ALAMEDA Alliance FOR HEALTH

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

Board of Governors

Regular Meeting

Friday, June 10th, 2022
12:00 p.m. – 2:00 p.m.

Video Conference Call Only

1240 South Loop Road, Alameda, CA 94502

AGENDA

BOARD OF GOVERNORS
Regular Meeting
Friday, June 10th, 2022
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 June 10th, 2022, at 12:00 p.m. in Alameda County, California, by Dr. Evan Seevak, Presiding Officer. This meeting is to take place by video conference call.)

2. **ROLL CALL**

3. **AGENDA APPROVAL OR MODIFICATIONS**

4. **INTRODUCTIONS**

5. **CONSENT CALENDAR**

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

   a) **MAY 13th, 2022, BOARD OF GOVERNORS MEETING MINUTES**

   b) **JUNE 7th, 2022, 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 APRIL 2022 MONTHLY FINANCIAL STATEMENTS**

   b) **REVIEW AND APPROVE FY2023 PRELIMINARY BUDGET**

9. **STANDING COMMITTEE UPDATES**

   a) **PEER REVIEW AND CREDENTIALING 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 comments during the meeting at the end of each topic.

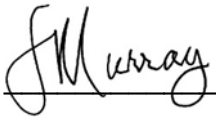
Supplemental Material Received After the Posting of the Agenda: Any supplemental writings or documents distributed to a majority of the Board regarding any item on this agenda after the posting of the

agenda will be available for public review. To obtain a document, please call the Clerk of the Board at 510-747-6160.

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

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

I hereby certify that the agenda for the Board of Governors was posted on the Alameda Alliance for Health's web page at www.alamedaalliance.org on June 3rd, 2022, by 12:00 p.m.



_____Clerk of the Board – Jeanette Murray

ALAMEDA Alliance FOR HEALTH

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Consent Calendar

ALAMEDA Alliance FOR HEALTH

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Board of Governors Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
BOARD OF GOVERNORS
REGULAR MEETING
May 13th, 2022
12:00 pm – 2:00 pm
(Video Conference Call)
Alameda, CA

SUMMARY OF PROCEEDINGS

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

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

Guests Present on Conference Call: Bobbie Wunsch

Excused: Anastacia Swift

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
1. CALL TO ORDER			
Dr. Evan Seevak	The regular board meeting was called to order by Dr. Seevak at 12:03 pm. The following public announcement was read. "The Board recognizes that there is a proclaimed state of emergency at both the State and the local Alameda County levels, and there are recommended measures to promote social distancing in place. The Board shall therefore conduct its meetings via teleconference in accordance with Assembly Bill 361 for the duration of the proclaimed State of emergency." "Audience, during each agenda item, you will be provided a reasonable amount of time to provide public comment."	None	None

2. ROLL CALL			
Dr. Evan Seevak	A telephonic roll call was taken of the Board Members, and a quorum was confirmed.	None	None
3. AGENDA APPROVAL OR MODIFICATIONS			
Dr. Evan Seevak	None	None	None
4. INTRODUCTIONS			
Dr. Evan Seevak	None	None	None
5. CONSENT CALENDAR			
Dr. Evan Seevak	Dr. Seevak presented the May 13h, 2022, Consent Calendar. a) April 8th, 2022, Board of Governors Meeting Minutes b) May 10th, 2022, Finance Committee Meeting Minutes Motion to Approve May 13th, 2022, Board of Governors Consent Calendar. A roll call vote was taken, and the motion passed.	Motion to Approve May 13th, 2022, Board of Governors Consent Calendar. Motion: Dr. Marty Lynch Second: Andrea Schwab-Galindo Vote: Yes No opposed or abstained.	None

6. a. BOARD MEMBER REPORT – COMPLIANCE ADVISORY COMMITTEE			
Rebecca Gebhart	The Compliance Advisory Committee (CAC) was held telephonically on May 13th, 2022, at 10:30 am. Rebecca Gebhart gave the following Compliance Advisory Committee updates. Kindred Focused Audit: • DHCS has closed the Audit and accepted the corrective action plan. • The Alliance staff will continue to monitor and make the Compliance Committee aware of anything that comes up. However, in the future, the Kindred Audit will not be reported to the Board as it is closed. 2022 DHCS Audit Observations: • Non-Emergency & Non-Medical Transport – in the observations, it was noted that non-emergency and non-medical requirements did not follow policy on collecting a PCS (Position Certification Statement), which is the paperwork that outlines the particular modality authorized by the transport. The forms were not collected in advance of the transport. • We understand all plans have trouble getting providers to fill out this form in advance of the trip or service that the member must take; the Plan's perspective is we don't want to hold up transportation for a member. Without a form, technically, it would be possible to deny transportation to the member and they would not get to where they need to go to deal with their health matter. • Our priority is to get members where they need to go for their visit, however, we do need to make improvements. Our leadership is engaged with the State because it is important to put the member first and not delay service. • HIPAA – the Plan did not report disclosures within twenty-four (24) hours of discovery. If we are unable to navigate this out of the Audit, it will be a repeat finding. The issue is we made several referrals of disclosures within twenty-four (24) hours of the Compliance Department receiving the information, but the State wants the twenty-four-hour clock to start ticking when the referral is made to the Plan. We are working on a front-office	Informational update to the Board of Governors. Vote not required.	

	automated solution so when it is received, we do not lose time in migrating to the Compliance Department. • Similarly, with Fraud, Waste, and Abuse – if we do not report a preliminary investigation within ten (10) working days of discovery, the clock starts ticking at the time the front office or Member Services discover it. We are working to put into place an automated solution and diligently training our front office staff to be able to recognize what they are seeing relating to Privacy, HIPAA, or Fraud, Waste, and Abuse. There would be an automated alert that goes directly to Compliance so that Compliance could receive it when the front office or Member Services do. Question: Is the requirement that every time transport is ordered, a form is completed by a physician or a provider and submitted to the Alliance? Answer: There are a couple of different ways by which a provider can prescribe a particular modality for a member – in completing the form, the provider can outline a particular period of time or a one-time use. Question: For purposes of compliance and completing the form in a timely manner, would it be more effective to send out the form through DocuSign between the Plan and providers ahead of time? Answer: That is an excellent suggestion. I don't know if it is in the Plan's current workflow, but it is something we can look into. NCQA Reaccreditation: • A significant risk has been identified that may impact the NCQA reaccreditation status. • Our CEO has launched an internal Audit, and a mitigation plan will be developed to address the self-identified deficiencies. The CEO will be updating the Compliance Committee and the Board of Governors prior to the survey in June. 2022 Financial Audit: • The 2022 Financial Audit is taking place in the fall. It is a tri-annual audit, which takes place every three (3) years. The last one was in 2019. Last month, the Compliance Committee asked the CFO to refresh our memory		

	about what is covered in the Finance Audit so that we have anticipatory guidance and are prepared for the fall. • The 2022 Financial Audit will be taking place at the same time as the Moss Adams Financial Audit for the Plan. The auditors will be looking at four (4) areas: (1) the financial statements; (2) the calculation of total net equity; (3) compliance issues and especially issues related to claims; and (4) internal controls. This audit will commence in August, and we will provide more information in the future. DMHC Behavioral Health Investigation: • The Behavioral Health Investigation is related to the commercial line (NOT Medi-Cal). The investigations started last year with various other plans, and we are one of the plans that is being reviewed in the second year. • The interview for that Behavioral Health Investigation is for the IHSS commercial line and will be taking place September 5th. More information will be available in the fall. Informational update to the Board of Governors. Vote not required.		
6. b. BOARD MEMBER REPORT – FINANCE COMMITTEE			
Dr. R. Ferguson	The Finance Committee was held telephonically on Tuesday, May 10th, 2022. Highlights: • Tangible Net Equity (TNE) remains above what is required at 575%. • Enrollment continues to increase – most recent numbers showed we increased by 2,335 members since February 2022. • Positive revenue adjustment – there was discussion due to the MCO tax and the expected fourteen million-plus ($14M+) that was anticipated to be paid back to the State for the FY14 through FY16. The team did an	Informational update to the Board of Governors. Vote not required.	None

	excellent job in responding and answering the State. As a result, we have $6.7M retroactive adjustment to our revenue. Question: With the incredibly positive results we have had, does that impact your opinion on what we may want to strategically spend on? Answer: I don't think there's room for any over-spending, especially with the new State-mandates we will go through. We will likely run some major deficits, especially as related to Major Organ Transplants. We are not sure how that will turn out in the future, but it may likely be an issue. Therefore, I don't think we will have extra money for spending, we will likely be running close depending on what happens with our new programs, especially the Major Organ Transplants. Board Retreat Discussion: A discussion regarding Board Retreat Topics. The Board was informed a survey would be sent to them to find a date for the retreat. Informational update to the Board of Governors. Vote not required.		
7. CEO UPDATE			
Scott Coffin	Scott Coffin, Chief Executive Officer, presented the following updates: Executive Summary: • Public Health Emergency: Governor Newsom renewed the Public Health Emergency (PHE) for COVID-19 through the month of July. It is anticipated to be terminated by September. • The Executive Order that defers the Medi-Cal redeterminations will subsequently be terminated. • The Alameda County Social Services Agency will resume the redetermination process for Medi-Cal beneficiaries; this results in beneficiaries being disenrolled from the Medi-Cal program based on their	Informational update to the Board of Governors. Vote not required.	None

	eligibility. The redetermination process is expected to be prospective, meaning going forward, people would be redetermined based on their redetermination date. • The forecast for enrollment is expected to reach approximately 320,000 before the redetermination date. Finances: • Update on our preliminary budget for FY2023: We have put together a forecast which supports the revenue projections as well as the expense projections. • We are on track for the preliminary budget for FY2023. In the month of June, we will be presenting to the Finance Committee and the full Board of Governors, asking for approval on the preliminary budget. Key Performance Indicators: • Regulatory metrics: We made some progress in grievances and appeals. The remediation plan was implemented in the organization to address the standard and the expedited grievances, and specifically, the regulatory turn-around time, which we need to meet. • The standard member grievances met compliance at 95%, and our expedited grievances missed by five percent (5%) this last month. There was a total of ten (10) cases in this category, and one (1) case was not met in the three-calendar days timeframe. Improvements have been made; however, we will continue to monitor and assess the work we are doing on the grievances. • Encounter data submissions for institutional claims for the month of April were seventy-seven-point-five percent (77.5%). The institutional encounters must be at eighty percent (80%) or higher, so we missed by two-point-five percent (2.5%). This was a temporary situation related to some data cleanup involving the encounters from 2021. We are expecting to be back on track next month. • The Member Services team has worked very hard on their remediation plan to improve the customer service metrics We still have some distance to go to get where we need to be, but the team has done a great job on making the right improvements.		

	Program Implementations: • Insourcing of Beacon Health Options: The team has done a fantastic job of going through the detailed planning stages and looking at all the essential parts that we need to move as part of this transition. • We met in May to go through the status. My last report to the Board was that we are going to transition on October 1st, 2022. I have decided to move this out thirty days (30) days to November 1st, 2022 based on the information we have available to us. Kaiser Permanente: • During the week of May 2nd, 2022, legislative hearings were held in Sacramento to discuss the direct contract between the State of California and Kaiser Permanente. • There is an assembly bill that has been created, AB 2724, also known as the Arambula Bill. This bill is being modified through this public process and is expected to conclude by August 2022, prior to a vote. There will be more public forums that will be available for people to comment as they finalize the changes to the bill. We will continue to update the Board on any changes that relates to our arrangement with Kaiser Permanente. Question: The fact that Alameda County is Kaiser's home – would this have a greater impact on us? Are they going to be more focused on their work in Alameda County than other parts of California? Answer: The indicator is the location, size and the open capacity of their facilities. While the contract spans across thirty-two (32) counties in the State, they have different sized facilities and different staffed facilities in each of these counties. In our county, they have a strong presence between San Leandro and Oakland. The question will be on that mandate of growth that they have contracted with the state on for five percent (5%) growth; they don't necessarily have to do five percent (5%) in each county, it can be mixed, but it is an aggregate of five percent statewide. There may be some disproportionate growth in counties they have a stronger presence in. It is unclear on what the strategy is, Kaiser is likely still working on how to meet those growth requirements.		

	Question: The case management numbers in the executive dashboard – does that include everyone who is getting care coordination or case management from the Alliance? Answer: It includes care coordination complex but does not include transition of care. Question: What is the difference between open and enrolled cases? Answer: The open cases are for our internal programs of care coordination and complex cases. Our open cases are different than our external cases of "enrolled." Through March of this year, we have had six-hundred eleven (611) care coordination patients, fifty-five (55) complex case management, and five-hundred sixty-five (565) transition of care patients. Medi-Cal Incentive Programs: • The funding for these programs comes from the American Rescue Plan Act, Home and Community-Based Services, State general funds, and other waivers. All of these came through and were introduced through the Governor's budget. • We are seeing more of these programs starting to break out services as part of the CalAIM program, but they all tie back into core Medi-Cal services. • Participation in the services is voluntary, but strongly encouraged by the department. We are aggressive on moving forward with these funding programs because they create a lot of opportunity to draw down funding to continue services that we started, built in partnership with Alameda County Health Care Services Agency. • There is a caveat that the incentive funding comes with performance outcomes as well as performance measures; if they are not met, there is a risk to Alameda Alliance that funding could be taken back by the State. These funds are not grants – they are performance-based funds, which come with outcomes and measures. Therefore, we must approach carefully on making sure we understand all the different aspects involved. • The funding is allocated to build capacity in local systems and intended to establish sustainable operations. After these programs end in 2024, we		

	must demonstrate how we can continue offering these services; the initial indication is through savings. • Besides our community-based organizations, Alameda Alliance also has the opportunity to apply for incentive funds to use for building capacity – this would be for the entire Alameda community. We are pulling together all available information to build these programs effectively. • The actual structure for each program is still in process. Once we demonstrate the outcomes, the State releases funding. To simplify the process, Alameda Alliance and Anthem are partnering to develop a single plan application process, which will make it simpler for our providers and community-based organizations to apply. We are starting this off with one incentive program on the CalAIM Incentive Program. The goal is to extend this concept to the other incentive programs. We currently do not have agreement with Anthem to proceed on the other programs, but we are intending to pursue that. • In FY2023, in order to track all the reporting requirements of outcomes, which are broken down to quality, performance, and generating reports, coordinating directly with community-based organizations then to submit to the State – we are proposing to create a new department called Incentives and Reporting. This is a cross-divisional department that will be reporting to the Integrated Planning division. • The incentive program Behavioral Health Integration has been in operation for the longest. So far, we have been awarded two-hundred thousand, ($200K) and we have paid out two-hundred thousand ($200K), and we still have more funding available that will be coming. • For all incentive programs, the maximum amounts listed – for example, nearly fifteen million dollars ($14.8M) for CalAIM – we would have to earn this amount. This is a key concept, for all these programs, we have to earn these funds through our actions and outcomes. • The Student Behavioral Health initiative program – we have been awarded up to nine-point-seven million ($9.7M) and we have received three-hundred-eighty-one thousand ($381K). We are in process of doing the planning in order to draw down and pay out funds into the county. • The incentive program with the highest maximum amount is the Housing and Homelessness Program, with the amount of forty-four-point-three million dollars ($44.3M) over a two-year period. Currently, this program we know the least about because we have just received the guidance.		

Tiffany Cheang	• Across all incentive programs, the amount that has been awarded to us so far is ten-point-one million dollars ($10.1M), and the amount we have paid out is one-point-six million dollars ($1.6M). We will be updating the Board as we go through each month, because we will be making progress on each of these incentive programs. • The total maximum amount that Alameda Alliance has been awarded across all incentive programs from the State is seventy-eight million dollars ($78M). What is more important is how we are going to earn these dollars – and then how we would spend it, and the accountability for these funds. • The COVID-19 Vaccination program was concluded at the end of February. Matt Woodruff presented to the Board of Governors our progress each month throughout the program; we started at a sixty-two-point-two percent (62.2%) and we ended at seventy-five-point-one percent (75.1%). As of today, the number continues going up because even though the program stopped, we are continuing to provide incentives for our members to get vaccinated. We had surplus on this program, which we are applying toward incentive dollars for our members. Enhanced Care Management & Community Support Programs: • In January of this year, we launched the enhanced care management and community support programs, and this incentive payment is to support those programs. The bigger goals of this is to increase capacity, improve infrastructure or build infrastructure, and increase the uptake of the community support services, all in addition to addressing disparities, equity, and improving the quality of care. • In this program, any provider or organization can submit to apply, under the condition that the provider or organization joins the Alliance's ECM and Community Supports program. The program years commenced January 1st, 2022 and goes through June 30th, 2024. • For the first year, we have allocated fourteen-point-eight million dollars ($14.8M), and so far to date, we have received fifty percent of that with seven-point-four-million dollars ($7.4M). This is considered an advanced payment for total earnings, and the State reserves the right to recoup that if they feel we have not made sufficient progress.		

	• Payments issued to Providers: This is where we are in the process right now. All applications have been distributed to our current ECM providers and CS providers who we are contracted with or in the process contracting with. We did this in collaboration with Anthem, by working with them to create a single application form to ease the burden on the providers. We are also going to work with Anthem on reviewing the applications. • In the fall, we will have to submit to the State our status report describing how we are doing and the efforts we have made. This submission describing our outcomes will determine the full amount we get for program year 1, and if we receive the remaining fifty percent or not. Question: Is this money intended to pay for the ECM services, or to build infrastructure to provide ECM and community support services and be paid for separately? Answer: It is not to provide for the actual services, this is to support and build up the programs. Supporting and building capacity, which could be supporting staffing or technology needs. We do have requirements as an ECM or community supports provider; certain providers may not have these capabilities or require support, and that is what some of this funding is for. Also, there are programs to address inequities – we have specific outcomes and quality outcomes that we need to show improvement on. An area that we have to show improvement on is diversity metrics; based on ethnicities, and how we are improving those numbers. Question: Could that infrastructure include staffing infrastructure? How to staff up before you have enough members to pay for that staff? Answer: It is to support your hiring of staff, but not to sustain it. The ramp-up time is when you struggle – when you hire someone, and they cannot take on the full load. The idea is that once they are up to speed, the rate you are getting should pay for that individual provider's salary. This funding could help support that and fund that, as well as training. Question: Could you please say more about diversity? Would this information be coming to the Board? Answer: For all our ECM members, we have to break up the numbers by ethnicity,		

	and report that to the State. The next time we report our numbers, we must show improvement on our lowest percentage ethnicities. This is for ECM and CSO. This is intended to address disparities and the hard-to-reach populations. We had to turn in our baseline numbers for the ethnicity metric and this will be our baseline for how the State judges us on for how well we improve when we submit our numbers in the fall. We can share that with the Board. Question: Once the funding gets up and started, how do we determine how to continue these programs? Is it intrinsic that it is put into the budget, or is there some other way to approach it? Answer: Specifically for this program, we are asking the applicants how they can sustain the program for the future. A lot of the funding can be categorized as a "start-up" cost, or development cost, helping with getting up to speed to become a provider, or helping with hiring so you can get up to speed and earn your regular payment on the services. Scott Coffin provided the following information on Incentive Programs: • We are looking and trying to understand the cost structures. The funding comes with the responsibility of doing the reporting and accounting. To do this, we need all our partners working with us and providing us the data. • The fourth program is the Student Behavioral Health Incentive Program. This incentive program introduces the managed care system to the school system, so we are working with school districts now where in the past we were not. Health services, dental services, and mental health services are being rendered in schools – this program helps to increase the capacity and we are building relationships. There will be additional funding that comes in as we finish the workplan and determine what we will focus on for the first year. • Housing and Homelessness Incentive Program is the program with the largest dollar allocation to it – we know the general structure, but we know the least about this program right now. This program addresses street medicine and some of the services that have not been directly called out in other programs. We are going to have to navigate these funds to avoid duplication and ensure when we are reporting back to the State, that we can tie back the service to the specific incentive program.		

	• One that is not listed because it is not directly under our oversight is the PATH fund – Providing Access and Transforming Health fund. This incentive fund is coordinated between the State of California and each of the county health agencies. In Alameda County, a request for PATH funds has been submitted in three different areas: (1) Sobriety Centers; (2) Housing Navigation Tendency Sustaining Services and Housing Deposits; and (3) Street Health Outreach. • We will be coordinating with Alameda County Health Care Services Agency as well as other agencies and community-based organizations that are applying for PATH funds. We must demonstrate to the State how these funds were separated, what activity they were tied to, and what were the outcomes and performance measures were applied. • We will be providing more information and progress reports as we move forward. Question: The forty-four million dollars ($44M) for the Homeless Program Initiative – how does it compare to what we are spending now? Answer: We do not have an indication, but we will try and get initial information. Informational update to the Board of Governors. Vote not required.		
8. a. BOARD BUSINESS – REVIEW AND APPROVE MARCH 2022 MONTHLY FINANCIAL STATEMENTS			
Gil Riojas	Gil Riojas gave the following March 2022 Finance updates: Enrollment: • For the month ending March 31st, 2022, the Alliance had an enrollment over 306,787 members, a net income of $8.4M, and the tangible net equity was 575% of the required amount. • Our enrollment has increased by over 2,300 members since February 2022, and on a fiscal YTD, we gained over 18,000 members since June 2021. Net Operating Results:	Motion to Approve March 2022 Monthly Financial Statements as presented. Motion: Dr. R. Ferguson Second: Dr. Kelley Meade Vote: Yes	None

	• For the fiscal YTD ending March 31st, 2022, the actual net income was $12.9M, and the budgeted net loss was $4.9M. Revenue: • For the month ending March 31st, 2022, the actual revenue was $109.1M vs. the budgeted revenue of $94.8M. • For the fiscal year ending March 31st, 2022, the actual revenue was $889.4M vs. the budgeted revenue of $877.2M. • For the month ending March 31st, 2022, the favorable revenue variance of $14.3M is largely due to the $6.7M retroactive MCO Tax Adjustment for FY14-FY16. Medical Expense: • For the month ending March 31st, 2022, the actual medical expense was $95.2M, and the budgeted medical expense was $85.0M. • For the fiscal year ending March 31st, 2022, the actual medical expense was $828.2M vs. the budgeted medical expense of $821.5M. • On a PMPM basis, medical expense is 1.0% favorable to the budget. Medical Loss Ratio (MLR): • For the month ending March 31st, 2022, the MLR was 87.2% and 93.1% for the fiscal year-to-date. Administrative Expense: • For the month ending March 31st, 2022, the actual administrative expense was $5.2M vs. the budgeted administrative expense of $7.6M. • For the fiscal YTD ending March 31st, 2022, the actual administrative expense was $47.7M vs. the budgeted administrative expense $60.7M. Other Income / (Expense):	No opposed or abstained.	

	• As of March 31st, 2022, our YTD investment revenue is $157,000 and the YTD claims interest expense is $300,000. Tangible Net Equity (TNE): • Tangible net equity results continue to remain healthy, and at the end of March 31st, 2022, the TNE was reported at 575% of the required amount. Cash Position and Assets: • For the month ending March 31st, 2022, the Alliance reported $386.2M in cash; $164.1M in uncommitted cash. Our current ratio is above the minimum required at 1.47 compared to the regulatory minimum of 1.0. Capital Investment: • Fiscal year-to-date capital assets acquired: $234,000. • Annual capital budget: $1.4M. Question: Do we have a strategy for what we can to assure our members get redetermined? Answer: We've been speaking with our community partners and are having those conversations now, but we don't have a strategy solidified yet, but we are preparing those now for September. Motion to Approve March 2022 Monthly Financial Statements as presented. A roll call vote was taken, and the motion passed.		
8. b. BOARD BUSINESS – BOARD OF GOVERNORS EFFECTIVENESS ENGAGEMENT			
Bobbie Wunsch	Board Self-Assessment Report: • Board Effectiveness Survey had two major parts – the Standard Board Source survey for non-profits implemented electronically, which 100% of the Board members completed, and Individual Board Interviews. • The overall scores in the Board Source Survey were good to excellent and were slightly higher than average scores for all nationally surveyed non-profit Boards nationally.	Informational update to the Board of Governors. Vote not required.	None

	• In the major categories of People, Culture, Work, and Impact, generally, the Alameda Alliance Board rated themselves somewhat higher than other Boards nationally. • The Board rated themselves highest in the areas of financial oversight and mission, vision and strategic direction. The lowest scores were in culture and board composition. Board Individual Interviews: • There was general agreement with the Board Effectiveness Survey results. There was interest in emergency succession planning for CEO, Executive Team, and department heads. • The Board also wants more time for discussion and questions at meetings. Many Board members believe the agendas are too packed. • Several Board members came on during the pandemic and suggested new board member orientation. • There was also a preference for mixed, hybrid board meetings going forward, some in person and some virtual. • Additionally, there was very strong support for adding the additional county seats and Community Health Center Network to the Board and adding them as soon as the Board decides how to do this. This will be a main topic covered during the Board Retreat, including Board composition options, single plan transition, Kaiser Contract and Medicare. • Every single Board member found 1:1 with CEO Scott extremely helpful. Question: Please elaborate on the hybrid meeting model? Answer: There are many Board members who would like to meet in person, especially the members who joined during the pandemic. There are others who prefer either all in person or all virtual. The preference was either or a combination. Dr. Kelley Meade, Dr. Marty Lynch, and Rebecca Gebhart provided positive feedback on the process.		

	Dr. Seevak and Scott Coffin provided updates on changing Board packets based on Board's feedback for shorter Board packets, to be effective in the new fiscal year in July. Informational update to the Board of Governors. Vote not required.		
8. c. BOARD BUSINESS – MENTAL HEALTH MILD-TO-MODERATE AND AUTISM SPECTRUM DISORDER SERVICES			
Ruth Watson & Scott Coffin	Background: • Phase One was Internal Planning, and this was completed in December 2020. This helped us plan for the next step effectively. • Phase Two was Community Engagement, and this was completed in March 2021. We met with multiple organizations and Community Partners currently engaged in mental health and Autism Spectrum Services to listen and discuss what worked and what did not. • In April 2021, we received approval from this Board to terminate our contract with Beacon Health Options no later than December 2022, insourcing seven domains of service. Our original implementation costs were estimated between $1.2 million to $1.7 million, and our original annual administrative costs were estimated $3.0 million to $4.5 million excluding provider payments, which resulted in the hiring of 36.5 new employees. Service Domains: • The service domains that we are insourcing from Beacon that are currently outsourced to them are (1) Care Transitions; (2) Utilization Management; (3) Quality Improvement; (4) Provider Network; (5) Credentialing; (6) Customer Service; and (7) Claims Processing and Payment. Organization Priorities in 2022-2023: • The first is the Insourcing of Mental Health and Autism Spectrum Services; every division head has committed staff, resources, and whatever is needed to bring this in-house. We will go live with this on November 1st, 2022.	Informational update to the Board of Governors. Vote not required.	None

	• There is also the CalAIM project, Incentive Programs, and various Federal and State-mandated projects and Enterprise Portfolio. We currently have twenty (20) active projects and five (5) projects in the intake phase. Matthew Woodruff presented Mental Health & Substance Use Services: • Currently, our responsibilities do not involve mental health services, some of the services on page 174 of the chart are handled by Beacon and several others by Alameda County Health Care Services. • What we are bringing in-house through Medi-Cal is Mild to Moderate Acuity. For Group Care, we are bringing the other side as well, which is the Severe Acuity. For Medi-Cal, Severe Acuity will stay with the County. • This will be confusing for a little while until we bring these services in-house. We will be providing trainings on this transition online and potentially in-person. Tami Lewis, Senior Director of Integrated Planning presented the Integrated Planning Update: • We have hired the Senior Director of Behavioral Health, Dr. Peter Currie who has insourced behavioral health at another managed care plan and is now assisting us with building a Medi-Cal Behavioral Health program. • We have re-assessed the provider network and refreshed Beacon utilization data – this is important as we continue to evaluate the services our members receive and the providers who are rendering those services. We will also be utilizing consultant services to assist with the contracting effort, as well as all the contracting we have associated with the CalAIM activities. • From a project planning and initiation perspective, we have a detailed project plan and timeline creation in progress. We have created the workstreams to identify and plan for the work that supports the "Lift and Shift" methodology. • Additionally, we have updated the cost estimates for insourcing behavioral health. • Internal Reassessment: We will continue to conduct monthly Executive Level evaluation of project deliverables, risk and timelines associated with this project. We have begun recruitment of new staff, and workstream		

	meetings are taking place, which will allow us to identify both the business and technology requirements needed. • We are also identifying regulatory compliance requirements, so we are complying with regulator notification, member and provider notifications, as well as policy and procedure development. Corry Keenan, Director of Portfolio Management & Service Excellence presented the Insourcing Timeline: • We are currently working through critical path items, such as the member and provider notifications that require DHCS notification and approval; IT infrastructure; hiring and staffing; as well as member communications. Gil Riojas presented Cost Estimates: • We refreshed implementation and recurring cost data from April 2021 and had a slight increase in the range of implementation costs and the recurring costs. The increased implementation costs include member and provider materials, such as the increased costs for ID cards and member notifications and project consulting support. • Our recurring costs added half of an FTE, we now have 37 FTEs and that also increased our potential range from a high of four-point-five million ($4.5M) to five-point-four million ($5.4M). • Cost Comparison for Outsource vs. Insource: We estimated outsourcing would cost us an estimated thirty-three point two million ($33.2M) and insourcing will cost us more, an estimated thirty-five point four million ($35.4M), nearly a two million dollar ($2M) increase from the outsource model. • Our Staffing Model shows by division new FTEs that will help support the transition from outsourcing to insourcing mental health services. Dr. Bhatt and Dr. Currie presented the Lift & Shift Approach for Insourcing: • One of our measures of success is zero disruption in care of services on the day of insourcing – ensuring that on November 1st, our members continue to have access to their providers with ongoing approval of treatment. • Some of the pieces on Day 1 will include assurance of regulatory compliance; direct contracting to strengthen Provider relationships; continuing Tele-Psych Program which began during the pandemic and		

	allowing patients to receive virtual care, as long as the State permits; and utilizing and leveraging existing core systems and staff, such as the IT services we have; building out a team with expertise; cohesive medical and behavioral health records in our Medical Management System (MMS); and access issues and the "no wrong door" concept. • Several of the over thirty FTE's will be behavioral health clinicians by training, and hopefully with managed care experience to perform care management and utilization management processes. The intent is to integrate fully with the plan and work with the existing systems and policies to build in behavioral health competency. • "No Wrong Door" – we are participating with the Alameda County Behavioral Health Department in creating a no wrong door process for our members, so that wherever our members seek to access care, we can collaborate behind-the-scenes and help them navigate to where they can best be served. • For Day 2 and Beyond of insourcing, we will evaluate and seek improvement in areas such as warm handoffs; members who step up into care utilizing County services, or step down into care, from the County, SMI Services, back to Mild-to-Moderate Services; how to better utilize Member and Provider Portals; the referral and re-authorization process; exploring payment reform; primary care physician engagement; telehealth psych program; and assessing network gaps through considering linguistic, cultural, racial disparities and barriers to care. Ruth Watson concluded by discussing the Next Steps: • We need to notify Beacon of contract termination by June 30th, 2022 and the termination will be effective October 31st, 2022. • The insourcing implementation has been initiated and is ongoing. We have been meeting with teams regularly to review detailed planning. Additionally, we have reviewed our regulatory notification concerning important dates and what we need to provide. • We brought in individuals to help with the network development and network contracting to ensure timeliness and have started discussing with the IT Team on system updates and configuration – they unfortunately must wait until we complete our requirements.		

	• Our HR department is bringing in someone to help with recruitment of the positions and we have looked at space planning. We are currently working on member notifications. It is going to take the entire Alliance to make this transition happen. We will go live November 1st, 2022. Question: Insourcing will cost more – will we be able to cover that via rates? Answer: Not necessarily; if we are intending to increase our administrative costs, typically those are not impacted in our rate, our REP. There is certainly going to be an increase in our medical expenses, but there might an increase related to administrative expenses. I don't necessarily think we will be able to incur all of that. Question: How do we see rates costing control in the future, is there any way we can predict cost increases and how we can reduce costs? Answer: The development of a network is going to be critical to ensure this insourcing transition goes smoothly. Every time there's network development, there are cost considerations. I don't know if at the beginning of this we will see any savings. Ultimately, all of that will be impacted by the network rates. Question: How do you integrate services when the providers are in different places? It is harder to understand the integration if the patient is served by different parts of our system. Answer: A part of the component that we are insourcing is care coordination, which includes coordinating information between the providers. Part of our goal and part of our education with our psychiatry providers is to be able to share information to the extent that is allowable by law. We are also working in Phase 2 on an IT component that will be a portal and will try and help share information in care plans and make it easier for providers to share information. Dr. Seevak, Rebecca Gebhart and Dr. Marty Lynch expressed appreciation to the Alliance for the insourcing project. Informational update to the Board of Governors.		

	Vote not required.		
9. a. STANDING COMMITTEE UPDATES – PEER REVIEW AND CREDENTIALING COMMITTEE			
Dr. Steve O'Brien	The Peer Review and Credentialing Committee (PRCC) was held telephonically on April 19th, 2022. Dr. Steve O'Brien gave the following Committee updates: • We credentialed twenty-four (24) initial applicants. Additionally, fifty-one (51) providers were re-credentialed at this meeting. • There were eleven (11) providers terminated. We had a net gain of thirteen (13). Informational update to the Board of Governors. Vote not required.	Informational update to the Board of Governors. Vote not required.	None
9. b. STANDING COMMITTEE UPDATES – HEALTH CARE QUALITY COMMITTEE			
Dr. Steve O'Brien	The Health Care Quality Committee (HCQC) was held telephonically on April 28th, 2022. Dr. Steve O'Brien gave the following Committee updates: • We introduced Dr. Tritto, the interim CMO at CHCN, our new Access to Care Manager, Loc Tran, and we said goodbye to Ms. Stephanie Wakefield, who is retiring from her role as Senior Quality Director. • We reviewed many PNP's for NCQA Reaccreditation, the 2021 QI Program Evaluation, which includes our population health strategy, annual member experience assessment including a review of a full year of complaints and grievances, and finally, our cultural and linguistic report.	Informational update to the Board of Governors. Vote not required.	None

	Pharmacy Update: • One trend we are noticing since exchange in Medi-Cal Rx is an increase use of opioids of some of our members. This is something we are highly watching. Informational update to the Board of Governors. Vote not required.		
10. STAFF UPDATES			
Scott Coffin	None	None	None
11. UNFINISHED BUSINESS			
Scott Coffin	None	None	None
12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS			
Scott Coffin	None	None	None
13. PUBLIC COMMENT (NON-AGENDA ITEMS)			
Dr. Evan Seevak	None	None	None
14. ADJOURNMENT			
Dr. Evan Seevak	Dr. Evan Seevak adjourned the meeting at 2:19 pm.	None	None

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

ALAMEDA Alliance FOR HEALTH

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Finance Committee Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

June 7th, 2022
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

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

Alliance Staff on Conference Call: Brian Butcher, Scott Coffin, Tiffany Cheang, Richard Golfin III, Sasi Karaiyan, Dr. Steve O'Brien, Anastacia Swift, Ruth Watson, Carol van Oosterwijk, Linda Ly, Jennifer Vo, Danube Serri, Jeanette Murry, Mashon Jones

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
CALL TO ORDER, ROLL CALL, and INTRODUCTIONS			
Dr. Rollington Ferguson	Dr. Ferguson called the Finance Committee meeting to order at 8:02 am. The following public announcement was read. "The Board recognizes that there is a proclaimed state of emergency at both the State and the local Alameda County level, and there are recommended measures to promote social distancing in place. The Board shall therefore conduct its meetings via teleconference in accordance with Assembly Bill 361 for the duration of the proclaimed state of emergency." A telephonic Roll Call was then conducted.		
CONSENT CALENDAR			
Dr. Rollington Ferguson	Dr. Ferguson presented the Consent Calendar. May 10th, 2022, Finance Committee Minutes were approved at the Board of Governors meeting on May 13th, 2022, 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 updates to the committee on the following: **<u>Fiscal Year 2023 Budget</u>:** Today a summary of the Preliminary fiscal year 2023 Budget is being presented along with the April 2022 Finance Report. A full presentation of the preliminary budget will be presented Friday at the Board of Governors Meeting. We focus on the Administrative and Medical expenses which are supported by all the cost and utilization trend data that is available for both lines of business (Medi-Cal and Group Care). During the fiscal year the Finance Committee and full Board of Governors receive quarterly forecasting in addition to the preliminary budget. We have a final budget that will deliver in December. The preliminary budget gets us into the July 1 start date for our new fiscal year. The public health emergency remains in effect and is tied to the suspension of Alameda County's Medi-Cal Redetermination Process. Since the start of the Public Health Emergency (PHE) in the start of March 2020, the Alliance had 249,000 enrolled and today we have over 313,000. We have seen a steady gain primarily in the Medi-Cal enrollment group care as it remains steady at about 6,000 adult members. Whereas Medi-Cal has set new records each month. The month of June we exceeded 313,000 adults and children on our preliminary enrollment which is still 98% of our enrollment. The growth in Medi-Cal is forecasted to continue through January 2023. Our assumptions may need to change if the Public Health Emergency is extended beyond October 2022. The CalAIM program combined with other Medi-Cal policy changes creates more benefits and services. It also requires more administrative capacity within the Alliance's operations. The preliminary budget funds more than 30 projects that are all running parallel. They are managed through our Integrated Planning division. It also has a little over $3 million allocated per community based programs that support our corporate mission and vision. These are with our community partners. Part of what's driving the budget is the addition of approximately 100 new staff positions across the organization. This represents about $16 million in additional administrative expenses and (82%) of those are related to staffing. The strategy is, we have to grow the company (the capacity of the organization) in order to meet our regulatory obligations as well as the commitments that we have to our members and providers as part of the services we administer. As a reminder, in November 2022, as was presented	Informational update to the Finance Committee Vote not required	

	at the last Board of Governors meeting, we are transitioning the Mental Health and Autism Spectrum Services into our core operations. This is being coordinated through local county agencies, health centers, hospitals, and our community based organizations. We also have the addition of Long Term Care on January 1, 2023. Earlier this year we also received Major Organ Transplants, full scope into Medi-Cal Managed Care. This program will continue to expand into next fiscal year. We have several major initiatives that are coming into Managed Care from the Fee-for-Service system all within a close approximate of time in January. With our forecast of nearly $1.3 billion in revenue next year (over $100 million more than this current fiscal year) – with the revenue comes expenses.		
b.) Review and approve April 2022 Monthly Financial Statements			
Gil Riojas	**<u>April 2022 Financial Statement Summary</u>** **Enrollment:** Current enrollment is 308,741 and continues to trend upward. Total enrollment has increased by 1,954 members from March 2022, and 20,187 members since June 2021. Increases were primarily in the Child, Adult, and Optional Expansion categories of aid, and include slight increases in the Duals and SPD categories of aid. Group Care remains relatively flat. Monthly enrollment trends are projected to increase as the Public Health Emergency (PHE) is currently expected to be extended through October 2022. **Net Income:** For the month ending April 30th, 2022, the Alliance reported a Net Income of $2.3 million (versus budgeted Net Income of $2.6 million). The variance is attributed to higher than anticipated Medical Expenses and lower than anticipated Total Other Income. For the year-to-date, the Alliance recorded a Net Income of $15.2 million versus a budgeted Net Loss of $2.3 million. **Revenue:** For the month ending April 30th, 2022, actual Revenue was at $101.6 million vs. our budgeted amount of $93.9 million. The favorable variance was in relation to the continuation of Public Health Emergency (PHE). The increase in enrollment beyond what we had budgeted drives the increase in our revenue.		

	Medical Expense: Actual Medical Expenses for the month were $93.2 million, vs. our budgeted amount of $84.5 million. For the year-to-date, actual Medical Expenses were $921.5 million versus budgeted $905.7 million. Primarily driven by the continuation of our enrollment increase beyond what we had budgeted in December 2021. Directly related to the Public Health Emergency (PHE). Drivers leading to this variance can be seen on the tables on page 11. Further explanation of the variances can be seen on pages 11 and 12. In looking on a Per-Member-Per-Month (PMPM) basis, taking into consideration the increase in volume a look solely at the PMPM expense, we can see that we are actually relatively close. Less than a percent variance from a PMPM number in terms of our medical expenses. The largest areas of negative variance being in our Ancillary Fee-for-Service (FFS), Pharmacy FFS, and our Emergency FFS. However, they are offset by the positive variances of Capitated Medical Expenses, Primary FFS, Specialty FFS, and our Inpatient Hospital FFS. **Incurred-But-Not-Paid (IBNP) claims:** There is a slight increase in our IBNP claims of about $1.3 million. **Medical Loss Ratio:** Our MLR ratio for this month was reported at 91.7%. Year-to-date MLR was at 93.0%. **Administrative Expense:** Actual Administrative Expenses for the month ending April 30th, 2022 were $5.8 million vs. our budgeted amount of $7.1million. Our Administrative Expense represents 5.7% of our Revenue for the month, and 5.4% of Net Revenue for year-to-date. Reasons for the favorable month-end variances, as well as the favorable year-to-date variances can be attributed to 1) Delayed timing of new project start dates for Consultants, Computer Support Services, and Purchased Services, 2) Delayed hiring of new employees and 3) COVID-19 Vaccination Incentives. **Other Income / (Expense):** As of April 30th, 2022, our realized YTD interest income from investments was $411,000. YTD claims interest expense is $337,000.		

	TangibleNet Equity (TNE): We reported a TNE of 574%, with an excess of $182.1 million. This remains a healthy number in terms of our reserves. There was a recent letter from the Department of Managed Healthcare (DMHC) that they are increasing the red line from 130% of Required TNE to 150%. Meaning any plan that reports 150% of TNE or lower will require monthly reporting to the DMHC. **Cash and Cash Equivalents:** We reported $284.7 million in cash; $182.6 million is uncommitted. Our current ratio is above the minimum required at 1.70 compared to regulatory minimum of 1.0. **Capital Investments:** We have spent $234,000 in Capital Assets year-to-date. Our annual capital budget is $1.4 million. **Question:** Dr. Marchiano stated he is concerned about the continuing increase in enrollment among the adult category. What is your sense about why the adults continue to enroll? It's a good thing, just wondering why. **Gil**: My perspective is the continuation of the Public Health Emergency (PHE) has caused this enrollment process. A lot of this is the continuation of these members that are maintaining as adults, and the addition of new members moving into the county are also adding to the adult number.	Motion to accept **April 2022 Financial Statements** Motion: J. Jackson Seconded: Dr. Marchiano Vote taken. No opposed or abstained. Motion Passed	
c.) FY2023 Preliminary Budget Summary Update			
Gil Riojas **Anastacia Swift**	Gil Riojas gave a presentation for the Preliminary FY2023 budget for review by the Finance Committee, to bring to the Board of Governors for approval. Gil turned the mic over to Anastacia Swift, Chief Human Resource Officer, to give an update on our recruiting strategy for FY2023. Anastacia shared a strategy to reach this goal. We are looking at over 100 additional positions. The labor market is very tight at this time. We have experienced difficulty with sourcing, as all organizations have. We do want to stop and assess how we will reach this goal. As an organization, we are adding to our resources (internal and external recruiters) to assist with the candidate pipeline. We have also looked at revising our internal process to		

	reduce steps to expedite onboarding new hires. We are considering a more competitive initial salary offer at the time that we have made selections. Our goal is to fill from 8-10 positions a month. Everyone on our Leadership Team knows what we are facing in terms of the programs, deadlines, and timelines, so we have the commitment internally to get these positions filled. That is the plan moving forward, and we are ready to move forward. **Question:** Dr. Ferguson referenced in the meeting last week that there was concern about how do we become more inclusive? How do we address becoming more inclusive in our hiring? I hadn't given that thought until the recent meeting and survey. Are we taking steps specifically to address those issues? **Anastacia**: In terms of our outreach for the candidate pools, we are posting on a more diverse stance. We are posting on sites like Diversity.com so that they are going to a broader network, community-based organizations that are minority focused, also in alumni associations, historically Black colleges, and other different associations. We are posting the jobs and putting the information out there. Will that drive more traffic? We don't know. This will be the first time that we've really pushed this far to see what happens. Based on the return on that, we will continue to do it. We have also considered increasing employee referrals so that the current staff we have represents a decent population of our members internally. As we use these resources, hopefully, they are referring people to meet that concern about being more inclusive. Our population is more females than males here at the Alliance. We are adding to the team a Chief Health and Equity Officer, so that will be coming this fiscal year as well and HR will be working in collaboration with this Chief. **Scott**: My addition is around the focus on Diversity/Equity/Inclusion, as you were briefed on the roadmap, that is one of the areas we will pursue this year and subsequent years moving forward. As Anastacia stated, we have the hiring of a new officer that will focus on Equity. This position will report to the CEO and work across the entire organization, looking at ways to identify opportunities within the organization. Also looking at how we comply with the regulatory guidelines that are also being drafted right now by the Department of Managed Healthcare and the Department of Healthcare Services as it relates to member and provider services. We are taking this seriously and will make changes as we proceed forward with the hiring practices by changing		

	how we do some of the screenings, interviews, etc. We will address some of the inclusion you are referring to. Gil resumed and concluded his Preliminary FY2023 presentation. Scott emphasized the Long Term Care Transition by adding the State of California is also in the process of figuring out the final scope of implantation for the Long Term Care Services. The Department of Healthcare Services (DHCS) is still finalizing the actual scope and deployment. Once we know more information and receive the actual Fee-for-Service data, we will have a better view and will include that in the final budget in December. **Question:** Dr. Ferguson asked if we are adjusting our reinsurance rate to anticipate the impact of the transplant case that we expect? The fact that we are expecting an increase cost associated with transplants, and the reinsurance is supposed to cover some of our over expenses (if understood correctly), so are we anticipating that? **Gil:** No. We do not have major organ transplants covered in our reinsurance. Primarily, because the State has put forth a risk corridor for major organ transplants. So essentially, we are using DHCS as reinsurance. If our major organ transplant expense goes beyond a certain percentage, the state will kick in to cover some of the expense. Adversely, if the major organ transplant expense is substantially lower, we will have to pay back some of our major organ transplant revenue. Our experience has been too limited to know more at this time, but we will keep the Board updated as we move into the future. **Dr. Ferguson:** The risk corridor will only cover so much, and we have no idea where it's going to go, isn't that something we should include in our reinsurance? Because of our limited experience the reinsurance rate will probably be reasonable. **Gil:** We talked to our reinsurance broker about this (6-7 months back). The rates we were going to get would be significantly higher if we added in the major organ transplant. We looked into it as something to add, and at the time it wasn't sensible for us as the premium would have significantly increased, and we have the backup of DHCS acting as the reinsurer with the risk corridor so that was the more feasible direction to go.	Motion to accept **FY2021 Preliminary Budget Summary Update** Motion: Dr. Marchiano Seconded: J. Jackson Vote taken. No opposed or abstained. Motion Passed	

UNFINISHED BUSINESS / DISCUSSION			
	None.		
ADJOURNMENT			
Dr. Rollington Ferguson	Dr. Ferguson requested motion to adjourn the meeting. The meeting adjourned at 8:57 am.	Motion to adjourn: Scott Coffin No opposed or abstained.	

Respectfully Submitted by:
Mashon Jones, Executive Assistant to CISO

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CEO Update

Scott Coffin

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

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

Date: **June 10th, 2022**

Subject: **CEO Report**

- **Financials:**
    - Revenue $101.6 million in April 2022, and $991 million Year-to-Date (YTD).
        - Medical expenses for April were $93.2 million, and $921.4 million year-to-date, representing the ten months of the fiscal year, and 5.7% in administrative expenses.
    - Tangible Net Equity (TNE): Financial reserves are 574% above the regulatory requirement, representing $182.1 million in excess TNE.
    - Total enrollment 306,787 in April 2022, increasing by nearly 2,000 Medi-Cal members as compared to March. Preliminary enrollment in the month of June exceeds 311,000 members.
    - Medi-Cal enrollment increases range from 1,200 to 1,500 members per month. Approximately 5,000 to 6,000 new Medi-Cal beneficiaries are projected to enroll in the months of June, July, and August 2022 related to the transition of undocumented adults (age 50 and over) into Medi-Cal managed care; population is currently enrolled in Alameda County's HealthPAC program.
    - The Public Health Emergency is approved through the month of July and is anticipated to be terminated by Governor Newsom in October; subsequently the Medi-Cal re-determination process may resume by January 2023.
    - Net Operating Performance by Line of Business:

	April	YTD
Medi-Cal.....	$2.6M	$16.6M
Group Care	($285K)	($1.4M)
Totals	$2.3M	$15.2M

- **Preliminary Budget – Fiscal Year (FY) 2023:**

    - Preliminary budget presented to the Finance Committee on June 7th, 2022, and presentation to the full Board of Governors is scheduled for June 10th, 2022.
    - DHCS has announced that final Medi-Cal rates will be issued two months later than normal this year (November vs. September).
    - First Quarter forecast to be presented in December 2022, and final budget will be presented in early Calendar Year 2023.
    - Total enrollment is projected to decline by more than 22,000 to 297,000; 98% Medi-Cal and 2% IHSS (Group Care). Enrollment reduction primarily in the Medi-Cal line of business due to the resumption of the re-determination process in January 2023 (6 months in fiscal year).
    - Combined FY2023 forecasted revenue, expense, and net operating results by line of business:

	Enrollment	Revenue	Expense	Net
Medi-Cal	291,391	$1.28B	$1.29B	($16.3M)
Group Care	5,828	$32M	$30.5M	$1.4M
Totals	**297,219**	**$1.31B**	**$1.33B**	**($14.9M)**

- **Key Performance Indicators:**

    - Regulatory Metrics:

        - Standard member grievances (turnaround within 30 calendar days) met compliance at 95% based on 671 cases. 60% of the expedited grievances (2 of 5) were processed within the 'three calendar day' turnaround requirement.
        - Encounter data submissions, for institutional claims 180 days or less, resumed into full compliance in the month of May after missing by 2.5% in the previous month.

    - Non-Regulatory Metrics:

        - The Member Services call center received 12,436 inbound calls in April, approximately 4% lower than previous month. The average wait time to speak with a Member Services Representative was 2 minutes and 20 seconds, nearly 50% better than previous month;

abandonment rate also reduced by 50% to 8% for the month of May, 2% above the internal threshold. The Member Services Team implemented a remediation plan in January, including the recent addition of an external call center vendor to support the inbound call queues.

- **Program Implementations [2022-2023]**

  - The following program implementations are currently in the operational readiness phase and being administered through the Alliance's Integrated Planning Division.

  - Medi-Cal and Group Care:
    - Presentation today to the Board of Governors on the insourcing of mental health & autism spectrum services.
    - Go-Live date extended by 30 days to 11/1/22.

  - Medi-Cal Only:
    - CalAIM: Recipe4Health is scheduled for September 2022 go-live.
    - CalAIM: New ECM Populations of Focus phases in 2023.
    - CalAIM: Long-Term Care begins 1/1/23.
    - CalAIM: Justice Involved * deferred by the DHCS, no date certain.
    - CalAIM: Behavioral health in schools begins 1/1/23.
    - CalAIM: Population health begins 1/1/23.

- **Regulatory Audits & Accreditation**

  - The NCQA re-accreditation survey is scheduled for July 2022, and the required documents have been delivered to the NCQA survey team. The re-accreditation applies to both lines of business for calendar years 2020 and 2021. A risk has been identified that may impact the accreditation status, and a mitigation plan is being developed to address the self-identified deficiencies. In addition, an internal audit is being conducted by an external agency in July and August to assess NCQA practices, and to identify opportunities for improvement.
  - The DMHC routine financial survey is scheduled for mid-August.
  - The DMHC focused mental health parity audit is pending confirmation and is expected to occur in calendar year 2022.

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Executive Dashboard

OPERATIONS DASHBOARD

JUNE 2022

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Financials

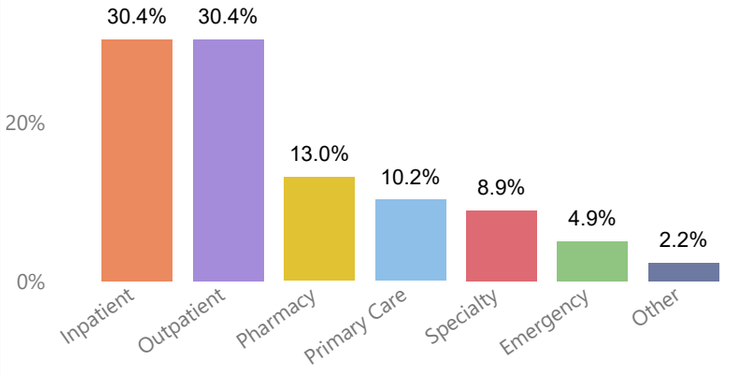
Income & Expenses

	APRIL 2022	FISCAL YTD
REVENUE	$ 101.6 M	$ 991.0 M
MEDICAL EXPENSE	$ (93.2) M	$ (921.5) M
ADMIN EXPENSE	$ (5.8) M	$ (53.5) M
OTHER	$ (318) K	$ (865) K
NET INCOME	$ 2.3 M	$ 15.2 M

Gross Margin %

7.0%

Medical Expenses



Liquid Reserves

MLR Net %

93.0%

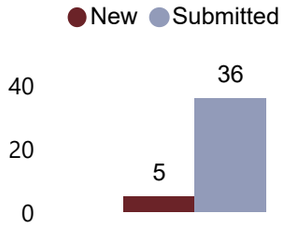
TNE %

573.6%

TNE $

$220.6M

Reinsurance Cases



Balance Sheet

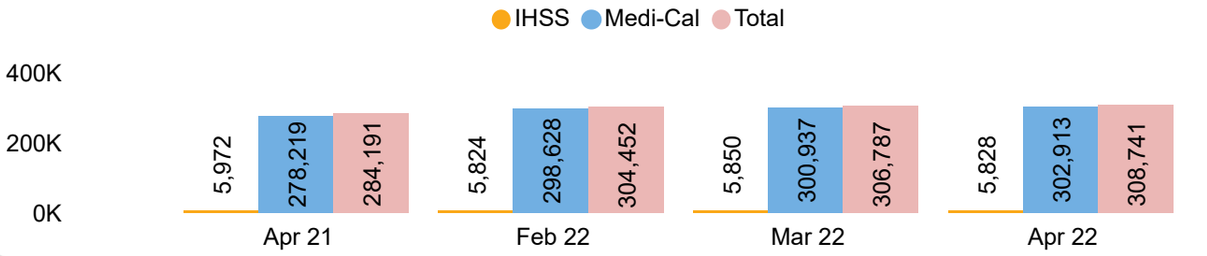
Cash Equivalents	$284.7M
Pass-Through Liabilities	$102.1M
Uncommitted Cash	$182.6M
Working Capital	$176.9M

Current Ratio %

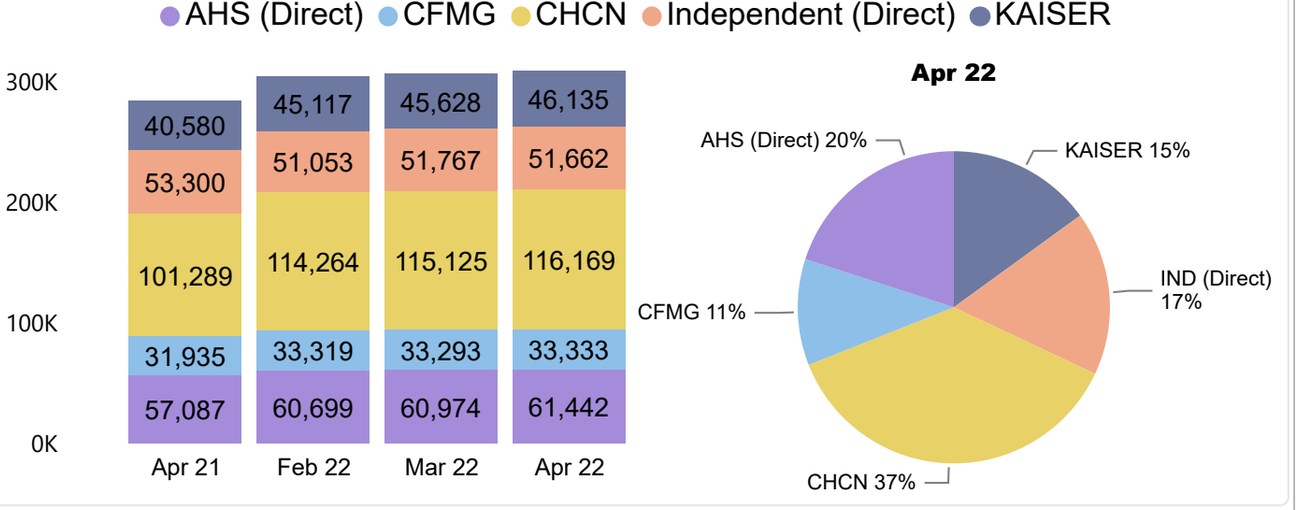
169.6%

Membership

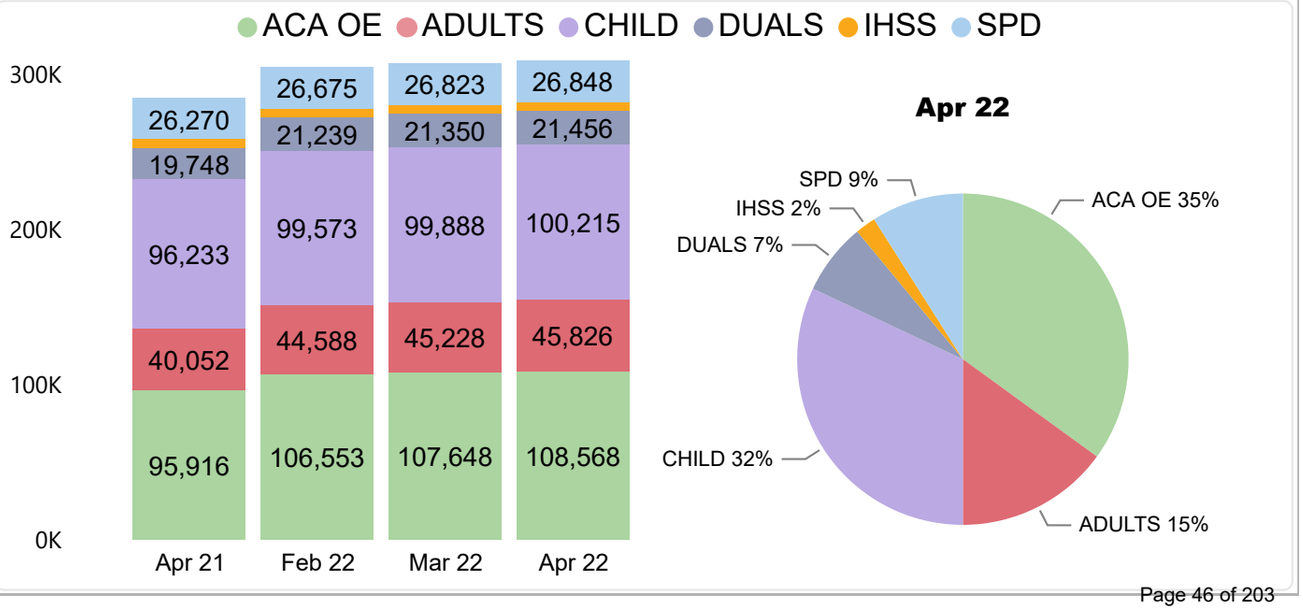
By Plan



By Network



By Category



OPERATIONS DASHBOARD

JUNE 2022

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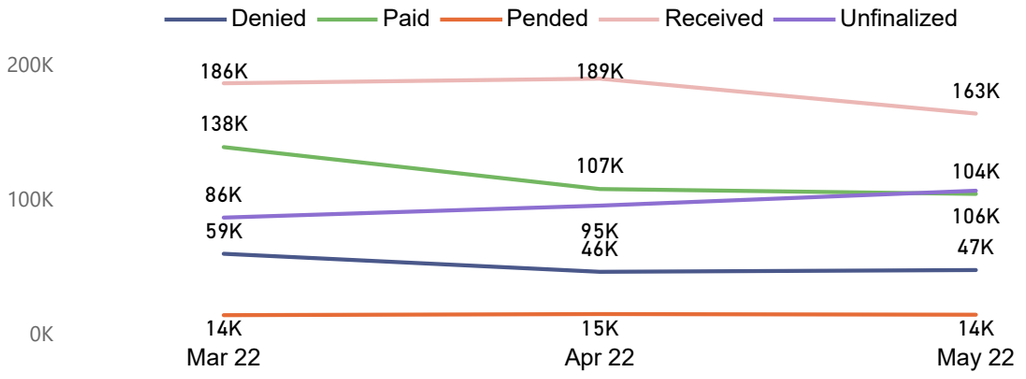
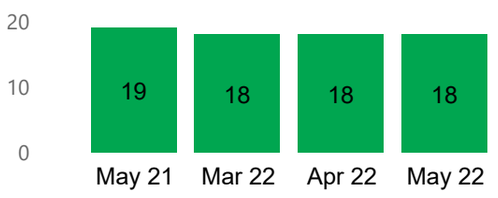
Claims

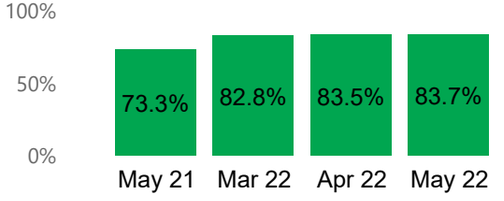
Claims Processing



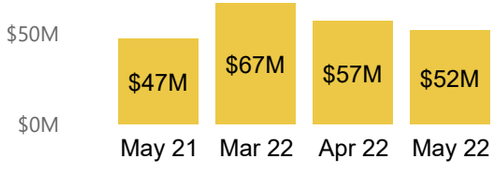
Average Payment TAT (Days)



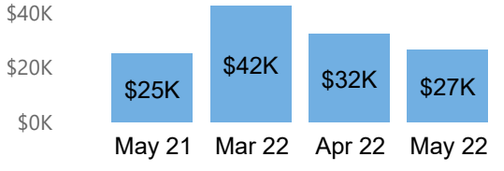
Auto Adjudication Rate (%)



Claims Paid ($)

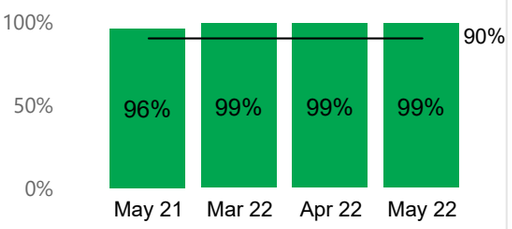


Interest Paid ($)

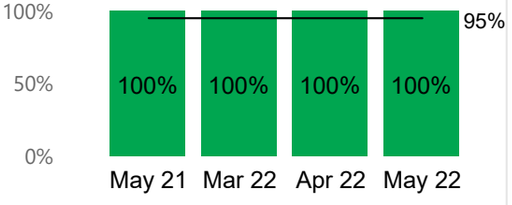


Claims Compliance

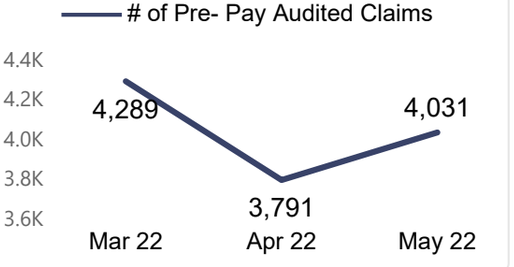
Processed 30 Cal Days (%)



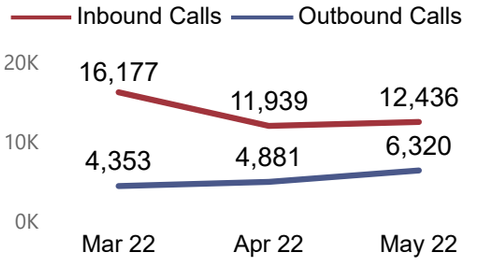
Processed 45 Work Days (%)



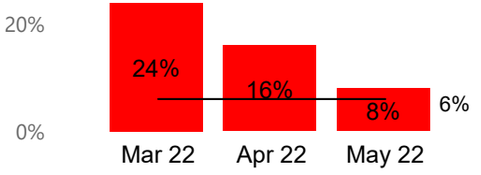
Claims Auditing



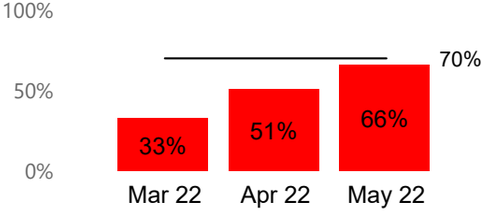
Member Services



Abandoned Call Rate (%)

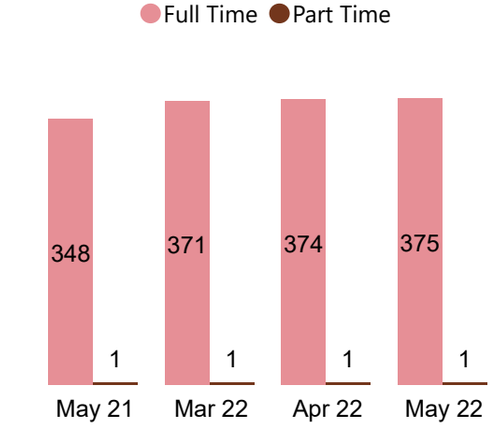


Calls Answered in 60 Seconds (%)

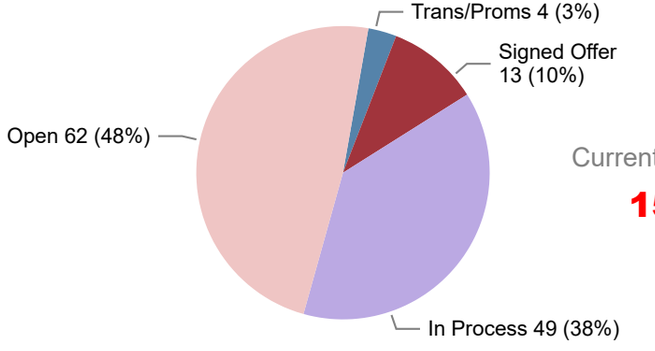


Average Call Times	Mar 22	Apr 22	May 22
Wait Time	08:49	04:30	02:20
Call Duration	05:56	06:58	06:30

Human Resources

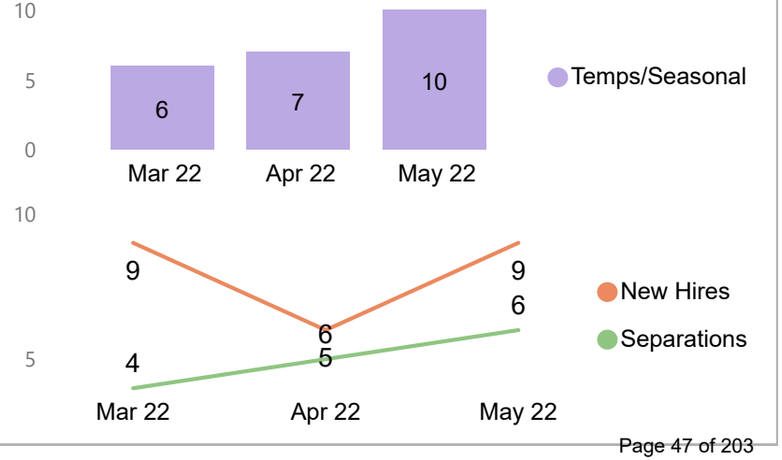


Recruiting Status May 22



Current Vacancy

15%



OPERATIONS DASHBOARD

JUNE 2022

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Provider Services

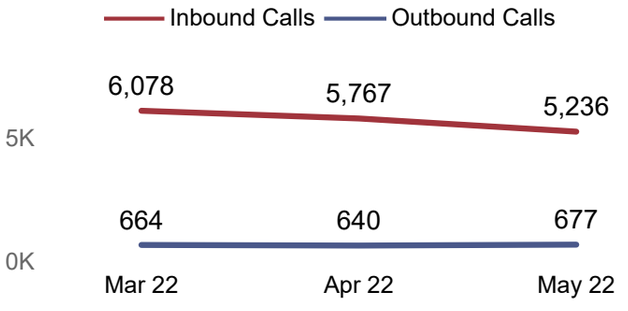
Provider Network

Hospital	17
Specialist	8,539
Primary Care Physician	733
Skilled Nursing Facility	66
Urgent Care	9
Health Centers (FQHCs and Non-FQHCs)	68
Transportation	380
TOTAL	**9,812**

Provider Credentialing

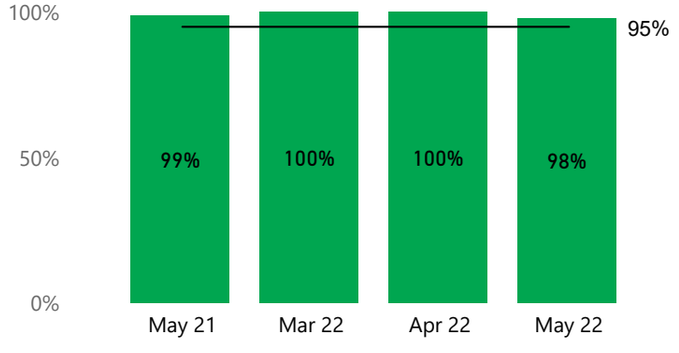
1,396

Provider Call Center



Provider Disputes & Resolutions

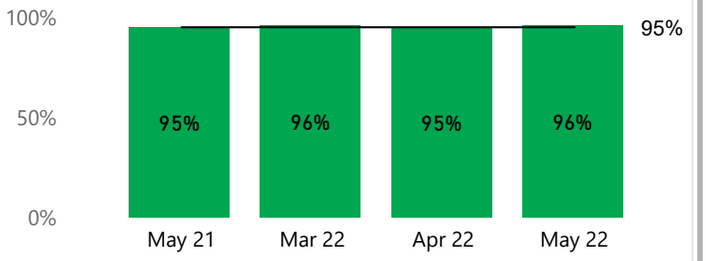
Turnaround Compliance (45 business days)



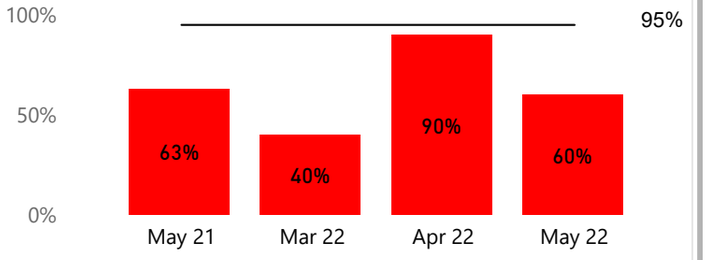
Compliance

Member Grievances

Standard (30 calendar days)

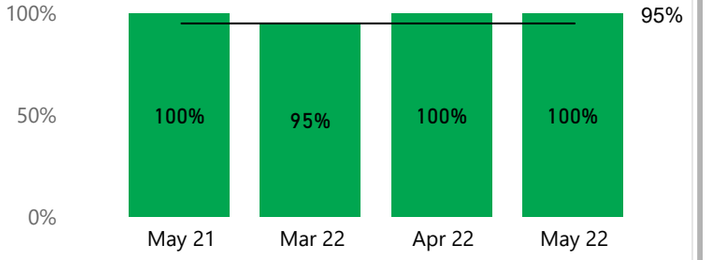


Expedited (3 calendar days)

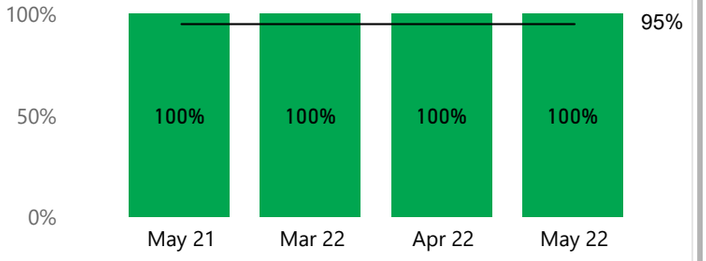


Member Appeals

Standard (30 calendar days)

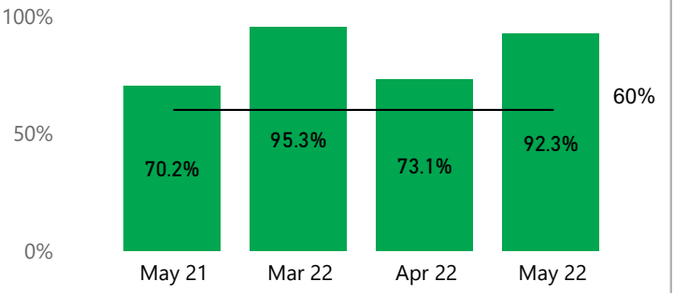


Expedited (3 calendar days)

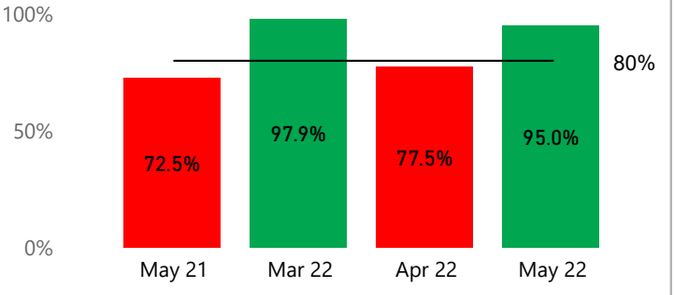


Encounter Data

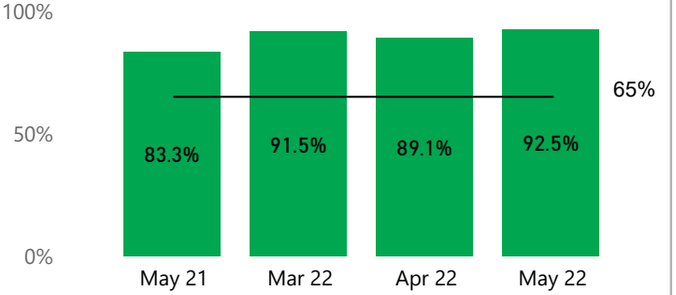
Institutional 0-90 days



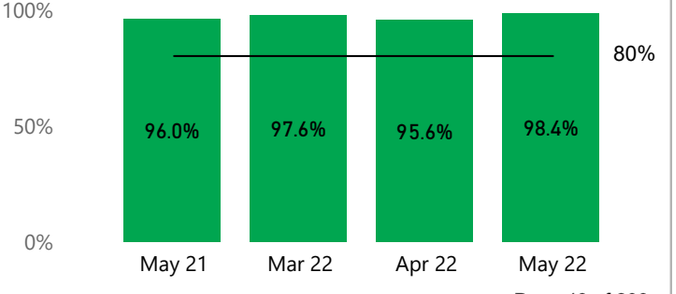
Institutional 0-180 days



Professional 0-90 days

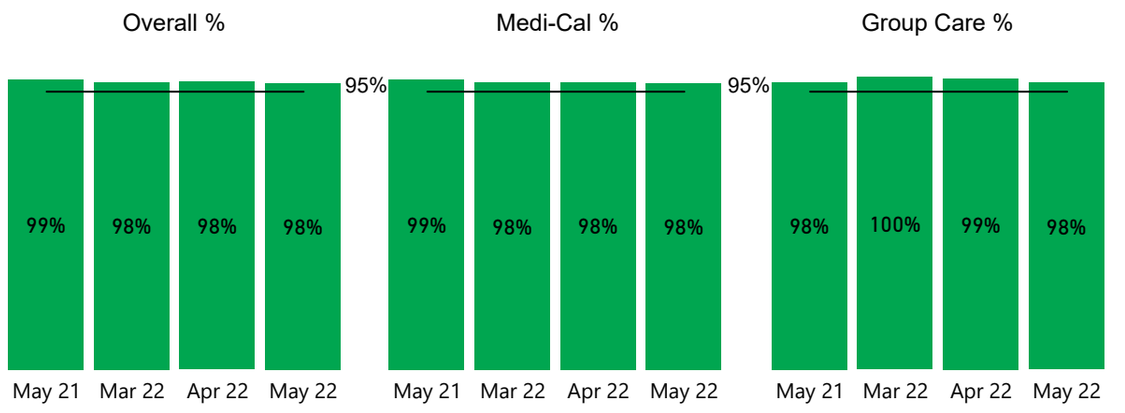


Professional 0-180 days

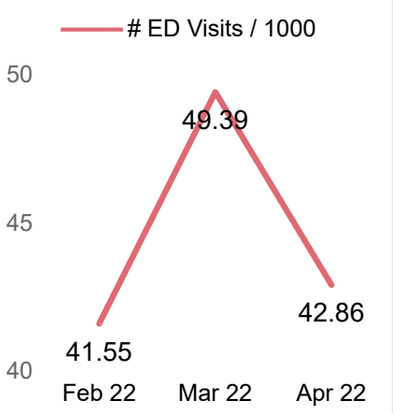


Health Care Services

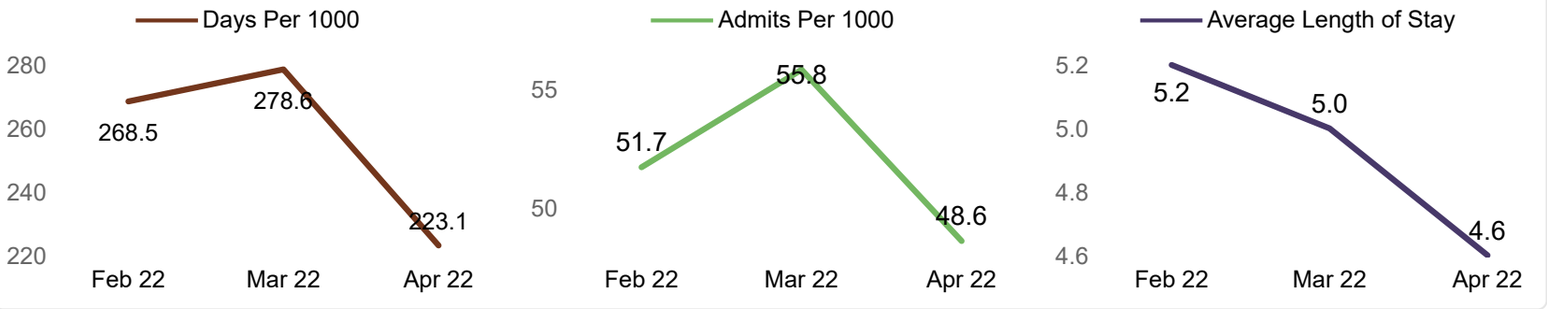
Authorization Turnaround



ED Utilization

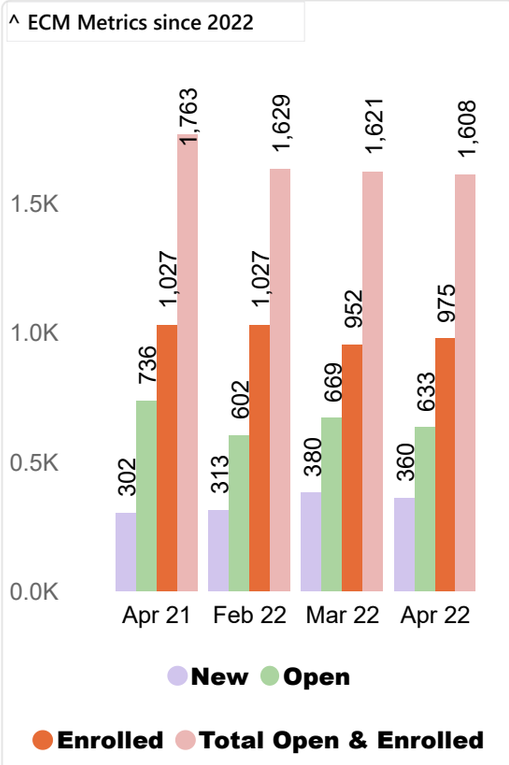


Inpatient Utilization

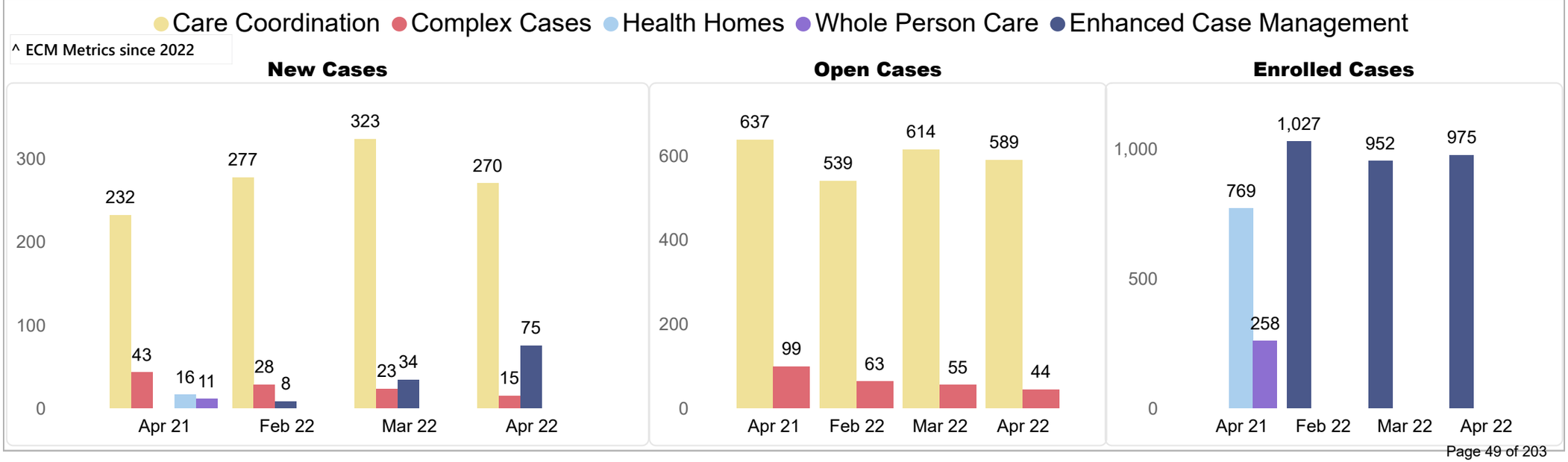


Case Management

Total Cases^



Case Management^



Technology (Business Availability)

Applications	May 21	Mar 22	Apr 22	May 22
HEALTHsuite System	100.0%	100.0%	100.0%	100.0%
Other Applications	100.0%	100.0%	100.0%	100.0%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	May 21	Mar 22	Apr 22	May 22
Denial Rate Excluding Partial Denials (%)	4.1%	4.0%	3.7%	3.2%
Overall Denial Rate (%)	4.2%	4.6%	4.3%	3.7%
Partial Denial Rate (%)	0.1%	0.6%	0.6%	0.5%

*** IHSS and Medi-Cal Line Of Business**

Pharmacy Authorizations

Authorizations	May 21	Mar 22	Apr 22	May 22
Approved Prior Authorizations	796	17	19	20
Closed Prior Authorizations	552	59	67	20
Denied Prior Authorizations	583	31	33	27
Total Prior Authorizations	1,931	107	119	67

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Legislative Tracking

2022 Legislative Tracking List

The following is a list of state bills tracked by the Public Affairs Department that were introduced during the 2021 and 2022 Legislative Sessions. This list includes 2-year bills introduced in 2021 that did not make it through the legislature and have moved through the legislature in 2022, as well as bills introduced in 2022. These bills are of interest to and could have a direct impact on Alameda Alliance for Health and its membership. **The bills on this list are updated as of 6/6/2022.**

May 27th was the last day for each house to pass bills introduced in that house. Bills that were not moved for action in the second house failed to make it through the legislative process.

Medi-Cal (Medicaid)

- **AB 1355 (Levine – D) Medi-Cal: Independent Medical Review System**
  - **Introduced:** 2/19/2021
  - **Status:** 6/1/2022-From committee: Do pass and re-refer to Com. on JUD. (Ayes 9. Noes 0.) (June 1st). Re-referred to Com. on JUD.
  - **Summary:** Current law authorizes the State Department of Health Care Services to enter into various types of contracts for the provision of services to beneficiaries, including contracts with a managed care plan. Current law generally requires Medi-Cal managed care plan contractors to be licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975. The act provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. The act requires the Department of Managed Health Care to establish the Independent Medical Review System, which generally serves to address grievances involving disputed health care services based on whether the service is medically necessary. This bill would require the State Department of Health Care Services to establish the Independent Medical Review System (IMRS) for the Medi-Cal program, commencing on January 1st, 2023, which generally models the above-described requirements of the Knox-Keene Health Care Service Plan Act. The bill would provide that any Medi-Cal beneficiary appeal involving a disputed health care service is eligible for review under the IMRS if certain requirements are met, and would define “disputed health care service” as any service covered under the Medi-Cal program that has been denied, modified, or delayed by a decision of the department, or by one of its contractors that makes a final decision, in whole or in part, due to a finding that the service is not medically necessary.

- **AB 1859 (Levine – D) Mental Health Services**
  - **Introduced:** 2/8/2022
  - **Status:** 5/27/2022-In Senate. Read first time. To Com. on RLS. for assignment.
  - **Summary:** Would require a health care service plan or a health insurance policy issued, amended, or renewed on or after January 1st, 2023, that includes coverage for mental health services to, among other things, approve the provision of mental health services for persons who are detained for 72-hour treatment and evaluation under the Lanterman-Petris-Short Act and to schedule an initial outpatient appointment for that person with a licensed mental health

professional on a date that is within 48 hours of the person's release from detention. The bill would prohibit a noncontracting provider of covered mental health services from billing the previously described enrollee or insured more than the cost-sharing amount the enrollee or insured would pay to a contracting provider for those services.

- **AB 1880 (Arambula – D) Prior Authorization and Step Therapy**
  - **Introduced:** 1/24/2022
  - **Status:** 5/27/2022-In Senate. Read first time. To Com. on RLS. for assignment.
  - **Summary:** Current law authorizes a health care service plan or health insurer to require step therapy if there is more than one drug that is appropriate for the treatment of a medical condition, as specified. Current law requires a health care service plan or health insurer to expeditiously grant a step therapy exception request if the health care provider submits justification and supporting clinical documentation, as specified. Current law permits a health care provider or prescribing provider to appeal a denial of a step therapy exception request for coverage of a nonformulary drug, a prior authorization request, or a step therapy exception request, consistent with the current utilization management processes of the health care service plan or health insurer. Current law also permits an enrollee or insured, or the enrollee's or insured's designee or guardian, to appeal a denial of a step therapy exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request by filing a grievance under a specified provision. This bill would require health care service plan's or health insurer's utilization management process to ensure that an appeal of a denial of an exception request is reviewed by a clinical peer of the health care provider or prescribing provider, as specified.

- **AB 1892 (Flora - R) Medi-Cal: orthotic and prosthetic appliances**
  - **Introduced:** 2/9/2022
  - **Status:** 6/1/2022-Referred to Com. on HEALTH.
  - **Summary:** Under the Medi-Cal program, current law requires the State Department of Health Care Services to establish a list of covered services and maximum allowable reimbursement rates for prosthetic and orthotic appliances and requires that the list be published in provider manuals. Current law prohibits reimbursement for prosthetic and orthotic appliances from exceeding 80% of the lowest maximum allowance for California established by the federal Medicare Program for the same or similar services. This bill would instead require reimbursement for these appliances to be set at least at 80% of the lowest maximum allowance for California established by the federal Medicare Program, and would require that reimbursement to be adjusted annually, as specified.

- **AB 1900 (Arambula – D): Medi-Cal: income level for maintenance**
  - **Introduced:** 2/9/2022
  - **Status:** 6/1/2022-Referred to Com. on HEALTH.
  - **Summary:** Under current law, certain medically needy persons with higher incomes qualify for Medi-Cal with a share of cost, if they meet specified criteria. Under current law, the share of the cost for those persons is generally the total after deducting an amount for maintenance from the person's monthly income. Current law requires the State Department of Health Care Services to establish income levels for maintenance at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. Under existing law, for a

single individual, the amount of the income level for maintenance per month is based on a calculation of 80% of the highest amount that would ordinarily be paid to a family of 2 persons, without any income or resources, under specified cash assistance provisions, multiplied by the federal financial participation rate, adjusted as specified. This bill, to the extent that any necessary federal authorization is obtained, would increase the above-described income level for maintenance per month to be equal to the income limit for Medi-Cal without a share of cost for individuals who are 65 years of age or older or are disabled, generally totaling 138% of the federal poverty level.

- **AB 1929 (Gabriel - D) Medi-Cal: violence preventive services**
  - **Introduced:** 2/10/2022
  - **Status:** 6/1/2022-Referred to Com. on HEALTH.
  - **Summary:** Would require the State Department of Health Care Services to establish a community violence prevention and recovery program, under which violence preventive services would be provided by qualified violence prevention professionals, as defined, as a covered benefit under the Medi-Cal program, in order to reduce the incidence of violent injury or reinjury, trauma, and related harms, and promote trauma recovery, stabilization, and improved health outcomes. Under the bill, the services would be available to a Medi-Cal beneficiary who (1) has been violently injured as a result of community violence, as defined, (2) for whom a licensed health care provider has determined that the beneficiary is at significant risk of experiencing violent injury as a result of community violence, or (3) has experienced chronic exposure to community violence. The bill would authorize the department to meet these requirements by ensuring that qualified violence prevention professionals are designated as community health workers.

- **AB 1930 (Arambula - D) Medi-Cal: comprehensive perinatal services**
  - **Introduced:** 2/10/2022
  - **Status:** 5/27/2022-In Senate. Read first time. To Com. on RLS. for assignment.
  - **Summary:** The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under current law, a pregnant individual or targeted low-income child who is eligible for, and is receiving, health care coverage under any of specified Medi-Cal programs is eligible for full-scope Medi-Cal benefits for the duration of the pregnancy and for a period of one year following the last day of the individual's pregnancy. This bill, during the one-year post pregnancy eligibility period, and as part of comprehensive perinatal services under Medi-Cal, would require the department to cover additional comprehensive perinatal assessments and individualized care plans and to provide additional visits and units of services in an amount, duration, and scope that are at least proportional to those available on July 27th, 2021, during pregnancy and the initial 60-day post pregnancy period in effect on that date. The bill would require the department to collaborate with the State Department of Public Health and a broad stakeholder group to determine the specific number of additional comprehensive perinatal assessments, individualized care plans, visits, and units of services to be covered.

- **AB 1937 (Patterson - R) Medi-Cal: out-of-pocket pregnancy costs**
  - **Introduced:** 2/10/2022
  - **Status:** 4/29/2022 Failed Deadline pursuant to Rule 61(b)(5). (Last location was HEALTH on 2/18/2022)
  - **Summary:** Would require the State Department of Health Care Services, on or before July 1st, 2023, to establish a health expense account program for pregnant Medi-Cal beneficiaries and pregnant subscribers of the Medi-Cal Access Program. The bill would make a Medi-Cal

beneficiary who is pregnant or a pregnant subscriber of the Medi-Cal Access Program eligible for reimbursement for “out-of-pocket pregnancy-related costs,” as specified, in an amount not to exceed $1,250. The bill would require the person to submit the request for reimbursement within 3 months of the end of the pregnancy in order to be reimbursed. The bill would require the department to seek to maximize federal financial participation in implementing the program. The bill would require the department, to the extent federal financial participation is unavailable, to implement the program only with state funds. The bill would require the department to contract out for purposes of implementing the health expense account program, as specified. The bill would authorize the department to implement the above-described provisions through all-county or plan letters, or similar instructions, and would require regulatory action no later than January 1st, 2026.

- **AB 1944 (Lee – D) Local governments: open and public meetings**
  - **Introduced:** 1/24/2022
  - **Status:** 5/27/2022-In Senate. Read first time. To Com. on RLS. for assignment.
  - **Summary:** The Ralph M. Brown Act requires, with specified exceptions, that all meetings of a legislative body of a local agency, as those terms are defined, be open and public and that all persons be permitted to attend and participate. The act contains specified provisions regarding the timelines for posting an agenda and providing for the ability of the public to observe and provide comment. The act allows for meetings to occur via teleconferencing subject to certain requirements, particularly that the legislative body notice each teleconference location of each member that will be participating in the public meeting, that each teleconference location be accessible to the public, that members of the public be allowed to address the legislative body at each teleconference location, that the legislative body post an agenda at each teleconference location, and that at least a quorum of the legislative body participate from locations within the boundaries of the local agency’s jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined. This bill would require the agenda to identify any member of the legislative body that will participate in the meeting remotely.

- **AB 1995 (Arambula - D) Medi-Cal: premiums or contribution**
  - **Introduced:** 1/24/2022
  - **Status:** 5/27/2022-In Senate. Read first time. To Com. on RLS. for assignment.
  - **Summary:** Current law requires that Medi-Cal benefits be provided to optional targeted low-income children, as defined, based on a certain income eligibility threshold. Current law also establishes the Medi-Cal Access Program, which provides health care services to a woman who is pregnant or in her postpartum period and whose household income is between certain thresholds, and to a child under 2 years of age who is delivered by a mother enrolled in the program, as specified. Current law also establishes a program under which certain employed persons with disabilities are eligible for Medi-Cal benefits based on income and other criteria. Existing law requires the department to exercise the option, available to the state under federal law, to impose specified monthly premiums, based on income level, for the above-described children and employed persons with disabilities. Existing law requires the department to determine schedules for subscriber contribution amounts for persons enrolled in the Medi-Cal Access Program. This bill would eliminate the premiums and subscriber contributions for the above-described populations.

- **AB 2007 (Valladares – R) Health care language assistance services**
  - **Introduced:** 2/14/2022
  - **Status:** 4/29/2022 Failed Deadline pursuant to Rule 61(b)(5). (Last location was HEALTH on 2/24/2022)
  - **Summary:** The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Current law requires the Department of Managed Health Care to adopt regulations establishing standards and requirements for health care service plans to provide enrollees with appropriate access to language assistance in obtaining health care services. Current law requires the department to report biennially to, among others, the Legislature, regarding plan compliance with the standards. This bill would instead require the department to provide that report 3 times a year.

- **AB 2024 (Friedman - D) Health care coverage: diagnostic imaging**
  - **Introduced:** 2/14/2022
  - **Status:** 5/27/2022-In Senate. Read first time. To Com. on RLS. for assignment.
  - **Summary:** Current law requires a health care service plan contract issued, amended, delivered, or renewed on or after January 1st, 2000, or an individual or group policy of disability insurance or self-insured employee welfare benefit plan to provide coverage for mammography for screening or diagnostic purposes upon referral by specified professionals. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1st, 2023, to provide coverage for screening mammography, medically necessary diagnostic or supplemental breast examinations, or testing for screening or diagnostic purposes upon referral by specified professionals. The bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1st, 2023, from imposing cost sharing for screening mammography, medically necessary or supplemental breast examinations, or testing, unless the contract or policy is a high deductible health plan and the deductible has not been satisfied for the year.

- **AB 2029 (Wicks - D) Health care coverage: treatment for infertility**
  - **Introduced:** 2/14/2022
  - **Status:** 5/20/2022-Failed Deadline pursuant to Rule 61(b)(8). (Last location was A. APPR. SUSPENSE FILE on 5/18/2022)
  - **Summary:** Would require a health care service plan contract or disability insurance policy that is issued, amended, or renewed on or after January 1st, 2023, to provide coverage for the diagnosis and treatment of infertility and fertility services, as specified, up to a lifetime maximum benefit of $75,000. The bill would except specialty health care service plan contracts and disability insurance policies from that requirement. The bill also would require a small group health care service plan contract or disability insurance policy, except a specialized contract or policy, that is issued, amended, or renewed on or after January 1st, 2023, to offer coverage for the treatment of infertility, as specified. The bill would revise the definition of infertility and would remove the exclusion of in vitro fertilization from coverage. The bill would also delete a requirement that a health care service plan contract and health insurance policy provide infertility treatment under agreed-upon terms that are communicated to all group contract holders and policyholders and prospective group contract holders and policyholders. With respect to a health care service plan, the bill would not apply to Medi-Cal managed care health care service plan contracts or any entity that enters into a contract with the State Department of Health Care Services for the delivery of health care services pursuant to specified provisions.

- **AB 2077 (Calderon - D) Medi-Cal: monthly maintenance amount: personal and incidental needs**
  - **Introduced:** 2/14/2022
  - **Status:** 6/1/2022-Referred to Com. on HEALTH.
  - **Summary:** Current law requires the State Department of Health Care Services to establish income levels for maintenance needs at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. In calculating the income of a medically needy person in a medical institution or nursing facility, or a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization, the required monthly maintenance amount includes an amount providing for personal and incidental needs in the amount of not less than $35 per month while a patient. Existing law authorizes the department to increase, by regulation, this amount as necessitated by increasing costs of personal and incidental needs. This bill would increase the monthly maintenance amount for personal and incidental needs from $35 to $80.

- **AB 2117 (Gipson – D) Mobile stroke units**
  - **Introduced:** 2/14/2022
  - **Status:** 5/25/2022-In committee: Set, first hearing. Hearing canceled at the request of author.
  - **Summary:** Current law provides for the licensure and regulation of health facilities by the State Department of Public Health and defines various types of health facilities for those purposes. This bill would define "mobile stroke unit" to mean a multijurisdictional mobile facility that serves as an emergency response critical care ambulance under the direction and approval of a local emergency medical services (EMS) agency, and as a diagnostic, evaluation, and treatment unit, providing radiographic imaging, laboratory testing, and medical treatment under the supervision of a physician in person or by telehealth, for patients with symptoms of a stroke, to the extent consistent with any federal definition of a mobile stroke unit, as specified.

- **AB 2123 (Villapudua – D) Bringing Health Care into Communities Act of 2023**
  - **Introduced:** 2/15/2022
  - **Status:** 4/29/2022 Failed Deadline pursuant to Rule 61(b)(5). (Last location was H. & C.D. on 3/28/2022)
  - **Summary:** Current law establishes various programs to facilitate the expansion of the health care workforce in rural and underserved communities, including, but not limited to, the Health Professions Career Opportunity Program and the California Registered Nurse Education Program. This bill, the Bringing Health Care into Communities Act of 2023, would establish the Bringing Health Care into Communities Program to be administered by the agency to provide housing grants to specified health professionals to be used for mortgage payments for a permanent residence in a health professional shortage area, as specified. Under the bill, a health professional would be eligible for a grant for up to 5 years. The bill would make its provisions operative upon appropriation by the Legislature.

- **AB 2304 (Bonta – D) Nutrition Assistance: “Food as Medicine”**
  - **Introduced:** 2/16/2022
  - **Status:** 5/6/22 Failed Deadline pursuant to Rule 61(b)(6). (Last location was A. PRINT on 2/16/2022)
  - **Summary:** Current law provides for the California Health and Human Services Agency, which includes the State Department of Health Care Services, the State Department of Public Health, and the State Department of Social Services. Current law establishes various programs and

services under those departments, including the Medi-Cal program, under which qualified low-income individuals receive health care services, such as enteral nutrition products, the California Special Supplemental Nutrition Program for Women, Infants, and Children, which is administered by the State Department of Public Health and counties and under which nutrition and other assistance are provided to eligible individuals who have been determined to be at nutritional risk, and the CalFresh program, under which supplemental nutrition assistance benefits allocated to the state by the federal government are distributed to eligible individuals by each county. This bill would declare the intent of the Legislature to enact the Wilma Chan Food as Medicine Act of 2022.

- **AB 2352 (Nazarian - D) Prescription drug coverage**
  - **Introduced:** 2/16/2022
  - **Status:** 6/1/2022-Referred to Com. on HEALTH.
  - **Summary:** Current law limits the maximum amount an enrollee or insured may be required to pay at the point of sale for a covered prescription drug to the lesser of the applicable cost-sharing amount or the retail price, and requires that payment apply to the applicable deductible. This bill would require a health care service plan or health insurer that provides prescription drug benefits and maintains one or more drug formularies to furnish specified information about a prescription drug upon request by an enrollee or insured, or their prescribing provider. The bill would require the plan or insurer to respond in real time to that request and ensure the information is current no later than one business day after a change is made. The bill would prohibit a health care service plan or health insurer from, among other things, restricting a prescribing provider from sharing the information furnished about the prescription drug or penalizing a provider for prescribing a lower cost drug.

- **AB 2402 (Rubio, Blanca - D) Medi-Cal: continuous eligibility**
  - **Introduced:** 2/17/2022
  - **Status:** 5/26/2022-In Senate. Read first time. To Com. on RLS. for assignment.
  - **Summary:** Current law requires the State Department of Health Care Services, to the extent federal financial participation is available, to exercise a federal option to extend continuous eligibility for the Medi-Cal program to children 19 years of age and younger until the earlier of either the end of a 12-month period following the eligibility determination or the date the child exceeds 19 years of age. Under this bill, a child under 5 years of age would be continuously eligible for Medi-Cal, including without regard to income, until the child reaches 5 years of age. The bill would prohibit the redetermination of Medi-Cal eligibility before the child reaches 5 years of age, unless the department or county possesses facts indicating that the family has requested the child's voluntary disenrollment, the child is deceased, the child is no longer a state resident, or the child's original enrollment was based on a state or county error or on fraud, abuse, or perjury, as specified. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and, except as specified, on the availability of federal financial participation.

- **AB 2449 (Rubio, Blanca – D) Open meetings: local agencies: teleconferences**
  - **Introduced:** 1/24/2022
  - **Status:** 5/27/2022-In Senate. Read first time. To Com. on RLS. for assignment.

- **Summary:** The Ralph M. Brown Act requires, with specified exceptions, that all meetings of a legislative body of a local agency, as those terms are defined, be open and public and that all persons be permitted to attend and participate. The act contains specified provisions regarding the timelines for posting an agenda and providing for the ability of the public to observe and provide comment. The act allows for meetings to occur via teleconferencing subject to certain requirements, particularly that the legislative body notice each teleconference location of each member that will be participating in the public meeting, that each teleconference location be accessible to the public, that members of the public be allowed to address the legislative body at each teleconference location, that the legislative body post an agenda at each teleconference location, and that at least a quorum of the legislative body participate from locations within the boundaries of the local agency's jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined. This bill would revise and recast those teleconferencing provisions and, until January 1st, 2028, would authorize a local agency to use teleconferencing without complying with the teleconferencing requirements that each teleconference location be identified in the notice and agenda and that each teleconference location be accessible to the public if at least a quorum of the members of the legislative body participates in person from a singular physical location clearly identified on the agenda that is open to the public and situated within the local agency's jurisdiction.

- **AB 2458 (Weber – D) California Children's Services: reimbursement rates.**
  - **Introduced:** 2/17/2022
  - **Status:** 5/20/22 Failed Deadline pursuant to Rule 61(b)(8). (Last location was A. APPR. SUSPENSE FILE on 4/6/2022)
  - **Summary:** Would make legislative findings relating to the need for an increase in the reimbursement rates for physician services provided under the California Children's Services (CCS) Program. Under the bill, subject to an appropriation, and commencing January 1st, 2023, those reimbursement rates would be increased by adding at least 25% to the above-described augmentation percentage relative to the applicable Medi-Cal rates. The bill would make the rate increase applicable only if the services are provided by a physician in a practice in which at least 30% of the practice's pediatric patients are Medi-Cal beneficiaries.

- **AB 2539 (Choi - R) Public health: COVID-19 vaccination: proof of status**
  - **Introduced:** 2/17/2022
  - **Status:** 4/29/22 Failed Deadline pursuant to Rule 61(b)(5). (Last location was PRINT on 2/17/2022)
  - **Summary:** Would require a public or private entity that requires a member of the public to provide documentation regarding the individual's vaccination status for any COVID-19 vaccine as a condition of receipt of any service or entrance to any place to accept a written medical record or government-issued digital medical record in satisfaction of the condition, as specified.

- **AB 2581 (Salas – D) Health Care Service Plans: Mental Health and Substance Use Disorders: Provider Credentials**
  - **Introduced:** 2/18/2022
  - **Status:** 6/1/22 Referred to Com. on HEALTH.
  - **Summary:** Current law requires a health care service plan contract issued, amended, or renewed on or after January 1st, 2021, that provides hospital, medical, or surgical coverage to provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions, as specified. For provider contracts issued, amended, or renewed on and after January 1st, 2023, this bill would require a

health care service plan that provides coverage for mental health and substance use disorders and credentials health care providers of those services for the health care service plan's networks, to assess and verify the qualifications of a health care provider within 60 days after receiving a completed provider credentialing application. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

- **AB 2659 (Patterson - R) Medi-Cal managed care: midwifery services**
  - **Introduced:** 2/18/2022
  - **Status:** 4/29/2022 Failed Deadline pursuant to Rule 61(b)(5). (Last location was HEALTH on 3/10/2022)
  - **Summary:** Would require a Medi-Cal managed care plan to have within its provider network at least one licensed midwife (LM) and one certified-nurse midwife (CNM) within each county where the Medi-Cal managed care plan provides services to Medi-Cal beneficiaries. The bill would exempt a Medi-Cal managed care plan from that requirement for purposes of a given county if no LM or CNM is available in that county or if no LM or CNM in that county accepts Medi-Cal payments. If a Medi-Cal managed care plan is exempt from that requirement, the bill would require the Medi-Cal managed care plan to reevaluate its network adequacy for midwifery care in the county on an annual basis and to make a good faith effort to work with the appropriate professional midwifery organizations for LMs and CNMs, and their respective licensing and regulatory agencies, to assist in determining the availability of midwives in the county who accept Medi-Cal payments. The bill would also require a Medi-Cal managed care plan to have within its provider network at least one licensed alternative birth center specialty clinic within each county where the Medi-Cal managed care plan provides services to Medi-Cal beneficiaries provided that at least one qualified licensed alternative birth center specialty clinic is available in that county and is willing to contract with the Medi-Cal managed care plan.

- **AB 2680 (Arambula - D) Medi-Cal: Community Health Navigator Program**
  - **Introduced:** 2/19/2022
  - **Status:** 5/26/2022-In Senate. Read first time. To Com. on RLS. for assignment.
  - **Summary:** Current law also authorizes a county to collaborate with a community-based organization to maintain up-to-date contact information in order to assist with the timely submission of annual reaffirmation forms, among others. This bill would require the State Department of Health Care Services to create the Community Health Navigator Program to make direct grants to qualified community-based organizations, as defined, to conduct targeted outreach, enrollment, retention, and access activities for Medi-Cal-eligible individuals and families. The bill would specify the basis for issuing a grant, including specified factors in the applicant's service area. The bill would require the department to contract with a private foundation to administer the grant application and allocation process. The bill would require the department to contract with specified providers to furnish training and technical assistance to grant recipients. The bill would also require the department to coordinate and partner with Covered California and counties that elect to participate, on an approach for outreach, enrollment, retention, and access activities for marketing to eligible individuals, including the development of a joint application tracker system to allow specified persons and entities to track application and referrals between commercial and Medi-Cal enrollment progress and facilitation of quarterly meetings on enrollment and access barriers and solutions, among other requirements.

- **AB 2724 (Arambula – D) Medi-Cal: alternate health care service plan**
  - **Introduced:** 2/18/2022
  - **Status:** 5/27/2022-In Senate. Read first time. To Com. on RLS. for assignment.
  - **Summary:** Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services through various delivery systems, including managed care pursuant to Medi-Cal managed care plan contracts. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would authorize the department to enter into one or more comprehensive risk contracts with an alternate health care service plan (AHCSP), as defined, to serve as a primary Medi-Cal managed care plan for specified eligible beneficiaries in geographic regions designated by the department. The bill would authorize the department to contract with an AHCSP as a Medi-Cal managed care plan in any geographic region of the state for which federal approval is available and for which the AHCSP maintains appropriate licensure or an approved exemption from the Department of Managed Health Care.

- **AB 2727 (Wood – D) Medi-Cal Eligibility**
  - **Introduced:** 1/24/2022
  - **Status:** 6/2/2022-Read second time. Ordered to third reading.
  - **Summary:** Current law prohibits the use of resources, including property or other assets, to determine Medi-Cal eligibility for applicants or beneficiaries whose eligibility is not determined using the MAGI-based financial methods, and requires the department to seek federal authority to disregard all resources as authorized by the flexibilities provided under federal law. Current law conditions implementation of that provision on the Director of Health Care Services determining that systems have been programmed for those disregards and their communicating that determination in writing to the Department of Finance, no sooner than January 1, 2024. Current law also conditions implementation of that provision on receipt of any necessary federal approvals and the availability of federal financial participation. Current law states the intent of the Legislature to provide, to the extent practicable, through the Medi-Cal program, for health care for those aged and other persons, including family persons who lack sufficient annual income to meet the costs of health care, and whose other assets are so limited that their application toward the costs of that care would jeopardize the person or family's future minimum self-maintenance and security. This bill would, commencing on the date that the resource disregards are implemented, remove from that statement of legislative intent the above-described assets as an eligibility criterion.

- **AB 2813 (Santiago - D) Long-Term Services and Supports Benefit Program**
  - **Introduced:** 2/18/2022
  - **Status:** 4/29/2022 Failed Deadline pursuant to Rule 61(b)(5). (Last location was AGING & L.T.C. on 3/17/2022)
  - **Summary:** Would require the California Department of Aging, upon appropriation, in conjunction with an unspecified board operating under the auspices of the State Treasurer, to establish and administer a Long-Term Services and Supports Benefits Program with the purpose of providing supportive care to aging Californians and those with physical disabilities. The bill would establish the Long-Term Services and Supports Benefit Program Fund and would require the department and the board to administer the program using proceeds from the fund. The bill would require an individual to have paid into the fund for an unspecified number of years to be eligible to receive benefits pursuant to the program.

- **AB 2833 (Irwin – D) COVID-19 testing capacity**
  - **Introduced:** 2/18/2022
  - **Status:** 6/1/22 Referred to Com. on HEALTH.
  - **Summary:** Current law sets forth various provisions specific to COVID-19 testing, including, among others, provisions relating to health care coverage for testing and certain programs or requirements for the workplace or educational setting. This bill would require the State Department of Public Health to make plans to ensure that the laboratory infrastructure in the state is sufficient and prepared for COVID-19 testing capacity to be scaled, within a period of 2 calendar weeks, to 500,000 tests per day, and for results of at least 90% of those COVID-19 tests to be returned to the individuals tested and to the department within 24 hours of collection of the testing samples. The bill would require the department, for purposes of making these plans, to prioritize local public health laboratories and the state laboratory and to consider sufficient staffing.

- **AB 2942 (Daly - D) Prescription drug cost sharing**
  - **Introduced:** 2/18/2022
  - **Status:** 4/29/2022 Failed Deadline pursuant to Rule 61(b)(5). (Last location was HEALTH on 3/17/2022)
  - **Summary:** Current law limits the maximum amount an enrollee or insured may be required to pay at the point of sale for a covered prescription drug to the lesser of the applicable cost-sharing amount or the retail price. This bill would require an enrollee's or insured's defined cost sharing for each prescription drug to be calculated at the point of sale based on a price that is reduced by an amount equal to 90% of all rebates received or to be received, in connection with the dispensing or administration of the drug. The bill would require a health care service plan or health insurer to, among other things, pass through to each enrollee or insured at the point of sale a good faith estimate of their decrease in cost sharing. The bill would require a health care service plan or health insurer to calculate an enrollee's or insured's defined cost sharing and provide that information to the dispensing pharmacy, as specified.

- **AB 2516 (Aguiar-Curry - D) Health care coverage: human papillomavirus**
  - **Introduced:** 2/17/2022
  - **Status:** 5/26/22 In Senate. Read first time. To Com. on RLS. for assignment.
  - **Summary:** Current law requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1st, 2002, to provide coverage for an annual cervical cancer screening test, including a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA). Current law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which health care services are provided to low-income individuals pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Current law also establishes the Family Planning, Access, Care, and Treatment (Family PACT) Program, administered by the Office of Family Planning within the department, under which comprehensive clinical family planning services are provided to a person who has a family income at or below 200% of the federal poverty level, and who is eligible to receive these services. This bill would expand the coverage requirement for an annual cervical cancer screening test to disability insurance policies that provide coverage for hospital, medical, or surgical benefits and would require a health care service plan contract or disability insurance policy that provides

coverage for hospital, medical, or surgical benefits issued, amended, or renewed on or after January 1st, 2023, to provide coverage without cost sharing for the HPV vaccine for persons for whom the vaccine is FDA approved.

- **SB 245 (Gonzalez – D) Health Care Coverage: Abortion Services: Cost of Sharing**
  - **Introduced:** 1/24/2022
  - **Status:** 3/22/2022 Chaptered by Secretary of State – Chapter 11, Statutes of 2022
  - **Summary:** Would prohibit a health care service plan or an individual or group policy or certificate of health insurance or student blanket disability insurance that is issued, amended, renewed, or delivered on or after January 1st, 2023, from imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement on coverage for all abortion and abortion-related services, as specified. The bill would prohibit a health care service plan and an insurer subject to these requirements from imposing utilization management or utilization review on the coverage for outpatient abortion services. The bill would require that for a contract, certificate, or policy that is a high deductible health plan, the cost-sharing prohibition would apply once the enrollee's or insured's deductible has been satisfied for the benefit year. The bill would not require an individual or group contract or policy to cover an experimental or investigational treatment. The bill's requirements would also apply to Medi-Cal managed care plans and their providers, independent practice associations, preferred provider groups, and all delegated entities that provide physician services, utilization management, or utilization review. The bill would require the Department of Managed Health Care and the Department of Insurance to adopt related regulations on or before January 1st, 2026.

- **SB 853 (Wiener – D) Prescription drug coverage**
  - **Introduced:** 1/19/2022
  - **Status:** 6/2/2022-Referred to Com. on HEALTH. From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
  - **Summary:** Current law generally authorizes a health care service plan or health insurer to use utilization review, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Current law prohibits a health care service plan contract that covers prescription drug benefits or a specified health insurance policy from limiting or excluding coverage for a drug on the basis that the drug is prescribed for a use that is different from the use for which it was approved by the federal Food and Drug Administration if specified conditions are met. Current law also prohibits a health care service plan that covers prescription drug benefits from limiting or excluding coverage for a drug that was previously approved for coverage if an enrollee continues to be prescribed that drug, as specified. This bill would expand the above-described prohibitions to prohibit limiting or excluding coverage of a drug, dose, or dosage form, and would apply the prohibition to blanket disability insurance policies and certificates. The bill would prohibit a health care service plan or disability insurer that provides coverage for prescription drugs from limiting or declining to cover a drug or dose of a drug as prescribed, or imposing additional cost sharing for covering a drug as prescribed, if specified criteria apply.

- **SB 858 (Wiener – D) Health care service plans: discipline: civil penalties.**
  - **Introduced:** 1/19/2022
  - **Status:** 6/2/2022-Referred to Com. on HEALTH.

- **Summary:** Current law authorizes the Director of the Department of Managed Health Care to take disciplinary measures, including the imposition of civil penalties, against a licensee when the director determines that the licensee has committed an act or omission constituting grounds for disciplinary action, as specified. Under current law, a person who violates the act, or a rule or order adopted or issued under the act, is generally liable for a civil penalty not to exceed $2,500 per violation. Current law also includes various provisions that assess specific civil and administrative penalties for certain violations. Fines and penalties under the act are deposited into the Managed Care Administrative Fines and Penalties Fund, and used, upon appropriation by the Legislature, for designated purposes. This bill would increase the base amount of the civil penalty from $2,500 per violation to not less than $25,000 per violation, which would be adjusted annually commencing January 1st, 2024, as specified. The bill would multiply the amounts of other specified civil and administrative penalties by 4, commencing January 1st, 2023, and would also annually adjust those penalties, commencing January 1st, 2024.

- **SB 871 (Pan – D) Public Health: Immunization**
  - **Introduced:** 4/29/2022 Failed Deadline pursuant to Rule 61(b)(5). (Last location was HEALTH on 3/17/2022)
  - **Status:** 2/24/2022 Referral to Com on JUD. Rescinded because of the limitation placed on committee hearings due to ongoing health and safety risks of the COVID-19 virus.
  - **Summary:** Current law prohibits the governing authority of a school or other institution from unconditionally admitting any person as a pupil of any public or private elementary or secondary school, childcare center, day nursery, nursery school, family day care home, or development center, unless prior to their admission to that institution they have been fully immunized against various diseases, including measles, mumps, pertussis, hepatitis B, and any other disease deemed appropriate by the State Department of Public Health, as specified. Current law authorizes an exemption from those provisions for medical reasons. Under existing law, notwithstanding the above-described prohibition, full immunization against hepatitis B is not a condition by which the governing authority admits or advances a pupil to the 7th grade level of a public or private elementary or secondary school. This bill would remove the above-described exception relating to hepatitis B. The bill would additionally prohibit the governing authority of a school or other institution from unconditionally admitting any person as a pupil of any public or private elementary or secondary school, childcare center, day nursery, nursery school, family day care home, or development center, unless prior to their admission to that institution they have been fully immunized against COVID-19.

- **SB 912 (Limon – D) Biomarker testing**
  - **Introduced:** 2/3/2022
  - **Status:** 6/2/2022-Referred to Com. on HEALTH.
  - 2/9/2022 Referred to Com. on HEALTH.
  - **Summary:** Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1st, 2023, to provide coverage for biomarker testing, including whole genome sequencing, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's or insured's disease or condition if the test is supported by medical and scientific evidence, as prescribed. This bill would apply these provisions relating to biomarker testing to the Medi-Cal program, including Medi-Cal managed care plans, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

- **SB 923 (Wiener – D) Gender- affirming care**
  - **Introduced:** 1/25/2022
  - **Status:** 5/31/2022-From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
  - **Summary:** Would require a Medi-Cal managed care plan, a PACE organization, a health care service plan, or a health insurer, as specified, to require its staff to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care, as defined, for individuals who identify as transgender, gender diverse, or intersex (TGI). The bill would specify the required components of the training and would make use of any training curricula subject to approval by the respective departments. The bill would require an individual to complete a refresher course if a complaint has been filed, and a decision has been made in favor of the complainant against that individual for not providing trans-inclusive health care, or on a more frequent basis if deemed necessary.

- **SB 958 (Limon - D) Medication and Patient Safety Act of 2022**
  - **Introduced:** 2/09/2022
  - **Status:** 5/27/2022-Referred to Com. on HEALTH.
  - **Summary:** Would prohibit a health care service plan or health insurer, or its designee, from requiring a vendor to dispense an infused or injected medication directly to a patient with the intent that the patient will transport the medication to a health care provider for administration. The bill would authorize a plan or insurer, or its designee, to arrange for an infused or injected medication to be administered in an enrollee's or insured's home when the treating health care provider and patient determine home administration is in the best interest of the patient. The bill would prohibit a plan or insurer, or its designee, from requiring an infused or injected medication to be supplied by a vendor specified by the plan or insurer, or its designee, as a condition of coverage, unless specified criteria are met.

- **SB 966 (Limon – D) Federally qualified health centers and rural health clinics**
  - **Introduced:** 2/09/2022
  - **Status:** 6/2/22 Referred to Com. on HEALTH.
  - **Summary:** The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, to the extent that federal financial participation is available, FQHC and RHC services are reimbursed on a per-visit basis, as specified. "Visit" is defined as a face-to-face encounter between an FQHC or RHC patient and any of specified health care professionals, including a physician, a licensed clinical social worker, or a marriage and family therapist. This bill would also include, within the definition of a visit, a face-to-face encounter between an FQHC or RHC patient and an associate clinical social worker or associate marriage and family therapist when supervised by a licensed behavioral health practitioner as required by the Board of Behavioral Sciences, as specified. The bill would make this provision operative 60 days after the termination of the national emergency declared on March 13th, 2020.

- **SB 974 (Portantino - D) Health care coverage: diagnostic imaging**
  - **Introduced:** 2/10/2022
  - **Status:** 6/2/2022-Referred to Com. on HEALTH.
  - **Summary:** Would require a health care service plan contract, an individual or group policy of disability insurance that provides hospital, medical, or surgical coverage, or a self-insured employee welfare benefit plan issued, amended, or renewed on or after January 1st, 2023, to

provide coverage without imposing cost sharing for screening mammography and medically necessary diagnostic breast imaging, including diagnostic breast imaging following an abnormal mammography result and for an enrollee or insured indicated to have a risk factor associated with breast cancer.

- **SB 987 (Portantino – D) California Cancer Equity Act**
  - **Introduced:** 2/14/2022
  - **Status:** 5/27/2022-Referred to Com. on HEALTH.
  - **Summary:** Would require a Medi-Cal managed care plan to include in its contracted provider network at least one National Cancer Institute (NCI)-Designated Cancer Center, as specified, and ensure that any beneficiary diagnosed with a complex cancer diagnosis, as defined, is referred to an NCI-Designated Cancer Center within 15 business days of the diagnosis, unless the beneficiary selects a different cancer treatment provider. This bill contains other related provisions and other existing laws.

- **SB 1019 (Gonzalez – D) Medi-Ca managed care plans: mental health benefits**
  - **Introduced:** 2/14/2022
  - **Status:** 6/2/2022-Referred to Com. on HEALTH.
  - **Summary:** Current law requires a Medi-Cal managed care plan to provide mental health benefits covered in the state plan, excluding those benefits provided by county mental health plans under the Specialty Mental Health Services Waiver. This bill would require a Medi-Cal managed care plan to conduct annual outreach and education to its enrollees regarding the mental health benefits that are covered by the plan, and to also develop annual outreach and education to inform primary care physicians regarding those mental health benefits.

- **SB 1033 (Pan – D) Health care coverage**
  - **Introduced:** 2/15/2022
  - **Status:** 6/2/2022-Referred to Com. on HEALTH.
  - **Summary:** Current law requires the Department of Managed Health Care and the Insurance Commissioner, in developing the regulations, to require health care service plans and health insurers to assess the linguistic needs of the enrollee and insured population, and to provide for translation and interpretation for medical services, as indicated. Current law requires the regulations to include, among other things, requirements for conducting assessments of the enrollees and insured groups, and requires health care service plans and health insurers to update the needs assessment, demographic profile, and language translation requirements every 3 years. This bill would require the Department of Managed Health Care and the commissioner to revise these regulations, no later than July 1st, 2023, and to require health care service plans and health insurers to assess the cultural, linguistic, and health-related social needs of the enrollees and insured groups for the purpose of identifying and addressing health disparities, improving health care quality and outcomes, and addressing population health. The bill would also require the department and commissioner to require plans and insurers to obtain accreditation, as described, establish standardized categories for the collection and reporting of self-reported demographic and health-related social needs, as outlined, and establish a program to provide technical assistance and other support to plans and providers.

- **SB 1089 (Walk – R) Medi-Cal Eyeglasses: Prison Industry Authority**
  - **Introduced:** 1/24/2022
  - **Status:** 5/27/2022-Referred to Coms. on HEALTH and PUB. S.
  - **Summary:** Current law establishes the Prison Industry Authority within the Department of Corrections and Rehabilitation and authorizes it to operate industrial, agricultural, and service enterprises that will provide products and services needed by the state, or any political subdivision of the state, or by the federal government, or any department, agency, or corporation of the federal government, or for any other public use. Current law requires state agencies to purchase these products and services at the prices fixed by the authority. Current law also requires state agencies to make maximum utilization of these products and consult with the staff of the authority to develop new products and adapt existing products to meet their needs. This bill, for purposes of Medi-Cal reimbursement for covered optometric services, would authorize a provider to obtain eyeglasses from a private entity, as an alternative to the purchase of eyeglasses from the Prison Industry Authority.

- **SB 1180 (Pan – D) Medi-Cal: time and distance standards for managed care services**
  - **Introduced:** 2/17/2022
  - **Status:** 6/2/2022-Referred to Com. on HEALTH.
  - **Summary:** Current law establishes, until January 1st, 2023, certain time and distance and appointment time standards for specified Medi-Cal managed care covered services, consistent with federal regulations relating to network adequacy standards, to ensure that those services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as specified. This bill would extend the operation of those standards to January 1st, 2026, and would require the department to seek input from stakeholders, as specified, prior to January 1st, 2025, to determine what changes are needed to these provisions.

- **SB 1184 (Cortese - D) Confidentiality of Medical Information Act: school-linked services coordinators**
  - **Introduced:** 2/17/2022
  - **Status:** 5/24/2022-In Assembly. Read first time. Held at Desk.
  - **Summary:** The Confidentiality of Medical Information Act prohibits a provider of health care, a health care service plan, or a contractor from disclosing medical information, as defined, regarding a patient of the provider of health care or an enrollee or subscriber of the health care service plan without first obtaining an authorization, except as prescribed. The act authorizes a provider of health care or a health care service plan to disclose medical information in certain circumstances, including by authorizing disclosure to providers of health care, health care service plans, contractors, or other health care professionals or facilities for purposes of diagnosis or treatment of the patient. This bill would additionally authorize a provider of health care or a health care service plan to disclose medical information to a school-linked services coordinator, as prescribed. The bill would define the term “school-linked services coordinator” as an individual located on a school campus or under contract by a county behavioral health provider agency for the treatment and health care operations and referrals of students and their families that holds any of certain credentials, including a services credential with a specialization in pupil personnel services, as specified.

- **SB 1207 (Portantino – D) Health care coverage: maternal and pandemic-related mental health conditions**

- **Introduced:** 2/17/2022
- **Status:** 5/27/2022-Referred to Com. on HEALTH.
- **Summary:** Current law requires health care service plans and health insurers to provide specified mental health and substance use disorder coverage, and requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1st, 2021, that provides hospital, medical, or surgical coverage to provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions, as specified. Current law requires health care service plans and health insurers, by July 1st, 2019, to develop, consistent with sound clinical principles and processes, a maternal mental health program designed to promote quality and cost-effective outcomes, as specified. This bill would make findings and declarations relating to the effect of the COVID-19 pandemic on mental health in California and the importance of outreach, education, and access to quality mental health treatment. The bill would extend the deadline for establishment of the maternal mental health program to July 1st, 2023.

- **SB 1298 (Ochoa Bogh - R) Behavioral Health Continuum Infrastructure Program**
  - **Introduced:** 2/18/2022
  - **Status:** 5/19/22 May 19th hearing: Held in committee and under submission.
  - **Summary:** Current law authorizes the State Department of Health Care Services to, subject to an appropriation, establish a Behavioral Health Continuum Infrastructure Program. Current law authorizes the department, pursuant to this program, to award competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets or to invest in needed mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources to build or expand the capacity of various treatment and rehabilitation options for persons with behavioral health disorders, as specified. This bill would authorize the department, in awarding the above-described grants, to give preference to qualified entities that are intending to place their projects in specified facilities or properties.

- **SB 1361 (Kamlager - D) Prescription drugs: cost sharing: pharmacy benefit managers**
  - **Introduced:** 2/18/2022
  - **Status:** 5/20/2022-Failed Deadline pursuant to Rule 61(b)(8). (Last location was S. APPR. SUSPENSE FILE on 5/16/2022)
  - **Summary:** Current law provides for the regulation of health insurers by the Department of Insurance under the authority of the Insurance Commissioner. Current law limits the maximum amount an enrollee or insured may be required to pay at the point of sale for a covered prescription drug to the lesser of the applicable cost-sharing amount or the retail price. This bill, commencing no later than January 1st, 2024, would require an enrollee's or insured's defined cost sharing for each prescription drug to be calculated at the point of sale based on a price that is reduced by an amount equal to 90% of all rebates received, or to be received, in connection with the dispensing or administration of the drug. The bill would require a health care service plan or health insurer to, among other things, pass through to each enrollee or insured at the point of sale a good faith estimate of the enrollee's or insured's decrease in cost sharing. The bill would require a health care service plan or health insurer to calculate an enrollee's or insured's defined cost sharing and provide that information to the dispensing pharmacy, as specified.

- **SB 1379 (Ochoa Bogh - R) Pharmacy: remote services**
  - **Introduced:** 2/18/2022

- **Status:** 4/29/2022 Failed Deadline pursuant to Rule 61(b)(5). (Last location was B., P. & E.D. on 3/9/2022)
- **Summary:** The Controlled Substances Act regulates, among other matters, the dispensing by prescription of controlled substances, which are classified into schedules, and the Pharmacy Law regulates, among other matters, the dispensing by prescription of dangerous drugs and dangerous devices, which also include controlled substances. Current law authorizes a prescriber, a prescriber's authorized agent, or a pharmacist to electronically enter a prescription or order from outside of a pharmacy or hospital, as specified, except for prescriptions for controlled substances classified in Schedules II, III, IV, or V. Under current law, a violation of these provisions is a crime. This bill would extend the authority to remotely enter a prescription or order to include prescriptions for controlled substances classified in Schedules II, III, IV, or V. The bill would also authorize a pharmacist to perform various services remotely, as specified, on behalf of a pharmacy located in California and under the written authorization of a pharmacist-in-charge.

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Board Business

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Finance

Gil Riojas

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

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

Date: **June 10th, 2022**

Subject: **Finance Report – April 2022**

Executive Summary

- For the month ended April 30th, 2022, the Alliance had enrollment of 308,741 members, a Net Income of $2.3 million and 574% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$101,645	$991,002
Medical Expense	93,222	921,468
Admin. Expense	5,838	53,493
Other Inc. / (Exp.)	(318)	(865)
Net Income	**$2,268**	**$15,176**

Net Income by Program:

	Month	YTD
Medi-Cal	$2,552	$16,645
Group Care	(284)	(1,469)
	$2,268	**$15,176**

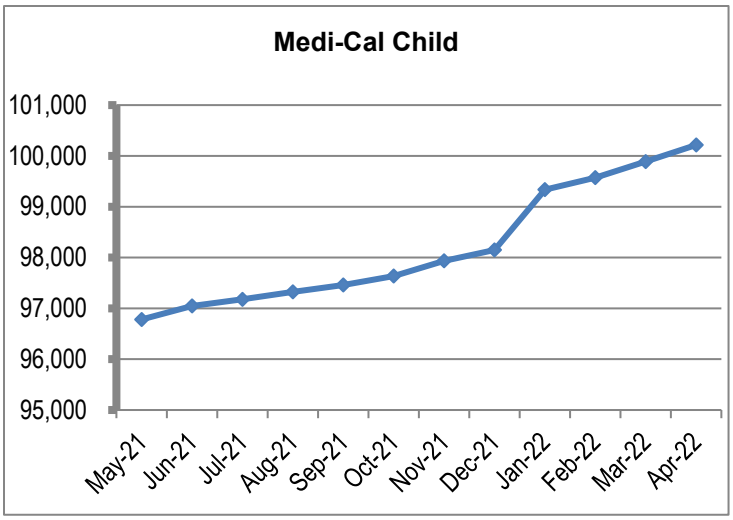
Enrollment

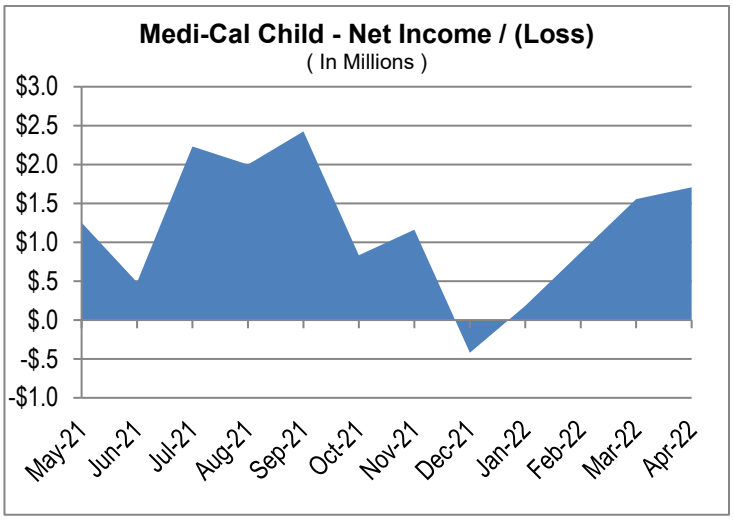
- Total enrollment increased by 1,954 members since March 2022.
- Total enrollment increased by 20,187 members since June 2021.
- Higher enrollment compared to Budget is due to the extension of the Public Health Emergency.

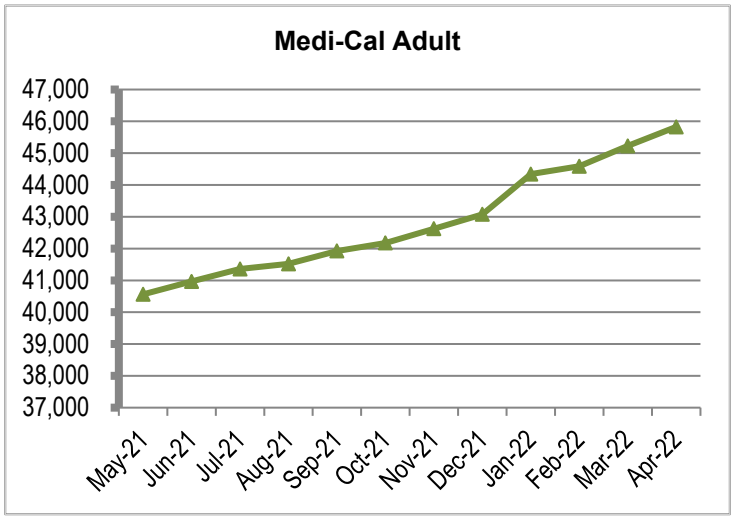
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

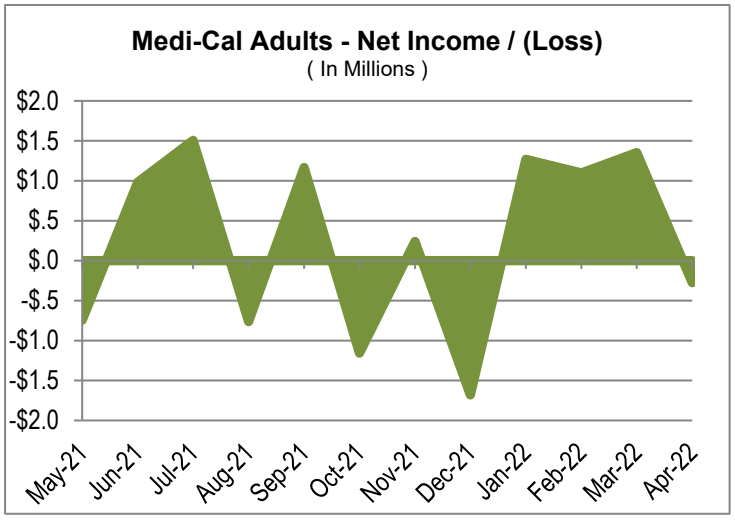
Enrollment					Member Months			
April-2022					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
45,826	41,901	3,925	9.4%	Adult	432,659	422,196	10,463	2.5%
100,215	96,710	3,505	3.6%	Child	984,698	977,982	6,716	0.7%
26,848	25,734	1,114	4.3%	SPD	265,185	262,569	2,616	1.0%
21,456	20,178	1,278	6.3%	Duals	208,784	205,608	3,176	1.5%
108,568	98,990	9,578	9.7%	ACA OE	1,032,643	1,004,549	28,094	2.8%
302,913	**283,513**	**19,400**	**6.8%**	**Medi-Cal Total**	**2,923,969**	**2,872,904**	**51,065**	**1.8%**
5,828	5,852	(24)	-0.4%	Group Care	58,588	58,729	(141)	-0.2%
308,741	**289,365**	**19,376**	**6.7%**	**Total**	**2,982,557**	**2,931,633**	**50,924**	**1.7%**

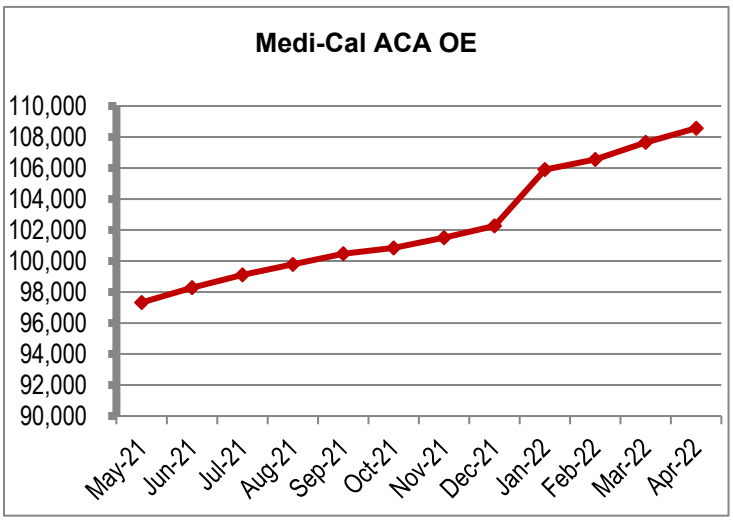
Enrollment and Profitability by Program and Category of Aid

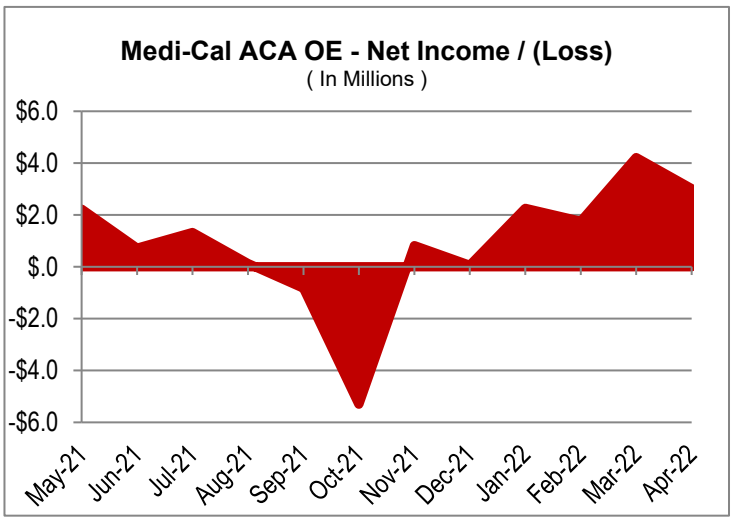




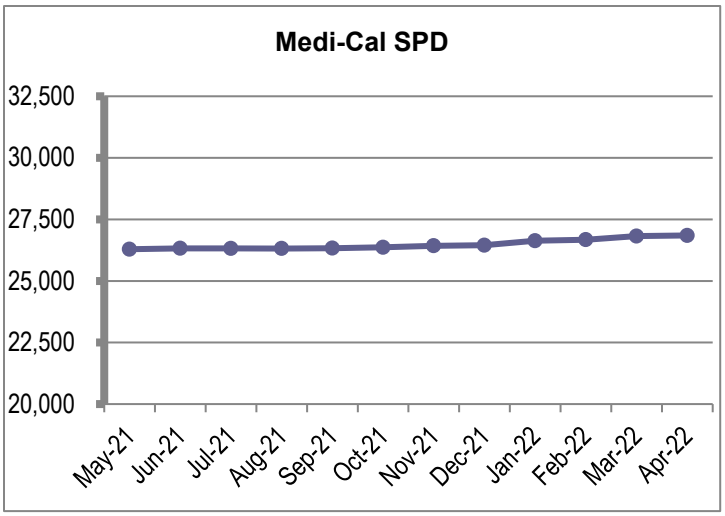


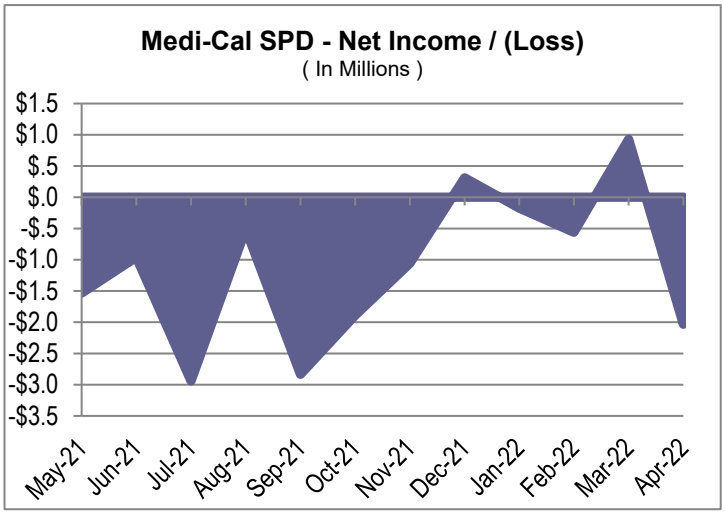


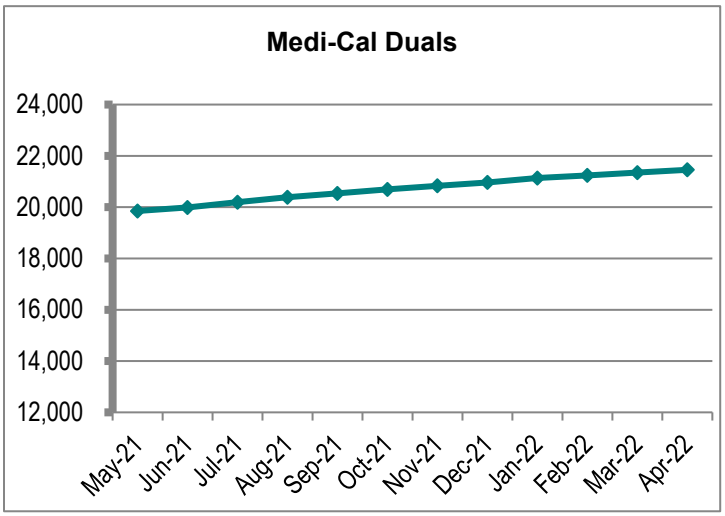


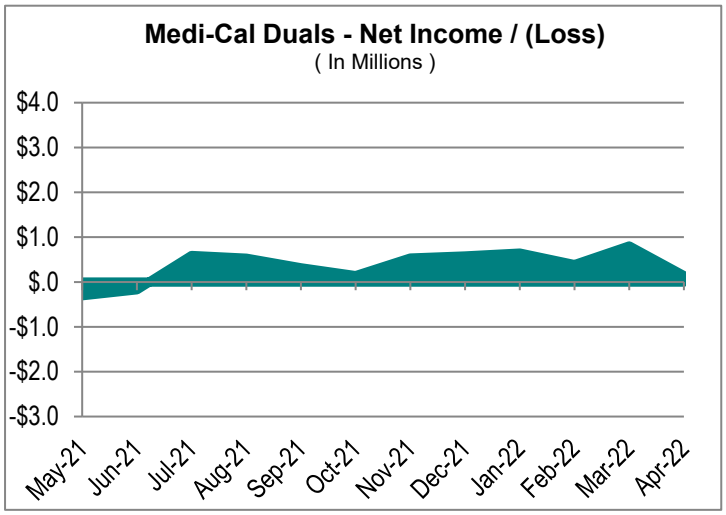


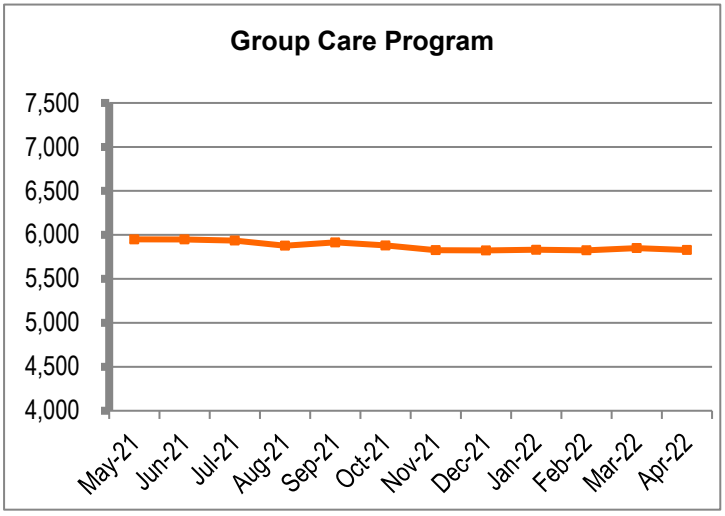
Enrollment and Profitability by Program and Category of Aid

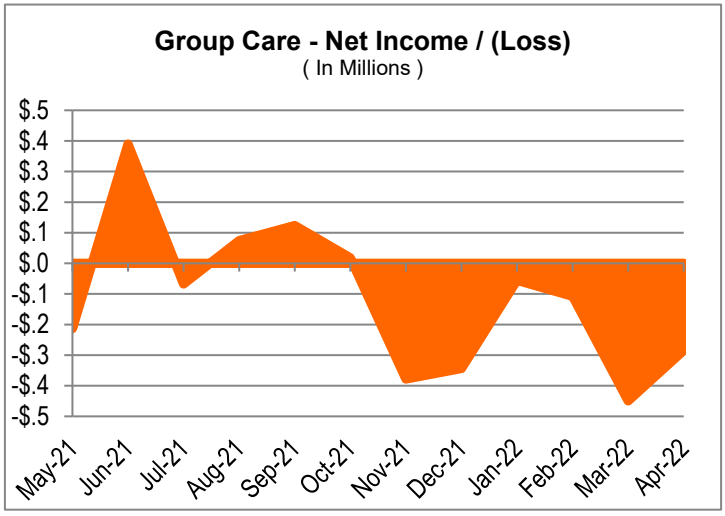




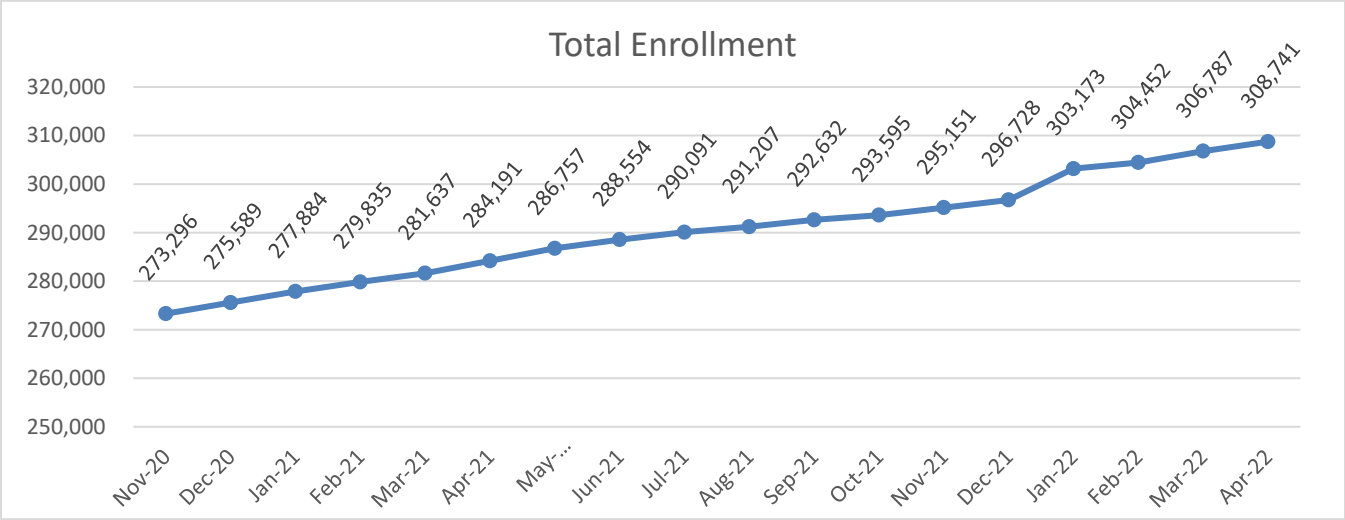


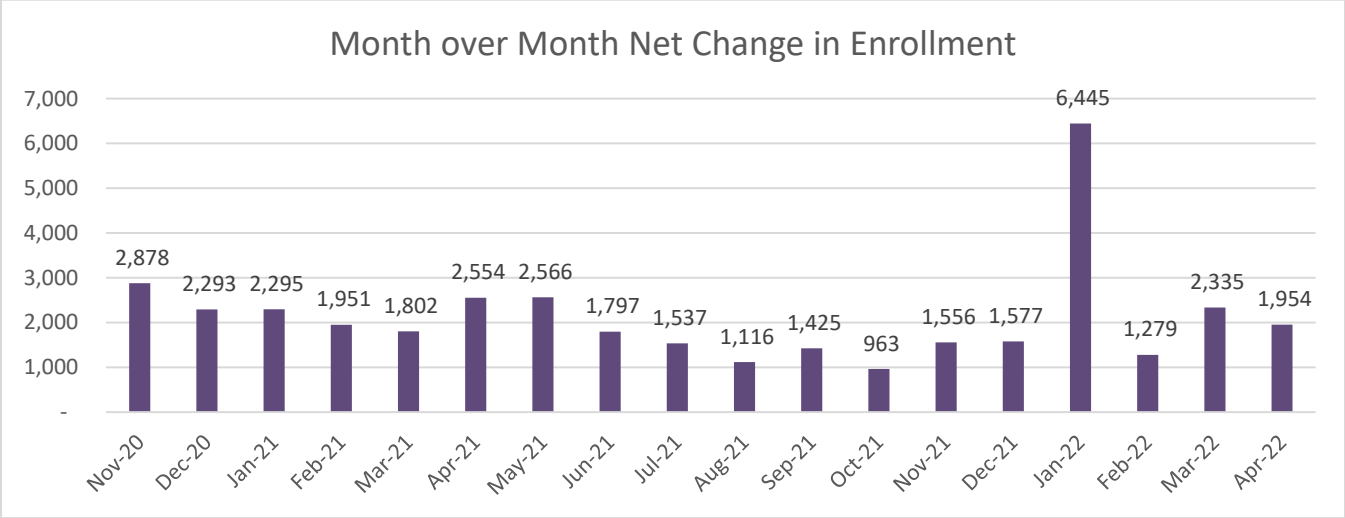






Net Change in Enrollment



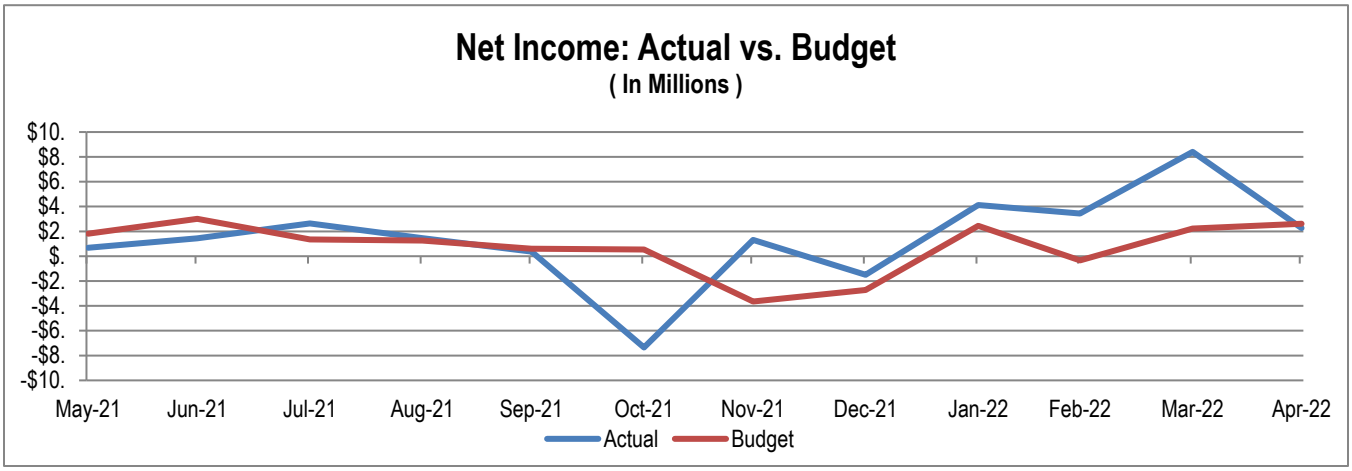


- Total monthly enrollment is projected to continue to increase for the rest of the Fiscal Year. The Public Health Emergency (PHE) is currently expected to be extended through October 2022.

Net Income

- For the month ended April 30th, 2022:
  - Actual Net Income: $2.3 million.
  - Budgeted Net Income: $2.6 million.

- For the fiscal YTD ended April 30th, 2022:
  - Actual Net Income: $15.2 million.
  - Budgeted Net Loss: $2.3 million.

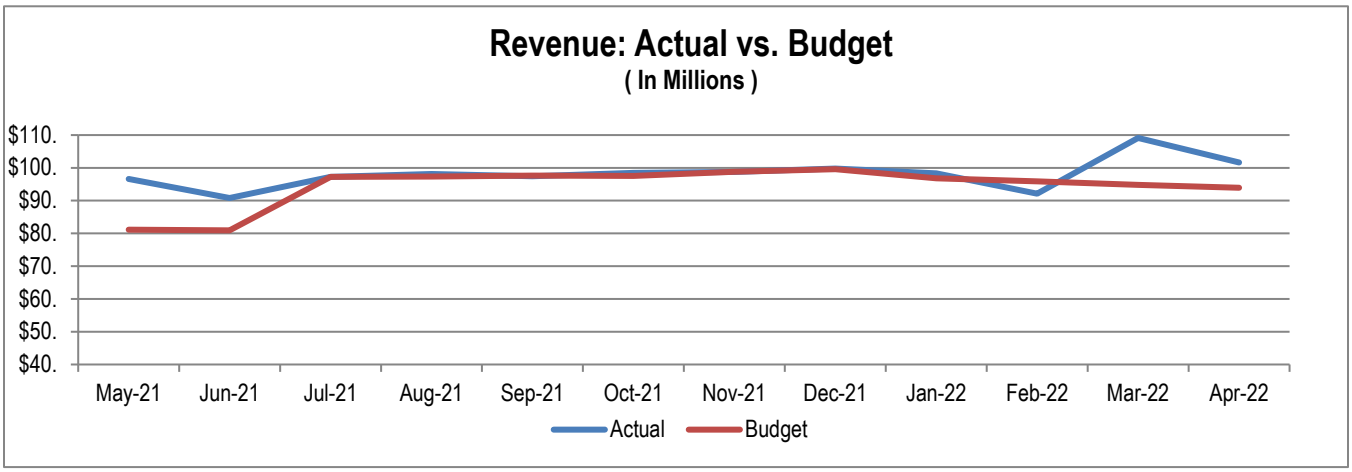


- The unfavorable variance of $343,000 in the current month is primarily due to:
  - Favorable $7.7 million higher than anticipated Revenue.
  - Unfavorable $9.0 million higher than anticipated Medical Expense.
  - Favorable $1.3 million lower than anticipated Administrative Expense.
  - Unfavorable $327,000 lower than anticipated Total Other Income.

Revenue

- For the month ended April 30th, 2022:
  - Actual Revenue: $101.6 million.
  - Budgeted Revenue: $93.9 million.

- For the fiscal YTD ended April 30th, 2022:
  - Actual Revenue: $991.0 million.
  - Budgeted Revenue: $971.1 million.

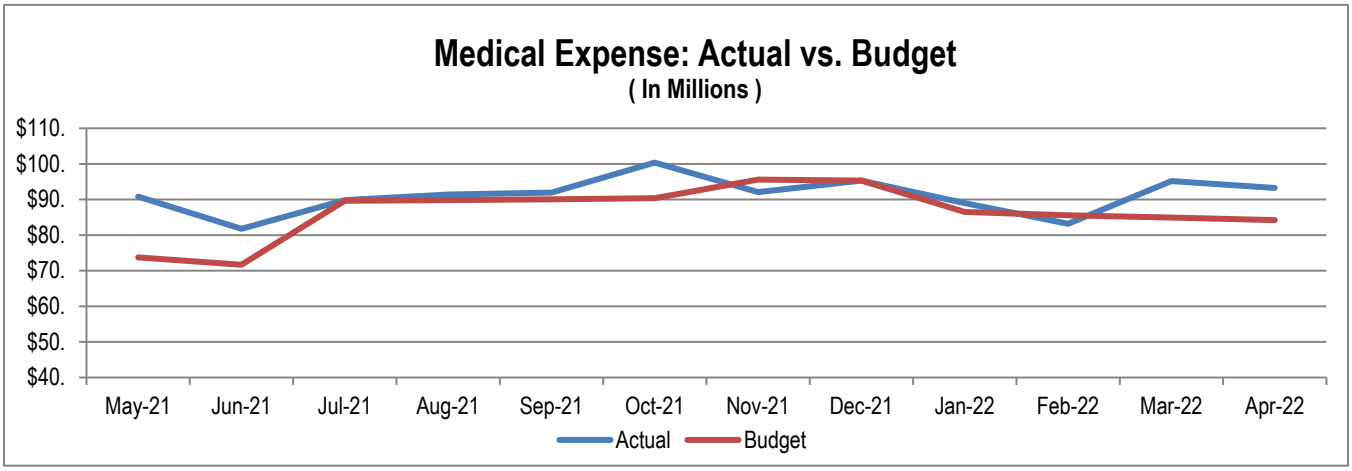


- For the month ended April 30, 2022, the favorable revenue variance of $7.7 million is largely due to $4.1 million favorable Medi-Cal Base Capitation Revenue, largely due to higher enrollment. Additional favorability is due to $1.5 million CalAIM Incentive Revenue, and $1.4 million Behavioral Health Supplemental Revenue.

Medical Expense

- For the month ended April 30th, 2022:
  - Actual Medical Expense: $93.2 million.
  - Budgeted Medical Expense: $84.2 million.

- For the fiscal YTD ended April 30th, 2022:
  - Actual Medical Expense: $921.5 million.
  - Budgeted Medical Expense: $905.7 million.



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

- For April, updates to Fee-For-Service (FFS) increased the estimate for prior period unpaid Medical Expenses by $1.3 million. The estimate for prior years increased by $5.0 million (per table below).

Medical Expense - Actual vs. Budget (In Dollars)

Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$224,163,917	$0	$224,163,917	$222,743,674	($1,420,243)	-0.6%
Primary Care FFS	44,532,523	$34,217	$44,566,739	44,946,775	$414,252	0.9%
Specialty Care FFS	46,776,885	$220,064	$46,996,949	46,599,568	($177,317)	-0.4%
Outpatient FFS	82,033,222	$537,320	$82,570,542	83,476,991	$1,443,769	1.7%
Ancillary FFS	56,850,936	$243,912	$57,094,849	51,283,989	($5,566,947)	-10.9%
Pharmacy FFS	118,528,059	$1,605,742	$120,133,802	114,531,684	($3,996,375)	-3.5%
ER Services FFS	45,314,593	$252,921	$45,567,515	44,488,268	($826,325)	-1.9%
Inpatient Hospital & SNF FFS	277,659,791	$2,072,446	$279,732,237	275,129,377	($2,530,414)	-0.9%
Other Benefits & Services	21,163,790	$0	$21,163,790	21,714,485	$550,695	2.5%
Net Reinsurance	(522,290)	$0	($522,290)	769,181	$1,291,470	167.9%
	$916,501,427	**$4,966,623**	**$921,468,050**	**$905,683,992**	**($10,817,435)**	**-1.2%**

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

Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

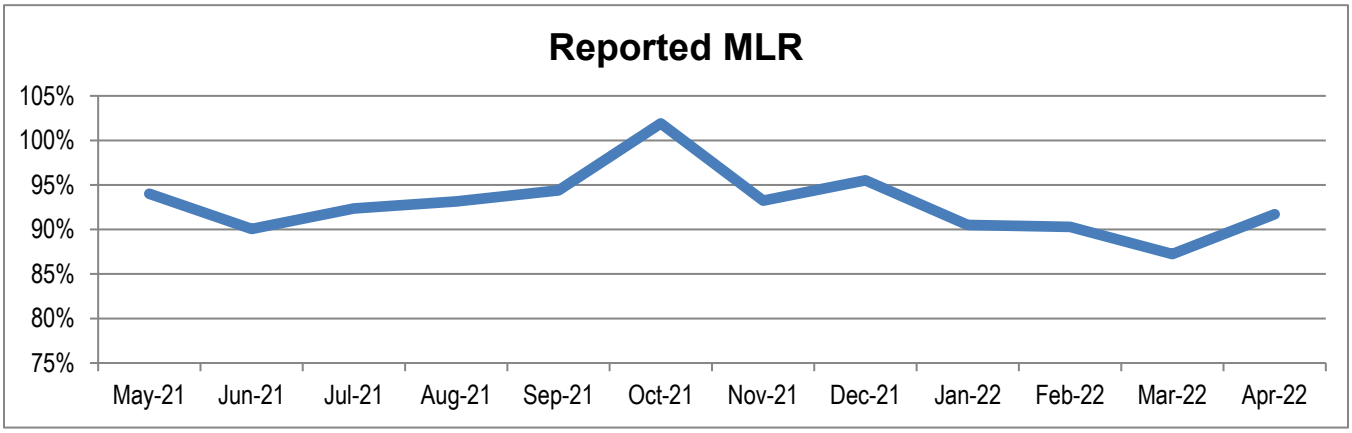
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$75.16	$0.00	$75.16	$75.98	$0.82	1.1%
Primary Care FFS	$14.93	$0.01	$14.94	$15.33	$0.40	2.6%
Specialty Care FFS	$15.68	$0.07	$15.76	$15.90	$0.21	1.3%
Outpatient FFS	$27.50	$0.18	$27.68	$28.47	$0.97	3.4%
Ancillary FFS	$19.06	$0.08	$19.14	$17.49	($1.57)	-9.0%
Pharmacy FFS	$39.74	$0.54	$40.28	$39.07	($0.67)	-1.7%
ER Services FFS	$15.19	$0.08	$15.28	$15.18	($0.02)	-0.1%
Inpatient Hospital & SNF FFS	$93.09	$0.69	$93.79	$93.85	$0.75	0.8%
Other Benefits & Services	$7.10	$0.00	$7.10	$7.41	$0.31	4.2%
Net Reinsurance	($0.18)	$0.00	($0.18)	$0.26	$0.44	166.7%
	$307.29	**$1.67**	**$308.95**	**$308.93**	**$1.65**	**0.5%**

- Excluding the effect of prior year estimates for IBNP, year-to-date medical expense variance is $10.8 million unfavorable to final budget, primarily due to higher enrollment. On a PMPM basis, medical expense is 0.5% favorable to budget. For per-member-per-month expense:
    - Capitated Expense is slightly over budget, with unfavorable global delegate expense and unfavorable BHT Supplemental expense, offset by favorable Maternity Supplemental expense.

- Primary Care Expense is below budget, driven by favorable unit cost in the SPD population and, to a lesser degree, favorable utilization in the ACA OE population.
- Specialty Care is unfavorable compared to budget, generally driven by unfavorable unit cost in the Duals population and unfavorable utilization in SPD population.
- Outpatient Expense is under budget, driven by favorable utilization offset by unfavorable unit cost.
- Ancillary Expense is above budget due to Home Heath, DME, Outpatient Therapy, Laboratory and Radiology, Non-Emergency Transportation, Other Medical Professional, ECM, Community Supports and Ambulance offset by CBAS and Hospice service categories. Overall utilization is unfavorable offset by favorable unit cost.
- Pharmacy Expense is above budget due to unfavorable Non-PBM expense, driven mostly by unfavorable unit cost in the ACA OE, Adult and Group Care populations.
- Emergency Room Expense is unfavorable, due to unfavorable unit cost in the Child population and unfavorable utilization in the ACA OE and SPD populations.
- Inpatient Expense is over budget, driven by unfavorable utilization offset by favorable unit cost.
- Other Benefits & Services are favorable to budget, primarily due to open positions in the Clinical Organization and lower than expected costs in incentive programs, purchased services, supplies and other expenses, partially offset by CalAIM Incentive expenses, which were not included in the Budget.
- Net Reinsurance year-to-date is favorable because more recoveries were received than budgeted.

Medical Loss Ratio (MLR)

- The Medical Loss Ratio (total reported medical expense divided by operating revenue) was 91.7% for the month and 93.0% for the fiscal year-to-date.



Administrative Expense

- For the month ended April 30th, 2022:
  - Actual Administrative Expense: $5.8 million.
  - Budgeted Administrative Expense: $7.1 million.
- For the fiscal YTD ended April 30th, 2022:
  - Actual Administrative Expense: $53.5 million.
  - Budgeted Administrative Expense: $67.8 million.

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

Month					Year-to-Date			
Actual	**Budget**	**Variance $**	**Variance %**		**Actual**	**Budget**	**Variance $**	**Variance %**
$3,065,872	$3,610,519	$544,647	15.1%	Employee Expense	$30,116,420	$33,355,301	$3,238,881	9.7%
313,623	309,503	(4,120)	-1.3%	Medical Benefits Admin Expense	5,286,809	5,293,585	6,776	0.1%
809,950	1,630,466	820,516	50.3%	Purchased & Professional Services	7,059,032	13,054,759	5,995,727	45.9%
1,648,459	1,567,351	(81,108)	-5.2%	Other Admin Expense	11,030,807	16,110,855	5,080,048	31.5%
$5,837,903	$7,117,839	$1,279,935	18.0%	Total Administrative Expense	$53,493,066	$67,814,500	$14,321,432	21.1%

The year-to-date variances include:

- Delayed timing of new project start dates for Consultants, Computer Support Services and Purchased Services.
- Delayed hiring of new employees.
- COVID-19 Vaccination Incentives.

Administrative loss ratio (ALR) represented 5.7% of net revenue for the month and 5.4% of net revenue year-to-date.

Other Income / (Expense)

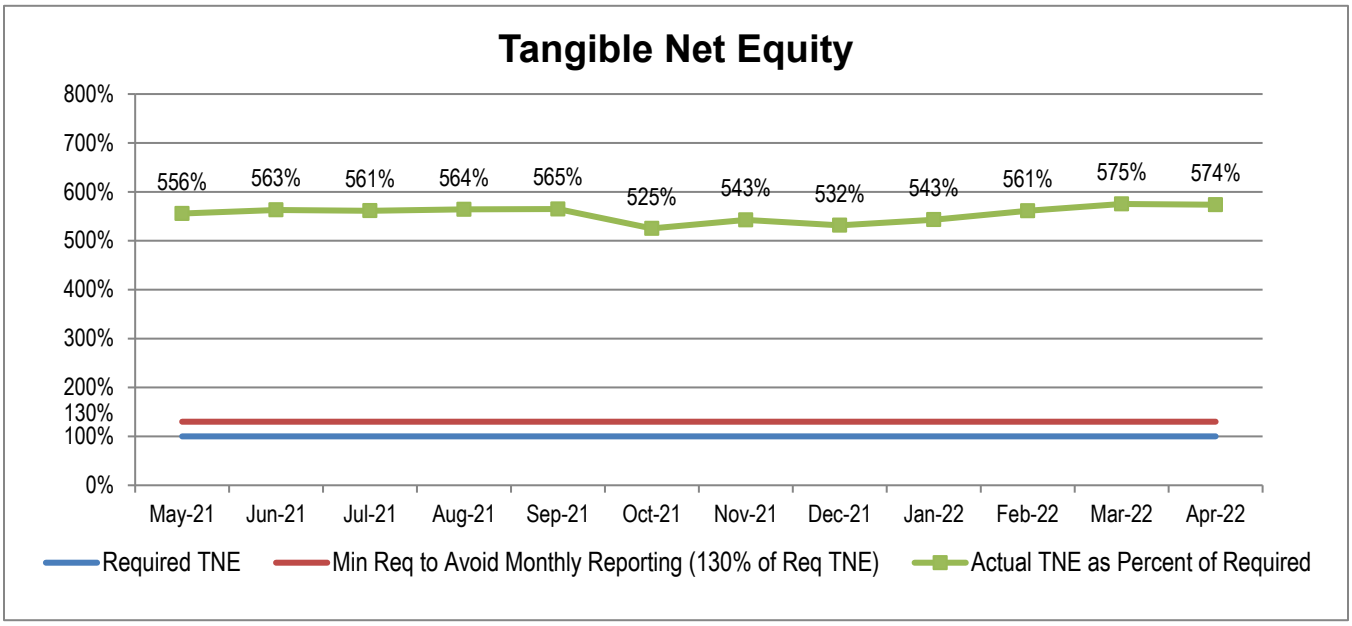
Other Income & Expense is comprised of investment income and claims interest.

- Fiscal year-to-date net investment revenue is $411,000.
- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $337,000.

Tangible Net Equity (TNE)

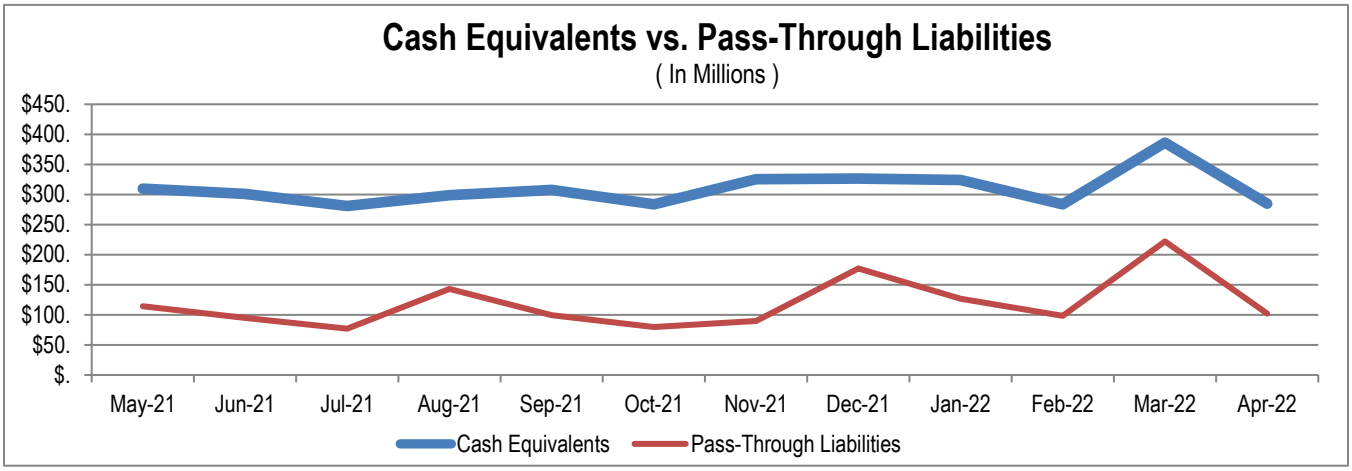
- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to consumers. TNE is a calculation of a company's total tangible assets minus the company's total liabilities. The Alliance exceeds DMHC's required TNE.

- Required TNE $38.5 million
- Actual TNE $220.6 million
- Excess TNE $182.1 million
- TNE % of Required TNE 574%



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

- Key Metrics
  - Cash & Cash Equivalents $284.7 million
  - Pass-Through Liabilities $102.1million
  - Uncommitted Cash $182.6 million
  - Working Capital $176.9 million
  - Current Ratio 1.70 (regulatory minimum is 1.0)



Capital Investment

- Fiscal year-to-date capital assets acquired: $234,000.
- Annual capital budget: $1.4 million.
- A summary of year-to-date capital asset acquisitions is included in this monthly financial statement package.

Caveats to Financial Statements

- We continue to caveat these financial statements that, due to challenges of projecting medical expense and liabilities based on incomplete claims experience, financial results are subject to revision.
- The full set of financial statements and reports are included in the Board of Governors Report. This is a high-level summary of key components of those statements, which are unaudited.

Finance

Supporting Documents

ALAMEDA ALLIANCE FOR HEALTH
STATEMENT OF REVENUE & EXPENSES
ACTUAL VS. BUDGET (WITH MEDICAL EXPENSE BY PAYMENT TYPE)
COMBINED BASIS (RESTRICTED & UNRESTRICTED FUNDS)
FOR THE MONTH AND FISCAL YTD ENDED April 30, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				MEMBERSHIP				
302,913	283,513	19,400	6.8%	1 - Medi-Cal	2,923,969	2,872,904	51,065	1.8%
5,828	5,852	(24)	(0.4%)	2 - Group Care	58,588	58,729	(141)	(0.2%)
308,741	**289,365**	**19,376**	**6.7%**	**3 - Total Member Months**	**2,982,557**	**2,931,633**	**50,924**	**1.7%**
				REVENUE				
$101,645,362	**$93,940,171**	**$7,705,191**	**8.2%**	**4 - TOTAL REVENUE**	**$991,001,541**	**$971,142,675**	**$19,858,866**	**2.0%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses:				
24,065,849	21,828,647	(2,237,202)	(10.2%)	5 - Capitated Medical Expense	224,163,917	222,743,691	(1,420,226)	(0.6%)
				Fee for Service Medical Expenses:				
30,710,458	27,218,346	(3,492,112)	(12.8%)	6 - Inpatient Hospital & SNF FFS Expense	279,732,237	275,129,379	(4,602,858)	(1.7%)
4,669,477	4,488,784	(180,693)	(4.0%)	7 - Primary Care Physician FFS Expense	44,566,739	44,946,772	380,033	0.8%
5,177,455	4,583,886	(593,569)	(12.9%)	8 - Specialty Care Physician Expense	46,996,949	46,599,569	(397,380)	(0.9%)
6,894,611	6,294,259	(600,353)	(9.5%)	9 - Ancillary Medical Expense	57,094,849	51,283,987	(5,810,861)	(11.3%)
9,121,000	8,055,248	(1,065,752)	(13.2%)	10 - Outpatient Medical Expense	82,570,542	83,476,989	906,447	1.1%
4,430,699	4,246,174	(184,525)	(4.3%)	11 - Emergency Expense	45,567,515	44,488,269	(1,079,246)	(2.4%)
6,365,129	5,068,884	(1,296,245)	(25.6%)	12 - Pharmacy Expense	120,133,802	114,531,691	(5,602,111)	(4.9%)
67,368,829	59,955,581	(7,413,248)	(12.4%)	13 - Total Fee for Service Expense	676,662,632	660,456,656	(16,205,976)	(2.5%)
1,832,364	2,303,026	470,662	20.4%	14 - Other Benefits & Services	21,163,790	21,714,470	550,680	2.5%
(45,480)	133,131	178,611	134.2%	15 - Reinsurance Expense	(522,290)	769,181	1,291,471	167.9%
93,221,562	**84,220,385**	**(9,001,178)**	**(10.7%)**	**17 - TOTAL MEDICAL EXPENSES**	**921,468,050**	**905,683,999**	**(15,784,051)**	**(1.7%)**
8,423,799	**9,719,786**	**(1,295,987)**	**(13.3%)**	**18 - GROSS MARGIN**	**69,533,492**	**65,458,676**	**4,074,815**	**6.2%**
				ADMINISTRATIVE EXPENSES				
3,065,872	3,610,519	544,647	15.1%	19 - Personnel Expense	30,116,417	33,355,301	3,238,884	9.7%
313,623	309,503	(4,120)	(1.3%)	20 - Benefits Administration Expense	5,286,811	5,293,585	6,774	0.1%
809,947	1,630,466	820,519	50.3%	21 - Purchased & Professional Services	7,059,035	13,054,759	5,995,724	45.9%
1,648,457	1,567,351	(81,106)	(5.2%)	22 - Other Administrative Expense	11,030,805	16,110,855	5,080,051	31.5%
5,837,899	**7,117,839**	**1,279,940**	**18.0%**	**23 -Total Administrative Expense**	**53,493,067**	**67,814,500**	**14,321,433**	**21.1%**
2,585,900	**2,601,947**	**(16,047)**	**(0.6%)**	**24 - NET OPERATING INCOME / (LOSS)**	**16,040,425**	**(2,355,823)**	**18,396,248**	**780.9%**
				OTHER INCOME / EXPENSE				
(318,397)	**8,751**	**(327,148)**	**(3,738.4%)**	**25 - Total Other Income / (Expense)**	**(864,514)**	**50,191**	**(914,705)**	**(1,822.4%)**
$2,267,503	**$2,610,698**	**($343,195)**	**(13.1%)**	**26 - NET INCOME / (LOSS)**	**$15,175,911**	**($2,305,632)**	**$17,481,543**	**758.2%**
5.7%	7.6%	1.8%	24.2%	27 - Admin Exp % of Revenue	5.4%	7.0%	1.6%	22.7%

ALAMEDA ALLIANCE FOR HEALTH
SUMMARY BALANCE SHEET 2022
CURRENT MONTH VS. PRIOR MONTH
April 30, 2022

	April	March	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	$33,854,888	$37,291,391	($3,436,503)	-9.22%
Short-Term Investments	250,838,515	348,925,042	(98,086,527)	-28.11%
Interest Receivable	263,865	292,168	(28,303)	-9.69%
Other Receivables - Net	137,909,180	150,297,034	(12,387,854)	-8.24%
Prepaid Expenses	5,248,674	5,127,523	121,151	2.36%
Prepaid Inventoried Items	29,325	28,741	584	2.03%
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	**430,981,119**	**544,798,572**	**(113,817,452)**	**-20.89%**
OTHER ASSETS:				
Long-Term Investments	37,634,132	37,987,619	(353,487)	-0.93%
Restricted Assets	350,000	350,000	0	0.00%
TOTAL OTHER ASSETS	**37,984,132**	**38,337,619**	**(353,487)**	**-0.92%**
PROPERTY AND EQUIPMENT:				
Land, Building & Improvements	9,626,797	9,626,797	0	0.00%
Furniture And Equipment	11,540,223	11,540,223	0	0.00%
Leasehold Improvement	902,447	902,447	0	0.00%
Construction in Process	275,666	275,666	0	0.00%
Internally-Developed Software	14,824,002	14,824,002	0	0.00%
Fixed Assets at Cost	37,169,134	37,169,134	0	0.00%
Less: Accumulated Depreciation	(31,483,040)	(31,416,075)	(66,965)	0.21%
NET PROPERTY AND EQUIPMENT	**5,686,094**	**5,753,059**	**(66,965)**	**-1.16%**
TOTAL ASSETS	**$474,651,345**	**$588,889,250**	**($114,237,905)**	**-19.40%**
CURRENT LIABILITIES:				
Accounts Payable	$1,782,148	$3,699,423	($1,917,275)	-51.83%
Pass-Through Liabilities	102,056,923	222,118,231	(120,061,308)	-54.05%
Claims Payable	23,348,554	20,980,727	2,367,827	11.29%
IBNP Reserves	111,998,329	109,069,132	2,929,197	2.69%
Payroll Liabilities	5,657,433	5,458,757	198,677	3.64%
CalPERS Deferred Inflow	859,093	859,093	0	0.00%
Risk Sharing	8,124,932	8,124,932	0	0.00%
Provider Grants/ New Health Program	237,981	260,506	(22,525)	-8.65%
TOTAL CURRENT LIABILITIES	**254,065,392**	**370,570,800**	**(116,505,408)**	**-31.44%**
TOTAL LIABILITIES	**254,065,392**	**370,570,800**	**(116,505,408)**	**-31.44%**
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)	15,175,911	12,908,408	2,267,503	17.57%
TOTAL NET WORTH	**220,585,953**	**218,318,450**	**2,267,503**	**1.04%**
TOTAL LIABILITIES AND NET WORTH	**$474,651,345**	**$588,889,250**	**($114,237,905)**	**-19.40%**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 4/30/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$2,184,778	$6,544,616	$13,068,571	$21,943,497
Total	2,184,778	6,544,616	13,068,571	21,943,497
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	99,363,602	296,184,756	585,560,435	966,850,992
Allowance for Doubtful Accounts	0	0	0	0
Deferred Premium Revenue	0	(200,000)	0	0
Premium Receivable	10,851,860	(12,690,767)	(10,270,108)	(9,789,795)
Total	110,215,462	283,293,989	575,290,327	957,061,197
Investment & Other Income Cash Flows				
Other Revenue (Grants)	64,833	61,734	974,966	2,090,807
Interest Income	(254,104)	(551,203)	(523,411)	(411,445)
Interest Receivable	28,303	(161,070)	(242,538)	(254,294)
Total	(160,968)	(650,539)	209,017	1,425,068
Medical & Hospital Cash Flows				
Total Medical Expenses	(93,221,564)	(271,594,179)	(547,927,216)	(921,468,052)
Other Receivable	1,535,994	1,165,118	1,603,459	8,275,270
Claims Payable	2,367,825	9,197,571	3,482,442	(10,115,716)
IBNP Payable	2,929,197	(3,772,577)	4,596,438	13,357,771
Risk Share Payable	0	0	0	(2,224,917)
Health Program	(22,525)	(42,679)	(154,109)	(213,162)
Other Liabilities	0	0	0	0
Total	(86,411,073)	(265,046,746)	(538,398,986)	(912,388,806)
Administrative Cash Flows				
Total Administrative Expenses	(5,870,045)	(16,530,623)	(33,097,383)	(53,829,890)
Prepaid Expenses	(121,735)	686,436	(618,806)	896,127
CalPERS Pension Asset	0	0	0	0
CalPERS Deferred Outflow	0	0	0	0
Trade Accounts Payable	(1,917,274)	(395,604)	(751,337)	(2,516,992)
Other Accrued Liabilities	0	0	0	0
Payroll Liabilities	198,676	505,155	271,512	891,166
Depreciation Expense	66,966	209,384	449,191	819,699
Total	(7,643,412)	(15,525,252)	(33,746,823)	(53,739,890)
Interest Paid				
Debt Interest Expense	0	0	0	0
Total Cash Flows from Operating Activities	**18,184,787**	**8,616,068**	**16,422,106**	**14,301,066**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 4/30/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	353,487	(23,175,328)	(37,634,132)	(37,634,132)
	353,487	(23,175,328)	(37,634,132)	(37,634,132)
Restricted Cash & Other Asset Cash Flows				
Provider Pass-Thru-Liabilities	(120,061,309)	(24,718,365)	22,429,304	7,224,386
Restricted Cash	0	0	0	0
	(120,061,309)	(24,718,365)	22,429,304	7,224,386
Fixed Asset Cash Flows				
Depreciation expense	66,966	209,384	449,191	819,699
Fixed Asset Acquisitions	0	(121,290)	(121,291)	(233,657)
Change in A/D	(66,966)	(209,384)	(449,191)	(819,699)
	0	(121,290)	(121,291)	(233,657)
Total Cash Flows from Investing Activities	**(119,707,822)**	**(48,014,983)**	**(15,326,119)**	**(30,643,403)**
Financing Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Total Cash Flows	**(101,523,035)**	**(39,398,915)**	**1,095,987**	**(16,342,337)**
Rounding	6	12	12	3
Cash @ Beginning of Period	386,216,432	324,092,306	283,597,404	301,035,737
Cash @ End of Period	**$284,693,403**	**$284,693,403**	**$284,693,403**	**$284,693,403**
Difference (rounding)	0	0	0	0

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 4/30/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$2,267,506	$14,115,113	$18,055,975	$15,175,910
Add back: Depreciation	66,966	209,384	449,191	819,699
Receivables				
Premiums Receivable	10,851,860	(12,690,767)	(10,270,108)	(9,789,795)
First Care Receivable	0	0	0	0
Family Care Receivable	0	0	0	0
Healthy Kids Receivable	0	0	0	0
Interest Receivable	28,303	(161,070)	(242,538)	(254,294)
Other Receivable	1,535,994	1,165,118	1,603,459	8,275,270
FQHC Receivable	0	0	0	0
Allowance for Doubtful Accounts	0	0	0	0
Total	12,416,157	(11,686,719)	(8,909,187)	(1,768,819)
Prepaid Expenses	(121,735)	686,436	(618,806)	896,127
Trade Payables	(1,917,274)	(395,604)	(751,337)	(2,516,992)
Claims Payable, IBNR & Risk Share				
IBNP	2,929,197	(3,772,577)	4,596,438	13,357,771
Claims Payable	2,367,825	9,197,571	3,482,442	(10,115,716)
Risk Share Payable	0	0	0	(2,224,917)
Other Liabilities	0	0	0	0
Total	5,297,022	5,424,994	8,078,880	1,017,138
Unearned Revenue				
Total	0	(200,000)	0	0
Other Liabilities				
Accrued Expenses	0	0	0	0
Payroll Liabilities	198,676	505,155	271,512	891,166
Health Program	(22,525)	(42,679)	(154,109)	(213,162)
Accrued Sub Debt Interest	0	0	0	0
Total Change in Other Liabilities	176,151	462,476	117,403	678,004
Cash Flows from Operating Activities	**$18,184,793**	**$8,616,080**	**$16,422,119**	**$14,301,067**
Difference (rounding)	6	12	13	1

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 4/30/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received From:				
Capitation Received from State of CA	$110,215,462	$283,293,989	$575,290,327	$957,061,197
Commercial Premium Revenue	2,184,778	6,544,616	13,068,571	21,943,497
Other Income	64,833	61,734	974,966	2,090,807
Investment Income	(225,801)	(712,273)	(765,949)	(665,739)
Cash Paid To:				
Medical Expenses	(86,411,073)	(265,046,746)	(538,398,986)	(912,388,806)
Vendor & Employee Expenses	(7,643,412)	(15,525,252)	(33,746,823)	(53,739,890)
Interest Paid	0	0	0	0
Net Cash Provided By (Used In) Operating Activities	18,184,787	8,616,068	16,422,106	14,301,066
Cash Flows from Financing Activities:				
Purchases of Fixed Assets	0	(121,290)	(121,291)	(233,657)
Net Cash Provided By (Used In) Financing Activities	0	(121,290)	(121,291)	(233,657)
Cash Flows from Investing Activities:				
Changes in Investments	353,487	(23,175,328)	(37,634,132)	(37,634,132)
Restricted Cash	(120,061,309)	(24,718,365)	22,429,304	7,224,386
Net Cash Provided By (Used In) Investing Activities	(119,707,822)	(47,893,693)	(15,204,828)	(30,409,746)
Financial Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Net Change in Cash	**(101,523,035)**	**(39,398,915)**	**1,095,987**	**(16,342,337)**
Cash @ Beginning of Period	386,216,432	324,092,306	283,597,404	301,035,737
Subtotal	$284,693,397	$284,693,391	$284,693,391	$284,693,400
Rounding	6	12	12	3
Cash @ End of Period	**$284,693,403**	**$284,693,403**	**$284,693,403**	**$284,693,403**
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	$2,267,506	$14,115,113	$18,055,975	$15,175,910
Depreciation	66,966	209,384	449,191	819,699
Net Change in Operating Assets & Liabilities:				
Premium & Other Receivables	12,416,157	(11,686,719)	(8,909,187)	(1,768,819)
Prepaid Expenses	(121,735)	686,436	(618,806)	896,127
Trade Payables	(1,917,274)	(395,604)	(751,337)	(2,516,992)
Claims payable & IBNP	5,297,022	5,424,994	8,078,880	1,017,138
Deferred Revenue	0	(200,000)	0	0
Accrued Interest	0	0	0	0
Other Liabilities	176,151	462,476	117,403	678,004
Subtotal	18,184,793	8,616,080	16,422,119	14,301,067
Rounding	(6)	(12)	(13)	(1)
Cash Flows from Operating Activities	**$18,184,787**	**$8,616,068**	**$16,422,106**	**$14,301,066**
Rounding Difference	(6)	(12)	(13)	(1)

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF APRIL 2022

	Child	Adult	Medi-Cal SPD	ACA OE	Duals	Medi-Cal Total	Group Care	Grand Total
Enrollment	100,215	45,826	26,848	108,568	21,456	302,913	5,828	308,741
Net Revenue	$13,831,786	$14,732,132	$26,953,551	$39,795,214	$4,147,901	$99,460,584	$2,184,778	$101,645,362
Medical Expense	$11,630,074	$14,173,691	$26,820,644	$34,517,365	$3,809,136	$90,950,910	$2,270,652	$93,221,562
Gross Margin	$2,201,712	$558,441	$132,907	$5,277,849	$338,765	$8,509,674	($85,874)	$8,423,799
Administrative Expense	$473,644	$794,684	$2,044,902	$2,148,868	$186,786	$5,648,884	$189,015	$5,837,899
Operating Income / (Expense)	$1,728,068	($236,244)	($1,911,995)	$3,128,981	$151,979	$2,860,789	($274,889)	$2,585,900
Other Income / (Expense)	($21,070)	($40,588)	($120,805)	($116,567)	($10,142)	($309,171)	($9,226)	($318,397)
Net Income / (Loss)	$1,706,998	($276,831)	($2,032,800)	$3,012,414	$141,837	$2,551,619	($284,116)	$2,267,503
Revenue PMPM	$138.02	$321.48	$1,003.93	$366.55	$193.32	$328.35	$374.88	$329.23
Medical Expense PMPM	$116.05	$309.29	$998.98	$317.93	$177.53	$300.25	$389.61	$301.94
Gross Margin PMPM	$21.97	$12.19	$4.95	$48.61	$15.79	$28.09	($14.73)	$27.28
Administrative Expense PMPM	$4.73	$17.34	$76.17	$19.79	$8.71	$18.65	$32.43	$18.91
Operating Income / (Expense) PMPM	$17.24	($5.16)	($71.22)	$28.82	$7.08	$9.44	($47.17)	$8.38
Other Income / (Expense) PMPM	($0.21)	($0.89)	($4.50)	($1.07)	($0.47)	($1.02)	($1.58)	($1.03)
Net Income / (Loss) PMPM	$17.03	($6.04)	($75.72)	$27.75	$6.61	$8.42	($48.75)	$7.34
Medical Loss Ratio	84.1%	96.2%	99.5%	86.7%	91.8%	91.4%	103.9%	91.7%
Gross Margin Ratio	15.9%	3.8%	0.5%	13.3%	8.2%	8.6%	-3.9%	8.3%
Administrative Expense Ratio	3.4%	5.4%	7.6%	5.4%	4.5%	5.7%	8.7%	5.7%
Net Income Ratio	12.3%	-1.9%	-7.5%	7.6%	3.4%	2.6%	-13.0%	2.2%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE - APRIL 2022

	Child	Adult	Medi-Cal SPD	ACA OE	Duals	Medi-Cal Total	Group Care	Grand Total
Member Months	984,698	432,659	265,185	1,032,643	208,784	2,923,969	58,588	2,982,557
Net Revenue	$126,085,213	$142,890,075	$275,315,256	$386,621,839	$38,144,440	$969,056,824	$21,944,717	$991,001,541
Medical Expense	$109,100,062	$132,737,365	$267,072,831	$359,251,251	$31,730,703	$899,892,212	$21,575,837	$921,468,050
Gross Margin	$16,985,151	$10,152,710	$8,242,426	$27,370,589	$6,413,736	$69,164,612	$368,880	$69,533,492
Administrative Expense	$4,383,397	$7,253,872	$18,701,574	$19,624,042	$1,716,489	$51,679,375	$1,813,692	$53,493,067
Operating Income / (Expense)	$12,601,754	$2,898,838	($10,459,148)	$7,746,546	$4,697,247	$17,485,237	($1,444,812)	$16,040,425
Other Income / (Expense)	($54,775)	($141,372)	($298,537)	($317,781)	($27,538)	($840,004)	($24,510)	($864,514)
Net Income / (Loss)	$12,546,979	$2,757,466	($10,757,685)	$7,428,765	$4,669,708	$16,645,233	($1,469,322)	$15,175,911
Revenue PMPM	$128.04	$330.26	$1,038.20	$374.40	$182.70	$331.42	$374.56	$332.27
Medical Expense PMPM	$110.80	$306.79	$1,007.12	$347.89	$151.98	$307.76	$368.26	$308.95
Gross Margin PMPM	$17.25	$23.47	$31.08	$26.51	$30.72	$23.65	$6.30	$23.31
Administrative Expense PMPM	$4.45	$16.77	$70.52	$19.00	$8.22	$17.67	$30.96	$17.94
Operating Income / (Expense) PMPM	$12.80	$6.70	($39.44)	$7.50	$22.50	$5.98	($24.66)	$5.38
Other Income / (Expense) PMPM	($0.06)	($0.33)	($1.13)	($0.31)	($0.13)	($0.29)	($0.42)	($0.29)
Net Income / (Loss) PMPM	$12.74	$6.37	($40.57)	$7.19	$22.37	$5.69	($25.08)	$5.09
Medical Loss Ratio	86.5%	92.9%	97.0%	92.9%	83.2%	92.9%	98.3%	93.0%
Gross Margin Ratio	13.5%	7.1%	3.0%	7.1%	16.8%	7.1%	1.7%	7.0%
Administrative Expense Ratio	3.5%	5.1%	6.8%	5.1%	4.5%	5.3%	8.3%	5.4%
Net Income Ratio	10.0%	1.9%	-3.9%	1.9%	12.2%	1.7%	-6.7%	1.5%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED April 30, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSE SUMMARY				
$3,065,872	$3,610,519	$544,647	15.1%	Personnel Expenses	$30,116,417	$33,355,301	$3,238,884	9.7%
313,623	309,503	(4,120)	(1.3%)	Benefits Administration Expense	5,286,811	5,293,585	6,774	0.1%
809,947	1,630,466	820,519	50.3%	Purchased & Professional Services	7,059,035	13,054,759	5,995,724	45.9%
207,091	273,839	66,748	24.4%	Occupancy	2,556,497	2,759,669	203,172	7.4%
147,707	253,458	105,751	41.7%	Printing Postage & Promotion	1,854,190	2,163,363	309,173	14.3%
538,767	1,007,958	469,191	46.5%	Licenses Insurance & Fees	5,006,588	6,338,067	1,331,479	21.0%
754,893	32,096	(722,797)	(2,252.0%)	Supplies & Other Expenses	1,613,530	4,849,756	3,236,226	66.7%
2,772,027	3,507,320	735,293	21.0%	Total Other Administrative Expense	23,376,650	34,459,199	11,082,549	32.2%
$5,837,899	**$7,117,839**	**$1,279,940**	**18.0%**	**Total Administrative Expenses**	**$53,493,067**	**$67,814,500**	**$14,321,433**	**21.1%**

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED April 30, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
$2,052,830	$2,219,324	$166,494	7.5%	Salaries & Wages	$19,948,481	$20,638,254	$689,773	3.3%
188,425	244,593	56,168	23.0%	Paid Time Off	2,043,144	2,243,320	200,176	8.9%
1,496	2,645	1,149	43.5%	Incentives	19,158	26,693	7,535	28.2%
0	25,000	25,000	100.0%	Severance Pay	0	150,000	150,000	100.0%
34,827	36,835	2,008	5.5%	Payroll Taxes	401,061	521,190	120,129	23.0%
22,866	15,418	(7,448)	(48.3%)	Overtime	273,497	246,494	(27,003)	(11.0%)
174,730	188,270	13,540	7.2%	CalPERS ER Match	1,579,333	1,691,689	112,356	6.6%
0	0	0	0.0%	Mandated Covid -19 Supplemental Sick Leave	10,398	10,400	2	0.0%
517,638	708,445	190,807	26.9%	Employee Benefits	4,871,552	5,760,464	888,912	15.4%
325	0	(325)	0.0%	Personal Floating Holiday	103,721	112,983	9,262	8.2%
1,082	15,180	14,098	92.9%	Employee Relations	44,830	136,424	91,594	67.1%
7,830	9,572	1,742	18.2%	Work from Home Stipend	71,220	82,600	11,380	13.8%
200	5,441	5,241	96.3%	Transportation Reimbursement	829	12,754	11,925	93.5%
1,515	11,424	9,909	86.7%	Travel & Lodging	3,447	63,033	59,586	94.5%
33,348	59,743	26,395	44.2%	Temporary Help Services	534,396	832,489	298,094	35.8%
21,237	57,257	36,020	62.9%	Staff Development/Training	86,771	434,542	347,771	80.0%
7,523	11,372	3,849	33.8%	Staff Recruitment/Advertising	124,581	391,972	267,391	68.2%
3,065,872	**3,610,519**	**544,647**	**15.1%**	**Total Employee Expenses**	**30,116,417**	**33,355,301**	**3,238,884**	**9.7%**
				Benefit Administration Expense				
20,354	52,099	31,745	60.9%	RX Administration Expense	2,556,400	2,659,511	103,111	3.9%
274,860	240,816	(34,044)	(14.1%)	Behavioral Hlth Administration Fees	2,552,521	2,463,356	(89,165)	(3.6%)
18,409	16,588	(1,821)	(11.0%)	Telemedicine Admin Fees	177,889	170,718	(7,171)	(4.2%)
313,623	**309,503**	**(4,120)**	**(1.3%)**	**Total Employee Expenses**	**5,286,811**	**5,293,585**	**6,774**	**0.1%**
				Purchased & Professional Services				
247,615	375,948	128,333	34.1%	Consulting Services	2,650,759	4,434,868	1,784,109	40.2%
288,932	656,979	368,047	56.0%	Computer Support Services	2,838,206	4,864,621	2,026,414	41.7%
11,584	11,583	(1)	0.0%	Professional Fees-Accounting	131,866	119,822	(12,044)	(10.1%)
0	10	10	100.0%	Professional Fees-Medical	95	60	(35)	(58.7%)
142,264	292,185	149,921	51.3%	Other Purchased Services	452,051	1,496,531	1,044,480	69.8%
0	5,000	5,000	100.0%	Maint.& Repair-Office Equipment	7,696	51,809	44,113	85.1%
62,114	123,340	61,226	49.6%	HMS Recovery Fees	404,854	859,370	454,516	52.9%
0	0	0	0.0%	MIS Software (Non-Capital)	0	250,002	250,002	100.0%
26,624	48,001	21,377	44.5%	Hardware (Non-Capital)	204,969	348,118	143,149	41.1%
13,722	21,492	7,770	36.2%	Provider Relations-Credentialing	126,957	173,698	46,741	26.9%
17,093	95,928	78,835	82.2%	Legal Fees	241,579	455,860	214,281	47.0%
809,947	**1,630,466**	**820,519**	**50.3%**	**Total Purchased & Professional Services**	**7,059,035**	**13,054,759**	**5,995,724**	**45.9%**
				Occupancy				
66,965	92,407	25,442	27.5%	Depreciation	819,700	923,337	103,637	11.2%
69,890	70,286	396	0.6%	Building Lease	704,837	705,233	396	0.1%
3,818	2,006	(1,812)	(90.3%)	Leased and Rented Office Equipment	54,417	20,158	(34,259)	(170.0%)
12,906	14,879	1,973	13.3%	Utilities	124,874	143,557	18,683	13.0%
38,197	71,401	33,205	46.5%	Telephone	709,656	717,807	8,151	1.1%
15,315	22,860	7,545	33.0%	Building Maintenance	143,014	249,577	106,563	42.7%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED April 30, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
$207,091	**$273,839**	**$66,748**	**24.4%**	**Total Occupancy**	**$2,556,497**	**$2,759,669**	**$203,172**	**7.4%**
				Printing Postage & Promotion				
4,913	36,821	31,908	86.7%	Postage	295,769	433,463	137,694	31.8%
1,955	32,000	30,045	93.9%	Design & Layout	26,035	83,888	57,853	69.0%
32,895	44,230	11,336	25.6%	Printing Services	556,550	546,994	(9,556)	(1.7%)
(4,066)	2,500	6,566	262.6%	Mailing Services	32,627	25,894	(6,733)	(26.0%)
3,998	3,225	(773)	(24.0%)	Courier/Delivery Service	41,072	35,578	(5,494)	(15.4%)
319	334	15	4.3%	Pre-Printed Materials and Publications	921	4,937	4,016	81.4%
0	0	0	0.0%	Promotional Products	0	2,500	2,500	100.0%
0	150	150	100.0%	Promotional Services	0	300	300	100.0%
93,280	125,698	32,418	25.8%	Community Relations	726,935	877,175	150,241	17.1%
0	0	0	0.0%	Health Education-Member	(67)	0	67	0.0%
14,414	8,500	(5,914)	(69.6%)	Translation - Non-Clinical	174,349	152,634	(21,715)	(14.2%)
147,707	**253,458**	**105,751**	**41.7%**	**Total Printing Postage & Promotion**	**1,854,190**	**2,163,363**	**309,173**	**14.3%**
				Licenses Insurance & Fees				
0	150,001	150,001	100.0%	Regulatory Penalties	0	250,001	250,001	100.0%
23,676	20,800	(2,876)	(13.8%)	Bank Fees	207,142	206,465	(677)	(0.3%)
61,920	61,377	(543)	(0.9%)	Insurance	616,484	613,768	(2,716)	(0.4%)
368,288	522,008	153,720	29.4%	Licenses, Permits and Fees	3,441,219	4,338,124	896,905	20.7%
84,883	253,772	168,889	66.6%	Subscriptions & Dues	741,743	929,709	187,966	20.2%
538,767	**1,007,958**	**469,191**	**46.5%**	**Total Licenses Insurance & Postage**	**5,006,588**	**6,338,067**	**1,331,479**	**21.0%**
				Supplies & Other Expenses				
2,140	7,283	5,143	70.6%	Office and Other Supplies	44,046	134,522	90,476	67.3%
1,491	12,400	10,909	88.0%	Ergonomic Supplies	22,302	61,679	39,377	63.8%
1,240	7,797	6,557	84.1%	Commissary-Food & Beverage	6,782	33,304	26,522	79.6%
0	0	0	0.0%	Miscellaneous Expense	534	0	(534)	0.0%
0	4,150	4,150	100.0%	Member Incentive Expense	4,850	31,800	26,950	84.7%
750,022	0	(750,022)	0.0%	Covid-19 Vaccination Incentive Expense	1,534,219	4,581,255	3,047,036	66.5%
0	100	100	100.0%	Covid-19 IT Expenses	0	600	600	100.0%
0	366	366	100.0%	Covid-19 Non IT Expenses	797	6,596	5,799	87.9%
754,893	**32,096**	**(722,797)**	**(2,252.0%)**	**Total Supplies & Other Expense**	**1,613,530**	**4,849,756**	**3,236,226**	**66.7%**
$5,837,899	**$7,117,839**	**$1,279,940**	**18.0%**	**TOTAL ADMINISTRATIVE EXPENSE**	**$53,493,067**	**$67,814,500**	**$14,321,433**	**21.1%**

ALAMEDA ALLIANCE FOR HEALTH
CAPITAL SPENDING INCLUDING CONSTRUCTION-IN-PROCESS
ACTUAL VS. BUDGET
FOR THE FISCAL YEAR-TO-DATE ENDED APRIL 30, 2022

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco Network Hardware	IT-FY22-07	$ -	$ -	**$ -**	$ 150,000	$ 150,000
	Cisco UCS Blade	IT-FY22-08	$ -		**$ -**	$ 100,000	$ 100,000
	Veeam Backup	IT-FY22-10	$ -		**$ -**	$ 60,000	$ 60,000
	Call Center Hardware	IT-FY22-11	$ -		**$ -**	$ 100,000	$ 100,000
	Network / AV Cabling	IT-FY22-13	$ -		**$ -**	$ 150,000	$ 150,000
Hardware Subtotal			**$ -**	**$ -**	**$ -**	**$ 560,000**	**$ 560,000**
2. Software:							
	Patch Management	AC-FY22-01	$ -		**$ -**	$ 20,000	$ 20,000
	Zerto Licenses (DR - Replication Orchestration)	AC-FY22-02	$ -		**$ -**	$ 50,000	$ 50,000
	Monitoring Software	AC-FY22-03	$ -		**$ -**	$ 40,000	$ 40,000
	Identity and Access Management (Security)	AC-FY22-04	$ -		**$ -**	$ 40,000	$ 40,000
Software Subtotal			**$ -**	**$ -**	**$ -**	**$ 150,000**	**$ 150,000**
3. Building Improvement:							
	1240 Emergency Generator (carryover from FY21)	FA-FY22-06	**$ 227,316**		**$ 227,316**	$ 360,800	$ 133,484
	1240 Electrical Requirements for EV Charging Stations (est.)	FA-FY22-07	$ -		**$ -**	$ 20,000	$ 20,000
	1240 EV Charging stations installation, fees (est. only)	FA-FY22-08	$ -		**$ -**	$ 50,000	$ 50,000
	1240 Seismic Improvements (carryover from FY21)	FA-FY22-09	$ -		**$ -**	$ 50,000	$ 50,000
	Contingency	FA-FY22-16	**$ 6,341**		**$ 6,341**	$ 100,000	$ 93,659
Building Improvement Subtotal			**$ 233,657**	**$ -**	**$ 233,657**	**$ 580,800**	**$ 347,143**
4. Furniture & Equipment:							
	Replace, reconfigure, re-design workstations/add barriers or plexiglass	FA-FY22-20	$ -		**$ -**	$ 125,000	$ 125,000
Furniture & Equipment Subtotal			**$ -**	**$ -**	**$ -**	**$ 125,000**	**$ 125,000**
GRAND TOTAL			**$ 233,657**	**$ -**	**$ 233,657**	**$ 1,415,800**	**$ 1,182,143**

5. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 4/30/22	**$ 37,169,134**
Fixed Assets @ Cost - 6/30/21	**$ 36,935,477**
Fixed Assets Acquired YTD	**$ 233,657**

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

TANGIBLE NET EQUITY (TNE)	Jul-21	Aug-21	QTR. END Sep-21	Oct-21	Nov-21	QTR. END Dec-21	Jan-22	Feb-22	QTR. END Mar-22	Apr-22
Current Month Net Income / (Loss)	$2,645,613	$1,455,041	$370,178	($7,350,897)	$1,314,900	($1,496,048)	$4,122,017	$3,443,438	$8,404,167	$2,267,503
YTD Net Income / (Loss)	$2,645,613	$4,100,654	$4,470,832	($2,880,065)	($1,565,165)	($3,061,213)	$1,060,804	$4,504,242	$12,908,409	$15,175,912
Actual TNE										
Net Assets	$208,055,654	$209,510,696	$209,880,873	$202,529,977	$203,844,876	$202,348,828	$206,470,845	$209,914,283	$218,318,450	$220,585,953
Subordinated Debt & Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Actual TNE	**$208,055,654**	**$209,510,696**	**$209,880,873**	**$202,529,977**	**$203,844,876**	**$202,348,828**	**$206,470,845**	**$209,914,283**	**$218,318,450**	**$220,585,953**
Increase/(Decrease) in Actual TNE	$3,467,237	$1,455,042	$370,177	($7,350,896)	$1,314,899	($1,496,048)	$4,122,017	$3,443,438	$8,404,167	$2,267,503
Required TNE[1]	**$37,061,269**	**$37,134,762**	**$37,155,961**	**$38,560,140**	**$37,568,385**	**$38,067,278**	**$38,019,954**	**$37,402,476**	**$37,954,630**	**$38,456,012**
Min. Req'd to Avoid Monthly Reporting (130% of Required TNE)	$48,179,650	$48,275,191	$48,302,749	$50,128,181	$48,838,900	$49,487,461	$49,425,940	$48,623,218	$49,341,019	$49,992,815
TNE Excess / (Deficiency)	$170,994,385	$172,375,934	$172,724,912	$163,969,837	$166,276,491	$164,281,550	$168,450,891	$172,511,807	$180,363,820	$182,129,941
Actual TNE as a Multiple of Required	**5.61**	**5.64**	**5.65**	**5.25**	**5.43**	**5.32**	**5.43**	**5.61**	**5.75**	**5.74**

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	$209,880,873	$202,529,977	$203,844,876	$202,348,828	$206,470,845	$209,914,283	$218,318,450	$220,585,953
Fixed Assets at Net Book Value	(6,161,088)	(6,073,778)	(6,093,339)	(6,013,994)	(5,931,375)	(5,851,942)	(5,774,186)	(5,821,605)	(5,753,060)	(5,686,094)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$201,544,566**	**$203,086,918**	**$203,437,534**	**$196,165,983**	**$197,563,501**	**$196,146,886**	**$200,346,659**	**$203,742,678**	**$212,215,390**	**$214,549,859**
Liquid TNE as Multiple of Required	**5.44**	**5.47**	**5.48**	**5.09**	**5.26**	**5.15**	**5.27**	**5.45**	**5.59**	**5.58**

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

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

	Actual Jul-21	Actual Aug-21	Actual Sep-21	Actual Oct-21	Actual Nov-21	Actual Dec-21	Actual Jan-22	Actual Feb-22	Actual Mar-22	Actual Apr-22	Actual May-22	Actual Jun-22	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	97,179	97,324	97,460	97,636	97,935	98,150	99,337	99,573	99,889	100,215			984,698
Adult	41,358	41,519	41,924	42,177	42,623	43,077	44,340	44,588	45,227	45,826			432,659
SPD	26,320	26,316	26,330	26,366	26,427	26,450	26,633	26,675	26,820	26,848			265,185
ACA OE	99,105	99,783	100,469	100,844	101,508	102,264	105,897	106,553	107,652	108,568			1,032,643
Duals	20,194	20,388	20,535	20,692	20,832	20,964	21,135	21,239	21,349	21,456			208,784
Medi-Cal Program	284,156	285,330	286,718	287,715	289,325	290,905	297,342	298,628	300,937	302,913			2,923,969
Group Care Program	5,935	5,877	5,914	5,880	5,826	5,823	5,831	5,824	5,850	5,828			58,588
Total	**290,091**	**291,207**	**292,632**	**293,595**	**295,151**	**296,728**	**303,173**	**304,452**	**306,787**	**308,741**			**2,982,557**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	131	145	136	176	299	215	1,187	236	316	326			3,167
Adult	392	161	405	253	446	454	1,263	248	639	599			4,860
SPD	(3)	(4)	14	36	61	23	183	42	145	28			525
ACA OE	824	678	686	375	664	756	3,633	656	1,099	916			10,287
Duals	206	194	147	157	140	132	171	104	110	107			1,468
Medi-Cal Program	1,550	1,174	1,388	997	1,610	1,580	6,437	1,286	2,309	1,976			20,307
Group Care Program	(13)	(58)	37	(34)	(54)	(3)	8	(7)	26	(22)			(120)
Total	**1,537**	**1,116**	**1,425**	**963**	**1,556**	**1,577**	**6,445**	**1,279**	**2,335**	**1,954**			**20,187**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	34.2%	34.1%	34.0%	33.9%	33.8%	33.7%	33.4%	33.3%	33.2%	33.1%			33.7%
Adult % of Medi-Cal	14.6%	14.6%	14.6%	14.7%	14.7%	14.8%	14.9%	14.9%	15.0%	15.1%			14.8%
SPD % of Medi-Cal	9.3%	9.2%	9.2%	9.2%	9.1%	9.1%	9.0%	8.9%	8.9%	8.9%			9.1%
ACA OE % of Medi-Cal	34.9%	35.0%	35.0%	35.0%	35.1%	35.2%	35.6%	35.7%	35.8%	35.8%			35.3%
Duals % of Medi-Cal	7.1%	7.1%	7.2%	7.2%	7.2%	7.2%	7.1%	7.1%	7.1%	7.1%			7.1%
Medi-Cal Program % of Total	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.1%	98.1%	98.1%	98.1%			98.0%
Group Care Program % of Total	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	1.9%	1.9%	1.9%	1.9%			2.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**			**100.0%**

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

	Actual Jul-21	Actual Aug-21	Actual Sep-21	Actual Oct-21	Actual Nov-21	Actual Dec-21	Actual Jan-22	Actual Feb-22	Actual Mar-22	Actual Apr-22	Actual May-22	Actual Jun-22	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	53,189	53,441	53,246	53,081	53,438	52,288	57,046	51,053	51,767	51,662			530,211
Alameda Health System	58,045	57,812	58,060	58,049	58,073	58,590	58,927	60,699	60,974	61,442			590,671
	111,234	111,253	111,306	111,130	111,511	110,878	115,973	111,752	112,741	113,104			1,120,882
Delegated:													
CFMG	32,217	32,167	32,217	32,232	32,266	32,573	32,689	33,319	33,293	33,333			326,306
CHCN	104,433	105,113	106,050	106,808	107,583	109,059	109,878	114,264	115,125	116,169			1,094,482
Kaiser	42,207	42,674	43,059	43,425	43,791	44,218	44,633	45,117	45,628	46,135			440,887
Delegated Subtotal	178,857	179,954	181,326	182,465	183,640	185,850	187,200	192,700	194,046	195,637			1,861,675
Total	**290,091**	**291,207**	**292,632**	**293,595**	**295,151**	**296,728**	**303,173**	**304,452**	**306,787**	**308,741**			**2,982,557**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(24)	19	53	(176)	381	(633)	5,095	(4,221)	989	363			1,846
Delegated:													
CFMG	20	(50)	50	15	34	307	116	630	(26)	40			1,136
CHCN	1,094	680	937	758	775	1,476	819	4,386	861	1,044			12,830
Kaiser	447	467	385	366	366	427	415	484	511	507			4,375
Delegated Subtotal	1,561	1,097	1,372	1,139	1,175	2,210	1,350	5,500	1,346	1,591			18,341
Total	**1,537**	**1,116**	**1,425**	**963**	**1,556**	**1,577**	**6,445**	**1,279**	**2,335**	**1,954**			**20,187**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	38.3%	38.2%	38.0%	37.9%	37.8%	37.4%	38.3%	36.7%	36.7%	36.6%			37.6%
Delegated:													
CFMG	11.1%	11.0%	11.0%	11.0%	10.9%	11.0%	10.8%	10.9%	10.9%	10.8%			10.9%
CHCN	36.0%	36.1%	36.2%	36.4%	36.5%	36.8%	36.2%	37.5%	37.5%	37.6%			36.7%
Kaiser	14.5%	14.7%	14.7%	14.8%	14.8%	14.9%	14.7%	14.8%	14.9%	14.9%			14.8%
Delegated Subtotal	61.7%	61.8%	62.0%	62.1%	62.2%	62.6%	61.7%	63.3%	63.3%	63.4%			62.4%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**			**100.0%**

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

	Budget Jul-21	Budget Aug-21	Budget Sep-21	Budget Oct-21	Budget Nov-21	Budget Dec-21	Budget Jan-22	Budget Feb-22	Budget Mar-22	Budget Apr-22	Budget May-22	Budget Jun-22	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	97,179	97,324	97,460	97,636	97,812	97,988	99,591	98,621	97,661	96,710	95,743	94,811	1,168,536
Adult	41,358	41,519	41,924	42,177	42,430	42,683	43,156	42,733	42,315	41,901	41,482	41,076	504,754
SPD	26,320	26,316	26,330	26,366	26,402	26,438	26,467	26,220	25,976	25,734	26,997	26,745	316,311
ACA OE	99,105	99,783	100,469	100,844	101,219	101,594	101,787	100,845	99,913	98,990	104,404	103,436	1,212,389
Duals	20,194	20,388	20,535	20,692	20,849	21,006	20,796	20,588	20,382	20,178	19,976	19,776	245,360
Medi-Cal Program	284,156	285,330	286,718	287,715	288,712	289,709	291,797	289,007	286,247	283,513	288,602	285,844	3,447,350
Group Care Program	5,935	5,877	5,914	5,880	5,863	5,852	5,852	5,852	5,852	5,852	5,852	5,852	70,433
Total	**290,091**	**291,207**	**292,632**	**293,595**	**294,575**	**295,561**	**297,649**	**294,859**	**292,099**	**289,365**	**294,454**	**291,696**	**3,517,783**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(346)	145	136	176	176	176	1,603	(970)	(960)	(951)	(967)	(932)	(2,714)
Adult	1,053	161	405	253	253	253	473	(423)	(418)	(414)	(419)	(406)	771
SPD	122	(4)	14	36	36	36	29	(247)	(244)	(242)	1,263	(252)	547
ACA OE	3,254	678	686	375	375	375	193	(942)	(932)	(923)	5,414	(968)	7,585
Duals	676	194	147	157	157	157	(210)	(208)	(206)	(204)	(202)	(200)	258
Medi-Cal Program	4,760	1,174	1,388	997	997	997	2,088	(2,790)	(2,760)	(2,734)	5,089	(2,758)	6,448
Group Care Program	(74)	(58)	37	(34)	(17)	(11)	0	0	0	0	0	0	(157)
Total	**4,686**	**1,116**	**1,425**	**963**	**980**	**986**	**2,088**	**(2,790)**	**(2,760)**	**(2,734)**	**5,089**	**(2,758)**	**6,291**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	34.2%	34.1%	34.0%	33.9%	33.9%	33.8%	34.1%	34.1%	34.1%	34.1%	33.2%	33.2%	33.9%
Adult % of Medi-Cal	14.6%	14.6%	14.6%	14.7%	14.7%	14.7%	14.8%	14.8%	14.8%	14.8%	14.4%	14.4%	14.6%
SPD % of Medi-Cal	9.3%	9.2%	9.2%	9.2%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%	9.4%	9.4%	9.2%
ACA OE % of Medi-Cal	34.9%	35.0%	35.0%	35.0%	35.1%	35.1%	34.9%	34.9%	34.9%	34.9%	36.2%	36.2%	35.2%
Duals % of Medi-Cal	7.1%	7.1%	7.2%	7.2%	7.2%	7.3%	7.1%	7.1%	7.1%	7.1%	6.9%	6.9%	7.1%
Medi-Cal Program % of Total	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%
Group Care Program % of Total	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

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

	Budget Jul-21	Budget Aug-21	Budget Sep-21	Budget Oct-21	Budget Nov-21	Budget Dec-21	Budget Jan-22	Budget Feb-22	Budget Mar-22	Budget Apr-22	Budget May-22	Budget Jun-22	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted	111,234	111,253	111,306	111,130	111,539	111,951	112,449	111,411	110,386	109,370	112,142	111,106	1,335,277
Delegated:													
CFMG	32,217	32,167	32,217	32,232	32,294	32,356	32,848	32,529	32,214	31,902	31,716	31,408	386,100
CHCN	104,433	105,113	106,050	106,808	107,165	107,525	108,250	107,240	106,240	105,250	107,230	106,231	1,277,535
Kaiser	42,207	42,674	43,059	43,425	43,577	43,729	44,102	43,679	43,259	42,843	43,366	42,951	518,871
Delegated Subtotal	178,857	179,954	181,326	182,465	183,036	183,610	185,200	183,448	181,713	179,995	182,312	180,590	2,182,506
Total	**290,091**	**291,207**	**292,632**	**293,595**	**294,575**	**295,561**	**297,649**	**294,859**	**292,099**	**289,365**	**294,454**	**291,696**	**3,517,783**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(81)	19	53	(176)	409	412	498	(1,038)	(1,025)	(1,016)	2,772	(1,036)	(209)
Delegated:													
CFMG	(159)	(50)	50	15	62	62	492	(319)	(315)	(312)	(186)	(308)	(968)
CHCN	1,533	680	937	758	357	360	725	(1,010)	(1,000)	(990)	1,980	(999)	3,331
Kaiser	3,394	467	385	366	152	152	373	(423)	(420)	(416)	523	(415)	4,138
Delegated Subtotal	4,768	1,097	1,372	1,139	571	574	1,590	(1,752)	(1,735)	(1,718)	2,317	(1,722)	6,501
Total	**4,686**	**1,116**	**1,425**	**963**	**980**	**986**	**2,088**	**(2,790)**	**(2,760)**	**(2,734)**	**5,089**	**(2,758)**	**6,291**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	38.3%	38.2%	38.0%	37.9%	37.9%	37.9%	37.8%	37.8%	37.8%	37.8%	38.1%	38.1%	38.0%
Delegated:													
CFMG	11.1%	11.0%	11.0%	11.0%	11.0%	10.9%	11.0%	11.0%	11.0%	11.0%	10.8%	10.8%	11.0%
CHCN	36.0%	36.1%	36.2%	36.4%	36.4%	36.4%	36.4%	36.4%	36.4%	36.4%	36.4%	36.4%	36.3%
Kaiser	14.5%	14.7%	14.7%	14.8%	14.8%	14.8%	14.8%	14.8%	14.8%	14.8%	14.7%	14.7%	14.7%
Delegated Subtotal	61.7%	61.8%	62.0%	62.1%	62.1%	62.1%	62.2%	62.2%	62.2%	62.2%	61.9%	61.9%	62.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

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

	Variance Jul-21	Variance Aug-21	Variance Sep-21	Variance Oct-21	Variance Nov-21	Variance Dec-21	Variance Jan-22	Variance Feb-22	Variance Mar-22	Variance Apr-22	Variance May-22	Variance Jun-22	Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	0	0	0	0	123	162	(254)	952	2,228	3,505			6,716
Adult	0	0	0	0	193	394	1,184	1,855	2,912	3,925			10,463
SPD	0	0	0	0	25	12	166	455	844	1,114			2,616
ACA OE	0	0	0	0	289	670	4,110	5,708	7,739	9,578			28,094
Duals	0	0	0	0	(17)	(42)	339	651	967	1,278			3,176
Medi-Cal Program	0	0	0	0	613	1,196	5,545	9,621	14,690	19,400			51,065
Group Care Program	0	0	0	0	(37)	(29)	(21)	(28)	(2)	(24)			(141)
Total	**0**	**0**	**0**	**0**	**576**	**1,167**	**5,524**	**9,593**	**14,688**	**19,376**			**50,924**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted	0	0	0	0	(28)	(1,073)	3,524	341	2,355	3,734			8,853
Delegated:													
CFMG	0	0	0	0	(28)	217	(159)	790	1,079	1,431			3,330
CHCN	0	0	0	0	418	1,534	1,628	7,024	8,885	10,919			30,408
Kaiser	0	0	0	0	214	489	531	1,438	2,369	3,292			8,333
Delegated Subtotal	0	0	0	0	604	2,240	2,000	9,252	12,333	15,642			42,071
Total	**0**	**0**	**0**	**0**	**576**	**1,167**	**5,524**	**9,593**	**14,688**	**19,376**			**50,924**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED April 30, 2022

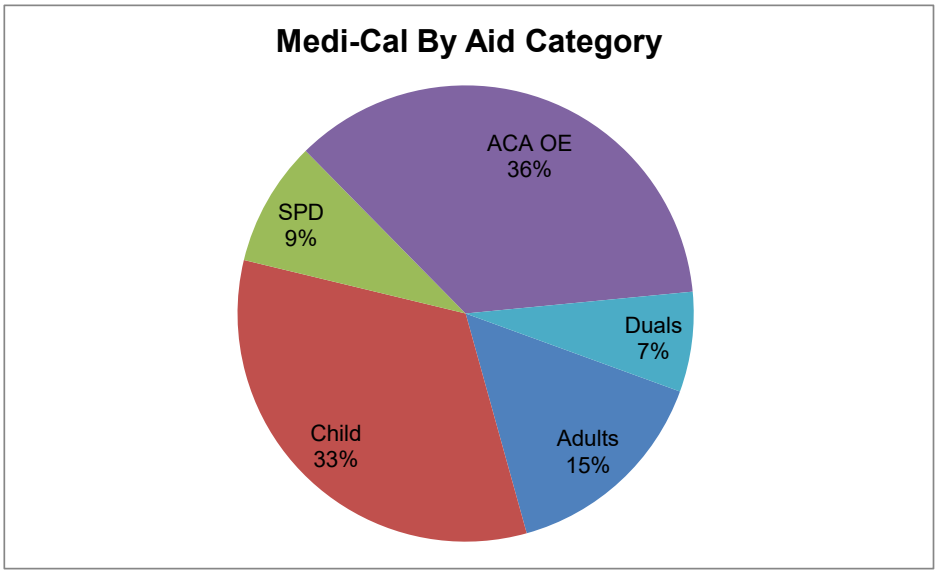
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES:				
$1,131,298	$1,800,329	$669,031	37.2%	PCP-Capitation	$11,085,866	$18,451,701	$7,365,835	39.9%
4,037,653	3,123,361	(914,292)	(29.3%)	PCP-Capitation - FQHC	38,383,250	30,537,480	(7,845,770)	(25.7%)
289,788	269,275	(20,513)	(7.6%)	Specialty-Capitation	2,833,765	2,771,863	(61,902)	(2.2%)
3,365,754	3,263,443	(102,311)	(3.1%)	Specialty-Capitation FQHC	31,830,129	31,833,821	3,692	0.0%
381,900	358,875	(23,025)	(6.4%)	Laboratory-Capitation	3,698,741	3,636,546	(62,195)	(1.7%)
927,702	868,095	(59,607)	(6.9%)	Transportation (Ambulance)-Cap	9,299,141	8,888,707	(410,434)	(4.6%)
225,282	211,793	(13,489)	(6.4%)	Vision Cap	2,181,825	2,147,523	(34,302)	(1.6%)
84,410	78,452	(5,958)	(7.6%)	CFMG Capitation	825,677	807,622	(18,055)	(2.2%)
169,354	163,980	(5,374)	(3.3%)	Anc IPA Admin Capitation FQHC	1,603,270	1,601,353	(1,917)	(0.1%)
10,532,245	9,897,586	(634,659)	(6.4%)	Kaiser Capitation	105,662,199	104,826,704	(835,495)	(0.8%)
2,085,456	750,249	(1,335,207)	(178.0%)	BHT Supplemental Expense	7,910,747	7,371,124	(539,623)	(7.3%)
0	0	0	0.0%	Hep-C Supplemental Expense	102,679	100,877	(1,802)	(1.8%)
277,683	478,714	201,031	42.0%	Maternity Supplemental Expense	3,276,021	4,154,754	878,733	21.2%
557,325	564,495	7,170	1.3%	DME - Cap	5,470,608	5,613,616	143,008	2.5%
24,065,849	**21,828,647**	**(2,237,202)**	**(10.2%)**	**5-TOTAL CAPITATED EXPENSES**	**224,163,917**	**222,743,691**	**(1,420,226)**	**(0.6%)**
				FEE FOR SERVICE MEDICAL EXPENSES:				
1,352,106	0	(1,352,106)	0.0%	IBNP-Inpatient Services	7,085,059	0	(7,085,059)	0.0%
40,563	0	(40,563)	0.0%	IBNP-Settlement (IP)	212,547	0	(212,547)	0.0%
108,167	0	(108,167)	0.0%	IBNP-Claims Fluctuation (IP)	566,800	0	(566,800)	0.0%
25,977,483	25,929,054	(48,429)	(0.2%)	Inpatient Hospitalization-FFS	238,099,418	267,310,143	29,210,725	10.9%
1,033,635	0	(1,033,635)	0.0%	IP OB - Mom & NB	12,106,083	0	(12,106,083)	0.0%
299,293	0	(299,293)	0.0%	IP Behavioral Health	2,350,884	0	(2,350,884)	0.0%
878,114	1,289,292	411,178	31.9%	IP - Long Term Care	10,914,886	7,819,236	(3,095,650)	(39.6%)
1,021,097	0	(1,021,097)	0.0%	IP - Facility Rehab FFS	8,396,560	0	(8,396,560)	0.0%
30,710,458	**27,218,346**	**(3,492,112)**	**(12.8%)**	**6-Inpatient Hospital & SNF FFS Expense**	**279,732,237**	**275,129,379**	**(4,602,858)**	**(1.7%)**
111,696	0	(111,696)	0.0%	IBNP-PCP	(139,152)	0	139,152	0.0%
3,350	0	(3,350)	0.0%	IBNP-Settlement (PCP)	(4,172)	0	4,172	0.0%
8,936	0	(8,936)	0.0%	IBNP-Claims Fluctuation (PCP)	(11,129)	0	11,129	0.0%
0	0	0	0.0%	Telemedicine FFS	8,820	0	(8,820)	0.0%
1,157,003	1,295,160	138,157	10.7%	Primary Care Non-Contracted FF	11,923,665	25,569,009	13,645,345	53.4%
47,214	80,047	32,833	41.0%	PCP FQHC FFS	505,221	486,289	(18,932)	(3.9%)
1,914,833	3,113,577	1,198,744	38.5%	Prop 56 Direct Payment Expenses	18,491,228	18,891,474	400,246	2.1%
13,612	0	(13,612)	0.0%	Prop 56 Hyde Direct Payment Expenses	53,529	0	(53,529)	0.0%
76,109	0	(76,109)	0.0%	Prop 56-Trauma Expense	754,520	0	(754,520)	0.0%
98,195	0	(98,195)	0.0%	Prop 56-Dev. Screening Exp.	990,617	0	(990,617)	0.0%
659,232	0	(659,232)	0.0%	Prop 56-Fam. Planning Exp.	6,423,722	0	(6,423,722)	0.0%
579,299	0	(579,299)	0.0%	Prop 56-Value Based Purchasing	5,569,872	0	(5,569,872)	0.0%
4,669,477	**4,488,784**	**(180,693)**	**(4.0%)**	**7-Primary Care Physician FFS Expense**	**44,566,739**	**44,946,772**	**380,033**	**0.8%**
400,681	0	(400,681)	0.0%	IBNP-Specialist	482,054	0	(482,054)	0.0%
2,536,000	4,579,027	2,043,027	44.6%	Specialty Care-FFS	24,401,425	46,569,972	22,168,547	47.6%
269,769	0	(269,769)	0.0%	Anesthesiology - FFS	1,283,238	0	(1,283,238)	0.0%
786,852	0	(786,852)	0.0%	Spec Rad Therapy - FFS	7,551,420	0	(7,551,420)	0.0%
107,770	0	(107,770)	0.0%	Obstetrics-FFS	1,124,062	0	(1,124,062)	0.0%
204,680	0	(204,680)	0.0%	Spec IP Surgery - FFS	2,662,587	0	(2,662,587)	0.0%
457,952	0	(457,952)	0.0%	Spec OP Surgery - FFS	5,170,630	0	(5,170,630)	0.0%
329,047	0	(329,047)	0.0%	Spec IP Physician	3,838,343	0	(3,838,343)	0.0%
40,629	4,859	(35,770)	(736.2%)	SCP FQHC FFS	430,165	29,597	(400,568)	(1,353.4%)
12,020	0	(12,020)	0.0%	IBNP-Settlement (SCP)	14,460	0	(14,460)	0.0%
32,054	0	(32,054)	0.0%	IBNP-Claims Fluctuation (SCP)	38,564	0	(38,564)	0.0%
5,177,455	**4,583,886**	**(593,569)**	**(12.9%)**	**8-Specialty Care Physician Expense**	**46,996,949**	**46,599,569**	**(397,380)**	**(0.9%)**
513,082	0	(513,082)	0.0%	IBNP-Ancillary	1,711,489	0	(1,711,489)	0.0%
15,393	0	(15,393)	0.0%	IBNP Settlement (ANC)	51,346	0	(51,346)	0.0%
41,046	0	(41,046)	0.0%	IBNP Claims Fluctuation (ANC)	136,918	0	(136,918)	0.0%
433,574	0	(433,574)	0.0%	Acupuncture/Biofeedback	4,358,586	0	(4,358,586)	0.0%
105,050	0	(105,050)	0.0%	Hearing Devices	963,745	0	(963,745)	0.0%
30,073	0	(30,073)	0.0%	Imaging/MRI/CT Global	324,241	0	(324,241)	0.0%
54,726	0	(54,726)	0.0%	Vision FFS	484,957	0	(484,957)	0.0%
25,275	0	(25,275)	0.0%	Family Planning	230,489	0	(230,489)	0.0%
961,186	0	(961,186)	0.0%	Laboratory-FFS	7,972,938	0	(7,972,938)	0.0%
110,120	0	(110,120)	0.0%	ANC Therapist	958,408	0	(958,408)	0.0%
0	0	0	0.0%	ANC Diagnostic Procedures	(166)	0	166	0.0%
266,642	0	(266,642)	0.0%	Transportation (Ambulance)-FFS	2,946,372	0	(2,946,372)	0.0%
138,971	0	(138,971)	0.0%	Transportation (Other)-FFS	1,266,593	0	(1,266,593)	0.0%
369,948	0	(369,948)	0.0%	Hospice	5,090,068	0	(5,090,068)	0.0%
482,936	0	(482,936)	0.0%	Home Health Services	6,402,840	0	(6,402,840)	0.0%
0	3,391,565	3,391,565	100.0%	Other Medical-FFS	0	38,435,311	38,435,311	100.0%

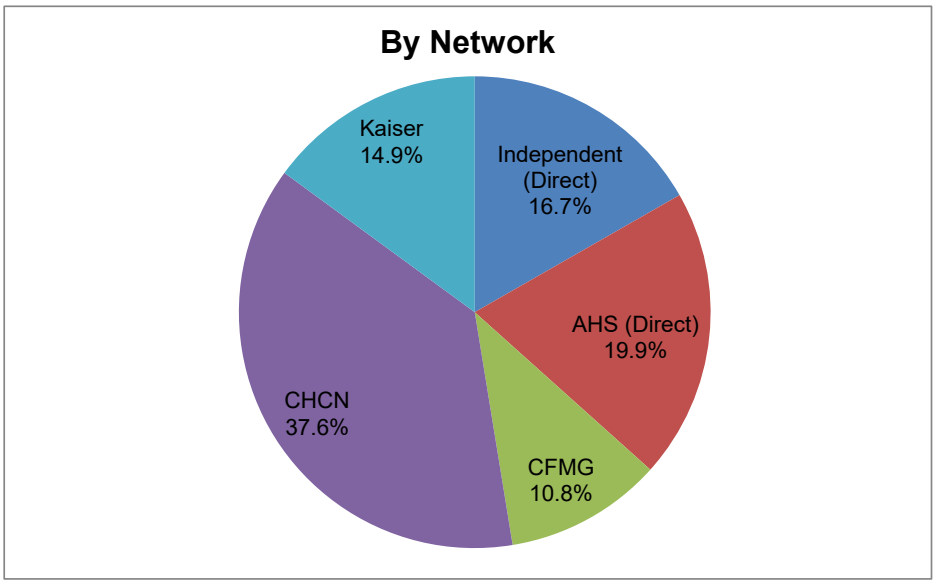
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED April 30, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
($147,455)	$0	$147,455	0.0%	HMS Medical Refunds	($407,562)	$0	$407,562	0.0%
(75)	0	75	0.0%	Refunds-Medical Payments	0	0	0	0.0%
423,413	0	(423,413)	0.0%	DME & Medical Supplies	4,706,999	0	(4,706,999)	0.0%
0	0	0	0.0%	Denials	167	0	(167)	0.0%
120,127	575,882	455,755	79.1%	GEMT Direct Payment Expense	5,485,382	3,504,085	(1,981,297)	(56.5%)
430,458	0	(430,458)	0.0%	Community Based Adult Services (CBAS)	4,531,580	0	(4,531,580)	0.0%
50,541	0	(50,541)	0.0%	COVID Vaccination Incentive	50,541	0	(50,541)	0.0%
854,557	704,944	(149,613)	(21.2%)	ECM Base FFS Ancillary	3,378,248	2,857,120	(521,128)	(18.2%)
2,520	10,000	7,480	74.8%	ECM Outreach FFS Ancillary	2,560	40,000	37,440	93.6%
398,608	398,608	0	0.0%	CS - Housing Deposits FFS Ancillary	1,594,431	1,594,431	0	0.0%
407,667	407,667	0	0.0%	CS - Housing Tenancy FFS Ancillary	1,630,668	1,630,668	0	0.0%
298,956	298,956	0	0.0%	CS - Housing Navigation Services FFS Ancillary	1,195,823	1,195,824	1	0.0%
241,313	241,312	(1)	0.0%	CS - Medical Respite FFS Ancillary	965,250	965,248	(2)	0.0%
230,081	230,081	0	0.0%	CS - Medically Tailored Meals FFS Ancillary	920,325	920,324	(1)	0.0%
35,244	35,244	0	0.0%	CS - Asthma Remediation FFS Ancillary	140,978	140,976	(2)	0.0%
634	0	(634)	0.0%	MOT- Wrap Around (Non Medical MOT Cost)	634	0	(634)	0.0%
6,894,611	**6,294,259**	**(600,353)**	**(9.5%)**	**9-Ancillary Medical Expense**	**57,094,849**	**51,283,987**	**(5,810,861)**	**(11.3%)**
14,857	0	(14,857)	0.0%	IBNP-Outpatient	970,602	0	(970,602)	0.0%
445	0	(445)	0.0%	IBNP Settlement (OP)	29,119	0	(29,119)	0.0%
1,188	0	(1,188)	0.0%	IBNP Claims Fluctuation (OP)	77,648	0	(77,648)	0.0%
1,502,898	8,055,248	6,552,350	81.3%	Out-Patient FFS	13,167,194	83,476,989	70,309,795	84.2%
1,564,101	0	(1,564,101)	0.0%	OP Ambul Surgery - FFS	13,312,903	0	(13,312,903)	0.0%
1,233,460	0	(1,233,460)	0.0%	OP Fac Imaging Services-FFS	11,335,666	0	(11,335,666)	0.0%
924,743	0	(924,743)	0.0%	Behav Health - FFS	16,118,324	0	(16,118,324)	0.0%
1,420,466	0	(1,420,466)	0.0%	Behavioral Health Therapy - FFS	4,508,939	0	(4,508,939)	0.0%
516,590	0	(516,590)	0.0%	OP Facility - Lab FFS	4,729,735	0	(4,729,735)	0.0%
99,322	0	(99,322)	0.0%	OP Facility - Cardio FFS	1,013,891	0	(1,013,891)	0.0%
51,286	0	(51,286)	0.0%	OP Facility - PT/OT/ST FFS	482,975	0	(482,975)	0.0%
1,791,644	0	(1,791,644)	0.0%	OP Facility - Dialysis FFS	16,823,546	0	(16,823,546)	0.0%
9,121,000	**8,055,248**	**(1,065,752)**	**(13.2%)**	**10-Outpatient Medical Expense Medical Expense**	**82,570,542**	**83,476,989**	**906,447**	**1.1%**
387,258	0	(387,258)	0.0%	IBNP-Emergency	1,455,266	0	(1,455,266)	0.0%
11,619	0	(11,619)	0.0%	IBNP Settlement (ER)	43,658	0	(43,658)	0.0%
30,983	0	(30,983)	0.0%	IBNP Claims Fluctuation (ER)	116,424	0	(116,424)	0.0%
558,432	0	(558,432)	0.0%	Special ER Physician-FFS	6,164,994	0	(6,164,994)	0.0%
3,442,407	4,246,174	803,767	18.9%	ER-Facility	37,787,173	44,488,269	6,701,096	15.1%
4,430,699	**4,246,174**	**(184,525)**	**(4.3%)**	**11-Emergency Expense**	**45,567,515**	**44,488,269**	**(1,079,246)**	**(2.4%)**
(140,763)	0	140,763	0.0%	IBNP-Pharmacy	468,708	0	(468,708)	0.0%
(4,223)	0	4,223	0.0%	IBNP Settlement (RX)	14,063	0	(14,063)	0.0%
(11,261)	0	11,261	0.0%	IBNP Claims Fluctuation (RX)	37,499	0	(37,499)	0.0%
749,783	367,369	(382,414)	(104.1%)	Pharmacy-FFS	72,321,109	70,781,358	(1,539,751)	(2.2%)
5,798,138	4,719,647	(1,078,491)	(22.9%)	Pharmacy- Non-PBM FFS-Other Anc	51,469,419	47,251,017	(4,218,402)	(8.9%)
(26,544)	0	26,544	0.0%	HMS RX Refunds	(751,868)	0	751,868	0.0%
0	(18,132)	(18,132)	100.0%	Pharmacy-Rebate	(3,425,129)	(3,500,684)	(75,555)	2.2%
6,365,129	**5,068,884**	**(1,296,245)**	**(25.6%)**	**12-Pharmacy Expense**	**120,133,802**	**114,531,691**	**(5,602,111)**	**(4.9%)**
67,368,829	**59,955,581**	**(7,413,248)**	**(12.4%)**	**13-TOTAL FFS MEDICAL EXPENSES**	**676,662,632**	**660,456,656**	**(16,205,976)**	**(2.5%)**
0	(47,176)	(47,176)	100.0%	Clinical Vacancy	0	(338,943)	(338,943)	100.0%
97,765	121,448	23,683	19.5%	Quality Analytics	771,304	866,917	95,613	11.0%
377,514	502,316	124,802	24.8%	Health Plan Services Department Total	4,026,222	4,827,607	801,385	16.6%
(1,006,008)	418,970	1,424,978	340.1%	Case & Disease Management Department Total	3,746,635	5,455,371	1,708,736	31.3%
1,675,334	236,965	(1,438,369)	(607.0%)	Medical Services Department Total	6,137,158	1,832,890	(4,304,268)	(234.8%)
385,934	752,474	366,540	48.7%	Quality Management Department Total	4,457,157	6,745,684	2,288,527	33.9%
56,486	123,789	67,303	54.4%	HCS Behavioral Health Department Total	334,122	595,725	261,603	43.9%
127,164	140,051	12,887	9.2%	Pharmacy Services Department Total	1,199,433	1,292,138	92,705	7.2%
118,174	54,189	(63,985)	(118.1%)	Regulatory Readiness Total	491,761	437,081	(54,680)	(12.5%)
1,832,364	**2,303,026**	**470,662**	**20.4%**	**14-Other Benefits & Services**	**21,163,790**	**21,714,470**	**550,680**	**2.5%**
				Reinsurance Expense				
(607,852)	(399,395)	208,457	(52.2%)	Reinsurance Recoveries	(6,003,237)	(4,635,279)	1,367,958	(29.5%)
562,372	532,526	(29,846)	(5.6%)	Stop-Loss Expense	5,480,947	5,404,460	(76,487)	(1.4%)
(45,480)	**133,131**	**178,611**	**134.2%**	**15-Reinsurance Expense**	**(522,290)**	**769,181**	**1,291,471**	**167.9%**
93,221,562	**84,220,385**	**(9,001,178)**	**(10.7%)**	**17-TOTAL MEDICAL EXPENSES**	**921,468,050**	**905,683,999**	**(15,784,051)**	**(1.7%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Current Membership by Network By Category of Aid							
Category of Aid	**Apr 2022**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	45,826	15%	9,097	9,347	722	18,309	8,351
Child	100,215	33%	7,594	9,115	30,418	34,845	18,243
SPD	26,848	9%	8,128	4,222	1,037	11,387	2,074
ACA OE	108,568	36%	16,289	35,527	1,155	41,325	14,272
Duals	21,456	7%	8,171	2,351	1	7,738	3,195
Medi-Cal	302,913		49,279	60,562	33,333	113,604	46,135
Group Care	5,828		2,383	880	-	2,565	-
Total	**308,741**	**100%**	**51,662**	**61,442**	**33,333**	**116,169**	**46,135**
Medi-Cal %	98.1%		95.4%	98.6%	100.0%	97.8%	100.0%
Group Care %	1.9%		4.6%	1.4%	0.0%	2.2%	0.0%
	Network Distribution		*16.7%*	*19.9%*	*10.8%*	*37.6%*	*14.9%*
			% Direct:	**37%**		**% Delegated:**	**63%**

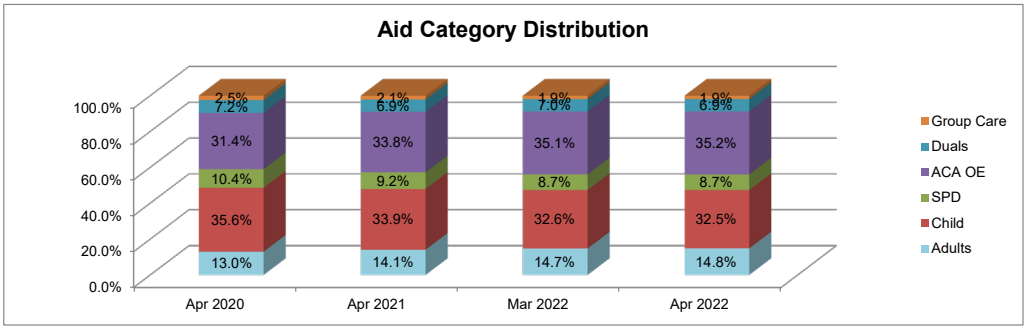




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

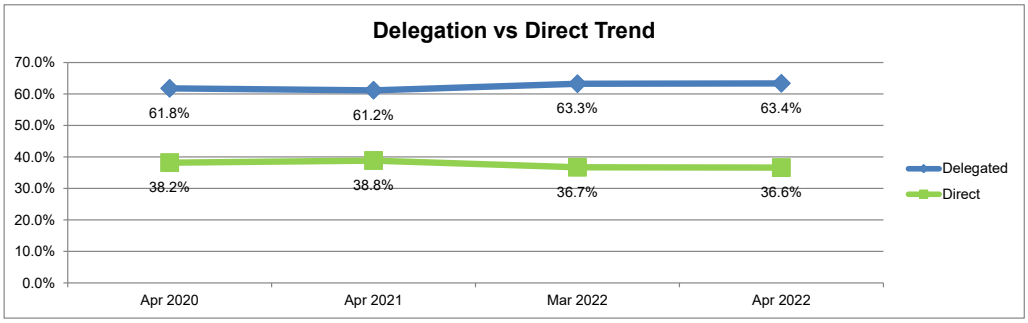
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Apr 2020	Apr 2021	Mar 2022	Apr 2022	Apr 2020	Apr 2021	Mar 2022	Apr 2022	Apr 2020 to Apr 2021	Apr 2021 to Apr 2022	Mar 2022 to Apr 2022
Adults	32,423	40,052	45,228	45,826	13.0%	14.1%	14.7%	14.8%	23.5%	14.4%	1.3%
Child	88,633	96,233	99,888	100,215	35.6%	33.9%	32.6%	32.5%	8.6%	4.1%	0.3%
SPD	25,894	26,270	26,823	26,848	10.4%	9.2%	8.7%	8.7%	1.5%	2.2%	0.1%
ACA OE	78,295	95,916	107,648	108,568	31.4%	33.8%	35.1%	35.2%	22.5%	13.2%	0.9%
Duals	17,858	19,748	21,350	21,456	7.2%	6.9%	7.0%	6.9%	10.6%	8.6%	0.5%
Medi-Cal Total	243,103	278,219	300,937	302,913	97.5%	97.9%	98.1%	98.1%	14.4%	8.9%	0.7%
Group Care	6,148	5,972	5,850	5,828	2.5%	2.1%	1.9%	1.9%	-2.9%	-2.4%	-0.4%
Total	**249,251**	**284,191**	**306,787**	**308,741**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**14.0%**	**8.6%**	**0.6%**



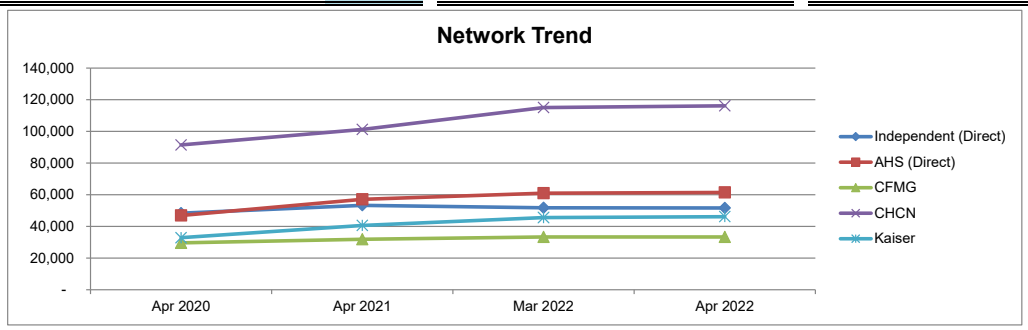
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Apr 2020	Apr 2021	Mar 2022	Apr 2022	Apr 2020	Apr 2021	Mar 2022	Apr 2022	Apr 2020 to Apr 2021	Apr 2021 to Apr 2022	Mar 2022 to Apr 2022
Delegated	153,983	173,804	194,046	195,637	61.8%	61.2%	63.3%	63.4%	12.9%	12.6%	0.8%
Direct	95,268	110,387	112,741	113,104	38.2%	38.8%	36.7%	36.6%	15.9%	2.5%	0.3%
Total	**249,251**	**284,191**	**306,787**	**308,741**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**14.0%**	**8.6%**	**0.6%**



Network Trend

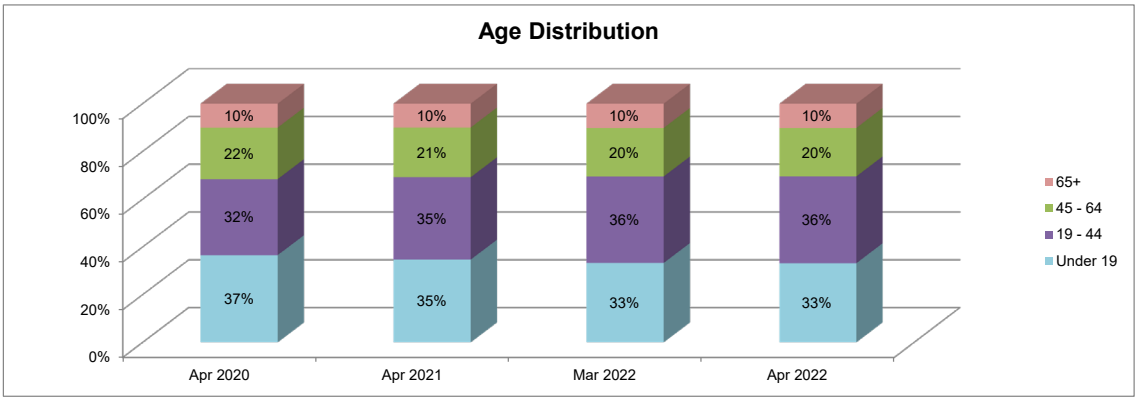
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Apr 2020	Apr 2021	Mar 2022	Apr 2022	Apr 2020	Apr 2021	Mar 2022	Apr 2022	Apr 2020 to Apr 2021	Apr 2021 to Apr 2022	Mar 2022 to Apr 2022
Independent (Direct)	48,363	53,300	51,767	51,662	19.4%	18.8%	16.9%	16.7%	10.2%	-3.1%	-0.2%
AHS (Direct)	46,905	57,087	60,974	61,442	18.8%	20.1%	19.9%	19.9%	21.7%	7.6%	0.8%
CFMG	29,619	31,935	33,293	33,333	11.9%	11.2%	10.9%	10.8%	7.8%	4.4%	0.1%
CHCN	91,469	101,289	115,125	116,169	36.7%	35.6%	37.5%	37.6%	10.7%	14.7%	0.9%
Kaiser	32,895	40,580	45,628	46,135	13.2%	14.3%	14.9%	14.9%	23.4%	13.7%	1.1%
Total	**249,251**	**284,191**	**306,787**	**308,741**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**14.0%**	**8.6%**	**0.6%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

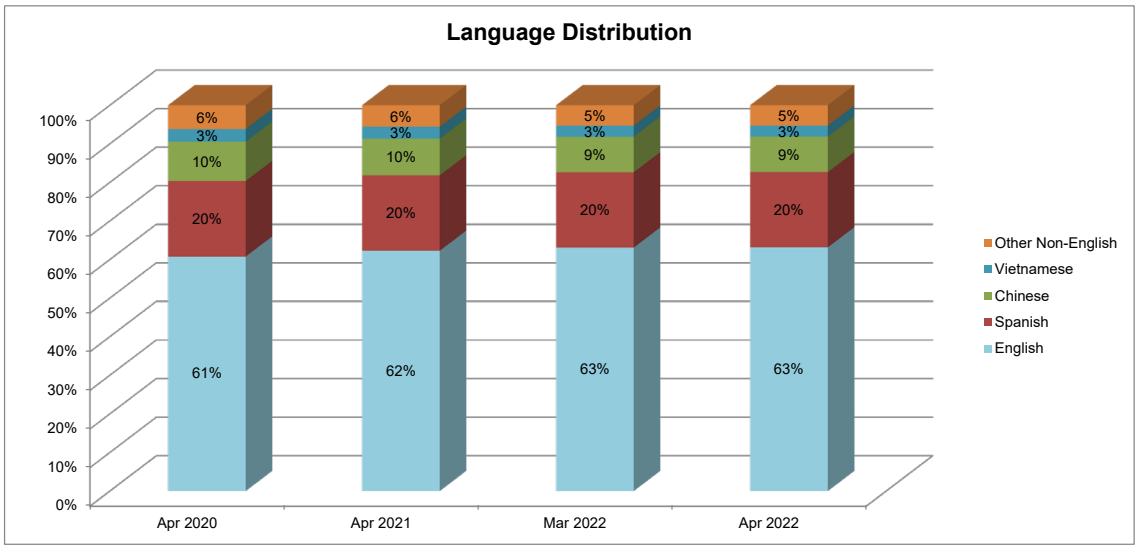
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Apr 2020	Apr 2021	Mar 2022	Apr 2022	Apr 2020	Apr 2021	Mar 2022	Apr 2022	Apr 2020 to Apr 2021	Apr 2021 to Apr 2022	Mar 2022 to Apr 2022
Under 19	91,177	98,595	102,146	102,464	37%	35%	33%	33%	8%	4%	0%
19 - 44	79,413	98,096	111,172	112,308	32%	35%	36%	36%	24%	14%	1%
45 - 64	53,750	59,184	62,347	62,659	22%	21%	20%	20%	10%	6%	1%
65+	24,911	28,316	31,122	31,310	10%	10%	10%	10%	14%	11%	1%
Total	**249,251**	**284,191**	**306,787**	**308,741**	**100%**	**100%**	**100%**	**100%**	**14%**	**9%**	**1%**



Language Trend

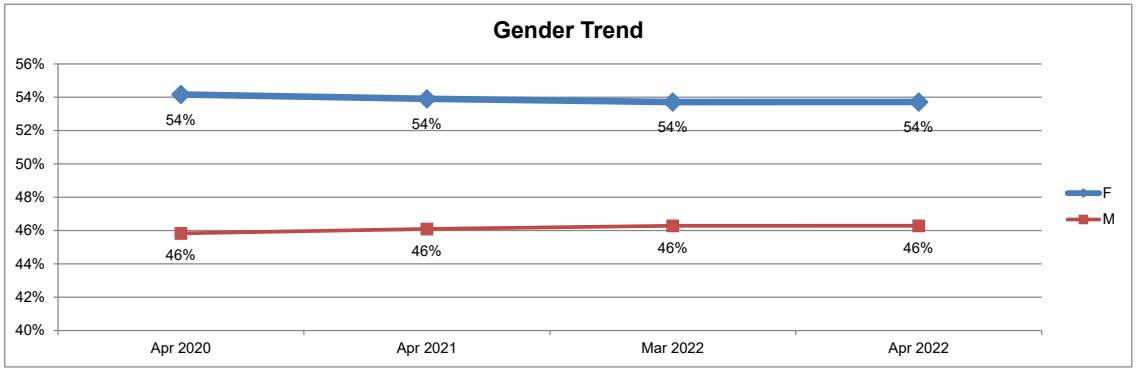
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Apr 2020	Apr 2021	Mar 2022	Apr 2022	Apr 2020	Apr 2021	Mar 2022	Apr 2022	Apr 2020 to Apr 2021	Apr 2021 to Apr 2022	Mar 2022 to Apr 2022
English	151,454	176,931	193,534	194,983	61%	62%	63%	63%	17%	10%	1%
Spanish	48,853	55,588	59,913	60,230	20%	20%	20%	20%	14%	8%	1%
Chinese	25,363	27,029	28,316	28,433	10%	10%	9%	9%	7%	5%	0%
Vietnamese	8,285	8,790	8,888	8,863	3%	3%	3%	3%	6%	1%	0%
Other Non-English	15,296	15,853	16,136	16,232	6%	6%	5%	5%	4%	2%	1%
Total	**249,251**	**284,191**	**306,787**	**308,741**	**100%**	**100%**	**100%**	**100%**	**14%**	**9%**	**1%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

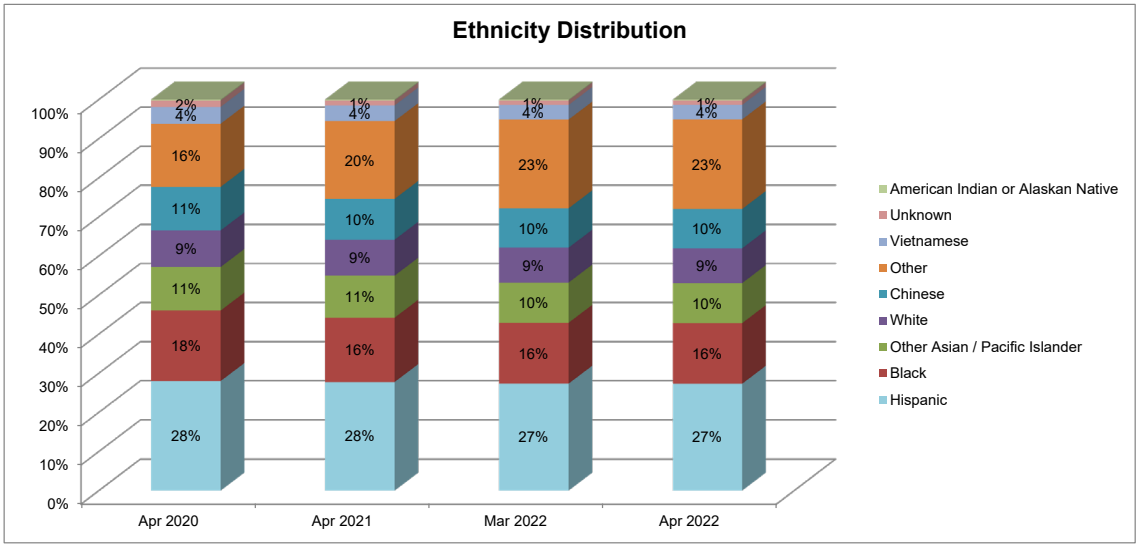
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Apr 2020	Apr 2021	Mar 2022	Apr 2022	Apr 2020	Apr 2021	Mar 2022	Apr 2022	Apr 2020 to Apr 2021	Apr 2021 to Apr 2022	Mar 2022 to Apr 2022
F	135,011	153,186	164,784	165,836	54%	54%	54%	54%	13%	8%	1%
M	114,240	131,005	142,003	142,905	46%	46%	46%	46%	15%	9%	1%
Total	**249,251**	**284,191**	**306,787**	**308,741**	**100%**	**100%**	**100%**	**100%**	**14%**	**9%**	**1%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Apr 2020	Apr 2021	Mar 2022	Apr 2022	Apr 2020	Apr 2021	Mar 2022	Apr 2022	Apr 2020 to Apr 2021	Apr 2021 to Apr 2022	Mar 2022 to Apr 2022
Hispanic	69,755	78,831	83,813	84,250	28%	28%	27%	27%	13%	7%	1%
Black	44,971	46,780	47,769	47,891	18%	16%	16%	16%	4%	2%	0%
Other Asian / Pacific Islander	27,749	30,527	31,540	31,590	11%	11%	10%	10%	10%	3%	0%
White	23,355	26,179	27,426	27,524	9%	9%	9%	9%	12%	5%	0%
Chinese	27,754	29,693	30,921	31,057	11%	10%	10%	10%	7%	5%	0%
Other	40,272	56,572	69,621	70,736	16%	20%	23%	23%	40%	25%	2%
Vietnamese	10,741	11,339	11,419	11,420	4%	4%	4%	4%	6%	1%	0%
Unknown	4,076	3,648	3,633	3,612	2%	1%	1%	1%	-11%	-1%	-1%
American Indian or Alaskan Native	578	622	645	661	0%	0%	0%	0%	8%	6%	2%
Total	**249,251**	**284,191**	**306,787**	**308,741**	**100%**	**100%**	**100%**	**100%**	**14%**	**9%**	**1%**



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

Medi-Cal By City

City	Apr 2022	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	119,173	39%	12,763	29,028	14,164	50,132	13,086
Hayward	47,075	16%	7,042	10,357	5,380	15,875	8,421
Fremont	27,501	9%	9,816	4,272	954	7,818	4,641
San Leandro	27,424	9%	4,397	4,182	3,453	10,374	5,018
Union City	12,707	4%	3,890	2,022	517	3,833	2,445
Alameda	11,622	4%	2,081	1,887	1,623	4,144	1,887
Berkeley	11,398	4%	1,548	1,695	1,316	5,072	1,767
Livermore	9,311	3%	1,041	756	1,894	3,914	1,706
Newark	6,963	2%	1,812	2,236	228	1,354	1,333
Castro Valley	7,615	3%	1,303	1,230	1,096	2,410	1,576
San Lorenzo	6,432	2%	849	1,113	735	2,362	1,373
Pleasanton	5,063	2%	951	431	508	2,288	885
Dublin	5,435	2%	963	451	679	2,308	1,034
Emeryville	2,064	1%	326	405	307	665	361
Albany	1,909	1%	272	215	362	663	397
Piedmont	368	0%	48	103	21	99	97
Sunol	60	0%	13	10	5	19	13
Antioch	38	0%	8	10	4	7	9
Other	755	0%	156	159	87	267	86
Total	**302,913**	**100%**	**49,279**	**60,562**	**33,333**	**113,604**	**46,135**

Group Care By City

City	Apr 2022	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	1,934	33%	477	365	-	1,092	-
Hayward	645	11%	322	139	-	184	-
Fremont	624	11%	460	46	-	118	-
San Leandro	578	10%	223	94	-	261	-
Union City	320	5%	225	30	-	65	-
Alameda	282	5%	109	19	-	154	-
Berkeley	167	3%	47	10	-	110	-
Livermore	81	1%	30	1	-	50	-
Newark	142	2%	85	36	-	21	-
Castro Valley	184	3%	80	18	-	86	-
San Lorenzo	119	2%	50	15	-	54	-
Pleasanton	58	1%	22	3	-	33	-
Dublin	108	2%	37	10	-	61	-
Emeryville	35	1%	12	6	-	17	-
Albany	14	0%	6	1	-	7	-
Piedmont	14	0%	4	-	-	10	-
Sunol	-	0%	-	-	-	-	-
Antioch	27	0%	6	8	-	13	-
Other	496	9%	188	79	-	229	-
Total	**5,828**	**100%**	**2,383**	**880**	**-**	**2,565**	**-**

Total By City

City	Apr 2022	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	121,107	39%	13,240	29,393	14,164	51,224	13,086
Hayward	47,720	15%	7,364	10,496	5,380	16,059	8,421
Fremont	28,125	9%	10,276	4,318	954	7,936	4,641
San Leandro	28,002	9%	4,620	4,276	3,453	10,635	5,018
Union City	13,027	4%	4,115	2,052	517	3,898	2,445
Alameda	11,904	4%	2,190	1,906	1,623	4,298	1,887
Berkeley	11,565	4%	1,595	1,705	1,316	5,182	1,767
Livermore	9,392	3%	1,071	757	1,894	3,964	1,706
Newark	7,105	2%	1,897	2,272	228	1,375	1,333
Castro Valley	7,799	3%	1,383	1,248	1,096	2,496	1,576
San Lorenzo	6,551	2%	899	1,128	735	2,416	1,373
Pleasanton	5,121	2%	973	434	508	2,321	885
Dublin	5,543	2%	1,000	461	679	2,369	1,034
Emeryville	2,099	1%	338	411	307	682	361
Albany	1,923	1%	278	216	362	670	397
Piedmont	382	0%	52	103	21	109	97
Sunol	60	0%	13	10	5	19	13
Antioch	65	0%	14	18	4	20	9
Other	1,251	0%	344	238	87	496	86
Total	**308,741**	**100%**	**51,662**	**61,442**	**33,333**	**116,169**	**46,135**

FY 2023 Preliminary Budget

Presented to the Alameda Alliance Board of Governors

June 10th, 2022

ALAMEDA Alliance FOR HEALTH

Budget Process

- Preliminary budget presented to Finance Committee on June 7th , and the Board of Governors on June 10th.
- DHCS has announced that final Medi-Cal rates will be issued two months later than normal this year (November vs. September).
- First Quarter Forecast to be presented in December 2022, and final budget will be presented in early Calendar Year 2023.

Summary of Proposed Budget to the Board of Governors

- Net Loss is ($14.9 million). Medi-Cal loss is ($16.3 million); Group Care Income is $1.4 million.
- Tangible Net Equity of 479%, or $163.7 million above required at June 2023 year-end.
- Membership is 297,000 in Medi-Cal and Group Care, approximately 14,000 members lower than FY 2022 (primarily Medi-Cal). Decrease due to the resumption of disenrollments, offset by the addition of Long-Term Care members.
- Revenue is $1.3 billion, $122 million higher than FY 2022. Increases include Long-Term Care carve-in, member month volume changes, a full year of CalAIM and base rate changes, partially offset by of the carve-out of pharmacy services.
- Fee-for-service and capitation expenses are $1.2 billion, $120.0 million higher. This is comprised of a full year of the carve-out of pharmacy services, largely offset by Long-term Care carve-in, a full year of CalAIM, Behavioral Health Insourcing, contract changes, increasing medical trends and member month volume changes.
- $8.4 million in net savings are included for claims avoidance and recovery activities.
- Administrative expenses are 6.6% of revenue, $19.5 million higher than FY 2022. Led by labor ($15.7 million) and Purch. & Prof. services ($6.2 million). Grants of $3.3 million are included.
- Clinical expenses are 3.0% of revenue, $9.3 million higher. Led by labor ($21.5 million), largely offset by reduction in member Benefits Administration ($9.0 million) and Purchased and Professional Services ($4.0 million).

Budget Assumptions FY 2023

Staffing:

- Staffing includes 478 full-time equivalent employees by June 30th, 2023.
- There are 57 new positions budgeted. The new positions are in: Operations (11), Health Care Services (26), Finance/Vendor Management (6), Integrated Planning (5), Human Resources (3), Information Technology (2), Compliance/Legal (2), and Executive (2). Some of the new positions will be offset by the release of temporary employees.
- Year-end headcount includes 21 positions for new projects: The largest ones are Behavioral Health Insourcing (12), CalAIM Enhanced Care Management, Major Organ Transplants, Community Supports (5) and Long-Term Care (4).

Enrollment:

- Medi-Cal membership increases through December, driven primarily by the postponement of redetermination activity. Increases include undocumented adults ages 50 and older transitioning from HealthPAC and persons re-entering from incarceration. Disenrollments are anticipated to begin in January 2023, with the end of the Public Health Emergency.
- Group Care enrollment remains steady at approximately 6,000.

Budget Assumptions FY 2023 (con't)

Revenue:

- 98% of Revenue for Medi-Cal, 2% for Group Care.
- Medi-Cal base rates (excluding Pharmacy carve-out) assumed to increase by 3.2% on a per member/per month basis, equating to an increase of $32.0 million in revenue.
- The continuation of CalAIM initiatives of Enhanced Care Management, Community Supports and Major Organ Transplants represent $43.6 million in revenue.
- Long-Term Care data has not been received from the State. Placeholder revenue of $79.3 million is included.
- Per-member-per-month Group Care rates increase by 22.3% adding $5.8 million.

Medical Expense:

- 98% of Expense for Medi-Cal, 2% for Group Care.
- Medical loss ratio is 94.5%, an increase of 1.7%.
- The continuation of CalAIM initiatives of Enhanced Care Management, Community Supports and Major Organ Transplants represent $42.7 million in expense.
- Long-Term Care data has not been received from the State. Expense of $75.0 million is included.
- Excluding Rx carve-out and CalAIM, utilization trend is 0.7%; unit cost trend is 4.6%.

Hospital & Provider Rates:

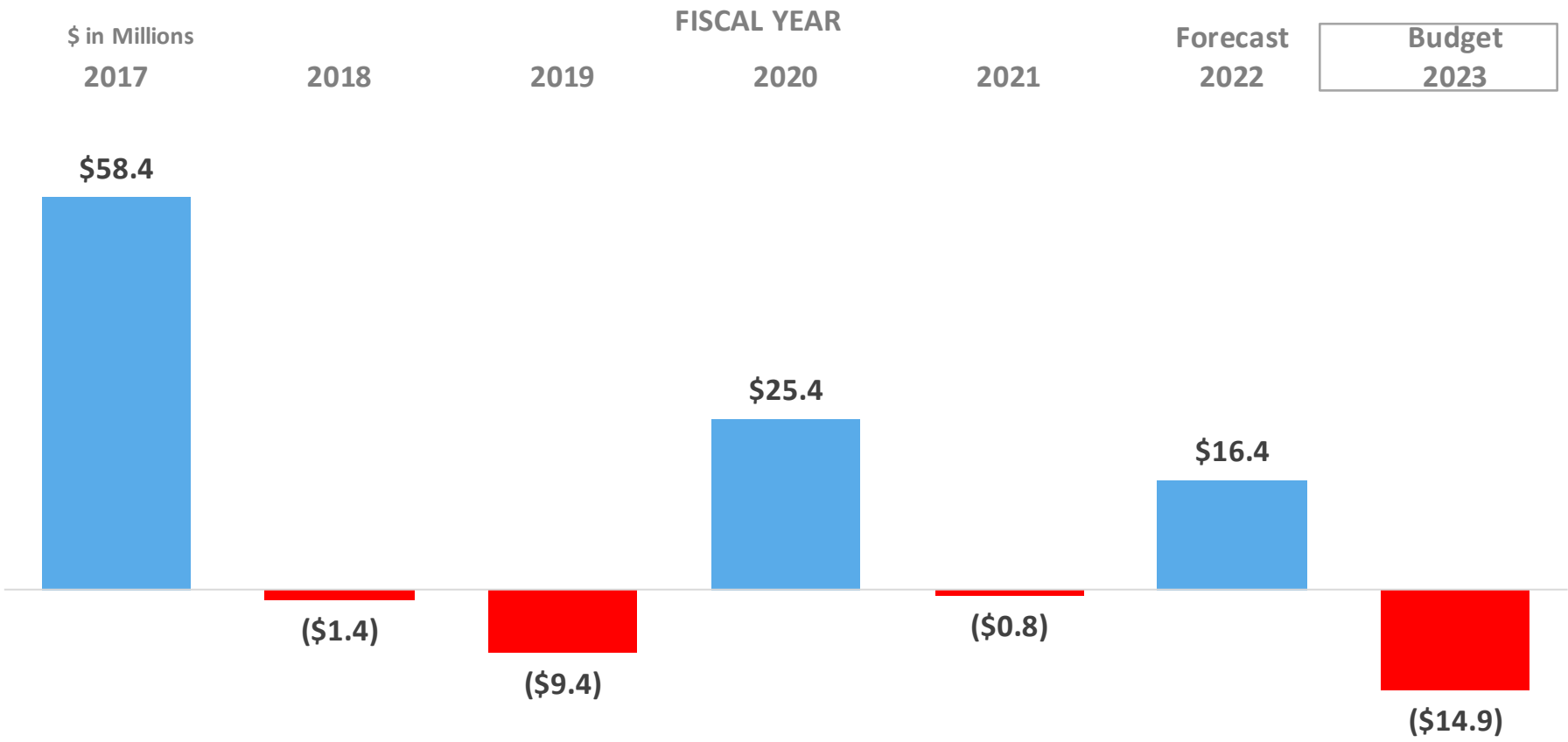
- Hospital contract rates increase by $25.4 million over FY 2022.
- Professional capitation rates increase by $5.4 million .
- $1.9 million is included for higher rates resulting from Behavioral Health Insourcing.

Preliminary FY 2023 Budget Comparison to FY 2022 Forecast

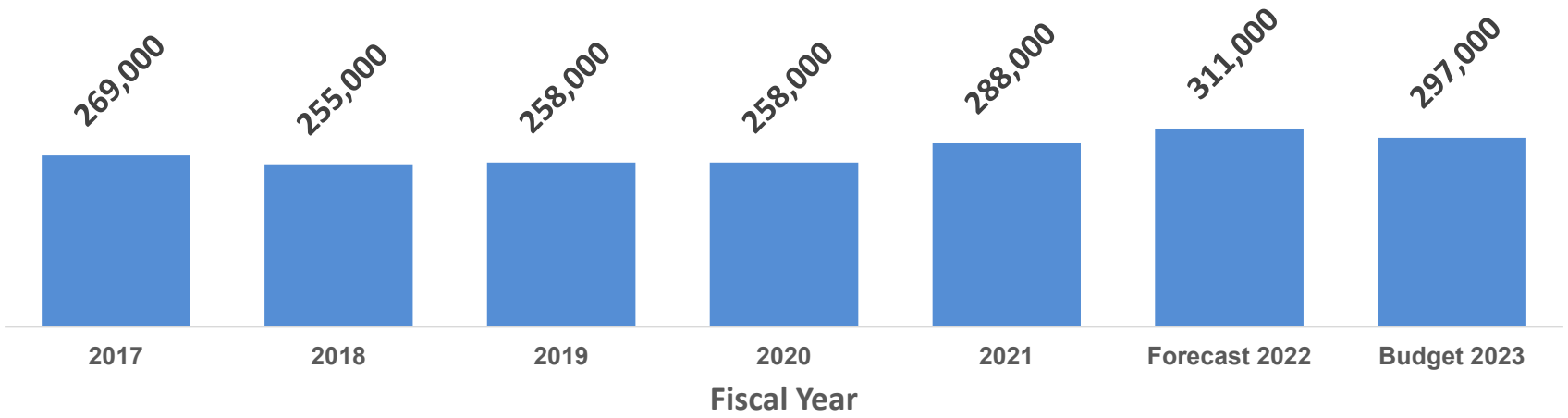
ALAMEDA Alliance FOR HEALTH

$ in Thousands	FY 2023 Budget			FY 2022 Forecast			Variance F/(U)		
	Medi-Cal	Group Care	Total	Medi-Cal	Group Care	Total	Medi-Cal	Group Care	Total
Enrollment at Year-End	**291,391**	**5,828**	**297,219**	**305,633**	**5,828**	**311,461**	**(14,242)**	**0**	**(14,242)**
Member Months	**3,704,216**	**69,936**	**3,774,152**	**3,533,871**	**70,244**	**3,604,115**	**170,345**	**(308)**	**170,037**
Revenues	$1,282,206	$31,977	$1,314,183	$1,165,870	$26,303	$1,192,173	$116,336	$5,674	$122,010
Medical Expense	1,214,740	27,790	1,242,530	1,081,315	26,079	1,107,394	(133,425)	(1,711)	(135,136)
Gross Margin	**67,466**	**4,186**	**71,652**	**84,555**	**224**	**84,779**	**(17,089)**	**3,962**	**(13,127)**
Administrative Expense	84,305	2,794	87,099	65,289	2,280	67,570	(19,015)	(514)	(19,529)
Operating Margin	**(16,839)**	**1,392**	**(15,447)**	**19,266**	**(2,056)**	**17,209**	**(36,104)**	**3,448**	**(32,656)**
Other Income / (Expense)	568	17	585	(823)	(24)	(847)	1,391	41	1,432
Net Income / (Loss)	**($16,271)**	**$1,410**	**($14,862)**	**$18,443**	**($2,080)**	**$16,362**	**($34,714)**	**$3,490**	**($31,224)**
Admin. Expense % of Revenue	**6.6%**	**8.7%**	**6.6%**	**5.6%**	**8.7%**	**5.7%**	**-1.0%**	**-0.1%**	**-1.0%**
Medical Loss Ratio	**94.7%**	**86.9%**	**94.5%**	**92.7%**	**99.1%**	**92.9%**	**-2.0%**	**12.2%**	**-1.7%**
TNE at Year-End			**$163,734**			**$183,391**			**($19,657)**
TNE Percent of Required at YE			**479%**			**578%**			**(99%)**

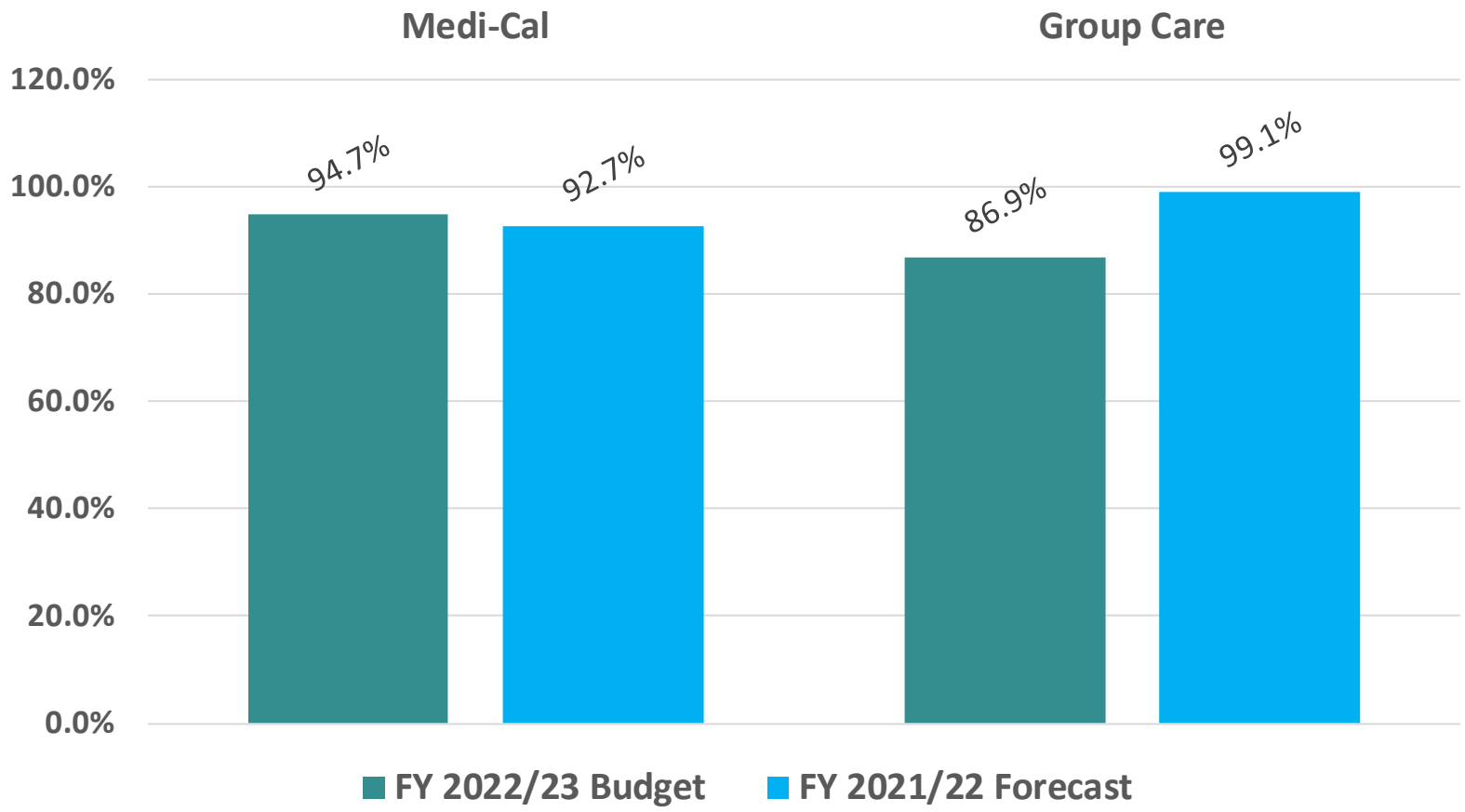
Operating Performance: 2017 to 2023: Net Profit (Loss)



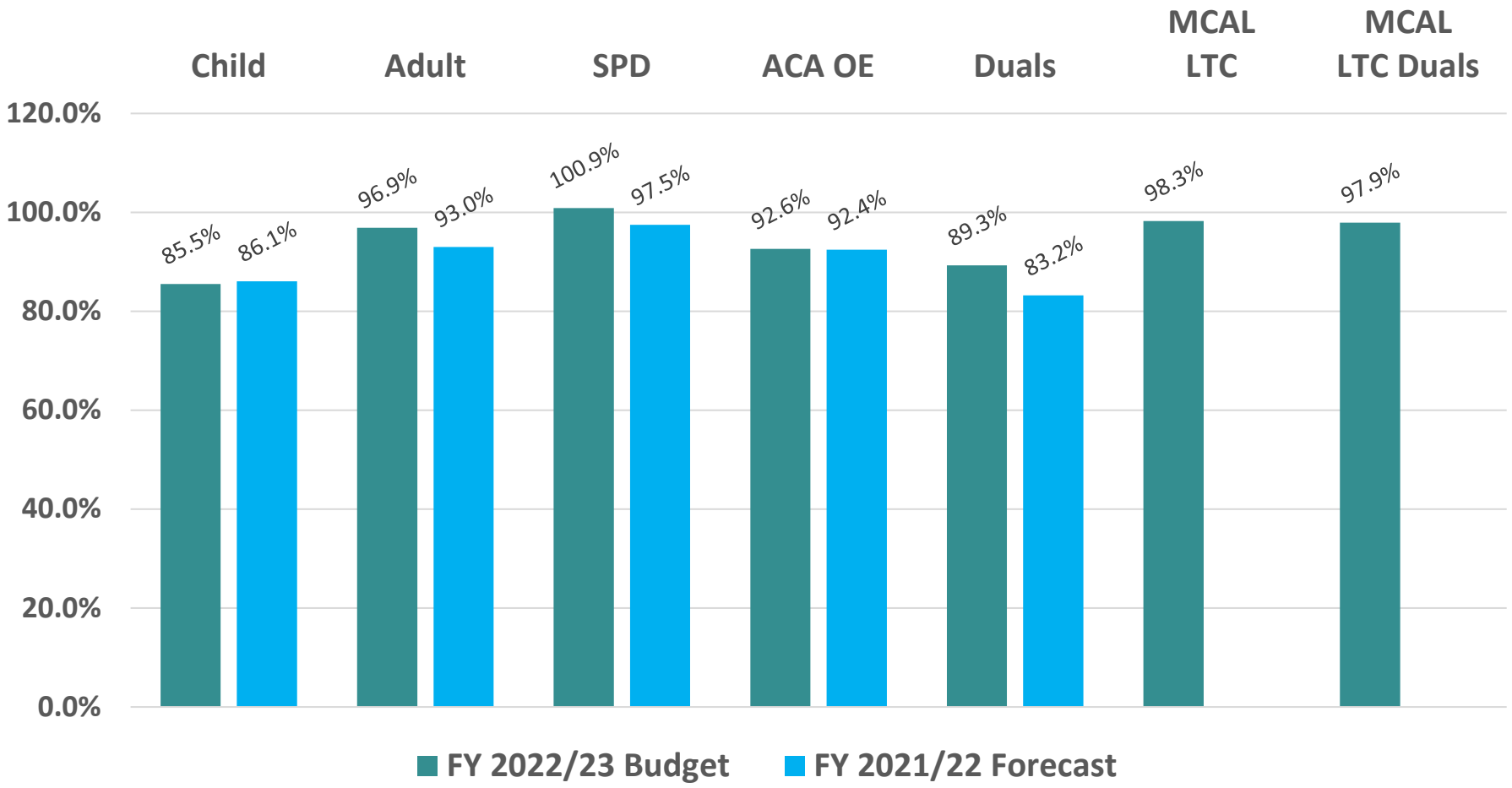
Enrollment Year End: 2017 to 2023



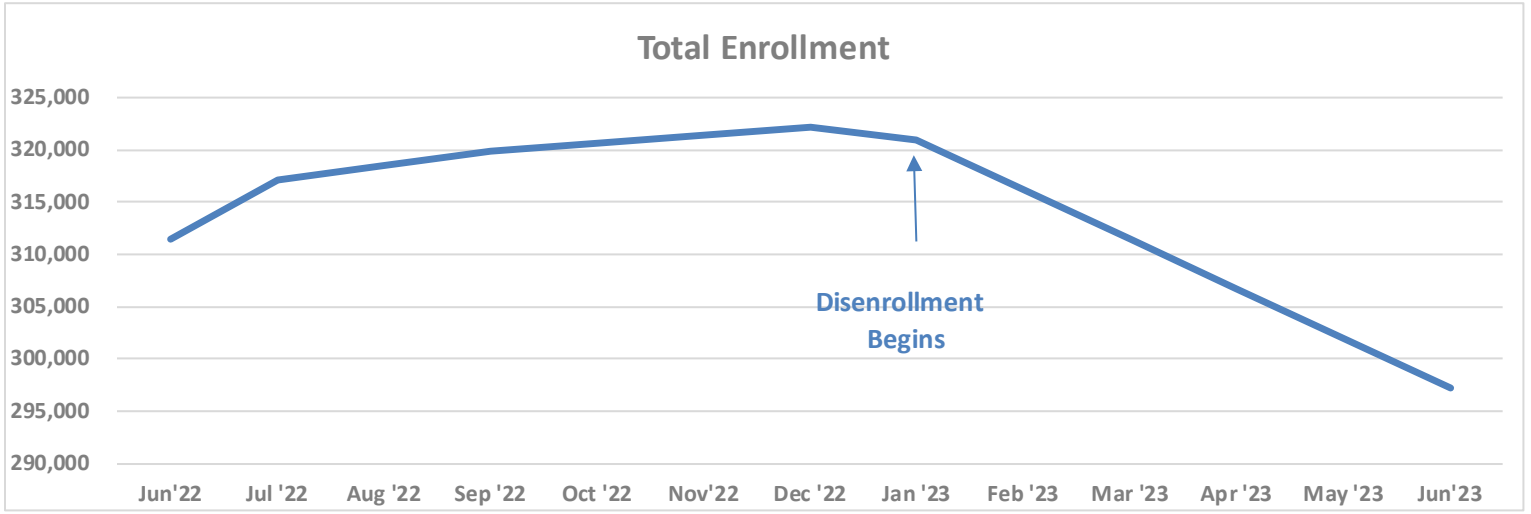
Medical Loss Ratio by Line of Business

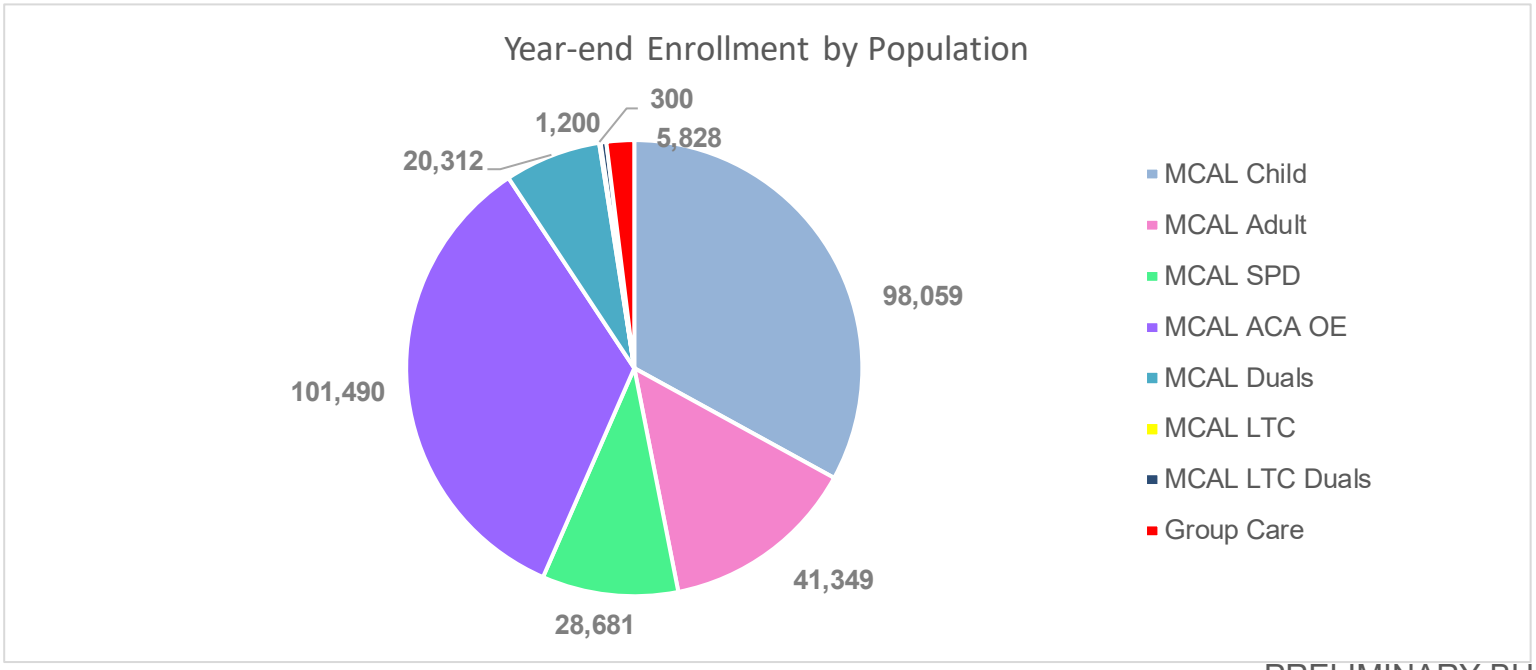


Medi-Cal Loss Ratio by Category of Aid

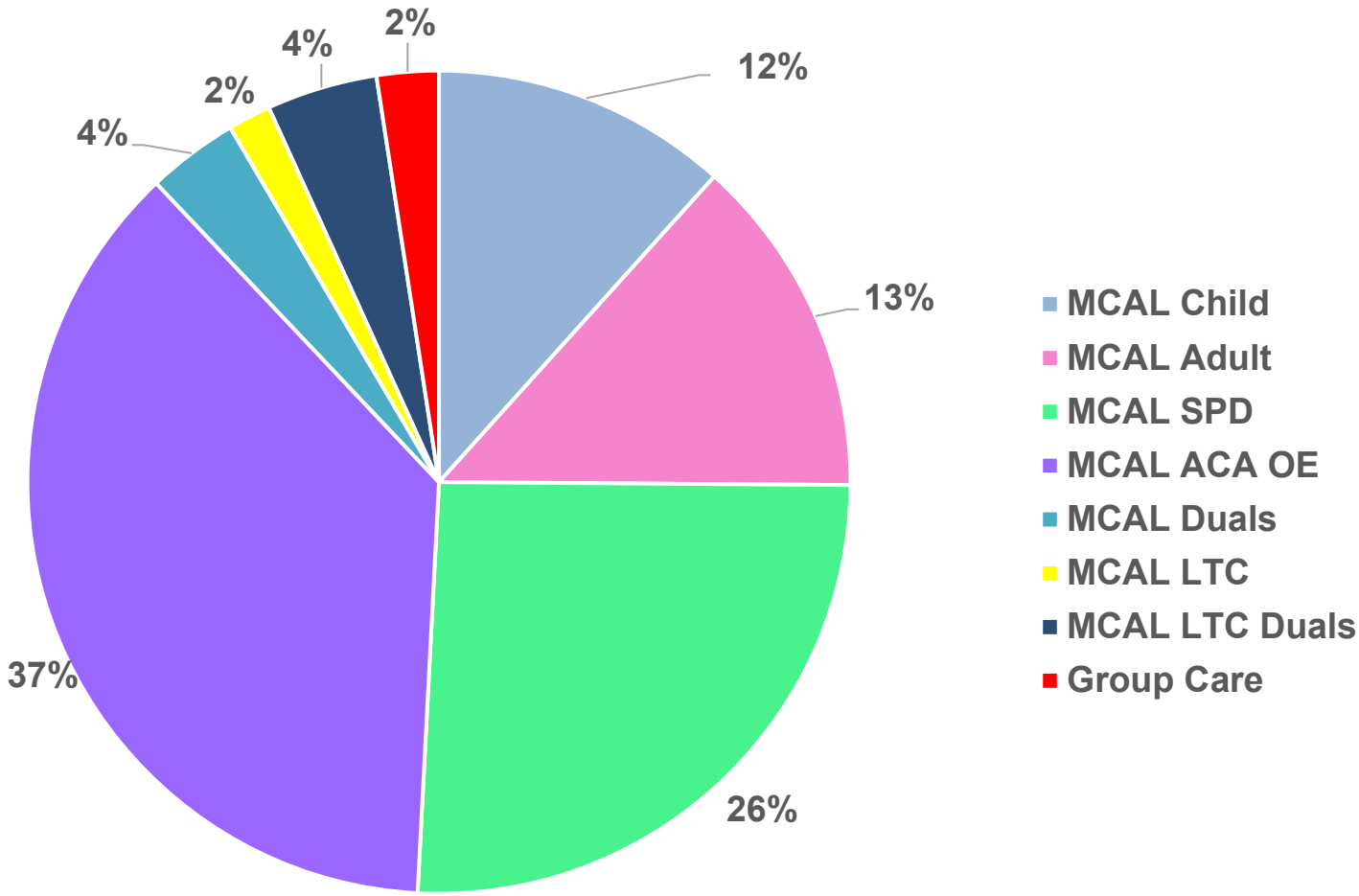


FY 2023 Enrollment by Month

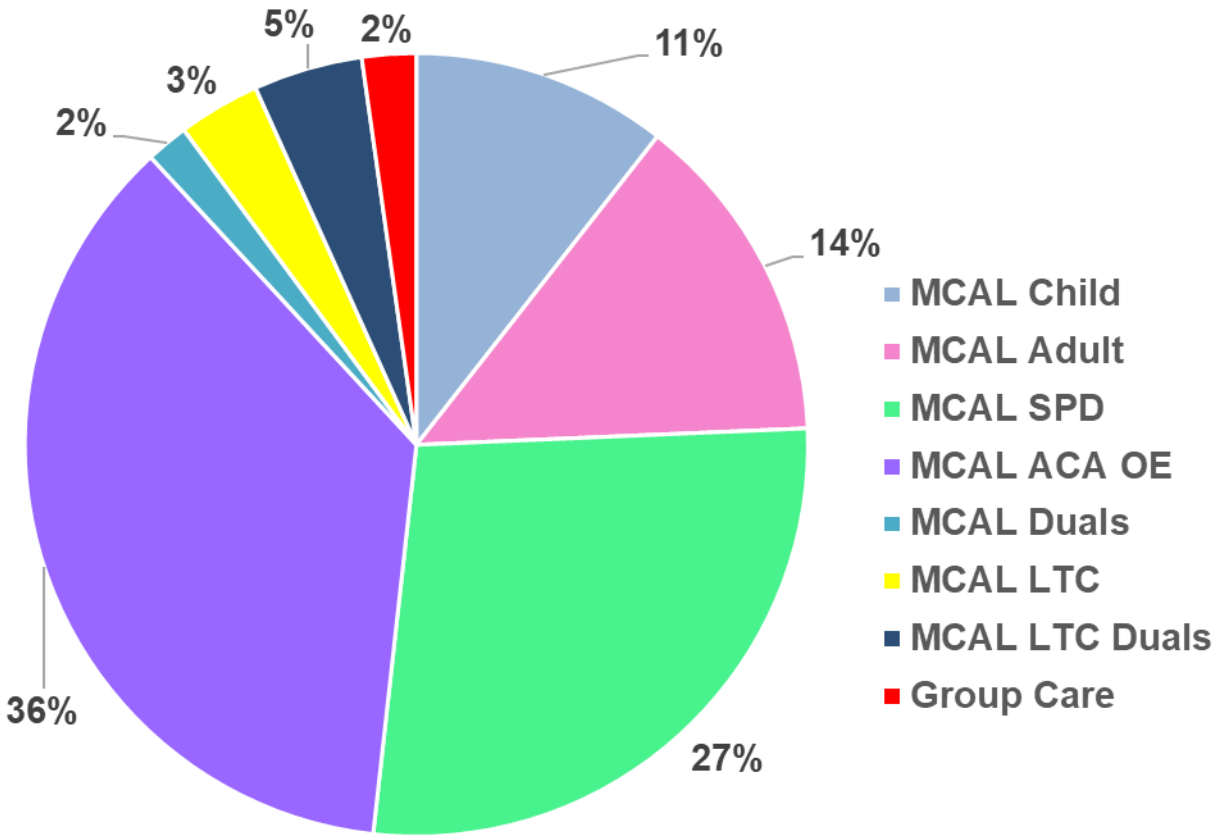




FY 2023 Revenue by Aid Category and Group Care



FY 2023 Medical Expense by Aid Category and Group Care



FY 2023 Administrative Expenses

Addition of $19.5 million in Administrative Expenses:

• Employee expense increases	$15.7 million
• Member benefits administration	($4.3) million
• Purchased and professional services	$6.2 million
• Technology infrastructure & licensing	$0.3 million
• Supplies, postage, and other expenses	$1.6 million
Total	**$19.5 million**

FY 2023 Capital Expenditures

Full Year budget of $979,000 in capitalized purchases for Information Technology and Facilities. This is an addition of $349,000 from the FY 2022 Forecast.

Information Technology: $640,000

- Hardware: $560,000
  - Network hardware and cabling: $280,000
  - Voice Infrastructure: $140,000
  - Backup Hardware: $140,000
- Software: 80,000
  - Zerto Replication Orchestration Software: $80,000

Facilities: $339,000

- Building Improvements (Seismic, ADT & HVAC maintenance, and Contingency): $239,000
- EV Charging Stations: $100,000

Administrative and Clinical Expenses by Line of Business

FY 2023 Budget

	Administrative Departments			Clinical Departments			Total
	Medi-Cal	Group Care	Total	Medi-Cal	Group Care	Total	
Employee Related Expense	$51,257	$1,551	$52,808	$21,320	$646	$21,966	74,774
Member Benefits Administration	$1,431	$234	$1,665	$7,178	$0	$7,178	8,843
Purchased & Professional Services	$16,658	$496	$17,154	$6,643	$5	$6,648	23,802
Other	$14,959	$512	$15,471	$3,930	$5	$3,935	19,406
Total	**$84,305**	**$2,794**	**$87,099**	**$39,071**	**$657**	**$39,727**	**$126,826**

Staffing: Administrative and Clinical FTEs at Year-end

Administrative FTEs	Prelim Budget FY23	FY22 Forecast	Increase /Decrease
Administrative Vacancy	(33.1)	(45.1)	11.9
Operations	3.0	3.0	0.0
Executive	4.0	2.0	2.0
Finance	28.0	25.0	3.0
Healthcare Analytics	16.0	16.0	0.0
Claims	43.0	39.0	4.0
Information Technology	11.0	8.0	3.0
IT Infrastructure	7.0	7.0	0.0
Apps Mgmt., IT Quality & Proces	15.0	15.0	0.0
IT Development	15.0	13.0	2.0
IT Data Exchange	9.0	8.0	1.0
IT-Ops and Quality Apps Mgt.	9.0	8.0	1.0
Member Services	69.0	61.6	7.5
Provider Services	32.0	25.0	7.0
Credentialing	6.0	4.0	2.0
Health Plan Operations	1.0	1.0	0.0
Human Resources	16.0	15.0	1.0
Vendor Management	7.0	5.0	2.0
Legal Services	7.0	6.0	1.0
Facilities & Support Services	7.0	5.0	2.0
Marketing & Communication	10.0	10.0	0.0
Privacy and SIU	11.0	10.0	1.0
Regulatory Affairs & Compliance	6.0	7.0	(1.0)
Grievance and Appeals	17.0	16.5	0.5
Integrated Planning	19.0	12.0	7.0
Total Administrative FTEs	**334.9**	**277.0**	**57.9**

Clinical FTEs	Prelim Budget FY23	FY22 Forecast	Increase /Decrease
Clinical Vacancy	(4.0)	(6.6)	2.6
Quality Analytics	4.0	4.0	0.0
Utilization Management	42.9	43.9	(1.0)
Case/Disease Management	36.0	31.0	5.0
Medical Services	9.0	6.0	3.0
Quality Management	29.0	25.0	4.0
HCS Behavioral Health	10.0	8.0	2.0
Pharmacy Services	9.0	9.0	0.0
Regulatory Readiness	7.0	2.0	4.0
Total Clinical FTEs	**142.9**	**122.3**	**19.6**

Total FTEs	**477.7**	**399.3**	**77.5**

**FTE = Full-Time Equivalent Personnel working approximately 2,080 hours per year. Includes Temporary Employees.*

Material Areas of Uncertainty

FY 2023 Budget

- AAH has not received Long Term Care data from DHCS. Both revenue and expense could differ significantly from the placeholders in the Preliminary Budget.
- The change in DHCS risk adjustment methodologies could decrease premium.
- In CY 2023, the State will begin dividing members in each Medi-Cal Category of Aid into three categories of immigration status. Statewide initiative in response to CMS requirements. Although DHCS says they will aim for budget neutrality, there is some risk that our revenue rates will be impacted.
- The number of and cost of transplants that will occur is difficult to predict. AAH is just beginning to accumulate MOT experience.
- There remains uncertainty regarding the end of the Public Health Emergency and resumption of Medi-Cal disenrollments.
- Future COVID-related changes in utilization may occur.
- Contract changes for hospitals and delegated providers in projections have not been finalized.

ALAMEDA Alliance FOR HEALTH

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

Operations

Matt Woodruff

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

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

Date: **June 10th, 2022**

Subject: **Operations Report**

Member Services

- 12-Month Trend Summary:

    - The Member Services Department received less than one percent (.9%) decrease in calls in May 2022, totaling 12,436 compared to 12,551 in May 2021. Call volume pre-pandemic in May 2019 was 14,462, which is fourteen percent (14%) higher than the current call volume.
    - The abandonment rate for May 2022 was eight percent (8%), compared to seven percent (7%) in May 2021.
    - The Department's service level was sixty-six percent (66%) in May 2022, compared to sixty-seven percent (67%) in May 2021. The Department continues to recruit to fill open positions. Service levels continue to be directly impacted due to staffing challenges (unplanned callouts related to personal or family illnesses with COVID-19). Training of customer call support vendor is ongoing to augment queue support.
    - The average talk time (ATT) was six minutes and thirty seconds (06:30) for May 2022 compared to six minutes and nine seconds (06:09) for May 2021.
    - The top five call reasons for May 2022 were: 1). Change of PCP, 2). Eligibility/Enrollment, 3) Kaiser., 4). Benefits, 5). Provider Network Information. The top five call reasons for May 2021 were: 1). Eligibility/Enrollment, 2). Change of PCP, 3). Kaiser, 4). Benefits, 5). ID Card Requests.
    - The Department continues to service members via multiple non-contact communication channels (telephonic, email, web-based requests) while honoring the organization's policies. The Department responded to six hundred fifty-two (652) web-based requests (20% increase) in May 2022 compared to four hundred ninety-five (495) in May 2021. The top three web reason requests for May 2022 were: 1). ID Card Requests 2). Change of PCP, 3). Update Contact Information.

- Training:

- Routine and new hire training are conducted via (remote) model by the MS Leadership Team until staff returns to the office.

Claims

- 12-Month Trend Summary:
    - The Claims Department received 163,272 claims in May 2022 compared to 129,847 in May 2021.
    - The Auto Adjudication was 83.7% in May 2022 compared to 73.3% in May 2021.
    - Claims compliance for the 30-day turn-around time was 98.7% in May 2022 compared to 96.0% in May 2021. The 45-day turn-around time was 99.9% in May 2022 compared to 99.9% in May 2021

- Training:
    - Routine and new hire training is being conducted remotely by the Claims Trainer.

- Monthly Analysis:
    - In May, we received a total of 163,272 claims in the HEALTHsuite system. This represents a decrease of 13.69% from April and is higher, albeit by 33,425 claims, than the number of claims received in May 2021; the higher volume of received claims remains attributed to COVID-19, COBA implementation, and increased membership.
    - We received 86% of claims via EDI and 14% of claims via paper.
    - During May, 99.9% of our claims were processed within 45 working days.
    - The Auto Adjudication rate was 83.7% for May

Provider Services

- 12-Month Trend Summary:
    - The Provider Services department's call volume in May 2022 was 5,236 calls compared to 5,222 calls in May 2021.
    - Provider Services continuously works to achieve first call resolution and reduction of the abandonment rates. Efforts to promote provider satisfaction is our first priority.

- The Provider Services department completed 248 calls/visits during May 2022.
- The Provider Services department answered 3,903 calls for May 2022 and made 677 outbound calls.

Credentialing

- 12-Month Trend Summary:
    - At the Peer Review and Credentialing (PRCC) meeting held on May 17th, 2022, there were seventeen (17) initial providers approved; six (6) primary care providers, five (5) specialists, one (1) ancillary provider, and five (5) midlevel providers. Additionally, forty-nine (49) providers were re-credentialed at this meeting; twelve (12) primary care providers, twenty-two (22) specialists, one (1) ancillary provider, and fourteen (14) midlevel providers.
    - Please refer to the Credentialing charts and graphs located in the Operations supporting documentation for more information.

Provider Dispute Resolution

- 12-Month Trend Summary:
    - In May 2022, the Provider Dispute Resolution (PDR) team received 737 PDRs versus 859 in May 2021.
    - The PDR team resolved 852 cases in May 2022 compared to 593 cases in May 2021.
    - In May 2022, the PDR team upheld 70% of cases versus 71% in May 2021.
    - The PDR team resolved 98.1% of cases within the compliance standard of 95% within 45 working days in May 2022 compared to 99.5% in May 2021.

- Monthly Analysis:
    - AAH received 737 PDRs in May 2022.
    - In May, 852 PDRs were resolved. Out of the 852 PDRs, 597 were upheld, and 255 were overturned.
    - The overturn rate for PDRs was 30% which did not meet our goal of 25% or less.

Community Relations and Outreach

- 12-Month Trend Summary:
    - In May 2022, the Alliance completed 434-member orientation outreach calls and 151 member orientations by phone.
    - The C&O Department reached 151 people (100% identified as Alliance members) during outreach activities, compared to 162 individuals (100% self-identified as Alliance members) in May 2021.
    - The C&O Department spent a total of $0 in donations, fees, and/or sponsorships, compared to $0 in May 2022.
    - The C&O Department reached members in 15 cities/unincorporated areas throughout Alameda County, Bay Area, and the U.S., compared to 16 cities in May 2021.

- Monthly Analysis:
    - In May 2022, the C&O Department completed 434-member orientation outreach calls and 151 member orientations by phone and 46 Alliance website inquiries.
    - Among the 151 people reached, 100% identified as Alliance members.
    - In May 2022, the C&O Department reached members in 15 locations throughout Alameda County, Bay Area, and the U.S.
    - Please see attached **Addendum A**.

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	May 2022
Incoming Calls (R/V)	12,436
Abandoned Rate (R/V)	8%
Answered Calls (R/V)	11,386
Average Speed to Answer (ASA)	02:20
Calls Answered in 60 Seconds (R/V)	66%
Average Talk Time (ATT)	06:30
Outbound Calls	6,320

Top 5 Call Reasons (Medi-Cal and Group Care) May 2022
Change of PCP
Eligibility/Enrollment
Kaiser
Benefits
Provider Network

Top 3 Web-Based Request Reasons (Medi-Cal and Group Care) May 2022
Change of PCP
ID Card Requests
Update Contact Info

Claims Department
April 2022 Final and May 2022 Final

METRICS

Claims Compliance	Apr-22	May-22
90% of clean claims processed within 30 calendar days	98.7%	98.7%
95% of all claims processed within 45 working days	99.9%	99.9%

Claims Volume (Received)	Apr-22	May-22
Paper claims	23,865	22,061
EDI claims	165,307	141,211
Claim Volume Total	**189,172**	**163,272**

Percentage of Claims Volume by Submission Method	Apr-22	May-22
% Paper	12.62%	13.51%
% EDI	87.38%	86.49%

Claims Processed	Apr-22	May-22
HEALTHsuite Paid (original claims)	107,291	103,670
HEALTHsuite Denied (original claims)	45,904	47,209
HEALTHsuite Original Claims Sub-Total	**153,195**	**150,879**
HEALTHsuite Adjustments	1,396	1,470
HEALTHsuite Total	**154,591**	**152,349**

Claims Expense	Apr-22	May-22
Medical Claims Paid	$56,765,361	$51,796,011
Interest Paid	$32,142	$26,542

Auto Adjudication	Apr-22	May-22
Claims Auto Adjudicated	127,946	126,251
% Auto Adjudicated	83.5%	83.7%

Average Days from Receipt to Payment	Apr-22	May-22
HEALTHsuite	18	18

Pended Claim Age	Apr-22	May-22
0-29 calendar days		
HEALTHsuite	14,827	13,693
30-59 calendar days		
HEALTHsuite	368	383
Over 60 calendar days		
HEALTHsuite	7	4

Overall Denial Rate	Apr-22	May-22
Claims denied in HEALTHsuite	45,904	47,209
% Denied	29.7%	31.0%

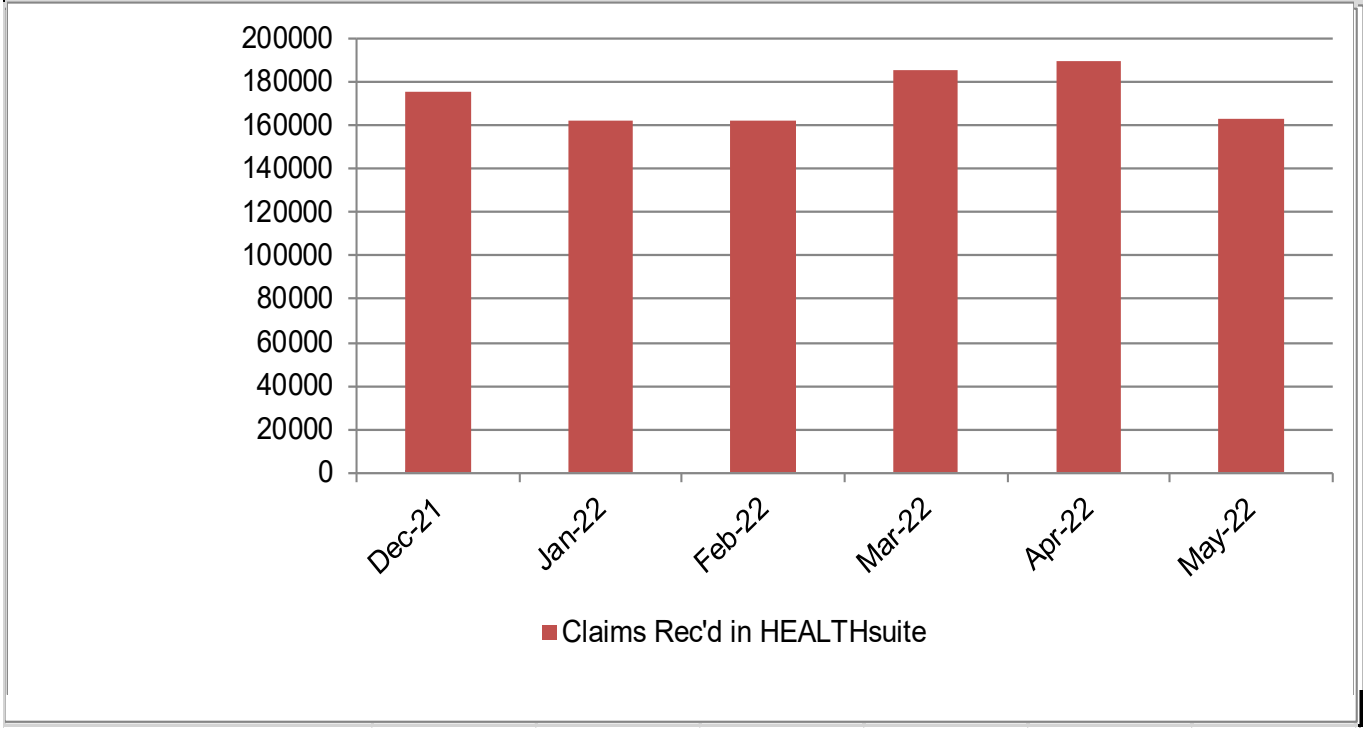
Claims Department
April 2022 Final and May 2022 Final

May-22

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	26%
No Benefits Found For Dates of Service	14%
Non-Covered Benefit for this Plan	12%
Duplicate Claim	9%
This is a Capitated Service	5%
% Total of all denials	**66%**

Claims Received By Month

Claims Received Through	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Claims Rec'd in HEALTHsuite	175,441	162,201	162,433	185,738	189,172	163,272



Provider Relations Dashboard May 2022

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	4810	4334	6078	5767	5236							
Abandoned Calls	626	586	2149	2219	1333							
Answered Calls (PR)	4184	3748	3929	3548	3903							
Recordings/Voicemails	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Incoming Calls (R/V)	332	373	1067	1309	677							
Abandoned Calls (R/V)												
Answered Calls (R/V)	332	373	1067	1309	677							
Outbound Calls	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Outbound Calls	624	680	664	640	677							
N/A												
Outbound Calls	624	680	664	640	677							
Totals	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Total Incoming, R/V, Outbound Calls	5766	5387	7809	7716	6590							
Abandoned Calls	626	586	2149	2219	1333							
Total Answered Incoming, R/V, Outbound Calls	5140	4801	5660	5497	5257							

Provider Relations Dashboard May 2022

Call Reasons (Medi-Cal and Group Care)

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	3.4%	4.2%	3.4%	3.0%	3.3%							
Benefits	4.1%	3.4%	3.1%	3.8%	3.9%							
Claims Inquiry	40.2%	41.5%	40.8%	48.8%	44.8%							
Change of PCP	2.4%	4.0%	4.8%	4.1%	5.0%							
Complaint/Grievance (includes PDR's)	4.9%	5.3%	4.8%	4.2%	3.8%							
Contracts	0.5%	0.7%	0.8%	0.7%	1.1%							
Correspondence Question/Followup	0.0%	0.1%	0.1%	0.1%	0.1%							
Demographic Change	0.1%	0.3%	0.0%	0.1%	0.0%							
Eligibility - Call from Provider	25.3%	23.2%	22.6%	21.4%	23.2%							
Exempt Grievance/ G&A	0.0%	0.1%	0.0%	0.1%	0.0%							
General Inquiry/Non member	0.0%	0.0%	0.0%	0.0%	0.0%							
Health Education	0.0%	0.0%	0.0%	0.0%	0.0%							
Intrepreter Services Request	0.8%	0.4%	0.8%	0.7%	1.0%							
Kaiser	0.0%	0.1%	0.1%	0.7%	0.1%							
Member bill	0.0%	0.2%	0.0%	0.0%	0.0%							
Mystery Shopper Call	0.0%	0.0%	0.0%	0.0%	0.0%							
Provider Portal Assistance	4.5%	5.4%	4.9%	3.9%	4.2%							
Pharmacy	1.2%	0.3%	0.3%	0.3%	0.2%							
Provider Network Info	0.1%	0.1%	0.2%	0.1%	0.1%							
Transferred Call	0.0%	0.0%	0.0%	0.0%	0.0%							
All Other Calls	12.3%	10.8%	13.4%	8.2%	9.2%							
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Field Visit Activity Details

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Claims Issues	9	18	17	12	7							
Contracting/Credentialing	8	10	28	20	12							
Drop-ins	0	0	0	0	0							
JOM's	1	2	3	1	4							
New Provider Orientation	22	15	34	22	22							
Quarterly Visits	211	274	159	175	201							
UM Issues	2	4	2	1	2							
Total Field Visits	253	323	243	231	248	0	0	0	0	0	0	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS

Practitioners		AHP 404	PCP 352	SPEC 625	PCP/SPEC 15
AAH/AHS/CHCN Breakdown		AAH 401	AHS 159	CHCN 428	COMBINATION OF GROUPS 408
Facilities	**294**				

VENDOR SUMMARY
Credentialing Verification Organization, Symply CVO

	Number	Average Calendar Days in Process	Goal - Business Days	Goal - 98% Accuracy	Compliant
Initial Files in Process	5	3	25	Y	Y
Recred Files in Process	8	6	25	Y	Y
Expirables updated Insurance, License, DEA, Board Certifications					Y
Files currently in process	**13**				

CAQH Applications Processed in May 2022

	Invoice not received
Standard Providers and Allied Health	

May 2022 Peer Review and Credentialing Committee Approvals

Initial Credentialing	Number
PCP	6
SPEC	5
ANCILLARY	1
MIDLEVEL/AHP	5
	17
Recredentialing	
PCP	12
SPEC	22
ANCILLARY	1
MIDLEVEL/AHP	14
	49
TOTAL	**66**

May 2022 Facility Approvals

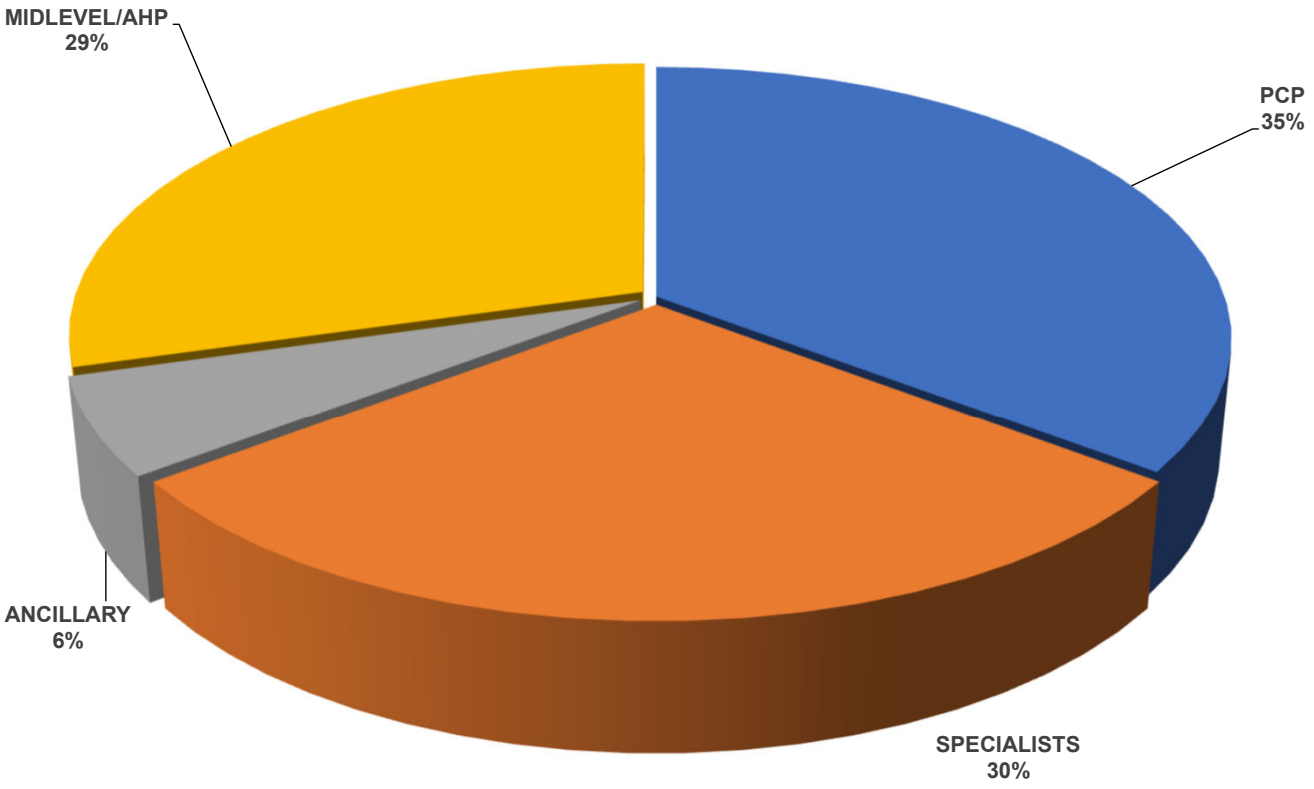
Initial Credentialing	1
Recredentialing	8
Facility Files in Process	**35**

May 2022 Employee Metrics	4	
File Processing	Timely processing within 3 days of receipt	Y
Credentialing Accuracy	<3% error rate	Y
DHCS, DMHC, CMS, NCQA Compliant	98%	Y
MBC Monitoring	Timely processing within 3 days of receipt	Y

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RECRED	CRED DATE
Angle	Niren	Specialist	5/17/2022	INITIAL
Athos	Laurence	Specialist	5/17/2022	INITIAL
Baron	John	Specialist	5/17/2022	INITIAL
Bushman	Leah	Allied Health	5/17/2022	INITIAL
Cordova	Ryan	Ancillary	5/17/2022	INITIAL
Di Franco	Pamela	Allied Health	5/17/2022	INITIAL
Lemp	Melissa	Primary Care Physician	5/17/2022	INITIAL
Mendez	Ricardo	Allied Health	5/17/2022	INITIAL
Milne	Lawrence	Specialist	5/17/2022	INITIAL
Nguyen	Thanh Trung	Allied Health	5/17/2022	INITIAL
Parekh	Sejal	Primary Care Physician	5/17/2022	INITIAL
Poon	James	Allied Health	5/17/2022	INITIAL
Seshadri	Sheshashree	Primary Care Physician	5/17/2022	INITIAL
Shahi	Rajvir	Primary Care Physician	5/17/2022	INITIAL
Sombredero-Sanchez	Alisson	Primary Care Physician	5/17/2022	INITIAL
Spicher	Allison	Primary Care Physician	5/17/2022	INITIAL
Suarez	David	Specialist	5/17/2022	INITIAL
Alwattar	Basil	Specialist	5/17/2022	RECRED
Armani	Kathy	Ancillary	5/17/2022	RECRED
Balakrishnan	Sangeetha	Specialist	5/17/2022	RECRED
Beg	Sumbul	Specialist	5/17/2022	RECRED
Britt	William	Allied Health	5/17/2022	RECRED
Carter	Kristine	Allied Health	5/17/2022	RECRED
Chawla	Harman	Specialist	5/17/2022	RECRED
DeGalan	Steven	Specialist	5/17/2022	RECRED
Deutsch	Robert	Specialist	5/17/2022	RECRED
Duir	Kimberly	Primary Care Physician	5/17/2022	RECRED
Ellis	Selena	Specialist	5/17/2022	RECRED
Fagan	James	Specialist	5/17/2022	RECRED
Gersten	Dana	Primary Care Physician	5/17/2022	RECRED
Goodman	Suzan	Specialist	5/17/2022	RECRED
Gordon	Stracey	Allied Health	5/17/2022	RECRED
Kang	Steven	Specialist	5/17/2022	RECRED
Kaur	Harpreet	Allied Health	5/17/2022	RECRED
Lahsaei	Saba	Specialist	5/17/2022	RECRED
Lam	Julia	Primary Care Physician	5/17/2022	RECRED
Lande	Arthur	Primary Care Physician	5/17/2022	RECRED
Lien	Kenneth	Specialist	5/17/2022	RECRED
Lopez	Monica	Specialist	5/17/2022	RECRED
Madathanapalli	Padmavathi	Primary Care Physician	5/17/2022	RECRED
Majarian	Jennifer	Allied Health	5/17/2022	RECRED
Marriner	Ken	Primary Care Physician	5/17/2022	RECRED
McDonald	Shivaun	Allied Health	5/17/2022	RECRED
Merjavy	Stephen	Primary Care Physician	5/17/2022	RECRED
Nachtwey	Frederick	Specialist	5/17/2022	RECRED
Nguyen	Tam	Primary Care Physician	5/17/2022	RECRED
Nguyen-Magdael	Gina	Allied Health	5/17/2022	RECRED
Ortlip	Timothy	Specialist	5/17/2022	RECRED
Poggio	Anthony	Specialist	5/17/2022	RECRED
Reier	Alice	Specialist	5/17/2022	RECRED
Rhodes	Katherine	Allied Health	5/17/2022	RECRED
Rishi	Rahul	Specialist	5/17/2022	RECRED
Rogers	Kallyn	Allied Health	5/17/2022	RECRED
Rosenfield	Michael	Primary Care Physician	5/17/2022	RECRED
Sabharwal	Maskeen	Specialist	5/17/2022	RECRED
Sata	Nicole	Allied Health	5/17/2022	RECRED
Silkiss	Rona	Specialist	5/17/2022	RECRED
Singh	Harpreet	Primary Care Physician	5/17/2022	RECRED
Smith	Amy	Allied Health	5/17/2022	RECRED
Staples	Omar	Allied Health	5/17/2022	RECRED
Sundar	Shalini	Specialist	5/17/2022	RECRED
Takeda	Alisa	Primary Care Physician	5/17/2022	RECRED
Trilesskaya	Marina	Specialist	5/17/2022	RECRED
Trinclisti	Bonita	Allied Health	5/17/2022	RECRED
Tsao	Lilian	Primary Care Physician	5/17/2022	RECRED
Wren	Jyesha	Allied Health	5/17/2022	RECRED

MAY PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY

PCP	6
Specialists	5
Ancillary	1
MIDLEVEL/AHP	5
Total	17



Provider Dispute Resolution
April 2022 and May 2022

METRICS

PDR Compliance	Apr-22	May-22
# of PDRs Resolved	878	852
# Resolved Within 45 Working Days	877	836
% of PDRs Resolved Within 45 Working Days	99.9%	98.1%

PDRs Received	Apr-22	May-22
# of PDRs Received	962	737
PDR Volume Total	**962**	**737**

PDRs Resolved	Apr-22	May-22
# of PDRs Upheld	589	597
% of PDRs Upheld	67%	70%
# of PDRs Overturned	289	255
% of PDRs Overturned	33%	30%
Total # of PDRs Resolved	**878**	**852**

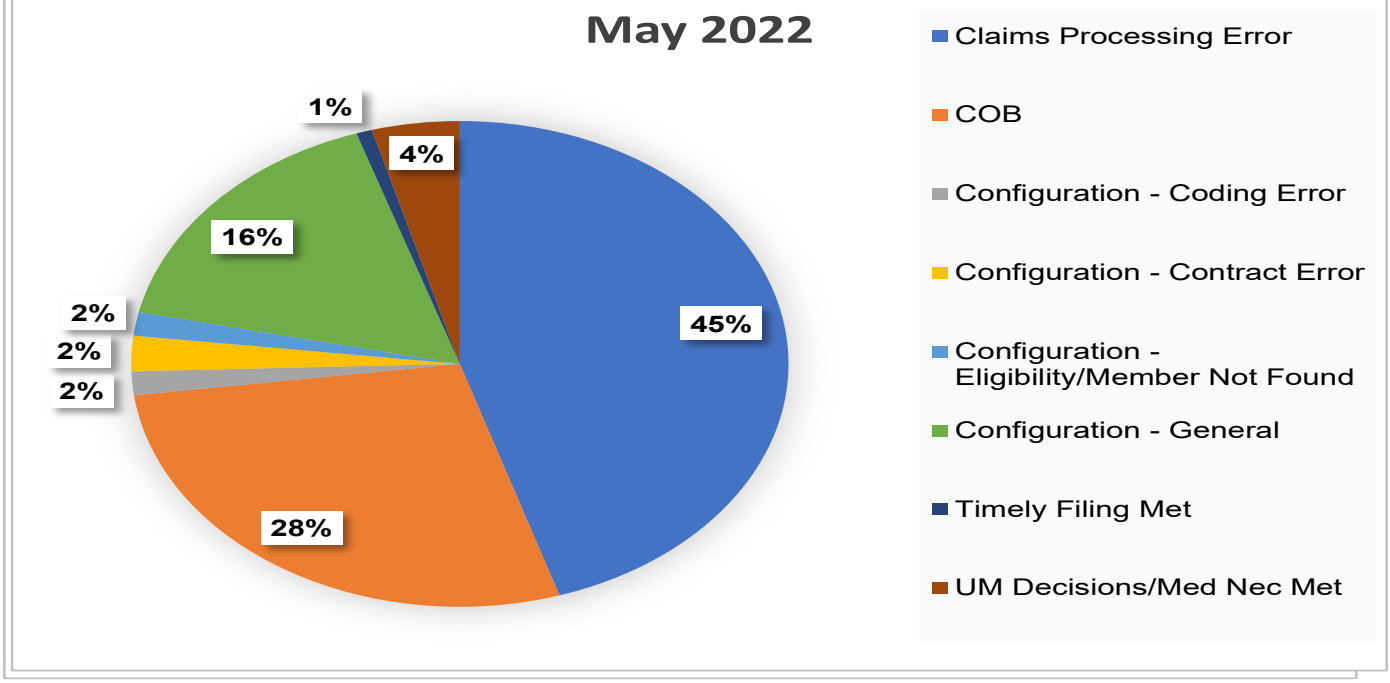
Average Turnaround Time	Apr-22	May-22
Average # of Days to Resolve PDRs	26	29
Oldest Unresolved PDR in Days	52	85

Unresolved PDR Age	Apr-22	May-22
0-45 Working Days	1,081	799
Over 45 Working Days	1	0
Total # of Unresolved PDRs	**1,082**	**799**

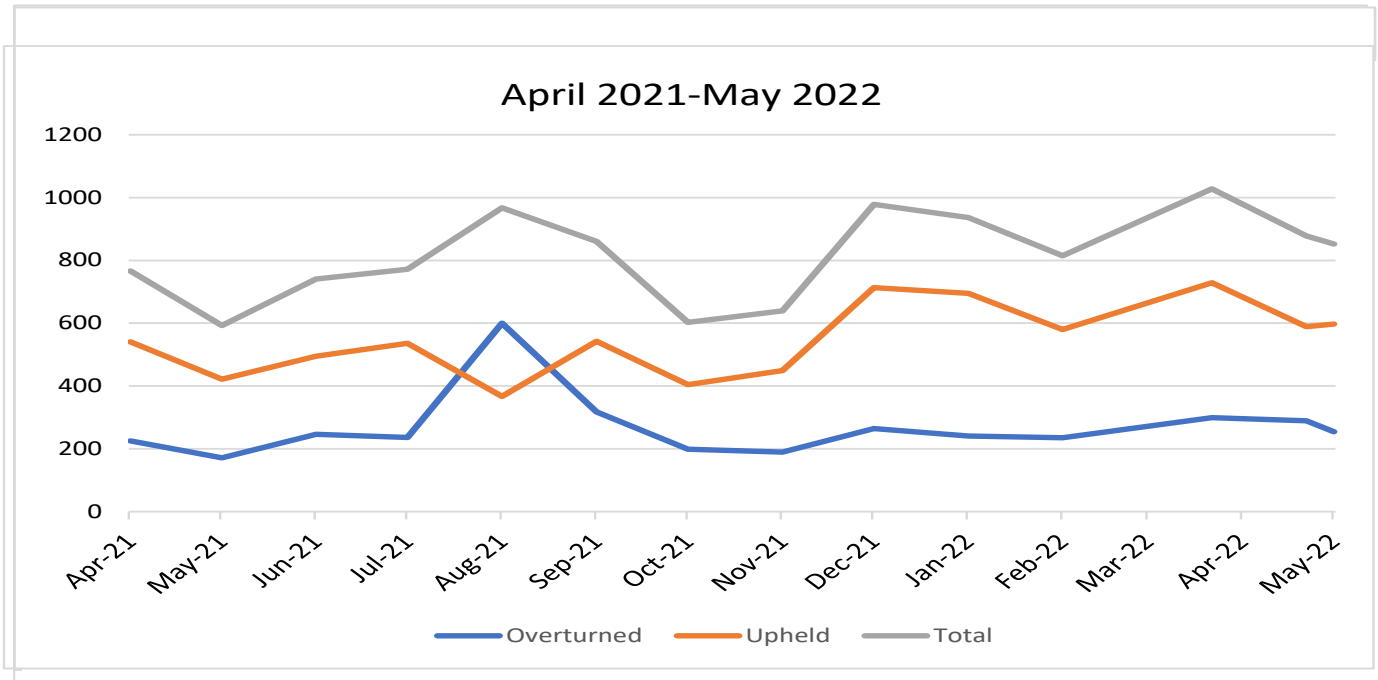
Provider Dispute Resolution
April 2022 and May 2022

May-22

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



ALLIANCE IN THE COMMUNITY

FY 2021-2022 | MAY 2022 OUTREACH REPORT

During May 2022, the Alliance completed **434** member orientation outreach calls and conducted **151** member orientations (**35%** member participation rate). In addition, in May 2022, the Outreach team completed **46** Alliance website inquiries.

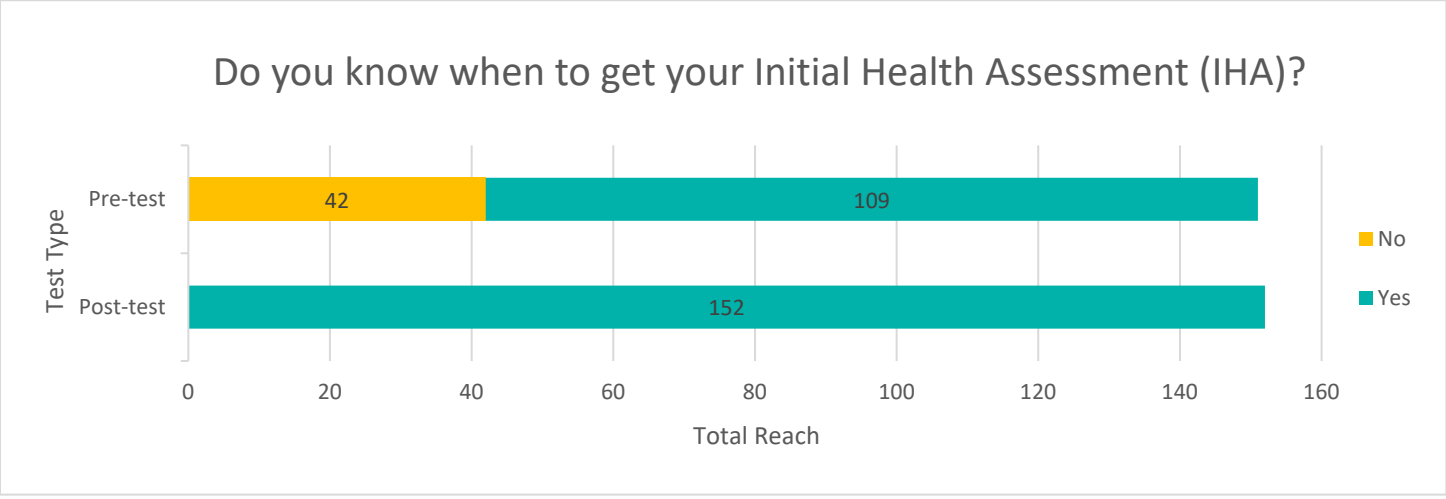
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **25,151** self-identified Alliance members have been reached during outreach activities.

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

On **Wednesday, March 18th, 2020,** the Alliance began conducting member orientations by phone. As of May 31st, 2022, the Outreach Team completed 18,854-member orientation outreach calls and conducted 5,326 member orientations (28% member participation rate).

The Alliance Member Orientation (MO) program has been in place since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Assessment, by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between May 1st, through May 31st, 2022 (21 working days) – **151** net new members completed a MO by phone.

After completing a MO **100%** of members who completed the post-test survey in May 2022 reported knowing when to get their IHA, compared to only **72.2%** of members knowing when to get their IHA in the pre-test survey.



All report details can be reviewed at: **W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Outreach Reports\FY 21-22\Q4\2. May**

FY 2020-2021 MAY 2021 TOTALS

- 0 COMMUNITY EVENTS
- 0 MEMBER EDUCATION EVENTS
- 161 MEMBER ORIENTATIONS
- 1 MEETINGS/ PRESENTATIONS/
- 0 COMMUNITY TRAINING
- 0 TOTAL INITIATED/ INVITED EVENTS
- 162 TOTAL COMPLETED **EVENTS**

16 CITIES

Alameda
Albany
Berkeley
Castro Valley
Dublin
El Sobrante
Fremont
Hayward
Livermore
Newark
Oakland
Pleasanton
Sacramento
San Leandro
San Lorenzo
Union City

- 0 TOTAL REACHED AT COMMUNITY EVENTS
- 0 TOTAL REACHED AT MEMBER EDUCATION EVENTS
- 161 TOTAL REACHED AT MEMBER ORIENTATIONS
- 3 TOTAL REACHED AT MEETINGS/PRESENTATIONS
- 0 TOTAL REACHED AT COMMUNITY TRAINING
- 162 MEMBERS REACHED AT ALL EVENTS
- 164 **TOTAL REACHED AT ALL EVENTS**

$0.00
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

FY 2021-2022 MAY 2022 TOTALS

- 0 COMMUNITY EVENTS
- 0 MEMBER EDUCATION EVENTS
- 151 MEMBER ORIENTATIONS
- 0 MEETINGS/ PRESENTATIONS
- 0 COMMUNITY TRAINING
- 0 TOTAL INITIATED/ INVITED EVENTS
- 151 TOTAL COMPLETED **EVENTS**

15 CITIES*

Alameda
Berkeley
Castro Valley
Dublin
Elk Grove
Fremont
Hayward
Livermore
Newark
Oakland
Piedmont
Pleasanton
San Leandro
San Lorenzo
Union City

- 0 TOTAL REACHED AT COMMUNITY EVENTS
- 0 TOTAL REACHED AT MEMBER EDUCATION EVENTS
- 151 TOTAL REACHED AT MEMBER ORIENTATIONS
- 0 TOTAL REACHED AT MEETINGS/PRESENTATIONS
- 0 COMMUNITY TRAINING
- 151 MEMBERS REACHED AT ALL EVENTS
- 151 **TOTAL REACHED AT ALL EVENTS**

$0.00
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

**Cities represent the mailing address designations for members who completed a member orientation by phone. The italicized cities are outside of Alameda County. The C&O Department started including these cities in the Q3 FY21 Outreach Report.*

Compliance

Richard Golfin III

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

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

Date: **June 10th, 2022**

Subject: **Compliance Division Report**

Compliance Audit Updates

- 2022 DHCS Routine Medical Survey:
  - The 2022 DHCS Routine Medical Survey has concluded the on-site portion of the review process. The audit began on April 4th, 2022 and was completed early on April 13th, 2022. The review covered the following areas:
    - Utilization Management;
    - Case Management & Care Coordination;
    - Access & Availability;
    - Member's Rights & Responsibilities;
    - Quality Improvement System; and
    - Organization and Administration.
  - The Plan continues to respond to DHCS inquiries, which may resolve any remaining questions prior to the preliminary report being issued.

- 2022 DMHC Routine Financial Examination:
  - On May 23rd, 2022, the DMHC sent formal notice to the Plan of the 2022 DMHC Routine Financial Examination beginning August 15th, 2022. The audit will review the Plan's fiscal and administrative affairs and activities through the quarter-ending March 31st, 2022. Staff are currently preparing the pre-audit documentation, which is due on July 15th, 2022.

- 2022 DMHC Behavioral Health Investigation:
  - In 2021, the DMHC began investigating full-service commercial health plans to evaluate and assess barriers providers experience in providing behavioral health services. The DMHC has announced it plans to conduct on average, 5-investigations per year with the first five plans having been investigated in 2021.
  - On May 9th, 2022, the Plan received notice that the DMHC will conduct interviews with staff from the Plan and its delegate beginning September 5th, 2022. The review period for this audit is from April 1st, 2020, through April 30th, 2022. This audit will exclude Medi-Cal members.
  - The Plan has been working on submitting its pre-audit documentation to the DMHC, which has been a collaborative process with the Plan's delegate, Beacon. All pre-audit documents are due on June 23rd, 2022.

- 2022 NCQA Re-Accreditation Survey:
    - On February 24th, 2022, the Plan received confirmation from the National Committee of Quality Assurance (NCQA) of its 2022 Re-Accreditation Survey. The Audit is scheduled to begin on June 7th, 2022, with an on-site portion to last from July 25th, 2022, through July 26th, 2022. Staff are working internally and with delegates to close out the last of the requested documents from the review team.
    - The Plan holds active accreditation for both its Medi-Cal and Commercial Lines of Business.

- 2022 DMHC Risk Bearing Organization (RBO) Reviews:
    - On May 20th, 2022, the Plan received notification that the DMHC will conduct an Examination (Audit) of Children First Medical Group (CFMG) and Community Health Center Network (CHCN). The Examination will focus on claims settlement practices and dispute resolution mechanisms for both delegates. DMHC Auditors will review one quarter of data from January 1st, 2022, through March 31st, 2022. The Plan completed submission of CHCN audit documentation on June 8th, 2022. The Plan anticipates completion of the CFMG submission by June 15th, 2022. The DMHC will conduct their reviews of Plan submissions in July 2022.

- 2021 DMHC Full Medical Survey:
    - The 2021 DMHC Routine Medical Survey, virtual audit took place from April 13th, 2021, through April 16th, 2021. On May 25th, 2022, the Plan received its 2021 Preliminary Audit Report and survey results. The preliminary report had a total of six (6) findings: three (3) in Grievances and Appeals; and three (3) in Prescription Drug Coverage. The Preliminary Report has been distributed internally to Plan staff, who are currently drafting responses to each of the findings. The Plan's response is due 45-days after receipt of the preliminary report, on July 9th, 2022.

- 2020 DHCS Kindred Focused Audit:
    - On October 23rd, 2020, the DHCS sent notice to the Plan of a focused audit involving the Plan's delegate, CHCN, and Kindred facilities. The Plan submitted its CAP response and stated CAP milestones which involves Audits of the delegate's Concurrent Review Process and Notice of Action letters. On April 19th, 2022, the DHCS found that all CAPs and milestones were met and subsequently closed the audit.

Delegation Oversight Audit Activity Updates

- 2022 Kaiser Collaborative Plan Audit:
    - As part of a joint collaborative effort among Northern California Medi-Cal health plans, the Kaiser Foundation Health Plan audit is divided into sections to be completed by each Plan sponsor holding subcontracting agreements with Kaiser. For 2022, the Alliance has been assigned to review Network Management. The Plan must also complete file reviews for the following oversight areas: Claims, PDR, UM, Appeals and Grievances,

NPT, NEMT/NMT, MH, BHT, CCM. The remaining delegated audit functions will be assigned to other Plans.

Compliance Activity Updates

- 2022 RFP Contract Award & Review:
  - On February 9th, 2022, the DHCS released Request for Proposal (RFP) #20-10029 soliciting submissions for the 2024 Contract for the provision of managed health care services to Medi-Cal beneficiaries. The contract award is expected in August 2022, with implementation to take place through December 31st, 2023.

  - On June 2nd, 2022, the Staff presented to the Local Health Plans of California (LHPC) Compliance Officer's Workgroup on Provision 1.3 of the RFP Contract. The key changes and requirements that were discussed include:
    - (1) Development of a Compliance program adhering to the components listed in Provision 1.3.1;
    - (2) Development of a Fraud, Waste and Abuse Prevention program, including designation of a fraud prevention officer who will be responsible for developing, implementing, and ensuring compliance with the Fraud Prevention program;
    - (3) The prohibition of delegating program integrity and compliance program functions;
    - (4) Oversight of sub-contractor program integrity and compliance programs;
    - (5) The public posting of corrective action plans (CAPs) including resolution activity.

  - Staff are continuing discussions of the RFP Contract with LHPC to strategize on the implementation of various key changes. The DHCS is planning an RFP kick-off June 15th, 2022, with select Plans to discuss 2024 Contract Operational Readiness.

- DHCS Contract Exhibit G – Business Associate Addendum:
  - In the fall of 2021, the Plan received proposed changes to Exhibit G of the DHCS contract. Those changes were placed on hold by DHCS in November 2021. The Plan has completed its analysis of the new Exhibit G and is prepared to implement its recommended changes to materials and procedures once a date of execution is received from DHCS. The Plan anticipates elements of the new Exhibit G will be incorporated into the 2024 Contract.

Compliance

Supporting Documents

2022 APL/PL IMPLEMENTATION TRACKING LIST						
#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
1	DMHC	22-001	1/4/2022	LARGE GROUP RENEWAL NOTICE REQUIREMENTS	MEDI-CAL	California Health and Safety Code (HSC) section 1374.21, subdivision (a)(2) requires all commercial full-service health care service plans ("plans") to comply with disclosure requirements relating to large group renewal notices. Specifically, no change in premium rates or changes in coverage stated in a large group health care service plan contract shall become effective unless the plan has delivered in writing a notice indicating the change or changes at least 120 days prior to the contract renewal effective date.
2	DHCS	22-001	1/11/2022	2022-2023 MEDI-CAL MANAGED CARE HEALTH PLAN MEDS/834 CUTOFF AND PROCESSING SCHEDULE	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with the 2022-2023 Medi-Cal Eligibility Data System (MEDS)/834 cutoff and processing schedule.
3	DMHC	22-002	1/19/2022	HOSPITAL BLOCK TRANSFER FILINGS FOR PPO ENROLLEES	MEDI-CAL	The Department of Managed Health Care is reminding health care service plans to comply with the Block Transfer filing and notice requirements applicable to hospital contract terminations affecting PPO enrollees. The block transfer statute and regulation is not limited in applicability to a particular product type and therefore applies to PPO products. Accordingly, health plans shall submit a Block Transfer filing for hospital contract terminations that will result in the redirection of 2,000 or more PPO enrollees (or PPO combined with other lines of business).
4	DMHC	22-003	1/21/2022	ASSEMBLY BILL 457 PROTECTION OF PATIENT CHOICE IN TELEHEALTH PROVIDER ACT	GROUP CARE	On October 1, 2021, Governor Gavin Newsom signed AB 457, which amends Section 1374.14 and adds Section 1374.141. Section 1374.141 requires a plan to meet certain conditions if it offers telehealth services to an enrollee through a third-party corporate telehealth provider. AB 457 also requires a plan that provides services to an enrollee through a third-party corporate telehealth provider to (a) notify the enrollee of their right to access their medical records, (b) share the records of any telehealth services provided with the enrollee's PCP, (c) ensure such records are shared with the enrollee's PCP unless the enrollee objects, and (d) notify the enrollee that all services received through the thirdparty corporate telehealth provider are available at in-network cost-sharing and all costsharing shall accrue to the out-of-pocket maximum and deductible (if any).
5	DMHC	22-004	1/21/2022	ASSEMBLY BILL 347 STEP THERAPY EXCEPTION COVERAGE GUIDANCE	MEDI-CAL & GROUP CARE	On October 9, 2021, Governor Gavin Newsom signed Assembly Bill (AB) 347. AB 347 requires health care service plans (health plans or plans), effective January 1, 2022, to expeditiously grant step therapy exceptions within specified time periods when use of the prescription drug required under step therapy is inconsistent with good professional practice. AB 347 also permits providers to appeal a health plan's denial of an exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request.
6	DMHC	22-005	1/25/2022	FEDERAL REQUIREMENT TO COVER AT-HOME COVID-19 TESTS PURCHASED OVER-THE COUNTER	GROUP CARE	On January 10, 2022, the federal Departments of Labor, Health and Human Services,and the Treasury issued guidance regarding commercial health plan coverage of athome, over-the-counter COVID-19 tests (OTC COVID-19 tests) authorized by the U.S. Food and Drug Administration.
7	DMHC	22-006	2/1/2022	PLAN YEAR 2023 QHP AND QDP FILING REQUIREMENTS	MEDI-CAL & GROUP CARE	The DMHC offers current and prospective Qualified Health and Dentla Plans, Covered California for Small Business Issuers, and health plans offering non-grandfathered Individual and Small Group product(s) outside of the California Health Benefit Exchange (Covered Calfornia), guidance to assist in the preparation of Plan Year 2023 regulatory submissions, in compliance with Knox-Keene Act at California Health and Safety Code Sections 1340.
8	DMHC	22-007	3/4/2022	DPN MONITORING AND ANNUAL REPORTING CHANGES	MEDI-CAL & GROUP CARE	This All Plan Letter (APL) provides an overview of the changes to monitoring and annual reporting of the Timely Access Compliance Report and the Annual Network Report, as required under the Knox-Keene Act.
9	DMHC	22-008	3/9/2022	2022 ANNUAL ASSESSMENTS	MEDI-CAL & GROUP CARE	The Report of Enrollment Plan, as required by Health and Safety Code section 1356 and the California Code of Regulations, title 28, section 1300.84.6(a) must be filed with DMHC no later than May 15, 2022.
10	DHCS	22-002	3/14/2022	ALTERNATIVE FORMAT SELECTION FOR MEMBERS WITH VISUAL IMPAIRMENTS	MEDI-CAL & GROUP CARE	The purpose of this All Plan Letter (APL) is to provide information about the Department of Health Care Services' (DHCS) processes to ensure effective communication with members with visual impairments or other disabilities requiring the provision of written materials in alternative formats, by tracking members' alternative format selections (AFS).

2022 APL/PL IMPLEMENTATION TRACKING LIST						
#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
11	DMHC	22-009	3/16/2022	PROVIDER DIRECTORY ANNUAL FILING REQUIREMENTS	MEDI-CAL & GROUP CARE	California Health and Safety Code section 1367.27, subdivision (m), requires health care service plans to annually submit provider directory policies and procedures to the Department of Managed Health Care (Department).
12	DMHC	22-010	3/17/2022	GUIDANCE REGARDING AB 1184 - CONFIDENTIALITY OF MEDICAL INFORMATION	MEDI-CAL & GROUP CARE	On September 22, 2021, Governor Gavin Newsom signed AB 1184, which amends the Confidentiality of Medical Information Act to require plans to take specified steps to protect the confidentiality of a subscriber's or enrollee's medical information.
13	DHCS	22-003	3/17/2022	MEDI-CAL MANAGED CARE HEALTH PLAN RESPONSIBILITY TO PROVIDE SERVICES TO MEMBERS WITH EATING DISORDERS	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with clarification and guidance regarding their responsibility to coordinate and provide medically necessary services for members who are diagnosed with feeding and eating disorders and are currently receiving Specialty Mental Health Services (SMHS) from a county Mental Health Plan (MHP). Corresponding guidance to MHPs is contained in Behavioral Health Information Notice (BHIN) 22-009.
14	DHCS	22-004	3/17/2022	STRATEGIC APPROACHES FOR USE BY MANAGED CARE PLANS TO MAXIMIZE CONTINUTIY OF COVERAGE AS NORMAL ELIGIBILITY AND ENROLLMENT OPERATIONS RESUME	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide instruction to Medi-Cal managed care health plans (MCPs) about strategies that must be used by MCPs in collaboration with counties to help ensure eligible beneficiaries retain coverage in Medi-Cal and ease transitions for individuals eligible for coverage through Covered California as the Department of Health Care Services (DHCS) prepares for the resumption of normal operations after the end of the COVID-19 Public Health Emergency (PHE).
15	DMHC	22-011	3/21/2022	NO SURPRISES ACT (NSA) GUIDANCE	GROUP CARE	Effective for plan years beginning on or after January 1, 2022, the NSA prohibits surprise balance billing, as specified, and establishes other consumer protections. To date, the federal government has issued four rulemaking packages, issued guidance, and established a dedicated web page, No Surprises to implement the NSA.
16	DMHC	22-012	3/24/2022	SECTION 1357.503 COMPLIANCE AND MEWA REGISTRATION	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to inform health care service plans (Plans) and association of employers defined as multiple employer welfare arrangement (MEWA) of the requirements of SB 255 (Portantino, Ch. 725, Stats. 2021) and SB 718 (Bates, Ch. 736, Stats. 2021), including California Health and Safety Code section 1357.503. This APL discusses the requirements of Section 1357.503, including requirements of Plans, registration of MEWAs, and other requirements.
17	DHCS	22-005	3/30/2022	NO WRONG DOOR FOR MENTAL HEALTH SERVICES POLICY	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCP) with guidance and clarification regarding the No Wrong Door for Mental Health Services policy. This policy ensures that members receive timely mental health services without delay regardless of the delivery system where they seek care and that members are able to maintain treatment relationships with trusted providers without interruption.
18	DMHC	22-013	4/6/2022	COMPLIANCE WITH SENATE BILL 368	GROUP CARE	On October 6, 2021, Governor Gavin Newsom signed Senate Bill (SB) 368. SB 368 requires individual or group health care service plan (health plans or plans) contracts, issued, amended, or renewed on or after July 1, 2022, to provide enrollees with their up-to-date accrual towards their annual deductible and out-of-pocket maximum for every month benefits were used until the accrual balances are met. SB 368 also requires plans to notify enrollees of their rights to such accrual information and the ability to opt in to receiving the accrual information electronically instead of via mail. Delegated entities with claims payment functions must also comply with the provisions of SB 368.
19	DHCS	22-006	4/8/2022	MEDI-CAL MANAGED CARE HEALTH PLAN RESPONSIBILITIES FOR NON-SPECIALTY MENTAL HEALTH SERVICES	MEDI-CAL	The purpose of this All Plan Letter (APL) is to explain the responsibilities of Medi-Cal managed care health plans (MCPs) for the provision or arrangement of clinically appropriate and covered non-specialty mental health services (NSMHS) and the regulatory requirements for the Medicaid Mental Health Parity Final Rule (CMS-2333-F). This APL also delineates MCP responsibilities for referring to, and coordinating with, County Mental Health Plans (MHPs) for the delivery of specialty mental health services (SMHS).
20	DMHC	22-014	4/25/2022	SENATE BILL 510 COVID-19 TESTING AND VACCINATION COVERAGE GUIDANCE	MEDI-CAL & GROUP CARE	SB 510 requires health care service plans (health plans) to cover, among other things, the costs associated with COVID-19 diagnostic and screening testing and immunization against COVID-19 without cost-sharing, prior authorization, utilization management, or in-network requirements.
21	DMHC	22-015	5/31/2022	FINANCIAL REPORTING REGULATION	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to notify health care service plans (health plans) about the recent amendments to the annual, quarterly, and monthly financial reporting requirements.

2022 APL/PL IMPLEMENTATION TRACKING LIST						
#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
22	DHCS	22-007	5/5/2022	CALIFORNIA HOUSING AND HOMELESSNESS INCENTIVE PROGRAM	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCP) with guidance on the incentive payments linked to the Housing and Homelessness Incentive Program (HHIP) implemented by the California Department of Health Care Services (DHCS) in accordance with the Medi-Cal Home and CommunityBased Services (HCBS) Spending Plan.
23	DHCS	22-008	5/18/2022	NON-EMERGENCY MEDICAL AND NON-MEDICAL TRANSPORTATION SERVICES AND RELATED TRAVEL EXPENSES	MEDI-CAL	This All Plan Letter (APL) provides Medi-Cal managed care health plans (MCPs) with guidance regarding Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services. In addition, this APL clarifies MCP responsibilities regarding the coverage of transportation for pharmacy services with the implementation of Medi-Cal Rx, Medi-Cal enrollment requirements for transportation providers, as well as MCP coverage of transportation related travel expenses.

ALAMEDA Alliance FOR HEALTH

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

Health Care Services

Steve O'Brien, MD

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

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

Date: **June 10th, 2022**

Subject: **Health Care Services Report**

Utilization Management: Outpatient

- The carve in of Major Organ Transplant/Bone Marrow Transplant (MOT/BMT) went live on 1/1/2022. So far, 139 members in various stages of the Transplant process are being managed, and the systems developed to coordinate care between UM, CM and the Centers of Excellence are working well. UCSF has 83% of the cases (primarily kidney and liver); Stanford 7%; Out of network (Sutter) 10%; (cornea specialists).

- Progress continues with UM/Claims/Configuration alignment, now adding in the Pharmacy claims. Standardization improves accuracy and timeliness of claims payment through appropriate data integration between the authorization process and the claims processing. This results in fewer instances of accrued interest because of claim payment delays. This project is also supporting accurate reporting of data to the state for a variety of initiatives.

- CCS process enhancements are underway to integrate into the larger EPSDT strategy. Reports on shared members and workflows are being refined and will be used to enhance the coordination of care between AAH and CCS on our mutual members under age 21. There is also coordination of effort to assist hospitals not currently paneled with CCS to become paneled.

- The process to refer members to Tertiary/Quaternary (T/Q) centers for specialized care is being revised to ensure that members appropriate for this higher-level care receive it in the most appropriate setting. Prior authorization will be required for office visits and consultations to a T/Q center, (ex. UCSF, Stanford) using a standard process reviewing appropriateness of referrals and transitions to T/Q centers.

Outpatient Authorization Denial Rates			
Denial Rate Type	**March 2022**	**April 2022**	**May 2022**
Overall Denial Rate	**4.6%**	**4.3%**	**3.7%**
Denial Rate Excluding Partial Denials	**4.0%**	**3.7%**	**3.2%**
Partial Denial Rate	**0.6%**	**0.6%**	**0.5%**

Turn Around Time Compliance			
Line of Business	**March 2022**	**April 2022**	**May 2022**
Overall	**98%**	**98%**	**98%**
Medi-Cal	**98%**	**98%**	**98%**
IHSS	**100%**	**99%**	**98%**
Benchmark	***95%***	***95%***	***95%***

Utilization Management: Inpatient

- The IP team has developed workflows, standard work, and reports to manage members with catastrophic illness or injury, to ensure that they receive high quality, timely care in the right setting. Reports are discussed at Utilization Management Committee and Medical Expense committee. Part of the workflow includes communication to Finance for more refined forecasting of medical expense.

- IP Team implemented Unsafe Discharge & Administrative Day Review workflow, conducted staff training on inpatient admissions that meet criteria for review and standard practice for escalation to Medical Directors. Internal focused audit of relevant cases was also conducted and will be presented at Utilization Management Committee.

- IP UM Department underwent training on appropriate submission of PQI (Potential Quality Incident) for hospital acquired infections. Inpatient stays during which a member acquired a multi drug resistant organism infection are identified by IP UM team and referred to Quality Team for review and follow up.

- Inpatient department continues to track COVID admissions: Covid admissions increased slightly in the month of May, however, continue to remain low, consistent with Alameda County data. There are also fewer Intensive Care days than in the earlier time periods, and significantly shorter than average length of stay.

- Weekly complex/long stay patient rounds continue with partner hospitals and CHCN with a goal of removing barriers to discharge. The focus of these rounds is on members with catastrophic injury or illness, longer lengths of stay, and patients

with challenging barriers to placement. Opportunities are identified for referral to ECM, Community Supports, and Case Management for high risk members.

- Readmission reduction: CM is continuing to collaborate with hospital partners and with their community-based TOC programs to focus on readmission reduction, aligning with their readmission reduction goals. There has been CM leadership changes at AHS, and AAH is re-establishing the partnership. Data on readmission drivers is being refined to focus efforts. One data refinement opportunity appears to be the misidentification of Transfers between acute hospitals as a readmission.

- AAH has engaged with CHCN to fund the Care Transition RN program to facilitate access to follow up care with the FQHC clinics and referrals for ongoing care after hospitalization. This initiative extends the reach of the TOC program to more hospitals and strengthens the relationship with AAH's largest delegate, CHCN.

Inpatient Med-Surg Utilization Total All Aid Categories Actuals (excludes Maternity)			
Metric	**February 2022**	**March 2022**	**April 2022**
Authorized LOS	**5.2**	**5.0**	**4.6**
Admits/1,000	**51.7**	**55.8**	**48.6**
Days/1,000	**268.5**	**278.6**	**223.1**

Pharmacy

- Pharmacy Services process outpatient pharmacy claim, and pharmacy prior authorization (PA) has met turn-around time compliance for all lines of business.

Decisions	Number of PAs Processed
Approved	20
Denied	27
Closed	20
Total	**67**

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

- Medications for hepatitis B, Diabetes, Osteoporosis, Glaucoma, Constipation, Irritable Bowel Disease, Nasal Allergies and Weight Management are top ten categories for denials.

Rank	Drug Name	Common Use	Common Denial Reason
1	VEMLIDY 25 MG TABLET	Hepatitis B	Criteria for approval not met
2	JARDIANCE 10M G TABLET	Diabetes	Criteria for approval not met
3	FORTEO 600 MCG/2.4 ML PEN INJ	Osteoporosis	Criteria for approval not met
4	LUMIGAN 0.01% EYE DROPS	Glaucoma	Criteria for approval not met
5	LINZESS 145 MCG CAPSULE	Constipation	Criteria for approval not met
6	JANUVIA 25 MG TABLET	Diabetes	Criteria for approval not met
7	RYBELSUS 3 MG TABLET	Diabetes	Criteria for approval not met
8	VIBERZI 75 MG TABLET	Irritable Bowel Disease	Criteria for approval not met
9	IPRATROPIUM 0.03% SPRAY	Nasal Allergies	Criteria for approval not met
10	WEGOVY 1 MG/0.5ML PEN	Weight Management	Criteria for approval not met

- The Alameda Alliance for Health (AAH) Pharmacy Department has successfully carried out Medi-Cal RX go-live as of 1/1/2022 and continues to serve its members with the same high standards of care.
    - As of May 31st, 2022, processed more than 49.65 million point-of-sale pharmacy paid claims with a sub second response time to participating pharmacies totaling more than $ 5.90 billion in payments
    - Processed more than 201,432 prior authorizations. PA continues to decline (i.e., 3,856 per 5/27 weekly data).
    - Answered 256,105 calls and 100 percent of virtual hold calls and voicemails have been returned. Call volume continues to decline (i.e., 10,045 per 5/27 weekly data).
    - The most edits/PA/limitations have been removed/lifted.
        - We have closed submitted Medi-Cal PAs and informing doctor offices to submitted to Medi-Cal RX:

Month	Number of Total PA Closed
January 2022	169
February 2022	44
March 2022	31
April 2022	25
May 2022	7

- Pharmacy Services continues to collaborate with other Health Care Services teams for member on use of opioids and/or benzodiazepines.

- The AAH Pharmacy Department is working with its Inpatient Department and Case Management Disease Management (CMDM) Department.
    - The AAH Pharmacy Department's TOC (Transition of Care) medication reconciliation Program is still in the early stages of development, though showing great promise, as it continues collaborating with the AAH Inpatient Department and Case Management Disease Management (CMDM) Department to help reduce the number of re-admissions after members are discharged from hospitals through education to the members as well as filling potential gaps between providers and their patients.
    - This not only increases the quality of life of our members, but also provides great cost-benefit to the Alliance as well. The Pharmacy Department also continues to work with the IT Department to improve metrics and outcomes tracking to ensure effective data-driven optimization of the program, which not only improves cost-benefit to the plan but helps us better serve our members as well.

- As a result of an AAH population needs assessment, Pharmacy Services, QI, HealthEd and Case Management continue to work together to improve drug adherence for two hundred Black adults with asthma between 21 to 44 years of age with asthma medication possession rate of 50% or below.

- Pharmacy is leading initiatives on PAD focused internal and external partnership and biosimilar optimization.
    - AAH has been working to revise and update their single UM medication prior authorization (PA) list. This list is a list of drugs that will require PA before reimbursement. The list has gone under review with AAH workgroup and AAH medical directors for approval.
    - AAH is working to transition the billing of continuous glucose monitors (CGM) for Type 1 Diabetic Members under Medi-Cal line of business to MediCal-Rx. This change will require providers to submit prescriptions to the pharmacy instead of our vendor partner. AAH workgroup identified 97 Type 1 Diabetic members who may be impacted and is currently working on an outreach campaign to notify members and providers of this transition.

- Pharmacy Services and Operations continue to collaborate to drive up COVID-19 vaccination rates.

Case and Disease Management

- Population health-driven, disease-specific case management bundles (standard sets of actions developed to address the specific needs of members with significant diseases,) continue development. Major Organ Transplant (MOT) CM Bundle was deployed, and the volume is higher than anticipated, (138 cases YTD) The processes to support the members is working well across CM, UM, and the Centers of Excellence.

- Dialysis CM Bundle work continues with the DaVita Shared Patient Care Coordination, (SPCC) program. CM works with DaVita on very high-risk members to ensure wrap around support so that the member can successfully manage their dialysis needs. Regular high-risk rounds have launched with DaVita SPCC to coordinate interventions and support to these highest risk members who require dialysis.

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

- NCQA 2022: CM team has submitted documents that address the NCQA PHM standards for submission to NCQA in June 2022, documents related to care coordination for members Out of Network and readmissions work being done with multiple departments across AAH and community partners. Submission was on June 7th, will follow up from the NCQA expected in the coming weeks.

Case Type	New Cases Opened in Mar 2022	Total Open Cases as of Mar 2022	New Cases Opened in April 2022	Total Open Cases as of April 2022
Care Coordination	323	614	270	589
Complex Case Management	23	55	15	44
Transitions of Care (TOC)	285	563	256	514
ECM	34	1027	34	1027

Enhanced Case Management and Community Supports Services

- Enhanced Case Management (ECM): ECM Providers on track to re-evaluate "grandfathered" members from HHP to see if they meet criteria for ECM or are ready for step down to other CM services by 6/30/2022.

- Work continues to launch Alameda County Behavioral Health as an ECM provider by 07/01/22.

- Work with PPD team continues for next POFs (LTC to home; LTC diversion) to launch 01/01/23.

- Formerly incarcerated adults/youth/children POF is delayed by DHCS to align the implementation dates of the justice-involved pre-release services initiative and the statewide launch of ECM justice-involved POF. (date: TBD)

- Revised MOC Parts 1 & 2 on the new Populations of Focus are in development and will be ready for submission by 07/01/22.

- Community Supports: CS services are focused on reducing unnecessary hospitalizations and ED visits. The six initial CS services launched on 1/1/2022 were:
    - Housing Navigation
    - Housing Deposits
    - Tenancy Sustaining Services
    - Medical Respite
    - Medically Tailored/Supportive meals
    - Asthma Remediation

- DHCS has approved the updated Community Supports Model of Care (MOC) that describes how the Alliance is implementing the CS services.

- CalAIM Community Supports (CS): The planned staff for the CS program have been hired and are refining the authorization processes for referrals, and for program tracking.

- Close collaboration with each CS provider is ongoing, with continued weekly meetings with each provider to work through logistical issues as they arise. Members are receiving care from all the CS provider types.

Community Supports	Services Started in Jan 2022	Services Started in Feb 2022	Services Started in Mar 2022	Services Started in Apr 2022
Housing Navigation	**8**	**10**	**14**	**0**
Housing Deposits	**0**	**1**	**3**	**34**
Housing Tenancy	**4**	**13**	**7**	**3**
Asthma Remediation	**1**	**5**	**6**	**5**
Meals	**24**	**16**	**30**	**14**
Medical Respite	**10**	**1**	**12**	**24**

Grievances & Appeals

- All cases were resolved within the goal of 95% within regulatory timeframes; however, expedited grievances were not resolved within our goal of 95%.
    - Expedited Grievances:
        - 2 out of the 5 cases were out of compliance.
            - One case was missed during intake by the G&A Department; therefore, kept expedited as we missed the 72-hour resolution TAT.
            - One case was assigned late by the G&A Department after the case was kept expedited, there were also issues with received a response timely from the provider.
        - During the month of April, the G&A Department received 103 complaints that were originally logged as expedited and de-expedited within the required timeframe.

- Total grievances resolved in May were 6.54 complaints per 1,000 members.

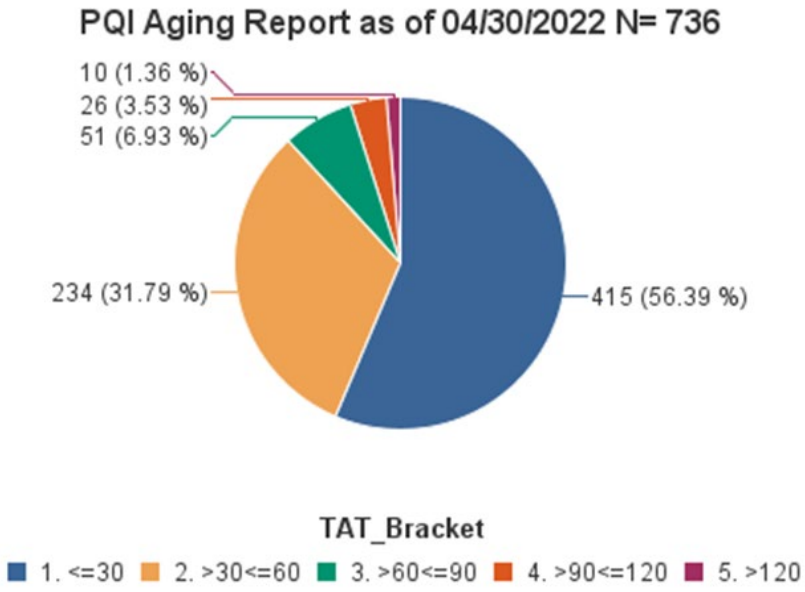
- The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of May 2022; we did meet our goal at 20% overturn rate.

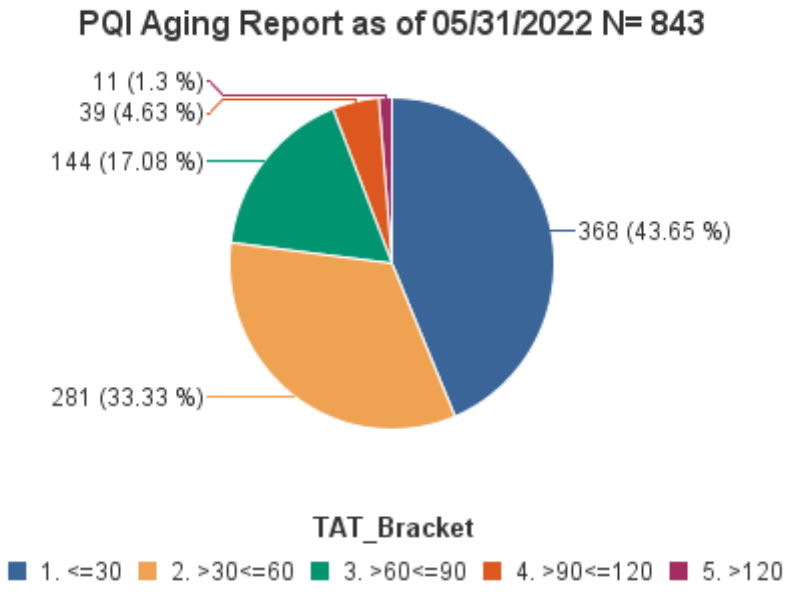
May 2022 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	646	30 Calendar Days	95% compliance within standard	621	96.1%	2.08
Expedited Grievance	5	72 Hours	95% compliance within standard	3	60.0%	0.02
Exempt Grievance	1,362	Next Business Day	95% compliance within standard	1,362	100.0%	4.38
Standard Appeal	20	30 Calendar Days	95% compliance within standard	20	100.0%	0.06
Expedited Appeal	0	72 Hours	95% compliance within standard	NA	NA	NA
Total Cases:	2,033		95% compliance within standard	2,006	98.7%	6.54

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

Quality

- Quality continues to track and trend PQI Turn-Around-Time (TAT) compliance. Our aging report month to month goal is closure of PQIs cases within 120 days from receipt to resolution via nurse investigation and procurement of medical records. PQI cases open > 120 days made up 1.3% of total cases for May with a noted increase of 1 case in May when compared to April. Cases open for >120 days continues to be primarily related to delay in submission of medical records by specific providers. Quality continues to work with providers to identify operations barriers in medical record procurement to maintain a TAT goal of < 5% for cases open >120 days. It was also noted that for cases open >90 days, there was a slight increase of 1.1% from 3.53% in April to 4.63% in May.



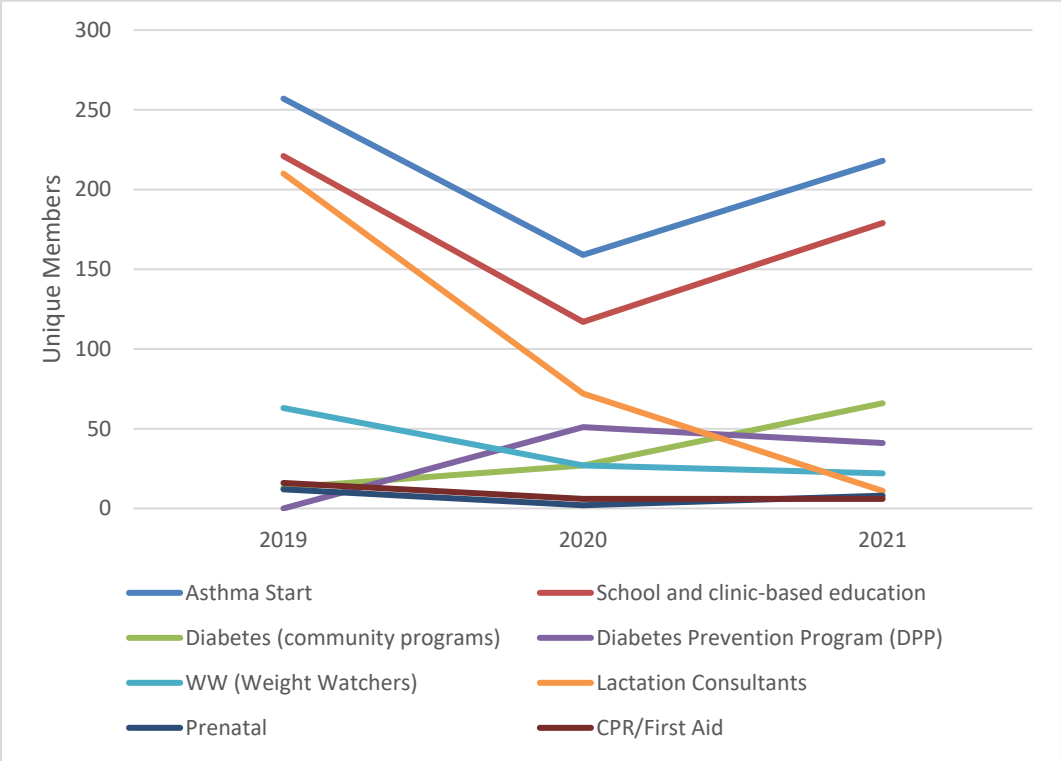


- Health Education continues to offer educational handouts and programs to members covering a wide variety of prevention, healthy lifestyle, and condition self-management topics. Below are highlights from the 2021 Health Education Evaluation.

- Distribution of health education materials and community referrals through member mailings from Health Education (524) and Case Management (1031) totaled 1555 in 2021 and included topics such as nutrition and exercise, heart health, diabetes and falls prevention and health care tools such as advance directives, medication lists, and health care visit checklist.

- Top health education programs by enrollment included:
    - Asthma Start pediatric case management (218)
    - Nutrition counseling (156)
    - AC Public Health Diabetes Self-Management Education (60)
    - Diabetes Prevention Program/DPP (41)
    - WW healthy lifestyle (21)
    - Family Paths parenting classes (20)

- After a 2020 dip in health education program participation, rates are climbing back up or remain steady for most programs:



- Health Education success in 2021 included:
    - Completed all planned program audits with no issues identified.
    - Funded Asthma Start outreach and supported transition of program to asthma remediation.
    - Alameda County Public Health Diabetes Program increased participation during the pandemic because of the availability of one on one consults.
    - Second round of Diabetes Prevention Program (DPP) outreach campaign had 115 commitments.

- Health Education areas for Improvement in 2021 included:
    - Reduction in pediatric asthma referrals from BCH Oakland due to process changes.
    - Low completion of member satisfaction surveys.
    - Decline in members receiving Alliance lactation supports due to changes in the program and limits to in-person services.
    - Unmet engagement goals for WW (formerly Weight Watchers).

- Health education will address these areas through the following activities in 2022:
    - Reestablish process for receiving weekly ED reports from BCH Oakland for referral to Asthma Start.
    - Create program satisfaction survey incentive program.
    - Seek second lactation consultant vendor.
    - Increase diabetes self-management participation through expansion of disease management program outreach and engagement.
    - Maintain DPP participation with a third outreach campaign.
    - Expand member support for WW engagement.

ALAMEDA Alliance FOR HEALTH

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

Information Technology

Sasikumar Karaiyan

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

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

Date: **June 10th, 2022**

Subject: **Information Technology Report**

Call Center System Availability

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

Office 365 Initiative

- The Alliance continues to enhance and expand the Microsoft Office 365 platform to the maximum potential as part of the cloud migration strategy. One of our goals is to move away from the silo operated platform to a consolidated shared services platform which will allow technology team to manage and maintain efficiently.

- Microsoft Teams training and deployment phase has been successfully completed as planned. Microsoft Teams is now deployed to the entire organization and all employees have participated in training.

- WebEx meetings is on schedule to be retired by the end of June 2022, and the retirement of Cisco Jabber chat has been rescheduled to June 17th, 2022. The adoption rate continues to grow positively during this transition and part of our ongoing campaign is to encourage our staff to use Microsoft Teams as the primary application for chat and meetings.

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

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

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

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

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

- **Full telephony:** Microsoft TEAMS will be integrated with our existing Cisco VOIP to allow for flexible voice communications without the use of physical phones.

Disaster Recovery and Business Continuity

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

- IT Disaster Recovery involves a set of policies, tools, and procedures to enable the recovery or continuation of vital technology infrastructure and systems following a natural or human-induced disaster. IT Disaster Recovery focuses on technology systems supporting critical business functions, which involve keeping all essential aspects of the business functioning, despite significant disruptive events.

- We have concluded our initial discovery meetings and have provided documents for all tier 1 applications and compiled a list of essential reports to our vendor (Quest) to review.

- DR runbook templates have been completed and our vendor (Quest) is now working on the construct to populate the DR runbook with all the provided documentations for each tier 1 applications and is on target for business and application owner review by June 10th, 2022.

IT Security Program

- IT Security 2.0 initiative is one of the Alliance's top priorities for fiscal year 2022 and 2023. Our goal is to elevate and further improve our security posture, ensure that our network perimeter is secure from threats and vulnerabilities, and to improve and strengthen our security policies and procedures.

- This program will include multiple phases and remediation efforts are now in progress.

- Cyber Security is at 38% complete, M365 is at 83% complete, and Azure 73% and overall, 58% complete for high-severity items.

- Protecting shared cloud applications with Multi-Factor Authentication and Single Sign-On has been included in the overall project. The design modeling of current and future state of each cloud application is in progress and expected to be completed by June 17th, 2022.

- The Extended Security Support contract with Arctic Wolf has been signed and approved. The kick-off call meeting has been scheduled for June 14th, 2022.
    - **Key initiatives include:**
        - Remediating issues from security assessments. (e.g., Cyber, Microsoft Office 365, & Azure Cloud).
        - Create, update, and implement policies and procedures to operationalize and maintain security level after remediation.
        - Set up extended support for monitoring, alerting and supplementary support in cases of security issues.
        - Implement Security Information and Event Management (SIEM) tool for the enterprise to provide real-time visibility across the organization's information security systems.

Encounter Data

- In the month of May 2022, the Alliance submitted 130 encounter files to the Department of Health Care Services (DHCS) with a total of 265,802 encounters.

Enrollment

- The Medi-Cal Enrollment file for the month of May 2022 was received and processed on time.

HealthSuite

- A total of 150,879 claims were processed in the month of May 2022 out of which 126,251 claims auto adjudicated. This sets the auto-adjudication rate for this period to 83.7%.
- HealthSuite experienced a short after-hours outage on Tuesday, May 31st, 2022, at 5:05pm and lasted until 5:26pm.

TruCare

- A total of 13,075 authorizations were loaded and processed in the TruCare application.
- TruCare application continues to operate with an uptime of 99.99%.

- The Alliance has started the process of upgrade to TruCare Clinical Management platform 9.1 version. This upgrade is expected to go-live before end of June 2022. This version has additional features and is also compatible with Milliman Care Guideline v25. However, the plan is also to have the latest version of Milliman Care Guideline v26 by August 2022. Support for this version is being released by the vendor in July 2022.

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 May 2022, we completed adding the Case Management data domains to the Data Warehouse. With this project culminating the Data Warehouse has all critical domains.

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 “Summary of Medi-Cal and Group Care member enrollment in the month of May 2022”.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of May 2022”.
- The following tables 1-1 and 1-2 are supporting documents from the enrollment summary section.

Table 1-1 Summary of Medi-Cal and Group Care Member enrollment in the month of May 2022

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
May	304, 941	4,832	2,460	5,809	115	132

1. MC – Medi-Cal Member 2. GC – Group Care Member

Table 1-2 Summary of Primary Care Physician (PCP) Auto-Assignment For the Month of May 2022

Auto-Assignments	Member Count
Auto-assignments MC	1,490
Auto-assignments Expansion	1,334
Auto-assignments GC	43
PCP Changes (PCP Change Tool) Total	2,667

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of May 2022.”
- There were 13,075 authorizations processed in TruCare application.
- TruCare Application Uptime – 99.99%.
- The following table 2-1 is a supporting document from the TruCare summary section.

Table 2-1 Summary of TruCare Authorizations for the Month of May 2022

Transaction Type	Inbound EDI Auths	Errored	Total Auths loaded in TruCare
Provider Portal (HX)	2,438	566	2,181
EDI (CHCN)	4,227	435	4,181
Paper to EDI (DCS)	2,990	2,141	1,106
Community Supports	N/A	N/A	0
ECM	N/A	N/A	28
Other Manual entry	N/A	N/A	1,651
Total Manual Entry in TC	N/A	N/A	1,679
Total			10,826

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 April 2022

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	6,052	3,390	149, 435	384
MCAL	83,298	2,652	6,229	983
IHSS	3,096	105	262	25
AAH Staff	173	54	824	5
Total	**92, 619**	**6, 201**	**156, 750**	**1,397**

Table 3-2 Top Pages Viewed for the Month of April 2022

Top 25 Pages Viewed		
Category	**Page Name**	**April - 22**
Provider	Member Eligibility	673,816
Provider	Claim Status	148,325
Provider - authorizations	Auth Submit	7,933
Member My Care	Member Eligibility	3,201
Provider - authorizations	Auth Search	3,090
Provider	Member Roster	1,795
Member Help Resources	ID Card	1,774
Member Help Resources	Find a Doctor or Hospital	1,771
Member Help Resources	Select or Change Your PCP	1,135
Member My Care	MC ID Card	991
Member My Care	My Claims Services	783
Member Help Resources	Request Kaiser as my Provider	740
Provider - Provider Directory	Provider Directory	641
Member My Care	Authorization	472
Provider - Home	Forms	344
Member My Care	My Pharmacy Medication Benefits	320
Member Help Resources	FAQs	295
Member Help Resources	Forms Resources	250
Provider - Provider Directory	Instruction Guide	236
Member Help Resources	Contact Us	210
Provider	Pharmacy	207
Provider - Provider Directory	Manual	195
Member Help Resources	Authorizations Referrals	184
Member My Care	Member Benefits Materials	169
Member Help Resources	Update My Contact Info	82

Table 3-3 Member Portal Preferred Language for the Month of April 2022

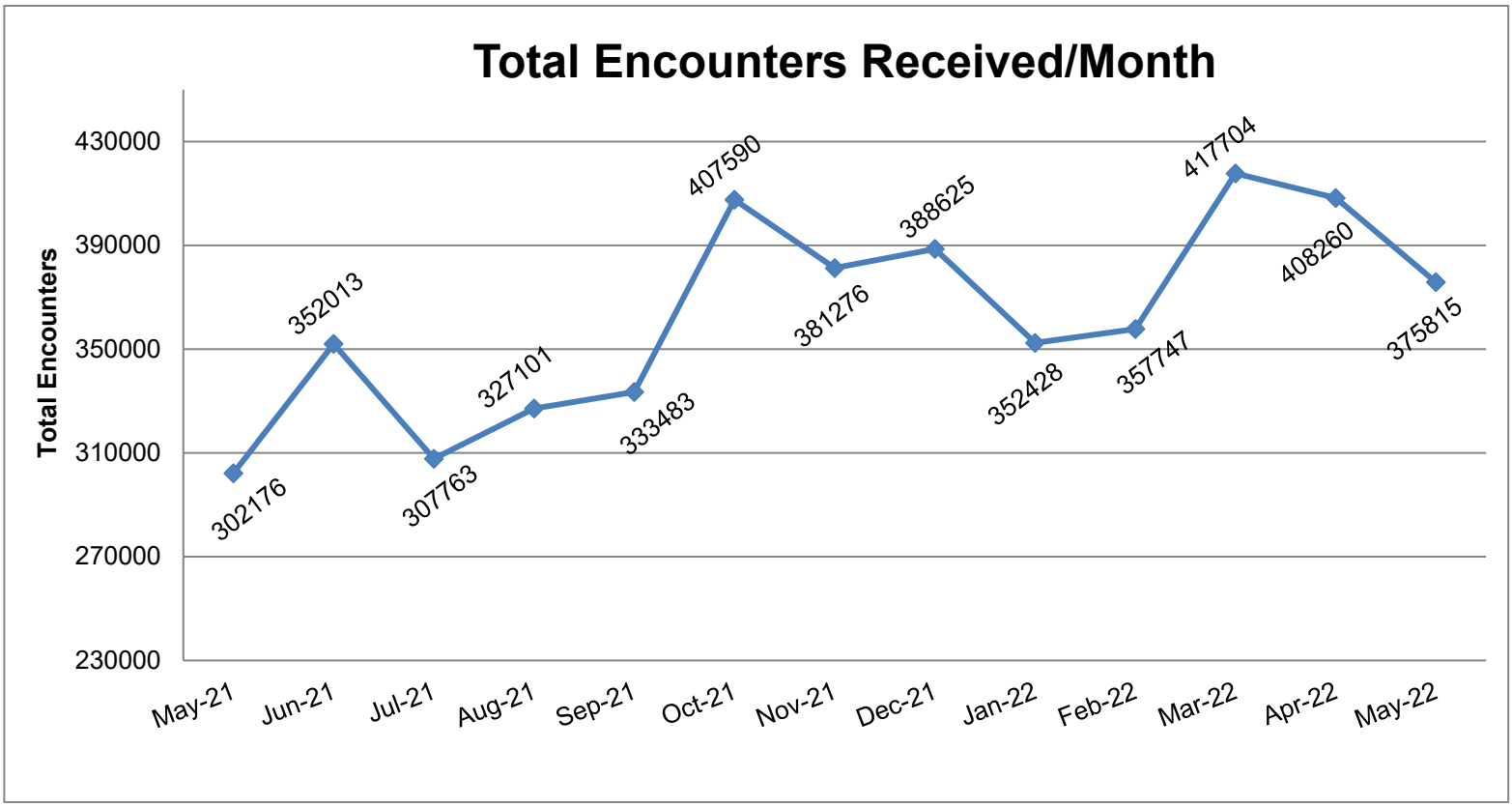
Member Portal Preferred Languages		
Member Group	**# of Individual User Accounts Accessed**	**Total Logins**
MCAL - English	2,652	6,229
MCAL - Spanish	0	15
MCAL - Vietnamese	0	0
MCAL - Tagalog	0	0
MCAL - Chinese	0	0
IHSS - English	105	262
IHSS - Spanish	0	0
IHSS - Vietnamese	0	0
IHSS - Tagalog	0	0
IHSS - Chinese	0	0
Total	**2,757**	**6,491**

Encounter Data from Trading Partners 2022

- **AHS**: May weekly files (6,105 records) were received on time.
- **BAC**: May monthly file (63 records) were received on time.
- **Beacon**: May weekly files (13,796 records) were received on time
- **CHCN**: May weekly files (80,340 records) were received on time.
- **CHME**: May monthly file (4,551 records) were received on time.
- **CFMG**: May weekly files (14,075 records) were received on time.
- **Docustream**: May monthly files (1,140 records) were received on time.
- **HCSA**: May monthly files (1,824 records) were received on time.
- **PerformRx**: May monthly files (0 records) were received on time.
- **Magellan**: May monthly files (272,796 records) were received on time.
- **Kaiser**: May bi-weekly files (51,214 records) were received on time.
- **LogistiCare**: May weekly files (20,299 records) were received on time.
- **March Vision**: May monthly file (3,345 records) were received on time.
- **Quest Diagnostics**: May weekly files (15,757 records) were received on time.
- **Teladoc**: May monthly files (34 records) were received on time.

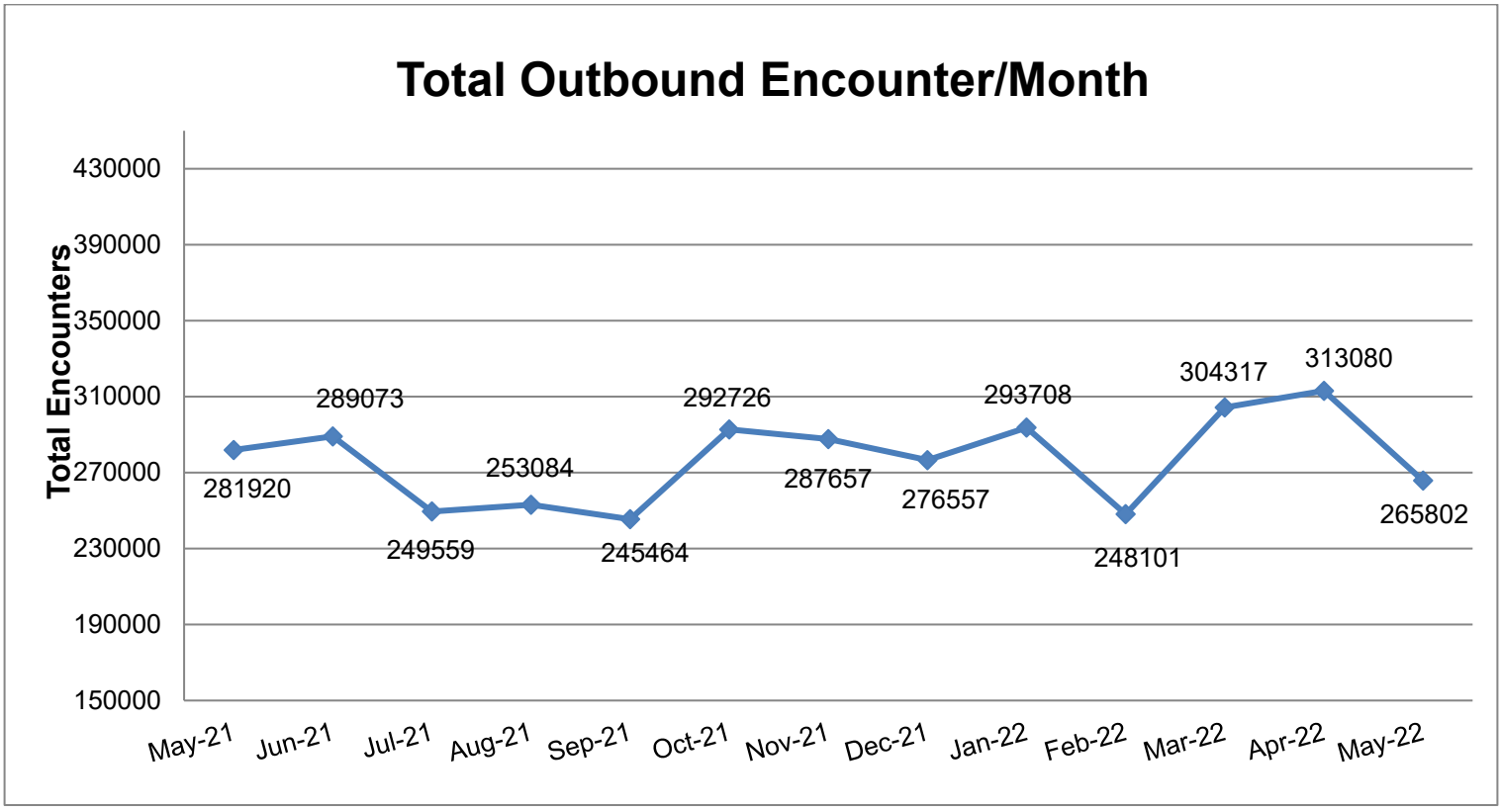
Trading Partner Medical Encounter Inbound Submission History

Trading Partners	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
HealthSuite	129847	136687	133958	139079	159558	177483	167057	175441	162201	162433	185738	189172	163272
AHS	9074	10138	8913	7869	7640	10625	8791	9314	6944	5630	6215	7717	6105
BAC										34	12	45	63
Beacon	14951	17079	15236	13320	14618	13693	12456	14899	9796	10966	16088	14303	13796
CHCN	66260	82211	63905	80862	60227	71581	99117	73269	75302	77276	79363	74683	80340
CHME	4885	4700	4960	4926	5393	4814	5003	4908	9254	4706	4778	4955	4551
Claimsnet	10834	8129	9774	7712	9880	15598	11032	12410	8643	13228	13522	10943	14075
Docustream	1445	1218	1296	1568	1594	1474	1185	1586	1703	1304	2130	2220	1140
HCSA											3630	2029	1824
Kaiser	30039	60081	39398	35165	44366	75112	38085	63939	46458	52179	68530	69174	51214
Logisticare	14399	15473	14415	17306	13803	16977	22403	17125	16536	16393	19841	16232	20299
March Vision	3708	3306	3303	3531	3297	3377	3584	3220	2872	1445	3559	3425	3345
Quest	16718	12979	12563	15746	13084	16841	12542	12494	12696	12121	14268	13330	15757
Teladoc	16	12	42	17	23	15	21	20	23	32	30	32	34
Total	302176	352013	307763	327101	333483	407590	381276	388625	352428	357747	417704	408260	375815



Outbound Medical Encounter Submission

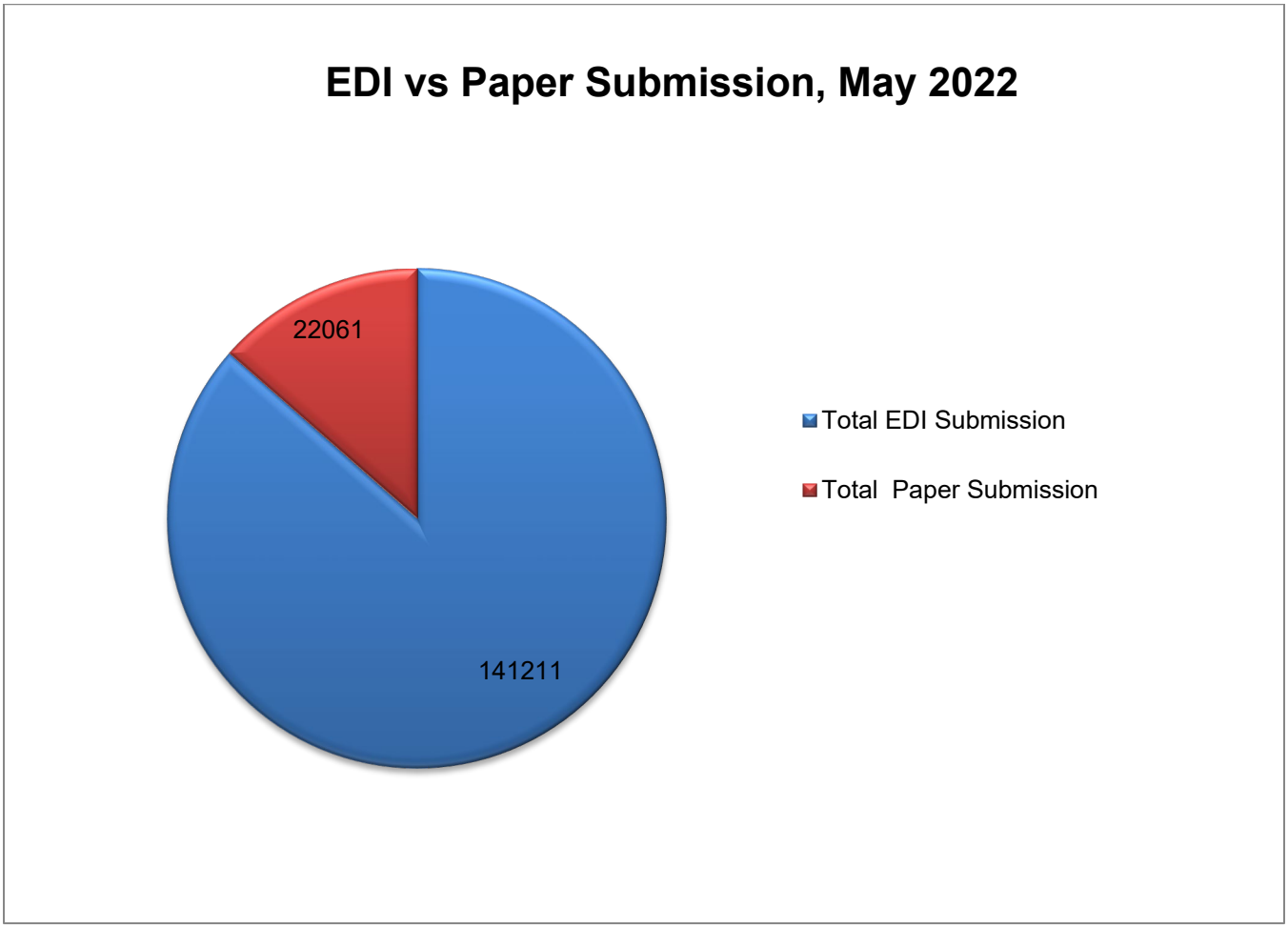
Trading Partners	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
HealthSuite	130885	128980	85346	109070	83690	100925	114507	95489	139452	97141	103843	133252	93919
AHS	10762	9912	7163	9172	7476	10176	8541	7728	7943	5524	6142	6251	7156
BAC										34	12	45	61
Beacon	12347	11746	12684	10959	9355	11423	9969	12659	7566	8140	12332	11273	9221
CHCN	48573	58519	45338	46573	54958	49171	67383	49080	52531	44745	58795	49365	49911
CHME	4767	4586	4753	4820	5280	4587	4849	4691	4496	4585	4702	4686	4448
Claimsnet	8110	5993	5625	7335	7452	10829	7406	8465	6114	9917	9677	8100	8410
Docustream	1286	1016	1120	1273	1209	1094	981	1185	1176	66	72	14	3406
HCSA											3112	1810	1518
Kaiser	29570	38443	59215	33798	43779	73264	37473	63433	44248	51831	67559	67177	50894
Logisticare	17299	15178	14008	12751	17657	16231	19240	19787	16309	16242	19700	16123	19777
March Vision	2850	2624	2596	2665	2483	2608	2831	2490	2175	1072	2724	2575	2464
Quest	15455	12066	11711	14632	12102	12403	14457	11531	11676	8774	15620	12378	14602
Teladoc	16	10	0	36	23	15	20	19	22	30	27	31	15
Total	281920	289073	249559	253084	245464	292726	287657	276557	293708	248101	304317	313080	265802



HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total Claims
22-May	141211	22061	163272

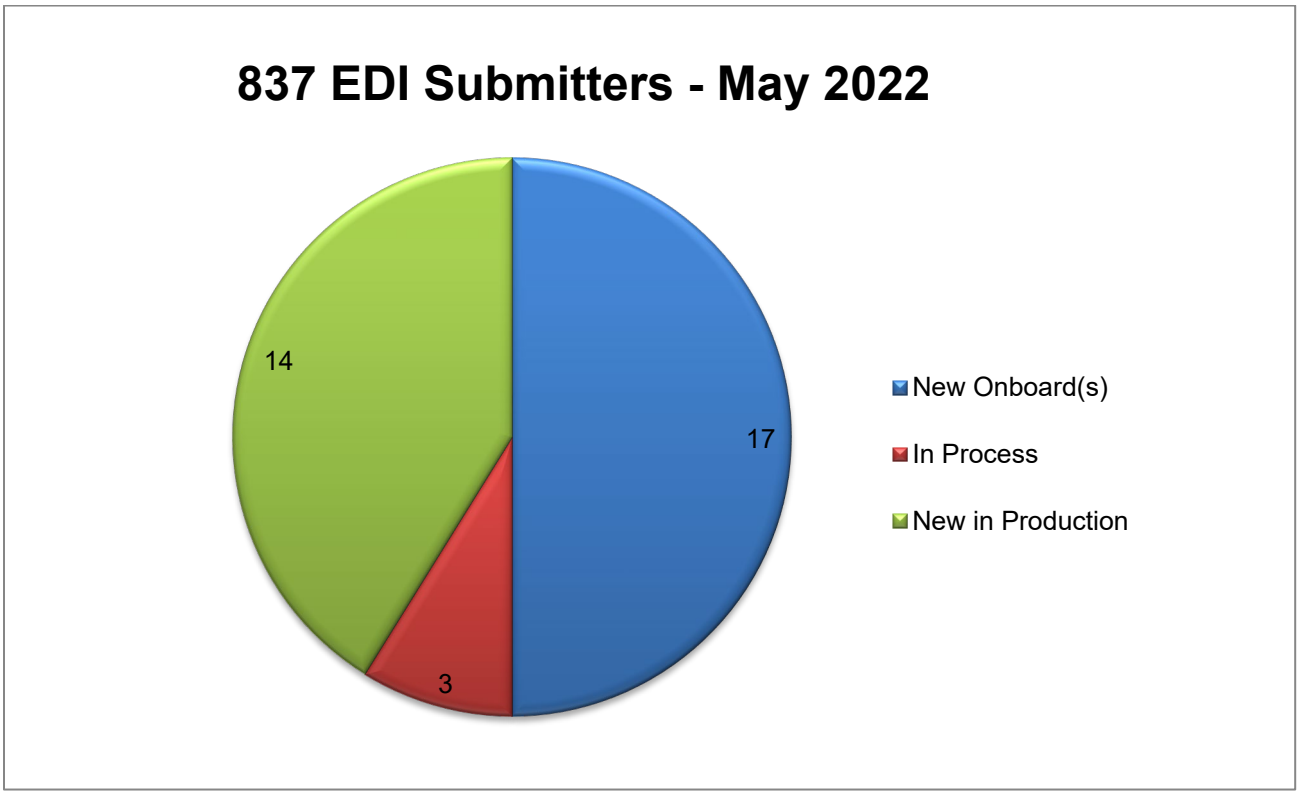
Key: EDI – Electronic Data Interchange

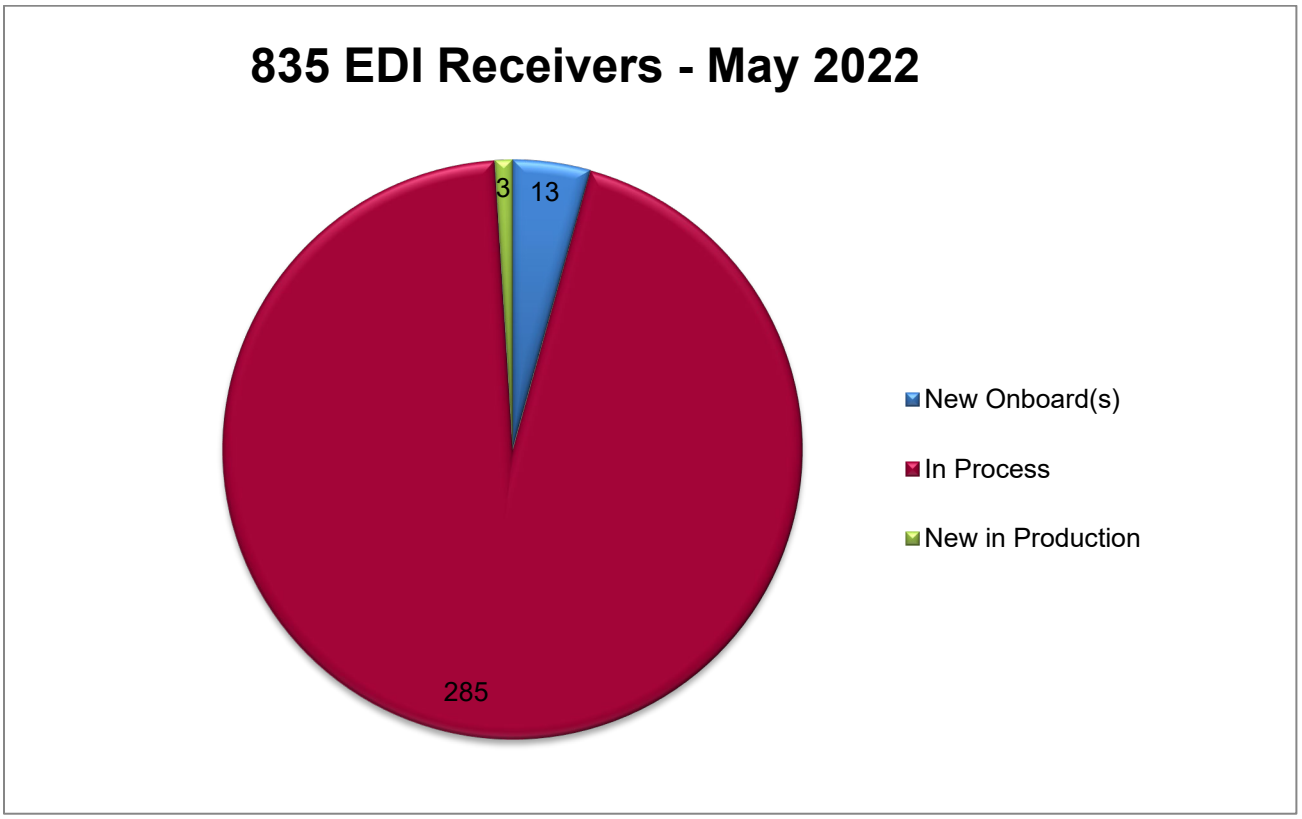


Onboarding EDI Providers - Updates

- May 2022 EDI Claims:
  - A total of 1339 new EDI submitters have been added since October 2015, with 14 added in May 2022.
  - The total number of EDI submitters is 2079 providers.
- May 2022 EDI Remittances (ERA):
  - A total of 429 new ERA receivers have been added since October 2015, with 3 added in May 2022.
  - The total number of ERA receivers is 456 providers.

	837				835			
	New On Boards	In Process	New In Production	Total In Production	New On Boards	In Process	New In Production	Total In Production
Jun-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
Oct-21	17	0	17	1956	30	205	18	381
Nov-21	14	0	14	1970	19	210	14	395
Dec-21	8	0	8	1978	18	223	5	400
Jan-22	29	1	28	2006	44	253	14	414
Feb-22	17	2	15	2021	20	258	15	429
Mar-22	36	0	36	2057	22	268	12	441
Apr-22	11	3	8	2065	19	275	12	453
May-22	17	3	14	2079	13	285	3	456


837 EDI Submitters - May 2022
14
17
3
New Onboard(s)
In Process
New in Production


835 EDI Receivers - May 2022
3
13
285
New Onboard(s)
In Process
New in Production

Encounter Data Submission Reconciliation Form (EDSRF) and File Reconciliations

- EDSRF Submission: Below is the total number of encounter files that AAH submitted in the month of May 2022.

File Type	May-22
837 I Files	24
837 P Files	106
NCPDP	0
Total Files	130

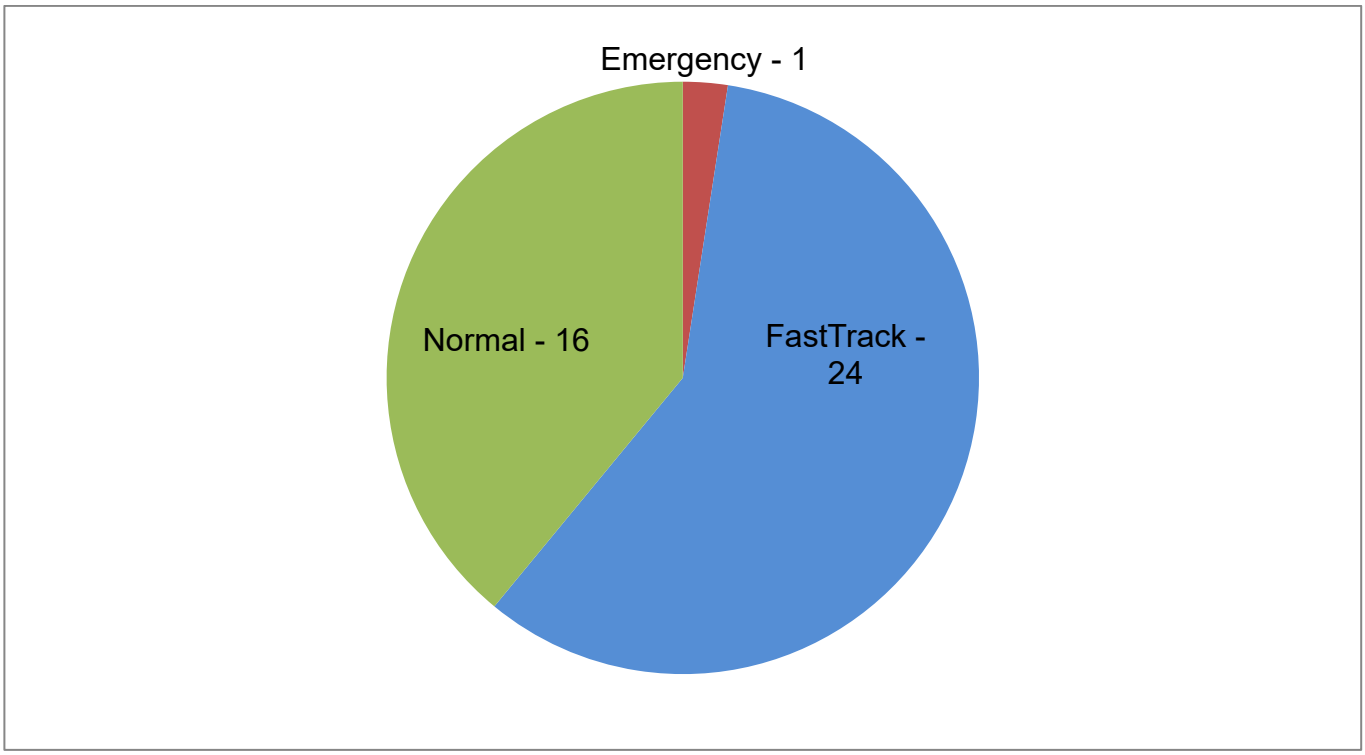
Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	May-22	Target
Timeliness-% Within Lag Time – Institutional 0-90 days	92%	60%
Timeliness-% Within Lag Time – Institutional 0-180 days	95%	80%
Timeliness-% Within Lag Time – Professional 0-90 days	92%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	98%	80%

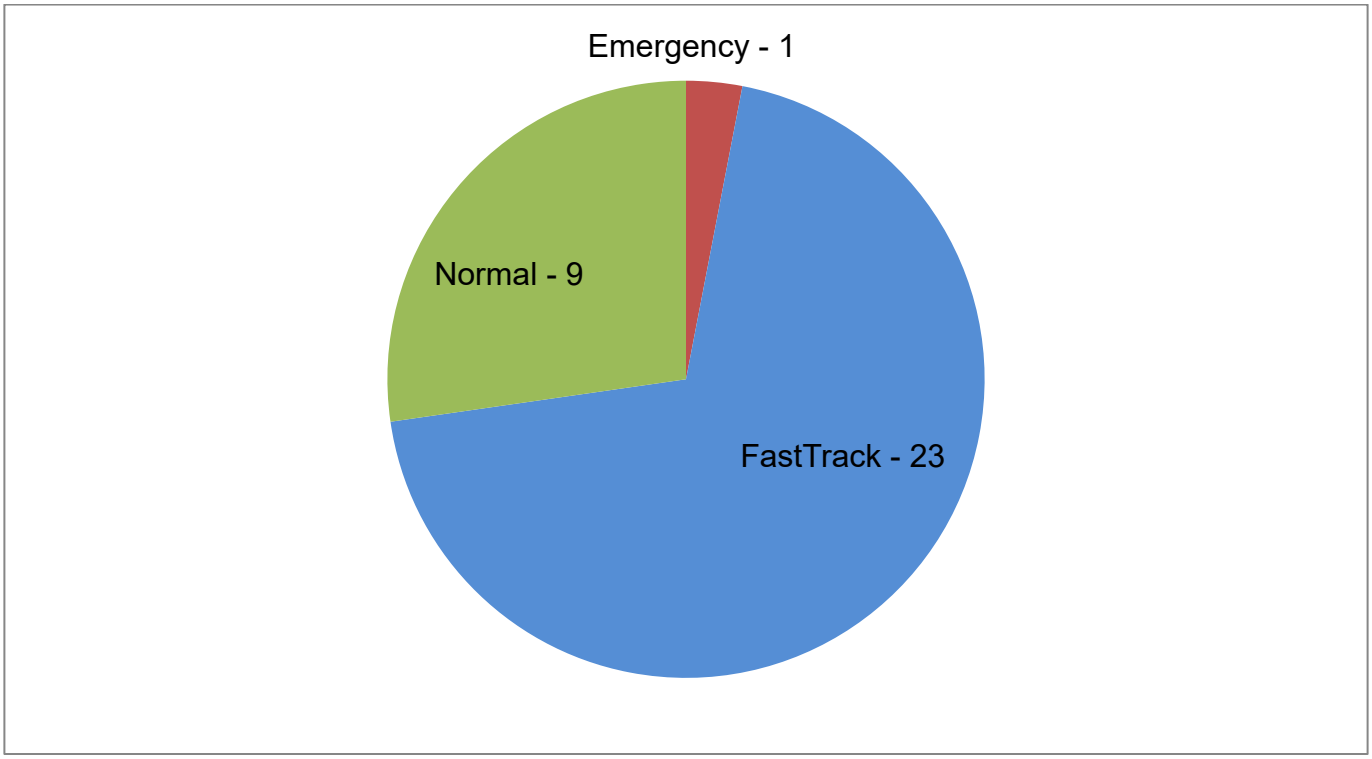
Change Management Key Performance Indicator (KPI)

- Change Request Overall Summary in the month of May 2022 KPI:
  - 41 Changes Submitted.
  - 33 Changes Completed and Closed.
  - 134 Active Change Requests in pipeline.
  - 1 Change Request Cancelled or Rejected.

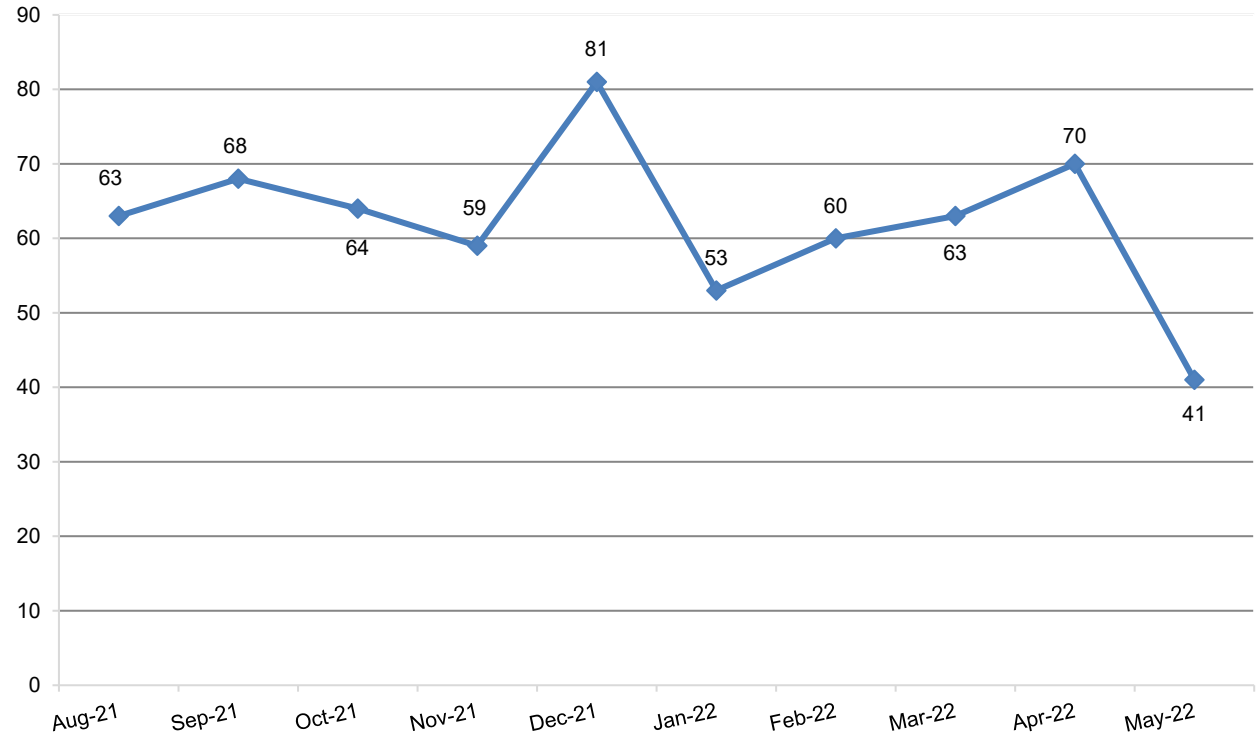
- 41 Change Requests Submitted/Logged in the month of May 2022



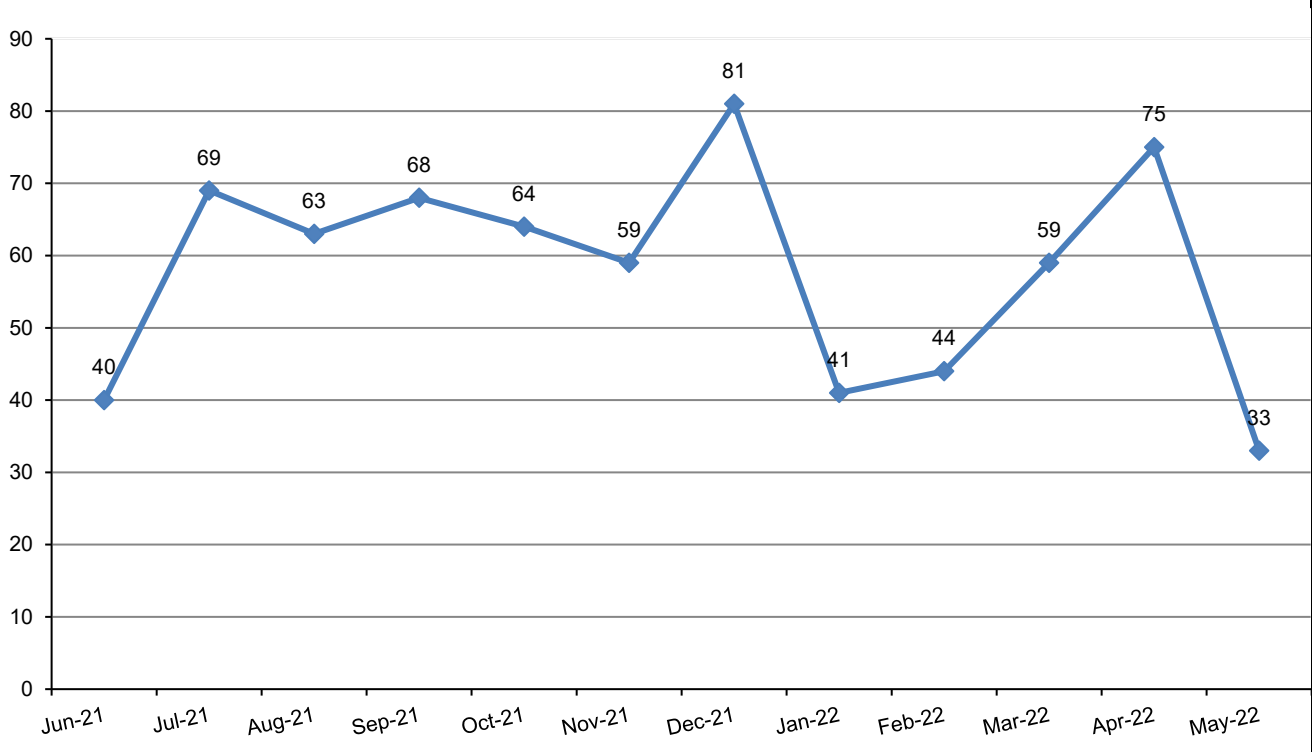
- 33 Change Requests Closed in the month of May 2022



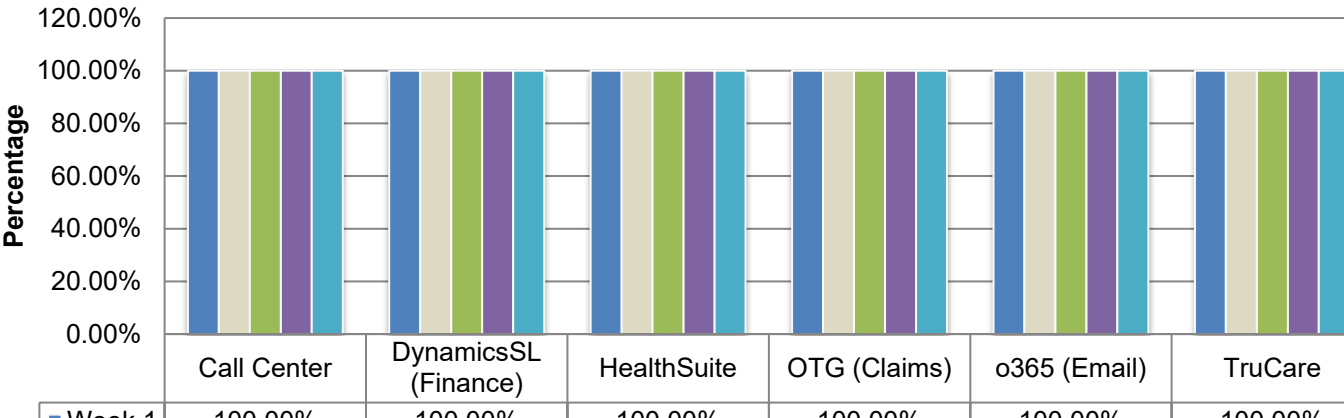
- Change Requests Submitted: Monthly Trend



- Change Requests Closed: Monthly Trend



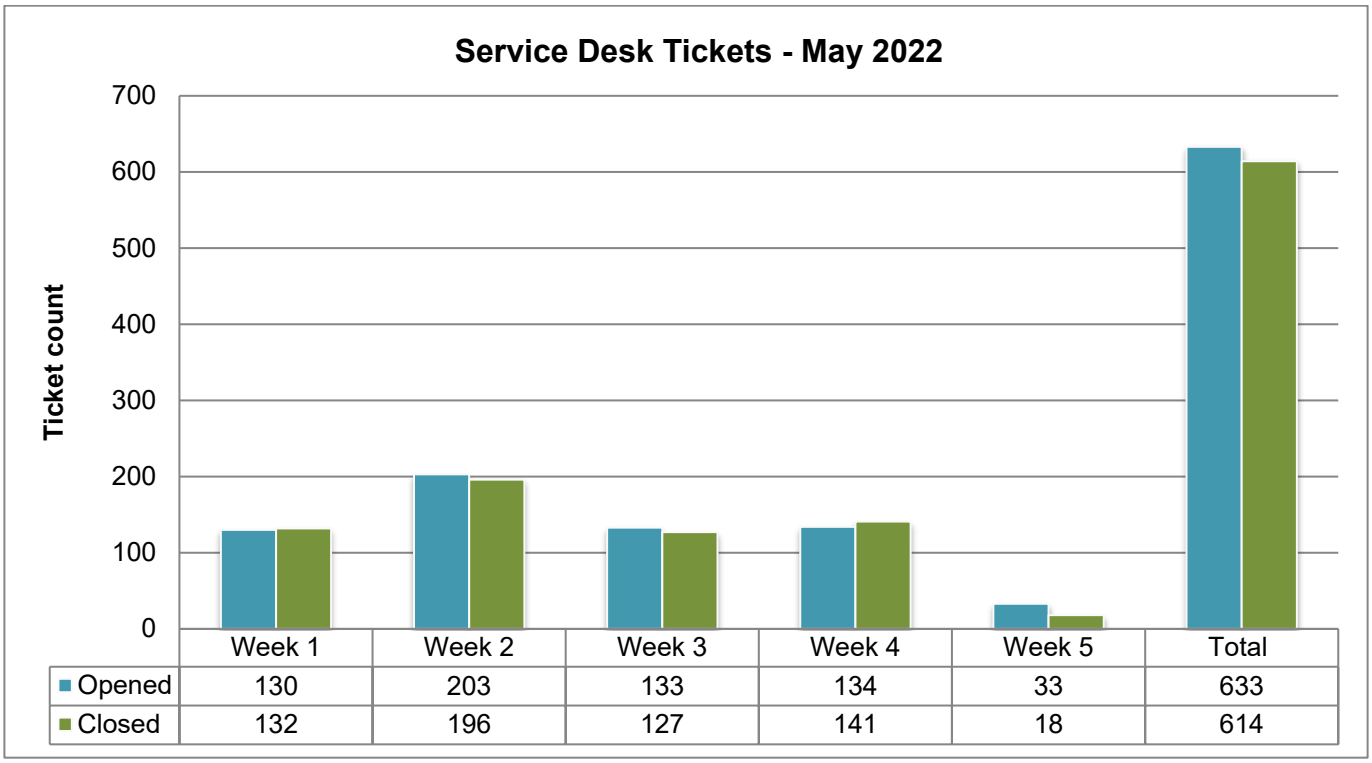
IT Stats: Infrastructure



	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 two minor outages experienced in the month of May 2022**.**
    - Calabrio Call Recording experienced a short outage on Wednesday, May 4th, 2022, at 9:30am and was restored at 10:10am.
    - HealthSuite experienced a short outage on Tuesday, May 31st, 2022, at 5:05pm and lasted until 5:26pm.

- 633 Service Desk tickets were opened in the month of May 2022, which is 18.3% higher than the previous month and 614 Service Desk tickets were closed, which is 6.5% lower than the previous month.

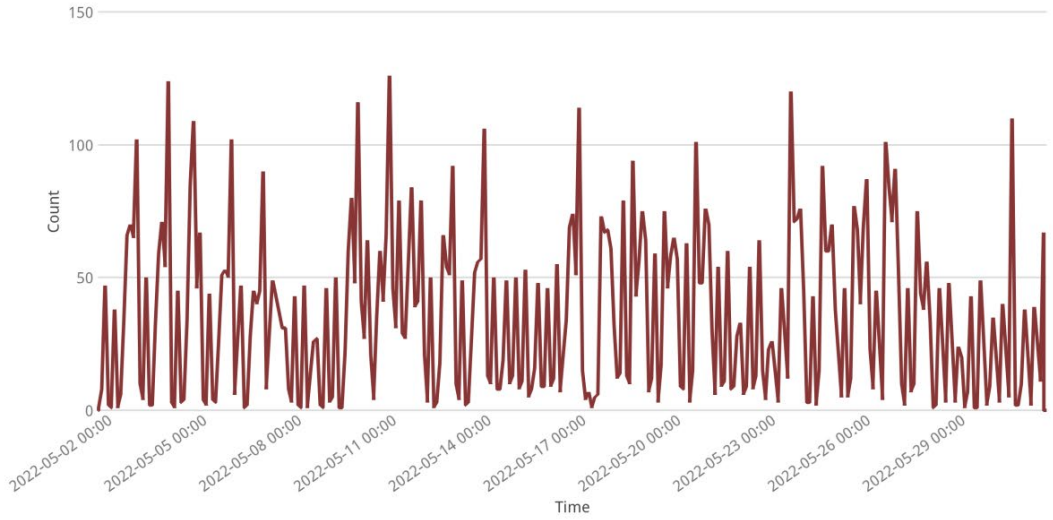


	Week 1	Week 2	Week 3	Week 4	Week 5	Total
Opened	130	203	133	134	33	633
Closed	132	196	127	141	18	614

- The open ticket count for the month of May aligns with the previous 3-month average of 700.

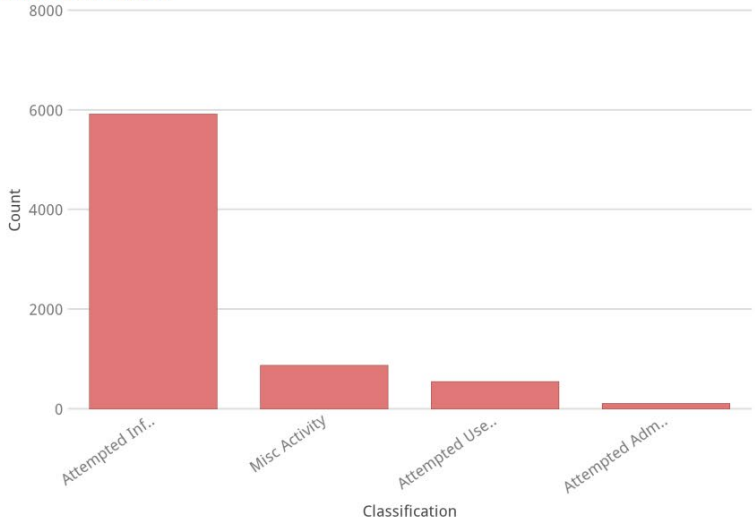
All Intrusion Events

Time Window: *2022-05-01 09:29:00 - 2022-05-31 09:29:00*



Dropped Intrusion Events

Time Window: *2022-05-01 09:30:00 - 2022-05-31 09:30:00*
Constraints: *Inline Result = dropped*

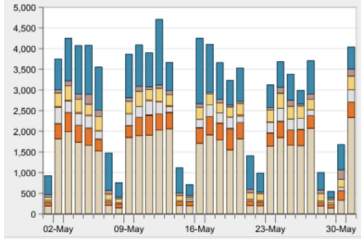


Classification	Count
Attempted Information Leak	5,924
Misc Activity	874
Attempted User Privilege Gain	549
Attempted Administrator Privilege Gain	113

IronPort Email Security Gateways
Email Filters

MX4

Overview > Incoming Mail Graph



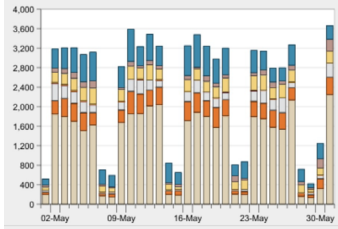
Export...

Overview > Incoming Mail Summary

Message Category	%	Messages
Stopped by IP Reputation Filtering	26.3%	23.7k
Stopped by Domain Reputation Filtering	3.3%	3,000
Stopped as Invalid Recipients	0.1%	61
Spam Detected	8.2%	7,363
Virus Detected	0.0%	8
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.2%	150
Stopped by Content Filter	0.1%	46
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**38.1%**	**34.4k**
Marketing Messages	6.4%	5,796
Social Networking Messages	0.4%	337
Bulk Messages	10.1%	9,111
Total Graymails:	**16.9%**	**15.2k**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	45.0%	40.6k
Total Attempted Messages:		**90.2k**

MX9

Overview > Incoming Mail Graph



Export...

Overview > Incoming Mail Summary

Message Category	%	Messages
Stopped by IP Reputation Filtering	16.6%	12.3k
Stopped by Domain Reputation Filtering	3.5%	2,615
Stopped as Invalid Recipients	0.1%	39
Spam Detected	8.7%	6,486
Virus Detected	0.0%	10
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.2%	146
Stopped by Content Filter	0.1%	62
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**29.1%**	**21.7k**
Marketing Messages	6.6%	4,944
Social Networking Messages	0.4%	306
Bulk Messages	10.4%	7,767
Total Graymails:	**17.5%**	**13.0k**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	53.4%	39.7k
Total Attempted Messages:		**74.5k**

Item / Date	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	***May-22***
Stopped By Reputation	65.4	78.8k	62.7k	43.1k	41.5k	24.3k	39.3k	69.7k	42.4k	329.9k	52.8k	36k	***36k***
Invalid Recipients	99	1,982	742	185	132	82	92	153	185	69	389	117	***100***
Spam Detected	18	17.4k	27	12.8k	10.8k	5.6k	9,684	13.2k	10.3k	10.3k	15k	13.7k	***13.8k***
Virus Detected	2	2	9	14	14	0	1	1	5	13	1	4	***18***
Advanced Malware	6	0	1	3	2	0	0	9	0	4	2	1	***0***
Malicious URLs	264	30	12	9	7	6	43	39	16	89	41	159	***296***
Content Filter	264	167	78	58	89	27	27	8	371	54	39	115	***108***
Marketing Messages	6,366	6,357	6,256	6,710	7,383	4,489	9,221	6,147	8,864	9,588	8,864	11.3k	***10.7k***
Attempted Admin Privilege Gain	95	109	101	129	157	128	124	116	103	116	132	143	***113***
Attempted User Privilege Gain	1	0	3	7	6	6	13	49	117	663	789	401	***549***
Attempted Information Leak	18	38	15	32	3,700	7,782	9,376	13.7k	13.7k	5,813	5,192	5,207	***5,924***
Potential Corp Policy Violation	0	0	0	0	0	0	0	0	0	0	0	0	***0***
Network Scans Detected	0	0	0	0	0	0	0	0	0	0	0	0	***0***
Web Application Attack	0	3	1	0	0	0	0	0	0	1	0	0	***0***
Attempted Denial of Service	0	0	0	0	0	0	0	0	0	0	0	50	***0***
Misc. Attack	3,851	1,516	975	446	5,733	8,550	76	161	275	626	308	78	***874***

- 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 36k.

- Attempted information leaks detected and blocked at the firewall is at 5,924 for the month of May 2022.

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

- Attempted User Privilege Gain is slightly higher at 549 from a previous six-month average of 428.

Projects and Programs

Ruth Watson

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

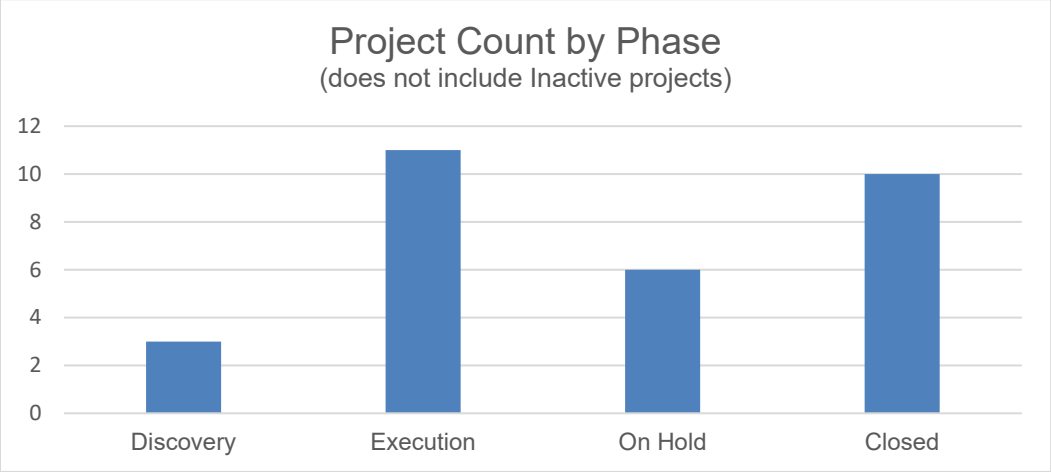
From: **Ruth Watson, Chief of Integrated Planning**

Date: **June 10th, 2022**

Subject: **Integrated Planning Report**

Project Management Office

- 37 projects currently on the Alliance enterprise-wide portfolio
  - 14 Active projects (discovery, initiation, planning, execution, warranty)
  - 6 On Hold projects
  - 10 Closed projects
  - 7 Inactive projects (**not included on chart as Inactive is not a phase**)



Integrated Planning

- CalAIM Initiatives – Enhanced Care Management (ECM) and Community Supports (CS):
  - Launched three (3) ECM Populations of Focus (PoFs) and six (6) CS on January 1st.
  - ECM portion of the Model of Care (MOC) fully approved by the Department of Health Care Services (DHCS) on March 8th.
  - CS portion of the MOC fully approved by DHCS on June 1st.
  - Implementation of additional ECM PoFs effective January 2023 (2) and July 2023 (1).
    - Individuals Transitioning from Incarceration PoF, originally scheduled for implementation in January 2023, has been delayed by DHCS with no new implementation date.
    - DHCS released separate MOC Addendum templates for ECM and CS to be used with required July 1st and September 1st submissions.

- AAH has notified DHCS that it intends to offer two (2) additional CS services by January 2024.
  - Environmental Accessibility Adaptations (Home Modifications)
  - Sobering Centers (Cherry Hill facility only)
- Post-Implementation Activities – Work continues in two-week increments to complete identified activities.

- CalAIM Major Organ Transplants (MOT):
  - Submitted response to DHCS on January 7th regarding the Corrective Action Plan (CAP) received on December 10th, 2021 for lack of a certified MOT network; CAP will remain in place until AAH has an executed contract with a transplant program that is a Center of Excellence (COE) for adult kidney-pancreas transplants.
    - AAH only contracted with UCSF and Stanford for transplants and Stanford is not a COE for kidney-pancreas transplants.
    - Still waiting for DHCS to issue rate guidance so we can execute a formal contract with UCSF for kidney-pancreas transplants.

- Long Term Care (LTC) Carve-In – AAH will be responsible for all members residing in LTC facilities as of January 1st, 2023.
  - Does not include Intermediate Care Facilities/Institutions for Mental Disease (ICF/IMD) which is delayed until July 1st, 2023.
  - Boilerplate contract, amendment and cover letter have been drafted and are in final review.
  - Communications
    - Member notification – pending templates from DHCS
    - Provider notification – developing FAQs and call scripts
  - Individual workstreams have been identified and meetings are underway.

- Population Health Management (PHM) Program – effective January 1st, 2023.
  - MCP 2023 PHM Readiness Submission due in October.

- CalAIM Incentive Payment Program – three-year DHCS program to provide funding for the support of ECM and CS in the following areas:
  - 1) Delivery System Infrastructure
  - 2) ECM Provider Capacity Building
  - 3) Community Supports Provider Capacity Building and Community Supports Take-Up
  - Program Year 1 (PY1), Payment 1 of $7.4M (50% of PY1 funding) received from DHCS.
  - Provider funding application, developed jointly with Anthem, was released on May 6th; seven (7) applications received to date.

- Mental Health (Mild to Moderate/Autism Spectrum Disorder) Insourcing – services currently performed by Beacon Health Options will be brought in-house as of November 1st, 2022.
  - Boilerplate contract and cover letter have been drafted and are in final review.

    - Communications
        - Member notification – pending approval from DHCS.
        - Provider notification – developing FAQs and call scripts.
    - Individual workstreams have been identified and meetings are underway.
    - Deliverables, timelines and risk will be assessment monthly.

- Behavioral Health Integration (BHI) Incentive Program – DHCS pilot program commenced January 1st, 2021 and continues through December 31st, 2022.
    - DHCS has given Managed Care Plans (MCPs) and Grantees the option to rollover or revise missed milestones from PY1; AAH has worked with the two grantees that missed milestones and submitted the required documentation to DHCS on May 16th.
    - The consolidated PY2Q1 Milestones report was submitted to DHCS on May 30th.

- Student Behavioral Health Incentive Program (SBHIP) – DHCS program commenced January 1st, 2022 and continues through December 31st, 2024:
    - First stakeholder meeting with all Partners was held on May 6th.
    - Draft MOU for Alameda County Office of Education created and being reviewed.
    - Draft MOU for Health Care Services Agency (HCSA) for work being completed by the Center for Healthy Schools and Communities (CHSC) has been created and is being reviewed.
    - Received DHCS approval for the first funding milestone (50% of Needs Assessment allocation) on April 22nd; funding was released May 27th.
    - Initial Needs Assessment meetings for participating Local Education Agencies (LEAs) underway.

- Housing and Homelessness Incentive Program (HHIP) – DHCS program: commenced January 1st, 2022 and continues through December 31st, 2023.
    - Final program guidance received from DHCS on May 9th.
    - Local Homelessness Plan (LHP) due to DHCS by June 30th.
        - Portions of the plan must be completed by both AAH and Anthem jointly while other parts require AAH-specific responses.
    - Contracted with consultant to assist with project.

- Justice-Involved/Coordinated Re-Entry:
    - January 2023 implementation has been delayed by DHCS; awaiting additional program guidance.
    - Contracted with consultant to assist with project.

Recruiting and Staffing

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

Projects and Programs

Supporting Documents

Project Descriptions

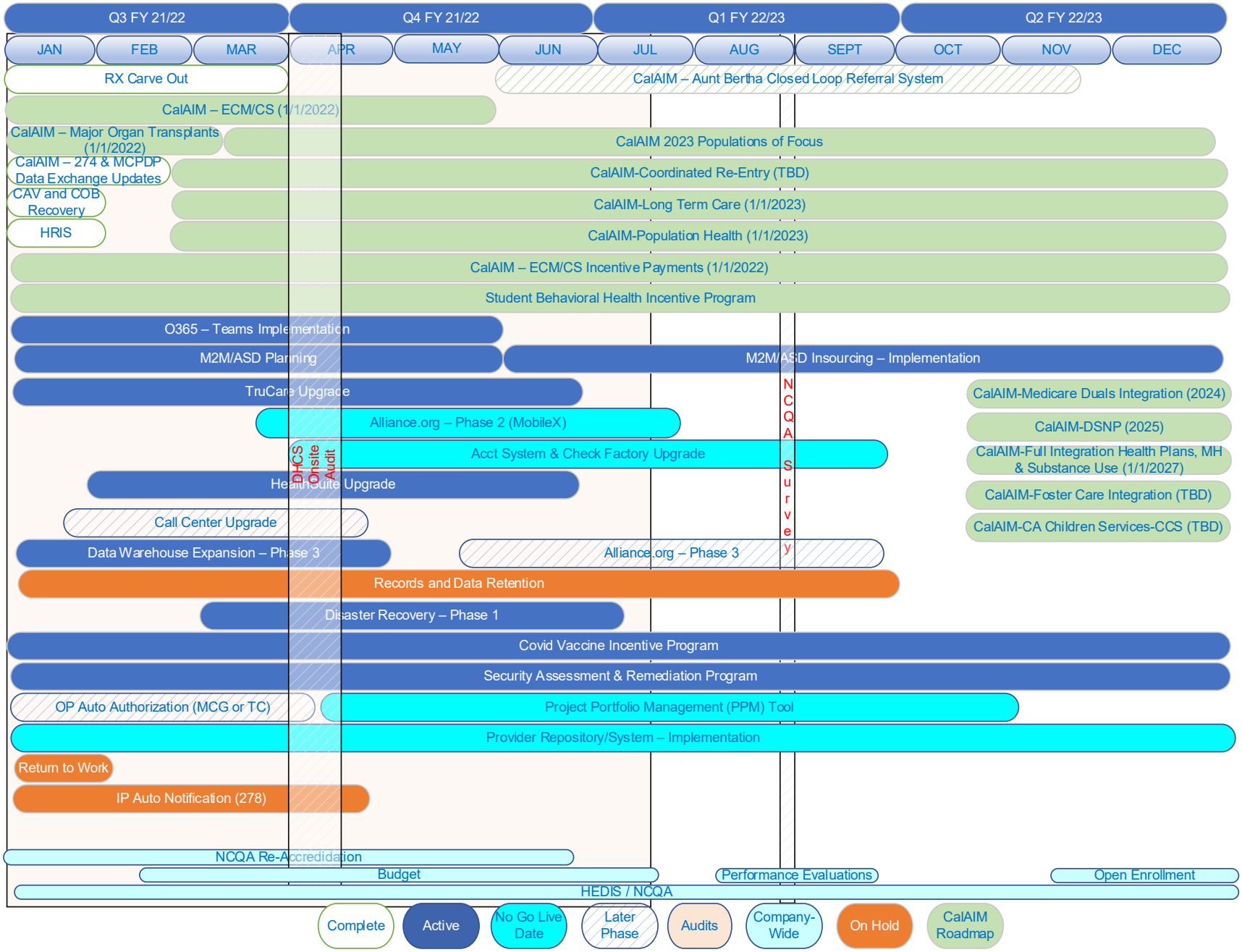
Key projects currently in-flight:

- 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) – ECM will target seven (7) specific populations of vulnerable and high-risk children and adults.
        - Three (3) Populations of Focus (PoF) transitioned from HHP and/or WPC on January 1st, 2022.
        - Two (2) additional PoFs will become effective on January 1st, 2023.
        - Third PoF scheduled for January 1st has been delayed by DHCS until further notice.
        - One (1) PoF will become effective on July 1st, 2023.
    - Community Supports (CS) effective January 1st, 2022 – menu of optional services, including housing-related and flexible wraparound services, to avoid costlier alternatives to hospitalization, skilled nursing facility admission and/or discharge delays.
        - Six (6) Community Supports were implemented on January 1st, 2022
        - Two (2) additional CS services are targeted for implementation by January 1st, 2024.
    - Major Organ Transplants (MOT) – currently not within the scope of many Medi-Cal managed care plans (MCPs); carved into all MCPs effective January 1st, 2022.
        - Applicable to all adults as well as children if the transplant is not covered by California Children's Services
    - CalAIM Incentive Payment Program (IPP) – The CalAIM ECM and CS programs will require significant new investments in care management capabilities, ECM and CS infrastructure, information technology (IT) and data exchange, and workforce capacity across MCPs, city and county agencies, providers and other community-based organizations. CalAIM incentive payments are intended to:
        - Build appropriate and sustainable ECM and ILOS capacity.
        - Drive MCP investment in necessary delivery system infrastructure.
        - Incentivize MCP take-up of ILOS.
        - Bridge current silos across physical and behavioral health care service delivery.
        - Reduce health disparities and promote health equity.
        - Achieve improvements in quality performance.
    - Long Term Care - currently not within the scope of many Medi-Cal MCPs; will be carved into all MCPs effective January 1st, 2023
        - ICF/IMD facilities will be delayed until July 1st, 2023.
    - Justice Involved/Coordinated Re-Entry – adults and children/youth transitioning from incarceration or juvenile facilities will be enrolled into Medi-Cal upon release.
        - Originally scheduled for January 1st, 2023 but has now been delayed by DHCS with no new implementation date.
    - Population Health Management (PHM) – all Medi-Cal managed care plans will be required to develop and maintain a whole system, person-centered population health management strategy effective January 1st, 2023.

        - PHM is a cohesive plan of action for addressing member needs across the continuum of care based on data driven risk stratification, predictive analytics, and standardized assessment processes.
- Return to Work – assessment of current state work environment and recommendations for future configurations (remote/onsite/hybrid)
    - Current targeted date for returning to the office is July 5th, 2022.
- Project Portfolio Management (PPM) Tool – vendor demonstrations complete; target implementation in FY 2022-23.
- Accounting & Enterprise Resource Planning (ERP) System Upgrade – upgrade current system to supported platform.
- Student Behavioral Health Incentive Program (SBHIP) – program launched in January 2022 to support new investments in behavioral health services, infrastructure, information technology and data exchange, and workforce capacity for school-based and school-affiliated behavioral health providers. Incentive payments will be paid to Medi-Cal managed care plans (MCPs) to build infrastructure, partnerships and capacity, statewide, for school behavioral health services.
    - Letter of Intent submitted to DHCS on January 27th.
    - Partners Form submitted to DHCS on March 15th.
    - Meetings completed with Alameda County Office of Education (ACOE), Center for Healthy Schools and Communities (CHSC) and interested Local Education Agencies (LEAs) to begin work on Needs Assessment which will identify which of the fourteen (14) Targeted Interventions are a priority for Alameda County
    - Needs Assessment and Project Plans for the selected Targeted Interventions are due to DHCS by December 31st, 2022.
- Housing and Homelessness Incentive Program (HHIP) – program launched in January 2022 and is part of the Home and Community-Based (HCBS) Spending Plan
    - Enables MCPs to earn incentive funds for making progress in addressing homelessness and housing insecurity as social determinants of health
    - MCPs must collaborate with local homeless Continuums of Care (CoCs) and submit a Local Homelessness Plan (LHP) to be eligible for HHIP funding
        - LHP is due to DHCS by June 30th, 2022.
        - LHP is expected to be in alignment with local Homeless Housing, Assistance and Prevention (HHAP) grant application.
        - In counties with more than one MCP, MCPs need to work together to submit one LHP per county.

Key Projects on Hold:

- In Patient (IP) Auto Notification (278 Data File) – pilot hospitals are not ready to start implementation
- Records and Data Retention – on hold due to internal resource constraints re-directed to regulatory required projects


Q3 FY 21/22
Q4 FY 21/22
Q1 FY 22/23
Q2 FY 22/23
JAN
FEB
MAR
APR
MAY
JUN
JUL
AUG
SEPT
OCT
NOV
DEC
RX Carve Out
CalAIM – Aunt Bertha Closed Loop Referral System
CalAIM – ECM/CS (1/1/2022)
CalAIM – Major Organ Transplants (1/1/2022)
CalAIM 2023 Populations of Focus
CalAIM – 274 & MCPDP Data Exchange Updates
CalAIM-Coordinated Re-Entry (TBD)
CAV and COB Recovery
CalAIM-Long Term Care (1/1/2023)
HRIS
CalAIM-Population Health (1/1/2023)
CalAIM – ECM/CS Incentive Payments (1/1/2022)
Student Behavioral Health Incentive Program
O365 – Teams Implementation
M2M/ASD Planning
M2M/ASD Insourcing – Implementation
TruCare Upgrade
NCQA Survey
CalAIM-Medicare Duals Integration (2024)
Alliance.org – Phase 2 (MobileX)
CalAIM-DSNP (2025)
DHCS Onsite Audit
Acct System & Check Factory Upgrade
CalAIM-Full Integration Health Plans, MH & Substance Use (1/1/2027)
HealthSuite Upgrade
CalAIM-Foster Care Integration (TBD)
Call Center Upgrade
CalAIM-CA Children Services-CCS (TBD)
Data Warehouse Expansion – Phase 3
Alliance.org – Phase 3
Records and Data Retention
Disaster Recovery – Phase 1
Covid Vaccine Incentive Program
Security Assessment & Remediation Program
OP Auto Authorization (MCG or TC)
Project Portfolio Management (PPM) Tool
Provider Repository/System – Implementation
Return to Work
IP Auto Notification (278)
NCQA Re-Accreditation
Budget
Performance Evaluations
Open Enrollment
HEDIS / NCQA
Complete
Active
No Go Live Date
Later Phase
Audits
Company-Wide
On Hold
CalAIM Roadmap

ALAMEDA Alliance FOR HEALTH

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

Analytics

Tiffany Cheang

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

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

Date: **June 10th, 2022**

Subject: **Performance & Analytics Report**

Member Cost Analysis

- The Member Cost Analysis below is based on the following 12 month rolling periods:
  Current reporting period: March 2021 – Feb 2022 dates of service
  Prior reporting period: March 2020 – Feb 2021 dates of service
  (Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 8.9% of members account for 83.9% of total costs.

- In comparison, the Prior reporting period was lower at 8.0% of members accounting for 83.6% of total costs.

- Characteristics of the top utilizing population remained fairly consistent between the reporting periods:

    - The SPD (non-duals) and ACA OE categories of aid slightly increased to account for 60.7% of the members, with SPDs accounting for 27.1% and ACA OE's at 33.6%.
    - The percent of members with costs >= $30K slightly increased from 1.7% to 1.9%.
    - Of those members with costs >= $100K, the percentage of total members remained consistent at 0.4%.
        - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 50.2%.

- Demographics for member city and gender for members with costs >= $30K follow the same distribution as the overall Alliance population.

    - However, the age distribution of the top 8.9% is more concentrated in the 45-66-year-old category (40.0%) compared to the overall population (20.3%).

Analytics

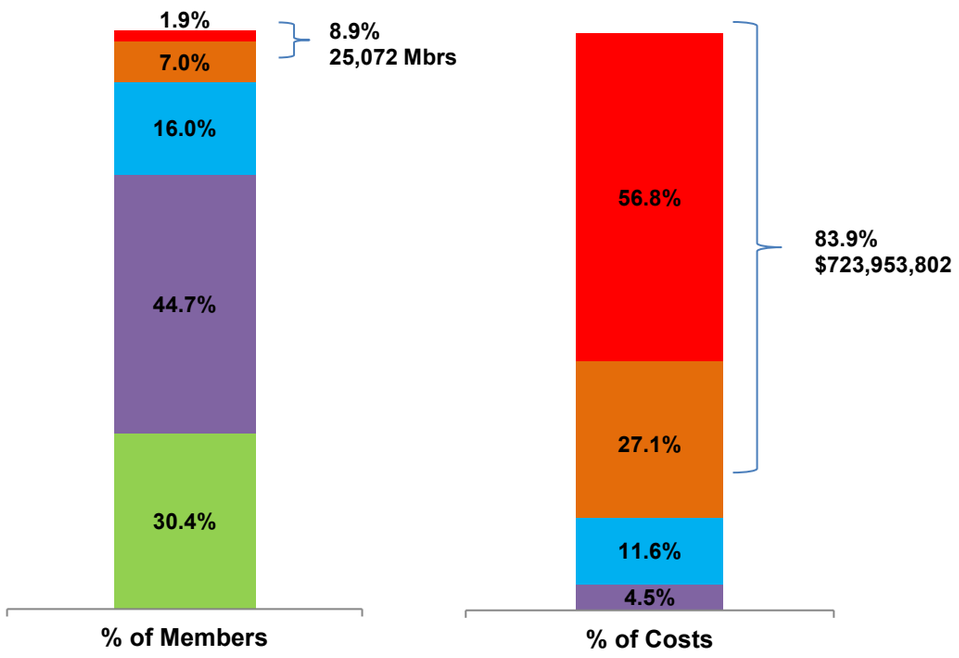
Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Mar 2021 - Feb 2022

Note: Data incomplete due to claims lag

Run Date: 05/30/2022

Member Cost Distribution



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	5,305	1.9%	$ 490,437,939	56.8%
$5K - $30K	19,767	7.0%	$ 233,515,863	27.1%
$1K - $5K	44,968	16.0%	$ 100,369,324	11.6%
< $1K	125,896	44.7%	$ 38,535,595	4.5%
$0	85,774	30.4%	$ -	0.0%
Totals	**281,710**	**100.0%**	**$ 862,858,721**	**100.0%**

Top 8.9% of Members = 83.9% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	1,254	0.4%	$ 273,582,293	31.7%
$75K to $100K	667	0.2%	$ 57,659,360	6.7%
$50K to $75K	1,287	0.5%	$ 78,613,804	9.1%
$40K to $50K	812	0.3%	$ 36,255,190	4.2%
$30K to $40K	1,285	0.5%	$ 44,327,292	5.1%
SubTotal	***5,305***	***1.9%***	***$ 490,437,939***	***56.8%***
$20K to $30K	2,579	0.9%	$ 62,751,966	7.3%
$10K to $20K	7,185	2.6%	$ 99,487,705	11.5%
$5K to $10K	10,003	3.6%	$ 71,276,193	8.3%
SubTotal	***19,767***	***7.0%***	***$ 233,515,863***	***27.1%***
Total	**25,072**	***8.9%***	**$ 723,953,802**	***83.9%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Feb 2022	258,936	$ 766,537,722
Dis-Enrolled During Year	22,774	$ 96,320,999
Totals	**281,710**	**$ 862,858,721**

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
8.9% of Members = 83.9% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Mar 2021 - Feb 2022
Note: Data incomplete due to claims lag
Run Date: 05/30/2022

8.9% of Members = 83.9% of Costs
27.1% of members are SPDs and account for 32.7% of costs.
33.6% of members are ACA OE and account for 32.8% of costs.
6.8% of members disenrolled as of Feb 2022 and account for 12.5% of costs.

Highest Cost Members; Cost Per Member >= $100K
36.4% of members are SPDs and account for 186.9% of costs.
31.7% of members are ACA OE and account for 170.6% of costs.
18.7% of members disenrolled as of Feb 2022 and account for 100.0% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	140	593	733	2.9%
MCAL	MCAL - ADULT	601	3,659	4,260	17.0%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	218	1,632	1,850	7.4%
	MCAL - ACA OE	1,697	6,718	8,415	33.6%
	MCAL - SPD	1,869	4,914	6,783	27.1%
	MCAL - DUALS	109	1,226	1,335	5.3%
Not Eligible	Not Eligible	671	1,025	1,696	6.8%
Total		**5,305**	**19,767**	**25,072**	**100.0%**

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	22	1.8%
MCAL	MCAL - ADULT	116	9.3%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	9	0.7%
	MCAL - ACA OE	398	31.7%
	MCAL - SPD	456	36.4%
	MCAL - DUALS	19	1.5%
Not Eligible	Not Eligible	234	18.7%
Total		**1,254**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 9,958,538	$ 6,591,732	$ 16,550,270	2.3%
MCAL	MCAL - ADULT	$ 47,705,736	$ 42,653,616	$ 90,359,352	12.5%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 10,901,155	$ 19,006,774	$ 29,907,929	4.1%
	MCAL - ACA OE	$ 159,620,855	$ 77,495,484	$ 237,116,339	32.8%
	MCAL - SPD	$ 176,886,481	$ 59,689,677	$ 236,576,158	32.7%
	MCAL - DUALS	$ 7,843,014	$ 15,029,318	$ 22,872,333	3.2%
Not Eligible	Not Eligible	$ 77,522,159	$ 13,049,262	$ 90,571,421	12.5%
Total		**$ 490,437,939**	**$ 233,515,863**	**$ 723,953,802**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 4,105,955	7.8%
MCAL	MCAL - ADULT	$ 22,997,462	43.5%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 1,621,735	3.1%
	MCAL - ACA OE	$ 90,089,323	170.6%
	MCAL - SPD	$ 98,692,012	186.9%
	MCAL - DUALS	$ 3,264,419	6.2%
Not Eligible	Not Eligible	$ 52,811,387	100.0%
Total		**$ 273,582,293**	**518.0%**

% of Total Costs By Service Type

Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs
$100K+	7%	0%	0%
$75K to $100K	7%	0%	1%
$50K to $75K	7%	0%	1%
$40K to $50K	7%	0%	1%
$30K to $40K	13%	1%	1%
$20K to $30K	6%	2%	1%
$10K to $20K	1%	0%	1%
$5K to $10K	0%	0%	0%
Total	**6%**	**0%**	**1%**

Breakout by Service Type/Location

Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
10%	58%	1%	14%	6%	2%	7%
15%	45%	3%	9%	5%	7%	12%
14%	43%	4%	8%	7%	9%	13%
13%	46%	6%	8%	6%	2%	16%
13%	37%	14%	7%	6%	1%	18%
16%	34%	10%	10%	7%	1%	18%
17%	31%	6%	12%	10%	1%	16%
18%	18%	9%	13%	15%	0%	18%
13%	**44%**	**5%**	**11%**	**7%**	**3%**	**12%**

Notes:
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.
- Report excludes Capitation Expense

ALAMEDA Alliance FOR HEALTH

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

Human Resources

Anastacia Swift

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

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

Date: **June 10th, 2022**

Subject: **Human Resources Report**

Staffing

- As of June 1st, 2022, the Alliance had 375 full time employees and 1-part time employees.

- On June 1st, 2022, the Alliance had 62 open positions in which 13 signed offer acceptance letters have been received with start dates in the near future, resulting in a total of 49 positions open to date. The Alliance is actively recruiting for the remaining 49 positions and several of these positions are in the interviewing or job offer stage.

- Summary of open positions by department:

Department	Open Positions June 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	17	3	14
Operations	21	6	15
Healthcare Analytics	3	0	3
Information Technology	8	2	6
Finance	4	1	3
Regulatory Compliance	4	1	3
Human Resources	4	0	4
Integrated Planning	1	0	1
Total	62	13	49

- Our current recruitment rate is 15%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in May 2022 included:
    - 5 years:
        - Kwan Park (IT Data Exchange)
        - Rahel Negash (Pharmacy Services)
    - 6 years:
        - Aracely Melendez (Claims)
        - Riandria Hollie (Claims)
    - 7 years:
        - Thomas Garrahan (Provider Relation)
        - Scott Coffin (Executive)
        - Jeremy Alonzo (IT Ops & Quality Apps Management)
    - 9 years:
        - Alicia Garibay (Utilization Management)
        - Michelle Lewis (Community Relations)
    - 10 years:
        - Brian Butcher (Information Technology)
        - Linda Ayala (Quality Improvement)
    - 14 years:
        - Saudia Lacy (Member Services)
        - Cecilia Gomez (Provider Relation)
    - 19 years:
        - Nancy Kuo (Case & Disease Management)