmacist to dispense a prescription in a container that, among other things, is correctly labeled with the name of the patient or patients. Current regulation requires a pharmacist to ensure that a patient receives written notice of their right to consult with a pharmacist when the patient or the patient's agent is not present. This bill would name the above practice "expedited partner therapy." The bill would require a health care provider to include "expedited partner therapy" or "EPT" on a prescription if the practitioner is unable to obtain the name of a patient's sexual partner, and would authorize a pharmacist to dispense an expedited partner therapy prescription and label the drug without an individual's name if the prescription includes "expedited partner therapy" or "EPT."

- **SB 221 (Wiener – D) Health Care Coverage: Timely Access to Care**
  - **Introduced:** 1/13/2021
  - **Status:** 9/15/21 Enrolled and presented to the Governor at 2:30 p.m.
  - **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, as specified.

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

- **AB 71 (Rivas – D) Homeless Funding: Bring California Home Act**
  - **Introduced:** 12/7/2020
  - **Status:** 9/10/21 Failed Deadline pursuant to Rule 61(a)(15). (Last location was INACTIVE FILE on 6/3/2021) (May be acted upon Jan 2022)
  - **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.

- **AB 93 (Garcia, Eduardo – D) Pandemic Response Practices**
  - **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 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 97 (Nazarian – D) Health Care Coverage: Insulin affordability**
  - **Introduced:** 12/8/2020
  - **Status:** 8/27/21 Failed Deadline pursuant to Rule 61(a)(12). (Last location was APPR. on 8/17/2021) (May be acted upon Jan 2022)
  - **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:** 8/27/21 Failed Deadline pursuant to Rule 61(a)(12). (Last location was APPR. SUSPENSE FILE on 7/5/2021) (May be acted upon Jan 2022)
  - **Summary:** This bill would require the State Department of Public Health to contract with an appropriate and qualified entity to conduct an evaluation of the adequacy of the local health

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

- **AB 383 (Salas – D) Behavioral Health: Older Adults**
  - **Introduced:** 2/2/2021
  - **Status:** 8/27/21 Failed Deadline pursuant to Rule 61(a)(12). (Last location was APPR. SUSPENSE FILE on 8/16/2021) (May be acted upon Jan 2022)
  - **Summary:** Would establish within the State Department of Health Care Services an Older Adult Behavioral Health Services Administrator to oversee behavioral health services for older adults. The bill would require that position to be funded with administrative funds from the Mental Health Services Fund. The bill would prescribe the functions of the administrator and its responsibilities, including, but not limited to, developing outcome and related indicators for older adults for the purpose of assessing the status of behavioral health services for older adults, monitoring the quality of programs for those adults, and guiding decision making on how to improve those services. The bill would require the administrator to receive data from other state agencies and departments to implement these provisions, subject to existing state or federal confidentiality requirements. The bill would require the administrator to report to the entities that administer the MHSA on those outcome and related indicators by July 1, 2022 and would require the report to be posted on the department's internet website.

- **AB 393 (Reyes – D) Early Childhood Development Act of 2020**
  - **Introduced:** 2/2/2021
  - **Status:** 9/10/21 Failed Deadline pursuant to Rule 61(a)(15). (Last location was APPR. SUSPENSE FILE on 5/5/2021) (May be acted upon Jan 2022)
  - **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 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 493 (Wood – D) Health Insurance**
  - **Introduced:** 2/8/2021
  - **Status:** 7/14/21 Failed Deadline pursuant to Rule 61(a)(11). (Last location was HEALTH on 5/12/2021) (May be acted upon Jan 2022)
  - **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.

- **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 1130 (Wood D) California Health Care Quality and Affordability Act**
  - **Introduced:** 2/18/2021
  - **Status:** 7/14/21 Failed Deadline pursuant to Rule 61(a)(11). (Last location was HEALTH on 6/16/2021) (May be acted upon Jan 2022)

Updated 10/5/2021

- **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 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 17 (Pan – D) Office of Racial Equity**
  - **Introduced:** 12/7/2020
  - **Status:** 8/27/21 Failed Deadline pursuant to Rule 61(a)(12). (Last location was APPR. on 6/30/2021) (May be acted upon Jan 2022)
  - **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 40 (Hurtado – D) Health Care Workforce Development: California Medicine Scholars Program**
  - **Introduced:** 12/7/2020
  - **Status:** 8/27/21 Failed Deadline pursuant to Rule 61(a)(12). (Last location was APPR. on 7/6/2021) (May be acted upon Jan 2022)
  - **Summary:** Would, contingent upon an appropriation by the Legislature, as specified, create the California Medicine Scholars Program, a 5-year pilot program commencing January 1, 2023, and would require the Office of Statewide Health Planning and Development to establish and facilitate the pilot program. The bill would require the pilot program to establish a regional pipeline program for community college students to pursue premedical training and enter medical school, in an effort to address the shortage of primary care physicians in California and the widening disparities in access to care in vulnerable and underserved communities, including building a comprehensive statewide approach to increasing the number and representation of minority primary care physicians in the state.

- **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)

Updated 10/5/2021

- **Summary:** Would require the State Department of Social Services to convene a working group to examine the extended foster care program and make recommendations for improvements to the program. The bill would require the working group to submit a report to the Legislature with the recommendations on or before July 1, 2022. The bill would require the working group to include representatives from specified state agencies and stakeholders. The bill would require the working group to evaluate and provide recommendations on the overall functioning of the extended foster care system, and on other specified components of the foster care system, including higher education opportunities, job training, and employment opportunities for nonminor dependents, housing access, and access to health care and mental health services. The bill would require the recommendations to reflect a consensus of the working group, as specified.

ALAMEDA Alliance FOR HEALTH

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Service you can trust.

# Board Business


# Moss Adams Fiscal Year 2021 Audit

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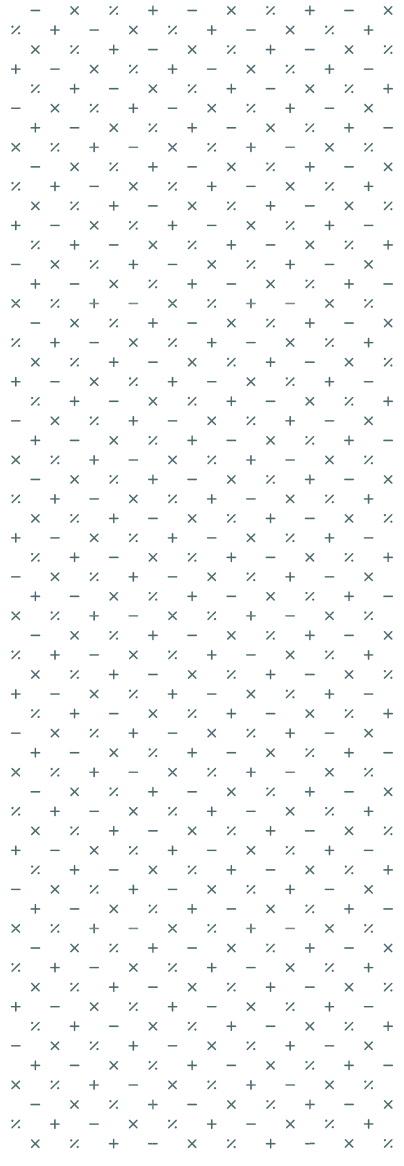
# 2021 Audit Results: Alameda Alliance for Health and Alameda Alliance Joint Powers Authority

Rianne Suico
Health Care and Insurance Services Partner

Chris Pritchard
Health Care and Insurance Services Partner



# 2021 Audit Objectives

- Opinion on whether the financial statements are reasonably stated and free of material misstatement in accordance with generally accepted accounting principles.

- Consideration of internal controls and compliance

# Report of Independent Auditors

## Unmodified Opinion

Combined financial statements are presented fairly and in accordance with generally accepted accounting principles.

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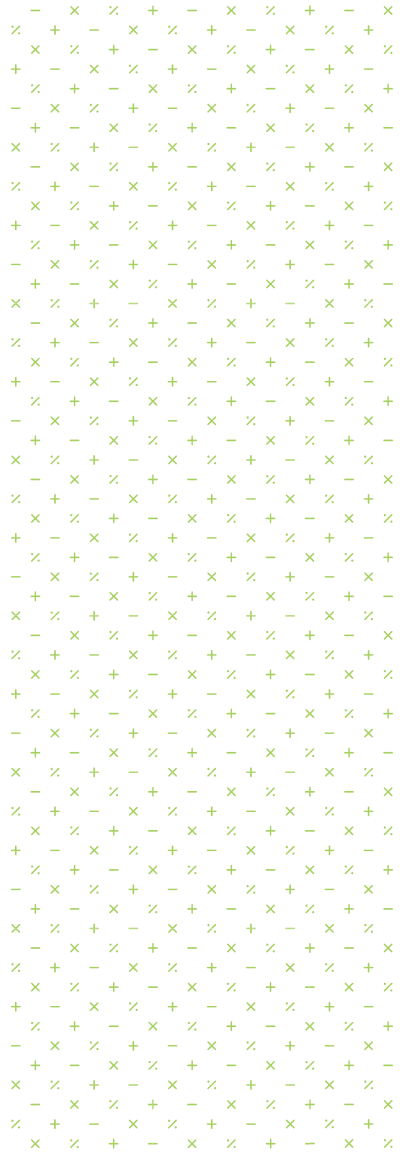
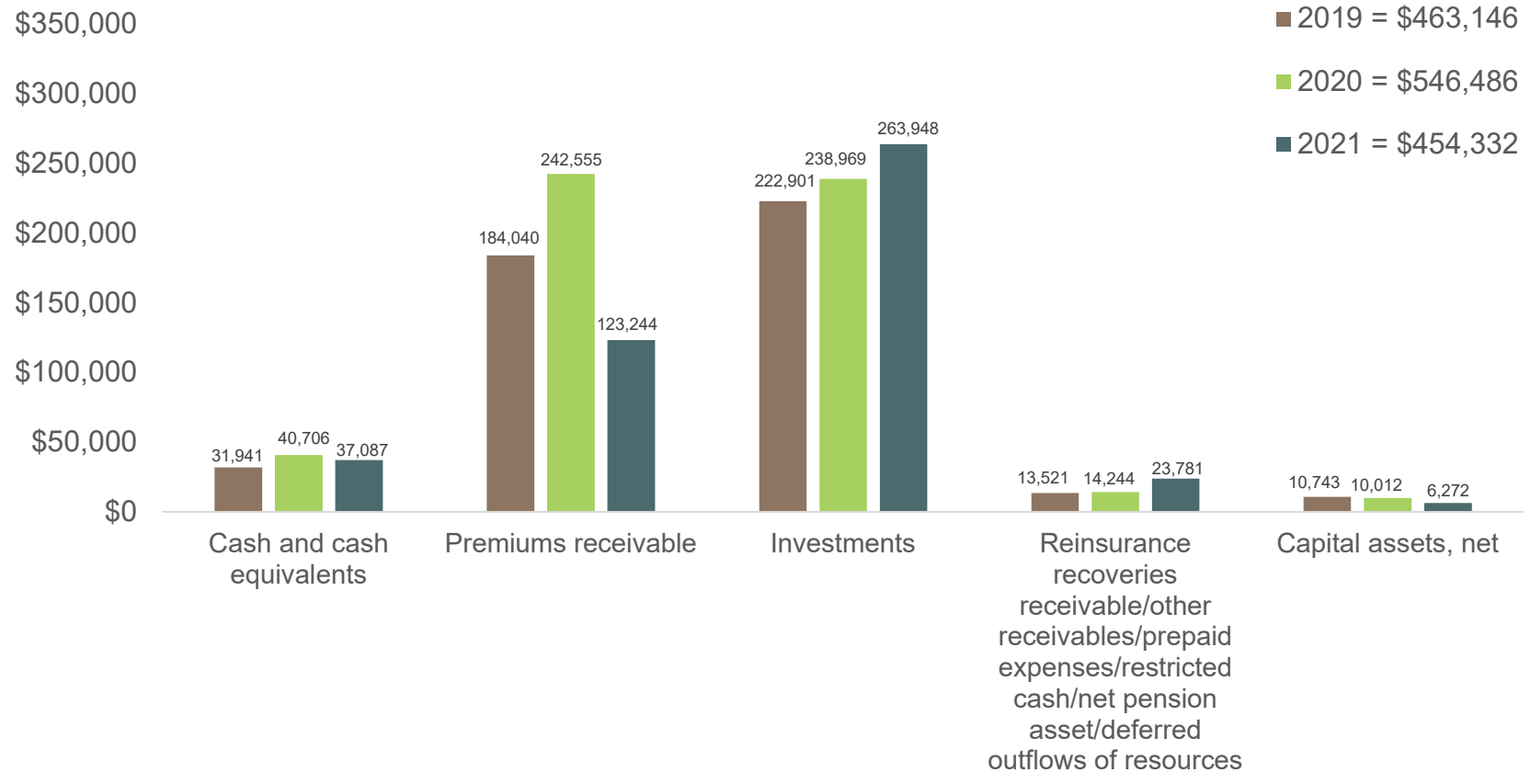
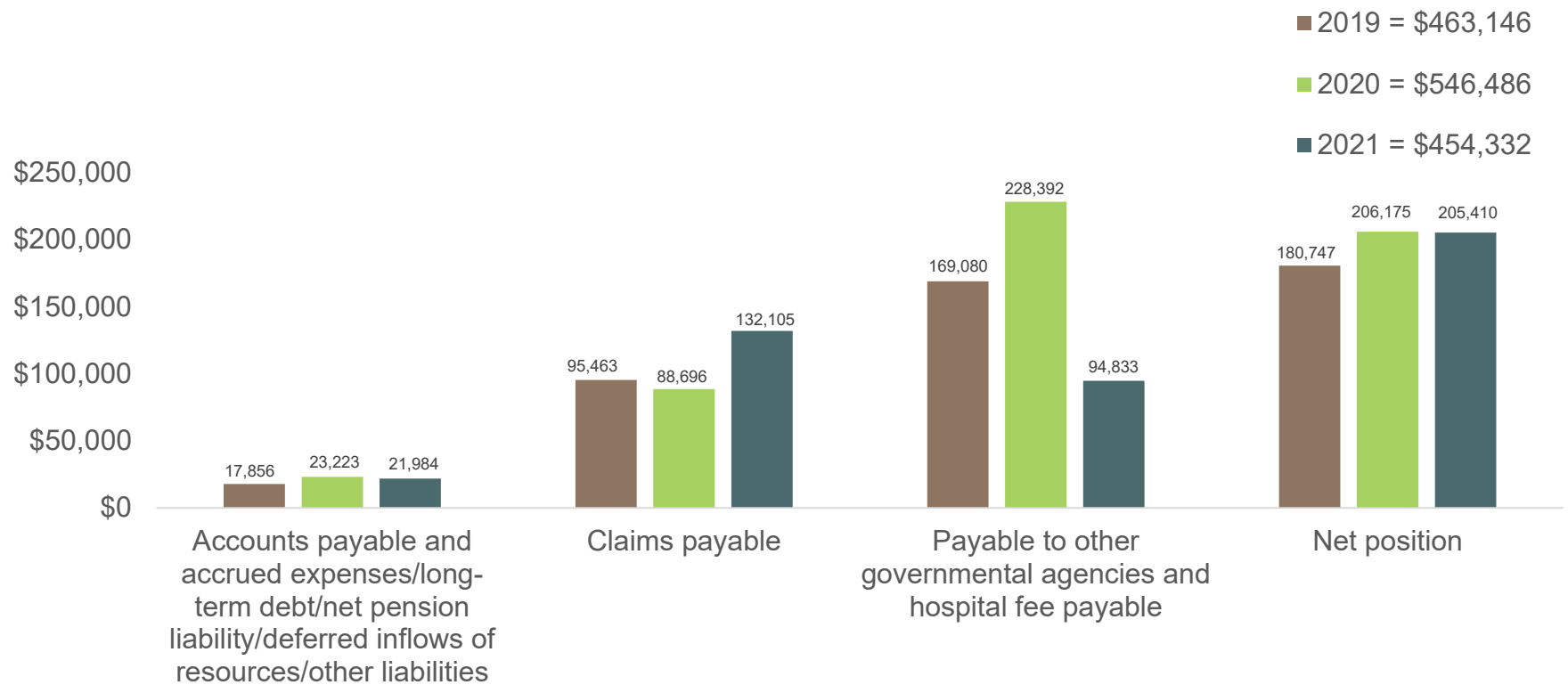
# Combined Statements of Net Positions



# Assets and Deferred Outflows of Resources Composition (in thousands)



# Liabilities, Deferred Inflows of Resources and Net Position Balance (in thousands)



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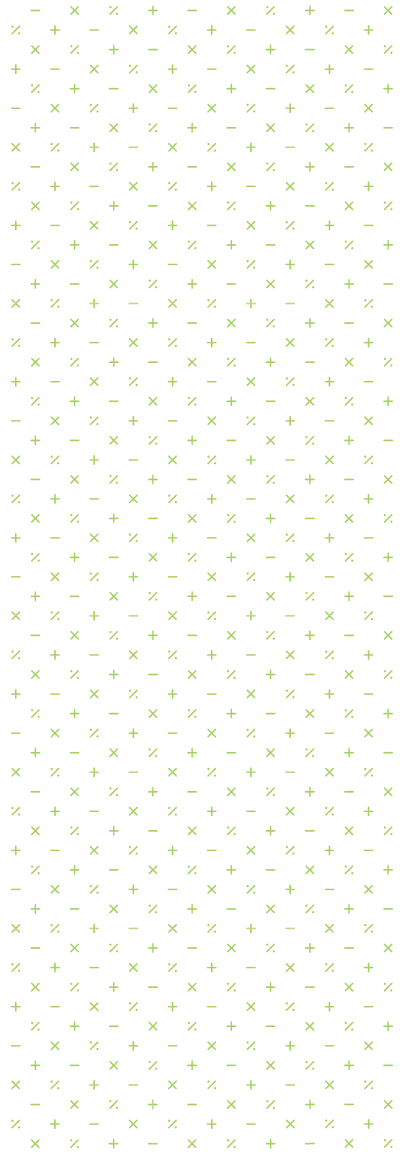
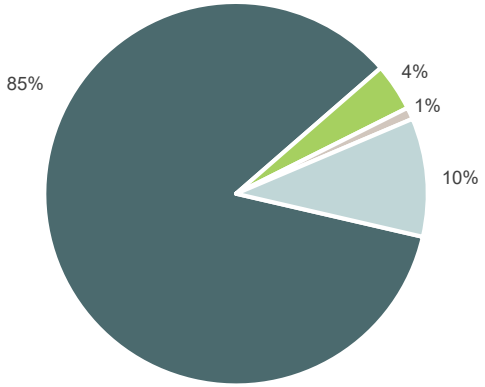
# Operations



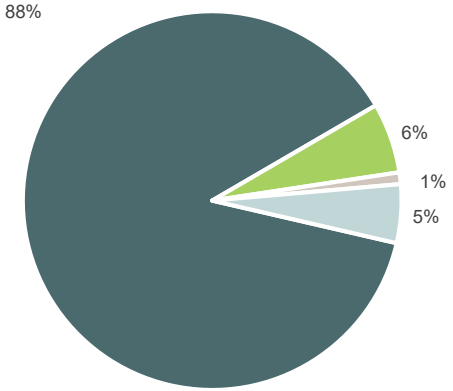
# Operating Expenses (in thousands)

June 30, 2021
$1,193,599

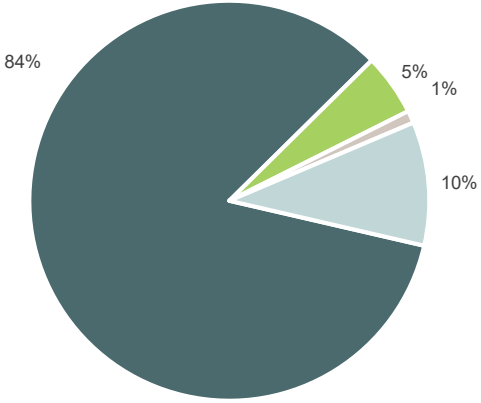



- Medical services
- Marketing, general, and administrative expenses
- Depreciation and amortization expense
- Premium tax

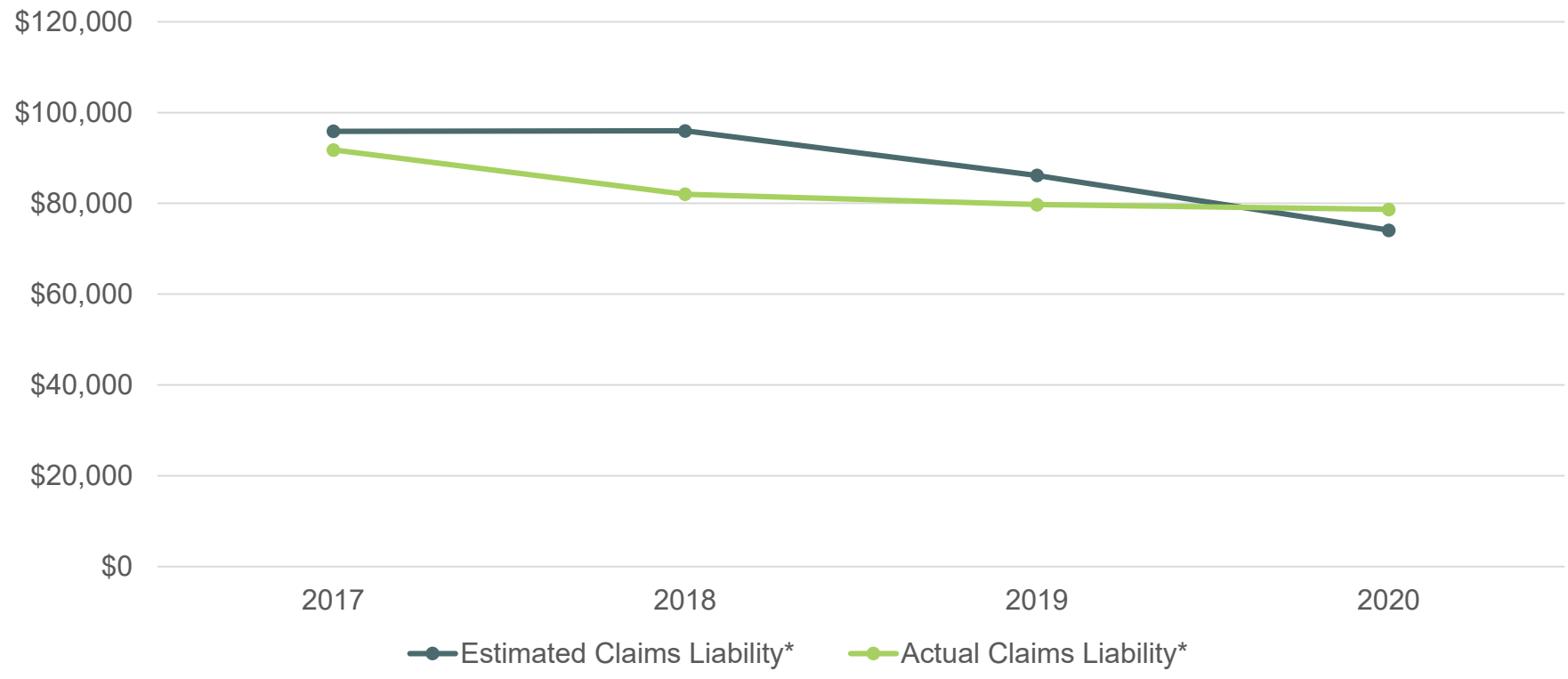
June 30, 2020
$994,634




June 30, 2019
$1,043,877



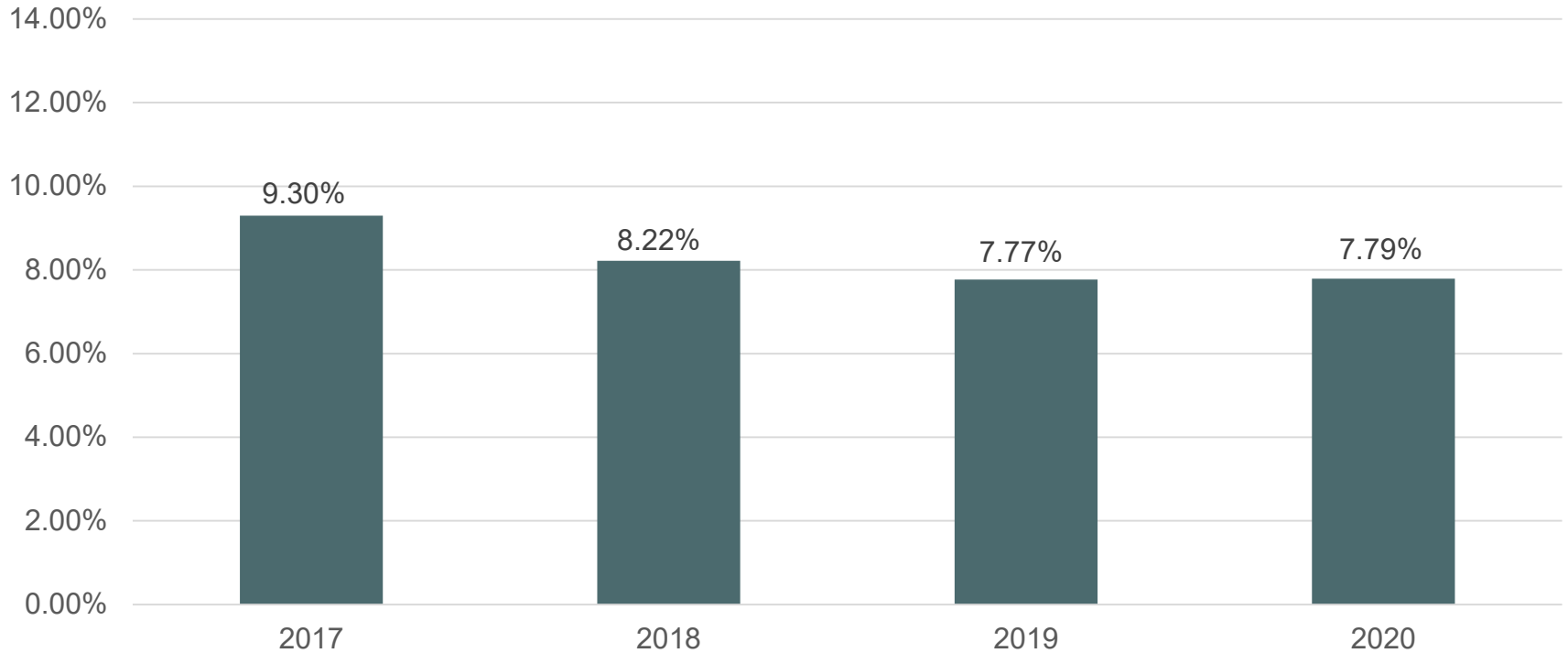
# Historic Estimated Claims Liability and Historic Actual Claims Liability (in thousands)




* Estimated claims liability and actual claims liability excludes non-hospital claims.

**Source**: Alliance's internal reports

# Historic Actual Claims Liability* as a % of Capitation and Premium Revenues




* Actual claims liability excludes non-hospital claims.

**Source**: Alliance's internal reports

# Tangible Net Equity (in thousands)


**Source**: Annual Department of Managed Health Care Filing

# Important Board Communications

- AU-C Section 260 – *The Auditor's Communication with Those Charged with Governance*
- Significant accounting policies
- Accounting estimates are reasonable
- No audit adjustments
- No issues discussed prior to our retention as auditors
- No disagreements with management
- No awareness of instances of fraud or noncompliance with laws and regulations

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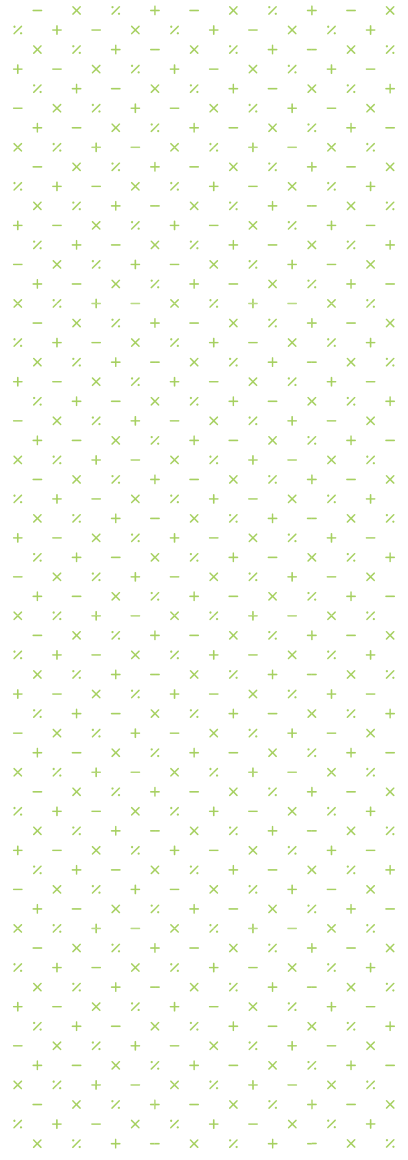
# Questions?



*Report of Independent Auditors and*
*Combined Financial Statements*

# Alameda Alliance for Health and Alameda Alliance Joint Powers Authority

*June 30, 2021 and 2020*

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# Management's Discussion and Analysis

# Alameda Alliance for Health and
# Alameda Alliance Joint Powers Authority
## Management's Discussion and Analysis
## As of and for the Years Ended June 30, 2021, 2020, and 2019

### INTRODUCTION

In accordance with the Governmental Accounting Standards Board ("GASB") Codification Section 2200, *Comprehensive Annual Financial Report*, Alameda Alliance for Health and Alameda Alliance Joint Powers Authority (collectively the "Alliance") presents comparative financial highlights as of and for the fiscal years ended June 30, 2021, 2020, and 2019. This discussion and analysis should be read in conjunction with the combined financial statements in this report.

Alameda Alliance for Health is a licensed health maintenance organization that operates in Alameda County (the "County"). The County's Board of Supervisors established Alameda Alliance for Health in March 1994 in accordance with the State of California Welfare and Institutions Code (the "Code") Section 14087.54. This legislation provides that the Alliance is a public entity, separate and apart from the County and is not considered an agency, division, or department of the County. Alameda Alliance for Health is not governed by, nor is it subject to, the Charter of the County and is not subject to the County's policies or operational rules. Alameda Alliance for Health received its Knox-Keene license in September 1995 and commenced operations in January 1996.

Alameda Alliance for Health operates the Alameda Alliance Joint Powers Authority (the "JPA"), a licensed health maintenance organization that operates in the County. The County's Board of Supervisors established the JPA in October 2005 in accordance with Section 14087.54. This legislation provides that the JPA is also a public entity, separate and apart from the County, and is not an agency, division, or department of the County. The JPA is not governed by, nor is it subject to, the Charter of the County and is not subject to the County's policies or operational rules. The JPA received its Knox-Keene license and commenced operations in December 2005. Alameda Alliance for Health and the JPA have a mutual guarantee agreement, ensuring mutual solvency for the two organizations. In September 2020, both parties agreed to dissolve the JPA and transfer existing business of JPA to Alameda Alliance for Health license. Subsequently, California Department of Managed Care, the licensing body, approved the surrender of its JPA license in July 2021.

The mission and purpose of the Alliance is to improve the quality of life of our members and people throughout our diverse community by collaborating with our provider partners in delivering high quality, accessible, and affordable health care services. As participants of the safety-net system, we recognize and seek to collaboratively address social determinants of health as we proudly serve Alameda County. No individual or entity has any ownership interest in the Alliance and all accumulated net position is available to invest in programs consistent with its mission.

Alameda Alliance for Health contracts with the California Department of Health Care Services ("CDHCS") to receive funding to provide health care services to the Medi-Cal eligible County residents who are enrolled as members of the Alliance ("CDHCS Contract"). The CDHCS Contract specifies capitation rates that may be adjusted annually. CDHCS revenue is paid monthly and is based upon contracted rates and actual Medi-Cal enrollment. Alameda Alliance for Health, in turn, has contracted with hospitals and physicians whereby capitation payments (agreed-upon monthly payments per member) and fee-for-service payments are made in return for contracted health care services for its members. Provider contracts are typically evergreen and contain annual rate change provisions, termination clauses, and risk-sharing provisions.

The original JPA entity contracted with the Public Authority of Alameda County to provide health coverage to In-Home Supportive Service home care workers in the County via the Group Care program. Due to the dissolution of the JPA, Group Care program is assigned to Alameda Alliance for Health with previous contract terms. The contract is automatically renewed on an annual basis, absent adequate written notice to terminate by either party. No written notice of termination was provided by either party during the years ended June 30, 2021, 2020, and 2019, except for the change of assignment.

In September 2009, CDHCS implemented Assembly Bill No. 1422 ("AB 1422") or Managed Care Organization ("MCO") premium tax. This program imposes an assessment on Alameda Alliance for Health's capitation and premium revenue. The proceeds from the tax are appropriated from the Children's Health and Human Services Special Fund to the State Department of Health Care Services for specified purposes. This provision was effective retroactively to January 1, 2009, and continued through June 30, 2013. The provisions of AB 1422 were continued, a higher tax rate implemented, and a sales tax replaced the premium tax, via Senate Bill ("SB") 78, beginning July 1, 2013 through June 30, 2016. On March 1, 2016, SB X2-2 established a new MCO provider tax, to be administered by CDHCS, effective July 1, 2016 through July 1, 2019. The tax would be assessed by CDHCS on licensed health care service plans, managed care plans contracted with CDHCS to provide Medi-Cal services, and alternate health care service plans ("AHCSP"), as defined, except as excluded by the bill. This bill would establish applicable taxing tiers and per enrollee amounts for the 2016–2017, 2017–2018, and 2018–2019 fiscal years for Medi-Cal enrollees, AHCSP enrollees, and all other enrollees, as defined. On September 27, 2019, Assembly Bill 115 (Chapter 348, Statutes 2019) authorized CDHCS to implement a modified MCO tax model on specified health plans, which was approved by the federal Centers for Medicare & Medicaid Services on April 3, 2020. The effective date range for this approval is January 1, 2020 through December 31, 2022.

Commencing in June 2010, CDHCS implemented a supplemental revenue or intra-governmental transfer program. This program assesses fees on the revenue of participating providers. CDHCS uses these assessments to obtain matching federal funds, which are returned to participating Alliance providers through the Alliance's administration. Alameda Alliance for Health received supplemental medical revenue of $76,642,409, $63,124,258, and $61,511,930 for the years ended June 30, 2021, 2020, and 2019, respectively, representing the assessment and matching funds, net of MCO premium tax of $0 for the years ended June 30, 2021, 2020, and 2019, respectively. Related liabilities are recorded under payable to other governmental agencies, hospital fee, and directed payments payables in the combined statements of net position as of June 30, 2021, 2020, and 2019.

On September 8, 2010, the California State Legislature ratified Assembly Bill No. 1653, which established a Hospital Quality Assurance Fee ("HQAF") program allowing additional draw down of federal funding to be used for increased payments to general acute care hospitals for inpatient services rendered to Medi-Cal beneficiaries. Pursuant to Section 14167.6 (a), CDHCS increased capitation payments to Medi-Cal managed health care plans retroactive for the months of April 2009 through December 2010. Additionally, Medi-Cal managed care plans are required to adhere to the following regarding the distribution of the increased capitation rates with HQAF funding: Section 14167.6 (h)(1), "Each managed health care plan shall expend 100 percent of any increased capitation payments it receives under this section, on hospital services"; and, Section 14167.10 (a), "Each managed health care plan receiving increased capitation payments under Section 14167.6 shall expend increased capitation payments on hospital services within 30 days of receiving the increased capitation payments." These payments were received and distributed in the manner as prescribed as a pass through to revenue. The payments did have an effect on the overall AB 1422 gross premium tax paid. In April of 2011, California approved SB 90, which extended the HQAF through June 30, 2012. SB 335, signed into law in September of 2011, extended the HQAF portion of SB 90 for an additional 30 months through December 31, 2013. SB 239, signed into law in October of 2013, extended the HQAF portion of SB 90 for an additional 36 months through December 31, 2016. In November of 2016, California approved Proposition 52, which made SB 239 permanent and also created HQAF V. The program period for HQAF V is from January 1, 2017 through June 30, 2019. Alameda Alliance for Health received HQAF payments of $76,015,141, $52,269,646, and $107,069,449 for the years ended June 30, 2021, 2020, and 2019, respectively, net of MCO premium tax of $0 for the years ended June 30, 2021, 2020, and 2019, respectively.

Beginning with the July 1, 2017, rating period, the CDHCS implemented managed care Directed Payments: 1) Private Hospital Directed Payment ("PHDP"), 2) Designated Public Hospital Enhanced Payment Program ("EPP"), and 3) Designated Public Hospital Quality Incentive Pool ("QIP"). (1) For PHDP, CDHCS will direct Managed Care Plans ("MCP") to reimburse private hospitals as defined in the Welfare and Institutions Code 14169.51, based on actual utilization of contracted services. The enhanced payment is contingent upon hospitals providing adequate access to service, including primary, specialty, and inpatient (both tertiary and quaternary) care. The total funding available for the enhanced contracted payments are limited to a predetermined amount (pool). (2) For EPP Pools, CDHCS has directed MCPs to reimburse California's 21 Designated Public Hospitals and University of California systems ("DPHs") for network contracted services, enhanced by either a uniform percentage or dollar increment based on actual utilization of network contracted services. (3) For QIP, CDHCS has directed the MCPs to make QIP payments tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The payments are linked to the delivery of services under the MCP contracts and increase the amount of funding tied to quality outcomes. To receive QIP payments, the DPHs must achieve specified improvement targets through year-over-year improvement or sustained high performance requirements. The total funding available for the QIP payments will be limited to a predetermined amount (pool).

**Impact of COVID-19 and the Outlook** – The "Shelter in Place" went into effect on March 2020, causing a spike of unemployment in Alameda County, where an increased number of residents became eligible for Medi-Cal. Additionally, the State of California's declaration of a Public Health Emergency paused the normal Medi-Cal disenrollment process. The Alliance saw a significant increase in enrollment for fiscal year ended June 30, 2021 and in the last quarter of 2020. Management expects the increase of Medi-Cal enrollment will gradually slow down when the economy recovers and may decline when the Public Health Emergency is declared over and the Medi-Cal disenrollment process restarts.

In addition to COVID-19 impact, California launched a multi-year initiative called California Advancing and Innovating Medi-Cal ("CalAIM") to improve the quality of life and health outcomes of Medi-Cal population by implementing broad delivery system and program and payment reform across the Medi-Cal program. CalAIM is expected to take effect on January 1, 2022. This major initiative will bring the Alliance new funding and increased expenses, the net impact of this funding and increased expense is unknown at this time. In addition, California is transitioning pharmacy benefits from Medi-Cal Managed Care plan to Fee-for-Service effective January 1, 2022. The Alliance will have decreased premium revenue and decreased pharmacy expenses, with net neutral impact to the bottom line.

**Using This Annual Report** – The Alliance's combined financial statements consist of three statements – statements of net position; statements of revenues, expenses, and changes in net position; and statements of cash flows. These combined financial statements and related notes provide information about the activities of the Alliance, including resources held by the Alliance but restricted or designated for specific purposes. The combined financial statements include Alameda Alliance for Health and the JPA as they are under common management and control.

**The Combined Statements of Net Position and Combined Statements of Revenues, Expenses, and Changes in Net Position** – The statements of net position and statements of revenues, expenses, and changes in net position report information about the Alliance's resources and activities during the period. These statements include all restricted and unrestricted assets and all liabilities using the accrual basis of accounting. All revenue and expenses are included, regardless of when cash is received or paid.

These two combined financial statements report the Alliance's net position and changes in net position. Over time, increases and decreases in the Alliance's net position are indicators of whether its financial health is improving or deteriorating. Other nonfinancial factors should also be considered, such as changes in the Alliance's membership, measurements for the quality of service provided to members, and local economic factors, to assess the overall health of the Alliance.

**The Combined Statements of Cash Flows** – The final required statements are the statements of cash flows. These statements present cash receipts, cash payments, and net changes in cash resulting from operations, investing, noncapital financing, and capital and related financing activities.



## Overview of the Combined Financial Statements and Financial Analysis

On June 30, 2021, the Alliance had assets and deferred outflows of resources of $454,332,084 and liabilities and deferred inflows of resources of $248,922,042. The resulting net position, which represents the Alliance's assets and deferred outflows of resources after the liabilities and deferred inflows of resources are deducted, decreased by $764,773 to $205,410,042 at June 30, 2021, compared to $206,174,815 at June 30, 2020. The change in net position is due to total net operating loss and nonoperating income recorded during the 2021 fiscal year.

On June 30, 2020, the Alliance had assets and deferred outflows of resources of $546,485,883 and liabilities and deferred inflows of resources of $340,311,068. The resulting net position, which represents the assets and deferred outflows of resources after the liabilities and deferred inflows of resources are deducted, increased by $25,427,563 to $206,174,815 at June 30, 2020, compared to $180,747,252 at June 30, 2019. The change in net position is due to total net operating income and nonoperating income recorded during the 2020 fiscal year.

## ASSETS

### *Cash and Cash Equivalents*

Cash and cash equivalents decreased by $3,618,590 from $40,706,013 at June 30, 2020 to $37,087,423 at June 30, 2021. The decrease is due to cash provided by operating activities of $22,044,819, cash used in capital and related financing activities of $1,205,447, and cash used in investing activities of $24,457,962. Much of the decrease in cash reflects enhanced investing activities.

Cash and cash equivalents increased by $8,765,113 from $31,940,900 at June 30, 2019 to $40,706,013 at June 30, 2020. The increase is due to cash provided by operating activities of $22,005,121, cash used in capital and related financing activities of $1,461,026, and cash used in investing activities of $11,778,982. Much of the increase in cash reflects enhanced investing activities.

Changes in cash balances are due largely to the timing of collection of year end receivables. All financial assets are invested in highly-liquid, short-term instruments held in two large money market funds and a managed investment account. Alliance management believes it has adequate liquidity to meet its operating and cash flow needs for the foreseeable future.

### *Investments*

Investments consist of money market funds, commercial paper, U.S. government agency bonds, corporate bonds, and certificate of deposits. Investments increased by $24,979,240 from $238,969,073 at June 30, 2020 to $263,948,313 at June 30, 2021. The increase reflects purchases of investments. Investments increased by $16,067,679 from $222,901,394 at June 30, 2019 to $238,969,073 at June 30, 2020. The increase reflects purchases of investments and unrealized gains.

### *Premiums Receivable*

Premiums receivable represent amounts owed to the Alliance for capitation and premium revenue. Premiums receivable decreased by $119,311,448 from $242,555,462 at June 30, 2020 to $123,244,014 at June 30, 2021, largely reflecting the timing of receipts of certain premium revenues due from the State of California and the Directed Payment pools, which is passed through to Private and Designated Public hospitals. Premiums receivable increased by $58,515,672 from $184,039,790 at June 30, 2019 to $242,555,462 at June 30, 2020, largely reflecting the timing of receipts of certain premium revenues due from the State of California and the Directed Payment pools, which is passed through to Private and Designated Public hospitals.

### *Reinsurance Recoveries Receivable*

Reinsurance recoveries receivable represent anticipated, but not yet received collections under the reinsurance policy. Reinsurance recoveries receivable increased by $3,176,347 from $1,608,233 at June 30, 2020 to $4,784,580 at June 30, 2021. The increase reflects a timing difference in processing of high dollar claims by the reinsurance company. Reinsurance recoveries receivable increased by $1,464,156 from $144,077 at June 30, 2019 to $1,608,233 at June 30, 2020. The increase reflects a timing difference in processing of high dollar claims by the reinsurance company.

***Other Receivables***

Other receivables represent miscellaneous non-premium amounts due to the Alliance. Other receivables increased by $4,741,323 from $3,634,309 at June 30, 2020 to $8,375,632 at June 30, 2021. The increase reflects the timing of cash receipts of certain payments owed at year end. Other receivables represent miscellaneous non-premium amounts due to the Alliance. Other receivables decreased by $1,593,227 from $5,227,536 at June 30, 2019 to $3,634,309 at June 30, 2020. The decrease reflects the timing of cash receipts of certain payments owed at year end.

***Prepaid Expenses***

Prepaid expenses consist of payments made in the current period for goods or services to be received in one or more future periods. Prepaid expenses increased by $1,220,818 from $4,953,308 at June 30, 2020 to $6,174,126 at June 30, 2021. The component increases and decreases are attributable to the timing of payments for various costs that are to be charged to expense after year end. Prepaid expenses increased by $712,734 from $4,240,574 at June 30, 2019 to $4,953,308 at June 30, 2020. The component increases and decreases are attributable to the timing of payments for various costs that are to be charged to expense after year end.

***Restricted Cash***

The California Department of Managed Health Care requires restricted cash of at least $300,000 be held in trust. Restricted cash remained at $350,000 at June 30, 2021. Restricted cash increased by $3,073 from $346,927 at June 30, 2019 to $350,000 at June 30, 2020, due to an increase in market value of the investment.

***Capital Assets***

Net capital assets decreased by $3,739,804 from $10,011,939 at June 30, 2020 to $6,272,135 at June 30, 2021. The overall decrease reflects current year capital asset acquisitions of $1,205,447, loss on disposal of $2,907,150 and, annual depreciation and amortization expenses of $2,038,101.

Net capital assets decreased by $731,268 from $10,743,207 at June 30, 2019 to $10,011,939 at June 30, 2020. The overall decrease reflects current year capital asset acquisitions of $1,461,026 less annual depreciation and amortization expenses of $2,192,294.

***Deferred Outflows of Resources***

Deferred outflows of resources represent the unamortized changes in assumptions, unamortized net difference between projected and actual earnings on pension plan investments, unamortized difference between expected and actual experience, and employee contributions made during 2018, 2019, and 2020 that are deferred under GASB 68. Deferred outflows of resources increased by $398,315 from $3,697,546 at June 30, 2020 to $4,095,861 at June 30, 2021, due to changes in assumptions, changes in the difference between projected and actual earnings on pension plan investments, and employee contributions made during fiscal year 2020.

Deferred outflows of resources increased by $244,027 from $3,453,519 at June 30, 2019 to $3,697,546 at June 30, 2020, due to changes in assumptions, changes in the difference between projected and actual earnings on pension plan investments, and employee contributions made during fiscal year 2020.

## LIABILITIES

### *Accounts Payable and Accrued Expenses*

Accounts payable and accrued expenses represent the cost of services received in the current period for which payment has yet to be made. Accounts payable and accrued expenses increased by $1,424,158 from $2,874,981 at June 30, 2020 to $4,299,139 at June 30, 2021, due to an increase in accrued invoices at year end. Accounts payable and accrued expenses decreased by $4,725,548 from $7,600,529 at June 30, 2019 to $2,874,981 at June 30, 2020, due to a decrease in accrued invoices at year end.

### *Claims Payable*

Claims payable represents the Alliance's estimated liability for health care and pharmacy expenses for which services have been performed but have not yet been paid for by the Alliance. Claims payable includes the estimated value of claims that have been incurred but not yet reported to the Alliance as well as the estimated value of claims that have been received by the Alliance but not yet paid.

Total claims payable increased by $43,408,851 from $88,695,976 at June 30, 2020 to $132,104,827 at June 30, 2021. Included in this change is an increase of $24,549,183 in the liability for incurred but not paid claims, and an increase of $11,042,772 in the liability for other medical payments. The change in the liability for incurred but not paid claims reflects increased estimates of 2020 and 2021 claims. The change in the liability for other medical payments is mainly due to a net increase in payables to certain providers.

Total claims payable decreased by $6,767,058 from $95,463,034 at June 30, 2019 to $88,695,976 at June 30, 2020. Included in this change is a decrease of $12,071,351 in the liability for incurred but not paid claims, and a decrease of $1,858,387 in the liability for other medical payments. The change in the liability for incurred but not paid claims reflects decreased estimates of 2019 and 2020 claims. The change in the liability for other medical payments is mainly due to a net decrease in payables to certain providers.

### *Payable to Other Governmental Agencies, Hospital Fee, and Directed Payments Payables*

Payable to other governmental agencies, hospital fee, and directed payments payables includes the amounts due for MCO tax assessments, liabilities related to IGT due to participating safety net hospitals, HQAF, Directed Payments due to Private and Designed Public hospitals, and medical loss ratio requirements. Payable to other governmental agencies and hospital fee payables decreased by $133,559,765 from $228,392,300 at June 30, 2020 to $94,832,535 at June 30, 2021, mainly due to the payout of the new Directed Payment program. Payable to other governmental agencies and hospital fee payables increased by $59,312,571 from $169,079,729 at June 30, 2019 to $228,392,300 at June 30, 2020, mainly due to the payout of the new Directed Payment program.

***Other Liabilities***

Other liabilities are comprised of a liability for payroll earned but not paid, a liability for provider pay-for-performance earned but not paid, and a liability for provider grants and new health management programs. Payroll liabilities increased by $1,275,710 from $3,490,557 as of June 30, 2020 to $4,766,267 as of June 30, 2021. Most of the increase reflected higher accrued paid time off. The pay-for-performance liability increased by $4,198,232 from $6,151,617 at June 30, 2020 to $10,349,849 at June 30, 2021, due to increase in funding for calendar year 2020 incentive programs. The provider grants and new health management liability decreased by $8,400,000 from $8,851,143 at June 30, 2020 to $451,143 at June 30, 2021, due to the termination of Provider Sustainability Fund program.

Payroll liabilities increased by $617,485 from $2,873,072 as of June 30, 2019 to $3,490,557 as of June 30, 2020. Most of the increase reflected higher accrued paid time off. The pay-for-performance liability increased by $1,352,998 from $4,798,619 at June 30, 2019 to $6,151,617 at June 30, 2020, due to increase in funding for calendar year 2019 incentive programs. The provider grants and new health management liability increased by $7,750,300 from $1,100,843 at June 30, 2019 to $8,851,143 at June 30, 2020, due to increase in funding for new Provider Sustainability Fund payout.

***Net Pension Liability***

Net pension liability represents the deficit between the California Public Employees' Retirement System ("CalPERS") pension assets and the CalPERS pension liability under GASB Statement No. 68, *Accounting and Financial Reporting for Pensions* ("GASB 68"). Net pension liability increased by $832,375 from $832,801 at June 30, 2020 to $1,665,176 at June 30, 2021. The increase reflects that costs for the operation of the plan exceeded contributions for the year. Net pension liability increased by $832,801 from $0 at June 30, 2019 to $832,801 at June 30, 2020. The increase reflects that costs for the operation of the plan exceeded contributions for the year.

***Deferred Inflows of Resources***

Deferred inflows of resources represent the unamortized difference between projected and actual earnings on pension plan investments, unamortized changes in assumptions, and unamortized differences between expected and actual experiences under GASB 68. Deferred inflows of resources decreased by $568,587 from $1,021,693 at June 30, 2020 to $453,106 at June 30, 2021, due to the difference between projected and actual earnings on pension plan investments, changes in assumptions, and differences between expected and actual experiences.

Deferred inflows of resources decreased by $460,873 from $1,482,566 at June 30, 2019 to $1,021,693 at June 30, 2020, due to the difference between projected and actual earnings on pension plan investments, changes in assumptions, and differences between expected and actual experiences.

***Net Position***

Total net position decreased by $764,773 from $206,174,815 at June 30, 2020 to $205,410,042 at June 30, 2021. The decrease is due to the following:

| | |
|---|---|
| Net operating loss | $ (1,351,806) |
| Investment income | 587,033 |
| Decrease in net position | $ (764,773) |

Total net position increased by $25,427,563 from $180,747,252 at June 30, 2019 to $206,174,815 at June 30, 2020. The increase is due to the following:

| | |
|---|---|
| Net operating income | $ 20,776,333 |
| Investment income | 4,651,230 |
| Increase in net position | $ 25,427,563 |

**STATEMENTS OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION**

***Capitation and Premium Revenue and Membership***

***Member Months***

For the fiscal years ended June 30, 2021 and 2020, member months were as follows:

| | 2021 | 2020 | Decrease/ Increase | % Decrease/ Increase |
|---|---|---|---|---|
| Medi-Cal | 3,237,461 | 2,944,297 | 293,164 | 10% |
| Group Care | 71,864 | 73,285 | (1,421) | -2% |
| Total | 3,309,325 | 3,017,582 | 291,743 | 10% |

There were increases in all categories of aid, but the largest increases were experience in Optional Expansion, Child and Audit category of aid.

For the fiscal years ended June 30, 2020 and 2019, member months were as follows:

| | 2020 | 2019 | Decrease/ Increase | % Decrease/ Increase |
|---|---|---|---|---|
| Medi-Cal | 2,944,297 | 3,074,247 | (129,950) | -4% |
| Group Care | 73,285 | 70,612 | 2,673 | 4% |
| Total | 3,017,582 | 3,144,859 | (127,277) | -4% |

There were decreases in all categories of aid, but the greatest decreases were experience in the Child and Audit category of aid.

***Revenues***

For fiscal year 2021, capitation and premium revenue increased by $176,005,962 from $1,009,502,184 in 2020 to $1,185,508,146 in 2021. Medi-Cal revenue, net of premium taxes, increased by $174,059,105 or 18% due to higher supplemental payments, changes in capitation rates, and changes to the mix of members. Group Care revenue increased by $1,946,857 or 8% due to an increase in member months and offset by a 42% decrease in Hepatitis C Drug revenues.

For fiscal year 2020, capitation and premium revenue decreased by $16,613,528 from $1,026,115,712 in 2019 to $1,009,502,184 in 2020. Medi-Cal revenue, net of premium taxes, decreased by $17,458,933 or 2% due to higher supplemental payments, changes in capitation rates, and changes to the mix of members. Group Care revenue increased by $845,405 or 3.5% due to an increase in member months and offset by a 59.7% decrease in Hepatitis C Drug revenues.

***Medical Reinsurance***

Medical reinsurance, included in other revenue, includes reinsurance premium payments less refunds received or accrued. Net reinsurance income increased by $2,053,067 from ($4,727) in 2020 to $2,048,340 in 2021, due to higher recoveries offset by fewer deductibles. Net reinsurance income increased by $1,126,142 from ($1,130,869) in 2019 to ($4,727) in 2020, due to higher recoveries offset by fewer deductibles.

***Health Care Expense***

Health care expense represents the Alliance's cost of providing physician, hospital, pharmacy, laboratory, and other medical services to members. The Alliance has contracted with various health care providers whereby capitation payments (agreed-upon payments per member) and fee-for-service payments are made in return for contracted health care services for its members.

Health care expense increased by $143,373,360 or 16%, from $881,735,086 in 2020 to $1,025,108,446 in 2021 due to increased member months.

The chart below shows the per-member-per-month ("PMPM") effect of these costs:

| Health Care Expenses | 2021 | 2020 | 2021 PMPM | 2020 PMPM |
|---|---|---|---|---|
| Medical services | $ 1,025,108,446 | $ 881,735,086 | $ 309.76 | $ 292.20 |
| Total member months | 3,309,325 | 3,017,582 | | |

Health care expenses increased by $38,992,889 or 5%, from $883,021,602 in 2019 to $881,735,086 in 2020; decrease by 4% due to COVID-19.

The chart below shows the PMPM effect of these costs:

| Health Care Expenses | 2020 | 2019 | 2020 PMPM | 2019 PMPM |
|---|---|---|---|---|
| Medical services | $ 881,735,086 | $ 883,021,602 | $ 292.20 | $ 280.78 |
| Total member months | 3,017,582 | 3,144,859 | | |

***Marketing, General, and Administrative Expenses***

Marketing, general, and administrative expenses decreased by $8,718,997 from $60,606,447 in 2020 to $51,887,450 in 2021, due largely to the termination of Provider Sustainability Fund program.

Marketing, general, and administrative expenses increased by $10,955,588 from $49,650,859 in 2019 to $60,606,447 in 2020, due largely to the unplanned Provider Sustainability Fund payout of $8,400,000.

***Nonoperating Income/Expense***

Nonoperating income/expense represents interest income, unrealized gains and losses resulting from cash held in financial institutions, changes in the market value of investments and investments held for restricted cash balances, contributions received for purposes other than capital asset acquisition, and interest expense.

Nonoperating income decreased by $4,064,197 from $4,651,230 in 2020 to $587,033 in 2021, largely due to decreased investment income, net of unrealized losses.

Nonoperating income decreased by $2,528,069 from $7,179,299 in 2019 to $4,651,230 in 2020, largely due to decreased investment income, net of unrealized losses.

***Three Year Trend in Net Position***

| | 2021 | 2020 | 2019 |
|---|---|---|---|
| **ASSETS** | | | |
| Current assets | $ 443,614,088 | $ 532,426,398 | $ 448,494,271 |
| Noncurrent assets | 6,622,135 | 10,361,939 | 11,090,134 |
| Net pension asset | - | - | 107,720 |
| Deferred outflows of resources | 4,095,861 | 3,697,546 | 3,453,519 |
| Total assets and deferred outflows of resources | $ 454,332,084 | $ 546,485,883 | $ 463,145,644 |
| **LIABILITIES** | | | |
| Current liabilities | $ 246,803,760 | $ 338,456,574 | $ 280,915,826 |
| Net pension liability | 1,665,176 | 832,801 | - |
| Deferred inflows of resources | 453,106 | 1,021,693 | 1,482,566 |
| Total liabilities and deferred inflows of resources | $ 248,922,042 | $ 340,311,068 | $ 282,398,392 |
| **NET POSITION** | | | |
| Invested in capital assets | $ 6,272,135 | $ 10,011,939 | $ 10,743,207 |
| Restricted assets | 350,000 | 350,000 | 346,927 |
| Unrestricted assets | 198,787,907 | 195,812,876 | 169,657,118 |
| Total net position | $ 205,410,042 | $ 206,174,815 | $ 180,747,252 |
| Total liabilities, deferred inflows of resources, and net position | $ 454,332,084 | $ 546,485,883 | $ 463,145,644 |

***Changes in Net Assets***

| | 2021 | 2020 | 2019 |
|---|---|---|---|
| Total member months | 3,309,325 | 3,017,582 | 3,144,859 |
| Operating revenues | $ 1,192,246,807 | $ 1,015,409,930 | $ 1,027,285,388 |
| Health care expenses | 1,025,108,446 | 881,735,086 | 883,021,602 |
| Marketing, general, and administrative expenses | 51,887,450 | 60,606,447 | 49,650,859 |
| Depreciation and amortization expense | 2,038,101 | 2,192,294 | 2,203,013 |
| Premium tax | 114,564,616 | 50,099,770 | 109,001,668 |
| Total operating expenses | 1,193,598,613 | 994,633,597 | 1,043,877,142 |
| Net (loss) income from operations | (1,351,806) | 20,776,333 | (16,591,754) |
| Nonoperating income, net | 587,033 | 4,651,230 | 7,179,299 |
| Change in net position | $ (764,773) | $ 25,427,563 | $ (9,412,455) |

During the three-year period ended June 30, 2021, overall member months increased 5%, primarily due to year-over-year increase in Medi-Cal member months. During the three-year period ended June 30, 2021, revenue increased 16% due to higher supplemental payments, changes to capitation rates, and changes to the mix of members. During the three-year period ended June 30, 2021, health care expenses increased 16%, as a result of changes in enrollment in all programs. The above factors combined to yield the overall slightly unfavorable change in net position.

During the three-year period ended June 30, 2020, overall member months decreased 6%, primarily due to year over year decreased in Medi-Cal member months. During the three-year period ended June 30, 2020, revenue increased 1% due to higher supplemental payments, changes to capitation rates, and changes to the mix of members. During the three-year period ended June 30, 2020, health care expenses increased 4%, as a result of changes in enrollment in all programs. During the three-year period ended June 30, 2020, marketing, general, and administrative expenses increased 18%, primarily due to the unbudgeted fiscal year 2020 Provider Sustainability Funding payout. The above factors combined to yield the overall favorable change in net position.

As a limited license plan under Knox-Keene Health Care Services Plan Action of 1975, the Alliance is required to maintain a minimum level of tangible net equity and working capital. The required tangible net equity is $36,486,113, $31,962,073, and $32,453,431 at June 30, 2021, 2020, and 2019, respectively. The tangible net equity of the Alliance is $205,410,042, $206,174,815, and $180,747,252, at June 30, 2021, 2020, and 2019, respectively.

The Alliance was in compliance with regulatory tangible net equity and working capital requirements at June 30, 2021, 2020, and 2019.

# Report of Independent Auditors

To the Board of Governors
Alameda Alliance for Health and
Alameda Alliance Joint Powers Authority

**Report on the Financial Statements**

We have audited the accompanying combined statements of net position of the Alameda Alliance for Health and Alameda Alliance Joint Powers Authority (collectively the "Alliance"), as of June 30, 2021 and 2020, and the related combined statements of revenues, expenses, and changes in net position, and cash flows for the years then ended, and the related notes to the combined financial statements.

***Management's Responsibility for the Financial Statements***

Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

***Auditor's Responsibility***

Our responsibility is to express an opinion on these combined financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America, the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the combined financial statements are free from material misstatements.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

***Opinion***

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the combined net position of Alameda Alliance for Health and Alameda Alliance Joint Powers Authority, as of June 30, 2021 and 2020, and the combined results of their operations and their cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

***Other Matter***

*Required Supplementary Information*

The accompanying Management's Discussion and Analysis on pages 1 through 13, supplementary schedule of changes in net pension liability (asset) and related ratios and supplementary schedule of contributions on pages 40 through 41 are not a required part of the combined financial statements but are supplementary information required by the Governmental Accounting Standards Board, who considers them to be an essential part of financial reporting for placing the combined financial statements in an appropriate operational, economic, or historical context.

The accompanying supplementary statement of revenues and expenses – AC Care Connect on page 42 is not a required part of the combined financial statements but is supplementary information required by the AC Care Connect contract.

This supplementary information is the responsibility of the Alliance's management. We have applied certain limited procedures in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's response to our inquiries, the combined financial statements, and other knowledge we obtained during our audit of the combined financial statements. We do not express an opinion or provide any assurance on the supplementary information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

**Other Reporting Required by Government Auditing Standards**

In accordance with *Government Auditing Standards,* we have also issued our report dated _____, 2021, on our consideration of the Alliance's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Alliance's internal control over financial reporting and compliance.

San Francisco, California
_____, 2021

# Combined Financial Statements

# Alameda Alliance for Health and
# Alameda Alliance Joint Powers Authority
## Combined Statements of Net Position
## As of June 30, 2021 and 2020

| | 2021 | 2020 |
|---|---|---|
| **ASSETS AND DEFERRED OUTFLOWS OF RESOURCES** | | |
| Current assets | | |
| Cash and cash equivalents | $ 37,087,423 | $ 40,706,013 |
| Investments | 263,948,313 | 238,969,073 |
| Premiums receivable | 123,244,014 | 242,555,462 |
| Reinsurance recoveries receivable | 4,784,580 | 1,608,233 |
| Other receivables | 8,375,632 | 3,634,309 |
| Prepaid expenses | 6,174,126 | 4,953,308 |
| Total current assets | 443,614,088 | 532,426,398 |
| Noncurrent asset | | |
| Restricted cash | 350,000 | 350,000 |
| Capital assets | | |
| Nondepreciable | 1,557,283 | 1,557,283 |
| Depreciable, net of accumulated depreciation and amortization | 4,714,852 | 8,454,656 |
| Total capital assets | 6,272,135 | 10,011,939 |
| Total assets | 450,236,223 | 542,788,337 |
| Deferred outflows of resources | 4,095,861 | 3,697,546 |
| Total assets and deferred outflows of resources | $ 454,332,084 | $ 546,485,883 |
| **LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION** | | |
| Current liabilities | | |
| Accounts payable and accrued expenses | $ 4,299,139 | $ 2,874,981 |
| Claims payable | 132,104,827 | 88,695,976 |
| Payable to other governmental agencies, hospital fee, and directed payments payables | 94,832,535 | 228,392,300 |
| Other liabilities | 15,567,259 | 18,493,317 |
| Total current liabilities | 246,803,760 | 338,456,574 |
| Net pension liability | 1,665,176 | 832,801 |
| Total liabilities | 248,468,936 | 339,289,375 |
| Deferred inflows of resources | 453,106 | 1,021,693 |
| Net position | | |
| Invested in capital assets | 6,272,135 | 10,011,939 |
| Restricted | | |
| Required by legislative authority | 350,000 | 350,000 |
| Unrestricted | 198,787,907 | 195,812,876 |
| Total net position | 205,410,042 | 206,174,815 |
| Total liabilities, deferred inflows of resources, and net position | $ 454,332,084 | $ 546,485,883 |





See accompanying notes.

# Alameda Alliance for Health and
# Alameda Alliance Joint Powers Authority
## Combined Statements of Revenues, Expenses, and Changes in Net Position
## For the Years Ended June 30, 2021 and 2020

| | 2021 | 2020 |
|---|---|---|
| Operating revenues | | |
| Capitation and premium revenue | $ 1,185,508,146 | $ 1,009,502,184 |
| Other revenue | 6,738,661 | 5,907,746 |
| Total operating revenues | 1,192,246,807 | 1,015,409,930 |
| Health care expenses | | |
| Medical services | 1,025,108,446 | 881,735,086 |
| Total health care expenses | 1,025,108,446 | 881,735,086 |
| Marketing, general, and administrative expenses | 51,887,450 | 60,606,447 |
| Depreciation and amortization expense | 2,038,101 | 2,192,294 |
| Premium tax | 114,564,616 | 50,099,770 |
| Total operating expenses | 1,193,598,613 | 994,633,597 |
| Operating (loss) income | (1,351,806) | 20,776,333 |
| Nonoperating income | | |
| Investment income | 587,033 | 4,651,230 |
| Total nonoperating income, net | 587,033 | 4,651,230 |
| Change in net position | (764,773) | 25,427,563 |
| Net position, beginning of year | 206,174,815 | 180,747,252 |
| Net position, end of year | $ 205,410,042 | $ 206,174,815 |



See accompanying notes.

# Alameda Alliance for Health and
# Alameda Alliance Joint Powers Authority
## Combined Statements of Cash Flows
## For the Years Ended June 30, 2021 and 2020

| | 2021 | 2020 |
|---|---|---|
| Cash flows provided by operating activities | | |
| Cash received from | | |
| Capitation and premium revenue | $ 1,304,819,594 | $ 950,986,512 |
| Other revenue | 6,804,416 | 6,267,206 |
| Cash paid to providers for | | |
| Medical and hospital expenses | (1,229,823,976) | (879,289,343) |
| Vendors and employees | (59,755,215) | (55,959,254) |
| Net cash provided by operating activities | 22,044,819 | 22,005,121 |
| Cash flows used in capital and related financing activities | | |
| Purchases of furniture and equipment | (1,205,447) | (1,461,026) |
| Net cash used in capital and related financing activities | (1,205,447) | (1,461,026) |
| Cash flows used in investing activities | | |
| Purchase of investments | (1,338,237,657) | (809,592,186) |
| Proceeds from sale of investments | 1,313,192,662 | 793,161,974 |
| Investment income | 587,033 | 4,651,230 |
| Net cash used in investing activities | (24,457,962) | (11,778,982) |
| Net (decrease) increase in cash and cash equivalents | (3,618,590) | 8,765,113 |
| Cash and cash equivalents, beginning of year | 40,706,013 | 31,940,900 |
| Cash and cash equivalents, end of year | $ 37,087,423 | $ 40,706,013 |
| Reconciliation of operating (loss) income to net cash provided by operating activities | | |
| Operating (loss) income | $ (1,351,806) | $ 20,776,333 |
| Adjustments to reconcile operating (loss) income to net cash provided by operating activities | | |
| Depreciation and amortization | 2,038,101 | 2,192,294 |
| Net unrealized losses on investments | 65,755 | 359,460 |
| Loss on disposal of capital assets | 2,907,150 | - |
| Net change in operating assets and liabilities | | |
| Premiums receivable | 119,311,448 | (58,515,672) |
| Reinsurance recoveries receivable | (3,176,347) | (1,464,156) |
| Other receivables | (4,741,323) | 1,593,227 |
| Prepaid expenses | (1,220,818) | (712,734) |
| Accounts payable and accrued expenses | 1,424,158 | (4,725,548) |
| Claims payable | 43,408,851 | (6,767,058) |
| Payable to other governmental agencies, hospital fee, and directed payments payables | (133,559,765) | 59,312,571 |
| Other liabilities | (2,926,058) | 9,720,783 |
| Net pension liability | (134,527) | 235,621 |
| Net cash provided by operating activities | $ 22,044,819 | $ 22,005,121 |
| Supplemental cash flow disclosure | | |
| Cash paid during the year for premium tax | $ 132,822,055 | $ 27,002,807 |





See accompanying notes.

## NOTE 1 – ORGANIZATION

Alameda Alliance for Health is a licensed health maintenance organization that operates in Alameda County (the "County"). The County's Board of Supervisors established Alameda Alliance for Health in March 1994 in accordance with the State of California Welfare and Institutions Code (the "Code") Section 14087.54. This legislation provides that the Alliance is a public entity, separate and apart from the County and is not considered an agency, division, or department of the County. Alameda Alliance for Health is not governed by, nor is it subject to, the Charter of the County and is not subject to the County's policies or operational rules. Alameda Alliance for Health received its Knox-Keene license in September 1995 and commenced operations in January 1996.

Alameda Alliance for Health operates the Alameda Alliance Joint Powers Authority (the "JPA"), a licensed health maintenance organization that operates in the County (collectively the "Alliance"). The County's Board of Supervisors established the JPA in October 2005 in accordance with Section 14087.54. This legislation provides that the JPA is also a public entity, separate and apart from the County, and is not an agency, division, or department of the County. The JPA is not governed by, nor is it subject to, the Charter of the County and is not subject to the County's policies or operational rules. The JPA received its Knox-Keene license and commenced operations in December 2005. Alameda Alliance for Health and the JPA have a mutual guarantee agreement, ensuring mutual solvency for the two organizations. In September 2020, both parties agreed to dissolve the JPA and transfer existing business of JPA to Alameda Alliance for Health license. Subsequently, California Department of Managed Care, the licensing body, approved the surrender of its JPA license in July 2021.

The mission and purpose of the Alliance is to improve the quality of life of its members and people throughout its diverse community by collaborating with provider partners in delivering high quality, accessible, and affordable health care services. As participants of the safety-net system, the Alliance recognizes and seeks to collaboratively address social determinants of health as it serves Alameda County. No individual or entity has any ownership interest in the Alliance and all accumulated net position is available to invest in programs consistent with its mission.

Alameda Alliance for Health contracts with the California Department of Health Care Services ("CDHCS") to receive funding to provide health care services to the Medi-Cal eligible County residents who are enrolled as members of the Alliance ("CDHCS Contract"). The CDHCS Contract specifies capitation rates that may be adjusted annually. CDHCS revenue is paid monthly and is based upon contracted rates and actual Medi-Cal enrollment. Alameda Alliance for Health, in turn, has contracted with hospitals and physicians whereby capitation payments (agreed-upon monthly payments per member) and fee-for-service payments are made in return for contracted health care services for its members. Provider contracts are typically evergreen and contain annual rate change provisions, termination clauses, and risk-sharing provisions.

The original JPA entity contracted with the Public Authority of Alameda County to provide health coverage to In-Home Supportive Service home care workers in the County via the Group Care program. Due to the dissolution of the JPA, Group Care program is assigned to Alameda Alliance for Health with previous contract terms. The contract is automatically renewed on an annual basis, absent adequate written notice to terminate by either party. No written notice of termination was provided by either party during the years ended June 30, 2021 and 2020, except for the change of assignment.

In September 2009, CDHCS implemented Assembly Bill No. 1422 ("AB 1422") or Managed Care Organization ("MCO") premium tax. This program imposes an assessment on Alameda Alliance for Health's capitation and premium revenue. The proceeds from the tax are appropriated from the Children's Health and Human Services Special Fund to the State Department of Health Care Services for specified purposes. This provision was effective retroactively to January 1, 2009, and continued through June 30, 2013. The provisions of AB 1422 were continued, a higher tax rate implemented, and a sales tax replaced the premium tax, via Senate Bill ("SB") 78, beginning July 1, 2013 through June 30, 2016. On March 1, 2016, SB X2-2 established a new MCO provider tax, to be administered by CDHCS, effective July 1, 2016 through July 1, 2019. The tax would be assessed by CDHCS on licensed health care service plans, managed care plans contracted with CDHCS to provide Medi-Cal services, and alternate health care service plans ("AHCSP"), as defined, except as excluded by the bill. This bill would establish applicable taxing tiers and per enrollee amounts for the 2016–2017, 2017–2018, and 2018–2019 fiscal years for Medi-Cal enrollees, AHCSP enrollees, and all other enrollees, as defined. On September 27, 2019, Assembly Bill 115 (Chapter 348, Statutes 2019) authorized DHCS to implement a modified MCO tax model on specified health plans, which was approved by the federal Centers for Medicare & Medicaid Services on April 3, 2020. The effective date range for this approval is January 1, 2020 through December 31, 2022.

Commencing in June 2010, CDHCS implemented a supplemental revenue or intra-governmental transfer program. This program assesses fees on the revenue of participating providers. CDHCS uses these assessments to obtain matching federal funds, which are returned to participating Alliance providers through the Alliance's administration. Alameda Alliance for Health received supplemental medical revenue of $76,642,409 and $63,124,258 for the years ended June 30, 2021 and 2020, respectively, representing the assessment and matching funds, net of MCO premium tax of $0 for the years ended June 30, 2021 and 2020. Related liabilities are recorded under payable to other governmental agencies, hospital fee, and directed payments payables in the combined statements of net position as of June 30, 2021 and 2020.

On September 8, 2010, the California State Legislature ratified Assembly Bill No. 1653, which established a Hospital Quality Assurance Fee ("HQAF") program allowing additional draw down of federal funding to be used for increased payments to general acute care hospitals for inpatient services rendered to Medi-Cal beneficiaries. Pursuant to Section 14167.6 (a), CDHCS increased capitation payments to Medi-Cal managed health care plans retroactive for the months of April 2009 through December 2010. Additionally, Medi-Cal managed care plans are required to adhere to the following regarding the distribution of the increased capitation rates with HQAF funding: Section 14167.6 (h)(1), "Each managed health care plan shall expend 100 percent of any increased capitation payments it receives under this section, on hospital services"; and, Section 14167.10 (a), "Each managed health care plan receiving increased capitation payments under Section 14167.6 shall expend increased capitation payments on hospital services within 30 days of receiving the increased capitation payments." These payments were received and distributed in the manner as prescribed as a pass through to revenue. The payments did have an effect on the overall AB 1422 gross premium tax paid. In April of 2011, California approved SB 90, which extended the HQAF through June 30, 2012. SB 335, signed into law in September of 2011, extended the HQAF portion of SB 90 for an additional 30 months through December 31, 2013. SB 239, signed into law in October of 2013, extended the HQAF portion of SB 90 for an additional 36 months through December 31, 2016. In November of 2016, California approved Proposition 52, which made SB 239 permanent and also created HQAF V. The program period for HQAF V is from January 1, 2017 through June 30, 2019. Alameda Alliance for Health received HQAF payments of $76,015,141 and $52,269,646 for the years ended June 30, 2021 and 2020, respectively, net of MCO premium tax of $0 for the years ended June 30, 2021 and 2020.

Beginning with the July 1, 2017, rating period, CDHCS implemented managed care Directed Payments: 1) Private Hospital Directed Payment ("PHDP"), 2) Designated Public Hospital Enhanced Payment Program ("EPP"), and 3) Designated Public Hospital Quality Incentive Pool ("QIP"). (1) For PHDP, CDHCS will direct Managed Care Plans ("MCP") to reimburse private hospitals as defined in the Welfare and Institutions Code 14169.51, based on actual utilization of contracted services. The enhanced payment is contingent upon hospitals providing adequate access to service, including primary, specialty, and inpatient (both tertiary and quaternary) care. The total funding available for the enhanced contracted payments are limited to a predetermined amount (pool). (2) For EPP Pools, CDHCS has directed MCPs to reimburse California's 21 Designated Public Hospitals and University of California systems (DPHs) for network contracted services, enhanced by either a uniform percentage or dollar increment based on actual utilization of network contracted services. (3) For QIP, CDHCS has directed the MCPs to make QIP payments tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The payments are linked to the delivery of services under the MCP contracts and increase the amount of funding tied to quality outcomes. To receive QIP payments, the DPHs must achieve specified improvement targets, which grow more difficult through year-over-year improvement or sustained high performance requirements. The total funding available for the QIP payments will be limited to a predetermined amount (pool).



**NOTE 2 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES**

**Basis of accounting** – Pursuant to Governmental Accounting Standards Board ("GASB") Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*, the Alliance's proprietary fund accounting and financial reporting practices are based on all applicable GASB pronouncements as well as codified pronouncements issued on or before November 30, 1989, and the California Code of Regulations, Title 2, Section 1131, State Controller's *Minimum Audit Requirements* for California Special Districts and the State Controller's Office prescribed reporting guidelines.

**Proprietary fund accounting** – The Alliance utilizes the proprietary fund method of accounting whereby revenues and expenses are recognized on the accrual basis and the combined financial statements are prepared using the economic resources measurement focus.

**Basis of combination** – The accompanying combined financial statements include the Alameda Alliance for Health and JPA as both entities are under common management and control. The operations of JPA are included from the date of its inception on December 1, 2005.

**Use of estimates** – The preparation of combined financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the combined financial statements and the reported amounts of revenues and expenses during the reporting period. Claims payable, useful lives of fixed assets, premiums receivable, and net pension liability represent significant estimates. Actual results could differ from those estimates.

**Cash and cash equivalents** – The Alliance considers all highly-liquid instruments with a maturity of three months or less at the time of purchase to be cash and cash equivalents. Cash and cash equivalents are carried at cost which approximates fair value. At June 30, 2021 and 2020, the Alliance's cash deposits had carrying amounts of $37,087,423 and $40,706,013, respectively, and bank balances of $43,864,773 and $45,111,217, respectively. Of the bank balances at June 30, 2021 and 2020, $43,570,809 and $44,782,356, respectively, were not covered by federal depository insurance.

**Investments** – The Alliance adopted GASB Statement No. 72, *Fair Value Measurement and Application* ("GASB 72"), effective July 1, 2016. GASB 72 requires the Alliance to use valuation techniques that are appropriate under the circumstances and are consistent with the market approach, the cost approach, or the income approach. GASB 72 establishes a hierarchy of inputs used to measure fair value consisting of three levels. Level 1 inputs are quoted prices in active markets for identical assets or liabilities. Level 2 inputs are inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly. Level 3 inputs are unobservable inputs.

**Concentration of credit risk** – The Alliance is highly dependent upon the State of California for its revenues. Vast majority of accounts receivable and revenue are from the State of California. Loss of the contracts with the State of California due to nonrenewal or legislative decisions that impact program funding or result in discontinuation could materially affect the combined financial position of the Alliance.

As of June 30, 2021 and 2020, the Alliance had premiums receivable of $123,244,014 and $242,555,462 due from the State of California, respectively. For the years ended June 30, 2021 and 2020, the Alliance recognized capitation and premium revenue of $1,158,542,296 and $984,483,191 from the State of California, respectively.

**Restricted cash** – The Alliance is required by the California Department of Managed Health Care to restrict cash having a fair value of at least $300,000 for the payment of member claims in the event of its insolvency. The amounts recorded were $350,000 at June 30, 2021 and 2020. Restricted cash is comprised of U.S. Treasury securities and is stated at fair value.

**Capital assets** – Capital assets include land, building and improvements, furniture and equipment, and computer hardware and software. Capital assets are recorded at cost. Depreciation and amortization of building and improvements, furniture and equipment, computer hardware, and computer software is calculated using the straight-line method over 3 to 40 years, which approximates the estimated useful lives of the assets. The Alliance capitalizes capital expenditures over $5,000, which will have a useful life of three or more years.

The Alliance evaluates prominent events or changes in circumstances affecting capital assets to determine whether impairment of a capital asset has occurred. Impairment losses on capital assets are measured using the method that best reflects the diminished service utility of the capital asset.

**Net position** – Net position is classified as invested in capital assets, restricted or unrestricted. Invested in capital assets represents investments in land, building and improvements, furniture and equipment, computer hardware, and computer software, net of depreciation and amortization. Restricted net position is for specific operating activities and represents the total cash balances that are restricted in their use as they represent monies received that must only be utilized for a specified purpose. It also pertains to external constraints placed on net position by law. Unrestricted net position consists of net position that does not meet the definition of restricted or invested in capital assets.

**Capitation and premium revenue** – Capitation and premium revenue includes amounts received from the CDHCS for Medi-Cal members and from Alameda County for In-Home Supportive Services ("IHSS") home care workers.

Capitation and premium revenue is recorded as revenue in the month for which enrollees are entitled to health care services. Medi-Cal eligibility of enrollees is determined by Alameda County Social Services Agency and validated by the State of California. The State of California provides the Alliance the validated monthly eligibility file of program enrollees who are continuing, newly added, or terminated from the program in support of capitation revenue for the respective month. A portion of revenues received from the CDHCS is subject to possible retroactive adjustments. Management has made provisions for estimated retroactive adjustments. IHSS eligibility of enrollees is determined by Alameda County Social Services Agency. The County of Alameda provides the Alliance the validated monthly eligibility file of program enrollees who are continuing, newly added, or terminated from the IHSS program. Once Alameda Alliance receives current month enrollment data, AAH issues invoice to Alameda County Social Services for monthly premium revenue.

Effective with the enrollment of the Adult Expansion population per the Affordable Care Act on January 1, 2014, the Alliance is subject to CDHCS requirements to meet a minimum 85% medical loss ratio ("MLR") for this population. Specifically, the Alliance will be required to expend at least 85% of the Medi-Cal capitation revenue received for this population on allowable medical expenses as defined by CDHCS. In the event the Alliance expends less than the 85% requirement, the Alliance will be required to return to CDHCS the difference between the minimum threshold and the actual allowed medical expenses. In 2019, the Alliance made a payment to the CDHCS of $179,309,877 related to the original MLR reporting period of January 2014 to June 2016. At June 30, 2021 and 2020, the accrued payable back to CDHCS, which is included in payable to other governmental agencies, hospital fee, and directed payments payables in the accompanying statements of net position, was $1,000,000 and $11,476,054, respectively.

**Premium deficiencies** – The Alliance performs periodic analyses of its expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve is recorded. Management determined that no premium deficiency reserves were needed at June 30, 2021 or 2020.

**Health care expense recognition and claims payable** – The cost of health care services is recognized in the period provided and includes an estimate of the cost of services that have been incurred but not yet reported. The estimate for reserves for claims is based on actuarial projections of hospital and other costs using historical analysis of claims paid and authorization and admission data. Estimates are monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions.

**Operating revenues and expenses** – The Alliance's statements of revenues, expenses, and changes in net position distinguishes between operating and nonoperating revenues and expenses. The primary operating revenue is derived from capitation and other sources in support of providing health care services to its members. Operating expenses are all expenses incurred to provide such health care services. Nonoperating revenues and expenses consist of those revenues and expenses that are related to financing and investing activities, net interest income, and from contributions received for purposes other than capital asset acquisition.

**Insurance coverage** – The Alliance maintains its general liability insurance coverage through outside insurers in the form of "claims-made" policies. Should the "claims-made" policies not be renewed or replaced with equivalent insurance, claims related to the occurrences during the terms of the "claims-made" policies but reported subsequent to the termination of the insurance contract may be uninsured. These policies were renewed subsequent to year end. Physicians and hospitals that the Alliance contracts with are required to maintain their own malpractice insurance coverage.

**Income taxes** – The Alliance is a public entity established pursuant to Section 14087.54 of the Code and is further subject to the provisions of Ordinance No. 0-94-13 and related resolutions of the Board of Supervisors of the County. As a public entity defined by Internal Revenue Code Section 115, the Alliance is exempt from federal and state income taxes.

**New accounting pronouncements** – In January 2017, the GASB issued Statement No. 84, *Fiduciary Activities* ("GASB 84"). GASB 84 provides improved guidance regarding the identification of fiduciary activities for accounting and financial reporting purposes and how those activities should be reported. The statement also provides for recognition of a liability to the beneficiaries in a fiduciary fund when an event has occurred that compels the government to disburse fiduciary resources. In May 2020, the GASB issued Statement No. 95, *Postponement of the Effective Dates of Certain Authoritative Guidance*, which deferred the effective date of GASB 84 to reporting periods beginning after December 15, 2019. The Alliance adopted GASB 84 in the current fiscal year. The adoption of this standard did not have significant impact to the combined financial statements.

In June 2017, the GASB issued GASB Statement No. 87, *Leases* ("GASB 87"). GASB 87 increases the usefulness of financial statements by requiring recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. GASB 87 also establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. In May 2020, the GASB issued Statement No. 95, *Postponement of the Effective Dates of Certain Authoritative Guidance*, which deferred the effective date of GASB 87 to fiscal years beginning after June 15, 2021. The Alliance is reviewing the impact of the adoption of GASB 87 for the fiscal year ending 2022.

In June 2020, the GASB issued Statement No. 97, *Certain Component Unit Criteria, and Accounting and Financial Reporting for Internal Revenue Code Section 457 Deferred Compensation Plans – an amendment of GASB Statements No. 14 and No. 84, and a supersession of GASB Statement No. 32* ("GASB 97"). GASB 97 amends the criteria for reporting governmental fiduciary component units – separate legal entities included in a government's financial statements. GASB 97 clarifies rules related to reporting of fiduciary activities under Statements No. 14 and No. 84 for defined contribution plans and to enhance the relevance, consistency, and comparability of the accounting and financial reporting of IRC Code section 457 plans that meet the definition of a pension plan. The Alliance adopted GASB 97 in the current fiscal year. The adoption of this standard did not have significant impact to the combined financial statements.

## NOTE 3 – INVESTMENTS

At June 30, 2021 and 2020, the Alliance's investments consisted of money market funds, commercial paper, U.S. government agency bonds, corporate bonds, and certificate of deposits.

**Interest rate risk** – Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. The Alliance manages risk of market value fluctuations due to overall changes in the general level of interest rates by complying with California Government Code Section 53600.5. As of June 30, 2021 and 2020, the Alliance's investments all have maturities of less than one year.

**Credit risk** – Generally, credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of rating by a nationally recognized statistical rating organization. The following are the credit ratings for each investment type at June 30, 2021:

| Description | Fair value | Unrated | Aaa |
|---|---|---|---|
| Investments in: | | | |
| Commercial paper | $ 218,817,617 | $ 64,739,165 | $ 154,078,452 |
| Certificate of deposits | 45,130,696 | 45,130,696 | - |
| Total investments | $ 263,948,313 | $ 109,869,861 | $ 154,078,452 |

The following are the credit ratings for each investment type at June 30, 2020:

| Description | Fair value | Unrated | Aaa |
|---|---|---|---|
| Investments in: | | | |
| Commercial paper | $ 162,860,325 | $ 71,635,325 | $ 91,225,000 |
| Certificate of deposits | 75,925,802 | 75,925,802 | - |
| Money market funds | 182,946 | 182,946 | - |
| Total investments | $ 238,969,073 | $ 147,744,073 | $ 91,225,000 |

**Concentration of credit risk** – Concentration of credit risk is the risk of loss attributed to the magnitude of a government's investment in a single issuer. The Alliance's investments as a percentage of its portfolio at June 30, 2021, were as follows:

| Investment | Issuer | Percentage of portfolio |
|---|---|---|
| Commercial paper | Various | 83.0 % |
| Certificate of deposits | Various | 17.0 |
| | | 100 % |

The Alliance's investments as a percentage of its portfolio at June 30, 2020, were as follows:

| Investment | Issuer | Percentage of portfolio |
|---|---|---|
| Commercial paper | Various | 68.0 % |
| Certificate of deposits | Various | 31.0 |
| Money market funds | | 1.0 |
| | | 100 % |

**NOTE 4 – FAIR VALUE**

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. A fair value hierarchy is also established which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The standard describes three levels of inputs that may be used to measure fair value:

**Level 1** – Quoted prices in active markets for identical assets or liabilities.

**Level 2** – Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in active markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

**Level 3** – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

The following tables present fair value measurements of assets recognized in the accompanying financial statements measured at fair value on a recurring basis at June 30:

| Description | 2021 |
|---|---|
| Investments and restricted cash not subject to fair value hierarchy | |
| Commercial paper | $ 218,817,617 |
| Certificate of deposits | 45,130,696 |
| U.S. Treasury securities | 350,000 |
| Total investments and restricted cash | $ 264,298,313 |

| Description | 2020 |
|---|---|
| Investments and restricted cash not subject to fair value hierarchy | |
| Commercial paper | $ 162,860,325 |
| Certificate of deposits | 75,925,802 |
| Money market funds | 182,946 |
| U.S. Treasury securities | 350,000 |
| Total investments and restricted cash | $ 239,319,073 |

## NOTE 5 – CAPITAL ASSETS

Capital asset additions, retirements, and balances for the years ended June 30, 2021 and 2020, were as follows:

| | Balance July 1, 2020 | Increases | Decreases | Transfers | Balance June 30, 2021 |
|---|---|---|---|---|---|
| Capital assets | | | | | |
| Land | $ 1,557,283 | $ - | $ - | $ - | $ 1,557,283 |
| Building and improvements | 9,072,277 | 49,181 | (171,104) | - | 8,950,354 |
| Furniture and equipment | 2,465,084 | 1,720 | (774,132) | - | 1,692,672 |
| Computer hardware | 8,288,761 | 1,062,701 | (3,396,106) | - | 5,955,356 |
| Computer software | 20,840,553 | 28,230 | (2,152,588) | - | 18,716,195 |
| Construction in progress | - | 63,615 | - | | 63,615 |
| Total capital assets | 42,223,958 | 1,205,447 | (6,493,930) | - | 36,935,475 |
| Less accumulated depreciation for | | | | | |
| Building and improvements | (5,132,805) | (653,730) | 141,942 | - | (5,644,593) |
| Furniture and equipment | (2,259,218) | (73,522) | 649,606 | - | (1,683,134) |
| Computer hardware | (5,810,106) | (1,025,964) | 2,143,164 | - | (4,692,906) |
| Computer software | (19,009,890) | (284,885) | 652,068 | - | (18,642,707) |
| Total accumulated depreciation | (32,212,019) | (2,038,101) | 3,586,780 | - | (30,663,340) |
| Net capital assets | $ 10,011,939 | $ (832,654) | $ (2,907,150) | $ - | $ 6,272,135 |

| | Balance July 1, 2019 | Increases | Decreases | Transfers | Balance June 30, 2020 |
|---|---|---|---|---|---|
| Capital assets | | | | | |
| Land | $ 1,557,283 | $ - | $ - | $ - | $ 1,557,283 |
| Building and improvements | 8,834,750 | 237,527 | - | - | 9,072,277 |
| Furniture and equipment | 2,410,114 | 54,970 | - | - | 2,465,084 |
| Computer hardware | 7,206,916 | 1,081,845 | - | - | 8,288,761 |
| Computer software | 20,753,869 | 86,684 | - | - | 20,840,553 |
| Total capital assets | 40,762,932 | 1,461,026 | - | - | 42,223,958 |
| Less accumulated depreciation for | | | | | |
| Building and improvements | (4,328,293) | (804,512) | - | - | (5,132,805) |
| Furniture and equipment | (2,183,841) | (75,377) | - | - | (2,259,218) |
| Computer hardware | (4,829,908) | (980,198) | - | - | (5,810,106) |
| Computer software | (18,677,683) | (332,207) | - | - | (19,009,890) |
| Total accumulated depreciation | (30,019,725) | (2,192,294) | - | - | (32,212,019) |
| Net capital assets | $ 10,743,207 | $ (731,268) | $ - | $ - | $ 10,011,939 |



**NOTE 6 – CLAIMS PAYABLE**

The Alliance estimates claims payable based on historical claims payment and other relevant information. Estimates are monitored and reviewed, and as settlements are made or estimates are adjusted, differences are reflected in current operation. Such estimates are subject to impact of changes in the regulatory environment. The following is a reconciliation of the claims payable liability for the years ended June 30, 2021 and 2020:

| | 2021 | 2020 |
|---|---|---|
| Balance, July 1 | $ 88,695,976 | $ 95,463,034 |
| Incurred - current | 907,307,851 | 710,469,774 |
| Paid | | |
| Current | (773,016,174) | (631,269,347) |
| Prior | (90,882,826) | (85,967,485) |
| Balance, June 30 | $ 132,104,827 | $ 88,695,976 |

As noted in the table above, $907,307,851 and $710,469,774 in medical claims were incurred for the years ended June 30, 2021 and 2020, respectively, which are reflected in medical services in the combined statements of revenues, expenses, and changes in net position.

Claims payable liability increased by $43,408,851 in comparison to the previous year as a result of changes between actual payments for medical services and estimated amounts in previous years. Management believes the increase in estimated prior year's claims experience is largely a result of higher-than-anticipated adverse health care claims experience.

## NOTE 7 – OPERATING LEASES

The Alliance has entered into various operating lease agreements for office space, which provides for minimum annual rental payments expiring in May of 2025. The total future minimum lease commitments under noncancelable leases at June 30, 2021, are as follows:

| Year Ending June 30, | |
|---|---|
| 2022 | $ 864,800 |
| 2023 | 890,023 |
| 2024 | 916,003 |
| 2025 | 864,101 |
| | $ 3,534,927 |

Rent expense was $844,241 and $801,357 for the years ended June 30, 2021 and 2020, respectively, and is included in marketing, general, and administrative expenses in the combined statements of revenues, expenses, and changes in net position.

## NOTE 8 – MEDICAL REINSURANCE ("STOP-LOSS INSURANCE")

The Alliance has entered into certain reinsurance ("stop-loss") agreements with third parties in order to limit its losses on individual claims. Under the terms of these agreements, the third parties will reimburse the Alliance certain proportions of the cost of each member's hospital, professional, and out-of-area services, excluding those that are capitated, in excess of specified deductibles ranging from $600,000 per contract, up to a maximum of $5,000,000 per member per contract year. Reinsurance premiums are recorded as other health care expenses and recoveries are recorded as a reduction of these expenses. Stop-loss recoveries exceeded premiums by $2,048,340 in 2021. Premiums exceeded stop-loss recoveries by $4,727 in 2020.

## NOTE 9 – EMPLOYEE BENEFIT PLANS

### Pension Plan

The Alliance has a defined contribution employee benefit plan (the "Plan"). The Plan is named the Alameda Alliance for Health Money Purchase Pension Plan and is administered by the Alliance. The Board of Governors has the authority to establish and amend benefit provisions and contribution requirements. All employees who have met certain service requirements are eligible to participate. During the years ended June 30, 2021 and 2020, the Alliance contributed 5% of each eligible employee's gross compensation to certain investment vehicles chosen by the employee. Contributions are subject to limitations on annual compensation and annual contributions per Internal Revenue Code Section 401(a)(17). Contributions to the Plan are made by the Alliance at the discretion of the Board of Governors. Employees do not contribute to this Plan. Employees become vested with respect to the Alliance's contributions ratably over five years.

**CalPERS Plan**

**Plan description** – Effective January 1, 1999, the Alliance joined the California Public Employees Retirement System ("CalPERS"), an agent multiple-employer defined benefit pension plan. CalPERS acts as a common investment and administrative agent for participating public entities within the State of California. Benefit provisions and all other requirements are established by state statute. Copies of the CalPERS annual financial report may be obtained from their Executive Office: 400 Q Street, Sacramento, California 95814.

**Benefits provided** – CalPERS provides service retirement and disability benefits, annual cost of living adjustments, and death benefits to plan members, who must be public employees and beneficiaries. Benefits are based on years of credited service, equal to one full year of full-time employment. Members with five years of total service are eligible to retire at age 50 with statutorily reduced benefits. All members are eligible for nonduty disability benefits after five years of service. The death benefit is one of the following: the Basic Death Benefit, the 1957 Survivor Benefit, or the Optional Settlement 2W Death Benefit. The cost of living adjustments for the plan are applied as specified by the Public Employees' Retirement Law.

The CalPERS plan provisions and benefits in effect at June 30, 2021 and 2020, are summarized as follows:

| | Hire date prior to January 1, 2013 | Hire date on or after January 1, 2013 |
|---|---|---|
| Benefit formula | 2% at 60 | 2% at 62 |
| Benefit vesting schedule | 5 years of service | 5 years of service |
| Benefit payments | monthly for life | monthly for life |
| Retirement age | 50 to 67 | 52 to 67 |
| Monthly benefits as a % of eligible compensation | 1.1% to 3.1% | 1.0% to 2.6% |
| Required employee contribution rates | 7.0% | 7.0% |
| Required employer contribution rates | 7.985% | 7.985% |

**Employees covered** – At June 30, 2021 and 2020, the following employees were covered by the CalPERS plan:

| | 2021 | 2020 |
|---|---|---|
| Active | 316 | 304 |
| Terminated | 361 | 340 |
| Transferred | 41 | 39 |
| Retired and beneficiaries | 35 | 31 |
| Total participants | 753 | 714 |

**Contributions** – Section 20814(c) of the California Public Employees' Retirement Law requires that the employer contribution rates for all public employers be determined on an annual basis by the actuary and shall be effective on the July 1 following notice of a change in the rate. The total plan contributions are determined through CalPERS' annual actuarial valuation process. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability. The employer is required to contribute the difference between the actuarially determined rate and the contribution rate of employees. Employer contribution rates may change if plan contracts are amended. Payments made by the employer to satisfy contribution requirements that are identified by the pension plan terms as plan member contribution requirements are classified as plan member contributions.

**Net pension asset/liability** – The Alliance's net pension asset/liability for the CalPERS plan is measured as the total pension liability, less the pension's fiduciary net position. The net pension liability at June 30, 2021 is measured as of June 30, 2020, using an annual actuarial valuation as of June 30, 2019, rolled forward to June 30, 2020, using standard update procedures. The net pension asset at June 30, 2020 is measured as of June 30, 2019, using an annual actuarial valuation as of June 30, 2018, rolled forward to June 30, 2019, using standard update procedures. A summary of principal assumptions and methods used to determine the net pension asset/liability is shown below.

The total pension liability in the June 30, 2021, actuarial valuations were determined using the following actuarial assumptions:

| | |
|---|---|
| Valuation date | June 30, 2019 |
| Measurement date | June 30, 2020 |
| Actuarial cost method | Entry age normal |
| Actuarial assumptions | |
| Discount rate | 7.15% |
| Inflation | 2.625% |
| Salary increases | Varies by entry age and service |
| Payroll growth | 2.875% |
| Investment rate of return | 7.25% net of pension plan investment and administrative expenses; includes inflation |
| Mortality rate table | Derived using CalPERS' membership data for all funds |
| Post retirement benefit increase | The lesser of contract COLA or 2.50% until purchasing power protection allowance floor on purchasing power applies; 2.50% thereafter |

The total pension liability in the June 30, 2020, actuarial valuations were determined using the following actuarial assumptions:

| | |
|---|---|
| Valuation date | June 30, 2018 |
| Measurement date | June 30, 2019 |
| Actuarial cost method | Entry age normal |
| Actuarial assumptions | |
| Discount rate | 7.15% |
| Inflation | 2.75% |
| Salary increases | Varies by entry age and service |
| Payroll growth | 3.00% |
| Investment rate of return | 7.375% net of pension plan investment and administrative expenses; includes inflation |
| Mortality rate table | Derived using CalPERS' membership data for all funds |
| Post retirement benefit increase | The lesser of contract COLA or 2.50% until purchasing power protection allowance floor on purchasing power applies; 2.50% thereafter |

The mortality table used was developed based on CalPERS' specific data. The table includes 20 years of mortality improvements using Society of Actuaries Scale BB. All other actuarial assumptions used in the 2016 and 2015 valuation were based on the results of an actuarial experience study for the period from 1997 to 2011, including updates to salary increase, mortality, and retirement rates. The Experience Study can be obtained at the CalPERS website.

**Change of assumptions** – GASB Statement No. 68, *Accounting and Financial Reporting for Pensions* ("GASB 68"), paragraph 68 states that the long-term rate of return should be determined net of pension plan investment expense but without reduction for pension plan administrative expense. For the June 30, 2021 and 2020 measurement date, there were changes in demographic assumptions and inflation rate and there were no changes in discount rate.

**Discount rate** – The discount rate used to measure the total pension asset/liability at June 30, 2021 and 2020, was 7.15%, for the CalPERS plan. To determine whether the municipal bond rate should be used in the calculation of a discount rate for each plan, CalPERS stress-tested plans that would most likely result in a discount rate that would be different from the actuarially assumed discount rate. Based on the testing, none of the tested plans would run out of assets. Therefore, the current 7.15% discount rate is adequate and the use of the municipal bond rate calculation is not necessary. The long-term expected discount rate of 7.15% will be applied to all plans in the Public Employees Retirement Fund. The cash flows used in the testing were developed assuming that both members and employers will make their required contributions on time and as scheduled in all future years. The stress-test results are presented in a detailed report called "GASB Crossover Testing Report", which can be obtained from the CalPERS website.

The long-term expected rate of return on pension plan investments was determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class.

In determining the long-term expected rate of return, CalPERS took into account both short-term and long-term market return expectations as well as the expected pension fund cash flows. Such cash flows were developed assuming that both members and employers will make the required contributions as scheduled in all future years. Using historical returns of all the funds' asset classes, expected compound returns were calculated over the short-term (first 10 years) and the long-term (11 to 60 years) using a building-block approach. Using the expected nominal returns for both short-term and long-term, the present value of benefits was calculated for each fund. The expected rate of return was set by calculating the single equivalent expected return that arrived at the same present value of benefits for cash flows as the one calculated using both short-term and long-term returns. The expected rate of return was then set equivalent to the single equivalent rate calculated above and rounded down to the nearest one-quarter of one percent.

The table below reflects long-term expected real rate of return by asset class. The rate of return was calculated using the capital market assumptions applied to determine the discount rate and asset allocation.

| Asset Class | Current Target Allocation | Real Return Years 1 to 10 [a] | Real Return Years 11+ [b] |
|---|---|---|---|
| Global equity | 50.0% | 4.80% | 5.98% |
| Fixed income | 28.0% | 1.00% | 2.62% |
| Inflation assets | 0.0% | 0.77% | 1.81% |
| Private equity | 8.0% | 6.30% | 7.23% |
| Real estate | 13.0% | 3.75% | 4.93% |
| Liquidity | 1.0% | 0.00% | -0.92% |

[a] An expected inflation rate of 2.00% was used for this period
[b] An expected inflation rate of 2.92% was used for this period

The changes in the net pension liability for the years ended June 30, 2021 and 2020, were as follows:

| | Total Pension Liability | Plan Fiduciary Net Position | Net Pension Liability |
|---|---|---|---|
| Balance at June 30, 2020 | $ 46,262,830 | $ 45,430,029 | $ 832,801 |
| Changes during the year | | | |
| Service cost | 3,861,461 | - | 3,861,461 |
| Interest on the total pension liability | 3,397,686 | - | 3,397,686 |
| Differences between expected and actual experience | (109,296) | - | (109,296) |
| Contributions - employer | - | 2,110,925 | (2,110,925) |
| Contributions - employees | - | 1,912,291 | (1,912,291) |
| Net investment income | - | 2,358,305 | (2,358,305) |
| Benefit payments, including refunds of employee contributions | (1,128,346) | (1,128,346) | - |
| Administrative expense | - | (64,045) | 64,045 |
| Net change in total pension liability | 6,021,505 | 5,189,130 | 832,375 |
| Balance at June 30, 2021 | $ 52,284,335 | $ 50,619,159 | $ 1,665,176 |

| | Total Pension Liability | Plan Fiduciary Net Position | Net Pension Liability (Asset) |
|---|---|---|---|
| Balance at June 30, 2019 | $ 39,934,477 | $ 40,042,197 | $ (107,720) |
| Changes during the year | | | |
| Service cost | 3,625,677 | - | 3,625,677 |
| Interest on the total pension liability | 2,999,802 | - | 2,999,802 |
| Differences between expected and actual experience | 713,029 | - | 713,029 |
| Contributions - employer | - | 1,984,998 | (1,984,998) |
| Contributions - employees | - | 1,741,232 | (1,741,232) |
| Net investment income | - | 2,700,240 | (2,700,240) |
| Benefit payments, including refunds of employee contributions | (1,010,155) | (1,010,155) | - |
| Administrative expense | - | (28,575) | 28,575 |
| Other miscellaneous income | - | 92 | (92) |
| Net change in total pension liability | 6,328,353 | 5,387,832 | 940,521 |
| Balance at June 30, 2020 | $ 46,262,830 | $ 45,430,029 | $ 832,801 |

**Sensitivity of the proportionate share of the net pension liability to changes in the discount rate** – The following presents the net pension liability for the CalPERS plan, calculated using the discount rate, as well as what the net pension liability (asset) would be if it were calculated using a discount rate that is 1 percentage point lower or 1 percentage point higher than the current rate.

| | June 30, 2021 | | |
|---|---|---|---|
| | 1% Decrease (6.15%) | Current Discount Rate (7.15%) | 1% Increase (8.15%) |
| Net pension liability (asset) | $ 10,077,007 | $ 1,665,176 | $ (5,104,651) |

| | June 30, 2020 | | |
|---|---|---|---|
| | 1% Decrease (6.15%) | Current Discount Rate (7.15%) | 1% Increase (8.15%) |
| Net pension liability (asset) | $ 8,284,994 | $ 832,801 | $ (5,160,875) |

**Pension plan fiduciary net position** – Detailed information about each pension plan's fiduciary net position is available in the separately issued CalPERS financial reports.

**Pension expense and deferred outflows/inflows of resources related to pensions** – For the year ended June 30, 2021, the Alliance recognized pension expense of $1,719,096, included in marketing, general, and administrative expenses. At June 30, 2021, the Alliance reported deferred outflows of resources and deferred inflows of resources related to the CalPERS plan from the following sources:

| | |
|---|---|
| Deferred outflows of resources as of June 30, 2021 | |
| Changes of assumptions | $ 477,109 |
| Differences between expected and actual experience | 469,833 |
| Net difference between projected and actual earnings on pension plan investments | 542,242 |
| Total | $ 1,489,184 |
| Deferred inflows of resources as of June 30, 2021 | |
| Differences between expected and actual experience | $ (158,960) |
| Changes of assumptions | (294,146) |
| Total | $ (453,106) |
| Contributions between the measurement date and fiscal year end recognized as deferred outflows of resources | $ 2,606,677 |

For the year ended June 30, 2020, the Alliance recognized pension expense of $1,752,612, included in marketing, general, and administrative expenses. At June 30, 2020, the Alliance reported deferred outflows of resources and deferred inflows of resources related to the CalPERS plan from the following sources:

| | |
|---|---|
| Deferred outflows of resources as of June 30, 2020 | |
| Changes of assumptions | $ 910,846 |
| Differences between expected and actual experience | 632,447 |
| Total | $ 1,543,293 |
| Deferred inflows of resources as of June 30, 2020 | |
| Differences between expected and actual experience | $ (293,129) |
| Changes of assumptions | (608,232) |
| Net difference between projected and actual earnings on pension plan investments | (120,332) |
| Total | $ (1,021,693) |
| Contributions between the measurement date and fiscal year end recognized as deferred outflows of resources | $ 2,154,253 |

The Alliance reported $2,606,677 and $2,154,253 as deferred outflows of resources related to contributions made subsequent to the measurement date for the years ended June 30, 2021 and 2020, respectively. This amount will be recognized as a reduction/increase of net pension liability for the measurement period ended June 30, 2020 and 2019, respectively. Other amounts reported as deferred outflows and deferred inflows of resources related to the CalPERS plan will be recognized in future pension expense as follows:

| Year Ending June 30, | |
|---|---|
| 2022 | $ 257,983 |
| 2023 | $ 364,731 |
| 2024 | $ 178,152 |

At June 30, 2021 and 2020, the Alliance had no outstanding amount of contributions to the pension plan required for the years ended June 30, 2021 and 2020.

**Deferred Compensation Plan** – The Alliance offers its employees a deferred compensation plan with Voya Financial created in accordance with Internal Revenue Code Section 457. The deferred compensation plan is available to all employees and permits them to defer a portion of their salary. No employer contribution to the plan is required. Deferred compensation is not available to employees until termination, retirement, death, or an unforeseeable emergency.



## NOTE 10 – TANGIBLE NET EQUITY

As a limited license plan under Knox-Keene Health Care Services Plan Act of 1975, the Alliance is required to maintain a minimum level of tangible net equity and working capital. The required tangible net equity is $36,486,113 and $31,962,073 at June 30, 2021 and 2020, respectively. The tangible net equity of the Alliance is $205,410,042 and $206,174,815 at June 30, 2021 and 2020, respectively. At June 30, 2021 and 2020, management believes the Alliance was in compliance with their tangible net equity regulatory requirement.

## NOTE 11 – RISK MANAGEMENT

The Alliance is exposed to various risks of loss related to torts; theft of, damage to, and destruction of assets; business interruptions; errors and omissions; employee injuries and illness; natural disasters; and employee health, dental, and accident benefits. The Alliance carries commercial insurance for claims arising from such matters, and no settled claims have ever exceeded the Alliances' commercial coverage.

## NOTE 12 – COMMITMENTS AND CONTINGENCIES

The Alliance is aware of certain asserted and unasserted legal claims. While the outcome cannot be determined at this time after consultation with legal counsel, it is management's opinion that the liability, if any, from these actions will not have a material adverse effect on the Alliance's combined financial position or results of operations.

**NOTE 13 – HEALTH CARE REFORM**

The Patient Protection and Affordable Care Act ("PPACA") allowed for the expansion of Medi-cal members in the State of California. Any further changes in federal or state funding could have an impact on the Alliance. The future of the PPACA and the impact of future changes in Medicaid to the Alliance is uncertain at this time.

## Supplementary Information

# Alameda Alliance for Health and
# Alameda Alliance Joint Powers Authority
## Schedule of Changes in Net Pension Liability (Asset) and Related Ratios

| | 2021 | 2020 | 2019 | 2018 | 2017 | 2016 |
|---|---|---|---|---|---|---|
| Measurement period | 2019-2020 | 2018-2019 | 2017-2018 | 2016-2017 | 2015-2016 | 2014-2015 |
| **Total pension liability** | | | | | | |
| Service cost | $ 3,861,461 | $ 3,625,677 | $ 3,233,750 | $ 2,936,812 | $ 2,378,725 | $ 2,192,498 |
| Interest on total pension liability | 3,397,686 | 2,999,802 | 2,582,178 | 2,275,291 | 2,016,770 | 1,844,544 |
| Changes of assumptions | - | - | (386,048) | 2,212,057 | - | (545,758) |
| Difference between expected and actual experience | (109,296) | 713,029 | 102,040 | (731,181) | (1,285,655) | (97,677) |
| Benefit payments, including refunds of employee contributions | (1,128,346) | (1,010,155) | (757,893) | (811,011) | (581,326) | (604,984) |
| Net change in total pension liability | 6,021,505 | 6,328,353 | 4,774,027 | 5,881,968 | 2,528,514 | 2,788,623 |
| Total pension liability beginning of fiscal year | 46,262,830 | 39,934,477 | 35,160,450 | 29,278,482 | 26,749,968 | 23,961,345 |
| Total pension liability end of fiscal year | $ 52,284,335 | $ 46,262,830 | $ 39,934,477 | $ 35,160,450 | $ 29,278,482 | $ 26,749,968 |
| **Plan fiduciary net position** | | | | | | |
| Contributions - employer | $ 2,110,925 | $ 1,984,998 | $ 1,854,342 | $ 1,541,099 | $ 1,252,041 | $ 1,099,813 |
| Contributions - employee | 1,912,291 | 1,741,232 | 1,583,972 | 1,373,631 | 1,157,507 | 1,054,870 |
| Net investment income | 2,358,305 | 2,700,240 | 2,987,504 | 3,330,394 | 153,646 | 571,106 |
| Benefit payments, including refunds of employee contributions | (1,128,346) | (1,010,155) | (757,893) | (811,011) | (581,326) | (604,984) |
| Net plan to plan resource movement | - | - | (92) | - | - | - |
| Administrative expense | (64,045) | (28,575) | (53,808) | (43,022) | (16,561) | (30,578) |
| Other miscellaneous income (expense) | - | 92 | (102,182) | - | - | - |
| Net change in fiduciary net position | 5,189,130 | 5,387,832 | 5,511,843 | 5,391,091 | 1,965,307 | 2,090,227 |
| Plan fiduciary net position beginning of fiscal year | 45,430,029 | 40,042,197 | 34,530,354 | 29,139,263 | 27,173,956 | 25,083,729 |
| Plan fiduciary net position end of fiscal year | $ 50,619,159 | $ 45,430,029 | $ 40,042,197 | $ 34,530,354 | $ 29,139,263 | $ 27,173,956 |
| **Plan net pension liability (asset)** | $ 1,665,176 | $ 832,801 | $ (107,720) | $ 630,096 | $ 139,219 | $ (423,988) |
| **Plan fiduciary net position as a percentage of the total pension liability** | 96.82% | 98.20% | 100.27% | 98.21% | 99.52% | 101.59% |
| **Covered employee payroll** | $ 26,466,489 | $ 24,934,165 | $ 22,106,576 | $ 19,552,678 | $ 17,110,667 | $ 15,964,019 |
| **Plan net pension liability (asset) as a percentage of covered payroll** | 6.29% | 3.34% | -0.49% | 3.22% | 0.81% | -2.66% |

# Alameda Alliance for Health and
# Alameda Alliance Joint Powers Authority
## Schedule of Pension Contributions

| | 2021 | 2020 | 2019 | 2018 | 2017 | 2016 |
|---|---|---|---|---|---|---|
| Measurement period | 2019-2020 | 2018-2019 | 2017-2018 | 2016-2017 | 2015-2016 | 2014-2015 |
| Actuarially determined contribution | $ 2,110,925 | $ 1,984,998 | $ 1,854,342 | $ 1,541,099 | $ 1,252,041 | $ 1,099,813 |
| Contributions in relation to the actuarially determined contribution | (2,110,925) | (1,984,998) | (1,854,342) | (1,541,099) | (1,252,041) | (1,099,813) |
| Contribution deficiency (excess) | $ - | $ - | $ - | $ - | $ - | $ - |
| **Covered employee payroll** | $ 26,466,489 | $ 24,934,165 | $ 22,106,576 | $ 19,552,678 | $ 17,110,667 | $ 19,552,678 |
| **Contributions as a percentage of covered employee payroll** | 7.98% | 7.96% | 8.39% | 7.88% | 7.32% | 6.89% |

# Alameda Alliance for Health and
# Alameda Alliance Joint Powers Authority
## Statement of Revenues and Expenses – AC Care Connect
## For the Years Ended June 30, 2021 and 2020

Contract Number: 15764
Contract Amount: $8,684,669
Contract Period: July 1, 2019 - December 31, 2021

| | 2021* |
|---|---|
| Revenues | |
| Care Connect revenue (95%) | $ 810,972 |
| Care Connect administrative revenue (5%) | 719,560 |
| Total revenues | 1,530,532 |
| Expenses | |
| Care Connect CB-CME payments | 810,972 |
| Total expenses | 810,972 |
| Net income | $ 719,560 |

* Amounts shown are for the period July 1, 2020 - June 30, 2021.

Contract Number: 15764
Contract Amount: $8,684,669
Contract Period: July 1, 2019 - December 31, 2021

| | 2020* |
|---|---|
| Revenues | |
| Care Connect revenue (95%) | $ 692,417 |
| Care Connect administrative revenue (5%) | 712,526 |
| Total revenues | 1,404,943 |
| Expenses | |
| Care Connect CB-CME payments | 692,417 |
| Total expenses | 692,417 |
| Net income | $ 712,526 |

* Amounts shown are for the period July 1, 2019 - June 30, 2020.

# Report of Independent Auditors on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

To the Board of Governors
Alameda Alliance for Health and
Alameda Alliance Joint Powers Authority

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the combined financial statements of Alameda Alliance for Health and Alameda Alliance Joint Powers Authority (collectively the "Alliance"), which comprise the combined statement of net position as of June 30, 2021, and the related combined statement of revenues, expenses, and changes in net position, and cash flows for the year then ended, and the related notes to the combined financial statements and have issued our report thereon dated October xx, 2021.



## Internal Control Over Financial Reporting

In planning and performing our audit of the combined financial statements, we considered the Alliance's internal control over financial reporting ("internal control") to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinions on the combined financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Alliance's internal control. Accordingly, we do not express an opinion on the effectiveness of the Alliance's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

**Compliance and Other Matters**

As part of obtaining reasonable assurance about whether the Alliance's combined financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audits and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

**Purpose of this Report**

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

San Francisco, California
October xx, 2021

ALAMEDA Alliance FOR HEALTH

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

# Finance

## Gil Riojas

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

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

**Date:** **October 8, 2021**

**Subject:** **Finance Report – August 2021**

## Executive Summary

- For the month ended August 31, 2021, the Alliance had enrollment of 291,207 members, a Net Income of $1.5 million, and 564% of required Tangible Net Equity (TNE).

**Overall Results**: (in Thousands)

| | Month | YTD |
|---|---|---|
| Revenue | $98,128 | $195,391 |
| Medical Expense | 91,407 | 181,232 |
| Admin. Expense | 5,240 | 10,042 |
| Other Inc. / (Exp.) | (27) | (16) |
| Net Income | **$1,455** | **$4,101** |

**Net Income by Program:**

| | Month | YTD |
|---|---|---|
| Medi-Cal | $1,381 | $4,094 |
| Group Care | 74 | 7 |
| | **$1,455** | **$4,101** |

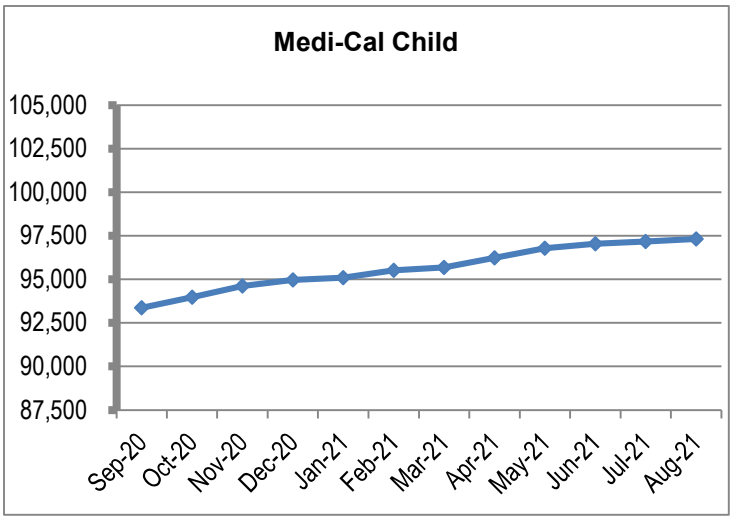
## Enrollment

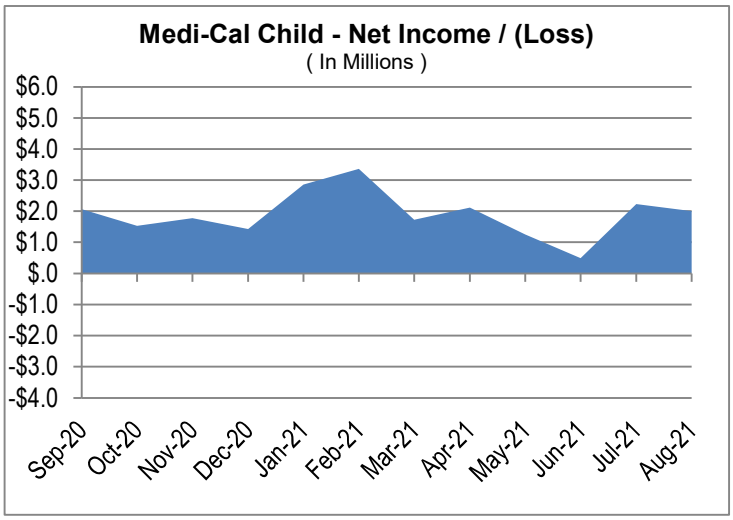
- Total enrollment increased by 1,116 members since July 2021.
- Total enrollment increased by 2,653 members since June 2021.

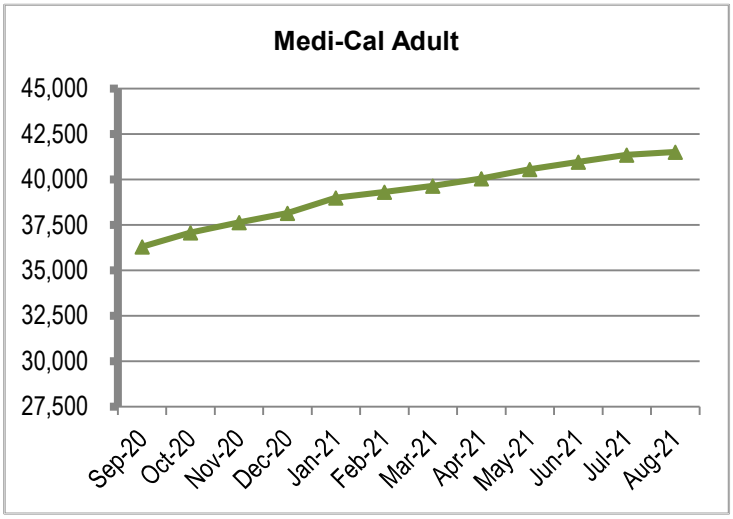
**Monthly Membership and YTD Member Months**
**Actual vs. Budget**
**For the Month and Fiscal Year-to-Date**

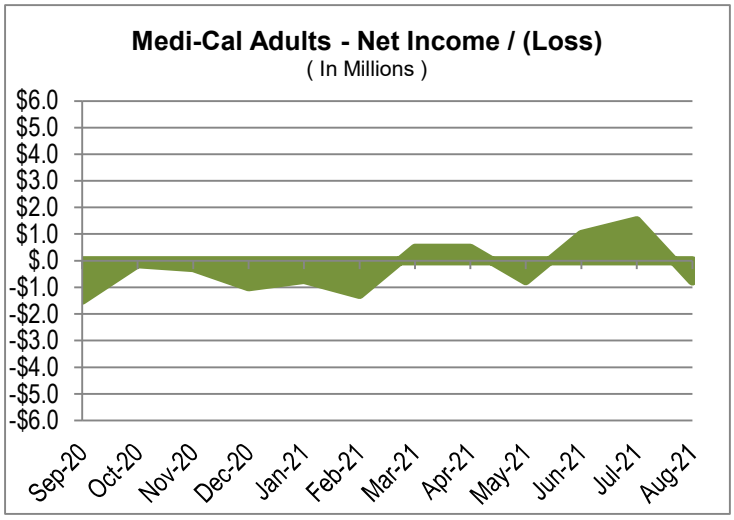
| Enrollment | | | | | Member Months | | | |
|---|---|---|---|---|---|---|---|---|
| August-2021 | | | | | Year-to-Date | | | |
| Actual | Budget | Variance | Variance % | | Actual | Budget | Variance | Variance % |
| | | | | **Medi-Cal:** | | | | |
| 41,519 | 40,790 | 729 | 1.8% | Adult | 82,877 | 81,527 | 1,350 | 1.7% |
| 97,324 | 97,331 | (7) | 0.0% | Child | 194,503 | 194,536 | (33) | 0.0% |
| 26,316 | 26,395 | (79) | -0.3% | SPD | 52,636 | 52,756 | (120) | -0.2% |
| 20,388 | 20,038 | 350 | 1.7% | Duals | 40,582 | 40,050 | 532 | 1.3% |
| 99,783 | 98,431 | 1,352 | 1.4% | ACA OE | 198,888 | 196,734 | 2,154 | 1.1% |
| **285,330** | **282,985** | **2,345** | **0.8%** | **Medi-Cal Total** | **569,486** | **565,603** | **3,883** | **0.7%** |
| 5,877 | 5,939 | (62) | -1.0% | Group Care | 11,812 | 11,878 | (66) | -0.6% |
| **291,207** | **288,924** | **2,283** | **0.8%** | **Total** | **581,298** | **577,481** | **3,817** | **0.7%** |

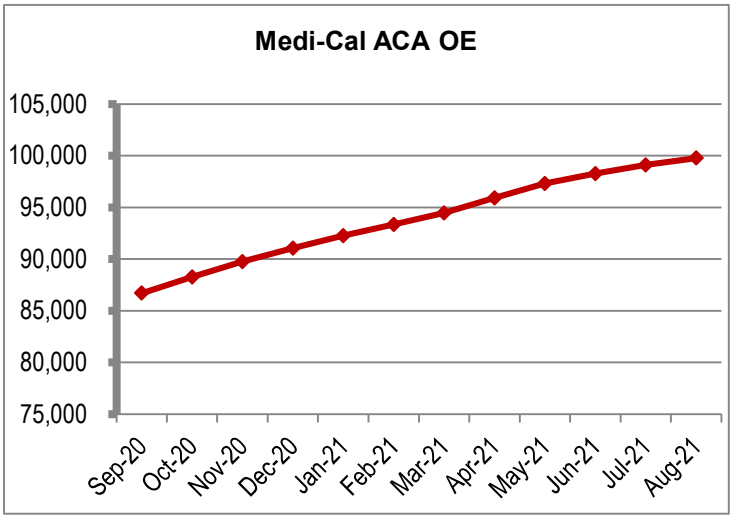
# Enrollment and Profitability by Program and Category of Aid

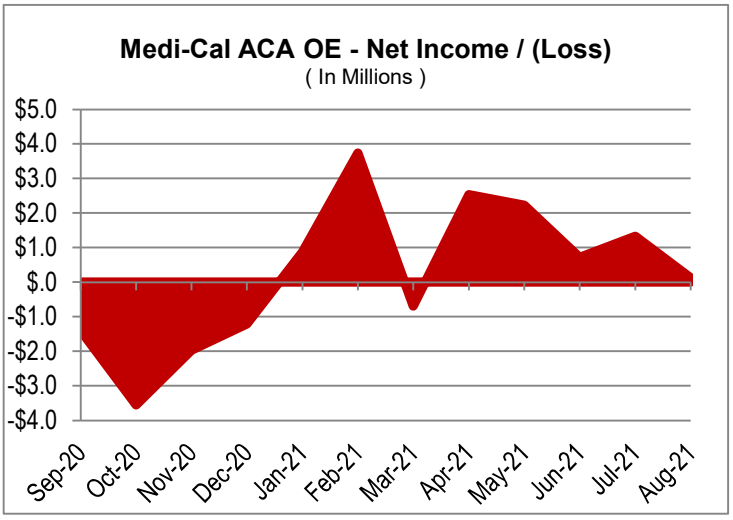


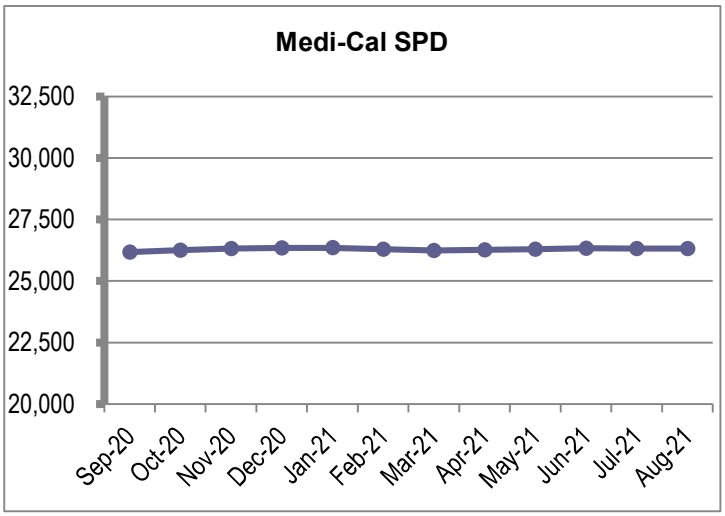



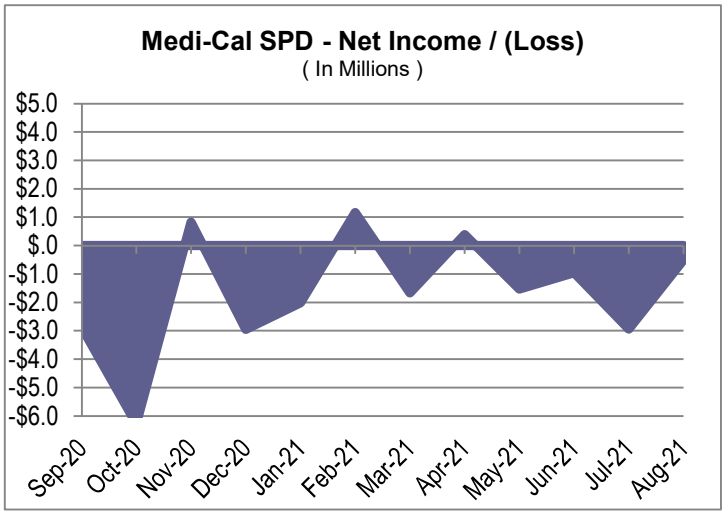



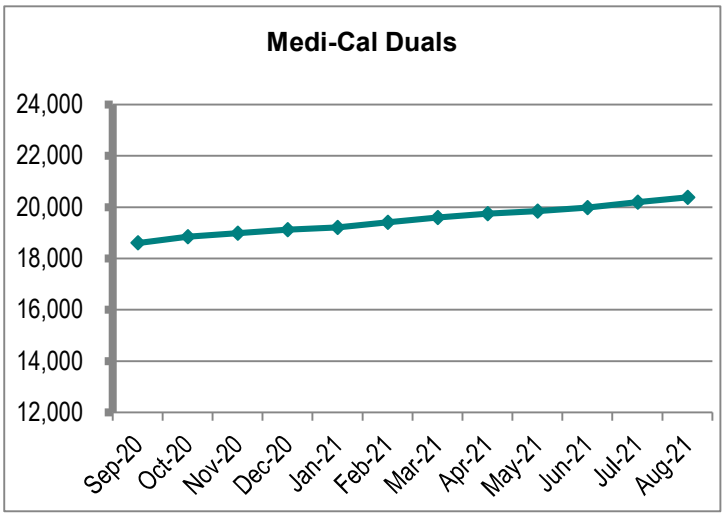



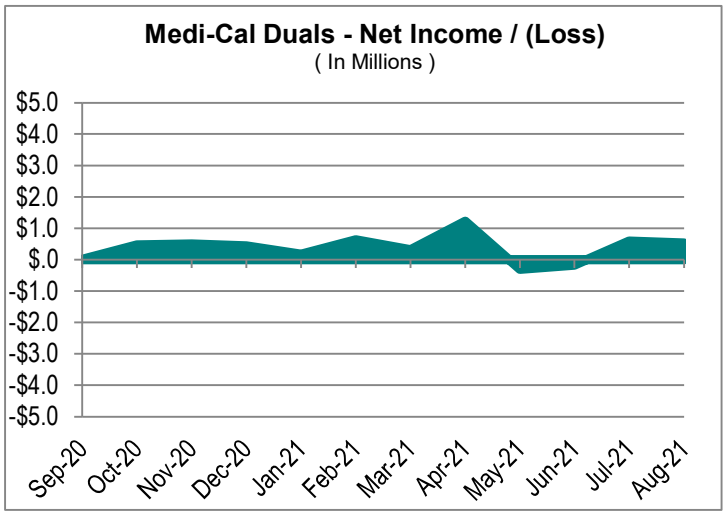



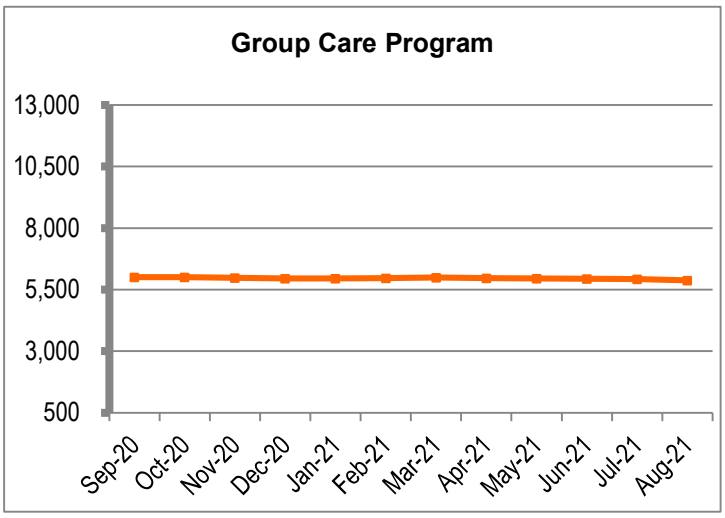
# Enrollment and Profitability by Program and Category of Aid

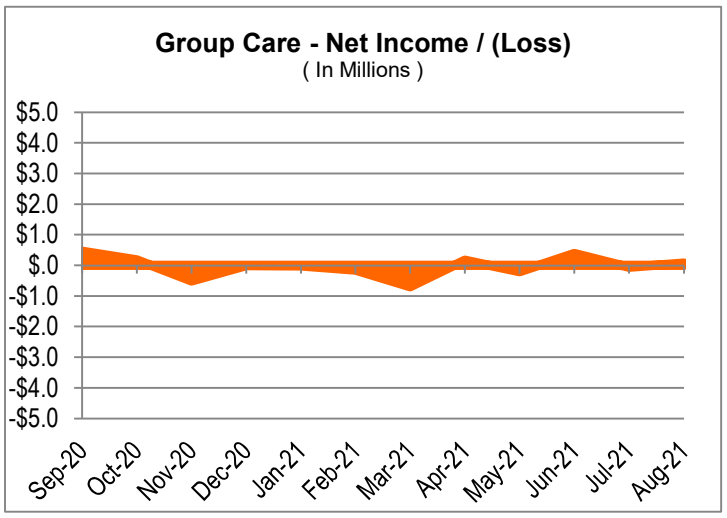


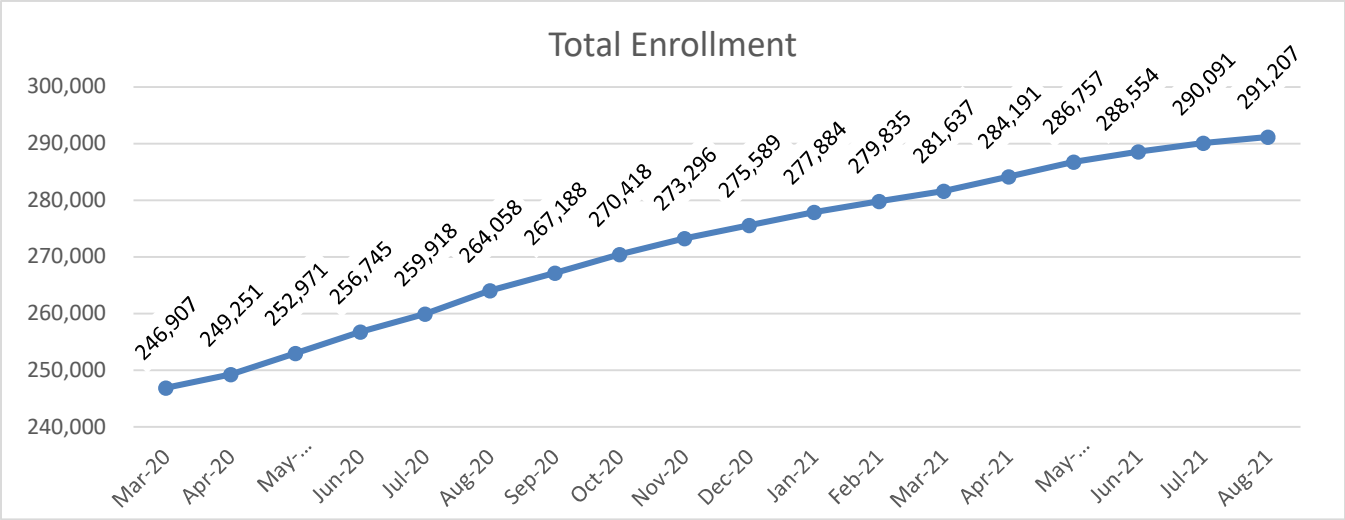



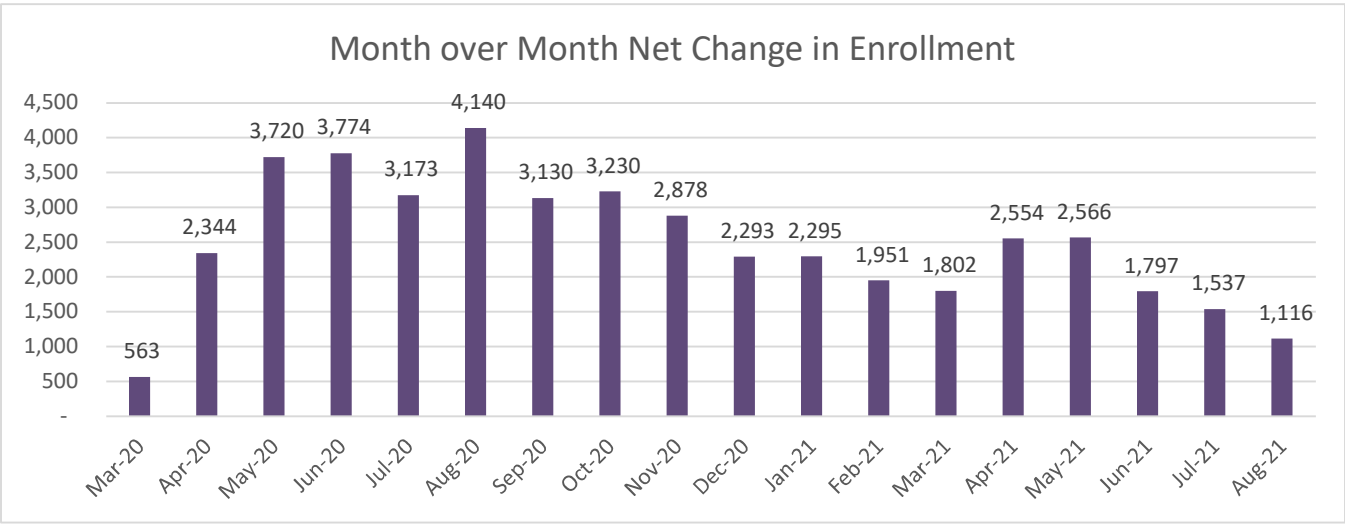



## Net Change in Enrollment



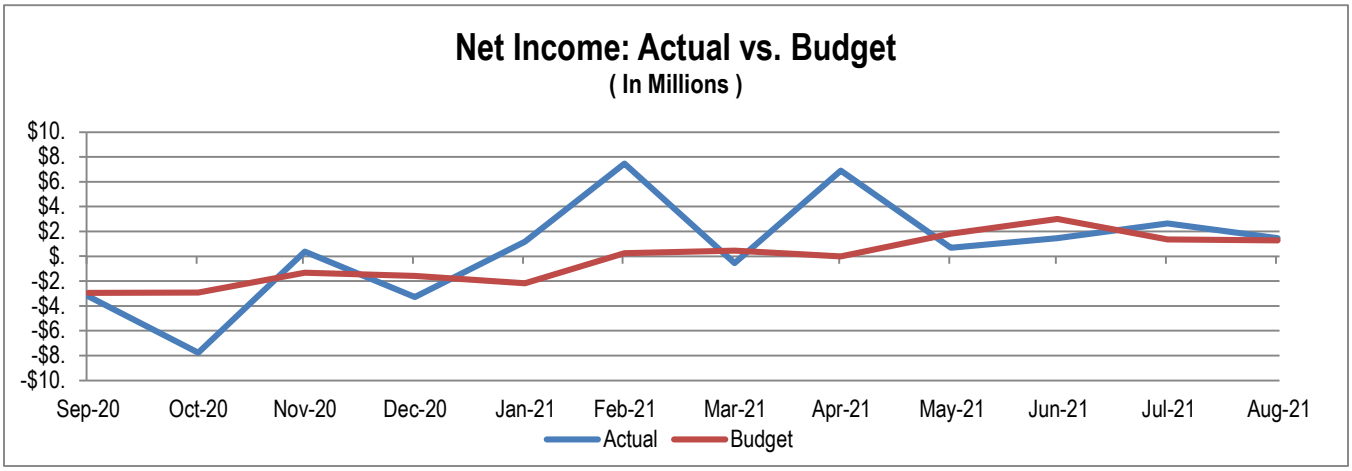




- Total Enrollment continues to increase however, the rate of increase has fallen from the high of 4,140 members in August 2020. The change in the rate of increase will be a considered in enrollment projections for the remainder of the fiscal and calendar year.

**Net Income**

- For the month ended August 31, 2021:
  - Actual Net Income: $1.5 million.
  - Budgeted Net Income: $1.3 million.

- For the fiscal YTD ended August 31, 2021:
  - Actual Net Income: $4.1 million.
  - Budgeted Net Income: $2.6 million.

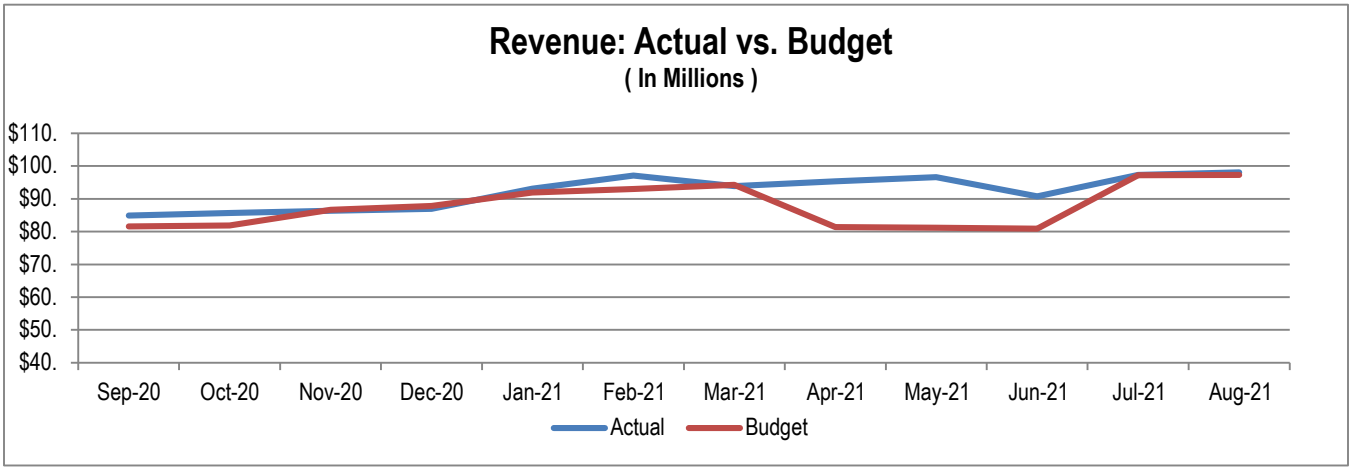



- The favorable variance of $194,000 in the current month is primarily due to:
  - Favorable $777,000 higher than anticipated Revenue.
  - Unfavorable $1.6 million higher than anticipated Medical Expense.
  - Favorable $1.0 million lower than anticipated Administrative Expense.

## Revenue

- For the month ended August 31, 2021:
  - Actual Revenue: $98.1 million.
  - Budgeted Revenue: $97.4 million.

- For the fiscal YTD ended August 31, 2021:
  - Actual Revenue: $195.4 million.
  - Budgeted Revenue: $194.6 million.

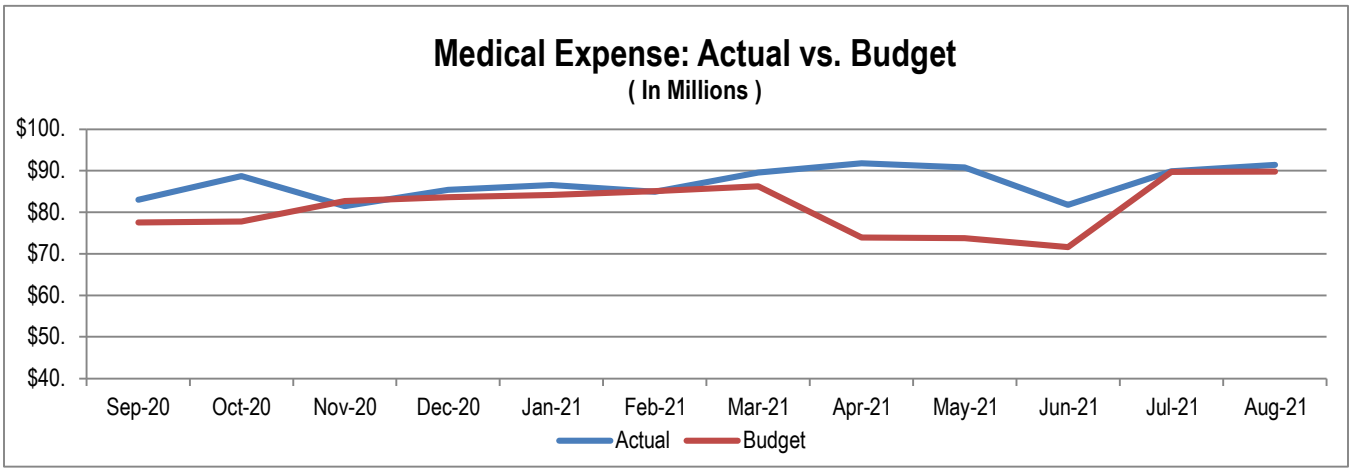



- For the month ended August 31, 2021, the favorable revenue variance of $777,000 is mainly due to favorable Behavioral Health supplemental revenue.

## Medical Expense

- For the month ended August 31, 2021:
  - Actual Medical Expense: $91.4 million.
  - Budgeted Medical Expense: $89.8 million.

- For the fiscal YTD ended August 31, 2021:
  - Actual Medical Expense: $181.2 million.
  - Budgeted Medical Expense: $179.5 million.




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

- For August, updates to Fee-For-Service (FFS) decreased the estimate for unpaid Medical Expenses for prior months by $1.3 million. Year-to-date, the estimate for prior years decreased by $3.3 million vs. Budget (per table below).

## Medical Expense - Actual vs. Budget (In Dollars)

**Adjusted to Eliminate the Impact of Prior Period IBNP Estimates**

| | Actual | | | Budget | Variance Actual vs. Budget Favorable/(Unfavorable) | |
|---|---|---|---|---|---|---|
| | Excluding IBNP Change | Change in IBNP | Reported | | $ | % |
| **Capitated Medical Expense** | $43,960,015 | $0 | $43,960,015 | $43,420,362 | ($539,653) | -1.2% |
| **Primary Care FFS** | 9,049,551 | (178,852) | 8,870,699 | 8,910,672 | ($138,878) | -1.6% |
| **Specialty Care FFS** | 9,390,914 | (7,748) | 9,383,166 | 9,343,519 | ($47,395) | -0.5% |
| **Outpatient FFS** | 16,979,806 | (1,004,135) | 15,975,671 | 16,442,916 | ($536,890) | -3.3% |
| **Ancillary FFS** | 8,431,039 | 18,121 | 8,449,160 | 7,589,065 | ($841,973) | -11.1% |
| **Pharmacy FFS** | 31,928,684 | (989,042) | 30,939,642 | 30,815,320 | ($1,113,364) | -3.6% |
| **ER Services FFS** | 8,607,250 | 208,179 | 8,815,429 | 7,385,361 | ($1,221,889) | -16.5% |
| **Inpatient Hospital & SNF FFS** | 52,220,282 | (1,301,584) | 50,918,698 | 50,959,807 | ($1,260,475) | -2.5% |
| **Other Benefits & Services** | 3,627,392 | 0 | 3,627,392 | 4,383,119 | $755,727 | 17.2% |
| **Net Reinsurance** | 292,380 | 0 | 292,380 | 264,570 | ($27,810) | -10.5% |
| **Provider Incentive** | 0 | 0 | 0 | 0 | $0 | - |
| | **$184,487,313** | **($3,255,061)** | **$181,232,252** | **$179,514,711** | **($4,972,602)** | **-2.8%** |

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

**Adjusted to Eliminate the Impact of Prior Year IBNP Estimates**

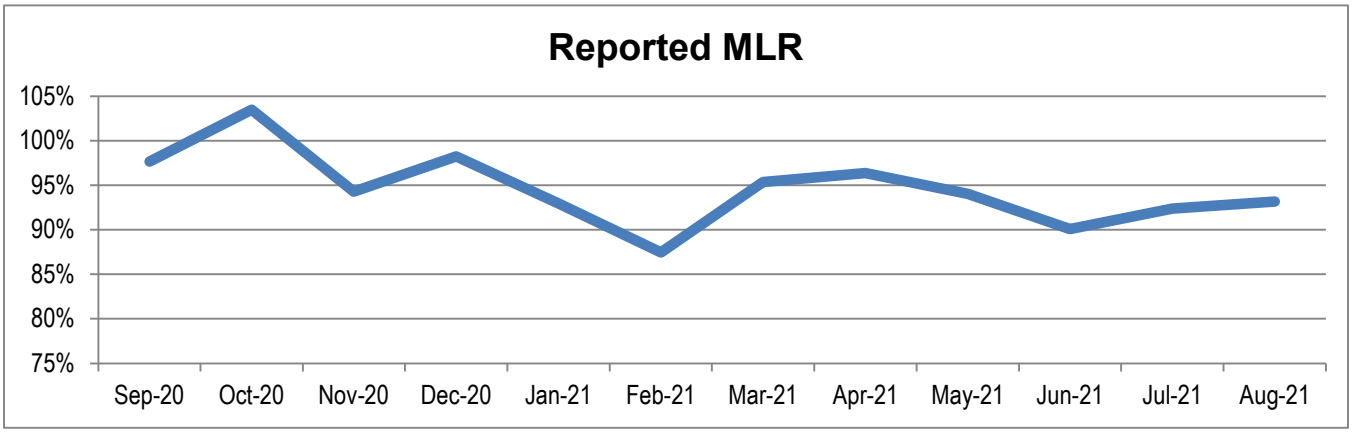
| | Actual | | | Budget | Variance Actual vs. Budget Favorable/(Unfavorable) | |
|---|---|---|---|---|---|---|
| | Excluding IBNP Change | Change in IBNP | Reported | | $ | % |
| **Capitated Medical Expense** | $75.62 | $0.00 | $75.62 | $75.19 | ($0.43) | -0.6% |
| **Primary Care FFS** | 15.57 | (0.31) | 15.26 | 15.43 | (0.14) | -0.9% |
| **Specialty Care FFS** | 16.16 | (0.01) | 16.14 | 16.18 | 0.02 | 0.2% |
| **Outpatient FFS** | 29.21 | (1.73) | 27.48 | 28.47 | (0.74) | -2.6% |
| **Ancillary FFS** | 14.50 | 0.03 | 14.53 | 13.14 | (1.36) | -10.4% |
| **Pharmacy FFS** | 54.93 | (1.70) | 53.23 | 53.36 | (1.56) | -2.9% |
| **ER Services FFS** | 14.81 | 0.36 | 15.17 | 12.79 | (2.02) | -15.8% |
| **Inpatient Hospital & SNF FFS** | 89.83 | (2.24) | 87.59 | 88.24 | (1.59) | -1.8% |
| **Other Benefits & Services** | 6.24 | 0.00 | 6.24 | 7.59 | 1.35 | 17.8% |
| **Net Reinsurance** | 0.50 | 0.00 | 0.50 | 0.46 | (0.04) | -9.8% |
| **Provider Incentive** | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | - |
| | **$317.37** | **($5.60)** | **$311.77** | **$310.86** | **($6.51)** | **-2.1%** |

- Excluding the effect of prior year estimates for IBNP, year-to-date medical expense variance is $5.0 million unfavorable to budget. On a PMPM basis, medical expense is 2.1% unfavorable to budget.
    - Pharmacy Expense is 3.6% higher than budget driven by unfavorable PBM and Non-PBM unit cost in the SPD, ACA OE, Adult, Child, and Group Care populations.

- Inpatient Expense is over budget by 2.5% due to unfavorable SPD unit cost and utilization, primarily offset by favorable utilization in the Child population.
- Other Benefits & Services are favorable to budget, primarily due to open positions in the Health Care Services Organization.
- Ancillary Expense is above budget due to Home Heath, DME, Outpatient Therapy, Laboratory & Radiology and Ambulance expense, offset by favorability in the CBAS, Non-Emergency Transportation, Other Medical Professional and Hospice service categories. Overall utilization is unfavorable, offset by favorable unit cost.
- Outpatient Expense is over budget, driven by unfavorable unit cost offset by favorable utilization.
    - Behavioral Health: unfavorable due to unfavorable utilization offset by favorable unit cost trends.
    - Lab & Radiology: unfavorable due to favorable utilization offset by unfavorable unit cost trends.
    - Dialysis: unfavorable due to unfavorable utilization and unit cost trends.
    - Facility-Other: favorable due to favorable utilization offset by unfavorable unit cost trends.
- Capitated Expense is slightly over budget primarily due to higher than budgeted enrollment with our global subcontractor along with increased behavioral health utilization, partially offset by lower transportation expenses.
- Emergency Room Expense is unfavorable, due to unfavorable unit cost, offset by favorable utilization across all member categories except for the Duals population which is driven by more favorable utilization.
- Specialty Care is slightly favorable to budget, due to unfavorable utilization more than offset by favorable unit cost. Expenses across all member groups are favorable except for the Group Care line of business.
- Primary Care Expense is higher than budget driven by unfavorable utilization except for the Child and Dual populations which are driven by favorable utilization.

**Medical Loss Ratio (MLR)**

- The Medical Loss Ratio (total reported medical expense divided by operating revenue) was 93.2% for the month and 92.8% for the fiscal year-to-date.




## Administrative Expense

- For the month ended August 31, 2021:
  - Actual Administrative Expense: $5.2 million.
  - Budgeted Administrative Expense: $6.3 million.

- For the fiscal YTD ended August 31, 2021:
  - Actual Administrative Expense: $10.0 million.
  - Budgeted Administrative Expense: $12.5 million.

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

| Month | | | | | Year-to-Date | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | Variance $ | Variance % | | Actual | Budget | Variance $ | Variance % |
| $2,993,202 | $3,508,634 | $515,432 | 14.7% | Employee Expense | $5,768,915 | $6,893,685 | $1,124,770 | 16.3% |
| 657,477 | 647,328 | (10,149) | -1.6% | Medical Benefits Admin Expense | 1,334,781 | 1,293,999 | (40,782) | -3.2% |
| 737,939 | 1,052,754 | 314,816 | 29.9% | Purchased & Professional Services | 1,299,405 | 2,164,554 | 865,149 | 40.0% |
| 851,239 | 1,042,872 | 191,632 | 18.4% | Other Admin Expense | 1,639,046 | 2,117,799 | 478,753 | 22.6% |
| $5,239,857 | $6,251,588 | $1,011,731 | 16.2% | Total Administrative Expense | $10,042,148 | $12,470,037 | $2,427,889 | 19.5% |

The year-to-date variances include:

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

- Administrative expense represented 5.3% of net revenue for the month and 5.1% of net revenue year-to-date.

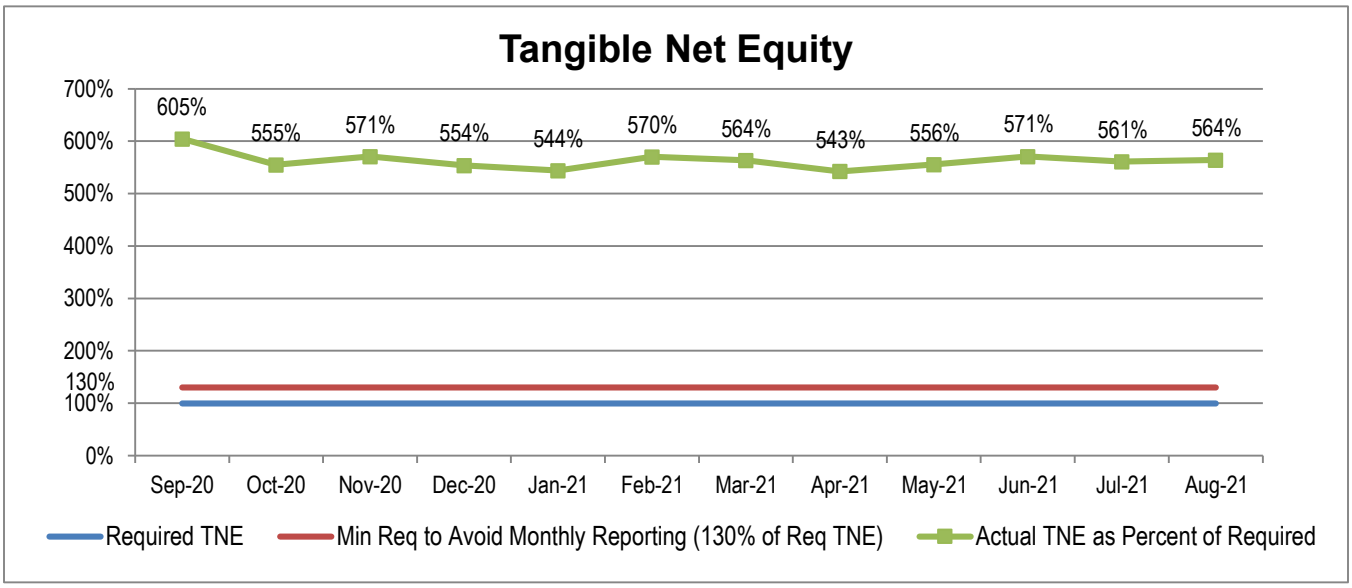
## Other Income / (Expense)

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

- Fiscal year-to-date interest income from investments is $54,000.
- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims or recalculated interest on previously paid claims is $72,000.

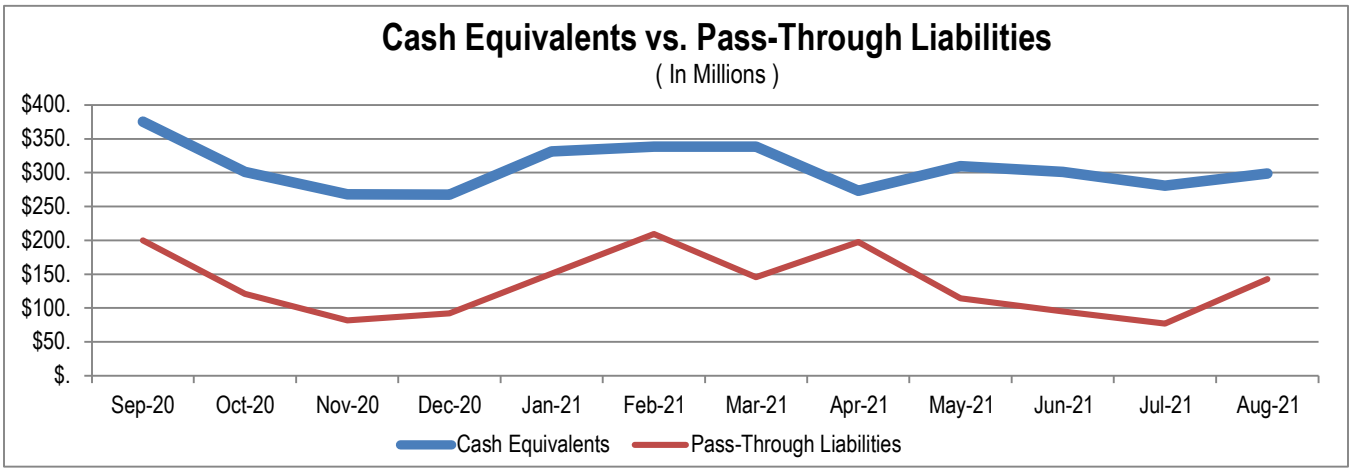
## Tangible Net Equity (TNE)

- 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 $37.1 million
    - Actual TNE $209.5 million
    - Excess TNE $172.4 million
    - TNE as % of Required TNE 564%




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

- Key Metrics
    - Cash & Cash Equivalents $298.8 million
    - Pass-Through Liabilities $142.9 million
    - Uncommitted Cash $155.9 million
    - Working Capital $203.1 million
    - Current Ratio 1.69 (regulatory minimum is 1.0)




## Capital Investment

- No Capital Assets have been purchased year-to-date.
- Annual capital budget: $1.4 million.

## 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 August 31, 2021**

| CURRENT MONTH | | | | | FISCAL YEAR TO DATE | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | $ Variance (Unfavorable) | % Variance (Unfavorable) | Account Description | Actual | Budget | $ Variance (Unfavorable) | % Variance (Unfavorable) |
| | | | | **MEMBERSHIP** | | | | |
| 285,330 | 282,985 | 2,345 | 0.8% | 1 - Medi-Cal | 569,486 | 565,603 | 3,883 | 0.7% |
| 5,877 | 5,939 | (62) | (1.0%) | 2 - Group Care | 11,812 | 11,878 | (66) | (0.6%) |
| **291,207** | **288,924** | **2,283** | **0.8%** | **3 - Total Member Months** | **581,298** | **577,481** | **3,817** | **0.7%** |
| | | | | **REVENUE** | | | | |
| **$98,128,068** | **$97,351,220** | **$776,849** | **0.8%** | **4 - TOTAL REVENUE** | **$195,391,249** | **$194,579,505** | **$811,744** | **0.4%** |
| | | | | **MEDICAL EXPENSES** | | | | |
| | | | | **Capitated Medical Expenses:** | | | | |
| 22,328,717 | 21,576,747 | (751,970) | (3.5%) | 5 - Capitated Medical Expense | 43,960,016 | 43,420,365 | (539,651) | (1.2%) |
| | | | | **Fee for Service Medical Expenses:** | | | | |
| 25,582,575 | 25,559,673 | (22,902) | (0.1%) | 6 - Inpatient Hospital & SNF FFS Expense | 50,918,697 | 50,959,807 | 41,110 | 0.1% |
| 4,408,905 | 4,464,675 | 55,770 | 1.2% | 7 - Primary Care Physician FFS Expense | 8,870,699 | 8,910,672 | 39,973 | 0.4% |
| 4,714,589 | 4,696,494 | (18,095) | (0.4%) | 8 - Specialty Care Physician Expense | 9,383,167 | 9,343,519 | (39,648) | (0.4%) |
| 4,040,202 | 3,804,417 | (235,785) | (6.2%) | 9 - Ancillary Medical Expense | 8,449,159 | 7,589,065 | (860,094) | (11.3%) |
| 8,368,657 | 8,235,801 | (132,856) | (1.6%) | 10 - Outpatient Medical Expense | 15,975,670 | 16,442,916 | 467,246 | 2.8% |
| 3,999,056 | 3,701,179 | (297,877) | (8.0%) | 11 - Emergency Expense | 8,815,430 | 7,385,360 | (1,430,070) | (19.4%) |
| 15,868,469 | 15,463,702 | (404,767) | (2.6%) | 12 - Pharmacy Expense | 30,939,643 | 30,815,321 | (124,322) | (0.4%) |
| 66,982,453 | 65,925,941 | (1,056,512) | (1.6%) | 13 - Total Fee for Service Expense | 133,352,465 | 131,446,660 | (1,905,805) | (1.4%) |
| 1,945,055 | 2,211,762 | 266,707 | 12.1% | 14 - Other Benefits & Services | 3,627,391 | 4,383,119 | 755,728 | 17.2% |
| 150,325 | 132,599 | (17,726) | (13.4%) | 15 - Reinsurance Expense | 292,380 | 264,569 | (27,811) | (10.5%) |
| **91,406,550** | **89,847,049** | **(1,559,501)** | **(1.7%)** | **17 - TOTAL MEDICAL EXPENSES** | **181,232,252** | **179,514,713** | **(1,717,539)** | **(1.0%)** |
| **6,721,519** | **7,504,170** | **(782,652)** | **(10.4%)** | **18 - GROSS MARGIN** | **14,158,998** | **15,064,793** | **(905,795)** | **(6.0%)** |
| | | | | **ADMINISTRATIVE EXPENSES** | | | | |
| 2,993,201 | 3,508,634 | 515,433 | 14.7% | 19 - Personnel Expense | 5,768,916 | 6,893,685 | 1,124,769 | 16.3% |
| 657,477 | 647,328 | (10,148) | (1.6%) | 20 - Benefits Administration Expense | 1,334,782 | 1,293,999 | (40,783) | (3.2%) |
| 737,938 | 1,052,754 | 314,816 | 29.9% | 21 - Purchased & Professional Services | 1,299,404 | 2,164,555 | 865,151 | 40.0% |
| 851,238 | 1,042,872 | 191,634 | 18.4% | 22 - Other Administrative Expense | 1,639,045 | 2,117,798 | 478,753 | 22.6% |
| **5,239,853** | **6,251,589** | **1,011,735** | **16.2%** | **23 -Total Administrative Expense** | **10,042,147** | **12,470,036** | **2,427,890** | **19.5%** |
| **1,481,665** | **1,252,582** | **229,084** | **18.3%** | **24 - NET OPERATING INCOME / (LOSS)** | **4,116,851** | **2,594,756** | **1,522,095** | **58.7%** |
| | | | | **OTHER INCOME / EXPENSE** | | | | |
| **(26,624)** | **8,750** | **(35,374)** | **(404.3%)** | **25 - Total Other Income / (Expense)** | **(16,197)** | **17,502** | **(33,699)** | **(192.5%)** |
| **$1,455,041** | **$1,261,332** | **$193,710** | **15.4%** | **26 - NET INCOME / (LOSS)** | **$4,100,654** | **$2,612,258** | **$1,488,396** | **57.0%** |
| 5.3% | 6.4% | 1.1% | 16.8% | 27 - Admin Exp % of Revenue | 5.1% | 6.4% | 1.3% | 19.8% |

**ALAMEDA ALLIANCE FOR HEALTH**
**SUMMARY BALANCE SHEET 2022**
**CURRENT MONTH VS. PRIOR MONTH**
**August 31, 2021**

| | August | July | Difference | % Difference |
|---|---|---|---|---|
| **CURRENT ASSETS:** | | | | |
| Cash & Equivalents | | | | |
| Cash | $35,679,871 | $42,829,684 | ($7,149,813) | -16.69% |
| Short-Term Investments | 263,127,849 | 238,125,431 | 25,002,418 | 10.50% |
| Interest Receivable | 30,299 | 17,721 | 12,578 | 70.97% |
| Other Receivables - Net | 188,695,221 | 134,269,742 | 54,425,479 | 40.53% |
| Prepaid Expenses | 6,061,240 | 6,149,432 | (88,192) | -1.43% |
| Prepaid Inventoried Items | 3,971 | 39,721 | (35,750) | -90.00% |
| CalPERS Net Pension Asset | (1,665,176) | (1,665,176) | 0 | 0.00% |
| Deferred CalPERS Outflow | 4,501,849 | 4,501,849 | 0 | 0.00% |
| **TOTAL CURRENT ASSETS** | **496,435,124** | **424,268,404** | **72,166,720** | **17.01%** |
| **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 | 9,605,191 | 9,605,191 | 0 | 0.00% |
| Furniture And Equipment | 11,540,223 | 11,540,223 | 0 | 0.00% |
| Leasehold Improvement | 902,447 | 902,447 | 0 | 0.00% |
| Construction in Process | 63,615 | 63,615 | 0 | 0.00% |
| Internally-Developed Software | 14,824,002 | 14,824,002 | 0 | 0.00% |
| Fixed Assets at Cost | 36,935,478 | 36,935,478 | 0 | 0.00% |
| Less: Accumulated Depreciation | (30,861,700) | (30,774,390) | (87,310) | 0.28% |
| **NET PROPERTY AND EQUIPMENT** | **6,073,778** | **6,161,088** | **(87,310)** | **-1.42%** |
| **TOTAL ASSETS** | **$502,858,902** | **$430,779,492** | **$72,079,410** | **16.73%** |
| **CURRENT LIABILITIES:** | | | | |
| Accounts Payable | $2,937,058 | $2,691,784 | $245,274 | 9.11% |
| Pass-Through Liabilities | 142,886,342 | 76,986,756 | 65,899,586 | 85.60% |
| Claims Payable | 28,695,918 | 26,566,563 | 2,129,355 | 8.02% |
| IBNP Reserves | 102,625,801 | 100,447,275 | 2,178,526 | 2.17% |
| Payroll Liabilities | 4,575,329 | 4,371,376 | 203,953 | 4.67% |
| CalPERS Deferred Inflow | 859,093 | 859,093 | 0 | 0.00% |
| Risk Sharing | 10,349,849 | 10,349,849 | 0 | 0.00% |
| Provider Grants/ New Health Program | 418,818 | 451,143 | (32,325) | -7.17% |
| **TOTAL CURRENT LIABILITIES** | **293,348,207** | **222,723,838** | **70,624,369** | **31.71%** |
| **TOTAL LIABILITIES** | **293,348,207** | **222,723,838** | **70,624,369** | **31.71%** |
| **NET WORTH:** | | | | |
| Contributed Capital | 840,233 | 840,233 | 0 | 0.00% |
| Restricted & Unrestricted Funds | 204,569,809 | 204,569,809 | 0 | 0.00% |
| Year-to Date Net Income / (Loss) | 4,100,654 | 2,645,613 | 1,455,041 | 55.00% |
| **TOTAL NET WORTH** | **209,510,696** | **208,055,654** | **1,455,041** | **0.70%** |
| **TOTAL LIABILITIES AND NET WORTH** | **$502,858,902** | **$430,779,492** | **$72,079,410** | **16.73%** |

**CONFIDENTIAL**
*For Management and Internal Purposes Only.*

9. BALSHEET 22

09/21/21
**REPORT #3**

**ALAMEDA ALLIANCE FOR HEALTH**
**CASH FLOW STATEMENT**
**FOR THE MONTH AND FISCAL YTD ENDED 8/31/2021**

| | MONTH | 3 MONTHS | 6 MONTHS | YTD |
|---|---|---|---|---|
| **CASH FLOW STATEMENT:** | | | | |
| **Cash Flows from Operating Activities:** | | | | |
| Cash Received From: | | | | |
| Capitation Received from State of CA | $39,590,089 | $227,680,428 | $569,508,575 | $133,242,659 |
| Commercial Premium Revenue | 2,195,530 | 6,645,709 | 13,410,550 | 4,410,728 |
| Other Income | 198,697 | 893,135 | 1,834,721 | 395,474 |
| Investment Income | 18,925 | 58,238 | 161,802 | 38,479 |
| Cash Paid To: | | | | |
| Medical Expenses | (85,414,809) | (257,623,043) | (535,030,449) | (177,009,063) |
| Vendor & Employee Expenses | (4,635,413) | (21,589,706) | (28,558,285) | (11,360,097) |
| Interest Paid | 0 | 0 | 0 | 0 |
| Net Cash Provided By (Used In) Operating Activities | (48,046,981) | (43,935,239) | 21,326,914 | (50,281,820) |
| **Cash Flows from Financing Activities:** | | | | |
| Purchases of Fixed Assets | 0 | 4,424,625 | 5,831,489 | 0 |
| Net Cash Provided By (Used In) Financing Activities | 0 | 4,424,625 | 5,831,489 | 0 |
| **Cash Flows from Investing Activities:** | | | | |
| Changes in Investments | 0 | 0 | 0 | 0 |
| Restricted Cash | 65,899,586 | 28,552,007 | (66,613,970) | 48,053,805 |
| Net Cash Provided By (Used In) Investing Activities | 65,899,586 | 28,552,007 | (66,613,970) | 48,053,805 |
| Financial Cash Flows | | | | |
| Subordinated Debt Proceeds | 0 | 0 | 0 | 0 |
| **Net Change in Cash** | **17,852,605** | **(10,958,607)** | **(39,455,567)** | **(2,228,015)** |
| **Cash @ Beginning of Period** | 280,955,114 | 309,766,327 | 338,263,286 | 301,035,733 |
| Subtotal | $298,807,719 | $298,807,720 | $298,807,719 | $298,807,718 |
| Rounding | 1 | 0 | 1 | 2 |
| **Cash @ End of Period** | **$298,807,720** | **$298,807,720** | **$298,807,720** | **$298,807,720** |
| **RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:** | | | | |
| **Net Income / (Loss)** | $1,455,041 | $6,364,278 | $13,382,681 | $4,100,654 |
| Depreciation | 87,310 | (2,776,290) | (2,795,061) | 198,360 |
| Net Change in Operating Assets & Liabilities: | | | | |
| Premium & Other Receivables | (54,438,057) | (49,657,499) | 12,186,471 | (52,321,296) |
| Prepaid Expenses | 123,942 | 78,363 | (509,952) | 108,915 |
| Trade Payables | 245,274 | (99,202) | 269,745 | (1,362,081) |
| Claims payable & IBNP | 4,307,881 | 2,973,921 | 9,665,786 | (783,109) |
| Deferred Revenue | 0 | 0 | 0 | 0 |
| Accrued Interest | 0 | 0 | 0 | 0 |
| Other Liabilities | 171,628 | (818,810) | (10,872,755) | (223,262) |
| Subtotal | (48,046,981) | (43,935,239) | 21,326,915 | (50,281,819) |
| Rounding | 0 | 0 | (1) | (1) |
| **Cash Flows from Operating Activities** | **($48,046,981)** | **($43,935,239)** | **$21,326,914** | **($50,281,820)** |
| Rounding Difference | 0 | 0 | (1) | (1) |

**ALAMEDA ALLIANCE FOR HEALTH**
**CASH FLOW STATEMENT**
**FOR THE MONTH AND FISCAL YTD ENDED 8/31/2021**

| | MONTH | 3 MONTHS | 6 MONTHS | YTD |
|---|---|---|---|---|
| **CASH FLOWS FROM OPERATING ACTIVITIES** | | | | |
| **Commercial Premium Cash Flows** | | | | |
| Commercial Premium Revenue | $2,195,530 | $6,645,709 | $13,410,550 | $4,410,728 |
| Total | 2,195,530 | 6,645,709 | 13,410,550 | 4,410,728 |
| **Medi-Cal Premium Cash Flows** | | | | |
| Medi-Cal Revenue | 95,731,753 | 278,718,019 | 556,800,722 | 190,581,850 |
| Allowance for Doubtful Accounts | 0 | 0 | 0 | 0 |
| Deferred Premium Revenue | 0 | 0 | 0 | 0 |
| Premium Receivable | (56,141,664) | (51,037,591) | 12,707,853 | (57,339,191) |
| Total | 39,590,089 | 227,680,428 | 569,508,575 | 133,242,659 |
| **Investment & Other Income Cash Flows** | | | | |
| Other Revenue (Grants) | 198,697 | 893,135 | 1,834,721 | 395,474 |
| Interest Income | 31,503 | 78,955 | 185,653 | 59,207 |
| Interest Receivable | (12,578) | (20,717) | (23,851) | (20,728) |
| Total | 217,622 | 951,373 | 1,996,523 | 433,953 |
| **Medical & Hospital Cash Flows** | | | | |
| Total Medical Expenses | (91,406,550) | (261,965,448) | (534,136,379) | (181,232,252) |
| Other Receivable | 1,716,185 | 1,400,809 | (497,531) | 5,038,623 |
| Claims Payable | 2,129,355 | 4,504,984 | 10,791,622 | (4,768,352) |
| IBNP Payable | 2,178,526 | (5,314,397) | (7,159,169) | 3,985,243 |
| Risk Share Payable | 0 | 3,783,333 | 6,033,333 | 0 |
| Health Program | (32,325) | (32,325) | (10,062,325) | (32,325) |
| Other Liabilities | 0 | 1 | 0 | 0 |
| Total | (85,414,809) | (257,623,043) | (535,030,449) | (177,009,063) |
| **Administrative Cash Flows** | | | | |
| Total Administrative Expenses | (5,295,892) | (18,006,092) | (24,712,587) | (10,114,354) |
| Prepaid Expenses | 123,942 | 78,363 | (509,952) | 108,915 |
| CalPERS Pension Asset | 0 | 0 | 0 | 0 |
| CalPERS Deferred Outflow | 0 | 0 | 0 | 0 |
| Trade Accounts Payable | 245,274 | (99,202) | 269,745 | (1,362,081) |
| Other Accrued Liabilities | 0 | 0 | 0 | 0 |
| Payroll Liabilities | 203,953 | (786,485) | (810,430) | (190,937) |
| Depreciation Expense | 87,310 | (2,776,290) | (2,795,061) | 198,360 |
| Total | (4,635,413) | (21,589,706) | (28,558,285) | (11,360,097) |
| **Interest Paid** | | | | |
| Debt Interest Expense | 0 | 0 | 0 | 0 |
| **Total Cash Flows from Operating Activities** | **(48,046,981)** | **(43,935,239)** | **21,326,914** | **(50,281,820)** |

**ALAMEDA ALLIANCE FOR HEALTH**
**CASH FLOW STATEMENT**
**FOR THE MONTH AND FISCAL YTD ENDED 8/31/2021**

| | MONTH | 3 MONTHS | 6 MONTHS | YTD |
|---|---|---|---|---|
| **CASH FLOWS FROM INVESTING ACTIVITIES** | | | | |
| **Restricted Cash & Other Asset Cash Flows** | | | | |
| Provider Pass-Thru-Liabilities | 65,899,586 | 28,552,036 | (66,613,970) | 48,053,805 |
| Restricted Cash | 0 | (29) | 0 | 0 |
| | 65,899,586 | 28,552,007 | (66,613,970) | 48,053,805 |
| **Fixed Asset Cash Flows** | | | | |
| Depreciation expense | 87,310 | (2,776,290) | (2,795,061) | 198,360 |
| Fixed Asset Acquisitions | 0 | 4,424,625 | 5,831,489 | 0 |
| Change in A/D | (87,310) | 2,776,290 | 2,795,061 | (198,360) |
| | 0 | 4,424,625 | 5,831,489 | 0 |
| **Total Cash Flows from Investing Activities** | **65,899,586** | **32,976,632** | **(60,782,481)** | **48,053,805** |
| **Financing Cash Flows** | | | | |
| Subordinated Debt Proceeds | 0 | 0 | 0 | 0 |
| **Total Cash Flows** | **17,852,605** | **(10,958,607)** | **(39,455,567)** | **(2,228,015)** |
| Rounding | 1 | 0 | 1 | 2 |
| **Cash @ Beginning of Period** | 280,955,114 | 309,766,327 | 338,263,286 | 301,035,733 |
| **Cash @ End of Period** | **$298,807,720** | **$298,807,720** | **$298,807,720** | **$298,807,720** |
| Difference (rounding) | 0 | 0 | 0 | 0 |

**ALAMEDA ALLIANCE FOR HEALTH**
**CASH FLOW STATEMENT**
**FOR THE MONTH AND FISCAL YTD ENDED 8/31/2021**

| | MONTH | 3 MONTHS | 6 MONTHS | YTD |
|---|---|---|---|---|
| **NET INCOME RECONCILIATION** | | | | |
| **Net Income / (Loss)** | $1,455,041 | $6,364,278 | $13,382,681 | $4,100,654 |
| **Add back: Depreciation** | 87,310 | (2,776,290) | (2,795,061) | 198,360 |
| **Receivables** | | | | |
| Premiums Receivable | (56,141,664) | (51,037,591) | 12,707,853 | (57,339,191) |
| First Care Receivable | 0 | 0 | 0 | 0 |
| Family Care Receivable | 0 | 0 | 0 | 0 |
| Healthy Kids Receivable | 0 | 0 | 0 | 0 |
| Interest Receivable | (12,578) | (20,717) | (23,851) | (20,728) |
| Other Receivable | 1,716,185 | 1,400,809 | (497,531) | 5,038,623 |
| FQHC Receivable | 0 | 0 | 0 | 0 |
| Allowance for Doubtful Accounts | 0 | 0 | 0 | 0 |
| Total | (54,438,057) | (49,657,499) | 12,186,471 | (52,321,296) |
| **Prepaid Expenses** | 123,942 | 78,363 | (509,952) | 108,915 |
| **Trade Payables** | 245,274 | (99,202) | 269,745 | (1,362,081) |
| **Claims Payable, IBNR & Risk Share** | | | | |
| IBNP | 2,178,526 | (5,314,397) | (7,159,169) | 3,985,243 |
| Claims Payable | 2,129,355 | 4,504,984 | 10,791,622 | (4,768,352) |
| Risk Share Payable | 0 | 3,783,333 | 6,033,333 | 0 |
| Other Liabilities | 0 | 1 | 0 | 0 |
| Total | 4,307,881 | 2,973,921 | 9,665,786 | (783,109) |
| **Unearned Revenue** | | | | |
| Total | 0 | 0 | 0 | 0 |
| **Other Liabilities** | | | | |
| Accrued Expenses | 0 | 0 | 0 | 0 |
| Payroll Liabilities | 203,953 | (786,485) | (810,430) | (190,937) |
| Health Program | (32,325) | (32,325) | (10,062,325) | (32,325) |
| Accrued Sub Debt Interest | 0 | 0 | 0 | 0 |
| Total Change in Other Liabilities | 171,628 | (818,810) | (10,872,755) | (223,262) |
| **Cash Flows from Operating Activities** | **($48,046,981)** | **($43,935,239)** | **$21,326,915** | **($50,281,819)** |
| Difference (rounding) | 0 | 0 | 1 | 1 |

**ALAMEDA ALLIANCE FOR HEALTH**
**OPERATING STATEMENT BY CATEGORY OF AID**

**GAAP BASIS**
**FOR THE MONTH OF AUGUST 2021**

| | Child | Adult | Medi-Cal SPD | ACA OE | Duals | Medi-Cal Total | Group Care | Grand Total |
|---|---|---|---|---|---|---|---|---|
| **Enrollment** | 97,324 | 41,519 | 26,316 | 99,783 | 20,388 | 285,330 | 5,877 | 291,207 |
| **Net Revenue** | $12,570,140 | $13,882,243 | $28,342,975 | $37,642,303 | $3,494,737 | $95,932,399 | $2,195,669 | $98,128,068 |
| **Medical Expense** | $10,136,713 | $13,899,914 | $27,015,302 | $35,600,294 | $2,796,123 | $89,448,346 | $1,958,204 | $91,406,550 |
| **Gross Margin** | $2,433,427 | ($17,671) | $1,327,673 | $2,042,009 | $698,614 | $6,484,053 | $237,466 | $6,721,519 |
| **Administrative Expense** | $430,437 | $714,643 | $1,837,747 | $1,925,193 | $168,604 | $5,076,624 | $163,229 | $5,239,853 |
| **Operating Income / (Expense)** | $2,002,990 | ($732,314) | ($510,074) | $116,816 | $530,010 | $1,407,428 | $74,237 | $1,481,665 |
| **Other Income / (Expense)** | ($4,528) | ($29,316) | ($937) | $7,781 | $150 | ($26,850) | $226 | ($26,624) |
| **Net Income / (Loss)** | $1,998,462 | ($761,630) | ($511,011) | $124,597 | $530,160 | $1,380,578 | $74,463 | $1,455,041 |
| | | | | | | | | |
| **Revenue PMPM** | $129.16 | $334.36 | $1,077.02 | $377.24 | $171.41 | $336.22 | $373.60 | $336.97 |
| **Medical Expense PMPM** | $104.15 | $334.78 | $1,026.57 | $356.78 | $137.15 | $313.49 | $333.20 | $313.89 |
| **Gross Margin PMPM** | $25.00 | ($0.43) | $50.45 | $20.46 | $34.27 | $22.72 | $40.41 | $23.08 |
| **Administrative Expense PMPM** | $4.42 | $17.21 | $69.83 | $19.29 | $8.27 | $17.79 | $27.77 | $17.99 |
| **Operating Income / (Expense) PMPM** | $20.58 | ($17.64) | ($19.38) | $1.17 | $26.00 | $4.93 | $12.63 | $5.09 |
| **Other Income / (Expense) PMPM** | ($0.05) | ($0.71) | ($0.04) | $0.08 | $0.01 | ($0.09) | $0.04 | ($0.09) |
| **Net Income / (Loss) PMPM** | $20.53 | ($18.34) | ($19.42) | $1.25 | $26.00 | $4.84 | $12.67 | $5.00 |
| **Medical Loss Ratio** | 80.6% | 100.1% | 95.3% | 94.6% | 80.0% | 93.2% | 89.2% | 93.2% |
| **Gross Margin Ratio** | 19.4% | -0.1% | 4.7% | 5.4% | 20.0% | 6.8% | 10.8% | 6.8% |
| **Administrative Expense Ratio** | 3.4% | 5.1% | 6.5% | 5.1% | 4.8% | 5.3% | 7.4% | 5.3% |
| **Net Income Ratio** | 15.9% | -5.5% | -1.8% | 0.3% | 15.2% | 1.4% | 3.4% | 1.5% |

**ALAMEDA ALLIANCE FOR HEALTH**
**OPERATING STATEMENT BY CATEGORY OF AID**

**GAAP BASIS**
**FOR THE FISCAL YEAR TO DATE - AUGUST 2021**

| | Medi-Cal | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Child | Adult* | SPD* | ACA OE | Duals | Medi-Cal Total | Group Care | Grand Total |
| Member Months | 194,503 | 82,877 | 52,636 | 198,888 | 40,582 | 569,486 | 11,812 | 581,298 |
| Net Revenue | $25,152,844 | $27,407,787 | $56,304,091 | $75,139,963 | $6,975,697 | $190,980,382 | $4,410,867 | $195,391,249 |
| Medical Expense | $20,089,545 | $25,277,523 | $56,237,352 | $70,012,229 | $5,530,566 | $177,147,215 | $4,085,037 | $181,232,252 |
| Gross Margin | $5,063,300 | $2,130,264 | $66,739 | $5,127,734 | $1,445,131 | $13,833,167 | $325,831 | $14,158,998 |
| Administrative Expense | $829,488 | $1,360,088 | $3,519,234 | $3,689,309 | $324,861 | $9,722,979 | $319,168 | $10,042,147 |
| Operating Income / (Expense) | $4,233,812 | $770,176 | ($3,452,495) | $1,438,425 | $1,120,270 | $4,110,188 | $6,663 | $4,116,851 |
| Other Income / (Expense) | ($3,058) | ($26,232) | $1,293 | $10,960 | $428 | ($16,609) | $412 | ($16,197) |
| Net Income / (Loss) | $4,230,753 | $743,945 | ($3,451,202) | $1,449,386 | $1,120,698 | $4,093,579 | $7,075 | $4,100,654 |
| Revenue PMPM | $129.32 | $330.70 | $1,069.69 | $377.80 | $171.89 | $335.36 | $373.42 | $336.13 |
| Medical Expense PMPM | $103.29 | $305.00 | $1,068.42 | $352.02 | $136.28 | $311.07 | $345.84 | $311.77 |
| Gross Margin PMPM | $26.03 | $25.70 | $1.27 | $25.78 | $35.61 | $24.29 | $27.58 | $24.36 |
| Administrative Expense PMPM | $4.26 | $16.41 | $66.86 | $18.55 | $8.01 | $17.07 | $27.02 | $17.28 |
| Operating Income / (Expense) PMPM | $21.77 | $9.29 | ($65.59) | $7.23 | $27.61 | $7.22 | $0.56 | $7.08 |
| Other Income / (Expense) PMPM | ($0.02) | ($0.32) | $0.02 | $0.06 | $0.01 | ($0.03) | $0.03 | ($0.03) |
| Net Income / (Loss) PMPM | $21.75 | $8.98 | ($65.57) | $7.29 | $27.62 | $7.19 | $0.60 | $7.05 |
| Medical Loss Ratio | 79.9% | 92.2% | 99.9% | 93.2% | 79.3% | 92.8% | 92.6% | 92.8% |
| Gross Margin Ratio | 20.1% | 7.8% | 0.1% | 6.8% | 20.7% | 7.2% | 7.4% | 7.2% |
| Administrative Expense Ratio | 3.3% | 5.0% | 6.3% | 4.9% | 4.7% | 5.1% | 7.2% | 5.1% |
| Net Income Ratio | 16.8% | 2.7% | -6.1% | 1.9% | 16.1% | 2.1% | 0.2% | 2.1% |

*** 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**
**CURRENT VS. PRIOR PERIOD**
**FOR THE MONTH AND FISCAL YTD ENDED August 31, 2021**

| CURRENT MONTH VS. PRIOR MONTH | | | | | CURRENT YEAR VS. PRIOR YEAR | | | |
|---|---|---|---|---|---|---|---|---|
| Current Month | Prior Month | $ Variance (Unfavorable) | % Variance (Unfavorable) | | Current YTD | Prior YTD | $ Variance (Unfavorable) | % Variance (Unfavorable) |
| | | | | **ADMINISTRATIVE EXPENSE SUMMARY** | | | | |
| $2,993,684 | $2,775,715 | ($217,969) | (7.9%) | Personnel Expenses | $5,769,399 | $5,157,818 | ($611,581) | (11.9%) |
| 737,938 | 561,466 | (176,472) | (31.4%) | Purchased & Professional Services | 1,299,404 | 1,276,822 | (22,582) | (1.8%) |
| 267,469 | 278,225 | 10,756 | 3.9% | Occupancy | 545,693 | 760,140 | 214,447 | 28.2% |
| 137,435 | 25,049 | (112,386) | (448.7%) | Printing Postage & Promotion | 162,484 | 160,384 | (2,100) | (1.3%) |
| 437,203 | 479,870 | 42,667 | 8.9% | Licenses Insurance & Fees | 917,073 | 848,188 | (68,885) | (8.1%) |
| 666,607 | 681,969 | 15,362 | 2.3% | Supplies & Other Expenses | 1,348,576 | 1,267,054 | (81,522) | (6.4%) |
| 2,246,652 | 2,026,578 | (220,074) | (10.9%) | Total Other Administrative Expense | 4,273,231 | 4,312,589 | 39,358 | 0.9% |
| **$5,240,336** | **$4,802,294** | **($438,043)** | **(9.1%)** | **Total Administrative Expenses** | **$10,042,630** | **$9,470,407** | **($572,223)** | **(6.0%)** |

# ALAMEDA ALLIANCE FOR HEALTH
**ADMINISTRATIVE EXPENSE DETAIL**
**CURRENT VS. PRIOR PERIOD**
**FOR THE MONTH AND FISCAL YTD ENDED August 31, 2021**

| CURRENT MONTH VS. PRIOR MONTH | | | | | CURRENT YEAR VS. PRIOR YEAR | | | |
|---|---|---|---|---|---|---|---|---|
| Current Month | Prior Month | $ Variance (Unfavorable) | % Variance (Unfavorable) | | Current YTD | Prior YTD | $ Variance (Unfavorable) | % Variance (Unfavorable) |
| | | | | **Personnel Expenses** | | | | |
| $1,965,994 | $1,776,635 | ($189,359) | (10.7%) | Salaries & Wages | $3,742,629 | $3,421,540 | ($321,089) | (9.4%) |
| 264,544 | 184,147 | (80,396) | (43.7%) | Paid Time Off | 448,691 | 371,390 | (77,301) | (20.8%) |
| 175 | 25 | (150) | (600.0%) | Incentives | 200 | 466 | 266 | 57.1% |
| 0 | 0 | 0 | 0.0% | Severance Pay | 0 | 7,605 | 7,605 | 100.0% |
| 33,446 | 28,479 | (4,967) | (17.4%) | Payroll Taxes | 61,925 | 54,550 | (7,374) | (13.5%) |
| 28,535 | 36,391 | 7,856 | 21.6% | Overtime | 64,926 | 36,160 | (28,766) | (79.6%) |
| 158,707 | 144,600 | (14,107) | (9.8%) | CalPERS ER Match | 303,307 | 272,372 | (30,935) | (11.4%) |
| 2,583 | 862 | (1,721) | (199.7%) | Mandated Covid-19 Supplemental Sick Lea | 3,445 | 4,633 | 1,188 | 25.6% |
| 463,926 | 461,818 | (2,108) | (0.5%) | Employee Benefits | 925,744 | 838,814 | (86,929) | (10.4%) |
| 1,566 | (17) | (1,583) | 9,166.6% | Personal Floating Holiday | 1,549 | 99 | (1,449) | (1,459.9%) |
| 1,065 | 92 | (973) | (1,057.6%) | Employee Relations | 1,157 | 1,431 | 274 | 19.2% |
| 7,200 | 7,080 | (120) | (1.7%) | Work from Home Stipend | 14,280 | 0 | (14,280) | 0.0% |
| 26 | 0 | (26) | 0.0% | Transportation Reimbursement | 26 | 54 | 28 | 52.0% |
| 617 | 0 | (617) | 0.0% | Travel & Lodging | 617 | (615) | (1,231) | 200.3% |
| 57,587 | 122,709 | 65,123 | 53.1% | Temporary Help Services | 180,296 | 61,083 | (119,213) | (195.2%) |
| 2,443 | 7,032 | 4,590 | 65.3% | Staff Development/Training | 9,475 | 12,616 | 3,141 | 24.9% |
| 5,272 | 5,862 | 590 | 10.1% | Staff Recruitment/Advertising | 11,134 | 75,618 | 64,485 | 85.3% |
| **2,993,684** | **2,775,715** | **(217,969)** | **(7.9%)** | **Total Employee Expenses** | **5,769,399** | **5,157,818** | **(611,581)** | **(11.9%)** |
| | | | | **Purchased & Professional Services** | | | | |
| 261,708 | 241,644 | (20,065) | (8.3%) | Consulting Services | 503,352 | 263,695 | (239,657) | (90.9%) |
| 259,967 | 252,760 | (7,207) | (2.9%) | Computer Support Services | 512,726 | 762,734 | 250,008 | 32.8% |
| 9,916 | 9,916 | 0 | 0.0% | Professional Fees-Accounting | 19,832 | 17,500 | (2,332) | (13.3%) |
| 52,392 | 26,512 | (25,880) | (97.6%) | Other Purchased Services | 78,904 | 44,333 | (34,571) | (78.0%) |
| 9,312 | 3,818 | (5,493) | (143.9%) | Maint.& Repair-Office Equipment | 13,130 | 29,655 | 16,525 | 55.7% |
| 6,621 | 17,547 | 10,925 | 62.3% | HMS Recovery Fees | 24,168 | 75,288 | 51,119 | 67.9% |
| 58,669 | 80 | (58,589) | (73,072.2%) | Hardware (Non-Capital) | 58,750 | (3,948) | (62,697) | 1,588.2% |
| 11,580 | 9,189 | (2,390) | (26.0%) | Provider Relations-Credentailing | 20,769 | 9,140 | (11,629) | (127.2%) |
| 67,773 | 0 | (67,773) | 0.0% | Legal Fees | 67,773 | 78,425 | 10,652 | 13.6% |
| **737,938** | **561,466** | **(176,472)** | **(31.4%)** | **Total Purchased & Professional Service** | **1,299,404** | **1,276,822** | **(22,582)** | **(1.8%)** |
| | | | | **Occupancy** | | | | |
| 87,310 | 111,050 | 23,740 | 21.4% | Depreciation | 198,360 | 334,304 | 135,944 | 40.7% |
| 0 | 0 | 0 | 0.0% | Amortization | 0 | 52,215 | 52,215 | 100.0% |
| 73,056 | 69,890 | (3,166) | (4.5%) | Building Lease | 142,946 | 135,710 | (7,236) | (5.3%) |
| 2,005 | 2,002 | (3) | (0.2%) | Leased and Rented Office Equipment | 4,007 | 5,559 | 1,552 | 27.9% |
| 12,595 | 14,349 | 1,754 | 12.2% | Utilities | 26,945 | 23,959 | (2,986) | (12.5%) |
| 71,869 | 73,137 | 1,268 | 1.7% | Telephone | 145,006 | 181,701 | 36,695 | 20.2% |
| 20,633 | 7,797 | (12,837) | (164.6%) | Building Maintenance | 28,430 | 26,692 | (1,738) | (6.5%) |
| **267,469** | **278,225** | **10,756** | **3.9%** | **Total Occupancy** | **545,693** | **760,140** | **214,447** | **28.2%** |
| | | | | **Printing Postage & Promotion** | | | | |

# ALAMEDA ALLIANCE FOR HEALTH
## ADMINISTRATIVE EXPENSE DETAIL
## CURRENT VS. PRIOR PERIOD
## FOR THE MONTH AND FISCAL YTD ENDED August 31, 2021

| CURRENT MONTH VS. PRIOR MONTH | | | | | CURRENT YEAR VS. PRIOR YEAR | | | |
|---|---|---|---|---|---|---|---|---|
| Current Month | Prior Month | $ Variance (Unfavorable) | % Variance (Unfavorable) | | Current YTD | Prior YTD | $ Variance (Unfavorable) | % Variance (Unfavorable) |
| $29,098 | $221 | ($28,877) | (13,066.0%) | Postage | $29,319 | $28,624 | ($696) | (2.4%) |
| 6,230 | 3,060 | (3,170) | (103.6%) | Design & Layout | 9,290 | 4,080 | (5,210) | (127.7%) |
| 53,562 | 0 | (53,562) | 0.0% | Printing Services | 53,562 | 61,551 | 7,989 | 13.0% |
| 3,989 | 0 | (3,989) | 0.0% | Mailing Services | 3,989 | 4,967 | 978 | 19.7% |
| 3,444 | 6,012 | 2,569 | 42.7% | Courier/Delivery Service | 9,456 | 4,742 | (4,713) | (99.4%) |
| 0 | 34 | 34 | 100.0% | Pre-Printed Materials and Publications | 34 | 17 | (17) | (105.0%) |
| 0 | 0 | 0 | 0.0% | Promotional Products | 0 | 18,221 | 18,221 | 100.0% |
| 2,363 | 5,513 | 3,150 | 57.1% | Community Relations | 7,875 | 25,356 | 17,481 | 68.9% |
| 38,750 | 10,209 | (28,541) | (279.6%) | Translation - Non-Clinical | 48,959 | 12,826 | (36,132) | (281.7%) |
| **137,435** | **25,049** | **(112,386)** | **(448.7%)** | **Total Printing Postage & Promotion** | **162,484** | **160,384** | **(2,100)** | **(1.3%)** |
| | | | | **Licenses Insurance & Fees** | | | | |
| 18,257 | 21,318 | 3,061 | 14.4% | Bank Fees | 39,575 | 37,503 | (2,073) | (5.5%) |
| 68,460 | 54,293 | (14,167) | (26.1%) | Insurance | 122,753 | 106,014 | (16,739) | (15.8%) |
| 280,804 | 350,664 | 69,860 | 19.9% | Licenses, Permits and Fees | 631,468 | 589,847 | (41,621) | (7.1%) |
| 69,682 | 53,595 | (16,088) | (30.0%) | Subscriptions & Dues | 123,277 | 114,825 | (8,452) | (7.4%) |
| **437,203** | **479,870** | **42,667** | **8.9%** | **Total Licenses Insurance & Postage** | **917,073** | **848,188** | **(68,885)** | **(8.1%)** |
| | | | | **Supplies & Other Expenses** | | | | |
| 3,813 | 6 | (3,807) | (68,480.0%) | Office and Other Supplies | 3,819 | 3,938 | 119 | 3.0% |
| 19 | 3,385 | 3,366 | 99.4% | Ergonomic Supplies | 3,404 | 1,648 | (1,756) | (106.5%) |
| 449 | 1,273 | 825 | 64.8% | Commissary-Food & Beverage | 1,722 | 1,433 | (289) | (20.2%) |
| 4,850 | 0 | (4,850) | 0.0% | Member Incentive Expense | 4,850 | 4,850 | 0 | 0.0% |
| 404,472 | 407,758 | 3,286 | 0.8% | RX Administrative Fees | 812,230 | 757,945 | (54,285) | (7.2%) |
| 235,602 | 252,202 | 16,600 | 6.6% | Behavioral Hlth Admin Fees | 487,803 | 462,301 | (25,502) | (5.5%) |
| 17,403 | 17,345 | (57) | (0.3%) | Telemedicine Admin Fees | 34,748 | 31,684 | (3,065) | (9.7%) |
| 0 | 0 | 0 | 0.0% | Covid-19 IT Expenses | 0 | 888 | 888 | 100.0% |
| 0 | 0 | 0 | 0.0% | Covid-19 Non IT Expenses | 0 | 2,368 | 2,368 | 100.0% |
| **666,607** | **681,969** | **15,362** | **2.3%** | **Total Supplies & Other Expense** | **1,348,576** | **1,267,054** | **(81,522)** | **(6.4%)** |
| **$5,240,336** | **$4,802,294** | **($438,043)** | **(9.1%)** | **TOTAL ADMINISTRATIVE EXPENSE** | **$10,042,630** | **$9,470,407** | **($572,223)** | **(6.0%)** |

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

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

**5. Reconciliation to Balance Sheet:**

| | |
|---|---|
| Fixed Assets @ Cost -8/31/21 | **$ 36,935,477** |
| Fixed Assets @ Cost - 6/30/21 | **$ 36,935,477** |
| **Fixed Assets Acquired YTD** | **$ -** |

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

## TANGIBLE NET EQUITY (TNE)

| | Jul-21 | Aug-21 |
|---|---|---|
| **Current Month Net Income / (Loss)** | $2,645,613 | $1,455,041 |
| **YTD Net Income / (Loss)** | $2,645,613 | $4,100,654 |
| **Actual TNE** | | |
| Net Assets | $208,055,654 | $209,510,696 |
| Subordinated Debt & Interest | $0 | $0 |
| **Total Actual TNE** | **$208,055,654** | **$209,510,696** |
| **Increase/(Decrease) in Actual TNE** | $3,467,237 | $1,455,042 |
| **Required TNE[(1)]** | **$37,061,269** | **$37,134,762** |
| **Min. Req'd to Avoid Monthly Reporting (130% of Required TNE)** | $48,179,650 | $48,275,191 |
| **TNE Excess / (Deficiency)** | $170,994,385 | $172,375,934 |
| **Actual TNE as a Multiple of Required** | **5.61** | **5.64** |

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

## LIQUID TANGIBLE NET EQUITY

| | | |
|---|---|---|
| Net Assets | $208,055,654 | $209,510,696 |
| Fixed Assets at Net Book Value | (6,161,088) | (6,073,778) |
| CD Pledged to DMHC | (350,000) | (350,000) |
| **Liquid TNE (Liquid Reserves)** | **$201,544,566** | **$203,086,918** |
| **Liquid TNE as Multiple of Required** | **5.44** | **5.47** |

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

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

| | Actual Jul-21 | Actual Aug-21 | Actual Sep-21 | Actual Oct-21 | Actual Nov-21 | Actual Dec-21 | Actual Jan-22 | Actual Feb-22 | Actual Mar-22 | Actual Apr-22 | Actual May-22 | Actual Jun-22 | YTD Member Months |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Enrollment by Plan & Aid Category:** | | | | | | | | | | | | | |
| Medi-Cal Program: | | | | | | | | | | | | | |
| Child | 97,179 | 97,324 | | | | | | | | | | | 194,503 |
| Adult | 41,358 | 41,519 | | | | | | | | | | | 82,877 |
| SPD* | 26,320 | 26,316 | | | | | | | | | | | 52,636 |
| ACA OE | 99,105 | 99,783 | | | | | | | | | | | 198,888 |
| Duals | 20,194 | 20,388 | | | | | | | | | | | 40,582 |
| Medi-Cal Program | 284,156 | 285,330 | | | | | | | | | | | 569,486 |
| Group Care Program | 5,935 | 5,877 | | | | | | | | | | | 11,812 |
| **Total** | **290,091** | **291,207** | | | | | | | | | | | **581,298** |
| **Month Over Month Enrollment Change:** | | | | | | | | | | | | | |
| Medi-Cal Monthly Change | | | | | | | | | | | | | |
| Child | 131 | 145 | | | | | | | | | | | 276 |
| Adult | 392 | 161 | | | | | | | | | | | 553 |
| SPD* | (3) | (4) | | | | | | | | | | | (7) |
| ACA OE | 824 | 678 | | | | | | | | | | | 1,502 |
| Duals | 206 | 194 | | | | | | | | | | | 400 |
| Medi-Cal Program | 1,550 | 1,174 | | | | | | | | | | | 2,724 |
| Group Care Program | (13) | (58) | | | | | | | | | | | (71) |
| **Total** | **1,537** | **1,116** | | | | | | | | | | | **2,653** |
| **Enrollment Percentages:** | | | | | | | | | | | | | |
| Medi-Cal Program: | | | | | | | | | | | | | |
| Child % of Medi-Cal | 34.2% | 34.1% | | | | | | | | | | | 34.2% |
| Adult % of Medi-Cal | 14.6% | 14.6% | | | | | | | | | | | 14.6% |
| SPD % of Medi-Cal | 9.3% | 9.2% | | | | | | | | | | | 9.2% |
| ACA OE % of Medi-Cal | 34.9% | 35.0% | | | | | | | | | | | 34.9% |
| Duals % of Medi-Cal | 7.1% | 7.1% | | | | | | | | | | | 7.1% |
| Medi-Cal Program % of Total | 98.0% | 98.0% | | | | | | | | | | | 98.0% |
| Group Care Program % of Total | 2.0% | 2.0% | | | | | | | | | | | 2.0% |
| **Total** | **100.0%** | **100.0%** | | | | | | | | | | | **100.0%** |

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


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


| | Actual Jul-21 | Actual Aug-21 | Actual Sep-21 | Actual Oct-21 | Actual Nov-21 | Actual Dec-21 | Actual Jan-22 | Actual Feb-22 | Actual Mar-22 | Actual Apr-22 | Actual May-22 | Actual Jun-22 | YTD Member Months |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Current Direct/Delegate Enrollment:** | | | | | | | | | | | | | |
| Directly-Contracted | | | | | | | | | | | | | |
| Directly Contracted (DCP) | 53,189 | 53,441 | | | | | | | | | | | 106,630 |
| Alameda Health System | 58,045 | 57,812 | | | | | | | | | | | 115,857 |
| | 111,234 | 111,253 | | | | | | | | | | | 222,487 |
| Delegated: | | | | | | | | | | | | | |
| CFMG | 32,217 | 32,167 | | | | | | | | | | | 64,384 |
| CHCN | 104,433 | 105,113 | | | | | | | | | | | 209,546 |
| Kaiser | 42,207 | 42,674 | | | | | | | | | | | 84,881 |
| Delegated Subtotal | 178,857 | 179,954 | | | | | | | | | | | 358,811 |
| **Total** | **290,091** | **291,207** | | | | | | | | | | | **581,298** |
| **Direct/Delegate Month Over Month Enrollment Change:** | | | | | | | | | | | | | |
| Directly-Contracted | (24) | 19 | | | | | | | | | | | (5) |
| Delegated: | | | | | | | | | | | | | |
| CFMG | 20 | (50) | | | | | | | | | | | (30) |
| CHCN | 1,094 | 680 | | | | | | | | | | | 1,774 |
| Kaiser | 447 | 467 | | | | | | | | | | | 914 |
| Delegated Subtotal | 1,561 | 1,097 | | | | | | | | | | | 2,658 |
| **Total** | **1,537** | **1,116** | | | | | | | | | | | **2,653** |
| **Direct/Delegate Enrollment Percentages:** | | | | | | | | | | | | | |
| Directly-Contracted | 38.3% | 38.2% | | | | | | | | | | | 38.3% |
| Delegated: | | | | | | | | | | | | | |
| CFMG | 11.1% | 11.0% | | | | | | | | | | | 11.1% |
| CHCN | 36.0% | 36.1% | | | | | | | | | | | 36.0% |
| Kaiser | 14.5% | 14.7% | | | | | | | | | | | 14.6% |
| Delegated Subtotal | 61.7% | 61.8% | | | | | | | | | | | 61.7% |
| **Total** | **100.0%** | **100.0%** | | | | | | | | | | | **100.0%** |

* BCCTP included in SPD Category of Aid

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

| | Preliminary Budget Jul-21 | Preliminary Budget Aug-21 | Preliminary Budget Sep-21 | Preliminary Budget Oct-21 | Preliminary Budget Nov-21 | Preliminary Budget Dec-21 | Preliminary Budget Jan-22 | Preliminary Budget Feb-22 | Preliminary Budget Mar-22 | Preliminary Budget Apr-22 | Preliminary Budget May-22 | Preliminary Budget Jun-22 | Preliminary YTD Member Months |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Enrollment by Plan & Aid Category:** | | | | | | | | | | | | | |
| Medi-Cal Program: | | | | | | | | | | | | | |
| Child | 97,205 | 97,331 | 97,448 | 97,497 | 97,497 | 97,497 | 95,547 | 93,636 | 91,763 | 89,928 | 88,129 | 86,366 | 1,129,844 |
| Adult | 40,737 | 40,790 | 40,839 | 40,859 | 40,859 | 40,859 | 40,042 | 39,241 | 38,456 | 37,687 | 36,933 | 36,194 | 473,496 |
| SPD | 26,361 | 26,395 | 26,427 | 26,440 | 26,440 | 26,440 | 26,414 | 26,388 | 26,388 | 26,388 | 26,388 | 26,388 | 316,857 |
| ACA OE | 98,303 | 98,431 | 98,549 | 98,598 | 98,598 | 98,598 | 96,626 | 94,693 | 92,799 | 90,943 | 89,124 | 87,342 | 1,142,604 |
| Duals | 20,012 | 20,038 | 20,062 | 20,072 | 20,072 | 20,072 | 19,671 | 19,278 | 18,892 | 18,514 | 18,144 | 17,781 | 232,608 |
| Medi-Cal Program | 282,618 | 282,985 | 283,325 | 283,466 | 283,466 | 283,466 | 278,300 | 273,236 | 268,298 | 263,460 | 258,718 | 254,071 | 3,295,409 |
| Group Care Program | 5,939 | 5,939 | 5,939 | 5,942 | 5,942 | 5,942 | 5,942 | 5,942 | 5,942 | 5,942 | 5,942 | 5,942 | 71,295 |
| **Total** | **288,557** | **288,924** | **289,264** | **289,408** | **289,408** | **289,408** | **284,242** | **279,178** | **274,240** | **269,402** | **264,660** | **260,013** | **3,366,704** |
| **Month Over Month Enrollment Change:** | | | | | | | | | | | | | |
| Medi-Cal Monthly Change | | | | | | | | | | | | | |
| Child | (320) | 126 | 117 | 49 | 0 | 0 | (1,950) | (1,911) | (1,873) | (1,835) | (1,799) | (1,763) | (11,159) |
| Adult | 432 | 53 | 49 | 20 | 0 | 0 | (817) | (801) | (785) | (769) | (754) | (739) | (4,111) |
| SPD | 163 | 34 | 32 | 13 | 0 | 0 | (26) | (26) | 0 | 0 | 0 | 0 | 190 |
| ACA OE | 2,452 | 128 | 118 | 49 | 0 | 0 | (1,972) | (1,933) | (1,894) | (1,856) | (1,819) | (1,782) | (8,509) |
| Duals | 494 | 26 | 24 | 10 | 0 | 0 | (401) | (393) | (386) | (378) | (370) | (363) | (1,737) |
| Medi-Cal Program | 3,222 | 367 | 340 | 141 | 0 | 0 | (5,166) | (5,064) | (4,938) | (4,838) | (4,742) | (4,647) | (25,325) |
| Group Care Program | (70) | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (67) |
| **Total** | **3,152** | **367** | **340** | **144** | **0** | **0** | **(5,166)** | **(5,064)** | **(4,938)** | **(4,838)** | **(4,742)** | **(4,647)** | **(25,392)** |
| **Enrollment Percentages:** | | | | | | | | | | | | | |
| Medi-Cal Program: | | | | | | | | | | | | | |
| Child % of Medi-Cal | 34.4% | 34.4% | 34.4% | 34.4% | 34.4% | 34.4% | 34.3% | 34.3% | 34.2% | 34.1% | 34.1% | 34.0% | 34.3% |
| Adult % of Medi-Cal | 14.4% | 14.4% | 14.4% | 14.4% | 14.4% | 14.4% | 14.4% | 14.4% | 14.3% | 14.3% | 14.3% | 14.2% | 14.4% |
| SPD % of Medi-Cal | 9.3% | 9.3% | 9.3% | 9.3% | 9.3% | 9.3% | 9.5% | 9.7% | 9.8% | 10.0% | 10.2% | 10.4% | 9.6% |
| ACA OE % of Medi-Cal | 34.8% | 34.8% | 34.8% | 34.8% | 34.8% | 34.8% | 34.7% | 34.7% | 34.6% | 34.5% | 34.4% | 34.4% | 34.7% |
| Duals % of Medi-Cal | 7.1% | 7.1% | 7.1% | 7.1% | 7.1% | 7.1% | 7.1% | 7.1% | 7.0% | 7.0% | 7.0% | 7.0% | 7.1% |
| Medi-Cal Program % of Total | 97.9% | 97.9% | 97.9% | 97.9% | 97.9% | 97.9% | 97.9% | 97.9% | 97.8% | 97.8% | 97.8% | 97.7% | 97.9% |
| Group Care Program % of Total | 2.1% | 2.1% | 2.1% | 2.1% | 2.1% | 2.1% | 2.1% | 2.1% | 2.2% | 2.2% | 2.2% | 2.3% | 2.1% |
| **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 2022**

| | Preliminary Budget Jul-21 | Preliminary Budget Aug-21 | Preliminary Budget Sep-21 | Preliminary Budget Oct-21 | Preliminary Budget Nov-21 | Preliminary Budget Dec-21 | Preliminary Budget Jan-22 | Preliminary Budget Feb-22 | Preliminary Budget Mar-22 | Preliminary Budget Apr-22 | Preliminary Budget May-22 | Preliminary Budget Jun-22 | Preliminary YTD Member Months |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Current Direct/Delegate Enrollment:** | | | | | | | | | | | | | |
| Directly-Contracted | 112,236 | 112,862 | 112,508 | 113,050 | 112,563 | 113,050 | 110,621 | 109,186 | 106,862 | 105,498 | 103,265 | 101,956 | 1,313,657 |
| Delegated: | | | | | | | | | | | | | |
| CFMG | 32,271 | 32,436 | 32,352 | 32,492 | 32,369 | 32,492 | 31,743 | 31,248 | 30,528 | 30,056 | 29,363 | 28,910 | 376,260 |
| CHCN | 102,840 | 103,586 | 103,090 | 103,758 | 103,141 | 103,758 | 101,332 | 100,151 | 97,835 | 96,706 | 94,484 | 93,397 | 1,204,078 |
| Kaiser | 41,210 | 40,040 | 41,314 | 40,108 | 41,335 | 40,108 | 40,546 | 38,593 | 39,015 | 37,142 | 37,548 | 35,750 | 472,709 |
| Delegated Subtotal | 176,321 | 176,062 | 176,756 | 176,358 | 176,845 | 176,358 | 173,621 | 169,992 | 167,378 | 163,904 | 161,395 | 158,057 | 2,053,047 |
| **Total** | **288,557** | **288,924** | **289,264** | **289,408** | **289,408** | **289,408** | **284,242** | **279,178** | **274,240** | **269,402** | **264,660** | **260,013** | **3,366,704** |
| **Direct/Delegate Month Over Month Enrollment Change:** | | | | | | | | | | | | | |
| Directly-Contracted | 921 | 626 | (354) | 542 | (487) | 487 | (2,429) | (1,435) | (2,324) | (1,364) | (2,233) | (1,309) | (9,359) |
| Delegated: | | | | | | | | | | | | | |
| CFMG | (105) | 165 | (84) | 140 | (123) | 123 | (749) | (495) | (720) | (472) | (693) | (453) | (3,466) |
| CHCN | (60) | 746 | (496) | 668 | (617) | 617 | (2,426) | (1,181) | (2,316) | (1,129) | (2,222) | (1,087) | (9,503) |
| Kaiser | 2,397 | (1,170) | 1,274 | (1,206) | 1,227 | (1,227) | 438 | (1,953) | 422 | (1,873) | 406 | (1,798) | (3,063) |
| Delegated Subtotal | 2,232 | (259) | 694 | (398) | 487 | (487) | (2,737) | (3,629) | (2,614) | (3,474) | (2,509) | (3,338) | (16,032) |
| **Total** | **3,152** | **367** | **340** | **144** | **0** | **0** | **(5,166)** | **(5,064)** | **(4,938)** | **(4,838)** | **(4,742)** | **(4,647)** | **(25,392)** |
| **Direct/Delegate Enrollment Percentages:** | | | | | | | | | | | | | |
| Directly-Contracted | 38.9% | 39.1% | 38.9% | 39.1% | 38.9% | 39.1% | 38.9% | 39.1% | 39.0% | 39.2% | 39.0% | 39.2% | 39.0% |
| Delegated: | | | | | | | | | | | | | |
| CFMG | 11.2% | 11.2% | 11.2% | 11.2% | 11.2% | 11.2% | 11.2% | 11.2% | 11.1% | 11.2% | 11.1% | 11.1% | 11.2% |
| CHCN | 35.6% | 35.9% | 35.6% | 35.9% | 35.6% | 35.9% | 35.6% | 35.9% | 35.7% | 35.9% | 35.7% | 35.9% | 35.8% |
| Kaiser | 14.3% | 13.9% | 14.3% | 13.9% | 14.3% | 13.9% | 14.3% | 13.8% | 14.2% | 13.8% | 14.2% | 13.7% | 14.0% |
| Delegated Subtotal | 61.1% | 60.9% | 61.1% | 60.9% | 61.1% | 60.9% | 61.1% | 60.9% | 61.0% | 60.8% | 61.0% | 60.8% | 61.0% |
| **Total** | **100.0%** | **100.0%** | **100.0%** | **100.0%** | **100.0%** | **100.0%** | **100.0%** | **100.0%** | **100.0%** | **100.0%** | **100.0%** | **100.0%** | **100.0%** |

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

| | Variance Jul-21 | Variance Aug-21 | Variance Sep-21 | Variance Oct-21 | Variance Nov-21 | Variance Dec-21 | Variance Jan-22 | Variance Feb-22 | Variance Mar-22 | Variance Apr-22 | Variance May-22 | Variance Jun-22 | Member Month Variance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)** | | | | | | | | | | | | | |
| Medi-Cal Program: | | | | | | | | | | | | | |
| Child | (26) | (7) | | | | | | | | | | | (33) |
| Adult | 621 | 729 | | | | | | | | | | | 1,350 |
| SPD | (41) | (79) | | | | | | | | | | | (120) |
| ACA OE | 802 | 1,352 | | | | | | | | | | | 2,154 |
| Duals | 182 | 350 | | | | | | | | | | | 532 |
| Medi-Cal Program | 1,538 | 2,345 | | | | | | | | | | | 3,883 |
| Group Care Program | (4) | (62) | | | | | | | | | | | (66) |
| **Total** | **1,534** | **2,283** | | | | | | | | | | | **3,817** |
| **Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)** | | | | | | | | | | | | | |
| Directly-Contracted | (1,002) | (1,609) | | | | | | | | | | | (2,611) |
| Delegated: | | | | | | | | | | | | | |
| CFMG | (54) | (269) | | | | | | | | | | | (323) |
| CHCN | 1,593 | 1,527 | | | | | | | | | | | 3,120 |
| Kaiser | 997 | 2,634 | | | | | | | | | | | 3,631 |
| Delegated Subtotal | 2,536 | 3,892 | | | | | | | | | | | 6,428 |
| **Total** | **1,534** | **2,283** | | | | | | | | | | | **3,817** |

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

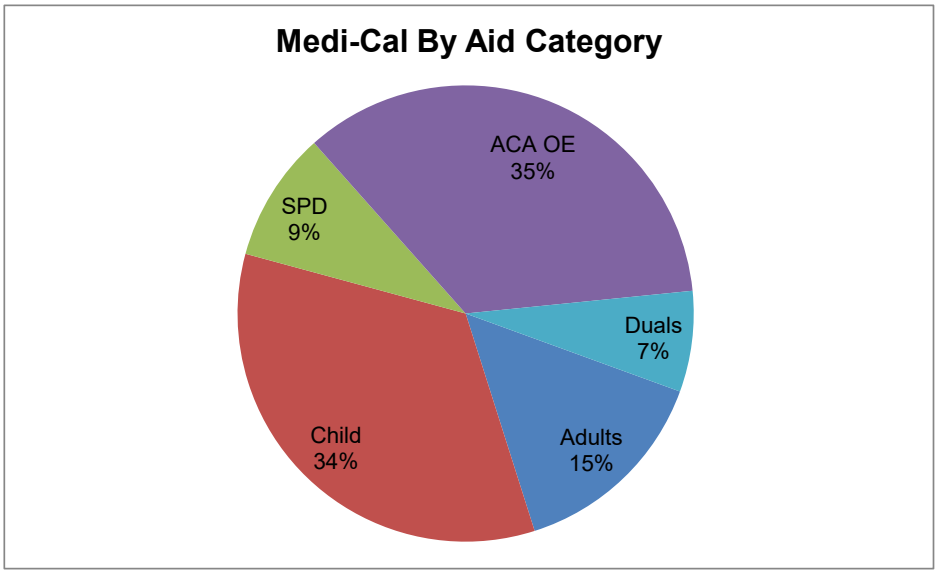
| CURRENT MONTH | | | | | FISCAL YEAR TO DATE | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | $ Variance (Unfavorable) | % Variance (Unfavorable) | Account Description | Actual | Budget | $ Variance (Unfavorable) | % Variance (Unfavorable) |
| | | | | **CAPITATED MEDICAL EXPENSES:** | | | | |
| $1,856,326 | $1,824,310 | ($32,016) | (1.8%) | PCP-Capitation | $3,719,241 | $3,642,383 | ($76,858) | (2.1%) |
| 2,957,960 | 2,942,187 | (15,773) | (0.5%) | PCP-Capitation - FQHC | 5,900,548 | 5,865,177 | (35,371) | (0.6%) |
| 279,529 | 270,941 | (8,588) | (3.2%) | Specialty-Capitation | 559,863 | 540,640 | (19,223) | (3.6%) |
| 3,072,311 | 3,045,443 | (26,868) | (0.9%) | Specialty-Capitation FQHC | 6,124,614 | 6,074,052 | (50,562) | (0.8%) |
| 361,690 | 329,381 | (32,309) | (9.8%) | Laboratory-Capitation | 721,853 | 656,252 | (65,601) | (10.0%) |
| 874,248 | 1,011,235 | 136,987 | 13.5% | Transportation (Ambulance)-Cap | 1,542,290 | 2,021,179 | 478,889 | 23.7% |
| 213,797 | 274,501 | 60,704 | 22.1% | Vision Cap | 427,166 | 547,264 | 120,098 | 21.9% |
| 81,444 | 78,945 | (2,499) | (3.2%) | CFMG Capitation | 163,118 | 157,527 | (5,591) | (3.5%) |
| 154,824 | 153,728 | (1,096) | (0.7%) | Anc IPA Admin Capitation FQHC | 308,740 | 306,530 | (2,210) | (0.7%) |
| 10,543,893 | 9,932,720 | (611,173) | (6.2%) | Kaiser Capitation | 20,911,570 | 20,159,664 | (751,906) | (3.7%) |
| 1,085,696 | 712,933 | (372,763) | (52.3%) | BHT Supplemental Expense | 1,829,048 | 1,436,272 | (392,776) | (27.3%) |
| 25,685 | 10,982 | (14,703) | (133.9%) | Hep-C Supplemental Expense | 42,809 | 22,262 | (20,547) | (92.3%) |
| 280,159 | 414,136 | 133,977 | 32.4% | Maternity Supplemental Expense | 628,236 | 842,694 | 214,458 | 25.4% |
| 541,154 | 575,305 | 34,151 | 5.9% | DME - Cap | 1,080,918 | 1,148,469 | 67,551 | 5.9% |
| **22,328,717** | **21,576,747** | **(751,970)** | **(3.5%)** | **5-TOTAL CAPITATED EXPENSES** | **43,960,016** | **43,420,365** | **(539,651)** | **(1.2%)** |
| | | | | **FEE FOR SERVICE MEDICAL EXPENSES:** | | | | |
| 1,033,626 | 0 | (1,033,626) | 0.0% | IBNP-Inpatient Services | 647,817 | 0 | (647,817) | 0.0% |
| 31,007 | 0 | (31,007) | 0.0% | IBNP-Settlement (IP) | 19,434 | 0 | (19,434) | 0.0% |
| 82,689 | 0 | (82,689) | 0.0% | IBNP-Claims Fluctuation (IP) | 51,824 | 0 | (51,824) | 0.0% |
| 21,141,386 | 24,345,672 | 3,204,286 | 13.2% | Inpatient Hospitalization-FFS | 43,224,556 | 48,539,130 | 5,314,574 | 10.9% |
| 1,244,511 | 0 | (1,244,511) | 0.0% | IP OB - Mom & NB | 2,382,712 | 0 | (2,382,712) | 0.0% |
| 191,050 | 0 | (191,050) | 0.0% | IP Behavioral Health | 330,870 | 0 | (330,870) | 0.0% |
| 1,174,873 | 1,214,001 | 39,128 | 3.2% | IP - Long Term Care | 2,260,079 | 2,420,677 | 160,598 | 6.6% |
| 683,433 | 0 | (683,433) | 0.0% | IP - Facility Rehab FFS | 2,001,405 | 0 | (2,001,405) | 0.0% |
| **25,582,575** | **25,559,673** | **(22,902)** | **(0.1%)** | **6-Inpatient Hospital & SNF FFS Expense** | **50,918,697** | **50,959,807** | **41,110** | **0.1%** |
| 57,409 | 0 | (57,409) | 0.0% | IBNP-PCP | 173,990 | 0 | (173,990) | 0.0% |
| 1,723 | 0 | (1,723) | 0.0% | IBNP-Settlement (PCP) | 5,222 | 0 | (5,222) | 0.0% |
| 4,594 | 0 | (4,594) | 0.0% | IBNP-Claims Fluctuation (PCP) | 13,919 | 0 | (13,919) | 0.0% |
| 882 | 0 | (882) | 0.0% | Telemedicine FFS | 1,596 | 0 | (1,596) | 0.0% |
| 1,099,233 | 1,323,220 | 223,987 | 16.9% | Primary Care Non-Contracted FF | 2,200,250 | 2,632,171 | 431,921 | 16.4% |
| 61,672 | 80,771 | 19,099 | 23.6% | PCP FQHC FFS | 118,197 | 161,112 | 42,915 | 26.6% |
| 1,796,568 | 3,060,684 | 1,264,116 | 41.3% | Prop 56 Direct Payment Expenses | 3,586,416 | 6,117,389 | 2,530,973 | 41.4% |
| 77,416 | 0 | (77,416) | 0.0% | Prop 56-Trauma Expense | 154,780 | 0 | (154,780) | 0.0% |
| 102,147 | 0 | (102,147) | 0.0% | Prop 56-Dev. Screening Exp. | 204,371 | 0 | (204,371) | 0.0% |
| 648,857 | 0 | (648,857) | 0.0% | Prop 56-Fam. Planning Exp. | 1,296,893 | 0 | (1,296,893) | 0.0% |
| 558,404 | 0 | (558,404) | 0.0% | Prop 56-Value Based Purchasing | 1,115,066 | 0 | (1,115,066) | 0.0% |
| **4,408,905** | **4,464,675** | **55,770** | **1.2%** | **7-Primary Care Physician FFS Expense** | **8,870,699** | **8,910,672** | **39,973** | **0.4%** |
| 586,914 | 0 | (586,914) | 0.0% | IBNP-Specialist | 980,837 | 0 | (980,837) | 0.0% |
| 2,120,503 | 4,612,945 | 2,492,442 | 54.0% | Specialty Care-FFS | 4,358,675 | 9,176,787 | 4,818,112 | 52.5% |
| 179,478 | 0 | (179,478) | 0.0% | Anesthesiology - FFS | 309,235 | 0 | (309,235) | 0.0% |
| 608,181 | 0 | (608,181) | 0.0% | Spec Rad Therapy - FFS | 1,174,974 | 0 | (1,174,974) | 0.0% |
| 124,362 | 0 | (124,362) | 0.0% | Obstetrics-FFS | 246,556 | 0 | (246,556) | 0.0% |
| 255,017 | 0 | (255,017) | 0.0% | Spec IP Surgery - FFS | 498,200 | 0 | (498,200) | 0.0% |
| 399,757 | 0 | (399,757) | 0.0% | Spec OP Surgery - FFS | 949,884 | 0 | (949,884) | 0.0% |
| 343,276 | 0 | (343,276) | 0.0% | Spec IP Physician | 693,618 | 0 | (693,618) | 0.0% |
| 32,541 | 83,549 | 51,008 | 61.1% | SCP FQHC FFS | 63,297 | 166,732 | 103,435 | 62.0% |
| 17,607 | 0 | (17,607) | 0.0% | IBNP-Settlement (SCP) | 29,423 | 0 | (29,423) | 0.0% |
| 46,953 | 0 | (46,953) | 0.0% | IBNP-Claims Fluctuation (SCP) | 78,467 | 0 | (78,467) | 0.0% |
| **4,714,589** | **4,696,494** | **(18,095)** | **(0.4%)** | **8-Specialty Care Physician Expense** | **9,383,167** | **9,343,519** | **(39,648)** | **(0.4%)** |
| (34,591) | 0 | 34,591 | 0.0% | IBNP-Ancillary | 382,369 | 0 | (382,369) | 0.0% |
| (1,037) | 0 | 1,037 | 0.0% | IBNP Settlement (ANC) | 11,473 | 0 | (11,473) | 0.0% |
| (2,767) | 0 | 2,767 | 0.0% | IBNP Claims Fluctuation (ANC) | 30,589 | 0 | (30,589) | 0.0% |
| 265,386 | 0 | (265,386) | 0.0% | Acupuncture/Biofeedback | 519,941 | 0 | (519,941) | 0.0% |
| 78,394 | 0 | (78,394) | 0.0% | Hearing Devices | 202,268 | 0 | (202,268) | 0.0% |
| 31,939 | 0 | (31,939) | 0.0% | Imaging/MRI/CT Global | 46,184 | 0 | (46,184) | 0.0% |
| 41,542 | 0 | (41,542) | 0.0% | Vision FFS | 95,650 | 0 | (95,650) | 0.0% |
| 20,407 | 0 | (20,407) | 0.0% | Family Planning | 42,705 | 0 | (42,705) | 0.0% |
| 585,322 | 0 | (585,322) | 0.0% | Laboratory-FFS | 1,123,222 | 0 | (1,123,222) | 0.0% |
| 78,978 | 0 | (78,978) | 0.0% | ANC Therapist | 157,421 | 0 | (157,421) | 0.0% |
| 293,777 | 0 | (293,777) | 0.0% | Transportation (Ambulance)-FFS | 572,317 | 0 | (572,317) | 0.0% |
| 105,570 | 0 | (105,570) | 0.0% | Transportation (Other)-FFS | 218,454 | 0 | (218,454) | 0.0% |

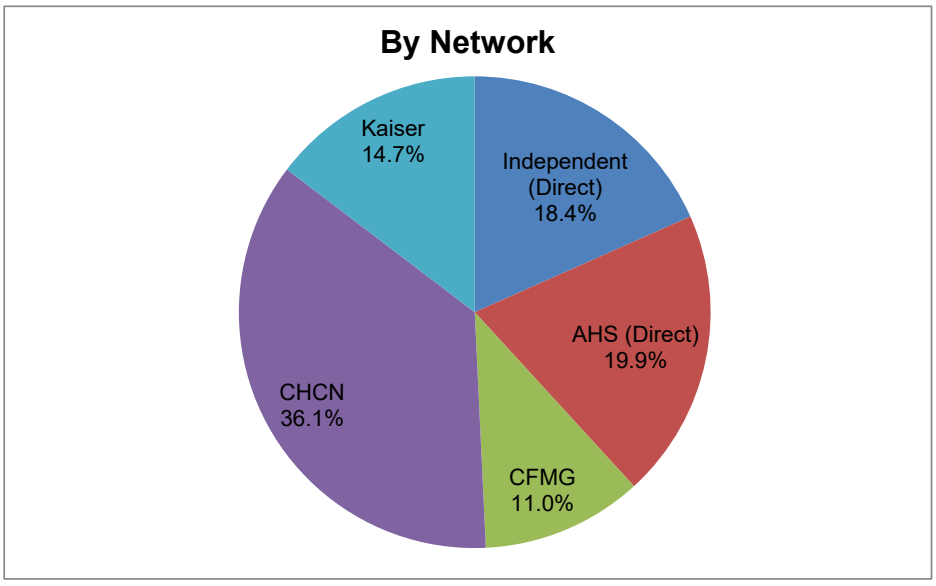
**ALAMEDA ALLIANCE FOR HEALTH**
**MEDICAL EXPENSE DETAIL**
**ACTUAL VS. BUDGET**
**FOR THE MONTH AND FISCAL YTD ENDED August 31, 2021**

| CURRENT MONTH | | | | | FISCAL YEAR TO DATE | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | $ Variance (Unfavorable) | % Variance (Unfavorable) | Account Description | Actual | Budget | $ Variance (Unfavorable) | % Variance (Unfavorable) |
| $700,643 | $0 | ($700,643) | 0.0% | Hospice | $1,221,073 | $0 | ($1,221,073) | 0.0% |
| 580,573 | 0 | (580,573) | 0.0% | Home Health Services | 1,327,941 | 0 | (1,327,941) | 0.0% |
| 0 | 3,231,601 | 3,231,601 | 100.0% | Other Medical-FFS | 0 | 6,444,177 | 6,444,177 | 100.0% |
| (4,288) | 0 | 4,288 | 0.0% | HMS Medical Refunds | (81,856) | 0 | 81,856 | 0.0% |
| 160 | 0 | (160) | 0.0% | Refunds-Medical Payments | 160 | 0 | (160) | 0.0% |
| 470,246 | 0 | (470,246) | 0.0% | DME & Medical Supplies | 842,657 | 0 | (842,657) | 0.0% |
| 582,511 | 572,816 | (9,695) | (1.7%) | GEMT Direct Payment Expense | 1,160,312 | 1,144,888 | (15,424) | (1.3%) |
| 247,437 | 0 | (247,437) | 0.0% | Community Based Adult Services (CBAS) | 576,279 | 0 | (576,279) | 0.0% |
| **4,040,202** | **3,804,417** | **(235,785)** | **(6.2%)** | **9-Ancillary Medical Expense** | **8,449,159** | **7,589,065** | **(860,094)** | **(11.3%)** |
| 80 | 0 | (80) | 0.0% | IBNP-Outpatient | 468,556 | 0 | (468,556) | 0.0% |
| 2 | 0 | (2) | 0.0% | IBNP Settlement (OP) | 14,056 | 0 | (14,056) | 0.0% |
| 7 | 0 | (7) | 0.0% | IBNP Claims Fluctuation (OP) | 37,484 | 0 | (37,484) | 0.0% |
| 1,125,696 | 8,235,801 | 7,110,105 | 86.3% | Out-Patient FFS | 2,234,046 | 16,442,916 | 14,208,870 | 86.4% |
| 1,474,133 | 0 | (1,474,133) | 0.0% | OP Ambul Surgery - FFS | 2,598,697 | 0 | (2,598,697) | 0.0% |
| 938,108 | 0 | (938,108) | 0.0% | OP Fac Imaging Services-FFS | 1,859,671 | 0 | (1,859,671) | 0.0% |
| 2,599,230 | 0 | (2,599,230) | 0.0% | Behav Health - FFS | 4,281,330 | 0 | (4,281,330) | 0.0% |
| 415,983 | 0 | (415,983) | 0.0% | OP Facility - Lab FFS | 795,893 | 0 | (795,893) | 0.0% |
| 97,414 | 0 | (97,414) | 0.0% | OP Facility - Cardio FFS | 172,782 | 0 | (172,782) | 0.0% |
| 41,494 | 0 | (41,494) | 0.0% | OP Facility - PT/OT/ST FFS | 90,895 | 0 | (90,895) | 0.0% |
| 1,676,511 | 0 | (1,676,511) | 0.0% | OP Facility - Dialysis FFS | 3,422,260 | 0 | (3,422,260) | 0.0% |
| **8,368,657** | **8,235,801** | **(132,856)** | **(1.6%)** | **10-Outpatient Medical Expense Medical Expense** | **15,975,670** | **16,442,916** | **467,246** | **2.8%** |
| 236,057 | 0 | (236,057) | 0.0% | IBNP-Emergency | 1,074,213 | 0 | (1,074,213) | 0.0% |
| 7,083 | 0 | (7,083) | 0.0% | IBNP Settlement (ER) | 32,228 | 0 | (32,228) | 0.0% |
| 18,886 | 0 | (18,886) | 0.0% | IBNP Claims Fluctuation (ER) | 85,938 | 0 | (85,938) | 0.0% |
| 571,112 | 0 | (571,112) | 0.0% | Special ER Physician-FFS | 1,122,049 | 0 | (1,122,049) | 0.0% |
| 3,165,917 | 3,701,179 | 535,262 | 14.5% | ER-Facility | 6,501,002 | 7,385,360 | 884,358 | 12.0% |
| **3,999,056** | **3,701,179** | **(297,877)** | **(8.0%)** | **11-Emergency Expense** | **8,815,430** | **7,385,360** | **(1,430,070)** | **(19.4%)** |
| 83,140 | 0 | (83,140) | 0.0% | IBNP-Pharmacy | (137,473) | 0 | 137,473 | 0.0% |
| 2,493 | 0 | (2,493) | 0.0% | IBNP Settlement (RX) | (4,125) | 0 | 4,125 | 0.0% |
| 6,651 | 0 | (6,651) | 0.0% | IBNP Claims Fluctuation (RX) | (10,998) | 0 | 10,998 | 0.0% |
| 4,532,053 | 4,421,461 | (110,592) | (2.5%) | RX - Non-PBM FFFS | 8,597,036 | 8,814,078 | 217,042 | 2.5% |
| 11,815,909 | 11,612,300 | (203,609) | (1.8%) | Pharmacy-FFS | 23,632,744 | 23,137,064 | (495,680) | (2.1%) |
| (1,718) | 0 | 1,718 | 0.0% | HMS RX Refunds | (1,718) | 0 | 1,718 | 0.0% |
| (570,060) | (570,059) | 1 | 0.0% | Pharmacy-Rebate | (1,135,823) | (1,135,821) | 2 | 0.0% |
| **15,868,469** | **15,463,702** | **(404,767)** | **(2.6%)** | **12-Pharmacy Expense** | **30,939,643** | **30,815,321** | **(124,322)** | **(0.4%)** |
| **66,982,453** | **65,925,941** | **(1,056,512)** | **(1.6%)** | **13-TOTAL FFS MEDICAL EXPENSES** | **133,352,465** | **131,446,660** | **(1,905,805)** | **(1.4%)** |
| 0 | (9,744) | (9,744) | 100.0% | Clinical Vacancy | 0 | (19,706) | (19,706) | 100.0% |
| 86,967 | 88,210 | 1,243 | 1.4% | Quality Analytics | 152,792 | 177,580 | 24,788 | 14.0% |
| 464,006 | 501,763 | 37,757 | 7.5% | Health Plan Services Department Total | 833,427 | 979,262 | 145,835 | 14.9% |
| 585,494 | 618,512 | 33,019 | 5.3% | Case & Disease Management Department Total | 1,093,847 | 1,223,062 | 129,215 | 10.6% |
| 151,943 | 224,468 | 72,525 | 32.3% | Medical Services Department Total | 263,720 | 443,233 | 179,513 | 40.5% |
| 490,033 | 581,376 | 91,343 | 15.7% | Quality Management Department Total | 965,881 | 1,172,708 | 206,827 | 17.6% |
| 38,447 | 29,384 | (9,063) | (30.8%) | HCS Behavioral Health Department Total | 63,853 | 57,640 | (6,213) | (10.8%) |
| 111,767 | 123,536 | 11,769 | 9.5% | Pharmacy Services Department Total | 224,467 | 241,844 | 17,377 | 7.2% |
| 16,399 | 54,257 | 37,858 | 69.8% | Regulatory Readiness Total | 29,403 | 107,495 | 78,092 | 72.6% |
| **1,945,055** | **2,211,762** | **266,707** | **12.1%** | **14-Other Benefits & Services** | **3,627,391** | **4,383,119** | **755,728** | **17.2%** |
| | | | | Reinsurance Expense | | | | |
| (388,322) | (397,798) | (9,476) | 2.4% | Reinsurance Recoveries | (784,233) | (793,709) | (9,476) | 1.2% |
| 538,647 | 530,397 | (8,250) | (1.6%) | Stop-Loss Expense | 1,076,613 | 1,058,278 | (18,335) | (1.7%) |
| **150,325** | **132,599** | **(17,726)** | **(13.4%)** | **15-Reinsurance Expense** | **292,380** | **264,569** | **(27,811)** | **(10.5%)** |
| | | | | Preventive Health Services | | | | |
| **91,406,550** | **89,847,049** | **(1,559,501)** | **(1.7%)** | **17-TOTAL MEDICAL EXPENSES** | **181,232,252** | **179,514,713** | **(1,717,539)** | **(1.0%)** |

## Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

| Current Membership by Network By Category of Aid | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Category of Aid** | **Aug 2021** | **% of Medi-Cal** | **Independent (Direct)** | **AHS (Direct)** | **CFMG** | **CHCN** | **Kaiser** |
| Adults | 41,519 | 15% | 9,096 | 8,898 | 606 | 15,453 | 7,466 |
| Child | 97,324 | 34% | 9,403 | 8,729 | 29,348 | 32,323 | 17,521 |
| SPD | 26,316 | 9% | 8,381 | 4,041 | 1,079 | 10,822 | 1,993 |
| ACA OE | 99,783 | 35% | 16,037 | 33,050 | 1,133 | 36,688 | 12,875 |
| Duals | 20,388 | 7% | 8,026 | 2,188 | 1 | 7,354 | 2,819 |
| Medi-Cal | 285,330 | | 50,943 | 56,906 | 32,167 | 102,640 | 42,674 |
| Group Care | 5,877 | | 2,498 | 906 | - | 2,473 | - |
| **Total** | **291,207** | **100%** | **53,441** | **57,812** | **32,167** | **105,113** | **42,674** |
| Medi-Cal % | 98.0% | | 95.3% | 98.4% | 100.0% | 97.6% | 100.0% |
| Group Care % | 2.0% | | 4.7% | 1.6% | 0.0% | 2.4% | 0.0% |
| | *Network Distribution* | | *18.4%* | *19.9%* | *11.0%* | *36.1%* | *14.7%* |
| | | | **% Direct:** | **38%** | | **% Delegated:** | **62%** |

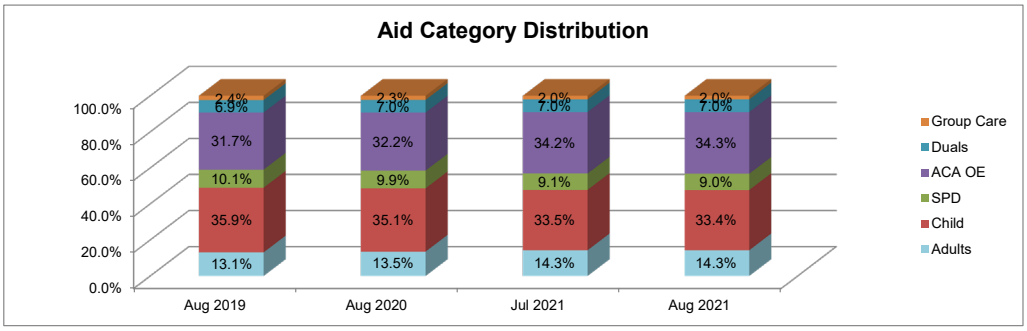


**Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile**

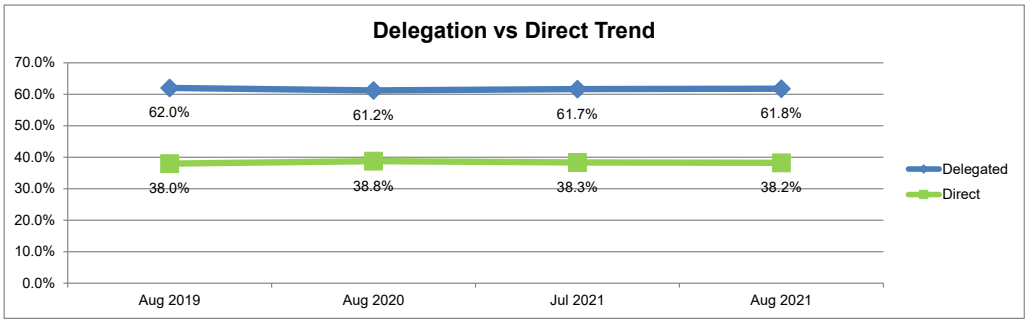
**Category of Aid Trend**

| | Members | | | | % of Total (ie.Distribution) | | | | % Growth (Loss) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Category of Aid | Aug 2019 | Aug 2020 | Jul 2021 | Aug 2021 | Aug 2019 | Aug 2020 | Jul 2021 | Aug 2021 | Aug 2019 to Aug 2020 | Aug 2020 to Aug 2021 | Jul 2021 to Aug 2021 |
| Adults | 33,448 | 35,689 | 41,358 | 41,519 | 13.1% | 13.5% | 14.3% | 14.3% | 6.7% | 16.3% | 0.4% |
| Child | 91,728 | 92,692 | 97,179 | 97,324 | 35.9% | 35.1% | 33.5% | 33.4% | 1.1% | 5.0% | 0.1% |
| SPD | 25,751 | 26,094 | 26,320 | 26,316 | 10.1% | 9.9% | 9.1% | 9.0% | 1.3% | 0.9% | 0.0% |
| ACA OE | 80,966 | 85,081 | 99,105 | 99,783 | 31.7% | 32.2% | 34.2% | 34.3% | 5.1% | 17.3% | 0.7% |
| Duals | 17,700 | 18,495 | 20,194 | 20,388 | 6.9% | 7.0% | 7.0% | 7.0% | 4.5% | 10.2% | 1.0% |
| Medi-Cal Total | 249,593 | 258,051 | 284,156 | 285,330 | 97.6% | 97.7% | 98.0% | 98.0% | 3.4% | 10.6% | 0.4% |
| Group Care | 6,020 | 6,007 | 5,935 | 5,877 | 2.4% | 2.3% | 2.0% | 2.0% | -0.2% | -2.2% | -1.0% |
| **Total** | **255,613** | **264,058** | **290,091** | **291,207** | **100.0%** | **100.0%** | **100.0%** | **100.0%** | **3.3%** | **10.3%** | **0.4%** |



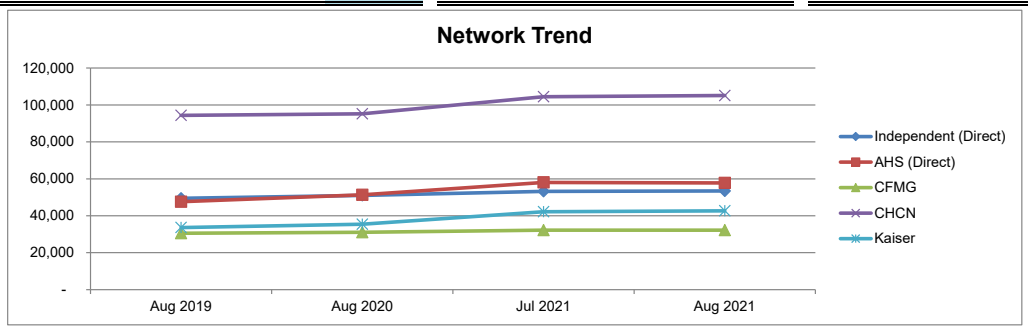

**Delegation vs Direct Trend**

| | Members | | | | % of Total (ie.Distribution) | | | | % Growth (Loss) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Members | Aug 2019 | Aug 2020 | Jul 2021 | Aug 2021 | Aug 2019 | Aug 2020 | Jul 2021 | Aug 2021 | Aug 2019 to Aug 2020 | Aug 2020 to Aug 2021 | Jul 2021 to Aug 2021 |
| Delegated | 158,520 | 161,689 | 178,857 | 179,954 | 62.0% | 61.2% | 61.7% | 61.8% | 2.0% | 11.3% | 0.6% |
| Direct | 97,093 | 102,369 | 111,234 | 111,253 | 38.0% | 38.8% | 38.3% | 38.2% | 5.4% | 8.7% | 0.0% |
| **Total** | **255,613** | **264,058** | **290,091** | **291,207** | **100.0%** | **100.0%** | **100.0%** | **100.0%** | **3.3%** | **10.3%** | **0.4%** |




**Network Trend**

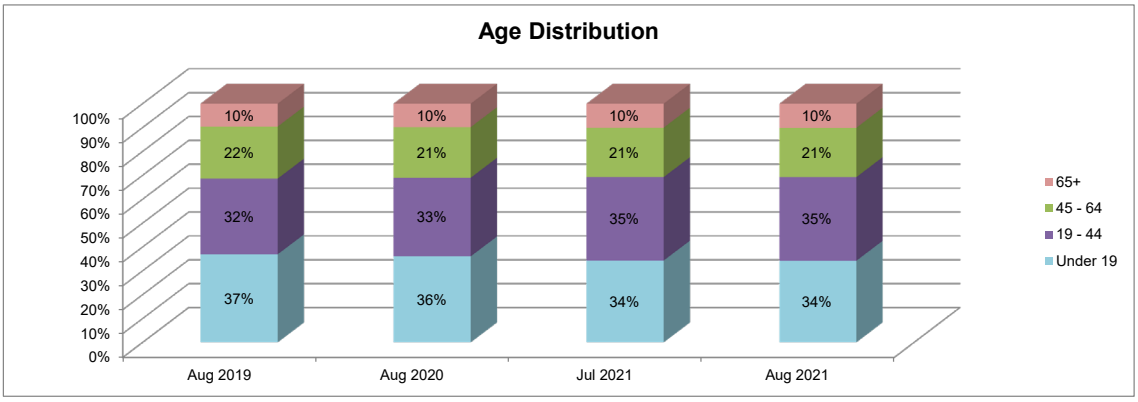
| | Members | | | | % of Total (ie.Distribution) | | | | % Growth (Loss) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Network | Aug 2019 | Aug 2020 | Jul 2021 | Aug 2021 | Aug 2019 | Aug 2020 | Jul 2021 | Aug 2021 | Aug 2019 to Aug 2020 | Aug 2020 to Aug 2021 | Jul 2021 to Aug 2021 |
| Independent (Direct) | 49,463 | 51,057 | 53,189 | 53,441 | 19.4% | 19.3% | 18.3% | 18.4% | 3.2% | 4.7% | 0.5% |
| AHS (Direct) | 47,630 | 51,312 | 58,045 | 57,812 | 18.6% | 19.4% | 20.0% | 19.9% | 7.7% | 12.7% | -0.4% |
| CFMG | 30,542 | 31,072 | 32,217 | 32,167 | 11.9% | 11.8% | 11.1% | 11.0% | 1.7% | 3.5% | -0.2% |
| CHCN | 94,360 | 95,194 | 104,433 | 105,113 | 36.9% | 36.1% | 36.0% | 36.1% | 0.9% | 10.4% | 0.7% |
| Kaiser | 33,618 | 35,423 | 42,207 | 42,674 | 13.2% | 13.4% | 14.5% | 14.7% | 5.4% | 20.5% | 1.1% |
| **Total** | **255,613** | **264,058** | **290,091** | **291,207** | **100.0%** | **100.0%** | **100.0%** | **100.0%** | **3.3%** | **10.3%** | **0.4%** |



**Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile**

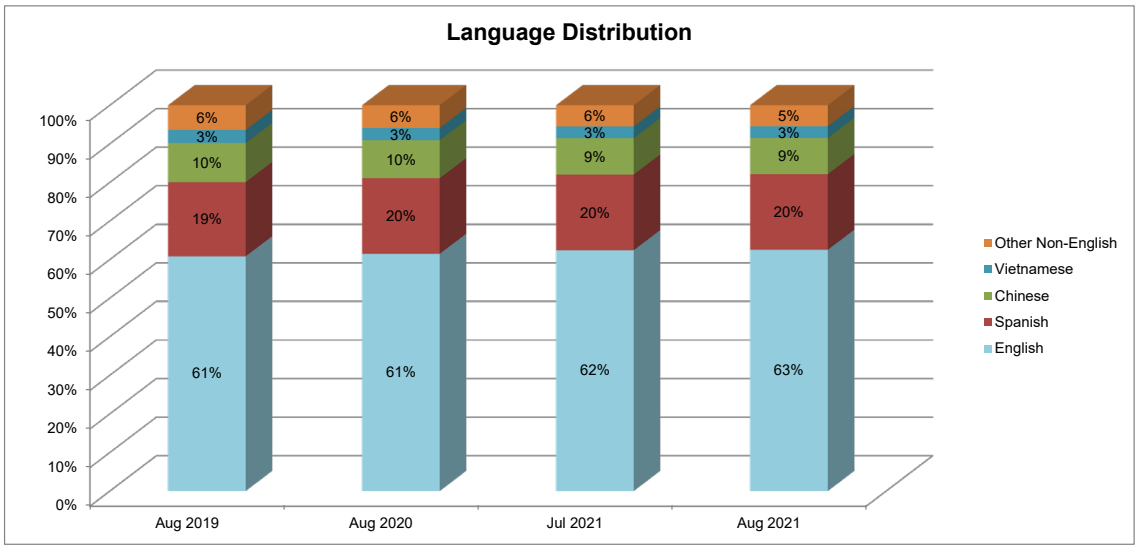
**Age Category Trend**

| | Members | | | | % of Total (ie.Distribution) | | | | % Growth (Loss) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Age Category | Aug 2019 | Aug 2020 | Jul 2021 | Aug 2021 | Aug 2019 | Aug 2020 | Jul 2021 | Aug 2021 | Aug 2019 to Aug 2020 | Aug 2020 to Aug 2021 | Jul 2021 to Aug 2021 |
| Under 19 | 94,368 | 95,188 | 99,517 | 99,634 | 37% | 36% | 34% | 34% | 1% | 5% | 0% |
| 19 - 44 | 81,099 | 87,011 | 101,407 | 102,009 | 32% | 33% | 35% | 35% | 7% | 17% | 1% |
| 45 - 64 | 55,662 | 55,910 | 60,069 | 60,200 | 22% | 21% | 21% | 21% | 0% | 8% | 0% |
| 65+ | 24,484 | 25,949 | 29,098 | 29,364 | 10% | 10% | 10% | 10% | 6% | 13% | 1% |
| **Total** | **255,613** | **264,058** | **290,091** | **291,207** | **100%** | **100%** | **100%** | **100%** | **3%** | **10%** | **0%** |




**Language Trend**

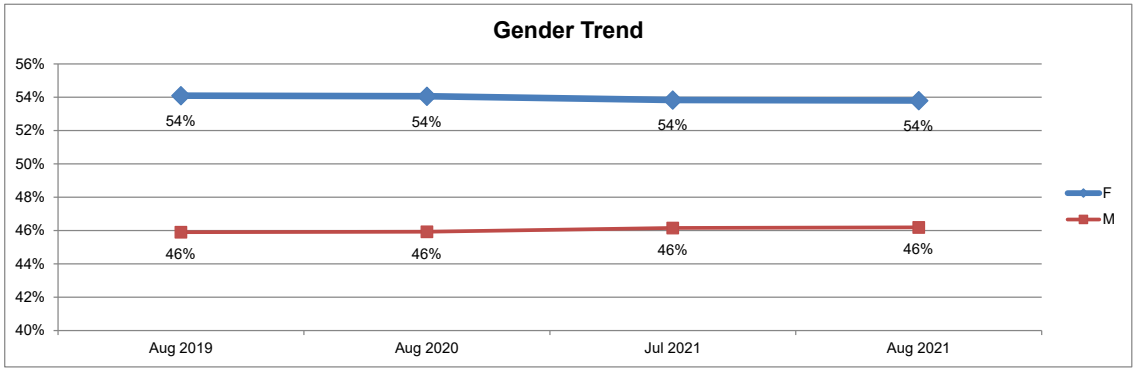
| | Members | | | | % of Total (ie.Distribution) | | | | % Growth (Loss) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Language | Aug 2019 | Aug 2020 | Jul 2021 | Aug 2021 | Aug 2019 | Aug 2020 | Jul 2021 | Aug 2021 | Aug 2019 to Aug 2020 | Aug 2020 to Aug 2021 | Jul 2021 to Aug 2021 |
| English | 155,483 | 162,321 | 181,065 | 182,065 | 61% | 61% | 62% | 63% | 4% | 12% | 1% |
| Spanish | 49,190 | 51,725 | 56,862 | 57,124 | 19% | 20% | 20% | 20% | 5% | 10% | 0% |
| Chinese | 25,891 | 25,941 | 27,378 | 27,385 | 10% | 10% | 9% | 9% | 0% | 6% | 0% |
| Vietnamese | 8,626 | 8,470 | 8,828 | 8,772 | 3% | 3% | 3% | 3% | -2% | 4% | -1% |
| Other Non-English | 16,423 | 15,601 | 15,958 | 15,861 | 6% | 6% | 6% | 5% | -5% | 2% | -1% |
| **Total** | **255,613** | **264,058** | **290,091** | **291,207** | **100%** | **100%** | **100%** | **100%** | **3%** | **10%** | **0%** |



**Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile**

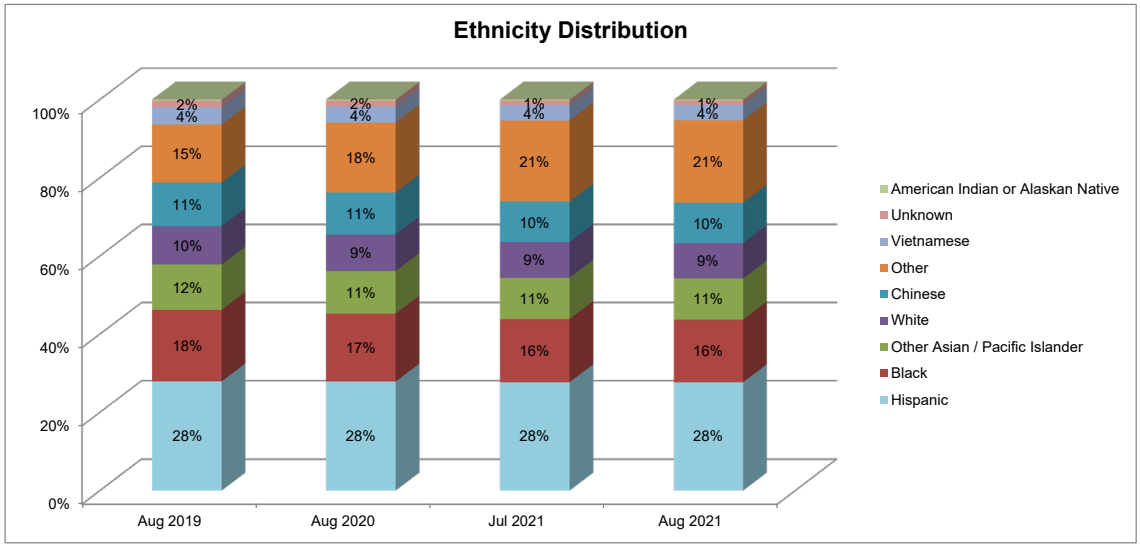
**Gender Trend**

| | Members | | | | % of Total (ie.Distribution) | | | | % Growth (Loss) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Gender | Aug 2019 | Aug 2020 | Jul 2021 | Aug 2021 | Aug 2019 | Aug 2020 | Jul 2021 | Aug 2021 | Aug 2019 to Aug 2020 | Aug 2020 to Aug 2021 | Jul 2021 to Aug 2021 |
| F | 138,278 | 142,759 | 156,178 | 156,688 | 54% | 54% | 54% | 54% | 3% | 10% | 0% |
| M | 117,335 | 121,299 | 133,913 | 134,519 | 46% | 46% | 46% | 46% | 3% | 11% | 0% |
| **Total** | **255,613** | **264,058** | **290,091** | **291,207** | **100%** | **100%** | **100%** | **100%** | **3%** | **10%** | **0%** |




**Ethnicity Trend**

| | Members | | | | % of Total (ie.Distribution) | | | | % Growth (Loss) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Ethnicity | Aug 2019 | Aug 2020 | Jul 2021 | Aug 2021 | Aug 2019 | Aug 2020 | Jul 2021 | Aug 2021 | Aug 2019 to Aug 2020 | Aug 2020 to Aug 2021 | Jul 2021 to Aug 2021 |
| Hispanic | 71,300 | 73,556 | 80,361 | 80,668 | 28% | 28% | 28% | 28% | 3% | 10% | 0% |
| Black | 46,805 | 45,864 | 46,843 | 46,640 | 18% | 17% | 16% | 16% | -2% | 2% | 0% |
| Other Asian / Pacific Islander | 29,677 | 28,805 | 30,700 | 30,667 | 12% | 11% | 11% | 11% | -3% | 6% | 0% |
| White | 25,084 | 24,655 | 26,392 | 26,303 | 10% | 9% | 9% | 9% | -2% | 7% | 0% |
| Chinese | 28,526 | 28,346 | 30,090 | 30,056 | 11% | 11% | 10% | 10% | -1% | 6% | 0% |
| Other | 37,897 | 47,252 | 60,195 | 61,466 | 15% | 18% | 21% | 21% | 25% | 30% | 2% |
| Vietnamese | 11,218 | 10,987 | 11,369 | 11,324 | 4% | 4% | 4% | 4% | -2% | 3% | 0% |
| Unknown | 4,478 | 3,991 | 3,523 | 3,468 | 2% | 2% | 1% | 1% | -11% | -13% | -2% |
| American Indian or Alaskan Native | 628 | 602 | 618 | 615 | 0% | 0% | 0% | 0% | -4% | 2% | 0% |
| **Total** | **255,613** | **264,058** | **290,091** | **291,207** | **100%** | **100%** | **100%** | **100%** | **3%** | **10%** | **0%** |



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

**Medi-Cal By City**

| City | Aug 2021 | % of Total | Independent (Direct) | AHS (Direct) | CFMG | CHCN | Kaiser |
|---|---|---|---|---|---|---|---|
| Oakland | 113,465 | 40% | 12,596 | 27,249 | 13,978 | 47,483 | 12,159 |
| Hayward | 44,356 | 16% | 8,749 | 9,476 | 4,907 | 13,378 | 7,846 |
| Fremont | 25,485 | 9% | 9,662 | 3,901 | 842 | 6,817 | 4,263 |
| San Leandro | 25,707 | 9% | 4,353 | 4,014 | 3,335 | 9,473 | 4,532 |
| Union City | 12,186 | 4% | 4,400 | 1,861 | 382 | 3,208 | 2,335 |
| Alameda | 10,939 | 4% | 2,017 | 1,741 | 1,610 | 3,831 | 1,740 |
| Berkeley | 10,205 | 4% | 1,496 | 1,703 | 1,281 | 4,142 | 1,583 |
| Livermore | 8,686 | 3% | 996 | 844 | 1,900 | 3,353 | 1,593 |
| Newark | 6,552 | 2% | 1,779 | 2,066 | 192 | 1,261 | 1,254 |
| Castro Valley | 7,073 | 2% | 1,350 | 1,149 | 1,059 | 2,061 | 1,454 |
| San Lorenzo | 6,077 | 2% | 935 | 1,037 | 728 | 2,094 | 1,283 |
| Pleasanton | 4,615 | 2% | 876 | 468 | 469 | 2,001 | 801 |
| Dublin | 4,959 | 2% | 879 | 481 | 641 | 2,012 | 946 |
| Emeryville | 1,878 | 1% | 319 | 361 | 305 | 575 | 318 |
| Albany | 1,748 | 1% | 270 | 233 | 360 | 525 | 360 |
| Piedmont | 330 | 0% | 47 | 82 | 27 | 88 | 86 |
| Sunol | 62 | 0% | 10 | 12 | 7 | 20 | 13 |
| Antioch | 20 | 0% | 2 | 12 | 1 | 3 | 2 |
| Other | 987 | 0% | 207 | 216 | 143 | 315 | 106 |
| **Total** | **285,330** | **100%** | **50,943** | **56,906** | **32,167** | **102,640** | **42,674** |

**Group Care By City**

| City | Aug 2021 | % of Total | Independent (Direct) | AHS (Direct) | CFMG | CHCN | Kaiser |
|---|---|---|---|---|---|---|---|
| Oakland | 1,990 | 34% | 491 | 374 | - | 1,125 | - |
| Hayward | 660 | 11% | 377 | 131 | - | 152 | - |
| Fremont | 609 | 10% | 451 | 57 | - | 101 | - |
| San Leandro | 566 | 10% | 219 | 90 | - | 257 | - |
| Union City | 317 | 5% | 228 | 30 | - | 59 | - |
| Alameda | 285 | 5% | 109 | 25 | - | 151 | - |
| Berkeley | 171 | 3% | 52 | 12 | - | 107 | - |
| Livermore | 82 | 1% | 30 | 1 | - | 51 | - |
| Newark | 141 | 2% | 86 | 37 | - | 18 | - |
| Castro Valley | 181 | 3% | 88 | 22 | - | 71 | - |
| San Lorenzo | 129 | 2% | 56 | 19 | - | 54 | - |
| Pleasanton | 52 | 1% | 27 | 1 | - | 24 | - |
| Dublin | 106 | 2% | 41 | 12 | - | 53 | - |
| Emeryville | 25 | 0% | 9 | 3 | - | 13 | - |
| Albany | 15 | 0% | 7 | 2 | - | 6 | - |
| Piedmont | 15 | 0% | 4 | 1 | - | 10 | - |
| Sunol | - | 0% | - | - | - | - | - |
| Antioch | 27 | 0% | 6 | 10 | - | 11 | - |
| Other | 506 | 9% | 217 | 79 | - | 210 | - |
| **Total** | **5,877** | **100%** | **2,498** | **906** | **-** | **2,473** | **-** |

**Total By City**

| City | Aug 2021 | % of Total | Independent (Direct) | AHS (Direct) | CFMG | CHCN | Kaiser |
|---|---|---|---|---|---|---|---|
| Oakland | 115,455 | 40% | 13,087 | 27,623 | 13,978 | 48,608 | 12,159 |
| Hayward | 45,016 | 15% | 9,126 | 9,607 | 4,907 | 13,530 | 7,846 |
| Fremont | 26,094 | 9% | 10,113 | 3,958 | 842 | 6,918 | 4,263 |
| San Leandro | 26,273 | 9% | 4,572 | 4,104 | 3,335 | 9,730 | 4,532 |
| Union City | 12,503 | 4% | 4,628 | 1,891 | 382 | 3,267 | 2,335 |
| Alameda | 11,224 | 4% | 2,126 | 1,766 | 1,610 | 3,982 | 1,740 |
| Berkeley | 10,376 | 4% | 1,548 | 1,715 | 1,281 | 4,249 | 1,583 |
| Livermore | 8,768 | 3% | 1,026 | 845 | 1,900 | 3,404 | 1,593 |
| Newark | 6,693 | 2% | 1,865 | 2,103 | 192 | 1,279 | 1,254 |
| Castro Valley | 7,254 | 2% | 1,438 | 1,171 | 1,059 | 2,132 | 1,454 |
| San Lorenzo | 6,206 | 2% | 991 | 1,056 | 728 | 2,148 | 1,283 |
| Pleasanton | 4,667 | 2% | 903 | 469 | 469 | 2,025 | 801 |
| Dublin | 5,065 | 2% | 920 | 493 | 641 | 2,065 | 946 |
| Emeryville | 1,903 | 1% | 328 | 364 | 305 | 588 | 318 |
| Albany | 1,763 | 1% | 277 | 235 | 360 | 531 | 360 |
| Piedmont | 345 | 0% | 51 | 83 | 27 | 98 | 86 |
| Sunol | 62 | 0% | 10 | 12 | 7 | 20 | 13 |
| Antioch | 47 | 0% | 8 | 22 | 1 | 14 | 2 |
| Other | 1,493 | 1% | 424 | 295 | 143 | 525 | 106 |
| **Total** | **291,207** | **100%** | **53,441** | **57,812** | **32,167** | **105,113** | **42,674** |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# Resolution

RESOLUTION NO. 2021-14

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH AMENDING THE ALLOWABLE MEMBERSHIP TO ITS STRATEGIC PLANNING COMMITTEE

WHEREAS the Alameda Alliance for Health ("Alliance") Board of Governors ("the Board") has adopted Bylaws, Article 7 of which allows for the creation of standing committees by way of resolution; and

WHEREAS the Board approved Resolution No. 99-01[1] on April 22, 1999, which provides for the composition of the Strategic Planning Committee to consist of seven (7) Board Members and the Chief Executive Officer of Alliance ("the CEO") serving ex officio as a voting member.

WHEREAS Alliance Bylaws section 4.D.7, as approved by the Alameda County Board of Supervisors on March 2, 2021, state that the CEO shall serve ex officio as a non-voting member on the Strategic Planning Committee and shall not be counted towards a quorum.

WHEREAS Alliance Bylaws superseded all conflicting resolutions to the Board and therefore predicate the composition and role of the CEO on the Strategic Planning Committee.

WHEREAS the Board at this time desires to change the voting membership of the Strategic Planning Committed from seven (7) members to four (4) members.

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

SECTION 1. The Chief Executive Officer of Alliance shall serve ex officio as a non-voting member on the Strategic Planning Committee and shall not be counted towards a quorum in compliance with Alliance Bylaws.

SECTION 2. The Strategic Planning Committee will consist of four (4) voting members. Appointments to this Committee shall be for a term of two (2) years, and members may be reappointed to additional terms with the Board's approval. As stated in Alliance Bylaws section 7.C.8, the Chair and Vice Chair of the Committee shall be selected and approved by the Board.

[1] 99-01 Resolution to Amend Resolution 96-03 and 97-01 Changing the Composition of the Standing Strategic Planning Committee of the Alameda Alliance for Health Board of Governors and Appointment of New Members to the Committee.

PASSED AND ADOPTED by Alliance's Board of Governors at a meeting held on the 8th day of October 2021.

_____
CHAIR, BOARD OF GOVERNORS

ATTEST:

_____
Secretary


# Staff Report

TO: Alameda Alliance for Health Board of Governors

FROM: David B. Vliet, Alameda Alliance Board of Governors

DATE: October 8, 2021

SUBJECT: Member Nominations to the Standing Strategic Planning Committee

**RECOMMENDED ACTION**

To approve a motion to nominate four (4) seats to the Strategic Planning Committee for a term of two (2) years and corresponding nomination of a Chair and Vice Chair. The following members of the Alameda Alliance Board of Governors are proposed for nomination:

- David B. Vliet (Chair)
- Marty Lynch (Vice Chair)
- Dr. Kelley Meade
- Dr. Evan Seevak

**DISCUSSION**

The Alameda Alliance ("Alliance") Board of Governors ("Board") approved Resolution No. 2021-14[1] on October 8, 2021, which provides for the composition of the Strategic Planning Committee ("Committee") of four (4) Board Members and the Chief Executive Officer ("CEO") serving ex officio as a non-voting member. This is in alignment with the Alliance Bylaws, as approved by the Alameda County Board of Supervisors on March 2, 2021. Bylaws section 4.D.7, states that the CEO of the Alliance shall serve ex officio as a non-voting member on the Committee and shall not be counted towards a quorum. Bylaws section 7.A.1, states that the composition of the Committee shall be as set forth by Resolution. Bylaws Section 7.C.8, provides for the selection of the Chair and Vice Chair of the Committee by the Board.

**FISCAL IMPACT**

This action will not have a fiscal impact.

**ATTACHMENTS**

N/A

[1] 2021-14 A Resolution of Alameda Alliance for Health Amending the Allowable Membership to Its Strategic Planning Committee

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# CalAIM Progress Report

# *CalAIM Implementation Readiness*

## *Progress Report*

*Presented to the Alameda Alliance Board of Governors*

*Scott Coffin, Chief Executive Officer*

*October 8th, 2021*

# Current Financial Projections

- DHCS changed the name “In Lieu Of Services” to “Community Supports” in September
- Alameda Alliance is launching a total of six (6) Community Supports on January 1, 2022
- As more information has been provided, the projected annual costs for Community Supports has increased to $18.75 million per year (adding 11% contingency increases to $21 million)
- Preliminary budget excludes the projected revenue and expenses for Enhance Care Management, Community Supports, and Major Organ Transplants (to be included in the final budget in December)

| Community Supports | Potential Annual Costs | Contracted Entity |
|---|---|---|
| Asthma Remediation | $750K | Alameda County HCSA |
| Housing Navigation & Tenancy Sustaining | $7.5M | Alameda County HCSA |
| Housing Deposits & Other | $5.8M | Alameda County HCSA |
| Meals / Medically Tailored Meals | $2.5M | Alameda County ALL IN and Community Based Organizations |
| Recuperative Care / Medical Respite | $2.2M | Community Based Organizations |
| **Totals** | **$18.75M** | |

# Funding Approach for 2022, 2023, and 2024

- The Department of Health Care Services (DHCS) released base rates and incentives for Calendar Year (CY) 2022, and these funds will be applied to the actual costs, and supplemented through the Alliance's financial reserves as needed
- "Projects for Assistance in Transition from Homelessness", or PATH funding, will be pursued jointly by Alameda County HCSA and Alameda Alliance for funding in CY2023 and CY2024 to sustain the housing services
- In addition to PATH funding, enhanced Home- and Community-Based services (HCBS) funding may be available in CY2023 and CY2024

# Progress Report

- Contract negotiations continued in the month of September between Alliance & Alameda County Health Care Services Agency (HCSA) and Alameda Alliance for housing navigation & tenancy sustaining services, including housing deposits, and asthma remediation
  - October: Base contract is submitted to Alameda County Legal Counsel
  - November: Final contract will be submitted to the Alameda County Board of Supervisors for approval
- Alameda Alliance & Alameda County ALL IN met with the DHCS to review the food & nutrition costs related to the Recipe4Health program
- Alameda County and Alameda Alliance meetings with DHCS were completed in July and September, and more meetings are scheduled in October to validate the reimbursement assumptions for rate development (e.g. actual expenses in CY2022 are incorporated by DHCS into base rates in CY2025)

# Progress Report (cont'd)

- Last week the DHCS released rates & incentives for Calendar Year 2022 (January – December), includes Enhance Care Management, Community Supports, and Major Organ Transplants
  - Alameda Alliance's Finance Team is reviewing the rates and incentives, and will be adjusting the FY2022 revenue and expense forecasts later in the month of October
- Final submission of the Model of Care delivered to the DHCS on October 1st
- CalAIM Operational Readiness continues for the next 90 days
  - Approximately 232 members being served in Whole Person Care and 717 in the Health Homes Program may be eligible to transition on January 1, 2022 (subject to change by December 31st)
  - Operations readiness includes community-based organizations and other contracted entities

# Questions?

**Scott Coffin**
Chief Executive Officer
Alameda Alliance for Health

scoffin@alamedaalliance.org

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# Vaccination Incentive Program Update

# COVID-19 Vaccinations & Incentives

## Progress Report

*Presented to the Alameda Alliance Board of Governors*

*Matt Woodruff, Chief Operations Officer*

*October 8th, 2021*

# Progress Report
## COVID-19 Vaccinations

- As of October 4th, 2021
  - 66% of members 12 years and older are vaccinated (fully/partially)
    - → Medi-Cal: 154,232 of 226,017 persons
    - → Group Care: 4,128 of 6,000 persons
- 78% of older adults (65 and older) are vaccinated
- Alameda County average is 91% vaccinated

# Progress Report
## Vaccination Incentives

- The state approved the Alliance's vaccination response plan. The Alliance was awarded up to $8.4 million dollars to fund outreach activities and local investments in vaccination services, leveraging vaccination resources administered by Alameda County and local health centers.
- New announcement from The Department of Health Care Services - as of October 1, 2021 - 85% threshold set for vaccination rates. The Alliance needs to reach 85% of Medi-Cal members being vaccinated by the end of February 2022 in order to receive 100% of the allocated funding.
- Performance measures related to the incentive funding are being assessed.
- Goal to increase vaccination rates, for Alliance Medi-Cal Beneficiaries, by 19%

# Progress Report

## Vaccination Incentives

- The Alliance hired a part-time consultant to manage the work plan, coordinate resources to execute activities, monitor & report performance, and to engage as our community liaison.
- Outreach plan includes ‘gap in care’ reports, live outbound calling (after hours and weekends), pharmacy outreach, billboards around town, bus stops and BART terminals, provider incentives, and working with HCSA (mobile clinics, schools, Santa Rita Jail) and many faith-based organizations.

# Progress Report

## Vaccination Incentives

- The first ‘gap in care’ reports were sent to providers on September 17th, 2021, showing their patients who are not yet vaccinated.
- A final workplan will be completed the week of October 4th, 2021.
- Social Media messaging for round 4 was completed the week of September 27th, 2021. Messages will be shared weekly to counter misinformation.
- Billboards for round 4 will be installed the week of October 18th, 2021. A media buy for Bart and AC Transit placement is being reviewed and will be a part of the upcoming work plan.
- Meetings with community partners started the week of September 27th, 2021 and will continue through the month of February 2022.

# COVID-19 Vaccination Dashboard Summary as % of Population

**(Ages >= 12 Years) Data as of: 2021-10-03**

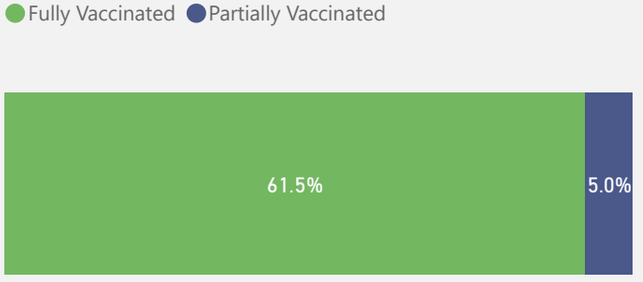
v4 | Network: All | LOB: All | City: All

ALAMEDA Alliance FOR HEALTH

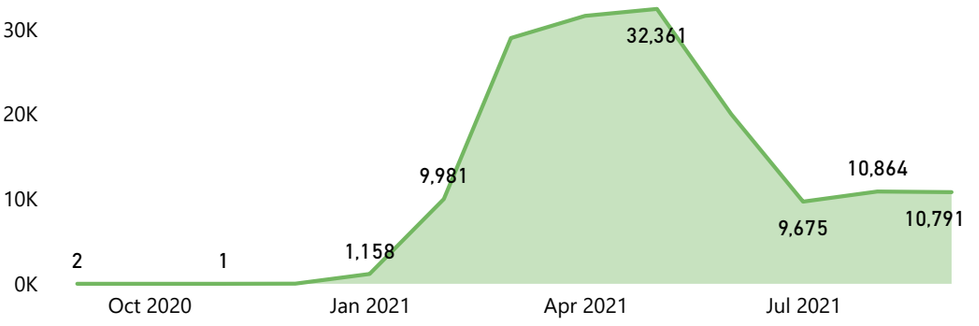
Members Fully Or Partially Vaccinated: **155,308**

% Fully Or Partially Vaccinated: **66.5%**

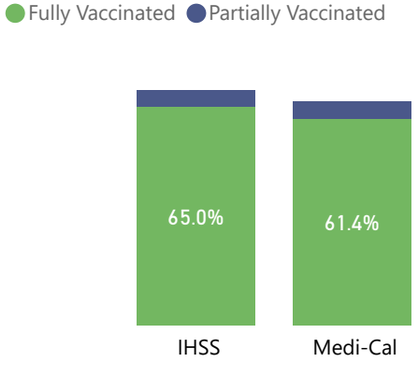
## Breakout by Status



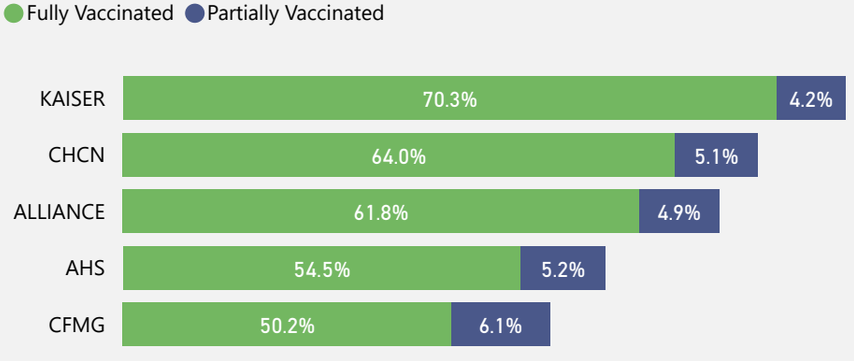

## Monthly Trend




## Medi-Cal vs IHSS

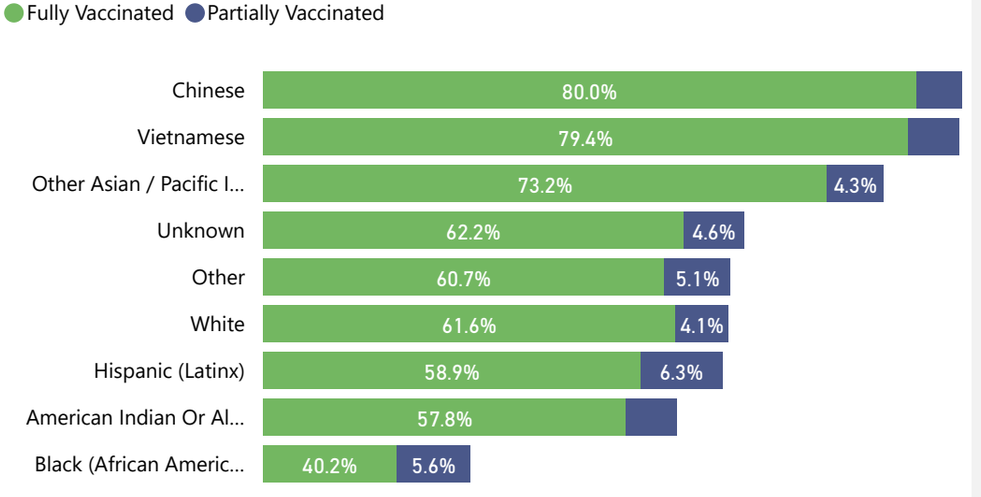



## Network

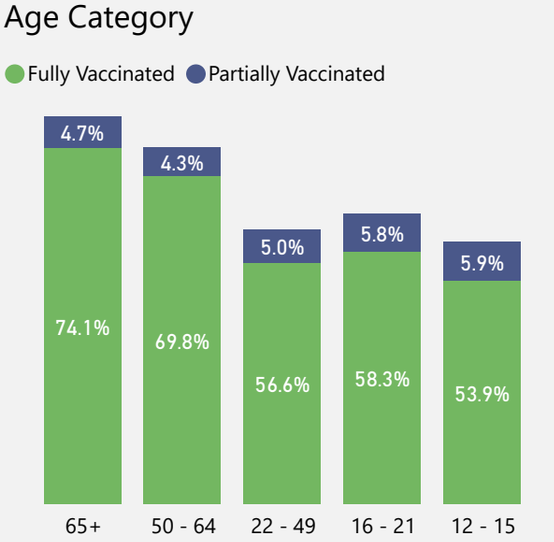



| Top 15 Cities | Fully Vaccinated | Partially Vaccinated |
|---|---|---|
| ALAMEDA | 69.4% | 4.2% |
| ALBANY | 74.6% | 4.1% |
| BERKELEY | 64.5% | 4.6% |
| CASTRO VALLEY | 67.0% | 4.7% |
| DUBLIN | 65.0% | 5.1% |
| EMERYVILLE | 58.2% | 5.2% |
| FREMONT | 67.4% | 4.4% |
| HAYWARD | 60.6% | 5.4% |
| LIVERMORE | 57.9% | 5.3% |
| NEWARK | 64.6% | 5.1% |
| OAKLAND | 56.5% | 5.5% |
| PLEASANTON | 66.3% | 4.2% |
| SAN LEANDRO | 65.4% | 4.5% |
| SAN LORENZO | 69.1% | 4.0% |
| UNION CITY | 68.7% | 4.4% |

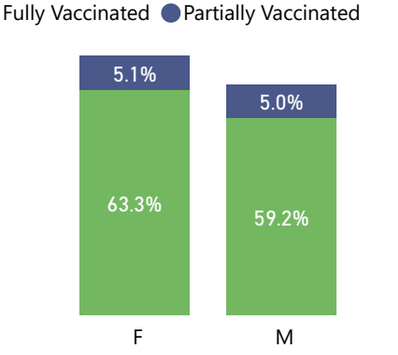
## Ethnicity




## Age Category




## Gender



# COVID-19 Vaccinated vs Unvaccinated Comparison (Ages >= 12 Years) v4

**Data as of: 2021-10-03**

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

ALAMEDA Alliance FOR HEALTH

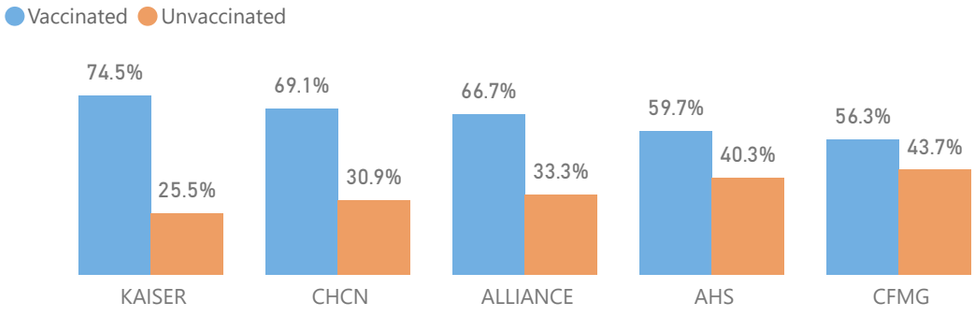
## Vaccinated Members

155,308 Members | 66.5% % of Population

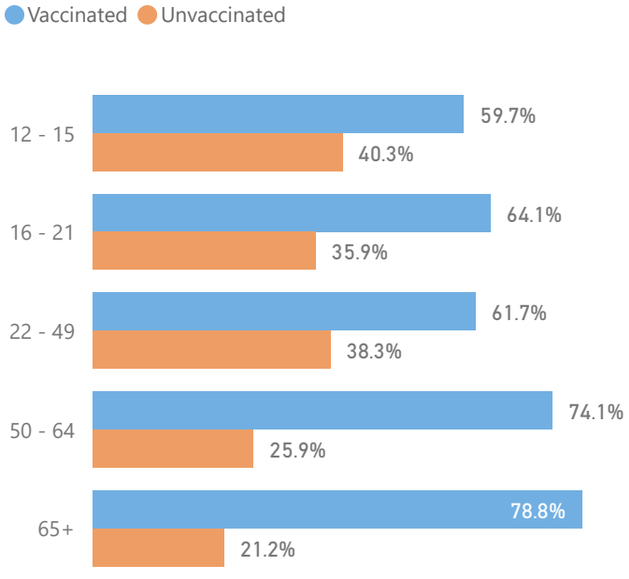
## Unvaccinated Members

78,213 Members | 33.5% % of Population

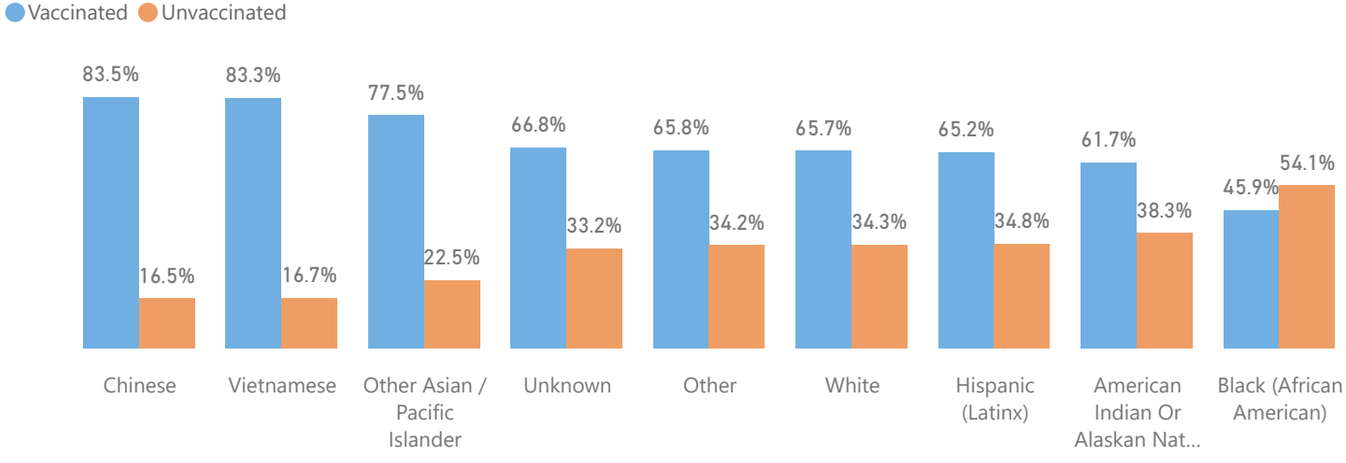
### By Network



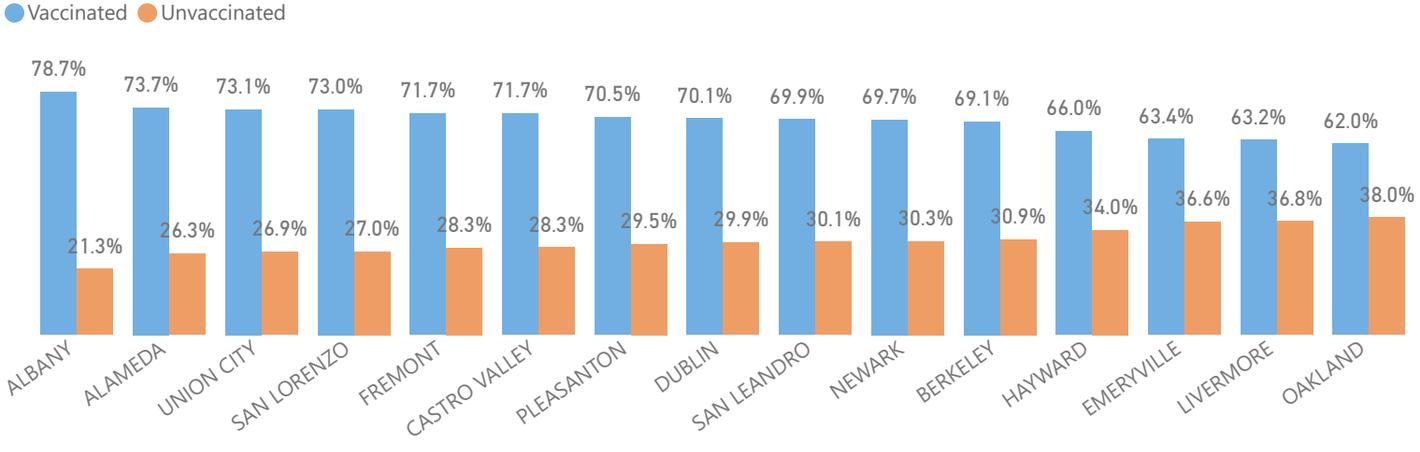

### By AgeBand



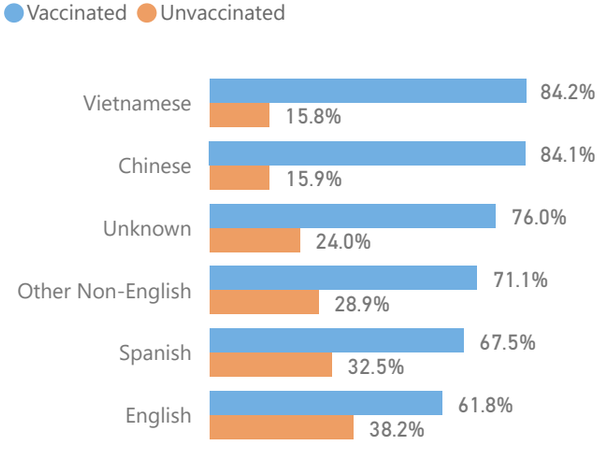

### By Ethnicity




### By City




### By Language



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# Single Plan Model Update

# *Single Plan Model*

## *Progress Report*

*Presented to the Alameda Alliance Board of Governors*

*Scott Coffin, Chief Executive Officer*

*October 8th, 2021*

# Background

- In October of 2020, the California Department of Health Care Services (DHCS) invited county public health agencies the option to change Medi-Cal managed care models
- Independent assessment launched in May 2021 to identify the benefits and impacts to members, providers, and county; financials, governance, and legislative requirements also included in the assessment. Active participation by senior leadership from Alameda Health System, Community Health Center Network, Alameda County Health Care Services Agency, and other caregivers.
- The Alliance's Board of Governors approved to file a Letter of Intent, in partnership with Alameda County Board of Supervisors and Alameda County Health Care Services Agency.
- The Letter of Intent was filed with the California Department of Health Care Services (DHCS) in April 2021, and DHCS conditionally approved on August 31st.
- Series of progress reports delivered to the Alameda Alliance Board of Governors, beginning in the fourth quarter of 2020 and continuing in 2021 as progress was made, including presentations to Alameda County Board of Supervisors and Health Committee

# Progress Report

- The Alameda County Board of Supervisors approved a new Ordinance on September 28th that establishes a single health plan to serve Medi-Cal managed care beneficiaries in Alameda County.
- The DHCS is defining the roadmap to complete the transition to a single plan model, expecting to announce within the next 30-60 days; includes the 1115 Waiver provisions, regulatory requirements, and operational readiness criteria.
- Alameda Alliance to initiate capacity assessment to understand the operational impacts by adding 140,000+ members, provider network expansion, and to identify the projected costs to scale operations.
  - Initial estimate is $3 - $4 million dollars to complete organizational readiness by 2024
- The independent assessment is scheduled to conclude in the month of November, and may be extended based on the regulatory process.
- Currently preparing to submit financial and compliance filings to the DHCS in October and December.
- Operational readiness phase would occur in calendar years 2022 and 2023, including a series of public stakeholder engagements and notifications to Medi-Cal Beneficiaries and Medi-Cal Providers.

# Comparison of the Single Plan and Two-Plan Models

| Category | Two-Plan | Single Plan Model |
|---|---|---|
| Board of Supervisors / Governance | Local Ordinance | Local Ordinance |
| Health Plan Operations & Solvency (Incurred risk to Alameda County) | Alameda Alliance operates independently, and carries full risk | Alameda Alliance operates independently, and carries full risk |
| Medi-Cal Beneficiary Choice | Alameda Alliance, Commercial health plan | Alameda Alliance |
| Medi-Cal Rate Development | Retrospective, 3 years | Retrospective, 3 years |
| Covered Benefits & Services | Base Medi-Cal covered services | Base plus long-term care, whole child, other |
| Medi-Cal Enrollment & Disenrollment | AC Social Services | AC Social Services |
| Regulatory Oversight | DMHC/DHCS | DMHC/DHCS |
| Medi-Cal Procurement | Commercial health plan chosen by DHCS | Exempt |

# Statewide Status

## Counties pursuing change in their Medi-Cal Delivery Model

- **Two-Plan Counties converting to Single Plan Model**
  - **Alameda County: Single Plan Model with Alameda Alliance for Health**
  - Contra Costa County: Single Plan Model with Contra Costa Health Plan
  - Imperial County: Single Plan Model with California Health and Wellness
- **COHS with Central California Alliance for Health**
  - Mariposa County
  - San Benito County
- **COHS with Partnership Health Plan**
  - Colusa, Nevada, Plumas, Placer, Butte, Tehama, Glenn, Sierra, Yuba, and Sutter Counties
- **Two-Plan with Health Plan of San Joaquin**
  - El Dorado County
  - Alpine County

# Questions?

**Scott Coffin**
Chief Executive Officer
Alameda Alliance for Health

scoffin@alamedaalliance.org


# Compliance

## Richard Golfin III

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

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

**Date:** **October 8, 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. One (1) out of the seven (7) the deficiencies has been remediated. the Plan and CHCN continue to pursue milestones in its implementation of the remaining corrective measures, as well as addressing follow-up items from the State.

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

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

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

  - The Plan received the preliminary audit report on July 15, 2021, and the Plan submitted its response to the preliminary findings on August 4, 2021. The Plan received the final audit report on August 24, 2021 which had a total of 33 findings. The Corrective Action Plan response was submitted to

DHCS on September 23, 2021.The Plan is working to remediate the audit findings.

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

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

**Delegation Oversight Auditing Activities 2020**

- The Plan conducts annual audits of its delegated entities to monitor compliance with regulatory and contractual requirements. The Plan has seven (7) delegates, and all seven (7) delegates were audited during the previous calendar year. The Plan issued Final Audit Report and CAP to each delegate. One (1) CAP remains open, all others have been closed. The Compliance Department continues to work closely with the delegate and Plan staff to close the remaining CAP.

**Delegation Oversight Auditing Activities 2021**

- On April 27, 2021, the Plan launched 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 audit took place on August 10, 2021, and was performed by the Plan's consultant, PillarRx, in collaboration with Plan staff. The Final Audit Report was received by

the Plan on September 16, 2021. PerformRx was issued the Report on October 4, 2021.There were no findings identified in the Final Audit Report.

- In collaboration with 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. Alliance Staff held an internal kick-off meeting on May 6, 2021, to discuss scope, timing, expectations, and key dates. The Alliance is responsible for reviewing policies and procedures for the Kaiser Population Health Management Program, Provider Dispute Resolution Program and Claims Administration Programs. On June 23, 2021, the Plan received pre-audit documentation and the audit is currently in progress.

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# Health Care Services

## Steve O'Brien, MD

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

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

**Date:** **October 8, 2021**

**Subject:** **Health Care Services Report**

## Utilization Management: Outpatient

- DMHC/DHCS combined audit: Action Plans on UM findings from the DHCS audit have are launching, including workflow improvement, staff training and monitoring.

- Significant progress continues on UM/Claims/Configuration collaboration and improved alignment, and the work is ongoing. This standardization improves accuracy and timeliness of claims payment.

- Provider Portal prior authorization submissions: The UM team is receiving authorizations submitted online via the Provider Portal. The percentage of referrals being received via the Portal is hovering around 35 to 40%. Work is being done to continue to identify providers with low usage of the portal for provider outreach and training on the portal system.

- Major Organ Transplant (MOT) workgroups developed to meet DHCS MOT certification for 1/1/2022 implementation. Focused work is being done on network certification requirements, workflows, prior authorization, and coding.

- Enhancements for CCS connectivity are in planning, with development of reports and workflows to identify members who would benefit from referrals to CCS and coordination of services for those in CCS.

| Outpatient Authorization Denial Rates | | | |
|---|---|---|---|
| **Denial Rate Type** | **June 2021** | **July 2021** | **Aug 2021** |
| Overall Denial Rate | 4.3% | 3.6% | 3.5% |
| Denial Rate Excluding Partial Denials | 4.4% | 3.8% | 3.8% |
| Partial Denial Rate | 0.1% | 0.2% | 0.2% |

| Turn Around Time Compliance | | | |
|---|---|---|---|
| **Line of Business** | **June 2021** | **July 2021** | **Aug 2021** |
| Overall | 99% | 98% | 99% |
| Medi-Cal | 99% | 98% | 99% |
| IHSS | 100% | 100% | 100% |
| *Benchmark* | *95%* | *95%* | *95%* |

**Utilization Management: Inpatient**

- With the spread of the Delta variant, acute COVID hospitalizations had sharply increased during the months of July and August but have since declined again. Inpatient department is tracking these admissions, along with vaccination status, and referring members with acute COVID admission to the Case Management team for TOC follow up.

- Weekly complex/long stay patient rounds continue with Sutter, AHS, Washington, Kindred and Kentfield hospitals with a goal of removing barriers to discharge. Focus is on longer lengths of stay and challenging placement patients, including COVID.

- Ongoing work with UM Medical Director Rosalia Mendoza includes refinement of policies and procedures related to NOA language, round formats refinements, case escalations to medical directors and facility transfers.

- Partnerships in TOC continues with Alameda Health System (AHS). The decline in the AHS Readmission rate is continuing since the launch of the TOC program with them.

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

| **Inpatient Med-Surg Utilization**<br>Total All Aid Categories<br>**Actuals (excludes Maternity)** | | | |
|---|---|---|---|
| **Metric** | **May 2021** | **June 2021** | **July 2021** |
| Authorized LOS | 4.6 | 4.9 | 4.7 |
| Admits/1,000 | 56.5 | 55.5 | 60.2 |
| Days/1,000 | 259.8 | 272.4 | 282.2 |

**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 | 808 |
| Denied | 624 |
| Closed | 672 |
| Total | **2104** |

| Line of Business | Turn Around Rate compliance (%) |
|---|---|
| Medi-CAL | 98 |
| Group Care | 100 |

- Medications for diabetes, acne, pain, hypertriglyceridemia, and actinic keratoses are top 10 categories for denials.

| Rank | Drug Name | Common Use | Common Denial Reason |
|---|---|---|---|
| 1 | LIDOCAINE 5% PATCH | Pain | Approval criteria not met |
| 2 | TRETINOIN 0.025% CREAM | Acne | Approval criteria not met |
| 3 | JANUVIA 100 MG TABLET | Diabetes | Approval criteria not met |
| 4 | JARDIANCE 10 MG TABLET | Diabetes | Approval criteria not met |
| 5 | JANUVIA 50 MG TABLET | Diabetes | Approval criteria not met |
| 6 | JARDIANCE 25 MG TABLET | Diabetes | Approval criteria not met |
| 7 | OMEGA-3 ETHYL ESTERS 1 GM CAP | Hypertriglyceridemia | Approval criteria not met |
| 8 | TRETINOIN 0.05% CREAM | Acne | Approval criteria not met |
| 9 | HUMALOG 100 UNIT/ML KWIKPEN | Diabetes | Approval criteria not met |
| 10 | DICLOFENAC SODIUM 3% GEL | Actinic keratoses | Approval criteria not met |

- DHCS announced MediCAL RX go-live date of 1/1/2022.

- 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.

- AAH is on track for the MediCal RX go-live date beginning 1/1/2022. The AAH Pharmacy Services Department is working with all other relevant departments

internally who receive outpatient pharmacy data or deal with providers or members directly to prepare teams with training for this transition. As AAH will no longer own the Medi-Cal LOB post-Carve Out, our health plan will be required to find new ways to pull data either through custom reports from Magellan (if possible) or through our Data Warehouse with the help of analytics. Communications department is notifying members through a member letter of the new MediCal RX go live date. AAH is reaching out to our providers by various means as well (Fax Blast, Quarterly Provide Report Notifications, Online, etc.). Magellan is in the process of setting-up training directly for providers to prepare for this transition. Pharmacy Services is setting up training as needed for each department to train personnel both internally and with Magellan.

- Providers, pharmacies, and managed care representatives will be required to sign-up for the Medi-Cal RX portal (medi-calrx.dhcs.ca.gov). Pharmacies, providers, and managed care reps (not beneficiaries) will be sent a PIN# as part of this sign-up process which can take up to ten business days. Providers will be able to submit Prior Authorization Requests and Appeals through the online Portal as well. Registration will be required in order to speak someone when calling Medi-Cal RX about non-general matters.

- Pharmacy Services collaborates with other Health Care Services teams for member on use of opioids and/or benzodiazepines.
    - > 300 morphine milligram equivalents (MME) users remain about the same. There was increase in utilization of and 50 MME and 90 MME, while 120 MME and 200 MME remain around the same. No drastic increase or decrease in any MME.

**Q3 2021**

| MME | IHSS | MCAL | Total |
|---|---|---|---|
| **July** | | | **240** |
| **50** | 5 | **50** | 5 |
| **90** | 2 | **90** | 2 |
| **120** | 1 | **120** | 1 |
| **200** | 0 | **200** | 0 |
| **300** | 1 | **300** | 1 |
| **400** | 0 | **400** | 0 |
| **August** | | | **287** |
| **50** | 11 | **50** | 11 |
| **90** | 2 | **90** | 2 |
| **120** | 2 | **120** | 2 |
| **200** | 0 | **200** | 0 |
| **300** | 1 | **300** | 1 |
| **400** | 0 | **400** | 0 |

- Pharmacy is leading initiatives on Physician Administered Drugs focused internal and external partnership and biosimilar optimization.
    - Between the months of July 2020-June 2021 the biosimilar utilization average was 54.1%
    - Fiscal year savings $1.3 million (July 2020-June 2021)
    - Percentage of savings per drug type Oncology ($676k), White Blood Cell Stimulator ($378k) and Immunology ($245k) drugs

- Pharmacy Services and QI explore sharing member vaccination status with network pharmacies to offer vaccines during member prescription pick-ups thru bag tagging with tailored messages for members and reminder by pharmacy technicians and/or pharmacists.

- P&T Committee – Q3 Summary:

    - The P&T Committee reviewed the efficacy, safety, cost, and utilization profiles of 6 therapeutic categories and drug monographs, 32 generics and 48 PA guidelines on Sep 21, 2021.

        1. IBS-C & D CIC and opioid induced constipation
        2. Intranasal steroid
        3. Chelating agents
        4. Peak Flow Meters
        5. Glaucoma
        6. Influenza antivirals

- The P&T Committee approved the following modifications to the formulary for the Alliance's Medi-Cal, and Alliance Group Care programs (shown in the data chart below).

| Generic Name & Strength/Dosage Form | Brand Name | Committee Actions |
|---|---|---|
| **Formulary Changes for IHSS** | | |
| buprenorphine 8 mg-naloxone 2 mg sublingual tablet | Suboxone | Add quantity limit #90/30 |
| buprenorphine HCl 8 mg sublingual tablet | Suboxone | Add quantity limit #90/30 |
| raloxifene 60 mg tablet | Evista | Add quantity limit #30/30 |

| | | |
|---|---|---|
| buprenorphine 2 mg-naloxone 0.5 mg sublingual tablet | Suboxone | Add quantity limit #180/30 |
| buprenorphine HCl 2 mg sublingual tablet | Suboxone | Add quantity limit #180/30 |
| Linzess 145 mcg capsule | Linzess | Add to formulary with Prior Authorization |
| Linzess 290 mcg capsule | Linzess | Add to formulary with Prior Authorization |
| Linzess 72 mcg capsule | Linzess | Add to formulary with Prior Authorization |
| Bunavail 2.1 mg-0.3 mg buccal film | Bunavail | Add to formulary with Prior Authorization |
| Bunavail 4.2 mg-0.7 mg buccal film | Bunavail | Add to formulary with Prior Authorization |
| Bunavail 6.3 mg-1 mg buccal film | Bunavail | Add to formulary with Prior Authorization |
| Zubsolv 11.4 mg-2.9 mg sublingual tablet | Zubsolv | Add to formulary with Prior Authorization |
| Zubsolv 0.7 mg-0.18 mg sublingual tablet | Zubsolv | Add to formulary with Prior Authorization |
| Zubsolv 2.9 mg-0.71 mg sublingual tableT | Zubsolv | Add to formulary with Prior Authorization |
| Zubsolv 8.6 mg-2.1 mg sublingual tablet | Zubsolv | Add to formulary with Prior Authorization |
| Xifaxan 200 mg tablet | Xifaxan | Add to formulary with Prior Authorization |
| Xifaxan 550 mg tablet | Xifaxan | Add to formulary with Prior Authorization |
| palonosetron 0.25 mg/2 mL intravenous solution | Aloxi | Add to formulary with Prior Authorization |
| palonosetron 0.25 mg/5 mL intravenous syringe | Aloxi | Add to formulary with Prior Authorization |

| | | |
|---|---|---|
| BromSite 0.075 % eye drops | BromSite | Add to formulary with Prior Authorization |
| Ziextenzo 6 mg/0.6 mL subcutaneous syringe | Ziextenzo | Add to formulary with Prior Authorization on 10/1/2021 |
| Nivestym 300 mcg/mL injection solution | Nivestym | Add to formulary with Prior Authorization |
| Nivestym 480 mcg/1.6 mL injection solution | Nivestym | Add to formulary with Prior Authorization |
| Rhinocort Allergy 32 mcg nasal spray | Rhinocort | Add to Formulary |
| Mini Wright Peak Flow Meter | Mini Wright Peak Flow Meter | Add to Formulary |
| Truzone Peak Flow Meter | Truzone | Add to Formulary |
| Airzone Peak Flow Meter | Airzone | Add to Formulary |
| Asthma Check Meter | Asthma Check Meter | Add to Formulary |
| Personal Best Low Range device | Personal Best Low Range device | Add to Formulary |
| Pocket Peak Flow Meter | Pocket Peak Flow Meter | Add to Formulary |

| Generic Name & Strength/Dosage Form | Brand Name | Committee Actions |
|---|---|---|
| **Formulary Changes for MCAL** | | |
| raloxifene 60 mg tablet | Evista | Add quantity limit #30/30 |
| Ziextenzo 6mg/0.6ml subcutaneous syringe | Ziextenzo | Add to formulary with Prior Authorization on 10/1/2021 |

| Prior Authorization Guideline Updates | |
|---|---|
| Specialty Biological Agents for Crohn's Disease | Oral and Injectable Oncology Medications |
| Specialty Biological Agents for Rheumatoid Arthritis | Orilissa (elagolix) |
| Calcitonin Gene-Related Peptide (CGRP) Antagonists for Headache Prevention | Injectable/Infusible Agents for Osteoporosis and Paget's Disease |
| Acute Migraine Treatments | Dronabinol |
| Oriahnn | Desvenlafaxine succinate (Pristiq) |
| Injectable/Infusible Bone-Modifying Agents for Oncology Indications | Corticosteroids for Ulcerative Colitis and Crohn's disease |
| Antiemetics | Ophthalmic Anti-inflammatory Agents |
| Topical Acne Agents | Moxifloxacin Oral Tablet |
| Adenosine Triphosphate-Citrate Lyase (ACL) inhibitors | Malaria prophylaxis and treatment agents |
| Non-Formulary and PA Required Medications without Drug-Specific Criteria | Cartilaginous Repair Agents |
| Opioid Dependency Agents | Rifamycin Antibiotics |
| Erythropoiesis-Stimulating Agents | Botulinum Toxins A&B |
| White Blood Cell Stimulators | Sedative Hypnotics |
| Injectable Atypical Antipsychotic Medications | Makena |
| Anti-Obesity Medications | Medications for the treatment of Multi-Drug Resistant Tuberculosis |
| Pediculicides | Tetracycline Antibiotics |
| Raloxifene (Evista) | Diabetes Medications and Diabetes Medications used for Heart Failure or Chronic Kidney Disease |

| Prior Authorization Guidelines Reviewed (No Updates) | |
|---|---|
| Safety Edit Exception | Inhaler Assistant Devices |
| Quantity Limit Exception | Mesalamine |
| Nuedexta (dextromethorphan/quinidine) | Rifabutin (Mycobutin) |
| Memantine ER (Namenda XR) | Spravato (esketamine) Intranasal |
| Vancomycin | Santyl Ointment |
| Diclofenac sodium (Solaraze) 3% gel | Physician Administered Medication (PAD)/ Medical Benefit Guidelines |
| Multaq (dronedarone) | Off-label uses |

**Case and Disease Management**

- Population health-driven, disease-specific case management bundles continue development. CM Bundles are standard sets of actions developed to address the specific needs of members with significant diseases. Oncology Bundle is deployed. Planning for Major Organ Transplant (MOT) CM bundle continues, with workflows and assessments in development.

- For CalAIM program planning for Community Supports, (CS) formerly In Lieu of Services (ILOS) and MOT planning: CM is refining current policies and procedures, creating workflows, and collaborative efforts to implement into TruCare CM software. Configuration in the TruCare CM software has begun.

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

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

- 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.

- DMHC/DHCS combined audit: Action Plans on CM findings from the DHCS audit have are launching, including workflow improvement, staff training and monitoring.

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

- Enhanced Case Management (ECM): Planning continues with the AAH Project Management Office (PMO) to ensure a successful integration of HHP and AC3 into ECM. AAH CM and PMO are working closely with Alameda County HCSA on the transition of AC3 members into ECM. Parts 1, 2 and 3 of the Model of Care and Transitions documents have been submitted, all within the deadlines. The plan is receiving clarifying question back from DHCS and are providing the clarifications as requested.

- Community Supports, (CS) [formerly In Lieu of Services (ILOS)] are services not typically provided by managed health plans, to be provided in lieu of higher cost medical services. Working closely with the Project Office AAH/CM has finalized 6 services to be provided starting January 2022 (Phase 1). The ILOS selections are focused on services that will have the most impact on members to reduce unnecessary hospitalizations and ED visits. The six initial CS services are:

    - Housing Navigation
    - Housing Deposits
    - Tenancy Sustaining Services
    - Medical Respite
    - Medically Tailored/Supportive meals
    - Asthma Remediation

- Work to operationalize the six services is well under way to meet the January 1, 2022 launch.

| Case Type | New Cases Opened in Jul 2020 | Total Open Cases as of May 2021 | New Cases Opened in June 2021 | Total Open Cases as of July 2021 |
|---|---|---|---|---|
| Care Coordination | 265 | 651 | 244 | 520 |
| Complex Case Management | 6 | 60 | 128 | 134 |
| Health Homes Program | 25 | 787 | 11 | 749 |
| Whole Person Care | 11 | 235 | 1 | 241 |

## Grievances & Appeals

- All cases were resolved within the goal of 95% within regulatory timeframes.
- Total grievances resolved in September were 7.38 complaints per 1,000 members.
- The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of September 2021; we did not meet our goal at 27.3% overturn rate.

| September 2021 Cases | Total Cases | TAT Standard | Benchmark | Total in Compliance | Compliance Rate | Per 1,000 Members* |
|---|---|---|---|---|---|---|
| **Standard Grievance** | 929 | 30 Calendar Days | 95% compliance within standard | 899 | 96.8% | 3.17 |
| **Expedited Grievance** | 2 | 72 Hours | 95% compliance within standard | 1 | 50.0% | 0.007 |
| **Exempt Grievance** | 1,174 | Next Business Day | 95% compliance within standard | 1,174 | 100.0% | 4.01 |
| **Standard Appeal** | 54 | 30 Calendar Days | 95% compliance within standard | 54 | 100.0% | 0.18 |
| **Expedited Appeal** | 1 | 72 Hours | 95% compliance within standard | 1 | 100.0% | 0.003 |
| **Total Cases:** | 2,160 | | 95% compliance within standard | 2,129 | 98.6% | 7.38 |

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

- Out of Compliance Case: Expedited grievances were out of compliance because out of the two cases that were processed one was overlooked because of the large increase of inventory the G&A Department is experiencing.
- Grievance tracking and trending by quarter:
    - There has been an overall increase of cases received throughout 2021; however, coverage disputes are still the highest numbers of cases resolved, examples of coverage disputes include:
        - Member calling to ask for reimbursement of monies paid, we used to capture as exempt and refer them to the website to complete the reimbursement form.
        - Member calling with regards to receiving a bill for services that are covered.
        - Member calling with regards to being balanced billed, member services used to contact the provider to bill the Alliance.
        - Denied pharmacy services at point of sale, member services used to educate the member that they were either OON or the medication required a PA and close as an exempt grievance.

## Quality

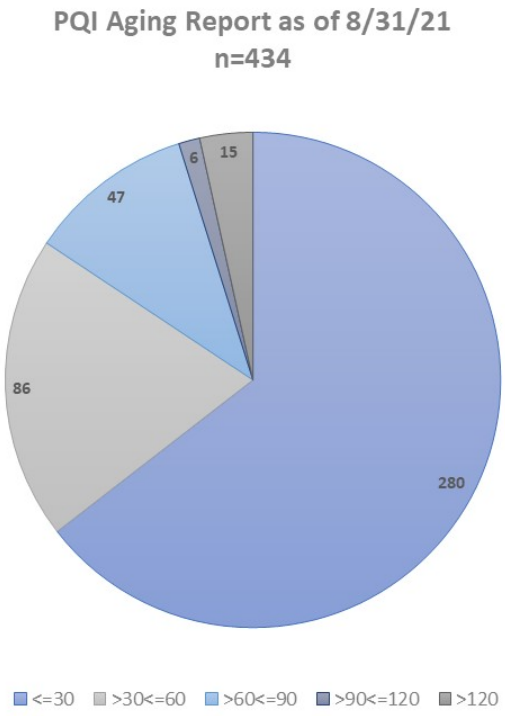
- Starting in 2019, the Quality Improvement Department developed an initiative, HEDIS® Crunch, that focused on improving well-child screening rates by offering a $25 member incentive at the completion of the visit. During the initial pilot, 21 providers participated which resulted in 397 members between the ages of 0 – 19 years old being seen during October 1, 2019 through December 31, 2019. As a result, the participating providers saw an average increase of 7.25% in their well-child rates.

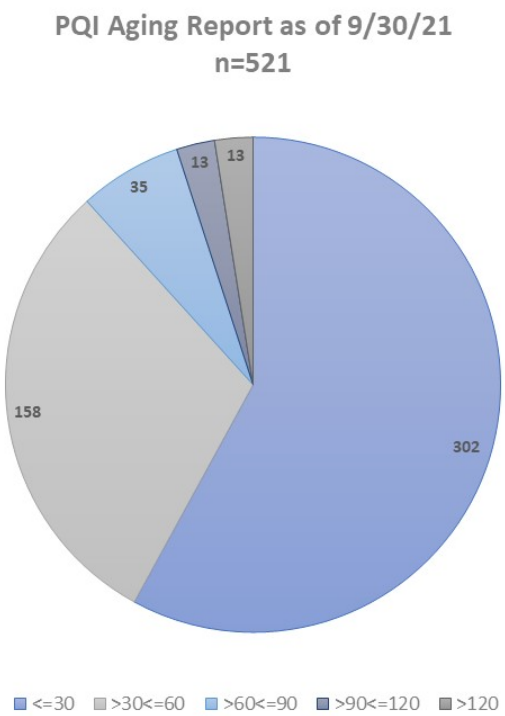
- In 2020, the Quality Improvement Department attempted to continue the momentum of HEDIS® Crunch however, only 9 providers agreed to participate given the COVID-19 public health emergency. Despite the decrease in participation, the Alliance was able to provide 734 gift cards, which is a 84.89% increase in the number of gift cards distributed, which equates to 84.89% increase in well-child visits from 2019 to 2020. Below is an overview of the HEDIS® Crunch 2020 project.

- Given the continued success of the HEDIS® Crunch project, the Quality Improvement Department has already partnered with 16 providers that are part of the CFMG network to improve the Alliance's rates for Well-Child Visits in the First 30 Months of Life (W30) and Well-Child Visits (WCV) for members 3-21 years old. Currently, the Quality Improvement Department has provided 640 gift cards to participating providers of which 30 have already been given to members who received their well-child exam.

## Potential Quality Issues (PQI) Aging Report

- A PQI is defined as a suspected deviation from expected provider performance, clinical care or outcome of care that requires further investigation to determine whether an actual quality issue exists. Current PQI TAT is 120 days, which is calculated from the receipt of the PQI by QI to resolution date.



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# Information Technology

# Sasikumar Karaiyan

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

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

**Date:** **October 8, 2021**

**Subject:** **Information Technology Report**

## Call Center System Availability

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

## Office 365 Initiative

- The Alliance continues to enhance and expand the Microsoft Office 365 platform to the maximum potential as part of the cloud migration strategy. One of our goals is to move away from the silo operated platform to a consolidated shared services platform which will allow technology team to manage and maintain efficiently. As part of this implementation, the Alliance will deploy Microsoft TEAMS to enable and offer the following newly updated capabilities and we expect to complete this project by December 2021.

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

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

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

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

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

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

**Disaster Recovery and Business Continuity**

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

- IT Disaster Recovery involves a set of policies, tools, and procedures to enable the recovery or continuation of vital technology infrastructure and systems following a natural or human-induced disaster. IT Disaster Recovery focuses on technology systems supporting critical business functions, which involve keeping all essential aspects of the business functioning, despite significant disruptive events. This initiative was planned to start in August 2021 and complete before the end of December 2021 but encountered contractual challenges that forced us to proceed with another vendor. This delay will move our target date to complete to February 2022.

**Multi-Factor Authentication (MFA) Rollout (Security)**

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

- Multi-Factor Authentication (MFA) is part of a comprehensive strategy to enhance security with more robust authentication methods to access the Alliance assets, data, and information. The Alliance migrated 80% of our staff to use Multi-Factor Authentication (MFA). Token hardware deployment is on target for the remaining migration and shall be completed before mid-October 2021.

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

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

- The Alliance is in full motion on this Secure File Transfer Protocol (SFTP) Server Upgrade which is designed to expand its capabilities and provide redundancy for improved availability. At the end of September 2021, 100% of our trading Partners have been migrated to the new Secure File Transfer Protocol (SFTP) Environment and successfully met the target completion. Final cleanup and decommission efforts of the old server will be completed by mid-October 2021.

**Encounter Data**

- In the month of September 2021, the Alliance submitted 99 encounter files to the Department of Health Care Services (DHCS) with a total of 245,464 encounters.

**Enrollment**

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

**HealthSuite**

- A total of 158,547 claims were processed in the month of September out of which 126,995 claims auto adjudicated. This sets the auto-adjudication rate for this period to 80.1%.

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

**TruCare**

- A total of 12,023 authorizations were loaded and processed in the TruCare application.

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

**Consumer and the Alliance Public Portal**

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

- As a part of the customer channel optimization, the Alliance is enhancing the customer channels. The new features and capabilities include Mobile Application on smartphones and Tagalog as additional threshold Language on Member channel. Tagalog went live on September 28th. The Mobile version of the member channel is tentatively estimated to go-live by December 2021.

**Information Security**

- All security activity data is based on the current month's metrics as a percentage. This is compared to the previous three month's average, except as noted.

- Email based metrics currently monitored have increased with a return to a reputation-based block for a total of 41.5k.

- Attempted information leaks detected and blocked at the firewall are higher from 32 to 37 for the month of September 2021.

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

- Attempted User Privilege Gain is slightly lower at 6 from a previous six-month average of 4.5.

**Secure Email**

- The Alliance's ability to send secure emails was impacted by a global issue that affected many Microsoft and Cisco customers from September 17th to the 28th. During the outage, we provided our staff with an alternative method to send files securely using our Secure FTP (File Transfer Protocol) Web Client. This issue has now been resolved by Microsoft.

**Data Warehouse**

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

- In the month of September 2021, the Alliance continued work on integrating Authorization data into the Data Warehouse. The Authorization and Case Management data domains will be added to the Data Warehouse and the project is expected to be completed in the month of January 2022.

# Information Technology

## Supporting Documents

## Enrollment

- See Table 1-1 “Summary of Medical and Group Care member enrollment in the month of September 2021”.
- Summary of Primary Care Physician (PCP) Auto-assignment in the month of September 2021.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of September 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 September 2021

| Month | Total MC[1] | MC[1] - Add/ Reinstatements | MC[1] - Terminated | Total GC[2] | GC[2] - Add/ Reinstatements | GC[2]- Terminated |
|---|---|---|---|---|---|---|
| September | 286,687 | 3,640 | 2,428 | 5,913 | 136 | 100 |

1. MC – Medical Member 2. GC – Group Care Member

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

| Auto-Assignments | Member Count |
|---|---|
| Auto-assignments MC | 1,399 |
| Auto-assignments Expansion | 1,168 |
| Auto-assignments GC | 32 |
| PCP Changes (PCP Change Tool) Total | 2,505 |

## TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of September 2021”.
- There were 12,023 authorizations processed into TruCare application.
- TruCare Application Uptime – 99.99%.
- The following table 2-1 is a supporting document from the TruCare summary section.

Table 2-1 Summary of TruCare Authorizations for the Month of September 2021

| Transaction Type | Inbound EDI Auths | Errored | Total Auths Loaded In TruCare |
|---|---|---|---|
| **EDI** | 4,852 | 611 | 4,652 |
| **Paper to EDI** | 2,623 | 1,542 | 1,154 |
| **Provider Portal** | 2,070 | 87 | 2,058 |
| **Manual Entry** | 0 | 0 | 1,302 |
| **Total** | | | 9,166 |

Key: EDI – Electronic Data Interchange

## Web Portal Consumer Platform

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

Table 3-1 Web Portal Usage for the Month of August 2021

| Group | Individual User Accounts | Individual User Accounts Accessed | Total Logins | New Users |
|---|---|---|---|---|
| **Provider** | 6,977 | 3,281 | 156,909 | 303 |
| **MCAL** | 75,560 | 2,544 | 5,978 | 1,104 |
| **IHSS** | 2,864 | 72 | 150 | 23 |
| **AAH Staff** | 138 | 46 | 769 | 3 |
| **Total** | 85,539 | 5,943 | 163,806 | 1,433 |

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

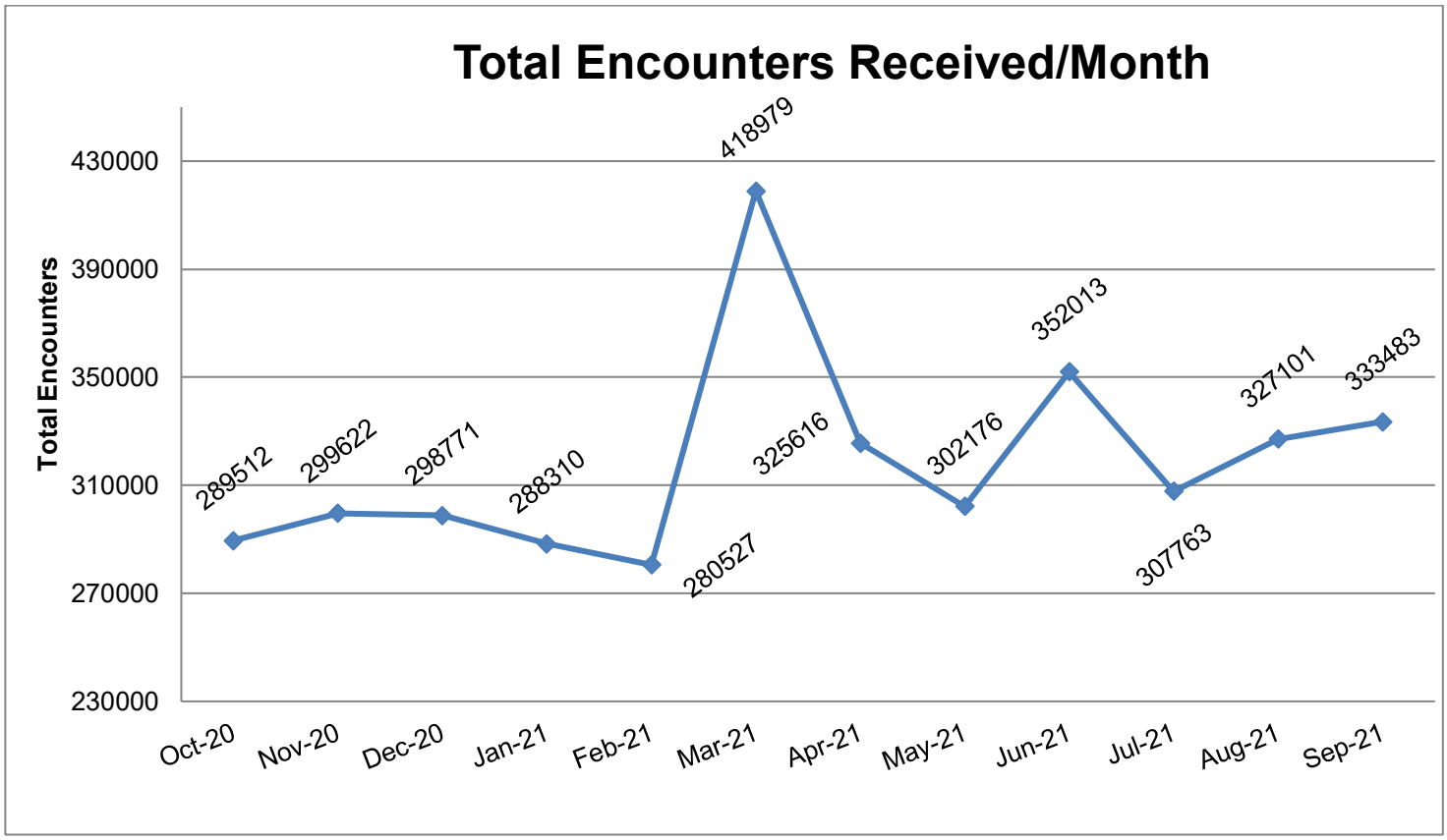
| Top 25 Pages Viewed | | |
|---|---|---|
| **Category** | **Page Name** | **August - 21** |
| **Provider** | Member Eligibility | 670,471 |
| **Provider** | Claim Status | 151,001 |
| **Provider - Authorizations** | Auth Submit | 6,567 |
| **Member My Care** | Member Eligibility | 3,611 |
| **Provider - Authorizations** | Auth Search | 2,715 |
| **Provider** | Member Roster | 1,823 |
| **Member Help Resources** | ID Card | 1,803 |
| **Member Help Resources** | Find a Doctor or Hospital | 1,630 |
| **Member Help Resources** | Select or Change Your PCP | 1,097 |
| **Member My Care** | MC ID Card | 946 |
| **Member My Care** | My Claims Services | 839 |
| **Member Help Resources** | Request Kaiser as my Provider | 637 |
| **Provider - Provider Directory** | Provider Directory | 582 |
| **Member My Care** | Authorization | 451 |
| **Member My Care** | My Pharmacy Medication Benefits | 358 |
| **Provider - Home** | Forms | 330 |
| **Provider - Provider Directory** | Instruction Guide | 250 |
| **Member Help Resources** | FAQs | 242 |
| **Member My Care** | Member Benefits Materials | 227 |
| **Provider** | Pharmacy | 222 |
| **Member Help Resources** | Authorizations Referrals | 195 |
| **Member Help Resources** | Forms Resources | 183 |
| **Member Help Resources** | Contact Us | 174 |
| **Member My Care** | My Pharmacy Argus | 152 |
| **Provider - Provider Directory** | Manual | 152 |

## Encounter Data from Trading Partners 2021

- **AHS:** September weekly files (7,640 records) were received on time.
- **Beacon:** September weekly files (14,618 records) were received on time.
- **CHCN:** September weekly files (60,227 records) were received on time.
- **CHME:** September monthly file (5,393 records) were received on time.
- **CFMG:** September weekly files (9,880 records) were received on time.
- **Docustream:** September monthly files (1,594 records) were received on time.
- **PerformRx:** September monthly files (166,185 records) were received on time.
- **Kaiser:** September bi-weekly files (44,366 records) and monthly Kaiser Pharmacy files (23,360 records) were received on time.
- **LogistiCare:** September weekly files (13,803 records) were received on time.
- **March Vision:** September monthly file (3,297 records) were received on time.
- **Quest Diagnostics:** September weekly files (13,084 records) were received on time.
- **Teladoc:** September monthly files (23 records) were received on time.

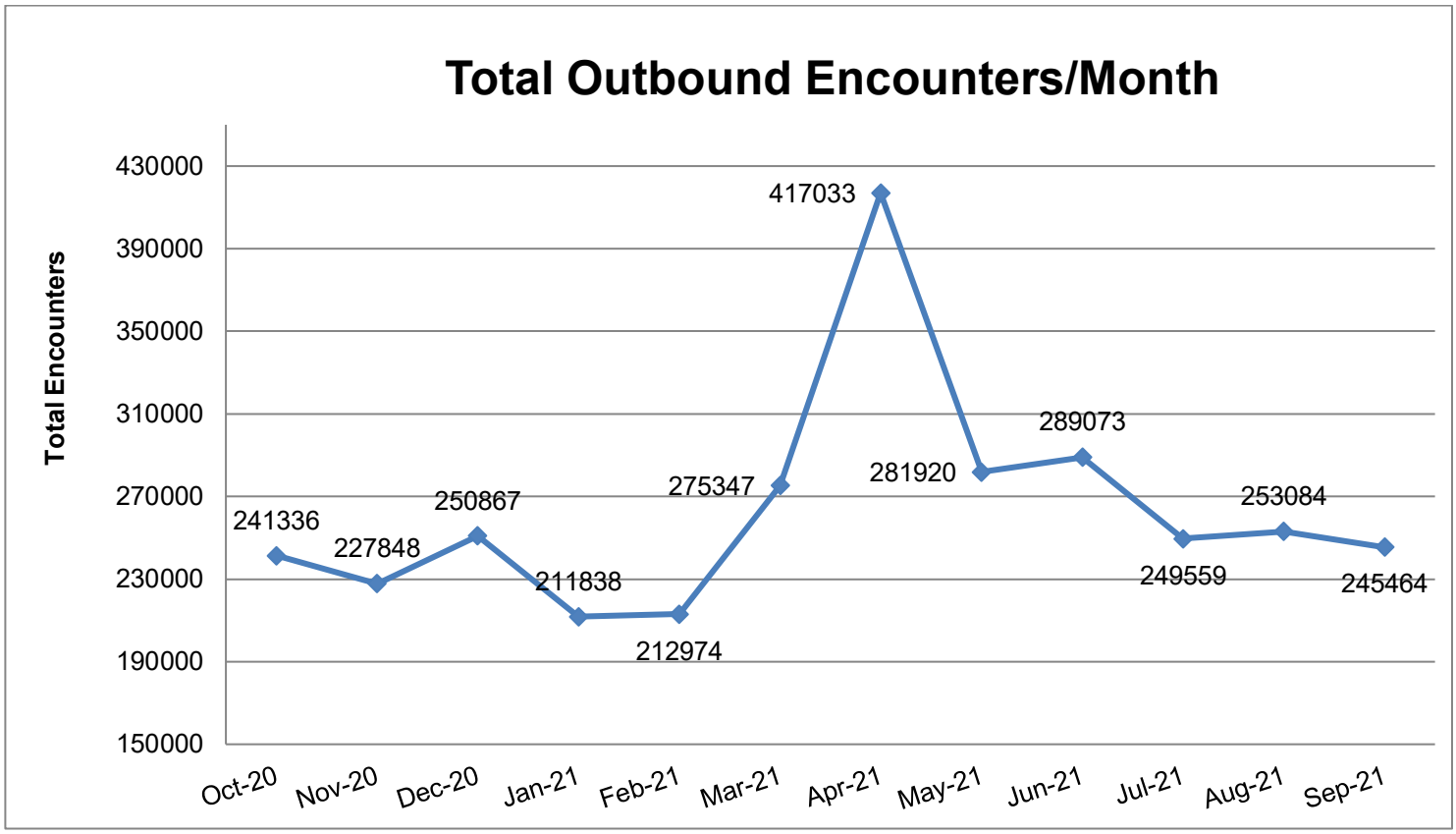
### Trading Partners Medical Encounter Inbound Submission History

| Trading Partners | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HealthSuite | 120149 | 111676 | 123248 | 116784 | 119001 | 143171 | 140678 | 129847 | 136687 | 133958 | 139079 | 159558 |
| AHS | 12762 | 16814 | 8419 | 9404 | 9702 | 9326 | 11166 | 9074 | 10138 | 8913 | 7869 | 7640 |
| Beacon | 14637 | 12673 | 21326 | 15812 | 14616 | 13002 | 19247 | 14951 | 17079 | 15236 | 13320 | 14618 |
| CHCN | 65094 | 85984 | 66473 | 59612 | 62867 | 89453 | 69080 | 66260 | 82211 | 63905 | 80862 | 60227 |
| CHME | 5814 | 5152 | 4388 | 6143 | 6548 | 5776 | 5497 | 4885 | 4700 | 4960 | 4926 | 5393 |
| Claimsnet | 11018 | 6504 | 12819 | 7693 | 12059 | 10905 | 8835 | 10834 | 8129 | 9774 | 7712 | 9880 |
| Docustream | 926 | 865 | 909 | 803 | 1160 | 935 | 1166 | 1445 | 1218 | 1296 | 1568 | 1594 |
| Kaiser | 29431 | 35590 | 29885 | 43639 | 25903 | 112545 | 39632 | 30039 | 60081 | 39398 | 35165 | 44366 |
| Logisticare | 11599 | 12665 | 15505 | 12603 | 14208 | 16924 | 12945 | 14399 | 15473 | 14415 | 17306 | 13803 |
| March Vision | 3012 | 2928 | 2361 | 3103 | 1917 | 2230 | 3156 | 3708 | 3306 | 3303 | 3531 | 3297 |
| Quest | 15047 | 8724 | 13406 | 12665 | 12515 | 14699 | 14203 | 16718 | 12979 | 12563 | 15746 | 13084 |
| Teladoc | 23 | 47 | 32 | 49 | 31 | 13 | 11 | 16 | 12 | 42 | 17 | 23 |
| Total | 289512 | 299622 | 298771 | 288310 | 280527 | 418979 | 325616 | 302176 | 352013 | 307763 | 327101 | 333483 |




## Outbound Medical Encounter Submission

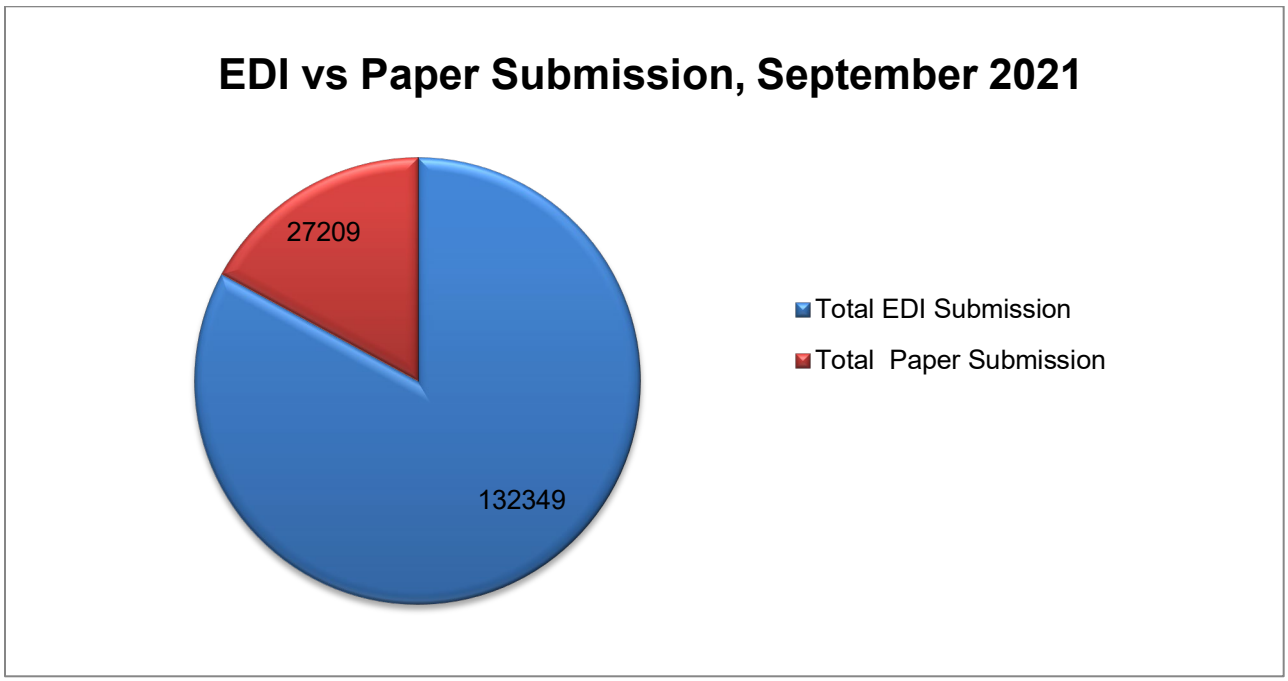
| Trading Partners | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HealthSuite | 97258 | 79162 | 100653 | 70368 | 81305 | 84220 | 216640 | 130885 | 128980 | 85346 | 109070 | 83690 |
| AHS | 11922 | 15980 | 7909 | 8729 | 9089 | 8655 | 8812 | 10762 | 9912 | 7163 | 9172 | 7476 |
| Beacon | 13291 | 10580 | 16229 | 13315 | 11631 | 10171 | 14881 | 12347 | 11746 | 12684 | 10959 | 9355 |
| CHCN | 48065 | 50051 | 54860 | 41461 | 45137 | 64275 | 49446 | 48573 | 58519 | 45338 | 46573 | 54958 |
| CHME | 5232 | 4801 | 3696 | 5327 | 5508 | 5283 | 5136 | 4767 | 4586 | 4753 | 4820 | 5280 |
| Claimsnet | 7398 | 5707 | 8595 | 5160 | 8578 | 7964 | 6489 | 8110 | 5993 | 5625 | 7335 | 7452 |
| Docustream | 849 | 969 | 807 | 764 | 1071 | 860 | 1070 | 1286 | 1016 | 1120 | 1273 | 1209 |
| Kaiser | 29031 | 35096 | 29087 | 42638 | 23810 | 59157 | 89295 | 29570 | 38443 | 59215 | 33798 | 43779 |
| Logisticare | 14600 | 12263 | 14773 | 12315 | 13881 | 16652 | 9705 | 17299 | 15178 | 14008 | 12751 | 17657 |
| March Vision | 2665 | 2470 | 2013 | 2655 | 1686 | 1930 | 2455 | 2850 | 2624 | 2596 | 2665 | 2483 |
| Quest | 11002 | 10743 | 12214 | 9085 | 11247 | 16169 | 13093 | 15455 | 12066 | 11711 | 14632 | 12102 |
| Teladoc | 23 | 26 | 31 | 21 | 31 | 11 | 11 | 16 | 10 | 0 | 36 | 23 |
| Total | 241336 | 227848 | 250867 | 211838 | 212974 | 275347 | 417033 | 281920 | 289073 | 249559 | 253084 | 245464 |




## HealthSuite Paper vs EDI Claims Submission Breakdown

| Period | Total EDI Submission | Total Paper Submission | Total Claims |
|---|---|---|---|
| 21-Sep | 132,349 | 27,209 | 159,558 |

Key: EDI – Electronic Data Interchange

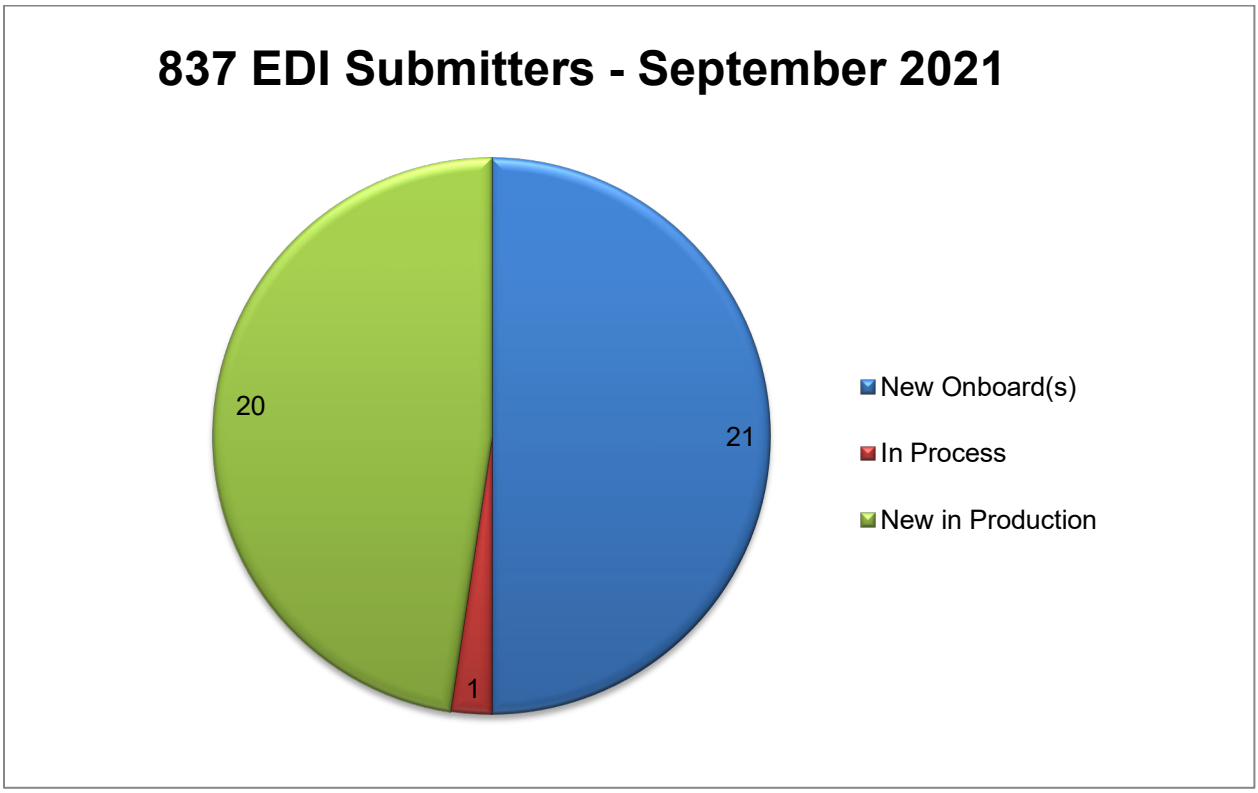


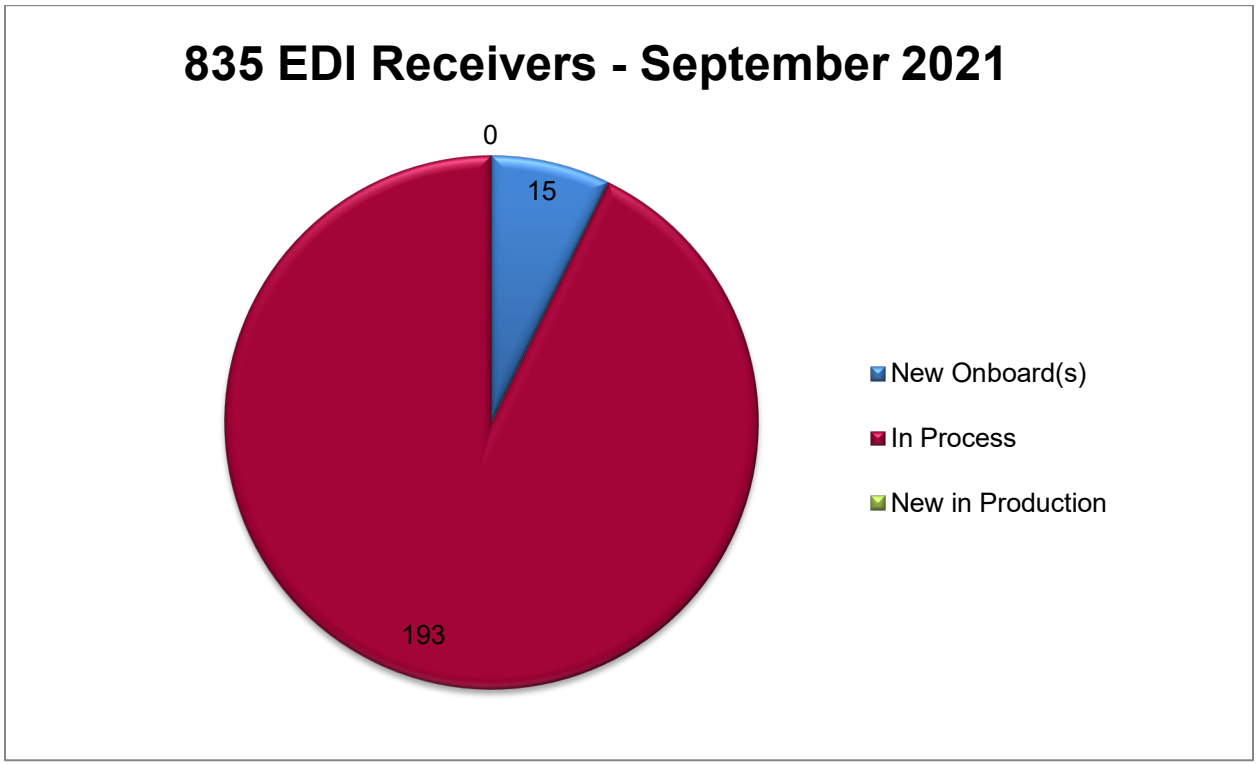
## Onboarding EDI Providers – Updates

- September 2021 EDI Claims:
  - A total of 1207 new EDI submitters have been added since October 2015, with 20 added in September 2021.
  - The total number of EDI submitters is 1939 providers.

- September 2021 EDI Remittances (ERA):
  - A total of 324 new ERA receivers have been added since October 2015, with 0 added in September 2021.
  - The total number of ERA receivers is 363 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 |
| **Oct-20** | 23 | 0 | 23 | 1734 | 7 | 86 | 3 | 232 |
| **Nov-20** | 15 | 0 | 15 | 1749 | 7 | 91 | 2 | 234 |
| **Dec-20** | 21 | 0 | 21 | 1770 | 42 | 91 | 42 | 276 |
| **Jan-21** | 15 | 0 | 15 | 1785 | 19 | 92 | 18 | 294 |
| **Feb-21** | 22 | 0 | 22 | 1807 | 14 | 101 | 5 | 299 |
| **Mar-21** | 20 | 2 | 18 | 1825 | 23 | 117 | 7 | 306 |
| **Apr-21** | 5 | 0 | 5 | 1830 | 20 | 126 | 11 | 317 |
| **May-21** | 32 | 0 | 32 | 1862 | 20 | 134 | 12 | 329 |
| **Jun-21** | 13 | 0 | 13 | 1875 | 17 | 136 | 15 | 344 |
| **Jul-21** | 30 | 3 | 27 | 1902 | 14 | 138 | 12 | 356 |
| **Aug-21** | 17 | 0 | 17 | 1919 | 47 | 178 | 7 | 363 |
| **Sep-21** | 21 | 1 | 20 | 1939 | 15 | 193 | 0 | 363 |


837 EDI Submitters - September 2021
20
21
1
New Onboard(s)
In Process
New in Production


835 EDI Receivers - September 2021
0
15
193
New Onboard(s)
In Process
New in Production

## Encounter Data Submission. Reconciliation Form (EDSRF) and File Reconciliations

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

| File Type | Sept-21 |
|---|---|
| 837 I Files | 25 |
| 837 P Files | 65 |
| NCPDP | 9 |
| Total Files | 99 |

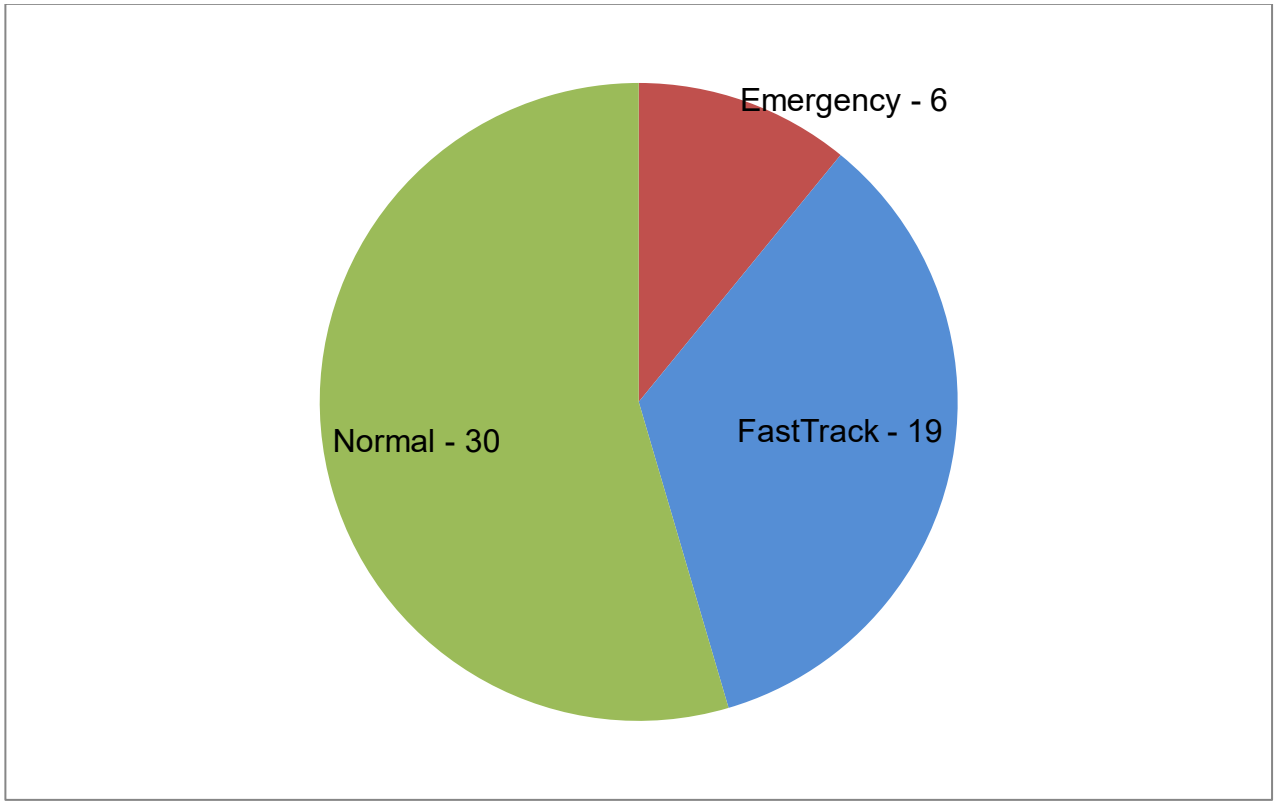
## Lag-time Metrics/Key Performance Indicators (KPI)

| AAH Encounters: Outbound 837 | Sept-21 | Target |
|---|---|---|
| Timeliness-% Within Lag Time – Institutional 0-90 days | 97% | 60% |
| Timeliness-% Within Lag Time – Institutional 0-180 days | 99% | 80% |
| Timeliness-% Within Lag Time – Professional 0-90 days | 94% | 65% |
| Timeliness-% Within Lag Time – Professional 0-180 days | 98% | 80% |

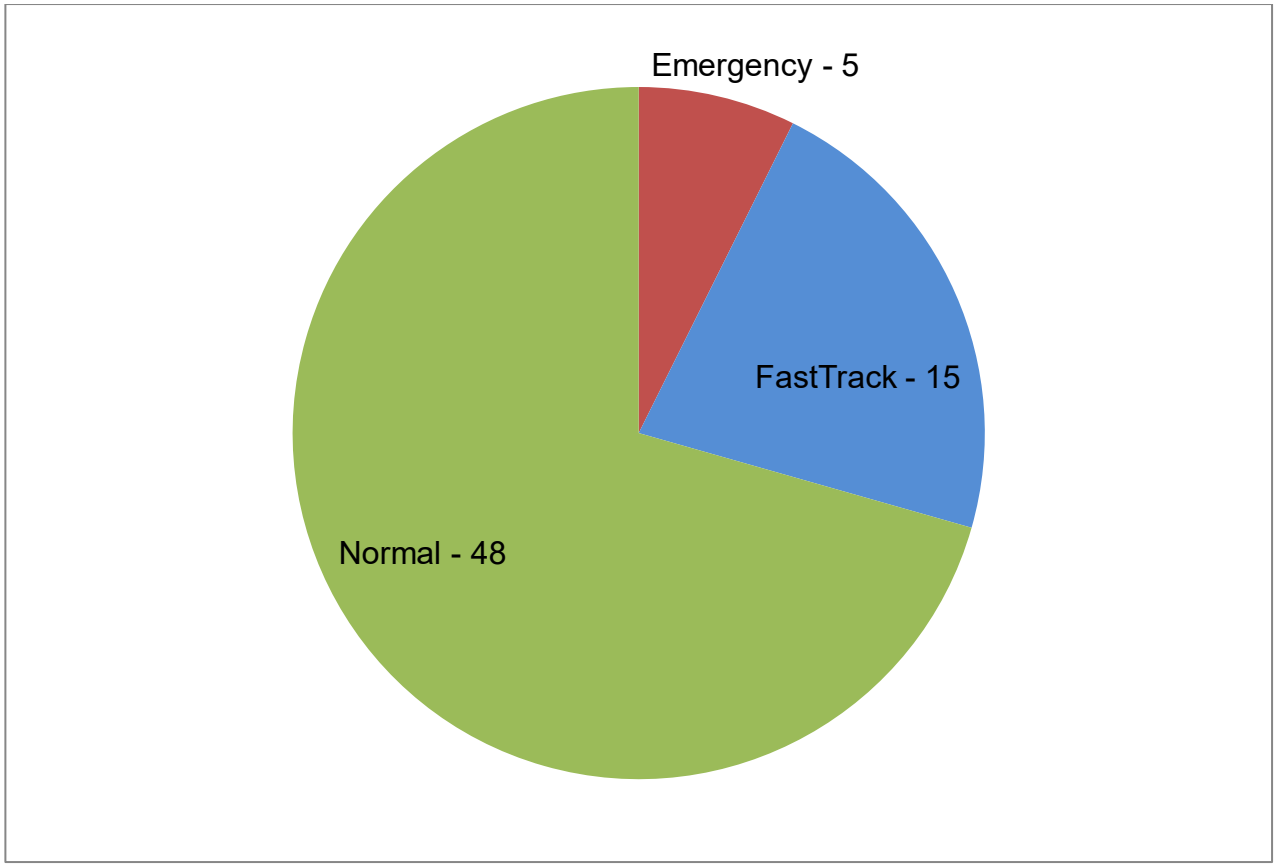
## Change Management Key Performance Indicator (KPI)

- Change Request Overall Summary in the month of September 2021 KPI:
  - 55 Changes Submitted.
  - 68 Changes Completed and Closed.
  - 129 Active Changes.
  - 5 Changes Cancelled or Rejected.

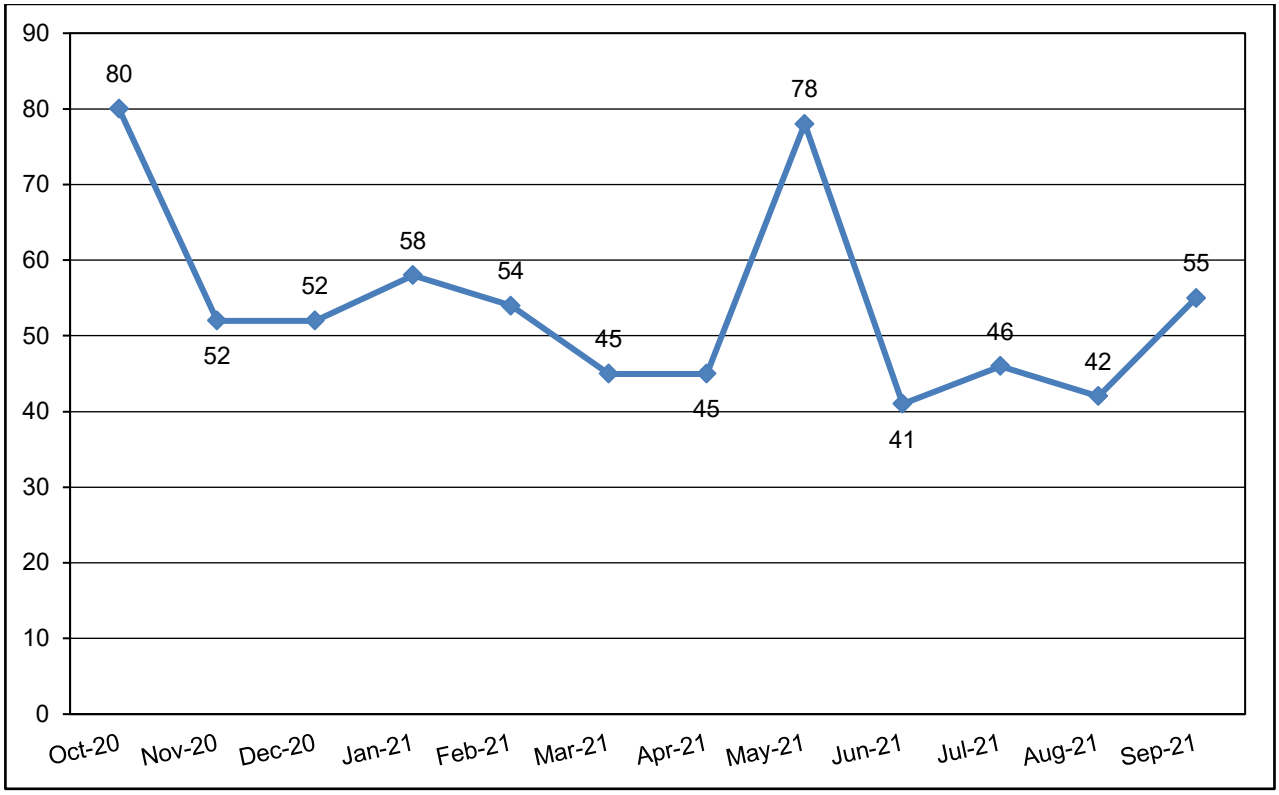
- 55 Change Requests Submitted/Logged in the month of September 2021



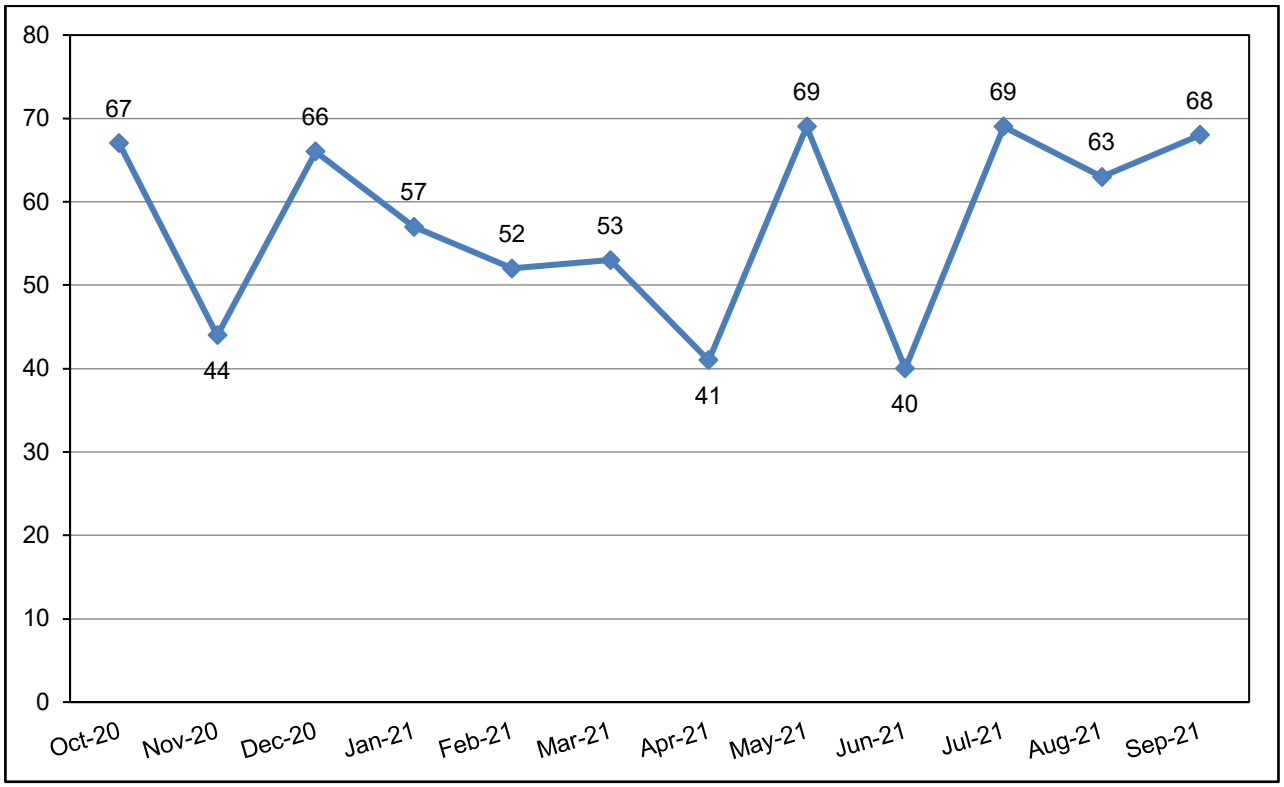

- 68 Change Requests Closed in the month of September 2021



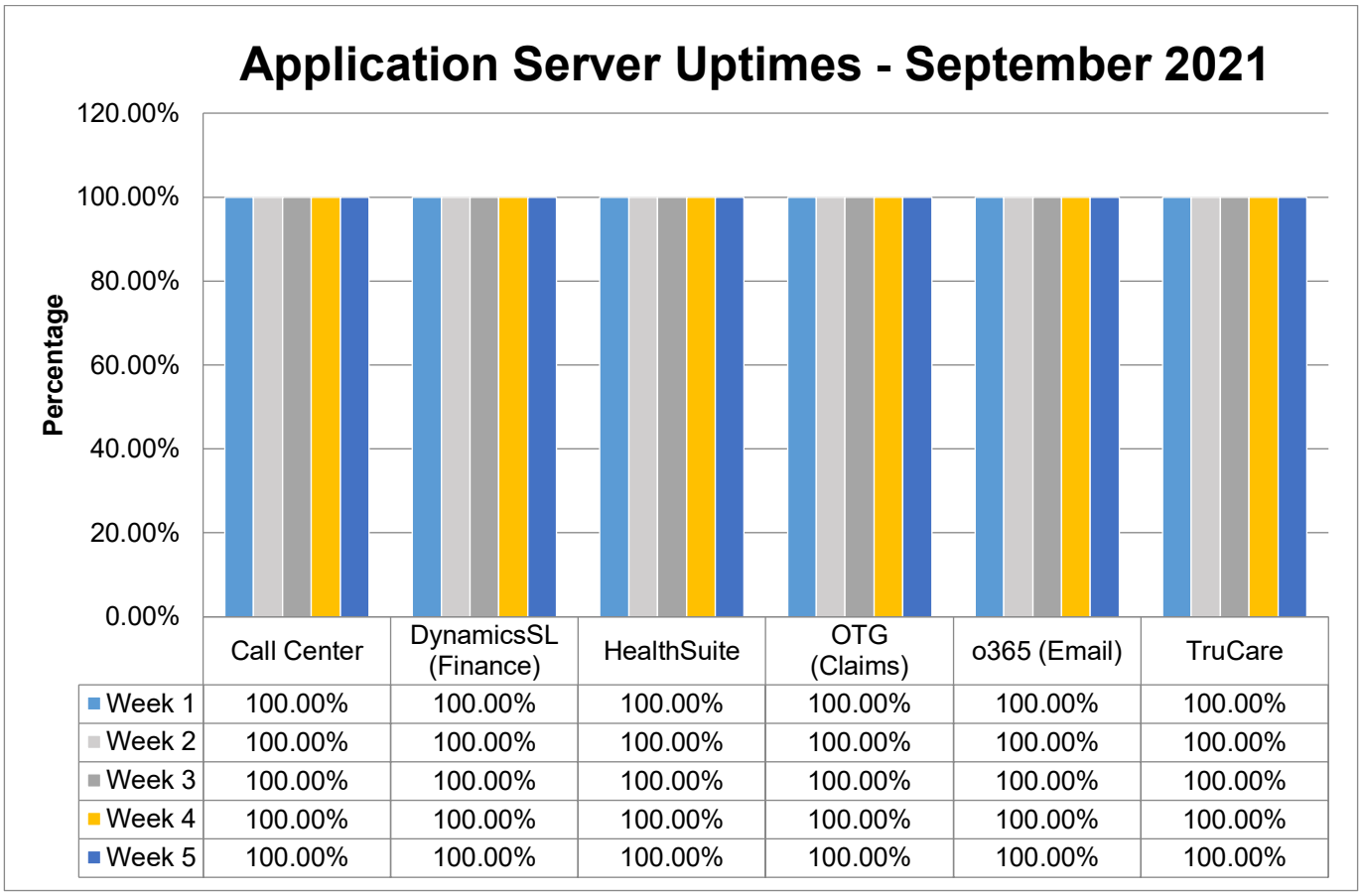
- Change Requests Submitted: Monthly Trend




- Change Requests Closed: Monthly Trend

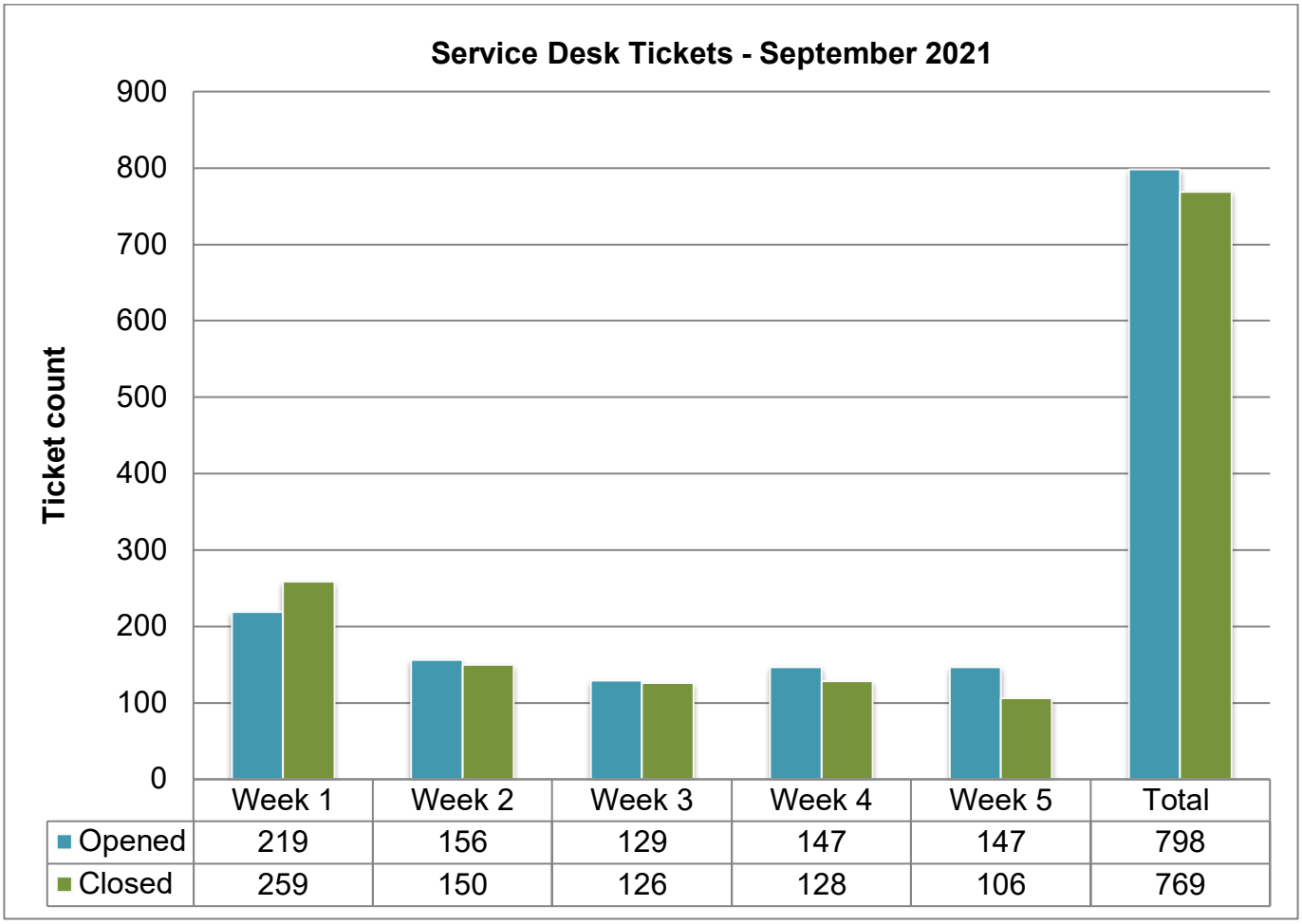


**IT Stats: Infrastructure**




| | 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 major outages experienced in the month of September 2021 despite supporting 97% of staff working remotely.
- The Alliance's ability to send secure emails was impacted by a global issue that affected many Microsoft and Cisco customers from September 17th to the 28th. During the outage, we have provided our staff with an alternative method to send files securely using our Secure FTP (File Transfer Protocol) Web Client. This issue has now been resolved by Microsoft.

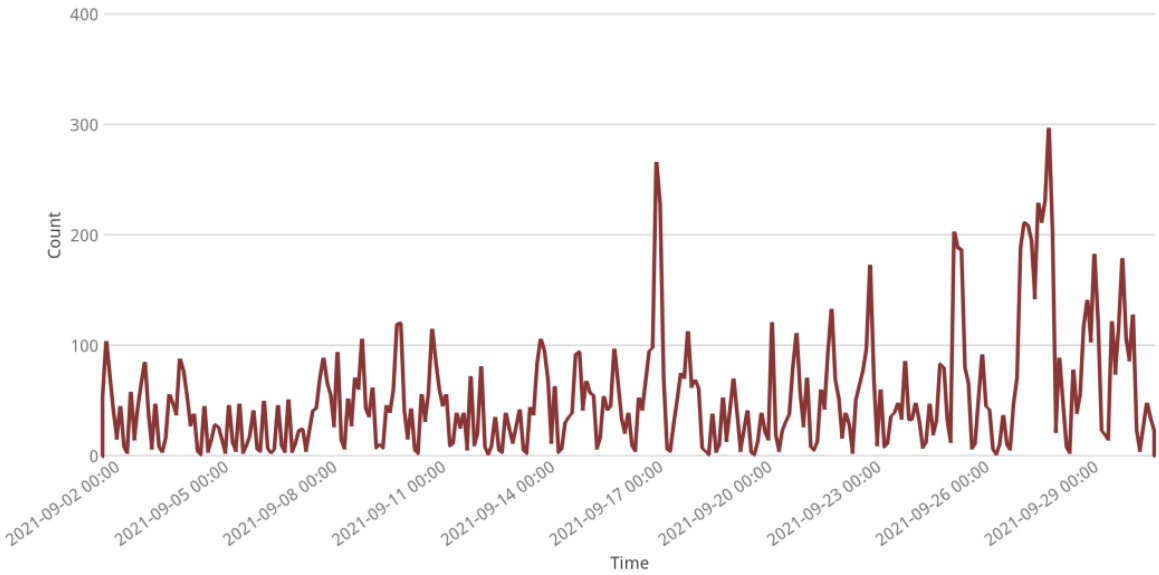



| | Week 1 | Week 2 | Week 3 | Week 4 | Week 5 | Total |
|---|---|---|---|---|---|---|
| Opened | 219 | 156 | 129 | 147 | 147 | 798 |
| Closed | 259 | 150 | 126 | 128 | 106 | 769 |

- 798 Service Desk tickets were opened in the month of September 2021, which is 14.7% higher than the previous month and 769 Service Desk tickets were closed, which is 6% higher than the previous month.
    - The open ticket count for the month of September is slightly higher and within the 3-month average of 720.
    - As expected, the ticket count slightly increased as we ended the 1st quarter of the fiscal year. We have ramped up efforts to deploy the Multi-Factor Authentication (MFA) tokens in September as we anticipate to reach our goal to close this project by mid-October 2021.

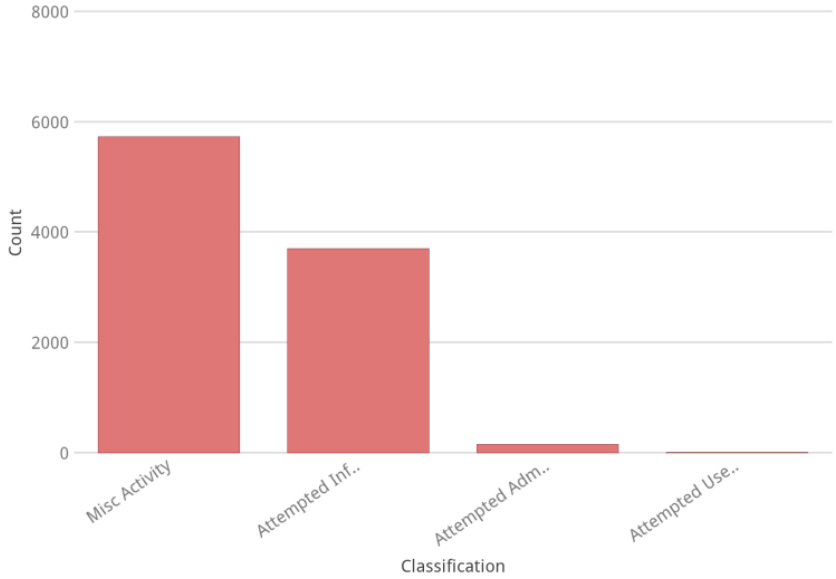
## All Intrusion Events

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



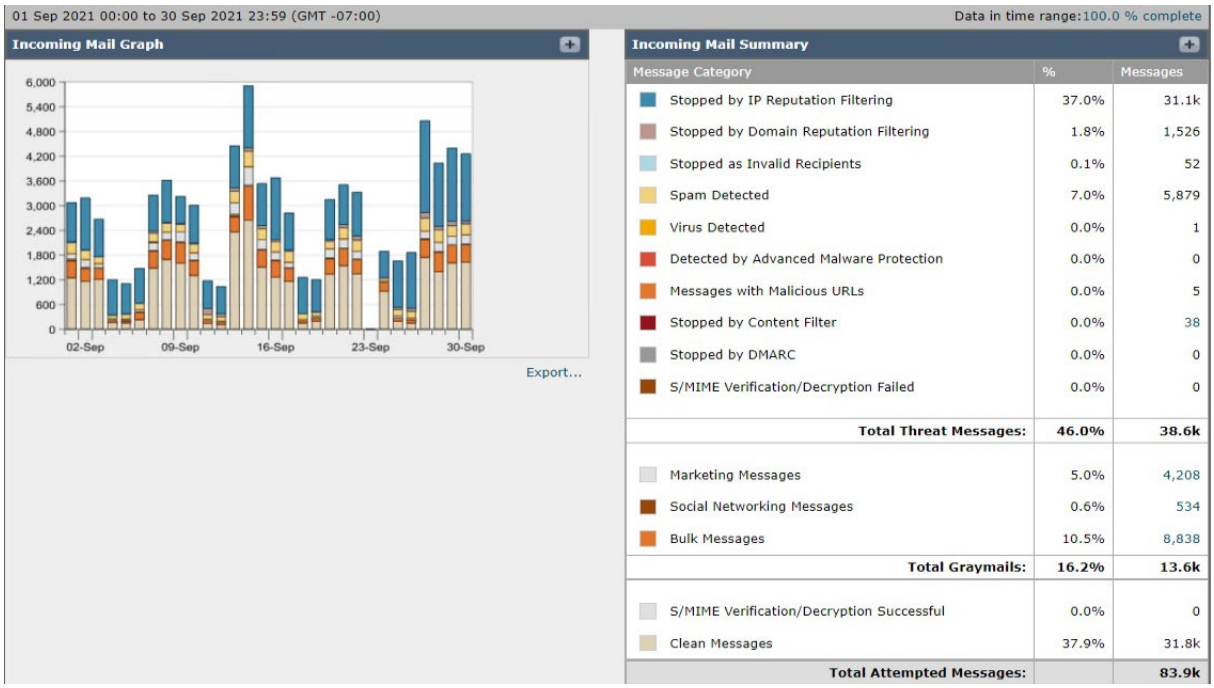

## Dropped Intrusion Events

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



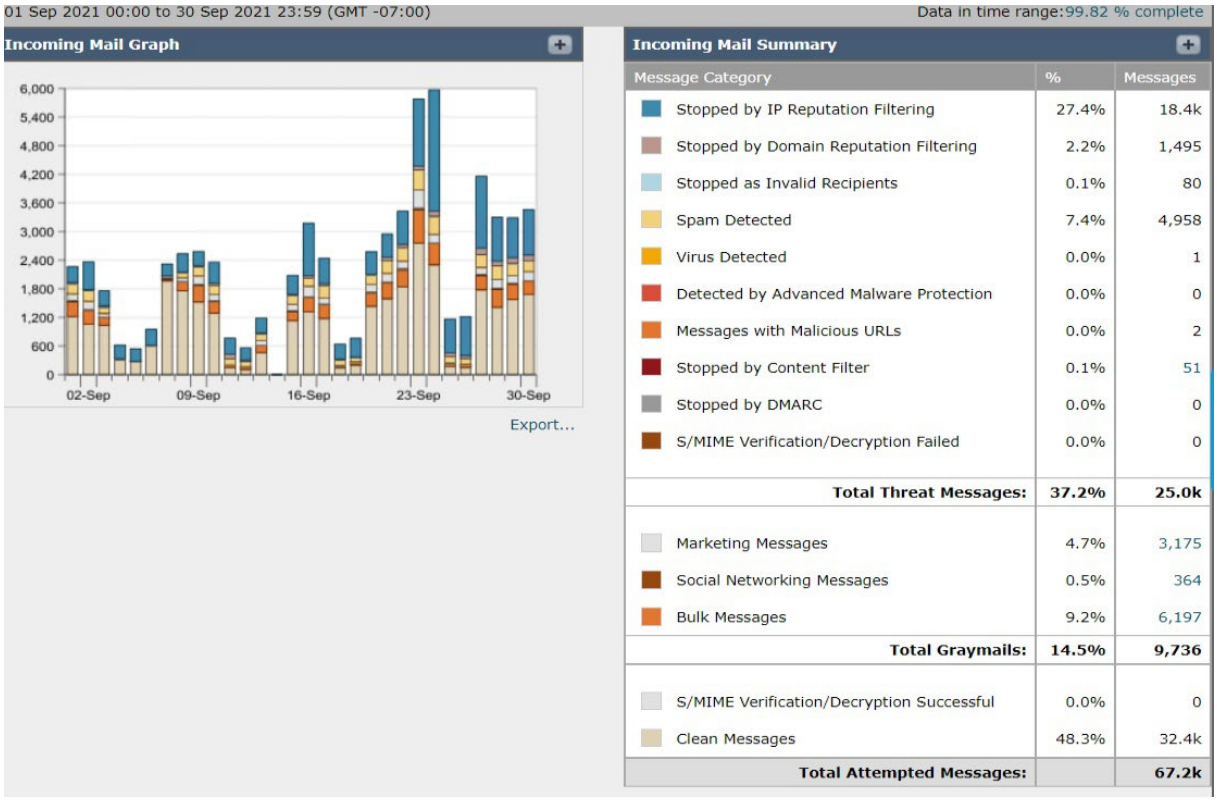

| Classification | Count |
|---|---|
| Misc Activity | 5,733 |
| Attempted Information Leak | 3,700 |
| Attempted Administrator Privilege Gain | 157 |
| Attempted User Privilege Gain | 6 |

MX4




| Message Category | % | Messages |
|---|---|---|
| Stopped by IP Reputation Filtering | 37.0% | 31.1k |
| Stopped by Domain Reputation Filtering | 1.8% | 1,526 |
| Stopped as Invalid Recipients | 0.1% | 52 |
| Spam Detected | 7.0% | 5,879 |
| Virus Detected | 0.0% | 1 |
| Detected by Advanced Malware Protection | 0.0% | 0 |
| Messages with Malicious URLs | 0.0% | 5 |
| Stopped by Content Filter | 0.0% | 38 |
| Stopped by DMARC | 0.0% | 0 |
| S/MIME Verification/Decryption Failed | 0.0% | 0 |
| **Total Threat Messages:** | **46.0%** | **38.6k** |
| Marketing Messages | 5.0% | 4,208 |
| Social Networking Messages | 0.6% | 534 |
| Bulk Messages | 10.5% | 8,838 |
| **Total Graymails:** | **16.2%** | **13.6k** |
| S/MIME Verification/Decryption Successful | 0.0% | 0 |
| Clean Messages | 37.9% | 31.8k |
| **Total Attempted Messages:** | | **83.9k** |

MX9




| Message Category | % | Messages |
|---|---|---|
| Stopped by IP Reputation Filtering | 27.4% | 18.4k |
| Stopped by Domain Reputation Filtering | 2.2% | 1,495 |
| Stopped as Invalid Recipients | 0.1% | 80 |
| Spam Detected | 7.4% | 4,958 |
| Virus Detected | 0.0% | 1 |
| Detected by Advanced Malware Protection | 0.0% | 0 |
| Messages with Malicious URLs | 0.0% | 2 |
| Stopped by Content Filter | 0.1% | 51 |
| Stopped by DMARC | 0.0% | 0 |
| S/MIME Verification/Decryption Failed | 0.0% | 0 |
| **Total Threat Messages:** | **37.2%** | **25.0k** |
| Marketing Messages | 4.7% | 3,175 |
| Social Networking Messages | 0.5% | 364 |
| Bulk Messages | 9.2% | 6,197 |
| **Total Graymails:** | **14.5%** | **9,736** |
| S/MIME Verification/Decryption Successful | 0.0% | 0 |
| Clean Messages | 48.3% | 32.4k |
| **Total Attempted Messages:** | | **67.2k** |

| Item / Date | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | ***Sep-21*** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Stopped By Reputation | 129.0k | 74.7k | 68.9k | 69.7k | 43.8k | 149k | 60.7k | 79.9k | 65.4 | 78.8k | 62.7k | 43.1k | ***41.5k*** |
| Invalid Recipients | 2,582 | 1,120 | 883 | 153 | 62 | 242 | 384 | 1,776 | 99 | 1,982 | 742 | 185 | ***132*** |
| Spam Detected | 11.2k | 15.4k | 13.6k | 13.2 | 8,650 | 30.2k | 19.2k | 19.2k | 18 | 17.4k | 27 | 12.8k | ***10.8k*** |
| Virus Detected | 2 | 1 | 1 | 1 | 0 | 9 | 3 | 5 | 2 | 2 | 9 | 14 | ***14*** |
| Advanced Malware | 1 | 1 | 2 | 9 | 10 | 10 | 0 | 6 | 6 | 0 | 1 | 3 | ***2*** |
| Malicious URLs | 33 | 22 | 31 | 39 | 3 | 6 | 14 | 0 | 264 | 30 | 12 | 9 | ***7*** |
| Content Filter | 26 | 5 | 2 | 8 | 18 | 189 | 56 | 151 | 264 | 167 | 78 | 58 | ***89*** |
| Marketing Messages | 4,127 | 3,794 | 6,511 | 6,147 | 3,203 | 68 | 68 | 6,707 | 6,366 | 6,357 | 6,256 | 6,710 | ***7,383*** |
| Attempted Admin Privilege Gain | 1,865 | 314 | 285 | 84 | 42 | 160 | 89 | 96 | 95 | 109 | 101 | 129 | ***157*** |
| Attempted User Privilege Gain | 339 | 1,948 | 1,019 | 650 | 37 | 6 | 64 | 10 | 1 | 0 | 3 | 7 | ***6*** |
| Attempted Information Leak | 18 | 52 | 156 | 167 | 44 | 11 | 3 | 20 | 18 | 38 | 15 | 32 | ***3,700*** |
| Potential Corp Policy Violation | 210 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | ***0*** |
| Network Scans Detected | 1 | 9 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | ***0*** |
| Web Application Attack | 65 | 25 | 25 | 0 | 0 | 0 | 24 | 11 | 0 | 3 | 1 | 0 | ***0*** |
| Attempted Denial of Service | 0 | 0 | 11.2k | 6,775 | 15,163 | 2,788 | 0 | 1 | 0 | 0 | 0 | 0 | ***0*** |
| Misc. Attack | 14 | 4,242 | 2,508 | 5,935 | 2,390 | 13,836 | 6,870 | 4,395 | 3,851 | 1,516 | 975 | 446 | ***5,733*** |

- 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 41.5k.

- Attempted information leaks detected and blocked at the firewall are higher from 32 to 37 for the month of September 2021.

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

- Attempted User Privilege Gain is slightly lower at 6 from a previous six-month average of 4.5.


# Projects and Programs

## Ruth Watson

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

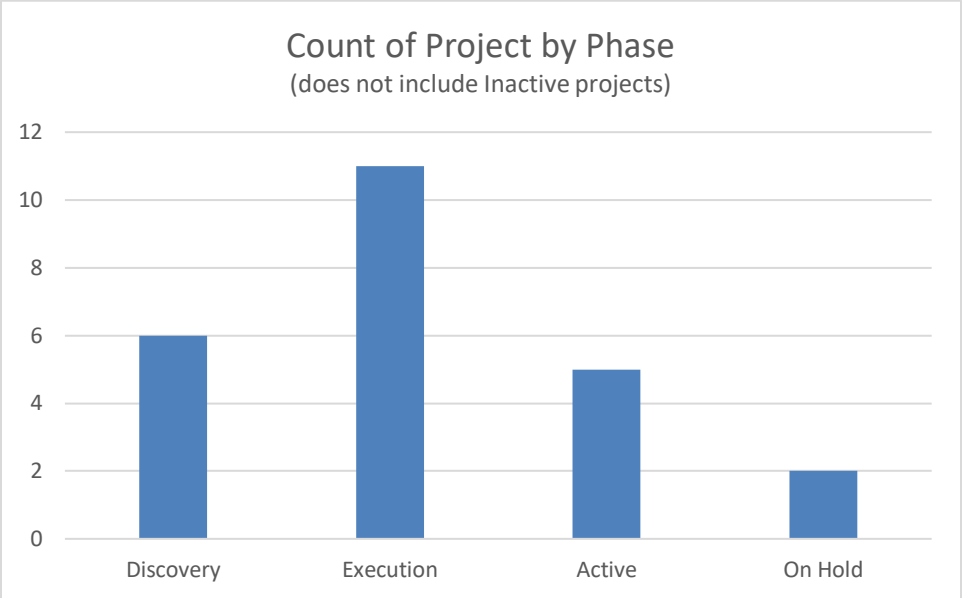
**From:** **Ruth Watson, Chief Projects and Programs Officer**

**Date:** **October 8, 2021**

**Subject:** **Projects & Programs Report**

## Project Management Office

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




## Integrated Planning

- CalAIM Enhanced Care Management (ECM) and Community Supports (CS):
  - Model of Care (MOC) Part 3 was submitted to the Department of Health Care Services (DHCS) on October 1, 2021.
    - Consisted of five (5) required responses including narrative responses, updated CS Policies & Procedures (P&Ps), ECM and CS Network Capacity spreadsheets, and the draft Community Supports Provider Contract boilerplate.
    - Additional Information Requests (AIRs) have been received from DHCS in response to the MOC Part 2 submission.
      - DHCS is requesting additional language be added to the P&Ps or ECM draft contract to reflect the Standard Terms

and Conditions for ECM/CS or DHCS-MCP contractual requirements.
        - The MOC will require periodic updating going forward to account for the additional ECM Populations of Focus that will be phased-in beginning in January 2023.
    - Operational Readiness planning is on-going:
        - Separate workgroup meetings with Health Care Services, Provider Services, Analytics, Member Services/Outreach & Communications and Finance occur weekly or more, as needed.
        - Contract discussions continued with Health Care Services Agency (HCSA) as the provider for CS Housing services and Asthma Remediation.
        - Contract discussions with existing CB-CME providers are underway to re-contract as ECM Providers.
        - Contract discussions are underway with potential CS Providers for the provision of Recuperative Care (Medical Respite) and Medically Tailored Meals/Medically Supportive Food.

- CalAIM Major Organ Transplants (MOT):
    - MOT Network Certification was submitted to DHCS as required on September 2, 2021.
    - MOT Deliverables (7) were submitted to DHCS on September 15, 2021; one remaining deliverable is due to DHCS on October 20th.
    - University of California hospitals have objected to the rate protections DHCS published in "trailer bill language"; the eventual rates are currently unknown.
    - An updated Network Certification template is due to DHCS by October 15th
    - AAH expects to finalize Stanford's contract prior to January 1st; UCSF is unknown at this time.
    - Functional requirements gathering sessions have been completed with all stakeholders.
    - Detailed technical requirements will be defined by the end of October.

- Behavioral Health Integration (BHI) Incentive Program – DHCS pilot program commenced January 1, 2021 and continues through December 31, 2022.

**Recruiting and Staffing**

- Project Management Open position(s):
    - Recruitment to commence for the following positions:
        - Manager, Project Management Office (PMO)
        - Senior Business Analyst
        - Project Manager (2)
        - Business Analyst, Integrated Planning

# Projects and Programs

## Supporting Documents

# Project Descriptions

Key projects currently in-flight:

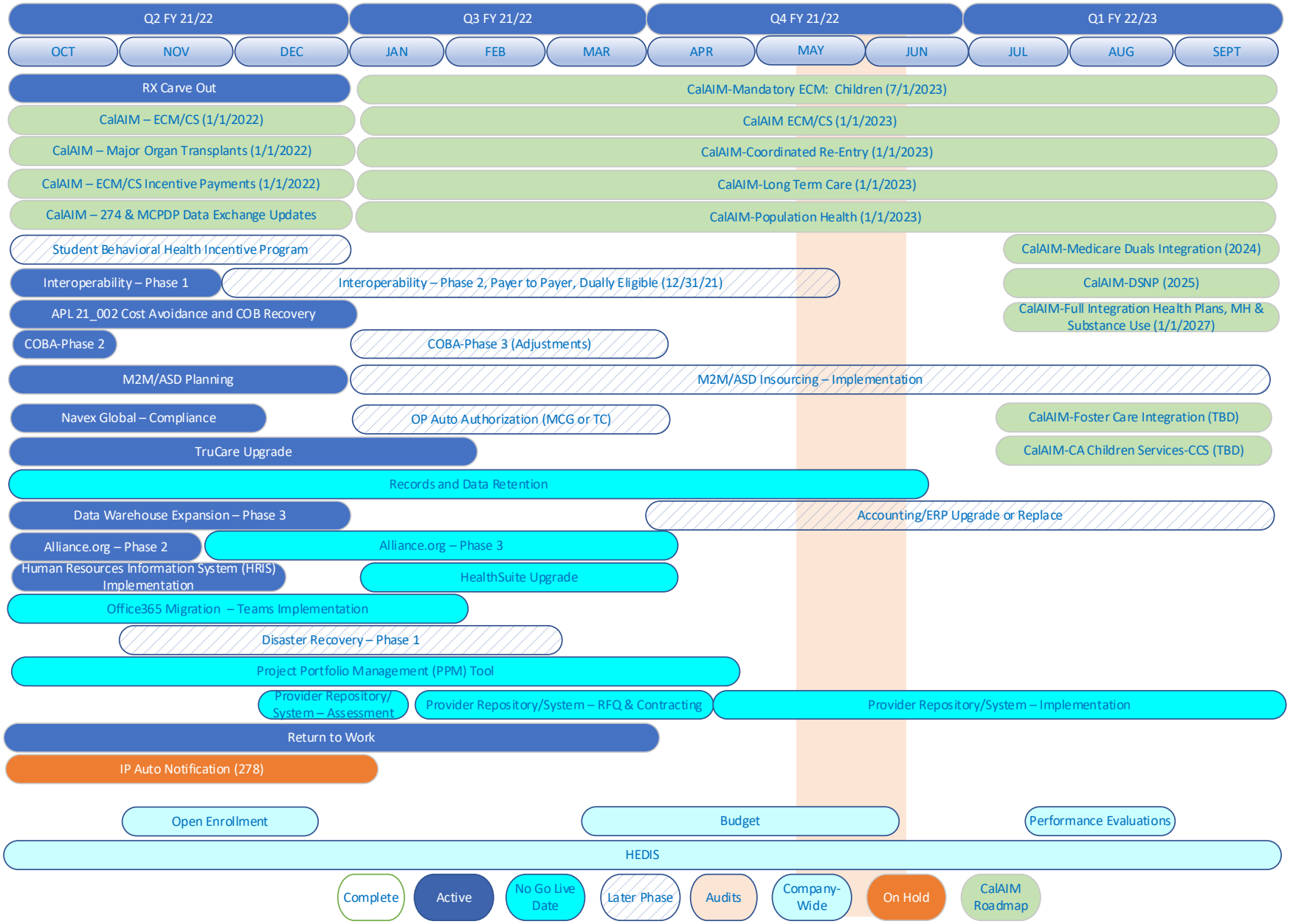
- California Advancing and Innovating Medi-Cal (CalAIM) – program to provide targeted and coordinated care for vulnerable populations with complex health needs
    - Enhanced Care Management (ECM) effective January 1, 2022 – ECM will target seven (7) specific populations of vulnerable and high-risk children and adults
        - Members currently receiving Whole Person Care (WPC) care management or Health Homes Program (HHP) services will transition into ECM
        - Model of Care Part 1 submitted to DHCS on June 30, 2021
        - Model of Care Part 2 submitted to DHCS on August 27, 2021
        - Model of Care Part 3 submitted to DHCS on October 1, 2021
    - Community Supports (CS) 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
        - Six Community Supports options have been selected for implementation on January 1, 2022
    - Major Organ Transplants (MOT) – currently not within the scope of many Medi-Cal managed care plans (MCPs); will be carved into all MCPs effective January 1, 2022.
        - Applicable to adults; also applicable to children for transplants not covered by California Children's Services
- 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
- Pharmacy Carve-Out – transition of the pharmacy benefit for Medi-Cal members from managed care plans to the State; DHCS announced the new start date of January 1, 2022
- Project Portfolio Management (PPM) Tool – vendor demonstrations are underway
- All Plan Letter (APL) 21-002 (formerly APL 20-010) Cost Avoidance, Other Health Coverage

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

Projects on Hold:

- In Patient (IP) Auto Notification (278 Data File) – pilot hospitals are not ready to start implementation

# AAH Project Portfolio - Active + (updated 10/8/2021)



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Service you can trust.

# Analytics

## Tiffany Cheang

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

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

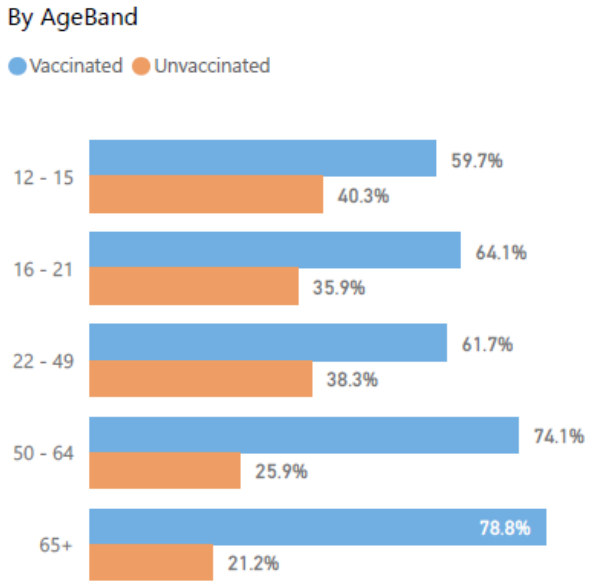
**Date:** **October 8, 2021**

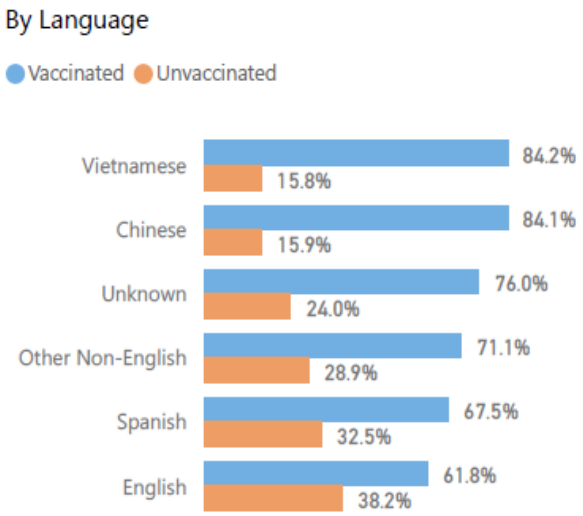
**Subject:** **Performance & Analytics Report**

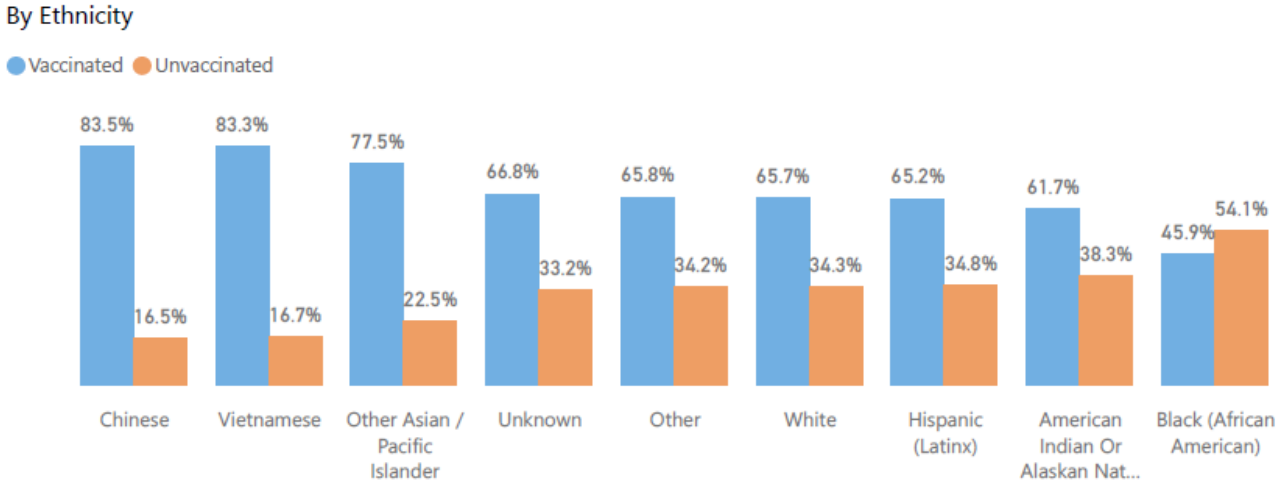
## COVID-19 Vaccination Rate

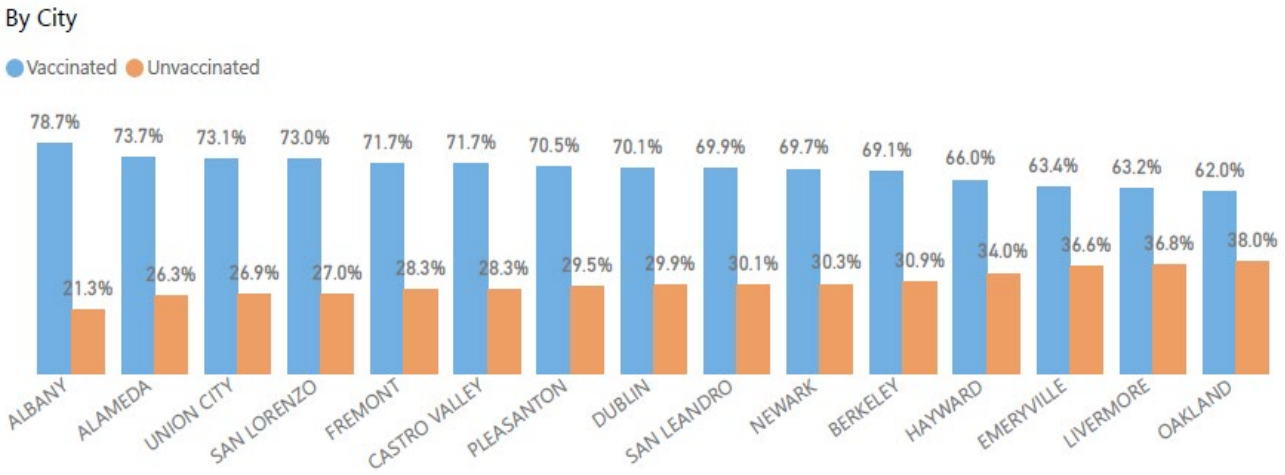
- The Alliance COVID-19 Vaccination rate is 66.5% for fully and partially vaccinated members aged 12 years and older.
  - 61.5% are fully vaccinated
  - 5.0% are partially vaccinated

- A comparison of the Alliance's vaccinated vs unvaccinated members (33.5%) shows the following demographic results:






**Member Cost Analysis**

- The Member Cost Analysis below is based on the following 12 month rolling periods:
  - Current reporting period: July 2020 – June 2021 dates of service
  - Prior reporting period: July 2019 – June 2020 dates of service

  (Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 8.5% of members account for 84.0% of total costs.

- In comparison, the Prior reporting period was lower at 7.5% of members accounting for 82.2% 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 27.6% and ACA OE's at 32.9%.
  - The percent of members with costs >= $30K slightly increased from 1.6% to 1.8%.
  - 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 49.8%.

- 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 8.5% is more concentrated in the 45-66 year old category (40.7%) compared to the overall population (20.7%).

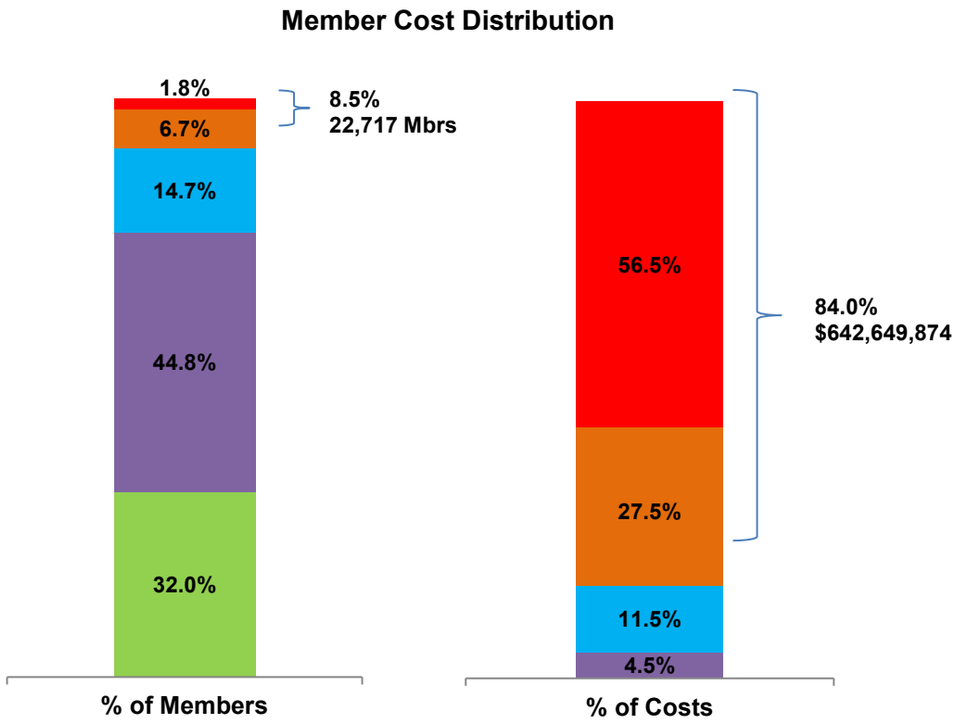
# Analytics

## Supporting Documents

**Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis**
**Lines of Business: MCAL, IHSS; Excludes Kaiser Members**
**Dates of Service: Jul 2020 - Jun 2021**

Note: Data incomplete due to claims lag

Run Date: 09/29/2021




| Cost Range | Members | % of Members | Costs | % of Costs |
|---|---|---|---|---|
| $30K+ | 4,873 | 1.8% | $ 432,193,340 | 56.5% |
| $5K - $30K | 17,844 | 6.7% | $ 210,456,534 | 27.5% |
| $1K - $5K | 39,127 | 14.7% | $ 87,642,826 | 11.5% |
| < $1K | 119,333 | 44.8% | $ 34,599,524 | 4.5% |
| $0 | 85,418 | 32.0% | $ - | 0.0% |
| **Totals** | **266,595** | **100.0%** | **$ 764,892,224** | **100.0%** |

**Top 8.5% of Members = 84.0% of Costs**

| Cost Range | Members | % of Total Members | Costs | % of Total Costs |
|---|---|---|---|---|
| $100K+ | 1,128 | 0.4% | $ 230,146,692 | 30.1% |
| $75K to $100K | 645 | 0.2% | $ 55,836,414 | 7.3% |
| $50K to $75K | 1,153 | 0.4% | $ 71,063,991 | 9.3% |
| $40K to $50K | 777 | 0.3% | $ 34,727,365 | 4.5% |
| $30K to $40K | 1,170 | 0.4% | $ 40,418,879 | 5.3% |
| ***SubTotal*** | ***4,873*** | ***1.8%*** | ***$ 432,193,340*** | ***56.5%*** |
| $20K to $30K | 2,274 | 0.9% | $ 55,452,118 | 7.2% |
| $10K to $20K | 6,483 | 2.4% | $ 90,205,876 | 11.8% |
| $5K to $10K | 9,087 | 3.4% | $ 64,798,540 | 8.5% |
| ***SubTotal*** | ***17,844*** | ***6.7%*** | ***$ 210,456,534*** | ***27.5%*** |
| **Total** | **22,717** | ***8.5%*** | **$ 642,649,874** | ***84.0%*** |

| Enrollment Status | Members | Total Costs |
|---|---|---|
| Still Enrolled as of Jun 2021 | 246,460 | $ 680,315,375 |
| Dis-Enrolled During Year | 20,135 | $ 84,576,849 |
| **Totals** | **266,595** | **$ 764,892,224** |

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**
**8.5% of Members = 84.0% of Costs**
**Lines of Business: MCAL, IHSS; Excludes Kaiser Members**
**Dates of Service: Jul 2020 - Jun 2021**
Note: Data incomplete due to claims lag
Run Date: 09/29/2021

**8.5% of Members = 84.0% of Costs**
**27.6% of members are SPDs and account for 34.1% of costs.**
**32.9% of members are ACA OE and account for 31.2% of costs.**
**6.7% of members disenrolled as of Jun 2021 and account for 12.4% of costs.**

**Member Breakout by LOB**

| LOB | Eligibility Category | Members with Costs >=$30K | Members with Costs $5K-$30K | Total Members | % of Members |
|---|---|---|---|---|---|
| IHSS | IHSS | 126 | 603 | 729 | 3.2% |
| MCAL | MCAL - ADULT | 513 | 3,337 | 3,850 | 16.9% |
| | MCAL - BCCTP | - | - | - | 0.0% |
| | MCAL - CHILD | 205 | 1,441 | 1,646 | 7.2% |
| | MCAL - ACA OE | 1,556 | 5,924 | 7,480 | 32.9% |
| | MCAL - SPD | 1,761 | 4,504 | 6,265 | 27.6% |
| | MCAL - DUALS | 107 | 1,129 | 1,236 | 5.4% |
| Not Eligible | Not Eligible | 605 | 906 | 1,511 | 6.7% |
| **Total** | | **4,873** | **17,844** | **22,717** | **100.0%** |

**Cost Breakout by LOB**

| LOB | Eligibility Category | Members with Costs >=$30K | Members with Costs $5K-$30K | Total Costs | % of Costs |
|---|---|---|---|---|---|
| IHSS | IHSS | $ 8,767,510 | $ 6,594,204 | $ 15,361,714 | 2.4% |
| MCAL | MCAL - ADULT | $ 40,354,043 | $ 38,263,154 | $ 78,617,196 | 12.2% |
| | MCAL - BCCTP | $ - | $ - | $ - | 0.0% |
| | MCAL - CHILD | $ 10,152,810 | $ 16,891,171 | $ 27,043,982 | 4.2% |
| | MCAL - ACA OE | $ 132,166,753 | $ 68,030,045 | $ 200,196,798 | 31.2% |
| | MCAL - SPD | $ 163,392,822 | $ 55,494,853 | $ 218,887,676 | 34.1% |
| | MCAL - DUALS | $ 9,267,578 | $ 13,756,222 | $ 23,023,800 | 3.6% |
| Not Eligible | Not Eligible | $ 68,091,824 | $ 11,426,885 | $ 79,518,709 | 12.4% |
| **Total** | | **$ 432,193,340** | **$ 210,456,534** | **$ 642,649,874** | **100.0%** |

**Highest Cost Members; Cost Per Member >= $100K**
**38.9% of members are SPDs and account for 39.1% of costs.**
**30.4% of members are ACA OE and account for 29.4% of costs.**
**18.8% of members disenrolled as of Jun 2021 and account for 19.7% of costs.**

**Member Breakout by LOB**

| LOB | Eligibility Category | Total Members | % of Members |
|---|---|---|---|
| IHSS | IHSS | 14 | 1.2% |
| MCAL | MCAL - ADULT | 98 | 8.7% |
| | MCAL - BCCTP | - | 0.0% |
| | MCAL - CHILD | 6 | 0.5% |
| | MCAL - ACA OE | 343 | 30.4% |
| | MCAL - SPD | 439 | 38.9% |
| | MCAL - DUALS | 16 | 1.4% |
| Not Eligible | Not Eligible | 212 | 18.8% |
| **Total** | | **1,128** | **100.0%** |

**Cost Breakout by LOB**

| LOB | Eligibility Category | Total Costs | % of Costs |
|---|---|---|---|
| IHSS | IHSS | $ 2,738,842 | 1.2% |
| MCAL | MCAL - ADULT | $ 18,874,090 | 8.2% |
| | MCAL - BCCTP | $ - | 0.0% |
| | MCAL - CHILD | $ 1,208,262 | 0.5% |
| | MCAL - ACA OE | $ 67,618,212 | 29.4% |
| | MCAL - SPD | $ 90,061,955 | 39.1% |
| | MCAL - DUALS | $ 4,350,945 | 1.9% |
| Not Eligible | Not Eligible | $ 45,294,385 | 19.7% |
| **Total** | | **$ 230,146,692** | **100.0%** |

**% of Total Costs By Service Type**

**Breakout by Service Type/Location**

| Cost Range | Trauma Costs | Hep C Rx Costs | Pregnancy, Childbirth & Newborn Related Costs | Pharmacy Costs | Inpatient Costs (POS 21) | ER Costs (POS 23) | Outpatient Costs (POS 22) | Office Costs (POS 11) | Dialysis Costs (POS 65) | Other Costs (All Other POS) |
|---|---|---|---|---|---|---|---|---|---|---|
| $100K+ | 6% | 0% | 0% | 12% | 56% | 1% | 15% | 5% | 3% | 8% |
| $75K to $100K | 6% | 0% | 1% | 17% | 43% | 2% | 8% | 5% | 12% | 13% |
| $50K to $75K | 7% | 0% | 1% | 20% | 40% | 3% | 7% | 7% | 7% | 16% |
| $40K to $50K | 7% | 0% | 2% | 15% | 45% | 5% | 8% | 7% | 2% | 17% |
| $30K to $40K | 11% | 1% | 1% | 16% | 39% | 11% | 8% | 6% | 1% | 19% |
| $20K to $30K | 8% | 2% | 1% | 18% | 34% | 11% | 10% | 7% | 1% | 18% |
| $10K to $20K | 1% | 0% | 1% | 21% | 33% | 6% | 13% | 10% | 2% | 16% |
| $5K to $10K | 0% | 0% | 0% | 24% | 19% | 8% | 13% | 15% | 1% | 19% |
| **Total** | **5%** | **0%** | **1%** | **17%** | **43%** | **5%** | **12%** | **7%** | **4%** | **14%** |

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

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# Human Resources

## Anastacia Swift

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

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

**Date:** **October 8, 2021**

**Subject:** **Human Resources Report**

## Staffing

- As of October 1, 2021, the Alliance had 355 full time employees and 1-part time employee.
- On October 1, 2021, the Alliance had 45 open positions in which 9 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 36 positions open to date. The Alliance is actively recruiting for the remaining 36 positions and several of these positions are in the interviewing or job offer stage.
- Summary of open positions by department:

| Department | Open Positions October 1st | Signed Offers Accepted by Department | Remaining Recruitment Positions |
|---|---|---|---|
| Healthcare Services | 11 | 2 | 9 |
| Operations | 18 | 5 | 13 |
| Healthcare Analytics | 2 | 0 | 2 |
| Information Technology | 5 | 1 | 4 |
| Finance | 4 | 1 | 3 |
| Compliance | 4 | 0 | 4 |
| Human Resources | 1 | 0 | 1 |
| Projects & Programs | 0 | 0 | 0 |
| Total | 45 | 9 | 36 |

- Our current recruitment rate is 12%.

**Employee Recognition**

- Employees reaching major milestones in their length of service at the Alliance in September 2021 included:
    - 5 years:
        - Anthony Taylor (Finance)
        - Sankar Ganesh Rathnasamy (IT Development)
        - Pandiyarajan Subburaman (IT Development
        - Tami Lewis (Projects & Programs)
        - Ed DeOcampo (IT Infrastructure)
        - Sasi Karaiyan (IT Information Technology)
        - Natalie McDonald (Utilization Management)
    - 6 years:
        - Smita Kaza (IT Ops & Quality Apps Management)
        - Shirish Mallavolu (Healthcare Analytics)
        - Dacheng Peng (IT Development)
    - 8 years:
        - Hellai Momen (Quality Improvement)
        - Alexandra Loza (Complaints & Resolution)
        - Catherine Patrick (Case & Disease Management)
    - 9 years:
        - B J Thomas Gerona (IT Infrastructure)
    - 17 years:
        - Carol van Oosterwijk (Finance)
    - 19 years:
        - Tung Le (Community Relations)