ALAMEDA Alliance FOR HEALTH

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

Board of Governors

Regular Meeting

Friday, July 14th, 2023
12:00 p.m. – 2:00 p.m.

Video Conference Call and

1240 South Loop Road, Alameda, CA 94502

AGENDA

BOARD OF GOVERNORS
Regular Meeting
Friday, July 14th, 2023
12:00 p.m. – 2:00 p.m.

In-Person and Video Conference Call

1240 S. Loop Road
Alameda, CA 94502

or

7830 MacArthur Blvd.
Oakland, CA 94605

PUBLIC COMMENTS: Public Comments can be submitted for any agendized item or for any item not listed on the agenda, by mailing your comment to: "Attn: Clerk of the Board," 1240 S. Loop Road, Alameda, CA 94502 or by emailing the Clerk of the Board at brmartinez@alamedaalliance.org. You may attend meetings in person or by computer by logging in to the following link: Click here to join the meeting. You may also listen to the meeting by calling in to the following telephone number: 1-510-210-0967 conference id 159517119#. If you use the link and participate via computer, you may use the chat function, and 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, please submit your comments to the Clerk of the Board at the email address listed above or by providing your comments during the meeting at the end of each agenda item. Oral comments to address the Board of Governors are limited to three (3) minutes per person. Whenever possible, the board would appreciate it if public comment communication was provided prior to the commencement of the meeting.

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.

1. CALL TO ORDER

(A regular meeting of the Alameda Alliance for Health Board of Governors will be called to order on July 14th, 2023, at 12:00 p.m. in Alameda County, California, by Rebecca Gebhart, Presiding Officer. This meeting is to take place in person and by video conference call)

2. ROLL CALL

3. AGENDA APPROVAL OR MODIFICATIONS

4. INTRODUCTIONS

5. CONSENT CALENDAR

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

a) **JUNE 9th, 2023, BOARD OF GOVERNORS MEETING MINUTES**

b) **JUNE 9th, 2023, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES**

c) **JULY 11th, 2023, FINANCE COMMITTEE MEETING MINUTES**

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

e) **2023 CASE MANAGEMENT & CARE COORDINATION, COMPLEX CASE MANAGEMENT & DISEASE MANAGEMENT PROGRAM DESCRIPTION**

f) **2022 UTILIZATION MANAGEMENT PROGRAM EVALUATION**

g) **2023 UTILIZATION MANAGEMENT PROGRAM DESCRIPTION**

h) **2022 QUALITY IMPROVEMENT – PROGRAM EVALUATION**

i) **2023 QUALITY IMPROVEMENT – PROGRAM DESCRIPTION**

j) **2022 POPULATION HEALTH MANAGEMENT – EVALUATION**

k) **2023 POPULATION HEALTH MANAGEMENT - STRATEGY**

l) **2023 CULTURAL AND LINGUISTIC – PROGRAM DESCRIPTION**

m) **RESOLUTION 2023-03 CHANGING MEMBERSHIP OF COMPLIANCE ADVISORY COMMITTEE TO 3-5 BOARD MEMBERS**

n) **RESOLUTION 2023-04 CHANGING MEMBERSHIP OF EXECUTIVE COMMITTEE TO 3-5 BOARD MEMBERS**

o) **RESOLUTION 2023-05 CHANGING MEMBERSHIP OF STRATEGIC PLANNING COMMITTEE TO 3-5 BOARD MEMBERS**

p) **APPROVE STANDING COMMITTEE MEMBERSHIP**

6. **BOARD MEMBER REPORTS**

    a) **COMPLIANCE ADVISORY COMMITTEE**

    b) **FINANCE COMMITTEE**

7. **CEO UPDATE**

8. **BOARD BUSINESS**

    a) **REVIEW AND APPROVE MAY 2023 MONTHLY FINANCIAL STATEMENTS**

    b) **REVIEW AND APPROVE RESOLUTION 2023-06 SETTING FORTH CHANGES TO THE FINANCE COMMITTEE MEETING**

    c) **REVIEW BOARD RECESS PRESENTATION AND APPROVE RESOLUTION 2023-01 CHANGING FREQUENCY OF BOARD OF GOVERNORS MEETINGS**

    d) **ALLIANCE MEDICARE DUAL SPECIAL NEEDS PLAN OPTIONS UPDATE**

    e) **TRANSPLANTS OVERVIEW PRESENTATION**

9. **STANDING COMMITTEE UPDATES**

    a) **PEER REVIEW AND CREDENTIALING COMMITTEE**

    b) **PHARMACY & THERAPEUTICS COMMITTEE**

    c) **CONSUMER MEMBER ADVISORY COMMITTEE**

10. **STAFF UPDATES**

11. **UNFINISHED BUSINESS**

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

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

14. **ADJOURNMENT**

NOTICE TO THE PUBLIC

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

The agenda may also be accessed through the Alameda Alliance for Health's Web page at: www.alamedaalliance.org

Board of Governors meetings are regularly held on the second Friday of each month at 12:00 p.m., unless otherwise noted. This meeting is held both in person and as a video conference call. Meeting agendas and approved minutes are kept current on the Alameda Alliance for Health's website at www.alamedaalliance.org.

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 items 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.

Supplemental Material Received After the Posting of the Agenda: Any supplemental materials 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 it to "Attn: 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, Brenda Martinez, 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 by July 7th, 2023, by 12:00 p.m.

Brenda Martinez, Clerk of the Board

BOARD OF GOVERNORS
Regular Meeting Minutes

Friday, June 9th, 2023
12:00 p.m. – 2:00 p.m.

In-Person and Video Conference Call
1240 S. Loop Road
Alameda, CA 94502
or
7830 MacArthur Blvd
Oakland CA,

Board of Governors Present: R. Gebhart (Chair), Dr. Marty Lynch, Dr. Michael Marchiano, Dr. Kelley Meade, Jody Moore, Andrea Schwab-Galindo, Dr. Rollington Ferguson, Aaron Basrai, Supervisor Lena Tam, James Jackson

Remote Attendance - **AB 2449 "Just Cause" Exception:** Dr. Noha Aboelata (Vice-Chair), Byron Lopez

Remote Attendance - Viewing Member: Yeon Park

Board of Governors Excused: Natalie Williams, Dr. Evan Seevak

1. CALL TO ORDER

Chair Gebhart called the regular Board of Governors meeting to order at 12:00 p.m.

2. ROLL CALL

Members of the Board are called to order, quorum is confirmed.

3. AGENDA APPROVAL OR MODIFICATIONS

None.

4. INTRODUCTIONS

None.

5. CONSENT CALENDAR

a) May 12th, 2023, Board of Governors Meeting Minutes

b) May 12th, 2023, Compliance Advisory Committee Meeting Minutes

c) June 6th, 2023, Finance Committee Meeting Minutes

Motion: A motion was made by Dr. Rollington Ferguson and seconded by Dr. Marty Lynch to approve Consent Calendar Agenda Items 5a through 5c.

Vote: Motion unanimously passed.

No opposition or abstentions.

6. BOARD MEMBER REPORTS

a) COMPLIANCE ADVISORY COMMITTEE

Dr. Meade announced that 178 findings from the compliance activity performance dashboard over the last five years, including self-identified and audit findings from the oversight body, were reviewed informationally.

The 2023 DHCS routine medical survey was conducted from April 17th to April 28th. The report has not yet been released, but the Alliance has identified 14 self-identified findings and begun addressing them.

The 2022 DHCS routine medical survey reported 15 findings, 9 of which were repeats. We have heard back from DHCS on eight of those 15 and will continue to track them. Two delegated entities, CFMG and CHCN, have some deficiencies in the DMHC sparing organization audit, but they have very good processes in place to follow up quarterly. In addition, the DMHC routine financial examination for 2022 is complete, and all issues have been resolved.

b) FINANCE COMMITTEE

Dr. Ferguson reported that our TNE continues to remain stable and is currently 724%. Several state changes are going to affect us, and we're anticipating the addition of many non-capitated members over the next year, which will significantly impact our TNE. There are also expectations of an increase in ALR, which will be primarily attributed to new hiring. Our net investment continues to increase, which drives up interest rates, and we're seeing pretty good returns.

7. CEO UPDATE

Net income for 2024 is projected at $21.9 million. As part of our DHS contract for 2024, we now have some details about this new term called Community Reinvestment. The term describes how a medical plan must reinvest a certain amount of money back into the community.

In April, all regulatory metrics were met. The Member Services Department and the Information Technology Department both met regulatory metrics but did not meet internal metrics.

As part of the insourcing of mental health and autism spectrum services, we have entered our stabilization period. The Alliance is now providing services to 1,860 LTC members.

The public health emergency has ended, and Medi-Cal redeterminations have begun. The first disenrollments are expected to take place in July 2023, and they will continue through May 2024.

An outreach campaign is being conducted by Alameda Alliance for Health in partnership with Alameda County Social Services Agency to minimize disruptions to county residents who are disenrolled from Medi-Cal.

Question: What steps are being taken to be able to meet member services call center metrics the way that we want to, considering membership is growing and call volume is increasing?

Answer: For the first six months of the year, we had our two highest volume months ever; in February, we had over 20,000 calls. In April, we had over 14,000 calls, and in May, we had over 19,000 calls. This month, in June, we have had new hires starting every Monday, and as call volumes continue to rise, we are continuing to staff up to meet our internal metrics.

8. BOARD BUSINESS

a) REVIEW AND APPROVE APRIL 2023 MONTHLY FINANCIAL STATEMENTS

Enrollment

- Enrollment has increased to 358,000 members, an increase of approximately 2900 members.
- The Child Category of Aid and Adults Optional Expansion continues to increase.
- In July 2023, the Alliance expects to restart disenrollment activities related to redetermination following the end of the Public Health Emergency in May 2023.
- Membership enrollment in Medi-Cal SPD's and Duals continues to increase.

Net Income

- For the month ended April 30th, 2023:
  - Actual Net Income: $13.5 million.
  - Budgeted Net Loss: $1.2 million.
- For the fiscal YTD ended April 30th, 2023:
  - Actual Net Income: $78.8 million.

Revenue

- For the month ended April 30th, 2023:
  - Actual Revenue: $138.8 million.
  - Budgeted Revenue: $138.1 million.
- For the fiscal YTD ended April 30th, 2023:
  - Actual Revenue: $1.2 billion.
  - Budgeted Revenue: $1.2 billion.
- The variance is related to our medical expenses, which were lower than what we anticipated in our budget, but also, our portfolio investment returns have been higher than expected.

Medical Expense

- For the month ended April 30th, 2023:
  - Actual Medical Expense: $121.2 million.
  - Budgeted Medical Expense: $130.4 million.
- For the fiscal YTD ended April 30th, 2023:
  - Actual Medical Expense: $1.0 billion.
  - Budgeted Medical Expense: $1.1 billion.
- There are three major categories that account for the variance between budget and actuals Long Term Care, inpatient hospitals, and people services, as well as ancillary services.

Question: What is the difference between Long Term Care FFS and Inpatient Hospital & SNF FFS?

Answer: It's really a summary of medical expenses and some of the key drivers of variance. We also look at our expenses per member per month. As a result, we've picked up some monthly volume impacts. It's about 4.8% off, but it's slightly less than what we had anticipated.

Medical Loss Ratio (MLR)

Medical Loss Ratios (total reported medical expenses divided by operating revenue) was 87.3% for the month and 89.1% for the fiscal year-to-date. 87.3% of each dollar is allocated to medical care. The remaining is allocated to administrative expenses and is part of our net equity.

Question: Are we not referring appropriately to transplant services?

Answer: This is not the case because we do not receive grievances. You do not see excess mortality in that area. As a result, we do not hear about PQIs (potential quality issue), as it may indicate lingering patients who have not been referred. In addition to the fact that we live very close to two major test centers, UCSF, and Stanford, most of our patients choose to undergo tests at UCSF.

Question: How many transplants did our members get in the last fiscal year?

Answer: As of right now, we do track a few members, but a specific number will have to be written up and provided.

Question: How do you intend to contextualize the entire number that they give you? What is the numerator, and what is the denominator? How will you utilize the number once you get it?

Answer: We will look to see if there is any available information in terms of rates, and we could also look to see, although I don't know if it is available, what the state fees for service are, and how their experience was before we took over the program.

Administrative Expenses

- For the month ended April 30th, 2023:
  - Actual Administrative Expense: $6.2 million.
  - Budgeted Administrative Expense: $9.0 million.
- For the fiscal YTD ended April 30th, 2023:
  - Actual Administrative Expense: $58.4 million.
  - Budgeted Administrative Expense: $67.2 million.
- Administrative expense budget has been lower than anticipated, and we include the categories of expenses on the table here.

- In total, about $8.8 million is favorable to our budget; the biggest area is the list of employee expenses. This is due to the delayed timing of start dates for Consulting for new projects, Computer Support Services, and Purchased Services, and the delayed hiring of new employees and temporary help.

Other Income / (Expense)
Other Income & Expense is comprised of investment income and claims interest. In this fiscal year, we gained $11.3 million. We experienced a small loss during the last fiscal year. Investing expenses amounted to $293,000. Our entire budget is $360,000.

Question: Are there any reasons why claims interest expense keeps going up?

Answer: There are several reasons, primarily programs and services that started. There is usually a kind of integration and late payment due to delays in authorizations. Additionally, as our membership has increased, we have more members and are adding more providers to provide care for them.

Tangible Net Equity (TNE)
The required amount by the Department of Mental Healthcare is about $43 million.

- Required TNE - $42.8 million
- Actual TNE - $309.5 million
- Excess TNE - $266.7 million
- TNE % of Required TNE – 724%

Cash & Cash Equivalents
Our cash position is $448 million in cash, of which $228 million of that is committed in our investment portfolio. $148 million in cash, which is 228% committed bulk of that is in our investment portfolio. Short-term investments that we earn interest on capital are $200 million, with a ratio of 1.8.

Capital Investments
Capital investments today $339,000 invested in capital assets.

Motion: A motion was made by Dr. Kelly Meade and seconded by Andrea Schwab-Galindo to approve the April 2023 monthly financial statements as presented.

Vote: Motion unanimously passed.

No opposition or abstentions.

b) REVIEW AND APPROVE FY24 DRAFT BUDGET PRESENTATION

- First quarter forecast for FY24 and final budget to be presented in December 2023.
- DHCS has announced that final Medi-Cal rates will be issued in December. The final rates will be incorporated in the second quarter forecast.
- FY24 Projected Highlights Proposed.
- 2024 Net Income of $22 million.
- Anticipating enrollments to lower by about 8000 Members.
- $1.7 billion for the next fiscal year, about a $30 million increase in revenue for the next fiscal year.
- $19.2 million in net savings from claims avoidance and recovery activities.
- Administrative expenses represented about 6.7% of revenue for the next fiscal year. $43 million higher than FY23.
- Staffing includes 659 full-time equivalent employees by June 30th, 2024.
- Higher enrollment and a higher proportion of fee-for-service vs. capitated expense generate a higher TNE requirement. Group Care enrollment remains steady at approximately 5,700.
- Medi-Cal base rates are assumed to increase by 11.8% on a per member/per month basis, equating to an increase of $110.0 million in revenue. This is driven by a full year of Long-Term Care.

- The continuation of CalAIM initiatives of Enhanced Care Management (ECM), Community Supports, and Major Organ Transplants (MOT) represent $42.9 million in revenue.
- Community Supports expenditures will exceed funding by approximately $15 million.
- CalAIM Incentives of $30.8 million are anticipated, most of which will be passed on to our community partners.
- ECM and MOT expense increases correspond to revenue, as a risk corridor is included for these services.
- FY24 Hospital contract rates increase by $27.2 million over FY23.
- Anthem members and other new populations join the Alliance. Healthcare costs for these members are largely paid via FFS claims. The FFS claims will requireincreases to required TNE .
- Our capital budget for next year is going to be about $1.5 million.
- The age band for the Child Adult Category of Aid will potentially be extended by 2 years, up to 21 years of age. This will cause budget discrepancies between the Child and Adult COAs.
- Contract changes for hospitals and delegated providers in projections have not been finalized.
- The Executive Committee recommendation is to retain the Designee language for the two County Department head seats as proposed by the County.

Question: The child's health in the MLR seems less than 85%. Are we spending less on children? Does that mean we anticipated giving the state money back?

Answer: We are spending less than our revenue percentage for the child category. Additionally, no, we don't because the state looks over the medical loss ratio and its entirety, and the average is over 85%.

Motion: A motion was made by Dr. Rollington Ferguson and seconded by Dr. Kelly Meade to approve the FY24 draft budget presentation as presented.

Vote: Motion unanimously passed.

No opposition or abstentions.

c) REVIEW AND APPROVE PROPOSED LANGUAGE FOR COUNTY DIRECTOR SEATS

- Designee proposed language indicates that in the event they do not possess the capacity to serve on the board or if another content expert who is a leader within the organization is better suited to serve on the board than they would.
- The Executive Committee recommendation is to retain the Designee language for the two County Department head seats as proposed by the County.
- There will be no change to the internal vetting process for all candidates, except for a proposal to include the Executive Committee invitation to all candidates:
  - The Board Chair and Vice Chair, with the Executive Committee as their availability permits, meet with the proposed Candidate, remotely or in person.
  - The Candidate’s name is taken to the Alliance Board of Governors for approval.
  - After approval, candidate names are forwarded to the Board of Supervisors for the official appointment, and after the appointment, there is an informal orientation with Board members and a formal orientation with the staff.

Question: Will there be an Onboarding position to the board moving forward?

Answer: Interpreting this as an opening to the entire Executive Committee for every new Board position that becomes open and not singling out the county positions.

Motion: A motion was made by Supervisor Lena Tam and seconded by James Jackson to approve the language and the composition as presented.

Vote: Motion unanimously passed.

No opposition or abstentions.

d) REVIEW AND APPROVE CHAIR AND VICE CHAIR POSITIONS FOR STANDING COMMITTEES

- Executive Committee: Rebecca Gebhart (Chair); Noha Aboelata, MD (Vice Chair)
- Compliance Advisory Committee: Kelley Meade, MD (Chair); Byron Lopez (Vice Chair)
- Finance Committee: Rollington Ferguson, MD (Chair); Michael Marchiano, MD (Vice Chair)
- Strategic Planning Committee: Marty Lynch, Ph.D. (Chair); Andrea Schwab Galindo (Vice Chair)

Question: Since this is now a two-year term, what's the definition?

Answer: Two fiscal years.

Motion: A motion was made by Aaron Basrai and seconded by Jody Moore to approve the chair and vice chair positions for standing committees as presented.

Vote: Motion unanimously passed.

No opposition or abstentions.

e) DISCUSS BOARD STANDING COMMITTEE MEMBERSHIP

9. STANDING COMMITTEE UPDATES

a) PEER REVIEW AND CREDENTIALING COMMITTEE

As of May 16th, 126 providers were approved; 74 were behavioral health providers, and 18 were recredentialed.

b) HEALTH CARE QUALITY COMMITTEE

HCQC is a health care quality committee established by statute from DHCS. The committee is going to change its name and slightly change its function to the Quality Improvement Health Equity Committee, which will be official in August once the bylaws and rules have changed.

10. STAFF UPDATES

None.

11. UNFINISHED BUSINESS

None.

12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

None.

13. PUBLIC COMMENT (NON-AGENDA ITEMS)

None.

14. ADJOURNMENT

Chair Gebhart adjourned the meeting at 2:02 p.m.

COMPLIANCE ADVISORY COMMITTEE
Regular Meeting Minutes

Friday, June 9th, 2023
10:30 a.m. – 11:30 p.m.

Video Conference Call or
1240 S. Loop Road
Alameda, CA 94502

Committee Members on Conference Call: Dr. Kelley Meade, Rebecca Gebhart

Committee Members Remote: Byron Lopez, Richard Golfin III

Committee Members Excused: Dr. Noha Aboelata

1. CALL TO ORDER

The regular Compliance Advisory Committee meeting was called to order by Dr. Kelley Meade at 10:30 a.m.

2. ROLL CALL

The Committee was called to order, quorum was not confirmed.

Action: The meeting will proceed as informational only.

3. AGENDA APPROVAL OR MODIFICATIONS

None

4. PUBLIC COMMENT (NON-AGENDA ITEMS)

None

5. CONSENT CALENDAR

a) MAY 12th, 2023, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

Follow Up: Approve item 5(a) on the Consent Calendar will be considered at the July meeting.

6. COMPLIANCE MEMBER REPORTS

a) COMPLIANCE ACTIVITY REPORT

i. Plan Audits and State Regulatory Oversight

1. Status Updates on State Audit Findings and Plan Responses

a) Compliance Dashboard

i. 2023 DHCS Routine Medical Survey

- We are still waiting for the final report, which is expected at the end of August. Based on the observations discussed during the closing session and our notes from the sessions, we developed a list of 14 self-identified observations, which we added to the dashboard. In the dashboard, we are tracking 178 findings, of which 162 have been completed and 16 are still pending.

1. Self-Identified Findings
    - UM: Delegate Notice of Action letters were not sent to approximately 400 members
        - These were denied cases where we would expect to see NOAs, however, most of them did not have NOAs due to a technical issue within the delegate's system.
        - Once identified, the letters were sent, though in most cases they were now months late.
        - This was disclosed to DHCS for full transparency.
        - In advance of getting a finding for DHCS, the delegate has taken action, and AAH has developed a CAP for the delegate, which they are actively working on.
    - QI: (2.1) Initial Health Assessments (IHA) did not always include a complete history of physical exams and screening. Documentation of attempts to contact members and schedule the IHA were not consistent.
    - CM: (2.2) PCP and members are not consistently notified of CM case closures
    - BHT: (2.3) BHT Treatment Plans do not consistently contain all criteria and required elements, including crisis plans and dates of mastery.
    - Family Planning: (3.6) APL 22-011 related reimbursements were underpaid.
        - This is a question of reimbursement of facility versus providers for claims, and we are still reviewing the analytics to determine the best way to resolve this potential finding.
    - State Supported Services: (3.6) 19-003 Abortion Payments for contracted providers were underpaid.
        - This is a result of a subset of providers who were set up incorrectly in the system, which was corrected immediately after this observation was identified.
    - Access and Availability: (3.1) The Plan did not ensure the first prenatal visit is available within two weeks of request.
    - (3.8) The Plan did not consistently obtain PCS forms for NEMT services. Additionally, the Plan did not ensure all transportation providers are enrolled in Medi-Cal
        - This is a repeat finding which we have worked to rectify, however during the look-back period included time before the corrections were put in place, which were captured during the review.
        - The metrics are being tracked and reported at UM Committee
    - Member Rights: (4.1) Resolution letters for QOC grievances were not always sent within the required timeframe of 30 calendar days. The Plan is not classifying complaints accurately. Complaints involving duals members, who have Medicare along with Medi-Cal, are not consistently being classified as grievances. The Plan is not consistently classifying exempt and standard grievances correctly. Grievances are being classified as exempt that require more investigation. The Plan was not compliant with the grievance extension letter timeframes.
    - Fraud and Abuse: (6.2) R The Plan did not report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10 working days of the Plan receiving notification of the incident.

<u>Question:</u> The provider community usually considers the IHA and the first three visits as satisfactory. Does that meet the definition?

<u>Answer</u>: From the provider's side, yes, it must be done within 120 days. However, at the Alliance, we identify a list of claims codes, and providers who submit those claims codes within 120 days get credit for completing the IHA.

<u>Question:</u> Is there a protocol for reaching out to the PCP when a patient isn't found after repeated attempts and the case is closed?

<u>Answer:</u> Yes, we attempt to reestablish contact with this member by using all means available to us, such as PCPs, AORs, and any other means we can find.

ii. 2022 DHCS Routine Medical Survey

- There is one pending finding, 2.1.1, which is The Plan did not document attempts to contact members to schedule the Initial Health Assessment. For this finding, IHA workflows were updated, and final documents were sent to DHCS in June, and we are now awaiting their response.

b) **Delegation Activity and Oversight**

ii. MLR Reporting for Delegation Activity

- So far, medical observation, reporting, and delegation activity, nothing really since our last update, the state is going to be providing final guidance in August of this year.

iii. 2022 DMHC RBO Audits

- The Plan received the audit report from DMHC in December 2022. Deficiencies were found in the following areas:

1. CFMG
   - Claims Payment Accuracy: 1 deficiency
   - Misdirected Claims: 1 deficiency
   - Reimbursement of Claim Overpayments: 1 deficiency
2. CHCN
   - Claims Payment Accuracy: 2 deficiencies
   - Incorrect Claim Denials: 1 deficiency

- The Plan's oversight includes quarterly audits of the RBOs claims settlement practices beginning with Q1 2023 dates of service. On May 31st, 2023, the Plan sent the audit notification letters to both CHCN and CFMG for their 1st quarterly audit. The claims documents are due back to the plan on June 14th.

c) **Medi-Cal Program Updates**

iv. 2022 RFP Contract Award

- In addition to 15 deliverables sent on May 22nd, another 15 were submitted on June 5th. There are 4 more deliverables to send on June 14th. Additionally, the state has provided us with two new submission dates, September 15th, and December 29th. The final submission date for 2023 is expected to be December 29th. We are still awaiting the release of 19 undisclosed requirements. Seven submissions will be made between July and December of 2023.

Question: Are the deliverables requested uniform across the state, across plans that are participating in this process, or are they targeted to us specifically because of our demographics or other reasons?

Answer: There are two groups, depending on whether you're transitioning to a single plan or not. As a result, everyone who is transitioning to single plan model in the same way as us will have the same deliverables and deadlines.

v. Behavioral Health Transition

- The administrative service agreement with Beacon was terminated effective April 1st. Although the Plan has received approval, DMHC's approval was subject to and condition upon the Plan's full performance to the department's satisfaction of 8 undertakings. 6 of the 8 undertakings required deliverables to DMHC, which compliance is coordinating with our internal stakeholders.

Question: When you said six have concrete deliverables, did the other two just do it?

Answer: Yes, they are just informational.

1. Review of Undertakings

vi. AB 2449 Follow-Up Q&A

- Our next steps will be to synthesize the data, conclude our research, summarize it, and bring it back to discuss and make a recommendation to the board as to which one, or if both, and why to proceed forward.

Question: Is there anything under the Traditional Brown Act that would help us, for instance, in this scenario?

Answer: There's a yes and a no. In theory, remote attendance is counted as a quorum under the Brown Act, but there are some requirements. Your address must be listed on the agenda, etc. If we can meet that, we will be fine. However, in certain circumstances, such as when there is a problem the day before or the day of, we may not have time.

7. COMPLIANCE ADVISORY COMMITTEE BUSINESS

Motion: Revisit the Motion to Hold Meetings Every Other Month.

Follow Up: Motion to be reconsidered and discussed during the next in-person quorum.

8. STAFF UPDATES

None

9. UNFINISHED BUSINESS

None

10. STAFF ADVISORIES ON COMPLIANCE BUSINESS FOR FUTURE MEETINGS

None

11. ADJOURNMENT

Dr. Kelley Meade adjourned the meeting at 11:30 a.m.

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

July 11th, 2023
8:00 am – 9:00 am

SUMMARY OF PROCEEDINGS

Meeting Conducted in-person and by Teleconference.

Committee Members in-person and on Conference Call: Dr. Rollington Ferguson, Dr. Michael Marchiano, James Jackson, Yeon Park, Gil Riojas

Board of Governor members in-person: Rebecca Gebhart

Alliance Staff in-person and on Conference Call: Matt Woodruff, Tiffany Cheang, Sasi Karaiyan, Richard Golfin III, Dr. Steve O'Brien, Anastacia Swift, Lao Paul Vang, Ruth Watson, Shulin Lin, Carol van Oosterwijk, Linda Ly, Brenda Martinez, Renan Ramirez, Danube Serri, Charles Walmann, James Zhong Xu, Christine Corpus

CALL TO ORDER, ROLL CALL, AND INTRODUCTIONS

Dr. Ferguson called the Finance Committee meeting to order at 8:00 am. A roll call was then conducted.

CONSENT CALENDAR

Dr. Ferguson presented the Consent Calendar.

The June 6th, 2023, Finance Committee Minutes were approved at the Board of Governors meeting on June 9th, 2023, and not presented today.

There were no modifications to the Consent Calendar, and no items to approve.

a.) CEO UPDATE

Matthew Woodruff provided updates to the committee on the following:

Overall, the Alliance had another good month in May. The income earned this year will help set the Alliance up for the long term. We expect our TNE to drop in fiscal year 2024 due to the Alliance moving to the single plan model and as we prepare for Medicare the Alliance will be spending money on system upgrades and FTEs before we see money come into the Plan.

A few program notes:

July 1, the Alliance started:

- ECM POF (kids) is live.
    1. Multiple new CBO ECM providers
    2. Over 8,000 new kids
- CS
    3. Caregiver respite
    4. Personal caregiver services
    5. Home modifications (EBI)
    6. We began our pilot with Roots community health center. The Justice involved pilot begins to prepare us for the post release work the Alliance will be doing in beginning in January 2024.

Community Reinvestment

- On Friday Gil and I will report on how the financials will work behind community reinvestment. This finance committee, the member advisory committee, and the Alliance full Board of Governors, over the next 6 months, will need to develop an, end-to-end process from intake to approval by the Board of Governors. There are many questions we hope the State answers by Fall, so we can build out the process.

Question: Dr. Ferguson asked about the impact of the KP breach on the Alliance, the cost and what effect this had on the Alliance. Matt discussed the FTE cost of the KP breach and added that we would present to the Board of Governors a full report on the security measures the Alliance has put into place. Dr. Ferguson asked if we could calculate the cost of the FTE by Friday's full Board meeting. Gil answered that he would work with his team to provide the information as soon as possible.

Informational update to the Finance Committee. Vote not required.

b.) REVIEW AND APPROVE MAY 2023 MONTHLY FINANCIAL STATEMENTS

MAY 2023 Financial Statement Summary

Enrollment:

Enrollment has increased by 1,956 members since April 2023, and 47,126 members since June 2022 bringing our Total Enrollment to 360,182. We expect our momentum to grow through June and then in July see a decrease as redetermination begins, until the end of December when we will move to the Single Plan Model and expect significant growth followed by continuing decreases from redetermination through the end of the fiscal year.

We see consistent increases in the Child, Adult, and Optional Expansion categories of aid, we've also seen increases in our SPDs and our Duals. Our Group Care line of business was showing a decline, however the month of May was flat as compared to April. We also saw slight increases in our Medi-Cal LTC, and Medi-Cal LTC Duals.

Net Income:

For the month ending May 31st, 2023, the Alliance reported a Net Income of $12.7 million (versus budgeted Net Loss of $1.3 million). The favorable variance is attributed to higher than anticipated Revenue, lower than anticipated Medical Expense, lower than anticipated Administrative Expenses, and higher than anticipated Total Other Income. For the year-to-date, the Alliance recorded a Net Income of $91.6 million versus a budgeted Net Income of $17.3 million.

Revenue:

For the month ending May 31st, 2023, actual Revenue was $144.5 million vs. our budgeted amount of $137.4 million. Our actual and budgeted year-to-date Revenue is currently at $1.3 billion.

Medical Expense:

Actual Medical Expenses for the month were $127.2 million, vs. our budgeted amount of $131.7 million. For the year-to-date, actual, and budgeted Medical Expenses were $1.2 billion. Drivers leading to the favorable variance can be seen on the tables on pages 10 and 11, with further explanation on pages 11 and 12.

Medical Loss Ratio:

Our MLR ratio for this month was reported at 88.1%. Year-to-date MLR was at 89.0%.

Administrative Expense:

Actual Administrative Expenses for the month ending May 31th, 2023 were $6.2 million vs. our budgeted amount of $7.1 million. Our Administrative Loss Ratio (ALR) is 4.3% of our Revenue for the month, and 5.0% of Net Revenue for year-to-date. Gil called out the variance in Employee Expenses for the month of May. The year-to-date favorable variances include 1) Delayed timing of new project start dates for Consultants, Computer Support Services, and Purchased Services, and 2) Overall delayed hiring of new employees and temporary help.

Other Income / (Expense):

As of May 31th, 2023, our YTD interest income from investments show a gain of $13.0 million.

YTD claims interest expense is $357,000.

TangibleNet Equity (TNE):

Our required TNE is at $41.4 million, and our actual TNE is at $322.2 million which leads us to our reported TNE of 778%. We are projecting our TNE to decrease starting in this fiscal year, because of the move to the single plan model. As we take on additional enrollment and additional fee-for-service expenses, that requirement is going to increase the TNE requirement which will mean our reserve requirement will go up which means our reserve percentage will go down.

Cash and Cash Equivalents:

We reported $472.0 million in cash; $329.9 million is uncommitted. Our current ratio is above the minimum required at 1.79 compared to regulatory minimum of 1.0.

Capital Investments:

We have spent $339,000 in Capital Assets year-to-date. Our annual capital budget is $1.1 million. We do not anticipate spending the entirety of our capital investment budget this year, but we do anticipate spending more before the end of June.

Question: Dr. Ferguson asked if there was a way to make the forecasts more accurate. Gil answered that one of the factors causing the greater variances in this year's forecasts was related to the delay in receiving final rates from the State last year. We do expect final rates in October of this next fiscal year, which will influence our Final Budget results as well as future forecasts. Matt mentioned the shifting of State redetermination dates also played a role in variances. Rebecca Gebhart added that it is important to be able to explain the variances, since many of them are out of our control.

Motion: A motion was made by Dr. Michael Marchiano and seconded by Gil Riojas to accept the May 2023 Financial Statements.

Motion Passed

No opposed or abstained.

c.) REVIEW AND APPROVE FY24 REVISED FINANCE COMMITTEE SCHEDULE

Gil Riojas gave a presentation proposing a new in-person meeting schedule for review and approval by the Finance Committee, to bring to the Board of Governors for final approval.

The proposal outlined mandatory meeting months as follows:

- October – Moss-Adams Financial Audit Results
- December – Final Budget Review
- June – Preliminary Budget Review

Gil further outlined other months suggested to meet with corresponding Recess months as follows:

- In- Person

    - July
    - September
    - October
    - December
    - February
    - May
    - June
- Recess
    - August (To correspond with BOG Recess)
    - November
    - January
    - March
    - April

Gil then provided the financial metrics that would warrant in in-person meeting as follows:

- Net Loss greater than $10 million in one month
- Reduction in TNE greater than 100% points in one month
- MLR above 110% cumulatively or in one month
- Current Ration at or below 1.1 (1.0 is regulatory minimum)
- Two or more metrics near minimum limits
- At the discretion of the Board and Finance Chair *(changed to below during discussion)*
- ***At the discretion of the Board Chair, Finance Chair, or CEO***

Recommendation: Dr. Ferguson recommended changing the last metric to read "At the discretion of the Board Chair, Finance Chair, or CEO". Gil informed Dr. Ferguson he would make the change for the Board of Governors meeting on Friday.

Motion: A motion was made by Dr. Michael Marchiano and seconded by Gil Riojas to accept the proposed schedule to the Finance Committee Meeting schedule with the changes indicated above and move to bring forward to the full Board of Governors for final approval.

Motion Passed

No opposed or abstained.

ADJOURNMENT

Dr. Ferguson adjourned the meeting at 8:45 a.m.

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

2022

Case Management/Care Coordination, Complex Case Management & Disease Management
2022 Program Evaluation

Signature Page

Date 06/19/2023

DocuSigned by:
Julie Anne Miller
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Julie Anne Miller, LCSW
Senior Director, Health Care Services

Date 06/20/2023

DocuSigned by:
Donna Carey, MD
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Donna Carey, MD
Medical Director, Case and Disease Management

Date 06/20/2023

DocuSigned by:
Sanjay Bhatt
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Sanjay Bhatt, M.D.
Senior Medical Director, Quality Improvement

Date 06/20/2023

DocuSigned by:
Lao "Paul" Vang
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Lao Paul Vang
Chief Health Equity Officer

Date 06/20/2023

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

Date 06/20/2023

DocuSigned by:
Matthew Woodruff
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Matthew Woodruff
Chief Executive Officer

Date 06/20/2023

DocuSigned by:
Rebecca Gebhart
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Rebecca Gebhart
Board Chair

2022
Case Management
Program Evaluation

Overview

Under the leadership and strategic direction established by Alameda Alliance for Health (The Alliance) Board of Directors and Quality Management Committee (QMC), senior management and the Health Care Quality Committee (HCQC), the Health Care Services 2022 Case Management Program was successfully implemented. This report serves as the annual evaluation of the effectiveness of the Case Management (CM) program activities, which include care coordination, care management, complex case management and disease management.

The processes and data reported covers activities conducted from January 1, 2022 through December 31, 2022.

Membership and Provider Network

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

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

Figure 1 2022 Trended enrollment by network and age group

Current Membership by Network By Category of Aid							
Category of Aid	Dec 2022	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Adults	50,351	16%	9,509	9,939	845	20,887	9,171
Child	101,791	32%	7,468	9,362	30,545	35,630	18,786
SPD	28,452	9%	8,375	4,527	1,021	12,360	2,169
ACA OE	118,397	37%	16,915	38,547	1,234	46,266	15,435
Duals	23,028	7%	8,588	2,535	3	8,239	3,663
Medi-Cal	322,019		50,855	64,910	33,648	123,382	49,224
Group Care	5,776		2,288	861	-	2,627	-
Total	**327,795**	**100%**	**53,143**	**65,771**	**33,648**	**126,009**	**49,224**
Medi-Cal %	98.2%		95.7%	98.7%	100.0%	97.9%	100.0%
Group Care %	1.8%		4.3%	1.3%	0.0%	2.1%	0.0%
	Network Distribution		*16.2%*	*20.1%*	*10.3%*	*38.4%*	*15.0%*
			% Direct:	**36%**		**% Delegated:**	**64%**

Age Category Trend				
	Members			
Age Category	Dec 2020	Dec 2021	Nov 2022	Dec 2022
Under 19	97,399	100,408	103,882	104,022
19 - 44	93,280	105,212	119,055	119,997
45 - 64	57,679	60,685	68,281	68,606
65+	27,231	30,423	34,707	35,170
Total	**275,589**	**296,728**	**325,925**	**327,795**

For 2022, The Alliance membership increased, as seen in Figure 1, to about 328 thousand members, from 297 thousand members in 2021. This trend is in alignment with the increase in Medi-Cal Enrollment in California in 2022 and suspension of disenrollment due to the Covid Public Health Emergency.

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

Figure 2 Provider Network by Type and Enrollment

Provider Network	Provider Type	Members (Enrollment)	% of Enrollment in Network
Direct-Contracted Network	Independent	53,143	16.2%
Alameda Health System	Managed Care Organization	65,771	20.1%

Children First Medical Group	Medical Group	33,648	10.3%
Community Health Clinic Network	Medical Group	126,009	38.4%
Kaiser Permanente	HMO	49,224	15.0%
TOTAL		327,795	100%

The percentage of members within each network has been relatively steady from 2021 to 2022, varying by less than 1%

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

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

Delegation

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

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

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

Figure 3 – 2022 the Alliance Delegated Network

2022 Alliance Delegated Network			
Provider Network/Delegate	**Provider Type**	**Delegated Activity- Care Coordination/CM**	**Delegated Activity- Complex Case Management**
Kaiser	HMO	Yes	Yes
CHCN	MCO	Yes	No
Beacon	MBHO	Yes	Yes

Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)			
Members	**Dec 2020**	**Dec 2021**	**Nov 2022**	**Dec 2022**	**Dec 2020**	**Dec 2021**	**Nov 2022**	**Dec 2022**
Delegated	168,412	185,850	206,973	208,881	61.1%	62.6%	63.5%	63.7%
Direct	107,177	110,878	118,952	118,914	38.9%	37.4%	36.5%	36.3%
Total	**275,589**	**296,728**	**325,925**	**327,795**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Overall, the network was sufficient to meet the needs of The Alliance membership and provider network through 2022. In 2022 there were ongoing improvements in the level of oversight, monitoring, reporting, and training of delegates to ensure they met the regulatory standards and Alliance requirements.

Program Structure

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

Responsibility, Authority and Accountability/ Governing Committee

The Alameda County Board of Supervisors appoints the Board of Governors (BOG) of the Alliance, a 12-member body representing provider and community partner stakeholders. The BOG is the final decision-making authority

for all aspects of The Alliance programs and is responsible for approving the Quality Improvement, Utilization Management and Case Management Programs. The Board of Governors delegates oversight of Quality and Utilization Management functions to The Alliance Chief Medical Officer (CMO) and the Health Care Quality Committee (HCQC) and provides the authority, direction, guidance, and resources to enable Alliance staff to carry out the Utilization Management and Case Management Programs. Utilization Management oversight is the responsibility of the HCQC. Utilization Management and Case Management activities are the responsibility of the Alliance Health Care Services staff under the direction of the Medical Director for Care Management and Special Programs and the Senior Director, Health Care Services in collaboration with the Alliance CMO.

Committee Structure

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

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

HCQC charters a sub-committee, the Utilization Management Committee (UMC) which meets at least once every 2 months (10 meetings in 2022,) serving as a forum for the Alliance to evaluate current CM activities, processes, and metrics. The UMC also evaluates the impact of CM programs on other key stakeholders within various departments and when needed and assesses and plans for the implementation of any needed changes.

The 2021 CM Program Evaluation and 2022 CM Program Description were developed and presented for review and approval at the March 17, 2022 HCQC meeting and documented in the minutes, for Board of Directors approval. The committee was chaired by the Chief Medical Officer with support of the Senior Director of Quality Management, external physicians, and key organizational staff.

In 2022 the UM Subcommittee of HCQC has continued to support the focus on CM activities, oversight for delegated CM activities, case management/care coordination, complex case management, transitions of care, population health, integration of behavioral health and medical as well as regulatory compliance.

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

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

During 2022 Dr. Aaron Chapman, a psychiatrist, and Medical Director of Alameda County Behavioral Health Care Services, actively participated in the HCQC meetings and provided clinical input ensuring policies and reports considered behavioral health implications. In 2022, Dr. Peter Currie, Ph.D., was hired as the Senior Director, Behavioral Health Services, to provide leadership to behavioral health care at AAH and participated in HCQC meetings as well, to further the integration of behavioral health care with medical care.

Program Scope and Structure

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

The comprehensive case management program is established to provide case management processes and procedures that enable the Alliance to improve the health and health care of its membership. Members from all Alliance health products are eligible for participation in the program. Alliance products include Medi-Cal and Alliance Group Care. The fundamental components of Alliance case management services encompass: member identification and screening; member assessment; care plan development, care plan implementation and management; evaluation of the member care plan; and closure of the case.

The structure of comprehensive case management is organized to promote quality case management, client satisfaction and cost efficiency using collaborative communications, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

Case Management Resources

The Alliance CM Department is staffed with physicians, nurses, social workers, and non-clinical support staff including clerical support and clinical support coordinators. A full description of staff roles and responsibilities is provided in the 2022 CM Program Description.

The assignment of work to the team, whether working on site or remotely for both clinical and non-clinical activities, is seamless to the process. In 2020, in response to the Covid 19 pandemic and public health requirements, the CM department transitioned to fully working from home, and have continued to do so throughout 2022. Staff were provided equipment, remote connectivity, and policies to follow to successfully work from home while maintaining full functionality and meeting regulatory requirements. The job descriptions with assigned tasks and responsibilities remained the same regardless of the geographical location of the team member.

In 2022, the leadership structure in the CM department is designed to meet the needs of the program and the staff:

-
- 1.0 Medical Director of Case Management
- 1.0 FTE Senior Director, Health Care Services
- 1.0 FTE Director, Social Determinants of Health
- 1.0 FTE Manager, CM
- 1.0 FTE Supervisor of CM.
- 1.0 FTE Lead CM.
- 1.0 Clinical Manager, Enhanced Care Management (ECM)

The department was successful in hiring and retaining Complex Case Managers in 2022.

In 2022, the CM department expanded to take on CalAIM, Community Supports (CS) services. The additional staff include:

- 1.0 Supervisor of CS
- 2.0 CS Coordinators

Delegated Case Management

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

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

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

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

In 2022, the CM staff conducted annual audits on the three (3) delegates. The threshold for CM audit compliance is 90%. For entities that do not meet the threshold, CM may require a corrective action plan which is tracked for compliance with the resolution of the deficiency. Entity audit results for 2022 were:

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

Figure 4 the Alliance Network – 2022 Annual Audit Score

Delegate	Provider Type	Delegated Activity- CM	2022 Audit Results	Corrective Action Required
Kaiser	HMO	X	No deficiencies found	None
CHCN	Medical Group	X	Deficiencies found, Corrective Action Plan Required	Yes: No evidence of review of clinical documentation for potential referral to CCM, No evidence of review

				of emotional and social support issues for potential referral, No evidence of appropriate coordination of member needs to completion (including but not limited to: resources and scheduling of appointments), Provider Collaboration
Beacon/College Health IPA (CHIPA)	Vendor-BH	X	Deficiencies found, Corrective Action Plan Required	Yes: No documentation of PCP collaboration and did not include review of clinical documentation

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

Recommend Actions/Next Steps

For 2023, there is an opportunity to continue to improve the oversight of delegated CM activities. The CM Department leadership continues to develop a robust level of delegate oversight and performance monitoring. The activities include dedicated staff, monitoring activities, performance management, delegate feedback and CM training. In 2022, planning for the insourcing of Mild to Moderate Behavioral Health and Substance Use Disorder care from Beacon/CHIPA was begun, to be insourced in 2023. This will improve the integration of BH with medical care, particularly care coordination functions.

Case Management Processes and Information Sources

Case Management Information Systems and Sources

The CM Department utilizes a clinical information system, TruCare, as the case management platform. TruCare is a member-centric application that

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

Evidence-based clinical guidelines are available to support the Case Managers in conducting assessments, developing care plans, and managing care. The clinical practice guidelines are based on current published literature, current practice standards, and expert opinion. Whenever possible, guidelines are derived from nationally recognized sources. If a nationally recognized guideline is not available, the Alliance will involve board certified specialists in the development of the appropriate guidelines, as well as medical and behavioral healthcare specialty societies and/or Alliance Clinical Practice Guidelines.

In July 2019, the CM Department conducted a comprehensive review of standard CM workflow using Lean Management principles. This included reviewing the functionality of the TruCare system. In 2020/2021, Casenet, the corporate parent of TruCare, worked in collaboration with CM and AAH IT leadership to optimize and improve the functionality of the TruCare system. 2022 optimization was not fully completed, and work will continue into 2023.

In 2021, CM Department collaborated with Senior Leadership to align Disease Management criteria with the Population Health initiatives. The enhancements made were based on the Population Health initiatives, leading to further strengthen of the Disease Management Program in 2022.

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

Care Coordination and Case Management Processes

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

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

Basic Care Management

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

Care Coordination

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

Targeted Care Management

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

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

Complex Case Management

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

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

Disease Management

The Alliance CM Disease Management (DM) program is integrated with the Quality Management Department and Population Health initiatives to provide interventions for members with targeted chronic illnesses. The Population Health initiative has identified target diagnoses affecting the Alliance membership at a disproportionate rate and/or with significant utilization. In 2021 and continuing in 2022, the DM program worked with children and adult members with Asthma and adult members with Diabetes. Multiple approaches were taken to enhance the service, ranging from identification of members with the disease, ensuring standard work was employed related to the level of acuity of the member and their disease. The program worked with community partners: Asthma Start, for children with asthma, and a variety of community programs to provide services for members with diabetes. In 2022, Community Supports

launched, and Asthma Remediation as a Community Support was chosen to further support members with Asthma.

Population Health Initiative

In 2022, the Population Health initiatives at the Alliance were strengthened and further integrated into ongoing Alliance work with members. A stratification of member acuity was developed, ranging from low-risk members who may need health promotion/education to the highest risk, most vulnerable members needing full wrap around Health Homes Program services. The CM interventions performed at each acuity level were identified, and the foci of CM work has been further targeted to the acuity level of the members.

Figure 5 Volume of CM cases in Population Health Target Diagnoses in 2022

Dx	Numbers with Disease State in the last 12 months	Care Coordination (Currently Enrolled)	Transitions of Care (Currently Enrolled)	Complex Case Management (Currently Enrolled)	Enhanced Care Management (ECM)
CAD	6448	45	49	7	135
CHF	3934	49	53	13	145
Cervical CA	403	1	1	0	7
Lung CA	274	5	4	1	1
Emphysema	3524	39	34	6	141
ESRD	980	30	17	8	38
Schizophrenia	3240	27	16	1	52
Sickle Cell Disease	128	2	3	0	1
Hepatitis C	879	3	11	0	21
Tuberculosis	151	0	1	0	5
SUD	8808	65	76	16	159
Asthma	20684	62	48	9	177
Breast CA	1233	9	6	4	5
Hyperlipidemia	40228	122	82	17	294
Hypertension	43912	185	141	33	428

Diabetes	23522	97	75	20	286
Obesity	29932	90	55	12	428
Pregnancy	7118	7	10	0	8
Gingivitis	986	2	2	1	9
Burns-1st degree	457	0	2	0	3
Tobacco	11994	70	66	15	155
Total Unique Members any DX	208835	910	752	163	2248

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

Specialty Programs

Transitions of Care

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

Continuing in 2022, the Transitions of Care Program included the hospitals of the Alameda Health System, and any Alliance member hospitalized with COVID-19 (including members who are delegated to CHCN). There was improved collaboration between CM, Utilization Management (UM) and Pharmacy on preparing members to safely transition out of the hospital to home.

2022 was spent preparing the established Transitions of Care Program to change to to Transitional Care Services (TCS) for high risk members by January 1, 2023.This included preparation to expand services for members discharging from any hospital and led to further preparatory collaboration with Inpatient Utilization Management (UM) to meet member's health care needs..

Community Supports

Case Management Processes

Community Supports (CS) services were initiated as part of the CalAIM initiative. This includes a variety of services not typically covered by managed care plans. These services were intended to provide additional cost-effective support to members in lieu of higher-level services. In 2022, the Alliance provided six (6) CS Services:

- Housing Navigation
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Recuperative Care (Medical Respite)
- Medically Tailored Meals/Medically Supportive Food
- Asthma Remediation

Health Risk Assessments

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

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

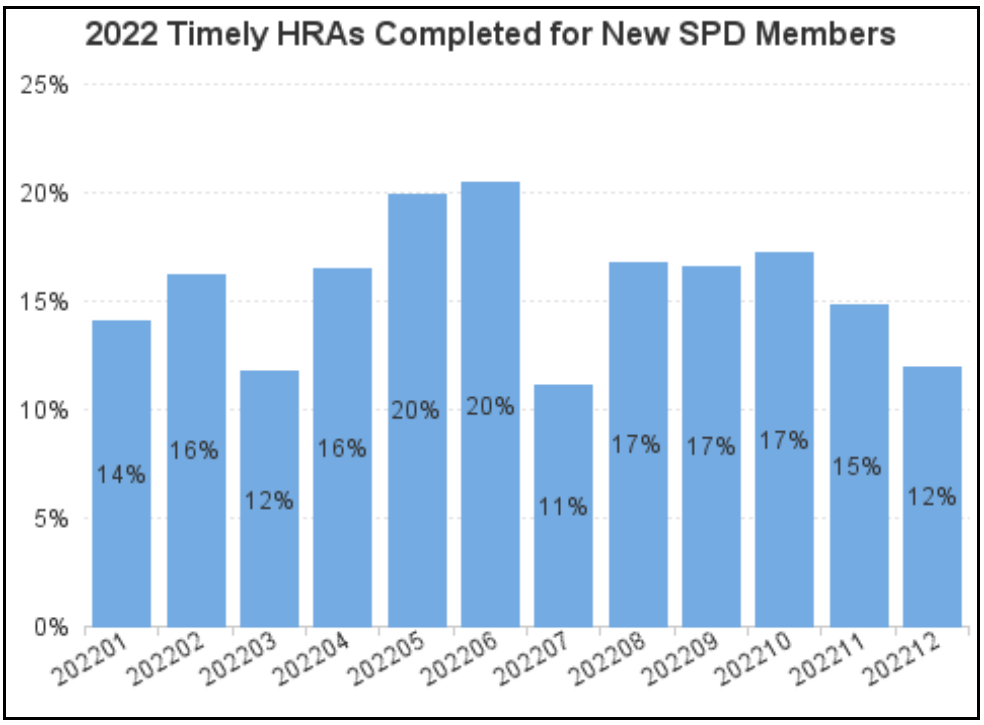
The Alliance outreaches to SPD members to administer the HRA and to develop a Care Plan. SPD members are re-assessed annually in the month of their enrollment. The responses from the HRA may result in the members being re-classified as higher or lower risk. (For some members, this HRA based re-classification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

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

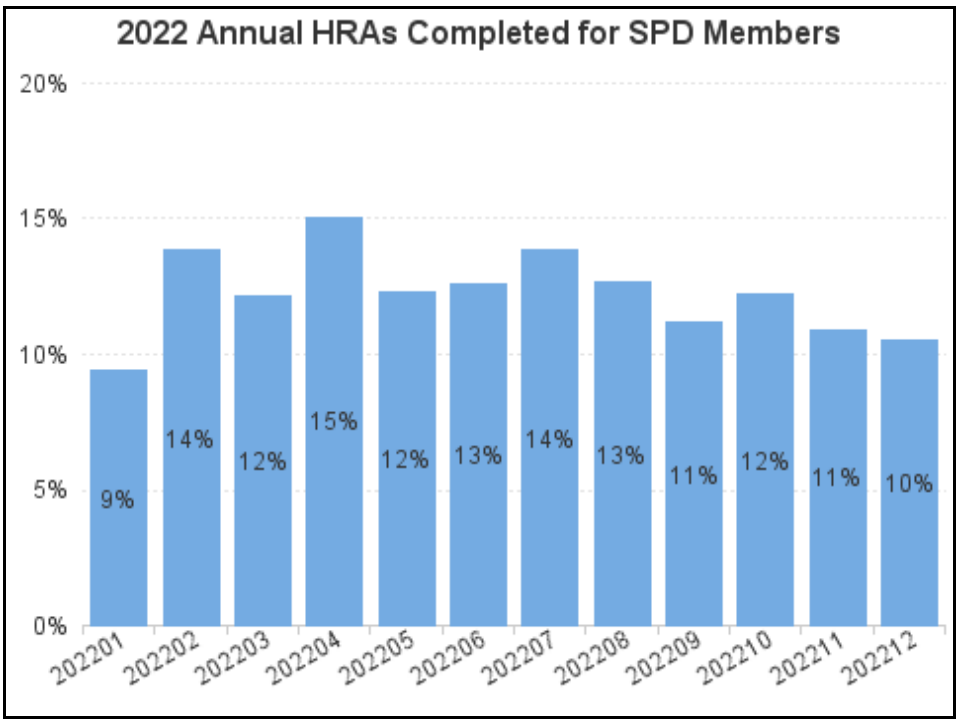
The Alliance uses Interactive Voice Response (IVR) calls to encourage members to complete an HRA. In 2021, the Alliance successfully shifted from contracting with a vendor to the Alliance's internal IT team, to make Interactive Voice Response (IVR) calls to members and this continued in 2022. These IVR calls are made to members so that the Alliance can give members every opportunity to complete the HRA and have the results acted upon by the CM department.

In collaboration with Healthcare Analytics, a HRA dashboard was created in 2018, to track compliance of outreach attempts and timely completion of the HRA for the SPD population, and this tracking continued in 2022.

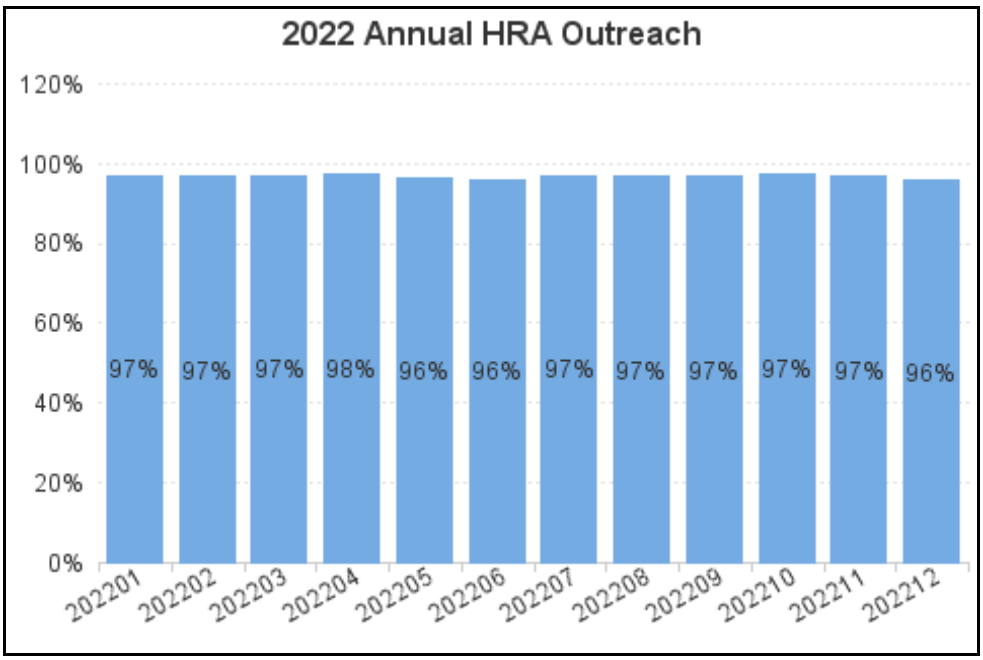
New HRA completion for SPD Members



Annual HRA completion for SPD Members



HRA Outreach for SPD Members



The outreach rates for 2022 remained consistently above 90%, reflecting the engagement of the vendor to assist with the HRA process, to remind members to return HRAs timely.
The completion numbers remained relatively stable in 2022 compared to 2021, but never going above 20%. Because this remains low, there will be further evaluation in 2023 to identify any opportunities for improvement. The plan will explore what potential barriers this at-risk population may have keeping them from sending back a completed HRA. The plan is considering additional personal interventions to assist with the completion of the HRA.

CM Referral and Identification

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

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

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

- Health Risk Assessment (HRA),

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

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

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

Direct referrals into Care Management are received from multiple sources, such as the staff from disease management, utilization management, hospitals, Provider Groups, the Primary Care Provider (PCP), Specialist or from the member, members' family or caregiver. Additional internal departments may refer based on their involvement with certain member situations, e.g. Grievance and Appeals, Member Services, Compliance, and Leadership.

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

Predictive Model Application

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

Data on members is stratified to target members for outreach. Adjusted Clinical Group, or ACGs, are the building blocks of the Johns Hopkins ACG System

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

Figure 6 - 2022 Care Analyzer data for Disease Management and Care Management Services

Care Analyzer	01/2022	02/2022	03/2022	04/2022	05/2022	06/2022	07/2022	08/2022	09/2022	10/2022	11/2022	12/2022
Asthma	3557	2963	4322	4126	13509	2873	9918	4540	3876	7418	4662	11804
Diabetes (Excluding CCM)	1954	8426	2003	2363	2125	1949	12716	2498	8202	9519	2994	2837
CCM (Diabetes + Non-Diabetes)	1001	992	959	945	943	949	968	943	983	994	1023	979
Care Coordination MCAL/Medical members	137	136	144	137	132	134	105	131	124	120	130	125
Percentage of CCM												
5%	50	50	48	47	47	47	48	47	49	50	51	49
3%	30	30	29	28	28	28	29	28	29	30	31	29
1%	10	10	10	9	9	9	10	9	10	10	10	10

Figure 6 above shows the number of members identified by CareAnalyzer algorithm for potential candidates for CCM services in 2022. The top volumes were in Asthma, averaging about 6100 per month, followed by Diabetes at around 4800 per month.

Members are identified as candidates for CCM through a variety of data sources and referrals. The criteria are determined using Care Analyzer data plus utilization history. The Care Analyzer data includes Member claims, including those for behavioral health, and pharmacy claims. The scores, together with the utilization history, provide a listing of Members who are most at risk. The criteria

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

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

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

In 2022, CM decided to retire the population health report to outreach members for CCM, for the following reasons: In 2021, only 0.1% to 7.9%, of members on the population health report were outreached to for CCM, varying across the months. Of these outreached members, less than 1% consented to CCM. As discussed in the Complex Case Management section of this evaluation below, the majority of and most successful referral source into CCM is escalation from a lower level of care. Furthermore, in compliance with updated population health management regulations, the Alliance is utilizing its predictive model application for a standardized risk stratification to be used for all health plan initiatives. High risk members will continue to receive CCM outreach through various other programmatic points of entry such as when they are outreached for: Transitional Care Services, Disease Management programs, and High Utilizer initiatives. High risk members will also receive CCM outreach when requesting any care coordination services from the Alliance.

Transitions of Care

In November 2019, Transitions of Care program was enhanced, piloting at the Alameda Health System (containing 3 hospitals), with the plan for further expansion in 2020. The criteria for Transitions of Care is a discharge from an inpatient stay from AHS hospitals, or (as of 2020,) a discharge from any hospital

following a hospitalization for Covid. Continued collaboration is ongoing to prevent duplication of work by other Transitions of Care Programs.

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

The onset of COVID-19 in 2020, delayed the expansion of the TOC Program to other hospitals. Instead of expanding to more hospitals, CM expanded the criteria to include every Alliance member discharged from any hospital with a diagnosis of COVID-19 into the TOC Program. This list of members included members assigned to our delegates (including CHCN). This continued in 2022, but the CM team found that hospitalizations related to COVID-19 significantly declined throughout the year. Referrals into the CM programs remained relatively stable as membership increased, and referrals from other sources increased.

Focus was also shifted to increased outreach to high utilizer members. For these reasons, and with the State of California declaring the end of the Covid-19 State of Emergency as of February 28, 2023, CM will retire specific TOC outreach to members discharged form any hospital with a diagnosis of Covid-19.

Q3 and Q4 of 2022 were spent preparing for further expansion of Transitions of Care into Transitional Care Services (TCS) to meet requirements starting January 1, 2023. Future plans for TCS expansion are in alignment with the regulatory requirements.

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

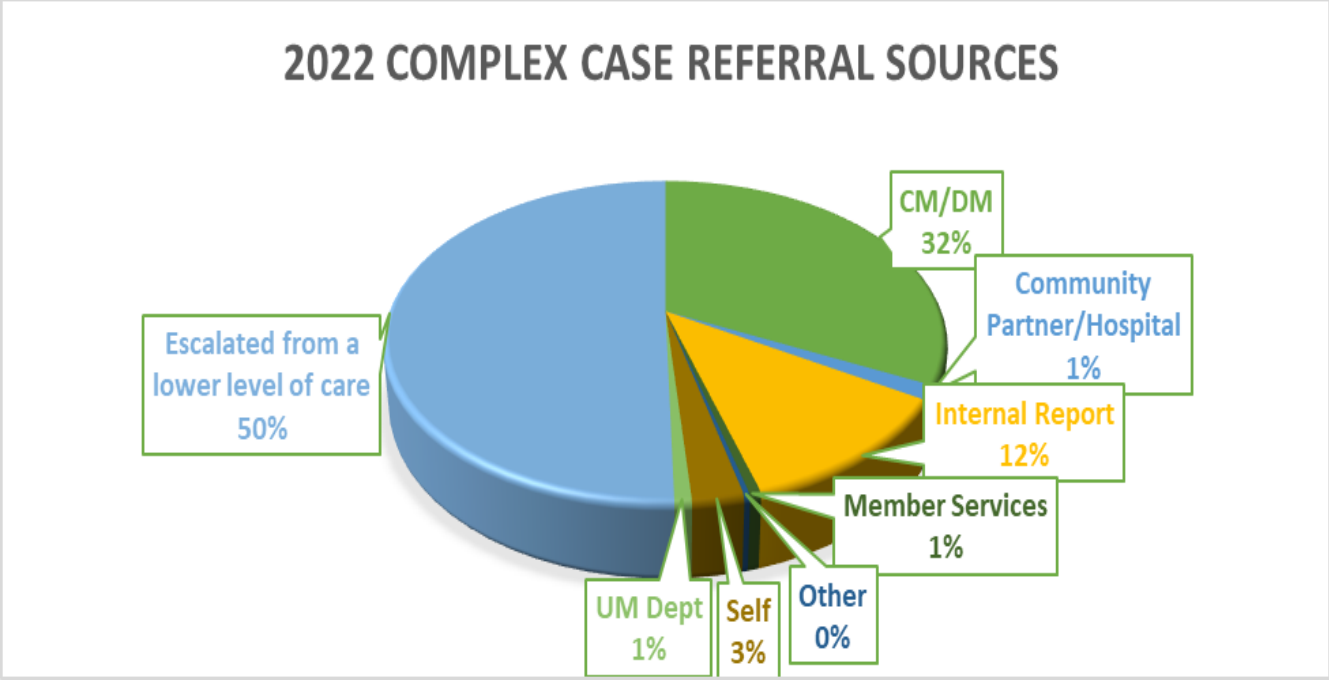
Methodology:

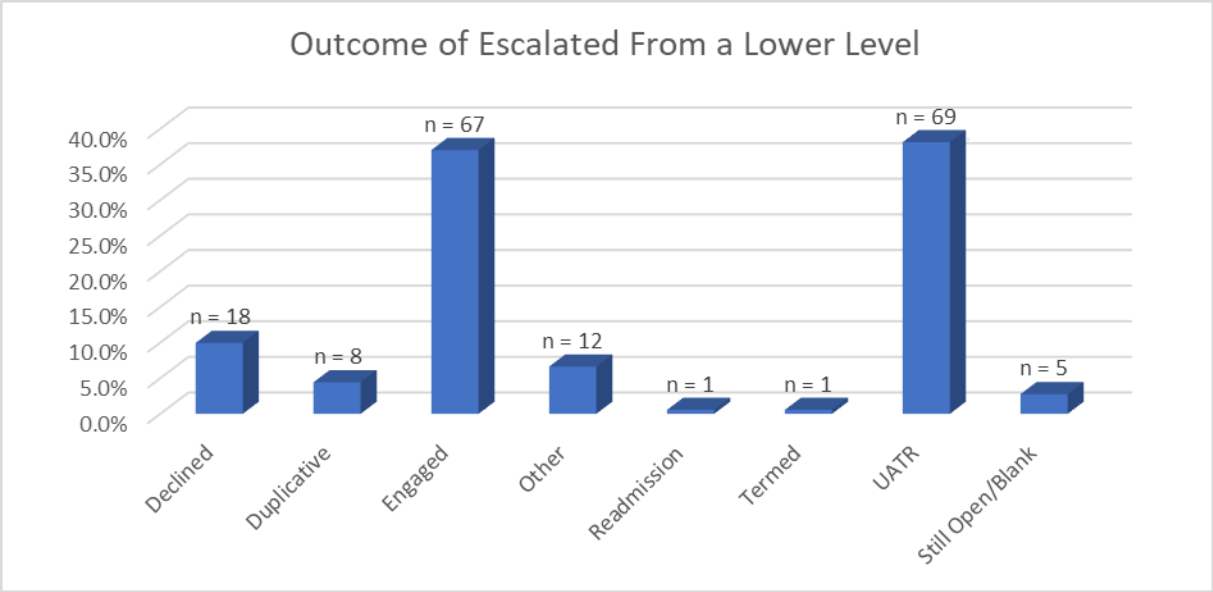
Using the Case Management Aging report, CCM cases created in 2022 were pulled and separated based on sources. Fifty (50) percent (181 out of 359) of CCM cases came from escalating cases from a lower level of care to CCM. Including the Transitions of Care (TOC) Program, the Internal Report category includes the ADT Feed and the Population Health Report.

Complex Case Management

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

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





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

- Overall, for 2022, 50% of CCM cases were identified from the Escalated from a Lower Level.
- Escalated from a lower lever referral type is defined as members who were engaged with CM in a lower level of care such as care coordination and were then identified as eligible for and consented to complex case management.
- CM has made progress in engaging with members with 37% of potential cases successfully engaged in the program. (This is up from 10% in 2021.)
- CM was Unable to Reach (UATR) 37% of members and 10% of members Declined services.

Qualitative analysis:

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

- Staff continues to be larger driver of identification and engagement of members into CCM indicating the importance of continued staff training to increase referrals into CCM.
- Monthly CCM productivity standard motivates staff to focus on increasing identification of and engagement of members into CCM.

In 2022, there were multiple initiatives to improve internal structures and processes. They included:

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

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

Through discussion and feedback, the following strategies resulted in increased volume of members engagement in CCM and identifying members for the program:

- Staff identifying members they are already working with at a lower level of care for CCM through increased training for staff on proper identification
- Motivational interviewing of members to assist in staff gaining more information that could qualify member for CCM and to assist in increasing member consent into CCM program

2023 Recommendations

- Continue to identify, implement, and evaluate different avenues to continue to increase member engagement.
- Continue SMART goal for:
    - Collaborative efforts with partnered hospitals
    - Productivity standard of Complex member outreach and engagement
    - Obtaining accurate member contact information.
    - Continue the use of the CHR and PCP for alternate phone numbers for member engagement
- Findings will be collected and submitted as part of the 2023 CM program evaluation.

Figure 7 - 2022 CM Care Coordination Program by Referral Source

Care Coordination	202201	202202	202203	202204	202205	202206	202207	202208	202209	202210	202211	202212
Referral Sources												
AAH Pharmacy	2	0	0	2	0	1	0	0	0	0	0	0
Behavioral Health Program	0	0	1	0	1	0	1	0	0	1	0	0
California Children's Services	0	0	0	0	0	0	0	0	0	0	0	0
CM/DM	37	42	57	44	69	52	50	53	47	41	78	55
Community Partner/Hospital	11	11	36	23	18	14	19	33	20	20	19	18
Compliance Dept	4	6	3	1	3	29	0	0	0	1	0	1
External Report	0	0	0	0	0	10	0	87	50	52	105	48
Grievance and Appeal	7	14	7	18	32	13	15	13	13	15	12	8
Health Education	0	0	0	1	0	0	0	1	0	0	0	0
Inpatient UM Dept	0	0	0	3	1	0	3	9	9	5	6	5
Internal Report	8	12	11	13	25	11	23	18	16	11	3	21
Member Services	52	38	56	46	43	62	57	65	55	44	53	57
Nurse Advice Line	6	3	1	0	1	1	3	0	4	0	2	3
Other	2	2	3	3	0	25	69	55	36	29	24	26
PCP/Specialty Provider	0	0	1	2	1	5	2	1	0	0	0	0
Provider Services Dept	0	0	0	0	0	0	0	0	0	0	0	0
Self	38	48	24	30	17	29	23	24	14	27	10	26
UM Dept	57	71	119	67	50	36	54	43	58	44	47	41
Total	**224**	**247**	**319**	**253**	**261**	**288**	**319**	**402**	**322**	**290**	**359**	**309**

Analysis of 2022 show the top three referral sources for Care Coordination cases are:

1) UM Dept at 687
2) Member Services at 628
3) CM/DM at 625

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

Figure 8 - 2022 CM Care Coordination Program by Active Cases

Care Coordination	202201	202202	202203	202204	202205	202206	202207	202208	202209	202210	202211	202212
ACTIVE CASES												
New Cases	228	279	325	275	265	334	313	425	335	311	342	338
Total Cases In Progress	481	514	590	572	538	599	548	687	607	596	679	716
Total Assessments Completed w/in 30 Days of Referral	5	1	3	1	0	2	2	2	2	3	2	4
Active Participation Rate % (Total Assessments Completed w/in 30 Days of Referral / Total Referrals)	2%	0%	1%	0%	n/a	1%	1%	0%	1%	1%	1%	1%

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

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

Though the Care Coordination Assessment to identify care coordination needs was developed in Q4 of 2020, it is not used often due to perceived lack of utility as member assessment may occur via other CM programs. In 2023, re-education will be provided to the CM team explaining assessments being used as a way to gauge member engagement. Also, while member assessment is consistently

happening throughout all member interactions, the care coordinator assessment will ensure consistency and be an additional safeguard to ensure all member needs are addressed. Using this assessment consistently will allow leadership to measure productivity and requested services by the member.

Figure 9 - 2022 CM Care Coordination Program by Case Closure

Care Coordination	202201	202202	202203	202204	202205	202206	202207	202208	202209	202210	202211	202212
CASE CLOSURE BY CLOSURE REASONS												
Admission	0	1	1	0	1	0	1	3	0	1	1	0
Already in Program	3	2	4	3	1	9	2	15	1	6	1	0
Case Closed via Business Approved List	0	0	0	0	1	0	0	10	1	0	0	0
Completed Program	51	51	63	62	49	87	90	100	79	65	117	185
Condition stable with no further Case Management needs	63	53	98	84	76	81	66	103	72	61	23	0
Condition stable with no further Disease Management needs	0	0	0	0	0	0	0	0	0	0	0	0
Deceased	3	5	2	2	0	5	0	1	2	0	0	0
Duplicate member record	0	0	0	0	0	0	0	0	0	0	0	0
Duplicative Program	1	2	4	4	6	11	3	2	6	4	22	9
Escalate services to higher level program	4	13	3	5	6	6	5	3	5	6	2	2
Inappropriately identified for program	0	0	0	0	0	0	0	0	0	0	0	0
Lost Contact	29	14	21	22	19	20	16	12	17	9	13	16
Member/AOR declines continued case management services	4	2	2	2	0	0	1	1	2	1	0	0
Member/AOR declines program	10	6	7	7	2	6	4	13	5	2	13	7
Member/Caregiver refuses services	0	0	0	0	0	0	0	0	0	0	0	0
Member declines continued Case Management services	0	0	0	0	0	0	0	0	0	0	0	0
Member declines continued Disease Management services	0	0	0	0	0	0	0	0	0	0	0	0
Member Ineligible	0	0	0	0	0	0	0	0	0	0	0	0
Member non-compliant	1	1	0	1	0	1	1	3	0	1	0	2
Member transferred to Delegate/Other	3	1	5	3	8	12	7	15	5	6	4	4
New case open	3	2	0	1	2	1	1	0	1	1	0	0
Other	41	46	23	24	42	50	25	54	54	43	48	41
Readmission	0	2	1	2	1	2	1	1	1	0	0	0
Referred to Disease Management	0	0	0	0	0	0	0	0	0	0	0	0
Step down to lower level program	1	0	0	0	0	2	0	0	0	0	0	0
Termination of coverage	3	3	1	3	5	5	2	7	6	2	3	1
Unable to contact member	26	45	58	74	54	66	61	72	65	51	54	67
Total	**246**	**249**	**293**	**299**	**273**	**364**	**286**	**415**	**322**	**259**	**301**	**334**

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

1) Completed Program at 999 members.
2) Condition stable with no further needs from CM at 780 members.
3) Unable to contact member at 693 members.

Plan for 2023

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

Complex Case Management

Complex Case Management (CCM) is provided to members with complex medical and social factors who meet the criteria for CCM.

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

Figure 10 – 2022 Complex Case Management – Referrals by Source

Complex	202201	202202	202203	202204	202205	202206	202207	202208	202209	202210	202211	202212
REFERRALS BY REFERRAL SOURCE												
AAH Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0
CM/DM	8	0	5	4	5	12	12	13	19	11	11	26
Community Partner/Hospital	0	0	0	0	0	0	0	1	1	1	0	3
External Report	0	0	0	0	0	1	0	0	0	0	0	0
Inpatient UM Dept	0	0	0	0	0	0	1	0	0	0	0	0
Internal Report	1	23	7	2	2	2	1	1	1	3	5	0
Member Services	0	0	0	0	0	1	1	1	0	0	1	0
Other	0	0	0	0	0	0	0	2	0	0	0	0
Self	0	0	0	0	0	0	1	1	1	2	0	4
UM Dept	0	1	0	0	0	0	0	0	1	0	1	0
Total	9	24	12	6	7	16	16	19	23	17	18	33

For 2022, the top three referral sources were:

1) CM/DM at 126
2) Internal Report at 48
3) Self at 9

It is noted that the referrals to Complex Case Management are lower than 2021. Some cases starting out as care coordination may have indicators for Complex Case Management, but the member must consent for formal Complex Case Management. Until the member consents, they will be managed as Care Coordination, but may involve the entire CM team, (CM RN, SW, Navigator.) If/when they consent, a referral is made to formal Complex Case Management.

Figure 11 2022 CCM Active Cases and Case Assessments Rates

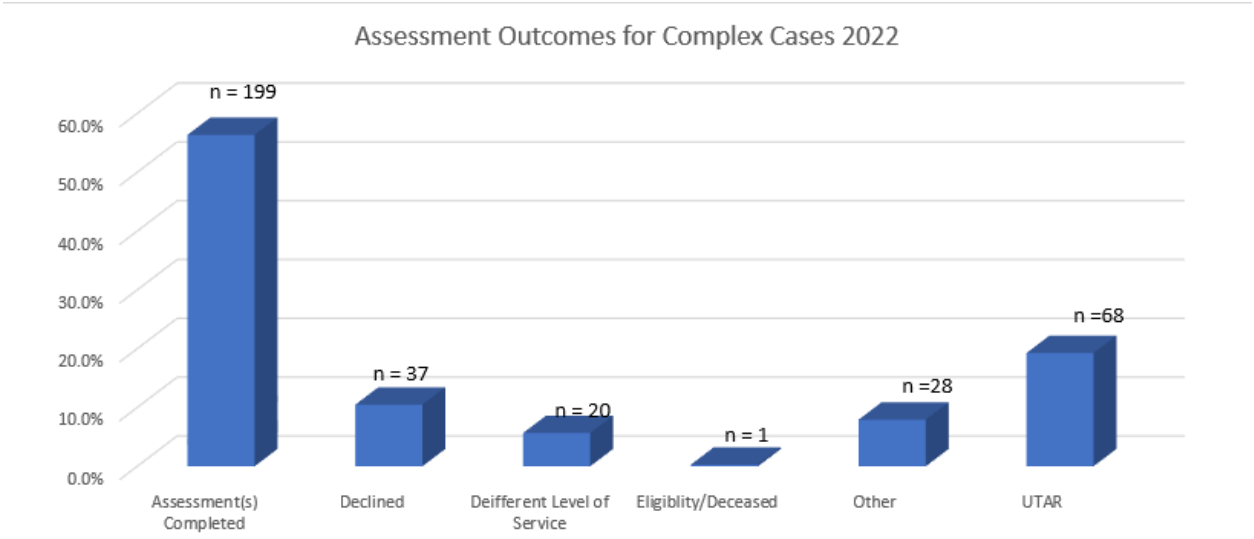
Complex	202201	202202	202203	202204	202205	202206	202207	202208	202209	202210	202211	202212
ACTIVE CASES												
New Cases	14	27	23	14	21	23	31	38	35	36	44	36
Total Cases In Progress	53	62	54	42	57	62	77	87	90	101	115	118
Total OptOut Assessments	0	8	4	0	0	1	0	0	0	0	0	0
Total Assessments Completed w/in 30 Days of Referral	3	1	4	5	2	4	5	10	8	11	4	7
Active Participation Rate % (Total Assessments Completed w/in 30 Days of Referral / Total	33%	4%	33%	83%	29%	25%	31%	53%	35%	65%	22%	21%

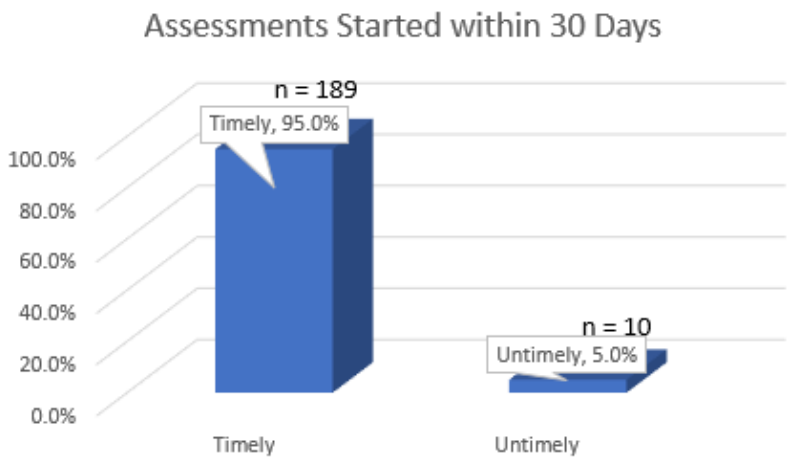
Figure 11 above describes the 2022 Active case activities by the number of new cases, (347) the total open cases in program (918) and the number of cases in which the members was identified and referred but opted not to engage in the program, (13).

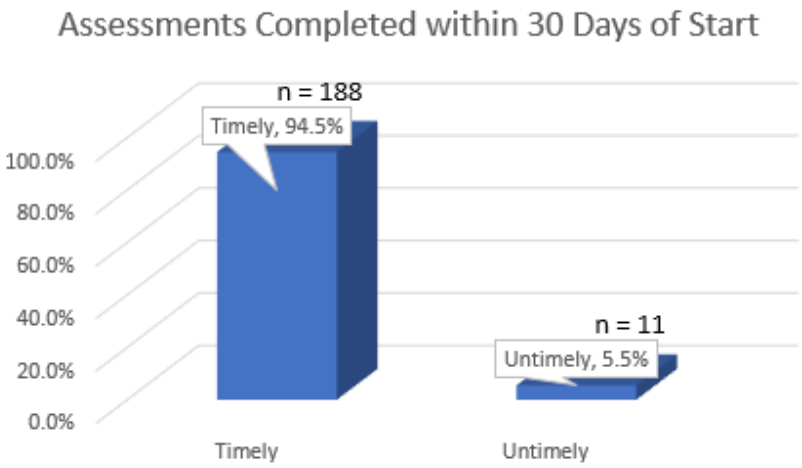
In addition, the data in Figure 11 monitors the number of assessments completed and the timeframe for completing the assessment from the referral. This value is created based on the assessments completed within 30 days of referral over the number of referrals.

Methodology for Data Validation:
Using the Daily Aging Report, all cases referred and created in 2022 were pulled to identify the assessment status. CCM assessments completed were pulled and evaluated for timeliness.

2022 Results:







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

- 56% of complex assessments were completed in 2022 compared to 29% in 2021
- Unable to reach went down to 19% in 2022 compared to 37% in 2021
- Out of 199 assessments (up from 167 in 2021), 189 were started within 30 days and only ten (10) were started after the 30-calendar day timeframe, not meeting the goal at 95.0%.
- Out of 199 assessments, 198 were completed (99.5%) within 60 days and only one (1) was completed after the 60-calendar day timeframe, not meeting the goal of 100%

Qualitative analysis:

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

- The assessments that were not started within 30 days were due to care coordination needs taking priority to starting the assessment and difficulty re-engaging the member.
- The one assessment that was not completed within 60 days was due to members who were challenging to re-engage to complete the assessment.

During 2020, CCM standard of work was created, and staff were trained. In 2021 a productivity standard was implemented to encourage staff to engage members and offer CCM. While the total number of complex cases decreased from 589 in 2021 to 342 in 2022, the engagement (assessments completed within 30 days) increased from 25% in 2021 to 36% in 2022, potentially showing more targeted offering of complex case management to members more likely to engage in completion of assessment after opening of the case.
In 2022, the TruCare Care Plan library was updated to provider more user friendly built-in care plan elements which should assist increased efficiency when it comes to completing care plans required of complex cases.

Interdisciplinary Care Team **(IDT)**

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

Methodology:

Review all cases that have been open for 90 days or more, regardless of case type.
IDT Rounds are held bi-weekly, and using the Daily Aging Report, staff are notified of cases that are open at 60 days or more, to prepare to present the case at the next IDT meeting. Upon notification, all cases are logged within the Complex Case Log.
CM identified 22 CCM cases (open for at least 90 days) from the Complex Case Log (and validated with the Daily Aging Report).

2022 Results:

Complex Cases ≥ 90 days	Outcome of IDT	% of Timely IDT based on Report
0	No IDT	0%
47	Timely	100%
0	Untimely	0%

Every CCM case open for 90 days or more was presented at IDT meeting and within timely deadlines.

This led to 100% of timely IDT presentation (compared to 95% in 2021). The successful improved process will be continued into 2023.

Figure 12 - 2022 Complex Case Management Case Closures by Reason

Complex	202201	202202	202203	202204	202205	202206	202207	202208	202209	202210	202211	202212
CASE CLOSURE BY CLOSURE REASONS												
Admission	0	0	0	0	0	0	0	0	0	0	1	0
Already in Program	1	0	0	0	0	0	0	0	0	0	0	0
Completed Program	3	5	5	1	4	3	4	7	5	5	12	13
Condition stable with no further Case Management needs	2	4	3	0	5	1	3	2	1	6	0	0
Deceased	0	0	0	0	0	1	0	0	0	0	0	0
Duplicate member record	0	0	0	0	0	0	0	0	0	0	0	0
Duplicative Program	0	0	2	1	0	0	1	2	1	1	2	0
Escalate services to higher level program	0	1	0	0	2	0	1	0	1	1	3	0
Inappropriately identified for program	0	0	0	0	0	0	0	0	0	0	0	0
Lost Contact	9	4	6	1	4	7	15	13	9	12	8	16
Member/AOR declines continued case management services	0	0	0	0	0	0	0	1	1	0	0	0
Member/AOR declines program	0	9	4	0	1	0	0	0	1	0	1	0
Member/Caregiver refuses services	0	0	0	0	0	0	0	0	0	0	0	0
Member declines continued Case Management services	0	0	0	0	0	0	0	0	0	0	0	0
Member Ineligible	0	0	0	0	0	0	0	0	0	0	0	0
Member non-compliant	0	0	0	0	0	0	1	0	1	1	1	1
Member transferred to Delegate/Other	0	0	1	0	0	0	1	0	0	1	0	0
New case open	0	0	0	0	0	0	0	0	0	0	0	0
Other	2	3	3	1	1	2	0	3	3	2	2	7
Readmission	0	0	0	0	0	0	0	0	0	0	0	0
Step down to lower level program	0	0	1	1	1	1	0	3	1	0	2	0
Termination of coverage	0	0	0	0	0	0	2	0	1	0	0	0
Unable to contact member	1	5	1	1	0	1	0	1	0	1	1	0
Total	**18**	**31**	**26**	**6**	**18**	**16**	**28**	**32**	**25**	**30**	**33**	**37**

As noted in Figure 12, the top three reasons for case closure in 2022 were:

1) Lost contact at 104
2) Completed Program at 67
3) Other at 29

Recommended Interventions/Next Steps for 2023:

There was increase in case closure reason "Completed Program" to 67 from 39 in 2021. This continues to show that while there were fewer complex cases in 2022 compared to 2021, there was higher engagement and a higher rate of program completion (13% in 2021, 31% in 2022). Lost contact case closure reason continues to be addressed via multiple telephone attempts and Lost Contact Letter.

Performance Measures

The Alliance maintains performance measures for the complex case management program to maximize member health, wellness, safety, satisfaction, and cost efficiency while ensuring quality care. The Alliance selects

measures that have significant and demonstrable bearing on the entire complex case management population or a defined subpopulation. The Alliance annually measures the effectiveness of its complex case management program based on the following performance goals and corresponding measures:

Figure 13 – CM Performance Measures

	Goal	Measure	Measurement	Performance Goal	2022 Rate	Goal Met?
#1	Achieve and maintain high level of satisfaction with CM services.	Member Satisfaction Rates	High level of satisfaction with CM services	90%	100%	No
#2	Improve member outcomes	All-Cause readmission Rate	readmission rates for all causes for members in CCM with admission within 6 months of enrollment in CCM	Report in development	Report in developme nt	NA
#3	Improve member outcomes	Emergency Room Visit Rate	ER rates for members enrolled in CCM	Report in development	Report in developme nt	NA
#4	Achieve optimal member functioning.	Health Status	% of members in CCM responding that their health status improved because of CCM	90%	97%	No
#5	Use of Appropriat e Health Care Services	Use of Services	Improvement in measures of office visits within Alliance Network	Report in development	Report in developme nt	NA

Figure 13 captures the 2022 Performance Measures. Of the five measures, two had an established benchmark.
For 2022, CM continued to achieve the goal of achieving and maintaining high level of satisfaction with CM services at 100%
The member surveys showed that 97% of members in CCM responded that their health status had improved because of CCM.
In collaboration with, Analytics reports are being developed to evaluate the remaining three measures.

Assessing Members Experience with the CM Process

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

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

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

In 2022, CM Department received a total of 6 surveys.

Figure 14 – 2022 Survey Results

	N	%	Sample Size	Goal Met?
Member Experience Criteria	Very Satisfied			
Time Spent with CM	5	83%	6	N
CM Understands Concerns	4	67%	6	N
Information to Manage Health	4	67%	6	N
Overall Experience	5	100%	5	Y
Member Experience Criteria	Moderately Satisfied			
Time Spent with CM	1	17%	6	N
CM Understands Concerns	2	33%	6	N
Information to Manage Health	2	33%	6	N
Member Experience Criteria	Much Improved			
Better Manage Health Condition	4	67%	6	N
Overall Health & Well-Being	4	80%	5	N
Member Experience Criteria	Improved			
Better Manage Health Condition	1	17%	6	N
Overall Health & Well-Being	1	20%	5	N
Member Experience Criteria	Much Worse			
Better Manage Health Condition	1	17%	6	N
Member Experience Criteria	Always True			
Ability to Speak to CM	5	83%	6	N
Member Experience Criteria	Usually True			
Ability to Speak to CM	1	17%	6	N
Member Experience Criteria	Highly Likely			
Recommend CM Services	5	100%	5	Y

Of the six surveys returned; the combined satisfaction was 89.3%

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

Figure 15 – 2022 Complaints Filed Regarding CM Process

Total Non-Exempt Grievances Against CM	G&A Decision - In Favor of Member	G&A Decision - Neutral	G&A Decision - In Favor of Plan
23	**18**	**3**	**2**

There was a total of 23 non-exempt grievances against CMDM in 2022. After review of the grievances the following trends were found:

- CMDM turnaround time for returning member calls
- CMDM's ability to assist in changing decision by a provider office

Recommended Interventions/Next Steps for 2023:

In 2023, there is an opportunity to ensure the CM Department:

- Review and revise the process on how CM initiates and collects the satisfaction survey to continue to increase the response rate.
- Identifies CM performance measures, goals, and benchmarks.
- Collaborates with Health Care Analytics to ensure the performance measures can be captured and reported semi-annually.
- Receive refresher training on communicating benefits to members to avoid unnecessary grievances due to miscommunication.

Special Programs

Transitions of Care

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

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

Figure 16 - 2022 Transitions of Care Referrals

Transitions of Care	202201	202202	202203	202204	202205	202206	202207	202208	202209	202210	202211	202212
REFERRALS BY REFERRAL SOURCE												
AAH Pharmacy	0	0	0	3	0	0	0	0	0	0	0	0
Behavioral Health Program	0	0	0	0	0	0	0	0	0	0	0	0
California Children's Services	0	0	0	0	0	0	0	0	0	0	0	0
CM/DM	18	12	12	12	10	17	16	14	12	22	22	37
Community Partner/Hospital	12	10	18	25	21	16	16	31	20	37	25	33
Compliance Dept	0	0	0	0	0	0	0	0	0	0	0	0
Grievance and Appeal	0	0	0	0	0	0	0	0	0	1	0	0
Inpatient UM Dept	0	0	0	8	13	10	16	7	6	5	13	21
Internal Report	179	174	223	195	230	171	196	141	143	130	159	133
Member Services	0	0	0	0	0	1	0	0	2	0	0	0
Other	0	3	0	0	1	0	1	0	0	0	0	0
PCP/Specialty Provider	0	0	0	1	0	0	0	0	0	0	0	0
Self	0	0	1	0	1	0	0	0	1	0	2	2
UM Dept	68	59	36	29	12	5	8	4	8	2	6	4
Total	277	258	290	273	288	220	253	197	192	197	227	230

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

1) Internal Report at 2074
2) Community Partner/Hospital at 264
3) UM Dept at 241

The Internal Reports refer to the ADT Feed.

Figure 17 – 2022 Transitions of Care Active Cases

Transitions of Care	202201	202202	202203	202204	202205	202206	202207	202208	202209	202210	202211	202212
ACTIVE CASES												
New Cases	263	254	286	258	295	220	239	214	206	196	230	228
Total Cases In Progress	527	493	565	516	543	490	439	426	389	393	423	443
Total OptOut Assessments	0	0	1	2	1	1	1	1	1	2	1	1
Total Assessments Completed w/in 30 Days of Referral	76	75	65	78	79	38	49	43	33	46	75	54
Active Participation Rate % (Total Assessments Completed w/in 30 Days of Referral / Total Referrals)	27%	29%	22%	29%	27%	17%	19%	22%	17%	23%	33%	23%

The data noted in Figure 17 shows a stabilization in TOC cases throughout 2022. The Active Participation Rate is calculated from the total assessments completed within 30 days of referral and the total referrals.
Analysis shows that some assessments were not completed because the corresponding referrals were declined because they were duplicate referrals, or the member was already enrolled in another CM program.
2023 will present an opportunity to improve the Active Participation Rate % score as staff will continuing training on new Transitional Care Services guidelines effective 1/1/2023.

On average for 2022, 24% of members were actively engaged in TOC. The low engagement could be caused by outreaching to members post-discharge. In Q4 of 2022, the CM team ran a pilot of reaching out to members prior to discharge. Anecdotally, the connect rate was much higher, leading to a

process change in 2023 to engage members prior to discharge from their inpatient facility.

Figure 18 – Transitions of Care Case Closures

Transitions of Care	202201	202202	202203	202204	202205	202206	202207	202208	202209	202210	202211	202212
CASE CLOSURE BY CLOSURE REASONS												
Admission	2	3	8	9	10	1	1	0	0	4	11	10
Already in Program	6	6	1	0	3	1	2	2	3	0	1	0
Case Closed via Business Approved List	0	0	1	2	0	2	0	0	0	0	0	0
Completed Program	56	35	65	82	74	77	72	84	58	65	53	73
Condition stable with no further Case Management needs	23	22	17	8	13	13	6	5	10	7	1	0
Condition stable with no further Disease Management needs	0	0	0	0	0	0	0	0	0	0	0	0
Deceased	5	2	2	3	3	4	0	5	3	4	4	3
Duplicate member record	0	0	0	0	0	0	0	0	0	0	0	0
Duplicative Program	9	9	17	13	11	7	12	7	8	7	11	7
Escalate services to higher level program	11	7	6	13	16	21	20	22	17	14	19	14
Inappropriately identified for program	0	0	0	0	0	0	0	0	0	0	0	0
Lost Contact	23	17	17	13	11	10	12	10	10	8	6	13
Member/AOR declines continued case management services	0	0	0	0	1	2	1	0	0	2	0	0
Member/AOR declines program	1	5	7	6	4	1	3	4	0	7	2	4
Member/Caregiver refuses services	0	0	0	0	0	0	0	0	0	0	0	0
Member declines continued Case Management services	0	0	0	0	0	0	0	0	0	0	0	0
Member declines continued Disease Management services	0	0	0	0	0	0	0	0	0	0	0	0
Member Ineligible	0	0	0	0	0	0	0	0	0	0	0	0
Member non-compliant	0	1	1	0	0	0	0	0	0	0	1	1
Member transferred to Delegate/Other	4	0	6	0	3	2	4	1	2	1	1	1
New case open	0	4	1	1	2	1	4	4	1	2	1	0
Other	35	19	23	28	26	40	15	25	25	13	18	27
Readmission	28	26	38	26	34	28	23	24	18	14	12	13
Step down to lower level program	1	1	0	2	0	0	0	0	0	0	0	0
Termination of coverage	1	4	6	2	1	4	1	1	0	1	6	6
Unable to contact member	83	53	91	60	61	76	51	49	37	51	61	42
Total	**288**	**214**	**307**	**268**	**273**	**290**	**227**	**243**	**192**	**200**	**208**	**214**

As noted in Figure 18, the top three (3) reasons for TOC Case Closure in 2022 were:

1) Complete Program (794)
2) Unable to Contact Member (715)
3) Other (294)

Unable to Contact member went down from 29% in 2021 to 24% in 2022. Completed program went up from 14% in 2021 to 27% in 2022. Use of the CHR, as well as the addition of beginning TOC outreach while member is still hospitalized may have contributed to this increase in successful outcome. Efforts to further improve connection rate will continue in 2023 via finding alternate phone numbers through CHR, and PCP office and continue to outreach to members while still inpatient.

Continuity of Care

The CM Department collaborates with the UM Department and Member Services on the management of the continuity of care program. CM is responsible for assisting members who have been approved to see providers

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

The UM department takes the leadership for assisting members who have exhausted a benefit or who are aging out of a benefit, i.e. California Children Services, or have needs beyond those provided by partner agencies. The UM Department coordinates these services through the care coordination referral process and identifies members who are aging out of CCS eligibility to ensure that they transition to appropriate providers, or other needs, and refers to CM as needed for further assistance to ensure that members receive the services required. Further work on these processes will occur in 2023 with the implementation of APL 22-032 on Continuity of Care.

LONG TERM SERVICES AND SUPPORTS (LTSS)

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

INTEGRATION OF MEDICAL AND BEHAVIORAL HEALTH

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

In 2022, the teams worked on efforts crossing the medical and behavioral health services which included:

- Enhancing CCM outreach to chronically ill
- Improve coordination of care by increasing clinical oversight and co-management with the medical management teams.

- Continued efforts toward improving communication between the primary care physician and behavioral health providers.
- Attendance by Beacon at the Interdisciplinary Care (IDT) Team meetings to collaborate, advise, refer, and provide additional insight into CCM cases.

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

In 2023, the services for members with Mild/Moderate Behavioral Health issues will be insourced back to the Alliance, which will help with further integration of BH and medical care. CM participated in the planning for the insourcing with the Director of BH services, and in the training of new BH staff in CM processes and practices.

ENHANCED CARE MANAGEMENT (ECM):

ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Members with the most complex medical and social needs. ECM provides systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch and person centered. ECM coordinates all care for Members who receive it, including across the physical and behavioral health delivery systems. ECM offers comprehensive, whole person care management to high-need, high-cost Medi-Cal Managed Care Members, with the overarching goals of:

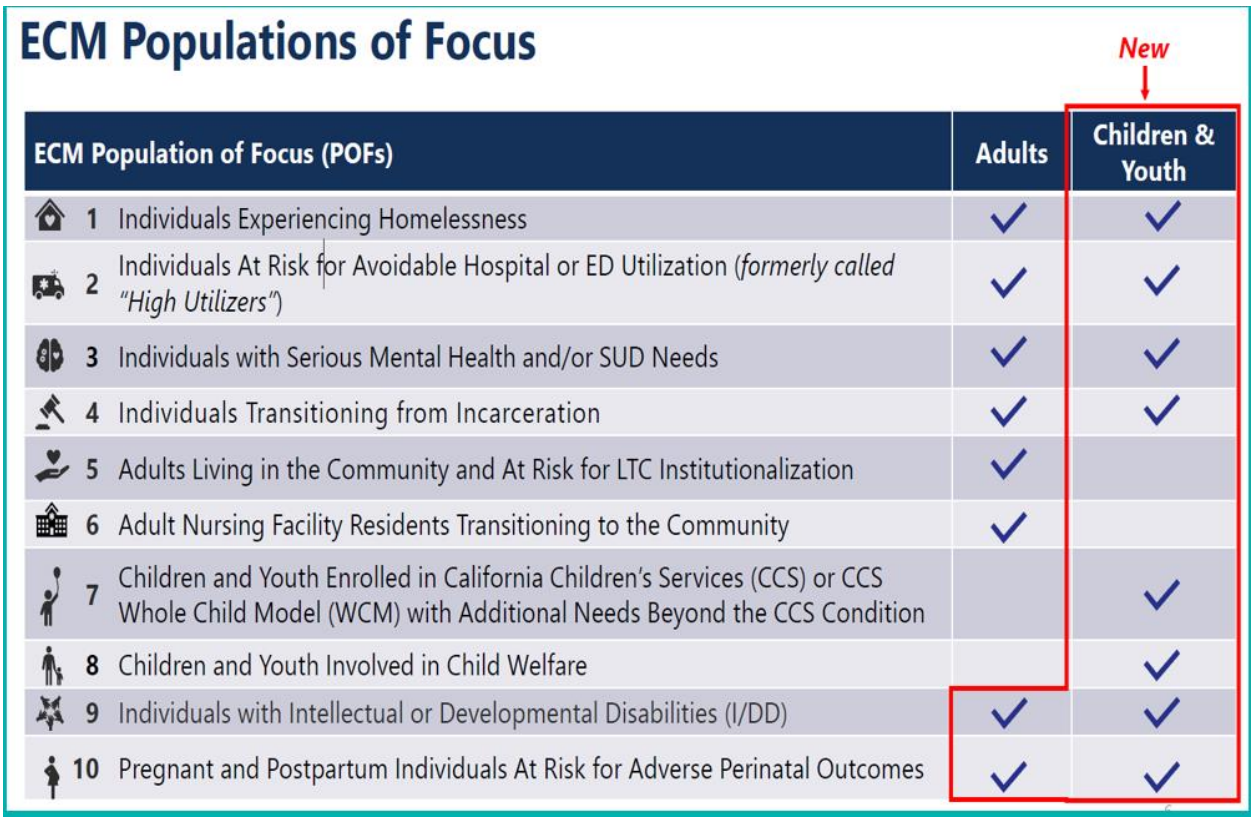
- Improving care coordination;
- Integrating services;
- Facilitating community resources;
- Addressing SDOH;
- Improving health outcomes; and
- Decreasing inappropriate utilization and duplication of services.

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

January 1, 2022, AAH successfully launched ECM for homeless, high utilizer, and Serious Mental Health (SMI)/Substance Use Disorder (SUD) populations of focus. September 1, 2022, Alameda County Behavioral Health (ACBH) became an ECM Provider.

AAH planned for the January 1, 2023 launch of two new populations of focus (Adults Living in the Community at Risk for Institutionalization & Adult Nursing Facility Residents Transtioning to the Community).

ECM Populations of Focus



ECM Populations of Focus

New

ECM Population of Focus (POFs)	Adults	Children & Youth
1 Individuals Experiencing Homelessness	✓	✓
2 Individuals At Risk for Avoidable Hospital or ED Utilization (*formerly called "High Utilizers"*)	✓	✓
3 Individuals with Serious Mental Health and/or SUD Needs	✓	✓
4 Individuals Transitioning from Incarceration	✓	✓
5 Adults Living in the Community and At Risk for LTC Institutionalization	✓	
6 Adult Nursing Facility Residents Transitioning to the Community	✓	
7 Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition		✓
8 Children and Youth Involved in Child Welfare		✓
9 Individuals with Intellectual or Developmental Disabilities (I/DD)	✓	✓
10 Pregnant and Postpartum Individuals At Risk for Adverse Perinatal Outcomes	✓	✓

Staff in 2022 included a Clinical Program Manager, three Health Navigators, and a Physician Champion, the CM Medical Director.

.

Program Outcomes: As of 12/31/2022, the ECM program had served 1,509 members at the 24 ECM sites in Alameda County:

In 2022, preliminary trends show ECM produced a reduction in admits, bed days, average length of stay, inpatient costs, emergency room visits, emergency room costs, readmission. Percent of readmissions increased. Preventive services (prescription rates and prescription costs) increased while PCP visits decreased.

Next Steps in 2023

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

Expand the network to include providers for the children/youth Populations of Focus on July 1, 2022.

Continue to develop and train new ECM providers in preparation for expansion of CalAIM populations of focus on January 1, 2024.

Plan and develop continuity of care process for Anthem ECM members in preparation for the January 1, 2024, Anthem conversion.

Develop a control group for ECM data to confirm preliminary trends.

COMMUNITY SUPPORTS

Community Supports (CS) services are provided as part of the CalAIM initiative that include a variety of services not typically covered by managed care plans. These services are intended to provide additional cost-effective support to members in lieu of higher-level services. In 2022, the Alliance provided six CS services:

Housing Navigation
Housing Deposits
Housing Tenancy and Sustaining Services
Recuperative Care (Medical Respite)
Medically Tailored/Medically Supportive Food

Asthma Remediation

GOALS

The primary goal for Community Supports (CS) services is to provide services to the membership that are medically appropriate and cost-effective alternatives. As the plan has not stood up all the CS services DHCS has approved, a goal for 2023 is to take on more programs to support diversion, transition and Long-Term Care.

To show CS services are cost effective alternatives the plan will continue to work with Analytics to develop a dashboard for CS services to analyze CS data and make sure we are serving population.

The plan also wants to provide confirmation that members are being serviced after authorizations have been determined. The plan will further develop accurate and reliable closed loop referral process with Community Supports providers.

Another goal is to provide training to all CS providers to promote best practices while working with our members and to continue to build rapport with CS providers.

OUTCOMES

To further prove cost-effectiveness and medically appropriate, dashboard development is underway.

Members authorized in 2022:

Community Supports Service	No. of Members
Housing Navigation	433
Housing Deposits	392
Housing Tenancy and Sustaining Services	1,141
Recuperative Care (Medical Respite)	129
Medically Tailored Meals/Medically Supportive Food	652
Asthma Remediation	79

NEXT STEPS

- Expand to add additional CS services.

- Increase staff where appropriate as department expands to better meet needs of members and providers.
- Continue to build relationship with billing to assist providers with receiving timely payments.

Coordination with Regulatory Compliance

The Alliance CM Department works closely with the Compliance Department in preparation for regulatory audits. In 2022, the department participated in DHCS, DMHC, and NCQA regulatory audits. There were no DHS, DMHCS, or NCQA findings in 2022.

Recommended Interventions/Next Steps for 2023:

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

CM Department will continue best practices regarding engagement and connect rate.
CM will also incorporate new regulations into current policies, procedures and desktop workflows and making appropriate adjustments to monitor and provide oversight.

CM Department will also work closely with the Analytics Department to further enhance and automate processes.

Conclusion

Overall, the 2022 CM Program continued to develop into an effective program, maintaining compliance with regulatory and contractual requirements, monitoring of performance within the established benchmarks or goals, identifying opportunities for improvement and enhancing processes and outcomes. The CM program activities have met the established targets or are developing strategies to meet targets. The Alliance leadership has played an active role in the CM Program structure by participating in various committee

meetings, providing input and assistance in resolving barriers and developing effective approaches to achieve improvements. To ensure that AAH used a comprehensive approach to the CM program structure, practicing physicians provided input through the UM Committee and subcommittees. The CM program continues to analyze internal benchmarks to further enhance progress and provide quality service to the Alliance membership.

CM Program Recommendations for 2023

As a result of internal performance monitoring performed in 2022, opportunities for improvement were identified and will be incorporated into the 2023 department goals. Highlights of opportunities for improvement based on the regulatory findings include:

- Focus on key CM activities, monitoring through the UM Committee and HCQC.
- Revise the CM staffing model to address operational needs and regulatory requirements develop and change.
- Leverage the information systems to provide accurate reflections of reporting needs for compliance monitoring and oversight, both internal and external.
- Identify appropriate performance measures and goals for CM and develop monitoring reports of performance toward the measures. This includes developing CM related activities to address improvement with the measures.
- A key focus in 2023 is the growth of the CalAIM Enhanced Care Management benefit, Community Supports services, and Transitional Care Services (TCS). This will include iterative process improvements in the structure, the planning for expansion of additional ECM and CS providers, and additional providers to focus on additional populations of focus and additional Community Supports services.
    - Work with the Alliance Project Management Office and all relevant Alliance departments to:

  Grow the CalAIM ECM benefit and Community Supports services.
  Expand the ECM provider network for current needs.
  Plan for the additional Populations of Focus in ECM in 2024.
  Identify and plan for additional Community Supports services.

- Monitor and enhance educational program for PCPs and Network Provider Groups on identification of members in need of CM/CCM, referral processes and engagement with CM team on management of ICPs and IDTs.
- Leverage reporting and analysis of CM activities focused on member experience with CM.

- Develop process for implementing activities addressing improved member experience with CM, including analysis of a member survey and member complaints.
- In collaboration with the Compliance Department, develop a department program focused on monitoring internal compliance and quality review of CM department operations.
- Continue to enhance the Palliative Care Program in collaboration with Alameda Health Systems.
- Enhance delegation oversight activities for CM, Care Coordination, CCM, and TCS.
- Collaborate with Health Care Analytics on identifying enhancements to the Case Management Dashboard to further evaluated trends.
- Continue internal auditing of cases for Care Coordination, CCM and TCS.

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
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Case Management/Care Coordination, Complex Case Management & Disease Management Program Program Description

2023

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

2023 Program Description

Signature Page

Date 06/19/2023

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Date 06/20/2023

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Rebecca Gebhart
Board Chair
Alameda Alliance for Health

I. Background

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

The Alliance provides health care coverage to over 300,000 children and adults through the Medi-Cal and Group Care programs. Alliance Members choose from a network of over 1,700 doctors, 17 hospitals, 68 community health centers, and more than 200 pharmacies throughout Alameda County. Through active partnerships with healthcare providers and community partnerships, Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan Members.

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

Comprehensive case management is one such Alliance service offering that assists Members and providers in aligning effective healthcare services and appropriate community resources. The activities of the comprehensive case management program support Alliance Members and providers to attain the highest level of functioning available to the Member in relation to their overall health condition. The CM Program ensures parity between medical/surgical care and behavioral health care throughout all structures and functions. The Alliance oversees and maintains the following case management services in the comprehensive case management program:

- Health Risk Assessments
- Basic Population Health Management
- Care Coordination/Service Coordination
- Complex Care Management
- Transitional Care Services
- Specialty Programs
- Continuity of Care

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

II. Purpose and Scope

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

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

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

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

III. Goals and Objectives

A. Goals

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

- To maximize the quality of life and promote a regular source of care for patients with chronic conditions.
- Improve Member engagement as active participants in the care process.
- Improve health, including behavioral health, outcomes.
- Support the foundational role of the primary care physician and care team to achieve high-quality accessible, efficient health care.
- Coordinate with community services to promote and provide Member access to available resources in the Alliance service area.
- Provide support, education, and advocacy to Members in collaborative communications and interactions.

- Engage the provider community as collaborative partners in the delivery of effective healthcare.
- Develop and implement a program that meets all regulatory compliance and NCQA accreditation standards.

B. Objectives

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

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

IV. Program Oversight and Staff Responsibility

A. Health Care Quality Committee (HCQC)

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

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

The HCQC functional responsibilities for the CM Program include:

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

B. The Utilization Management Committee

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

UM Committee Structure

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

Authority and Responsibility

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

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

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

UM Committee Membership

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

- The Alliance Chief Analytics Officer
- The Alliance Medical Directors, UM

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

UMC Voting Privileges

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

UMC Quorum

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

UMC Meetings

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

UMC Minutes

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

UM Committee Functions

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

- Improve quality of care for the Alliance Members.

- Evaluate and trend enrollment data for medical and behavioral health services provided to Alliance Members and benchmarks for care management program utilization.
- Provide a feedback mechanism to drive quality improvement efforts.
- Increase cross functional collaboration and provide accountability across all departments in Medical Services.
- Provide mechanism for oversight of delegated CM functions, including review and trend CM reports for delegated entities to identify improvement opportunities.
- Identify behaviors, practices patterns and processes that may contribute to fraud, waste, and abuse with a goal to support the financial stability of ~~our~~ providers and network.

UM Committee responsibilities are to:

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

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

V. Staff Resources

The Case Management and Disease Management Department in the Alliance is responsible for comprehensive case management program and activities. A department of multi-disciplinary staff administers the comprehensive case management program. (The organizational chart in Appendix A displays the reporting relationships for key staff responsible for comprehensive case management activities at the Alliance.) The Behavioral Health Department in the Alliance is responsible for behavioral health case management activities including triage and referral and participation on the multi-disciplinary case management teams to responsible for comprehensive case management activities at the Alliance.

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

I. **Chief Medical Officer**

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

II. **Medical Director**

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

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

The Senior Director of Health Care Services, a Licensed Clinical Social Worker, provides operational leadership to the Case and Disease Management programs and staff. The Senior Director provides additional guidance to the programs' designs with a focus on analytics, operations, and regulatory adherence. The Senior Director also ensures the collaboration of the programs with other internal and external stakeholders. The Senior Director provides leadership for case management accreditation and regulatory activities. The Senior Director works with the Director to carry out program goals.

IV. **Senior Director, Behavioral Health Services**

- The Senior Director, Behavioral Health Services is a licensed Psychologist and is responsible for the overall Behavioral Health department operations, staff training, and coordination of services between departments. The Senior Director's management responsibilities include:
- Develop and maintain the Behavioral Health (BH) Program in collaboration with the Senior Medical Director of Quality and the CMO.
- Coordinate BH activities with the Quality, UM, Case Management, Member Services Departments, as well as other Alliance units.
- Maintain compliance with the regulatory standards.
- Maintain professional collaboration with Alameda County Behavioral Health Care Services (ACBHCS) to coordinate care and care transitions across behavioral health care systems.
- Coordinate interventions with the Senior Medical Director and the CMO to address under and over utilization concerns when appropriate.

- Develop and monitor data and activities for clinical and utilization studies; and maintain professional relationships with colleagues from other Medi-Cal Managed Care Plans, sharing information about requirements and successful evaluation strategies.
- Monitor for consistent application of utilization criteria by BH staff, for each level and type of UM decision.
- Monitor for consistent application of Triage and Referral criteria by BH staff for each type of behavioral health service

V. **Director, Social Determinants of Health**

The Director of Social Determinants of Health provides operational leadership to the Case and Disease Management, Community Supports and Enhanced Care Management programs and staff. The Director provides guidance to the various programs with a focus on analytics, operations, and regulatory adherence. The Director assists with collaboration of the programs with other stakeholders. The Director develops the programs' goals and operationalizes processes needed to successfully commence and complete the desired goals.

VI. **Manager, Case Management and Disease Management**

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

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

The Clinical Manager of Enhanced Care Management is responsible the provision of daily oversight of components of the case management program, including programs between the Alliance and contracted Community Based Organizations (CBOs). Under the supervision of the Director of Social Determinants of Health, the scope of responsibilities of the Clinical Manager of Enhanced Care Management includes supervision and management of department staff; development of the operational plan; allocation and management of program resources; and accountability for the quality of care and services. The Manager reviews and evaluates the performance of the comprehensive case management program activities and presents regular reports to the UMC and HCQC.

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

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

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

IX. **Supervisor of Community Supports**

The Supervisor of Community Supports provides daily oversight over the Community Supports services. Under the supervision of the Director of Social Determinants of Health, the scope of responsibilities of the Supervisor of Community Supports include supervision of department staff; allocation and management of program resources; and accountability for the quality of care and services.

X. **Lead Case Manager**

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

XI. **Complex Case Manager**

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

XII. **Social Worker**

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

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

may be required to support delegated Provider Group teams with care coordination and community resources.

XIII. **Health Navigator**

Under guidance from the Case Management Manager or the Clinical Manager, Enhanced Care Management, the Health Navigator supports clinical staff through the completion of components of case management, disease management, and wellness/health maintenance programs. The Health Navigator provides the Member with individualized, patient-centered support and education to assist and guide the Member across the continuum of the healthcare delivery system. The Health Navigator works with the Complex Case Manager to perform follow up case management activities and coordinate care and services for the Member with providers and community resources. The Health Navigator also coordinates care for Members not admitted to the complex case management program.

XIV. **Community Supports Coordinator**

Under guidance from the Supervisor of Community Supports, the Community Supports Coordinator works with Community Supports providers to process authorizations into AAH's information system of record. The Community Supports Coordinator works with the Medical Director and Supervisor to perform follow up management to meet specific turn-around times for authorizations. They also assist with coordination of weekly meetings with Community Supports providers and facilitate communication to meet appropriate authorization regulatory requirements.

XV. **Transportation Coordinator**

Under guidance from the Manager of Case Management or the Supervisor of Case Management the Case Management Coordinator supports the case management department through assisting with ensuring that members receive transportation as needed to all covered services, acting as a coordinator between providers, the Transportation Vendor, members and AAH staff.

XVI. **Case Management Coordinator**

Under guidance from the Manager of Case Management or the Supervisor of Case Management the Case Management Coordinator supports the case management department through assisting with administrative duties. The Case Management Coordinator providers the member with individualized, patient-center support and assistance to help guide the member across the continuum of the healthcare delivery system.

XVII. **Behavioral Health Triage Specialist**

Under guidance from the Senior Director of Behavioral Health, Behavioral Health Triage Specialists provide the behavioral health case management components for members to

enables integration of physical and behavioral health to address the member's whole person health needs.
The Alliance uses California Licensed Clinical Social Workers, Licensed Marriage and Family Counselors and Licensed Psychologists in the role of the Behavioral Health Triage Specialist. The Behavioral Health Triage Specialist provides case management services for health plan Members with highly complex behavioral health conditions where advocacy and coordination are necessary to help the Member reach the optimum functional level and autonomy within the constraints of the Member's conditions. Working within a multi-functional team, the Behavioral Health Triage Specialist coordinates with the Member, Member caregiver(s), community resources, and health plan partners to assess Member health status, identify care needs and ensure access to appropriate services to achieve positive health outcomes.

XVIII. **Behavioral Health RN Case Manager**

Under guidance from the Senior Director of Behavioral Health, Behavioral Health RN Case Managers provide the behavioral health case management components for members to enables integration of physical and behavioral health to address the member's whole person health needs. Additionally, the Behavioral Health RN Case Manager participates in the Multi-disciplinary case management team when there are psychiatric conditions impacting the members health outcomes to ensure psychiatric conditions are addressed in coordination with physical health conditions.
The Alliance uses California Licensed registered nurses who have specialized in psychiatric/mental health nursing in the role of the Behavioral Health RN Case Manager. The Behavioral Health RN Case Manager provides case management services for health plan Members with highly complex behavioral health conditions where advocacy and coordination are necessary to help the Member reach the optimum functional level and autonomy within the constraints of the Member's conditions. Working within a multi-functional team, the Behavioral Health RN Case Manager coordinates with the Member, Member caregiver(s), community resources, and health plan partners to assess Member health status, identify care needs and ensure access to appropriate services to achieve positive health outcomes.

XIX. **Applied Behavioral Analysis (ABA) Analyst**

Under guidance from the Senior Director of Behavioral Health, the ABA Analyst provides the behavioral health therapy/Applied Behavioral Analysis (ABA) case management components for members to ensure member under the age of 21 who need ABA services for the treatment of Autism or other developmental conditions receive medically necessary services.
The Alliance uses Board Certified Behavioral Analysts (BCBA) in the role of the ABA Analyst. The ABA Analyst provides case management services for health plan Members with Autism or other developmental conditions where advocacy and coordination are necessary to help the Member reach the optimum functional level and autonomy within the constraints of the Member's conditions. Working within the behavioral health team the ABA Analyst coordinates with the Member, Member caregiver(s), community resources, and health plan partners to assess Member health status, identify care needs and ensure access to appropriate services to achieve positive health outcomes.

XX. **Health Assessment Coordinator**

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

XXI. **Behavioral Health Navigator**

- Under the guidance of the Senior Director of Behavioral Health, the Behavioral Health Navigator is responsible for the non-clinical support of the Alliance Behavioral Health Department. The Behavioral Health Navigator is responsible for the non-clinical support of members who need assistance in accessing the behavioral health services they need. The Behavioral Health Navigator supports the Behavioral Health Department's clinical staff in following through on referrals and services to ensure member health care needs are met. The Behavioral Health Navigator is also responsible for the management of mailings and data entry of hardcopy documents received for entry into the clinical information system.

VI. Population and Member Needs Assessment

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

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

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

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

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

VII. Case Management Clinical Systems

A. Clinical Information Systems

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

B. Clinical Decision Support Tools

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

VIII. Care Coordination and Case Management Services

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

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

A. Health Risk Assessment

To ensure that the appropriate level and quality of care is delivered to newly enrolled, non-dual Seniors and Persons with Disabilities (SPD), the Alliance makes every effort to identify each Member's individual medical and resource needs. On July 11, 2017, Department of Health Care Services issued a new All Plan Letter for Requirements for Health Risk Assessments of MediCal Seniors and Persons with Disabilities. This revised APL supersedes the existing notification and clarifies the Plan's responsibilities for the early identification of Members who need early intervention and care planning to prevent adverse outcomes. The new guidance also requires development of a process for utilizing the standardized LTSS referral questions to identify and ensure the proper referral of Members who may qualify for and benefit from

LTSS services. These questions are intended to assist in identifying Members who may qualify for and benefit from LTSS services. These questions are for referral purposes only and are not meant to be used in classifying high and low risk Members.

The Alliance utilizes a standardized HRA questionnaire to identify member care needs and provide early interventions for Members at higher risk for adverse outcomes. The questions are focused on medical care needs, community resource needs, the appropriate level of caregiver involvement, timely access to primary and specialty care needs, identification of communication of care needs across providers as well as identifying any activities or services to optimize a Member's health status including a mental health screener. In addition to the standardized HRA questions, the DHCS LTSS questionnaire is completed to identify whether a beneficiary is experiencing risk factors that make them a candidate for LTSS services that will help keep them in their home and community.

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

- Begin assessment within 30 days of member identification.
- Complete assessment within 60 days of member identification.

(In alignment with NCQA standards)

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

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

CM staff is responsible for ensuring the Member Care Plan is completed and shared as well as providing any community or health resources. For Members who completed the HRA and the final stratification is Low Risk, a CM staff will review the HRA responses to identify Member needs, i.e., resources for transportation, IHSS, food banks. The CM staff will generate the Care Plan, attach the resources, and prepare for mailing. If the Member remains UTC, CM staff will create a standardized care plan based on the needs identified for the initial data used to stratify the Member. The Alliance has chosen to generate

the standardized high-risk care plan because this care plan includes additional health education resources as well as health education materials. All copies of the care plans are mailed to the Member and Primary Care Provider as well as to the Provider Group for potential care coordination needs. A HRA letter and resources are sent to the Member; a copy of the Care Plan is sent to the Primary Care Provider for care coordination.

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

Starting in 2023, the Alliance will not be required to retain the use of our existing HRA tools that were previously approved by DHCS under the APLs 17-012 and 17- 013, although the Alliance is choosing to do so. Following federal and state law, the Alliance and/or our delegates will continue to assess members who may need LTSS, using the existing standardized LTSS referral questions. The Alliance will also comply with federal regulations that stipulate specific care plan requirements for members with LTSS needs. Additionally, for 2023, DHCS will retain the requirement that the Alliance assess Seniors and Persons with Disabilities who meet the definition of “high risk” for Seniors and Persons with Disabilities even if they do not have LTSS needs. DHCS has simplified the expected timeline for assessment of those with LTSS needs to align with NCQA’s requirements for care management assessments, which include beginning to assess within 30 days of identifying the member through RSS, referral, or other means, and completing assessment within 60 days of that identification.

B. Case Management

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

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

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

Care teams are assigned specific roles on the team to address the needs of the Members. The CM Nurse will serve as the medical lead for the team. The role of the CM Nurse is to ensure the CM assessments and follow-up is completed in a timely manner. The CM Nurse will communicate the outcomes of each

assessment with the other team Members to ensure the team is knowledgeable on care needs and understands their role in the care plan. The Behavioral Health Triage Specialist or the Behavioral Health RN Case Manager is engaged in the Care Team when behavioral health conditions are identified. The teams are directed by defined workflows between the team Members. Communication is key to the effectiveness of the program. The team meets daily to discuss the needs and expectations for the day.

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

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

1. Basic Population Health Management Services

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

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

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

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

2. Initial Health Assessment and Behavioral Risk Assessment

The PCP schedules with the Member and performs an Initial Health Assessment (IHA) and an Individual Health Education Behavioral Assessment (IHEBA). The IHA includes a history and physical evaluation sufficient to assess the acute, chronic, and preventive health needs of the Member. The IHEBA includes a series of age specific questions to evaluate risk factors for developing preventable illness, injury, disability, and major diseases. The PCP and/or the office staff are responsible for identifying and arranging for care needs. This includes referrals to the various linked and carved out County and State

programs. For medical services that are needed but managed through The Alliance, providers are responsible for contacting and arranging for UM or CM servicers to meet the identified needs.

C. Care Navigation (Case Management/Care Coordination)

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

1. Case Management/Care Coordination

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

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

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

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

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

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

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

2. Targeted Case Management Services

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

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

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

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

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

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

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

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

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

D. Special Programs

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

- Transitional Care Services
- Care Coordination for Members receiving continuity of care (CoC) with non-contracted providers.
- CCS
- Enhanced Care Management (ECM)
- Community Supports
- Major Organ Transplants
- Care Coordination for members receiving long-term care benefits at skilled nursing facilities

1. Transitional Care Services

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

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

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

- Enrollment
- Ensuring completion of the discharge risk assessment
- Ensuring completion of the discharge document (containing lead case manager's name and contact information) and share with appropriate parties
- Evaluation of post-discharge needs in association with TOC bundle.
- All care coordination activities – including facilitating communication, referrals, treatment/service authorizations, etc.
- Maintenance of comprehensive, written records based upon evaluation.
- Clear documentation of service(s) provided, provider communications, Member interactions, etc.
- Periodic review of cases
- Case closure and evaluation as appropriate

2. Continuity of Care (CoC) with Out-of-Network Providers

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

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

The Alliance's UM Department is responsible for the initial care determinations related to CoC situations. Once the CoC is approved, the Member is referred to Case Management for the identification of any care needs. The Case Management program engages in activity that monitors and assesses continuity and coordination of clinical care. Individual registered nurses work closely with the Member, the physicians and any other associated healthcare delivery organization involved in the case, to provide timely, quality-based care meeting the needs of the individual member. The CM staff ensure the coordination of services with the Primary Care Providers and Specialists. A full description of the various CoC programs can be found in the relevant UM Policies.

3. California Children Services

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

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

Referred children are screened for eligibility criteria and referred to a specialized contracted CCS provider. As the program is limited to providing services to children under the age of 21 years, The Alliance has developed a program to identify and provide care coordination of services for children in CCS whose needs are not covered with the CCS program, and who are nearing 21 years of age and aging out of pediatric health care services. As CCS children age out of the system, staff will assist with the transitions to appropriate adult specialists in a collaborative manner to protect the individual and ensure age-appropriate care is provided.

The CCS Program is coordinated through the UM department, including the Out of Plan RN, and the Case Managers provide coordination of care in collaboration with the UM department as needed to ensure that all needs are met.

4. Enhanced Care Management (ECM)

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

- Improving care coordination;

- Integrating services;
- Facilitating community resources;
- Addressing SDOH;
- Improving health outcomes; and
- Decreasing inappropriate utilization and duplication of services.

ECM service includes:

- Outreach & Engagement
- Comprehensive Assessment & Care Plan
- Enhanced Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Member & Family Supports
- Coordination of & Referral to Community & Support Services

5. Community Supports Services

Community Supports (CS) services are provided as part of the CalAIM initiative that include a variety of services not typically covered by managed care plans. These services are intended to provide additional cost-effective support to members in lieu of higher-level services. In 2023, the Alliance is providing six CS services:

- Housing Navigation
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Recuperative Care (Medical Respite)
- Medically Tailored/Medically Supportive Food
- Asthma Remediation

In January of 2023, the Alliance will begin a self-funded pilot for 2 additional CS-like services:

- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities
- Community Transition Services/Nursing Facility Transition to a Home

The Alliance is planning for the addition of three (3) more CS services in July of 2023.

- Respite Services
- Personal Care & Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)

Each CS service (whether self-funded pilot or other) has eligibility criteria and specific services provided per CS service, following the DHCS requirements.

6. Major Organ Transplants

In 2022, Major Organ Transplants (MOT) were carved back into the Plan from FFS Medi-Cal. This uniquely vulnerable set of members are provided focused Case Management services throughout the care continuum, from pre-transplant to post-transplant. The CM program works closely with Centers of Excellence providing the transplants to ensure comprehensive, wrap around services throughout. The Alliance program is a collaboration between the UM and CM department as well as other Alliance departments. The full program is described in the UM policies and procedures.

7. Long-Term Care

In 2023 the responsibility of ensuring members in need of skilled nursing facility (SNF) services and placed in a health care facility that provides the level of care most appropriate to the member's medical needs, was carved back into the Alliance. This requirement also includes ensuring all members have access to services based on needs across the care continuum. This varies from basic population health management to complex case management or enhanced care management. The Alliance case management team works closely with the Alliance Long Term Care team and community providers (including SNFs) to provide appropriate level of case management services.

E. Complex Case Management

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

- Case Management services
- Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team.
- Intense coordination of resources to ensure Member regains optimal health or improved functionality.
- With Member and PCP input, development of care plans specific to individual needs and updating at least annually.

IX. Case Management Program Description

A. Case Management

8. Identifying Members for Case Management

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

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

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

Referral Sources

Individual Members may be referred by:

- Internal referrals, e.g., UM, Disease Management, Health Information Line, Member Services, Appeals and Grievance, Leadership
- Direct referrals from inpatient facilities' Discharge Planners
- Self-referrals, e.g., Members, Caregivers
    - Instructions for self-referral and the phone number are provided in the Member handbook and on the Alliance website. In addition, Member Services and Health Navigators explain the process for self-referral when appropriate.
- Practitioners/provider network referrals, e.g., PCPs, Specialists, Medical Group Medical Directors
    - Instructions for referral and the phone number are documented in the provider manual and notified through Provider update communications.
    - Instructions for referral from behavioral health providers

- Predictive modeling, e.g., Care Analyzer

The cases identified through the data sources or referral sources cited above are reviewed by the CM triage nurses, taking into consideration the known information about the case from claims history,

medical records that may be on file for UM purposes, and Member Services call history. The triage nurse verifies Member appropriateness for CM and if determined as appropriate then a case is opened in the care management information system and assigned to a Case Manager. Members are deemed ineligible if the Member is not in the Plan, has died, is receiving duplicative services, or is in a long-term care facility.

9. Case Management Process

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

A. Intake

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

B. Identification of Care Needs

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

C. Communication with Member

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

D. Coordination of Services

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

E. Monitoring of PCP Services

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

F. Identification of Barriers to Care

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

G. Case Closure

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

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

B. Targeted Case Management

1. Identifying Members for Targeted Case Management

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

2. Targeted Case Management Process

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

A. Referral

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

B. Documented Assessment

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

C. Development of Comprehensive Service Plan

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

D. Coordination of Services

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

E. Crisis Assistance

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

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

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

G. Identification of Barriers to Care

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

H. Case Closure

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

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

IX. Complex Case Management Program Description

A. Identifying Members for Complex Case Management

1. Criteria

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

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

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

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

- Complex Psychosocial Needs (i.e., Homelessness)

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

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

2. Data Sources

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

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

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

3. Referrals to Complex Case Management

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

A. Health Information Line referral

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

b. DM program referral

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

c. Hospital discharge planner referrals

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

d. UM referral

The Utilization Management program, including the LTC UM Team, identifies Members in need of case management at admission, discharge, and concurrent review.

e. Member, caregiver, and practitioner referrals

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

f. Community-based referrals

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

g. Behavioral health referrals

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

4. Date of Eligibility for Complex Case Management

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

B. Complex Case Management Process

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

1. Referral & Screening

When a Member is identified, as described in Section IX.A ("Identifying Members for Complex Case Management") or a referral is received for case management, the CM staff enters the referral into the care management system and verifies Member health plan enrollment and eligibility. After health plan eligibility is confirmed, the staff submits the referral. The Case Manager then screens and determines program eligibility in complex case management or other appropriate programs by performing the initial screening assessment with the oversight of the Medical Director. If the Member does not meet criteria for complex case management, the Member may be referred to the other Alliance program for coordination of care, assistance in managing risk-factors, referral to community services or assistance in identifying a primary care practitioner. Appendix C & D contain the 2023 Case Management Criteria and Screening Checklist to assist clinical teams in consistency in assessment for CCM services.

2. Assessment of Health Status

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

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

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

3. Documentation of Clinical History Including Medications

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

4. Assessment of Activities of Daily Living

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

5. Assessment of Behavioral Health Status Including Cognitive Functions

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

6. Assessment of Social Determinants of Health

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

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

7. Assessment of Life-Planning Activities

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

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

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

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

To ensure an appropriate care plan and healthcare needs are effectively met, Member visual and hearing needs, preferences or limitations are assessed by the Case Manager or Social Worker during the General Assessment. In the event Case Managers or Social Workers identify impairment, details such as use of

hearing aids and eyeglasses, or any future known surgery will be provided to assist in the development of care planning.

10. Evaluation of Caregiver Resources and Involvement

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

11. Evaluation of Health Plan Benefits and Community Resources

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

12. Development of Individualized Person-Centered Case Management Plan

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

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

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

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

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

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

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

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

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

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

15. Development of Schedule for Follow-up and Communication

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

16. Development and Communication of Member Self-Management Plan

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

17. Process to Assess Progress

The Case Manager or Social Worker continuously monitors and reassesses the Member's condition, responses to case management interventions, and access to appropriate care. The case management plan

includes an assessment of the Member progress toward overcoming barriers to care and meeting treatment goals. The complex case management process includes reassessing and adjusting the care plan and its goals, as needed.

18. Case Closure

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

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

19 Patient Safety

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

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

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

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

If the Case Manager or Social Worker is unable to contact a newly assigned Member, the Case Manager or Social Worker sets a task in the care management system to attempt a second and third call in the next

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

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

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

21. Initial Assessment

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

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

22. Individualized Care Plan

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

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

- Maintaining a prescribed diet.
- Charting daily readings (e.g., weight, blood sugar).
- Changing a wound dressing as directed.
- Maintaining mental health wellness activities (e.g.: mindfulness, anxiety and depression management)

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

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

Case Managers establish care plan goals with the following characteristics:

- Goals are relevant to the Member's condition with identified goals driving optimally coordinated care.
- Goals take into consideration the Member's or primary caregiver's goals and preferences, and desired level of involvement. These goals must be:
    - **Specific** - usually defining a maximum of four behaviors or measurable outcomes.
    - **Measurable** - so that it is easily understood when the goal is achieved.
    - **Achievable** - it does no good for the patient or for the manager to set unrealistic or unachievable goals. This is an invitation to frustration and disappointment for all involved parties.
    - **Relevant** - are the chosen goals the ones for which the greatest value can be achieved for the time, resources, energy expended?
    - **Time-dimensioned** - Is there a realistic timeframe in which the goal can be achieved?
- Goals are prioritized. A complex case may have many goals toward regaining optimal health or improved function, therefore each goal is prioritized against other goals for dependencies. The Alliance designates goals on a scale of 1 to 10. 1 = High, 10 = Low.
- Goals have specific time frames for re-evaluation. Members with complex health concerns require ongoing assessment and management. When establishing a goal, the Case Management staff sets a specific date for follow-up on progress toward that goal. Upon re-evaluation the goal may be on track, may require revision, or may no longer be appropriate due to changes in condition or circumstance. When a goal is retained as is or revised the Case Management staff establishes a next follow-up date in the case management system.
- Goals have identified resources to be utilized, including the appropriate level of care when applicable.
- Goals include documentation of any collaborative approaches to be used, including family participation, to achieve the goal. Goals have an assessment of barriers. Barriers may be assessed at the individual goal level (such as limited transportation to physical therapist) or at the case level (such as Member is in denial about prognosis).

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

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

23. Ongoing Management

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

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

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

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

24. Case Management Integration

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

25. Inter-Disciplinary Care Teams

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

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

XI. Community Based Integration

As part of the CalAIM initiative, the Alliance has partnered with community-based agencies to provide both the Enhanced Care Management (ECM) benefit and Community Supports (CS). The purpose of the program is to build community infrastructure to improve integration, reduce unnecessary utilization of health services and improve health outcomes. AAH has contracted with Community Based Organizations (CBOs) to provide the ECM and the CS services. The ECM providers include both clinic-based CBOs and social agencies (see appendix I for full list.) CS Partners include the Alameda Health Care Services Agency (HCSA,) for housing services, Asthma Start, medical respite providers (Lifelong, Cardea Health, and BACS,) and Project Open Hand for Medically Tailored/Supportive Meals. HCSA infrastructure includes a community health record and AAH uses it as a tool for managing members through the continuum. The goal of the collaboration is to ensure targeted Members and providers can access intensive, community-based care management services from anywhere in the care continuum, providing the “right care-right place-right time”. The program outcomes focus of providing services that will:

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

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

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

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

XII. Disease Management

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

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

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

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

XIII. Case Management Monitoring and Oversight

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

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

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

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

XIV. Program Effectiveness

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

A. Complex Case Management Performance Measurement

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

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

Measure One - Member Satisfaction Rates

2. Improve Member outcomes

Measure Two - All-Cause Admission Rate

Measure Three – Emergency Room Visit Rate

3. Achieve optimal Member functioning.

Measure Four – Health Status Rate

4. Use of Appropriate Health Care Services

Measure Five – Use of Services (Primary Care)

A full description of the measures, goals, methodology and sources is available in Appendix E – 2023 Performance Measures.

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

1. Identifies a relevant process or outcome.

2. Uses valid methods that provide quantitative results.

3. Sets a performance goal.

4. Clearly identifies measure specifications.

5. Analyzes results.

6. Identifies opportunities for improvement, if applicable

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

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

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

B. Experience with Case Management

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

XV. Annual Complex Case Management Program Evaluation

The Chief Medical Officer and the Director or Manager of Case and Disease Management collaboratively conduct an annual evaluation of the Alliance complex case management program. This includes an analysis of performance measures, an evaluation of Member satisfaction, a review of policies and program description, analysis of population characteristics and an evaluation of the resources to meet the needs

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

XVI. Delegation of Case Management Activities

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

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

Delegate	Provider Type	HRA	Care coordination/ CM	CCM	DM
Kaiser	HMO	X	X	X	X
CHCN	Managed Care Organization	No	X	No	No

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

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

When a Provider Group is identified as interested in performing a delegated function, the CM team performs a pre-delegation review to ensure the entities can perform the functions in compliance with the regulatory and accreditation standards. When delegation occurs, the CM team works with Provider Relations to create an appropriate delegation agreement which requires the delegated entity to comply with the regulatory and accreditation requirements to evidence. The oversight of a delegated activity

includes regular reporting of CM services provided to Alliance Members. (e.g., monthly, quarterly, semi-annually, or annually).

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

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

2023 Improvement Opportunities Summary:

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

XVII. Transportation Services

- Transportation services are covered benefits. Transportation benefits include:
  - **A.** Emergency
  - **B.** Non-emergency medically necessary (NEMT)
  - **C.** Non-medical transportation (NMT)

- Benefits are administered based on the guidance of the Alliance product line. Those products include:
  - **A.** MediCal
  - **B.** IHSS

For the administration of the benefit:

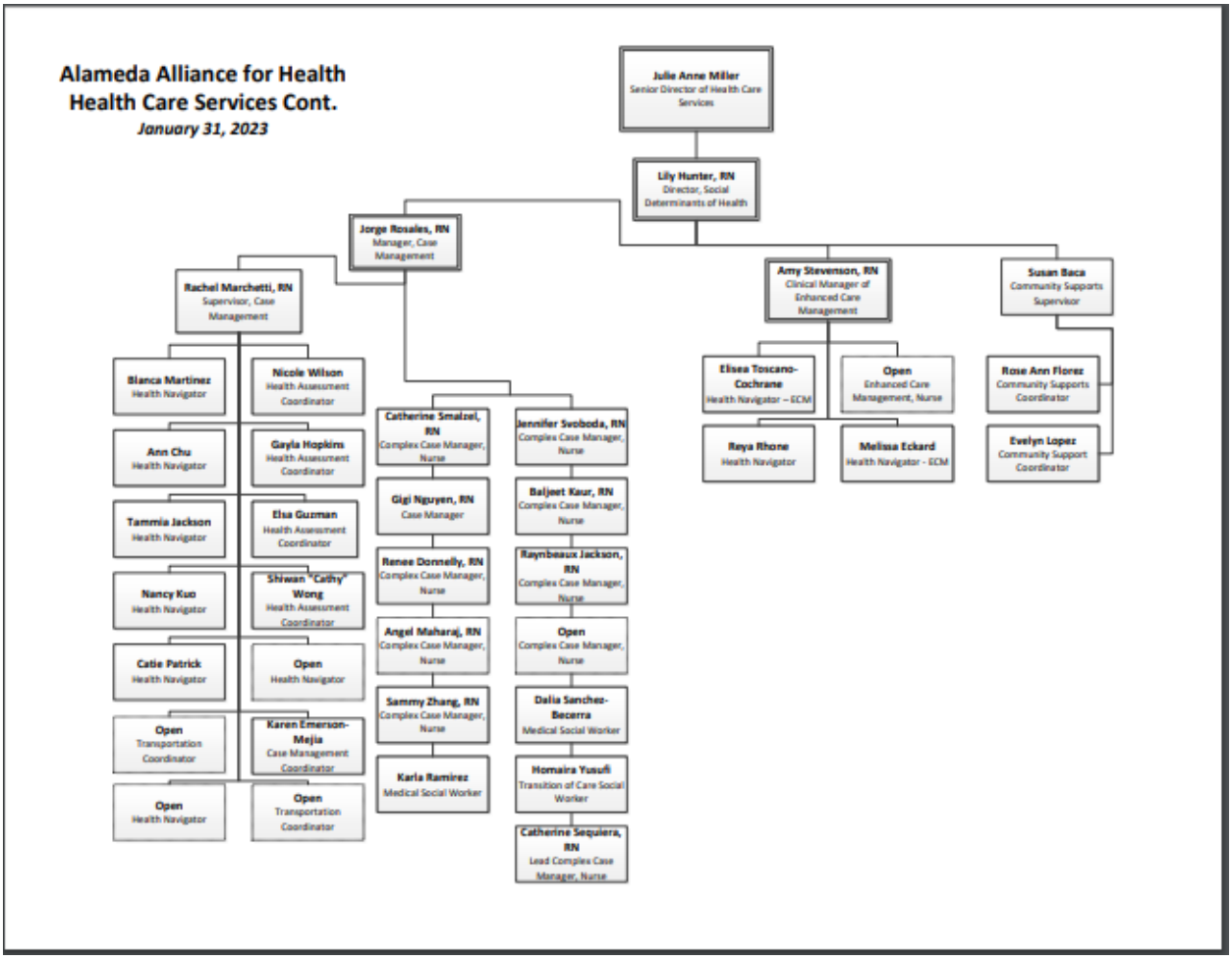
- For Members enrolled with Kaiser, the Alliance delegates the responsibility for the provision of transportation services to the contracted Plan Partner.
- For the administration of MediCal Direct and IHSS, the Alliance is responsible for the provision of transportation services.

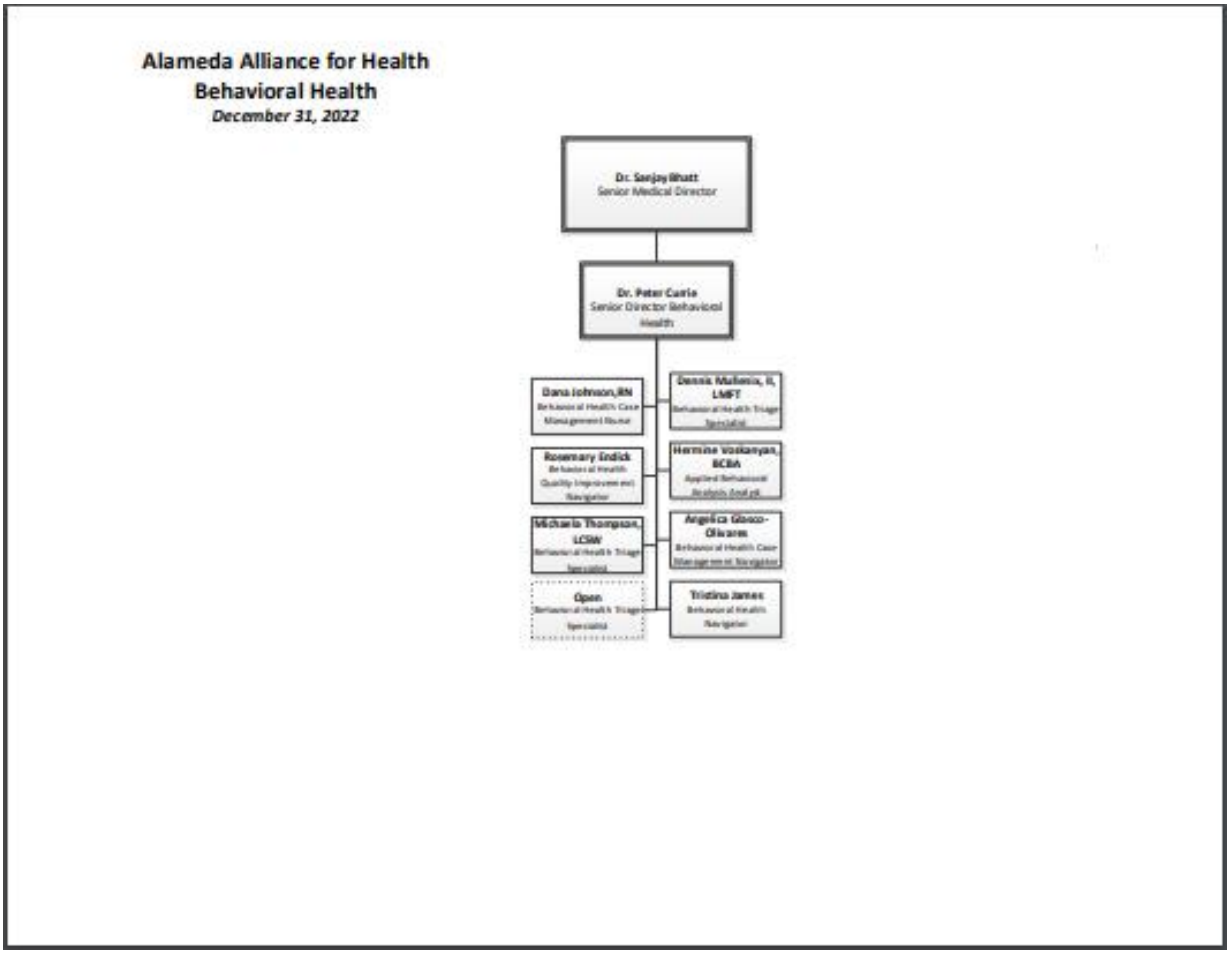
The Alliance contracts with a vendor, Modivcare, (formerly called Logisticare,) to provide the various modes of transportation. The Alliance does not delegate for the utilization review process to determine medical necessity when required. In October of 2022, Transportation management was transitioned over to the Case Management department to assist with the acquisition of the Physician Certification Statement (PCS). The Alliance will be working collaboratively with providers to acquire the PCS form prior to a ride being provided. Utilization review is performed using the transportation APL as guidance. A full description of the process is defined in the most recent policies on transportation services.

Transportation Access to Early and Periodic Screening, Diagnostic and Treatment Services

The Alliance is responsible for the provision of medical and non-medical transportation to eligible children under the age of 21 to access Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, (now called Medi-Cal for Kids and Teens.) The Alliance is required to provide appointment scheduling assistance and necessary transportation, including non-emergency medical transportation and non-medical transportation, to and from medical appointments for the medically necessary covered services. The Alliance is not responsible for providing non-medical transportation to and from the services that are carved-out, including dental services. AAH follows DHCS All Plan Letter 19-010 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment of Services for MediCal Members Under the Age of 21.

APPENDIX A: Case Management Organization Chart





APPENDIX B: Clinical Care Guidelines

Provider Resources – Alameda Alliance for Health
Tools – care that fits
alamedaalliance.org/providers/provider-resources/clinical-practice-guidelines/

TruCare 4.7 Disease Specific Content References

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

- **Asymptomatic Healthy Adults**

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

https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics

- **Members Under 21 Years of Age**

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

- **Perinatal Services**

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

- **Immunizations**

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

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

Appendix C – 2023 Criteria for Case Management

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

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

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

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

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

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

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

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

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

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

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

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

Appendix D- REFERRAL TO COMPLEX CASE MANAGEMENT CHECK LIST

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

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

Complex Case Management Criteria

(any 3 of ANY of the following)

High Utilization:

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

At Risk Diagnoses:

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

Complex Medical/Psychosocial Needs:

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

Appendix E - 2023 CCM Performance Measures

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

Appendix F: HRA Questionnaire

ALAMEDA Alliance FOR HEALTH

Health Survey

Member Name: _____ Alliance Member ID#: _____

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

1. What is your preferred language:
   ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese
   ☐ Other: _____

2. Where do you live:
   ☐ Own home ☐ Temporary housing
   ☐ Rent ☐ Homeless
   ☐ Staying with friends/family ☐ Group home
   ☐ Assisted living ☐ Other: _____

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

3. In general, how would you describe your health?
   ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Decline to answer

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

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

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

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

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

9. Are you pregnant? ☐ Yes ☐ No

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

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

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

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

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

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

15. Do you see a doctor regularly for a chronic condition? ☐ Yes ☐ No

If yes, check all that apply:

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

☐ Other: _____

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

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

Name of Medication	Dose (How Much)	How Often Taken

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

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

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

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

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

22.

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

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

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

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

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

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

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

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

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

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

Name of your helper: _____

What is your relationship to the helper: _____

May we contact your helper? ☐ Yes ☐ No

Phone number of helper: _____

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

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

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

    Name: _____

    Relationship: _____

31. As of today, do you receive any of these services from an agency?
    a. Home Health Nurse ☐ Yes ☐ No
    b. Physical, Occupational, Speech Therapy at Home ☐ Yes ☐ No
    c. Home Care Worker ☐ Yes ☐ No
    d. Social Worker ☐ Yes ☐ No
    e. Adult Day Care Center ☐ Yes ☐ No
    f. Help with Transportation ☐ Yes ☐ No

    Other (please list): _____

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

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

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

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

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

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

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

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

40. Have you fallen in the last month? ☐ Yes ☐ No

41. Are you afraid of falling? ☐ Yes ☐ No

42. Do you need help filling out health forms? ☐ Yes ☐ No

43. Do you need help answering questions during a doctor's visit? ☐ Yes ☐ No

44. Are you afraid of anyone or is anyone hurting you? ☐ Yes ☐ No

45. Is anyone using your money without your okay? ☐ Yes ☐ No

46. Do you sometimes run out of money to pay for food, rent, bills, and medicine? ☐ Yes ☐ No

This Health Survey is complete. Thank you!

Please return to:

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

If you have questions, please call:

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

Appendix G Long-Term Services and Supports Referral Questions

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

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

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

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

Although DHCS has retired APL 17-013 as of 12/31/2022, the Alliance will continue to use the Health Risk Assessment (HRA) to assess for members' LTSS needs.

Tier 1 LTSS Questions:

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

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

Appendix H – Disease Management Program Activities

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

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

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

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

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

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

Information needed for a DM referral includes:

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

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

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

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

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

DM Risk Stratification

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

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

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

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

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

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

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

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

Enrollment

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

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

Assessment

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

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

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

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

DM Plan Development and Management

1. The steps in developing the Care Plan involve:

    a. Development of case management goals, including prioritized goals

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

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

    d. Development and communication of member self-management plans

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

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

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

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

DM Case Evaluation and Closure

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

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

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

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

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

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

Appendix I – Enhanced Care Management Community Based Organizations

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

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2022
Utilization Management
Program Evaluation

2022 Utilization Management Program Evaluation

Signature Page

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Board Chair
Alameda Alliance for Health

2022
Utilization Management (UM) Program Evaluation
Jam in Teal
RM in Yellow

Overview

Under the leadership and strategic direction established by Alameda Alliance for Health (the Alliance) Board of Directors and Quality Management Committee (QMC), senior management and the Health Care Quality Committee (HCQC), the Health Services 2022 Utilization Management Programs were successfully implemented. This report serves as the annual evaluation of the effectiveness of the program activities.

The processes and data reported covers activities conducted from January 1, 2022 through December 31, 2022.

Membership and Provider Network

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

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

Figure 1. 2022 Trended Enrollment by Category of Aid and Age Groups:

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Dec 2020	Dec 2021	Nov 2022	Dec 2022	Dec 2020	Dec 2021	Nov 2022	Dec 2022	Dec 2020 to Dec 2021	Dec 2021 to Dec 2022	Nov 2022 to Dec 2022
Adults	38,150	43,077	50,069	50,351	13.8%	14.5%	15.4%	15.4%	12.9%	16.9%	0.6%
Child	94,969	98,150	101,653	101,791	34.5%	33.1%	31.2%	31.1%	3.3%	3.7%	0.1%
SPD	26,339	26,450	28,365	28,452	9.6%	8.9%	8.7%	8.7%	0.4%	7.6%	0.3%
ACA OE	91,050	102,264	117,328	118,397	33.0%	34.5%	36.0%	36.1%	12.3%	15.8%	0.9%
Duals	19,127	20,964	22,719	23,028	6.9%	7.1%	7.0%	7.0%	9.6%	9.8%	1.4%
Medi-Cal Total	269,635	290,905	320,134	322,019	97.8%	98.0%	98.2%	98.2%	7.9%	10.7%	0.6%
Group Care	5,954	5,823	5,791	5,776	2.2%	2.0%	1.8%	1.8%	-2.2%	-0.8%	-0.3%
Total	275,589	296,728	325,925	327,795	100.0%	100.0%	100.0%	100.0%	7.7%	10.5%	0.6%

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Dec 2020	Dec 2021	Nov 2022	Dec 2022	Dec 2020	Dec 2021	Nov 2022	Dec 2022	Dec 2020 to Dec 2021	Dec 2021 to Dec 2022	Nov 2022 to Dec 2022
Under 19	97,399	100,408	103,882	104,022	35%	34%	32%	32%	3%	4%	0%
19 - 44	93,280	105,212	119,055	119,997	34%	35%	37%	37%	13%	14%	1%
45 - 64	57,679	60,685	68,281	68,606	21%	20%	21%	21%	5%	13%	0%
65+	27,231	30,423	34,707	35,170	10%	10%	11%	11%	12%	16%	1%
Total	275,589	296,728	325,925	327,795	100%	100%	100%	100%	8%	10%	1%

Before 2020, the Alliance membership had been slowly declining over time with a total enrollment loss of 6% between 2018 and 2019. However, the 2020 pandemic and economic downturn, as well as a freeze on MCP disenrollment statewide correlated with an increase in enrollment in the Alliance, resulting in an overall increase of an additional increase of 19% by the end of 2022. The biggest jump in enrollment was in the Adult category (30% increase) and ACA/Optional Expansion category (29%.) The percentage of Child members to total membership declined from 36% to 32% from 2020 to 2022. The percentage of younger adults (19-44) increased from 34% in 2020 to 37% in 2022. There has also been an increase in the percentage of adults over 65 from 10% to 11%. The economic downturn may have been the driver of the percentage increases in the adult and ACA/OE membership as adults lost employer-based health coverage during the public health emergency.

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

Figure 2 2022 Provider Network by Type, Enrollment and Percentage Change

Network Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Dec 2020	Dec 2021	Nov 2022	Dec 2022	Dec 2020	Dec 2021	Nov 2022	Dec 2022	Dec 2020 to Dec 2021	Dec 2021 to Dec 2022	Nov 2022 to Dec 2022
Independent (Direct)	51,937	52,288	53,736	53,143	18.8%	17.6%	16.5%	16.2%	0.7%	1.6%	-1.1%
AHS (Direct)	55,240	58,590	65,216	65,771	20.0%	19.7%	20.0%	20.1%	6.1%	12.3%	0.9%
CFMG	31,529	32,573	33,498	33,648	11.4%	11.0%	10.3%	10.3%	3.3%	3.3%	0.4%
CHCN	98,920	109,059	124,637	126,009	35.9%	36.8%	38.2%	38.4%	10.2%	15.5%	1.1%
Kaiser	37,963	44,218	48,838	49,224	13.8%	14.9%	15.0%	15.0%	16.5%	11.3%	0.8%
Total	275,589	296,728	325,925	327,795	100.0%	100.0%	100.0%	100.0%	7.7%	10.5%	0.6%

Membership volume has increased significantly from 2020 to 2022, from 275 thousand to 328 thousand, with gains in all networks. Some of this was driven by the disenrollment pause during the public health emergency.
The percentage of members within each network has shifted to some degree since 2020:

- AAH Independent Direct declined to 16.2% from a high of 18.8% in 2020
- AHS Direct remained relatively steady at 20.1%
- CFMG held at 10.3% for two years, after dropping from 11.4% in 2020
- CHCN has had a steady increase, up to 38.4%
- Kaiser had gains from 2020, but has been relatively steady since 2022 at 15%

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

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

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

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

Figure 3 The Alliance Ancillary Network

The Alliance Ancillary Network	
Hospitals	17
Skilled Nursing Facilities	72
Health Centers (FQHCs and non-FQHCs)	81
Behavioral Health Network	1
DME Vendor	1 Capitated, 19 Non-Capitated
Transportation Vendor	1
Pharmacies/Pharmacy Benefit Manager (PBM)	Over 200

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

Delegation

The Alliance delegates UM activities to provider groups, networks and healthcare organizations that meet delegation standards. The contractual agreements between the Alliance and delegated groups specify the responsibilities of both parties; the functions or activities that are delegated; the frequency of reporting on those functions and responsibilities; how performance is evaluated; and corrective action plan expectations, if applicable. The Alliance conducts a pre-contractual evaluation of delegated functions to assure capacity to meet regulatory and accreditation standards and requirements—no new delegates were added in 2022. The Alliance's Compliance Department is responsible for the oversight of delegated activities. The Compliance Department works with the UM Department and other departments to conduct the annual delegation oversight audits. When delegation occurs, the Alliance requires the delegated entity to comply with regulatory, contractual and NCQA standards as well as submitted regular utilization reports, i.e., quarterly, semi-annual, and annual, to assess the delegate's performance on services provided to Alliance members. The Alliance has adopted the Industry Collaborative Efforts UM Reporting Templates as an acceptable format of reporting Results of the annual evaluation and audit results are reviewed by the Compliance and Delegation Oversight Committee. The UM

Department performs oversight audits of UM outpatient and inpatient activities as well as works with delegates on operational issues to ensure that members receive services from delegates that are in line with the Alliance's established policies and procedures.

The Alliance shares the performance of UM activities with several delegates. The Alliance's UM delegates are the following:

Figure 4 – 2022 The Alliance Delegated Network

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

Overall, the network was sufficient to meet the needs of the Alliance membership and provider network throughout 2022. The organization clarifies issues related to delegated activities and responsibilities as needed. The issues have led to additional clarification in contractual documents as well as additional training of delegates on roles and expectations, to align with standard Alliance UM workflows and policies. In 2022, Joint Operation Meetings (JOMs) facilitated communication and operational alignment. These JOMs, which are collaborative meetings between the Alliance and Delegates/Vendors to address operations and performance outcomes are also used to identify joint opportunities for improvement. For 2023, there will continue to be opportunities to continue to improve the level of oversight, monitoring, reporting, and training of delegates. Additionally, through quarterly delegate audits, UM will continue to analyze opportunities to further identify denial patterns and monitor approval type patterns to further ensure the appropriateness of decision making.

UM Program Structure

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

Responsibility, Authority and Accountability/ Governing Committee

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

Committee Structure

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

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

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

In 2022 the HCQC approved the 2022 UM Program Description, the 2021 UM Program Evaluation, and 2022 UM Workplan on March 17, 2022, for Board of Directors approval. The committee was chaired by the Chief Medical Officer with support of the Senior Director of Quality Management, external physicians, and key organizational staff. The UM Committee had ten meetings in 2022.

In 2023 the UM Subcommittee of HCQC will continue to support the focus on UM activities, oversight for delegated UM activities, case management/care coordination, population health, CalAIM implementation, integration of behavioral health and medical care while behavioral health is insourced from the delegate in 2023, as well as regulatory compliance.

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

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

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

Behavioral healthcare involvement in UM has been performed in partnership with two entities, Beacon Health Options (Beacon) and Alameda County Behavioral Health Care Services (ACBHCS.) The Alliance also hired a Senior Director of Behavioral Health in 2022, in preparation to insource the Non Specialty Mental Health Services (NSMHS) into the Alliance from Beacon. The behavioral health practitioner involvement reflects the behavioral health benefit administered by the Alliance. Behavioral health representation is provided by ACBHCS, Beacon and the Senior Director of Behavioral Health to participate in UM Program development and oversight. Each entity provides committee participation in the role of a behavioral health practitioner:

- Alameda County Behavioral Health Care System (ACBHCS) - For MediCal beneficiaries, the management of severe and persistent behavioral health conditions including Substance Use Disorders, (SUD) is managed by ACBHCS. In 2022, AAS and ACBHCS worked closely to revise their MOU to include changes needed to comply with all MOU regulatory requirements, including sharing responsibility for Eating Disorders and implementing new requirements under the No Wrong Door APL.
- Beacon Health Strategies (Beacon) – Provides services for MediCal beneficiaries for mild to moderate behavioral health conditions, including MH, BHT and SUD, and full spectrum behavioral health management for IHSS enrollees.
- AAH initiated planning and enterprise wide development to insource mental health and Behavioral Health Therapy/Applied Behavioral Analysis benefit management scheduled to transition from Beacon Health Options (Beacon) as of April 1, 2023. AAH hired a licensed psychologist, Peter Currie, Ph.D. as the Senior Director of Behavioral Health in March of 2022, and throughout the rest of 2022 a total of 32 staff were added and processes developed to ensure insourcing would be in compliance with all regulatory requirements and continuity of care will be provided for all members receiving behavioral health services. Seven service domains were developed within AAH to support the insourcing transition from Beacon to AAH.
    - Care Transitions
    - Utilization Management
    - Quality Improvement
    - Provider Network
    - Credentialing
    - Member Services
    - Claims Processing & Payment

    - The behavioral health entities and Senior Director of Behavioral Health have provided senior level behavioral health practitioner involvement in the UM Program by:

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

Program Scope and Structure

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

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

- Prior authorization of services and pre-admission education
- Admission and concurrent review
- Discharge planning: pre-admission, concurrent, and post hospital discharge follow-up/referrals with the member
- Retrospective review

- Quality improvement projects within the UM Program
- Integration of medical and behavioral health in collaboration with the behavioral health vendor and ACBHCS
- Continuity and coordination of care for members when a provider is terminated from the network
- Continuity and coordination of care for members newly eligible for Alliance coverage who are receiving active care and treatment from a non-Alliance provider.
- Evaluate and refer for members needing care coordination, (ex. EPSDT, CCS, Enhanced Care Management, Complex Case Management, Community Supports, Dental Health, Behavioral Health, Long Term Care, etc.)
- Ensuring that denials related to utilization issues are handled efficiently according to UM timeliness standards.
- Review of overturned PA Appeals
- Monitoring and auditing delegated entities UM activities for compliance to contractual requirements with implementation of corrective action plans as appropriate
- Internal monitoring and auditing for compliance to DHCS, DMHC, and NCQA requirements
- Departmental policies, procedures, and processes with implementation of corrective action plans as appropriate

Utilization Management Resources

The Alliance UM Department is staffed with physicians, nurses and non-clinical support staff including clerical support and clinical support coordinators. A full description of staff roles and responsibilities is provided in the 2022 UM Program Description.

The assignment of work to the team, whether working on site or remotely, for both clinical and non-clinical activities, does not change the team member's job responsibilities or job description. In 2020, in response to the Covid 19 pandemic and public health requirements, the UM department transitioned to fully working from home, and this continued through all of 2022. Staff were provided equipment, remote connectivity, and policies to follow to successfully work from home while maintaining full functionality and meeting regulatory requirements. The job descriptions with assigned tasks and responsibilities remained the same regardless of the geographical location of the team member.

In 2022, based on the established staffing ratios and roles, the UM Department hired staff for additional department roles. Clinical Supervisors for Outpatient UM and for Inpatient UM were hired and an RN for Major Organ Transplant was budgeted, and recruitment efforts began in the 3rd quarter. Hiring for the MOT RN is expected in 2023. Also in 2022, additional new staff were hired for the carve in of Long Term Care in 2023, with a Manager of Long Term Care, two Nurse Specialists for Long Term Care (LTC), and a LTC Coordinator. A LTC Social Worker was recruited in 2022 and was hired in early 2023. A CCS Outpatient nurse was hired, along with a CCS Coordinator to provide additional resources to this important population. With the onboarding of new staff, the Health Care Services Department teams reviewed the current organization goals and restructured some clinical assignments in the Department to achieve those goals.

Delegated Utilization Management

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

The Alliance has several levels of UM delegation: For Knox Keene licensed Health Plans, UM may be fully delegated. For certain medical groups, UM decision making is a shared risk; the Medical Groups are delegated for the performance of outpatient referral management and UM decision making while the Alliance UM Department maintains responsibility for

certain outpatient services and inpatient care. All delegates perform levels of UM decision making based on their contracts and performance. The Alliance maintains responsibility for UM decision making associated with transportation, MLTSS, and pharmacy, but excluding those pharmacy requests that as of 2022 fall under MediCal Rx. The resolution of clinical grievance and appeals are only delegated to the Alliance's Knox Keene licensed Health Plan (Kaiser.) For care management and complex case management, the Alliance delegates basic care management and care coordination to network providers. Currently, the Alliance delegates complex case management to Kaiser and Beacon. For Delegates unable to fulfill the delegated activities, the entity is subject to remediation activities up to and including revocation of delegation.

Behavioral health UM activities are delegated to and managed by the contracted managed behavioral health organization (MBHO), Beacon Health Options, (Beacon). In April 2023, the Alliance will end the delegation arrangement with Beacon, and will insource behavioral health services.

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

In 2022, the UM staff conducted annual audits on the four (4) delegates. The threshold for UM audit compliance is 90%. For entities that do not meet the threshold, the UM staff may require a corrective action plan which is tracked for compliance with the resolution of the deficiency. Entity audit results for 2022 were:

- Three groups did not pass UM audit ($\underline{\geq}$ 90.0%), and corrective actions were required of three of them, and one is in progress as of the end of 2022:

Figure #5 The Alliance Network – 2022 Annual Audit Score

Delegate	Provider Type	Delegated Activity-UM	2022 Audit Results	Corrective Action Required
Kaiser	HMO	X	Deficiencies found, Corrective Action Plan Required	Yes or No: Yes Final Audit Report issued 02/10/2023. CAP due date: March 27,2023. Two findings, with the following actions required: - Complete/submit a onetime audit of 30 cases where the denial NOAs reflect the correct references and to verify that appropriate guidelines are applied - Complete/submit a onetime audit of 30 cases where the member has a threshold language other than English, with post system update to verify that the new programming is working as stated - Provide documentation that member was referred for CM to ensure adequate and timely care was navigated to the county for at risk medical condition (SUD)
CHCN	Medical Group	X	Deficiencies found, Corrective Action Plan Required	Yes or No: Yes (Resolved) Final Audit report issued on 5/5/22. CAP Closure issued 09/16/2022 UM Program review: (Resolved 07/15/2022) The delegate's Utilization Management Program Description and

Delegate	Provider Type	Delegated Activity-UM	2022 Audit Results	Corrective Action Required
				supporting documents did not include the following elements: Address the process for recording dates in the system in UM Denial System Controls. UM Case File review: (Resolved 08/03/2022) • Cases did not meet the timeliness standards for notifications of UM decisions • Cases did not state specific reason for the denial in clear and concise language • Cases reviewed did not have notices to the member that were written in member's preferred language. • Cases did not cite minimum criteria for denial reason • Cases did not include the required appropriate reference to the benefit provision, guideline, protocol, or other criterion on which the denial decision is based in the Notice of Action (NOA) • Pended cases' notification letter did not indicate timeframe by when the information was needed • Pended cases' notification letter did not send deferral notification within 14 day deferral timeframe from the date of receipt
CFMG	Medical Group	X	TBD	Yes or No: TBD Final audit to be issued by Q1 2023
Beacon/College Health IPA (CHIPA)	MBHO	X	Deficiencies found, Corrective Action Plan Required	Yes or No: Yes. (Resolved) One UM Finding, which was resolved on 7.7.2022 with the CAP closure issued on 8.26.2022. The final finding and CAP issued on 5.5.2022 were the following: • For Sample #1: on the demographics file, the field for language is blank, and Beacon states that a blank field indicates that the preferred language is English. • Provide the procedure or training document that is used to train staff to use the blank Language field to indicate that the preferred language is English.

Additionally, the UM team is responsible for ongoing monitoring activities including review of the delegated entities annual work plans/evaluations, and semi- annual reporting. Quarterly Joint Operating Meetings (JOMs) are held with Delegated entities as well as ad hoc operational meetings throughout the year.

For 2022, the current UM delegates continued to meet the program's required scope of activities. The individual issues of compliance regarding delegation requirements are addressed with the delegate through the Compliance Department. The UM team works collaboratively with the Compliance Department on identifying potential process improvement activities and monitoring corrective action plans. In 2022, the team continued to collaborate with Senior Health Care Services Leadership and Compliance staff to resolve on-going corrective actions identified during regulatory audits.

Recommend Actions/Next Steps

For 2023, there will be additional opportunities to improve the oversight of delegated UM activities. The UM Department leadership is continuing the development of a robust level of delegate oversight, performance monitoring and engagement with operational processes. The activities include dedicated staff monitoring activities, quarterly chart audits, performance management, delegate feedback, and UM training.

Utilization Management Processes and Information Sources

Utilization Management Decision Making

Decision and screening criteria are designed to assist UM staff and delegates in assessing the appropriateness of care for clinical and behavioral health situations encountered in the clinical setting. Application of the criteria is not absolute but based upon the individual health care needs of the member, medical risk factors, and social determinants of health, and in accordance with the member's specific benefits plan and capacity of the health care delivery systems. The decision criteria are made available to the member, providers or public upon request by contacting the UM Department. A full description of the criteria utilized for UM decision making is available in the 2022 UM Program Description.

For 2022, the Alliance UM Department utilized the clinical criteria as defined in the UM Program. In 2022, the Alliance used the Milliman's CareWebQI® interactive software tools which integrate the MCG® guidelines into the core information system, TruCare, using the 25th Edition MCG® criteria. The 26th Edition MCG® criteria was released in early 2022 and was embedded into the UM platform TruCare (TC) in July 2022 to align with the platform upgrades supporting version compatibility. Upon review of member needs and the requirement to use alternative criteria as appropriate, there were no changes to the clinical criteria informed by the UM Medical Necessity hierarchy in UM-001. The criteria hierarchy first and foremost applies the DHCS Provider Manual guidelines and other regulatorily required guidelines, (such as the non-profit professional associations for the Group Care Behavioral Health members,) then MCG®, followed by the MCP's Policies, and other evidenced based clinical criteria including UpToDate®. In 2022 there were no requests from members, and no requests from providers for copies of the decision-making clinical criteria.

In 2022 the Alliance UM staff collaborated with Senior Leadership to ensure that Transportation processes were revised to adhere to the requirements of APL 22-008 for Non-Emergency Medical and Non-Medical Transportation and the requirement to provide non-medical transportation for Medi-Cal services that are not covered under the MCP contract. The Alliance monitors the performance of ModivCare's provision of this benefit by conducting operational meetings and JOMs, regular review of G&As, and performance metrics.

Consistency in Application of Criteria

The Alliance UM Department assesses the consistency with which physicians, pharmacist, UM nurses, Retrospective Review nurses and non-physician reviewers apply criteria to evaluate inter-rater reliability (IRR). A full description of the testing methodology is available in the Health Care Services policy for IRR which UM, CM, BH, and Pharmacy policies all reference. Quality IRR policy has set the overall IRR passing threshold to 90% using 10 cases. For corrective and educational actions needed those IRRs not passed, please reference Figure 6.

Figure #6 2022 **Inter-Rater Reliability Thresholds**

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

The IRR process uses hypothetical but realistic UM cases. IRRs included a combination of acute and/or outpatient IRR modules offered by MCG® specifically designed for staff training, educational, and IRR purposes. To maintain a high level of consistency in the performance of UM, the threshold to pass IRR was increased to 90%, and 5 cases were increased to 10 for UM staff.

All new hire staff will train and participate in the IRR process upon completion of their training. Results are tallied as they complete the process, appropriate feedback and follow-up education are provided, and corrective actions implemented as needed. When opportunities for improving the consistency in applying criteria, UM staff addresses corrective actions through requiring global or individualized training or completing additional IRR case reviews (see Figure #6).

UM Clinical Group	2022 Overall Passing Rate
OP Nursing	100%
IP Nursing	100%
G&A Nurse	100%
MDs	100%

For 2022, IRR testing was performed in Q4 for UM clinical staff and non-clinical staff to establish consistency in practice and outcomes for members, using 10 cases to reflect the outpatient, inpatient, or mixed scope for respective department UM or G&A clinical reviews.

OP Performance

- The overall passing rate meeting the minimum threshold was met by 100% of the OP nurses, however 1 nurse failed a single module after 3 attempts.

IP Performance

- The overall passing rate meeting the minimum threshold was met by 100% of the nurses, however 1 nurse failed a single module after 3 attempts.

G&A

- The overall passing rate meeting the minimum threshold was met by the G&A nurse, however 2 nurses failed a single module after 3 attempts.

MDs

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

Qualitative IRR Analysis

Overall, the overall scoring showed all team members in all departments. A few staff didn't pass a single IRR module after 3 attempts, but their overall passing rate for IRR threshold is 100%.

Opportunities for Improvement

1. Respective managers educated staff on the missed MCG medical necessity criteria by module
2. For those staff who did not pass an *individual module* at 90% score by the 3rd attempt, they will receive additional MCG training and repeat IRR testing within 1 month.
3. Will develop training opportunities for expanded UM services.
4. New and Temporary Hires will receive MCG education, case auditing, & assigned MCG learning modules for the onboarding process by respective team managers prior to completing independent medical reviews.
5. Continue with 90% threshold level for IRR passing rates consistent with the Quality IRR Policy.
6. Behavioral health staff supporting medical decision making and appeals will undergo IRR testing for the new BH carve out launching 4/2023.

Management of Non-Delegated Medical Determinations – Prior Authorization/ Concurrent Review/ Post-Service

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

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

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

- Hospital services, including acute, long-term acute and acute rehabilitation.
- Skilled Nursing Facilities services
- Sub-Acute Facility services
- Durable Medical Equipment
- Prosthetics/Orthotics/Medical Supplies
- Outpatient Facility Based Services (i.e., specialized radiology or diagnostic procedures, dialysis, etc.)
- Hospice
- Out of Network, Tertiary
- Out of Area Services (Per Contract)
- Managed Long Term Services and Support/Community Based Adult Services (CBAS)
- Long Term Care, month of admission plus the following month
- Transgender Services
- Transportation
- Major Organ Transplant Services
- Acupuncture

- Home Health
- Medications covered under the pharmacy benefit - i.e., non-formulary, some self- injectable medications.
- Experimental/investigational procedure/services determination
- Cancer clinical trial determinations

Opportunities for Improvement

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

UM Information Systems

The Alliance maintains a core information system, TruCare®, that is utilized by both UM and case management and Pharmacy staff. UM and CM staff have identified opportunities to enhance the functionality of the system to assist in managing UM referrals and case management functions, and in 2019 a major initiative to optimize the TruCare® platform was launched. It was completed in 2021 and resulted in both optimization of the software itself and upgrade to version 9.0 in 2022. These optimization and upgrades are ongoing as standard practices, including staff training to ensure standard workflows are in use and staff are competent in the use of the software. Information system version upgrades to version 10.0 and optimization are planned for staff into 2023.

UM DETERMINATIONS

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

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

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

Referrals are tracked and reported by:

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

Denials are reported in relationship to:

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

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

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

Quality of NOA letters regarding all types of authorization requests are monitored to ensure clear and concise language, reading literacy to the 6th grade level, contain all regulatorily required content and references. In 2019 AAH received regulatory findings of deficits in outpatient NOA content and continues to employ multiple strategies in 2022 to maintain the improved performance in this area. This includes NOA template standardization, SMOG (reading level,) checks as part of the quality assurance checks prior to the NOA sent out, retrospective review of the quality of the NOAs through annual and focused audits, feedback to all staff and MDs involved in the production of NOAs, ongoing training of all staff and MDs as indicated, active workgroup attention to new and expanding NOA needs, and ongoing quality monitoring of the NOA letters. Additionally, language translation was added in the clinical sections of the NOA and approval letters in threshold languages, in accordance with APL 21-004. Language translation is provided by an external vendor, AvantPage.

Usage of specialty referrals are monitored to ensure members have access to specialty services within or outside of the network to support continuity of care, timely access, and specialty and/ or tertiary/ quaternary care.

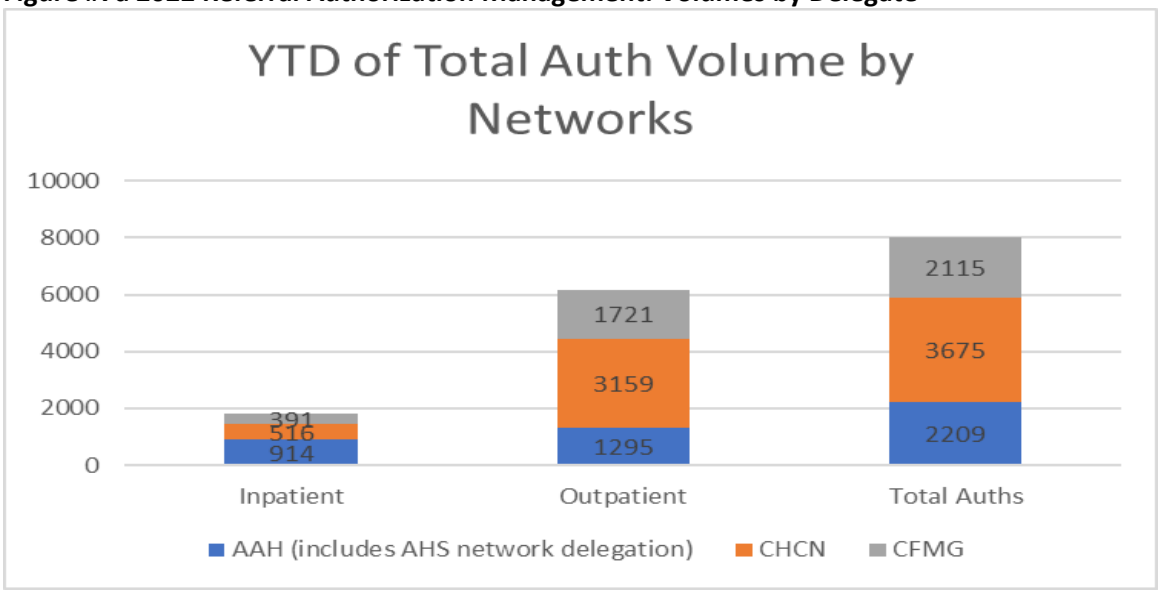
As discussed in a previous section, the Alliance manages two products, Medi-Cal and Commercial (Group Care). For the purpose of data analysis, because the commercial network, IHSS, represents only 2% of the total membership and 4% of the referral activities, the data is aggregated for reporting. In key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

Utilization Management Referral Management Data

Quantitative Analysis

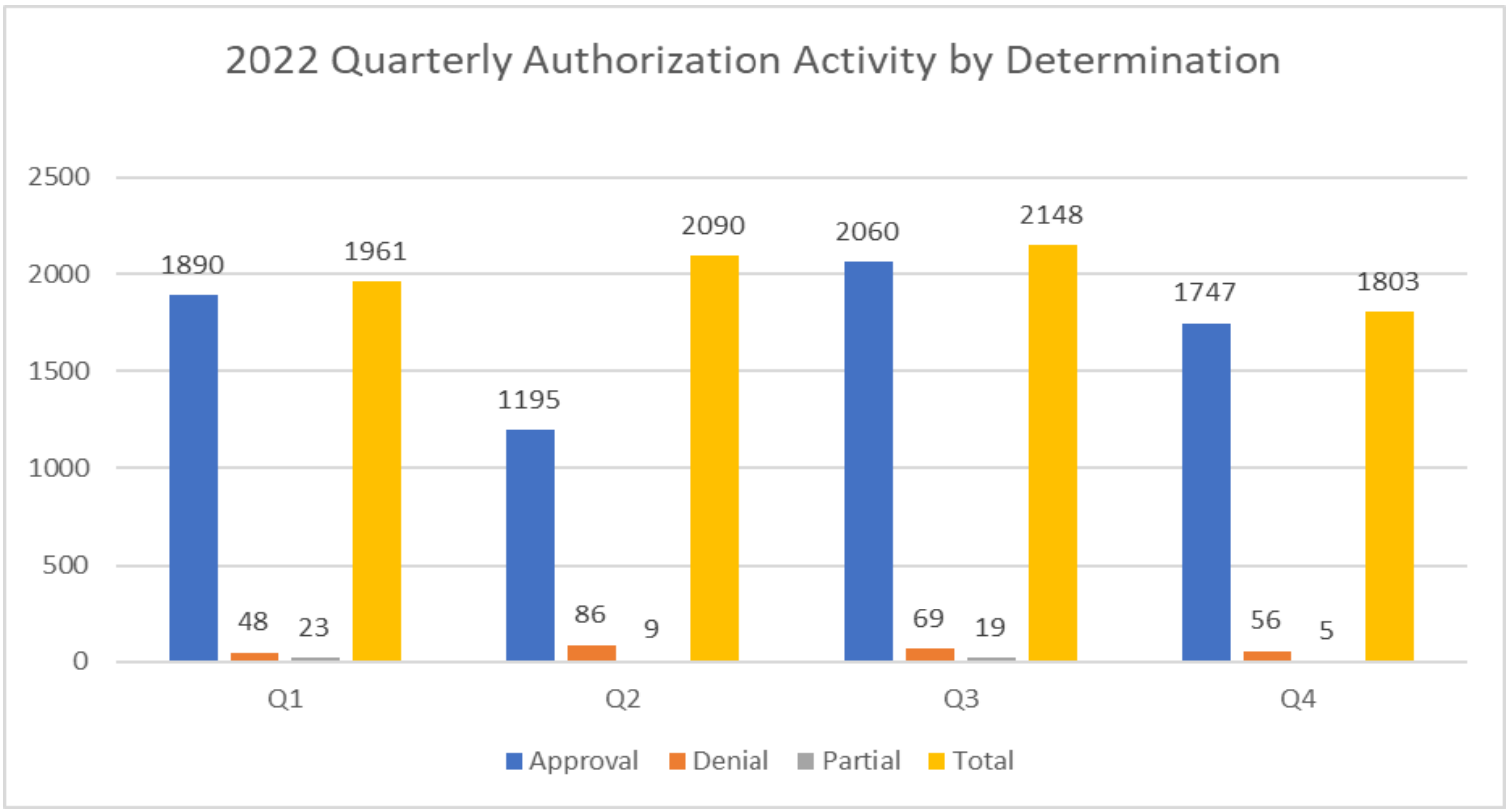
The data presented in Figures 7 – 11 represents key UM referral management functions by provider group, product, and UM determination.

Figure #7a 2022 Referral Authorization Management: Volumes by Delegate



Authorization volume data is based on the number of authorizations managed by the Networks year to date. The reporting period is January 1 through December 31, 2022, for all Delegates and all products. Total referral volume increased across all networks, in comparison to the outpatient authorizations drop in 2021 from the pandemic. All networks saw reductions in inpatient authorization reviewed, following decreased inpatient admissions/ 1000 members health plan wide.

Figure #8 2022 Quarterly Referral Management Activity by Determination



Quarterly Outpatient Referral Management data uses the final determination, reported by quarter, based on number of authorizations managed by the Managed Care Plan; Reporting period is January 1 through December 31, 2022, which includes Delegates and all products. Total denial and partial denial authorizations decreased in 2022 (51), whereas approval authorization increased by 642 from prior year, reflecting an increase in total authorizations reviewed. Q2 saw a decrease in approvals. Partial determinations remain stable across quarters and remain minimal.

Figure #9 Comparisons of 2021 and 2022 Outpatient Referral Authorization Denial Rate

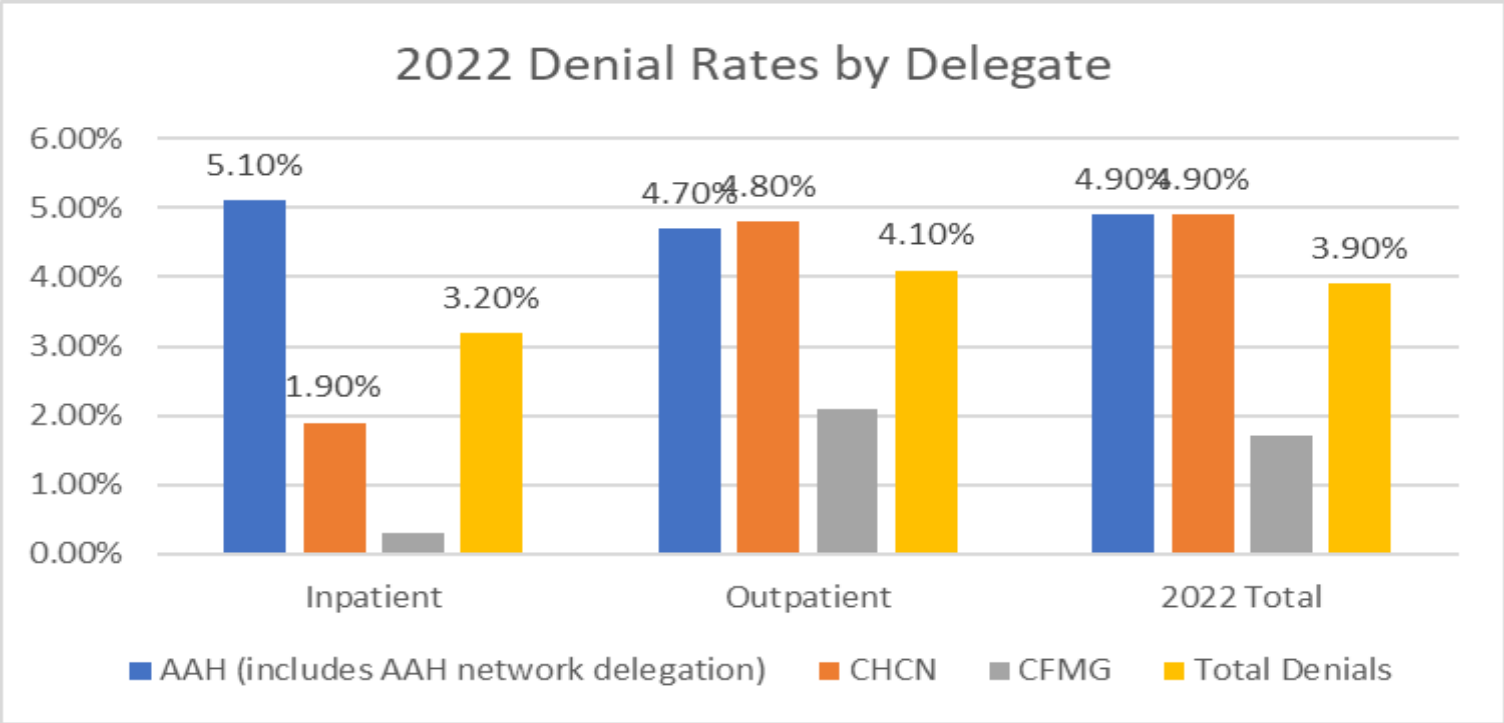
OP Denial Rates	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
2021	5.0%	5.8%	3.2%	6.4%	4.8%	6.3%	6.3%	6.2%	6.0%	5.4%	6.0%	5.3%	5.5%
2022	3.5%	4.3%	4.2%	4.2%	5.1%	3.9%	3.8%	4.4%	4.1%	2.6%	3.8%	4.9%	4.1%

Figure #10b Comparisons of 2021 and 2022 Outpatient excluding Partial Authorizations Denial Rate

OP Denial Rates excluding Partials	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
2021	4.4%	4.1%	3.2%	5.3%	4.1%	5.3%	5.2%	5.5%	5.2%	3.1%	5.0%	4.4%	4.6%
2022	2.5%	3.0%	3.2%	3.4%	4.5%	3.9%	3.0%	3.1%	3.9%	2.6%	3.2%	3.9%	3.4%

Outpatient Authorization Denial Rate by month is based on number of authorizations by date of service through December 31, 2022, for all Delegates. The 2022 Year to Date (YTD) denial rate was 3.9%, which is a decrease of 1.1 percentage points from 2021 and demonstrates a larger change in denial rate than previously seen in both Inpatient and Outpatient authorization categories. The 2022 Year to Date (YTD) denial rate was 3.4%, which is a decrease of 1.2 % points from 2021 and demonstrates a larger change in denial rate than previous seen in both Outpatient authorization categories.

Figure #10 2022 Authorization Denial Activity by Delegate



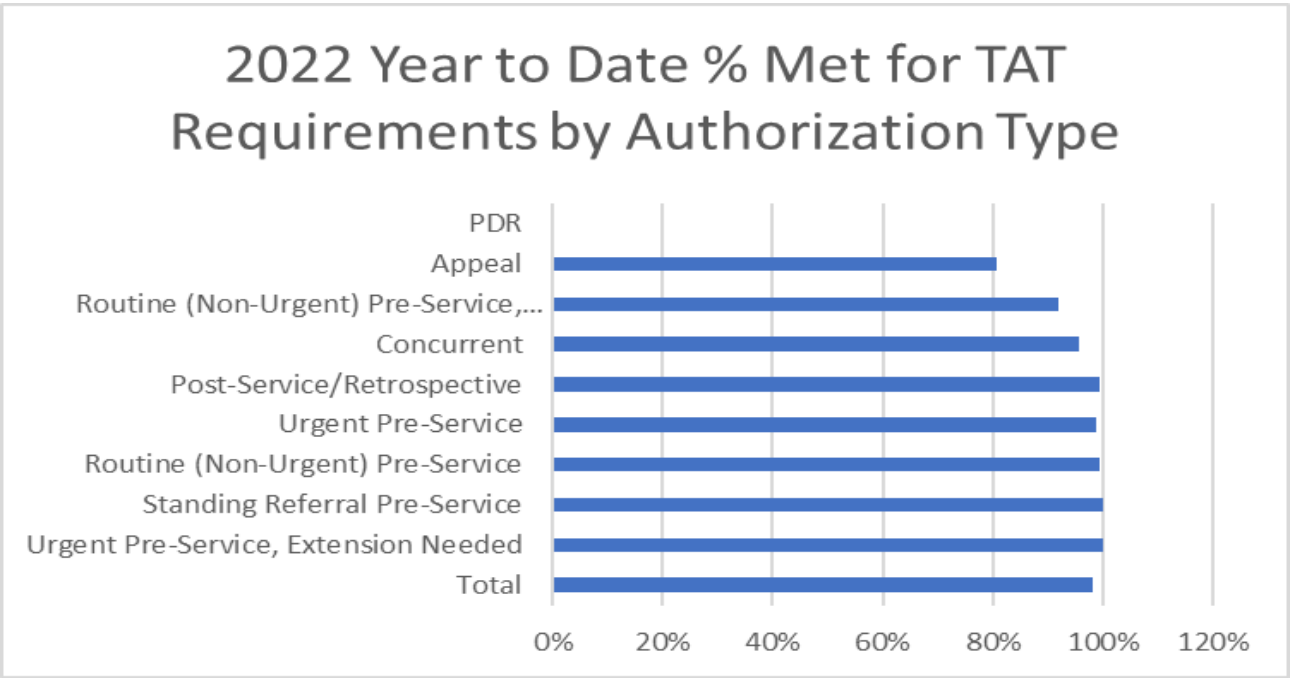
Authorization Denial Activity data by network is based on number of denials per total authorizations received in each Networks; Reporting period is January 1 through December 31, 2022, for all Delegates and all products. Overall denial rates dropped in 2022 by 1.1%. Inpatient denials rates increased overall by 0.7%. Within networks, there was an increase by 1.3% in the AAH network, a 0.4% increase in the CHCN network, and a 0.2% decrease in the CFMG network. Overall outpatient denial rates saw decreases of 1.4%. AAH denials increased by 0.8%, CHCN decreased by 2.1%, and CFMG decreased by 2% compared to 2021. Those outpatient denial rate reductions, however, differ by service types in each network.

Figure #11a 2021 UM Authorization TAT Reports

2022 Performance Referral Management TAT						
	Q1	**Q2**	**Q3**	**Q4**	**YTD**	**Goal**
Overall	98%	98%	98%	98%	**98%**	**95%**
MediCal	98%	98%	98%	98%	**98%**	**95%**
Group	100%	98%	98%	98%	**99%**	**95%**

Referrals are also monitored to ensure that staff process requests within the required timeframes or Turn-Around Times (TAT). The UM Department monitors turn-around time performance and reports it to the HCQA. The performance goal for TAT is 95%. For 2022, TAT performance maintained an overall TAT of 98%, MediCal TAT of 98%, and Group TAT of 99%. All TAT metrics were consistent met throughout the year and has been sustained since 2021.

Figure#11b 2022 TAT Reports by Authorization Type



The percent of all TAT requirements by referral type were measured to the performance threshold of 95%. Overall % Met TAT was almost 98%. TAT for Urgent Pre Service Extension Needed (100%), Standing Referral Pre-Service (100%), Routine Non-Urgent Pre-Service (99%), Urgent Preservice (99%), Retrospective (99%), and Concurrent Review (96%) met this threshold. However, performance thresholds were not met for Routine Non Urgent Authorizations (92%) and Appeals (81%). Focused work was done in the Grievance and Appeals department, with expected improvements. In 2022, threshold language Notification of Action translations became regulatory, and the updated authorization processes incorporated additional time into the production line to ensure that this goal will continue to be met in 2023.

Qualitative Authorization Management Analysis

The overall referral volume managed by the network increased in 2022. The volume of referrals by network provider reflecting the increased volume of overall member enrollment, with increases primarily seen in outpatient

authorizations; AAH UM and CHCN Delegate both saw increases in the outpatient authorization. CFMG continues to have the lowest number of referrals and smallest membership, comprised of primarily children and adolescents.

The 2022 Year to Date (YTD) denial rate of 4.1% is an acceptable rate and lower than 2021. In 2021, a review of custodial SNF authorizations was provided for dual members with the expectation that the MCP would be the payor of last resort when there was unsafe discharge to the next level of care or there were denials with the primary payer. Extensive education was provided on inpatient determinations in circumstances of unsafe discharge to the next level of care which is consistent with APL 17-017. Through these efforts AAH UM and Delegates aligned decision making and health plan responsibility for members for medically necessary care. Attention will continue with AAH and Delegates UM departments around CRE/ MDRO PQI and preventable readmissions identification that may impact hospital stay and discharge planning, appropriate goals of care discussions for palliative/ hospice eligible members, timely discharge planning between health plan with Transitions of Care for high-risk members and collaboration with Facility partners and expanded searches for difficult placement. UM will continue to analyze denial and approval type trends to ensure the appropriateness of decision making for regulation and medical necessity guidelines and maintain UM standardization. Following regular monitoring activities and data trending, any decision-making opportunities will be followed by UM education and staff feedback as needed. AAH also recognizes that validation is needed for outpatient service type categories to ensure data integration between health plan and Delegates databases reflects accurate utilization.

Overall authorization Turnaround Time for 2021 for Medi-Cal (98%) and Group Care (99%) both met the established goal. Attention will be placed on individual staff fall outs if there is a trend to direct education and support alignment with department goals. Continued monitoring will continue in 2023. Analytics report will evaluate for differences in TAT for inpatient notifications vs TAT for NOAs to ensure adequate goal capture. Analytics methodology will be refined in 2023.

Quality Assurance checks to ensure appropriate NOA templates, required elements of accurate medical necessity guidelines and health literacy translation will continue as a focus for the AAH UM delegation. Regulatory requirements for threshold language translations may have an impact on authorization TAT, but ongoing process improvement efforts will mitigate this potential. All networks continue to address APL releases and open CAPs. Close monitoring of UM processes for PAs enables the department leadership to ensure that TATs are met.

While the volume of referrals is reported in terms of product, ancillary network and determination, there is an additional opportunity to assess types of services by urgency type, service type trends, and rendering providers. This will assist with over and underutilization management, identifying opportunities for de-escalation, directing provider education for covered benefits, exploring auto approval opportunities, and network expansion needs. In 2023, provider education outreach will be directed at Rehabilitation Services, Home Health, Tertiary-Quaternary level of care, Post Service Requests up to 90 days from dates of service, Imaging de-escalation for Urgency requests not meeting urgent medical necessity criteria and evaluating whether elective surgery ambulatory exceptions are met. The auto-authorization list undergoes review to analyze opportunities when requests can be safely and appropriately automatically authorized, thus improving throughput for members' care. This will also assist in validating an appropriate staffing ratio for the department. Lastly, efforts will be explored for standardizing documentation of nursing clinical reviews and medical decision making by Medical Directors for clear medical necessity screening and decision-making communication, standardize workflows, and to improve UM throughput.

Tracking of Unused Authorizations

The Alliance monitors the use of authorizations to ensure Members are accessing approved services and to identify potential specialty access concerns. An unused authorization report is run mid-cycle during the authorization period. A letter is sent out to members to remind them to use their approved authorization. Since the unused authorizations are

based on claims sent in, there is a lag in knowing whether a given authorization was actually used or not. Unused Authorization data is reviewed in UMC. The most commonly unused service types were in Cardiology, Oncology, Urology and GI. Members with diabetes continue to represent between 20-30% of the unused podiatry authorizations. UMC recommendations were made to engage these members in complex case management and highlighted for Population Health Management review. Further discussion with PHM and CM will identify high risk populations that could benefit from TCS and CCM in 2023.

Tracking of Specialty Care Authorizations

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

Qualitative Specialty Care Authorization Analysis

In reviewing the tracking outcomes for Specialty Referrals, the Palliative Care benefit demonstrated increased utilization in 2022 but remains underutilized. In 2020, the Alliance began an engagement with a network partner, AHS, to enhance

and extend the use of this benefit by seriously ill members, and this will continue through the newly launched Transitions of Care, Long Term Care, and Enhanced Care Management programs. In Dec 2022 the Alliance increased eligible conditions to include advanced dementia and Alzheimer's disease in the Palliative referral form. Exploring expanded Palliative network access is a focus in 2023. Approved Podiatry visits decreased from 2022 and the highest podiatry denial trends are with AAH and CHCN, mostly for OON requests. This may reflect underutilization and will require further monitoring. MOT services represent a new carve-in benefit since Jan 2022, and the data demonstrates stable approved authorizations. Efforts in 2023 will align AAH delegation responsibilities for MOT. Acupuncture and chiropractic approvals have decreased in 2022 and continue to align with the DHCS guidelines, including chiropractic exception guidelines, and the management of chronic pain members. Approved OON authorization is relatively stable in 2022, but higher OON utilization continues with CFMG for DME/ Orthotics and CHCN Delegates for radiology, specialty services and DME. Efforts in 2022 focused on Delegate network validation to adjust for network differences and correct reporting errors, while also contacting OON providers and DME vendors with higher utilization to invite them to join the MCP's provider network. Additionally, Prior Authorization Delegation UM responsibility alignment discussions will occur in early 2023. Infusion contracts are underway to reduce OON infusion utilization.

Recommendations/Next Steps for 2023:

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

TRANSPORTATION

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

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

Benefits are administered based on the program guidance. The Alliance does not delegate UM decision making to the Modivcare. All UM determinations related to transportation for non-full risk provider groups is managed by the Alliance UM Department. Planning began in 2022 to move the oversight of the Transportation benefit to the CM department to align it with the use of transportation benefits for members for access to care.

Currently, the Alliance maintains four types of transportation:

- Emergency – all products, no authorization required.
- Non-Emergency Medical Transportation (NEMT) -
  Medi-Cal, authorization required,
- Non-Medical Transportation (NMT) – Medi-Cal/ESPDT services, no authorization required.

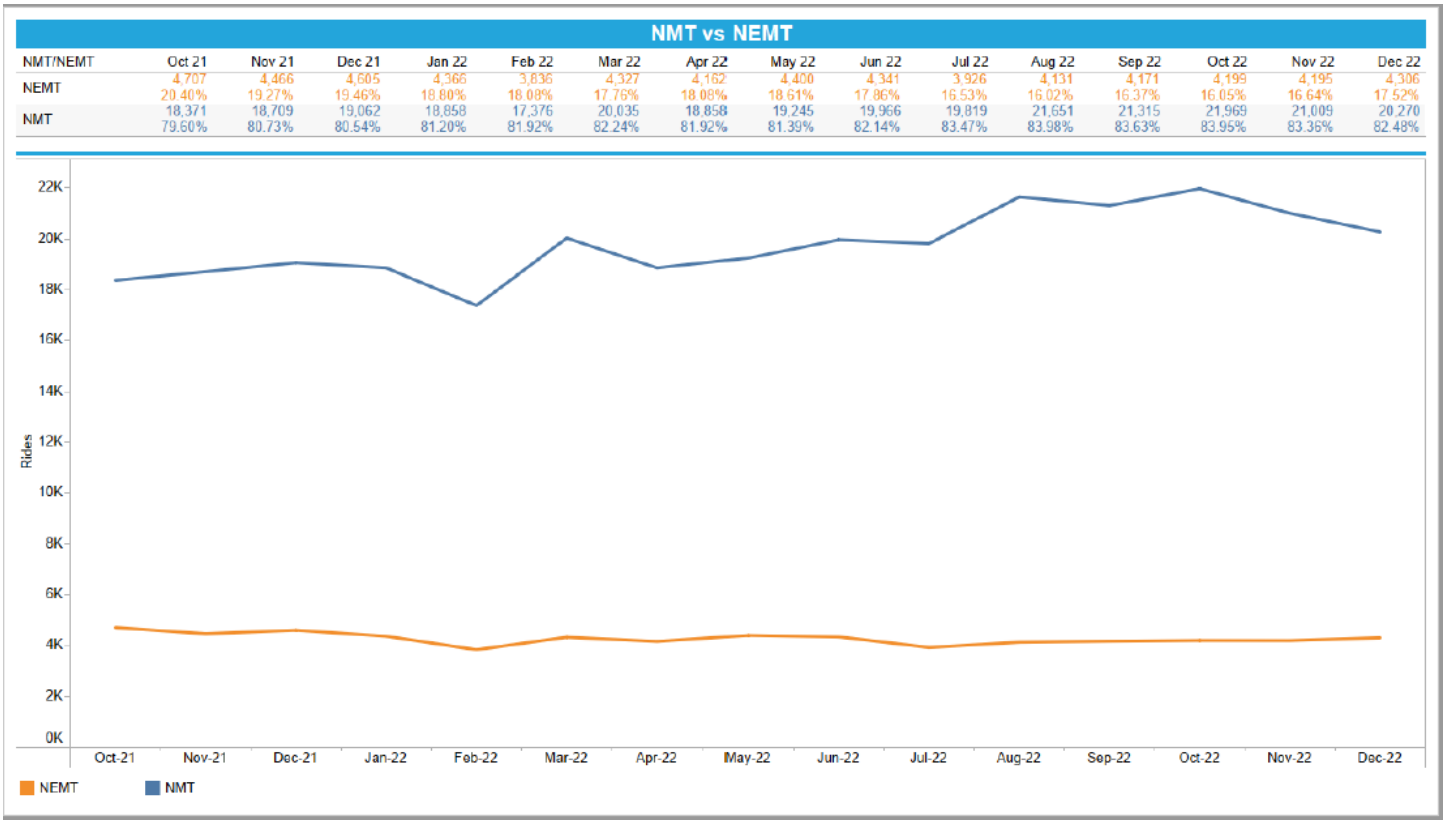
The Med-Cal benefit includes NMT services deemed to be necessary for members to obtain medically necessary services when other transportation resources have been reasonably exhausted.

The Medi-Cal benefit includes NEMT services deemed to be necessary for members to obtain medically necessary services and when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services.

TRANSPORTATION UTILIZATION QUANTITATIVE ANALYSIS

Figure#12 – 2022 Transportation Utilization

	Description		1st QTR Total	1st QTR Average	% of Total	2nd QTR Total	2nd QTR Average	% of Total	3rd QTR Total	3rd QTR Average	% of Total	4th QTR Total	4th QTR Average	% of Total	YTD	YTD Totals
Members	Members Served	Number of unique members utilizing transportation		1,897			1,947			1,980			2,017		1,960	1,960
	Enrollment	Total number of eligible members		304,335			311,543			317,146			324,250			
Advance Notice	Same Day Trips	Trips scheduled with less than 24 hr notice	1393	464	2.7%	1386	462	2.5%	1247	416	2.2%	1042	347	1.8%	2.3%	5,068
	Standing Orders	Standing Order Trips	31723	10574	61.5%	34130	11377	61.5%	34378	11459	60.0%	33725	11242	58.8%	60.4%	133,956
Utilizatio	Utilization Rate	Transportation utilization rate (completed trips/total enrollment)		5.7%			5.9%			6.0%			5.9%		5.88%	
Call Center	Calls Received	Measures number of Reservations calls received	8,369	2,790		8,383	2,794		8,191	2,730		7,964	2,655		2,742	32,907
	Average Hold Time	Average hold time should be less than 3 min for 90% of calls		0:00:43			0:00:31			0:00:37			0:00:38		00:37	
Qual	Service Level	Goal: 80% of calls answered within 30 seconds		88.9%			87.4%			85.2%			79.5%		85.3%	
	Complaint Percentage	Total complaint percentage based on gross reservations		0.27%			0.31%			0.25%			0.18%		0.3%	
Timeliness	On Time Performance*	Goal: 90% on time for all legs		72.3%			71.4%			74.7%			79.7%		74.5%	
	Will Call On Time	Goal: 90% on time for Will Call Legs		92.5%			90.7%			89.2%			94.3%		91.7%	



In 2022, the Alliance continued to ensure the provision of the transportation benefits, using ModivCare as the provider. The increase in AAH membership in 2022 is reflected in the increased overall use of the transportation benefit, with the rate of utilization hovering at nearly 6.0% of AAH membership. ModivCare quality outcomes show that they are meeting the performance metrics for request response times and have a low rate of complaints. Complaints are monitored through the G&A process and reported at UMC for review and action as needed. The on time performance rate for 2022 hovered around 75%, below the goal of 90%, reflecting an opportunity for improvement.

The amount of Ambulatory transport has a sustained increase since 2019, reflecting the increased use of the NMT benefit. However, the Covid 19 pandemic affected the use of the NEMT benefit starting in March of 2020 due to social distancing but have been normalizing into 2022. The majority of NMT trips are for Dialysis, which is an ongoing need, even during a pandemic. Work continued over the course of 2022 to ensure that members who needed transportation after leaving hospitals had timely responses, and improvement was made during the year. AAH also worked with Modivcare to enact all the regulatory requirements of APL 22-008.

AAH worked with Modivcare on the DHCS finding of not having PCS forms completed before taking NEMT trips throughout 2022. This work included changes in tracking of PCS forms by AAH, site visits to Modivcare call centers to evaluate their processes, and an additional audit of their processes in addition to the annual audit. The decision was made to take the responsibility for obtaining PCS forms back into AAH directly, as well as transitioning the transportation benefit to AAH's Case Management (CM) Department. As a member facing department with routine contact with members, the CM team is in a good position to ensure that members are receiving their transportation services timely and appropriately through direct contact with members. Planning for these changes began in Q4 2022 and included creating Transportation Coordinator roles and workflows.

Recommendations/Next Steps for 2023:
The Alliance UM Department will ensure a seamless transition of the transportation benefit oversight into the Alliance's CM Department. The CM Department will continue to monitor the provision of the transportation benefit using criteria to allow appropriate members in need of emergency, NMT, and NEMT transportation, access to the transportation benefits and ensure timely responses to requests. Hiring for the new role of Transportation Coordinator will be in Q1 2023. AAH will continue to ensure that vulnerable members receive transportation services to care.
The Alliance's CM Department will work with ModivCare to formulate strategies to address the on time performance rate and to ensure special attention is paid to the dialysis population. The CM department will also pilot a ride share program with Lyft for salvage-only rides in 2023 to evaluate the feasibility of an ongoing Lyft option for members.
The transition to AAH insourcing PCS form acquisition is anticipated to be completed at the beginning of Q2 of 2023.

Monitoring of Over/Under Utilization

Assessment of Over/Under Utilization is a collaborative report with the Quality Management and Utilization Management Department.

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

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

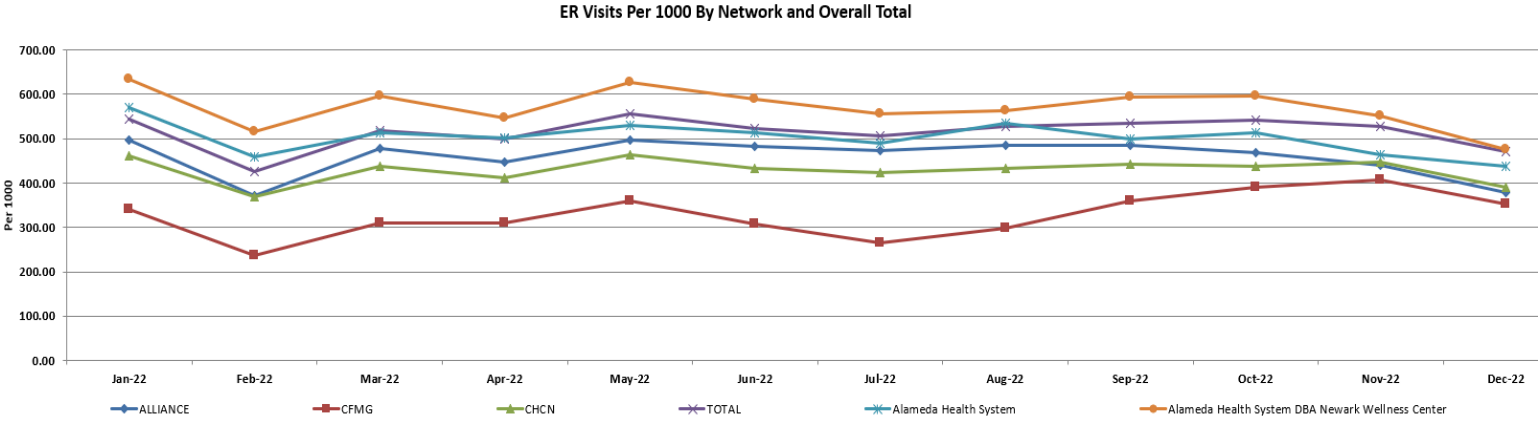
The UM Department has established monitoring activities to include:

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

Acute Hospitalization

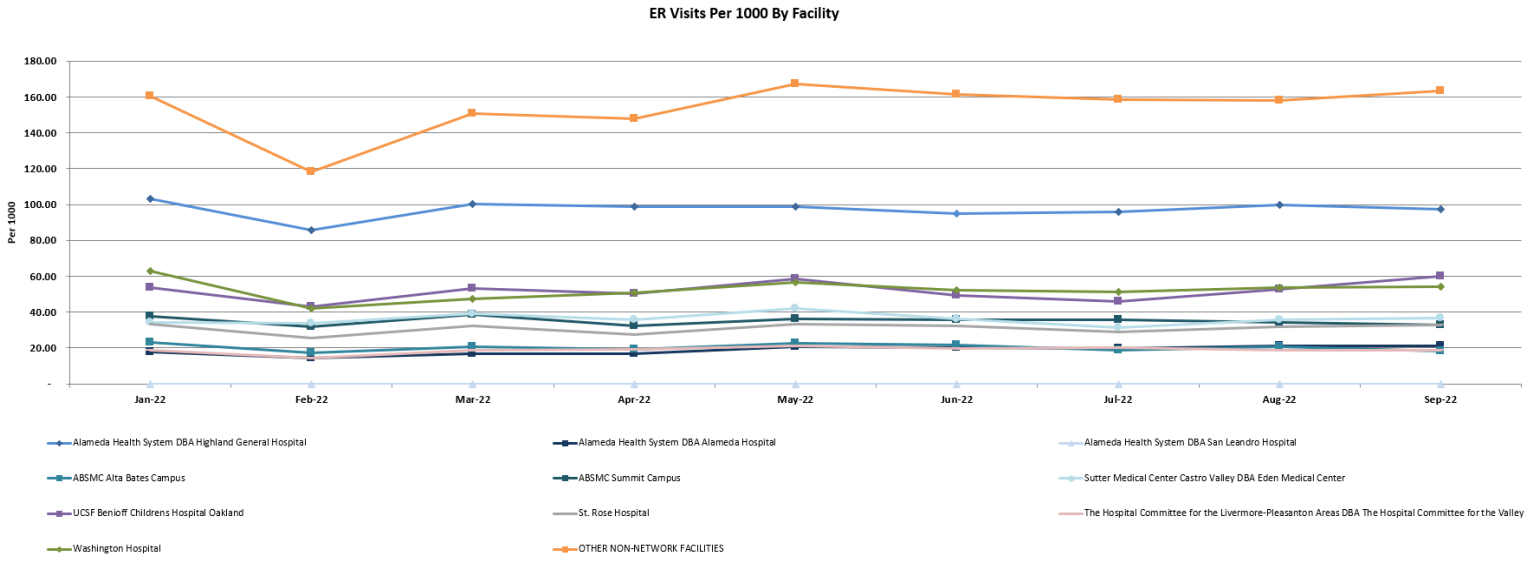
Emergency Room

Figure #13 depicts ER utilization by Networks from January to December 2022.



The claims data in Figure 13 show ER utilization across networks. ER rates and volumes have been relatively stable across all networks, with an overall downtrend from October through December 2022 for all networks, except with the CFMG network which has remained unchanged.

Figure 14 depicts ER Utilization by Facility for 2022



The claims data in Figure 14 show ER utilization across ER facilities/hospitals across time, with increases from OON facilities, UCSF Benioff Children's Hospital Oakland, and Alameda Hospital. Decrease ER volumes were seen with Highland Hospital, Washington Hospital, Sutter Summit Campus, and Sutter Alta Bates Campus. Unchanged ER volumes were seen at Eden Medical Center, St Rose Hospital, Valley Hospital, and San Leandro Hospital.

ER UTILIZATION ANALYSIS

ER utilization has not recovered to pre-pandemic levels in 2019 which likely reflects higher telehealth utilization rates in primary care and specialty care. 2020 was the only year that Highland Hospital exceeded out of network utilization. Throughout the year of 2022 ER utilization remained stable with several facilities even decreasing utilization by the end of the year during flu/ RSV season with trifecta with an omicron surge. On The trifecta explains the higher utilization of pediatric ER utilization at UCSF Benioff Children's Hospital Oakland and OON ER facilities.

In reviewing ER visits by facilities, the top three centers for ER visits are 1) OON ERs, (OON Kaiser facilities) 2) Highland Hospital which is a Tier 1 trauma center for Alameda County (Alameda Health Systems), and 3) Washington Hospital which is the only major facility in the southern part of the county. Drivers for most OON hospital volume stems from admissions through ED.

Among OON facilities, the highest OON ED to hospitalization occurs at Kaiser Richmond, Kaiser San Leandro, and Kaiser Hayward facilities. Explanations for OON Kaiser ED utilization leading to OON hospitalization in Richmond are explained by the geographic hospital desert in the northern part of Alameda County, following the closure of the Doctors Medical Center in Richmond (2015). The Alliance is considering exploring why members use OON ER utilization to understand member selection reasons and evaluate access to primary care access for urgent medical problems. Stanford hospitalization increased in 2022 in the areas of elective hospitalizations, due to a rise in Oncology and Major Organ Transplants services, which are now in-network carveout services lines.

Hospitalization Measures

Concurrent/continued stay review for acute hospitalization focuses on:

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

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

- Identifying a member's medical/psycho-social issues with potential need for post-hospital intervention
- Communicating to the attending physician, specialists, and member regarding covered benefits for services needed post-discharge or upon transfer to a lower level of care.
- Assisting with locating appropriate placement for members with complex medical or psychosocial barriers to discharge.
- Referral to the Case Management department for coordination of care needs and Transitions of Care for the members.
    - Identification of any Transitions of Care needs related to Discharge Planning and next level of care needs
    - Identification of any Disease Management condition prioritized by the Case Management Department
    - Identification of Community Resources or Enhanced Care Management needs
    - Identification of Community Support needs
    - Assessment for Readmission risk and facilitating referrals and/or support to mitigate

Quantitative INPATIENT ADMISSION Analysis

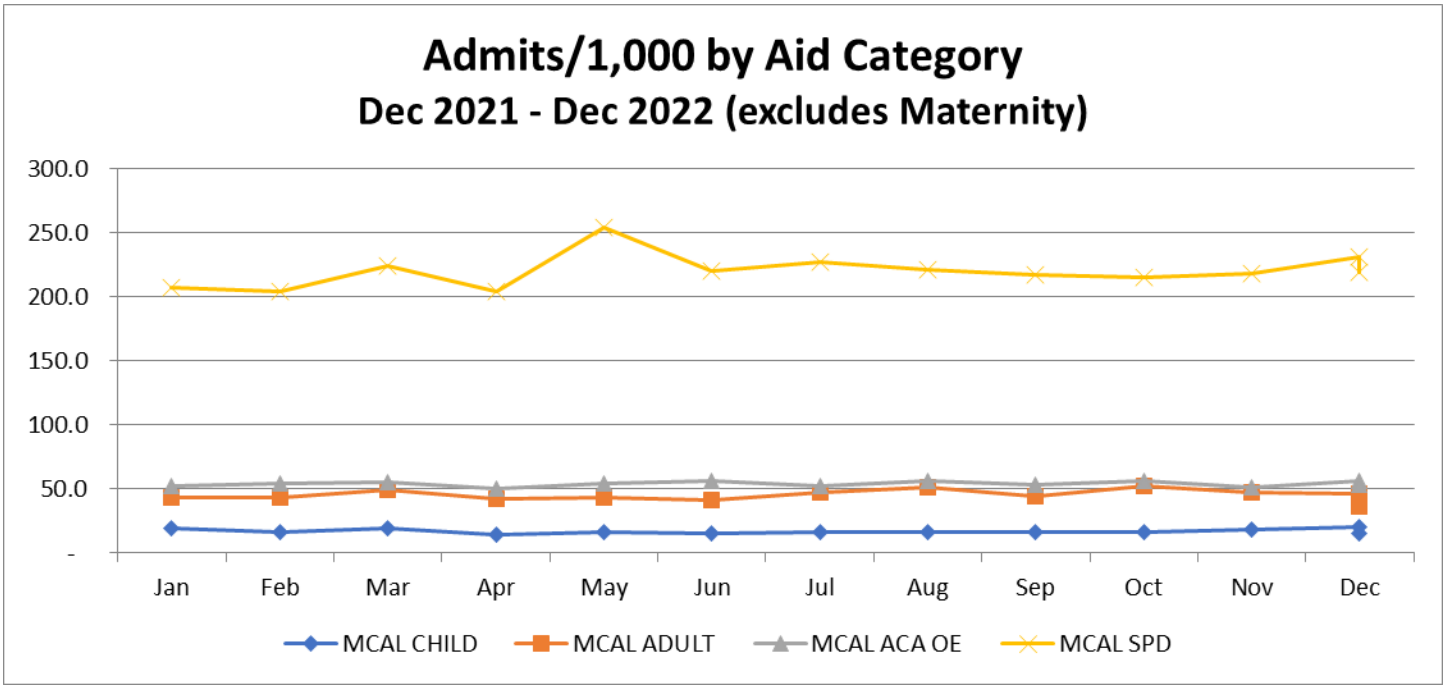
The Alliance has established benchmarks for inpatient admissions:

Figure #15 2022 **Hospitalization Targets**

Inpatient Barometer All Products	
Metric	Target
Average Length of Stay (ALOS)	5.2
Admits/1000	56
Bed Days/1000	300

In 2023 focused attention will focus on reducing LOS due to progression of care delays, active management of medically necessary hospital stays, timely discharge planning, and wider placement searches for difficulty discharge barriers (i.e., bariatric members, ventilation and hemodialysis needs, timely goals of care discussions, & close monitoring for carbapenem-resistant Enterobacterales and multidrug-resistant organism infections).

Figure #16 2022 **Hospitalization Admits per Thousand by Aid Category.**



The claims data above represents the 2022 performance for all lines of business in inpatient management by admits per thousand. Medi-Cal SPDs continue to have the highest admits per 1000 members while all other member aid categories remain significantly less. This is expected because SPD population has more complex medical needs and more frequent utilization. Admits have decreased compared to 2021. Admits have not returned to admit levels occuring before the pandemic despite having a higher membership. By Network, CHCN has replaced the Alliance for the highest volume of admits/ 1000: 39.4, followed by the Alliance 35.8, then CFMG 12.2. The facilities with the highest admits/ 1000 in decreasing order are: AHS Highland 10.7 (-.3), Sutter Summitt 8.1 (-.12), Washington Hospital 6.4 (0.0), Out of Network 6.0 (+0.1), Eden Medical Center 4.8 (-0.6), and San Leandro 3.7 (0.0).

Figure #17 **2022 Hospital bed days per thousand by Aid category**

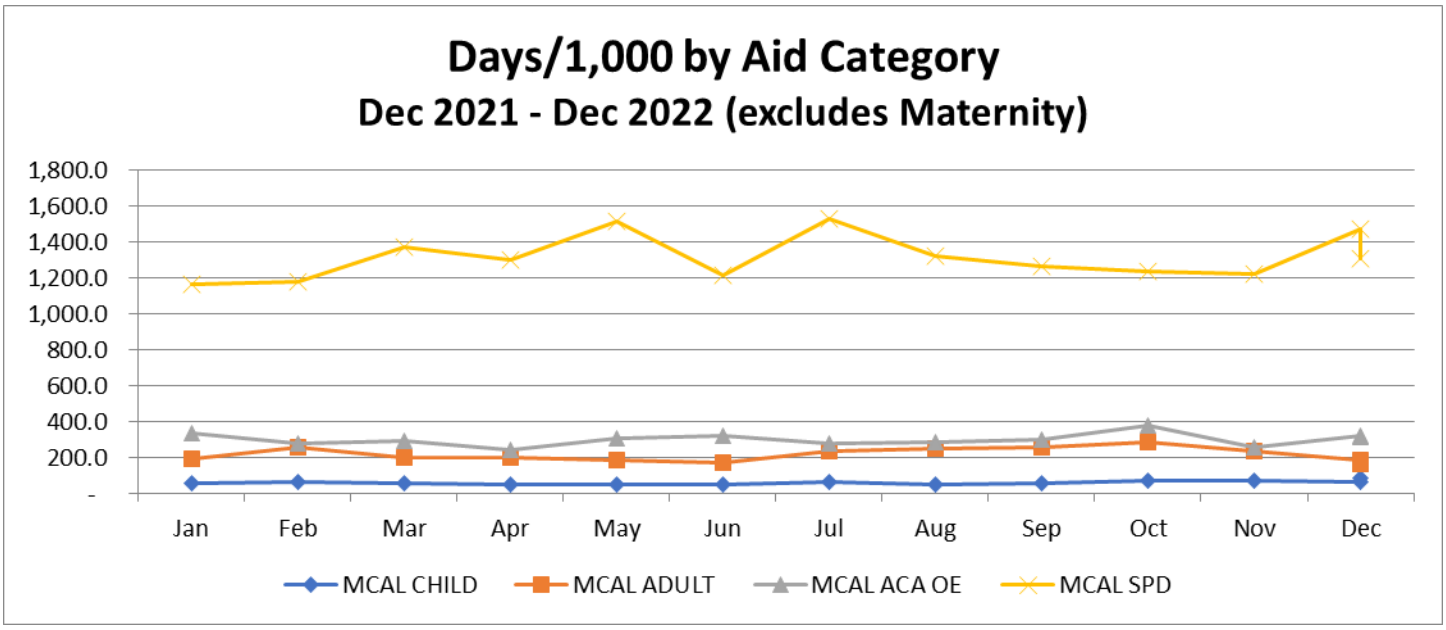


Figure #17 represents the 2022 performance for all lines of business in inpatient management by bed days per thousand. The claims data again shows Medi-Cal SPDs as having the highest bed days per 1000 members while all other member aid categories remain relatively flat, which is consistent with the much higher admssion rates in this aid category. However, the aid cateogry that increased the days/ 1000 were Adults (+37). Aid categories that decreased their days/ 1000 were SPD (-1172), MediCal Expansion (-25), and Child (-9). The only network that saw decreased days/ 1000 in 2022 was CHCN 271.9 days/1000 (-36.4). The Alliance 499 (+34) and CFMG 30.5 (+9.4) networks both saw increases in days/1000. By facility, AHS Highland continues to have the highest days/ 1000 of 61 (+0.4) and additionally saw an increase in hospitals days compared to 2021. Alameda Hospital services as an overflow for Highland Hospital for patients awaiting placement and it similarly saw an increase in admits/ 1000 of 11.2 (1.4+) in 2022. This is important because most other facilities demonstrated a decrease in days/ 1000 following the trend of fewer admits in 2022. Stanford also saw a rise in days/ 1000 with 6.8 (+2.4).

Figure #18 2022 **Hospital average length of stay per thousand by Aid Category.**

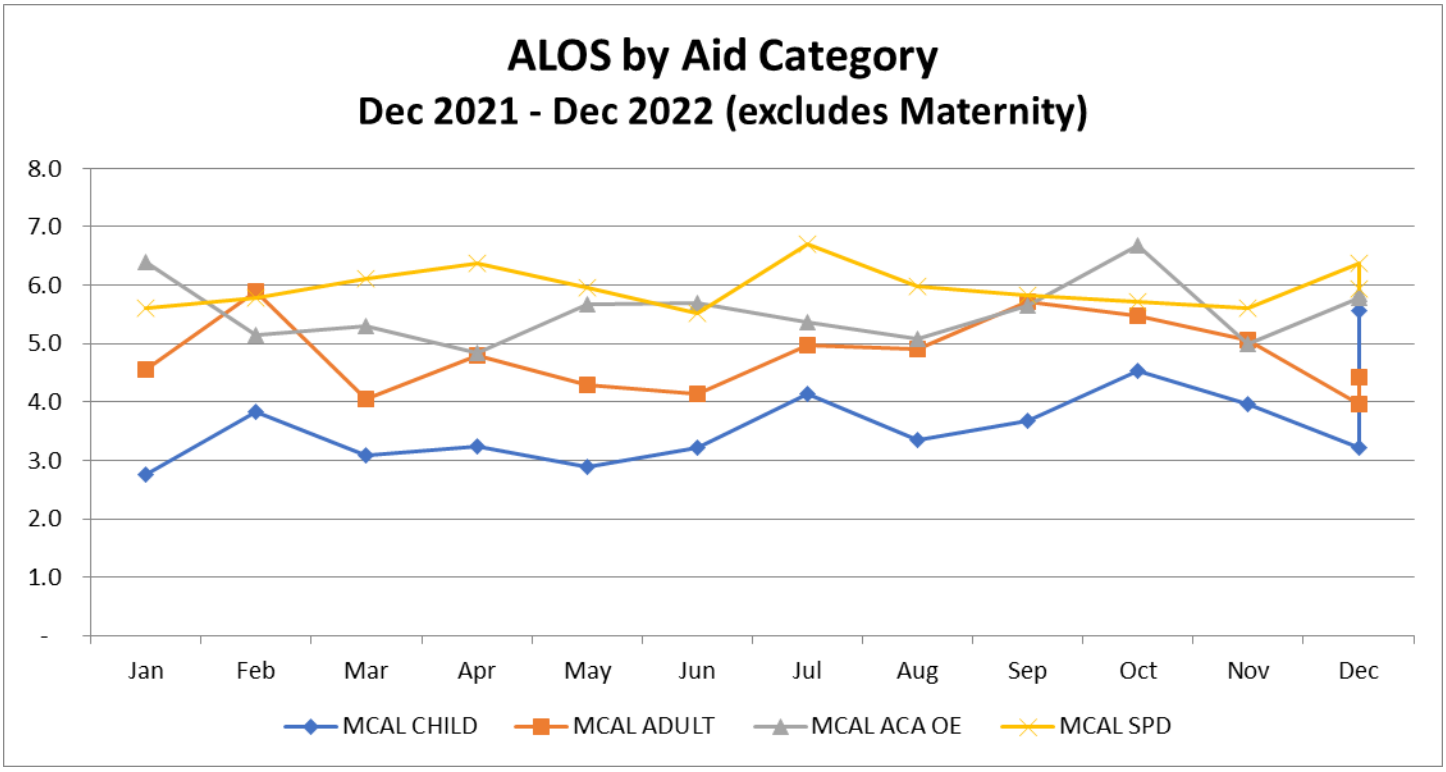
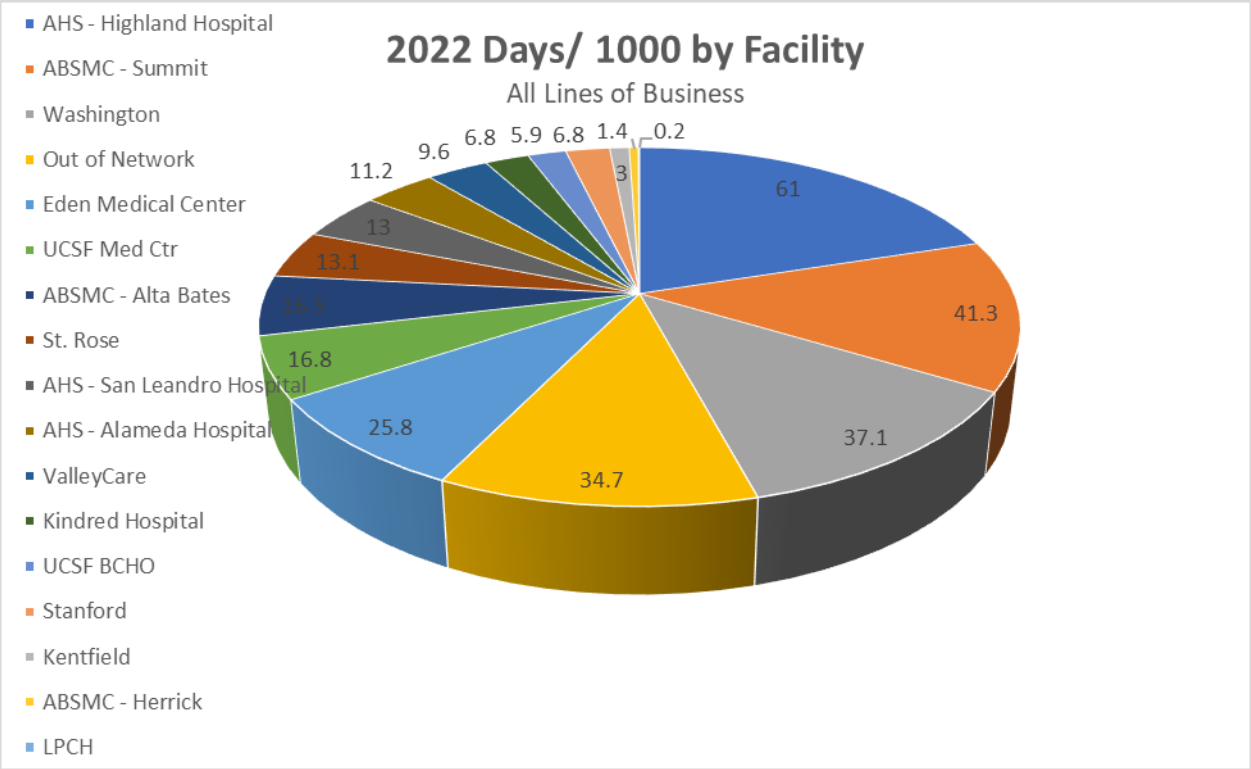


Figure 18 shows considerable variability, but Medi-Cal SPD and Medi-Cal Expansion (MCE) continue to be the longest aide category stays for inpatient hospitalizations, as expected for these medical complex populations. Medi-Cal Expansion LOS increased from 2021. The aid categories that increased in 2022 were MCAL CHILD (+0.8) and Adult (+0.9). Those that decreased in 2022 were MCE (-0.3) and SPD (-0.5). The overall ALOS increase to 5.3 (+0.1)) in 2022 and was affected by difficult placements due to periodic Covid outbreaks and related staffing shortages, CRE/ Multidrug Resistant Organism infections that required isolation in Subacute, LTACH and SNF beds that often could only be found in Southern California and which many family members refused, a limited number of medical respite beds for homeless members, goals of care discussion for palliative/hospice members, bariatric patients that exceeded facility staffing to the next level of care, and psychiatric and dementia related behaviors that next level of care facilities have difficulty managing. Overall administrative days contributed to catastrophic days due to unsafe discharge for these reasons. Additionally, facility to facility transfers were sent to Stanford Hospital for adults because the in network Tertiary Quaternary facility often lacked available beds to stabilize members requiring higher level of care in a timely manner. It is again notable that overall ALOS (5.3) has not returned to pre-pandemic metrics 4.8 (2019).

Figure #19 2022 **Hospital admits per thousand by facility.**



The top hospitals conitinue to see high hospital days/ 1000 compared with the biggest rise seen at Highland Hospital. The emerging hospital with increased days per 1000 is Stanford Hospital which serves as 1 of two Major Organ Transplant Centers of Excellence and has a new Oncology carve out. Between the 2 programs, the Oncology service line is driving the rise in hospital days due to both elective and acute hospitalizations and facility to facility transfers for higher level of oncology care. Additionally, when members need higher level of care at both tertiary and quartenary levels and community acute hospitals may not have available beds for facility to facility transfers for non-oncological conditions.

Qualitative Hospital Utilization Analysis

The Alliance evaluates inpatient utilization per 1000 members and Emergency Room (ER) visits per 1000 members as key utilization performance measures, by network. The Seniors and Persons with Disabilities (SPD) continue to have higher medical complexity and higher utilization. For this unique population, focus remains on engaging them in high-risk Transitions of Care programs, Enhanced Care Management, Complex Care Coordination, and Community Supports to reduce both ER and hospital utilization and assist with appropriate next level of care. They are also at risk of transitioning to Long Term Care over time and LTC data will be key in understanding this transition better. Duals are excluded because the Alliance is the secondary coverage and therefore will not generate UM authorizations for hospital care. Medi-Cal performance is compared to the DHCS rate targets.

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

Data provided to assess admissions by facilities, the top three hospitals are unchanged 1) Highland Hospital, 2) Summit Hospital and 3) Washington Hospital. Fewer ER visits to the top 3 high volume facilities resulted in fewer admits/1000 at Highland Hospital and Summit Hospitals. However, length of stay at these facilities increased which demonstrates opportunities for closer medical necessity monitoring, capture of PQI events, and earlier discharge planning with closer health plan and Delegate oversight. The Alliance has resumed joint weekly rounds with Highland because of the rising

LOS towards the end of 2022 into 2023. Washington hospital saw no change in admits/ 1000 in 2022 despite having fewer ER visits, which suggests that there is higher medical acuity when members in this southern county present to this ER. Washington Hospital also comprises of a higher % of SPD and Dual members which supports the need for focused TCS in 2023.

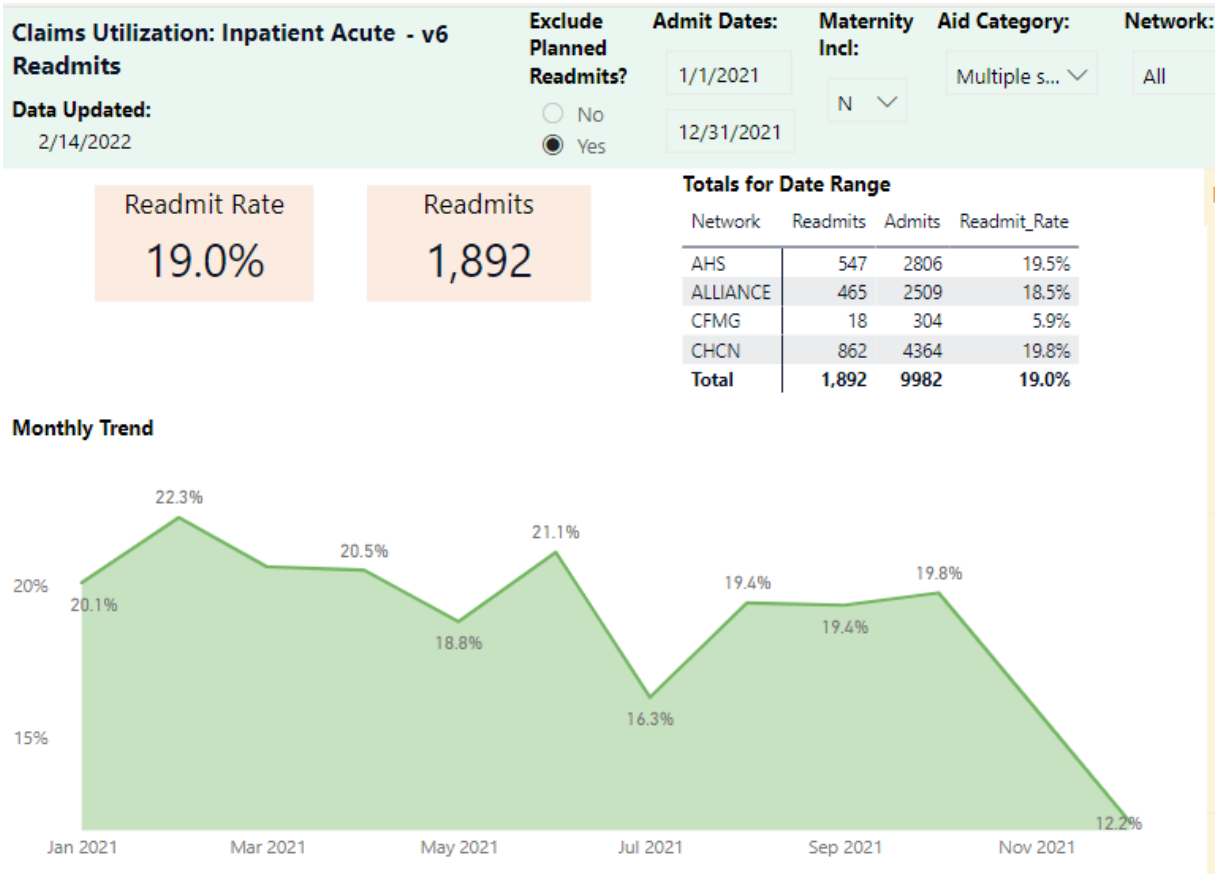
For reducing LOS related to placement challenges, the Alliance contracting department has added LTACH and Subacute facilities to the PAR network to assist with difficult discharge planning, and medical respite beds will be expanding at 1 facility in 2023. Of note, members who were enrolled in Enhanced Care Management program showed decreases in both ED visit volume and ALOS when hospitalized. Additional facilities that will need closer oversight is Alameda Hospital because it serves as an overflow for members awaiting placement to help Highland hospital throughput, so these hospital metrics are tied to one another. Stanford Hospital, which is a Tertiary Quaternary hospital, is also seeing a dramatic rises in days/ 1000 because of the expansion of Major Organ Transplant and Oncology program carveouts, and both service lines tend to offer higher complex care. These Stanford hospital utilization trends are expected to continue as membership grows. Monitoring is key for facility to facility utilization patterns in 2023 including but not limited to sending facility, services needed, and LOS at the respective 2 facilities. Continued staff education and training to nurses and medical directors is planned in 2023, supported by internal audits for UM oversight to monitor and ensure UM workflows are standardized for all UM reviews and during discharge planning to support LOS reduction strategies.

Readmissions

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

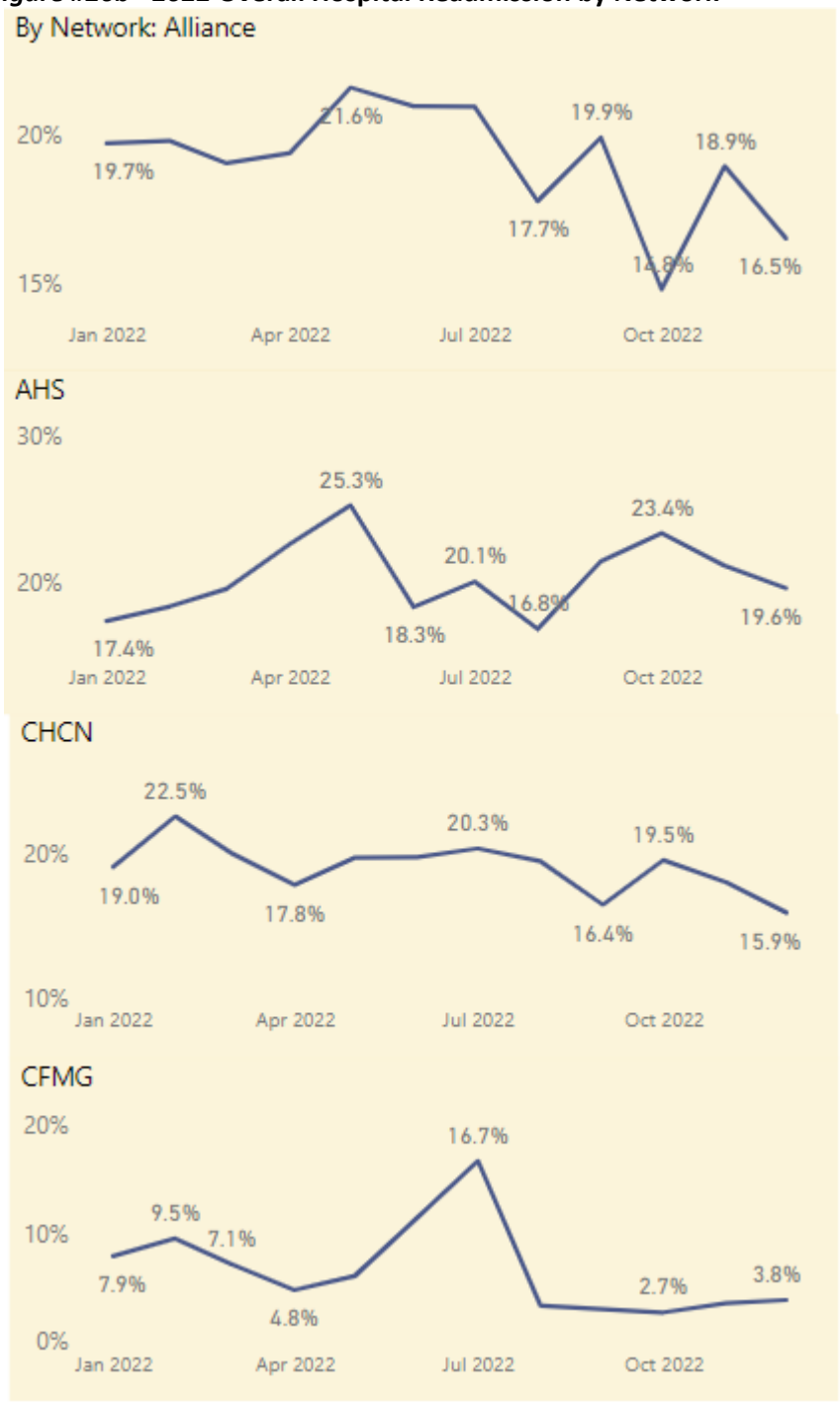
Quantitative Analysis: Readmissions Data in 2022

Figure #20a - 2022 **Overall Hospital Readmission**



Claims data identified in Figure 20 notes the overall readmission rates, and the rates per Network. The overall readmission rate increased to 19.1 from 2021 and continues to lie above the goal of 18%. There has been no significant reduction in overall readmission rates from 2020.

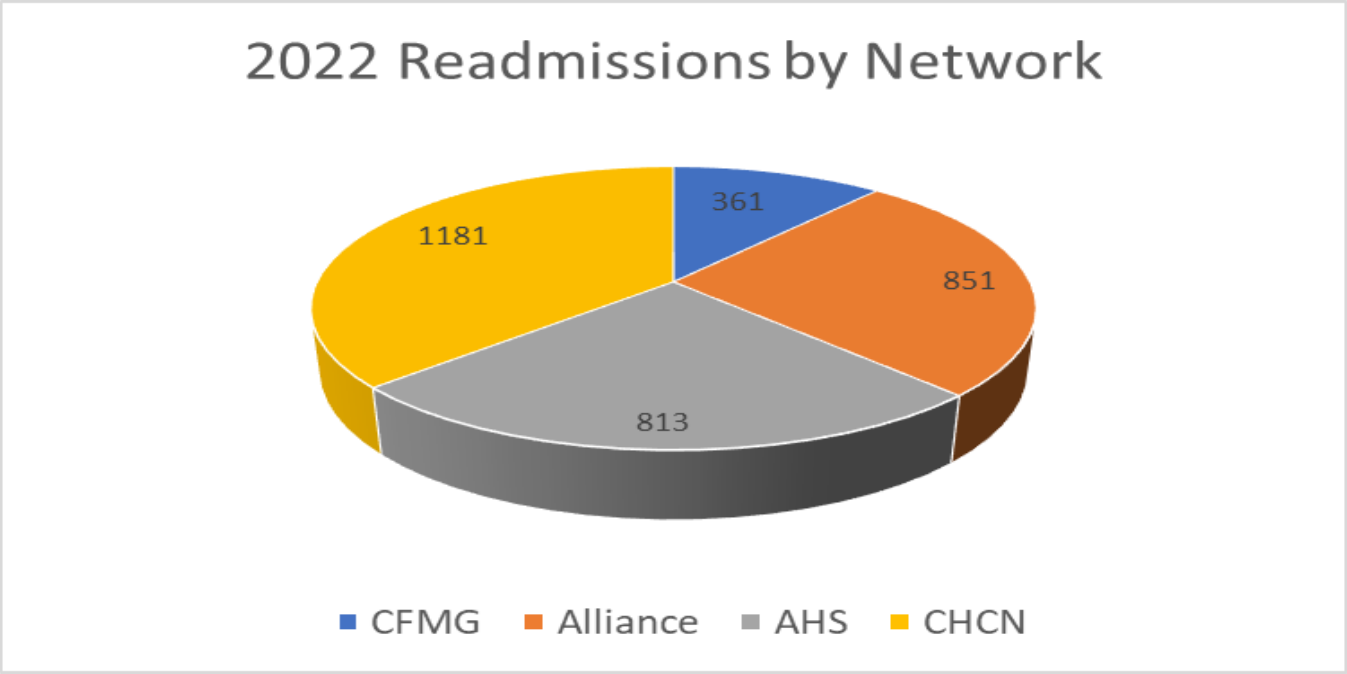
Figure #20b - 2022 **Overall Hospital Readmission by Network**



In 2022 the highest network readmit rate is the AHS network at 20.4% (+0.1). Members assigned to AHS are managed by AAH, and AAH contracts with AHS as an ECM provider. The Alliance network readmit rate is 19.1% (-1.5) and provides CCM/CC and TCS. AAH provides ECM benefits through contracted ECM providers. The CHCN network readmit rates is 19% (-1.9). This Alliance does not delegate CHCN for Complex Case Management, but does delegate UM, basic Case Management (CM) and TCS to CHCN. The CFMG network readmit rate is 5.3% (-

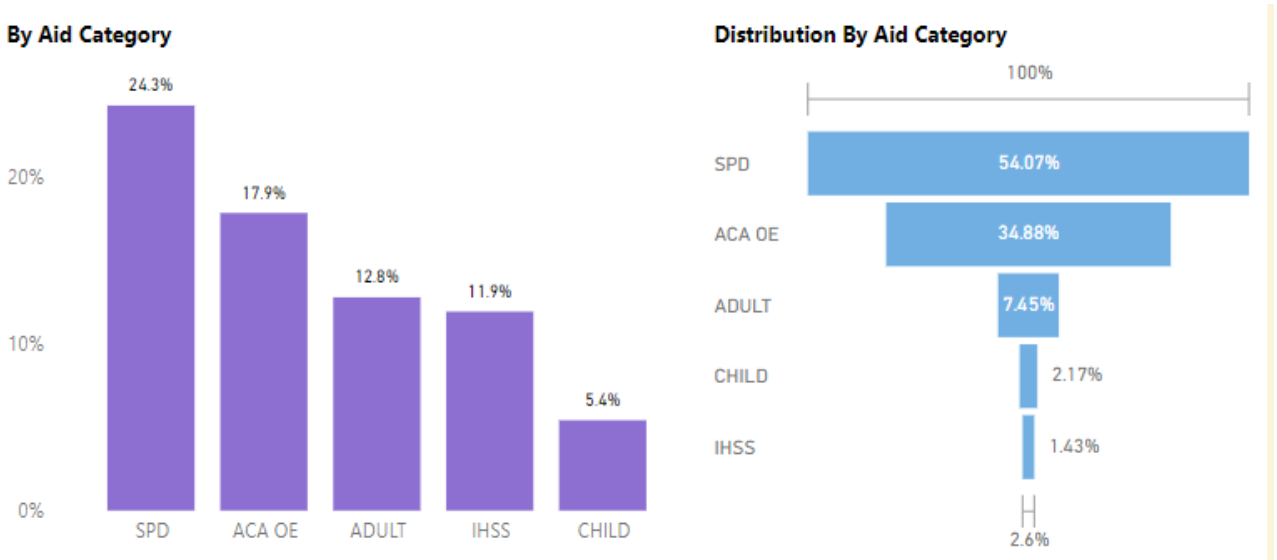
0.6) and is delegated for UM, basic CM, and TCS. All network readmit rates exceed the readmission goal rate of 18%, except the CFMG network.

Figure #20c - 2022 **Overall Hospital Readmission Counts by Network**



Network readmit rates examined alone can skew the impact of readmits on inpatient metrics like LOS, quality metrics like provider preventable conditions and hospital acquired conditions, clinical outcomes, and costs to the health plan. The volume of CHCN readmits is significant at 1181.

Figure #21 2022 **Hospital readmission rates by Aid Category and Distribution of Aid Category**



SPD has the highest readmit rate 24% (-0.2)across the networks, and Duals 18.7% have replaced Medi-Cal Expansion membership 17.9% (0.0) as the 2nd highest readmit rate by aid category in 2022. However, SPD 42% (-12%) and Medical Expansion 30 (-5%) by distribution contribute larger percentages to the health plan readmit rates.

Figure #22 2022 **Readmit Distribution by Aid Category and Hospital by Facility**

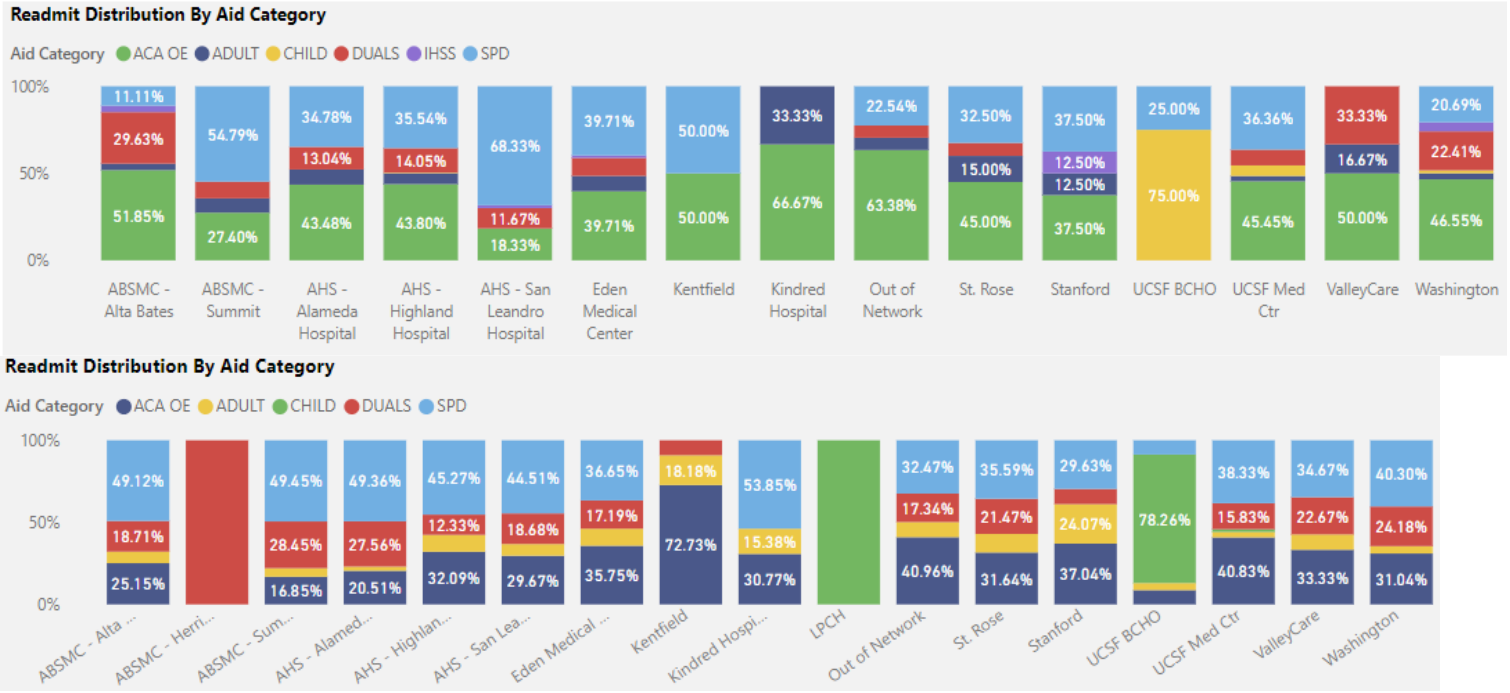


Figure 22 notes readmissions at facility/ hospitals by Aid Category. During a review of all catastrophic cases in 2022, (excluding LTACHs,) Summit (49.12%), the Alta Bates Compus (49.45%), Alameda Hospital (49.36%), and Highland Hospital (45.27%) have a high percentage of SPD members readmitting among all aid categories at their respective hospitals. The high risk TCS APL guidance will provide focused attention to engaging members in readmissions reduction programs through TCS, ECM, Complex CM, and Community Support programs in 2023. High utilizers are comprised of ER and hospital readmissions, outpatient care, outpatient drugs, hemodialysis, Hospice services. Readmissions carry significant impacts to the member, and enrollment in ECM and Complex CM is a long term strategy to meet this goal. Program enrollment in both programs is by member consent, but there may be opporutnities to engage in PCP and Specialist care coordination if the member declines to participate in these important programs. TCS and ECM enrollment can benefit from case management touch before the member discharges, through warm handoffs from the UM Inpatient team and Case Management staff.

Reduction in readmissions is the focus of the Transitions of Care (TOC) program, which became the Transitions of Care (TCS) benefit in 2023. This expanded benefit means that members discharge who were not previously referred to case management after discharge in 2022 (ex., no automatic referrals at Washington Hospital, which has high SPD and Dual admits), will receive this transitions support if high-risk. The volume of TCS will expand to all member discharges in Jan 2024, so the Population Health Management, Case Management, Quality and UM departments will during 2023 maximize TCS engagement strategies for high-risk member to improve workflow process and program reach.

Continuity of Care

Following the requirements to provide Continuity of Care (CoC), Alliance members with pre-existing provider relationships who made a continuity of care request to the Alliance were given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider who agreed to the terms and conditions used by the Alliance, with the exception of elective surgeries/ procedures that allowed up to 180 days under CoC after joining the MCP.

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

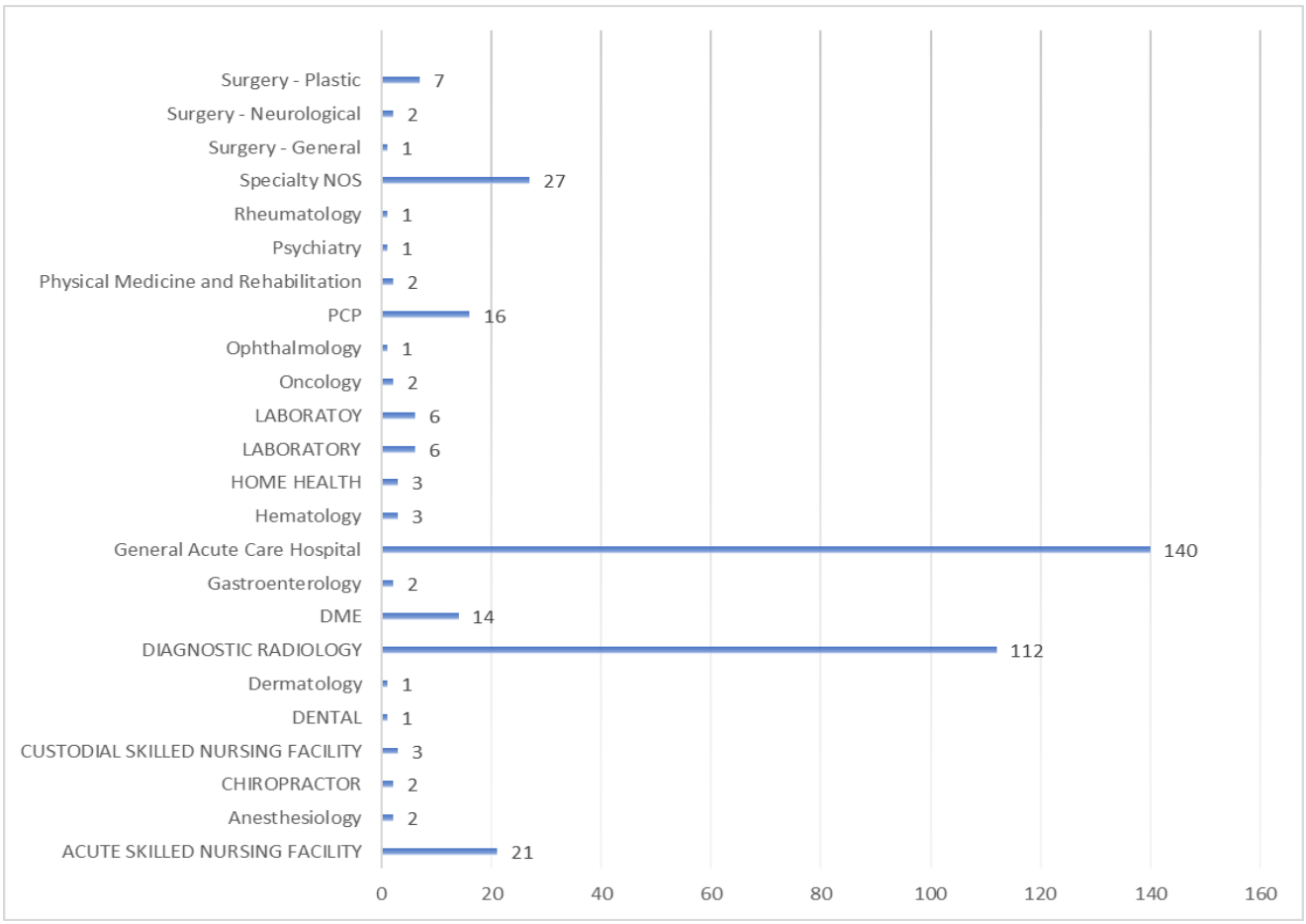
a. The Alliance treats every exemption on the MER report as an automatic CoC request for the identified beneficiary. That included CoC requests for PCP, Specialty Care, or behavioral health. Additionally, special consideration for CoC was applied for medical exception for designated type of problem or condition (i.e., Acute conditions, serious chronic condition, pregnancy, terminal illness, care of a child under 5 years old, previously scheduled surgery/ procedure, or behavioral health services that include acute, serious, or chronic services).
b. Very few denials for CoC requests were seen in 2022.

In December of 2022, DHCS released APL 22-032: Continuity of care for Medi-Cal beneficiaries who newly enroll in Medi-Cal managed care from Medi-Cal fee-for-service, and for Medi-Cal members who transition into a new Medi-Cal managed care health plan on or after January 1, 2023. Planning for policy and process changes to meet the requirements of this APL began in late 2022. AAH expects to meet the 90 day timeline to enact the APL in 2023.

Out of Network Services

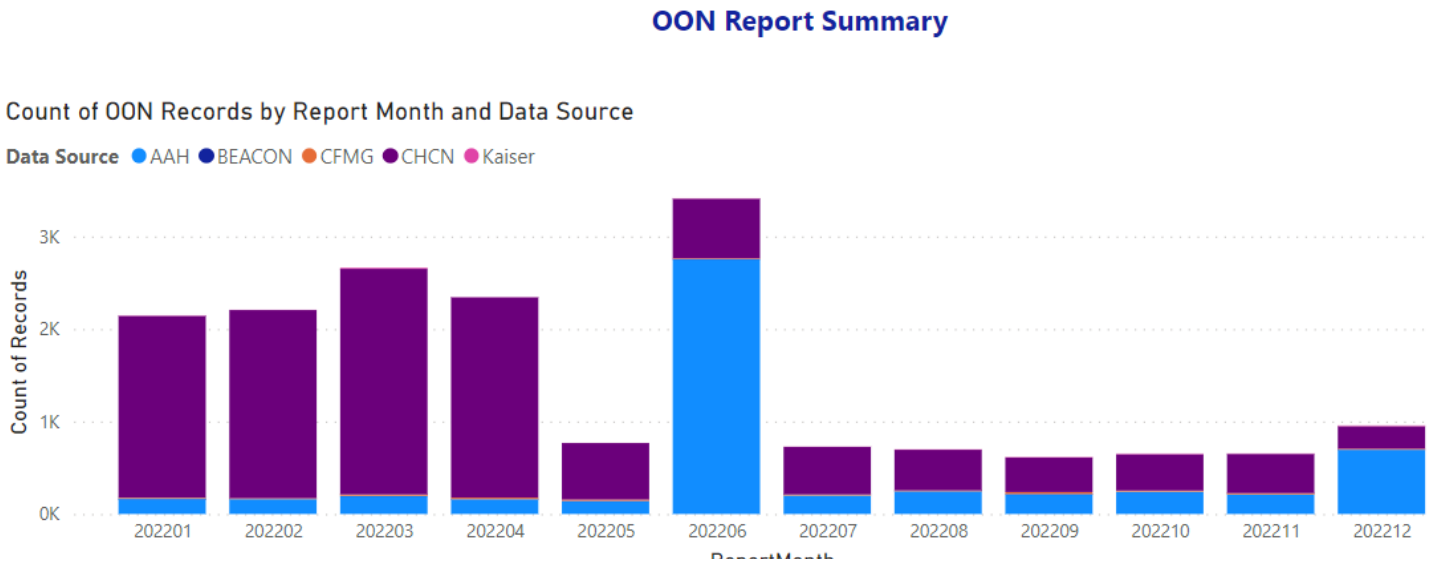
Out of the network (OON) services are defined as any service provided by non-participating practitioners or facilities. Members may access OON services either through an emergency or as a direct referral for specialty services not available within the network, timely access standards not met, continuity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

Figure 24a 2022 OON Report #01592



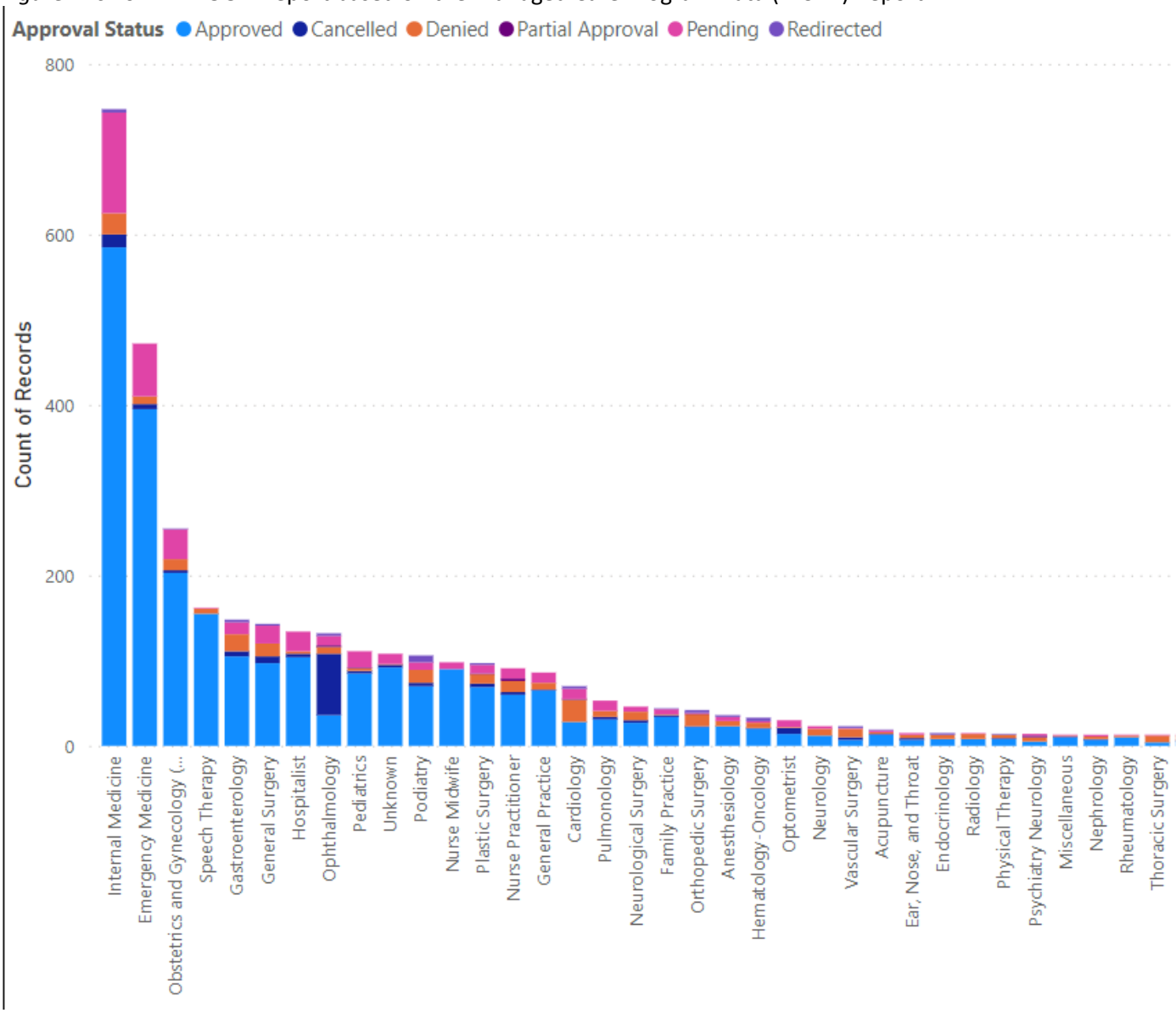
Joint UM, IT and Analytics efforts in 2022 refined the categories classifying OON utilization in Diagnostic Radiology, DME, acute SNFs, and laboratory approved services. Diagnostic radiology, Specialties not otherwise specified (NOS), and short term SNFs make up the next significant OON categories. AAH contracts with 18 acute hospitals in the East Bay, and OON reports show acute hospital stays account for the highest volume OON utilization. Drivers for most OON hospital volume stems from admissions through ED.

Figure 24b 2022 PBI OON Report based on the MCPCD Report



In 2022, the Alliance continued to review OON requests and approvals, and there was focused attention paid to network validation and Delegate data integration for DHCS reporting purposes. Various network validation steps were added for AAH and Delegate contracted networks, and improved data integration with Delegate CHCN databased in collaboration with joint IT and UM departments to address the OON discrepancy trends appearing in late 2021. The dramatic change in CHCN OON reporting starting in 6/2022 reflects improved OON data quality assurance efforts by IT in coordination with Provider Services to reflect the accurate Delegate network.

Figure 24c 2022 PBI OON Report based on the Managed Care Program Data (MCPD) Report



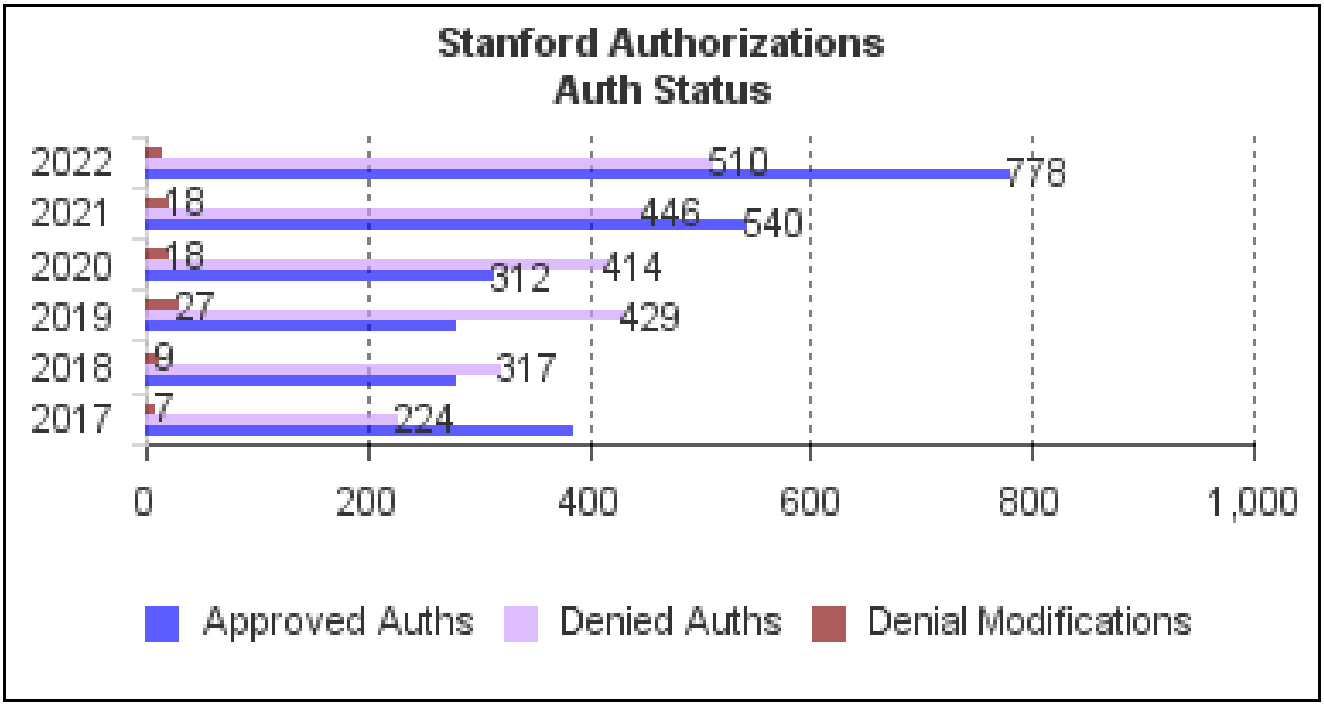
For dedicated OON Specialties, the top categories are Internal Medicine, Obstetrics for CoC perinatal care and high risk pregnancies, Speech Therapy is due to limited contracting providers for adults and children, GI is limited by few providers are willing to contract with MediCal and separately timely access standards are not met, and General Surgery. Steps have already begun for further classification of Specialty NOS categories. Internal medicine and general surgery will be validated further in 2023. Further analysis is planned in 2023 to understand if OON Radiology and laboratory utilization are tied to the PAR Oncology and MOT care at SHC (see Unique OON Changes in the Stanford Health Network below).

The process for denials of OON requests is accompanied by confirmation of the specialty and ancillary requested service within the Alliance network, Continuity of Care, timely access standards, time and distance requirements, Quality issues, Tertiary Quaternary needs, as well as MOT specialty needs and MOT Centers of Excellence. OON approval and denial reasons are measured. OON approval reasons are most often met because timely access is not met, specialty care is not available in network, established CoC, and finally continuity of tertiary/ quaternary care and MOT specialty needs. Network issues are relayed to the PR department. The most common OON denial reason is because there is existing

specialty care available within the network. OON denial determinations are routed to the AAH Case Management Department for assistance with care coordination and redirect assistance back to the PAR network.

OON Changes specific to the Stanford Health Network

Figure 24a 2022 OON UM Stanford Health Care Authorization Determinations



Data in Figure 24a show the Authorizations requests to Stanford Health Care (SHC) for services from Q1 2017 to Q4 2022, measuring the number of referrals to SHC by the authorization determination: approved, denied, or modified. Up until 2020, the authorization requests reflected OON requests because all of SHC was non-PAR. However, a new contracted service for Oncology services was launched in late 2020, with the intent to expand oncology services and access to clinical cancer trials for Alliance members, improved timely access, improved geographic location for the southern part of the county, and to ensure access to high quality specialty care. Secondarily, SHC became a designated Center of Excellence for the CalAIM expansion of Major Organ Transplant carve-in services as of 1/1/2022. As a consequence of these regulatory and contractual changes, approved auths for Stanford in 2021 began to rise, and has continued to increase for non-oncology related specialty referrals. Secondly, the driver for most SHC hospital volume is elective hospital stays. Analysis in 2023 will continue to closely monitor SHC oncology, major organ transplant, non-oncology specialties, as well as elective hospitalizations for these trends. Monitoring will also continue for oncology second opinions.

Pharmacy Utilization

The management and monitoring of Pharmacy utilization and activities is reported through the Pharmacy and Therapeutics Committee and HCQC. A full review of these activities can be found in the P&T Committee minutes. In collaboration with Pharmacy, UM reviewed and updated the UM Prior Authorization for Infusion Drug list under medical benefits and documented the methodology and rationale for these changes. Further work lies with investigating utilization of unclassified drugs and unclassified biologics for drug utilization patterns and appropriate coding.

The Alliance is planning to transfer the UM authorization and management of medical benefited drugs and affiliated supplies over to the Pharmacy department in Q2 2023. The Alliance's Medical Directors will continue to provide Advisor Reviews and final determinations for Pharmacy utilization. Oncology drugs were identified as an opportunity for further pharmacy training around clinical application and medical necessity in 2023.

Over and Under Utilization Recommendations/ Next Steps for 2023:

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

- Enhance UM system reporting to capture required elements for over/under utilization monitoring reports, with continued emphasis on Out of Network Analysis and validating service type categories to ensure accurate measurement among the Alliance and Delegate network, including integrating both databases. Developing standardized Determination reasons across the Alliance and Delegates will help to identify over/ under utilization trends.
- Analyze under and overutilized services to facilitate outreach to Providers to improve access (ex., Palliative Care)

- Emergency Room
  - Improve identification of potential and actual high utilizers of hospital services through Inpatient Risk Screening in coordination with Case Management and Quality departments.
  - Explore timely primary care access for urgent common medical conditions that generate high volume ED visits that do not lead to hospital admits
  - Coordinate with Case Management to identify and reduce high ED utilization for members not engaging with primary care or specialty care for non-emergent problems.
- Quality/ Population Health Management
  - Continue collaboration between AAH and Delegates' UM departments around CRE/ MDRO PQI and preventable readmissions that may impact hospital stay and discharge planning, appropriate goals of care discussions for palliative/ hospice eligible members, timely discharge planning with collaboration with Facility partners, and expanded searches for difficult placement.
  - Following regular monitoring activities and data trending, any decision-making opportunities will be followed by UM education and staff feedback as needed. AAH also recognizes that validation is needed for outpatient service type categories to ensure data integration between health plan and Delegates databases reflects accurate utilization.
- Hospital Utilization
  - Improve identification of potential and actual high utilizers of hospital services through Inpatient Risk Screening
  - Enhance identification of members at risk for readmission which will include frailty scores, frequent admissions medical conditions, aide categories & high-risk SDOH to revise medication reconciliation and develop other targeted interventions to improve outcomes.

  - Refine episodic warm handoffs to Case Management through high-risk Transitional Care Services workflows in 2023, and then expanding to all hospital discharges in 2024. Goals are to improve enrollment in Enhanced Care Management, Complex Care Coordination, and Community Supports
  - Coordinate stronger discharge planning and relationships with high volume admit facilities with prioritization of those with higher or increasing LOS.
- Ambulatory Setting - monitor for care.
  - Specialty Care encounters per thousand
  - Primary/Preventive Care in ambulatory setting with QM interventions, (ex., HEDIS measures,) through the Quality Improvement department.
- For OON:
  - Monitor Stanford Health Care oncology, major organ transplant, non-oncology specialties, ancillary services and elective hospitalizations for new service line and OON Stanford trends.
  - Standardize OON determination reasons to better monitor OON trends for over/ underutilization and emerging network needs.
  - Continue data validation of Alliance and Delegate network data and database integration for DHCS reporting purposes and confirming network needs.
  - Coordinate feedback with Provider Services on dynamic network needs to enhance specialty and ancillary services for members.
  - Continue to explore contracting options for providers who resist conventional contracting.

LONG TERM SERVICES AND SUPPORTS (LTSS)

The Alliance is responsible for ensuring Members who are eligible to receive LTSS services are identified and referred. Since 2020, the UM Department has taken responsibility for Community Based Adult Services (CBAS), to ensure that CBAS eligible members are identified, referred, and assessed appropriately and timely. The UM department Out of Plan RN provides assessment, re-assessments, and re-authorizations of services to the members.

Figure 25 - 2022 CBAS Enrollment by Facility by Delegate

CBAS Enrollment By Facility By Delegate					
Run Date:	1/3/2023				
Number of Members					
Facility Name	**Alliance**	**IHSS**	**CHCN**	**Kaiser**	**Total**
Alzheimer Services of The East Bay	3	0	5	0	8
Family Bridges Inc.	73	0	197	0	270
Golden Castle Adult Day Health Care Center	1	0	0	0	1
Grace Adult Day Healthcare	9	0	0	0	9
Silicon Valley Adult Day Health Care	3	0	2	0	5
Total	89	0	204	0	293

As seen in Figure 25, there were a total of 293 members receiving services through one of the five CBAS centers. The Center with the highest volume is Family Bridges, by a considerable margin. In 2022 CBAS Centers continued to provide remote services and remain in telephonic communication with their members through Temporary Alternative Services, (TAS). APL 22-020, CBAS Emergency Remote Services replaced the (TAS) in October to enact

requirements regarding circumstances in which remote services could be provided to members in CBAS, and AAH enacted processes to ensure that these requirements are met. The Alliance has stayed in close contact with the centers to ensure that the services were provided, to problem solve with the CBAS Centers, and to ensure the continuous support for these vulnerable members.

In 2023, changes in CalAIM will result members in Long Term Care (custodial) SNFs will carve back into the plan, rather than transitioning back into FFS MediCal in the month after admission for a custodial stay. Planning occurred throughout 2022 to ensure that this transition will occur with no care disruption to members coming into the plan. UM worked with all departments with AAH, with the Integrated Planning Department providing structure to the efforts across the plan. The Manager of LTC position was developed and hired, as well as LTC program staff to provide appropriate support to this change. Policies, procedures, and reports were developed in preparation to meet the needs for this population and meet the regulatory requirements.

BEHAVIORAL HEALTH

The Alliance provides access to mental health services for the Medi-Cal and Commercial membership in several ways:

- Basic mental health care needs are provided by Primary Care Providers
- Medi-Cal members with “mild to moderate” impairments in mental, emotional, or behavioral functioning are referred to the contracted behavioral health delegate, Beacon Health Options (Beacon.)
- Medi-Cal members diagnosed with a severe persistent mental health disorders and Substance Use Disorders are carved-out and managed by Alameda County Behavioral Health Care Services Department (ACBHCS).
- Commercial members access mental health/SUD benefits through the contracted BH delegate, Beacon Health Options (Beacon).

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

The UM/Behavioral Health (BH) Departments are also responsible for maintaining the relationship with ACBHCS to ensure eligible Medi-Cal members receive services through the Linked and Carved Out mental health programs. The focus of the activities is to ensure contracted providers continue to identify and refer members with serious persistent mental health/SUD conditions to the appropriate ACBHCS programs, as well as to facilitate coordination activities for co-existing medical and behavioral health disorders to assist with their treatment access and follow-up care.

After the No Wrong Door policy was issued by DHCS in 2022, AAH and ACBHCS began monthly meetings to jointly implement the new requirements that focused on closer coordination of care to ensure members could access appropriate behavioral health services in both systems and ensure appropriate members could receive non-duplicative services from both systems simultaneously. Additionally, AAH and ACBHCS worked to implement the new DHCS required age appropriate screening and care transitions tools scheduled to go into effect January 1, 2023. AAH participated in joint meetings with Beacon and ACBHCS to ensure that implementation of the new screening and care transition tools would be implemented for bi-directional referrals that would occur prior to the insourcing transition scheduled for April 1, 2023.

Throughout 2022, the Alliance contracted with Beacon to administer the applicable Medi-Cal benefits for members with Mild/Moderate behavioral health needs and Commercial (IHSS) mental health benefits. AAH worked collaboratively with Beacon all through 2022 planning for insourcing of the behavioral health benefit management in 2023.

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

Figure #26– 2022 Beacon Health Strategies Agreement

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

Figure #26A 2021 Q3 to 2022 Q4 Beacon Screening and Referrals

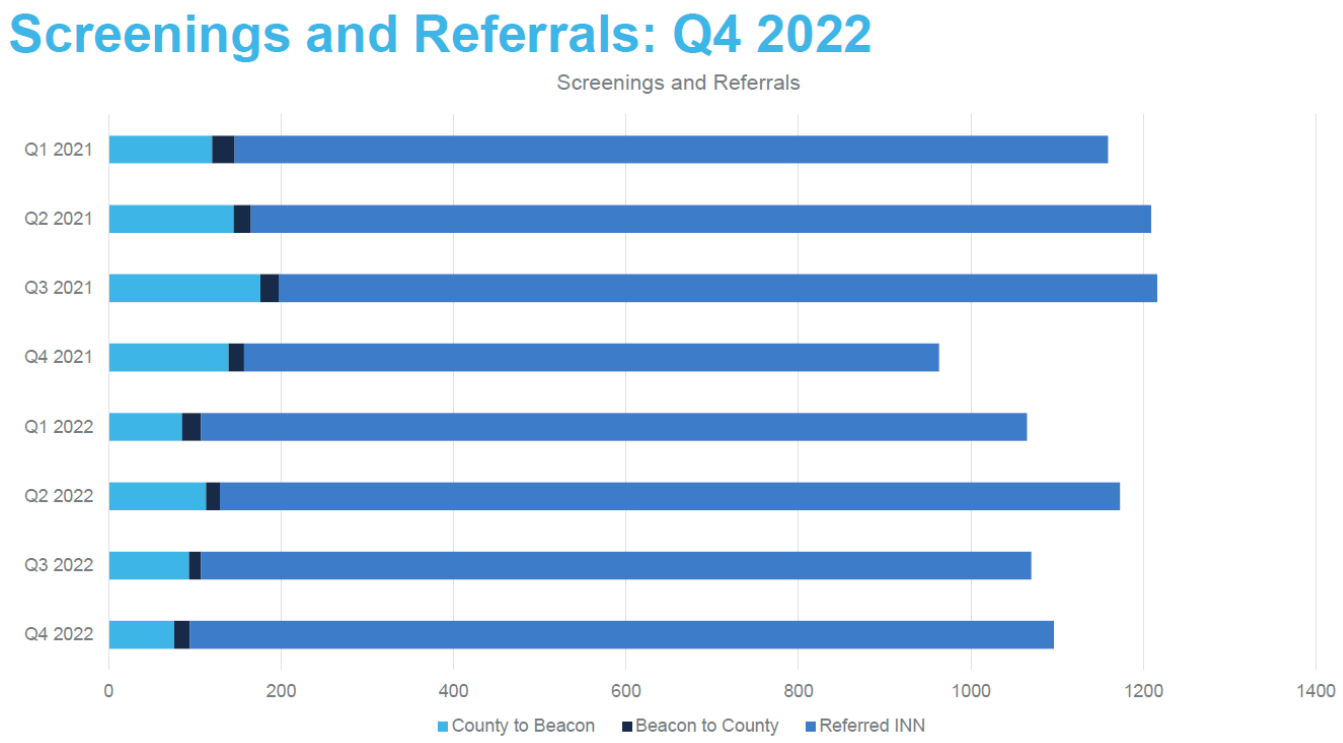


Figure 26b 2021Q2 to 2022Q4 Referrals to Beacon Care Management

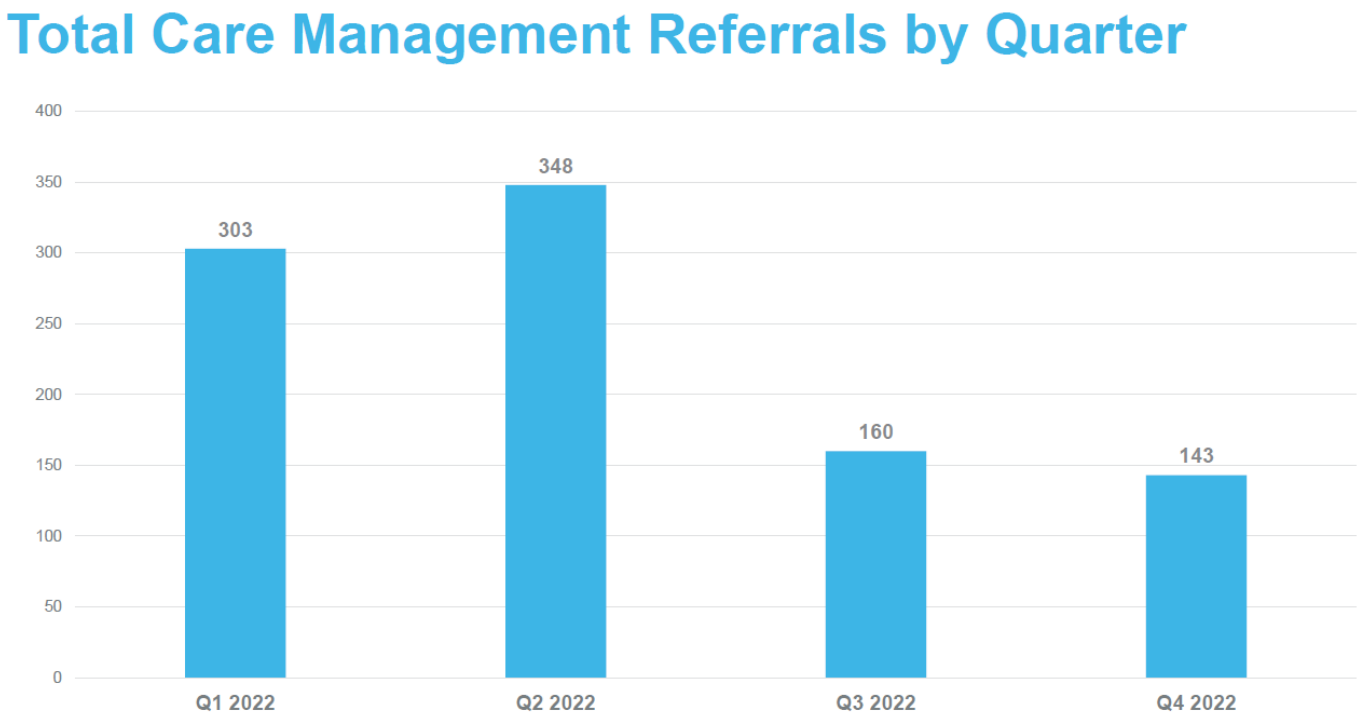
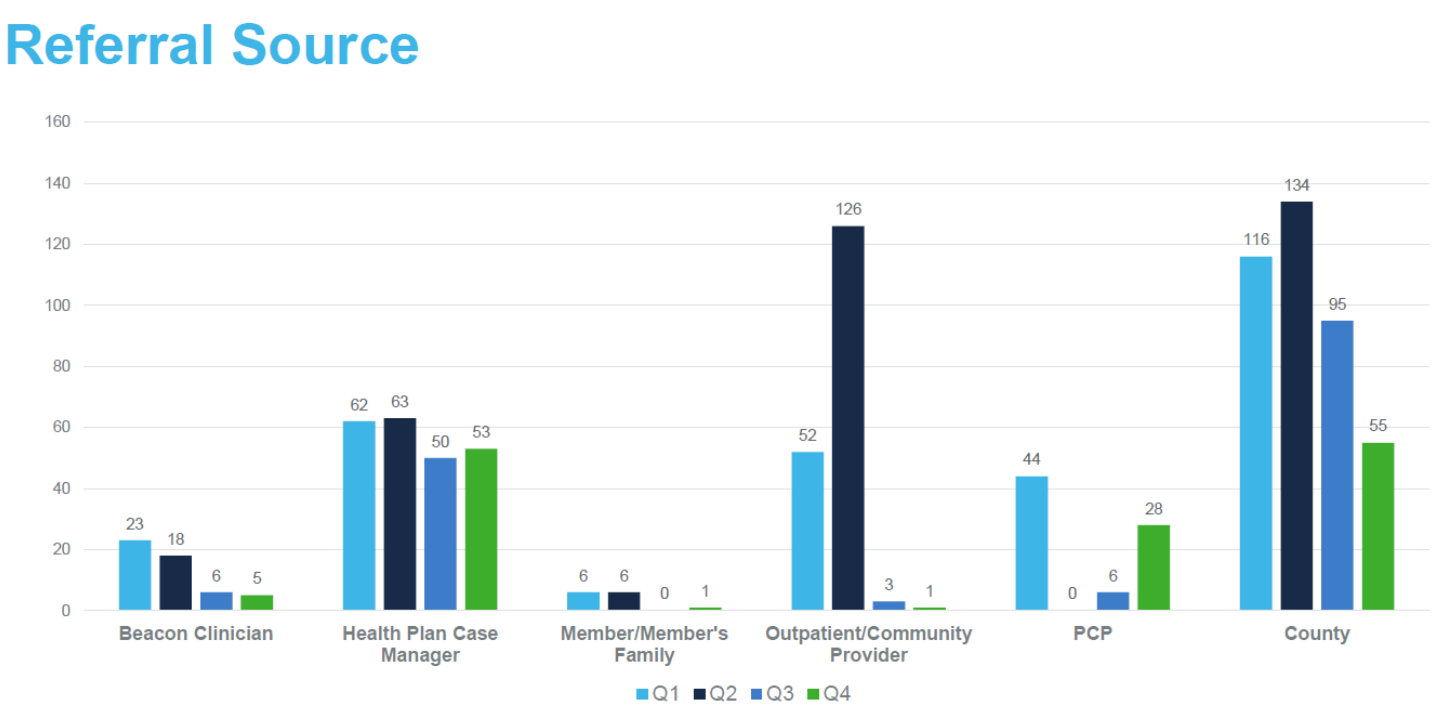


Figure 26c 2022 Case Management Referral Source



-In Q3 Call Center took over members in need of a psychological evaluation prior to bariatric surgery and not in need of Care Management.

Figure 26d Feb 2022 to Dec 2022 Behavioral Health Treatment (BHT)/Applied Behavioral Analysis (ABA) utilization

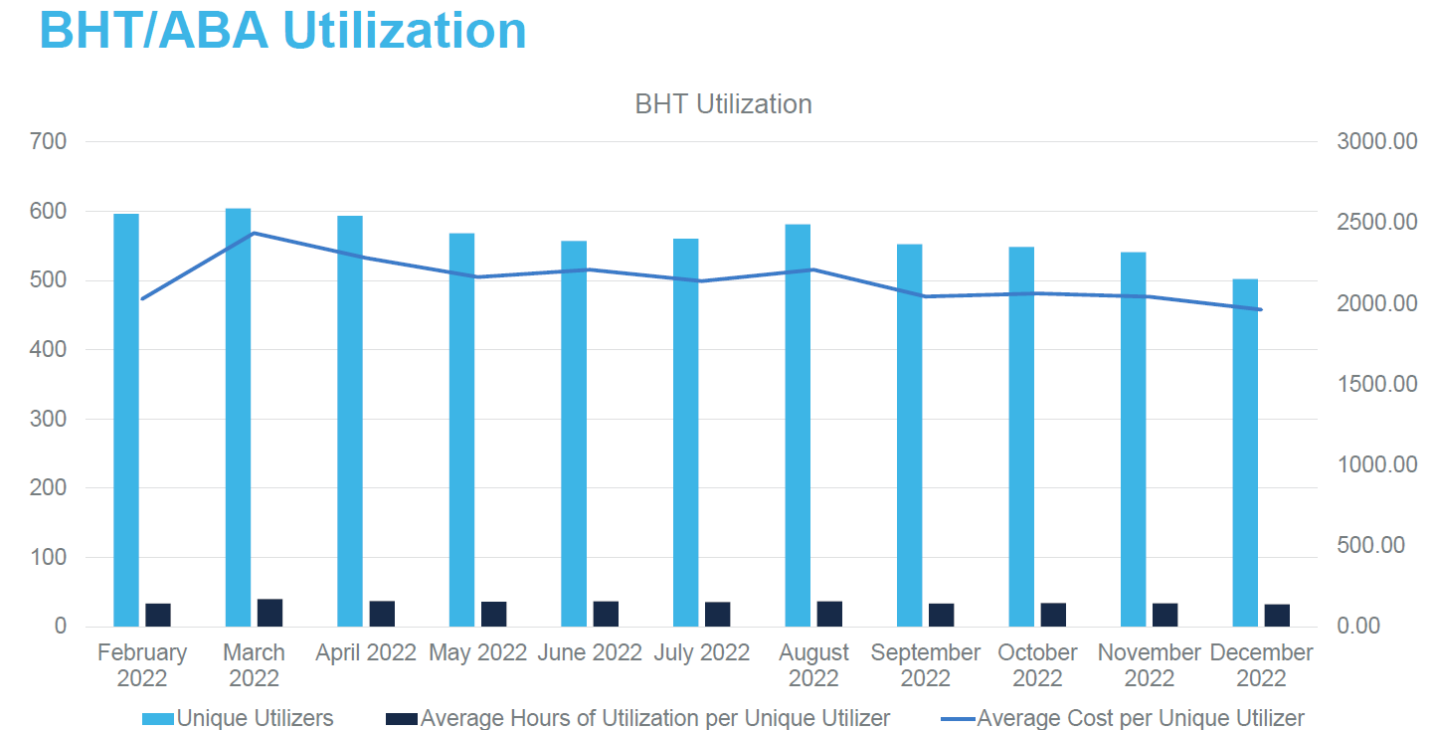


Figure 26a reflects the integration between Beacon for mild to moderate BH and ACBHCS for Severe Mental Illness, showing the referrals between the entities based on member acuity. The Alliance has developed a multi-disciplinary team to analyze data and identify opportunities for collaboration between medical and behavioral health. Figure 26b

reflects AAH members who were referred to Beacon for additional support to access mental health treatment. About a quarter of the referrals to Beacon Care Management come from the clinical staff at AAH, and approximately 40% were referred to Beacon as step down from ACBHCS. The spike in Q2 for Op/Community Provider referrals reflects a program change within Beacon in the management of Bariatric mental health assessments. Figure 26d shows the relatively steady state in BHT/ABA service volume in 2022. A full description of the program activities is defined in the Beacon Behavioral Health Program Evaluation and UM Program Description. The Beacon BH documents are reviewed and acted up at the Alliance HCQC, and in addition to quarterly JOMs, AAH and Beacon hold frequent operational meetings to ensure alignment in processes and provide avenues for problem resolution and process improvements.

Integration with Quality Improvement/Management

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

Assessing Members and Practitioners' Experience with the UM Process

The Benchmark is a comparison of the Alliance outcomes to the other plans participating in in the 2022 SPH survey:

Figure #27 2022 Provider Satisfaction with Utilization Management

Question	2020	2021	2022	Benchmark
Access to UM Staff	**49%**	44%	49% (83rd percentile)	35%
Obtaining Pre-Auth Info	**55%**	48%	57% (100th percentile	35%
Timeliness of Pre-Auth Info	**54%**	47%	53% (96th percentile)	36%
Facilitation of Care	**45%**	46%	52% (94th percentile)	37%
Coverage of Prevention	59%	60%	55% (87th Percentile)	42%

The Provider Satisfaction Survey results for 2022 show that the overall scores from 2020 to 2022 have fluctuated somewhat for most questions. However, the 2022 scores still place AAH at or above the 83rd percentile up to the 100th percentile compared to other plans for these metrics. The satisfaction rates are noted to be considerably higher than the benchmarks with other plans, hence the high percentile ranking. The Turnaround Time on authorization decisions and notification remain consistently above 95%, which likely contributes to provider satisfaction with the UM process.

Figure #28 2022 Member Satisfaction with Utilization Management

CAHPS Question	2021	2022	Percentile Rank
Getting Care Quickly	72%	76%	16th Percentile
Getting Needed Care	79%	76%	9th Percentile
Coordination of Care	83%	79%	12th Percentile

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

As found in Figure #28, Member satisfaction with Getting Care Quickly raised slightly to 76% in 2022. Getting Needed Care decreased from 2021 to 76% in 2022, to the 9th percentile. Member satisfaction with Coordination of Care dipped from 83% in 2021 to 79% in 2022, which was at the 12th percentile. The continued high performance in Turn Around Time for authorizations and the high rates of approved Authorization requests suggests that the dissatisfaction with these metrics are more driven by provider services than UM processes per se. Member satisfaction will need to have increased focus in the future, in collaboration with Provider Services, to assist in reminding Providers to communicate across Providers regarding members' care needs.

Recommended Interventions/Next Steps for 2023:

In 2023, there is an opportunity to ensure the UM Department takes part in the analysis of the data and development of activities associated with the member and provider experience with the UM processes. Provider Satisfaction is above the comparative benchmark and is over 80th percentile for access to staff and auth info, and above 85th percentile for care facilitation of care and preventive care coverage. However, Member experience is low compared to other health plans, and specific activities to address this will be required.

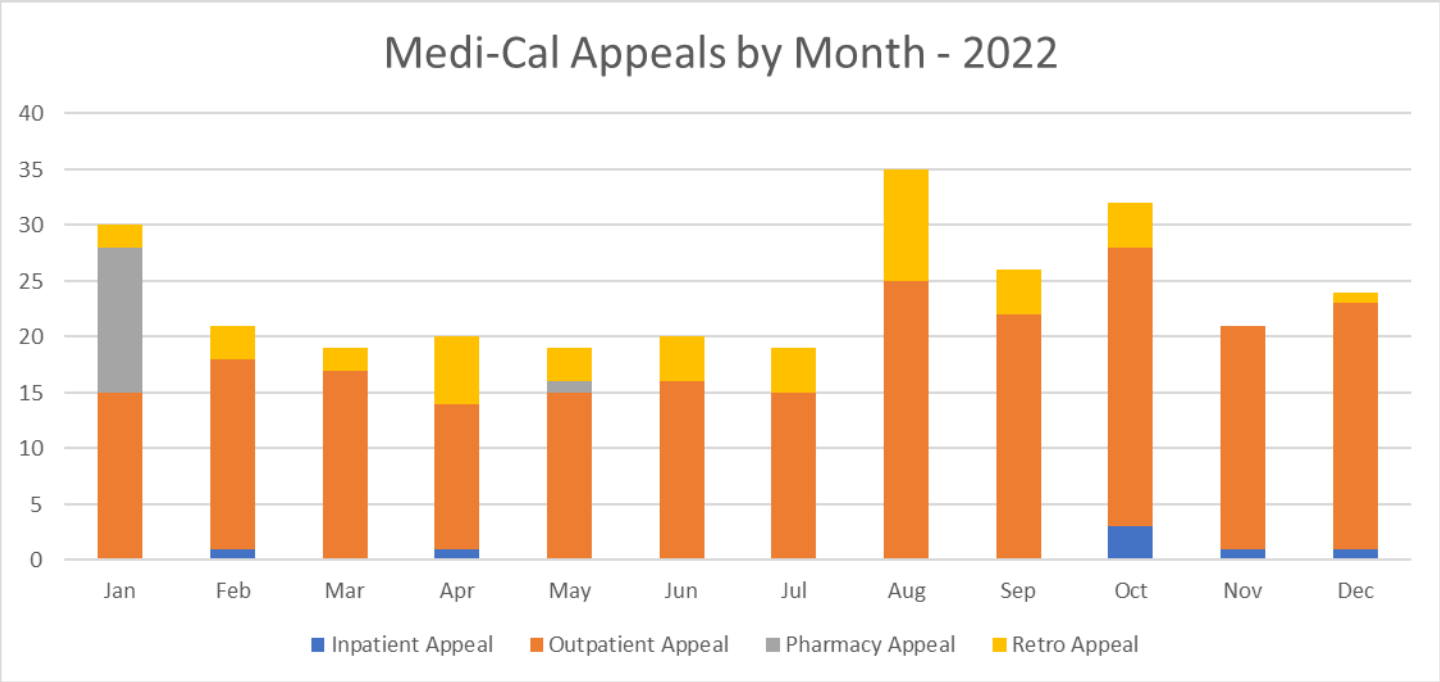
The continued lack of improvement with member satisfaction in 2023 will require strategies with Provider Services to address this lack of improvement for Member experiences with the obtaining care.

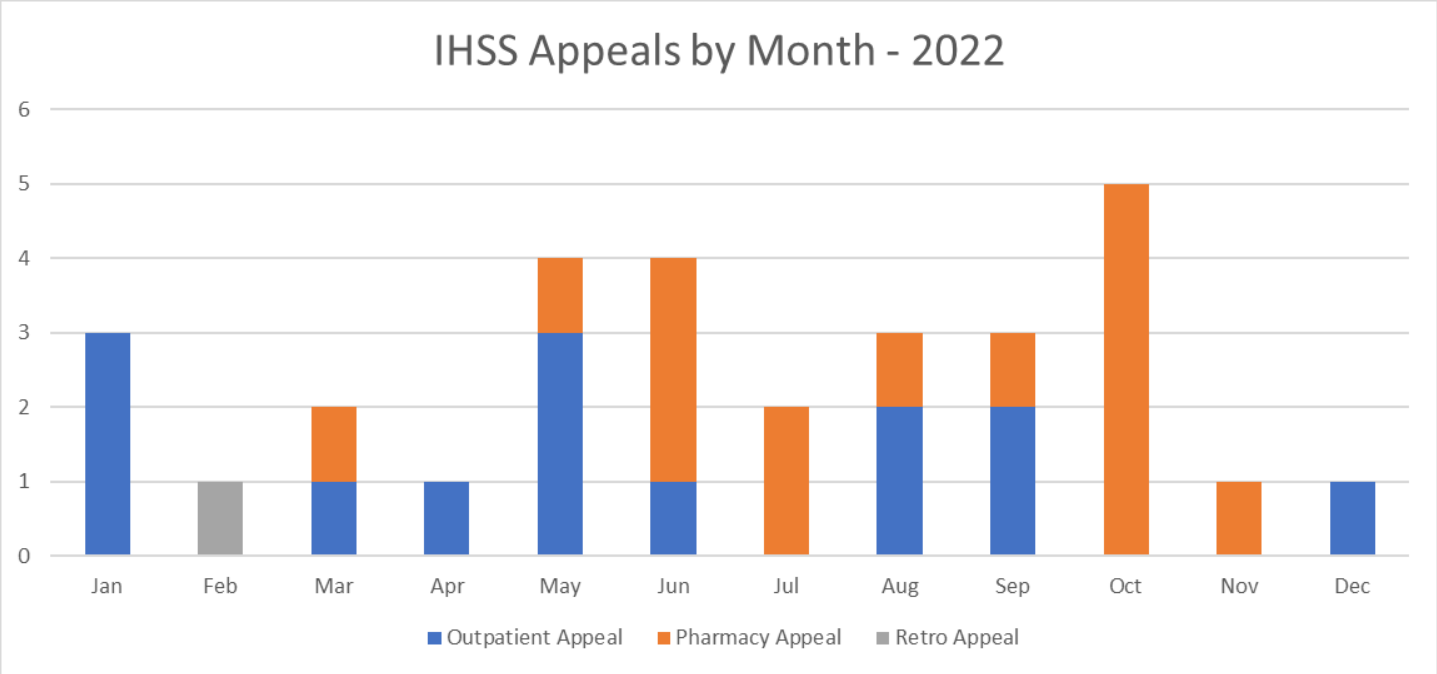
Analysis of Clinical Appeals

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

Clinical Appeals are investigated to determine if the initial UM determination was appropriate. The final appeal is resolved with determinations of upheld, overturn, or partially overturned. Overturn appeal determinations are considered an opportunity to assess the UM process, and all overturned cases are reviewed monthly with Medical Directors for educational feedback, adherence to DHCS regulation, and review of UM process opportunities. The Alliance established a threshold of the overturn determination of 25%. There is opportunity to explore mapping the service and provider trends for Appeals and separately overturns to identify upstream authorization optimization and processes.

Quantitative Analysis
Figure #28 – 2022 Clinical Appeals

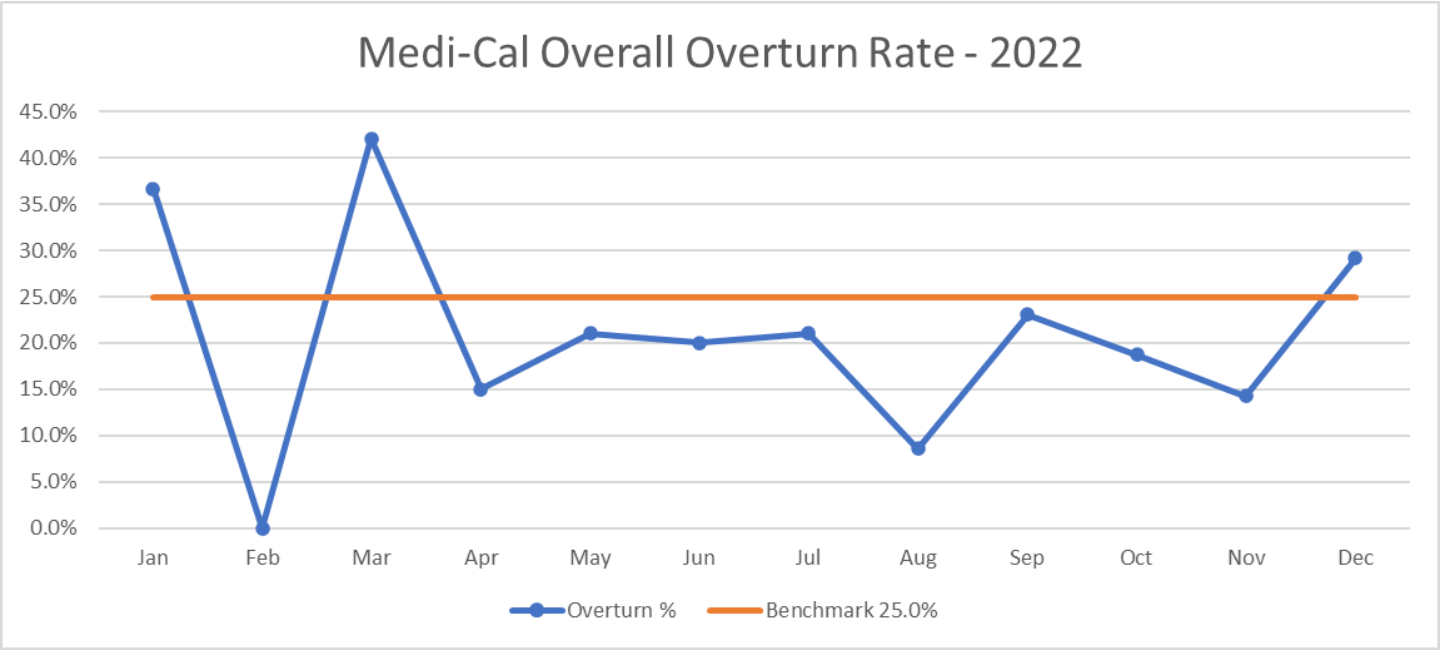


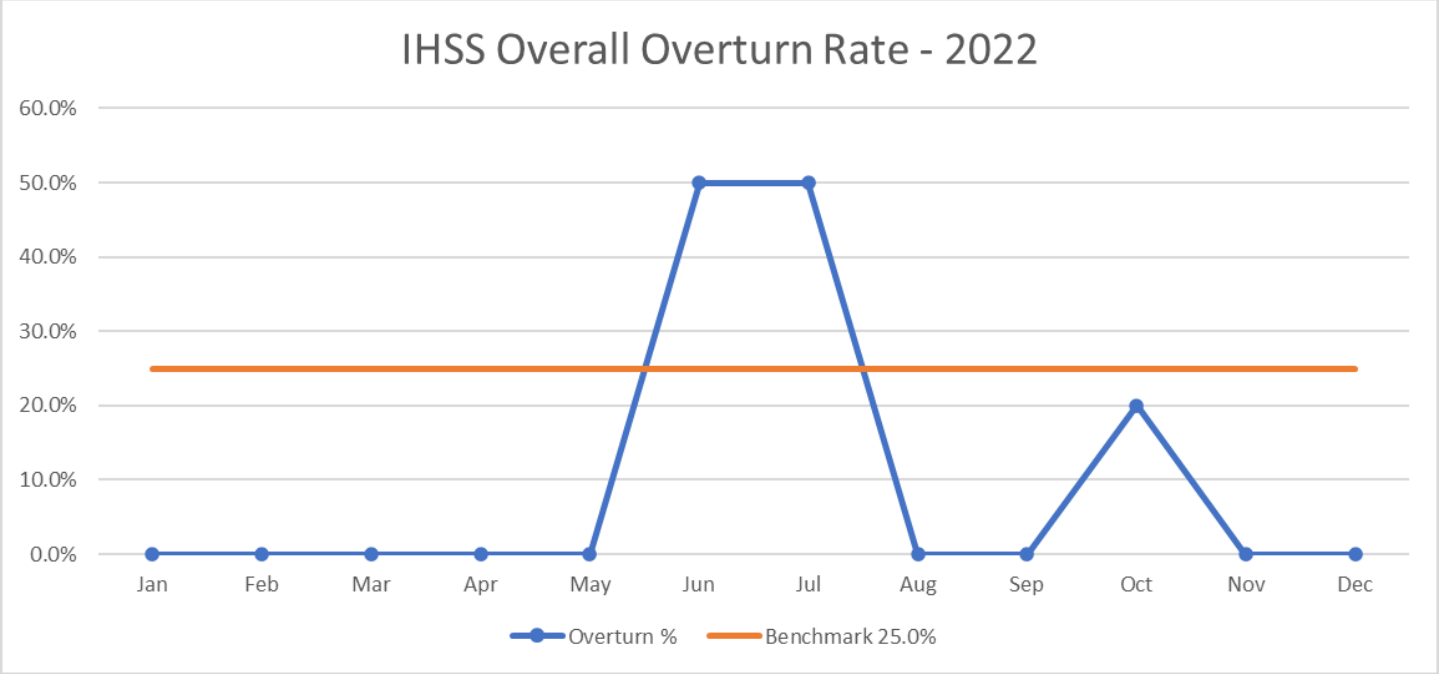


February Decrease: The total number of appeals decreased in February due to the MCAL Rx carve out that was effective 1/1/2022.

August Increase: There was an increase in outpatient appeals in response to CHCN's Tertiary/Quaternary policy, which increased the number of denials. There was also an increase of retro appeals for the month because one OON provider provided services to members after their authorizations were denied. Education has been provided to the provider and there has been a decrease in retro appeals towards the end of 2022.

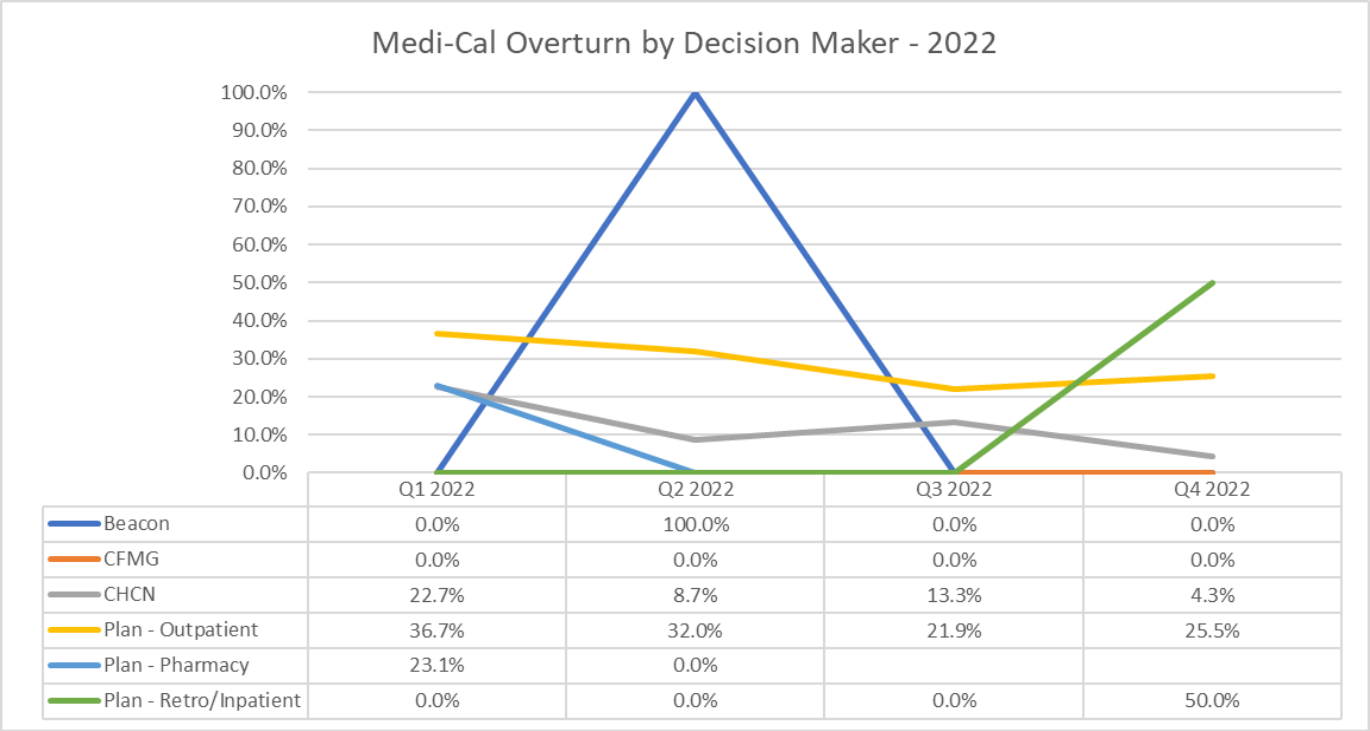
Figure #29a – 2021 Clinical Appeals by Resolution/ Overturn – Threshold Compliance





The Alliance had an average overturn rate of 19.9% for 2022, below the internal benchmark of 25.0%. Most months were consistent, excluding a large dip in February and an increase in the beginning of the year in January and March. However, the annual overturn met the internal benchmark, so no interventions were identified. The IHSS numbers were so low that no significant trend was identified.

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

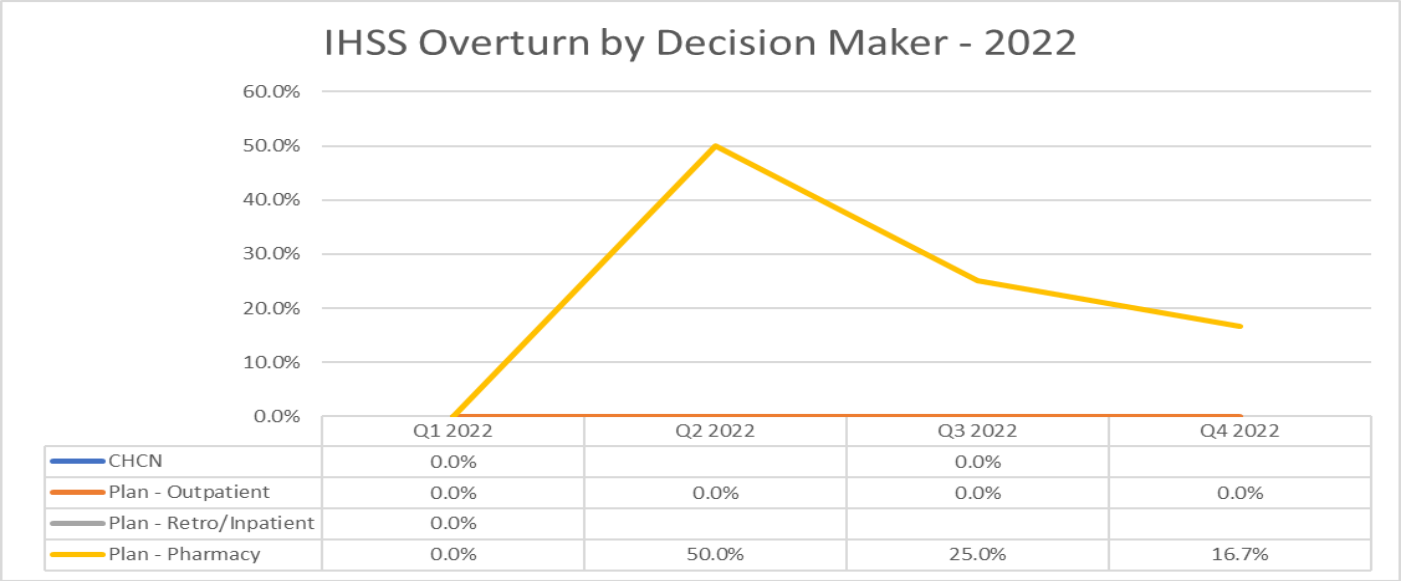


	Q1 2022	Q2 2022	Q3 2022	Q4 2022
Beacon	0.0%	100.0%	0.0%	0.0%
CFMG	0.0%	0.0%	0.0%	0.0%
CHCN	22.7%	8.7%	13.3%	4.3%
Plan - Outpatient	36.7%	32.0%	21.9%	25.5%
Plan - Pharmacy	23.1%	0.0%		
Plan - Retro/Inpatient	0.0%	0.0%	0.0%	50.0%

- There is not enough data to identify any trends with Beacon or CFMG.
- Beacon had one appeal in Q2 2022 that was overturned.
- CHCN has continued to meet the goal of an overturn rate less than 25%.
- The Plan – Pharmacy: Processing of prior authorizations moved over to DHCS 1/1/2022: there were a few appeals from authorizations that were denied by the plan prior to the transition. As of Q3 2022, there have been no Pharmacy appeals for the Medi-Cal line of business.
- The Plan - Retro/Inpatient: For Q4 2022 the numbers were so low that they dramatically impacted the rate: there were a total of 6 appeals that fell under the category of retro/inpatient, and 3 were overturned. This resulted in a 50% overturn rate. All 3 overturns were inpatient appeals.
- The Plan - Outpatient appeals experienced a decrease in overturn rate for Q3 and Q4 compared to Q1 & Q2 2022, meeting the internal benchmark.

Issues/Recommendations:

- Trend Identified: 3 out of 3 appeals received for 64721 - CARPAL TUNNEL SURGERY were overturned. Overturned appeals are presented during bi-weekly medical director meeting for review and discussion. Monitoring appeals for Carpal Tunnel Surgery will continue during Q1 2023 to see if the overturn trend continues and warrant continued education and ongoing monitoring.



	Q1 2022	Q2 2022	Q3 2022	Q4 2022
CHCN	0.0%		0.0%	
Plan - Outpatient	0.0%	0.0%	0.0%	0.0%
Plan - Retro/Inpatient	0.0%			
Plan - Pharmacy	0.0%	50.0%	25.0%	16.7%

- There is not enough data to identify any trends with CHCN.
- The Plan – Pharmacy: In Q2 2022, the overturn rate was above the benchmark of 25%, there were a total of 4 appeals where 2 were overturned resulting in a 50.0% overturn rate. The data is so limited to identify any trends or opportunities for improvement.
- The Plan - Retro/Inpatient: No trends identified.
- The Plan – Outpatient: No trends identified.

Recommended Interventions/Next Steps for 2023:

For 2023, tracking of the overturn rate will continue in order to identify any opportunities for improvement.

Integration of medical and behavioral health

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

In 2022, the teams continued efforts across medical and behavioral health services which included:

- Involvement of Behavioral Health practitioners in the HCQC.
- HEDIS activities related to behavioral health measures.
- Enhancing CCM outreach to chronically ill
- Improve coordination of care by increasing clinical oversight and co-management with the medical management teams.
- Continued efforts toward improving communication between the primary care physician and behavioral health providers.

- In 2022, planning began for the insourcing of mild to moderate BH back into the plan from the current delegate, Beacon Health Options in Q4 2022. The integration between BH and medical care is expected to be enhanced by AAH providing this service directly instead of via delegate.

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

Coordination with Regulatory Compliance

The Alliance UM Department works closely with the Compliance Department in preparation for regulatory audits. In 2022, the department participated in audits from DHCS. As a result of the reviews, several internal workgroups met to identify activities targeted at resolving the identified UM related issues. The workgroups managed these activities via ongoing work-plans. The activities identified are on target for completion within the established timeframes. The activities include mechanisms for ongoing monitoring to mitigate further regulatory deficiencies.

Recommended Interventions/Next Steps for 2023:

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

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

Conclusion

Overall, the 2022 UM Program was effective in maintaining compliance with regulatory and contractual requirements, monitoring of performance within the established benchmarks or goals, identifying opportunities for improvement and enhancing processes and outcomes. The Covid 19 pandemic stretching from 2020 through 2022 had affected volume trends in multiple areas, but as the volumes returned to normal rates, Alliance maintained the required processes within the regulatory timelines, tracked the effect of the pandemic on members, and change processes to mitigate any potentially negative effects and meet the regulatory requirements of pandemic related APLs. The UM program activities have met most of the established targets, including a reduction in regulatory findings. The UM department has provided leadership to the preparations for carving in the Long Term Care custodial care services in 2023. The Alliance leadership has played an active role in the UM Program structure by participating in committee meetings, providing input and assistance in resolving barriers and developing effective approaches to achieve improvements.

UM Program Recommendations for 2023

As a result of internal performance monitoring performed in 2022, opportunities for improvement were identified and will be incorporated into the 2023 department goals. Highlights of opportunities for improvement based on the evaluation and regulatory findings include:

- Delegate Oversight:
    - Enhance Delegate oversight activities, to ensure that regulatory, programmatic and UM process standards are aligned, through performance monitoring and engagement with operational processes. These activities may also include dedicated staff monitoring activities, chart audits, performance management, delegate feedback, and UM training.
- Data Integrity:
    - Enhance UM system reporting to capture required elements for over/under utilization monitoring reports, with continued emphasis on Out of Network Analysis and validating service type categories to ensure accurate measurement among the Alliance and Delegate network, including integrating databases. Develop standardized Determination reasons across the Alliance and Delegates to identify over/ under utilization trends.
- UM Processes Throughput:
    - Improve UM authorization process efficiency as it relates to authorization TAT, aligned staffing, auto authorization enhancement, and Provider outreach/ notification related to benefit and regulatory changes.
    - Expanded evaluation of specialty utilization as it pertains to Radiology/Lab regarding Oncology care, Rehabilitation services, OON, Tertiary/ Quaternary Care, and Retro authorization.
    - Analyze under and overutilized services to facilitate outreach to Providers to improve access (ex. Palliative Care)
    - Refine the ADT feed coming from contracted hospitals to enable automatic case creation in TruCare and to enhance Transitional Care Service capacity.
    - Continue implementation for tracking and intervening with unused Authorizations to ensure that members receive appropriate care and follow up.
    - Complete the Health Suite Claims/ UM Prior Authorization Alignment project with IT and Provider Services.
    -
- Emergency Room Utilization:
    - Improve identification of potential and actual high utilizers of hospital services through Inpatient Risk Screening in coordination with Case Management and Quality departments.
    - Explore timely primary care access for urgent common medical conditions that generate high volume ED visits that do not lead to hospital admits
    - Coordinate with Case Management to identify and reduce high ED utilization for members not engaging with primary care or specialty care for non-emergent problems.
- Hospital Utilization:
    - Improve identification of potential and actual high utilizers of hospital services through Inpatient Risk Screening
    - Enhance identification of members at risk for readmission which will include frailty scores, frequent admissions medical conditions, aide categories & high-risk SDOH to revise medication reconciliation and develop other targeted interventions to improve outcomes.
    - Refine episodic warm handoffs to Case Management through high-risk Transitions of Care workflows in 2023, and then expanding to all hospital discharges in 2024. Goals are to improve enrollment in Enhanced Care Management, Complex Care Coordination, and Community Supports
    - Coordinate stronger discharge planning and relationships with high volume admit facilities with prioritization of those with higher or increasing LOS.
    - Continue to assess social determinants of health drivers and medical conditions that lead to short stays, routine stays, facility to facility transfers trends, and extended length of stays.
- OON:

  - Analyze and closely monitor Stanford Health Care oncology, major organ transplant, non-oncology specialties, ancillary services and elective hospitalizations for new service line and OON Stanford trends.
  - Standardize OON determination reasons to better monitor OON trends for over/ underutilization and emerging network needs.
  - Continue data validation of Alliance and Delegate network data and database integration for DHCS reporting purposes and confirming network needs.
  - Coordinate feedback with Provider Services on dynamic network needs to enhance specialty and ancillary services for members.
  - Continue to explore contracting options for providers who resist conventional contracting.
- Quality/ Population Health Management:
  - Continue focused collaboration between AAH and Delegates UM departments around CRE/ MDRO PQI and preventable readmissions that may impact hospital stay and discharge planning, appropriate goals of care discussions for palliative/ hospice eligible members, timely discharge planning with collaboration with Facility partners, and expanded searches for difficult placement.
  - Continue to analyze denial and approval type trends to ensure the appropriateness of decision making for regulation and medical necessity guidelines and maintain UM standardization.
  - Opportunities to improve processes due to monitoring activities and data trending will be followed by UM education and staff feedback as needed.
  - AAH will align outpatient service type categories to ensure data integration between health plan and Delegates databases reflects accurate utilization.
  - Measure and monitor acute SNF and custodial LTC SNF quality metrics for patient choice and high quality Admissions/ Discharges.
- CM:
  - Work with the Alliance Case Management Department and all relevant Alliance departments to engage on UM aspects of CalAIM for Enhanced Care Management, Community Supports and Population Health Management, including Transitions of Care, in 2023.
  - Provide leadership in collaboration with Case Management to enhance service coordination for members being managed by CCS.
  - Continue the initiative for enhanced care coordination for high-risk hemodialysis members with DaVita.
- G&A:
  - Improve reporting and analysis of grievance and appeals activities related to UM decision making and analysis for member and provider experience with UM.
- LTC
  - Fully implement the 2023 Long Term Care SNF population carve in and prepare for Long Term Care Intermediate Care Facility carve in for 2024.

2023
Utilization Management
Program Description

2023 Utilization Management Program

Signature Page

Date 06/19/2023

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Rebecca Gebhart
Board Chair
Alameda Alliance for Health

- **Changes in UM Program Description from 2022 Version**
  - **Grammatical corrections**
  - **Pagination corrections**
  - **Addition/correction of relevant regulatory references**
  - **Integration with Quality Improvement Health Equity Program**
  - **Addition of Long Term Care SNF carve in**
  - **Addition of Behavioral Health Insourcing**
  - **Description of expanded Continuity of Care processes**
  - **Implementation of TCS for members at high risk**
  - **Updated Recommendations for 2023**

Introduction

Alameda Alliance for Health (the Alliance) is a public, not-for-profit managed care health plan committed to making high quality health care services accessible and affordable to lower-income people of Alameda County. Established in January 1996, the Alliance was created by and for Alameda County residents.

The Alliance provides health care coverage to over 320,000 children and adults through the Medi-Cal and Alliance Group Care programs. Alliance members choose from a network of over 1,700 doctors, 17 hospitals, 68 community health centers, and more than 200 pharmacies throughout Alameda County. The Alliance cares about the health of our community and reflects the community's cultural and linguistic diversity in the health plan's structure, operations, and services. In addition, many of the Alliance providers, employees, and Board of Governors (BOG) live in areas that we serve. The Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan members. Our members' optimal health is always our priority.

The Alliance's Utilization Management (UM) Program was established to provide basic and complex care management structures and key processes that enable the health plan to improve the health and health care of its members. The UM Program is a supportive and dynamic tool that the Alliance uses to achieve these objectives as well as respond to the needs and standards of consumers, the healthcare provider community, and regulatory and accrediting organizations. The UM Program ensures parity between medical/surgical care and behavioral health care throughout all structures and functions. The Behavioral Health Service of AAH follows all the UM principles and procedures as medical/surgical UM. The UM Program is compliant with Health and Safety Code Sections 1363.5, 1367.01, 1368.1, 1374.16, 1374.72, 1374.76, and Title 28, CCR, Sections 1300.1300.67.2, 1300.70(b)(2)(H) & (c).

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

The annual evaluation of the effectiveness of UM processes was conducted and the recommendations were documented in the 2022 UM Program Evaluation. Based on those recommendations, the Alliance will focus on the following areas for 2023:

- Monitor the existing UM infrastructure to ensure that it meets the needs of the members, providers, and the organization.
- Continue to optimize opportunities to enhance the existing clinical information system reporting capabilities to focus on the improvement of monitoring operational activities, i.e., Turn-around Time monitoring, referral types.
- Focus on strategies and tactics to reduce readmissions.
- Improve monitoring of network utilization (over/under), including out of network and specialty referrals.

- Insourcing the provision of Behavioral Health Services into the Alliance, rather than delegating out the Mild/Moderate/BHT services for Medi-Cal recipients and all behavioral health for the Group Care line of business.
- Enhance reporting and analysis of member and provider complaint data related to UM decision making to improve experiences with UM process.
- Implementing activities to improve member experience with UM, targeting CAHPs measures for “getting needed care” and “getting care quickly” as it relates to primary and specialty care.
- Provide leadership to the initiative on Long Term Care SNF population carve in, including expanding staffing to manage this vulnerable population, in collaboration with all relevant Alliance departments.
- Provide leadership in collaboration with Case Management to enhance transitional care service coordination for members being managed by CCS.
- Strengthen internal oversight of UM processes.
- Strengthen oversight of delegates; and
- Continue to focus on activities to mitigate regulatory audit deficiencies related to UM activities.
- Secure staffing and resourcing to support these initiatives.

Section I. Program Objectives & Principles

The purpose of the Alliance UM Program is to objectively monitor and evaluate the appropriateness of utilization management services delivered to members of the Alliance. The UM Program serves Alliance members through the following objectives:

- Ensure that appropriate processes are used to review and approve the provision of medically necessary covered services.
- Provide continuity of care and coordination of medical services.
- Improve health, including behavioral health, outcomes; and
- Assure the effectiveness and efficiency of healthcare services.

The Alameda Alliance for Health adheres to the following operating principles for the UM Program, for both the medical/surgical services and behavioral health services:

- Appropriately licensed and qualified health care professionals with clinical care expertise make UM review determinations according to approved clinical review criteria.
- UM decisions are made on appropriateness of care and service, as well as existence of benefit coverage.
- Appropriate processes are used to review and approve provision of medically necessary covered services.
- Prior authorization requirements are not applied to emergency, family planning, preventive, or basic prenatal care, and sexually transmitted disease or HIV testing services.
- The Alliance does not financially reward clinicians or other individuals for issuing denials of coverage, care, or service.

- The Alliance does not encourage UM decisions that result in under-utilization of care to members.
- Members have the right to:
    - Participate with providers in making decisions about their individual health care, including the right to refuse treatment.
    - Discuss candidly with providers the appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
    - Receive written notification of a decision to deny, defer, or modify requests for prior authorization.
    - Request a second opinion from a qualified health professional at no cost to the member.
    - Voice grievances or appeals, either verbally or in writing, about the organization of the care received.
    - Request a Medi-Cal state hearing, including information on the circumstances under which an expedited fair hearing is possible.
    - Have access to, and where legally appropriate, receive copies of, amend or correct their medical record; and
    - Receive information about how to access State resources for investigation and resolution of member complaints, including a description of the DHCS Medi-Cal Managed Care Ombudsman Program and its toll-free number, and the DMHC, Health Maintenance Organization (HMO) Consumer Service and its toll-free number

Section II. Program Structure

A. Program Authority and Accountability

1. Board of Governors

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

2. Committee Structure

The Board of Governors appoints and oversees the QIHEC, the Peer Review and Credentialing Committee (PRCC) and the Pharmacy and Therapeutics Committee

(P&TC) which, in turn, provide the authority, direction, guidance and resources to enable Alliance staff to carry out the Quality Improvement and UM Programs. Committee membership is made up of provider representatives from Alliance contracted networks and the community including those who provide health care services to Seniors and Persons with Disabilities (SPD) and chronic conditions.

Alliance committees meet on a regular basis and in accordance with Alliance Bylaws. Alliance Board meetings are open to the public, except for peer review activities, contracting issues, and other proprietary matters of business, which are held in closed session.

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

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

The QIHEC functional responsibilities for the UM Program include:

- Annual review and approval of the UM Program Description.
  Oversight and monitoring of the UM Program, including:
    - Recommend policy decisions.
    - Oversight of interventions to address over and under-utilization of health services.
    - Oversight of the integration of medical and behavioral health activities
    - Guide studies and improvement activities.
    - Review results of improvement activities, HEDIS measures, other studies and profiles and the results of audits; and
    - Recommend necessary actions.

3. Utilization Management Committee

The Utilization Management Committee (UMC) is a sub-committee of QIHEC. The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The sub-committee is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of

resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

4. UM Committee Structure

As a sub-committee of the QIHEC which reports to the full Board of Governors, the Utilization Management Committee (UMC) supports the activities of the UM department and reviews and approves the UM activities and program annually. Reporting through the QIHEC integrates UM activities into the Quality Improvement system.

5. Authority and Responsibility

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

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

- Annual review and approval of the effectiveness of the UM/BH Program
- Annual review and approval of the UM/BH Program
- UM/BH Policies/Procedures,
- UM/BH Criteria, and
- Other pertinent UM documents such as the UM Delegation Oversight Plan, UM Notice of Action Templates, and
- Case/ Care Management Program and Policies/ Procedures.

3. UM Committee Membership

The UMC is chaired by the Chief Medical Officer.

Members of the UM Committee include:

- The Alliance Chief Analytics Officer
- The Alliance Medical Directors, UM
- The Alliance Medical Director, CM
- The Alliance Senior Medical Director, Quality Improvement
- The Alliance Senior Director, Quality Improvement
- The Alliance Senior Director, Pharmacy & Formulary
- The Alliance Senior Director, Health Care Services
- The Alliance Senior Director, Behavioral Health
- The Alliance Director, Compliance
- The Alliance Director, Member Services
- The Alliance Director of Provider Relations and Provider Contracting
- The Alliance Director, Quality Assurance
- The Alliance Director, Utilization Management
- The Alliance Director, Social Determinants of Health

- The Alliance Manager, Healthcare Analytics
- The Alliance Managers, Case Management
- The Alliance Managers, Utilization Management
- The Alliance Manager, Grievance & Appeals

4. UMC Voting Privileges

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

5. UMC Quorum

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

6. UMC Meetings

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

7. UMC Minutes

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

8. UM Committee Functions

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

- Improve quality of care for the Alliance members.
- Evaluate and trend utilization data for medical and behavioral health services provided to Alliance members and benchmarks for over/under utilization. This includes in- network and out-of-network utilization data review to ensure services are accessible and available timely to members.
- Provide a feedback mechanism to drive quality improvement efforts in UM.
- Increase cross functional collaboration and provide accountability across all departments in Medical Services.
- Provide mechanism for oversight of delegated UM functions, including review and trend authorization and utilization reports for delegated entities to identify improvement opportunities.
- Identify behaviors, practices patterns and processes that may contribute to fraud, waste, and abuse with a goal to support the financial stability of our providers and network.

UM Committee responsibilities are to:

- Maintain the annual review and approval of the UM/BH Program, UM/BH

Policies/Procedures, UM/BH Criteria, and other pertinent UM documents such as the UM Delegation Oversight Plan, UM/BH Notice of Action Templates, and Case/ Care Management Program and Policies/ Procedures.

- Participate in the utilization management/ continuing care programs aligned with the Program's quality agenda.
- Assist in monitoring potential areas of over and underutilization and recommend appropriate actions when indicated.
- Review and analysis of utilization data for the identification of trends.
- Recommend actions to the Quality Improvement Health Equity Committee when opportunities for improvement are identified from review of utilization data including, but not limited to, Ambulatory Visits, Emergency Visits, Hospital Utilization Rates, Hospital Admission Rates, Average Length of Stay Rates, Behavioral Health usage and outcomes, and Discharge Rates.
- Review information about New Medical Technologies from the Pharmacy & Therapeutics Committee including new applications of existing technologies for potential addition as a new medical benefit for Members.

Based on the decision of the UM Committee and recommendations through the appropriate Quality Committees, the approval of a new technology or new application of an existing technology by the QIHEC shall be deemed to be the Alliance policy on coverage, and where the Alliance does not have the authority to modify the benefit package, the Chief Medical Officer shall notify, in writing, each payer for whom the Alliance manages benefits of its recommendation.

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

C. Program Oversight and Staff Responsibility

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

Appropriately qualified and trained clinical staff use approved criteria to conduct utilization reviews and make UM determinations relevant to their positions, e.g., non-physician staff may only approve services; qualified non-clinical staff may make non- medical necessity denial decisions (not eligible as an Alliance member); potential denials are referred to physician reviewers /doctoral Behavioral Health Specialists. The CMO, Medical Director, licensed MD or doctoral Behavioral Health Specialist staff review requests that require additional clinical interpretation or are potential denials. A qualified physician reviews all

denials made, whole or in part, based on medical necessity. The CMO, a Medical Director or a doctoral Behavioral Health Specialist makes medical necessity denial decisions for medical and pharmacy service requests. The Alliance Pharmacist, a licensed Pharm. D., may approve, defer, modify, or deny prior authorization requests for pharmaceutical services.

1. Chief Medical Officer

The Chief Medical Officer is a designated board-certified physician with responsibility for development, oversight, and implementation of the UM Program. The CMO holds a current unrestricted license to practice medicine in California. The CMO serves as the chair of the QIHEC and UMC, and makes periodic reports of committee activities, UM Program activities and the annual program evaluation to the BOG. The CMO works collaboratively with Alliance network physicians to continuously improve the services that the UM Program provides to members and providers.

Any changes in the status of the CMO shall be reported to the Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) within the required timeframe.

2. Medical Directors

The Medical Directors are licensed physicians with authority and responsibility for providing professional judgment and decision-making regarding matters of UM. The Medical Directors hold current unrestricted license to practice medicine in California. Medical Directors responsibilities include but are not limited to the following:

- Ensure that medical decisions are rendered by and are not influenced by fiscal or administrative management considerations.
- The decision to deny services based on medical necessity is made only by Medical Directors.
- Ensure that the medical care provided meets the standards for acceptable medical care.
- Ensure that medical protocols and rules of conduct for plan medical personnel are followed.
- The initial reviewer must not review any appeal cases in which they were the decision maker for the authorization.
- Develop and implement medical policy.

The Alliance may also use external specialized physicians to provide specific expertise in conducting reviews. These physicians are currently licensed, and many have board certification in specific areas of medical expertise. The CMO is responsible for managing access and use of specialized physicians.

6. Senior Director, Health Care Services

The Senior Director, Health Care Services is a Licensed Clinical Social Worker and is responsible for overall UM Department operations, staff training, and coordination of

services between departments. The Director's management responsibilities include:

- Develop and maintain the UM Program in collaboration with the CMO.
- Coordinate UM activities with the Quality Department and other Alliance units.
- Maintain compliance with the regulatory standards.
- Monitor utilization data for over and under-utilization.
- Coordinate interventions with the CMO to address under and over utilization concerns when appropriate.
- Monitor utilization data and activities for clinical and utilization studies; and maintain professional relationships with colleagues from other Medi-Cal Managed Care Plans, sharing information about requirements and successful evaluation strategies.
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision.
- Monitor documentation for adequacy.
- Available for UM staff on site or by telephone.

7. Senior Director, Behavioral Health Services

- The Senior Director, Behavioral Health Services is a licensed Psychologist and is responsible for the overall Behavioral Health department operations, staff training, and coordination of services between departments. The Senior Director's management responsibilities include:

  - Develop and maintain the Behavioral Health (BH) Program in collaboration with the Senior Medical Director of Quality and the CMO.
  - Coordinate BH activities with the Quality, UM, Case Management, Member Services Departments, as well as other Alliance units.
  - Maintain compliance with the regulatory standards.
  - Maintain professional collaboration with Alameda County Behavioral Health Care Services (ACBHCS) to coordinate care and care transitions across behavioral health care systems.
  - Coordinate interventions with the Senior Medical Director and the CMO to address under and over utilization concerns when appropriate.
  - Develop and monitor data and activities for clinical and utilization studies; and maintain professional relationships with colleagues from other Medi-Cal Managed Care Plans, sharing information about requirements and successful evaluation strategies.
  - Monitor for consistent application of utilization criteria by BH staff, for each level and type of UM decision.

8. Pharmacy Services Senior Director

The Pharmacy Services Senior Director is a licensed pharmacist (Pharm.D.) responsible for coordinating daily operations and reviewing and managing pharmacy utilization reports to identify trends and patterns. The Director provides clinical expertise relative to the Pharmacy, Quality and UM components of Alliance plan management including Member and Provider Services and Claims operations. The scope of

responsibilities of the Pharmacy Services Director includes:

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

9. Managers of UM

The Managers of UM are required to be Registered Nurses with current and unrestricted California nursing licenses. They supervise all AAH UM activities, including:

- Provide supervision of assigned UM staff.
- Participate in staff training.
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision.
- Monitor documentation for adequacy.
- Ensure staff are following policies, procedures, and all requirements
- Are available to UM staff on site or by telephone/computer.
- Collaborate with other departments on interdepartmental initiatives that involve UM activities or functions.
- Participate in delegate oversight activities, including annual and/or focused audits, meetings, and joint initiatives
- Participate in regulatory audits and enact regulatory changes or process changes as required.

10. Supervisors of UM

- Supervisors of UM may be RNs or non-clinical, according to the category of staff they supervise. RNs are supervised by RN Supervisors, and non-clinical staff are supervised by non-clinical Supervisor.
- Provide day to day oversight of the staff to ensure adherence to departmental processes, productivity, and departmental functions.
- Consult on or assume responsibility for challenging cases

- Provide staff training and coaching
- Assist in audit preparation.

11. Utilization Review Clinicians

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

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

12. UM Coordinators

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

Roles and responsibilities include:

- Outpatient UM Coordinators
  - Ensure appropriate UM referral entries into the information system.
  - Process UM referrals approvals for selected requests identified as Auto Authorizations or Authorization in their Scope of Work that do not require clinical interpretation.
  - Complete intake functions with the use of established scripted guidelines and
  - Manage and complete UM Member and Provider communications.
  - Complete administrative denials for non-eligibility, as defined in UM Policy 057 – Authorization Requests.
- Inpatient UM Coordinators:
  - monitor and collect facility admissions census data.
  - Complete data entry of initial cases.
  - Maintain member and provider communications.
  - Assist in requesting additional information as needed
  - Review of hospital referral to ensure appropriate case closure.

- Approve inpatients services as defined in UM Policy UM-057 Authorization Requests.
- Ensuring efficient processing for the authorization process and maintain documentation in support of the on-site and telephonic UM nurse staff.

13. Behavioral Health Navigators

The Behavioral Health Navigators are the non-clinical staff responsible for performing basic administrative and operational UM functions for behavioral health services. Behavioral Health Clinical staff provides oversight to the non-clinical staff.

Roles and responsibilities include:

- Behavioral Health Navigators;
  - Ensure appropriate UM referral entries into the information system.
  - Process UM referrals approvals for selected requests identified as Auto Authorizations or Authorization in their Scope of Work that do not require clinical interpretation.
  - Complete intake functions with the use of established scripted guidelines and
  - Manage and complete UM Member and Provider communications.
  - Complete administrative denials for non-eligibility, as defined in UM Policy 057 – Authorization Requests.
- Ensuring the efficient processing for the authorization process and maintain documentation in support of the on-site and telephonic Behavioral Health Clinical staff.

Section III. Program Scope, Processes & Information Sources

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

A. Utilization Management Activities

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

- Services exempt from Prior Authorization means services for which the health plan cannot require advance approval.
- Pre-service/Prospective Review means a formal process requiring a requesting health care provider to obtain advance approval to provide specific services or procedures. Preauthorization, Prior Authorization, and Pre-Certification are terms also used to describe Pre-service Review.
- Concurrent Review means a review for an extension of a previously approved,

ongoing course of treatment over a period or number of treatments. Concurrent reviews are typically associated with inpatient care, residential behavioral care, intensive outpatient behavioral health care, and ongoing ambulatory care.

- Post Service Review means the assessment of the appropriateness of medical services after the services have been provided. This is also called Retrospective Review.
- After Hours and Emergency Care

Emergency health care services are available and accessible within the service area 24 hours a day, seven days a week. The Alliance provides 24-hour access for members and providers to obtain timely authorization for medically necessary care, for circumstances where the member has received emergency services and care and is stabilized, but the treating provider believes that the member may not be discharged safely. A Physician is available 24 hours a day to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized Members in an emergency department, if necessary.

Emergency health care services including behavioral health care services are covered without prior approval:

- to screen and stabilize the member where a prudent layperson, acting reasonably, would have believed an emergency medical condition existed.
- when there is an imminent and serious threat to health including, but not limited to, the potential loss of life, limb, or other major bodily function.
- when a delay in decision making would be detrimental to the member's life or health or could jeopardize the member's ability to regain maximum function.
- If an authorized representative, acting for the Alliance, has authorized the provision of emergency services.

A "Prudent Layperson" is a person who is without medical training, and who draws on his/her practical experience when deciding whether emergency medical treatment is needed. A Prudent layperson is considered to have acted reasonably if other similarly situated laypersons would have believed that emergency medical treatment was necessary.

Other Alliance representatives who may direct members to emergency services include the Nurse Advice Line staff, and the Alliance nurse case manager or disease manager, an Alliance Member Services Representative or after-hours call answering service, or a contracted specialist. Additionally, the Alliance provides access to the Alameda County Crisis Services to respond to behavioral health calls after hours. The Alliance will honor health plan coverage for services when directed by any Alliance staff member or delegated representative.

B. Communication Services for UM Process with Members and Providers

The Alliance members, providers, and the public may contact the UM department to discuss any aspect of the UM program. Members contact the Member Services Department at 510-747-4567 and may be warm transferred to an UM Manager or Director. Providers contact the UM Department directly at 510.747.4540. UM staff are available at least 8 hours per normal business day (excludes weekends and holidays). During scheduled business hours, the Alliance provides access to staff for members and practitioners seeking information about the UM process and the authorization of care. After hours calls are answered by a contracted vendor and non-emergency calls are returned the following business day. After Hour calls requiring clinical decision-making are transferred to the Alliance on-call nurse or behavioral health crisis services for assistance. Staff identify themselves by name, title and as representatives of the Alliance when initiating or returning calls. HIPAA protocols are followed to ensure protection of privacy. Language assistance and TDD/TTY services are available as needed for members to communicate with the Alliance regarding the UM program.

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

C. Decision Support Tools

The appropriate use of criteria and guidelines require strong clinical assessment skills, sound professional medical judgment, and application of individual case information and local geographical practice patterns. Licensed UM/BH review staff apply professional judgment during all phases of decision-making regarding the Alliance members.

"Decision Support Tools" are intended for use by qualified licensed UM/BH review staff as references, resources, screening criteria, and guidelines with respect to the decisions regarding medical necessity of health care services, and not as a substitute for important professional judgment. The Medical Director/doctoral Behavioral Health Specialist evaluates cases that do not meet review criteria/guidelines and is responsible for authorization/denial determinations.

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

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

D. UM Review Criteria, Guidelines and Standards

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

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

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

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

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

Examples of regulations and guidelines are as follows:

- Regulations:
  - Code of Federal Regulations
  - California Health and Safety Code.
  - California Code of Regulations Title 22.
  - California Code of Regulations Title 28.
  - California Welfare and Institution Code
  - Behavioral Health criteria sets specified by law and regulations

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

1. Application of UM Criteria

The Alliance requires that UM criteria be applied in a consistent and appropriate manner by physician and non-physician UM staff based on available medical information and the needs of individual Members. For use in determining the appropriateness of UM

determinations at the Alliance Plan level for the direct requests for authorization, the Alliance adopts and maintains approved criteria with current versions of the following UMC approved UM Criteria hierarchy:

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

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

2. Clinical Review Criteria

Utilization review determinations to approve, defer, modify, or deny requested services are made based on a consistently applied, systematic evaluation of utilization management decision criteria. The criteria adopted by the Alliance are reviewed and discussed by the UMC. They are selected based on nationally recognized and evidence-based standards of practice for medical services and are applied based on individual need. Primary criteria used for utilization review decisions are from MCG® Care Guidelines. Other applicable publicly available

clinical guidelines from recognized medical authorities are referenced when indicated. For Group Care LOB, the non-profit professional association behavioral health guidelines are utilized, and for transgender care, the WPATH guidelines. Also, when applicable, government manuals, statutes and laws are referenced in the medical necessity decision making process. The UMC annually reviews the MCG® Care Guideline criteria and applicable government and clinical guidelines for changes and updates.

For mental health and substance use disorder care standards, the following definition applies: Standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. These standards reflect valid, evidence-based sources establish generally accepted standards of mental health and substance use disorder care, including peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the US FDA. H&S 1374.721(f)(1)

Additionally, the Alliance has a formal mechanism to evaluate and address new developments in technology and new applications of existing technology for inclusion in benefit plans to keep pace with changes and to ensure that members have equitable access to safe and effective care. The UMC reviews and approves all new coverage policies before implementation.

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

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

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

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

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

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

If criteria are requested, the organization makes them available:

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

E. Benefits

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

- Medi-Cal member benefits are developed by the State of California, DHCS and DHCS mandated benefits for Medi-Cal Members. DHCS benefits, available on the DHCS Web site, defined by, but not limited to:
  - Service requests for Medi-Cal beneficiaries.
  - Medi-Cal Manual of Criteria
  - Medi-Cal DME.
  - Medi-Cal Hospice
  - Medi-Cal Waivers.
  - Medi-Cal Linked and Carve Out Programs
  - Medi-Cal Enhanced Care Management (ECM)
- IHSS benefits are developed by Public Authority of Alameda County

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

1. Benefit Exclusions

Based on the specific contract requirements and applicable laws, some services are explicitly excluded from coverage. Per contract requirements, specific services may not be covered benefits, unless clinical indicators support medical necessity, as determined by the Medical Directors, in which case the medically needed services will be provided. Every attempt is made by the UM staff to identify additional community programs to provide wrap-around services to enhance the Alliance benefit package.

2. Transition to Other Care when Benefits End

The Alliance assists with, and/or ensures that practitioners assist with, a member's transition to other care, if necessary, when benefits end.

3. New Medical Technology Evaluation Assessment

The Alliance maintains a formal mechanism to evaluate and address new developments in technology and new applications of existing technology for inclusion in its benefits plan to keep pace with changes and to ensure that members have equitable access to safe and effective care. Evaluation of new technology is applied for medical and behavioral health procedures, pharmaceuticals, and devices. The UM Committee is responsible for evaluating and recommending coverage status for a new technology to the UM Committee or the Pharmacy and Therapeutics Committee, and to the Quality Improvement Health Equity Committee. This includes evaluation of medical and behavioral health procedures, pharmaceuticals, and devices. Requests for evaluation of a new technology or a new application of an existing technology may come from a member, practitioner, organization, the Alliance's physician reviewers, or other staff.

The following are evaluated when considering new technology:

- Organizational reviews from appropriate government regulatory bodies, such as FDA or CMS.
- Relevant scientific information from peer-review literature, professional societies, and/or specialists and professionals who have expertise in the technology.

Based on the decision of the UM Committee, P&T Committee and recommendations through the appropriate Quality Committees, the approval of a new technology or new application of an existing technology by the QIHEC shall be deemed to be the Alliance's policy on coverage. When the Alliance does not have the authority to modify the benefit package, the Chief Medical Officer shall notify, in writing, each payer for whom the Alliance manages benefits of its recommendation. A full description of the process is defined in UM policy and procedure.

4. Member Eligibility Verification

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

5. Determination Information Sources

UM clinical staff collects relevant clinical information from health care providers to make prospective, concurrent, and retrospective utilization review for medical necessity and health plan benefit coverage determinations. Clinical information is provided to the appropriate clinical reviewers to support the determination review process. Examples of relevant sources of patient clinical data and information used by clinical reviewers to

make medical necessity and health plan benefit coverage determinations include the following:

- History and physical examinations.
- Clinical examinations.
- Treatment plans and progress notes.
- Diagnostic and laboratory testing results.
- Consultations and evaluations from other practitioners or providers.
- Office and hospital records.
- Physical therapy notes.
- On-site, telephonic and fax concurrent reviews from inpatient facilities.
- Information regarding benefits for services or procedures.
- Information regarding the local delivery system.
- Patient characteristics and information.
- Information from responsible family members; and
- Independent, unbiased, and evidenced based analyses of new, emerging, and controversial healthcare technologies.

F. UM Determinations

Qualified health professionals supervise review decisions, including service reductions. UM decisions based on medical necessity to deny or authorize an amount, duration, or scope that is less than requested shall be made by qualified physicians/doctoral behavioral health specialists or appropriate health care professionals, who have appropriate clinical expertise in treating the condition and disease. Appropriate health care professionals at the Alliance are qualified physicians, qualified doctoral level behavioral health care professionals, and qualified pharmacists. The timeliness of UM decisions shall be commensurate with the seriousness and urgency of the request, whether the request is routine or expedited, and made in a timely manner and not unduly delayed for medical conditions requiring time sensitive services. Appropriately licensed and qualified health care professionals with clinical care expertise make UM review determinations according to approved clinical review criteria.
In addition to guidelines and criterion, patient records and conversations with appropriate practitioners are used in the decision-making process. Qualified health care professionals also supervise utilization review decisions. Under the supervision of a licensed medical professional, non-clinical staff collect administrative data or structured clinical data to administratively authorize cases that do not require clinical review.

Only a Medical Director or doctoral Behavioral Health Specialist with a current license to practice without restriction in California, makes medical necessity denial determinations. A Medical Director/ doctoral Behavioral Health Specialist is available to discuss UM denial determinations with providers. Providers are notified how to contact the Medical Director/ doctoral Behavioral Health Specialist about determination processes in the denial letter.

In accordance with the DHCS contract, only qualified health care professionals supervise

review decisions, including service reductions. A qualified physician/ doctoral Behavioral Health Specialist will review all denials that are made based on medical necessity. Additionally, a qualified physician or pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the Plan Medical Director in collaboration with the Plan Pharmacy and Therapeutics committee (P&T Committee) or its equivalent.

UM decisions are not based on the outcome of individual authorization decisions, or the number and type of non-authorization decisions rendered. UM staff involved in clinical and health plan benefit coverage determination processes are compensated solely based on overall performance and contracted salary and are not financially incentivized by the Alliance based on the outcome of clinical determinations.

Board certified physician and doctoral level behavioral health specialist advisors are available to the UM Program for consultation on clinical issues as well as consultation for potential denials. The UM Program maintains a list of board-certified physician specialists identified for consultation and documents their involvement in member authorization and appeal records when appropriate.

Decisions affecting care are communicated in writing to the provider and member in a timely manner, in accordance with regulatory guidelines for timeliness, and are not unduly delayed for medical conditions that require time-sensitive services. Reasons for decisions are clearly documented in the member/provider correspondence in easily understandable language. Notification must reference the benefit provision, guideline, protocol, or other similar criterion on which the denial decision is based. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based, upon request, must be included in the notification.

Providers are informed how to contact and speak with the Medical Director/doctoral Behavioral Health Specialist who made the decision. Notification communication includes appeal rights and procedures. Member notifications comply with appropriate contractual and regulatory guidance for each member's line of business. Member correspondence about authorization decisions includes a statement in each Alliance threshold language instructing the member how to obtain correspondence in their preferred language. Notice of Action Letters are sent in the Members' preferred language for those members whose preferred language is an identified threshold language, following the requirements of APL-21-004. Records, including Notice of Action letters, meet contractual retention requirements. Members are informed that they may request copies of their medical records at no cost.

G. UM Referral Management and UM Review Processes

The scope of medical management services and activities includes utilization review determinations, referral management, discharge planning, complex case management,

and UM documents.

1. Services Exempt from Prior Authorization

Exemptions from Prior Authorization services for members differ by product line and are listed in the member's benefit handbook, online at www.alamedaalliance.org and in the specific provider manuals. Exemptions include:

- Emergency Services, whether in or out of Alameda County; except for care provided outside of the United States. Care provided in Canada or Mexico are covered.
- Urgent care, whether in or out of network
- Primary Care Visits
- Preventative Services
- Mental Health Care and Substance Use treatment
- Women's health services – a woman can go directly to any network provider for women's health care such as breast or pelvic exams. This includes care provided by a Certified Nurse Midwife/OB-GYN and Certified Nurse Practitioners
- Basic prenatal care – a woman can go directly to any network provider for basic pre-natal care.
- Family planning services, including counseling, pregnancy tests and procedures for the termination of pregnancy (abortion)
- Treatment for Sexually Transmitted Diseases includes testing, counseling, treatment, and prevention.
- HIV testing and counseling
- Second Opinions from In Network providers arranged by the assigned PCP
- Initial Mental Health Assessments
- Early and Periodic Screening, Diagnostic and Treatment
- Biomarker testing for members with advanced or metastatic cancer stage 3 or 4
- Annual Cognitive Assessment for Medi-Cal members over 65 without Medicare.

2. Auto-Authorization

- Services approved on the most recent copy of the Medical Management Auto Authorization Matrix.
- Direct - Services for which UM requests are not required, include but are not limited to:
  - Specialty visits, direct network
  - Preventive health diagnostic services, i.e., mammogram, colonoscopy

3. Services Requiring Prior Authorization

The Alliance develops, reviews, and approves at least annually, lists of auto authorizations. Any procedure, treatment, or service not on these lists requires prior authorization. The Alliance communicates to all contracted health care practitioners the procedures, treatments, and services that require prior authorization and the procedures and timeframes necessary to obtain such prior authorization.

Authorization requirements for medical services are listed on the website, at

www.alamedaalliance.org. Providers can also review the approved drug formulary at this website.

The services that currently require prior authorization include, but are not limited to:

- Non-emergency out of area care, outside of Alameda County
- Out of network care, for services not provided by a contracted network doctor.
- Inpatient Admissions if non-emergency/elective
- Inpatient Admission to Skilled Nursing Facility or Nursing Home
- Outpatient hospital services/surgery
- Outpatient facilities, non-hospital based, such as surgeries or sleep studies.
- Outpatient diagnostic and radiology services, minimally invasive or invasive such as CT Scans, MRIs, cardiac catheterization, PET
- Durable Medical Equipment, standard or customized; rental or purchased.
- Medical Supplies
- Prosthetics and Orthotics
- Podiatry services
- Home Health Care, including skilled nursing, nursing aides, rehabilitation therapies, and social workers.
- Transportation
- Transplant Services
- Tertiary/Quaternary evaluation
- Experimental or Investigational Services
- Cancer Clinical Trials
- Medications not on the Alliance Approved Drug List and/or exceeding the monthly medication limit.
- All admissions to LTSS services - CBAS and Long-Term Care (LTC) facilities
- Acupuncture, greater than 4 visits per month.
- Chiropractic Services- See Prior Authorization grid for detail.
- Radiology Services (i.e., CT, MRI, PET)
- Second Opinions from OON providers
- Select behavioral health services.

The Alliance also routinely analyzes past utilization patterns to determine whether it would be in the member's best interests to remove any of the listed services from the prior authorization requirement or add additional requirements. The Alliance makes any adjustments to this list by amending the Prior Authorization Policies, as appropriate.

4. Medical Director Responsibilities

The Medical Directors/doctoral Behavioral Health Specialist are responsible for providing clinical expertise to the UM staff and exercising sound professional judgment during review determinations regarding health care and health services.

The CMO and Medical Directors/doctoral Behavioral Health Specialist, with support of

the UM Committee, have the authority, accountability, and responsibility for denial determinations. Physician review and determination is required for all final denial decisions based on medical necessity for requested medical services. The review of the denial of a pharmacy prior authorization for medical necessity, however, may be carried out by a qualified Physician or Pharmacist. For those contracted entities that are delegated UM responsibilities, the entity's Medical Director has the sole responsibility and authority to deny coverage; the Medical Director may also provide clarification of policy and procedure issues, and communicate with entity practitioners regarding referral issues, policies, and procedures, etc.

5. Appropriate Professionals for UM Decision Process

The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. Only physicians, pharmacists, or doctoral level behavioral health specialists can make decisions/determinations for denial or modification of care based on medical necessity.

6. Timeliness Standards

The Alliance maintains established timeliness standards for UM/BH determinations for routine and urgent Authorization Requests in compliance with Regulatory Standards for each Product Line as described in corresponding Policies/Procedures. The timeliness of UM decisions shall be commensurate with the seriousness and urgency of the request whether the request is routine or expedited. Time sensitive requests cannot be delayed waiting for medical information. Response to requests must meet required regulatory timeframes.

7. Utilization Review Processes

The UM/BH Program includes the following utilization review processes:

Prospective Review

Prospective (pre-service) review is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted prior to the delivery of a health care service or supply to a member. A prospective review decision is based on the collection of medical information available to the health care provider prior to the time the service or supply is provided.

Concurrent Review

Concurrent review is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted during a member's ongoing stay in a facility or course of outpatient treatment. The frequency of review is based on the member's medical condition with respect to applicable care guidelines.

Retrospective Review

Retrospective (post-service) review is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is

conducted after the health care service or supply is provided to a member.

Submissions received within 90 days from the date of service will be reviewed for medical necessity. Submissions received after 90 days from the date of service will be denied for not obtaining prior authorization. Exceptions include member eligibility issues, if the services were emergent/urgent, or inpatient services where the facility is unable to confirm enrollment with the Alliance. If the exceptions are met, then the submission will be reviewed for medical necessity regardless of when it was received.

The Alliance maintains instructions for the authorization process on the website and provider training which is available to contracted and non-contracted providers. For non-contracted facilities, the Alliance maintains a 24-hour UM contact notification process on the California DMHC website. The Alliance maintains a full list of conditions eligible for retrospective review by the Department and is reviewed annually for any changes.

8. Outpatient Referral Management

Alliance network physicians are the primary care managers for member healthcare services. Based on the member's assignment, referrals may be managed by the Alliance or a delegated Provider Group.

Network Primary Care Physicians (PCPs) may process in-network specialist and facility referrals directly to members as "direct referrals" without administrative pre-authorization from the UM Program or the Provider Group. These referrals are primarily for routine outpatient and diagnostic services and are tracked by the UM Program using claim and encounter data. Tertiary/Quaternary evaluations require prior authorization. For services identified as requiring prior authorization, PCPs must submit and coordinate prior authorization for several services that require prior authorization, such as DME, home health and certain radiology services. All elective inpatient surgeries and non-contracted provider referrals require prior authorization.

The UM Program clinical information system tracks all authorized, denied, deferred, and modified service requests and includes timeliness records. These processes are outlined in the Provider Manual and in internal policies and procedures.

Practitioners and providers send referrals and requests for prior authorization of services to the UM Department by the AAH provider portal, mail, fax and/or telephone, based on the urgency of the requested service. Request must include the following information for the requested service:

- Member demographic information (name, date of birth, etc.)
- Provider demographic information (Referring and Referred to)
- Requested service/procedure, including specific CPT/HCPCS Codes
- Member diagnosis (ICD-10 Code and description)

- Pertinent medical history and treatment
- Location where service(s) will be performed.
- Clinical indications necessitating service or referral *(See Section: Minimum Clinical Information for Review of UM Requests for Authorization)*

Requests for services are reviewed in accordance with approved UM criteria and the member's benefit structure. When decisions on coverage are based on medical necessity, relevant clinical information is obtained and consultation with the treating practitioner occurs, as necessary.

Requests for Authorization determinations related to Medi-Cal and IHSS Product Lines are defined differently as follows**:**

- Pre-Service Determinations for Medi-Cal and IHSS are defined in the following terms:
    - Approval - the determination to provide a service.
    - Modification – the determination to either approve less than what was requested or to approve something else in place of what was requested.
    - Denial - a determination to not provide the request service.
    - Delay – when a determination cannot be made, and additional time is required to obtain relevant clinical information.
    - Termination- to not extend an extension of a previously authorized service (e.g., PT visits, SNF days, etc.) (NOTE: must give 10 calendar days' notice of terminations)

UM staff receive requests for authorization of outpatient services and elective procedures prior to admission to ensure that admission to a healthcare facility is appropriate/medically necessary. Non-Clinical UM staff may approve services which can be automatically authorized, within their scope when the specific elements of the policy are met. Clinical UM staff will review services that require prior authorization based on medical necessity. The medical necessity clinical review is based on the severity and complexity of the individual case unless there are questions regarding the medical necessity of services.

Should the UM staff question the medical necessity of services to be rendered, or appropriateness of the level of care for service based on review criteria and guidelines, the Medical Director/doctoral Behavioral Health Specialist will be consulted for case review. The Medical Director/doctoral BH Specialist, or physician designee, will contact the attending physician to discuss the case, if necessary.

Should the Medical Director or physician designee/doctoral Behavior Health specialist determine that proposed services are not medically necessary or indicated, a denial determination may be made by the Medical Director/doctoral Behavioral Health specialist. Denial notification and communication will be made in accordance with current regulatory timeliness standards and denial notification requirements, as established by regulators, including the DHCS and Department of Managed Health Care (DMHC) and national accrediting organizations, such as NCQA.

9. Second Opinion

The Alliance members may request a second opinion from any qualified primary care provider or specialist within the same medical group. If a qualified specialist is not available within the medical group, a referral is provided within the Alliance's network. If a qualified specialist is not available in the Alliance network, staff will assist the medical group to identify an out-of-network specialist. The second opinion from a qualified health professional will be provided at no cost to the member. The Alliance provides a second opinion from a qualified health care professional when a member or a practitioner requests it for reasons that include, but are not limited to, the following:

- The member questions the reasonableness or necessity of recommended surgical procedures.
- The member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including but not limited to, a serious chronic condition.
- The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and requests consultation, or the member requests an additional diagnosis.
- The treatment plan in progress is not improving the medical condition of the member within an appropriate period given the diagnosis and plans of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment.
- The member has attempted to follow the practitioner's advice or consulted with the initial practitioner concerning serious concerns about the diagnosis or plan of care.

The Alliance educates its members and practitioners of the availability of second opinions in annual member publications. Policies regarding second opinions are available to the public upon request. Member rights related to second opinions include:

- To be provided with the names of two physicians who are qualified to give a second opinion.
- To obtain a second opinion within 30 calendar days, or if the medical need is emergent or urgent, to obtain an opinion within a timeframe that is appropriate to the member's condition and that does not exceed 72 hours
- To see the second opinion report.

10. Standing Referrals

The Alliance maintains processes to provide enrollees a standing referral to a specialist. The procedure shall provide for a standing referral if the PCP, in consultation with both the specialist, if any, and the Alliance Medical Director (or designee), determines that the enrollee has a condition or disease that requires continuing specialized medical care from the specialist or Specialty Care Center, (SCC).

The Alliance may require the PCP to submit a treatment plan during care or prior to the referral from the enrollee as determined by the Medical Director:

- If a treatment plan is necessary during care and is approved by the Alliance, in consultation with the PCP, specialist, and enrollee, a standing referral shall be made in accordance with the treatment plan.
- A treatment plan may be deemed unnecessary if the Alliance approves a current standing referral to a specialist.
- The treatment plan may limit the number of visits to the specialist, limit the period of time during which visits are authorized, or require that the specialist provide the PCP with regular reports on the care and treatment provided to the enrollee.

The Alliance maintains guidelines for standing referral requests for enrollees that required specialized medical care over a period and who have a life-threatening, degenerative, or disabling condition, to a specialist or SCC that has expertise in treating the condition or disease for having specialist coordinate he enrollee's health care. Standing referral to a specialist or SCC are provided within the Alliance's network to participating providers, unless there is no specialist or SCC within the Alliance's network that is appropriate to provide treatment to enrollee, as determined by the PCP in consultation with the Medical Director and as documented in the treatment plan.

11. Concurrent/Continued Stay Review (Acute, Skilled, Rehabilitation, Long Term Care/Custodial)

The Alliance provides telephonic UM services. Appropriate inpatient medical management is ensured through consistent and coordinated Concurrent Review of members, irrespective of the presence or utilization of a contracted hospitalist. Concurrent/Continued Stay Review is a process coordinated by the UM staff during a member's course of hospitalization, which may include acute/psychiatric hospital, skilled nursing, acute rehabilitation and long-term care facilities, to assess the medical necessity and appropriateness of continuation at the requested level of care. Concurrent/Continued Stay review also involves the telephonic or on-site medical record review that occurs after admission if no pre-admission review has occurred.

Additional objectives of continued stay review are to:

- Ensure that services are provided in a timely and efficient manner.
- Ensure that established standards of quality care are met.
- Implement timely and efficient transfer to lower levels of care when clinically indicated and appropriate.
- Implement effective and safe discharge planning.
- Identify cases appropriate for Transitional Care Services and ongoing Case Management services.

The Concurrent Review Procedure shall be followed throughout the member's hospitalization, utilizing approved criteria and guidelines. Telephonic, facsimile reviews or on-site are coordinated by the UM/BH staff daily, or on cyclic intervals based on individual case requirements. In the event a scheduled review date falls on a weekend or holiday, the UM staff will coordinate a Concurrent Review on the workday prior to the

scheduled review date, or not later than the first workday after the holiday or weekend.

Continued hospital care and/or ancillary services that do not meet continued stay criteria are referred to the Medical Director/doctoral BH Specialist, or physician designee, to evaluate and consult with the attending physician, as appropriate. When the Medical Director decides that the case does not meet criteria for continued stay based on medical necessity or appropriateness, the attending physician will be contacted, and discharge planning discussed. When an acceptable discharge plan is mutually agreed upon by the attending physician and the UM Medical Director, a Notice of Action (NOA) letter may be issued immediately by fax or via overnight Certified Mail to the attending physician, hospital, and the member, if the member disagrees with the discharge plan.

12. Transitional Care Services and Discharge Planning

Transitional Care Services and Discharge Planning management are components of the UM process that assess necessary services and resources available to facilitate member discharge and/or transition to the appropriate level of care. Discharge Planning refers to activities related to planning the discharge of a member out of an inpatient medical/psychiatric/SUD facility. Transitional Care Services (TCS) refers to activities related to transferring of a member from one setting or level of care to another. which may be facility based or community based. TCS involves the identification of a TCS care manager to follow through the inpatient stay to the post discharge period, the development of a discharge risk assessment, and ensuring the completion of a discharge document for the member. Members appropriate for TCS services are identified by the AAH Risk Stratification algorithm and/or assessment of the individual member. Once the State releases its Risk Stratification algorithm, AAH will adopt it. In 2023, members identified as high risk will receive TCS services as they transfer across settings. In 2024, all members transferring across settings will receive TCS services.

Discharge planning begins as early as possible during an inpatient admission, and is designed to identify and initiate cost effective, quality-driven treatment intervention for post-hospital care needs. It is a cooperative effort between the attending physicians, hospital discharge planner, UM/BH staff, assigned TCS Care Manager, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of high-risk medical/psycho-social issues with potential need for post-hospital intervention, including a discharge risk assessment.
- Development of an individual care plan involving an appropriate multi-disciplinary team and family members involved in the member’s care.
- Communication with the attending physician and member, when appropriate, to suggest alternate health care resources.
- Communication to attending physician and member regarding covered

benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization.

- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge Planning staff, assigned TCS Care Manager, and UM staff.
- Referral to Transitional Care Services or Home Health Programs within or outside of AAH programs.

The UM staff obtains medical record information and identifies the need for discharge to a lower level of care based on discharge review criteria/guidelines. If the attending physician orders discharge to a lower level of care, the UM/BH staff assists the hospital UM/Discharge Planner and assigned TCS Care Manager in coordinating post-hospital care needs. The same process is utilized for continued stay approval or denial determinations by the UM Medical Director, as previously noted in the Concurrent Review Process.

UM Review Clinicians work with facility discharge planners, attending physicians, assigned TCS Care Managers, ancillary and community service providers to assist in making necessary arrangements for member post- discharge needs. The UM Review Clinicians integrate with the Case Management Population Health Management driven initiatives by identifying, referring, communicating, and making recommendations that will help meet members' needs and address medical and psychosocial issues that result in hospitalization.

For SPD members, UM Review Clinicians are responsible for ensuring discharge planning is in place ensuring that necessary care, services, and supports are in place in the community for the SPD beneficiary once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the patient and/or caregiver. Minimum criteria for discharge planning activities includes:

A. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, durable medical equipment (DME), and other services received.
B. Documentation of pre-discharge factors, including an understanding of the medical condition by the SPD beneficiary or a representative of the SPD beneficiary as applicable, physical, and mental function, financial resources, and social supports.
C. Services needed after discharge, type of placement preferred by the SPD beneficiary/representative of the SPD beneficiary and hospital/institution, type of placement agreed to by the SPD beneficiary/representative of the SPD beneficiary, specific agency/home recommended by the hospital, specific agency/home agreed to by the SPD beneficiary/representative of the SPD beneficiary, and pre-discharge counseling recommended.
D. Summary of the nature and outcome SPD beneficiary/representative of the

SPD beneficiary involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, involvement of any assigned TCS Care Manager, and further action contemplated by the hospital/institution.

13. Denial Notifications

Adverse Benefit Determination letters or/and Notice of Action (NOA) letters for denials are provided to members and their practitioners in compliance with the member's regulatory appeal requirements. All potential denials and/or modifications of service are discussed with the appropriate Medical Director/doctoral Behavioral Health Specialist, who makes the final determination.

Services that are denied, modified, delayed shall contain the following elements:

- Clear, concise, and easily understandable explanation of the reason for denial in the Notice of Action (NOA) or adverse determination letter
- Reference to the specific benefit, guideline, protocol, or other similar criterion on which the denial decision is based.
- Statement that members can obtain a copy of the actual benefit, guideline, protocol, or other similar criterion on which the decision was based.
- Member Rights
- Appeal Rights and Process

In addition to the above for ongoing services that are terminated for all members, the NOA shall include:

- Agreement to an alternative treatment plan by attending practitioner for hospital concurrent decisions and by the PCP for Ambulatory Concurrent decisions
- In addition to the above for Medi-Cal members:
- Citation to the criteria used to support the decision (Medi-Cal only)
- Information about the member's State Hearing rights and process
- "Aid Paid Pending" process, as applicable for Medi-Cal, must also be included.

In addition, All UM NOA correspondences for pre-service and concurrent denials, modifications, and adverse decisions sent to the Requesting Practitioner shall include a name and phone number for contacting the Peer Reviewer to allow for the Requesting Practitioner to request a reconsider of the UM Determination

14. Peer to Peer Review (Discussing a Denial with a Peer Reviewer)

All UM Notice of Action correspondences for pre-service and concurrent denials, (including modifications, terminations, and adverse decisions) sent to the Requesting Practitioner shall include a name and phone number for contacting the Peer Reviewer to allow the Requesting Practitioner the opportunity to discuss issues or concerns regarding the decision. If a denial is being considered by the Peer Reviewer, a practitioner can discuss the decision by calling or writing to supply additional information for discussion

with the Peer Reviewer. The Peer Reviewer will make himself/herself available for discussion of the denial decision within one business day of the receipt of the provider telephone call or written request. If the discussion does not result in a fully reversed denial determination, the practitioner can initiate an expedited or standard appeal, as appropriate.

15. Required Internal Reporting for UM Staff

- Potentially fraudulent or abusive practices identified to the Compliance Department
- Potential under and over utilization to the UM Manager
- Coordination of care for results or facilitation to the UM Manager
- Opportunities for improvement to the UM Manager
- Breaches of adherence to confidentiality and HIPAA policies to the Alliance's designated Compliance staff member
- Potential quality issues identified through UM activities to the Quality Improvement Department
- Barriers to accessibility and availability of UM services to the UM Manager

16. UM Documents

In addition to this program description, other documents important in communicating UM/BH policies and procedures include:

- The Provider Manual, available on the Alliance web site and on a CD, provides an overview of operational aspects of the relationship between the Alliance, providers, and members. Information about the Alliance's UM Program, referral and tracking procedures, processes, and timeframes necessary to obtain prior authorization are included in the manual. In addition, the Provider Manual describes how providers may obtain a copy of the clinical guidelines used to make medical determinations.

- The Provider Bulletin is a periodic newsletter distributed to all contracted provider sites and delegated groups on topics relevant to the provider community and may include UM policies, procedures, and activities.
- The Member Alert is a periodic newsletter distributed to members in all lines of business. Each issue covers different topics of interest and importance to members about their health and may include information about UM policies and procedures.

- Evidence of Coverage (EOC) documents are distributed to members based on their product line.

    - Members have the right to submit a complaint or grievance about any Plan action. The Evidence of Coverage document directs members to call the Member Service phone number to initiate

complaints or grievances involving UM issues and actions. Member complaints or grievances are documented in the data system and forwarded to the UM unit for follow-up response. The Alliance Grievance and Appeal unit coordinates with the UM unit on appropriate responses to member complaints or grievances.

These documents, or summaries of the documents, are available upon request to providers, members, and community partners. In addition, the UM/BH Program information is available on the Alliance website.

H. Continuity of Care for Medical and Behavioral Health Services

Continuity of care (CoC) can be defined as the lack of interruption in the care provided to members when circumstances dictate a change in the member's insurance coverage, geographic location, entity, or provider assignment.

The Alliance must provide continuity of care with an out-of-network provider when:

- The Alliance can determine that the beneficiary has an existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider).
  - An existing relationship means the beneficiary has seen an out-of-network primary care provider (PCP,) behavioral health provider or specialist at least once during the 12 months prior to the date of his or her initial enrollment in the Alliance for a non-emergency visit, unless otherwise specified by regulation. CoC also extends to the following ancillary providers: DME, OP Rehabilitation, and respiratory therapy
- The provider is willing to accept the higher of the Alliance's contract rates or Medi-Cal FFS rates.
- The provider meets the applicable professional standards and has no disqualifying quality of care issues (a quality-of -care issue means the Alliance can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other Medi-Cal beneficiaries);
- The provider is a California State Plan approved provider; and
- The provider supplies the Alliance with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, if it is allowable under federal and state privacy laws and regulations.

The Alliance is not required to provide continuity of care for services not covered by Medi-Cal or those services managed directly by DHCS. In addition, provider continuity of care protections does not extend to additional ancillary services.

The UM staff works with the member and the member's current treating physician and/or PCP to assist the member in continuity of care. Every effort is made to maintain continuity of care for the member during the transition process. If the current treating physician is not affiliated with any of the existing Provider Groups, (PGs,) or with the member's PG selection, the UM staff works with the PGs to make arrangements with the physician to continue care of the member until the treatment is completed or the member can be safely transitioned to

a physician within the PG. The UM staff notifies each PG of its membership qualifying for continuity of care assistance.

When members are identified as possibly benefiting from coordination of care, both within and outside of the network, the case is referred to Case Management for further intervention. The Case Management actively engages in activity that monitors and assesses continuity and coordination of clinical care. Individual registered nurses work closely with the Member, the physicians and any other associated healthcare delivery organization involved in the case, to provide timely, quality-based care meeting the needs of the individual member.

Continuity of care is also evaluated when members are referred from primary care physicians and specialists, including behavioral health specialists, or when a member is transferred or admitted to another level of care, such as a transfer or admittance to a skilled nursing facility (SNF), Long Term Care nursing facility, rehabilitation, chemical dependency, or mental health facility, where member follow through is a risk.

The Alliance documents all requests for assistance with continuity of care and is responsible for monitoring and oversight of the activities. A full description of the various programs is listed in the applicable policies and procedures.

1. *New Enrollees*

The Alliance recognizes that a strong doctor-patient relationship, particularly for members with serious medical conditions, may enhance the healing process. Maintaining continuity of care as new enrollees change physicians and health plans are an important aspect of this relationship. Each newly enrolled Medi-Cal member is placed in a transition group for up to 30 days, during which time they select their Alliance, PG, and PCP.

For a newly enrolled members, the Alliance must honor any active MediCal FFS Treatment Authorization Requests (TARs) for 90 days and will continue until a new assessment is completed by the Alliance. A new assessment is considered completed by the Alliance if the beneficiary has been seen by an Alliance -contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. The FFS TAR must be honored as outlined above without a request by the beneficiary or the Provider.

2. ***Terminated Practitioners (Including PCPs, Behavioral Health Providers and Specialists)***

The Alliance’s contracts with delegates establish a mechanism to continue appropriate and timely care for members whose physicians are terminating from the PG. This process includes notification from practitioners of intent to terminate, in accordance with the laws applicable to the line of business. Members under current care, and those with approved prior authorizations, not yet utilized, are identified, so that their care can be managed and coordinated with the receiving entity or with the Alliance physicians. Members, such as, but not limited to those undergoing cancer treatments of

chemotherapy or radiation therapy, that are dialysis-dependent, awaiting transplants, in late-term pregnancies, have pending surgeries, or those awaiting transfer or admittance to a skilled nursing facility (SNF), rehabilitation, chemical dependency, or mental health facility, and any other members who might have their ongoing care negatively impacted by the termination of the group are identified.

The Alliance will notify members affected by the termination of a practitioner or practice group in general, family, or internal medicine of pediatrics, at least 30 calendar days prior to the effective termination date, and help them select a new practitioner.

For members undergoing active treatment for a chronic or acute medical condition, care may be continued through the current period of active treatment (acute care) or up to 12 months for serious/chronic care.**3**. ***Pregnant and Post- Partum Members***

Pregnant and post-partum Medi-Cal beneficiaries who are assigned a mandatory aid code and are transitioning from Medi-Cal FFS into the Alliance have the right to request out-of-network provider continuity of care for up to 12 months post-partum in accordance with the Alliance contracts and the general requirements listed in the regulatory guidance. This requirement is applicable to any existing Medi-Cal FFS provider relationship that is allowed under the general requirements of regulatory guidance.

For Alliance Group Care, continuation of care extends through the postpartum period for members in their second or third trimester of pregnancy.

4. *Medical Exemption Requests*

A Medical Exemption Request (MER) is a request for temporary exemption from enrollment into the Alliance only until the Medi-Cal beneficiary's medical condition has stabilized to a level that would enable the beneficiary to transfer to an Alliance provider of the same specialty without deleterious medical effects. A MER is a temporary exemption from the Alliance enrollment that only applies to beneficiaries transitioning from Medi-Cal FFS to the Alliance. A MER should only be used to preserve continuity of care with a Medi-Cal FFS provider under the circumstances described above in this paragraph. The Alliance is required to consider MERs that have been denied as an automatic continuity of care request to allow the beneficiary to complete a course of treatment with a Medi-Cal FFS provider in accordance with the most recent regulatory guidance.

5. *Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder*

The Alliance is responsible for providing Early and Periodic Screening, Diagnosis, and Treatment (Medi-Cal for Kids and Teens,) services for beneficiaries ages 0 to 21. The services include medically necessary Behavioral Health Treatment (BHT) services such as Applied Behavioral Analysis and other evidence-based behavioral intervention services that develop or restore, to the maximum extent practicable, the functioning of beneficiaries diagnosed with Autism Spectrum Disorder (ASD). In accordance with the

requirements listed in the most recent DHCS All Plan Letter, the Alliance must provide continued access to out-of-network BHT providers (continuity of care) for up to 12 months.

I. Behavioral Health Management

The provision of behavioral health and substance use services are applied to Alliance members according to their benefit. Group Care members receive a comprehensive benefit for all behavioral health services. Since 2021, the Alliance has implemented the requirements of All Plan Letter (APL) 21-002 – Implementation of SB 855, Mental Health and Substance Use Disorder Coverage for the Group Care Line of Business. Medi-Cal members receive services for mild to moderate behavioral health services. The provision of treatment for moderate to severe behavioral health services for Medi-Cal members is managed under a Memorandum of Understanding with Alameda County Behavioral Health Care Services, as described below.

The Alliance ensures services are provided in a culturally and linguistically appropriate manner.

1. Alameda County Behavioral Health Care Services (ACBHCS)

Specialty behavioral health services for Medi-Cal members excluded from the Alliance contract with DHCS are coordinated under a Memorandum of Understanding executed with ACBHCS. This is a carve-out arrangement for specialty behavioral health management with the State of California directly overseeing and reimbursing the behavioral health services provided to Medi-Cal members.

The referral procedure for Alliance members includes:

- Alliance Primary Care Providers (PCPs) render outpatient behavioral health and substance abuse services within their scope of practice.
- PCPs refer the members to ACBHCS for evaluation and coordination of medically necessary specialty behavioral health services by the Access Team, including inpatient psychiatric care.
- PCPs refer members to qualified Medi-Cal providers for the provision of services not covered by ACBHCS.

2. Behavioral Health

In 2023, AAH will insource the management of behavioral health services at the end of the first quarter, rather than using a delegated Managed Behavioral Health Organization, under the leadership of the Senior Director of Behavioral Health. For Medi-Cal beneficiaries, Alameda County Behavioral Health Care Services (ACBHCS) provides Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) services. The Alliance provides mild to moderate behavioral health and substance abuse services not covered through ACBHCS, and for all behavioral health and substance abuse services benefits for other lines of business. The Alliance provides Behavioral Health Therapy (BHT) services for Medi Cal members under the age of 21 for the treatment of Autism Spectrum Disorder and other conditions where excessive

and/or deficits of behaviors that significantly interfere with home and community activities. The Alliance provides behavioral health utilization management activities and maintains the provider network for behavioral health and substance abuse services.

All BH services are based on a member's benefit plan. The scope of the program covers behavioral health treatment that may be beyond the customary scope of practice of a primary care physician. Care settings include home and office based services, free-standing and hospital-based programs, residential treatment programs and facility based acute care treatment units. Medical necessity is determined by applying level of care criteria, while the clinical appropriateness of services are evaluated using criteria and guidelines developed by the nonprofit professional association for the relevant clinical specialty when conducting utilization review of treatment of mental health and substance use disorders.
. Member specific clinical information is obtained from the member and/or family member or other legal representative, behavioral health medical providers (through verbal case review and/or submission of medical records). Program processes include triage and referral; prospective; concurrent; post-service review and care coordination. Services include education to members and providers, coordination of care with primary care physicians, linkage and coordination with state and community agencies.

The Alliance reviews and approves LOC criteria through the QIHEC. The Alliance reviews the criteria to ensure its clinical criteria for both medical and behavioral health services are aligned. AAH's Level of Care criteria (LOC), as adopted by the UMC, were developed from the comparison of national, scientific and evidence-based criteria sets, including but not limited to those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA) and American Academy of Child and Adolescent Psychiatry (AACAP), (CALOCUS-CASII) Substance Abuse and Mental Health Services Administration (SAMHSA), the American Society of Addiction Medicine (ASAM,) American Association of Community Psychiatrists (LOCUS), and World Professional Association for Transgender Health, (WPATH)

AAH uses the LOC criteria as guidelines, not absolute standards, and considers them in conjunction with other indications of a member's needs, strengths, and treatment history in determining the best placement for a member. LOC criteria are applied to determine appropriate care for all members. In general, members will only be certified if they meet the specific medical necessity criteria for a particular LOC. However, the individual's needs and characteristics of the local service delivery system are taken into consideration prior to the making of UM decisions.

3. Alameda Alliance Triage and Referral

The Alliance arranges for triage and screening services available by telephone to members 24 hours per day, 7 days per week. The Alliance ensures that the telephone triage or screening services are provided in a timely manner appropriate for the requesting member's condition, including medical/surgical and behavioral health conditions.

The Alliance's contracted provider network provides triage services to its members. Primary care providers and mental health care providers provide triage and screening services 24 hours a day, 7 days a week for medical and behavioral health care services.

For cases when the providers are unable to meet the time-elapsed standards, the Plan provides members the Plan's nurse advice line and a behavioral health crisis service call line to call as an alternative triage and screening service arrangement. Providers who are unable to provide triage and screening services are required to inform members about the Alliance's nurse advice line information.

4. Monitoring Over and Under Utilization of Medical and Behavioral Health Services

The CMO or its physician designee monitors patterns of over and under-utilization.

Data is reviewed at the UMC and QIHEC and when a pattern of under or over utilization is identified an analysis of barriers is conducted and potential interventions are identified. Data is then re-evaluated to determine the efficacy of the interventions.

When a concern over potential over or under-utilization for a specific member is identified, the clinical team including the Primary Care Physician, under the direction of the UM Medical Director, develops a plan to address the utilization issue which may include referral to Behavioral Health Case Management and/or the Alliance's Case Management or Disease Management programs, physician peer to peer with the inpatient attending physician, referral to the Alameda county mental health authority for additional services and supports.

5. Behavioral Health Integration

Members may contact the Alliance Behavioral Health Service department or be referred by the PCP and/or health care professional. The Alliance maintains procedures for providers to coordinate care and services for members in need of behavioral health services including, but not limited to, all medical necessary services across the behavioral health provider network.

The Alliance uses a variety of mechanisms that ensure behavioral health services and management processes are actively integrated into the UM Program and include:

- A behavioral healthcare practitioner, who is a behavioral healthcare physician or a doctoral-level behavioral health practitioner, is involved in quarterly QIHEC meetings to support, advise, and coordinate behavioral healthcare aspects into UM Program policies, procedures, and processes.
- The Senior Director of Behavioral Health Services directs all aspects of the BH program to ensure that the program meets all regulatory requirements and integrates with the UM Program, Case Management Program, Member Services, and other departments within the Alliance.

- There are regular care coordination rounds, in which the staff attending rounds evaluates topics such as access, availability, health management systems, practice guidelines, clinical and service quality improvement activities, member satisfaction, continuity and coordination of care and member's rights and responsibilities.
- The Alliance routinely generates clinical reports reflecting metrics and outcomes of the Behavioral Health Services program, which are reviewed and acted upon as needed at appropriate AAH Committees and QIHEC.
- The Alliance participates in periodic operational meetings with ACBHCS to review and coordinate administrative, clinical, and operational activities.

J. Pharmacy Management

Starting in 2022, much of the pharmacy benefit for Medi-Cal members was carved out to the DHCS Medi-Cal Rx program. For those pharmacy benefits not carved out and for the commercial LOB, the Alliance ensures the provision of pharmacy management to a pharmacy benefit manager (PBM). The PBM possesses service level guarantees that manages pharmacy services under the delegated arrangement and maintains clinical policies and procedures that are revised at least annually. The Alliance delegates some of its pharmacy utilization management activities to the pharmacy benefit management company. The PBM supports full prior authorization review services, including confirmation of denials for weekends/holidays/emergency. The PBM provides support to the Alliance's Pharmacy and Therapeutic Committee activities including formulary management, guideline development and trend reviews related to pharmacy services. The Pharmacy and Therapeutics Committee meets quarterly and provides oversight for evidence-based, clinically appropriate pharmacy guideline criteria. Guidelines are developed in conjunction with review of peer-reviewed literature and with consideration for such factors as safety, efficacy, and cost effectiveness, with the input and evaluation of external clinical specialists appropriate to the subject matter.

The PBM receives and processes medication prior authorization requests for medications filled through network retail and specialty pharmacies. The PBM's Prior Authorization Department is comprised of certified technicians and clinical pharmacists who conduct reviews and approve requests that meet prior authorization criteria. All requests that the PBM cannot approve per their protocol are forwarded to Alliance for the final determination. All pharmacy PA requests must be processed, and a decision rendered within the regulatory requirement. Pharmacy UM decision monitoring is reported through the UM Committee.

K. Linked and Carved Out Services

For linked and carved out services the Alliance provides linkages with community programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions, receive wrap-around services that enhance their medical benefits. These linkages are established through special programs, such as the Alliance Community Liaisons, and specific program Memoranda of Understanding (MOU) with other

community agencies and programs, such as the California Children's Services, Alameda County Behavioral Health Care Services, and the Regional Center of the East Bay (RCEB). The UM staff and delegated entity practitioners are responsible for identification of such cases, and coordination of referral to appropriate State agencies and specialist care when the benefit coverage of the member dictates. The UM Department coordinates activities with the Case Management Department to assist members with the transition to other care, if necessary, when benefits end. This may include informing the member about ways to obtain continued care through other sources, such as community resources.

A full description of the program identification and referral process as well as the care coordination activities is maintained in the UM department policies and procedures.

Section IV. Special Programs

A. Transplant Programs

The Alliance provides an appropriate level of care and services within the member's benefits for transplants according to product line requirements, whether MediCal or Group Care. All patients are monitored according to contractual requirements on an inpatient and outpatient basis, and the member, physician, and facilities are assisted to assure timely, efficient, and coordinated access.
Medi-Cal Members are covered for all medically necessary organ transplants:

a) As of 2022, the Alliance became responsible for all Major Organ Transplants/Bone Marrow Transplants. (MOT/BMT,) in addition to the kidney and corneal transplants previously covered.

b) For members under 21 years of age, organ transplant coverage is provided by California Children Services (CCS). The Alliance refers members under 21 to CCS for evaluation of potential organ transplant. CCS will refer the CCS-eligible member to the transplant Special Care Center, (SCC.) for adjudication of the request and follow-up.

c) Major Organ transplant evaluations are referred to one of the Medi-Cal facilities noted as Center of Excellence (CoE) on the most recent DHCS CoE list of facilities for evaluation. The Alliance will authorize the request for the transplant after the transplant program confirms the transplant candidacy of the member. Once the transplant program confirms that the member is a suitable transplant candidate, the Alliance will authorize the request for the transplant.

d) Kidney and corneal transplants are provided through Alliance-approved practitioners.

e) Kidney transplants, along with related care such as dialysis, evaluation of potential donors, and nephrectomy from living or cadaver donors, continue to be covered benefits.

Group Care (IHSS) Members are covered for all medically necessary organ transplants. This coverage is provided by Alliance-approved practitioners and facilities.

A full description of the program, including the identification and referral process as well as the care coordination activities is maintained in the department policies and procedures.

B. Transportation Services

Transportation services are covered benefits. Transportation benefits include:

- Emergency
- Non-emergency medically necessary (NEMT)
- Non-medical transportation (NMT)

Benefits are administered based on the guidance of the Alliance product line. Those products include:

- MediCal
- IHSS

For the administration of the benefit:

- For Members enrolled with Kaiser, the Alliance delegates the responsibility for the provision of transportation services to the contracted Plan Partner.

- For the administration of MediCal Direct and IHSS, the Alliance is responsible for the provision of transportation services.

The Alliance contracts with a vendor, Modivcare, to provide the various modes of transportation. The transportation benefit is available for all medical/surgical/behavioral health care Medi-Cal covered services, including for carved out services. The vendor's UM Department is delegated for the utilization review process to determine medical necessity for approval when required; the vendor is not delegated for potential denials. All potential denials are referred to the Alliance UM Medical Director for final determination. Utilization review is performed using the transportation guidance for the product, and a Physician Certification Statement (PCS) is needed for Non-Emergency Medical Transportation (NEMT). A full description of the process is defined the most recent policies on transportation services.

C. Transportation Access to Medi-Cal for Kids and Teens, (formerly called Early and Periodic Screening, Diagnostic and Treatment Services-EPSDT)

The Alliance is responsible for the provision of medical and non-medical transportation to eligible children under the age of 21 to access Medi-Cal for Kids and Teens, (Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)) services. The Alliance is required to provide appointment scheduling assistance and necessary transportation, including non-emergency medical transportation and non-medical transportation, to and from medical appointments for the medically necessary covered services. The Alliance

is responsible for providing non-medical transportation to and from the services that are carved-out, including dental services. AAH follows DHCS All Plan Letter 19-010 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment of Services for MediCal Members Under the Age of 21.

D. Long Term Services and Supports

The UM program includes oversight of the UM clinical decision-making review and authorizations for access to Long Term Service and Support benefits including Long Term Care (LTC) and Community Based Adult Services (CBAS). LTSS is responsible for the programmatic management of the LTSS programs. The Alliance administers the LTC and CBAS program elements as defined by the most recent DHCS contract, MMCD letter, or APL.

1. Long Term Care

The Long-Term Care (LTC) UM activities includes long term skilled or custodial care authorizations for the following facilities: skilled nursing, intermediate care, sub-acute care, intermediate care; developmentally disabled, intermediate care–developmentally disabled—habilitative, and intermediate care–developmentally disabled—nursing, residential care facilities, board and care, and assisted living facilities. LTC excludes Institutes for Mental Disease and special behavioral health treatment programs at the beginning of 2023 but will follow state requirements if they carve back into the Plan. Authorizations are provided based on member's meeting criteria the eligibility and nursing facility admission criteria.

For Medi-Cal members: Long Term Care (LTC) services for eligible Medi-Cal members. As of January 2023, the Alliance is responsible for the provision of LTC services in Nursing Facilities Level A (NF-A) and Nursing Facilities Level B (NF-B). In 2024, the Alliance will become responsible for members in Intermediate Care Facilities (ICF,) Intermediate Care Facilities for Developmentally Disabled (ICF/DD), ICF for DD-Habilitative (ICF/DD-H), Intermediate Care Facility for Developmentally Disabled-Nursing (ICF/DD-N), Subacute facilities and Pediatric Subacute Facilities. DHCS will transition FFS Medi-Cal enrollees to AAH. AAH will ensure a seamless transition of care for enrollees from FFS Medi-Cal into the Alliance membership, following all the regulatory requirements and guidance.

. The UM Department is responsible for providing the following activities:

- . Provide all Medically Necessary Covered Services to the Member.
- Ensuring that there is no disruption in care for members coming into the Alliance... .
- Admission to a nursing facility of a MediCal Member who has elected hospice services does not affect the Member's eligibility for Enrollment. Hospice services are Covered Services under and are not long-term care services regardless of the Member's expected or actual length of stay in a nursing facility.

2. CBAS

The Alliance administers the CBAS program elements as defined by the most recent

DHCS contract, MMCD letter, or APL. The Alliance maintains procedures, processes, and mechanisms for administering assessments and re-assessments for CBAS services and includes CBAS Emergency Remote Services (ERS) when appropriate. For providers delegated to perform the CBAS assessments, the Alliance provides the necessary delegation oversight and monitoring activities. The Alliance develops mechanisms to generate and distribute the required reports to the identified DHCS departments.

E. Palliative Care

Palliative Care Services are provided to members per the requirements of the latest All Plan Letter Palliative care services may be delivered at the hospital, as part of the inpatient care treatment plan, or authorized and delivered in primary care, specialty care clinics, by home health teams, or by hospice entities. The Alliance offers a network of palliative care services to its members through various provider types.

The Alliance, as part of its palliative care network development, contracts with hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and /or training in palliative care. The Alliance may also contract with different types of providers depending on local provider qualifications and the need to reflect the diversity of their membership. Community-Based Adult Services (CBAS) facilities may be considered as a palliative care partner for facilitating advance care planning or palliative care referrals. The Alliance utilizes qualified providers for palliative care based on the setting and needs of the members if the provider complies with the existing Medi-Cal requirements.

The Alliance ensures that palliative care provided in a member's home complies with existing Medi-Cal requirements for in-home providers, services, and authorization, such as physician assessments and care plans.

The Alliance informs and educates its providers regarding availability of the palliative care benefit through its website and education materials.

The Alliance identifies members eligible for palliative care by the following:

- Screening for palliative care eligibility in Complex Case Management referrals
- Referrals from network providers, including through case management, concurrent review, and the general authorization process.
- Analysis of member data

Palliative care services follow the general authorization process outlined in the UM policy and procedures. Through the authorization review and decision process, the type of palliative care (including the location where palliative care services can be delivered) will be determined based on medical necessity. Referral and care coordination for palliative services will be provided to the member within the timely access standard requirements. Alliance's network providers receive instructions of the referral and authorization process for palliative care through the Alliance's provider educational materials and via the

Alliance's website.

Section V. Quality Improvement Integration

The UM Program includes a wide variety of quality assurance activities to support positive member medical/behavioral health outcomes and continuous quality improvement. The CMO guides these activities in collaboration with the Senior Director of Health Care Services, the Senior Director of Behavioral Health, the Senior Director of Quality and the Director of Accreditation, with oversight by the QIHEC. Performance results are analyzed and reviewed with opportunities for improvement identified for intervention and performance management. The following quality activities are included in the UM Program:

- Monitoring Under and Over Utilization, including Out of Network and Provider Capacity monitoring.
- Monitoring of Member Experience with the UM/BH process.
- Monitoring UM/BH Appeals for UM/BH Decision Making.
- Potential quality issue referrals.
- Provider Preventable Condition identification and referral.
- Inter-rater reliability assessments.
- Delegation oversight including Corrective Action Plan completion and process improvements if audit findings occur.

The UM data sources, and information used for quality monitoring and improvement activities include the following:

- Claims and encounter data.
- Medical records.
- Medical utilization data.
- Behavioral Health utilization data.
- Pharmacy utilization data.
- Appeal, denial, and grievance information.
- Internally developed data and reports.
- Audit findings; and
- Other clinical or administrative data.

A. Monitoring Over and Under Utilization

The Alliance regularly monitors member service utilization using industry standard utilization measures. Medi-Cal contracts require that plans report rates to detect over and under-utilization. Rates for these measures vary based on the relative health of each population. For instance, usage rates for Non-SPD Medi-Cal members tend to be significantly lower than those for SPD Medi-Cal and IHSS members because the former populations are generally younger and healthier. Monitoring reports include changes in membership totals for each line of business in the last 12 months. National and regional

benchmarks are not available for every line of business. In the absence of such benchmarks, the Alliance closely monitors monthly, quarterly, and annual data for significant changes and trends, reports the results quarterly to the UMC and QIHEC, and acts when indicated.

UM data elements are reviewed to assess over/under utilization of services for either medical and/or behavioral health include but are not limited to the following:

- Ambulatory Services – e.g., Outpatient encounters per enrollee per year primary care visits, specialist visits, preventive health care.
- Out of Network Specialty Referrals, e.g., specialists, behavioral health care.
- Acute/Psychiatric Hospital Services
    - Emergency room visit rates.
    - Hospital admit rates.
    - Bed days rates.
    - Length of Stay.
    - Re-admission rates.
- Behavioral health utilization data.
- Pharmacy utilization rates.
- HEDIS measures for use of services
- Complaint reports (Grievance & Appeals) that reflect barriers for access to care or delivery of care.

Through clinical data analyses, the Alliance identifies opportunities for improvement through root cause analysis, action plans and the continuous improvement cycle ensure the actions taken are improving performance. When appropriate, feedback is provided to both entities and individual practitioners allowing their input into the improvement activities. The Alliance continues to monitor the action plans to ensure the activities improvements in the care delivery process.

B. Experience with Utilization/Behavioral Health Management

Annually Alliance members and providers are surveyed to assess their experience with the plan's utilization management processes and services. Data is collected and analyzed to identify improvement opportunities. For identified opportunities, Alliance takes actions designed to improve the experience based on the data.

1. Member

Alliance uses survey data to assess the member experience with the UM process. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is

administered by mail to Alliance Medi-Cal members. Among the composite measures are member ratings for: 1) Getting Needed Care – member experience when attempting to get care, tests, or treatments; 2) Getting Care Quickly – member experience when receiving care; and 3) Rating the Health Plan. The CAHPS summary rate results are compared to Medicaid benchmarks. The UM department participates in the member satisfaction team and develops action plans to improve member satisfaction.

2. Provider

Annually, the Alliance surveys its providers for their experience with the plan's utilization management processes and services. A vendor employed by the plan contacts a sample of network providers by mail and/or internet. Among the survey questions, six (6) questions ask providers to rate the plan on:

- Access to knowledgeable UM staff.
- Procedures for obtaining prior authorization information.
- Timeliness for obtaining prior authorization information.
- The Plan's facilitation/support of appropriate clinical care for patients.
- Degree to which the Plan covers and encourages preventive care and wellness. Alliance provider survey responses are benchmarked against other Medi-Cal/Medicaid plans that use the same vendor's survey.

Alliance conducts quantitative and qualitative analysis to identify areas for improvement. Outcomes of the assessments are presented to the UMC and QIHEC to assist in identifying opportunities for improvement. If the analysis indicates that there are opportunities to improve experience with UM, Alliance UM Department participates on the provider satisfaction team. Activities identified to improve the member and provider experience with UM are used to update the following year's UM Program.

C. Grievances and Appeals

The Alliance maintains an effective member grievance and appeals (G&A) process that follows all regulatory, contractual and accreditation requirements. G&A is managed within Health Care Services, and complaints identified with clinical service needs are supported by UM/BH Nurses and Physicians. Trending data for clinical appeals and fair hearings is reported to the UMC for the identification and recommendations of opportunities to improve the UM experience for members and providers. On a quarterly basis, the UM Department will review and analyze grievance data. The evaluation is reported to the UMC.

Appeal decisions are made by a practitioner who was not involved in the initial decision unless the case is overturned. A same-or similar specialist review is required for all appeals of medical necessity decisions. The details of the appeal process are outlined in the Alliance Appeals Policy and Procedure.

D. Potential Quality of Care/ Provider Preventable Reportable Conditions

At any time during an UM review, staff identify a condition or situation that appears to deviate

from the professional standard of care or identified by regulatory guidance as a Potential Quality of Care or Provider Preventable Reportable Condition, are referred to the Quality Improvement Department to be evaluated per policy and procedure.

E. UM Delegation Activities

The Alliance delegates UM/BH, (BH delegation is limited to Kaiser) activities to provider groups, vendor networks and healthcare organizations that meet delegation agreement standards. The contractual agreements between the Alliance and delegated groups specify: the responsibilities of both parties; the functions or activities that are delegated; the frequency of reporting on those functions and responsibilities to the Alliance; how performance is evaluated; and corrective action plan expectations, if applicable. The Alliance conducts a pre- contractual evaluation of delegated functions to assure capacity to meet standards and requirements. The Alliance's Compliance Department is responsible for the oversight of delegated activities. The Compliance Department will work with other respective departments to conduct the annual delegation oversight audits. Delegate work plans, reports and evaluations are reviewed by the Alliance and the findings are summarized at QIHEC and Compliance Committee meetings, as appropriate. The Compliance Department in conjunction with each respective department monitors the delegated functions of each delegate through reports and annual oversight audits.

As part of delegation responsibilities, delegated providers must:

- Develop, enact, and monitor a UM Program description that addresses all State, Federal, health plan and accreditation requirements.
- Provide encounter information and access to medical records pertaining to Alliance members.
- Submit at least quarterly reports, annual evaluations, and program descriptions and work plans; and
- Cooperate with annual audits and complete any corrective actions necessary by the Alliance.
- Participate in performance improvement activities.

F. Inter-Rater Reliability Testing

Inter-Rater Reliability (IRR) Testing is a method used at the Alliance to assess the degree of agreement among personnel who make utilization management decisions. It provides a score of how much homogeneity or consensus there is in responses to utilization management cases. The purpose is for the Alliance to provide consistency and accuracy of review criteria applied by all reviewers - physicians and non-physicians and to act on improvement opportunities identified through this testing. This report provides an analysis of the Alliance's testing for each year and fulfills regulatory, contractual and accreditation requirements associated with ensuring the consistency in applying UM/BH criteria and acting on identified improvement opportunities.

IRR testing is conducted following the Alliance internal policy (QI-133 Inter-Rater

Reliability—Testing for Clinical Decision Making) for UM, QM, BH, and Pharmacy staff who participate in the Health Services medical necessity decision making process. IRR test results are collated and reviewed by management.

Reports on IRR test results are reviewed and approved by the QIHEC. The IRR process and reports are reviewed for delegated entities during the annual auditing process.

G. UM Department – Internal Quality Review

To ensure the oversight of the internal UM process, Alliance UM Department conducts ongoing auditing and monitoring of key operational areas to ensure compliance with all federal, state, regulatory, contractual and accreditation standards. Alliance UM Department has implemented a monitoring program for the early identification of potential compliance risks. In addition, the program includes an opportunity to provide quality oversight of the current UM processes. This is accomplished by internal monitoring of UM authorization files on a routine and/or periodic basis.

1. UM File Review

UM will complete file reviews using a defined methodology for the file selection. Files will be assessed to ensure compliance using the regulatory and accreditation requirements as well as to identify opportunities for process improvement. The process outcomes will also be utilized for staff performance. Elements of the review include, but are not limited to, ensuring the appropriate medical information is obtained, use of criteria, application of clinical decision making, and appropriate referral to physician reviewers as needed. For cases that are denied or modified, the file will assess the NOA requirements for communication to the member and provider.

2. Audit of Authorization Processing Turn-Around-Time (TAT)

An authorization aging report is used to monitor TATs for authorizations. Any opened authorization without a final determination will appear in this report. The UM Manager or designee will work this report daily to ensure all authorization determinations are compliant with UM will complete file reviews using a defined methodology for the file selection. Files will be assessed to ensure compliance using the regulatory and accreditation requirements as well as to identify opportunities for process improvement.

H. Annual UM Workplan

Each year, the Alliance establishes objectives and priorities and outlines a strategic UM Workplan for the coming year. The UM Workplan incorporates anticipated timeframes, responsible parties, and status of activities. The UM Workplan is submitted to the UM Committee for approval annually. See Attachment B – 2023 UM Workplan.

I. Annual UM Evaluation

Members of the UM/BH Program management team annually evaluate and update the

UM/BH Program to ensure the overall effectiveness of UM Program objectives, structure, scope.

and processes. The evaluation includes, at a minimum:

- Review of changes in staffing, reorganization, structure, or scope of the program.
- Resources allocated to support the program.
- Review of completed and ongoing UM work plan activities.
- Assessment of performance indicators.
- Review of delegated arrangement activities; and
- Recommendations for program revisions and modifications

The UM Program management team presents a written program evaluation to the UMC and QIHEC. The UMC and QIHEC review and approve the UM Program evaluation on an annual basis. The review and revision of the UM program description may be conducted more frequently as deemed appropriate by the UMC, QIHEC, CMO, CEO, or BOG.

The QIHEC's recommendations for revision are incorporated into the UM Program description, as appropriate, which is reviewed and approved by the BOG and submitted to DHCS on an annual basis.

UM Program Recommendations for 2023

As a result of internal performance monitoring performed in 2022, opportunities for improvement were identified and will be incorporated into the 2023 department goals. Highlights of opportunities for improvement based on the regulatory findings include:

- Delegate Oversight:
  - Enhance Delegate oversight activities, to ensure that regulatory, programmatic and UM process standards are aligned, through performance monitoring and engagement with operational processes. These activities may also include dedicated staff monitoring activities, chart audits, performance management, delegate feedback, and UM training.
- Data Integrity:
  - Enhance UM system reporting to capture required elements for over/under utilization monitoring reports, with continued emphasis on Out of Network Analysis and validating service type categories to ensure accurate measurement among the Alliance and Delegate network, including integrating databases. Develop standardized Determination reasons across the Alliance and Delegates to identify over/ under utilization trends.
- UM Processes Throughput:
  - Improve UM authorization process efficiency as it relates to authorization TAT, aligned staffing, auto authorization enhancement, and Provider outreach/ notification related to benefit and regulatory changes.
  - Expanded evaluation of specialty utilization as it pertains to Radiology/Lab regarding Oncology care, Rehabilitation services, OON, Tertiary/ Quaternary Care, and Retro authorization.
  - Analyze under and overutilized services to facilitate outreach to Providers to improve access (ex. Palliative Care)

    - Refine the ADT feed coming from contracted hospitals to enable automatic case creation in TruCare and to enhance Transitional Care Service capacity.
    - Continue implementation for tracking and intervening with unused Authorizations to ensure that members receive appropriate care and follow up.
    - Complete the Health Suite Claims/ UM Prior Authorization Alignment project with IT and Provider Services.
    -
- Emergency Room Utilization:
    - Improve identification of potential and actual high utilizers of hospital services through Inpatient Risk Screening in coordination with Case Management and Quality departments.
    - Explore timely primary care access for urgent common medical conditions that generate high volume ED visits that do not lead to hospital admits
    - Coordinate with Case Management to identify and reduce high ED utilization for members not engaging with primary care or specialty care for non-emergent problems.
- Hospital Utilization:
    - Improve identification of potential and actual high utilizers of hospital services through Inpatient Risk Screening
    - Enhance identification of members at risk for readmission which will include frailty scores, frequent admissions medical conditions, aide categories & high-risk SDOH to revise medication reconciliation and develop other targeted interventions to improve outcomes.
    - Refine episodic warm handoffs to Case Management through high-risk Transitions of Care workflows in 2023, and then expanding to all hospital discharges in 2024. Goals are to improve enrollment in Enhanced Care Management, Complex Care Coordination, and Community Supports
    - Coordinate stronger discharge planning and relationships with high volume admit facilities with prioritization of those with higher or increasing LOS.
    - Continue to assess social determinants of health drivers and medical conditions that lead to short stays, routine stays, facility to facility transfers trends, and extended length of stays.
- OON:
    - Analyze and closely monitor Stanford Health Care oncology, major organ transplant, non-oncology specialties, ancillary services and elective hospitalizations for new service line and OON Stanford trends.
    - Standardize OON determination reasons to better monitor OON trends for over/ underutilization and emerging network needs.
    - Continue data validation of Alliance and Delegate network data and database integration for DHCS reporting purposes and confirming network needs.
    - Coordinate feedback with Provider Services on dynamic network needs to enhance specialty and ancillary services for members.
    - Continue to explore contracting options for providers who resist conventional contracting.
- Quality/ Population Health Management:
    - Continue focused collaboration between AAH and Delegates UM departments around CRE/ MDRO PQI and preventable readmissions that may impact

hospital stay and discharge planning, appropriate goals of care discussions for palliative/ hospice eligible members, timely discharge planning with collaboration with Facility partners, and expanded searches for difficult placement.
    - Continue to analyze denial and approval type trends to ensure the appropriateness of decision making for regulation and medical necessity guidelines and maintain UM standardization.
    - Opportunities to improve processes due to monitoring activities and data trending will be followed by UM education and staff feedback as needed.
    - AAH will align outpatient service type categories to ensure data integration between health plan and Delegates databases reflects accurate utilization.
    - Measure and monitor acute SNF and custodial LTC SNF quality metrics for patient choice and high quality Admissions/ Discharges.
- CM:
    - Work with the Alliance Case Management Department and all relevant Alliance departments to engage on UM aspects of CalAIM for Enhanced Care Management, Community Supports and Population Health Management, including Transitions of Care, in 2023.
    - Provide leadership in collaboration with Case Management to enhance service coordination for members being managed by CCS.
    - Continue the initiative for enhanced care coordination for high-risk hemodialysis members with DaVita.
- G&A:
    - Improve reporting and analysis of grievance and appeals activities related to UM decision making and analysis for member and provider experience with UM.
- LTC:

  Fully implement the 2023 Long Term Care SNF population carve in and prepare for Long Term Care Intermediate Care Facility carve in for 2024.
- Behavioral Health:

  Full insourcing of the mild to moderate behavioral health services for Medi-Cal members and all behavioral health services for the Group Care members.

Attachment A

2023 The Alliance Delegated Network or Vendor Relationships

Delegate	Provider Type		Delegated Activity - UM	Delegated Activity – Grievance and Appeals	Exceptions
Kaiser	HMO		X	X	
Alameda Health	Delivery			NA	

System	System				
CHCN	Medical Group		X	NA	• Not delegated for BH
CFMG	Medical Group		X	NA	• Not delegated for BH
California Home Medical Equipment (CHME)	Vendor DME		X*	NA	* Not delegated for denials
Beacon/College Health IPA (CHIPA)	MBHO Ending at end of Q1 2023		X	NA	Ending at end of Q1 2023
ModivCare	Vendor - Transportation		NA	NA	* Not delegated for denials
March Vision	Vendor – Vision Services		NA	NA	

Attachment B – 2023 Utilization Management Work Plan

See attached document.

ALAMEDA ALLIANCE FOR HEALTH

QUALITY IMPROVEMENT PROGRAM EVALUATION 2022

ALAMEDA Alliance FOR HEALTH

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

2022 Quality Improvement Program Evaluation Signature Page

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07/13/2023

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Matthew Woodruff — **Date**
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Rebecca Gebhart — **Date**
Board Chair

Introduction

Alameda Alliance for Health (Alliance) is a local, public, not-for-profit managed care health plan committed to making high-quality health care services accessible and affordable to County residents. The Alliance staff and provider network reflect the county's cultural and linguistic diversity. Established in January 1996, the Alliance was created by the Alameda County Board of Supervisors for county residents. The Alliance currently provides health care coverage to over 354,822 children and adults through its programs.

Under the leadership and strategic direction established by the Board of Governors (BOG), senior management and the Health Care Quality Committee (HCQC), the Health Care Services 2022 Quality Improvement (QI) Program was successfully implemented. This report serves as the annual evaluation of the effectiveness of the program activities.

The processes and data reported covers activities conducted from January 1, 2022, through December 31, 2022.

Mission, Vision, and Values

Mission

Improving the health and well-being of our members by collaborating with our provider and community partners to deliver high quality and accessible services.

Vision

All residents of Alameda County will achieve optimal health and well-being at every stage of life.

Values

Teamwork: We actively participate, support each other, develop local talent, and interact as one team.

Respect: We put people first, embracing diversity and equity, striving to create a positive work environment, excellent customer service, and value all people's health and well-being.

Accountability: We work to create and maintain efficient processes and systems that minimize barriers, maximize access, and sustain high quality.

Commitment & Compassion: We are empathic and care for the communities we serve including our members, providers, community partners and staff.

Knowledge & Innovation: We collaborate to find better ways to address the needs of our members and providers by proactively focusing innovative resources on population health and clinical quality.

Scope of the 2022 Quality Improvement Program Evaluation

The Alliance's QI Department is designed to monitor the quality of clinical care and health care service delivery to all Alliance members. The structure provides ongoing reviews of activities and identifies opportunities to improve the quality of care provided, fosters financial stewardship to the health plan, and collaborates with internal and externals stakeholders to deliver high quality and accessible health care. Further, the department fosters consistency in quality

assessment and improvement to the health care system while:

- Adopting and integrating community health priorities, standards, and goals that impact the health of Alliance's members.
- Identify and target improvement to improve access, care, and service.
- Identify overuse, misuse, and underuse of health care services.
- Identify opportunities to improve patient safety and care.
- Address quality issues, both potential and tangible.
- Monitor data trends that display variations in services or disparities in care.

The QI Department set goals designed to improve quality and the effectiveness of clinical care served to our members:

- Primary goal: to objectively monitor and evaluate the quality, appropriateness, and outcome of care and services delivered to members of the Alliance.
- Overall goal: to ensure that members have access to quality health care services that are safe, effective, and meet their needs.

The QI Department is structured to continuously pursue opportunities for improvement and problem resolution by:

- Monitoring services and care provided.
- Improving data and analytics to validate care outcomes.
- Peruse opportunities for improvement in areas that are important to Alliance members' care and health.
- Identify interventions when opportunities for improvement are identified.
- Improving member experience through provider access to care.

Quality Improvement Structure

QI Structure

The structure of the Alliance QI Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate use of the Alliance health care delivery network for medical and behavioral health care services. Additionally, the structure is designed to enhance communication and collaboration on QI program goals and objectives, activities, and initiatives, that impact member care and safety both internal and external to the organization, inclusive of delegates. The QI Program is evaluated on an on-going basis for efficacy and appropriateness of content by Alliance staff and oversight committees.

Governing Committee

The Alameda County Board of Supervisors appoints the BOG of the Alliance, a 15-member body representing provider and community partner stakeholders. The BOG is the final decision-making authority for all aspects of the Alliance QI Programs and is responsible for approving the

annual QI Program Description, Work Plan, and Program Evaluation. The BOG delegates oversight of Quality functions to the Alliance Chief Medical Officer (CMO) and the HCQC and provides the authority, direction, guidance, and resources to enable Alliance staff to carry out responsibilities, functions, and activities of the QI Program. QI oversight is the responsibility of the HCQC.

The HCQC develops and implements the QI program and oversees the QI functions within the Alliance.

The HCQC:

- Recommends policies or revisions to policies for the operational effectiveness of the QI Program and the achievement of QI program objectives.
- Oversees the analysis and evaluation of the QI, Utilization Management (UM) and Case Management (CM) programs and Work Plan activities and assesses the results.
- Ensures practitioner participation in the QI program activities through attendance and discussion in relevant QI committee or QI subcommittee meetings.
- Identifies needed actions, and ensures follow-up to improve quality, prioritizing actions based on their significance and provides guidance on which to choose and pursue as appropriate. The HCQC also assesses the overall effectiveness of the QI, UM, CM and Pharmacy & Therapeutics Programs.
- The HCQC meets a minimum of four times per year or as often as needed, to follow-up on findings and required actions.
- Oversees the actions of the Internal Quality Sub-Committee, Utilization Management Sub-Committee, Access, and Availability Sub-Committee, Cultural and Linguistics Sub-Committee, and Population Health Sub-Committee.

Committee Structure

The BOG appoints and oversees the HCQC which, in turn, provides the authority, direction, guidance, and resources to enable Alliance staff to carry out the QI Programs. The BOG also oversees the Peer Review and Credentialing Committee (PRCC) which provides a peer review platform and, also a platform to review provider credentialing and re-credentialing. Committee membership is made up of provider representatives from the Alliance contracted networks and the Alliance community including, those who provide health care services to Behavioral Health, Seniors and Persons with Disabilities (SPD) and chronic conditions.

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

HCQC charters a sub-committee, the Internal Quality Improvement Sub-Committee (IQIC) which serves as a forum for the Alliance to evaluate current QI activities, processes, and metrics. The IQIC also evaluates the impact of QI programs on other key stakeholders within various departments and when needed, assesses, and plans for the implementation of any needed changes. HCQC assumes responsibility for oversight of the IQIC activities and monitoring its areas of accountability as needed. The structure of the committee meetings is designed to increase engagement from all participants.

The major committees that support the quality and utilization of care and service include:

- Healthcare Quality Committee (HCQC)
- Peer Review and Credentialing Committee (PRCC)
- Member Advisory Committee (MAC)
- Pharmacy and Therapeutics (P&T) Sub-committee
- Utilization Management (UM) Sub-committee
- Access and Availability Sub-committee
- Internal Quality Improvement Sub-committee (IQIC)
- Cultural and Linguistic Services Sub-committee
- Population Health Sub-Committee

Additionally, Joint Operations Meetings (JOMs) support the quality improvement work of the Alliance. Each committee meets at least quarterly, some monthly, and all committees / sub-committees, except the PRC and MAC committees, report directly to the HCQC. The PRC and MAC report directly to the BOG. The PRCC supports the quality and utilization of safe care and service for the Alliance membership and reports directly to the BOG. Each committee continues to meet the goals outlined in their charters, as applicable. The HCQC membership includes practitioners representing a broad range of specialties, as well as Alliance leadership and staff.

Evaluation of Senior-Level Physician and Behavioral Health Practitioners

The BOG delegates oversight of QI, CM and UM functions to the HCQC which is chaired by the Alliance CMO and vice-chaired by the Senior Medical Director. The CMO and Senior Medical Director provide the authority, direction, guidance, and resources to enable Alliance staff to carry out the QI Program. The CMO delegates senior level physician involvement in appropriate committees to provide clinical expertise and guidance to program development.

The committee is comprised of multiple physician representatives and includes CMOs of partner delegate groups. Dr. Aaron Chapman, a psychiatrist and CMO of Alameda County Behavioral Health Care (ACBH), actively participates in the HCQC meetings and provided clinical input ensuring policies and reports considered behavioral health implications. The active involvement of senior-level physicians including the psychiatrist from Alameda County Behavioral Health (ACBH) has provided consistent input into the quality program. Their participation helped ensure that the Alliance is meeting accreditation and regulatory requirements.

Program Structure and Operations

The Alliance QI Program encompasses quality of care across the Alliance enterprise and across the health care continuum.

2022 QI Program activities included, but were not limited to the following:

- Evaluation of the effectiveness of the QI program structure and oversight.
- Implementation and completion of ongoing QI activities that addressed quality and safety

or clinical care and quality of service.

- Trending of measures to assess performance in the quality and safety of clinical care and quality of service.
- Analysis of QI initiatives and barriers to improvement.
- Monitoring, auditing, and evaluation of delegated entities QI activities for compliance with contractual requirements with the implementation of corrective action plans as appropriate.
- Internal monitoring and auditing of QI activities for regulatory compliance, and assurance of quality and safety of clinical care and quality of service.
- Development and revision of department policies, procedures, and processes as applicable.
- Development and implementation of direct and delegate network corrective action plans because of non-compliance and identified opportunities for improvement, as applicable.

QI Resources

The Alliance QI Department key staff included licensed physicians and registered nurses, qualified non-clinical management staff, as well as non-clinical specialist staff and non-clinical administrative support coordinators. The assignment and performance of work within the team, whether working on site or remotely, for both clinical and non-clinical activities, is seamless to the Alliance operations processes. Established job description expectations with assigned tasks and responsibilities remain unchanged regardless of the geographical location of staff member.

The QI program moved forward in providing quality improvement guidance enterprise-wide meeting regulatory and accreditation standards and promoting positive health outcomes for the Alliance membership. In Q4, 2021 – Q4, 2022, the QI Department experienced a vacancy/turnover in multiple positions. In Q4, 2021, the QI Manager moved to the Alliance Quality Analytics Department. In Q2, 2022, the Sr. QI Director retired and left the Alliance. In Q1, 2022, the A&A Manager was hired. Throughout the vacancies, the Sr. Medical Director provided direction and oversight of the QI Department. QI, Health Care Services, and the Alliance continues to evaluate staff turnover and strives to provide a positive work environment while creating a stable work force.

Throughout 2022, vendor partnerships were a part of the QI resource strategy. The QI department continued to augment QI resources via consultants and analytic expertise for the Healthcare Effectiveness Data and Information Set (HEDIS) program.

Additionally, the Alliance maintained its strong relationship with healthcare services support and survey vendor, Symphony Performance Health (SPH) Analytics. In 2022 SPH supported the QI Department work with implementation, analysis, and reporting on the following surveys:

- Afterhours and Emergency Instruction Survey
- Member Satisfaction Survey (CAHPS 5.1H, CG CAHPS)
- Provider Satisfaction Survey

Membership and Provider Network

Membership

The Alliance product lines include Medi-Cal managed care and Group Care commercial insurance. Medi-Cal managed care beneficiaries, eligible through one of several Medi-Cal programs, e.g., Temporary Assistance Needy Families (TANF), SPD, Medi-Cal Expansion and Dually Eligible Medi-Cal members who do not participate in California's Coordinated Care Initiative (CCI). For dually eligible Medi-Cal and Medicare beneficiaries, Medicare remains the primary insurance and Medi-Cal benefits are coordinated with the Medicare provider.

Alliance Group Care is an employer-sponsored plan offered by the Alliance. The Group Care product line provides comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County.

Trended Enrollment by Network and Aid Category

Current Membership by Network by Category of Aid							
Category of Aid	**Nov-22**	**% of Medi- Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	101,680	32%	9,923	9,842	828	20,424	9,107
Child	50,124	16%	7,810	9,305	30,405	35,444	18,716
SPD	28,505	9%	8,442	4,532	1,039	12,314	2,178
ACA OE	117,051	37%	16,918	38,101	1,228	45,565	15,239
Duals	22,889	7%	8,483	2,545	3	8,253	3,605
Total Medi-Cal:	320,249	100%	51,576	64,325	33,503	122,000	48,845
Total: Group Care:	5,791		2,299	865		2,627	
Total	**326,040**	**100%**	**53,875**	**65,190**	**33,503**	**124,627**	**48,845**
Medi-Cal %	98.22%		95.73%	98.67%	100.00%	97.89%	100.00%
Group Care %	1.78%		4.27%	1.33%	0.00%	2.11%	0.00%
			16.52%	*19.99%*	*10.28%*	*38.22%*	*14.98%*
			% Direct:	**37%**		**% Delegated:**	**63%**

2022 Trended Categories of Aid, Distubution and Growth/Loss

Category of Aid Trend											
	Members				% of Total (ie. Distribution)				% Growth (Loss)		
Category of Aid	Nov-2020	Nov-2021	Oct-2022	Nov-2022	Nov-2020	Nov-2021	Oct-2022	Nov-2022	Nov 2020 to Nov 2021	Nov 2021 to Nov 2022	Oct 2022 to Nov 2022
Adults	37,638	42,623	49,215	50,124	13.77%	14.48%	15.22%	15.37%	13.2%	17.6%	1.8%
Child	94,620	97,935	101,350	101,680	34.62%	33.27%	31.34%	31.19%	3.5%	3.8%	0.3%
SPD	26,314	26,366	28,410	28,505	9.63%	8.96%	8.79%	8.74%	0.2%	8.1%	0.3%
ACA OE	89,752	100,844	115,888	117,051	32.84%	34.26%	35.84%	35.90%	12.4%	16.1%	1.0%
Duals	18,990	20,692	22,709	22,889	6.95%	7.03%	7.02%	7.02%	9.0%	10.6%	0.8%
Medi-Cal Total:	267,314	288,460	317,572	320,249	97.81%	98.00%	98.21%	98.22%	7.9%	11.0%	0.8%
Group Care Total:	5,982	5,880	5,788	5,791	2.19%	2.00%	1.79%	1.78%	-1.7%	-1.5%	0.1%
Total Membership:	**273,296**	**294,340**	**323,360**	**326,040**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**7.7%**	**10.8%**	**0.8%**

2022 Trend Enrollment by Age Category

	Members				% of Total (Distribution)				% Growth (Loss)		
Age Category	Nov-20	Nov-21	Oct-22	Nov-22	Nov-20	Nov-21	Oct-22	Nov-22	Nov-20 to Nov 2021	Nov-21 to Nov 2022	Oct-22 to Nov 2022
Under 19	97,068	100,206	103,652	103,974	36%	34%	32%	32%	3%	3%	0%
19 - 44	91,897	104,239	117,712	119,089	34%	35%	36%	37%	13%	13%	1%
45 - 64	57,413	60,571	67,689	68,279	21%	21%	21%	21%	6%	12%	1%
65+	26,918	30,135	34,307	34,698	10%	10%	11%	11%	12%	14%	1%
Total	**273,296**	**295,151**	**323,360**	**326,040**	**100%**	**100%**	**100%**	**100%**	8%	10%	1%

In November of 2022, the Alliance annual membership increased by 10.0% from November 2021. The Alliance experienced membership growth in all age categories from 2021 to 2022 with a 3.0% membership growth for ages under 19, 13% growth (largest growth category) in the 19-44 age category, 12.0% growth for 45-64 age category and 14.0% growth for the 65+ age category. Percent of total distribution by age category remained stable from 2021 – 2022.

A driver of the increase in membership was the economic downturn related to the 2021 – 2022 pandemic and the delayed in member dis-enrollments from health plans by the state.

Provider Network

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

2022 Provider Network by Type, Enrollment and Percentage

PROVIDER NETWORK	PROVIDER TYPE	MEMBERS (ENROLLMENT)	% OF ENROLLMENT IN NETWORK
Direct-Contracted Network	Independent	69,890	19.70%
Alameda Health System (AHS)	Managed Care Organization	66,703	18.80%
Children First Medical Group (CFMG)	Medical Group	34,388	9.69%
Community Health Clinic Network (CHCN)	Medical Group	132,090	37.23%
Kaiser Permanente	HMO	51,751	14.59%
TOTAL		**354,822**	**100%**

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

- Ambulatory care
- Hospital care

- Emergency Services
- Behavioral Health (mental health and addiction medicine)
- Home Health Care
- Hospice
- Palliative Care
- Rehabilitation Services
- Skilled Nursing Services – Skilled
- Managed Long-Term Services and Support (MLTSS)
- Community Based Adult Services
- Long Term SNF Care (limited)
- Transportation
- Pharmacy

Care coordination along the continuum of care including arrangements for linked and carved out services, programs, and agencies.

These services are provided through a network of contracted providers inclusive of hospitals, nursing facilities, ancillary providers, and service vendors. The providers/vendors are responsible for specifically identified services through contractual arrangements and delegation agreements.

The Alliance provider network includes:

Alliance Ancillary Network

Ancillary Type	Count
Behavioral Health Network	1
Durable Medical Equipment (DME) Vendor	1 Capitated, 12 Non-Capitated
Health Centers (FQHCs and non-FQHCs)	81
Hospitals	17
Pharmacies/Pharmacy Benefit Manager (PBM)	Over 200
Skilled Nursing Facilities (SNF)	72
Transportation Vendor	1 Individual Vendor with 380 Individual Transportation Providers

Alliance members may choose from a network of over 590 Primary Care Practitioners (PCPs), more than 7000 specialists, 17 hospitals, 81 health centers, 72 skilled nursing facilities and more than 200 pharmacies throughout Alameda County. The Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan members. Our members' optimal health is always our priority.

The Alliance QI Program strives to ensure that members have access to quality health care services.

Health Plan Quality Performance

HEDIS Performance

The Alliance is committed to ensuring the level of care provided to all enrollees meets professionally recognized standards of care and is not withheld or delayed for any reason. The Alliance adopts, re-adopts, and evaluates recognized standards of care for preventive, chronic and behavioral health care conditions. The Alliance also approves the guidelines used by delegated entities. Guidelines are approved through the HCQC. Adherence to practice guidelines and clinical performance is evaluated primarily using standard HEDIS measures. HEDIS is a set of national standardized performance measures used to report on health plan performance in preventive health, chronic condition care, access, and utilization measures. The California Department of Health Care Services (DHCS) requires all Medicaid plans to report a subset of the HEDIS measures. 2022 preliminary Medicaid administrative rates are noted below. Minimum Performance Level (MPL) and High-Performance Level are determined by the Medi-Cal Managed Care Division.

Note: 2022 rates are preliminary, final rates will be available July 2023

Medicaid Administrative HEDIS Rates

NCQA Acronym	Measure Description	2021 Admin Rates	2021 Hybrid Rates	2022 Admin Rates	2022 Hybrid Rates	MPL	Measure Type
Behavioral Health							
FUA1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30 Day	12.90%		29.46%		21.24%	Administrative
FUM1	Follow-Up After Emergency Department Visit for Mental Illness - 30 Day	59.77%		49.03%		54.51%	Administrative
Children's Domain							
CIS10	Childhood Immunization Status - Combo 10	44.31%	47.15%	45.20%	52.80%	34.79%	Administrative / Hybrid
IMA	Immunizations for Adolescents - Combo 2	45.14%	46.96%	49.36%	50.61%	35.04%	Administrative / Hybrid
LSC	Lead Screening in Children	53.76%		57.52%	60.58%	63.99%	Administrative / Hybrid
W15	Well-Child Visits in the First 15 Months of Life - 6 or More Visits	44.08%		46.56%		55.72%	Administrative
W30	Well-Child Visits for Age 15 Months to 30 Months - Two or More Visits	63.73%		69.01%		65.83%	Administrative
WCV	Child and Adolescent Well-Care Visits	51.64%		49.69%		48.93%	Administrative

Women's Health							
BCS	Breast Cancer Screening	53.02%		56.13%		50.95%	Administrative
CHL	Chlamydia Screening in Women	63.46%		64.14%		55.32%	Administrative
CCS	Cervical Cancer Screening	55.55%	61.52%	52.44%	53.83%	57.64%	Administrative / Hybrid
PPC2	Timeliness of Postpartum Care	78.98%	83.60%	81.72%	85.42%	77.37%	Administrative / Hybrid
PPC1	Timeliness of Prenatal Care	86.33%	92.00%	85.36%	87.50%	85.40%	Administrative / Hybrid
Chronic Disease							
CDC10	HbA1c Control (>9.0%)	37.30%	32.85%	37.06%	29.20%	39.90%	Administrative / Hybrid
CBP	Controlling High Blood Pressure	33.91%	55.72%	41.77%	54.74%	59.85%	Administrative / Hybrid

Analysis of HEDIS Medicaid Managed Care Accountability Set (MCAS)

In Measurement Year (MY) 2022, the Alliance continued to see the impact of COVID-19 on the HEDIS rates. First the growth in the Alliance membership due to the pandemic, increased the eligibility population across many measures. Members who were eligible for Medi-Cal during the pandemic did not seek care. Other measures where we see the impact of COVID-19 are those that meet the requirement across multiple years, such as Cervical Cancer Screening. As a result, the Alliance performed below the MPL on five measures (preliminary results):

- Behavioral Health: Follow-Up After Emergency Department Visits for Mental Illness-30 Day
- Children's Domain: Well Child Visits in the First 15 months of life 6x, Lead Screening
- Women's Health: Cervical Cancer Screening
- Chronic Disease: Controlling High Blood Pressure

The Alliance has initiated steps to improve the measures below performance in 2022. Our comprehensive quality strategy includes new interventions to meet or exceed the required 2023 milestones. The Alliance will continue its efforts to improve HEDIS measures below MPL by focusing on access, provider, and member education, and dedicated multidisciplinary workgroups to improve HEDIS rates.

Quality Improvement Performance Initiatives and Projects

Overview

The Alliance's quality improvement efforts strive to impact the safety and quality of care and service provided to our members and providers. Review of the Alliance's 2022 QI activities as described herein demonstrates the Alliance's QI department ability (in collaboration with internal

and external entities) to successfully assess, design, implement, and evaluate an effective QI Program including but not limited to, the following:

Improved focus on the importance of chronic condition management and accessing appropriate care through initiatives to educate and connect with members, direct and delegated providers, community-based organizations, state, and county entities and enhance our improvements to our internal operations.

1. Maintained a targeted focus on the analysis of key drivers, barriers, and best practices to improve access to care.
2. Expanded staff knowledge of health disparities and equity within the Alliance membership through population data collection, analysis, and segmentation and targeted quality improvement activities as part of Population Health Management Program
3. Promoted the awareness and concepts of inter-departmental QI initiatives and activities, including Plan-Do-Study-Act (PDSA), and Inter-Rater Reliability (IRR), to:
    a. Identify, investigate, and resolve Potential Quality Issues (PQIs).
    b. Identify and address service over-and-underutilization.
    c. Promote patient safety.
    d. Remove barriers to access to timely care and services.
4. Invested in quality measurement analysis expertise.
5. Identified PQIs operations gaps and root cause analysis to identify and overcome barriers, as well as best practices resulting in internal workflow improvements and staff retraining.
6. Monitor and demonstrate improvement in HEDIS measures.
7. Ensured timely Facility Site Review (FSR/Medical Record Review (MRR) audits and Physical Accessibility Review Surveys (PARS)) in person and virtually.
8. Targeted QI initiatives to improve direct and delegate provider engagement in access to care efforts to improve rates of preventive care and services, screenings, and referrals for members.
9. Targeted partnerships with community-based county agencies and delegate providers to improve referral and resources triage and management through technology collaboration and support.
10. Promoted healthcare access and safety education for members and providers through targeted pharmacy substance use programs.
11. Improved engagement with interpreter services vendors and Alliance network providers to ensure quality interpreter services at all points of healthcare service contact.
12. Enhanced engagement with Behavioral Health delegate for improved and timely access to care.
13. Collaborated with First 5 of Alameda County and delegate provider networks to improve WCV and EPSDT service utilization for pediatric and adolescent members.

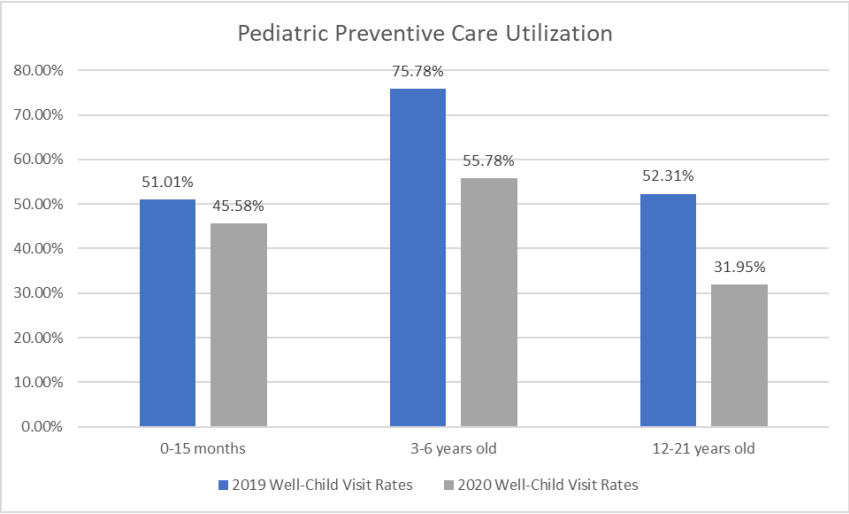
The Alliance is invested in a multi-year strategy to ensure that the organization adapts to health plan industry changes now and within 3 - 5 years. An effective QI program with adequate resources is essential to the Alliance's successful adaptation to expected changes and challenges.

Priority Performance Improvement Project (PIP) (2020-2022) – Well Child Visit 3-21 years

In California, it has been identified that children are not accessing comprehensive pediatric services consistently. The California State Auditor Report identified that, "an annual average of 2.4 million children enrolled in Medi-Cal do not receive all required preventive services." Additionally, this report confirms utilization rates for children in Medi-Cal have remained below 50 percent. As a result, the Alliance, has decided to focus on increasing pediatric access through its Pediatric Care Coordination Pilot. The goal of the pilot is to engage the Alliance's pediatric members to seek regular check-ups at age-appropriate intervals that follows the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule and anticipatory guidance with increased screenings and referrals to improve member health functional status and/or satisfaction.

The intervention will be focused on the HEDIS measure: Well Child Visits (WCV) -- the percentage of members 3–21 years of age who had one or more well-child visits with a PCP during the MY. The Alliance selected the MCAS WCV measure because the Plan identified an opportunity for improvement based on its administrative results for MY2020. Given the COVID-19 pandemic, the Plan saw a decrease in pediatric utilization of preventive care services. The Alliance saw a decline in pediatric utilization in MY2020.

Pediatric Preventive Care Utilization



The WCV MY2020 admin rates for direct Alliance providers demonstrate there is underutilization of preventative care among members 3-21 years old. As an initiative starting in 2022, the Alliance in partnership with Dr. Rhodora De La Cruz, a volume, low performing direct provider tested a birthday card and incentive program. The program included mailing a birthday card (members 3-21 years with a birthday between April – December 2022) with a reminder to complete a well visit and receive a $25 gift card. The Smart aim documented was to increase well child visit rate for Dr. Rhodora De La Cruz from 40.94% to 45% by December 31, 2022.

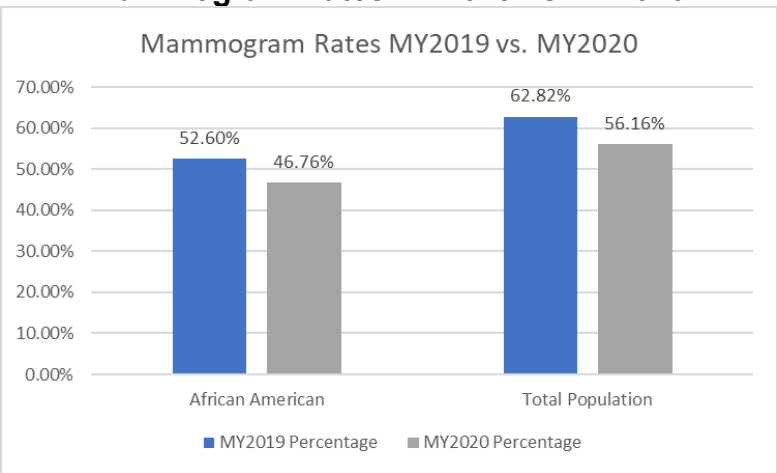
Although the Smart aim target of 45% was not met, Dr. De La Cruz's WCV rates for MY2022 showed an improvement, with a reported rate of 44.40%, a 4.93% increase from the previous year. A total of 971 members were sent birthday cards and/or received outreach calls reminding them to complete their well visit, with an added incentive of a $25 gift card upon completion. Out of these members, a total of 70 completed their well visit between April and December of 2022. The project encountered various difficulties, such as a shortage of staff to carry out multiple outreach calls. Despite Dr. De La Cruz's office making one outreach attempt, we believe that a second attempt would result in improved rates of well visits. The incorrect phone numbers and addresses of members also posed a challenge in reaching out to them. Another issue that arose was the high no-show rates for this project. Moreover, the timing of the project meant that members were less likely to see a PCP and complete a well visit during the months of November – December.

Equity Performance Improvement Project (PIP) (2020-2022) – Breast Cancer Screening

According to an American Cancer Society 2022-2020 report, approximately 1 in 8 women (13%) will be diagnosed with invasive breast cancer in their lifetime. The report also highlights and reinforces the disparities felt by African American women when it comes to receiving timely and accessible preventive care such as mammograms. African American women have the highest breast cancer death rate of 28.4 deaths per 100,000. They also have higher incidence rates than non-Hispanic Whites before the age of 40 and are more likely to die from breast cancer at every age. Early detection of breast cancer is the number one way to decrease mortality rates, therefore, The Alliance will focus on increasing breast cancer screening rates among our members with a narrowed focus on African American women.

The Alliance has selected the MCAS Breast Cancer Screening (BCS) measure because there have been identified opportunities for improvement based on MY 2020 data for MY 2021. The Alliance has seen a decrease in breast cancer screening services as depicted in the chart below comparing MY 2022 and MY 2020 admin rates for African American women and all other eligible women for the MCAS BCS measure.

Mammogram Rates MY2019 vs MY2020



There was a 5.84% decrease in mammogram rates among African American women, and a 6.66% decrease in mammogram rates among all Alliance female members that qualified for the BCS measure.

Increasing breast cancer screening rates among the Alliance's African American female members was the narrowed focus of this PIP. The MY2020 admin rate for the Alliance was 56.16%, and among African American women it was 46.76%. The Smart aim for this PIP was by December 31, 2022, use key driver diagram interventions to increase the percentage of breast cancer screenings among African American women between the ages of 52 and 74, from 46.76% to 53.76%.

The PDSA was conducted in partnership with LifeLong Medical Care (LifeLong), a high volume, low performing health center. The PDSA includes a texting campaign with a reminder to complete breast cancer screening and an offer to receive a $50 incentive gift card. LifeLong sent up to two text messages and a letter to members who opt out or have wrong phone numbers. The Care Coordinator confirmed the screening was complete and called members to confirm the address for the mailing of incentive.

The Smart aim was not achieved. Due to the Alliance staff turnover one intervention was tested and therefore the population size was not significant enough to achieve the Smart aim outlined in this project. However, the Alliance achieved a 1.06% increase in the overall BCS rates for African American women from 46.76% in 2021 to 47.82% in 2022. While this is not a significant improvement for the overall BCS rates for African American women we do believe it is clinically and programmatically significant because our partnering provider LifeLong who tested the intervention achieved an increase of 7.41% points over the same period the previous year.

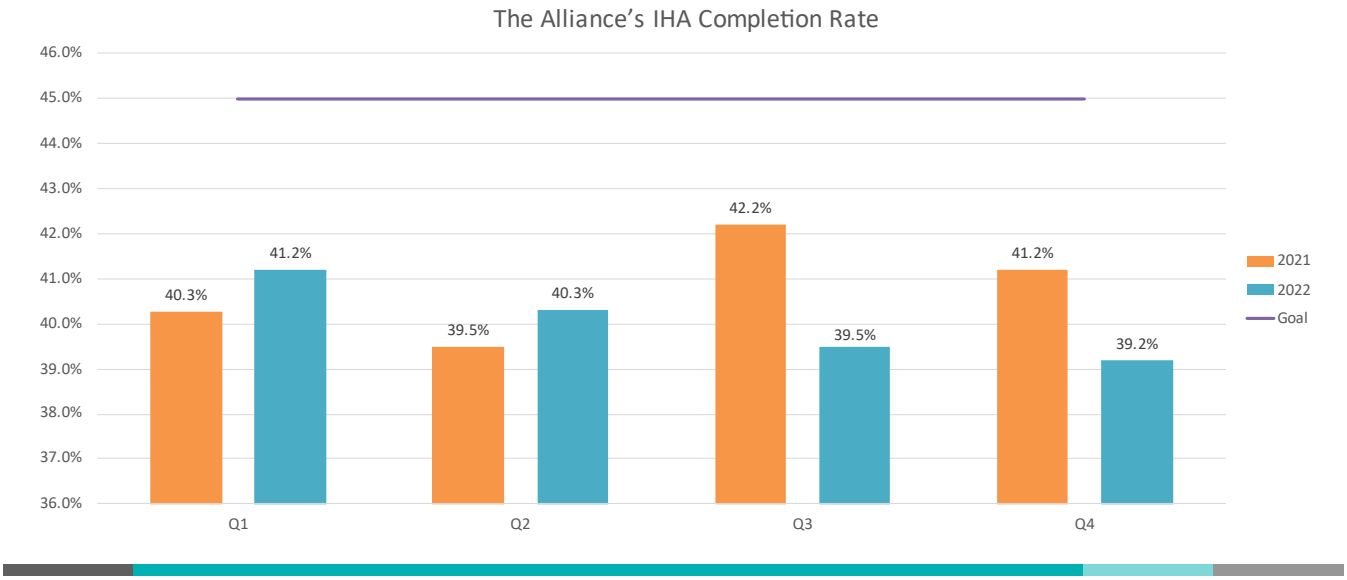
IHA Rates & Audits

The past 1 year of IHA rates is outlined below.

2022 IHA Completion Preliminary Rates – Medi-Cal

New Enrollee	Re-Enrollee	Total
Denominator:37,860 Numerator: 14,036 Rate: 37.1% Goal: 45% Gap to goal: Goal Not Met	Denominator: 16,077 Numerator: 6,014 Rate: 37.4% Goal: 45% Gap to goal: Goal Not Met	Denominator: 53,937 Numerator: 20,050 ate: 37.2% Goal: 45% Gap to goal: Goal Not Met

2022 IHA Completion Rates by Quarter



Annually the Alliance conducts an audit of the Initial Health Appointments (IHA). A random sample of 60 members are selected and medical records are requested to review if the six elements of the IHA has been completed, including:

- Patient history
- Review of organ systems
- Physical and mental examination
- Preventive care
- Diagnoses and plan of care
- Staying Healthy Assessment (SHA)

In 2022, 60 charts were requested, 31 received. In all 25 components of the IHA were missing, with the Staying Healthy Assessment (SHA) missing most often. Per APL22-030, the IHEBA/SHA, will no longer be required components of the IHA beginning January 1, 2023.

To improve IHA compliance rates, the Alliance is working to:

- Ensure member education – through mailings, member orientation and IVR calls.
- Improve provider education – through provider manual and newsletter/packets, JOMs, HCQC) meeting, site specific quality meetings, provider educational webinars.
- Improve data sharing – by sharing gaps in care lists with our delegates and providers.
- Monitor records – through IHA audits, FSR/MRR site review, monitoring of IHA rates.

CFMG Improve Well-Child Visits (0-21 years)

In collaboration with CFMG, an organization providing primary care and pediatric specialty care, the Alliance launched a texting campaign to boost well-child visit rates. The campaign was aimed at children aged 0-21 years and served as a reminder tool for parents/guardians to complete a well visit exam. From January 1, 2022, to September 18, 2022, more than 48,294 distinct Alliance members received a text message, with a reported engagement success rate of 15.50%. Among them, 845 members reported having already scheduled or completed an appointment.

Although there was no improvement in rates for the CFMG network in the W30 (0-30 months 6+) and Well Child Visit (3-21 years), an improvement was seen in the W30 (15-30 months 2+) from MY2021's 61.18% to MY2022's 64.54%.

Improve A1c Poor Control (>9%) Rates in Eastmont Wellness Center

In collaboration with our delegate AHS, the Alliance's objective was to enhance the HgA1c Poor Control (>9%) rates for members aged 18-75 years assigned to Eastmont Wellness Center, a clinic under AHS, to manage diabetes better. The smart goal for this project was to decrease the number of overdue HgbA1c tests for Eastmont Adult Medicine/Alameda Alliance patients by 50% by October 2022 and improve HgA1c Poor Control (>9%) rates by 5%.

To enhance the HgbA1c rates, the Eastmont Wellness Center team launched an outreach and incentive project. The team identified gaps in care, developed text message and call scripts, used a combination of text messages and outreach calls, and followed up with a letter. Members who completed an A1c test received a gift card, and those with out-of-control A1c levels were scheduled for a follow-up visit with their provider.

The Eastmont Wellness Center achieved an improvement of 5.56%, exceeding their goal of 5%, by decreasing HgA1c Poor Control (>9%) rates from 49.88% in MY2021 to 44.32% in MY2022.

**Note: HgbA1c Poor Control, lower rate is better.*

Improve Colon Cancer Screening Rates in West Oakland Health Center

In July 2021, The Alliance collaborated with West Oakland Health Council (WOHC), a Federally Qualified Health Center, to enhance colon cancer screening rates in African American men aged between 45-75 years. The Alliance implemented an outreach and incentive program for its members in partnership with WOHC. In 2022, the initiative continued with a $50 incentive gift card and an outreach call from WOHC. Based on the provider's recommendation, members were either scheduled for a colonoscopy or sent a FIT/Cologuard test at home with instructions on how to complete and mail or drop off the specimen. The objective of the project was to raise the colorectal cancer screening rates among African American male members at WOHC from 22.79% to 37.10%. The colorectal cancer screening rates in African American males assigned to WOHC was 37.89% in 2022, exceeding the set goal.

Improve Cervical Cancer Screening Rates in BACH, for Women Between the ages 21-64

The Alliance collaborated with Bay Area Community Health (BACH), a provider with high volume but low performance, to implement an outreach and incentive program aimed at improving rates

of Cervical Cancer Screening among women aged 21-64. BACH also offered Saturday Pap clinics to enhance appointment availability. As a result of this initiative, BACH completed 100 cervical cancer screenings, representing a 3% improvement from the baseline.

First 5 Alameda Partnership

The Alliance continued to partner with First 5 Alameda in 2022. The goal of the initiative was to engage, assess, and connect Medi-Cal enrolled children, ages 0-5 and their families to appropriate clinical and community-based services and support to improve their health and well-being through an integrated community-based care management program. First 5 Alameda served as a key care management entity for Alliance pediatric members, ages 0 to 5 and worked in partnership with the Alliance to:

- Conduct outreach and engagement to increase child access to well-child preventative care for select Alliance members, ages 0-5.
- Provide pediatric health education to families in a culturally appropriate and accessible manner.
- Bolster pediatric health provider capacity to deliver DHCS/Bright Futures mandated pediatric screenings, with an emphasis developmental screening, ACES, and social determinants of health.

Coordinate family-centered access to well-child visits, as well as needed developmental/behavioral services, mental health services, community-based services and supports, and social support needs, to enhance and supplement practice-based care coordination services and comply with EPSDT requirements.

Through our partnership with First 5, 981 members completed a well visit or had a scheduled well visit. First 5 facilitated 23 provider trainings to support pediatric providers to implement ACE's screening. Within the Alliance pediatric sites 10 providers participated in a QI project. 310 members with an identified need connected to at least one Alliance or Contractor early intervention services.

Opioid/SUD Continuation

In 2020, the Alliance partnered with our network providers and other local leaders to develop a Substance Use Disorder Program. This program has continued through 2022.

Alameda Alliance has continued to use multiple strategies involving *Member and Provider Educational Outreach and Pharmacy Safeguards*. The Alliance has accurate and comprehensive monthly reports that detail opioid overutilization, members grandfathered to high dose opioids, members excluded from the SUD Program (including those involved in hospice/palliative, cancer, and members with sickle cell disease), and monitoring the changes in Morphine Milligram Equivalence (MME).

The Alliance monitors a list of members who meet the definition of *chronic opioid users and potential chronic opioid users*. Chronic users are defined as members with prescriptions of greater than 120 MME consecutively for the last three months. Potential chronic opioid users are defined as members with prescriptions between 50 to 119 MME consecutively for the last three months.

The Alliance also has compiled a list of members who presented to the ED with opioid and benzodiazepine overdose and a separate list of members on concurrent use of opioids and benzodiazepines.

In 2022, the Alliance sent pertinent members and providers educational mailings. Mailing includes:

1. Provider Facing:
    a. Lists of identified members who are chronic users, high risk members on becoming chronic users, concurrent chronic opioid/benzodiazepine usage and members presenting to ED for opioid/benzodiazepine overdose.
    b. Provider Opioid and Benzodiazepine Tapering Tools.
    c. Treatment for opioid dependence.
2. Member Facing:
    a. Opioid Safety guide for members and caregivers.
3. Provider and Member Facing:
    a. Non-opioid formulary alternatives.
    b. Local alternative health services contracted with the Alliance (e.g., physical therapy, acupuncture, chiropractor, massage).

Mailer Timeline

Day	Member	Provider
1	Original mailing gets sent out	Original mailing gets sent out.
45	Repeat mailing. Refer to case management if a member is on greater than 300 MME.	Repeat mailing.
90	Check if member transition to buprenorphine or received appropriate pain treatment.	Receive letters from medical director. Submit a PQI.
120	N/A	Include operations and peer review committee to decide whether to keep in-network.

Note the above escalation process for members and providers with persistent chronic use of opioids. Cancer, hospice, and sickle cell anemia members are excluded from this. Pharmacy will work with QI to receive chart notes to check on this. Rising risk members will be tracked and looked at on a case-by-case basis. Handouts may include opioid safety, medication assisted therapy, non-opioid alternatives, opioid and benzodiazepines tapering tools and provider maps for non-opioid alternatives such as physical therapy, acupuncture, etc.

The table above outlines the actions to be taken after initially mailing to members and providers (day 1). Each respective row reflects a higher escalation process to be taken if members and providers continue to use opioid inappropriately or with no identified treatment plan.

This escalation process was implemented in our population health goals for 2022. This goal was as follows:" Between 1/1/22 and 12/31/22, ensure that 100% of members (>300MME) and

providers (of members on >300MME) with ongoing use of opioids follow the SUD Escalation Process."

This goal was not met. We surveyed providers who provided feedback that mailing was not the most effective method of receiving education. The Alliance will discuss next steps for provider education and escalation process. Lastly, the creation of the tracking log and mailing process was delayed due to limited C&O and Analytic capacity and Alliance staffing transitions.

Opioids Stewardship Report

April 2022: Mailings to 30 high-risk members with prescriptions of greater than 300 MME consecutively for the last three months. These members received:

- High risk cover letter
- Health education: Safety guide for patients and caregivers
- Health education: Treating pain without opioids.
- Health education: Medicines for opioid dependence

April 2022: Mailings to 41 rising risk members with prescriptions between 50 to 89 MME consecutively for the last three months. These members received:

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

October 2022: Mailings of a total of 37 providers with members who were on any of the following lists:

- Opioid and Benzodiazepine Co-use list
- Rising risk list: 50-119 MME for 3 consecutive months
- High risk list: 120+ MME for 3 consecutive months
- Opioid and Benzodiazepine ER list

The Alliance developed a Provider packet that included an Opioid and Benzodiazepine Tapering Tool, Shared Data for providers / delegates / committees, Health Education materials, Local Maps that identify providers who may meet the member's needs, and member facing materials.

Goals for 2022

- Continue educating members and providers who are chronic and rising risk opioid users.
- Continue sharing data for providers/delegates/committees.
- Organize materials on Alliance website to be accessible to members and providers.

Opioid and Benzodiazepine ER Reporting

- Reports are based on claims data and reflected on each unique claim with opioids/benzodiazepine related ICD code.

- Reports are shared with assigned PCPs of members quarterly.
- There were several peaks between 2020 and 2022 with opioid/benzodiazepine related ER visits. After July 2022, there was a steady decline in opioid/benzodiazepine overdose.

The Alliance will continue to improve our opioid stewardship program. Below are results of our interventions. As of January 1, 2022, DHCS has taken over the pharmacy benefit for outpatient drugs. The Alliance pharmacy has discontinued formulary safeguards for Medi-Cal but is continuing with formulary safeguards for IHSS members.

Table 1: 2020 – 2022 Benzodiazepines and Opioid ED visits

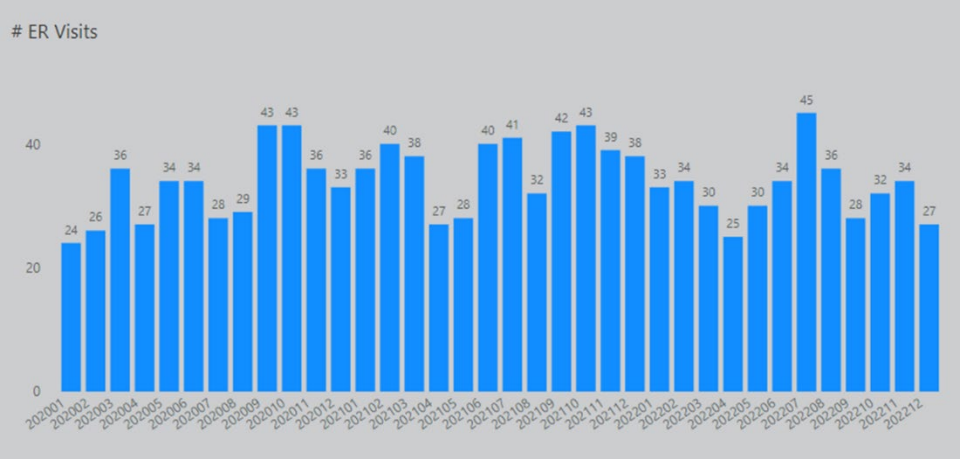
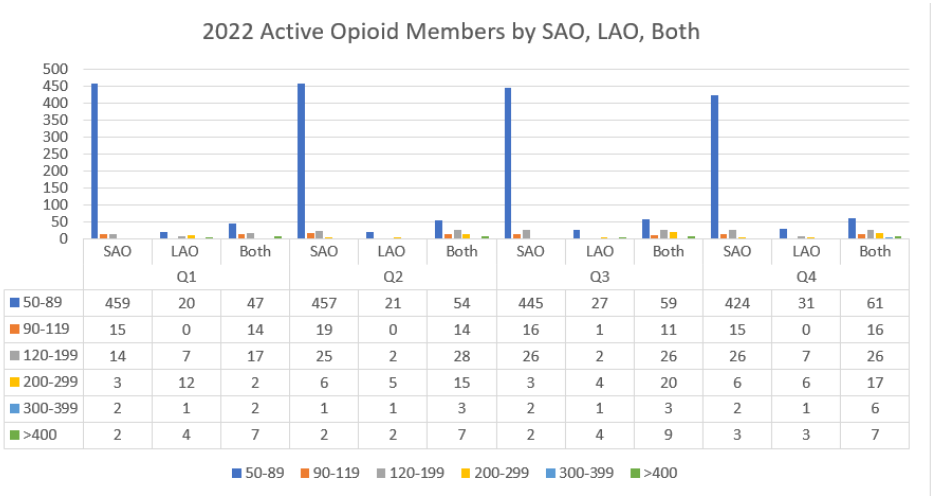


Figure 1: 2022 Data for Members on Short Actin Opioids (SAO), Long-Acting Opioids (LAO), and Both SAO and LAO



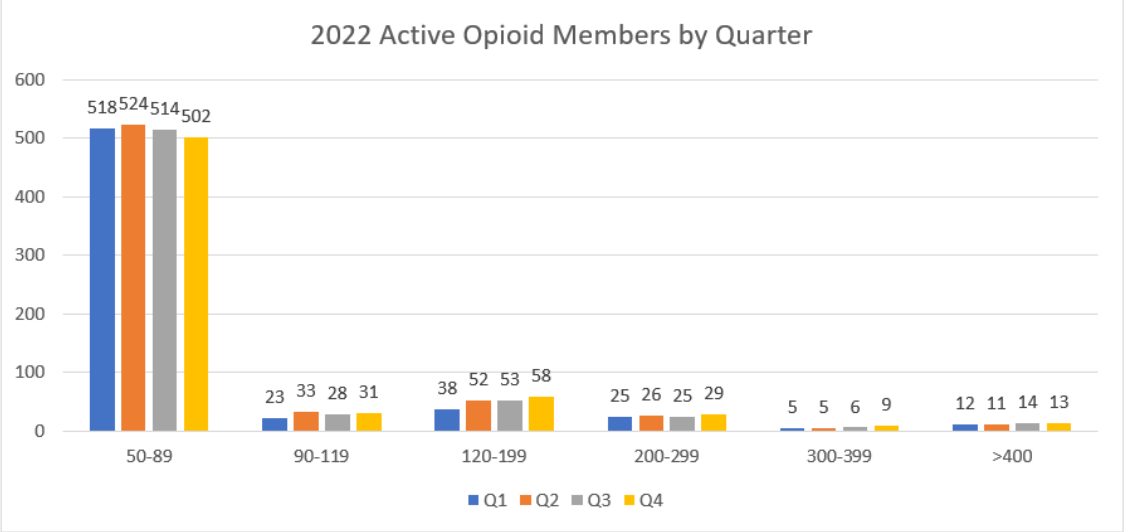
	SAO	LAO	Both	SAO	LAO	Both	SAO	LAO	Both	SAO	LAO	Both
	Q1			Q2			Q3			Q4		
50-89	459	20	47	457	21	54	445	27	59	424	31	61
90-119	15	0	14	19	0	14	16	1	11	15	0	16
120-199	14	7	17	25	2	28	26	2	26	26	7	26
200-299	3	12	2	6	5	15	3	4	20	6	6	17
300-399	2	1	2	1	1	3	2	1	3	2	1	6
>400	2	4	7	2	2	7	2	4	9	3	3	7

Table 2: 2022 Member per Quarter on >50MME

MME (MORPHINE MILLIGRAM EQUIVALENTS)				
MME	**Q1**	**Q2**	**Q3**	**Q4**
50-89	518	524	514	502
90-119	23	33	28	31

120-199	514	28	53	25
200-299	502	31	58	29
300-399	5	5	6	9
>400	12	11	14	13

Figure 2: 2022 Active Opioid Members by Quarter



2021 Active Members by Quarter

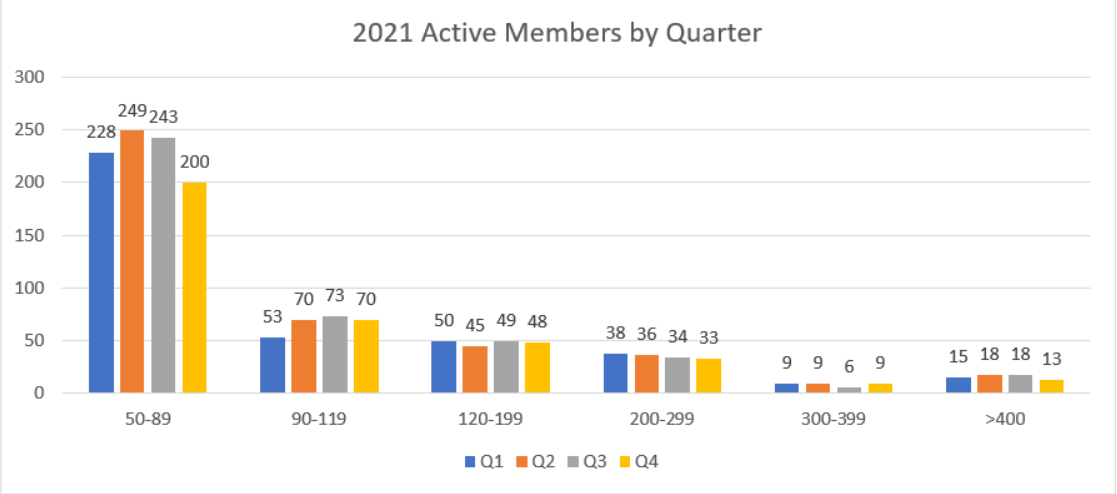
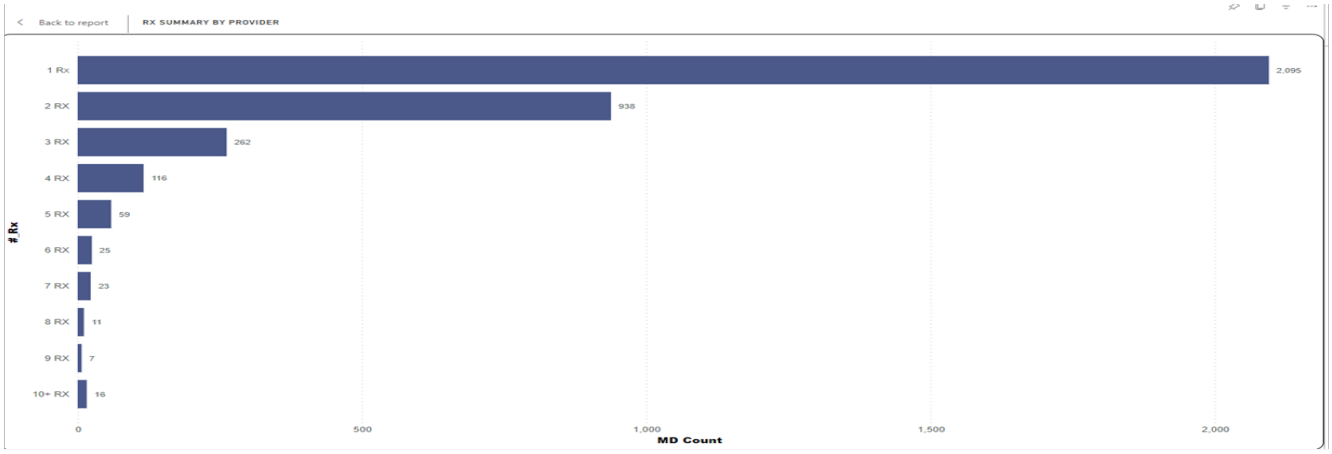


Figure 1 and Table 2 both show opioid utilization by type of opioids used and MME used. Figure 2 shows short-acting utilization doubled in 2022. Similarly, 50-89 MME utilizers also almost double in 2022 while >90 MME declined or had no change. This is an interesting trend as Medi-Cal RX started in 2022. After Medi-Cal Rx implementation, there was no DUR edits and PA in place until 9/2022, which explains the increase in opioid utilization for 50-89 MME. Prior to Medi-

Cal Rx, we restricted opioid naïve patients to only 14-day supply unless there was identified medical necessity.

Below is a graph depicting how many unique providers prescribing opioids categorized by ascending MME. These graphs are looking at provider prescription claims. There is a general decrease in prescribing trend as the MME goes up. In 2022, 44 providers each wrote 1 prescription for 300-399 MME and 129 providers each wrote 1 prescription greater than 400 MME. In addition, at least 16 providers wrote at least 10 prescriptions. The top five providers who wrote more than 300 MME were oncology, internal medicine, and family practitioners. In comparison with 2021, there was almost 4 times increase in prescription claims for 50-89 MME while >300 MME has decreased.

Figure 3: 2022 Frequency of Provider Opioid Prescription Count by MME for 2021 and 2022



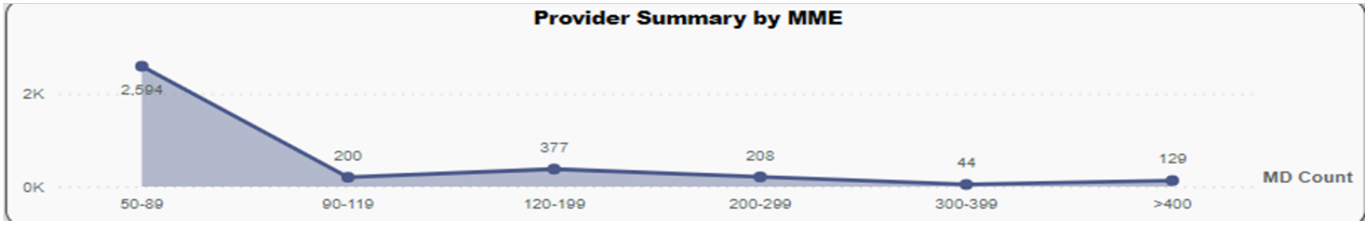
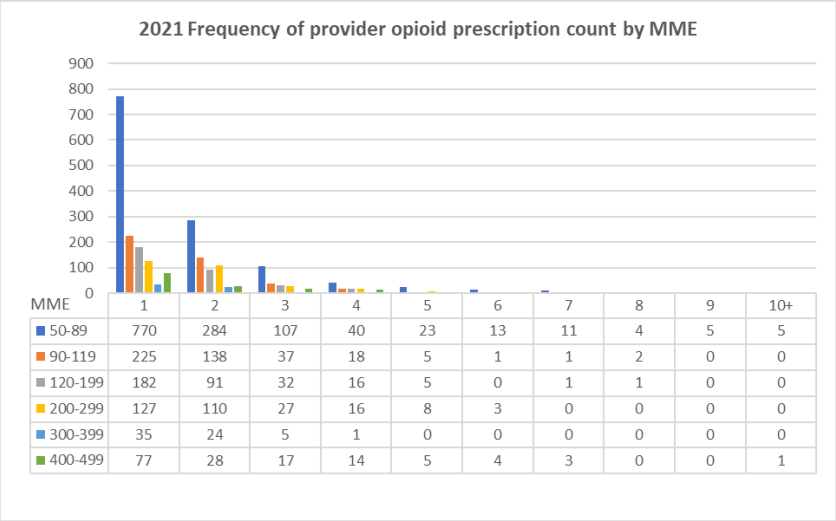


Table 3: 2021 Frequency of Provider Opioid Prescription Count by MME



MME	1	2	3	4	5	6	7	8	9	10+
50-89	770	284	107	40	23	13	11	4	5	5
90-119	225	138	37	18	5	1	1	2	0	0
120-199	182	91	32	16	5	0	1	1	0	0
200-299	127	110	27	16	8	3	0	0	0	0
300-399	35	24	5	1	0	0	0	0	0	0
400-499	77	28	17	14	5	4	3	0	0	1

Drug Recalls

The Pharmacy Department monitors all drug recalls. In 2022, there were 110 recalls. Recalls were monitored for adversely affected members. The number of notifications where the PBM completed a claims data review was 5.

2022 Pharmacy Recalls

RECALL TYPE	QUANTITY
Total number of safety notices/recalls	**110**
Total number of withdrawals	**0**
The number of notifications where PBM completed a claims data review	**5**

Pay-for-Performance Programs

Overview

The Alliance Pay-for-Performance (P4P) program offers performance-based incentive payments for delivered services. Through this program, primary care providers (PCPs) and PCP Groups are rewarded for superior performance and yearly improvement. The P4P program focuses on preventative care, pediatrics, access, and chronic disease and includes clinical quality (HEDIS) measures and other (non-HEDIS) measures. The MY for the program was January 1, 2021, through December 31, 2021.

2021 Program Summary

The MY 2021 P4P program is tailored to each delegate and directly contracted PCP group category: AHS, CHCN, CFMG, Directs – Family Medicine Providers, Directs – Pediatric Providers, Directs – Internal Medicine Providers. The measures for each are outlined below.

Category	Measure	AHS	CHCN	CFMG	Directs - Family Practice	Directs - Internal Medicine	Directs - Pediatrics
HEDIS	Childhood Immunizations: Combo 10 (CIS)			X			X
	Immunizations for Adolescents: Combo 2 (IMA)						X
	Well-Child Visits in the First 15 Months of Life: Six or More Visits (W30)	X	X	X			X
	Well-Child Visits 15- 30 Months of Life: Two or More Visits (W30)	X	X	X			X
	Child and Adolescent Well-Care Visits (WCV)	X	X	X	X		X
	Child and Adolescent - BMI percentile (WCC)			X			X
	Child and Adolescent - Nutrition (WCC)			X			X
	Child and Adolescent - Phys Activity (WCC)			X			X
	Asthma Medication Ratio (AMR)		X	X	X	X	Monitoring Measure
	Breast Cancer Screening (BCS)	X			X	X	
	Cervical Cancer Screening (CCS)	X	X		X	X	
	Chlamydia Screening for Women (CHL)				X	X	
	HbA1c Testing for Diabetes (CDC)	X	X		X	X	
Other	PCP Visits Per 1000	X	X	X	X	X	X
	ED Visits Per 1000	X	X	X	X	X	X
	Readmission Rate	X	X				
	Member Satisfaction Survey: Non-Urgent Appt Availability	X	X	X	X	X	X
	Screening for Depression	Monitoring Measure	Monitoring Measure		Monitoring Measure	Monitoring Measure	

For delegates, points were earned based on performance compared to the overall Alliance population and/or improvement from the prior year. For directly contracted PCP groups, points were earned based on performance compared to the overall Alliance population excluding members assigned to delegates and/or improvement from the prior year. This applied to all measures except for “Member Satisfaction Survey: Non-Urgent Appt Availability” and monitoring measures. Full points were earned for the “Member Satisfaction Survey: Non-Urgent Appt Availability” if 80% of survey responses for a PCP group indicated that the member was able to schedule a non-urgent appointment within 10 business days. No points were assigned to monitoring measures.

Delegates and directly contracted PCP groups earned 44.57% of the available pool dollars for the MY2021 P4P program. Directly contracted pediatric providers performed the best, earning 66.97% of the pool dollars available to them. A breakout by delegate and directly contracted provider category is below.

Delegate/Directly Contracted Provider Category	% of Pool Dollars Earned
AHS	31.00%
CHCN	42.00%
CFMG	50.38%
Directs - Family Practice Providers	51.40%
Directs - Internal Medicine Providers	47.90%
Directs - Pediatric Providers	66.97%
TOTAL	**44.57%**

The measures, point values, and benchmarks vary from year-to-year, so it is difficult to make an apples-to-apples comparison against prior year results.

QI Training and Coaching

To establish a culture of quality across the organization and disseminate knowledge of quality improvement methodologies, the Quality Team conducted a training program on the PDSA methodology. The training encompassed methods for enhancing quality, creating an aim statement, utilizing data for performance enhancement, tools for devising change ideas, and testing change ideas with the PDSA methodology. In October/November 2022, a webinar series comprising five one-hour sessions was held, attended by over 30 staff and management members from the QI and Behavioral Health Departments. Out of the 11 respondents who completed the survey, 99% gave the course an excellent/very good rating. The QI team is planning to offer a second session of the training, accessible to all departments within the Health Care Services umbrella, with the objective of extending the training to our external provider network while continuing to provide the training to internal staff.

The Alliance QI and Analytics departments will continue to focus on preventative care, pediatrics, access, and chronic disease in future year P4P programs.

Patient Safety and Quality Compliance

Consistency in Application of Criteria

The Alliance QI Department assesses the consistency with which clinical reviewers, physicians, pharmacists, UM nurses, Retrospective Review nurses and non-physician reviewers apply criteria to evaluate inter- Rater reliability (IRR). A full description of the testing methodology is available in policy QI-133. The QI has set the IRR passing threshold as noted below.

IRR Thresholds

SCORE	ACTION
High – 90%-100%	IRR Pass Rate No action required.
Medium – 61%-89%	Increased training and focus by supervisors/managers.

Low – Below 60%	• Additional training provided on clinical decision-making. • If staff fails the IRR test for the second time, a Corrective Action Plan is required with reports to the Director of Health Services and the Chief Medical Officer. • If staff fails to pass the IRR test a third time, the case will be escalated to Human Resources which may result in possible further disciplinary action.

The IRR process for PQIs uses actual PQI cases. Results will be tallied as they complete the process and corrective actions implemented as needed. When opportunities for improving the consistency in applying criteria, QI staff addresses corrective actions through requiring global or individualized training or completing additional IRR case reviews.

For 2021, IRR testing was performed with QI clinical staff to evaluate consistency in classification, investigation and leveling of PQIs. All QI Review Nurse and Medical Director Reviewers passed the IRR testing with scores of 100%.

Facility Site Reviews

Facility Site Review (FSR) and Medical Record Review (MRR) audits are mandated for each Health Plan under DHCS All Plan Letter 22-017 to occur every three (3) years. FSRs are another way the Alliance ensures member quality of care and safety within the provider office environment. Interim monitoring and follow-up of FSR and MRR occurs between each regularly scheduled full scope reviews. Corrective Action Plans (CAPs) for non-compliance are required depending on the site FSR and MRR scores and critical element failures.

During the PHE (Public Health Emergency) environment in 2020, 2021, and 2022, Alliance had backlogs in FSRs. Reviews were conducted onsite and virtually. In January 2022, Alliance fully resumed all FSR activities in person. APL 22-017 provides Alliance an option to choose to conduct the MRR on site or virtually. Most providers with electronic medical records opted to have a virtual MRR. The virtual process complies with all applicable Health Insurance Portability Accountability Act (HIPAA) standards.

Alliance continued to submit quarterly updates to DHCS regarding FSR status. In addition, the bi-annual DHCS reports were submitted in July 2022 (FSRs conducted in January to June 2022) and January 2023 (FSRs conducted in July to December 2022).

In 2022, there were 107 site reviews. The total number and types of audits are detailed in the table below.

2022 Facility Site Reviews

TYPE	Q1	Q2	Q3	Q4	TOTAL
FSR					
Initial FSR	3	1	0	2	**6**
Periodic FSR	13	8	9	4	**34**
Annual FSR	0	0	0	1	**1**

Urgent Care FSR	0	0	0	1	**1**
MRR					
Initial MRR	0	0	1	2	**3**
Periodic MRR	15	12	10	3	**40**
Annual MRR	0	0	0	1	**1**
Focused MRR	0	0	0	1	**1**
Interim Monitoring	0	3	6	11	**20**
Total Reviews	**31**	**24**	**26**	**26**	**107**

DHCS regulation requires that Critical Element (CE) CAPs be received by the Alliance within 10 business days and FSR/MRR CAPs within 45 days of the site review. In July 2022, the new FSR/MRR standards were in effect. There are changes to the CAP timelines. FSR/MRR CAPs are due within 30 days of the FSR and/or MRR Report.

Additionally, a CE CAP is issued for deficiencies in any of the 14 critical elements in the FSR that identify the potential for adverse effects on patient health or safety and must be corrected within 10 business days of the site review. In 2022, there were 68 CAPs issued and 1 CAP remain open for more than 120 days.

Per DHCS regulation, failed periodic reviews are reported bi-annually. In 2022, the Alliance had two providers with non-passing scores of 79% and below. A corrective action plan was provided to DHCS. New member assignment is put on hold for PCP sites that receive failing scores on FSR/MRR and/or providers who do not correct FSR/MRR deficiencies within established CAP timelines until the CAP is closed. In 2022, there were four providers with new member assignment holds (two providers failed the MRR, one provider did not close the CAP within timelines in Q4 2021, resulting in a hold in 2022 Q1 and another provider did not close CAP in 2022 Q4).

FSR/MRR CAPs Issued in 2022

TYPE	Q1	Q2	Q3	Q4	TOTAL
Total CAPs Issued	**22**	**21**	**15**	**10**	**68**
Open	0	0	0	2	2
Open >120 days	*2*	*0*	*0*	*1*	*2*
Closed	22	21	15	6	64

2022 Audits with Non-Passing Scores

QUARTER	Audit Date	FSR Score	MRR Score
Q1	N/A	N/A	N/A

Q2	5/2/2022	N/A	79.02%
Q3	N/A	N/A	N/A
Q4	10/31/2022	N/A	70.33%

Audit of Initial Health Appointments via FSR/MRR

IHAs include history and physical (H&P) and Individual Health Education Behavioral Assessment (IHEBA). An IHA must be completed within 120 days of member assignment.

Alliance reviewed records IHA for members enrolled before 2022 eligible for IHA criteria. IHA was also reviewed for newly enrolled members in 2022 who presented for well care visit at the providers office and where an IHEBA was completed. In 2022, medical records at 43 sites were reviewed for the presence of an IHA. During the MRR, the nurse reviewer, if possible, ensures at least 30% of records reviewed are for members eligible for IHA. Table 19 lists the results of these reviews. The 21 total non-compliant providers received CAP and re-education/training on IHA and IHEBA compliance.

2022 MRR Results

TYPE	Q1	Q2	Q3	Q4	TOTAL
Total IHAs Audited via FSR	13	12	11	7	43
# of MRRs with Compliant* IHAs	10 (77%)	4 (33%)	4 (36%)	3 (43%)	21
# of MRRs with Non-Compliant IHAs (CAPS)	3	8	7	4	22

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

Peer Review and Credentialing Committee

In 2022, 33 practitioners were reviewed for lack of board certification. If there were complaints about a practitioner's office, facility site reviews were conducted, and the outcome was reviewed by the PRCC. There were no site reviews conducted based on complaints in 2022. All grievances, complaints, and PQIs that required investigation were forwarded to this committee for review. In 2022, 125 practitioner grievances, complaints, or PQIs were investigated by the committee. There were no practitioners that required reporting to National Practitioner Data Bank (NPDB) by the Alliance.

In 2022, the PRCC granted one-year reappointment for three (3) practitioners for grievances filed regarding office procedures, quality of care and accessibility. The table below shows evidence of practitioners reviewed by the PRCC for credentialing and re-credentialing decisions.

Count of Practitioners Reviewed for Quality Issues at PRCC in 2022

Count of Practitioners Reviewed for Quality Issues At PRCC in 2022											
PRCC Date	PRC	NPDB	Attestation	Malpractice	Facility Site Review	Grievance, Complaints, PQI	License Action	Board Certification	CAP	GAP	Total
January						8		2	1	2	11
February				1		8		1		1	10
March		2		3		13		5	1	3	24
April		3		2		15		4		5	24
May		3	1	3		20		1	2	3	30
June		1		1		11		1		2	14
July				2		14		1	2	1	19
August No Committee Meeting											0
September		4				10		5		1	19
October		3				4	1			2	8
November		2		3		12		7	3	3	27
December				2		10		6	1	10	19
Total	**0**	**18**	**1**	**17**	**0**	**125**	**1**	**33**	**10**	**33**	**205**

Potential Quality Issues

Potential Quality Issues (PQIs) are defined as: A individual occurrence or occurrences with a potential or suspected deviation from accepted standards of care, including diagnostic or therapeutic actions or behaviors that are considered the most favorable in affecting the patient's health outcome, which cannot be affirmed without additional review and investigation to determine whether a quality issue exists. PQI cases are classified as Quality of Access (QOA), Quality of Care (QOC), or Quality of Service (QOS) issues. Quality of Language (QOL) was added as a separate PQI classification as an improvement opportunity to better capture, track, trend, investigate and resolve PQIs related to member grievances regarding language. The Alliance QI Department investigates all PQIs referred to as outlined in Policy QI-104, Potential Quality Issues. PQIs may be submitted via a wide variety of sources including but not limited to members, practitioners, internal staff, and external sources. PQIs are referred to the QI Department through a secure electronic feed or entered manually into the PQI application, for evaluation, investigation, resolution, and tracking.

Quality Review Nurses investigate PQIs and summarize their findings. QOA cases are referred to A&A for review and tracking while QOS cases that do not contain a clinical component are investigated and closed by the review nurse. QOL cases are reviewed and investigated by the Cultural and Linguistic Manager. The Senior Director and/or the QI RN Supervisor oversees and audits a random sample of all PQI case types. The QI Medical Director reviews all QOC cases, in addition to, any QOA, QOL, or QOS cases where the Quality Review Nurse and RN manager/director requests Medical Director case review. The QI Medical Director will refer cases to the Peer Review and Credentialing Committee (PRC) for resolution, on clinical discretion or if a case is found to be a significant quality of care issue (Clinical Severity 3, 4).

Quality of Care (QOC) Issue Severity Level

SEVERITY LEVEL	DESCRIPTION
C0	No QOC Issue
C1	Appropriate QOC May include medical / surgical complication in the *absence of negligence.* Examples: Medication or procedure side effect
C2	Borderline QOC With potential for adverse effect or outcome Examples: Delay in test with *potential* for adverse outcome
C3	Moderate QOC Actual adverse effect or outcome (non-life or limb threatening) Examples: Delay in / unnecessary test *resulting in* poor outcome
C4	Serious QOC With significant adverse effect or outcome (life or limb threatening) Examples: Life or limb threatening

The Alliance's QI Department received 6,458 PQIs, during MY2022, which is a 112% increase from 2021. The total volume of PQIs increased by 3,407 which is largely reflected in the number of QOS and QOA issues identified during this MY. Of the 6,458 PQIs received in 2022, 8%, or 509, of the PQIs were classified as a QOC. PQI monthly and quarterly totals are listed below:

2022 All PQI Type Monthly Totals

PQI Type	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	TOTAL	%
All Types of PQIs	328	321	589	563	489	483	570	687	727	412	593	696	**6458**	
QOA	100	123	229	183	146	164	189	246	259	123	150	215	**2127**	**33%**
QOC	58	20	32	47	38	41	57	68	43	55	34	16	**509**	**8%**
QOS	145	162	309	304	270	254	295	335	388	213	384	428	**3484**	**54%**
QOL*	14	7	14	21	23	17	24	26	23	14	15	30	**228**	**3%**
Other ***	11	9	8	8	12	7	5	12	14	7	10	7	**110**	**2%**

***Referred to Beacon or Kaiser*

QI clinical management investigated reviewed and triaged all referrals both internal and external

to the organization to ensure that access, clinical, language, service related PQIs were addressed through RN investigation and oversight support from Compliance and Vendor Management as applicable.

2022 OQC PQI Quarterly Totals

INDICATOR	Q1	Q2	Q3	Q4
Indicator 1: QOC PQIs	Denominator: **1238** Numerator: **110** Rate: **8.9%**	Denominator: **1535** Numerator: **126** Rate: **8.2%**	Denominator: **1984** Numerator: **168** Rate: **8.5%**	Denominator: **1701** Numerator: **105** Rate: **6.2%**
Indicator 2: QOC PQIs leveled at severity C2-4	Denominator: **109** Numerator: **25** Rate **22.9%**	Denominator: **125** Numerator: **17** Rate: **13.6%**	Denominator: **167** Numerator: **33** Rate: **19.8%**	Denominator: **112** Numerator: **8** Rate: **7.2%**

QI RN management continued to conduct Exempt Grievances case audits via random sampling, to ensure that clinical PQIs are not missed and forwarded to the Quality Department. QI Department clinical management provides oversight of exempt grievances via review of randomly selected exempt grievances. In 2022, 100 exempt grievance cases per quarter were reviewed with an overall performance rate of 98.5% which exceeds the established performance metric of 90%.

	Q4 2021	Q1 2022	Q2 2022	Q3 2022
Numerator	98	98	98	100
Denominator	100	100	100	100
Performance Rate	98	98	98	100
Gap to Goal	N/A	N/A	N/A	N/A
Universe	3126	3068	3684	4828

The Alliance IT department continues to provide support with workflow enhancements to the PQI application. The PQI application remains a robust and responsive system allowing for timely and accurate reporting, documentation, tracking, and adjudication of PQIs.

A full description of the PQI process is documented in Policy QI-104.

Quality in Member Experience

Overview

Analyses of member experience information helps managed care organizations identify aspects of performance that do not meet member and provider expectations and initiate actions to improve performance. The Alliance monitors multiple aspects of member and provider experience, including:

- Member Experience Survey
- Member Complaints (Grievances)

- Member Appeals

Standards and Provider Education

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

Primary Care Physician (PCP) Appointments

APPOINTMENTS WAIT TIMES	
Appointment Type:	**Appointment Within:**
Urgent Appointment that *does not* requires PA	48 Hours of Request
Urgent Appointment that *requires* PA	96 Hours of Request
Non-Urgent **Primary Care** Appointments	10 Business Days
First Prenatal Visit	10 Business Days
Non-Urgent Appointment with a **Specialist** Physician	15 Business Days
Non-Urgent Appointment with a **Behavioral Health** Provider	10 Business Days
Non-Urgent Appointment for **Ancillary Services** for the diagnosis or treatment of injury, illness, or other health conditions	15 Business Days

All Provider Wait Time/Telephone/Language Practices

ALL PROVIDER WAIT TIME/TELEPHONE/LANGUAGE PRACTICES	
Standard:	**Within:**
In-Office Wait Time	60 Minutes
Call Return Time	1 Business Day
Time to Answer Call	10 Minutes
Telephone Access – Provide coverage 24 hours a day, 7 days a week.	
Telephone Triage and Screening – Wait time not to exceed 30 minutes.	
Emergency Instructions – Ensure proper emergency instructions.	
Language Services – Provide interpreter services 24 hours a day, 7 days a week.	

**Per DMHC and DHCS Regulations, and NCQA HP Standards and Guidelines PA = Prior Authorization*

Urgent Care refers to services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).

Non-urgent Care refers to routine appointments for non-urgent conditions.

Triage or Screening refers to the assessment of a member's health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within their scope of practice. This individual must be trained to screen or triage and

determine the urgency of the member's need for care.

Each of these standards are monitored as described in the table below. In 2022, the Alliance made changes to the CG-CAHPS instrument to ensure that the collected data was consistent with the Alliance standards which remained in place during the MY2020.

Shortening or Extending Appointment Timeframes: The applicable waiting time to obtain a particular appointment may be extended if the referring or treating licensed health care Practitioner, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the Member's medical record that a longer waiting time will not have a detrimental impact on the health of the Member.

Primary Care Physician (PCP) Appointment

PRIMARY CARE PHYSICIAN (PCP) APPOINTMENT	
Appointment Type:	**Measured By:**
Urgent Appointment that *requires* PA	PAAS, CG-CAHPS, Confirmatory Survey
Urgent Appointment that *does not* require PA	PAAS, CG-CAHPS, Confirmatory Survey
Non-Urgent **Primary Care** Appointment	PAAS, CG-CAHPS, Confirmatory Survey
First Prenatal Appointment	Non-PAAS, Confirmatory Survey
Non-Urgent Appointment with a **Specialis**t Physician	PAAS, Confirmatory Survey
Non-Urgent Appointment with a **Behavioral Health** Provider	PAAS, Confirmatory Survey
Non-Urgent Appointment for **Ancillary Services** for the diagnosis or treatment of injury, illness, or other health conditions	PAAS, Confirmatory Survey

All Provider Wait Time/Telephone/Language Practices

ALL PROVIDER WAIT TIME/TELEPHONE/LANGUAGE PRACTICES	
Standard:	**Measured By:**
In-Office Wait Time	CG-CAHPS, Confirmatory Survey
Call Return Time	CG-CAHPS, Confirmatory Survey
Time to Answer Call	CG-CAHPS, Confirmatory
Telephone Access – Provide coverage 24 hours a day, 7 days a week	Confirmatory Survey

Telephone Triage and Screening – Wait time not to exceed 30 minutes	Confirmatory Survey
Emergency Instructions – Ensure proper emergency instructions	After Hours: Emergency Instructions Survey, Confirmatory Survey
Language Services-Provide interpreter services 24 hours a day, 7 days a week	CG-CAHPS

The Alliance and the QI team adopted a PDSA approach to the access standards:

Plan: The standards were discussed and adopted, and surveys have been aligned with our adopted standards.

Do: The surveys are administered, per our policies and procedures (P&Ps); survey methodologies, vendors, and processes are outlined in P&Ps.

Study: Survey results along with QI recommendations are brought forward to the A&A Committee; the Committee formalizes recommendations which are forwarded to the HCQC and Board of Governors

Act: Dependent on non-compliant providers and study / decision of the A&A Committee, actions may include, but are not limited to, provider education/re- education and outreach, focused discussions with providers and delegates, resurveying providers to assess/reassess provider compliance with timely access standard(s), issuing of corrective action plans (CAPs), and referral to the Peer Review and Credentialing Committee.

Provider Capacity

The Alliance reviews network capacity reports monthly to determine whether primary care providers are reaching network capacity standards of 1:2000. In 2022, there was one provider that exceeded the 2,000-member threshold for a Pediatric PCP. As a result, membership assignment was closed until the provider's capacity improved. The Network Data Validation team continues to monitor the threshold at 80% and above to ensure member assignment does not reach the 2,000-capacity standard. If a provider is close to the threshold, the plan reaches out to confirm if the provider intends to recruit other providers. If not, the panel is closed to the new assignment. During this time, the plan and the provider are in communication of such changes.

Geo Access

The geographic access reports are reviewed quarterly to ensure that the plan meets the geographic access standards for provided services in Alameda County. For PCPs, the Alliance has adopted standards of one provider within 30 minutes / 15 miles. For specialists, the Alliance has adopted standards of one provider within 30 minutes / 15 miles. During 2022, the Alliance continued its cross functional quarterly meeting to review access issues and concerns.

In 2022, the Alliance continues to face geographic access issues for certain pediatric specialists in various parts of Alameda County. In those instances, the Plan has requested alternatives access standards from the DHCS as a result. When reviewing the geographic access maps and data, there are a few members who reside in remote areas or unincorporated parts of Alameda County or where Pediatric Specialties may not be available (Livermore, Dublin, and Pleasanton), resulting in deficiencies. Even though the provider and member are in the same zip code, the time and distance standards are still compromised. The Plan requested alternative access standards in that instance.

Member Satisfaction Survey (CAHPS 5.1H)

The Medi-Cal and Commercial Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is administered by the National Committee for Quality Assurance (NCQA) a certified Health Effectives Data and Information Set (HEDIS) survey vendor. SPH Analytics was selected by the Alliance to conduct the 2022 CAHPS 5.1Hsurvey. NCQA used a new 5.1H version of the CAHPS survey starting 2021. The HEDIS CAHPS survey included minor changes to some of the instructions and survey items to indicate the different ways in which patients may be receiving care: in person or via telehealth.

The survey method includes mail and phone responses. Members in each Alliance line of business (LOB) are surveyed separately. The table below shows the survey response rates. As of April 2023, the Alliance had a total of 354, 822 members.

The breakdown of member enrollment by network is as follows:

- AHS: 19.7%
- Directs: 18.80%
- CHCN: 37.23%
- CFMG: 9.69%
- Kaiser: 14.59%

Survey Response Rates by Line of Business

	Medi-Cal Adult	Medi-Cal Child	Commercial Adult
2022	12.4%	12.3%	21.5%
2021	15.9%	18.2%	23.7%
2020	14.7%	16.5%	23.5%

The Medi-Cal Child, Adult Medi-Cal, and Adult Commercial Trended Survey Results in the tables below, contains trended survey results for the Medi-Cal Child, Medi-Cal Adult, and Commercial Adult populations across composites. Quality Compass All Plans (QCAP) benchmark noted within the tables is a collection of CAHPS 5.1H mean summary ratings for the Medicaid and Commercial samples that were submitted to NCQA in 2021 that provides for an aggregate or national summary.

In respect to benchmark scores, Red signifies that the current year 2022 score is significantly lower than the 2021 score. Green indicates that the current year 2022 score is significantly higher than the 2021 score.

Medi-Cal Child Trended Survey Results

Summary Rate Scores: Medi-Cal Child				
Composite	**2022**	**Previous Year Comparison**	**2021**	**2020**
Getting Needed Care	78.4%	↓	82.2%	81.0%
Getting Care Quickly	77.8%	↓	78.8%	82.0%
How Well Doctors Communicate	91.3%	↓	93.2%	92.7%
Customer Service	85.5%	↓	90.2%	84.0%
Rating of Health Care (8-10)	89.5%	↑	89.1%	87.3%
Rating of Personal Doctor (8-10)	90.6%	↓	91.0%	91.2%
Rating of Specialist (8-10)	85.3%	↓	87.2%	90.6%
Rating of Health Plan (8-10)	86.0%	↓	88.1%	87.5%
Coordination of Care	89.1%	↑	73.8%	82.4%

Medi-Cal Adult Trended Survey Results

Summary Rate Scores: Medi-Cal Adult				
Composite	**2022**	**Previous Year Comparison**	**2021**	**2020**
Getting Needed Care	75.9%	↓	79.0%	82.6%
Getting Care Quickly	75.9%	↑	72.4%	71.7%
How Well Doctors Communicate	92.3%	↑	83.5%	95.7%
Customer Service	89.4%	↑	84.1%	88.8%
Rating of Health Care (8-10)	66.3%	↓	73.1%	75.4%
Rating of Personal Doctor (8-10)	82.9%	↑	81.3%	84.7%
Rating of Specialist (8-10)	78.6%	↓	78.9%	91.7%

Rating of Health Plan (8-10)	74.4%	↓	74.9%	78.4%
Coordination of Care	79.0%	↓	83.0%	80.3%

Commercial Adult Trended Survey Results

Summary Rate Scores: Commercial Adult				
Composite	**2022**	**Previous Year Comparison**	**2021**	**2020**
Getting Needed Care	65.8%	↓	75.2%	65.6%
Getting Care Quickly	62.0%	↓	71.1%	68.7%
How Well Doctors Communicate	83.2%	↓	87.7%	90.0%
Customer Service	78.5%	↑	77.3%	80.3%
Rating of Health Care (8-10)	61.0%	↓	70.1%	66.1%
Rating of Personal Doctor (8-10)	74.9%	↓	77.4%	77.6%
Rating of Specialist (8-10)	72.6%	↓	82.9%	80.2%
Rating of Health Plan (8-10)	65.9%	↓	67.1%	68.5%
Coordination of Care	74.4%	↓	76.8%	83.5%

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

Medi-Cal Child Trended Survey Results - Delegates

		AHS			Alliance			CFMG			CHCN			Kaiser		
	2022 Plan Total	2022	2021	YoYT	2022	2021	YoYT	2022	2021	YoYT	2022	2021	YoYT	2022	2021	YoYT
Total Respondents	250	27			14			54			98			57		
Getting Needed Care	78.4%	63.9%	80.0%	↓	58.3%	95.5%	↓	75.8%	71.7%	↑	84.8%	92.6%	↓	78.8%	94.2%	↓
Getting Care Quickly	77.8%	88.9%	69.2%	↑	61.4%	58.3%	↑	71.1%	75.6%	↓	80.8%	86.5%	↓	83.1%	89.7%	↓
How Well Doctros Communicate	91.3%	80.0%	89.7%	↓	77.8%	90.6%	↓	92.3%	95.9%	↓	93.6%	91.4%	↑	93.9%	95.0%	↓
Customer Service	85.5%	83.3%	90.0%	↓	98.5%	78.6%	↑	83.2%	90.3%	↓	87.1%	90.6%	↓	85.6%	95.5%	↓
Rating of Health Care (8-10)	89.5%	88.9%	90.9%	↓	87.5%	83.3%	↑	87.5%	89.1%	↓	88.2%	86.9%	↑	93.9%	96.2%	↓
Rating of Personal Doctor (8-10)	90.6%	94.7%	92.0%	↑	81.8%	91.3%	↓	95.2%	92.4%	↑	88.2%	86.6%	↑	90.2%	96.1%	↓
Rating of Specialist (8-10)	85.3%	100.0%	75.0%	↑	100.0%	100.0%	↔	91.7%	81.0%	↑	83.3%	91.7%	↓	71.4%	100.0%	↓
Rating of Health Plan (8-10)	86.0%	78.3%	89.7%	↓	84.6%	83.3%	↑	85.2%	89.3%	↓	87.9%	86.8%	↑	87.3%	90.9%	↓
Coordination of Care	89.1%	66.7%	66.7%	↔	50.0%	62.5%	↓	88.9%	70.0%	↑	87.5%	76.2%	↑	100.0%	88.9%	↑

YoYT = Year-Over-Year Trend

Medi-Cal Adult Trended Survey Results - Delegates

		AHS			Alliance			CHCN			Kaiser		
	2022 Plan Total	2022	2021	YoYT	2022	2021	YoYT	2022	2021	YoYT	2022	2021	YoYT
Total Respondents	163	30	48		39	52		64	71		28	36	
Getting Needed Care	75.9%	76.3%	72.5%	↑	72.5%	82.3%	↓	70.9%	79.7%	↓	90.6%	80.4%	↑
Getting Care Quickly	75.9%	69.1%	81.3%	↓	66.4%	61.5%	↑	74.3%	62.1%	↑	93.7%	87.5%	↑
How Well Doctros Communicate	92.3%	94.6%	73.8%	↑	87.5%	86.6%	↑	91.4%	87.9%	↑	97.7%	80.9%	↑
Customer Service	89.4%	75.0%	81.3%	↓	95.8%	87.3%	↑	87.2%	82.7%	↑	95.8%	86.4%	↑
Rating of Health Care (8-10)	66.3%	50.0%	80.0%	↓	77.3%	65.5%	↑	52.5%	72.2%	↓	90.9%	76.2%	↑
Rating of Personal Doctor (8-10)	82.9%	63.6%	88.2%	↓	81.3%	73.0%	↑	87.2%	80.9%		92.6%	82.8%	↑
Rating of Specialist (8-10)	78.6%	70.0%	87.5%	↓	88.2%	64.3%	↑	71.0%	94.7%	↓	91.7%	50.0%	↑
Rating of Health Plan (8-10)	74.4%	62.1%	76.1%	↓	81.1%	68.0%	↑	70.0%	75.4%	↓	89.3%	81.3%	↑
Coordination of Care	79.0%	80.0%	73.3%	↑	72.2%	83.3%	↓	73.7%	87.5%	↓	92.9%	88.9%	↑

YoYT = Year-Over-Year Trend

Commercial Adult Trended Survey Results – Delegated Network

		Alliance			CHCN			Kaiser		
	2022 Plan Total	2022	2021	YoYT	2022	2021	YoYT	2022	2021	YoYT
Total Respondents	231	103	117		98	108		30	25	
Getting Needed Care	65.8%	62.5%	76.2%	↓	66.4%	74.7%	↓	77.4%	72.6%	↑
Getting Care Quickly	62.0%	59.9%	75.2%	↓	62.4%	70.5%	↓	68.6%	56.4%	↑
How Well Doctros Communicate	83.2%	82.6%	93.2%	↓	84.5%	84.1%	↔	81.9%	75.0%	↑
Customer Service	78.5%	81.9%	84.0%	↓	74.2%	70.3%	↑	83.3%	72.2%	↑
Rating of Health Care (8-10)	61.0%	58.6%	73.9%	↓	64.1%	69.8%	↓	57.1%	53.3%	↑
Rating of Personal Doctor (8-10)	74.9%	73.6%	96.4%	↓	76.8%	79.3%	↓	73.9%	73.3%	↔
Rating of Specialist (8-10)	72.6%	65.9%	91.5%	↓	83.9%	73.3%	↑	66.7%	60.0%	↑
Rating of Health Plan (8-10)	65.9%	68.3%	72.1%	↓	67.4%	62.6%	↑	53.3%	63.6%	↓
Coordination of Care	74.4%	77.1%	78.8%	↓	70.6%	75.6%	↓	76.9%	75.0%	↑

YoYT = Year-Over-Year Trend

The 2022 CAHPS survey results year-over-year trends show variation within the **Alliance** business lines. Across LOBs, the Medi-Cal Child population had the highest measure summary rate scores in 2022.

MY2022 – 2021 Alliance and Delegate Comparative Findings

Medi-Cal Child

- AHS: Five (5) of nine (9) scores decreased based on the above table. A significant increase in percentage scores were seen for 'Getting Care Quickly' and 'Rating of Specialist (8-19)'.
- Directs: Four (4) of nine (9) scores decreased based on the above table. With significant decrease in scores for 'Getting Needed Care' and 'How Well Doctors Communicate.'
- CFMG: Five (5) of the nine (9) scores decreased based on the above table. A significant increase in percentage scores was seen for 'Coordination of Care.'

- CHCN: Four (4) of nine (9) scores decreased based on the above table.
- Kaiser: Eight (8) of nine (9) scores decreased based on the above table. A significant decrease was seen for 'Getting Needed Care' and 'Rating of Specialist (8-10)'. However, a significant increase was seen for 'Coordination of Care' from 88.9% in 2021 to 100% in 2022.

Quantitative Trends:

- Overall, a consistent decrease in percentage scores was noted throughout all delegate groups.

Medi-Cal Adult

- AHS: Five (5) of nine (9) scores decreased based on the above table. A significant decrease was seen for 'Getting Care Quickly,' 'Rating of Health Care (8-10)' and 'Rating of Person Doctor (8-10). However, a significant increase was seen for 'How Well Doctors Communicate.'
- Directs: Two (2) of nine (9) scores increased based on the above table. With significant increases in scores for 'Rating of Specialist (8-10)' and 'Rating of Health Plan (8-10)'.
- CHCN: Five (5) of nine (9) scores decreased based on the above table. A significant decrease was seen for 'Rating of Health Care (8-10)' and 'Rating of Specialist (8-10)'.
- Kaiser: Nine (9) of nine (9) scores increased based on the above table. With a significant increase for 'Rating of Specialist (8-10)' with a 91.7% in 2022 compared to 50.0% in 2021.

Quantitative Trends:

- All delegates increased percentage scores in 'How Well Doctors Communicate.'

Commercial Adult

- AHS: Seven (7) of nine (9) scores increased based on the above table.
- Directs: Nine (9) of nine (9) scores decreased based on the above table. A significant decrease was seen for 'Getting Care Quickly,' 'Rating of Health Care (8-10)', 'Getting Needed Care' and 'Rating of Specialist (8-10)'.
- CHCN: Five (5) of nine (9) scores decreased based on the above table.

Quantitative Trends:

- Alliance had decreased in all measures in 2022. However, increases were seen for the following two measures for both CHCN and AHS:

Costumer Service

Rating of Specialist (8-10)

Composite Measures

Population	Top Measures	Bottom Measures
Medi-Cal Child	Coordination of Care	Getting Needed Care
	Rating of Health Care	How Well Doctors Communicate

Medi-Cal Adult	Rating of Specialist	Getting Care Quickly
	Customer Service	Getting Care Quickly
	How Well Doctors Communicate	Coordination of Care
	Rating of Personal Doctor	Getting Needed Care
	Rating of Health Plan	Getting Care Quickly
Commercial Adult	Rating of Health Care	How Well Doctors Communicate
	Care Coordination	Claims Processing

Getting Care Quickly' is identified again as the common bottom measure for all three Lines of Business. Low scoring composite provides opportunities for improvement via RCA as part of the QI Work Plan for 2022.

Composites and Key Drivers

Measures	Key Driver
Rating of Health Plan	Customer Service Providing Information and Help
	Getting Needed Care
	Health Plan Overall Rating
Rating of Health Care	Doctors Spending Enough Time with Patients
	How Well Doctors Communicate
Rating of Personal Doctor	Getting Needed Care

Next Steps

The Alliance will continue to collaborate interdepartmentally, focusing on maintaining power in top rating measures and improving member perception of care and services ranked at the bottom of composite scores. Additionally, the Alliance will continue to partner with providers on initiatives designed to improve the member experience and survey scores in 2022-2023 using PDSA cycle to improve or maintain Member Satisfaction scores. Commercial Adult for the Alliance shows an increase in scores.

Review Improvement Strategies recommendations by SPH for targeted improvement focus that include:

- Assess CAHPS data by direct and delegate provider/networks. Beginning Q3 2022 share results at Joint Operations Meetings (JOM) with delegates. Correlate with grievance data and access PQI complaint data to share with providers.
- Continue best practices for LOBs with increasing survey results.

- Educate providers and staff about Plan and regulatory appointment wait time requirements or standards (i.e., CAHPS, CMS, States, etc.). Identify opportunities for improvement.
- Support members and collaborate with providers to enhance routine and urgent access to care through proactive approaches within Member Services, Provider Relations and Utilization Management and Case and Care Management.

Provider Satisfaction Survey Overview

The Alliance contracted with its NCQA certified vendor, SPH, to conduct a Provider Satisfaction Survey for MY2022. Information obtained from these surveys allows plans to measure how well they are meeting their providers' expectations and needs. The Alliance provided SPH with a database of Primary Care Physicians (PCPs), Specialists (SPCs) and Behavioral Health (BH) providers who were part of the Alliance network. Duplicate provider names or NPIs were removed from the database prior to submitting to survey vendor. From the database of unique providers, a sample of 815 records was drawn. A total of 106 surveys were completed between October - December 2022 (59 mail, 26 internet, 21 phone).

The table below contains the survey response rates, survey respondents, and role of survey respondents for 2022 compared to 2021.

Survey Response Rates for Mail/Internet and Phone: 2022 vs. 2021

	Mail/Internet	Phone
2022	10.4%	2.5%
2021	12%	2%

Survey Respondents for PCPs, BH Providers, SPCs: 2022 vs. 2021

	PCPs	BH Providers	SPCs
2022	8.7%	28.4%	14.5%
2021	11.7%	32.1%	12.3%

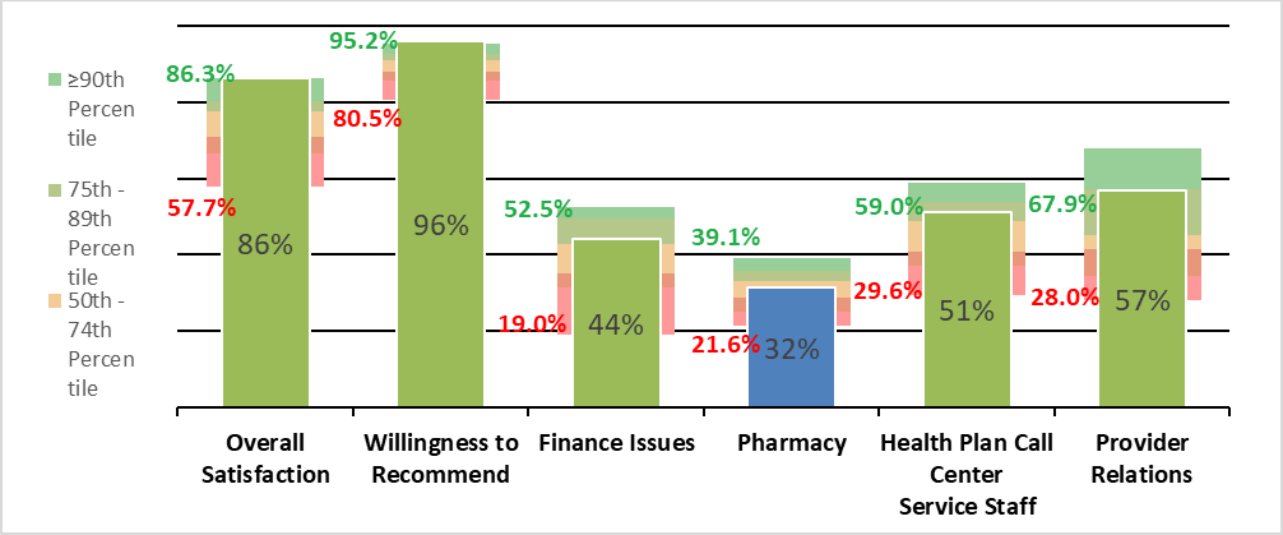
Year to Year Trend Comparisons

The table below contains the trended survey results across composites.

Trended Survey Results Across Composites

Summary Rate Scores					
Composite / Attribute	**MY 2022**	**Variance Compared to Previous Year**	**Variance Compared to SPH Commercial Benchmark BoB**	**2021**	**2020**
Overall Satisfaction	**86.3%**	**Higher**	**Significantly Higher**	**77.3 %**	**85.0%**
Overall Satisfaction with the Alliance	**86.3%**	Higher	Significantly Higher	77.3%	85.0%
All Other Plans (Comparative Rating)	**53.5**	Higher	Significantly Higher	50.0	55.6%
Finance Issues	**44.3%**	Stable	Higher	44.5%	45.0%
Utilization and Quality Management	**50.6%**	Higher	Significantly Higher	45.3%	50.9%
Network Coordination of Care	**31.2%**	Lower	N/A	37.3%	39.1%
Pharmacy	**31.6%**	Lower	N/A	35.1%	33.0%
Health Plan Call Center Service Staff	**51.3%**	Lower	Higher	54.0%	53.9%
Provider Relations	**56.7%**	Lower	Significantly Higher	63.5%	61.5%

The Alliance identified higher composite scores in 3 of 8 measures compared to 2021 scores. One (1) of the 8 composites scores remained stable compared to 2021. Four (4) of the 8 composites scores are significantly higher than the vendor commercial BoB score.



Green bar = AA performing at or above the 75th percentile

Red bar = AA performing below the 25th percentile

Survey results indicated that the Alameda Alliance is performing above the 75th percentile in 5 of 6 composites compared to the distribution of scores in the 2021 SPH Commercial Book of Business and performing above the median for the other measure.

SPH Alliance POWER List:

Promote and Leverage Strengths (Top 5 Listed):

1. Procedures for obtaining pre-certification/referral/authorization information.
2. Timeliness of plan decisions on routine prior authorization requests.
3. Timeliness of obtaining pre-certification/referral/authorization information.
4. Degree to which the plan covers and encourages preventive care and wellness.
5. The health plan's facilitation/support of appropriate clinical care for patients.

Best Practice

Below are the performance results for the past three years, for Overall Satisfaction with the Alliance, which has exceeded the SPH Aggregate BoB value in all three years.

Overall Satisfaction with Alameda Alliance for Health	Numerator: % Completely of Somewhat Satisfied	Denominator: No. of question respondents	Rate	SPH Aggregate Book of Business	Met SPH Aggregate BoB? (Y/N)
Measurement Y1 2020	119	140	85%	69%	Y

Measurement Y2 2021	85	110	77.3%	70.8%	Y
Measurement Y3 2022	88	102	86.3%	70.2%	Y

Next Steps

- Survey results will be shared at Health Care Quality Committee.
- A cross functional workgroup will study opportunities with SPH POWER listing to promote and leverage identified strengths for ongoing improvement.

CG-CAHPS Survey

The Alliance contracted with SPH Analytics to conduct its quarterly Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey within 2022, which measures member perception of and experience with three timely access standards: in-office wait time; call return time; and time to answer call. The CG-CAHPS survey was fielded in Q1, Q2, Q3, Q4 of 2022. In 2022 the Alliance was given approval by DHCS to modify the CG-CAHPS survey. Per approval from DHCS, the in-office wait time standard changed from within 30 minutes to within 60 minutes. Also, the call return time standard changed from within 30 minutes to within one business day. The time to answer the call standard remained the same (within 10 minutes). SPH followed a mixed methodology of mail and phone to administer the survey to a randomized selection of eligible members who had accessed care with their PCP within the previous six months.

The table below presents the compliance rates across the three metrics for the CG-CAHPS surveys that were conducted in 2022 within each quarter.

CG-CAHPS Survey Results 2022

Metric	Compliance Goal	Q1 2022	Q2 2022	Q3 2022	Q4 2022
In-Office Wait Time (Within 60 minutes)	80%	92.7%	92.3%	91.8%	91.1%
Call Return Time (Within 1 Business Day)	70%	76.8%	71.2%	74.4%	75.5%
Time To Answer Call (Within 10 minutes)	70%	77%	77.2%	73.7%	72.9%

Since the pandemic, many providers and delegates have faced staffing challenges due to burnout and high turnover. The Alliance recognized the challenges that our providers faced, started Q3, 2022 the compliance threshold goal has changed from 80% to 70% for Call Return Time and Time to Answer Call.

Possible Barriers	• **6-month delay in survey fielding from date of encounter. Results are based on *a member's perception* of encounter experience.** • **Survey conducted on member encounter experience during the COVID-19 PHE provider office operations restructuring.**
Next Action Steps	• Track and Trend compliance rates • Continue to follow escalation process for providers non-compliance with CG-CAHPS: o 1Q: Track & trend o 2Qs: Letter/JOM discussion o 3Qs: CAP/Discussion with COO/CFO • Share results with Provider Services department, FSR staff, to incorporate as part of Member & Provider Satisfaction work group discussions and PDSA/Intervention planning as applicable. • Share results with delegate groups and discuss improvement strategies. • Monitor new compliance goal of 70% for Call Return Time and Time to Answer Call

After Hours Care

The Alliance contracted with SPH Analytics to conduct the annual Provider After-Hours Survey for MY2022, which measures providers' compliance with the after-hours emergency instructions standard. The MY2022 After-Hours Survey was conducted in November of 2022. SPH followed a phone-only protocol to administer the survey to the eligible provider population during closed office hours. A total of 398 Alliance providers and/or their staff were surveyed, and included 73 primary care physicians (PCPs), 211 specialists, and 114 behavioral health (BH) providers. The survey assesses the presence of instructions for a caller in an emergency, either via a recording or auto-attendant, or a live person.

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

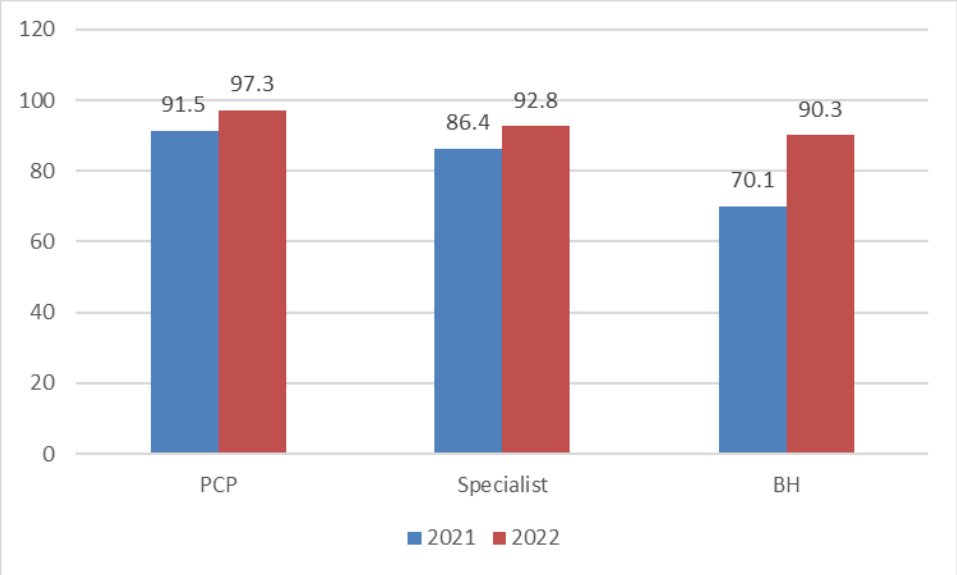
Compliance Rates for After Hours Survey

	Emergency Instructions		
Provider Type	**Total Compliant**	**Total Non-Compliant**	**Compliance Rate**
PCP	71	2	97.3%
Specialist	192	15	92.8%

BH	102	11	90.3%
Total	**365**	**28**	

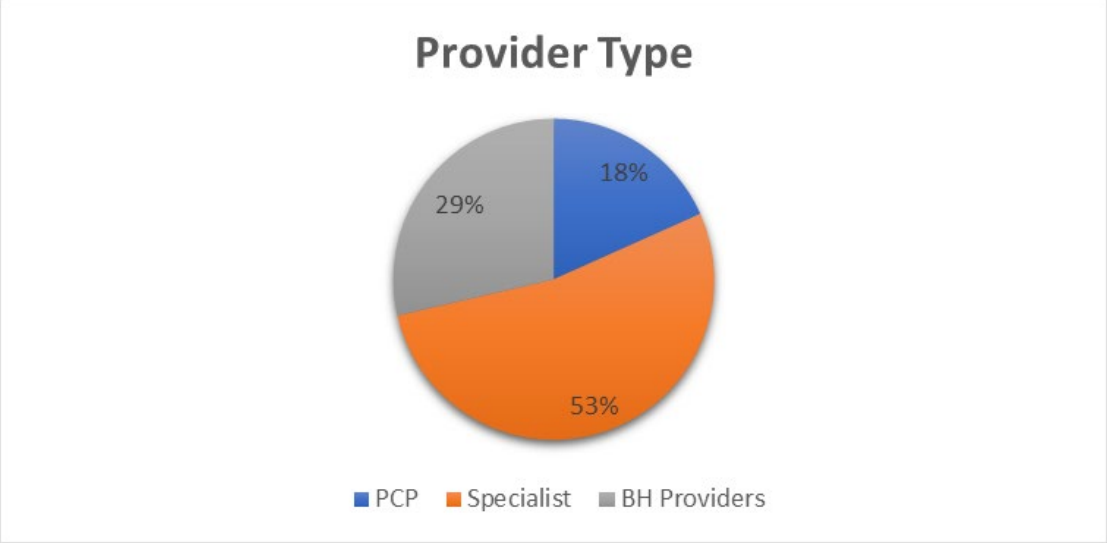
A total of 28 providers (2 PCPs, 15 Specialists, 11 BH) were found to be non-compliant with the emergency instructions standard because of the After-Hours Survey. Specialist providers had the highest non-compliance rate in 2022 but down from 30 in 2021 followed by BH, then PCP providers.

After Hours Emergency Instruction and Access to Physician Compliance Rate Comparison (2021 v 2022)

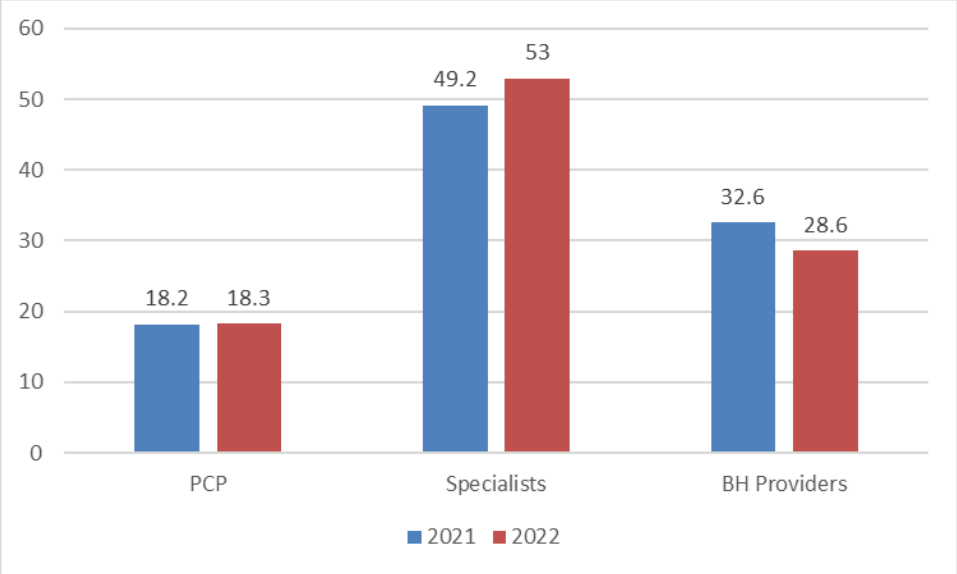


The figure below presents the response rate across provider types:

Response Rate by Provider Type



After Hours Emergency Instruction and Access to Provider Survey Response Rate Comparison (2021 v 2022)



- Number of survey respondents in 2021 = 451.
- Number of survey respondents in 2022 = 398.
- Year-over-year Specialist providers have had the highest response rate to the survey.
- BH providers response rate decreased in 2022 from 2021 by 4%.
- Specialist providers response rate increased in 2022 from 2021 by 3.8%.

In 2022, all the Alliance provider groups performed above 90%. Results of survey were presented at Q1 2023 Access and Availability Committee with the following next steps for improvement:

- Share results with Delegate and Direct entities.
- Share results with Provider Services and FSR staff to incorporate as part of provider and office staff education for identification of barriers and improvement opportunities.
- CAPs to be sent to non-compliant providers.
- CAPs are issued at the delegate level.
- CAPs are issued at the direct provider level.

Initial Pre-Natal Visits

The Alliance conducted the annual First Prenatal Visit Survey for MY2022, which measures providers' compliance with the first prenatal visit standard. The survey was conducted in September – November of 2022 and was administered to a random sample of eligible Alliance Obstetrics and Gynecology (OB/GYN) providers. The table below shows the results of the survey.

First Prenatal Visit Survey

Appointment within 10 business days	75% Target Goal Met	Percent of Ineligibles	Precent of Non-Responsive
55.6%	No	33.7%	25.5%

The 2022 First Prenatal Visit survey results showed a compliance rate of 17.6% lower than the 2021 which held a 73.2% compliance rate. The goal of 75% was not met and Corrective Action Plans (CAPs) will be issued to all non-responding and non-compliant providers within Q2 2022.

The Alliance's QI Department will continue:

1. Survey monitoring of First Prenatal Visit compliance via Quality of Access PQIs
2. Ongoing provider education and discussions at delegate JOMs regarding timely access standards
3. Collaboration with Analytics, Provider Services, and delegate networks to improve the accuracy of provider data, thus decreasing the number of ineligible providers.

Oncology Survey

The Alliance conducted the annual Oncology Survey for MY2022, which measures providers' compliance with the urgent and non-urgent appointment standards for Oncology specialists. The survey was conducted from September – November of 2022 and was administered to a random sample of eligible Alliance Oncology providers. The table below shows the results of the survey.

Oncology Survey

Urgent Appt	75% Target Goal Met	Non-Urgent Appt	75% Target Goal Met	Percent of Ineligibles	Percent of Non-Responsive
51.4%	No	82.9%	Yes	25.0%	28.9%

In 2022, the compliance rate for urgent appointments had a significant decline of 32.8%, a difference from 2021 which received a compliance score of 84.2%. Non-urgent appointments increased by 3% from 78.9% in 2021.

Time-sensitive corrective action plans (CAPs) will be issued to all non-responding and non-compliant providers within Q2 2023. Additionally, the Alliance's QI Department will:

1. Continue ongoing provider education and discussions at delegate JOMs regarding timely access standards.
2. Collaboration with Analytics, Provider Services, and delegate networks to improve the accuracy of provider data, thus decreasing the number of ineligible providers.

Provider Appointment Availability Survey

The Alliance's annual Provider Appointment Availability Survey (PAAS) for MY2022 was used to review appointment wait times for the following provider types:

- Primary Care Physicians (PCPs)
- Specialist Physicians (SPCs):
    - Cardiovascular Disease
    - Endocrinology
    - Gastroenterology
- Non-Physician Mental Health (NPMH) Providers (PhD-level and Masters-level)
- Ancillary Services Providers offering Mammogram and/or Physical Therapy
- Psychiatrists

The Alliance reviewed the results of its annual PAAS for MY2022 to identify areas of deficiency and areas for potential improvement. The Alliance defines deficiency as a provider group scoring less than a seventy-five percent (75%) compliance rate on any survey question related to appointment wait times.

The Alliance analyzed results for Alameda County, as most members live and receive care in Alameda County, the Alliance's service area. Additionally, per the MY2022 Department of Managed Health Care (DMHC) PAAS Methodology, the Alliance reported compliance rates for all counties in which its contracted providers were located, regardless of whether the providers were located outside the Alliance's service area. This included provider groups in the following counties – Contra Costa, San Joaquin, Sacramento, San Francisco, Santa Clara, San Jose, Solano, Marin, Madera, Monterey, San Mateo, Santa Cruz, San Luis Obispo, Santa Barbara, and Sonoma.

MY2022 Compliance Rates by Appointment/Type across All Provider Types

Ancillary		
LOB	**Urgent Appt**	**Routine Appt**
IHSS	Not applicable	83.3%
MCL	Not applicable	83.3%
PCPs		
LOB	**Urgent Appt**	**Routine Appt**
IHSS	54.4%	68.1%
MCL	57.3%	73.7%
NPMH		
LOB	**Urgent Appt**	**Routine Appt**
IHSS	73.8%	87.8%
MCL	76.6%	87.6%
Psychiatrists		
LOB	**Urgent Appt**	**Routine Appt**

IHSS	61.0%	84.7%
MCL	55.4%	90.8%
Specialists		
LOB	**Urgent Appt**	**Routine Appt**
IHSS	44.8%	55.6%
MCL	45.9%	56.2%

Across all provider types, there was greater compliance with the routine appointment standards than with the urgent appointment standard, and this was evidenced for both LOBs – MCL and IHSS for 2020, 2021, and 2022. As a result of COVID-19 PHE office visits (face-to-face and telehealth) dramatically declined. The Alliance will continue engaging in provider/delegate re-education around the timely access standards, to increase its efforts around compliance with the urgent appointment standard through the following ways:

- Fax blast timely access standard to all PCP.
- Provider Orientation,
- Create a provider facing document to be included in the provider quarterly packet,
- Timely access standard is included in CAP issued to non-compliant and non-responsive providers,
- Alliance community Health Medical Director and Access Availability Manager discussed timely access standard during on site visit,
- Targeted discussions with leadership staff during Joint Operations Meetings between the Alliance and its delegate leadership.

Percentage of Ineligible Provider Types

MY	Psychiatrists	PCPs	Specialists	Ancillary	NPMH
2022	27.2%	19%	26%	19%	25%
2021	40%	26%	34%	31%	21%

Across all provider types, Psychiatrists had the highest percentage of ineligible providers, followed by Specialist providers, NPMH, Ancillary and PCP. Results of the MY2021 PAAS also show Psychiatrists as having the highest percentage of ineligible providers. Psychiatrists, Specialist, PCP and Ancillary providers showed a decrease in percentage of ineligible providers from MY2021 to MY2022. While NPMH providers show an increase in eligible providers. The Alliance will ensure continued collaboration with its Analytics and Provider Services Teams, as well as with its delegate networks, to enhance accuracy of provider contact information, provider specialty, provider network status, and/or provider appointment availability, with the goal of decreasing the overall percentage of ineligible providers.

Percentage of Non-Responsive Provider Types

MY	Psychiatrists	PCPs	Specialists	Ancillary	NPMH
2022	27.6%	20.2%	34.7%	23.8%	28.1%

2021	19%	8%	30%	19%	27%

Across all provider types, Specialists had the highest percentage of non-responsive providers, followed by NPMH providers, Psychiatrists and Ancillary providers, with PCPs having the lowest percentages of non-responsive providers in MY2022 (see table above). The Alliance will increase its level of provider/delegate education around survey completion and purpose, including a focus on the development of provider/delegate improvement plans, with the overall goal of lessening and/or removing barriers for non-responsiveness. These efforts will include a focus on Specialists, given they had the highest level of survey non-responsiveness across provider types year-on-year.

Year-Over-Year Analysis

For eligible providers who completed the survey, Ancillary and PCP did not show improvement in compliance rates in either appointment types for both LOBs. NPMH providers showed improvement in compliance rates for routine appointment standard for both LOBs and urgent appointment for Medi-Cal LOB. Specialist providers showed a slight improvement in compliance rates for urgent and routine appointments for Medi-Cal LOB, and slight decreases in compliance rates for both appointment standard for IHSS LOB. Psychiatrists showed improvement in compliance rates for routine appointments for both LOBs and decreased in compliance rates for urgent appointments for both LOBs.

Alameda Health Systems (AHS)

For the PCP provider type, AHS again fell short of the compliance threshold for both appointment standards for both LOBs.

Children's First Medical Group (CFMG)

For the PCP provider type, CFMG providers maintained a stable rate of compliance with both appointment standards. For the Specialist provider types, CFMG providers showed a significant increase in compliance for both appointment standards for cardiology appointments and endocrinology. However, CFMG providers demonstrated zero compliance for gastroenterology appointments.

Community Health Center Network (CHCN)

For the PCP and Ancillary provider types, CHCN providers has continued to demonstrate best practice and maintained a stable rate of compliance with both appointment standards for both LOBs. For Specialist provider types, CHCN cardiology providers demonstrated a significant increase in their rates of compliance for routine appointments for both LOBs and urgent appointments for IHSS. For gastroenterology appointments, CHCN providers showed a significant decrease to zero rates of compliance for both appointment standards for both LOBs. For endocrinology appointments, CHCN providers demonstrated a significant improvement with both appointment standards for both LOBs.

Individual Contracted Providers (ICP)

For the PCP provider type, ICPs maintained a stable rate of compliance with both appointment

standards for both LOBs. For cardiology and gastroenterology, ICPs demonstrated best practice by maintaining 100% compliance with routine appointment standards for both LOBs. ICPs maintained 100% compliance with urgent appointments for gastroenterology for IHSS LOB. However, ICPs showed a significant decrease with urgent appointments standard for cardiology for both LOBs but maintained above 75% compliance rate for urgent appointment standard. For the Adult NPMH provider type, ICPs showed an overall increase in compliance rates for both appointment standards for both LOBs.

Provider-Focused Improvement Activities

As part of the QI strategy for 2023, the Alliance will continue its ongoing re-education of providers/delegates regarding timely access standards via various methods (e.g., quarterly provider packets, fax blasts, postings on the Alliance website, targeted outreach to providers/delegates, and in-office provider visits as appropriate), with the goal of increasing individual response and compliance rates to ≥ 75%. Additionally, the Alliance A&A unit will conduct focused scheduled and confirmatory surveys/audits that assess provider compliance with timely access standards. Time-sensitive corrective action plans (CAPs) will be issued to all non-responsive and non-compliant providers. Results and corrective actions needed for improvement will be discussed with delegate leadership staff during Joint Operations Meetings between the Alliance and its delegate. The Alliance will review other survey result indicators of access and availability to identify both best practice and opportunities for improvement throughout the year for performance improvement activities.

For PAAS MY2022 all non-compliant PCPs, Specialists, NPMH providers, Ancillary providers, and Psychiatrists receive notification of their survey results and the timely access standards in which they were deficient, along with time-sensitive CAPs. All non-responsive PCPs, Specialists, NPMH providers, Ancillary providers, and Psychiatrists receive notification of their non-responsiveness reminding them of the requirement to respond to timely access surveys, along with the timely access standards and time-sensitive CAPs.

The Alliance will share findings from the MY2022 PAAS at the Q3 2023 Access and Availability Sub-Committee for feedback and recommendations, as well as, in the Q3 HCQC, which is comprised of Chief Officer leadership from delegated networks, offering additional opportunities for discussion of best practice and improvement opportunities.

Provider Outreach and Engagement

During 2022, the Provider Services department provided continued outreach to all PCP, Specialists and Ancillary provider offices via the use of fax blasts. Outreach and engagement with providers were completed in a variety of ways including virtual meetings, email, telephone, and mail.

Topics covered in the outreach, engagement, and fax blasts included but, were not limited to: Member Satisfaction update and reminders, Provider Satisfaction updates, Provider Appointment Availability Survey (PAAS) updates, utilization management updates and reminders, Immunizations, provider network updates, Annual Healthcare Effectiveness Data and Information Set® (HEDIS) medical record data retrieval notice, Fraud, Waste and Abuse information, Timely Access Standards Reminders, Pay-for-Performance program, Long-Term Care updates, Community Health Worker benefit, and Member Rights.

In addition to ongoing quarterly visits, every newly credentialed provider received a new provider orientation within 10 business days of becoming effective with the Alliance. This orientation includes a very detailed summary which includes but not limited to:

- Plan review and summary of Alliance programs,
- Review of network and contract information,
- How to verify eligibility,
- Referrals and how to submit prior authorizations,
- Timely Access Standards,
- Member benefits and services that require PCP referral,
- Filing of complaints and the appeal process,
- Interpreter Services process,
- Transportation benefit information,
- Initial Health and Staying Healthy Assessment,
- Coordination of Care, CCS, Regional Center, WIC program,
- Claims and billing information,
- Child Health and Disability Program,
- Members' Rights and Responsibilities,
- Member Grievances,
- PQIs,
- Provider Portal, and
- Health Education.

Overall, there were over 500 quarterly packets mailed to providers with updates as mentioned above. Additionally, over 2,600 outreach occurrences were conducted during the 2022 calendar year. The Provider Services department plans to continue our robust provider outreach and engagement strategies in 2022.

Member Outreach and Member Services

The Alliance Member Services (MS) Department continues to have a strong focus on providing high-quality service. The Alliance mission is to help our members live a healthy life providing access to high-quality care and services that they need. Providing excellent customer service is just one of the many ways that we serve our members, providers, and community.

The Alliance monitors access to its Member Services Department quarterly. The following internal standards and goals are used to evaluate access to the Member Services Department by telephone.

Member Services Department Telephone Access Standards	
Standards	Goal
% of calls answered by a live agent within 30 seconds	80%
Calls Abandoned before a live voice is reached	≤ 5 %

The Alliance also offers a member orientation to help members better understand their benefits, the importance of the initial health assessment and who to call when they need help. The member orientation is available to all Alliance members.

Population Health Management and Health Education

Population Health Management (PHM) Overview

In accordance with NCQA 2023 Population Health Program Standards and Guidelines and in alignment with the California Department of Health Care Services Population Health Management Policy Guide, Alliance has developed a PHM Strategy for identifying and addressing member needs across the continuum of care with the aim of improving the health outcomes of the Alliance membership and supporting enhanced quality of life. This continuum includes members with the highest levels of needs, those with emerging risks, and wellness and prevention activities for all members. The Alliance conducts an annual analysis of the impact of its PHM strategy that includes quantitative and qualitative analysis for evidence of program effectiveness and opportunities for improvement.

PHM Strategy

Goal

Maintain and update a cohesive plan of action that addresses the Alliance member/population needs across the continuum of care.

Results

This goal was achieved. The Alliance created the 2022 Alliance Population Health Management Strategy, and approved the strategy at the April 26, 2022, HCQC meeting. The 2022 PHM Strategy is described in a separate document. The following table highlights member populations and interventions included in the 2022 Alliance PHM Strategy:

Subset of Population	Targeted Interventions for Eligible Members	Number of Members Eligible 2022*	Percentage of Membership 2022**
Managing Multiple Chronic Illnesses		**9,069**	**2.9%**
Members that meet 3 of the following: ED visits >4, IP admits>3, readmissions >1 in the past 6 months.	Complex Case Management	1,234	.39%
Members transitioning out of an AHS's inpatient facility.	Transitions of Care	3,659	1.2%
ECM	Enhanced Care Management	4,176	1.5%

Managing Members with Emerging Risk		**76,299**	**24.4%**
Pediatric members ages 0 -18 with Asthma.	Asthma Start – case management and asthma remediation	6,727	2.1%
Members 19 years and older with diagnosis of persistent asthma.	Educational mailing and asthma remediation	10,984	3.5%
Members with diabetes who are > 21 years or older.	Adult Diabetes Disease Management	22,147	7.1%
Families with children who are overweight or obese. This group also includes Children with Special Healthcare needs.	Connect members to healthy weight resources.	14,795	4.7%
Members who smoke.	Provide tobacco cessation and educational materials.	18,079	5.8%
Pregnant members and members who have recently given birth.	Increase prenatal and postpartum access to mental health and SUD screening and treatment	3,478	1.2%
Keeping Members Healthy		**312,699**	**100%**
Black (African American) males ages 50-75 years old who have not received a colon cancer screening or colonoscopy exam during 2021.	Colon cancer screening incentive program.	250	.1%
Females between the ages of 23-35 years old who have not received cervical cancer screening.	Cervical cancer screening incentive program.	51,682	16.5%
African American women who have not received a mammogram within the last 2 years.	Breast cancer screening incentive program.	2,450	.78%
Pediatric members ages 3-21 who have not received an annual well-child exam within the last year.	Well-Child Exam incentive program.	45,816	15.6%
Pregnant members and members who have recently given birth.	Prenatal and postpartum mailing, education, and connection to resources.	3,863	1.2%
All Members including those with no information or low risk.	Health education wellness request form – member-wide distribution through biannual newsletter.	312,699	100%
Unvaccinated members and missed immunization schedule as define by ACIP guidelines.	Identify members and work with pharmacy providers.	72,937	23.3%
Patient Safety of Outcomes Across Settings		75	.03%
Members that are acute and chronic users and members who are on >50 MME/day or had benzodiazepines overdose related ED visits due to concurrent use of opioids.	Substance use disorder provider and member outreach and education.	75	.03%

Population Needs Assessment

Goal

Conduct annual population health assessment according to NCQA (Group Care and Medi-Cal) and DHCS (Medi-Cal) guidelines including a gap analysis.

Results

This goal was achieved. The *2022 Alliance Population Needs Assessment* was completed and approved at the 4/28/2022 HCQC meeting. The document can be found on the Alliance website at www.alamedaalliance.org.

PHM Strategy Evaluation

Goal

This goal was achieved. Conduct yearly impact analysis of the PHM Strategy according to NCQA (Group Care and Medi-Cal) and DHCS (Medi-Cal) guidelines and implement activities to address findings.

Results

The Alliance conducted the 2022 comprehensive analysis of the impact of its Population Health Management (PHM) Strategy. The PHM Evaluation includes quantitative results for relevant clinical, cost, utilization, and experience measures. Quantitative and qualitative analysis is conducted on the results for evidence of program effectiveness and continuous improvement. This analysis is conducted by the Health Care Services Department to support Alliance members and promote an effective PHM Strategy.

On review of the 2022 Population Health Strategy outcomes, the Alliance noted continued strong foundational elements, building successes, and opportunities for continuous improvement. Significant successes of the PHM Program included member and provider engagement through Case Management, Health Education, QI, and Pharmacy programs and projects. Clinic and community partnerships supported more members in receiving preventive care and education. Challenges included delayed implementation of Disease Management and opioid use programs as well as barriers to member outreach across quality improvement projects.

Opportunities for Improvement

On review of the evaluation results, opportunities include:

- Improve data collection and monitoring and evaluation of outcomes.
- Increased monitoring of ECM providers and training for TCS staff.
- Develop and launch Disease Management programs with coordinated organizational support and integration of risk stratification and segmentation.
- Expand quality improvement projects with more innovative providers and public health collaborations.
- Align with state-level health equity goals and regulatory requirements.

Actions Based on Opportunities

Actions based on opportunities are listed below:

- Complex Case Management (CCM), Transitional Care Services (TCS), and Enhanced Care Management (ECM): The Alliance will develop evaluative studies to compare outcomes across groups, including a control group to understand the impact of various programs. The Alliance will expand TCS to all high-risk members in 2023 and by 2024 offer TCS to all Alliance members experiencing a care transition. As the program expands, the Alliance will enhance training to improve consistency in program implementation. In 2023 and 2024, ECM will expand to new populations including at-risk children & youth and pregnant or postpartum members. The Alliance will dedicate ECM staffing and resources to improve monitoring and oversight of program implementation.
- Disease Management: The Alliance will continue to develop and improve processes for asthma and diabetes disease management programs. Disease management is planned to expand to members with cardiovascular disease and depression in 2023.
- Quality Improvement: The Alliance will continue to work closely with clinics and community groups and explore strategies such as text messaging, community health workers, member education videos, provider webinars, and adapting best practices or successes from other clinics. One best practice that the Alliance has already begun to implement is the use of mobile mammography. QI will also address identified health disparities in quality measures.

Note: The complete 2022 PHM Strategy Evaluation is documented in a separate document.

Health Education Overview

Alliance promotes the appropriate use of plan health care services, risk reduction, healthy lifestyles, and self-management of health conditions through a Health Education Program available to all members. The Alliance Health Education Program develops culturally appropriate materials and programs that meet the diverse needs of the Alliance membership and participates in community collaborations to promote health and wellness in Alameda County. The 2022 Health Education objectives and results are as follows:

Member Wellness Handouts and Programs

Objective 1

Make health education programs and information available to 100% of Alliance members in 2022.

Results 1

This goal was achieved. 100% of members were informed of health education programs and information. Members request health education materials and program information through the Wellness Request Form, communications with Alliance staff and provider referrals. The wellness Request form is included in the Alliance biannual member newsletter (mailed out to all Alliance households) and Health Risk Assessment, Case Management and Health Education mailings.

Objective 2

Distribute upon request health education program listings and health education handouts to

100% of members and providers who request information in 2022.

Results 2

This goal was achieved. 100% of 3034 members received requested health education information and program referrals in 2022.

Top 6 Requested Health Topics

Topic	Member Requests
Nutrition	115
Exercise	104
Diabetes	90
Heart Health	85
Back Pain	84
Stress and Depression	79

Childhood Obesity

Objective 1

Launch Kurbo and healthy weight resources.

Result 1

This goal was partially met. The Alliance published a child healthy weight care book. Barriers to launching the pediatric weight management program were overcome and member and provider tools were drafted, however late in 2022, the Kurbo program was discontinued. Alliance Health Education continues to explore options for child healthy weight activities listings.

Objective 2

Connect 100 pediatric members 50% Hispanic (Latino) with healthy weight resources between January 1, 2022, and June 30, 2023.

Result 2

This goal is still in process, but to date 10 members requested healthy eating, exercise, and weight materials for themselves and/or child in 2022 (3 Hispanic). 39 members received nutrition education from La Clinica (36 Hispanic).

Pregnancy and Baby Care

Objective 1

Distribute pregnancy and baby care resources and referrals to 100% of all identified pregnant and postpartum members.

Results 1

Please see Population Health Management objective in above section.

Objective 2

Refer 100% of identified Black or Pacific Islander pregnant members into ACPH culturally tailored perinatal programs.

Results 2

This objective was achieved.

Prenatal/Postpartum Referrals and Mailings

Mailing/Referrals	Members reached
Prenatal Mailings	4,028
Postpartum Mailings	2,288
Black Infant Health Referrals	660
Pacific Islander Program Referrals	89 Prenatal 47 Postpartum

Smoking Cessation

Objective

Increase rate of CAHPS adult tobacco users who were advised to quit from the 2021 rate of 75.6% to 78.0% and discussed medications with their doctor from the 2021 rate of 48.8% to 51.5% by December 31, 2022.

Results

MY2022 results are not yet available; MY2021 results: Advised to quit - 71.1% Medi-Cal, 77.8% Group Care. Discussed medications - 50.0% Medi-Cal, 48.6% Group Care. Activities conducted to support the goal included:

1. Provider packet piece published about tobacco treatment resources. Submitted provider quarter packet for Q1 2023 about tobacco treatment challenges.
2. Member newsletter went out with article on smoking cessation, submitted article for 2023 on hookah, also included in article about preterm birth.
3. Held Tobacco Cessation Workgroup Meeting on July 27 and reviewed member utilization and treatment data with Pharmacy, QI, Health Education and Case Management.

Lactation Supports

Objective

Expand lactation support for members through 1 additional contract for services.

Results

Goal was modified. The Alliance reached out to Washington Hospital and ValleyCare lactation programs and discussed telephonic lactation consults through WIC but was unsuccessful in establishing another lactation contract. Another opportunity arose to support lactation through the integration of Infant Feeding best practices and referrals into the Electronic Health Record

for CHCN clinics. The Alliance funded the enhancement which will launch with provider trainings in 2023.

Member Wellness Library

Objective 1

Update content, design, and format for Alliance wellness library by June 30, 2022.

Results 1

This goal was not achieved by June, but it was completed by the end of 2022. Materials and translations were completed in the first quarter of 2022 and made ready for distribution by the fourth quarter. Presentations were made to Case Management, IQIC, HCQC, and Provider Services regarding updated materials and materials were published on the Alliance Intranet for distribution to members.

Objective 2

Automated Wellness Mailing through KP vendor. Automation will reduce COVID exposures, reduce staff workload, and increase speed in distributing member requests by December 31, 2022

Results 2

This goal was not achieved due to competing organizational priorities and delays in finalizing health education materials. Health Education has requested Project Management support to assist in prioritizing and completing this project.

Disease Management Overview

Alliance Health Education, Case Management and Pharmacy teams collaborate to launch programs that support members in disease self-management. In 2022, the Alliance focused on Adult and Pediatric Asthma and Diabetes.

Adult Asthma

Objective

The number of Alliance members with asthma who engage with the Alliance regarding self-management of their asthma will increase by 20% from 61 members in 2021 to 73 members in 2023.

Results

This objective is in progress. In 2022, 46 members received asthma education materials. The planned outreach mailing campaign to adults with asthma was delayed by pending DHCS approval, resulting in lower than anticipated program engagement. The Alliance continued promotion of asthma self-management support through the Alliance Wellness Program & Materials Request Form in the Member Newsletter and the Alliance website.

Pediatric Asthma

Objective

The number of Alliance members ages 0 – 18 with asthma whose parents engage with the Alliance regarding self-management of their child's asthma will increase by 20% from 136 in 2021 to 162 in 2023.

Results

In 2022, 67 members participated in Asthma Start (Alameda County's in-home case management program for pediatric asthma). Member engagement was facilitated by the reinstatement of the weekly ER report from the local children's hospital in the third quarter of 2022, increasing referrals from the Alliance to Asthma Start. The Alliance also educated providers about asthma remediation services through presentations and a handout.

Challenges to achieving our goal included: Suspension of the local children's hospital data on asthma-related ER visits. These reports were not available for most of the year, meaning fewer timely referrals. An increase in referrals was anticipated with an outreach mailing campaign to children with asthma, but this was delayed by pending DHCS approval of campaign materials. Asthma Start became a part of Community Supports-Asthma Remediation, which changed the criteria for engagement and added an authorization step. This may be a temporary barrier as providers and Asthma Start adjusting to the new processes.

Diabetes

Objective

Increase HEDIS Asthma Medication Ratio (AMR) measure from 49.17% in MY2020 to MY2020 MPL of 62.43% for Black (African American) adults ages 19 to 64.

Results

In 2022, 118 members engaged with the Alliance programs: 9 in Alliance Disease Management health coaching and 109 in contracted hospital Diabetes Self-Management Education and Support (DSMES) programs.

Health Education developed a new process for Case Management to refer members they are working with to diabetes health coaching and/or assistance in enrolling in Alliance-paid DSMES programs. Members continued to participate in DSMES through provider and self-referrals and can receive information and assistance through the Alliance. However, a planned outreach mailing campaign to adults with diabetes has not been approved to start. Case Management referrals depended on staffing buy-in to refer to health coaching. Staffing changes may have limited the number of referrals.

Delegation Oversight

As a part of its compliance program and strategy, the Alliance deploys an array of auditing and monitoring exercises throughout the year. Annually, First-tier subcontracted entities, called delegates, undergo an annual delegation oversight audit. The audits are conducted in accordance with DHCS, DMHC, and the NCQA regulations.

Audit results are reported to the Delegation Oversight Committee, which is an underreporting committee of the Compliance Committee.

In Calendar Year 2022, the Alliance conducted annual delegation oversight audits for the entities included in the Alameda Alliance Delegated Entities – 2022 attachment.

To supplement its approach to Compliance, the Alliance holds quarterly JOMs with delegates, as necessary. JOMs cover a variety of topics, to include individual Access and Timeliness of Care survey results; HEDIS rate performance and opportunities for improvement; strategies for score improvement, and HEDIS timelines for reporting in the current year. In addition to JOMs, the Alliance holds regular Executive Team meetings with its strategic partners CHCN and AHS.

Analysis of 2022 Quality Program Evaluation and Effectiveness

The Alliance has identified the challenges and barriers to improvement throughout the 2022 QI Evaluation MY. Both challenges and achievements helped to inform our 2022 QI Work Plan.

2022 brought an abundance of opportunities for improvement in ensuring that our members have high quality, safe, timely, effective, efficient, equitable, patient centered care. Recommended activities and interventions for the upcoming year consider these challenges and barriers in working toward success and achievement of the Alliance's goals in 2022.

Challenges and barriers to achieving objectives encountered within the 2022 program year included but are not limited to:

- COVID-19 pandemic and PHE shelter in place resulted in multiple quality initiatives and activities paused due to PHE.
- COVID-19 changes to interpreter needs from in-person to telephonic and video.
- COVID-19 caused Potential Quality Issue Medical Record / Corrective Action Plans to be impacted because of provider delays.
- IHA Audits to be impacted because of a delay in provider responses to medical record requests.
- Drop in health education program participation due to pandemic and move to virtual formats for classes.
- HEDIS measurement results impeded deployment of optimal strategic rapid cycle PDSA implementation for quality improvement activities.
- Member Services call center "call abandonment" rate negatively impacted by staffing challenges.
- QI leadership staffing challenges in staff hiring. During this time, the QI department had a temporary QI Director though with a stable QI Medical Director who performed the required functions.

Program major accomplishments with objectives met for 2022 include but are not limited to:

- Adequate QI program resources to carry out roles, functions, and responsibilities.
- A consistent and stable QI committee and program structure.
- Successful administration of all timely access surveys within the expected timeframes, allowing for timely analysis and implementation of next steps with providers and within the Alliance.
- Maintenance of favorable Provider Satisfaction Survey scores.

- HCQC meetings in 2022 remain active in ensuring requirements of the QI Program were met.
- Stable and consistent Senior Level Physician involvement and Appropriate External and Internal Leadership.
- Improved HEDIS performance rates for measures; above the MPL for most reported HEDIS metrics.
- Ongoing Pediatric Care Management Program to promote access to care and EPSDT service utilization in partnership with direct, delegate, and CBOs.
- Improved turn-around times and root cause analysis of PQIs.
- Robust Health Education and Cultural and Linguistic Programs adding Quality of Language (QOL) PQIs segmentation for tracking and trending.
- Ongoing Member Advisory Committee and member input via virtual formats to ensure continued member input into programs and services.
- Updated grievance tracking system for capturing exempt grievances and accurate reporting and PQI referral submission to Quality department.
- Comprehensive monitoring of all practitioners during credentialing / re-credentialing to ensure high quality network.

Conclusion

Overall, the Alliance's QI Program was effective in reviewing data, assessing trends, identifying issues, and developing improvement activities within the Health Plan related to access to care, member and provider experience and quality of care.

During 2022, Alameda Alliance focused on meeting the Program goals and completing all initiatives as outlined in the 2022 QI Work Plan. Starting in 2021 and continuing throughout 2022, Alameda Alliance began working on improving staffing and workgroups to ensure high quality and compliance with both accreditation and all regulatory agencies. Throughout 2022, PDSA activities were a main source for continuing to improve the Alliance's quality performance. These PDSA activities have created a culture at the Alliance that leads to innovative and thoughtful work. The culture is dedicated to the Alliance's mission.

The Alliance is committed to improving the quality of healthcare delivered to its members through proactive analysis of shared processes and integration of health initiatives that align with the industry and government quality standards; including a preventive health model for outreach and preemptive intervention related to health outcomes.

ALAMEDA ALLIANCE FOR HEALTH

QUALITY IMPROVEMENT HEALTH EQUITY PROGRAM DESCRIPTION 2023

ALAMEDA Alliance FOR HEALTH

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

2023 Quality Improvement Health Equity Program Description Signature Page

Michelle Stott, R.N., M.S.N.
Senior Director of Quality

Date

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07/13/2023
Date

OVERVIEW

Alameda Alliance for Health is a public, not-for-profit managed care health plan committed to making high quality health care services accessible and affordable to lower-income people of Alameda County. Established in January 1996, the Alliance was created by and for Alameda County residents. The Alliance currently provides health care coverage to approximately 358,725 children and adults through its programs.

Alameda Alliance for Health is licensed by the State of California and product lines include Medi-Cal managed care and Group Care commercial insurance. Medi-Cal managed care beneficiaries, eligible thorough one of several Medi-Cal programs, e.g., TANF, SPD, Medi-Cal Expansion and Dually Eligible Medi-Cal members do not participate in California's Coordinated Care Initiative (CCI). For dually eligible Medi-Cal and Medicare beneficiaries, Medicare remains the primary insurance and Medi-Cal benefits are coordinated with the Medicare provider.

Alliance Group Care is an employer-sponsored plan offered by the Alliance. The Group Care product line provides comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County.

Alameda Alliance for Health's (Alliance) Quality Improvement Health Equity (QIHE) Program strives to ensure that members have access to quality and safe health care services. The QIHE Program Description is a comprehensive document with a set of interconnected documents that describes our quality program governance, structure and responsibilities, operations, scope, goals, and measurable objectives.

The Alliance QIHE Program is applicable to all product lines and is designed to assess, measure, evaluate and improve the quality and safety of care that members receive. Participation of all Alliance departments and staff in quality improvement activities is essential to the organization achieving our QI goals and objectives.

The Alliance complies with applicable State and Federal civil rights laws and does not discriminate based on race, color, religion, ancestry, national origin, ethnic group, age, mental or physically disability, sex, gender, gender identity, or sexual orientation, medical condition, genetic condition, or marital status. The Alliance QIHE Program is committed to serving the healthcare needs of our culturally and linguistically diverse membership. The Alliance staff and provider network reflect the county's cultural and linguistic diversity.

MISSION AND VISION

Mission

Improving the health and wellbeing of our members by collaborating with our provider and community partners to deliver high quality and accessible services.

Vision

All residents of Alameda County will achieve optimal health and well-being at every stage of their life.

QIHE PROGRAM SCOPE AND GOALS

The purpose of the Alliance QIHE Program is to objectively monitor and evaluate the quality, safety, appropriateness, and outcome of care and services delivered to members of the Alliance. The overall goal of the QIHE Program is to ensure that members have access to quality medical and behavioral health care services that are safe, effective, and meet their needs. The QIHE Program is structured to continuously pursue opportunities for improvement and problem resolution. The QIHE Program is organized to meet overall program objectives as described below and as directed each year by the QI and UM Work Plans. Improvement priorities are selected based on volume, opportunities for improvement, risk, and evidence of disparities.

Although not limited to, the goals of the QIHE Program are to:

1. Maintain the delivery of high quality, safe, and appropriate medical and behavioral health care that meets professionally recognized standards of practice that is delivered to all enrollees.
2. Utilize objective and systematic measurement, monitoring, and evaluation through qualitative and quantitative analysis of health care services and to implement QIHE activities based on the findings.
3. Conduct performance improvement activities that are designed implemented, evaluated, and reassessed using industry recognized quality improvement models such as Plan-Do-Study-Act (PDSA).
4. Ensure physicians and other appropriate licensed professionals, including behavioral health, are an integral and consistent part of the QIHE Program.
5. Ensure medical and behavioral health care delivery is consistent with professionally recognized standards of practice.
6. Track and trend the delivery of healthcare service to ensure care and services are not withheld or delayed for any reason, such as potential financial gain or incentive to plan providers.
7. Design and maintain an ongoing organizational culture of quality to ensure continual HEDIS improvement and accreditation readiness.

The scope of the QIHE Program is comprehensive and encompasses the following:

1. Timely access and availability to quality and safe medical and behavioral care and services.
2. Care and Disease management services.
3. Cultural and linguistic services Patient safety.
4. Member and provider experience Continuity and coordination of care.
5. Tracking of service utilization trends, including over-and under-utilization Clinical practice guideline development, adoption, distribution, and monitoring.
6. Targeted focus on acute, chronic, and preventive care services for children and adults Member and provider education.
7. Prenatal, primary, specialty, emergency, inpatient, and ancillary care.
8. Case review, investigation, and corrective actions of potential quality issues Credentialing and re-credentialing activities.

9. Delegation oversight and monitoring.
10. Delegate performance improvement project collaborations.
11. Targeted support of special needs populations including Seniors and Persons with Disabilities and persons with chronic conditions.
12. Population Health Management Integration.
13. Health care diversity and equity.

ORGANIZATIONAL STRUCTURE AND SUPPORT COMMITTEES' RESPONSIBILITY

Overview

The Alliance Board of Governors (BOG) appoints and oversees the Quality Improvement Health Equity Committee (QIHEC), Pharmacy & Therapeutics (P&T) Committee, Peer Review/Credentialing Committee (PRCC), Member Advisory Committee, and Compliance Committee which in turn, provide the authority, direction, guidance, and resources to enable Alliance staff to carry out the QIHE Program.

The organizational chart in **Appendix A** displays the reporting relationships for key staff responsible for QIHE activities at the Alliance. **Appendix B** displays the committee reporting relationship and organizational bodies.

Board of Governors

The Alliance BOG is appointed by the Alameda County Board of Supervisors and consists of up to 15 members who represent members, provider, and community partner stakeholders. The BOG is the final decision-making authority for the Alliance QIHE Program. Its duties include:

- Reviewing annually, updating, and approving the QIHE Program description, defining the scope, objectives, activities, and structure of the program.
- Reviewing and approval of the annual QI report and evaluation of QI studies, activities, and data on utilization and quality of services.
- Assessing QIHE Program's effectiveness and direct modification of operations as indicated.
- Defining the roles and responsibilities of QIHEC.
- Designating a physician member of senior management with the authority and responsibility for the overall operation of the quality management program, who serves on QIHEC.
- Appointing and approving the roles of the Chief Medical Officer (CMO) and other management staff in the QIHE Program.
- Receiving a report from the CMO on the agenda and actions of QIHEC.

Quality Improvement Health Equity Committee (QIHEC)

The QIHEC is a standing committee of the BOG and meets a minimum of four times per year, and as often as needed, to follow-up on findings and required actions. The QIHEC is responsible for the implementation, oversight, and monitoring of the QIHE Program and Utilization Management (UM) Program. As it relates to the QIHE Program, the QIHEC recommends policy decisions, analyzes, and evaluates the QI work plan activities, and assesses the overall effectiveness of the QIHE Program. The QIHEC reviews results and outcomes for all QIHE activities to ensure performance meets standards and makes recommendations to resolve barriers to quality improvement activities. Any quality issues related to the health plan that are identified through the CAHPS and Provider Satisfaction surveys and health plan service reports are also discussed and addressed at QIHEC meetings. The QIHEC oversees and reviews all QI delegation summary reports and evaluates delegate quality program descriptions, program evaluations, and work plan activities. The QIHEC presents to the Board the annual QIHE Program description, work plan and prior year evaluation. Signed and dated minutes that summarize committee activities and decisions are maintained. The Annual QIHE Program, Work Plan, Evaluation, and minutes from the QIHEC are submitted to the California Department of Health Care Services (DHCS).

Responsibilities include but are not limited to:

- Approve, select, design, and schedule studies and improvement activities.
- Review results of performance measures, improvement activities and other studies.
- Review CAHPS and other survey results and related improvement initiatives.
- On-going reporting to the BOG.
- Meeting at least quarterly and maintaining approved minutes of all committee meetings.
- Approve definitions of outliers and develop corrective action plans.
- Recommend and approve of Medical Necessity Criteria, Clinical Practice Guidelines, as well as pediatric and adult Preventive Care Guidelines and review compliance monitoring.
- Review member grievance and appeals data.
- Oversee the Plan's process for monitoring delegated providers.
- Oversee the Plan's UM Program.
- Review advances in health care technology and recommend incorporation of new technology into delivery of services as appropriate.
- Provide guidance to staff on quality improvement activities.
- Monitor progress in meeting QIHE goals.
- Evaluate annually the effectiveness of the QIHE and Population Health Management program.
- Oversee the Plan's complex case management and disease management programs.
- Review and approve annual QIHE and UM Program Descriptions, Work Plans, and Evaluations.
- Recommends and approves resource allocation for the QI Department Program. The QIHEC is chaired by the CMO and vice-chaired by the Sr. QI Medical Director. The members are representatives of the Alliance contracted provider network including those who provide health care services to Seniors and Persons with Disabilities (SPD) and chronic conditions. The QIHEC

Members are appointed for two-year terms. The voting membership includes:

- Alliance CMO (Chair)
- Medical Director of Quality (Vice-Chair)
- Chief Executive Officer (ex officio)
- Chief Health Equity Officer
- Medical Director or designee from each delegated medical group (i.e., Community Health Center Network, Children First Medical Group, Kaiser)
- Physician representative of Alameda County Medical Center
- Physician representative of Alameda County Ambulatory Clinics
- Alliance contracted physicians (3 positions)
- Representative of County Public Health Department
- A Behavioral Health practitioner
- Alliance Medical Directors
- Alliance Senior QI Director

A quorum is established when the majority of the voting membership is present at the meeting. The Chief Executive Officer does not count in the determination of a quorum.

Pharmacy and Therapeutics Committee (P&T)

The P&T Committee assists the QIHEC in oversight and assurance of ensuring the promotion of clinically appropriate, safe, and cost-effective drug therapy by managing and approving the Alliance's drug formulary, monitoring drug utilization, and developing provider education programs on drug appropriateness. P&T Committee meeting minutes and pharmacy updates are shared at the QIHEC meetings.

The voting membership consists of:

- Alliance Chief Medical Officer (Chair) or designee
- Alliance Director of Pharmacy Services (Co-Chair)
- Practicing physician(s) representing Internal Medicine
- Practicing physician(s) representing Family Practice
- Practicing physician(s) representing Pediatrics
- Practicing physician(s) representing common medical specialties
- Practicing community pharmacists contracted with Alliance (not to exceed 1/3 of the voting membership of the committee or three pharmacists, whichever is greater).

Peer Review and Credentialing Committee (PRC)

The PRC is a standing committee of the BOG that meets a minimum of ten times per year. The chair of the Peer Review Committee is the Medical Director of QI. The chair of the Credentialing Committee is the CMO.

Responsibilities include:

- Recommending provider credentialing and re-credentialing actions.
- Performing provider-specific clinical quality peer review.
- Reviewing and approving PRC Program Description.
- Monitoring delegated entity credentialing and re-credentialing.

The voting membership consists of:

- Alliance Chief Medical Officer (Chair) or Designee
- Alliance Case Management and Quality Improvement Medical Directors
- Medical Director/physician designee from Children First Medical Group
- Medical Director/physician designee from Community Health Center Network
- Physician representative for Alameda County Medical Center
- Two physicians from the South County area contracted with the Alliance.
- Physician representative from the Alliance BOG

Internal Quality Improvement Committee (IQIC)

The IQIC assists the QIHEC in oversight and assurance of the quality of clinical care, patient safety, and customer service provided throughout the AAH organization. Its primary roles are to maintain and improve clinical operational quality, review organization-wide performance against the Alliance quality targets, and report results to the QIHEC. All members shall complete a confidentiality and conflict-of-interest form, as required. A quorum, defined as a simple majority of voting members, must be present to conduct a meeting. The IQIC shall meet quarterly, at least four times per year. If urgent matters (as determined by the Alliance CMO) arise between meetings, additional meetings will be scheduled. Meetings may be conducted via conference call or webinar. All relevant matters discussed in between meetings will be presented formally at the next meeting. An agenda and supplementary materials, including minutes of the previous meeting, shall be prepared, and submitted to the IQIC members prior to the meeting to ensure proper review of the material. IQIC members may request additions, deletions, and modifications to the standard agenda. Minutes of the IQIC proceedings shall be prepared and maintained in the permanent records of the Alliance. Minutes, relevant documents, and reports will be forwarded to QIHEC for review.

Committee Responsibilities include but are not limited to:

- Develop, approve, and monitor a dashboard of key performance and QI indicators compared to organizational goals and industry benchmarks.
- Oversee and evaluate the effectiveness of AAH's Performance Improvement and Quality Plans.
- Review reports from other sub-committees and, if acceptable, forward them for review at the next scheduled QIHEC.

- Review plan and delegate corrective plans regarding negative variances and serious errors.
- Oversee compliance with NCQA accreditation standards.
- Make recommendations to the QIHEC on all matters related to:
- Quality of Care, Patient Safety, and Member/Provider Experience.
- Performance Measurement.
- Preventive services including:
    - Seniors and Persons with Disability (SPD)
    - Members with chronic conditions
    - Medi-Cal Expansion (MCE) members.

The Committee shall be comprised of the following members:

- Alliance Chief Medical Officer (CMO)
- Alliance Medical Director(s)
- Sr. Director of Quality
- Quality Improvement Manager
- Access to Care Manager
- Population Health and Equity Director
- Members from Provider Relations, Member Services, Business Analytics, Health Education, Compliance, and Grievance and Appeals.

Utilization Management Committee (UCM)

The UMC is a forum for facilitating clinical oversight and direction. Its responsibilities are to:

- Maintain the annual review and approval of the:
    - UM Program, UM Policies/Procedures, UM Criteria
    - Other pertinent UM documents such as the UM, Evaluation and UM Workplan, UM Notice of Action Templates
    - Case/Care Management (CM) and Enhanced Care Management (ECM) Programs Policies/Procedures,
    - Health Risk Assessment (HRA) and Health Information Form/Member Evaluation Tool (HIF/MET) Policies and Procedures.
- Participate in the utilization management/continuing care programs aligned with the Program's quality agenda.
- Assist in monitoring for potential areas of over and under-utilization and recommend appropriate actions when indicated.
- Review and analysis of utilization data for the identification of trends.
- Recommend actions to the Quality Oversight Committee when opportunities for improvement are identified from review of utilization data including, but not limited to Ambulatory Visits,

Emergency Visits, Hospital Utilization Rates, Hospital Admission Rates, Average Length of Stay Rates, and Discharge Rates.

- Review information about New Medical Technologies from the Pharmacy & Therapeutics Committee including new applications of existing technologies for potential addition as a new medical benefit for Members.

Access and Availability Subcommittee (AASC)

The AASC reviews the Alliance's access and availability data to evaluate whether the Alliance is meeting regulatory standards and provides corrective actions and recommendations for improvement when needed. The committee identifies opportunities for improvement and provides recommendations to maintain compliance with access and availability regulatory requirements.

Membership is comprised of Alliance staff within departments that are involved with access and availability which include the following representation:

- Chief Medical Officer
- Senior Medical Directors
- Senior Quality Director
- Access to Care Manager
- Quality Improvement Manager
- Health Education (Cultural & Linguistics) Manager
- Quality Assurance
- Grievance and Appeals Management
- Compliance
- Healthcare Analytics
- Utilization Management
- Member Services
- Provider Services

The following are the monitoring activities the subcommittee reviews to ensure compliance with access and availability and network adequacy requirements including but not limited to:

- Provider network capacity levels
- Facility Site Reviews
- Geographic accessibility
- Appointment availability surveys
- High volume and high impact specialists
- Access-related grievances and appeals. Access-related potential quality issues. Provider language capacity. Wait time and telephone practices related to access. Member and provider satisfaction survey

- After hours care

Cultural and Linguistic Services Committee

The Cultural and Linguistic Services Committee (CLSC)'s role is to ensure members receive culturally and linguistically appropriate health care services and to monitor the Alliance's Cultural and Linguistic Services Program. The CLSC reviews demographic changes in the Alliance membership, language services, grievances and potential quality issues related to language access and discrimination, alternate format and translation services, and overall execution of the Alliance's Cultural and Linguistic Services Program. The CLSC makes recommendations for program improvements and corrective actions as needed. The CLSC reports results to the QIHEC.

Responsibilities include but are not limited to:

- Monitor the cultural and linguistic needs of members.
- Review reports related to provision of cultural and linguistic services.
- Ensure that language assistance services are provided at all points of contact.
- Maintain and update cultural and linguistic services policies and procedures to be compliant with ongoing regulatory and contractual requirements.
- Annually review Cultural and Linguistic Services program description and work plan.
- Review input from the Member Advisory Committee on cultural and linguistic services and consider how it may inform Alliance's programs, policies, and procedures.
- Identify issues related to access to and provision of culturally and linguistically appropriate services and develop corrective actions to correct deficiencies found.
- Review plan and delegate corrective action plans.

The CLSC is composed of the following voting members:

- Chief Medical Officer
- Chief Health Equity Officer
- Senior Director of Quality
- 1 Representative from Compliance
- 1 Representative from Communications and Outreach
- 1 Representative from Grievance and Appeals
- 1 Representative from Population Health and Equity
- 1 Representative from Health Care Services
- 1 Representative from Member Services
- 1 Representative from Provider Services
- 1 Representative from Quality Improvement

Joint Operations Committee/Delegation

The contractual agreements between the Alliance and delegated entities specify:

- The responsibilities of both parties.
- The functions or activities that are delegated.
- The frequency of reporting on those functions and responsibilities to the Alliance and how performance is evaluated.
- Corrective action plan expectations, if applicable.

The Alliance may delegate QI, Credentialing, UM, Case Management, Disease Management, Claims, Grievance and Appeals activities to Health Plans, County entities, and/or vendors that meet the requirements as defined in a written delegation agreement, delegation policies, accreditation standards, and regulatory standards.

To ensure delegated entities meet required performance standards, the Alliance:

- Provides oversight to ensure compliance with federal and state regulatory standards, and accreditation standards.
- Reviews and approves program documents, evaluations, and policies and procedures relevant to the delegated activities.
- Conducts required pre-delegation activities.
- Conducts annual oversight audits.
- Reviews reports from delegated entities.
- Collaborates with delegated entities to continuously improve health service quality.

As part of delegation responsibilities, delegated entities must:

- Develop, enact, and monitor quality plans that meet contractual requirements and Alliance standards.
- Provide encounter information and access to medical records pertaining to Alliance members as required for HEDIS and regulatory agencies.
- Provide a representative to the Joint Operations Committee.
- Submit at least semi-annual reports or more frequently if required on delegated functions.
- Cooperate with state/federal regulatory audits as well as annual oversight audits.
- Complete any corrective action deemed necessary by the Alliance.

The Alliance collaborates with delegated entities to formulate and coordinate QIHE activities and includes these activities in the QI work plan and program evaluation. Delegated activities are a shared function. Delegate program descriptions, work plans, reports, policies and procedures, evaluations and audit results are reviewed by the Delegation Oversight Committee and Joint Operations Committee and findings are summarized at QIHEC meetings, as appropriate.

The Alliance currently delegates the following functions:

Table 1: Alameda Alliance Delegated Entities

Delegate	Quality Improvement		Utilization Management		Credentialing		Grievances & Appeals		Claims		Call Center		Case Management		Cultural & Linguistic Services		Provider Training	
	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care
Community Health Center Network (CHCN)			X	X					X	X			X	X			X	X
March Vision Care Group, Inc.					X				X									
Children's First Medical Group (CFMG)			X		X				X									
PerformRx			X	X	X	X			X	X					X	X		
Kaiser	X		X		X		X		X		X		X		X		X	
UCSF					X	X												
Physical Therapy PN					X	X												
Lucile Packard					X	X												
Teledoc					X	X												

QUALITY IMPROVEMENT PROGRAM RESOURCES

Responsibilities for QIHE Program activities are an integral part of all Alliance departments. Each department is responsible for setting and monitoring quality goals and activities.

The Alliance QI Department is part of the Health Care Services Department, and responsible for implementing QIHE activities and monitoring the QIHE Program. The QI Department participates in the accreditation process, manages the HEDIS and CAHPS data collection and improvement process, conducts facility site reviews (FSRs), and oversees the quality activities in other departments and those performed by delegated groups.

Resource allocation for the QI Department is determined by recommendations from the QIHEC, CMO, CEO and BOG. The Alliance recruits, hires, and trains staff, and provides resources to support activities required to meet the goals and objectives of the QIHE Program.

The Alliance's commitment to the QIHE Program extends throughout the organization and focuses on QIHE activities linked to service, access, continuity and coordination of care, and member and provider experience. The Senior Director of Quality, with direction from the Medical Director of Quality and CMO, coordinates the QIHE Program. Titles, education and/or training for key positions within the Quality Department include:

Chief Medical Officer

The Alliance Chief Medical Officer (CMO) is a board-certified physician who holds a current unrestricted license to practice medicine in California. The CMO has relevant experience and current knowledge in clinical program administration, including utilization and quality improvement management. The CMO is responsible for and oversees the QIHE Program. The CMO provides leadership to the QIHE Program through oversight of QI study design, development, and implementation, and chairs the QIHEC, PRCC, and P&T committees. The CMO makes periodic reports of committee activities, QI study and activity results, and the annual program evaluation to the BOG. The CMO reports to the Alliance CEO.

Chief Health Equity Officer

The Chief Health Equity Officer (CHEO) reports directly to the Chief Executive Officer (CEO) and is matrixed to the Chief of Human Resources (CHR). The position partners with leaders across the organization to develop and drive forward the key strategies of the organization as they relate to Diversity, Equity, and Inclusion (DEI) for members, providers, and employees. The executive position implements policies that ensure health equity is prioritized and addressed and is responsible for setting and implementing an overarching vision of DEI for the organization, including programmatic and administrative outcomes. The position is responsible for the promotion of internal and external DEI for members, providers, and employees. With supervision by the Chief Medical Officer (or designee) of the QIHE program, the CHEO participates in QIHEC and collaborates on QIHE program activities.

Senior Medical Director

The Senior Medical Director is a board-certified physician trained in Emergency Medicine who holds a current unrestricted license to practice medicine in California. The Senior Medical Director has relevant experience and current knowledge in clinical program administration, including utilization and quality improvement management and holds a Medical Doctorate, Master of Medical Management, and Master of Science in Biomedical Investigations, over 16 years of clinical experience, and 12 years of QI experience. The Senior Medical Director is part of the medical team and is responsible for strategic

direction of the Quality and Program Improvement programs. The Medical Director also forms a dyad partner with the Sr. Director of Quality and will serve as an internal expert, consultant, and resource in QI. They are responsible for clinical appropriateness, quality of care, pay for performance, access and availability, provider experience, member experience and cost-effective utilization of services delivered to Alliance members. The Senior Medical Director has executive oversight over the Behavioral Health Program responsibilities include participating in the grievance and external medical review procedure process, resolving medically related and potential quality related grievances, and issuing authorizations, appeals, decisions, and denials. The Senior Medical Director reports to the CMO.

Senior Director of Quality

The Sr. Director of Quality is responsible for the strategic direction of the Quality Improvement Program. The Sr. Director of Quality holds a master's in nursing, with 20 years of QI management and experience. The Sr. Director of Quality is a Registered Nurse who holds an active license to practice in California. This position has direct responsibility for the development, implementation, and evaluation of HEDIS and CAHPS. This position is responsible for all performance improvement activities, including improving access and availability of network services; developing and managing quality programs as identified by DHCS, DMHC, and NCQA (PIPs, Improvement Programs i.e., EAS/MCAS measures, QI Standards) as well as managing, tracking, analyzing, and reporting member experience/satisfaction as requested. The Sr. Director is also responsible for the oversight of FSR and potential quality issues (PQIs) and will direct performance improvement, FSR, access and availability. The Sr. Director is also the senior nurse to the organization to augment clinical oversight. This position, along with the Director of Population Health, assists with setting the priorities of the Population Health Management program, and ensures Health Education and Cultural and Linguistic Services are incorporated into the QIHE program. The Sr. Director of Quality is a dyad partner with the QI Medical Director and reports to the CMO.

Senior Director of Behavioral Health

The Senior Director of Behavioral Health is a licensed psychologist with an active license to practice in California. The Senior Director of Behavioral Health has relevant experience and current knowledge in clinical program administration, including behavioral health and autism spectrum disorder management. Alongside the Sr. Medical Director, the Sr. BH Director is responsible for and oversees the BH program. Responsibilities include participating in the QI, UM, and CM processes as they pertain to behavioral health and autism spectrum disorder programs. The Senior Director of BH reports to the Senior Medical Director.

Quality Improvement Manager

The Quality Improvement Manager is a non-clinical/licensed staff member who holds a master's in business administration degree and has 7 years of Medicaid Health Plan experience and holds certification as a Project Management Professional. The QI Manger is responsible for the day-to-day management of the QI department, including but not limited to HEDIS project improvement development and submission oversight, Physician Profiling (practice profiling) activities, and Quality and Performance Improvement Project oversight. The Manager also acts as liaison between the Alliance's physician leadership and community practitioners/providers of care across all specialties and delegates. The Manager is also responsible for creating report cards and assessing gaps in care. The QI manager works collaboratively throughout the organization to lead and establish appropriate performance management/quality improvement systems including PDSA. The Quality Improvement Manager reports to the Sr. Director of Quality.

Access to Care Manager

The Access to Care Manager is a non-clinical/licensed staff member who holds a bachelor's degree in media and technology and has 11 years of community health and provider network experience. The Access to Care Manager is responsible for day-to-day management of access to care activities throughout the organization and leading and establish appropriate access to care systems. The Access to Care Manager ensures the access program complies with timely access standards as regulated by the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA). The Access to Care Manager ensures planning and oversight of access to care surveys, ensures appropriate follow up when compliance monitoring identifies deficiencies The Access to Care Manager reports to the Sr. Director of Quality.

Quality Improvement Nurse Supervisor

The QI Nurse Supervisor is a Registered Nurse who holds an active license to practice in California and has 10 years of managed care experience.

The Quality Improvement Nurse Supervisor works collaboratively throughout the organization to ensure appropriate oversight of performance management and clinical quality improvement assignments. The Quality Improvement Supervisor is responsible for day-to-day supervision of the work assigned to the clinical staff in the Quality Department. The Supervisor also acts as liaison between the health plan's physician leadership and community practitioners/providers of care across all specialties and delegates. The Quality Improvement Supervisor is responsible for oversight of timely and accurate investigation and completion of Potential Quality Issues (PQI), Provider Preventable Conditions (PPC), and quality of care corrective action plans, and participation in HEDIS activities. The QI Nurse Supervisor reports to the Sr. Director of Quality.

Quality Improvement Review Nurse (3)

The QI Review Nurse is a Registered Nurse who holds an active license to practice in California and has at least 3 years of managed healthcare experience. Under the direct supervision of the Quality Improvement Nurse Supervisor, the Quality Review Nurse is responsible for timely and accurate investigation and completion of Potential Quality of Care Issues (PQIs), collecting quality related data and reviewing medical records for HEDIS abstraction and over reads, regulatory compliance, Facility Site Review (FSR) evaluations, quality improvement (QI) activities development, data tracking and trending, and outcomes reporting. The Quality Review Nurse keeps accurate records, manages, and analyzes data, as well as responds appropriately and timely, both verbally and in writing to internal and external clinical issues of staff and regulatory agencies.

Senior Quality Improvement Nurse Specialist (1)

The QI Review Nurse is a Registered Nurse who holds an active license to practice in California and has at least 20 years of managed healthcare experience. Under the direct supervision of the Sr. Quality Improvement Director, the Sr. Quality Improvement (QI) Nurse Specialist is responsible for the training, certification and recertification of all Alliance Network Management and Delegated Provider Oversight staff in conducting FSR audits. The Sr. QI Nurse Specialist is also responsible for the oversight and monitoring of the qualitative and quantitative content of the medical record process and maintaining compliance with state and regulatory quality of care standards. The QI Nurse Specialist develops provider training and education materials to assist providers with meeting quality standards.

The Senior QI Nurse Specialist identifies, investigates, and reports on Potential Quality Issues (PQIs) and Provider Preventable Conditions (PPCs) as appropriate from FSR findings. The QI Nurse

Specialist prepares cases and presents quality of care issues to the Medical for review and determination with support from the Sr. Director of Quality Improvement.

Quality Improvement Project Specialist (5)

QI Project Specialist (QIPS) are bachelor or extensive health care experience prepared non-clinical support staff responsible for providing support for quality assessment and performance improvement activities including quality monitoring, accreditation, access, and availability monitoring, evaluation, and facilitation of performance improvement projects. The QI Project Specialist reports directly to either the Quality Improvement Manager or Access to Care Manager. The QIPS acts as a liaison between the Alliance and the survey vendors, assist with accreditation needs, collaborate on HEDIS interventions, and perform regular assessments of access surveys, provider surveys, CAHPS and grievances. The QIPS ensures accuracy of DHCS performance improvement projects, internal subcommittees and QIHEC and subcommittee meeting facilitation. QIPS have experience in managed care as well as other highly regulated organizations.

Facility Site Review QI Coordinator (1)

The Facility Site Review Coordinator (FSRC) has 8 years of training and experience within the managed healthcare industry. The FSRC reports to the Access to Care Manager and is responsible for performing facility site review audits and quality improvement activities in conjunction with the Sr. QI Nurse Specialists. The position assists with access and availability reports, provider training, HEDIS data collection, disease specific outreach, and preparation for accreditation and compliance surveys by external agencies such as DHCS, DMHC and NCQA.

Quality Program Coordinator (2)

The Quality Program Coordinator (QPC) is a bachelor's prepared non-clinical support staff. Under the general direction of the Quality Improvement Manager, the QPC is responsible for helping to plan, organize, and implement Alliance quality programs. Responsibilities include coordination of quality projects including PQI case tracking, conducting reminder calls/mailings to targeted members or providers participating in quality improvement initiatives or activities, represents the Alliance at community meetings/events, create/runs periodic departmental reports, and maintains departmental worksheets.

ANCILLARY SUPPORT SERVICES FOR THE QIHE PROGRAM

Population Health and Equity

The Population Health and Equity team consists of a Population Health and Equity Director, a Population and Health Equity Manager, a Cultural and Linguistics Services Manager and supporting staff. The Population Health and Equity team is a component of the QI Department. The Population Health and Equity staff ensure integration of the QI initiative into the Alliance Population Health Strategy and support the QI team in the development and implementation of member and provider educational interventions and community collaborations to address health care quality, health equity and access to care. The Population Health and Equity team also manages and monitors the Population Health Management, Health Education and Cultural and Linguistic programs for the Alliance. The Health Education and Cultural and Linguistic Programs and the Population Health Management Strategy are outlined in separate documents.

Healthcare Analytics Services

The Healthcare Analytics Department performs data analyses involving clinical, claims, provider, and member data in support of the Quality department with improvement activities and initiatives. The Healthcare Analysts are available to the QI department and produce analytics and reporting for various QI activities and projects including HEDIS. Additionally, some analytics and reporting for QI are produced by outside vendors under contract with the Alliance.

Quality Assurance

The Director, Quality Assurance is responsible for the operations management of the Grievance and Appeals Department, NCQA Standard Accreditation, and internal monitoring of regulatory requirements for Health Care Services. under the direction of the Chief Medical Officer. The Director is responsible for ensuring the Health Care Service's overall regulatory compliance with Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) contractual responsibilities for Health Care Service Departments. The role is also responsible for overseeing ongoing audit readiness activities for DHCS, DMHC and NCQA. The Director is also responsible in coordinating processes, activities, and regulatory compliance involving grievances and appeals for all lines of business. The position identifies, analyzes, and coordinates resolution of grievances and appeals.

Utilization Management (UM) Services

The UM and QI Departments are part of the Alliance Health Care Services Department. These departments work collaboratively to ensure that appropriate quality and safe health care is delivered to members in a timely and organized manner. QI ensures that QIHEC can identify improvement opportunities regarding concurrent reviews, tracking key utilization data, and the annual evaluation of UM activities.

The Alliance's Utilization Management (UM) activities are outlined in the UM Program Description which includes persons with complex health conditions. The UM Program Description defines how UM decisions are made in a fair and consistent manner. There is also a Case Management (CM) and Complex Case Management Program Description. These programs address serving members with complex health needs, such as, seniors and people with physical or developmental disabilities (SPDs) and/or multiple chronic conditions in addition to case management for high-risk members identified through the disease management program. Responsibilities include conducting outreach and care coordination activities for members in the programs to ensure the improvement of member outcomes and overall member satisfaction. The staff will also assist the QI department in QIHE activities through conducting member outreach calls and mailings.

There are identified staff persons dedicated to working with "linked and carved out services" such as East Bay Regional Center, California Children Services (children with complex health care needs), and the Alameda County Behavioral Health Care Department. The UM Program Description is approved by the UMC and QIHEC. For additional information, refer to the UM and CM/Complex CM Program Descriptions.

Pharmacy Services

The Pharmacy Department and QI Department work collaboratively on various QI projects. The Pharmacy Department supports patient safety initiatives including working with the Pharmacy Benefit Manager (PerformRx) to inform members, providers, and network pharmacies of medication safety alerts. Responsibilities also include review and update of the formulary through P&T, oversight of the Pharmacy Benefit Manager, and collaboration with QIHEC.

Network Management/Provider Relations

The Network Management/Provider Relations Department is the primary point of contact for network providers. They assist the QI Department on various QIHE activities with network providers as appropriate as well as disseminating QI information to practitioners. The Department monitors provider capacity and collaborates with Access and Availability in assessing provider satisfaction with Alliance processes and educates providers on monitoring availability and accessibility standards at physician offices, including after-hours coverage. Provider Services staff also assist the QI Department with practitioners who do not comply with requests from QI including scheduling HEDIS abstraction visits.

Credentialing Services

The Credentialing staff support the credentialing and re-credentialing processes for practitioners and network providers. The Credentialing staff conducts ongoing monitoring and evaluation of network practitioners to ensure the safety and quality of services to members. The QI Department provides the Credentialing Department with Facility Site Review and Medical Record audit scores. The Credentialing staff is responsible for coordinating the PRCC meetings.

Member Services and Member Outreach

The Member Services staff fields all member inquiries regarding eligibility, benefits, claims, programs, and access to care. The Communication and Outreach conducts New Member orientations to educate new members about the health plan benefits. Member Services staff also work with the QI Department on member complaints via the PQI referral process and appeals in accordance with established policies and procedures. To assist in improving HEDIS scores, the QI Department may conduct member outreach activities to get HEDIS services completed. Hold messages are used to remind members of plan benefits and services offered while waiting to speak to an agent.

Grievance and Appeals

Alameda Alliance for Health reviews and investigates all grievance and appeal information submitted to the plan to identify quality issues that affect member experience. The grievance and appeals intake process are broken down into two processes, complaints, and appeals. In both instances, the details of the member's complaints are collected, processed, and reviewed and actions are taken to resolve the issue and Potential Quality Issues are forwarded to QI for review and investigation as needed. QI will continue to collaborate with G&A for assurance of accurate reporting exempt grievance data in 2022.

Methods and Processes for Quality Improvement

The QIHE Program employs a systematic method for identifying opportunities for improvement and evaluating the results of interventions. All program activities are documented in writing and all quality studies are performed on any product line for which it seems relevant. The Alliance QIHE Program follows the recommended performance improvement framework used by the Department of Health Care Services (DHCS). The Alliance Quality department has adopted the DHCS framework based on a modification of the Institute for Health Care Improvement (IHI) Quality Improvement (QI) as a Model of Quality Improvement. Key concepts for DHCS performance improvement projects (PIP) utilize the following framework:

- PIP Initiation
- SMART Aim Data Collection

- Intervention Determination
- Plan-Do-Study-Act
- PIP Conclusion

Identification of Important Aspects of Care

The Alliance uses several methods to identify aspects of care that are the focus of QIHE activities. Some studies are initiated based on performance measured as part of contractual requirements (e.g., HEDIS). Other studies are initiated based on analyses of the demographic and epidemiologic characteristics of Alliance members and others are identified through surveys and dialogue with our member and provider communities (e.g., CAHPS, provider satisfaction survey). Particular attention is paid to those areas in which members are high risk, high volume, high cost, or problem prone.

Data Collection and Data Sources

The Alliance uses internal resources and capabilities to design sound studies of clinical and service quality that produce meaningful and actionable information.

Much of the data relevant to QIHE activities is sourced from our NCQA-certified HEDIS software (Cotiviti). Data integrity is validated annually through the HEDIS reporting audit process.

Data sources to support the QIHE Program include, but are not limited to the following:

- ODS (Operational Data Store) and Datawarehouse: These are the main databases and the primary sources for all data including member, eligibility, encounter, provider, pharmacy data, lab data, vision, encounters, etc. and claims. The databases are used for abstracting data required for quality reporting.
- HealthSuite: Claims processing system CareAnalyzer (DST): used to inform Population Health Management and Population Needs Assessment initiatives and provide QI/UM/CM access to risk-stratified, segmented data that can be effectively applied to target high-risk members for early intervention and improve the overall coordination of care.
- TruCare: in-house medical record software.
- HEDIS: Preventive, chronic care, utilization, access, and other measures run through NCQA-certified HEDIS software (Cotiviti).
- CAHPS 5.1H and CG-CAHPS: Member experience survey via SPH vendor support
- California Immunization Registry (CAIR): Immunization registry information.
- Laboratory results supplemental data sources from: Quest, Foundation, and AHS Credentialing via Cactus, a credentialing database.
- Provider satisfaction and coordination of care surveys via SHP vendor support
- Pre-service, concurrent, post-service and utilization review data (TruCare).
- Member and provider grievance and appeal data.
- Potential Quality of Care Issue Application database used for tracking/trending data.
- Internally developed reports (e.g., asthma and diabetes).
- Provider Appointment Availability Survey (PAAS), as well as after-hours access and emergency instructions.
- Other clinical or administrative data.

Evaluation

Health care analysts collect and summarize quality data. Quality performance staff analyzes the data to determine variances from established criteria, performance goals, and for clinical issues. Data is analyzed to determine priorities or achievement of a desired outcome. Data is also analyzed to identify disparities based on ethnicity and language. Subsets of our membership may also be examined when they are deemed to be particularly vulnerable or at risk.

HEDIS related analyses include investigating trends in provider and member profiling, data preparation (developing business rules for file creation, file creation for HEDIS vendors, mapping proprietary data to vendor and NCQA specifications, data quality review and data clean-up). These activities involve data sets maintained by the Alliance and supplemental files submitted by various trading partners, such as delegated provider organizations and various external health registries and programs (e.g., Kaiser Permanente, Quest Diagnostics, and the California Immunization Registry).

Aggregated reports are forwarded to the QIHEC. Status and final reports are submitted to regulatory agencies as contractually required. Evaluation is documented in committee minutes and attachments.

ACTIONS TAKEN AS A RESULT OF QIHE ACTIVITIES

Action plans are developed and implemented when opportunities for improvement are identified. Each performance improvement plan specifies who or what is expected to change, the person responsible for implementing the change, the appropriate action, and when the action is to take place. Actions will be prioritized according to possible impact on the member or provider in terms of urgency and severity.

Actions taken are documented in reports, minutes, attachments to minutes, and other similar documents.

An evaluation of the effectiveness of each QIHE activity is performed. A re-evaluation will take place after an appropriate interval between implementation of an intervention and remeasurement. The evaluation of effectiveness is described qualitatively and quantitatively, in most cases, compared to previous measurements, with an analysis of statistical significance when indicated.

Based on the HEDIS data presented, areas of focus for 2023 include but are not limited to the following:

- Childhood Immunizations: Combo 10
- Immunizations for Adolescents: Combo 2
- Well-Child Visits in the First 15 months of Life
- Well-Child Visits in members 3-15 months of Life
- Well Child Visit 3-21 Years of Age
- Breast Cancer Screening
- Cervical Cancer Screening
- HbA1c Testing for Diabetics
- Controlling Blood Pressure

Other Non-HEDIS related measures of focus will include but not be limited to:

- Initial Health Assessment
- Emergency Department Visits per 1,000 Members
- PCP Visits per 1,000 Members
- Readmission Rate
- Member Satisfaction Survey: Non-Urgent Appointment Availability
- Screening for Depression
- EPSDT Service Utilization
- Under and Over Service Utilization
- Behavioral Health Care Coordination

TYPES OF QI MEASURES AND ACTIVITIES

Healthcare Effectiveness Data Information Set (HEDIS)

The Managed Care Accountability Set (MCAS) Performance Measures, a subset of HEDIS (Health Effectiveness Data Information Set) are calculated, audited, and reported annually as required by DHCS. Additional measures from HEDIS are also reviewed. A root cause analysis may be performed, and improvement activities initiated for measures not meeting benchmarks.

Consumer Assessment of Health Plan Survey (CAHPS 5.1H and CG-CAHPS)

The Alliance evaluates member experience periodically. Third party vendors conduct the Consumer Assessment of Health Plan Survey (CAHPS). The Alliance assists in the administration of these surveys, receives, and analyzes the results, and follows up with prioritized improvement initiatives. Survey results are distributed to the QIHEC and made available to members and providers upon request. The CAHPS survey is conducted annually for the entire Medi-Cal population and the results from the CAHPS are reported in the annual QIHE evaluation and used to identify opportunities to improve health care and service for our members.

State of California Measures

DHCS has developed several non-HEDIS measures that the Alliance evaluates. These measures, specified in the Alliance contract with DHCS, involve reporting rates for Developmental Screening in the First Three Years of Life, Topical Fluoride and Under/Over-Utilization Monitoring Measure Set.

State Quality improvement Activities

DHCS requires Medi-Cal Managed Care plans to conduct at least four QI projects each year. Forms provided by DHCS are used for QI project milestones.

Annually, the Alliance submits its QIHE Program Description, an evaluation of the prior year's QIHE Work Plan and a QIHE Work Plan for the next year. The QIHE Work Plan is updated throughout the year as QIHE activities are designed, implemented, and reassessed.

The Alliance complies with the requirements described in the regulatory All Plan Letters.

Monitoring Satisfaction

The QIHE Program measures member and provider satisfaction using several sources of satisfaction, including the results of the CAHPS survey, the Population Needs Assessment (PNA), the annual DMHC Timely Access survey, plan member and provider satisfaction surveys, complaint and grievance data, disenrollment and retention data, and other data as available. These data sets are presented to the QIHEC and BOG at quarterly and annual intervals. The plan may administer topic specific satisfaction surveys depending on findings of other QIHE studies and activities.

Health Education Activities

The Health Education Program at the Alliance operates as part of the Health Care Services Department. The primary goal of Health Education is to improve members' health and well-being through the lifespan through promotion of appropriate use of health care services, preventive health care guidelines: Bright Futures/American Academy of Pediatrics and U.S. Preventive Services Task Force, healthy lifestyles and condition self-care and management. The primary goal of Health Education is to provide the means and opportunities for Alameda Alliance members to maintain and support their health.

Health education programs include individual, provider, and community-focused health education and disease management activities which address health concerns such as nutrition, injury prevention, maternal health, diabetes, pre-diabetes, asthma, hypertension, and mental health. The Alliance also collaborates on community projects to develop and distribute important health education messages for at risk populations.

Cultural and Linguistic Activities

The Alliance Cultural and Linguistic Services Program operates under the Health Care Services Department. It reflects the Alliance's adherence and commitment to the U.S. Department of Health & Human Services "National Standards for Culturally and Linguistically Appropriate Services". The program offers services and conducts activities designed to ensure that all members have access to quality health care services that are culturally and linguistically appropriate. These activities encompass efforts within the organization, as well as with Alliance members, providers, and our community partners.

Objectives include:

- Comply with state and federal guidelines related to assessment of enrollees to offer our members culturally and linguistically appropriate services.
- Provide no-cost language assistance services at all points of contact for covered benefits.
- Identify, inform, and assist Limited English Proficiency (LEP) members in accessing quality interpretation services and written information materials in threshold languages.
- Ensure that all staff, providers, and subcontractors are compliant with the cultural and linguistic services program through cultural competency training.
- Integrate community and Alliance member input into the development and implementation of Alliance cultural and linguistic accessibility standards and procedures.
- Monitor and continuously improve Alliance activities and services aimed at achieving cultural competence and reducing health care disparities.

The objectives for cultural and linguistic activities are addressed and monitored in the Cultural and

Linguistic Services work plan which is updated annually.

Diseases Surveillance

The Alliance has executed a Memoranda of Understanding with DMHC and maintains procedures to ensure accurate, timely, and complete reporting of any disease or condition to public health authorities as required by State law. The Provider Manual describes requirements and lists the Public Health Department contact phone and fax numbers.

Patient Safety and Quality of Care

The Alliance QI process incorporates several mechanisms to review incidents that pose potential risk or safety concerns for members. The following activities are performed to demonstrate the Alliance's commitment to improve quality of care and safety of its members via monitoring, investigation, track, and trending of:

- Complaints and grievances and determining quality of care impact.
- Iatrogenic events such as hospital-acquired infections reported on claims and reviewing encounter submissions.
- Inpatient admissions to evaluate and monitor the medical necessity and appropriateness of ongoing care and services. Safety issues may be identified during this review.
- Identified potential quality of care issues.
- Auditing Alliance internal processes/systems and delegated providers.
- Credentialing and re-credentialing of malpractice, license suspension registries, loss of hospital privileges for providers.
- Site review of provider offices for compliance with safety, infection control, emergency, and access standards.
- Operations compliance with local regulatory practices.
- Medication usage (e.g., monitoring the number of rescue medications used by asthmatics).
- Pharmacy benefit management to notify members and providers of medication recalls and warnings.
- Reviewing hospital readmission reports.
- Improve continuity and coordination of care between practitioners.
- In addition to providing educational outreach to members (e.g., member newsletter, telephonic outreach) on patient safety topics including questions asked prior to surgery and questions asked about drug-drug interaction.

Quality issues are referred to the QI Department to evaluate the issue, develop an intervention and involve the CMO when necessary.

ACCESS AND AVAILABILITY

The Alliance implements mechanisms to maintain an adequate network of primary care providers (PCP) and high volume and high impact specialty care providers. Alliance policy defines the types of practitioners who may serve as PCPs. Policies and procedures establish standards for the number and geographic distribution of PCPs and high-volume specialists. The Alliance monitors and assesses the cultural, ethnic, racial, and linguistic needs and preferences of members, and adjusts availability of

network providers, if necessary.

The following services are also monitored for access and availability:

- Children's preventive periodic health assessments/EPSDT
- Adult preventative health screenings
- Initial health appointments

The QIHE Program collaborates with the Provider Relations Department to monitor access and availability of care including member wait times and access to practitioners for routine, urgent, emergent, and preventive, specialty, and after-hours care. Access to medical care is ensured by monitoring compliance with timely access standards for practitioner office appointments, telephone practices, and appointment availability. The QIHEC also oversees appropriate access standards for appointment wait times. Alliance appointment access standards are no longer than DMHC and DHCS established standards. The Provider Manual and periodic fax blasts inform practitioners of these standards.

The QIHEC reviews the following data and makes recommendations for intervention and quality activities when network availability and access improvement is indicated:

- Member complaints about access.
- CAHPS 5.1H and CG-CAHPS results for wait times and telephone practices.
- HEDIS measures for well child and adolescent primary care visits.
- Immunizations.
- Emergency room utilization.
- Facility site review findings.
- The review of specialty care authorization denials and appeals.
- Additional studies and surveys may be designed to measure and monitor access.

BEHAVIORAL HEALTH QUALITY

The Alliance maintains procedures for monitoring the coordination and quality of behavioral healthcare provided to all members including, but not limited to, all medically necessary services across the health care network. The Alliance involves a senior behavioral healthcare in quarterly QIHEC meetings to monitor, support, and improve behavioral healthcare aspects of QI.

Prior to 4/1/23, Behavioral Health Services were delegated to Beacon Health Strategies, an NCQA Accredited MBHO, except for Specialty Behavioral Health for Medi-Cal members, excluded from the Alliance contract with DHCS. The Specialty Behavioral Health Services are coordinated under a Memorandum of Understanding between the Alliance and Alameda County Behavioral Health (ACBH).

Some primary care physicians may choose to treat mild mental health conditions. As of 4/1/2023, Behavioral Health Services were insourced and became the responsibility of the health plan.

The Alliance includes the involvement of a Senior Director of Behavioral Health in program oversight and implementation. In 2023, the Alliance will review Beacon's QIHE Program Description, Work Plan, and Annual Evaluation in addition to creating trilogy documents that include the plans responsibility of the QI / CM / UM Functions of Behavioral Health. The Alliance will review behavioral health quality,

utilization, and member satisfaction quarterly reports in its standing sub-committee meetings to ensure members obtain necessary and appropriate behavioral health services.

Please see the UM / CM Program Description for additional information.

COORDINATION, CONTINUITY OF CARE AND TRANSITIONS

Member care transitions present the greatest opportunity to improve quality of care and decrease safety risks by ensuring coordination and continuity of health care as members transfer between different locations or different levels of care within the same location and/or across the healthcare continuum.

The Alliance Health Care Services focuses on interventions that support planned and unplanned transitions and promote chronic disease self-management. Primary goals of the department are to reduce unplanned transitions, prevent avoidable transitions and maintain members in the least restrictive setting possible.

Comprehensive case management services are available to each member. It is the PCP's responsibility to act as the primary case manager to all assigned members. Members have access to these services regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability. All services are provided in a culturally and linguistically appropriate manner.

Members who may need or are receiving services from out-of-network providers are identified. Procedures ensure these members receive medically necessary coordinated services and joint case management, if indicated. Written policies and procedures direct the coordination of care for the following:

- Services for Children with Special Health Care Needs (CSHCN).
- California Children's Service (CCS) eligible children are identified and referred to the local CCS program.
- Overall coordination and case management for members who obtain Child Health and Disability Prevention Program (CHDP) services through local school districts or sites.
- Early Start eligible children are identified and referred to the local program.
- Members with developmental difficulties are referred to the Regional Center of the East Bay for evaluation and access to developmental services.

All new Medi-Cal members are expected to receive an Initial Health Appointment (IHA) within 120 days of their enrollment with the plan. Members are informed of the importance of scheduling and receiving an IHA from their PCP. The Provider Manual informs the PCP about the IHA, the HRA (for SPDs), and recommended forms. All new Medi-Cal members also receive a Health Information Form\Member Information Tool (HIF\MET) in the New Member Packet upon enrollment. The Alliance ensures coordination of care with primary care for all members who return the form with a condition that requires follow up.

The Alliance coordinates with PCPs to encourage members to schedule their IHA appointment. The medical record audit of the site review process is used to monitor whether baseline assessments and evaluations are sufficient to identify CCS eligible conditions, and if medically necessary follow-up services and referrals are documented in the member's medical record.

COMPLEX CASE MANAGEMENT PROCESS

All Alliance members are potentially eligible for participation in the complex case management program. The purpose of the complex case management program is to provide the case management process and structure to a member who has complex health issues and medical conditions. The components of the Alliance complex case management program encompass member identification and selection; member assessment; care plan development, implementation, and management; evaluation of the member care plan; and closure of the case. Program structure is designed to promote quality case management, client satisfaction and cost efficiency using collaborative communication, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

The objectives of the complex case management program are concrete measures that assess effectiveness and progress toward the overall program goal of making high quality health care services accessible and affordable to Alliance membership. The Chief Medical Officer, Senior Director of Health Care Services, Director of Social Determinants of Health, and Manager of Case and Disease Management develop and monitor the objectives. The QIHEC reviews and assesses program performance against objectives during the annual program evaluation, and if appropriate, provides recommendations for improvement activities or changes to objectives. The objectives of the program include:

- Preventing and reducing hospital and facility readmissions as measured by admission and readmission rates.
- Preventing and reducing emergency room visits as measured by emergency room visit rates.
- Achieving and maintaining member's high levels of satisfaction with case management services as measured by member satisfaction rates.
- Improving functional health status of complex case management members as measured by member self-reports of health condition.

The complex case management program is a supportive and dynamic resource that the Alliance uses to achieve these objectives as well as respond to the needs and standards of consumers, the healthcare provider community, regulatory and accrediting organizations.

The Alliance annually measures the effectiveness of its complex case management program based on the following measures (detailed information can be found in the Comprehensive Case Management Program Description):

1. Satisfaction with case management services - members are mailed a survey after case closure and are asked to rate experiences and various aspects of the program's service.
2. All-cause readmission rates - the Alliance measures admission rates for all causes within six months of being enrolled in complex case management.
3. Emergency room visit rate - the Alliance measures emergency room visit rates among members enrolled in complex case management.
4. Health status rate - the Alliance measures the percentage of members who received complex case management services and responded that their health status improved because of complex case management services.
5. Use of appropriate health care services - The Alliance measures enrolled members' office visit activity, to ensure members seek ongoing clinical care within the Alliance network.

The Chief Medical Officer and the Senior Director of Health Care Services collaboratively conduct an annual evaluation of the Alliance complex case management program. This includes an analysis of performance measures, an evaluation of member satisfaction, a review of policies and program description, analysis of population characteristics and an evaluation of the resources to meet the needs of the population. The results of the annual program evaluation are reported to the QIHEC for review and feedback. The QIHEC makes recommendations for improvement and interventions to improve program performance, as appropriate.

DISEASE MANAGEMENT PROGRAM

The Alliance makes available to its members a disease management program. The purpose of the disease management program is to provide coordinated health care interventions and communications to both pediatric and adult members with chronic asthma and adults with diabetes to support disease self-management and promote healthy outcomes. This is accomplished through the provision of interventions based on member acuity level. The intervention activities range from case management for those members at high risk, to those members at high risk to making educational materials and care coordination available for those members who may have gaps in care. The components of the Alliance disease management program include member identification and risk stratification; provision of case management services, chronic condition monitoring; identification of gaps in care, and education.

Program structure is designed to promote quality condition management, client satisfaction and cost efficiency using collaborative communications, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

The objectives of the disease management program are concrete measures that assess effectiveness and progress toward the overall program goals of meeting the health care needs of members and actively supporting members and practitioners to manage chronic asthma and diabetes. The QIHEC reviews and assesses program performance against objectives during the annual program evaluation, and if appropriate, provides recommendations for improvement activities or changes to objectives. The objectives of the disease management program include:

- Preventing and reducing hospital and facility readmissions as measured by admission and readmission rates.
- Preventing and reducing emergency room visits as measured by emergency room visit rates.
- Achieving and maintaining member's high levels of satisfaction with disease management services as measured by member satisfaction rates.
- Reducing gaps in care as measured by HEDIS clinical effectiveness measures specific to the management of asthma and diabetes.

POPULATION HEATLH MANAGEMENT (PHM) PROGRAM

Alameda Alliance for Health has a Population Health Management (PHM) Program that identifies member needs across the continuum of care and ensures access to a comprehensive set of services with the aim of improving health outcomes and supporting enhanced quality of life. This continuum includes intensive case management and support for members with the highest levels of needs, programs and interventions for those with emerging risks, and basic population health management for all members. The Alliance PHM Program follows the NCQA 2023 Population Health Program Standards and Guidelines and aligns with the California Department of Health Care Services

Population Health Management Policy Guide.

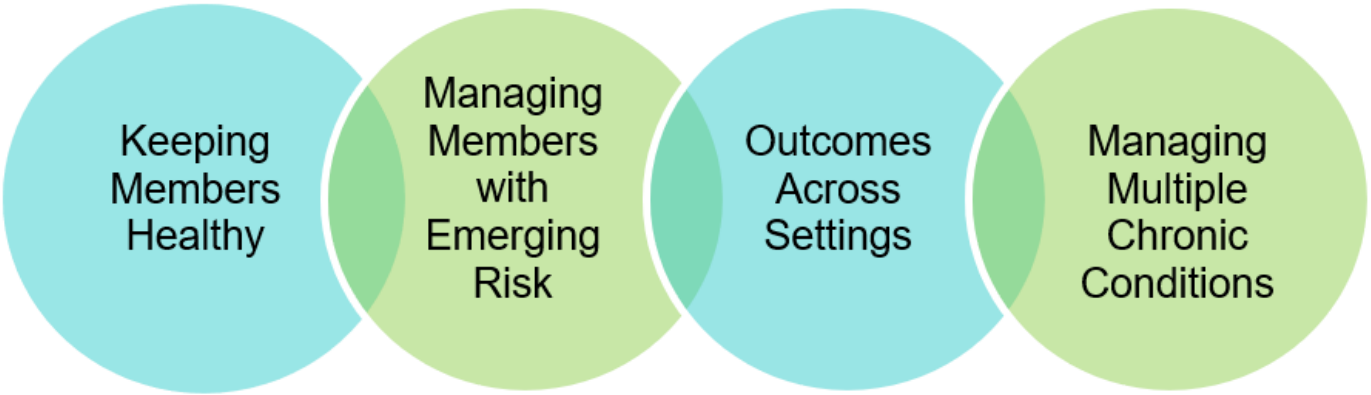
The PHM Program strives to target and close gaps in care and address upstream drivers of health disparities by addressing the social drivers of health (SDOH) that cause those disparities. The PHM Program is monitored via the Population Health Workgroup, which is comprised of representatives from Quality Improvement, Utilization Management, Case Management, Pharmacy and Quality Assurance. In addition, overall outcomes, and findings from the Alliance population health assessments, population health strategy and evaluations are presented, reviewed, and approved by the Quality Improvement Health Equity Committee (QIHEC).

The PHM Strategy is used to:

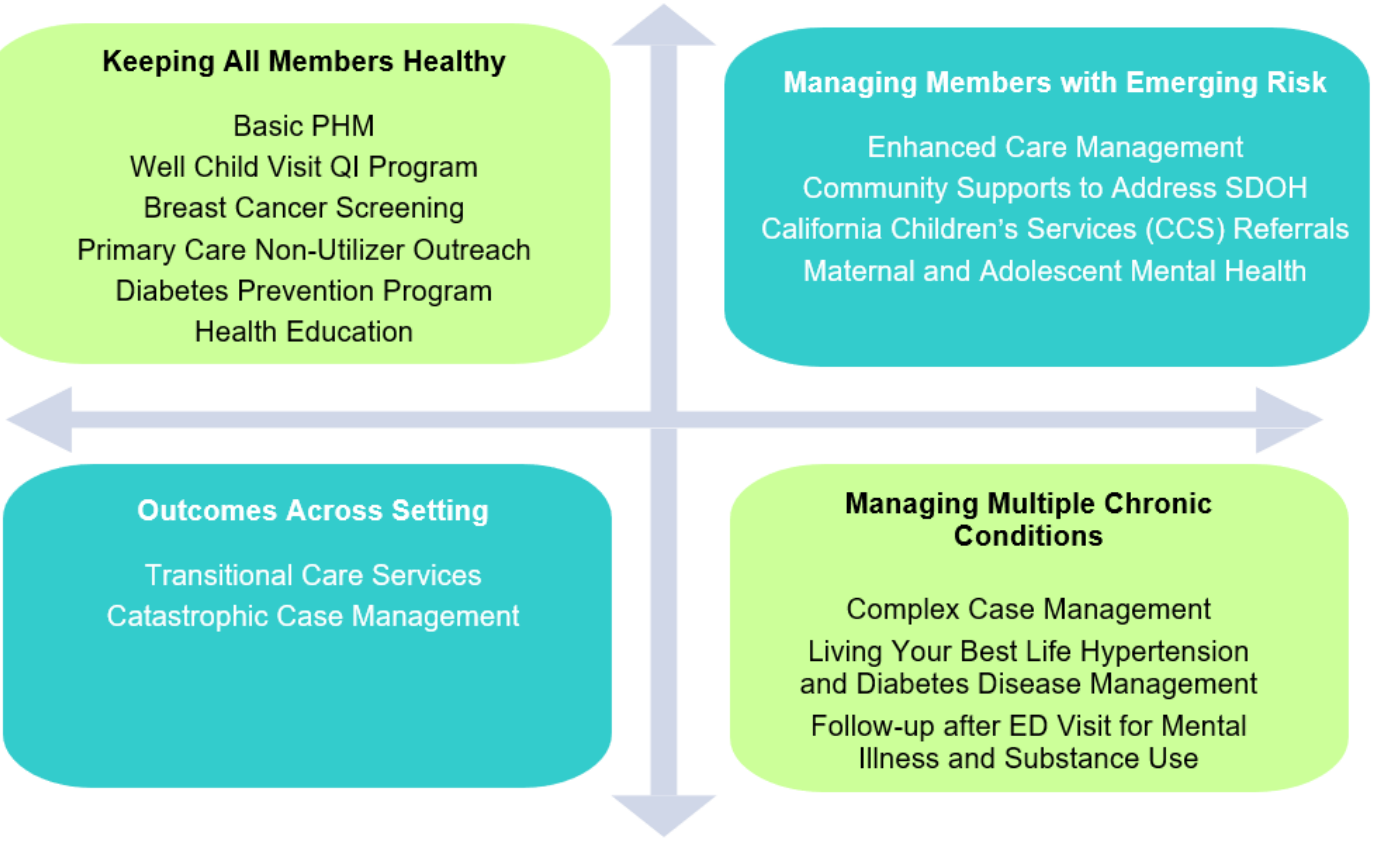
- Improve case management programs including Complex Case Management (CCM), Enhanced Care Management (ECM), Community Supports (CS), and Transitional Care Services (TCS).
- Support development of basic population health activities to promote self-management of conditions and preventative care.
- Inform quality improvement projects.
- Guide development of health education materials and programs.
- Influence interventions that target member safety and outcomes across settings.
- Better understand utilization and identify high-risk members.

The framework of this strategy is designed to address the four focus areas of population health that promote a whole-person approach to identify members at risk, and to provide strategies, programs, and services to mitigate or reduce that risk. The strategy has 4 areas of focus:

Four Areas of Focus



The Alliance also aims to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through best practice and culturally affirming member's needs:



The Population Health Strategy includes:

- Population health assessment
- Population risk stratification and segmentation
- PHM Strategy goals and programs
- Integration of Community Resources
- Delivery systems provider support structures:
- Sharing data – provider measures and gaps in care
- Quality Dashboards – HEDIS measure-specific data
- Comparable Data – Peer performance, local averages, and national benchmarks
- Value-Based Payment Programs
- Ongoing Education/Support – Provider Newsletters & Education

The Alliance Population Health Management Assessment and Strategy can be found in separate documents. The Alliance Population Health Evaluation is included in the QI Evaluation.

SENIORS AND PERSONS WITH DISABILITY (SPD)

The Alliance categories all new SPD members as high risk. High risk members are contacted for an HRA within 45 calendar days and low risk members are contacted within 105 calendar days from their date of enrollment. Existing SPD members receive an annual HRA on their anniversary date. The objectives of an HRA are to assess the health status, estimate health risk, and address members' needs relating to medical, specialty, pharmacy, and community resources. Alliance staff uses the responses to the HRAs, along with any relevant clinical information, to generate care plans with interventions to decrease health risks and improve care management.

DHCS has established performance measures to evaluate the quality of care delivered to the SPD population using HEDIS measures and a hospital readmissions measure.

PROVIDER COMMUNICATION

The Alliance contracts with its providers to foster open communication and cooperation with QIHE activities:

- Provider cooperation with QIHE activities.
- Plan access to provider medical records to the extent permitted by state and federal law.
- Provider maintenance of medical record confidentiality.
- Open provider-patient communication about treatment alternatives for medically necessary and appropriate care.
- Provider regulatory requirements

Provider involvement in the QIHE Program occurs through membership in standing and ad-hoc committees, and attendance at BOG and QIHEC meetings. Providers and members may request copies of the QIHE Program description, work plan, and annual evaluation. Provider participation is essential to the success of QI studies including HEDIS and those that focus on improving aspects of member care. Additionally, providing feedback on surveys and questionnaires is encouraged as a means of continuously improving the QIHE Program.

Providers have an opportunity to review the findings of the QIHE Program through a variety of mechanisms. The QIHEC reports findings from QIHE activities to the BOG, at least quarterly. Findings include aggregate results, comparisons to benchmarks, deviation from threshold, drill-down results for provider group or type, race/ethnicity, and language, and other demographic or clinical factors. Findings are distributed directly to the provider when data is provider specific. Findings are included in an annual evaluation of the QIHE Program and made available to providers and members upon request. The Provider Bulletin contains a calendar of future BOG and standing committee dates and times.

EVALUATION OF QIHE PROGRAM (SEPARATE DOCUMENT)

The QIHEC reviews, makes recommendations, and approves a written evaluation of the overall effectiveness of the QIHE Program on an annual basis. The evaluation includes, at a minimum:

- Changes in staffing, reorganization, structure, or scope of the program during the year.
- Allocation of resources to support the program.
- Comparison of results with goals and targets.

- Tracking and trending of key indicators.
- Description of completed and ongoing QIHE activities.
- Analysis of the overall effectiveness of the program, including assessment of barriers or opportunities.
- Recommendations for goals, targets, activities, or priorities in subsequent QIHE Work Plan.

The review and revision of the program may be conducted more frequently as deemed appropriate by the QIHEC, CMO, CEO, or BOG. The QIHEC's recommendations for revision are incorporated into the QIHE Program Description, as appropriate, which is reviewed by the BOG and submitted to DHCS on an annual basis.

ANNUAL QIHE WORK PLAN (SEPARATE DOCUMENT)

A QIHE Work Plan is received and approved annually by the QIHEC. The work plan describes the QI goals and objectives, planned projects, and activities for the year, including continued follow-up on previously identified quality issues, and a mechanism for adding new activities to the plan as needed. The work plan delineates the responsible party and the time frame in which planned activities will be implemented.

The work plan is included as a separate document and addresses the following:

- Quality of clinical care
- Quality of service
- Safety of clinical care
- Members’ experience
- Yearly planned activities and objectives
- Time frame within which each activity is to be achieved.
- The staff member responsible for each activity
- Monitoring previously identified issues.
- Evaluation of the QIHE Program

Progress on completion of activities in the QI work plan is reported to the QIHEC quarterly. A summary of this progress will be reported by the CMO to the BOG.

QI DOCUMENT

In addition to this program description, the annual evaluation and work plan, the other additional documents important in communicating QI policies and procedures include:

- "Provider Manual" provides an overview of operational aspects of the relationship between the Alliance, providers, and members. Information about the Alliance's QIHE Program is included in the provider manual. It is distributed to all contracted provider sites.
- "Provider Bulletin" is a newsletter distributed to all contracted provider sites on topics of relevance to the provider community, and can include QI policies, procedures, and activities.

- "Alliance Alert" is the member newsletter that also serves as a vehicle to inform members of QI policies and activities.

These documents, or summaries of the documents, are available upon request to providers, members, and community partners. In addition, the QIHE Program information is available on the Alliance website.

CONFIDENTIALITY AND CONFLICT OF INTEREST

All employees, contracted providers, delegated medical groups and sub-contractors of the Alliance maintain the confidentiality of personally identifiable health information, medical records, peer review, internal and external, and internal electronic transmissions, and quality improvement records. They will ensure that these records and information are not improperly disclosed, lost, altered, tampered with, destroyed, or misused in any manner. All information used in QIHE activities is maintained as confidential in compliance with applicable federal and state laws and regulations.

Access to member or provider-specific peer review and other QI information is restricted to individuals and/or committees responsible for these activities. Outside parties asking for information about QIHE activities must submit a written request to the CMO. Release of all information will be in accordance with state and federal laws.

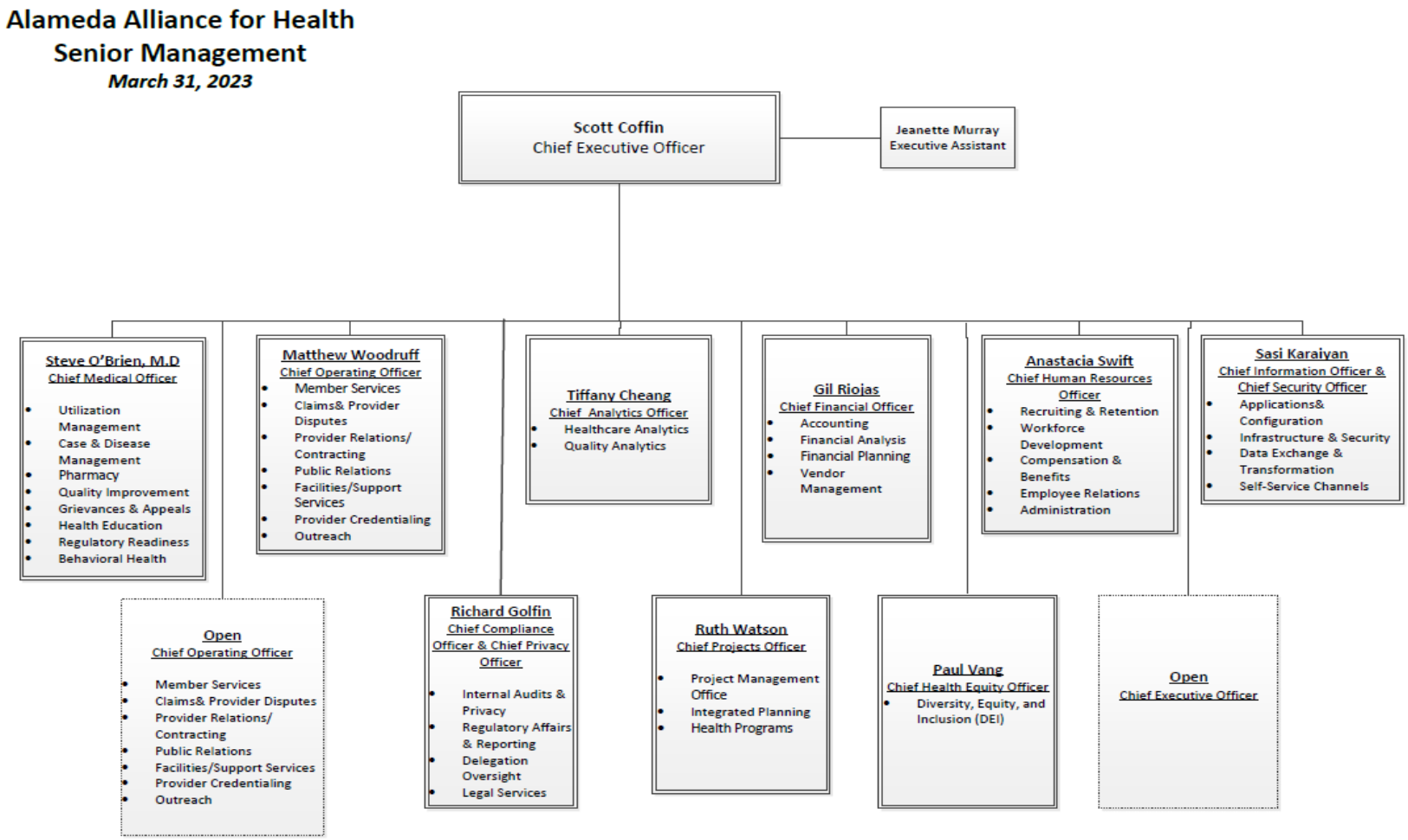
All providers participating in the QIHEC or any of its subcommittees, or other QIHE Program activities involving review of member or provider records, will be required to sign and annually renew confidentiality and conflict of interest agreements. Guests or additional Alliance staff attending QIHEC meetings will sign a confidentiality agreement.

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

All QI meeting materials and minutes are marked with the statement "Confidential". Copies of QI meeting documents and other QI data are maintained separately and secured to ensure strict confidentiality.

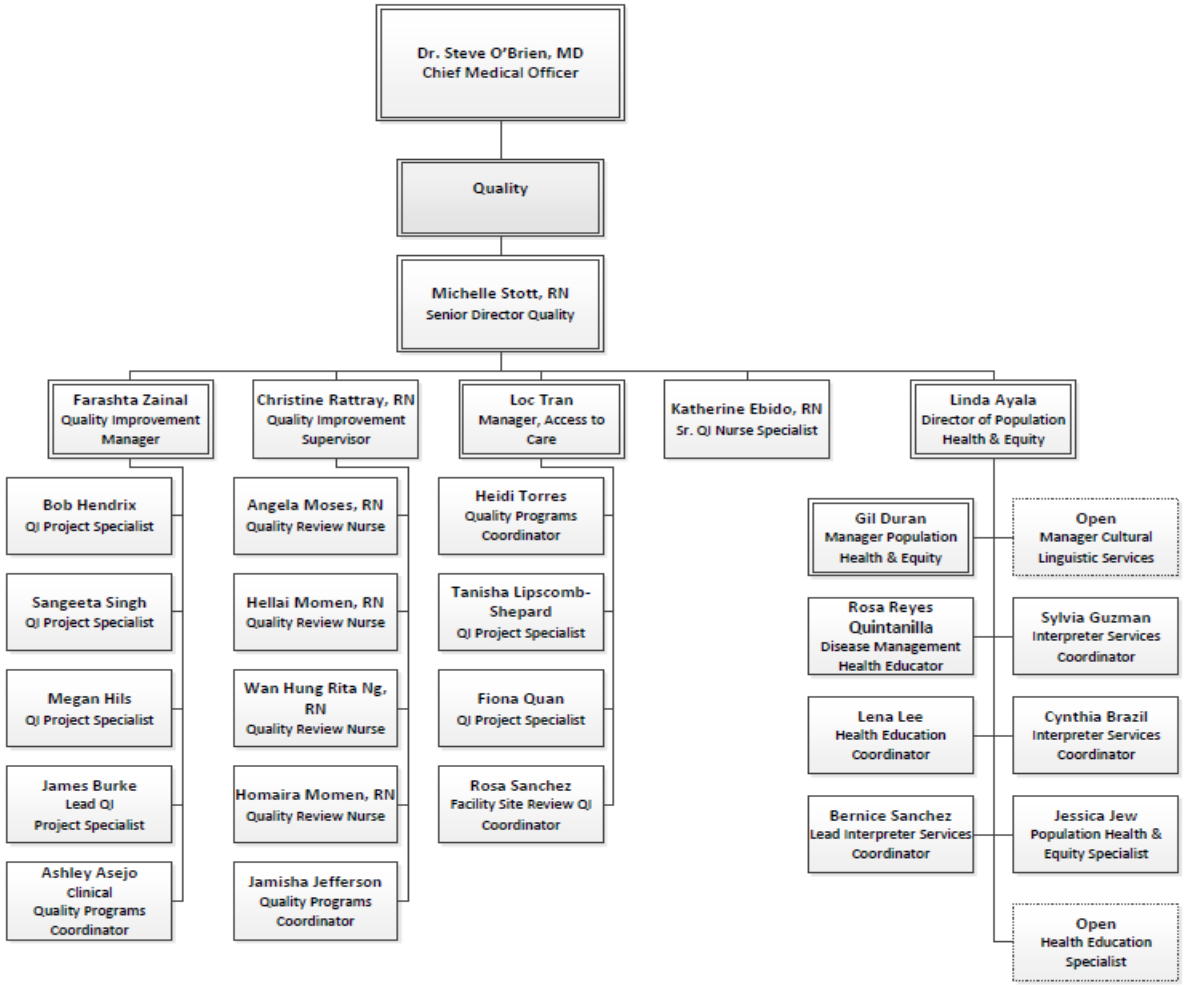
APPENDIX A: Organizational Charts

Senior Management



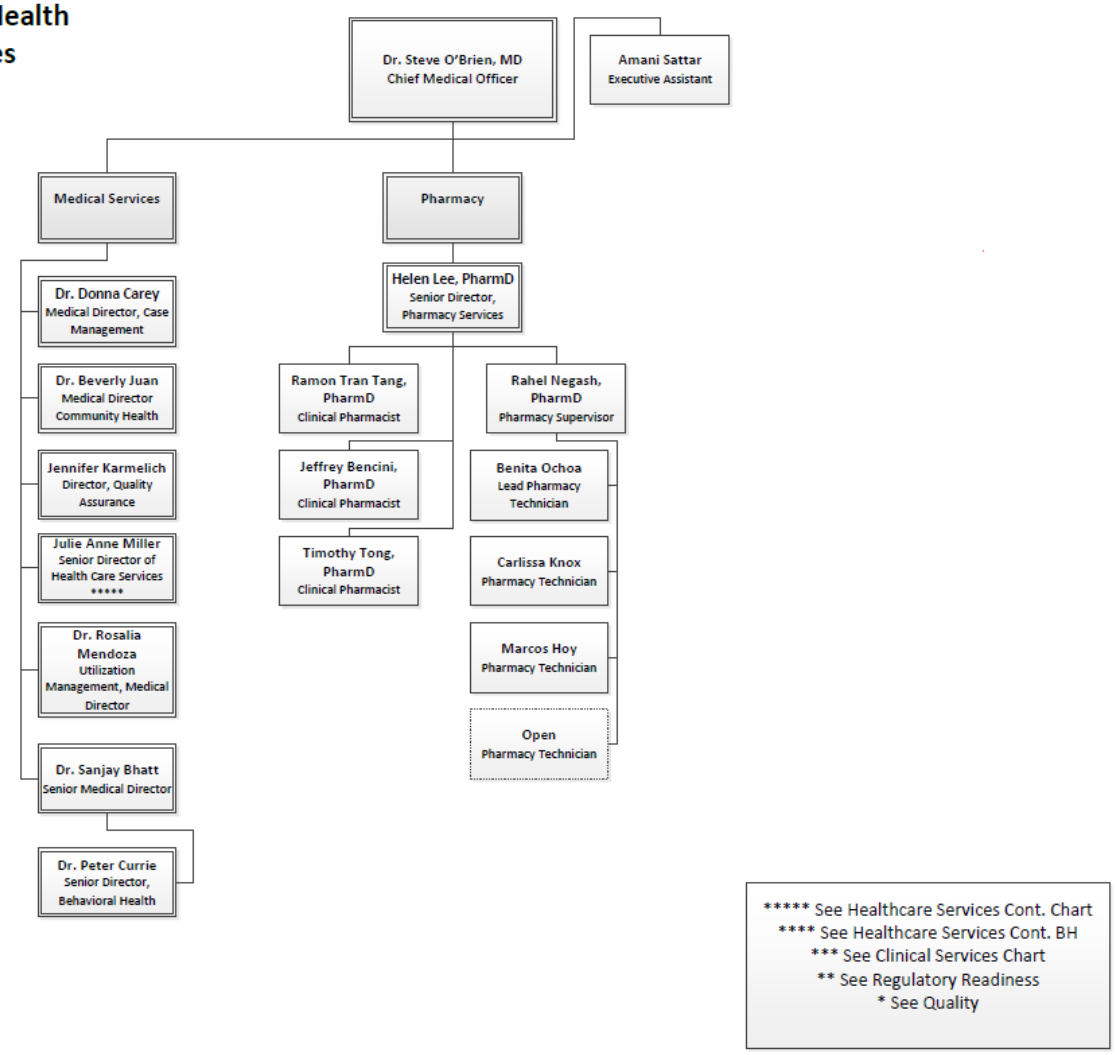
Health Care Services

Alameda Alliance for Health
Healthcare Services Cont. – Quality
March 31, 2023



Medical Services and Pharmacy

Alameda Alliance for Health
Healthcare Services
March 31, 2023



***** See Healthcare Services Cont. Chart
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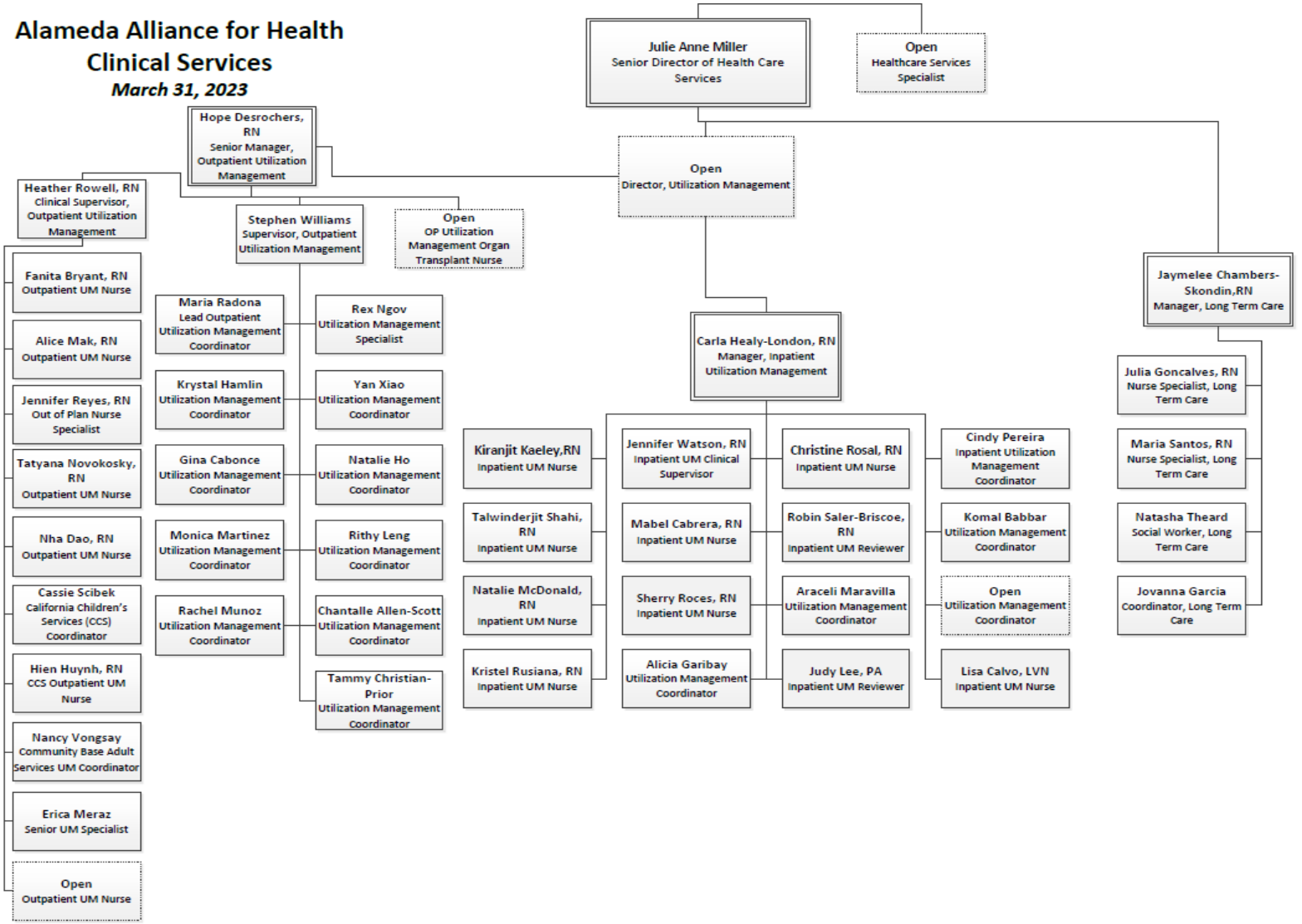
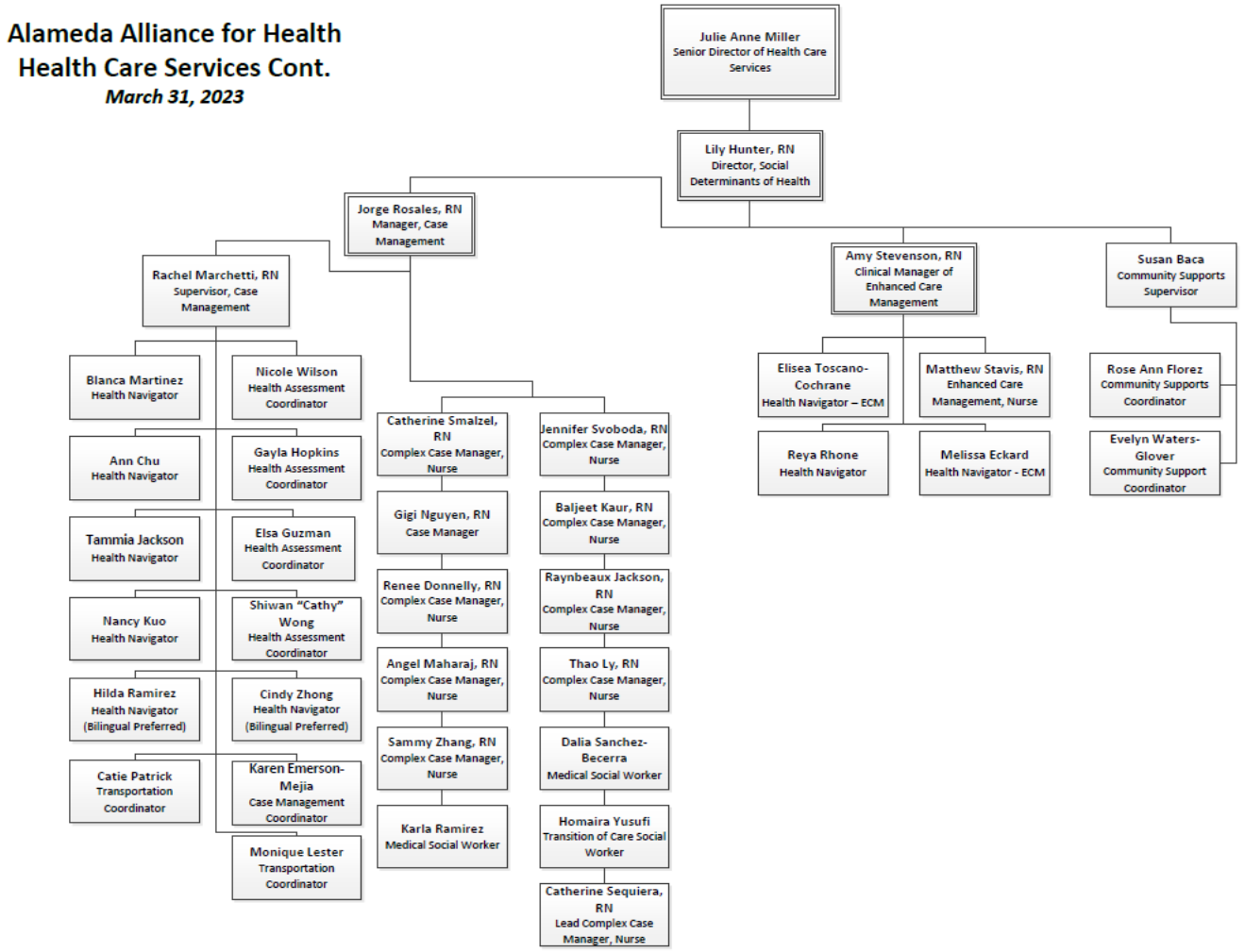
*** See Clinical Services Chart
** See Regulatory Readiness
* See Quality

Utilization Management

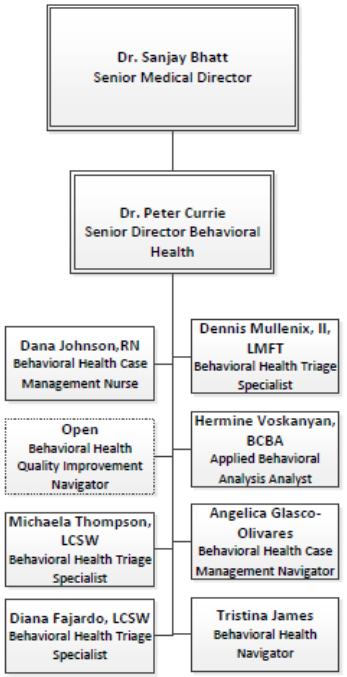


Case Management



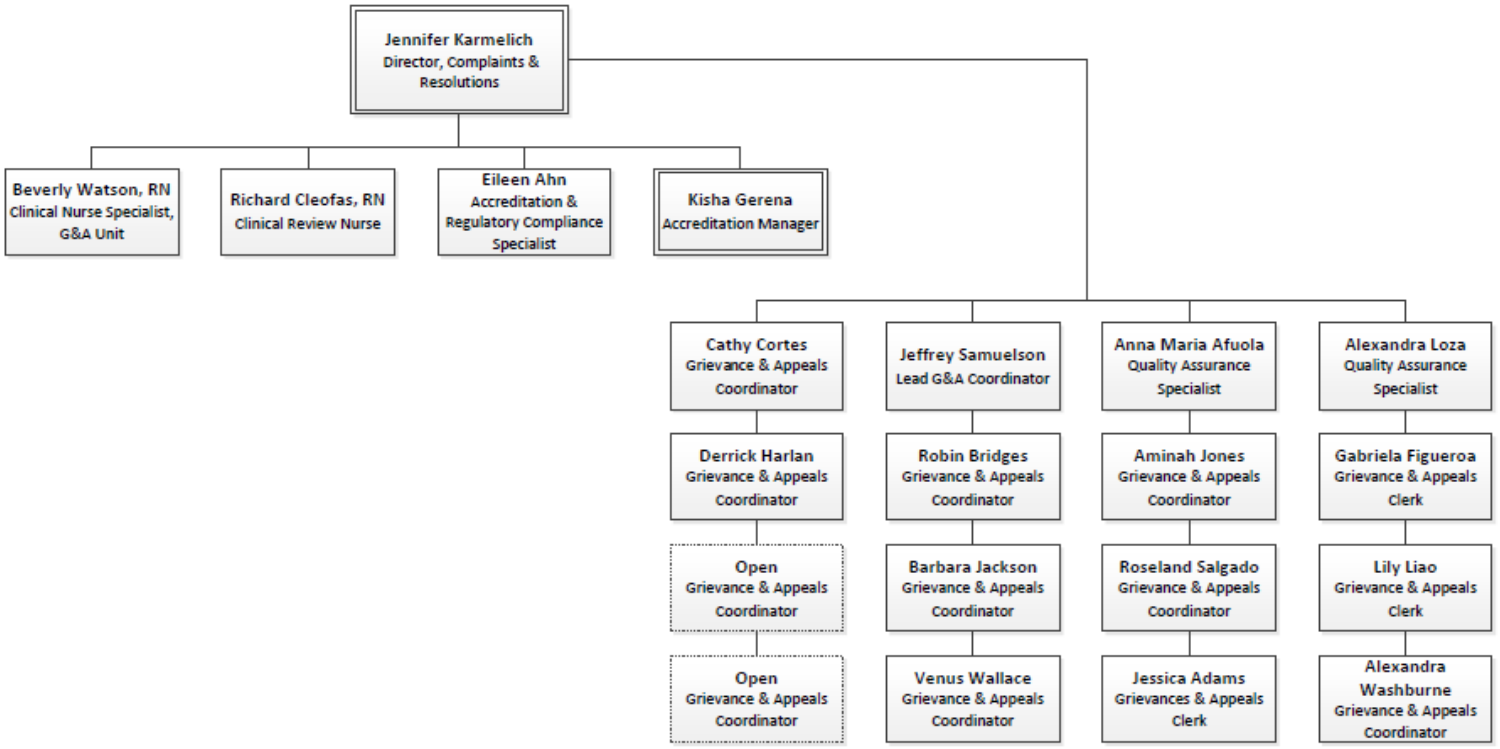
Behavioral Health

Alameda Alliance for Health
Behavioral Health
March 31, 2023

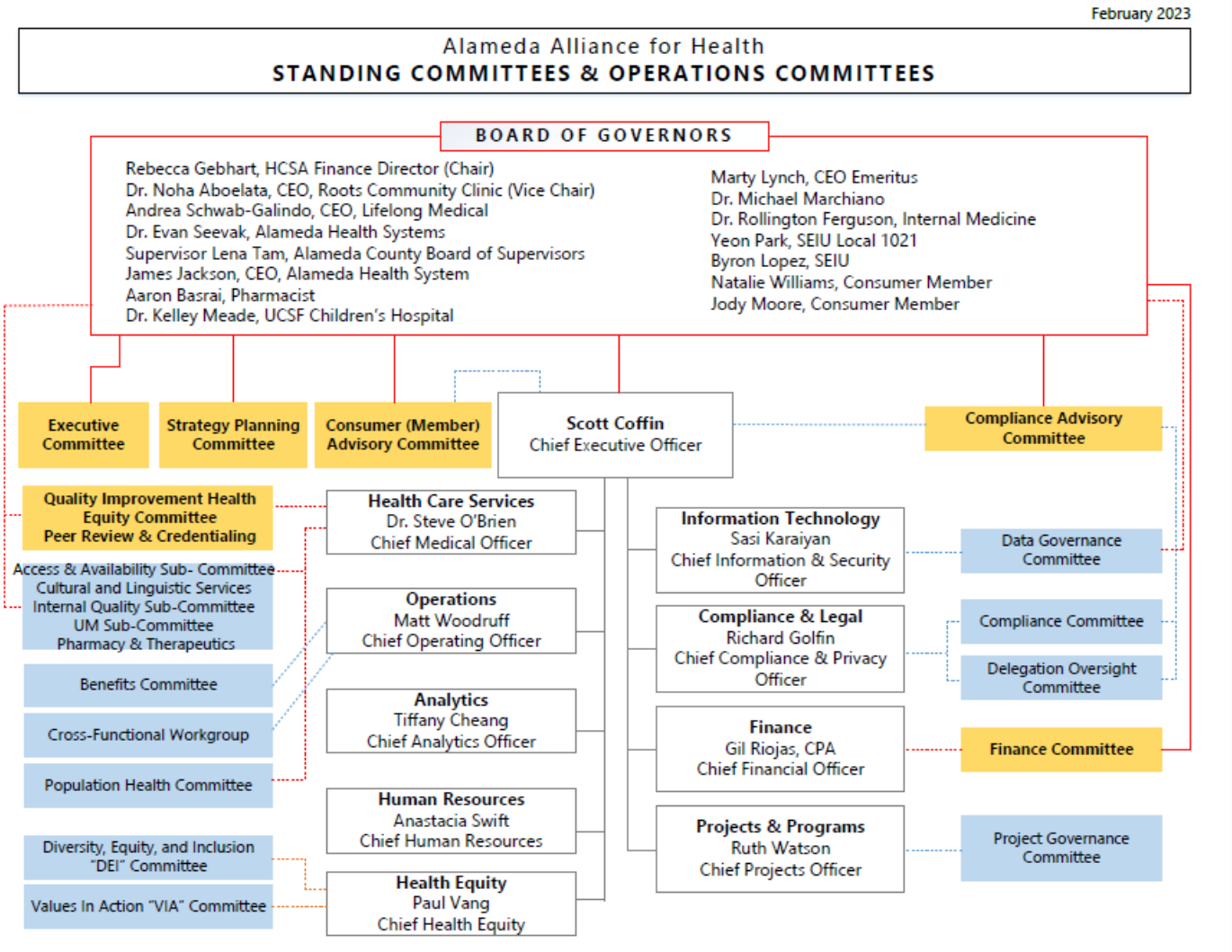


Regulatory Readiness

Alameda Alliance for Health
Regulatory Readiness
March 31, 2023



APPENDIX B: Alameda Alliance Committees



ALAMEDA ALLIANCE FOR HEALTH

2022 Population Health Management (PHM) Evaluation

Applicable to Group Care and Medi-Cal Lines of Business

Presented to the Health Care Quality Committee on 5/19/2023

Introduction

Alameda Alliance for Health (the Alliance) conducts an annual comprehensive analysis of the impact of its Population Health Management (PHM) Strategy. The PHM Evaluation includes quantitative results for relevant clinical, cost, utilization, and experience measures. Quantitative and qualitative analysis is conducted on the results for evidence of program effectiveness and continuous improvement. This analysis is conducted by the Health Care Services Department to support Alliance members and promote an effective PHM Strategy.

The Alliance uses the results of the PHM Evaluation as well as the PHM Assessment to review and update PHM programs, services, activities, and resources such as staffing ratios, clinical qualifications, job training, external resource needs and contacts and cultural competency in order to meet member needs. The Alliance Quality Improvement and Case Management Program Descriptions also describe the process used to update PHM programs, activities, and resources.

All programs and this document are applicable to both lines of business, Group Care and Medi-Cal, unless otherwise indicated.

2022 PHM Strategy Goals and Results

Managing Multiple Chronic Illnesses

All goals were updated to clarify how to measure the results. Complex Case Management (CCM) met its goals while Transitions of Care (TOC) and Enhanced Care Management (ECM) did not. Outcome evaluation methods are still being developed to report on the impact of these programs more accurately. Engagement with nurse case managers led to successful outcomes for CCM. Training for Alliance TCS staff and enhanced oversight of ECM providers were identified as opportunities for improvement.

Complex Case Management (Medi-Cal and Group Care)

Goal 1: Increase primary care adherence, by 1% in the FY 21/22 for members engaged in Complex Case Management. This will be measured by confirming an annual visit to PCP based off claims data.

Revised Goal 1: Increase the proportion of CCM-enrolled members who had a PCP visit by 1 percentage point from 2021 to 2022. Members were enrolled in CCM between January and June 2022 and continuously enrolled in the Alliance (11 out of 12 months) for both years.

- **Outcome:** Increased by 5.3 percentage points
- **Source**: Alliance data on enrollment and claims & encounters
- **Met Goal (Y/N):** Yes

Goal 2: Decrease readmission/utilization by 1% in FY 21/22 for members engaged in Complex Case Management. This will be measured by comparing 6-month readmission and utilization data of a member before and after engagement in Complex Case Management.

Revised Goal 2: Decrease all-cause readmission rate by 1 percentage point from 6 months before to 6 months after CCM enrollment. Members were enrolled in CCM between January

and June 2022 and continuously enrolled in the Alliance (11 out of 12 months) during the measurement timeframe.

- **Outcome:** Decreased by 5.9 percentage points
- **Source**: Alliance data on enrollment and claims & encounters
- **Met Goal (Y/N):** Yes

Goal 3: Increase member disease self-management by 1% in FY 21/22 for members engaged in Complex Case Management.

Revised Goal 3: Increase the number of outpatient visits by 1% from 6 months before to 6 months after CCM enrollment. Members were enrolled in CCM between January and June 2022 and continuously enrolled in the Alliance (11 out of 12 months) during the measurement timeframe.

- **Outcome:** Increased by 14.5%
- **Source**: Alliance data on enrollment and claims & encounters
- **Met Goal (Y/N):** Yes

- **Facilitators:** CCM nurses teach members about the health care system and disease processes. Nurses successfully developed trusted relationships with members and were able to support PCP and outpatient engagement and appropriate use of hospital services.
- **Barriers:** No barriers were identified to assist with meeting this goal.

Transitions of Care (TOC) (Medi-Cal and Group Care)

Goal: Decrease readmissions by 1% in FY 21/22 for members engaged in TOC.

Revised Goal: Decrease all-cause readmission rate by 1 percentage point from 6 months before to 6 months after TOC enrollment. Members were enrolled in TOC between January and June 2022 and continuously enrolled in the Alliance (11 out of 12 months) during the measurement timeframe.

- **Outcome:** Increased by 6.0 percentage points
- **Source**: Alliance data on enrollment and claims & encounters
- **Met Goal (Y/N):** No
- **Facilitators:** Basic training provided to all staff in how to assist TOC members.
- **Barriers:** CM staff interventions differ between various disciplines (Health Navigators vs. Social Workers vs. RNs). There is a need for structured training to make TOC interventions more consistent across disciplines.

Enhanced Care Management (Medi-Cal)

Goal 1: Increase primary care adherence, by 1% in the FY 21/22 for members engaged in Enhanced Care Management (ECM). This will be measured by confirming an annual visit to PCP based off claims data.

Revised Goal 1: Increase the proportion of ECM-enrolled members who had a PCP visit by 1 percentage point from 2021 to 2022. Members were enrolled in ECM between January and June 2022 and continuously enrolled in the Alliance (11 out of 12 months) for both years.

- **Outcome:** Decreased by 6.3 percentage points
- **Source**: Alliance data on enrollment and claims & encounters
- **Met Goal (Y/N):** No

Goal 2: Decrease readmission/utilization, by 1% in the FY 21/22 for members engaged in Enhanced Care Management. This will be measured by comparing 6-month readmission and utilization data of a member before and after engagement in Enhanced Care Management.

Revised Goal 2: Decrease all-cause readmission rate by 1 percentage point from 6 months before to 6 months after ECM enrollment. Members were enrolled in ECM between January and June 2022 and continuously enrolled in the Alliance (11 out of 12 months) during the measurement timeframe.

- **Outcome:** Increased by 3.3 percentage points
- **Source**: Alliance data on enrollment and claims & encounters
- **Met Goal (Y/N):** No

Goal 3: Increase member disease self-management and appropriate linkage to medical home/social services/community partners/housing, by 1% in the FY 21/22 for members engaged in Enhanced Case Management. This can be measured by observing an increase in member appointments and referrals 6 months before and after engagement in ECM program.

Revised Goal 3: Increase the number of outpatient visits by 1% from 6 months before to 6 months after ECM enrollment. Members were enrolled in ECM between January and June 2022 and continuously enrolled in the Alliance (11 out of 12 months) during the measurement timeframe.

- **Outcome:** Decreased by 4.4%
- **Source**: Alliance data on enrollment and claims & encounters
- **Met Goal (Y/N):** No

- **Facilitators:** Quality and diversity of ECM network providers.
- **Barriers:** This is a vulnerable population, which could contribute to higher hospitalization and variations in outpatient visits. In addition, there are a variety of ECM providers who understand the basic requirements but may execute member interventions differently. There is an opportunity to increase monitoring of program implementation to improve consistency.

Managing Members with Emerging Risk

Many of the goals in this focus area were Disease Management objectives to increase participation through outreach mailing campaigns (pediatric asthma, adult asthma, and adult diabetes), which were not launched in 2022 because of delays in obtaining California Department of Health Care Services (DHCS) approval of the outreach letters. The Alliance Complex Case Management team made referrals for diabetes disease management health coaching. Alliance Health Education continued community

partnerships and shared information through available channels such as wellness request mailings, member newsletter, and quarterly provider packets. There was also an outreach call project to Black (African American) members with asthma that ended early 2022, reaching a small number of members but with positive results.

Pediatric Asthma Disease Management (Medi-Cal)

Goal: The number of Alliance members ages 0 – 18 with asthma whose parents engage with the Alliance regarding self-management of their child's asthma will increase by 20% from 136 in 2021 to 162 in 2023.

- **Outcome:** 67 members participated in Asthma Start (Alameda County's in-home case management program for pediatric asthma) in 2022
- **Source**: Asthma remediation claims
- **Met Goal (Y/N):** In progress
- **Facilitators:** The weekly ER report from the local children's hospital was reinstated in the third quarter of 2022, increasing referrals from the Alliance to Asthma Start. The Alliance also educated providers about asthma remediation services through presentations and a handout.
- **Barriers:** The local children's hospital data was not available for most of the year, meaning fewer timely referrals. An increase in referrals was anticipated with an outreach mailing campaign to children with asthma, but this was delayed by pending DHCS approval of campaign materials. Asthma Start became a part of Community Supports-Asthma Remediation, which changed the criteria for engagement and added an authorization step. This may be a temporary barrier as providers and Asthma Start adjust to the new processes.

Adult Asthma (Equity focus, Medi-Cal and Group Care)

Goal: To improve asthma self-management for approximately 200 or more Black (African American) adults ages 21-44. 63.6% or more of the target population have an AMR rate of 0.5 or higher AND Asthma-related ED visits are decreased by 50% or more.

- **Outcome:** AMR for Black (African American) adults ages 21-44 was 65.03% for MY2022 as of February 3, 2023. Data was not available on asthma-related ED visits.
- **Source**: HEDIS Dashboard
- **Met Goal (Y/N):** Yes for AMR
- **Facilitators:** A total of 18 members completed an asthma survey and interventions. AMR improved based on available data after the calls for most of these members. This quality improvement project was supported by consultants through the Asthma Affinity Group. The project was a multi-departmental collaboration that benefited from the expertise of Pharmacy, Case Management, Quality, and Health Education staff.
- **Barriers:** There were a total of 62 members that were called. Barriers included accurate member contact information and staffing time for PCP appointment scheduling, identifying phone numbers, asthma education, survey completion, and referrals to appropriate departments. Data and results were also not easy to access.

Adult Asthma Disease Management (Medi-Cal and Group Care)

Goal: The number of Alliance members with asthma who engage with the Alliance regarding self-management of their asthma will increase by 20% from 61 members in 2021 to 73 members in 2023.

- **Outcome:** 46 members received asthma education materials in 2022
- **Source**: Health Education materials distribution report
- **Met Goal (Y/N):** In progress
- **Facilitators:** Continued promotion of asthma self-management resources through the Alliance Wellness Program & Materials Request Form in the Member Newsletter and the Alliance website.
- **Barriers:** The planned outreach mailing campaign to adults with asthma was delayed by pending DHCS approval.

Adult Diabetes Disease Management (Medi-Cal and Group Care)

Goal: The number of Alliance members with diabetes who engage with the Alliance regarding self-management of their diabetes will increase by 20% from 180 members in 2021 to 216 members in 2023.

- **Outcome:** 118 members engaged with the Alliance programs in 2022; 9 in Alliance Disease Management health coaching and 109 in contracted hospital Diabetes Self-Management Education and Support (DSMES) programs
- **Source**: Health Education program participation records
- **Met Goal (Y/N):** In progress
- **Facilitators:** Health Education developed a new process for Case Management to refer members they are working with to diabetes health coaching and/or assistance in enrolling in Alliance-paid DSMES programs. Members continued to participate in DSMES through provider and self-referrals and can receive information and assistance through the Alliance.
- **Barriers:** A planned outreach mailing campaign to adults with diabetes has not been approved to start. Case Management referrals depended on staffing buy-in to refer to health coaching. Staffing changes may have limited the number of referrals.

Pediatric Obesity (Medi-Cal)

Goal: Connect 100 pediatric members 50% Hispanic (Latino) with healthy weight resources between January 1, 2022 and June 30, 2023.

- **Outcome:** As of November 2022, 39 members received nutrition education from La Clinica (36 Hispanic). In addition, 10 members requested healthy eating, exercise, and weight materials for themselves and/or child in 2022 (3 Hispanic). In total, 49 members received healthy weight resources, 80% of which were Hispanic.
- **Source**: Health Education program participation records, Health Education materials distribution records
- **Met Goal (Y/N):** In progress
- **Facilitators:** The Alliance continued a partnership with La Clinica to support nutrition education provided by health educators via telehealth. Health Education added an

option for members to choose child healthy eating, exercise, and weight on the wellness request form.

- **Barriers:** La Clinica provided nutrition education mostly to adults and did not have nutrition programming at schools during the pandemic. There were few requests from members and providers for health education materials on child healthy weight. The Alliance had been working on launching Kurbo by WW, but the program was discontinued before launch in 2022.

Smoking Cessation (Medi-Cal and Group Care)

Goal: Increase rate of CAHPS adult tobacco users who were advised to quit from the 2021 rate of 75.6% to 78.0% and discussed medications with their doctor from the 2021 rate of 48.8% to 51.5% by December 31, 2022.

- **Outcome:** Data not yet available for MY2022. In MY2021 the advising to quit rate was 71.1% for Medi-Cal and 77.8% for Group Care and the discussing medications rate was 50.0% for Medi-Cal and 48.6% for Group Care. These are calculated on a rolling average over a period of two years.
- **Source**: MY 2021 SPH CAHPS Survey Results, Medicaid (p.34) and Commercial (p. 36)
- **Met Goal (Y/N):** Pending
- **Facilitators:** The Alliance distributed information on tobacco treatment resources in the Q1 2022 provider packet. One resource promoted was a new flyer about FDA-approved tobacco treatment medications. Health Education also published a member newsletter article about smoking cessation.
- **Barriers:** The denominators for CAHPS tobacco questions are under 100, the minimum sample for NCQA. Some challenges for a positive response on the questions are that patients might not be interested in discussing tobacco use or providers might not have time. Other priorities during the pandemic might have also limited the time providers devoted to tobacco cessation conversations.

Keeping Members Healthy

Quality Improvement successfully partnered with clinics on projects that involved the clinic staff conducting outreach from gap in care lists, ordering the screening or scheduling the visit, and providing a gift card upon completion. However, the rates in these equity-focused or general goals that had been created using the previous year's data were not met.

Health Education continues to make materials and program information available to members upon request and online, in addition to conducting mailing campaigns to specific populations, such as prenatal and postpartum members. The number of member requests for health education is small compared to the total membership who receive a wellness request form, but people may be accessing online resources.

Colon Cancer Screening (Equity focus, Medi-Cal and Group Care)

Goal: Close the disparity gap for Black (African American) males, ages of 50-75, who have not received a colon cancer screening or colonoscopy exam during 2021 that are patients at West Oakland Health Center. Improve the health of our patients by increasing the percentage of colorectal cancer screening completed for eligible patients by 3% moving from the MY2021 rate of 31.97% to 37.10% in MY 2022.

Revised Goal: Close the disparity gap for Black (African American) males, ages of 45-75, who have not received a colon cancer screening or colonoscopy exam during 2021 that are patients at West Oakland Health Center. West Oakland Health Council (a clinic under West Oakland Health Center) will improve colorectal cancer screening rates for members 45-75 years from MY2021 31.97% to 37.10% in MY2022.

- **Outcome:** West Oakland Health Council exceeded the goal of 37.10% by improving MY2022 rates to 37.66% for members ages 45-75. However, the rate for African American males was lower compared to the overall population at 35.95%.
- **Source**: HEDIS Dashboard
- **Met Goal (Y/N):** Yes for overall members; No for African American males
- **Facilitators:** The Alliance collaborated with West Oakland on clinic outreach and member incentives for completing an in-home screening.
- **Barriers:** Members may be reluctant to complete screening, afraid of the results, or think that it doesn't impact them. Returning the sample to the lab on time is also a key barrier; if the sample is not received within 48 hours, it is not a valid sample for testing.

Cervical Cancer Screening (Medi-Cal and Group Care)

Goal: By December 31, 2022, increase the cervical cancer screening rates of female members 23-35 years old from 50% to 55%.

- **Outcome:** The preliminary administrative CCS rate for ages 23 to 35 for MY2022 is 41.94% (Medi-Cal) as of February 3, 2023. Final rate will be determined after chart review.
- **Source**: HEDIS Dashboard
- **Met Goal (Y/N):** No based on administrative rates, pending final rates.

- **Facilitators:** The Alliance partnered with Bay Area Community Health (BACH), a high-volume, lower performing provider, to conduct Saturday clinics in combination with member outreach and incentive. 100 members completed a screening and received a gift card.
- **Barriers:** Barriers included no-shows to scheduled appointments and members not picking up phone calls during outreach. Some members did not have updated phone numbers for outreach or were no longer at the clinic as a patient.

Breast Cancer Screening (Equity focus, Medi-Cal and Group Care)

Goal: By December 31, 2022, use key driver diagram interventions to increase the percentage of breast cancer screenings among African American women between the ages of 52 and 74, from 46.76% to 53.76%.

- **Outcome:** 48.22% (Medi-Cal)
- **Source**: HEDIS Dashboard
- **Met Goal (Y/N):** No
- **Facilitators:** In partnership with LifeLong, a high-volume, low-performing provider, the Alliance conducted a texting campaign with member incentive. Through this program 79 African American members ages 52 to 74 completed a screening. Word of mouth helped promote the incentive among members.
- **Barriers:** Provider assignment was an issue since many members assigned to LifeLong were being seen elsewhere, including Kaiser. There was also a high no-show rate.

Well-Child Exams (EPSDT, Medi-Cal)

Goal: By December 31, 2022, increase the overall WCV admin rate from MY 2021 to MY 2022 for two to-be-determined providers as part of the Priority PIP.

Revised Goal:

Provider 1: By December 31, 2022, use key driver diagram interventions to increase the percentage of WCV 3-21 visit rate for Dr. Rhodora DeLa Cruz from 40.94% to 45%, as part of the Priority PIP.

Provider 2: Children's First Medical Group (CFMG) will improve the Well Child Visit screening rates for children's ages 3-21 from MY2021 57.98% to 60.00% in MY 2022.

- **Outcome:** Preliminary administrative rates for MY2022 were 44.40% for Provider 1 and 52.07% for Provider 2 as of February 3, 2023
- **Source**: HEDIS Dashboard
- **Met Goal (Y/N):** No
- **Facilitators:**
    - Provider 1: In partnership with Dr. DeLa Cruz, the Alliance conducted birthday card outreach and incentives for children 3-21 years. The Alliance mailed out birthday cards for members with birthdays from April-December 2022, and Dr. DeLa Cruz conducted outreach calls. 70 members completed a well visit.

    - Provider 2: For the HEDIS Crunch Project, the Alliance partnered with 18 providers from the CFMG network to conduct outreach and incentive. Providers conducted outreach via phone/text and provided members with gift card at the completion of well visit. 1,242 members received an incentive for completing a well visit.
- **Barriers:**
    - Provider 1: Many members assigned to Dr. DeLa Cruz are being seen elsewhere, including Kaiser. Some members also have other primary insurance. Wrong phone numbers and no-show rates were additional challenges.
    - Provider 2: The project was aligned with back to school and as a result started August and continued through December 2022. Provider indicated that a longer timeframe for outreach would be helpful. Another barrier noted was that the timeframe of the project intersected with fall/winter holidays. Incorrect phone numbers and difficulty reaching members was also a challenge.

Pregnancy (Medi-Cal and Group Care)

Goal: Distribute pregnancy and baby care resources and referrals to 100% of all identified pregnant and postpartum members.

- **Outcome:** 100%
- **Source**: Health Education mailing campaigns report
- **Met Goal (Y/N):** Yes
- **Facilitators:** Health Education has a process in place to identify pregnant and postpartum members and mail them a packet with resources. For 2022, there were 4,028 prenatal and 2,288 postpartum mailings completed.
- **Barriers:** None with mailing; accurate and timely identification of pregnant members through claims can be a challenge.

Health Education Materials and Programs (Medi-Cal and Group Care)

Goal: Make health education programs and information available to 100% of Alliance members in 2022.

- **Outcome:** 100%
- **Source**: Health Education materials assessment
- **Met Goal (Y/N):** Yes
- **Facilitators:** Health Education sends a wellness request form to all members through the member newsletter. This form and other materials are available on the Alliance website for members and providers. Members can also call in to request health education information. In 2022, 304 members received health education programs and information through mail.
- **Barriers:** Some members may still be unaware of health education resources if they do not read or receive the newsletter or visit the Alliance website.

Patient safety or outcomes across settings

The Alliance was able to mail out materials to identified members and providers with high-risk members, educating them on safety, treatment for opioid use disorder, and appropriate use of opioids. There were challenges with provider education to implement the substance use disorder (SUD) Escalation Process and referrals to Alliance Case Management, but these projects brought multiple Alliance departments together to discuss the needs of these members. Providers also indicated that mail was not their preferred method of receiving education.

Substance Use Disorder (Medi-Cal and Group Care)

Goal 1: Between 1/1/22 and 12/31/22, educate 100% of chronic opioid users on health habits, management of chronic pain, and alternative therapy and care (on between 120MME and 300 MME (morphine milligram equivalents) daily).

- **Outcome:** 100%
- **Source**: Communications & Outreach mailing report
- **Met Goal (Y/N):** Yes
- **Facilitators:** The annual mailing was completed with 30 chronic opioid users who did not have cancer, sickle cell anemia, or hospice/palliative in April 2022.
- **Barriers:** The Alliance decided to do one mailing per year due to staffing capacity, limiting the number of opioid users reached.

Goal 2: By 12/31/22, educate 100% of opioid users at risk of becoming chronic users (i.e., 90 to 120 MME/day).

- **Outcome:** 100%
- **Source**: Communications & Outreach mailing report
- **Met Goal (Y/N):** Yes
- **Facilitators:** The annual mailing was completed with 17 rising risk opioid users who did not have cancer, sickle cell anemia, or hospice/palliative in April 2022.
- **Barriers:** The Alliance decided to do one mailing per year due to staffing capacity, limiting the number of opioid users reached.

Goal 3: Refer 100% of member on greater than 300 MME/day to the Alliance Case Management program.

- **Outcome:** 0%
- **Source**: Internal discussions
- **Met Goal (Y/N):** No
- **Facilitators:** None
- **Barriers:** With a limited pain provider network, it is hard to provide appropriate care for these members. Health Care Services realized that these cases are beyond Case Management and require interdisciplinary support. Case Management also had other competing priorities with CalAIM.

Goal 4: Between 1/1/22 and 12/31/22, educate 100% of the providers who are assigned members that utilize high dose opioids (>300MME) and who are presenting to the Emergency Department with opioid and / or benzodiazepine overdose.

- **Outcome:** 100%
- **Source**: Communications & Outreach mailing report
- **Met Goal (Y/N):** Yes
- **Facilitators:** The annual mailing was completed with 24 providers in October 2022.
- **Barriers:** Providers received the mailed materials but reported that they did not have a chance to review them. With this feedback, the Alliance will switch to email, fax, and ad hoc town hall.

Goal 5: Between 1/1/22 and 12/31/22, ensure that 100% of members (>300MME) and providers (of members on >300MME) with ongoing use of opioids follow the SUD Escalation Process.

- **Outcome:** 0% of 25 unique members with greater than 300 ME, 10 of which do not have cancer, hospice/palliative, or sickle cell anemia
- **Source**: Internal discussions
- **Met Goal (Y/N):** No
- **Facilitators:** The team developed a tracking log for member outcomes and provider mailings to implement the escalation process in Q4 2022.
- **Barriers:** Developing the tracking log was delayed due to limited Communications & Outreach capacity and Alliance staffing transitions. Providers also gave feedback that mailing was not the most effective method of receiving education. The Alliance will discuss next steps for provider education and the escalation process.

PHM Overall Strategy Effectiveness

On review of the 2022 Population Health Strategy outcomes, the Alliance notes continued strong foundational elements, building successes, and opportunities for continuous improvement.

Significant successes of the PHM Program included member and provider engagement through Case Management, Health Education, Quality Improvement, and Pharmacy programs and projects. Clinic and community partnerships supported more members in receiving preventive care and education. Challenges included delayed implementation of Disease Management and opioid use programs as well as barriers to member outreach across Quality Improvement projects.

Opportunities for Improvement

On review of the evaluation results, opportunities include:

- Improve data collection and monitoring and evaluation of outcomes.
- Increased monitoring of ECM providers and training for TCS staff.
- Develop and launch Disease Management programs with coordinated organizational support and integration of risk stratification and segmentation.
- Expand Quality Improvement projects with more innovative provider and public health collaborations.
- Align with state-level health equity goals and regulatory requirements.

Actions Based on Opportunities

Actions based on opportunities are listed below:

1. Complex Case Management (CCM), Transitional Care Services (TCS), and Enhanced Care Management (ECM) – The Alliance will develop evaluative studies to compare outcomes across groups, including a control group to understand the impact of various programs. The Alliance began expansion of the members receiving TCS and will continue to expand to include all Alliance members experiencing a transition by 2024. As the program expands, the Alliance will enhance training to improve consistency in program implementation. In 2023 and 2024, ECM will expand to new populations including at-risk children & youth and pregnant or postpartum members. The Alliance will dedicate ECM staffing and resources to improve monitoring and oversight of program implementation.
2. Disease Management – The Alliance will continue to develop and improve processes for asthma and diabetes disease management programs. Disease management is planned to expand to members with cardiovascular disease and depression in 2023.
3. Quality Improvement – The Alliance will continue to work closely with clinics and community groups and explore strategies such as text messaging, community health workers, member education videos, provider webinars, and adapting best practices or successes from other clinics. One best practice that the Alliance has already begun to implement is the use of mobile mammography. Quality Improvement will also address identified health disparities in quality measures.

ALAMEDA ALLIANCE FOR HEALTH

2023 Population Health Management (PHM) Strategy

For Medi-Cal and Group Care lines of business

Presented to the Health Care Quality Committee 5/19/2023

Overview

Alameda Alliance for Health (Alliance) is a local, public, not-for-profit managed care health plan committed to improving the health and well-being of our members by collaborating with our provider and community partners to deliver high quality and accessible services. Our vision is that all residents of Alameda County will achieve optimal health and well-being at every stage of life.

The Alliance has two lines of business, Medi-Cal and Group Care. Medi-Cal is California's Medicaid program for children and adults who meet income guidelines. Alliance Group Care is an employer sponsored plan that provides low-cost comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County.

The Alliance Population Health Management (PHM) Strategy identifies and addresses member needs across the continuum of care and ensures access to a comprehensive set of services with the aim of improving health and supporting enhanced quality of life. This continuum includes intensive case management support for members with the highest level of need, programs for those with emerging risk, and basic population health management for all members. The Alliance PHM Strategy aligns with the NCQA 2023 Population Health Program Standards and Guidelines and the California Department of Health Care Services (DHCS) Population Health Management Policy Guide. The PHM Strategy is updated yearly based on an annual population assessment and outcomes from the previous year.

The PHM Strategy identifies program goals and target populations and describes programs or services offered to members, activities that are not direct member interventions, how member programs are coordinated, and how members are informed about available programs.

The PHM Strategy is used to:

- Better understand the needs, social determinants of health, and risk level of our members.
- Address and reduce identified health inequities.
- Improve case management programs including Complex Case Management (CCM), Enhanced Care Management (ECM), Community Supports (CS), and Transitional Care Services (TCS).
- Inform quality improvement projects.
- Influence interventions that target member safety and outcomes across settings.
- Develop basic population health management activities to ensure care coordination and promote self-management of conditions and preventive care.
- Guide development of health education, disease management, and wellness and prevention programs and materials.

Health Equity

The Alliance is deeply committed to advancing health equity among its diverse membership. A Chief Health Equity Officer newly joined the Alliance in 2023 and has outlined four key priority focus areas for the organization: 1) enhance diversity, equity, inclusion, and belonging among Alliance staff, 2) develop a systems-based approach to leverage physical and psychosocial data to analyze and understand and address avoidable and unjust differences in health status and well-being among historically marginalized and underserved populations, including through addressing social determinants of health (SDOH); 3) ensure members have equal access to culturally and linguistically responsive services; and 4) employ value contracting strategies to ensure equal opportunities for women and minority owned businesses to do business with the Alliance.

This Strategy assesses member health needs that differ based on subpopulations such as children and adolescents and racial and ethnic groups. When these differences are avoidable and therefore unjust or unfair, we strategize activities to help close those gaps. In 2023 the Alliance identified two disparities that we will address with an equity lens, breast cancer screening rates for Black (African American) women and well-child visits for Black (African American) children ages 0-30 months. These health equity initiatives are discussed in detail in the program goals section.

Evaluation

The Alliance conducts an annual impact evaluation of its PHM strategy that includes quantitative and qualitative analysis for evidence of program effectiveness and identifies opportunities for improvement. The PHM Strategy yearly evaluation is available in a separate document, the *2022 Population Health Management Evaluation*.

Data integration

Data integration is a key component of the PHM program. The Alliance uses the below data sources for population health management functions, including but not limited to:

- Membership reports identify Medi-Cal and Group Care members by age, aid code (including Seniors and Persons with Disabilities), language, gender, race and ethnicity, and geographic location.
- Medical, behavioral health, and pharmacy claims and encounters are used to calculate HEDIS and utilization rates, identify members for case management programs, and determine risk stratification and segmentation tiers.
- Laboratory results are received from Foundation, Kaiser, Quest, and Novius and used to calculate HEDIS rates and to identify members for case management programs.
- Health appraisal forms including the HIF-MET (Health Information Form/Member Evaluation Tool) and HRA (Health Risk Assessment) survey results are used to inform

providers of member needs, connect members to community resources, and refer members into Alliance case management programs as indicated.

- Electronic health records from Alameda Health System (AHS), Community Health Center Network (CHCN), and Kaiser are used to determine HEDIS rates.
- HEDIS data combines multiple data sources to measure and identify areas of improvement for preventive health, behavioral health, and chronic disease management.
- Alliance data on utilization of case management, disease management, and health education programs are reviewed to coordinate care and avoid duplication of services.
- Advanced data sources include the CAIR registry, Alameda County Behavioral Health Care Services (BHCS), Homeless Management Information System (HMIS) of the Alameda County Health Care Services Agency, and Fee-for-Service Medi-Cal data provided by DHCS.

Many of the data sources are imported into the CareAnalyzer health analytics platform. CareAnalyzer combines elements of patient-level and group-level risk, care opportunities and provider performance to provide insight into Alameda Alliance's member population. In addition, it utilizes the industry-leading predictive modeling capabilities and analytics of The Johns Hopkins ACG System. CareAnalyzer data is viewed in their online reporting user interface as well as exported and integrated into other analyses.

The Alliance uses Microsoft Power BI to build dashboards for population health, HEDIS, risk stratification, and program and utilization management. The dashboards are interactive and allow for analysis by member demographic groups, conditions, and utilization.

Population Assessment

Data Sources

The Alliance annually assesses the characteristics and needs, including social determinants of health, for our member population. Data sources used to identify members and priorities for supporting their care needs were:

- Alameda County Behavioral Health utilization data
- Alliance Enhanced Care Management (ECM) enrollment data
- Alliance homeless member indicators
- Alliance medical and pharmacy claims and encounters
- CareAnalyzer
- Cotiviti HEDIS software
- DHCS managed care health plan specific health disparities data
- DHCS monthly eligibility files
- Group Care enrollment files

Methodology and results from these data sources are found in the document "2023 NCQA PHM Assessment Methods and Data."

Social Determinants of Health

Social determinants of health (SDOH) are of great importance to the populations served by the Alliance. The SDOH characteristics included in this report were homelessness and language.

Members were categorized as "housed" or "unhoused" through several indicators for potential homelessness, including diagnosis codes, Homeless Management Information System (HMIS) data, and member home addresses that indicate social services agencies or programs. This is different than the U.S. Department of Housing and Urban Development definition of homelessness that is used for programs such as ECM but helps indicate who may have experienced housing instability at some time during the year. In 2022, 5.4% of Medi-Cal members (15,151 members) and 0.9% of Group Care members (45 members) had one or more homelessness indicators.

Limited English proficiency was both a subpopulation and an SDOH characteristic. Members who preferred a language other than English were analyzed as having limited English proficiency. In 2022, 35.1% of Medi-Cal members (98,408 members) and 37.3% of Group Care members (1,814 members) preferred a language other than English. Over a third of the Alliance membership may need interpreters, translation services, and/or bilingual staff to access health care.

Membership

Medi-Cal Membership

There were 280,547 members enrolled in Medi-Cal for at least 11 months during 2022 and eligible in December 2022. Their characteristics are listed below.

Medi-Cal Member Demographics Table

MEDI-CAL	Count	Percent
GENDER		
Female	149,748	53.4%
Male	130,799	46.6%
AGE BAND		
0-2	7,472	2.7%
3-6	19,725	7.0%
7-11	26,372	9.4%
12-20	48,766	17.4%
21-44	92,343	32.9%
45-64	55,163	19.7%
65+	30,706	10.9%
COUNTY REGION		
North	135,102	48.2%
Central	82,494	29.4%
South	43,274	15.4%
East	18,127	6.5%
Other	1,550	0.6%
PRIMARY RACE/ETHNICITY		
Hispanic (Latino)	77,936	27.8%
Other	68,344	24.4%
Black (African American)	42,592	15.2%
Chinese	28,026	10.0%
White	24,215	8.6%
Other Asian	13,063	4.7%
Vietnamese	10,496	3.7%
Filipino	7,912	2.8%
Pacific Islander	5,935	2.1%
Unknown	1,447	0.5%
American Indian or Alaskan Native	581	0.2%
PRIMARY LANGUAGE		
English	175,631	62.6%
Spanish	56,791	20.2%
Chinese	25,475	9.1%
Vietnamese	8,242	2.9%
Unknown	6,508	2.3%
Other Non-English	3,787	1.3%
Arabic	2,332	0.8%

Tagalog	1,781	0.6%
HOMELESSNESS		
Housed	265,396	94.6%
Unhoused	15,151	5.4%

Group Care Membership

There were 4,864 members enrolled in Group Care for at least 11 months during 2022 and eligible in December 2022. Their characteristics are listed below.

Group Care Demographics Table

GROUP CARE	Count	Percent
GENDER		
Female	3,505	72.1%
Male	1,359	27.9%
AGE BAND		
Under 21	2	0.0%
21-44	1,168	24.0%
45-64	2,777	57.1%
65-79	882	18.1%
80+	35	0.7%
COUNTY REGION		
North	2,022	41.6%
Central	1,295	26.6%
South	901	18.5%
Other	425	8.7%
East	221	4.5%
PRIMARY RACE/ETHNICITY		
Other Asian	1,413	29.1%
Unknown	1,341	27.6%
Chinese	664	13.7%
Black (African American)	527	10.8%
Other	381	7.8%
Hispanic (Latino)	174	3.6%
Vietnamese	156	3.2%
White	93	1.9%
Filipino	56	1.2%
Pacific Islander	54	1.1%
American Indian or Alaskan Native	5	0.1%
PRIMARY LANGUAGE		
English	2,879	59.2%
Chinese	1,180	24.3%
Spanish	228	4.7%
Vietnamese	191	3.9%
Other Non-English	182	3.7%

Unknown	171	3.5%
Tagalog	24	0.5%
Arabic	9	0.2%
HOMELESSNESS		
Housed	4,819	99.1%
Unhoused	45	0.9%

Member Needs

The Alliance analyzed assessment data for all members and by subpopulation, which included the following for both lines of business except where noted. Subpopulations were selected to adhere to NCQA standards, align with the DHCS Bold Goals, and reflect the unique characteristics of Alameda County.

- Child and adolescent members (Medi-Cal only)
- Members with disabilities
- Members with serious and persistent mental illness (Medi-Cal only)
- Members of racial and ethnic groups
- Members with limited English proficiency
- Relevant subpopulations:
    - Pregnant or postpartum members
    - Members enrolled in ECM (Medi-Cal only)
    - Older adult members (Group Care only)

The member needs identified from the data are described in the proceeding sections by subpopulation.

All members

For the membership, the following needs were identified:

- *Homelessness:* As described in the previous section about SDOH characteristics, 15,151, or 5.4%, of Medi-Cal members had homelessness indicators.
- *Cancer screening:* In Group Care, breast cancer, cervical cancer, and colorectal cancer screening HEDIS measures were all below the 50th percentile for Commercial plans in MY2022. For Medi-Cal, breast cancer screening was also below the 50th percentile (minimum performance level, or MPL) in MY2021. Breast cancer screening in members ages 65 to 74 and multiple race/ethnic groups were below MPL in both MY2021 and MY2022.
- *No PCP visits:* About half (49.6%) of Medi-Cal members and a third (34.1%) of Group Care members had no PCP visit in 2022.

Child and adolescent members

There were 102,335 child and adolescent Medi-Cal members ages 0 to 20 in 2022 with the following needs identified:

- *Well-care visits*: Well-child visits in the first 15 months (W30-6) was below MPL overall and for multiple race/ethnic groups. Child and adolescent well-care visits (WCV) was below MPL for ages 18 to 21 with 26.06% of the age group getting well visits compared to the MPL of 45.31%.
- *Depression*: The prevalence of depression was 2.2% in children and adolescents, or 2,212 members. As a comparison, the prevalence in Medi-Cal adults was 6.2% and in Group Care adults 3.9%.

Members with disabilities

In Medi-Cal, there were 2,551 children and adolescents ages 0 to 20 and 24,016 adults ages 21+ in the SPD (seniors and people with disabilities) aid category. In Group Care, there were 672 members with disabilities defined by a selection of CareAnalyzer diagnosis codes. The following needs were identified:

- *Chronic disease:* Chronic disease prevalence of asthma, depression, diabetes, and hypertension were all higher in the various groups of members with disabilities listed above compared to overall members in the same age group. Diabetes (25.5% for Medi-Cal, 31.1% for Group Care) and hypertension (45.2% for Medi-Cal, 53.3% for Group Care) in adults with disabilities and asthma in children with disabilities (9.3%) were highlighted as potential priorities.
- *Chlamydia screening:* Members in the SPD aid category were the only subgroup below the MPL for chlamydia screening at 44.31% compared to the MPL of 54.91%. Further monitoring and analysis are needed.

Members with serious and persistent mental illness

Care for members with serious and persistent mental illness is carved out to Alameda County Behavioral Health. There were 7,696 Medi-Cal members who received services from Alameda County Behavioral Health in 2022 with the following needs identified:

- *Homelessness:* Over a fifth (22.9%) of members with serious mental illness had a homelessness indicator.
- *Emergency Visits:* Emergency room visits per 1,000 member months was 87.9, compared to 25.3 for all Medi-Cal members.

Members of racial or ethnic groups

The following needs by racial or ethnic groups were identified:

- Asian American and Pacific Islander members:

- *Diabetes and hypertension:* The prevalence of both diabetes and hypertension were higher in various Asian American and Pacific Islander groups, which was expected since this is an older population. Race/ethnic groups with the highest prevalence of hypertension and more than 10 people were Filipino Group Care (35.7%), Other Asian Medi-Cal Adults (32.6%), and Filipino Medi-Cal Adults (30.8%). For diabetes, they were Filipino Group Care (32.1%), Other Asian Medi-Cal Adults (21.9%), and Filipino Medi-Cal Adults (20.9%). Chinese Medi-Cal Adults and Other Asian Group Care members were also noteworthy for having a large number of members and a prevalence higher than for all members.

- Black or African American members:
  - *Homelessness:* Black (African American) members had the highest prevalence of homelessness indicators in Medi-Cal among race/ethnic groups with 6.7% of children and 15.2% of adults. In Group Care, which has a low prevalence of homelessness of 0.9% for all members, they were the largest group with 12 out of the 45 members.
  - *Immunizations and well-child visits:* Childhood Immunization Status (CIS-10) was below MPL for Black (African American) children, with 15.79% completing the measure compared to the MPL of 38.20%. They were the only subgroup below the MPL on this measure. They were also below MPL for Well-Child Visits in the First 15 Months and Ages 15 to 30 Months. In addition, they had the highest rate of no PCP visits for children and adolescents at 56.6%.
  - *Breast cancer screening:* Breast cancer screening in Black (African American) Medi-Cal members was below MPL at 46.24% compared to the MPL of 53.93%. They were not the subgroup with the lowest rate, but they have been identified as a priority because they are a larger proportion of the sample size at 14.7%.
  - *Hypertension:* Hypertension in Black (African American) Medi-Cal adults has been identified as a need because of the size of the group, with 5,858 Medi-Cal adults with hypertension. The prevalence is higher than overall members at 21.7%.

Members with limited English proficiency

In 2022, 98,408 Medi-Cal members and 1,814 Group Care members preferred a language other than English. Members with limited English proficiency often were the same as or better than English-speaking members for the assessment measures.

- *Diabetes and hypertension:* There was a slightly higher prevalence of diabetes and hypertension for non-English speaking Medi-Cal adults, which correlates with the higher prevalence of these diseases in Chinese and Vietnamese adults. These ethnic groups have a high proportion of non-English speakers.

Pregnant or postpartum members

There were 6,273 pregnant or postpartum Medi-Cal members and 59 Group Care members ages 12 to 55 with the following needs identified:

- *Family and social problems:* "Family and social problems" was the fifth most common CareAnalyzer diagnosis in pregnant or postpartum Medi-Cal members at 18.1% (1,136 members) and tied for seventh most common diagnosis for Group Care at 18.6% (11 members). In addition, the prevalence of homelessness indicators in Medi-Cal pregnant or postpartum members was 8.2%.
- *Depression:* The prevalence of depression for pregnant or postpartum Medi-Cal members was 11.8% and for Group Care 10.2%, which were both higher than overall members (4.7% Medi-Cal and 3.9% Group Care).

Members enrolled in ECM (Enhanced Care Management)

There were 1,371 Medi-Cal members enrolled in ECM. Homelessness and Emergency Department use are both reasons that allow people to qualify for the program, so these were both high. Lowering readmissions is one of the priorities for this program.

- *Readmission rate:* The readmission rate for members enrolled in ECM was 32.9% in 2022, compared to the rate for members overall at 16.5%.

Older adult members in Group Care

There were 917 older adult members in Group Care, or 18.8% of the Group Care membership.

- *Diabetes and hypertension:* These two chronic diseases are more common with age. There were 394 older adults with hypertension and 213 with diabetes, which was a prevalence of 43.0% and 23.2%, respectively.

Population Assessment Analysis

Alliance conducts an annual comprehensive analysis of its population assessment needs for evidence of program effectiveness and opportunity. The Alliance uses assessment results to review and update PHM programs, services, and activities. Additionally, the assessment is used to identify health disparities and needed community resources. The assessment analysis was conducted on March 24, 2023, with documentation found in the document "PHM Meeting 3-24-2023 Presentation and Minutes."

Population Risk Stratification and Segmentation

The Alliance has developed a risk stratification and segmentation (RSS) methodology to categorize all eligible members into risk tiers based on all data sets currently available, including clinical and behavioral health utilization, risk scores, and social needs data. The risk stratification is used to highlight specific member needs and assists with determining the appropriate levels of care management or other services a member may need.

The Alliance RSS methodology includes predictive and status metrics from CareAnalyzer, which uses The Johns Hopkins ACG System. Metrics include probabilities for persistent high utilizers, high cost, and inpatient or ED utilization. In addition, criteria utilized for Enhanced Care Management (ECM) and Complex Case Management (CCM) identification are incorporated into the methodology. Members are stratified into three main tiers: High Risk, Medium-Rising Risk and Low Risk. As members are identified and assessed for needs, they may move to a higher tier for more intensive support. Members in one tier may be eligible for or receive interventions listed in other tiers based on individual need.

The Alliance assesses its RSS methodology to identify and address racial bias that may exacerbate health disparities. Reports and dashboards are maintained that allow for regular review of member stratification and segmentation by race/ethnicity and language. As additional data becomes available on social determinants of health, it will be incorporated into the RSS as needed to address racial bias.

The tables below show the risk tiers and number of eligible members by line of business. They also provide an overview of Alliance programs and services, with definitions found in the sections to follow.

Alliance Risk Stratification and Segmentation Table - Medi-Cal
(April 2023, Total Medi-Cal Membership 351,777)

Medi-Cal Subset of Population	Programs and Services for Eligible Members	Number of Eligible Members	Percentage of Membership
High Risk Tier		**7,101**	**2%**
High Risk as defined by predictive utilization metrics, or enrollment in ECM or CCM.	• Enhanced Care Management • Complex Case Management • Transitional Care Services • Catastrophic Case Management		
Medium-Rising Risk Tier		**44,443**	**13%**
Not High Risk; high care coordination need.	• Living Your Best Life (Diabetes and Hypertension Disease Management) • California Children's Services Referrals		

Medi-Cal Subset of Population	Programs and Services for Eligible Members	Number of Eligible Members	Percentage of Membership
	• Follow-up after ED Visit for Mental Illness and Substance Use QI project • Maternal and Adolescent Mental Health Program • Community Supports		
Low Risk Tier		**300,233**	**85%**
Low risk for care coordination.	• Non-utilizer outreach • Well-child Visits QI project • Breast Cancer Screening QI project • Doula Services • Community Health Worker Services • Health Education		

Alliance Risk Stratification and Segmentation Table – Group Care
(April 2023, Total Group Care Membership 5,670)

Group Care Subset of Population	Programs and Services for Eligible Members	Number of Eligible Members	Percentage of Membership
High Risk Tier		**157**	**3%**
High Risk as defined by predictive utilization metrics or enrollment in CCM.	• Complex Case Management • Transitional Care Services • Catastrophic Case Management		
Medium-Rising Risk Tier		**913**	**16%**
Not High Risk; high care coordination need.	• Living Your Best Life (Diabetes and Hypertension Disease Management) • Maternal and Adolescent Mental Health Program		
Low Risk Tier		**4,600**	**81%**
Low risk for care coordination.	• Non-utilizer outreach • Breast Cancer Screening QI project • Community Health Worker Services • Health Education		

Population Health Program Goals

The strategy goals were developed to align with the population assessment findings, the areas of focus, and DHCS priorities. The goals address the four areas of focus as outlined by NCQA for population health to help improve health for members across different risk tiers:

1. Keeping members healthy.
2. Managing members with emerging risk.
3. Patient safety or outcomes across settings.
4. Managing multiple chronic illnesses.

The Alliance also aims to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through best practice and culturally affirming solutions. The Department of Health Care Services (DHCS) Bold Goals for 2025 were also an important factor in prioritizing goals under each of the four areas of focus.

1. Close racial/ethnic disparities in well-child visits and immunizations by 50%.
2. Close maternity care disparity for Black and Native American persons by 50%.
3. Improve maternal and adolescent depression screening by 50%.
4. Improve follow up for mental health and substance use disorder by 50%.
5. Ensure all health plans exceed the 50th percentile for all children's preventive care measures.

Programs and services related to goals in the focus areas are described below. The next section describes additional Alliance programs and services.

Managing Multiple Chronic Illnesses

Hypertension and Diabetes (Medi-Cal and Group Care)

Living Your Best Life Diabetes and Hypertension Disease Management: Disease Management programs target members with specific disease states. The Alliance will offer diabetes and hypertension health coaching and self-management tools. The Alliance will conduct targeted mailings and outreach calls to encourage member participation. The programs will provide health coaching, nurse case management, and assistance with connecting to community services.

Goal 1: At least 2% of members receiving disease management outreach will engage in at least one disease management or case management conversation.

Target Population: Members with diagnosis of diabetes and hypertension who receive disease management outreach letter or call.

Programs or services:

- Disease Management letter campaign: Informs members of the program and provides educational materials.

- Disease Management health education outreach: Telephonic outreach calls by Health Educator based on request for disease management education materials.

Goal 2: Members who complete the post-participation assessment will average 85% or greater confidence in disease self-management knowledge and behaviors.

Target Population: Members with diagnosis of diabetes and hypertension who participate in Living Your Best Life and complete the post-participation assessment.

Programs or services:

- Disease Management health education: Health Educator works with members in setting goals and provides education regarding disease management.
- Care coordination: Case Management Health Navigators work with members to coordinate disease management care (for example, help to schedule appointments to have A1c checked regularly).

Homelessness (Medi-Cal)

Enhanced Care Management (ECM): ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of members with the most complex medical and social needs through systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch and person centered. DHCS' vision for ECM is to coordinate all care for members who receive it, including across the physical and behavioral health delivery systems. The program currently serves adults experiencing homelessness, adults with multiple chronic conditions, adult high utilizers, and adults with serious mental illness and/or substance use disorder (SUD). In July of 2023, the program will expand to meet the needs of at-risk children and youth, including those experiencing homelessness. The Alliance is contracting with new community partners with expertise in children and youth to offer this expansion in services.

Goal: Increase ECM enrollment for eligible members experiencing homelessness with chronic conditions by at least 1 percentage point from 2022 to 2023.

Target Population: ECM-eligible members who meet the population of focus criteria for homelessness and have multiple chronic conditions.

Programs or services:

- ECM program capacity expansion: Alliance will ensure appropriate case management for members and facilitate program completion. This will allow for more program capacity for member outreach and enrollment.

- ECM referrals: Community Supports participants will be referred to ECM if appropriate.

Managing Members with Emerging Risk

Children with Disabilities (Medi-Cal)

California Children's Services (CCS) Referrals: Alliance Utilization Management identifies children who are potentially eligible for CCS but not yet enrolled and makes referrals to CCS and Case Management.

Goal: Increase enrollment in case management programs including CCS for children identified as potentially eligible but not enrolled in CCS by at least 1 percentage point from 2022 to 2023.

Target Population: Children identified as potentially eligible but not enrolled in CCS.

Programs or services:

- Referrals and outreach: Utilization Management will identify and refer members to CCS and Case Management. Case Management will outreach to members, assess their needs, and enroll them in case management services as appropriate.

Maternal and Adolescent Depression (Medi-Cal and Group Care)

Maternal and Adolescent Mental Health Program: Mental health program designed to promote quality outcomes among pregnant, postpartum, and adolescent members by working collaboratively to improve rates of depression screening, diagnosis, treatment, and referral. The Alliance will develop and implement program guidelines and criteria and educate providers and members.

Goal 1: Improve HEDIS prenatal (PND-E) and postpartum (PDS-E) depression screening and follow-up rates by 2 percentage points from MY2022 (as of April 2023) to MY2024.

- Medi-Cal PND-E Screening: 40.86% to 42.86% and Follow-up: 70.32% to 72.32%.
- Medi-Cal PDS-E Screening: 25.47% to 27.47% and Follow-up: 83.20% to 85.20%.
- Group Care PND-E Screening: 35.29% to 37.29%.
- Group Care PDS-E Screening: 15.38% to 17.38%.

Target Population: Medi-Cal and Group Care members who are part of the Community Health Center Network during pregnancy and the postpartum period.

Programs or services:

- Prenatal depression education campaign: Targeted education for members eligible for the program.

- Specialty identification: Identify providers with specialty in maternal mental health so members can self-refer.
- Doula outreach campaign: Encourage utilization of doula benefit.

Goal 2: Improve HEDIS depression screening and follow-up (DSF) for adolescents by 2 percentage points from MY2022 to MY2024.

- Screening: 18.6% to 20.6%.
- Follow-up: 87.8% to 89.8%.

Target Population: Medi-Cal members ages 12-17.

Programs or services:

- School-based health centers: Collaborate with school-based health centers to expand capacity to screen and refer adolescents to mental health services.
- Adolescent depression member education: Targeted education for members.

Keeping Members Healthy

Well-Child Visits (Equity Focus, Medi-Cal)

Black (African American) Well-Child Visit QI Project: This project monitors and improves well-child visit measures to address disparities for Black (African American) members.

Goal: HEDIS well-child visit (W30) and immunization (CIS-10) rates will increase for Black (African American) members by 3 percentage points from MY2022 (as of April 2023) to MY2023.

- Well-Child Visits in the first 15 months of life (W30-6+): 30.54% to 33.54% (pending DHCS approval of Performance Improvement Project).
- Well-Child Visits in the first 15-30 months of life (W30-2+): 58.25% to 61.25%.
- Childhood Immunization Status (CIS-10): 24.20% to 27.20% (administrative rates).

Target Population: Medi-Cal Black (African American) members up to 30 months old.

Programs or services:

- Well-child visit outreach: Support for Children's First Medical Group (CFMG) and La Clinica outreach initiatives to remind parents of their child's well-visits and provide an incentive gift card when appointments are completed.

- First 5 care coordination: First 5 provides care coordination services to participating providers to help educate and schedule well-visits for their assigned members up to 5 years of age.
- Well-child visit prenatal campaign: The Alliance will send letters to members who are pregnant to inform them of the purpose, frequency, immunizations, and screenings of their child's well-visits and offer an incentive.

Breast Cancer Screening (Equity Focus, Medi-Cal and Group Care)

Black (African American) Breast Cancer Screening QI Project: This project will conduct outreach and education to Black (African American) members and increase access to mammograms.

Goal: Increase Breast Cancer Screening (BCS) rates for Black (African American) women ages 52-74 by 3 percentage points from MY2022 (as of April 2023) to MY2023.

- Medi-Cal: 48.30% to 51.30%.
- Group Care: 59.76% to 62.76%.

Target Population: Black (African American) women ages 52-74 years of age.

Programs or services:

- Mobile mammography: Partner with target clinics to offer mobile mammography services.
- Mammogram education mailing: Mail health education material to members about mammograms.
- Mammogram incentive program: Support member outreach and incentives at LifeLong health clinics. This clinic provides care to many African American women.

PCP Visits (Medi-Cal and Group Care)

Non-utilizer Outreach QI project: This project will conduct outreach calls to members to encourage PCP visits.

Goal 1: Outreach to at least 20% of non-utilizers ages 50 years and above and connect 2% to primary care services.

Target Population: Members ages 50 years and above who have not utilized PCP services for more than 12 months.

Programs or services:

- Non-utilizer call campaign: Conduct outreach calls to eligible members to connect members to their primary care providers.

Goal 2: Outreach to at least 20% of non-utilizers ages six and under and connect 2% to primary care services.

Target Population: Members ages six and under who have not utilized PCP services for more than 12 months.

Programs or services:

- Non-utilizer call campaign: Conduct outreach calls to parents or guardians of eligible members to connect members to their primary care providers.

Patient Safety or Outcomes Across Settings

ED Utilization for People with Mental Illness (Medi-Cal)

Follow-up after ED Visit for Mental Illness and Substance Use QI Project: This project will involve efforts to improve the timely follow-up to emergency department (ED) visits for mental illness and substance use by increasing provider knowledge and developing tools to support effective follow-up processes.

Goal 1: Follow-up After ED Visits for Mental Illness (FUM) - 30 days HEDIS rate for Medi-Cal members will increase from 49.03% in MY2022 to 54.51% in MY2023 (pending DHCS approval of Performance Improvement Project).

Target Population: Members ages 6 and older who were seen in the ED for mental illness.

Programs or services:

- ADT outreach: Improve follow-up by increasing the use of Admission, Discharge, and Transfer (ADT) reports to identify and outreach to members with mental illness diagnoses within 30 days of ED visit.

Goal 2: Follow-up After ED Visits for Substance Use (FUA) – 30 days HEDIS rate for Medi-Cal members will increase from 29.82% in MY2022 to 31.31% in MY2023 (pending DHCS approval of Performance Improvement Project).

Target Population: Members ages 13 years and older who were seen in the ED for substance use disorder.

Programs or services:

- ADT outreach: Improve follow-up by increasing the use of Admission, Discharge, and Transfer (ADT) reports to identify and outreach to members seen for substance use disorder within 30 days of ED visit.

Readmissions (Medi-Cal and Group Care)

Transitional Care Services (TCS): TCS are services provided to all members transferring from one institutional care setting or level of care to another institution or lower level of care including long-term care and home settings. Once a member is identified and referred to TCS, they are assigned to a Case Manager to take responsibility for completion of screening, referrals, care planning, and all other care coordination activities. The Alliance currently offers TCS to members who are identified as high risk through our risk stratification and segmentation methodology. By 2024, the Alliance will offer TCS to all members experiencing a care transition. The Alliance Case Management team will continue and enhance partnerships with delegates and ECM providers to support TCS for discharged members. This program will positively impact members by assisting them in navigating through the health care system and educating our members on appropriate follow-up, reconnecting them to their medical homes, and addressing coordination of care needs thereby decreasing hospital readmissions. The Alliance is evaluating internal staffing requirements and seeking new community partners to cover the TCS program expansion.

Goal: Decrease readmission rate from 6 months before TCS engagement to 6 months after engagement by at least 1 percentage point.

Target Population: Members engaged in TCS.

Programs or services:

- Pre-discharge outreach and care coordination: Begin member outreach pre-discharge. Provide care coordination as needed, even if member declines CM services.
- Closed loop referrals: Implement closed loop referrals for services and equipment provided to members.

Catastrophic Cases (Medi-Cal and Group Care)

Catastrophic Case Management: This program will identify catastrophic cases and refer members to enroll in case management programs. The purpose of the program is to ensure appropriate utilization of services, support transitions of care, and prevent unnecessary long term care placement, hospitalizations, or readmissions.

Goal: Identify catastrophic cases and refer 95% of the cases into case management programs.

Target Population: Members with catastrophic cases defined by cost and utilization criteria.

Programs or services:

- Care coordination: The Alliance will identify members who qualify as catastrophic cases and coordinate care with discharge planners, facilities, family, and members as needed.
- Case management referrals: Members will be referred to appropriate case management programs for outreach and engagement.

Other Alliance Programs and Services

Programs that were not covered in the PHM program goals are described below.

Basic Population Health Management (BPHM)

Formerly known as "Basic Case Management," Basic Population Health Management (BPHM) is an approach to care that ensures that needed programs and services are made available to each member, regardless of the member's risk, at the right time and in the right setting. BPHM services include access to primary care, care coordination, navigation and referrals across health and social services, information sharing, services provided by Community Health Workers (CHWs), wellness and prevention programs, chronic disease programs, programs focused on improving maternal health outcomes, and care management services for children under Early and Periodic Screening, Diagnosis and Treatment (EPSDT). BPHM services may be offered in a variety of settings, including but not limited to, primary care clinics, Alliance care management team telephonic supports, through Enhanced Care Management (ECM) community partners, or in long-term care settings.

Complex Case Management (CCM)

Complex Case Management (CCM) provides ongoing chronic care coordination, interventions for temporary needs, and disease-specific management interventions for members who are high and medium-rising risk and have conditions in which the degree and complexity of illness or conditions are typically severe. The level of management necessary and the resources required for the member to regain optimal health or improved functionality is often intensive. CCM is a member-centered collaborative process between primary and/or specialty care providers, the member, and the care manager. The care manager directs the care and works with the member to prioritize and achieve goals. The Alliance's CCM services follow the National Committee for Quality Assurance (NCQA) CCM requirements.

Community Health Worker (CHW)

The Alliance offers Community Health Worker (CHW) services as a preventive health benefit to members. These services may assist with a variety of concerns including but not limited to the control and prevention of chronic conditions or infections disease, behavioral health services and the need for preventive services. The Alliance is exploring Community Health Worker collaborations to support quality measures such as cervical cancer screening, breast cancer screening, follow-up after ED visits for mental illness and substance use, and well-child visits.

Community Supports (CS) *(Medi-Cal only)*

CS focuses on the social determinants of health and gives the Alliance the ability to support services to help keep members healthy and in their homes and out of hospital emergency departments (EDs), acute hospitals, and other facilities. The Community Supports currently

offered are asthma remediation, housing services including deposits, navigation, tenancy sustaining services, medically supportive food, and medical respite. In addition, the Alliance is piloting a diversion nursing facility/transition to assisted living facilities and community transition services/nursing facility transition to a home. In July 2023, the Alliance will offer caregiver respite services, personal care and homemaker services, and home modifications.

Diabetes Prevention Program (DPP) *(Medi-Cal only)*
DPP is an online program that helps participants adopt healthy habits, lose weight, and significantly decrease their risk of developing type 2 diabetes. The year-long program follows an approved curriculum by the Centers for Disease Control and Prevention (CDC). The curriculum teaches participants to make lasting changes by eating healthier, increasing physical activity, and managing the challenges that come with lifestyle change.

Doula Services *(Medi-Cal only)*
The Alliance is launching doula services as a new benefit. Doula services will address multiple concerns identified in the assessment. Doulas offer culturally competent care, education, and connection to community services to members during their pregnancy. They also can support members in understanding the importance of well-child visits.

Health Education
The Alliance Health Education Program seeks to promote the appropriate use of plan health care services, risk-reduction, healthy lifestyles, and self-management of health conditions through programs that include health information, online resources, programs, and classes. Programs are designed to meet the health literacy, health education, cultural, and linguistic needs of the Alliance's diverse membership.

How Members are Informed about PHM Programs

The Alliance informs members about all available PHM programs and services through its website, by mail, by telephone, and/or in person.

- Information on care management, wellness and prevention, and cultural and linguistic services are on the website and member portal.
- The Alliance mails members through the member newsletter, health education mailings, and care management care plans and communications.
- Telephonic and/or mail outreach is conducted to members in CCM, TCS, and targeted medium-rising risk, quality improvement, and wellness programs.
- Upon referral to Community Supports services, Transitional Care Services, Complex Case Management, or Disease Management, members are also evaluated for other care management needs.
- Alliance Member Advisory Committee meetings inform and provide opportunities for members and families to give feedback regarding Alliance policies, programs, and cultural and linguistic services.

The table below details how members are eligible to participate and utilize Alliance programs and services.

How Members are Informed about PHM Programs Table

Program	Member Eligibility	Utilizing Program Services	How to Opt In or Out
Basic Population Health Management	All Members	Members receive prevention, care coordination, referrals and chronic condition supports through primary care provider routine care visits and through engagement with Alliance member services, health education, case management teams (including delegates).	Members opt in by scheduling visits with their PCP, calling the Alliance, or accepting a call from Alliance staff or delegate offering services in response to provider or community referral. Members may opt out at any time by ending engagement.
Disease Management	Members identified with one or more chronic diseases: asthma, diabetes, hypertension, and/or depression.	Members receive health education and based on need can receive health coaching, care coordination, or nurse	Eligible members are enrolled in the program and can opt out at any time by communicating their preference to the Alliance.

Program	Member Eligibility	Utilizing Program Services	How to Opt In or Out
		case management services.	
Diabetes Prevention Program (DPP)	Members must meet the CDC guidelines for DPP eligibility.	Members participate online in health coaching, education, and nutrition and exercise tracking.	Members opt in by taking an online survey or calling to enroll and begin services. Members may opt out at any time by ending program engagement.
Health Education	All Members. Eligibility varies for specific classes or programs.	Depends on the program or class. Community agencies or vendors offer all programs. Participation may be online, via mail, or in-person.	Members call the Alliance or mail a Wellness Request Form to receive program information. Depending on the program or class, members self-enroll, or the Alliance facilitates enrollment. Members may opt out at any time by ending program engagement.
QI Projects	Members with one year of continuous enrollment may be in the denominator for a HEDIS measure. If they are assigned to targeted health clinic or delegate and have an outstanding care gap, they may be contacted to participate in a QI project.	Depends on the project. The project may involve direct member phone call, text message, provider discussion, and/or mailing.	Member are asked to participate in the project; if the member declines, they are considered having opted out.
Complex Case Management (CCM)	Member meets criteria for CCM based on hospital utilizations and co-morbidities. The monthly Population Health Report helps to	Members participate via telephone.	The CM team calls members to offer CCM. If they consent, the member is transferred to a RN to complete an assessment (or scheduled for a later call back date). If

Program	Member Eligibility	Utilizing Program Services	How to Opt In or Out
	identify members who meet CCM or high risk member criteria.		member declines, member has opted out.
Transitional Care Services (TCS)	High risk member transitions from one setting to another.	Member participates via telephone after a CM team member calls the member.	The assigned care manager contacts members to offer TCS. Members can actively participate in TCS. Members may choose to opt out or limit participation. In these cases, services will be coordinated as needed for members without their participation.
Enhanced Care Management (ECM)	Member meets eligibility criteria for ECM.	Member works with ECM provider for services.	ECM providers contact the member by telephone or face to face to offer ECM. If the member consents, they are enrolled in the program. If member declines, member has opted out.
Community Supports (CS)	Member meets eligibility criteria for CS service(s).	Member works with CS provider to determine the scope of services.	Alliance Case Management and medical or community providers offer CS services to members. Members must consent to participate in CS. If the member declines, member has opted out.
Community Health Worker	Member must meet eligibility criteria for CHW services, and a Licensed Practitioner must recommend CHW services.	Member may work with the CHW over the telephone, in a clinic, or in a community-based setting.	If the member consents to receiving CHW services, they receive the services. If the member declines or stops engagement, the member has opted out.

How Member Programs are Coordinated

The Alliance coordinates programs across settings, providers, and levels of care to minimize the confusion for members being contacted from multiple sources. The following are examples of how the Alliance coordinates care across various programs, with providers, and other entities:

Case Management Programs

The Alliance Case Management (CM) team documents their work and progress in their system of record, TruCare. TruCare has an easy identification system to determine if a care manager is working with a member, to prevent internal duplication of services. This easy identification also allows for the internal team members of various disciplines to collaborate and distribute the work associated with each member.

Community Health Center Network (CHCN), an Alliance delegate, offers basic population health management support to their members. The Alliance assists with evaluation of members for CHCN membership and basic case management services. There is communication between the Alliance and CHCN case management teams to prevent duplication of services and collaborate on cases.

Catastrophic Cases

The Alliance identifies catastrophic cases and conducts discharge risk and readmission assessments. There are internal and external rounds with appropriate clinical reviews and standard practice for assessment of appropriate next level of care. The Alliance will coordinate care with discharge planners and facilities including skilled nursing facilities, long-term care, and medical respite. The members are referred to case management programs (TCS, CCM, ECM, CS) for outreach and engagement.

Enhanced Care Management

The Alliance contracts with ECM providers who assign lead case managers to provide in-person care coordination. ECM coordinates all levels of care, including preventative services, transitional care services, medical and behavioral health services, and referrals to Community Supports and social services. The aim is to have one point of contact based in the community to provide wraparound services to members with complex medical and social needs. The Alliance monitors ECM services to ensure non-duplication with Alliance Complex Case Management services, Transitional Care Services, the Community Health Worker benefit, 1915C waiver, Alameda County Health Care Services Agency waivers, and Targeted Case Management programs.

Health Education

The Alliance's Health Education program offers health education materials and disease self-management tools and programs. Alliance CM staff can use TruCare to make a referral to Health Education for outreach to the member on health concerns identified during care management assessments. In addition, Health Education staff who identify members with needs for case management support will use the same referral function to refer members to CM. Health Education also refers members to community programs and resources such as nutrition classes, smoking cessation support, and diabetes self-management programs.

QI Projects

Monthly gaps in care reports shared with primary care providers support HEDIS and non-HEDIS interventions, including well-care visits and breast cancer screening. The Alliance monitors interventions offered through the primary care providers through claims and encounter data, electronic health record feeds, and the statewide immunization database.

Transitional Care Services (TCS)

The Alliance currently enrolls members who are transitioning from one setting to another into the TCS program. The Alliance CM team receives notification of admission through the facility's Admission, Discharge and Transfer (ADT) report or Inpatient UM team.

Upon receipt of the facility admission notification, the Alliance CM team will evaluate the member for enrollment into the TCS program. Evaluation occurs by reviewing the facility record and the Alliance's internal electronic medical record, checking for other external case management programs or teams.

Alameda Health System (AHS), an Alliance provider group, also has a case management team and flags their patients for further evaluation into their case management program. The Alliance can see these notifications to confirm their receipt of services and therefore no longer pursues the member to offer case management support.

The Alliance has entered into an agreement with CHCN, an Alliance delegated provider group, to provide Transitional Care Services (TCS) for CHCN members for high-risk members transitioning from one setting to another. The guidelines for this program are in alignment with DHCS' TCS requirements.

Integration of Community Resources

The Alliance uses the population assessment to review community resources for integration into program offerings to address member needs.

- **Coalition Meetings** – The Alliance regularly participates in community meetings that support the wellness goals of our PHM Strategy. These include the Breastfeeding Coalition, the County Nutrition Action Partnership, the Special Needs Committee, and the Perinatal Equity Initiative. Each of these meetings include various stakeholders that work together to share resources and collaborate with county wide initiatives to address member health needs.

- **Community Resources Webpage** – The Alliance website offers a listing of community resources for behavioral health; domestic violence; food, housing, and utilities assistance; LGBTQ; and older adults and people with disabilities.

- **Community Supports Meetings** – The Alliance hosts a countywide meeting that shares education and fosters coordination of community resources, ECM activities, and CS services amongst the network of ECM and CS providers.

- **FindHelp** – The Alliance uses the FindHelp tool to assist with case management referrals to community resources such as food assistance, help paying bills, and other free or reduced cost programs.

- **First 5** – In partnership with the Alliance, First 5 is actively engaging in programs including those on member outreach, provider assistance, connection to community resources and care coordination.

- **Health Education Provider Resource Directory –** This is a listing of health education classes, condition self-management support, community programs and ancillary services available to members at no cost. The listing is on the Alliance website as a resource to Alliance staff, providers, and community partners.

- **Women Infants and Children (WIC) Referrals** – The Alliance Health Education Department sends a weekly list of newly identified pregnant members and members who recently gave birth to Alameda County WIC for outreach and engagement.

Activities That Are Not Direct Member Interventions

The Alliance performs activities that are not direct member interventions, include sharing data and information with providers, administering a value-based payment program, and integrating with delivery systems.

Provider Data Sharing

- The Alliance provides provider partners ED utilization data through Admission, Discharge, and Transfer (ADT) reports to encourage follow-up after ED visits. For delegates, reports will be uploaded to a secure portal, where designated staff will access the reports and disseminate information to providers for patient follow-up according to each delegate's care coordination process.
- The Alliance shares monthly high-risk member reports based on our RSS methodology to delegates to assist in their prioritization of outreach and care.
- The monthly ECM Eligibility List shares information on patients who are eligible for ECM for outreach and engagement.
- Monthly gaps in care reports shared with primary care providers support HEDIS and non-HEDIS interventions, including well care visits and breast cancer screening.

Provider Education

- Education and important updates for Alliance providers are shared through provider quarterly packets, website and provider portal, quarterly provider representative visits, provider newsletter, Provider Manual, and new provider orientation.
- Clinical background and best practices related to well-child visits and follow-up after ED visits for mental illness and substance use are shared with providers through provider webinars and measure highlight handouts.
- The Alliance website shares a link to the Mayo Clinic 'Care That Fits' patient-centered decision-making tool to help guide provider-patient interactions. This content helps patients understand a wide range of health conditions so they make informed decisions about their care options.
- Alliance Case Management staff will further engage with ECM providers to ensure appropriate case management through participation in ECM case rounds at provider sites and oversight of Health Assessment Plans, Community Supports referrals, and graduation checklists.

Value-Based Payment Program

- Annually, the Alliance develops and distributes a Pay-for-Performance (P4P) program that offers performance-based incentive payments for delivered services. Through this program, primary care providers are rewarded for superior performance and yearly improvement. The P4P is aligned with HEDIS measures, especially the DHCS Managed Care Accountability Set (MCAS) quality improvement measures. Additionally, the P4P program aims to reduce ER visits and improve access to care.

Integration with Delivery Systems

- Utilization Management refers members who are potentially eligible for California Children's Services (CCS) but not yet enrolled. Case Management confirms engagement with CCS.
- The Alliance receives daily feeds from facilities in our network and identifies members in need of Transitional Care Services.
- The Alliance partners with Alameda County Health Care Services Agency for data sharing regarding housing status of members and participation in county sponsored services.

Integrating with Community Resources

- The Alliance is working closely with FindHelp to establish an interactive database and resource for staff, providers, and members that will facilitate closed loop referrals. Referrals will include ECM, CS services, WIC referrals, and IHSS.

Conclusion

The 2023 Population Health Management Strategy summarizes the Alliance's analysis and roadmap to meet the physical and mental health needs for our diverse and growing membership. This year's PHM Strategy outlines programs and services that care for members in times of high need, such as those experiencing transitions of care or catastrophic events, as well as strategies to address the social determinants of health that exacerbate inequities. We also provide programs designed to support our members with chronic conditions such as diabetes and hypertension, members experiencing homelessness, and adolescents and pregnant members at risk for depression. This year we continue to focus on preventive care efforts with programs to improve rates of well-child visits, immunizations, and screenings. The Alliance strives to employ creative and person-centered solutions that center equitable approaches and impact relevant clinical, utilization, and member experience measures. As our membership and programs expand throughout 2023, we aspire to partner with members, providers, and our community to achieve optimal health and wellness for all members.

Cultural and Linguistic Program Description

2023

February 17, 2023
Health Care Quality
Committee

Alameda Alliance for Health
Cultural and Linguistic Services Program Description
2023

Overview
The Alameda Alliance for Health (Alliance) is committed to delivering culturally and linguistically appropriate services (CLAS), to all eligible Medi-Cal and Group Care members. The Alliance's Cultural and Linguistic Services Program complies with 22 CCR sections 51202.5 and 51309.5(a), 28 CCR sections 1300.67.04(c)(2)(A) - (B) and 1300.67.04 (c)(2)(G)(v) - (c)(4), 42 CFR section 438.206(c)(2), Title VI of the Civil Rights Act of 1964, section 1557 of the Affordable Care Act of 2010, 42 CFR section 438.10, Exhibit A, Attachment III, Section 5.2.10 (Access Rights), and APL 21-004. The Alliance CLS Program aligns with the National Standards for Cultural and Linguistically Appropriate Services (CLAS) created by the U.S. Department of Health & Human Services (CLAS Standards - Think Cultural Health (hhs.gov).

The goal of the Cultural and Linguistic Services (CLS) Program is to ensure that all members receive equitable access to high quality health care services, including behavioral health services, that are culturally and linguistically appropriate. This includes ensuring culturally appropriate services and access for members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, creed, health status, or identification with any other persons or groups defined in Penal Code section 422.56.

Program objectives include:

- Comply with state and federal guidelines related to assessment of enrollees to offer its members culturally and linguistically appropriate services.
- Provide no-cost language assistance services at all points of contact for covered benefits.
- Ensure that all staff, providers, and subcontractors are compliant with the cultural and linguistic program through cultural competency training.
- Identify, inform, and assist limited English proficiency (LEP) members in accessing quality interpretation services.
- Ensure that Alliance health care providers follow the Alliance CLS Program.
- Integrate community input into the development and implementation of Alliance cultural and linguistic accessibility standards and procedures.
- Monitor and continuously improve Alliance activities aimed at achieving cultural competence and reducing health care disparities.

The Work Plan for the C & L Program in Appendix A includes a timetable for implementation of activities related to meeting the program goal and objectives.

The Organizational Chart in Appendix B displays reporting relationships for the Alliance organization and identifies key staff with overall responsibility for the operation of the Cultural and Linguistic Services Program.

Cultural and Linguistic Services Leadership

The **Quality Improvement Department** is responsible for developing, implementing and evaluating the Alliance's Cultural and Linguistic Services Program in coordination with other Alliance departments including Provider Services, Human Resources, Analytics and Performance, Member Services, Communications and Outreach, Quality Assurance, Vendor Management and Compliance.

Population Health and Equity is a part of the Alliance's Quality Improvement Department. The Manager of Cultural and Linguistic Service, under the direction of the Director of Population Health and Equity, and in collaboration with the aforementioned departments, develops the Cultural and Linguistic Services Program work plan and integrates information and resources on cultural competency into the Alliance's programs and services. The Manager of Cultural and Linguistic Services also facilitates the Cultural and Linguistic Services Subcommittee (CLSS) of the Health Care Quality Committee, which in turn reports to the Alliance Board of Governors. All participating persons/departments report ultimately to the Chief Executive Officer.

The **Director of Population Health and Equity** who oversees the Manager of Cultural and Linguistic Services has a Master's in Public Health with a concentration in Community Health Education and over 30 years' experience leading culturally and linguistically appropriate services. The staff include individuals who have bilingual capacity and experience in medical interpretation, program development in diverse Medi-Cal populations, and working with people with disabilities.

The **Chief Health Equity Officer** partners with leaders across the organization to develop and drive forward the key strategies of the organization as they relate to Diversity, Equity, and Inclusion (DEI) for members, providers, and employees.

The Manager of Cultural and Linguistic Services and the Communications and Outreach Senior Manager are responsible for supporting the **Alliance Member Advisory Committee** (see below for description) in accordance with Title 22, CCR, Section 53876 (c). The Health Programs Coordinator provides administrative support to the Member Advisory Committee.

Departmental Roles

The **Behavioral Health Department** oversees services provided for members with Mental Health Disease and Autism Spectrum Disorder. In April of 2023, Alameda Alliance has de-delegated responsibility of these services and is now responsible for the Program work plan. The BH team integrates information and resources on cultural competency into the Alliance's programs. It is also responsible for behavioral health utilization and case management activities including triage and referral and participation on the multi-disciplinary case management teams to responsible for comprehensive case management activities. The team is led by the Senior Director of Behavioral Health (Licensed Psychologist) and Senior Medical Director (MD).

The **Communications and Outreach** department is responsible for ensuring that marketing practices for eligible beneficiaries or potential enrollees do not discriminate due to race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability. In addition, they take into consideration results from member surveys and assessments, community feedback and other CLS monitoring activities when producing member materials. The department is also responsible for quality translations of member written materials and communications and assists all departments in sending the appropriate non-

discrimination and language assistance service notices to members.

Compliance is responsible for conducting audits of the Alliance Cultural and Linguistic Services program, monitoring delegated CLS responsibilities, and ensuring that all state and federal regulations are followed.

Health Education, also a part of Quality Improvement, staff ensure that members have access to qualified interpreters when participating in health education programs and make health education materials available to members and providers that meet the literacy, cultural, linguistic, clinical, and regulatory standards.

The **Human Resources** department is responsible for bilingual assessment of new staff who will use their bilingual skills with members. They maintain a listing of Alliance bilingual staff and ensure quality monitoring of bilingual staff not monitored through the Member Services quality assurance program.

The **Member Services** department assesses member cultural and linguistic needs at each contact by identifying and verifying language preferences, reported ethnicity and preference for use of interpreter services. Members are informed that they can access no cost oral interpretation in their preferred language and written materials translated into Alliance threshold languages or provided in alternative formats. Member Services also monitors call quality for Member Services Representatives ability to follow cultural and linguistic protocols.

The **Provider Services** department is responsible for ensuring that the Alliance provider network composition continuously meets members' cultural and linguistic needs. Provider Services also trains providers on the Alliance Cultural and Linguistic program requirements. Language capabilities of clinicians and other provider office staff are identified during the credentialing process and providers update language capacity with the Alliance regularly.

The **Quality Assurance** department supports the CLS program through monitoring and reporting of grievances related to CLS services.

Quality Improvement Specialists conduct member and provider surveys, and Quality Nurses conduct medical record and facility site reviews that monitor CLS requirement implementation at the provider office level and issue corrective action plans as needed.

Vendor Management supports compliance oversight of language services vendors and implements corrective action plans as needed.

Community Advisory Committee

The **Community Advisory Committee** at the Alliance is known as the Member Advisory Committee (MAC). The MAC is supported by the Senior Manager of Communications and Outreach and Manager of Cultural and Linguistic Services and their respective departments. The purpose of the Member Advisory Committee (MAC) is to provide a link between the Alliance and the community. The MAC advises the Alliance on the development and implementation of its cultural and linguistic accessibility standards and procedures. The committee's responsibilities include advising on cultural competency issues, and educational and operational issues affecting members, including seniors, people who speak a primary language other than English, and persons with disabilities. The MAC is comprised of Alliance members, community advocates, safety net providers, and at least one

traditional provider.

The MAC provides input about members' cultural and linguistic needs and the Alliance cultural and linguistic access standards (CLAS) and procedures. The MAC enables the Alliance to maintain community partnerships with consumers, community advocates and traditional and safety net providers regarding CLAS. Alliance procedures ensure MAC involvement in policy decisions related to educational, operational, and cultural competency decisions affecting groups that speak a primary language other than English.

Standards and Performance Requirements
The Alliance's policies and procedures comply with standards and performance requirements for the delivery of culturally and linguistically appropriate health care services. The Alliance has systems and processes to:

- Provide all members – including those with mental health and autism spectrum disorder - access to no cost language assistance services at all points of contact, 24 hours a day, 7 days a week. Educate members and providers about the availability of language services and how to access them.

- Assess and track linguistic capability of interpreters, bilingual employees, and contracted staff in medical and non-medical settings. Implement a system to provide adequate training regarding the Alliance language assistance programs to all employees and contracted staff that have routine contact with LEP Members or Potential Members.

- Conduct a Population Needs Assessment (PNA) according to the DHCS timeline to:
  - Identify member health needs and health disparities.
  - Evaluate health education, CLS, and quality improvement (QI) activities and available resources to address identified concerns.
  - Implement targeted strategies for health education, CLS, and QI programs and services.
  - Share with relevant stakeholders and inform the cultural and linguistic services program priorities.

- Provide annual Diversity, Equity and Inclusion Training that covers sensitivity, diversity, communication skills, Health Equity, and cultural competency training and related trainings for staff, providers, and clinical and non-clinical contracted staff. The training will cover the Alliance Cultural and Linguistic Program, language and literacy, gender affirming care, as well as working with identified diverse cultural groups within the Alliance service areas.

- Monitor and evaluate the Cultural and Linguistic Services Program and the performance of individuals providing linguistics services. The Alliance tracks and addresses any identified gaps in the Alliance's ability to address members' cultural and linguistic needs.

The program meets the standards detailed in the following Alliance Policies and Procedures:

- CLS-001 Cultural and Linguistic Services Program Description
- CLS-002 Cultural and Linguistic Services Program - Member Advisory Committee
- CLS-003 Cultural and Linguistic Services Program – Nondiscrimination, Language

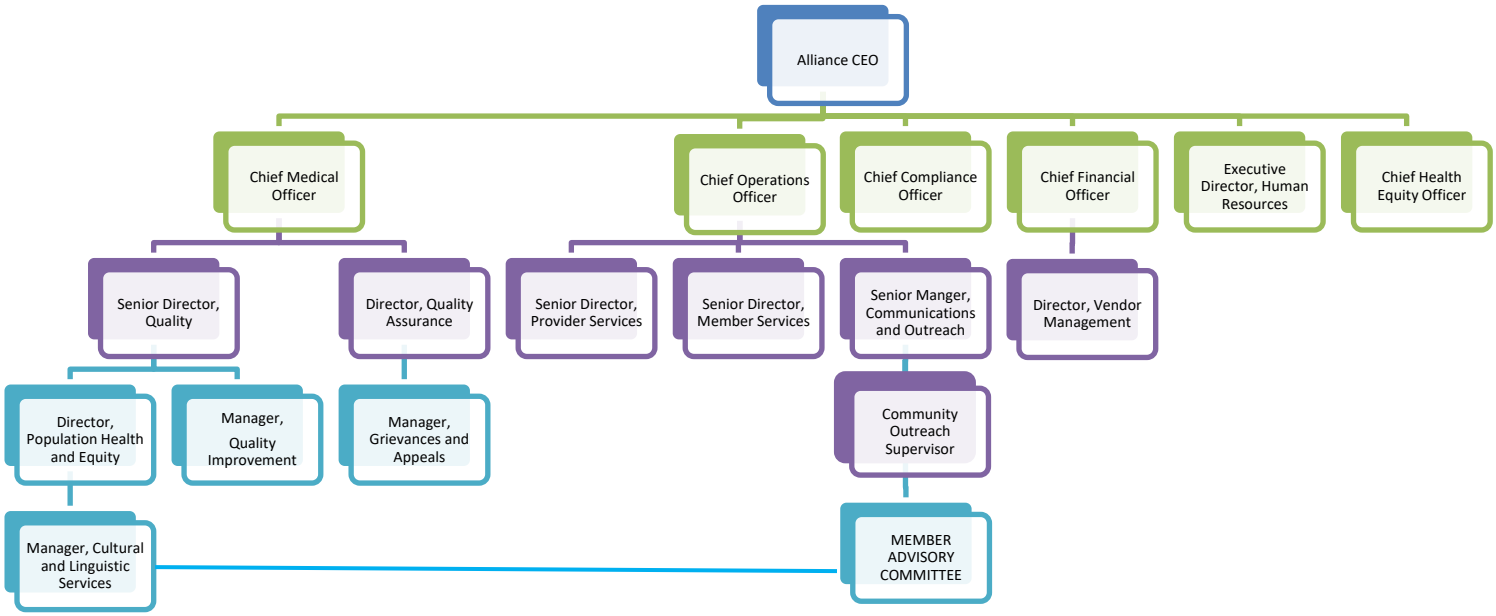
Assistance Services, and Effective Communication for Individuals with Disabilities

- CLS-008 Cultural and Linguistic Services Program - Member Assessment of Cultural and Linguistic NeedsCLS-009 Cultural and Linguistic Services Program – Contracted Providers
- CLS-010 Cultural and Linguistic Services Program - Staff Training and Assessment
- CLS-011 Cultural and Linguistic Services Program – Compliance Monitoring

Alameda Alliance for Health Workplan
Cultural and Linguistic Services
2023

Resp Party/ Business Lead	Project Manager	QI Activity/Initiative	Goal	Due Date/ Timeframe for Completion
Director, Population Health and Equity (Linda Ayala)	Manager, Cultural and Linguistic Services (TBD)	Member Cultural and Linguistic Assessment	Assess the cultural and linguistic needs of plan enrollees.	1/31/2023 4/31/2023 7/31/2023 10/31/2023
Director, Population Health and Equity (Linda Ayala)	Manager, Cultural and Linguistic Services (TBD)	Language Assistance Services	Reach or exceed an average fulfillment rate of ninety-five percent (95%) or more for in-person, video, and telephonic interpreter services.	3/31/2023 6/30/2023 9/30/2023 12/31/2023
Director, Population Health and Equity (Linda Ayala)	Manager, Cultural and Linguistic Services (TBD)	Provider Language Capacity (Member Satisfaction)	Based on the Member CG-CAHPS Survey 81% of adult members and 92% of child members who need interpreter services will report receiving a non-family qualified interpreter through their doctor's office or health plan.	3/31/2023 6/30/2023 9/30/2023 12/31/2023
Director, Population Health and Equity (Linda Ayala)	Manager, Cultural and Linguistic Services (TBD)	Provider Language Capacity (Provider Network)	Complete NCQA NET 1 A Analysis of Capacity of Alliance Provider Network to meet Cultural and Linguistic needs of members.	6/30/2023
Director, Population Health and Equity (Linda Ayala)	Manager, Cultural and Linguistic Services (TBD)	Cultural Sensitivity Training -Participation	96% of Alliance staff will participate in the annual Cultural Sensitivity training.	12/1/2023
Director, Population Health and Equity (Linda Ayala)	Manager, Cultural and Linguistic Services (TBD)	Cultural Sensitivity Training -Enhancements	Facilitate collaborative process to update Cultural Sensitivity Training (s) to meet DHCS 2024 requirements.	12/1/2023
Director, Population Health and Equity (Linda Ayala)	Manager, Population Health and Equity (Gil Duran)	Member Advisory Committee	Ensure implementation of DHCS 2024 Contract updates to Member Advisory Committee and community engagement.	12/1/2023

Alameda Alliance for Health Organizational Chart
Cultural and Linguistic Services
APPENDIX B



RESOLUTION NO. 2023-03

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH
AMENDING THE ALLOWABLE MEMBERSHIP TO ITS
STANDING COMPLIANCE ADVISORY COMMITTEE

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

WHEREAS, Section 7.A.1 of the Bylaws requires that the frequency, composition, compensation, terms, and nomination of members of standing committees shall be as set forth by resolution; and

WHEREAS, the Board approved Resolution No. 2021-11[1] on June 11th 2021, which created a standing Compliance Advisory Committee with a voting membership that includes two (2) or more members of the Board; and

WHEREAS, Section 7.C.1 of the Bylaws requires that the Alliance Chief Compliance Officer serve ex officio as a voting member of the Compliance Advisory Committee, and shall be counted towards determining whether a quorum is present.

WHEREAS, Section 7.C.1 of the Bylaws requires that the Chair and Vice Chair of the Compliance Advisory Committee shall be Board members selected and approved by the Board; and

WHEREAS, the Board at this time desires to change the Board membership requirements of the Compliance Advisory Committee to be no less than three (3) Board members and no more than five (5) Board members.

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

SECTION 1. The Chief Compliance Officer of the Alliance shall serve ex officio as a voting member on the Compliance Advisory Committee and shall be counted towards a quorum in accordance with the Bylaws.

SECTION 2. The Compliance Advisory Committee will consist of no less than three (3) Board members, and no more than five (5) Board members. Appointments to this Committee shall be for a term of two (2) years and members may be reappointed to additional terms with the Board's approval. As stated in the Bylaws section 7.C.1, the Chair and Vice Chair of the Committee shall be selected and approved by the Board.

[1] 2021-11 A Resolution of Alameda Alliance for Health to Amend Resolution 2017-04 by Making Ad Hoc Compliance Advisory Group into a standing Compliance Advisory Committee.

PASSED AND ADOPTED by the Board of Governors at a meeting held on the 14th day of July 2023.

_____
CHAIR, BOARD OF GOVERNORS

ATTEST:

_____
Secretary

RESOLUTION NO. 2023-04

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH AMENDING THE ALLOWABLE MEMBERSHIP TO ITS STANDING EXECUTIVE COMMITTEE

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

WHEREAS, Section 7.A.1 of the Bylaws requires that the frequency, composition, compensation, terms, and nomination of members of standing committees shall be as set forth by resolution; and

WHEREAS, the Board approved Resolution No. 2021-09[1] on May 14th 2021, which created a standing Executive Committee with a voting membership of five (5) members of the Board; and

WHEREAS, Section 7.C.3 of the Bylaws requires that the Chair and Vice Chair of the Executive Committee shall be Board members selected and approved by the Board; and

WHEREAS, the Board at this time desires to change the Board membership requirements of the Executive Committee to be no less than three (3) Board members and no more than five (5) Board members.

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

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

SECTION 2. The Executive Committee will consist of no less than three (3) Board members, and no more than five (5) Board members. Appointments to this Committee shall be for a term of two (2) years and members may be reappointed to additional terms with the Board's approval. As stated in Alliance Bylaws, the Chair and Vice Chair of the Committee shall be selected and approved by the Board.

PASSED AND ADOPTED by the Board of Governors at a meeting held on the 14th day of July 2023.

[1] 2021-09 A Resolution of Alameda Alliance for Health Creating a Standing Executive Committee.

_____
CHAIR, BOARD OF GOVERNORS

ATTEST:

_____
Secretary

RESOLUTION NO. 2023-05

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

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

WHEREAS, Section 7.A.1 of the Bylaws requires that the frequency, composition, compensation, terms, and nomination of members of standing committees shall be as set forth by resolution; and

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

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

WHEREAS, the Board approved Resolution No. 2021-14[2] on October 8th, 2021 which changed the voting membership of the Strategic Planning Committee to four (4) Board members; and

WHEREAS, the Board at this time desires to change the Board membership of the Strategic Planning Committee to be no less than three (3) Board members and no more than five (5) Board members.

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

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

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

[2] 2021-14 A Resolution of Alameda Alliance for Health Amendment the Allowable Membership to its Strategic Planning Committee.

SECTION 2. The Strategic Planning Committee will consist of no less than three (3) Board members, and no more than five (5) Board members. Appointments to this Committee shall be for a term of two (2) years and members may be reappointed to additional terms with the Board's approval. As stated in the Bylaws section 7.C.8, the Chair and Vice Chair of the Committee shall be selected and approved by the Board.

PASSED AND ADOPTED by Alliance's Board of Governors at a meeting held on the 14th day of July 2023.

_____
CHAIR, BOARD OF GOVERNORS

ATTEST:

_____
Secretary

Board of Governors

Committee Members

Presented to the Alameda Alliance Board of Governors

Matthew Woodruff, Chief Executive Officer

July 14th, 2023

ALAMEDA Alliance FOR HEALTH

Executive Committee

- Rebecca Gebhart (Chair)
- Noha Aboelata, MD (Vice Chair)
- Rollington Ferguson, MD
- Marty Lynch, Ph.D.
- Evan Seevak, MD

Compliance Advisory Committee

- Kelley Meade, MD (Chair)
- Byron Lopez (Vice Chair)
- Jody Moore

Finance Committee

- Rollington Ferguson, MD (Chair)
- Michael Marchiano, MD (Vice Chair)
- James Jackson
- Yeon Park

Strategic Planning Committee

- Marty Lynch, Ph.D. (Chair)
- Andrea Schwab Galindo (Vice Chair)
- James Jackson
- Evan Seevak, MD
- Noha Aboelata, MD

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

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

Date: **July 14th, 2023**

Subject: **CEO Report**

- **Financials:**
  - **June 2023:** Net Operating Performance by Line of Business for the month of May 2023 and Year-To-Date (YTD):

	May	YTD
Medi-Cal.....	($12.8M)	$89.3M
Group Care	$80K	$2.2M
Totals	**($12.7M)**	**$91.6M**

  - **Revenue was $144.5 million in May 2023 and $1.3 billion Year-to-Date (YTD)**.
    - Medical expenses were $127 million in May and $1.2 billion year-to-date; the medical loss ratio is 88.1% for the month and averages 89% for the fiscal year.
    - Administrative expenses were $6.2 million in May and $64.7 million year-to-date; the administrative loss ratio is 4.3% of revenue for the month and averages 5.0% for the fiscal year.
  - **Tangible Net Equity (TNE)**: Financial reserves are 778%, representing $280.8 million in excess TNE.
  - **Total enrollment in May 2023 went over 360,000**, increasing by more than 1,956 Medi-Cal members compared to April.

- **Community Reinvestment**
  - Presentation

- **Recruiting Incentives for our Network**
  - I have shared the draft document with Board members that offered to help review the program. If there are any other Board members that are interested in shaping the program please reach out to me.

- **Key Performance Indicators:**
  - **Regulatory Metrics:**
    - All regulatory metrics were met in the month of April.
  - **Non-Regulatory Metrics:**
    - The Member Services call center reported an abandonment rate of 22% and 63% for calls answered in under 30 seconds for the month of May. The results are 17% and 17% below the internal thresholds respectively. Inbound call volume exceeded 21,000 as membership grew.
    - The Information Technology Department fell below an internal up time metric. The Alliance working with our external vendor RAM found that the system has a bug which is being fixed through a patch. The patch should be in place and fully tested by the middle of August.

- **Program Implementations:**

  - **Single Plan Model**
    - Effective January 1st, 2024, Alameda Alliance will become the "Prime" Medi-Cal option for Alameda County residents enrolled in the Medi-Cal program.
    - At the end of June the DHCS sent out a 2024 transition guide
      - Kaiser will NOT receive default enrollment in Alameda County.
      - New members into Anthem will stop September 30, 2023
      - Notices to all Kaiser and Anthem members will be sent by the State for the January 2024 transition on November 1st and December 1st

- **Quality Improvement, HEDIS, and Medi-Cal Rate Development**
  - DHCS announced that our Alliance Quality scores will be compared to Kaiser in 2024.

- **Continuous Coverage**
  - The public health emergency has ended, and Medi-Cal redeterminations have started. The first disenrollments will occur in July 2023 and continue through May 2024.
  - Alameda Alliance for Health is partnering with Alameda County Social Services Agency on an outreach campaign to minimize the disruptions to county residents due to disenrollment from the Medi-Cal program.

- **CalAIM Incentive Programs**

Program #1. Behavioral Health Integration Incentive Program.

- Description & Purpose:

  The incentive program is designed to incentivize improvement of physical and behavioral health outcomes, care delivery efficiency, and patient experience. The goal is to increase provider network integration at all levels of integration (those just starting behavioral health integration in their practices as well as those that want to take their integration to the next level), focus on new target populations or health disparities, and improve the level of integration or impact of behavioral and physical health.
- Program Years: **1/1/2021 - 12/31/2022**
- Maximum allocation to Alameda Alliance: **$3.2 million**.

Payments issued to date: **$2.8 million awarded** to three contracted providers

Program #2. COVID-19 Vaccine Incentive Program.

- Description & Purpose:

  The incentive program began in October 2021 and ended on February 28, 2022. The vaccine program targeted children and adults enrolled in Medi-Cal managed care, ages 12 and older. During the vaccination campaign, the vaccination rates for Medi-Cal beneficiaries increased by 13.2%, from 62.2% to 75.4%. The Alliance was awarded $2.2 million, or 26% of the available funding.
  This incentive program ended on February 28, 2022.
- Program Years: **10/1/2021 – 2/28/2022**
- Maximum allocation to Alameda Alliance: **$8.4 million**.
- Earned incentive dollars: **$3.0 million**.

Payments issued to Providers: **$1.4 million awarded** to approximately nineteen (19) organizations across Alameda County.

Program #3. CalAIM Incentive Payment Program.

- Description & Purpose:

  CalAIM's Enhanced Care Management (ECM) and Community Supports (CS) programs began launching on January 1st, 2022. The purpose of this incentive program is to expand ECM and Community Supports by building capacity, investing in delivery system infrastructure, addressing disparities and equity, adding community supports, and improving quality.
  Any provider or community-based organization is invited to apply for incentive funding. In order to qualify for funding, the participating organizations are required to join the Alliance's ECM and Community Supports program, and to meet specified outcomes and performance measures.
- Program Years: **1/1/2022 – 6/30/2024**
- Maximum allocation to Alameda Alliance: **$14.8 million (year 1); $15.1 million (year 2).**
- Earned incentive dollars: **$7.4 million**.
- Payments issued: **$6.1 million**.

Program #4. Student Behavioral Health Incentive Program:

- Description & Purpose:

  Statewide $389 million is designated over a three-year period (January 1, 2022-December 31, 2024) for incentive payments to Medi-Cal managed care plans that meet predefined goals and metrics. The goals and metrics are associated with targeted interventions that increase access to preventive, early intervention, and behavioral health services by school-affiliated behavioral health providers for TK-12 children in public schools. Public charter schools are also included.
  The purpose of this incentive program is to invest in three priority areas of school-based behavioral health services: planning and coordination, infrastructure, and prevention and early intervention.
- Program Years: **1/1/2022 - 12/31/2024**
- Maximum allocation to Alameda Alliance: **$9.7 million**.
- Earned incentive dollars: **$5.2 million.**
- Payments issued to SBHIP Partners: **$3.3 million**.

Program #5. Housing and Homelessness Incentive Program:

- Description & Purpose:

  This incentive program is built upon the DHCS' quality strategy and the Home- and Community Based Spending Plan. The spending plan focuses on addressing homelessness and unhoused people and encompasses the community-based residential continuum pilots for older, frail adults and disabled populations. The plan includes the assisted living waiver waitlist, community care expansion program, and other services. Address homelessness and housing insecurity as social determinants of health. Developing a local homelessness plan will be jointly created with Alameda County Health Care Services Agency and Alameda Alliance and submitted to the DHCS. The existing partnership that originated during the Whole Person Care and Health Home Pilots (2017 – 2021) would be extended to build more capacity and to support more referrals for housing services, and to better coordinate housing needs.
  This incentive program enables further investing in the expansion of street medicine, data management systems, and staffing to attain three measurement areas: 1) local partnerships to address disparities and equity, 2) infrastructure to support housing navigation, and 3) service delivery and member engagement.
- Program Years: **1/1/2022 - 3/31/2024**
- Maximum allocation to Alameda Alliance: **$44.3 million.**
- Earned incentive dollars: **$20.4 million.**
- Payments issued to Providers: **$6.0 million.**

Community Reinvestment

Matthew Woodruff, Chief Executive Officer

and

Gilbert Riojas, Chief Financial Officer

July 14th, 2023

ALAMEDA Alliance FOR HEALTH

- Exhibit B, Section 1.17 of the new DHCS contract requires managed care plans to invest a portion of any Medi-Cal net income into community reinvestment activities.
- Plans are required to allocate 5% of a plan's net income less than or equal to 7.5% of the annual Medi-Cal revenue to community reinvestment.
- The plan must allocate 7.5% of any amount of net income that is over 7.5% of total revenue to community reinvestment.

Community Reinvestment Calculation using FY23 Projections (example)	
Projected Net Income for FY23	$ 90,000,000
Projected Annual Medi-Cal Revenue for FY23	$1,410,000,000
7.5% of Annual Medi-Cal Revenue	$ 105,750,000
5% of Net Income for FY23 required to be allocated to Community Reinvestment	$ 4,500,000

- Exhibit B, Section 1.18 requires managed care plans to meet quality outcome metrics defined by DHCS.
- If these quality metrics are not met, an additional 7.5% of annual net income must be allocated to community reinvestment activities.

Community Reinvestment Calculation using FY23 Projections (example)	
Projected Net Income for FY23	$ 90,000,000
Projected Annual Medi-Cal Revenue for FY23	$1,410,000,000
7.5% of Net Income for FY23 that may be allocated if quality metrics are not met	$ 6,750,000

- Using Fiscal Year 2023 as an example, the plan would be required to reinvest approximately $4.5M in Net Income into the community (details of this investment are currently undefined by DHCS).
- If the Alliance did not meet the quality metrics required by DHCS, an additional $6.8M would be required to be reinvested in the community.
- The total community reinvestment in this example would be $11.3M.

Community Reinvestment Calculation using FY23 Projections (example)	
Projected Net Income for FY23	$ 90,000,000
Projected Annual Medi-Cal Revenue for FY23	$1,410,000,000
7.5% of Annual Medi-Cal Revenue	$ 105,750,000
5% of Net Income for FY23 required to be allocated to Community Reinvestment	$ 4,500,000
7.5% of Net Income for FY23 that may be allocated if quality metrics are not met	$ 6,750,000
Total Potential Net Income required by DHCS to be reinvested	$ 11,250,000

- Timing
- Funding Opportunities
  - Quality
  - Access
- Governance

OPERATIONS DASHBOARD

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Financials

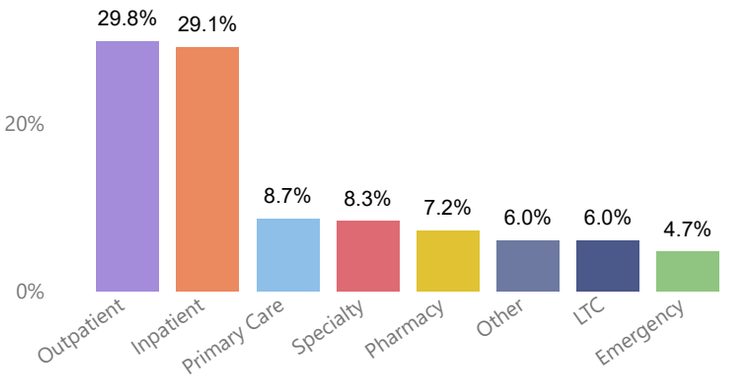
Income & Expenses

	MAY 2023	FISCAL YTD
REVENUE	$ 144.5 M	$ 1.3 B
MEDICAL EXPENSE	$ (127.2) M	$ (1.2) B
ADMIN EXPENSE	$ (6.2) M	$ (64.7) M
OTHER	$ 1.7 M	$ 13.0 M
NET INCOME	$ 12.7 M	$ 91.6 M

Gross Margin %

11.0%

Medical Expenses



Liquid Reserves

MLR Net %

89.0%

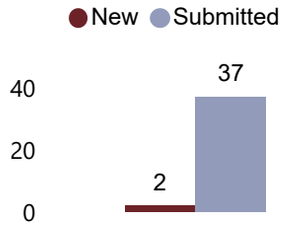
TNE %

778.2%

TNE $

$322.2M

Reinsurance Cases



Balance Sheet

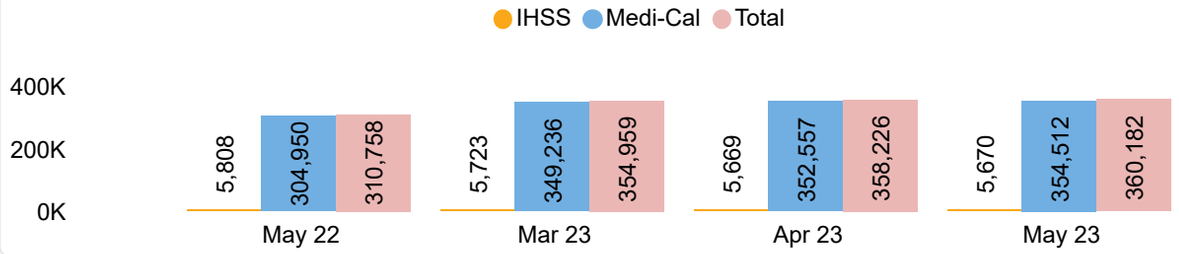
Cash Equivalents	**$472.0M**
Pass-Through Liabilities	**$142.1M**
Uncommitted Cash	**$329.9M**
Working Capital	**$297.3M**

Current Ratio

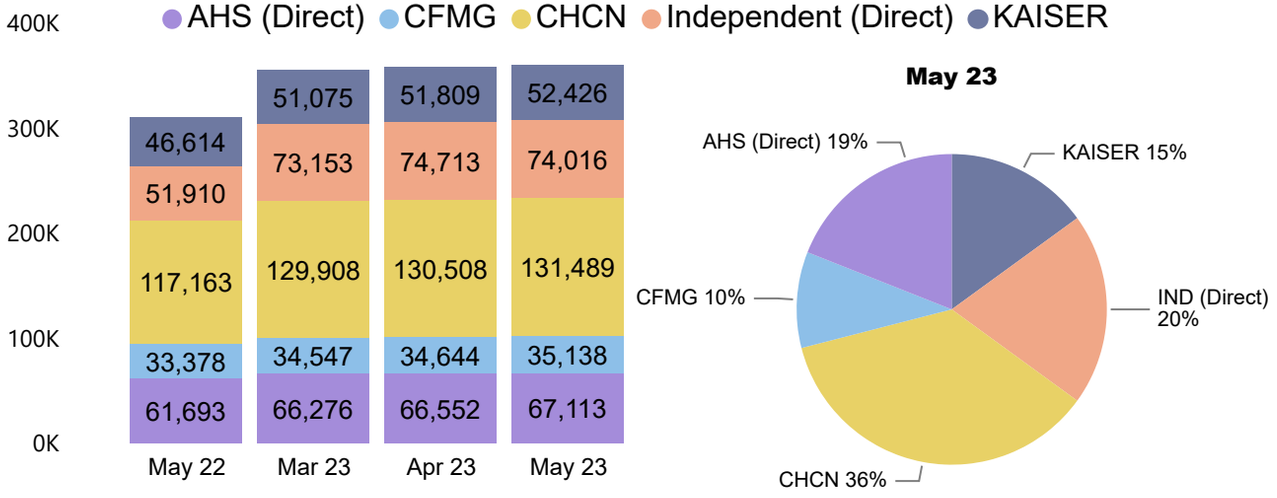
1.79

Membership

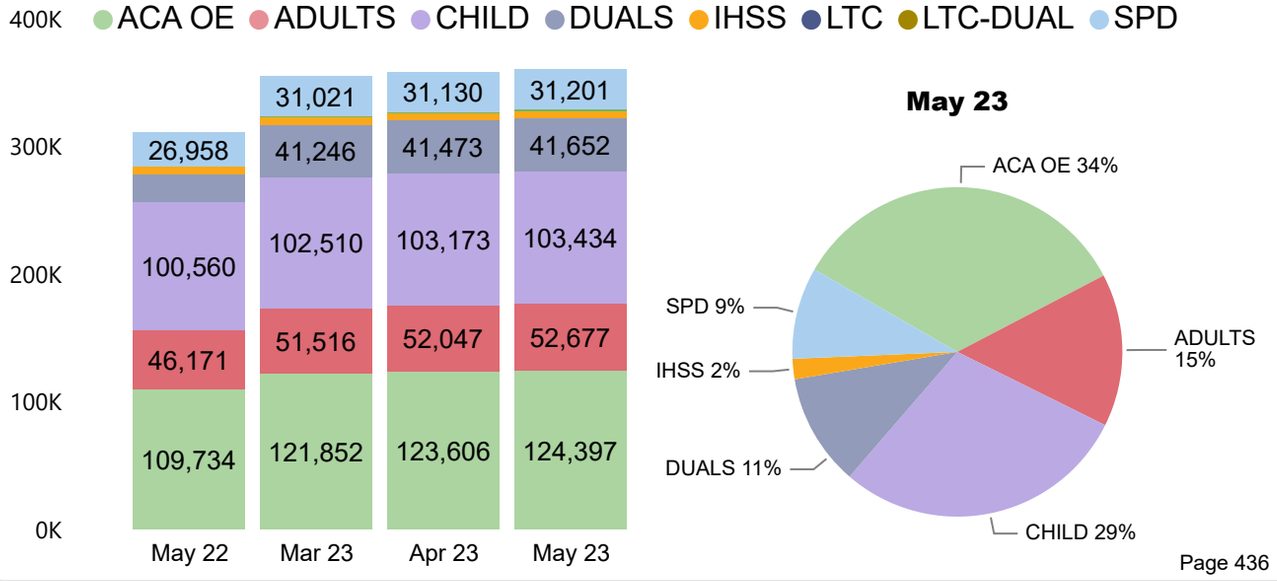
By Plan



By Network



By Category



OPERATIONS DASHBOARD

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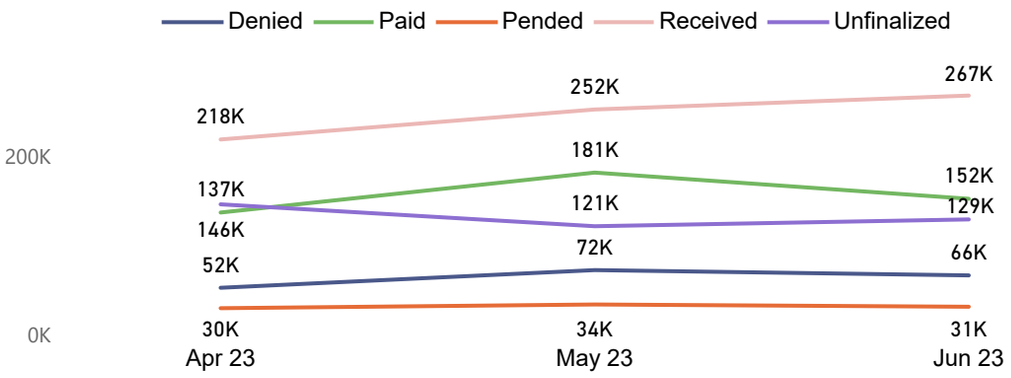
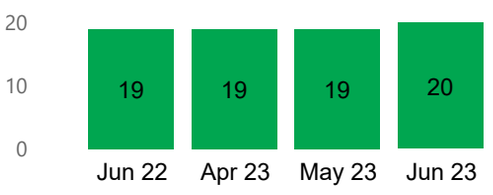
Claims

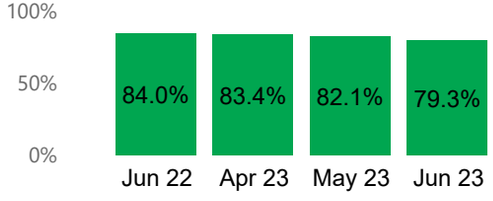
Claims Processing



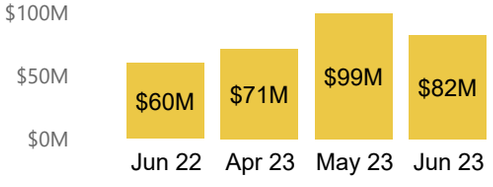
Average Payment TAT (Days)



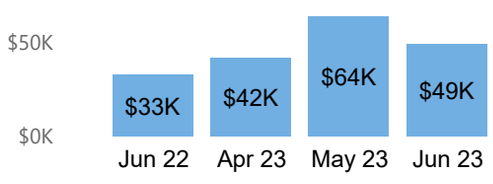
Auto Adjudication Rate (%)



Claims Paid ($)

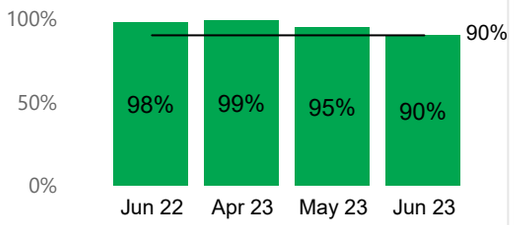


Interest Paid ($)

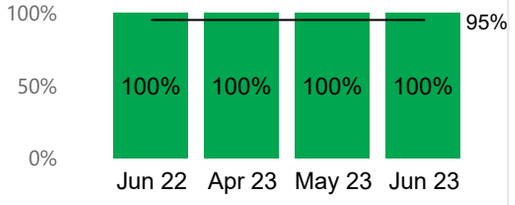


Claims Compliance

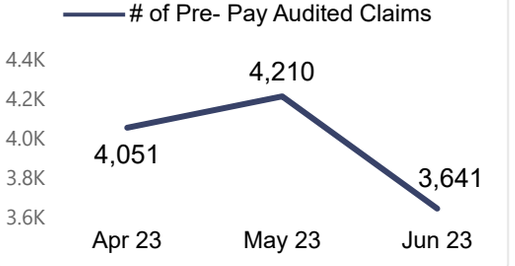
Processed 30 Cal Days (%)



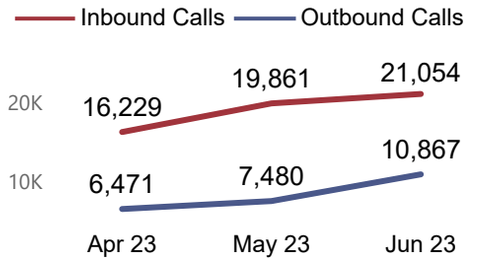
Processed 45 Work Days (%)



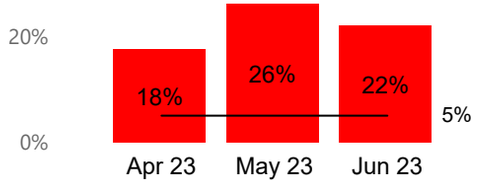
Claims Auditing



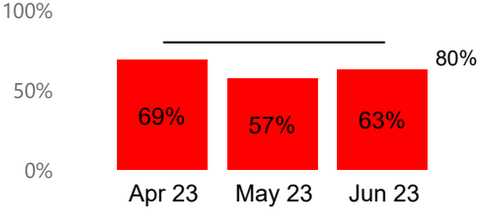
Member Services



Abandoned Call Rate (%)

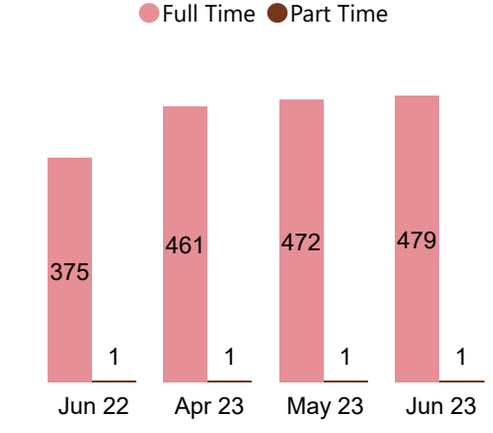


Calls Answered in 30 Seconds (%)

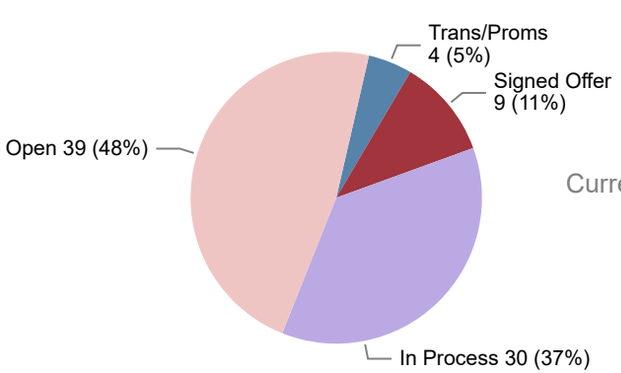


Average Call Times	Apr 23	May 23	Jun 23
Wait Time	01:48	02:17	01:29
Call Duration	04:57	05:50	06:21

Human Resources

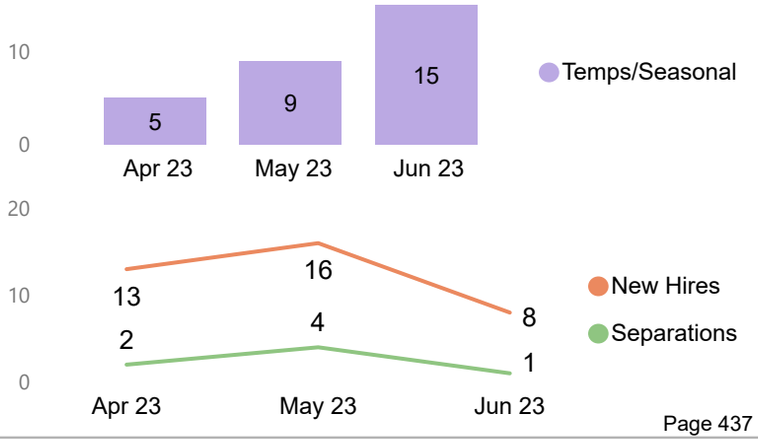


Recruiting Status Jun 23



Current Vacancy

8%



OPERATIONS DASHBOARD

JULY 2023

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Provider Services

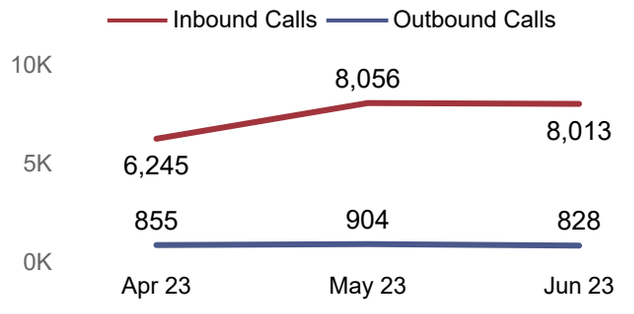
Provider Network

Hospital	17
Specialist	9,071
Primary Care Physician	773
Skilled Nursing Facility	101
Urgent Care	7
Health Centers (FQHCs and Non-FQHCs)	67
Transportation	380
TOTAL	**10,416**

Provider Credentialing

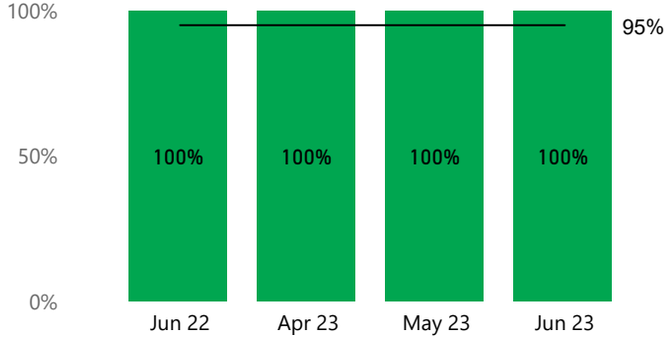
2,497

Provider Call Center



Provider Disputes & Resolutions

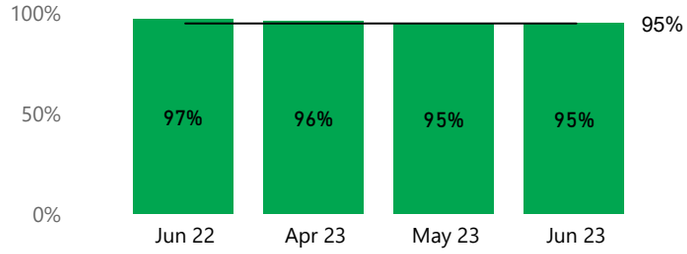
Turnaround Compliance (45 business days)



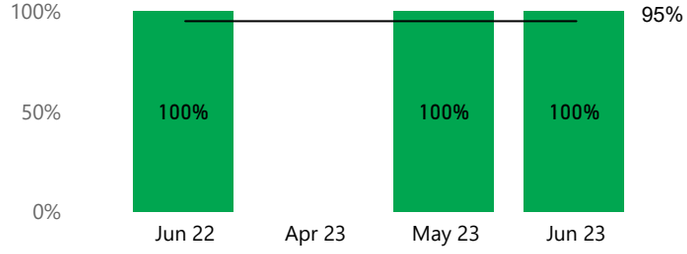
Compliance

Member Grievances

Standard (30 calendar days)

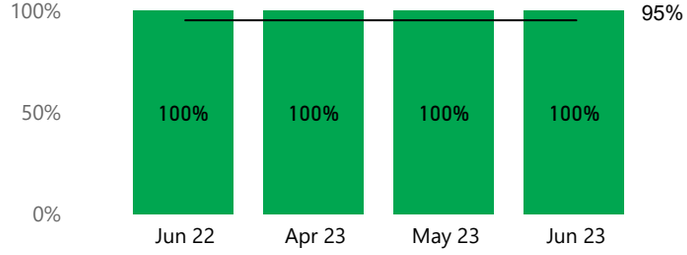


Expedited (3 calendar days)

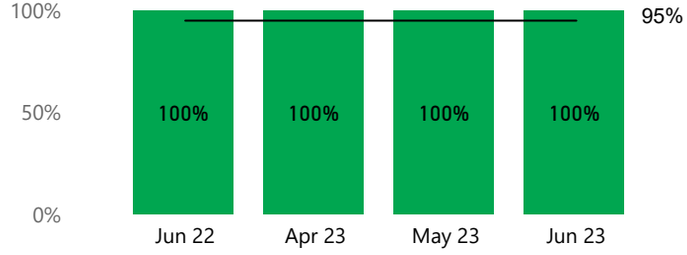


Member Appeals

Standard (30 calendar days)

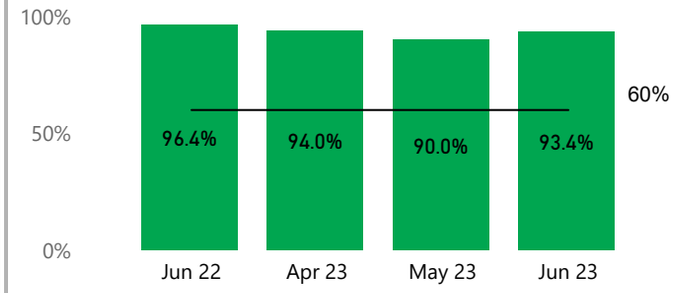


Expedited (3 calendar days)

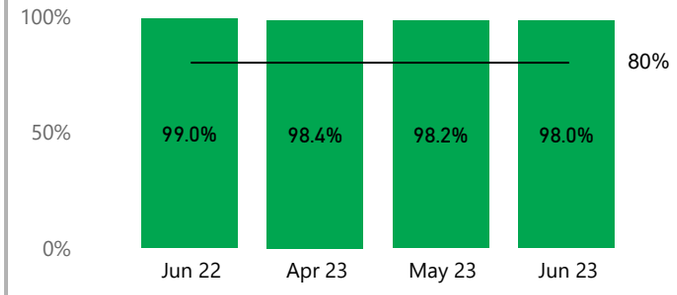


Encounter Data

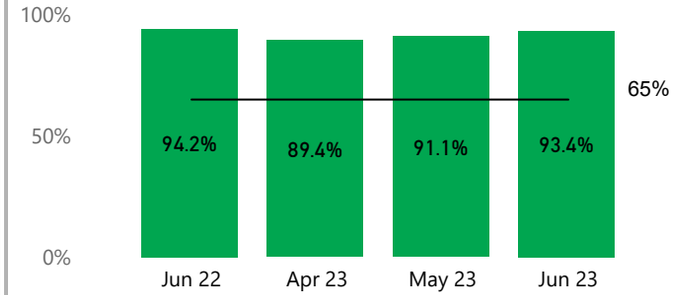
Institutional 0-90 days



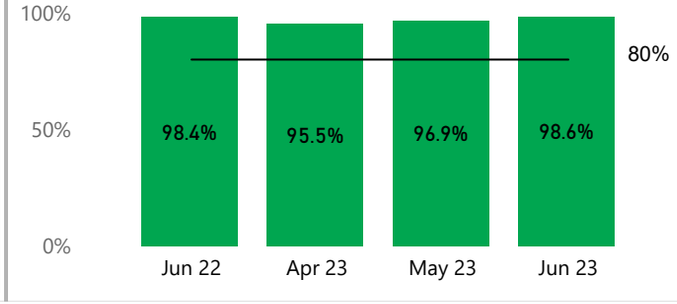
Institutional 0-180 days



Professional 0-90 days



Professional 0-180 days



OPERATIONS DASHBOARD

JULY 2023

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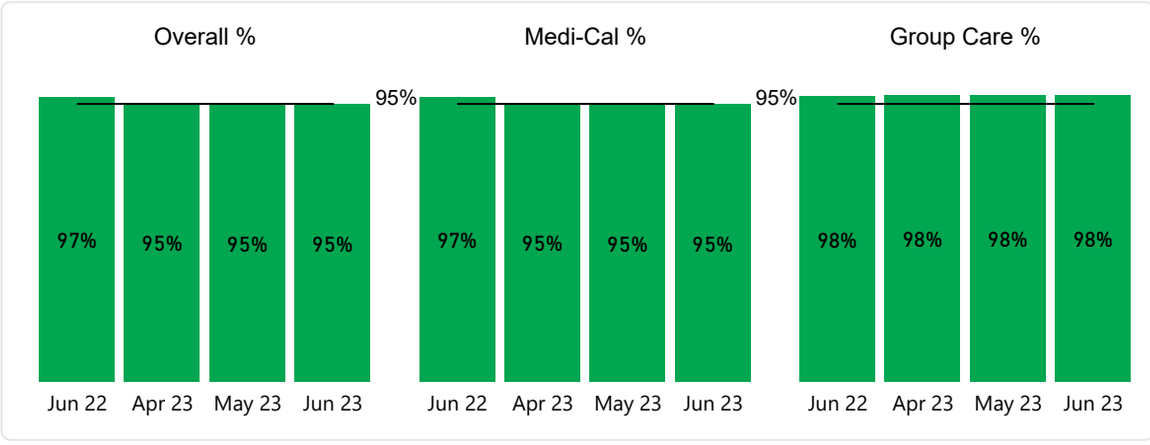
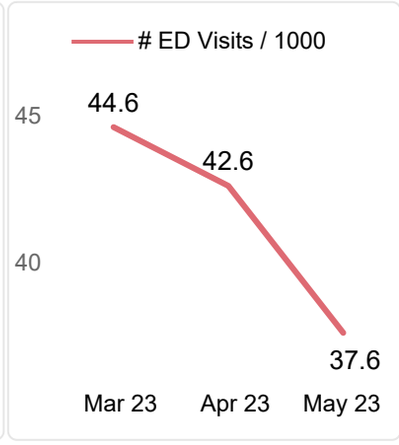
Health Care Services

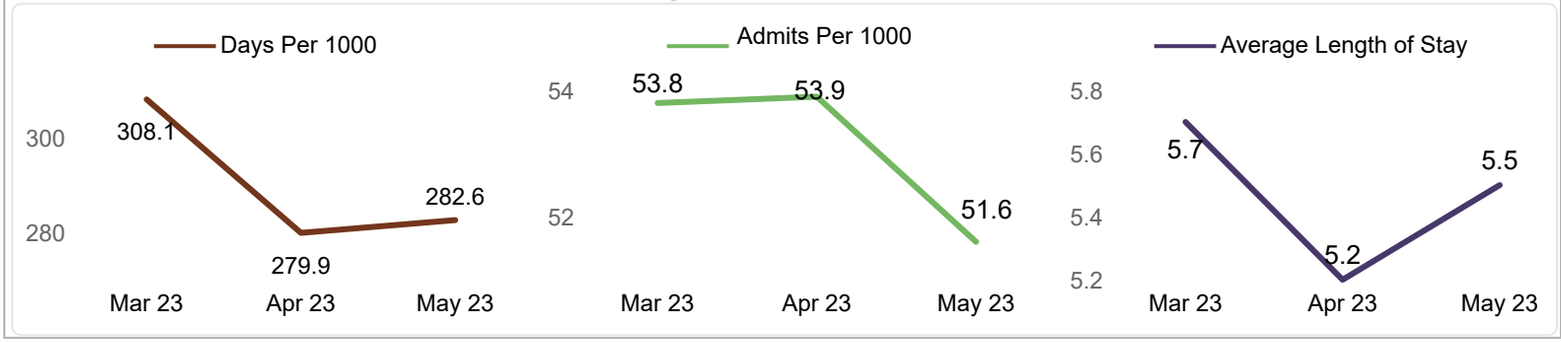
Authorization Turnaround



ED Utilization

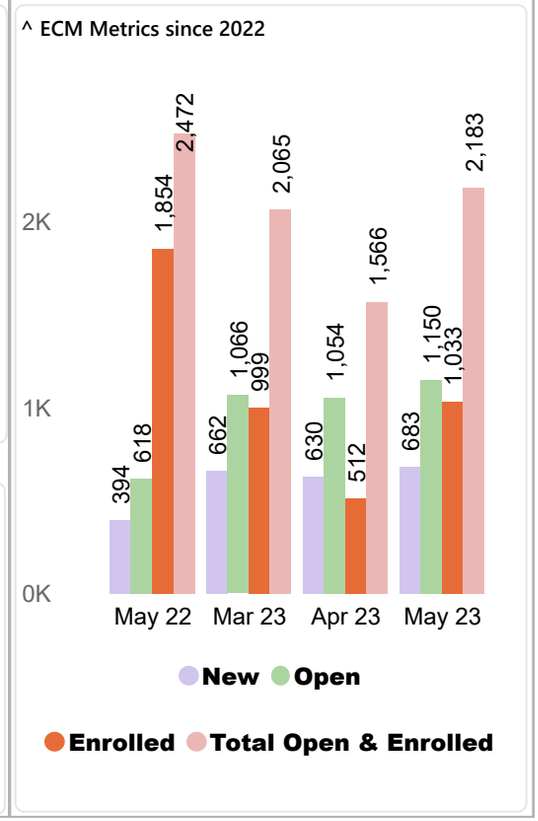


Inpatient Utilization

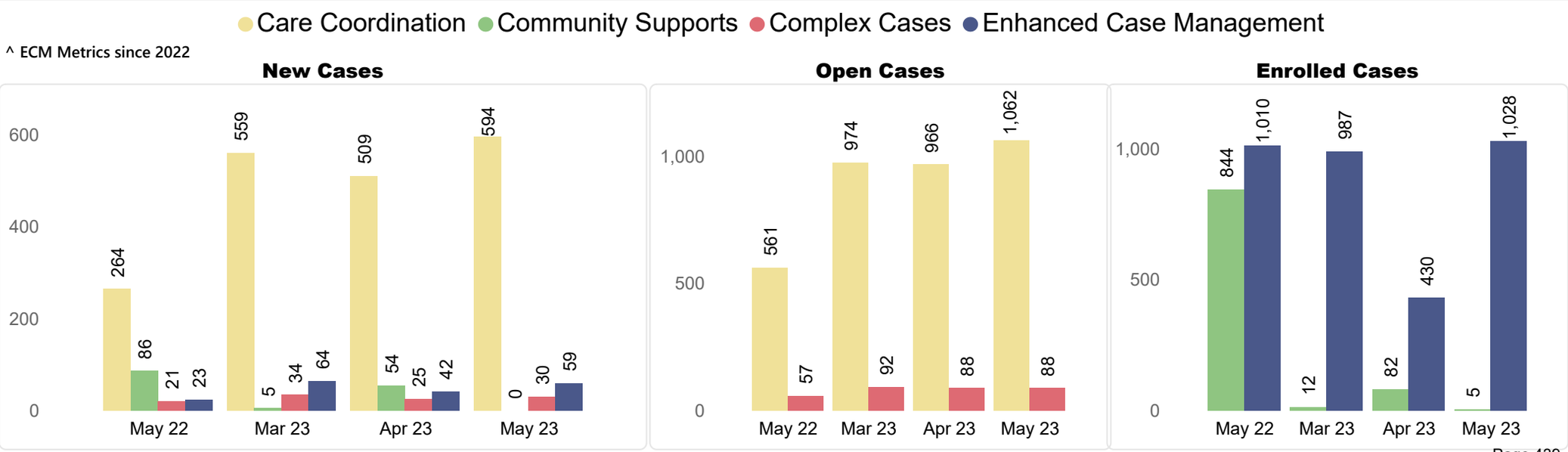


Case Management

Total Cases^



Case Management^



Technology (Business Availability)

Applications	Jun 22	Apr 23	May 23	Jun 23
HEALTHsuite System	100.0%	100.0%	100.0%	98.1%
Other Applications	100.0%	100.0%	98.0%	100.0%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Jun 22	Apr 23	May 23	Jun 23
Denial Rate Excluding Partial Denials (%)	4.1%	2.9%	3.3%	2.7%
Overall Denial Rate (%)	4.5%	3.2%	3.5%	2.9%
Partial Denial Rate (%)	0.4%	0.3%	0.2%	0.2%

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

Pharmacy Authorizations

Authorizations	Jun 22	Apr 23	May 23	Jun 23
Approved Prior Authorizations	18	37	33	38
Closed Prior Authorizations	26	95	117	95
Denied Prior Authorizations	33	43	50	50
Total Prior Authorizations	77	175	200	183

To: **Alameda Alliance for Health, Finance Committee**

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

Date: **July 14th, 2023**

Subject: **Finance Report – May 2023**

Executive Summary

- For the month ended May 31st, 2023, the Alliance had enrollment of 360,182 members, a Net Income of $12.7 million and 778% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$144,479	$1,304,602
Medical Expense	127,220	1,161,350
Admin. Expense	6,240	64,669
Other Inc. / (Exp.)	1,707	12,968
Net Income	**$12,725**	**$91,552**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal	$12,805	$89,341
Group Care	(80)	2,210
	$12,725	**$91,552**

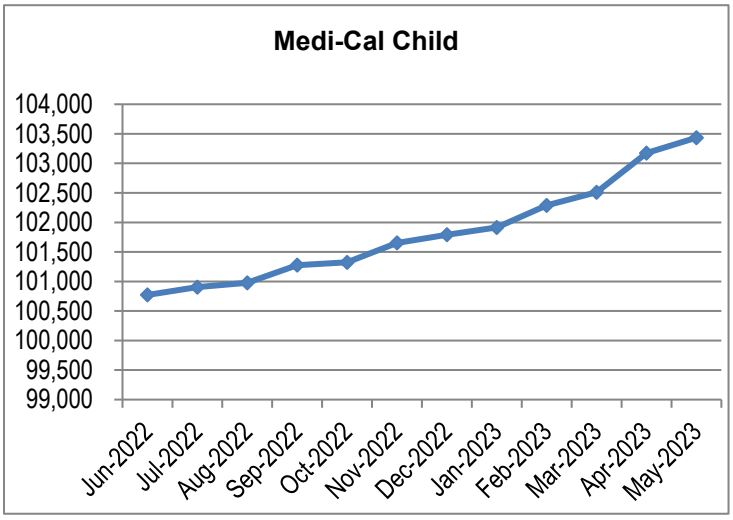
Enrollment

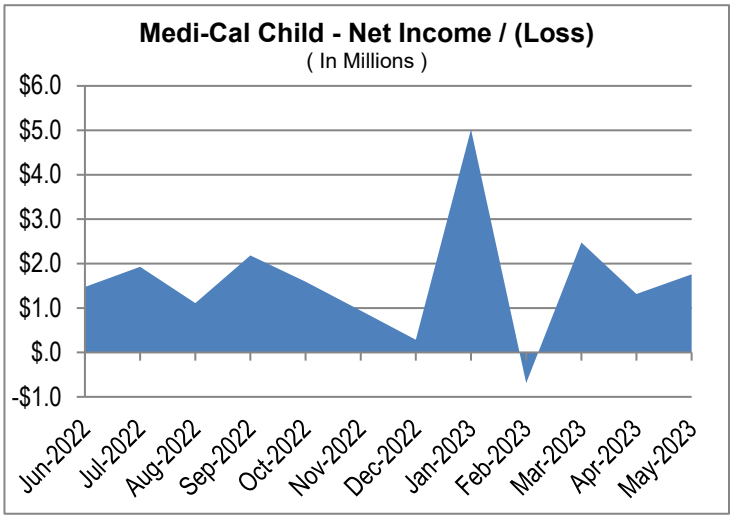
- Total enrollment increased by 1,956 members since May 2023.
- Total enrollment increased by 47,126 members since July 2022.

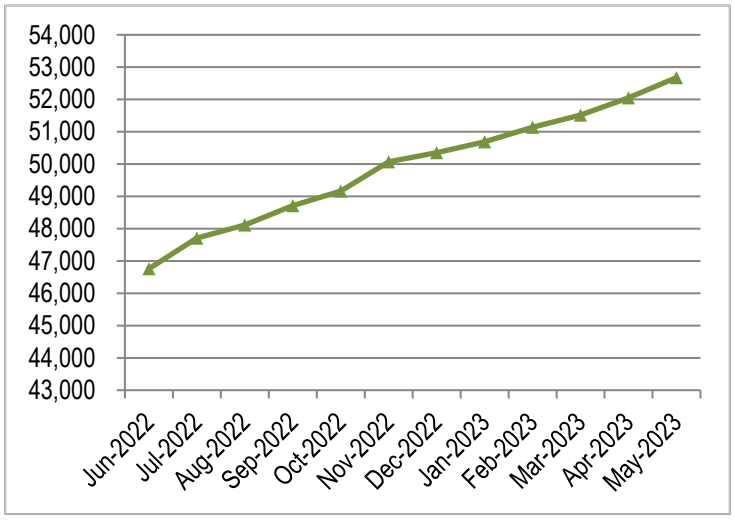
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

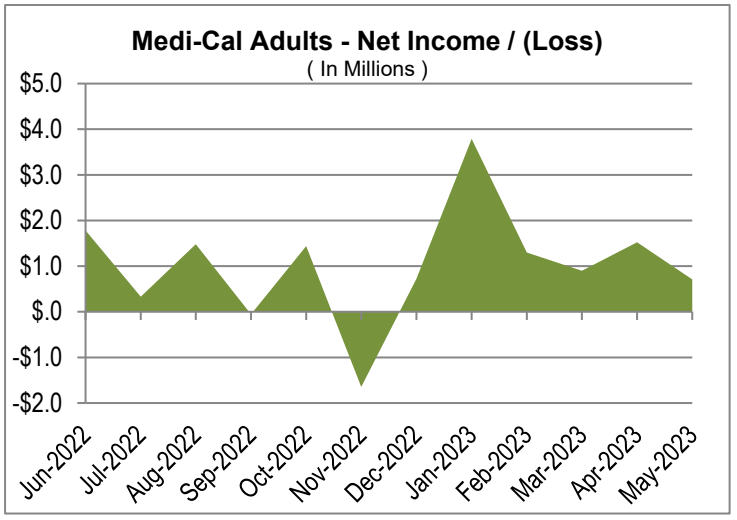
Enrollment					Member Months			
May 2023					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
52,677	50,572	2,105	4.2%	Adult	552,184	545,106	7,078	1.3%
103,434	102,427	1,007	1.0%	Child	1,121,242	1,119,514	1,728	0.2%
31,201	31,866	(665)	-2.1%	SPD	322,273	327,819	(5,546)	-1.7%
41,652	45,320	(3,668)	-8.1%	Duals	322,677	358,586	(35,909)	-10.0%
124,397	120,274	4,123	3.4%	ACA OE	1,304,288	1,294,473	9,815	0.8%
148	153	(5)	-3.3%	LTC	571	765	(194)	-25.4%
1,003	1,184	(181)	-15.3%	LTC Duals	3,798	5,920	(2,122)	-35.8%
354,512	**351,796**	**2,716**	**0.8%**	**Medi-Cal Total**	**3,627,033**	**3,652,183**	**(25,150)**	**-0.7%**
5,670	5,789	(119)	-2.1%	Group Care	63,333	63,720	(387)	-0.6%
360,182	**357,585**	**2,597**	**0.7%**	**Total**	**3,690,366**	**3,715,903**	**(25,537)**	**-0.7%**

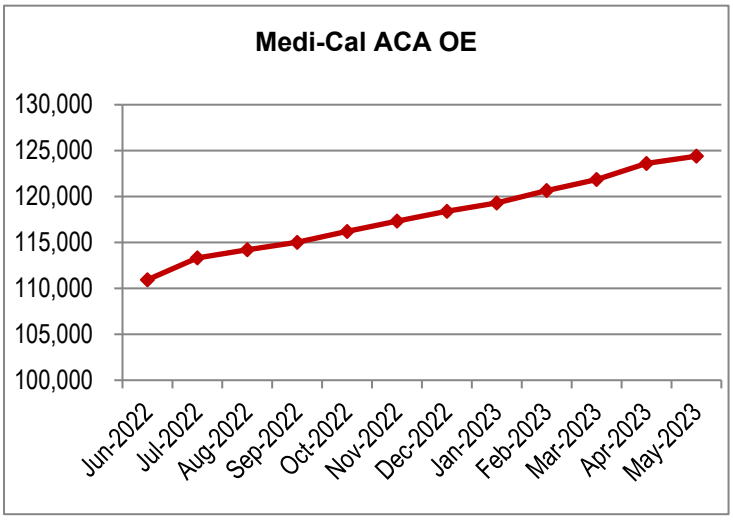
Enrollment and Profitability by Program and Category of Aid

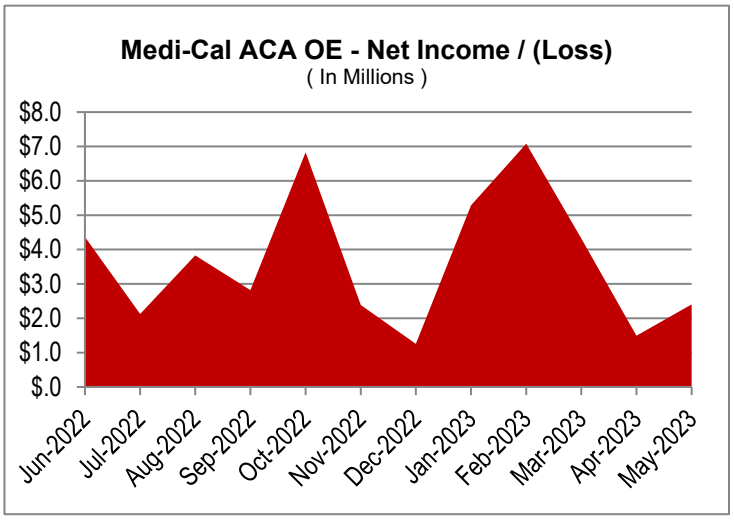




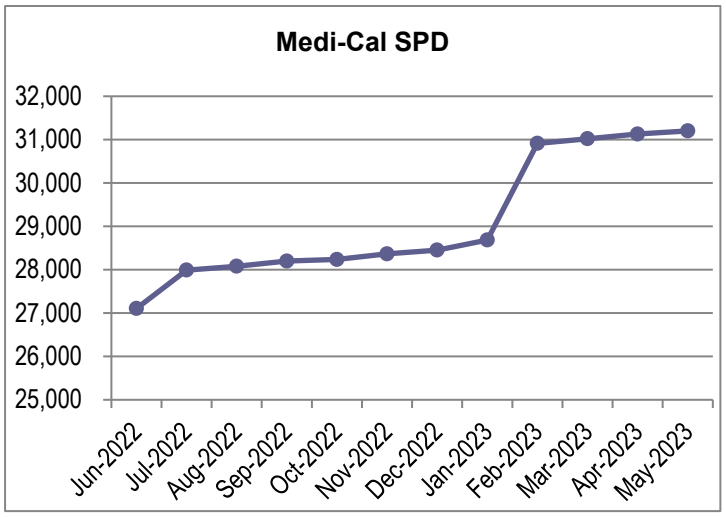


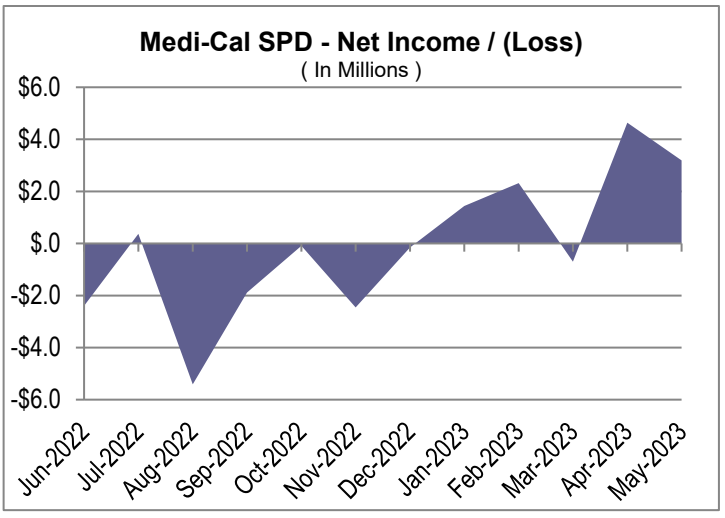


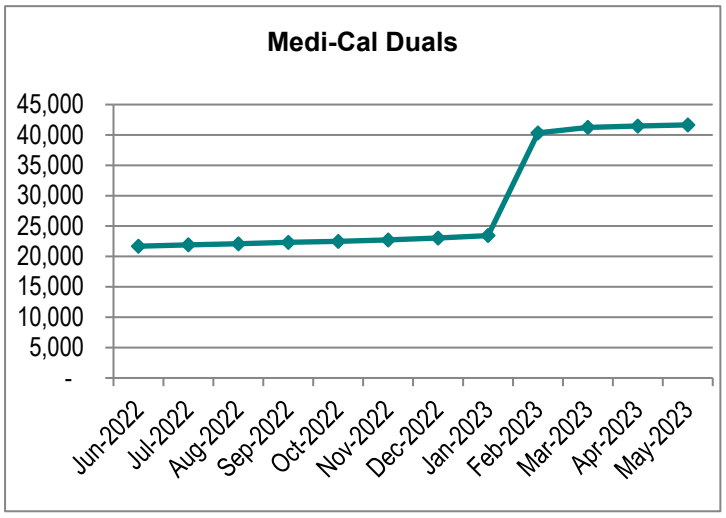


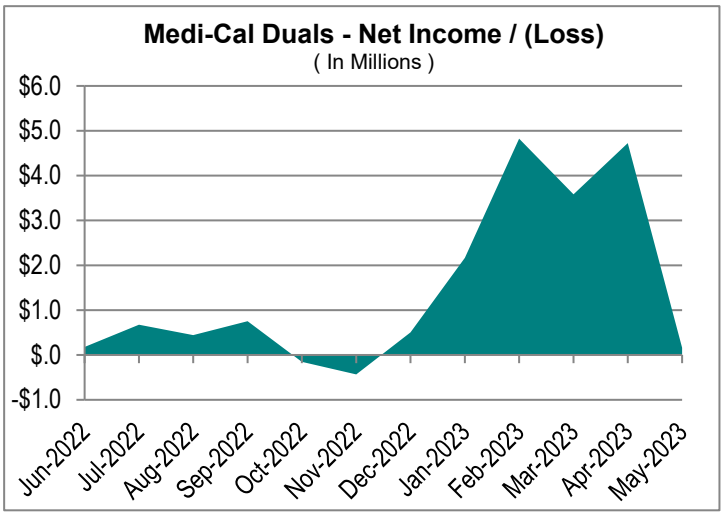


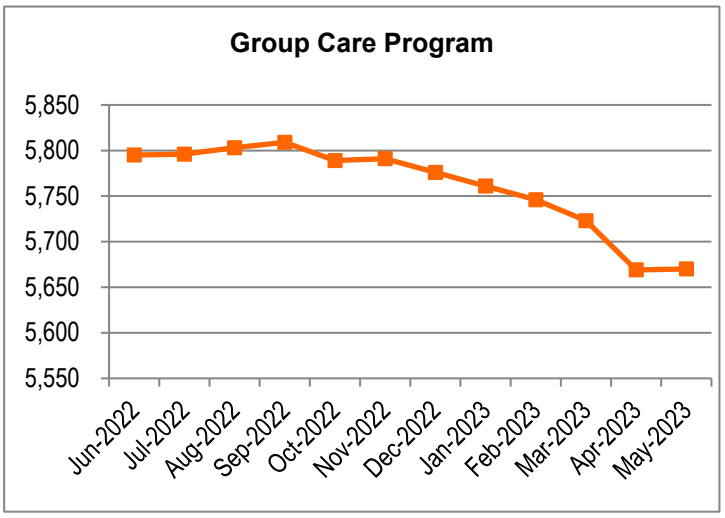
Enrollment and Profitability by Program and Category of Aid

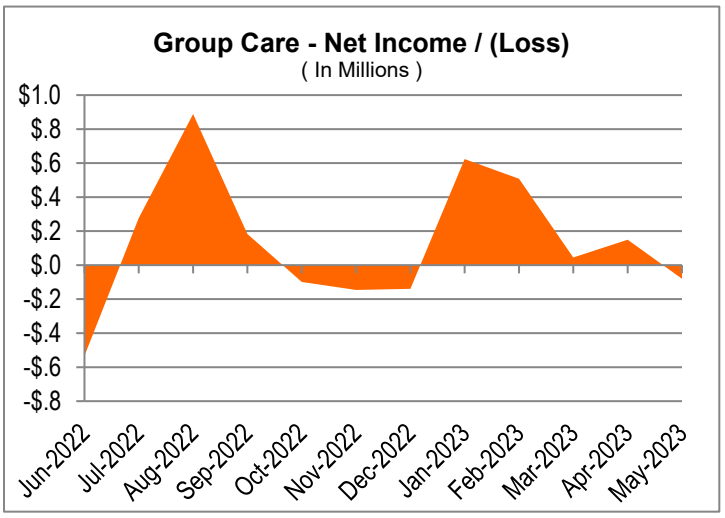




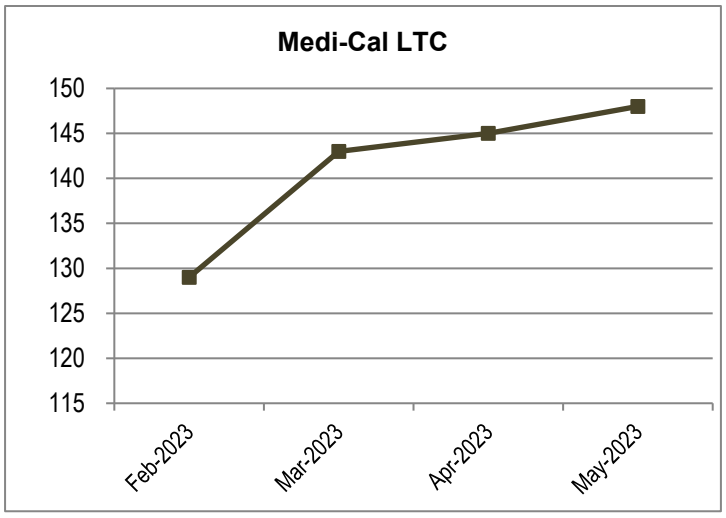


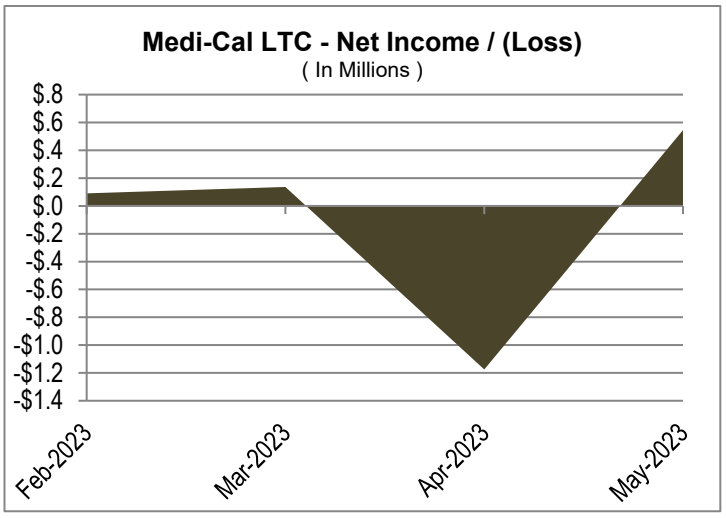


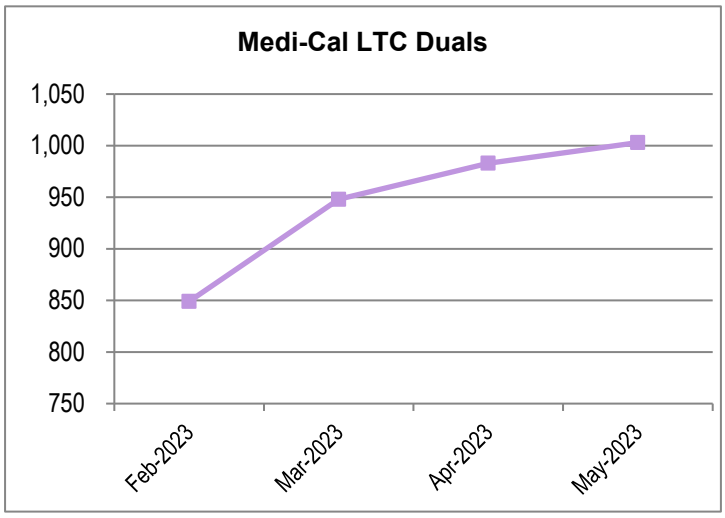


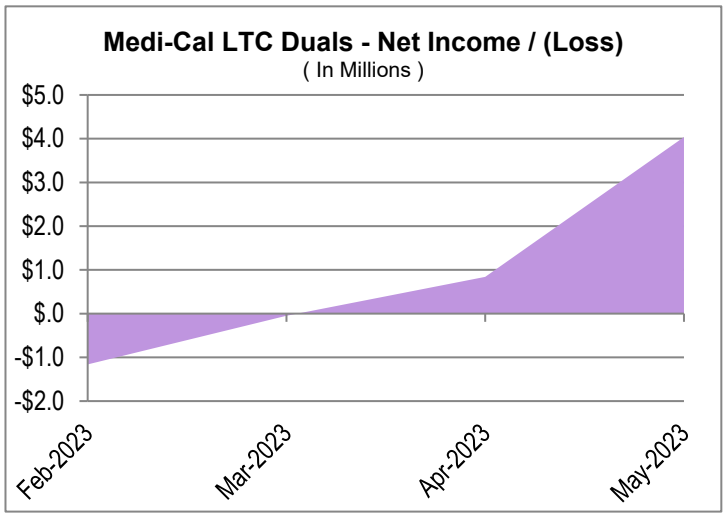


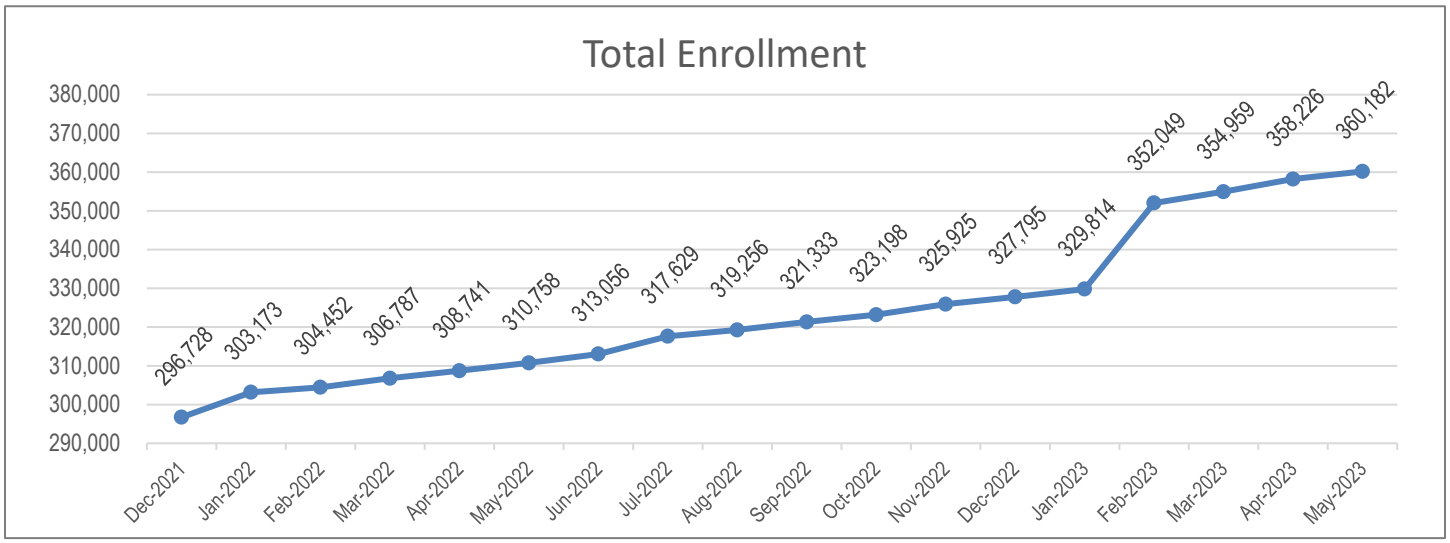
Enrollment and Profitability by Program and Category of Aid

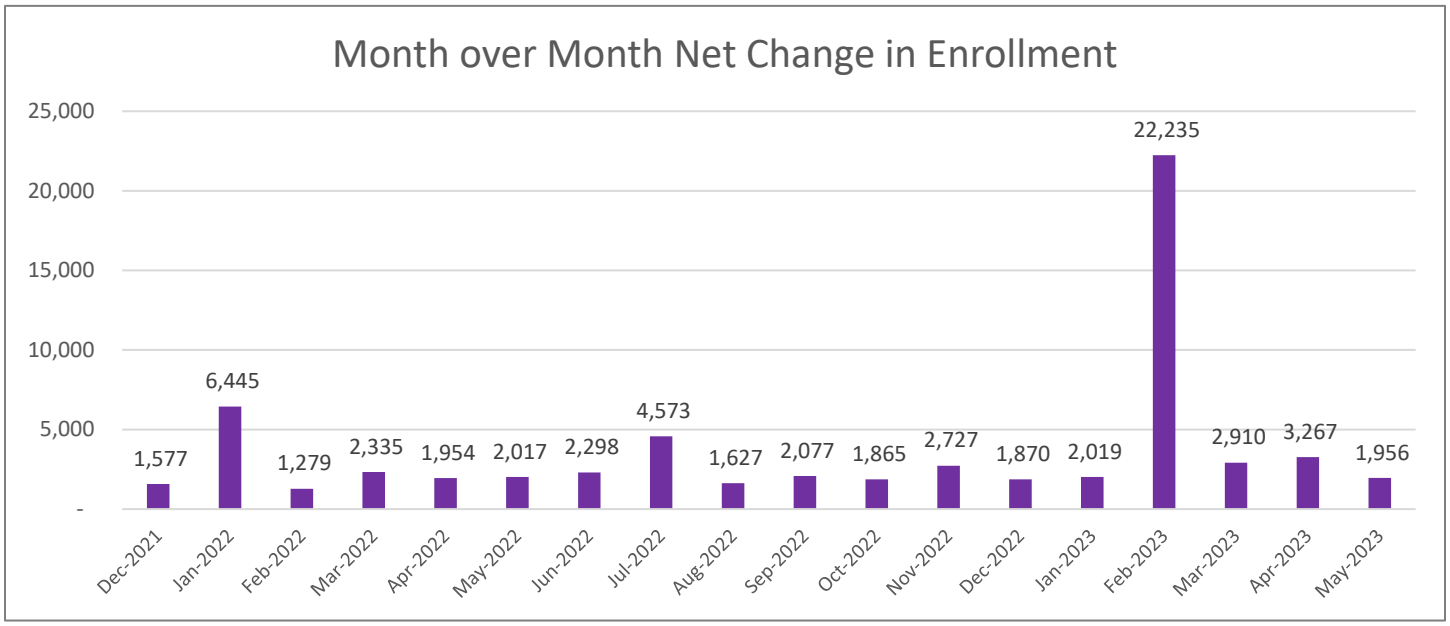










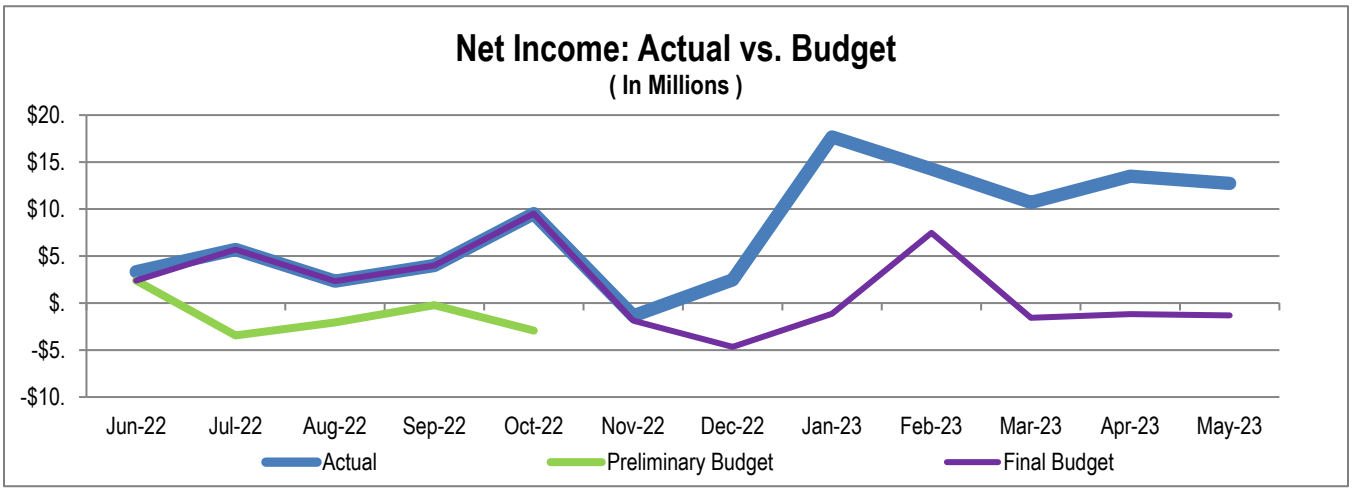


- The Public Health Emergency (PHE) ended May 2023. The Alliance expects disenrollment related to redetermination to restart in July 2023.

Net Income

- For the month ended May 31st, 2023
  - Actual Net Income $12.7 million.
  - Budgeted Net Loss $1.3 million.

- For the fiscal YTD ended May 31st, 2023
  - Actual Net Income $91.6 million.
  - Budgeted Net Income $17.3 million.

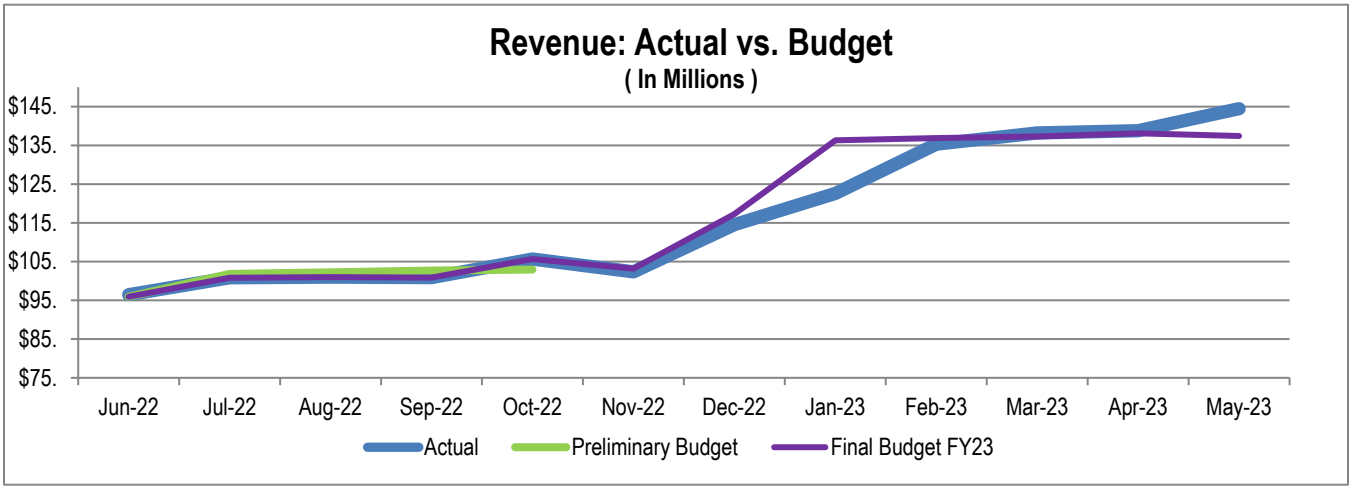


- The favorable variance of $14.0 million in the current month is primarily due to:
  - Favorable $7.0 million higher than anticipated Revenue.
  - Favorable $4.5 million lower than anticipated Medical Expense.
  - Favorable $1.7 million higher than anticipated Total Other Income.
  - Favorable $827,000 lower than anticipated Administrative Expense.

Revenue

- For the month ended May 31st, 2023
  - Actual Revenue: $144.5 million.
  - Budgeted Revenue: $137.4 million.

- For the fiscal YTD ended May 31st, 2023
  - Actual Revenue: $1.3 billion.
  - Budgeted Revenue: $1.3 billion.



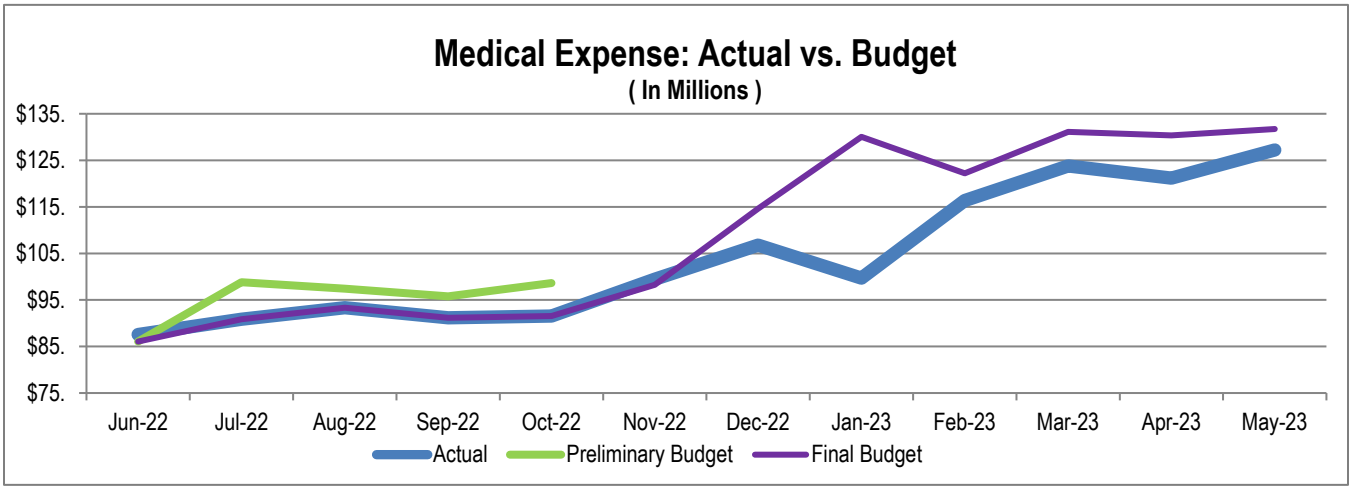
- For the month ended May 31st, 2023, the favorable revenue variance of $7.0 million is primarily due to:
  - Favorable $16.9 million CalAIM Incentive Program revenue (IPP, HHIP, and SBHIP). The majority of this revenue has corresponding CalAIM Incentive expenses.
  - Favorable $3.8 million capitation revenue due to higher than budgeted CY 2023 capitation rates for all components of capitation rate except Community Supports.
  - Unfavorable $13.0 million adjustment to the Prop 56 Risk Corridor for the period of July 2019 through December 2020. This revenue has a corresponding reduction to expense.
  - Unfavorable $1.1 million Medi-Cal Base Capitation. This is driven by lower than budgeted enrollment.

Medical Expense

- For the month ended May 31st, 2023

- Actual Medical Expense: $127.2 million.
- Budgeted Medical Expense: $131.7 million.

- For the fiscal YTD ended May 31st, 2023
  - Actual Medical Expense: $1.2 billion.
  - Budgeted Medical Expense: $1.2 billion.



- 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 by our Actuarial Consultants.

- For May, updates to Fee-For-Service (FFS) increased the estimate for prior period unpaid Medical Expenses by $1.6 million. Year to date, the estimate for prior years increased by $2.3 million (per table below).

Medical Expense - Actual vs. Budget (In Dollars)
Adjusted to Eliminate the Impact of Prior Period IBNP Estimates

	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$274,027,474	$0	$274,027,474	$284,085,742	$10,058,269	3.5%
Primary Care FFS	$41,598,794	$40,306	$41,639,099	$49,898,957	$8,300,163	16.6%
Specialty Care FFS	$52,340,270	$112,974	$52,453,243	$58,015,084	$5,674,814	9.8%
Outpatient FFS	$86,753,624	$890,286	$87,643,910	$99,242,324	$12,488,700	12.6%
Ancillary FFS	$87,112,910	$797,516	$87,910,426	$101,259,785	$14,146,875	14.0%
Pharmacy FFS	$83,714,991	$353,048	$84,068,039	$79,163,269	($4,551,722)	-5.7%
ER Services FFS	$54,560,363	$122,356	$54,682,719	$57,900,476	$3,340,113	5.8%
Long Term Care FFS	$338,296,802	$153,439	$338,450,241	$356,236,026	$17,939,224	5.0%
Inpatient Hospital & SNF FFS	$70,413,436	($198,255)	$70,215,182	$84,582,411	$14,168,975	16.8%
Other Benefits & Services	$69,727,007	$0	$69,727,007	$54,040,418	($15,686,589)	-29.0%
Net Reinsurance	$532,665	$0	$532,665	$794,182	$261,518	32.9%
	$1,159,078,335	**$2,271,670**	**$1,161,350,005**	**$1,225,218,674**	**$66,140,339**	**5.4%**

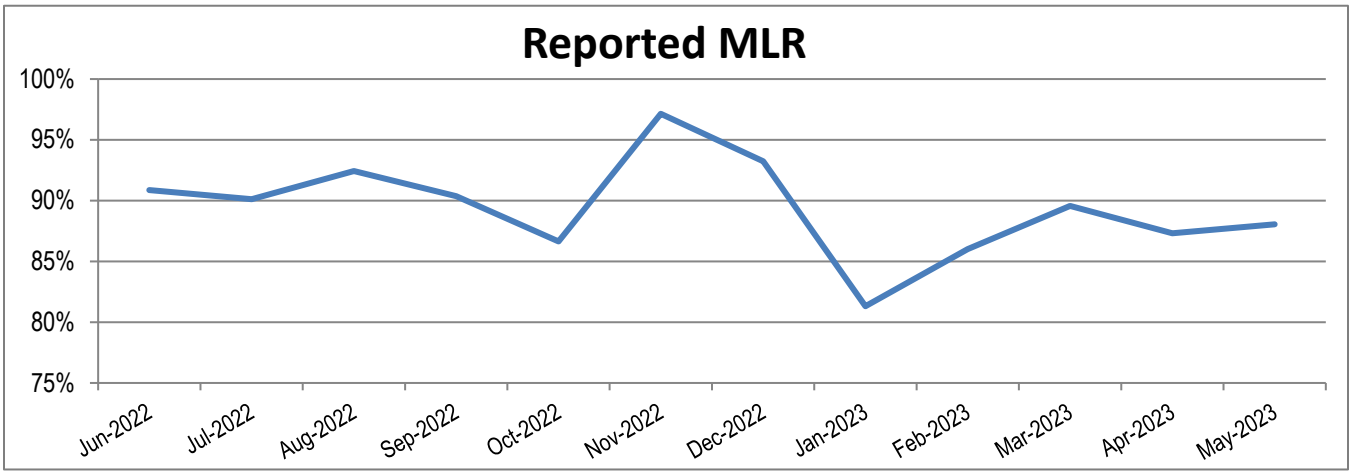
Medical Expense - Actual vs. Budget (Per Member Per Month) Adjusted to Eliminate the Impact of Prior Year IBNP Estimates						
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$74.25	$0.00	$74.25	$76.45	$2.20	2.9%
Primary Care FFS	$11.27	$0.01	$11.28	$13.43	$2.16	16.1%
Specialty Care FFS	$14.18	$0.03	$14.21	$15.61	$1.43	9.2%
Outpatient FFS	$23.51	$0.24	$23.75	$26.71	$3.20	12.0%
Ancillary FFS	$23.61	$0.22	$23.82	$27.25	$3.64	13.4%
Pharmacy FFS	$22.68	$0.10	$22.78	$21.30	($1.38)	-6.5%
ER Services FFS	$14.78	$0.03	$14.82	$15.58	$0.80	5.1%
Long Term Care FFS	$91.67	$0.04	$91.71	$95.87	$4.20	4.4%
Inpatient Hospital & SNF FFS	$19.08	($0.05)	$19.03	$22.76	$3.68	16.2%
Other Benefits & Services	$18.89	$0.00	$18.89	$14.54	($4.35)	-29.9%
Net Reinsurance	$0.14	$0.00	$0.14	$0.21	$0.07	32.5%
	$314.08	**$0.62**	**$314.70**	**$329.72**	**$19.62**	**4.7%**

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $66.1 million favorable to budget. On a PMPM basis, medical expense is 4.7% favorable to budget. For per-member-per-month expense:
    - Capitated Expense is slightly under budget, largely because the decision not to assign LTC and LTC Dual members to our global subcontractor was made after the Budget was finalized. Also unfavorable were FQHC expense and BHT Supplemental expense. This was offset by unfavorable transportation expense, reflecting the delay of that contract's transition to FFS.
    - Primary Care Expense is favorable compared to budget across all populations except for Duals, Group Care and LTC Duals, driven generally by lower unit cost. A favorable $13.0 million retroactive reduction to Prop 56 Expense, resulting from DHCS Risk Corridor Redetermination for July 2019 to December 2020, was recognized in May 2023. This expense reduction corresponds to a $13.0 million reduction to Prop 56 Revenue.
    - Specialty Care Expense is below Budget, favorable across all populations except for LTC Duals and generally driven by lower utilization except for the SPD aid code category which is driven by lower unit cost.
    - Outpatient Expense is under budget, driven mostly by favorable utilization across all populations except for the LTC and LTC Dual populations. This was driven by unfavorable unit cost.
    - Ancillary Expense is under Budget across all populations driven by favorable unit cost offset by unfavorable utilization. Some of the YTD variance is due to non-emergency transportation remaining as a capitated expense in Jan-23 instead of moving to fee-for-service.

- Pharmacy Expense is over Budget mostly due to unfavorable unit cost for Non-PBM expense, particularly for the ACA OE population.
- Emergency Room Expense is under budget driven by favorable unit cost across all populations except for the Child, LTC, and LTC Dual populations which experienced unfavorable utilization.
- Inpatient Expense is under budget driven by favorable utilization, and lower than expected catastrophic case expense and major organ transplant expense across most populations. Offsetting this was unfavorable utilization for the Group Care and Child populations and unfavorable unit cost for the LTC and LTC Dual populations.
- Other Benefits & Services is over budget due to CalAIM program expenses, including unbudgeted Student Behavioral Health Incentive (SBHIP) and unbudgeted Housing and Homelessness Incentive (HHIP). These CalAIM expenses are offset by corresponding increases in CalAIM revenue.
- 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 88.1% for the month and 89.0% for the fiscal year-to-date.



Administrative Expense

- For the month ended May 31st, 2023
  - Actual Administrative Expense: $6.2 million.
  - Budgeted Administrative Expense: $7.1 million.

- For the fiscal YTD ended May 31st, 2023
  - Actual Administrative Expense: $64.7 million.
  - Budgeted Administrative Expense: $74.3 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 %**
$4,121,205	$4,482,671	$361,466	8.1%	Employee Expense	$39,993,816	$44,349,224	$4,355,408	9.8%
80,593	54,830	(25,763)	-47.0%	Medical Benefits Admin Expense	3,391,302	3,422,823	31,521	0.9%
1,073,054	1,200,108	127,054	10.6%	Purchased & Professional Services	9,346,573	12,414,733	3,068,160	24.7%
965,563	1,330,020	364,457	27.4%	Other Admin Expense	11,937,172	14,100,632	2,163,459	15.3%
$6,240,415	$7,067,629	$827,214	11.7%	Total Administrative Expense	$64,668,863	$74,287,411	$9,618,548	12.9%

The year-to-date variances include:

- Delayed timing of start dates for Consulting for new projects, Computer Support Services and Purchased Services.
- Delayed hiring of new employees and temporary help.

The Administrative Loss Ratio (ALR) is 4.3% of net revenue for the month and 5.0% of net revenue year-to-date.

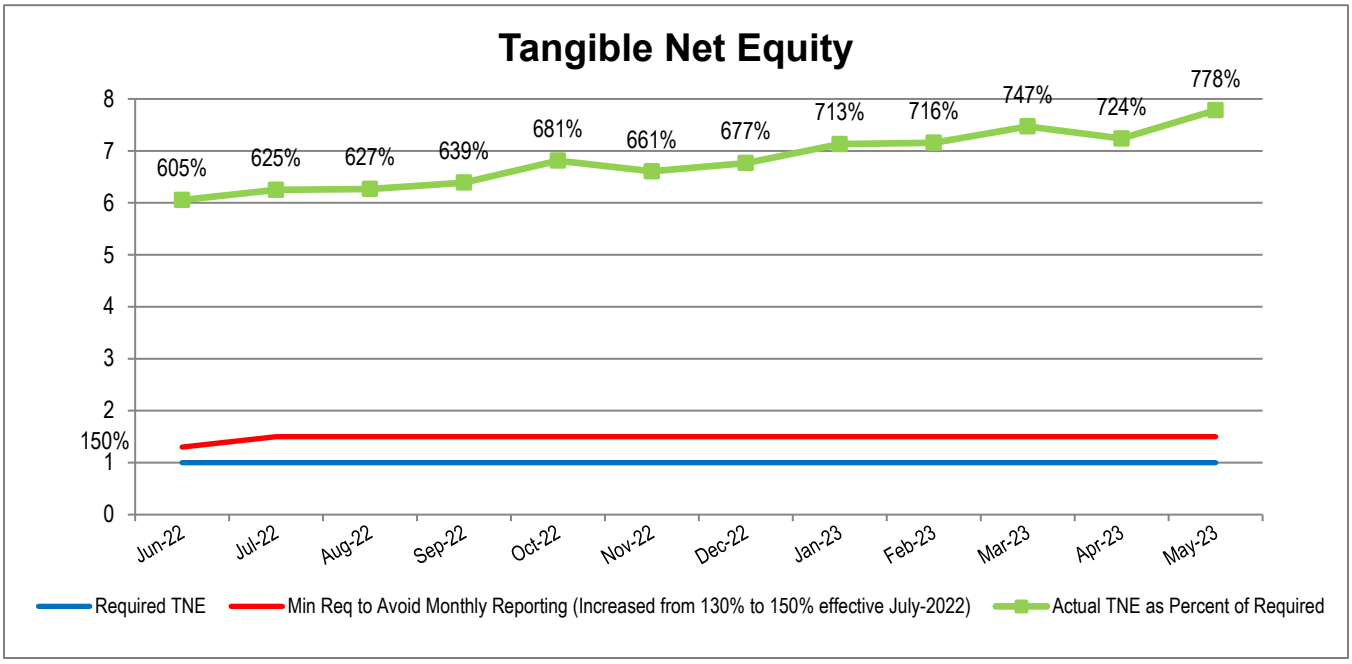
Other Income / (Expense)

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

- Fiscal year-to-date net investments show a gain of $13 million.
- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $357,000.

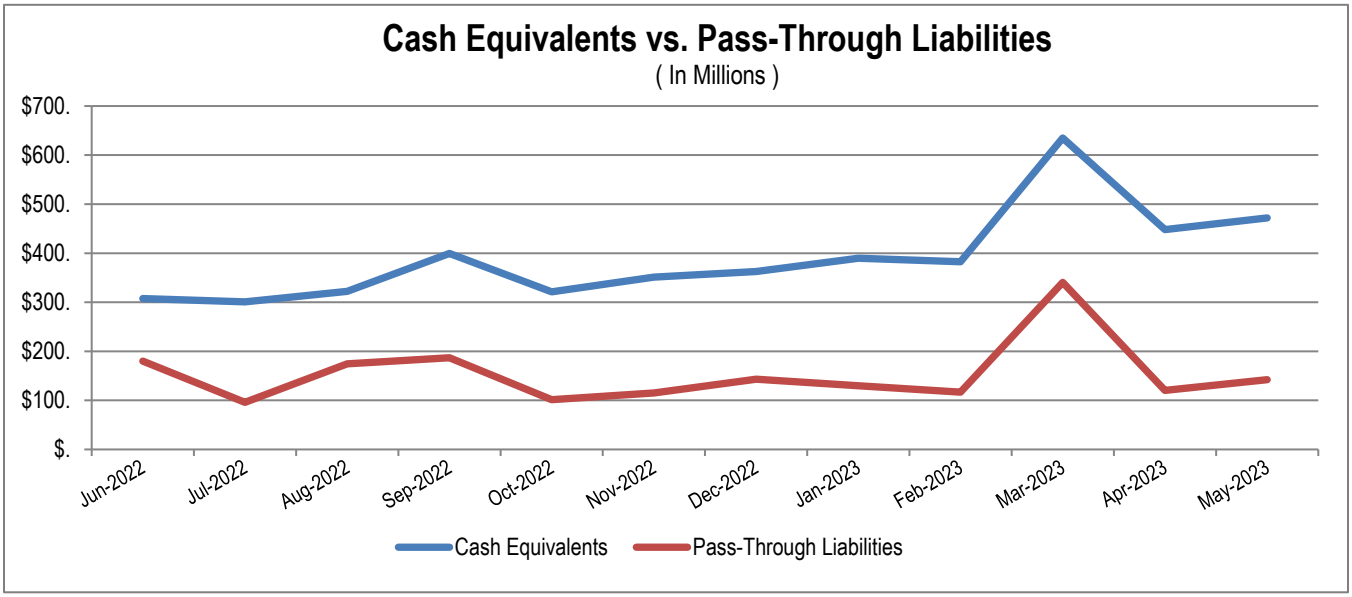
Tangible Net Equity (TNE)

- 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 $41.4 million
    - Actual TNE $322.2 million
    - Excess TNE $280.8 million
    - TNE % of Required TNE 778%



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

- Key Metrics
  - Cash & Cash Equivalents $472.0 million
  - Pass-Through Liabilities $142.1 million
  - Uncommitted Cash $329.9 million
  - Working Capital $297.3 million
  - Current Ratio 1.79 (regulatory minimum is 1.00)



Capital Investment

- Fiscal year-to-date capital assets acquired: $339,000
- Annual capital budget: $1.1 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.

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 MAY 30, 2023

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				MEMBERSHIP				
354,512	351,796	2,716	0.8%	1 - Medi-Cal	3,627,033	3,652,183	(25,150)	(0.7%)
5,670	5,789	(119)	(2.1%)	2 - Group Care	63,333	63,720	(387)	(0.6%)
360,182	**357,585**	**2,597**	**0.7%**	**3 - TOTAL MEMBER MONTHS**	**3,690,366**	**3,715,903**	**(25,537)**	**(0.7%)**
				REVENUE				
$144,478,949	**$137,430,950**	**$7,047,999**	**5.1%**	**4 - TOTAL REVENUE**	**$1,304,601,970**	**$1,314,890,122**	**($10,288,151)**	**(0.8%)**
				MEDICAL EXPENSES				
				Capitated Medical Expenses:				
$26,189,339	$28,255,299	$2,065,960	7.3%	5 - Capitated Medical Expense	$274,027,474	$284,085,743	$10,058,269	3.5%
				Fee for Service Medical Expenses:				
$36,829,825	$36,587,662	($242,164)	(0.7%)	6 - Inpatient Hospital FFS Expense	$338,450,241	$356,236,026	$17,785,785	5.0%
($7,531,267)	$4,668,644	$12,199,911	261.3%	7 - Primary Care Physician FFS Expense	$41,639,099	$49,898,957	$8,259,857	16.6%
$5,682,950	$5,812,733	$129,783	2.2%	8 - Specialty Care Physician Expense	$52,453,243	$58,015,085	$5,561,840	9.6%
$9,245,270	$11,413,490	$2,168,220	19.0%	9 - Ancillary Medical Expense	$87,910,426	$101,259,786	$13,349,359	13.2%
$8,041,744	$10,434,940	$2,393,196	22.9%	10 - Outpatient Medical Expense	$87,643,910	$99,242,324	$11,598,414	11.7%
$5,772,821	$5,840,069	$67,249	1.2%	11 - Emergency Expense	$54,682,719	$57,900,476	$3,217,757	5.6%
$8,126,659	$7,799,763	($326,896)	(4.2%)	12 - Pharmacy Expense	$84,068,039	$79,163,269	($4,904,770)	(6.2%)
$13,014,575	$15,948,324	$2,933,748	18.4%	13 - Long Term Care FFS Expense	$70,215,182	$84,582,411	$14,367,230	17.0%
$79,182,578	$98,505,625	$19,323,047	19.6%	14 - Total Fee for Service Expense	$817,062,859	$886,298,334	$69,235,473	7.8%
$21,669,823	$4,744,462	($16,925,360)	(356.7%)	15 - Other Benefits & Services	$69,727,007	$54,040,417	($15,686,589)	(29.0%)
$178,519	$221,218	$42,699	19.3%	16 - Reinsurance Expense	$532,665	$794,182	$261,518	32.9%
$127,220,259	**$131,726,604**	**$4,506,346**	**3.4%**	**18 - TOTAL MEDICAL EXPENSES**	**$1,161,350,005**	**$1,225,218,676**	**$63,868,670**	**5.2%**
$17,258,691	**$5,704,346**	**$11,554,345**	**202.6%**	**19- GROSS MARGIN**	**$143,251,965**	**$89,671,446**	**$53,580,519**	**59.8%**
				ADMINISTRATIVE EXPENSES				
$4,121,205	$4,482,673	$361,466	8.1%	20 - Personnel Expense	$39,993,816	$44,349,223	$4,355,408	9.8%
$80,593	$54,830	($25,763)	(47.0%)	21 - Benefits Administration Expense	$3,391,302	$3,422,823	$31,521	0.9%
$1,073,054	$1,200,108	$127,054	10.6%	22 - Purchased & Professional Services	$9,346,573	$12,414,733	$3,068,160	24.7%
$965,563	$1,330,019	$364,457	27.4%	23 - Other Administrative Expense	$11,937,172	$14,100,632	$2,163,460	15.3%
$6,240,415	**$7,067,630**	**$827,214**	**11.7%**	**24 - TOTAL ADMINISTRATIVE EXPENSE**	**$64,668,863**	**$74,287,411**	**$9,618,548**	**12.9%**
$11,018,276	**($1,363,284)**	**$12,381,560**	**908.2%**	**25 - NET OPERATING INCOME / (LOSS)**	**$78,583,102**	**$15,384,035**	**$63,199,067**	**410.8%**
				OTHER INCOME / EXPENSE				
$1,706,924	**$48,750**	**$1,658,174**	**3,401.4%**	**26 - TOTAL OTHER INCOME / (EXPENSE)**	**$12,968,437**	**$1,913,880**	**$11,054,557**	**577.6%**
$12,725,200	**($1,314,534)**	**$14,039,734**	**1,068.0%**	**27 - NET INCOME / (LOSS)**	**$91,551,539**	**$17,297,915**	**$74,253,624**	**429.3%**
4.3%	**5.1%**	**0.8%**	**15.7%**	**28 - Admin Exp % of Revenue**	**5.0%**	**5.6%**	**0.6%**	**10.7%**

ALAMEDA ALLIANCE FOR HEALTH
BALANCE SHEETS
CURRENT MONTH VS. PRIOR MONTH
FOR THE MONTH AND FISCAL YTD ENDED May 31, 2023

	May	April	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	$78,639,670	$27,867,655	$50,772,015	182.19%
Short-Term Investments	393,346,863	420,424,593	(27,077,730)	-6.44%
Interest Receivable	646,886	691,110	(44,224)	-6.40%
Other Receivables - Net	186,143,827	169,938,496	16,205,331	9.54%
Prepaid Expenses	4,943,321	5,970,114	(1,026,793)	-17.20%
Prepaid Inventoried Items	75,960	15,960	60,000	375.94%
CalPERS Net Pension Asset	6,930,703	6,930,703	0	0.00%
Deferred CalPERS Outflow	3,802,239	3,802,239	0	0.00%
TOTAL CURRENT ASSETS	**$674,529,469**	**$635,640,870**	**$38,888,599**	**6.12%**
OTHER ASSETS:				
Long-Term Investments	18,624,509	20,988,688	(2,364,179)	-11.26%
Restricted Assets	350,000	350,000	0	0.00%
Lease Asset - Office Space (Net)	1,503,323	1,565,962	(62,638)	-4.00%
Lease Asset - Office Equipment (Net)	199,509	203,805	(4,296)	-2.11%
TOTAL OTHER ASSETS	**$20,677,341**	**$23,108,455**	**($2,431,114)**	**-10.52%**
PROPERTY AND EQUIPMENT:				
Land, Building & Improvements	10,113,570	10,113,570	0	0.00%
Furniture And Equipment	11,855,077	11,855,077	0	0.00%
Leasehold Improvement	902,447	902,447	0	0.00%
Internally-Developed Software	14,824,002	14,824,002	0	0.00%
Fixed Assets at Cost	37,695,096	37,695,096	0	0.00%
Less: Accumulated Depreciation	(32,424,154)	(32,357,986)	(66,168)	0.20%
NET PROPERTY AND EQUIPMENT	**$5,270,942**	**$5,337,110**	**($66,168)**	**-1.24%**
TOTAL ASSETS	**$700,477,752**	**$664,086,435**	**$36,391,317**	**5.48%**
CURRENT LIABILITIES:				
Accounts Payable	25,520	38,688	(13,168)	-34.04%
Other Accrued Expenses	4,920,214	6,333,355	(1,413,142)	-22.31%
Interest Payable	8,156	8,479	(323)	-3.81%
Pass-Through Liabilities	142,075,505	120,341,970	21,733,535	18.06%
Claims Payable	58,205,840	41,857,748	16,348,092	39.06%
IBNP Reserves	151,603,016	164,977,608	(13,374,592)	-8.11%
Payroll Liabilities	7,160,182	6,578,305	581,877	8.85%
CalPERS Deferred Inflow	6,781,898	6,781,898	0	0.00%
Risk Sharing	5,619,919	5,619,919	0	0.00%
Provider Grants/ New Health Program	0	128,650	(128,650)	-100.00%
ST Lease Liability - Office Space	811,850	805,763	6,088	0.76%
ST Lease Liability - Office Equipment	50,568	50,394	174	0.35%
TOTAL CURRENT LIABILITIES	**$377,262,667**	**$353,522,777**	**$23,739,890**	**6.72%**
LONG TERM LIABILITIES:				
LT Lease Liability - Office Space	881,846	951,324	(69,478)	-7.30%
LT Lease Liability - Office Equipment	157,399	161,693	(4,294)	-2.66%
TOTAL LONG TERM LIABILITIES	**$1,039,245**	**$1,113,018**	**($73,773)**	**-6.63%**
TOTAL LIABILITIES	**$378,301,911**	**$354,635,794**	**$23,666,117**	**6.67%**
NET WORTH:				
Contributed Capital	840,233	840,233	0	0.00%
Restricted & Unrestricted Funds	229,784,068	229,784,068	0	0.00%
Year-to Date Net Income / (Loss)	91,551,539	78,826,339	12,725,200	16.14%
TOTAL NET WORTH	**$322,175,841**	**$309,450,640**	**$12,725,200**	**4.11%**
TOTAL LIABILITIES AND NET WORTH	**$700,477,752**	**$664,086,435**	**$36,391,317**	**5.48%**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 5/31/2023

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$2,565,340	$7,831,265	$15,764,174	$28,994,717
Total	2,565,340	7,831,265	15,764,174	28,994,717
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	141,913,607	413,616,221	778,107,078	1,275,606,722
Allowance for Doubtful Accounts	0	0	0	0
Deferred Premium Revenue	0	0	(184,626)	0
Premium Receivable	(15,977,760)	(6,184,503)	(39,946,299)	14,395,750
Total	125,935,847	407,431,718	737,976,153	1,290,002,472
Investment & Other Income Cash Flows				
Other Revenue (Grants)	6,127	44,537	41,839	10,720
Investment Income	1,773,676	6,103,154	10,395,565	13,427,668
Interest Receivable	44,224	(227,064)	(301,590)	(368,450)
Total	1,824,027	5,920,627	10,135,814	13,069,938
Medical & Hospital Cash Flows				
Total Medical Expenses	(127,220,258)	(372,158,695)	(694,990,891)	(1,161,350,006)
Other Receivable	(227,572)	(26,074)	(301,782)	(178,068)
Claims Payable	16,348,091	20,422,812	9,566,053	38,617,118
IBNP Payable	(13,374,592)	6,184,524	33,431,419	38,498,642
Risk Share Payable	0	27,980	27,980	(1,755,013)
Health Program	(128,650)	(127,540)	(165,773)	(226,672)
Other Liabilities	0	0	1	(1)
Total	(124,602,981)	(345,676,993)	(652,432,993)	(1,086,394,000)
Administrative Cash Flows				
Total Administrative Expenses	(6,313,294)	(18,492,767)	(37,958,079)	(65,138,285)
Prepaid Expenses	966,793	(809,513)	260,521	327,914
CalPERS Pension Asset	0	0	0	0
CalPERS Deferred Outflow	0	0	0	0
Trade Accounts Payable	(1,426,311)	(273,028)	3,119,541	2,239,976
Other Accrued Liabilities	(323)	(965)	(1,917)	(4,361)
Payroll Liabilities	581,877	1,286,825	535,239	2,452,747
Net Lease Assets/Liabilities (Short term & Long term)	(576)	(765)	1,337	4,891
Depreciation Expense	66,168	197,107	399,397	741,135
Total	(6,125,666)	(18,093,106)	(33,643,961)	(59,375,983)
Interest Paid				
Debt Interest Expense	0	0	0	0
Total Cash Flows from Operating Activities	**(403,433)**	**57,413,511**	**77,799,187**	**186,297,144**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 5/31/2023

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	2,364,179	6,627,260	15,953,139	16,444,340
	2,364,179	6,627,260	15,953,139	16,444,340
Restricted Cash & Other Asset Cash Flows				
Provider Pass-Thru-Liabilities	21,733,535	25,471,258	26,987,258	(37,826,461)
Restricted Cash	0	0	0	0
	21,733,535	25,471,258	26,987,258	(37,826,461)
Fixed Asset Cash Flows				
Depreciation expense	66,168	197,107	399,397	741,135
Fixed Asset Acquisitions	0	(114,070)	(130,991)	(338,846)
Change in A/D	(66,168)	(197,107)	(399,397)	(741,135)
	0	(114,070)	(130,991)	(338,846)
Total Cash Flows from Investing Activities	**24,097,714**	**31,984,448**	**42,809,406**	**(21,720,967)**
Financing Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Total Cash Flows	**23,694,281**	**89,397,959**	**120,608,593**	**164,576,177**
Rounding	5	1	0	5
Cash @ Beginning of Period	448,292,247	382,588,573	351,377,940	307,410,351
Cash @ End of Period	**$471,986,533**	**$471,986,533**	**$471,986,533**	**$471,986,533**
Difference (rounding)	0	0	0	0

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 5/31/2023

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$12,725,203	$36,943,715	$71,359,686	$91,551,540
Add back: Depreciation	66,168	197,107	399,397	741,135
Receivables				
Premiums Receivable	(15,977,760)	(6,184,503)	(39,946,299)	14,395,750
First Care Receivable	0	0	0	0
Family Care Receivable	0	0	0	0
Healthy Kids Receivable	0	0	0	0
Interest Receivable	44,224	(227,064)	(301,590)	(368,450)
Other Receivable	(227,572)	(26,074)	(301,782)	(178,068)
FQHC Receivable	0	0	0	0
Allowance for Doubtful Accounts	0	0	0	0
Total	(16,161,108)	(6,437,641)	(40,549,671)	13,849,232
Prepaid Expenses	966,793	(809,513)	260,521	327,914
Trade Payables	(1,426,311)	(273,028)	3,119,541	2,239,976
Claims Payable, IBNR & Risk Share				
IBNP	(13,374,592)	6,184,524	33,431,419	38,498,642
Claims Payable	16,348,091	20,422,812	9,566,053	38,617,118
Risk Share Payable	0	27,980	27,980	(1,755,013)
Other Liabilities	0	0	1	(1)
Total	2,973,499	26,635,316	43,025,453	75,360,746
Unearned Revenue				
Total	0	0	(184,626)	0
Other Liabilities				
Accrued Expenses	(323)	(965)	(1,917)	(4,361)
Payroll Liabilities	581,877	1,286,825	535,239	2,452,747
Net Lease Assets/Liabilities (Short term & Long term)	(576)	(765)	1,337	4,891
Health Program	(128,650)	(127,540)	(165,773)	(226,672)
Accrued Sub Debt Interest	0	0	0	0
Total Change in Other Liabilities	452,328	1,157,555	368,886	2,226,605
Cash Flows from Operating Activities	**($403,428)**	**$57,413,511**	**$77,799,187**	**$186,297,148**
Difference (rounding)	5	0	0	4

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 5/31/2023

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received From:				
Capitation Received from State of CA	$125,935,847	$407,431,718	$737,976,153	$1,290,002,472
Commercial Premium Revenue	2,565,340	7,831,265	15,764,174	28,994,717
Other Income	6,127	44,537	41,839	10,720
Investment Income	1,817,900	5,876,090	10,093,975	13,059,218
Cash Paid To:				
Medical Expenses	(124,602,981)	(345,676,993)	(652,432,993)	(1,086,394,000)
Vendor & Employee Expenses	(6,125,666)	(18,093,106)	(33,643,961)	(59,375,983)
Interest Paid	0	0	0	0
Net Cash Provided By (Used In) Operating Activities	(403,433)	57,413,511	77,799,187	186,297,144
Cash Flows from Financing Activities:				
Purchases of Fixed Assets	0	(114,070)	(130,991)	(338,846)
Net Cash Provided By (Used In) Financing Activities	0	(114,070)	(130,991)	(338,846)
Cash Flows from Investing Activities:				
Changes in Investments	2,364,179	6,627,260	15,953,139	16,444,340
Restricted Cash	21,733,535	25,471,258	26,987,258	(37,826,461)
Net Cash Provided By (Used In) Investing Activities	24,097,714	32,098,518	42,940,397	(21,382,121)
Financial Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Net Change in Cash	**23,694,281**	**89,397,959**	**120,608,593**	**164,576,177**
Cash @ Beginning of Period	448,292,247	382,588,573	351,377,940	307,410,351
Subtotal	$471,986,528	$471,986,532	$471,986,533	$471,986,528
Rounding	5	1	0	5
Cash @ End of Period	**$471,986,533**	**$471,986,533**	**$471,986,533**	**$471,986,533**
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	$12,725,203	$36,943,715	$71,359,686	$91,551,540
Depreciation	66,168	197,107	399,397	741,135
Net Change in Operating Assets & Liabilities:				
Premium & Other Receivables	(16,161,108)	(6,437,641)	(40,549,671)	13,849,232
Prepaid Expenses	966,793	(809,513)	260,521	327,914
Trade Payables	(1,426,311)	(273,028)	3,119,541	2,239,976
Claims payable & IBNP	2,973,499	26,635,316	43,025,453	75,360,746
Deferred Revenue	0	0	(184,626)	0
Accrued Interest	0	0	0	0
Other Liabilities	452,328	1,157,555	368,886	2,226,605
Subtotal	(403,428)	57,413,511	77,799,187	186,297,148
Rounding	(5)	0	0	(4)
Cash Flows from Operating Activities	**($403,433)**	**$57,413,511**	**$77,799,187**	**$186,297,144**
Rounding Difference	(5)	0	0	(4)

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE MAY 2023

	Medi-Cal Child	Medi-Cal Adults	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Grand Total
Member Months	1,121,242	552,184	322,273	1,304,288	322,677	571	3,798	3,627,033	63,333	3,690,366
Net Revenue	$149,858,005	$175,049,700	$345,816,320	$484,850,119	$82,284,713	$5,893,292	$31,855,103	$1,275,607,252	$28,994,718	$1,304,601,970
Medical Expense	$127,924,865	$157,936,351	$328,506,010	$426,827,012	$61,791,241	$6,363,918	$26,954,478	$1,136,303,877	$25,046,128	$1,161,350,005
Gross Margin	$21,933,139	$17,113,349	$17,310,310	$58,023,106	$20,493,472	-$470,626	$4,900,625	$139,303,375	$3,948,590	$143,251,965
Administrative Expense	$4,769,691	$8,198,961	$20,205,186	$22,529,207	$4,275,149	$387,640	$2,274,254	$62,640,089	$2,028,774	$64,668,863
Operating Income / (Expense)	$17,163,448	$8,914,388	-$2,894,876	$35,493,899	$16,218,322	-$858,267	$2,626,371	$76,663,286	$1,919,816	$78,583,102
Other Income / (Expense)	$755,138	$1,579,217	$4,148,122	$4,328,742	$1,024,426	$122,429	$719,738	$12,677,813	$290,624	$12,968,437
Net Income / (Loss)	**$17,918,586**	**$10,493,605**	**$1,253,246**	**$39,822,641**	**$17,242,748**	**-$735,837**	**$3,346,109**	**$89,341,098**	**$2,210,441**	**$91,551,539**
PMPM Metrics:										
Revenue PMPM	$133.65	$317.01	$1,073.05	$371.74	$255.01	$10,321.00	$8,387.34	$351.69	$457.81	$353.52
Medical Expense PMPM	$114.09	$286.02	$1,019.34	$327.25	$191.50	$11,145.22	$7,097.02	$313.29	$395.47	$314.70
Gross Margin PMPM	$19.56	$30.99	$53.71	$44.49	$63.51	-$824.21	$1,290.32	$38.41	$62.35	$38.82
Administrative Expense PMPM	$4.25	$14.85	$62.70	$17.27	$13.25	$678.88	$598.80	$17.27	$32.03	$17.52
Operating Income / (Expense) PMPM	$15.31	$16.14	-$8.98	$27.21	$50.26	-$1,503.09	$691.51	$21.14	$30.31	$21.29
Other Income / (Expense) PMPM	$0.67	$2.86	$12.87	$3.32	$3.17	$214.41	$189.50	$3.50	$4.59	$3.51
Net Income / (Loss) PMPM	$15.98	$19.00	$3.89	$30.53	$53.44	-$1,288.68	$881.02	$24.63	$34.90	$24.81
Ratio:										
Medical Loss Ratio	85.4%	90.2%	95.0%	88.0%	75.1%	108.0%	84.6%	89.1%	86.4%	89.0%
Gross Margin Ratio	14.6%	9.8%	5.0%	12.0%	24.9%	-8.0%	15.4%	10.9%	13.6%	11.0%
Administrative Expense Ratio	3.2%	4.7%	5.8%	4.6%	5.2%	6.6%	7.1%	4.9%	7.0%	5.0%
Net Income Ratio	12.0%	6.0%	0.4%	8.2%	21.0%	-12.5%	10.5%	7.0%	7.6%	7.0%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF MAY 2023

	Medi-Cal Child	Medi-Cal Adults	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Grand Total
Enrollments	103,434	52,677	31,201	124,397	41,652	148	1,003	354,512	5,670	360,182
Net Revenue	$16,234,497	$15,955,219	$38,762,597	$47,258,362	$13,380,616	$1,585,006	$8,737,313	$141,913,610	$2,565,339	$144,478,949
Medical Expense	$14,212,863	$14,733,815	$34,246,902	$43,516,285	$12,773,443	$985,022	$4,377,799	$124,846,130	$2,374,129	$127,220,259
Gross Margin	$2,021,634	$1,221,404	$4,515,694	$3,742,077	$607,173	$599,985	$4,359,513	$17,067,480	$191,211	$17,258,691
Administrative Expense	$360,594	$701,399	$1,854,410	$1,859,646	$621,938	$78,209	$458,847	$5,935,044	$305,371	$6,240,415
Operating Income / (Expense)	$1,661,040	$520,006	$2,661,284	$1,882,431	-$14,765	$521,775	$3,900,666	$11,132,437	-$114,160	$11,018,276
Other Income / (Expense)	$96,026	$190,678	$530,306	$521,805	$174,874	$22,930	$136,056	$1,672,675	$34,249	$1,706,924
Net Income / (Loss)	**$1,757,066**	**$710,684**	**$3,191,590**	**$2,404,237**	**$160,109**	**$544,705**	**$4,036,722**	**$12,805,112**	**-$79,912**	**$12,725,200**
PMPM Metrics:										
Revenue PMPM	$156.96	$302.89	$1,242.35	$379.90	$321.25	$10,709.50	$8,711.18	$400.31	$452.44	$401.13
Medical Expense PMPM	$137.41	$279.70	$1,097.62	$349.82	$306.67	$6,655.55	$4,364.71	$352.16	$418.72	$353.21
Gross Margin PMPM	$19.55	$23.19	$144.73	$30.08	$14.58	$4,053.95	$4,346.47	$48.14	$33.72	$47.92
Administrative Expense PMPM	$3.49	$13.32	$59.43	$14.95	$14.93	$528.44	$457.47	$16.74	$53.86	$17.33
Operating Income / (Expense) PMPM	$16.06	$9.87	$85.29	$15.13	-$0.35	$3,525.51	$3,889.00	$31.40	-$20.13	$30.59
Other Income / (Expense) PMPM	$0.93	$3.62	$17.00	$4.19	$4.20	$154.93	$135.65	$4.72	$6.04	$4.74
Net Income / (Loss) PMPM	$16.99	$13.49	$102.29	$19.33	$3.84	$3,680.44	$4,024.65	$36.12	-$14.09	$35.33
Ratio:										
Medical Loss Ratio	87.5%	92.3%	88.4%	92.1%	95.5%	62.1%	50.1%	88.0%	92.5%	88.1%
Gross Margin Ratio	12.5%	7.7%	11.6%	7.9%	4.5%	37.9%	49.9%	12.0%	7.5%	11.9%
Administrative Expense Ratio	2.2%	4.4%	4.8%	3.9%	4.6%	4.9%	5.3%	4.2%	11.9%	4.3%
Net Income Ratio	10.8%	4.5%	8.2%	5.1%	1.2%	34.4%	46.2%	9.0%	-3.1%	8.8%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED May 31, 2023

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSE SUMMARY				
$4,121,205	$4,482,671	$361,466	8.1%	Personnel Expenses	$39,993,816	$44,349,223	$4,355,408	9.8%
80,593	54,830	(25,763)	(47.0%)	Benefits Administration Expense	3,391,302	3,422,823	31,521	0.9%
1,073,054	1,200,108	127,054	10.6%	Purchased & Professional Services	9,346,573	12,414,733	3,068,160	24.7%
357,579	293,420	(64,159)	(21.9%)	Occupancy	2,818,968	3,028,014	209,046	6.9%
(26,222)	85,766	111,988	130.6%	Printing Postage & Promotion	2,431,499	2,028,943	(402,557)	(19.8%)
623,378	913,174	289,796	31.7%	Licenses Insurance & Fees	6,543,434	8,728,611	2,185,177	25.0%
10,827	37,660	26,833	71.3%	Supplies & Other Expenses	143,271	315,065	171,794	54.5%
$2,119,210	$2,584,958	$465,748	18.0%	Total Other Administrative Expense	$24,675,047	$29,938,188	$5,263,141	17.6%
$6,240,415	$7,067,629	$827,214	11.7%	Total Administrative Expenses	$64,668,863	$74,287,411	$9,618,548	12.9%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED May 31, 2023

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
2,955,878	2,591,837	(364,041)	(14.0%)	Salaries & Wages	26,866,526	26,761,956	(104,570)	(0.4%)
67,913	296,729	228,815	77.1%	Paid Time Off	2,585,129	3,074,718	489,589	15.9%
1,945	3,965	2,020	51.0%	Incentives	19,503	34,152	14,649	42.9%
0	23,077	23,077	100.0%	Severance Pay	0	173,077	173,077	100.0%
50,189	41,921	(8,268)	(19.7%)	Payroll Taxes	515,323	540,602	25,279	4.7%
57,134	19,147	(37,988)	(198.4%)	Overtime	303,481	240,852	(62,629)	(26.0%)
235,458	218,087	(17,371)	(8.0%)	CalPERS ER Match	2,051,062	2,161,859	110,798	5.1%
701,382	924,233	222,851	24.1%	Employee Benefits	6,271,577	7,844,702	1,573,125	20.1%
1,291	0	(1,291)	0.0%	Personal Floating Holiday	130,997	131,147	151	0.1%
7,497	31,987	24,490	76.6%	Employee Relations	148,673	241,238	92,565	38.4%
14,730	18,550	3,820	20.6%	Work from Home Stipend	138,310	169,110	30,800	18.2%
857	2,361	1,504	63.7%	Transportation Reimbursement	7,650	26,663	19,013	71.3%
6,836	6,641	(195)	(2.9%)	Travel & Lodging	63,117	135,310	72,193	53.4%
15,664	33,978	18,314	53.9%	Temporary Help Services	405,488	1,065,297	659,809	61.9%
17,006	209,870	192,864	91.9%	Staff Development/Training	158,189	842,229	684,041	81.2%
(12,575)	60,290	72,864	120.9%	Staff Recruitment/Advertising	328,791	906,311	577,520	63.7%
$4,121,205	**$4,482,671**	**$361,466**	**8.1%**	**Total Employee Expenses**	**$39,993,816**	**$44,349,223**	**$4,355,408**	**9.8%**
				Benefit Administration Expense				
40,898	15,394	(25,504)	(165.7%)	RX Administration Expense	242,735	176,918	(65,817)	(37.2%)
0	0	0	0.0%	Behavioral Hlth Administration Fees	2,814,883	2,880,913	66,030	2.3%
39,695	39,436	(259)	(0.7%)	Telemedicine Admin Fees	333,684	336,292	2,608	0.8%
0	0	0	0.0%	Housing & Homelessness Incentive Program (HHIP) Expense	0	28,700	28,700	100.0%
$80,593	**$54,830**	**($25,763)**	**(47.0%)**	**Total Benefit Administration Expenses**	**$3,391,302**	**$3,422,823**	**$31,521**	**0.9%**
				Purchased & Professional Services				
400,196	413,919	13,723	3.3%	Consulting Services	3,399,141	4,626,147	1,227,006	26.5%
477,988	399,963	(78,026)	(19.5%)	Computer Support Services	3,372,102	4,068,615	696,514	17.1%
11,475	12,017	542	4.5%	Professional Fees-Accounting	122,037	126,141	4,103	3.3%
0	17	17	100.0%	Professional Fees-Medical	276	392	117	29.7%
70,696	79,257	8,561	10.8%	Other Purchased Services	731,134	849,816	118,682	14.0%
1,471	1,400	(71)	(5.1%)	Maint.& Repair-Office Equipment	4,746	11,367	6,621	58.2%
56,016	129,359	73,343	56.7%	HMS Recovery Fees	829,197	1,169,057	339,860	29.1%
22,839	20,693	(2,146)	(10.4%)	Hardware (Non-Capital)	385,398	330,318	(55,080)	(16.7%)
29,645	30,150	505	1.7%	Provider Relations-Credentialing	346,008	302,655	(43,353)	(14.3%)
2,728	113,333	110,606	97.6%	Legal Fees	156,535	930,225	773,690	83.2%
$1,073,054	**$1,200,108**	**$127,054**	**10.6%**	**Total Purchased & Professional Services**	**$9,346,573**	**$12,414,733**	**$3,068,160**	**24.7%**
				Occupancy				
66,168	73,591	7,423	10.1%	Depreciation	741,135	769,318	28,183	3.7%
62,638	71,987	9,349	13.0%	Building Lease	686,450	751,890	65,440	8.7%
9,353	5,916	(3,436)	(58.1%)	Leased and Rented Office Equipment	53,263	58,728	5,464	9.3%
25,250	15,450	(9,800)	(63.4%)	Utilities	139,208	170,080	30,872	18.2%
140,573	79,700	(60,873)	(76.4%)	Telephone	875,159	856,138	(19,021)	(2.2%)
53,597	46,775	(6,822)	(14.6%)	Building Maintenance	323,752	421,860	98,108	23.3%
$357,579	**$293,420**	**($64,159)**	**(21.9%)**	**Total Occupancy**	**$2,818,968**	**$3,028,014**	**$209,046**	**6.9%**
				Printing Postage & Promotion				
32,608	24,733	(7,875)	(31.8%)	Postage	539,590	644,719	105,130	16.3%
7,745	5,500	(2,245)	(40.8%)	Design & Layout	49,890	84,350	34,460	40.9%
4,986	35,591	30,605	86.0%	Printing Services	1,051,122	906,175	(144,947)	(16.0%)
83	2,500	2,417	96.7%	Mailing Services	90,821	64,101	(26,720)	(41.7%)
10,806	5,358	(5,447)	(101.7%)	Courier/Delivery Service	61,951	58,931	(3,021)	(5.1%)
0	267	267	100.0%	Pre-Printed Materials and Publications	1,034	3,817	2,782	72.9%
9,091	2,000	(7,091)	(354.6%)	Promotional Products	9,091	23,000	13,909	60.5%
7,400	150	(7,250)	(4,833.3%)	Promotional Services	7,400	1,050	(6,350)	(604.8%)

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED May 31, 2023

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
(103,150)	1,500	104,650	6,976.7%	Community Relations	483,942	147,170	(336,772)	(228.8%)
4,209	8,167	3,957	48.5%	Translation - Non-Clinical	136,659	95,630	(41,029)	(42.9%)
($26,222)	**$85,766**	**$111,988**	**130.6%**	**Total Printing Postage & Promotion**	**$2,431,499**	**$2,028,943**	**($402,557)**	**(19.8%)**
				Licenses Insurance & Fees				
0	0	0	0.0%	Regulatory Penalties	25,000	300,000	275,000	91.7%
26,919	24,700	(2,219)	(9.0%)	Bank Fees	262,523	268,047	5,524	2.1%
77,935	94,481	16,547	17.5%	Insurance	847,190	960,523	113,333	11.8%
640,865	663,200	22,335	3.4%	Licenses, Permits and Fees	4,306,019	5,813,347	1,507,329	25.9%
(122,340)	130,793	253,133	193.5%	Subscriptions & Dues	1,102,703	1,386,693	283,990	20.5%
$623,378	**$913,174**	**$289,796**	**31.7%**	**Total Licenses Insurance & Postage**	**$6,543,434**	**$8,728,611**	**$2,185,177**	**25.0%**
				Supplies & Other Expenses				
4,485	3,617	(868)	(24.0%)	Office and Other Supplies	40,047	81,171	41,123	50.7%
2,292	14,000	11,708	83.6%	Ergonomic Supplies	59,964	71,005	11,041	15.5%
4,047	5,395	1,348	25.0%	Commissary-Food & Beverage	24,701	58,001	33,301	57.4%
0	0	0	0.0%	Miscellaneous Expense	34	0	(34)	0.0%
0	5,150	5,150	100.0%	Member Incentive Expense	16,576	35,600	19,024	53.4%
3	4,167	4,164	99.9%	Covid-19 Vaccination Incentive Expense	563	29,433	28,870	98.1%
0	100	100	100.0%	Covid-19 IT Expenses	0	700	700	100.0%
0	5,231	5,231	100.0%	Covid-19 Non IT Expenses	1,386	39,155	37,769	96.5%
$10,827	**$37,660**	**$26,833**	**71.3%**	**Total Supplies & Other Expense**	**$143,271**	**$315,065**	**$171,794**	**54.5%**
$6,240,415	**$7,067,629**	**$827,214**	**11.7%**	**TOTAL ADMINISTRATIVE EXPENSE**	**$64,668,863**	**$74,287,411**	**$9,618,548**	**12.9%**

ALAMEDA ALLIANCE FOR HEALTH
CAPITAL SPENDING INCLUDING CONSTRUCTION-IN-PROCESS
ACTUAL VS. BUDGET
FOR THE FISCAL YEAR-TO-DATE ENDED MAY 31, 2023

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco UCS Blade	IT-FY23-01	$ 102,807		**$ 102,807**	$ 100,000	$ (2,807)
	Veeam Backup Shelf	IT-FY23-02	$ -		**$ -**	$ 70,000	$ 70,000
	Cisco Nexus 9k	IT-FY23-03	$ 79,719		**$ 79,719**	$ 60,000	$ (19,719)
	Pure Storage Shelf	IT-FY23-04	$ 70,000		**$ 70,000**	$ 70,000	$ -
	Call Center Hardware	IT-FY23-05	$ -		**$ -**	$ 60,000	$ 60,000
	FAX DMG	IT-FY23-06	$ -		**$ -**	$ 80,000	$ 80,000
	Cisco Network Hardware (Switches, Routers, Firewalls, Wireless)	IT-FY23-07	$ -		**$ -**	$ 60,000	$ 60,000
	Network / AV Cabling	IT-FY23-08	$ 34,230		**$ 34,230**	$ 60,000	$ 25,770
Hardware Subtotal			**$ 286,755**	**$ -**	**$ 286,755**	**$ 560,000**	**$ 273,245**
2. Software:							
	Zerto	AC-FY23-01	$ -		**$ -**	$ 80,000	$ 80,000
	Ahead	AC-FY23-02	$ 28,099		**$ 28,099**	$ 80,000	$ 51,901
Software Subtotal			**$ 28,099**	**$ -**	**$ 28,099**	**$ 160,000**	**$ 131,901**
3. Building Improvement:							
	ADT (ACME) Security: Readers, HID Boxes, Doors - Planned/Unplanned requirements or replairs	FA-FY23-01	**$ -**	$ -	**$ -**	$ 50,000	$ 50,000
	HVAC (Clinton): Replace VAV boxes, equipment, duct work - Planned/Unplanned requirements or repairs	FA-FY23-02	$ -	$ -	**$ -**	$ 50,000	$ 50,000
	EV Charging Stations: Equipment, Electrical, Design, Engineering, Permits, Construction	FA-FY23-03	$ -	$ -	**$ -**	$ 100,000	$ 100,000
	Seismic Improvements (Carryover from FY22)	FA-FY23-07	$ 23,992	$ -	**$ 23,992**	$ 38,992	$ 15,000
	Contingencies	FA-FY23-16	**$ -**	$ -	**$ -**	$ 100,000	$ 100,000
Building Improvement Subtotal			**$ 23,992**	**$ -**	**$ 23,992**	**$ 338,992**	**$ 315,000**
4. Furniture & Equipment:							
			$ -		**$ -**	$ -	$ -
Furniture & Equipment Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
GRAND TOTAL			**$ 338,846**	**$ -**	**$ 338,846**	**$ 1,058,992**	**$ 720,146**

5. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 5/31/23	**$ 37,695,096**
Fixed Assets @ Cost - 6/30/22	**$ 37,356,250**
Fixed Assets Acquired YTD	**$ 338,846**

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
SUMMARY - FISCAL YEAR 2023

TANGIBLE NET EQUITY (TNE)

	Jul-22	Aug-22	QTR. END Sep-22	Oct-22	Nov-22	QTR. END Dec-22	Jan-23	Feb-23	QTR. END Mar-23	Apr-23	May-23
Current Month Net Income / (Loss)	$5,704,828	$2,337,974	$3,995,061	$9,515,888	($1,361,897)	$2,472,823	$17,673,766	$14,269,382	$10,713,105	$13,505,410	$12,725,200
YTD Net Income / (Loss)	$5,704,828	$8,042,802	$12,037,863	$21,553,751	$20,191,854	$22,664,677	$40,338,443	$54,607,825	$65,320,930	$78,826,340	$91,551,540
Actual TNE											
Net Assets	$236,329,129	$238,667,103	$242,662,164	$252,178,052	$250,816,155	$253,288,978	$270,962,743	$285,232,125	$295,945,230	$309,450,640	$322,175,840
Subordinated Debt & Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Actual TNE	**$236,329,129**	**$238,667,103**	**$242,662,164**	**$252,178,052**	**$250,816,155**	**$253,288,978**	**$270,962,743**	**$285,232,125**	**$295,945,230**	**$309,450,640**	**$322,175,840**
Increase/(Decrease) in Actual TNE	$5,704,827	$2,337,974	$3,995,061	$9,515,888	($1,361,897)	$2,472,823	$17,673,765	$14,269,382	$10,713,105	$13,505,410	$12,725,200
Required TNE[1]	**$37,812,719**	**$38,083,218**	**$37,973,977**	**$37,017,602**	**$37,956,874**	**$37,433,625**	**$37,998,057**	**$39,857,802**	**$39,614,744**	**$42,752,603**	**$41,398,426**
Min. Req'd to Avoid Monthly Reporting (Increased from 130% to 150% of Required TNE effective July-2022)	$56,719,078	$57,124,827	$56,960,965	$55,526,403	$56,935,311	$56,150,437	$56,997,086	$59,786,703	$59,422,115	$64,128,905	$62,097,639
TNE Excess / (Deficiency)	$198,516,410	$200,583,885	$204,688,187	$215,160,450	$212,859,281	$215,855,353	$232,964,686	$245,374,323	$256,330,486	$266,698,037	$280,777,414
Actual TNE as a Multiple of Required	**6.25**	**6.27**	**6.39**	**6.81**	**6.61**	**6.77**	**7.13**	**7.16**	**7.47**	**7.24**	**7.78**

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	$236,329,129	$238,667,103	$242,662,164	$252,178,052	$250,816,155	$253,288,978	$270,962,743	$285,232,125	$295,945,230	$309,450,640	$322,175,840
Fixed Assets at Net Book Value	(5,604,558)	(5,560,412)	(5,492,549)	(5,598,345)	(5,539,348)	(5,471,106)	(5,403,318)	(5,353,979)	(5,288,731)	(5,337,110)	(5,270,942)
Net Lease Assets/Liabilities/Interest	106,376	204,722	206,107	206,549	207,567	208,268	208,652	208,717	208,462	207,886	206,987
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$230,480,947**	**$232,961,413**	**$236,819,615**	**$246,229,707**	**$244,926,807**	**$247,467,872**	**$265,209,425**	**$279,528,146**	**$290,306,499**	**$303,763,530**	**$316,554,898**
Liquid TNE as Multiple of Required	**6.10**	**6.12**	**6.24**	**6.65**	**6.45**	**6.61**	**6.98**	**7.01**	**7.33**	**7.11**	**7.65**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2023	FINAL BUDGET												
	Budget Jul-22	Budget Aug-22	Budget Sep-22	Budget Oct-22	Budget Nov-22	Budget Dec-22	Budget Jan-23	Budget Feb-23	Budget Mar-23	Budget Apr-23	Budget May-23	Budget Jun-23	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program by Category of Aid:													
Child	100,903	100,977	101,276	101,323	101,526	101,729	102,032	102,236	102,440	102,645	102,427	102,209	1,221,723
Adult	47,707	48,112	48,711	49,162	49,408	49,655	50,068	50,318	50,570	50,823	50,572	50,320	595,426
SPD	27,990	28,079	28,200	28,237	28,322	28,407	31,537	31,632	31,727	31,822	31,866	31,911	359,730
ACA OE	113,322	114,208	115,018	116,205	116,554	116,904	119,956	120,316	120,677	121,039	120,274	119,507	1,413,980
Duals	21,911	22,077	22,319	22,482	22,617	22,753	44,376	44,642	44,910	45,179	45,320	45,462	404,048
MCAL LTC	0	0	0	0	0	0	153	153	153	153	153	153	918
MCAL LTC Duals	0	0	0	0	0	0	1,184	1,184	1,184	1,184	1,184	1,184	7,104
Medi-Cal Program	311,833	313,453	315,524	317,409	318,427	319,448	349,306	350,481	351,661	352,845	351,796	350,746	4,002,929
Group Care Program	5,796	5,803	5,809	5,789	5,789	5,789	5,789	5,789	5,789	5,789	5,789	5,789	69,509
Total	**317,629**	**319,256**	**321,333**	**323,198**	**324,216**	**325,237**	**355,095**	**356,270**	**357,450**	**358,634**	**357,585**	**356,535**	**4,072,438**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	6,092	74	299	47	203	203	303	204	204	205	(218)	(218)	7,398
Adult	6,631	405	599	451	246	247	413	250	252	253	(251)	(252)	9,244
SPD	1,245	89	121	37	85	85	3,130	95	95	95	44	45	5,166
ACA OE	9,886	886	810	1,187	349	350	3,052	360	361	362	(765)	(767)	16,071
Duals	2,135	166	242	163	135	136	21,623	266	268	269	141	142	25,686
MCAL LTC	0	0	0	0	0	0	153	0	0	0	0	0	153
MCAL LTC Duals	0	0	0	0	0	0	1,184	0	0	0	0	0	1,184
Medi-Cal Program	25,989	1,620	2,071	1,885	1,018	1,021	29,858	1,175	1,180	1,184	(1,049)	(1,050)	64,902
Group Care Program	(56)	7	6	(20)	0	0	0	0	0	0	0	0	(63)
Total	**25,933**	**1,627**	**2,077**	**1,865**	**1,018**	**1,021**	**29,858**	**1,175**	**1,180**	**1,184**	**(1,049)**	**(1,050)**	**64,839**
Enrollment Percentages:													
Medi-Cal Program:													
Child % (Medi-Cal)	32.4%	32.2%	32.1%	31.9%	31.9%	31.8%	29.2%	29.2%	29.1%	29.1%	29.1%	29.1%	30.5%
Adult % (Medi-Cal)	15.3%	15.3%	15.4%	15.5%	15.5%	15.5%	14.3%	14.4%	14.4%	14.4%	14.4%	14.3%	14.9%
SPD % (Medi-Cal)	9.0%	9.0%	8.9%	8.9%	8.9%	8.9%	9.0%	9.0%	9.0%	9.0%	9.1%	9.1%	9.0%
ACA OE % (Medi-Cal)	36.3%	36.4%	36.5%	36.6%	36.6%	36.6%	34.3%	34.3%	34.3%	34.3%	34.2%	34.1%	35.3%
Duals % (Medi-Cal)	7.0%	7.0%	7.1%	7.1%	7.1%	7.1%	12.7%	12.7%	12.8%	12.8%	12.9%	13.0%	10.1%
MCAL LTC % (Medi-Cal)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
MCAL LTC Duals % (Medi-Cal)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.2%
Medi-Cal Program % of Total	98.2%	98.2%	98.2%	98.2%	98.2%	98.2%	98.4%	98.4%	98.4%	98.4%	98.4%	98.4%	98.3%
Group Care Program % of Total	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.6%	1.6%	1.6%	1.6%	1.6%	1.6%	1.7%
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 2023	FINAL BUDGET												
	Budget Jul-22	Budget Aug-22	Budget Sep-22	Budget Oct-22	Budget Nov-22	Budget Dec-22	Budget Jan-23	Budget Feb-23	Budget Mar-23	Budget Apr-23	Budget May-23	Budget Jun-23	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted	117,124	116,108	116,842	117,370	117,768	118,167	132,827	133,300	133,775	134,250	133,844	133,438	1,504,813
Delegated:													
CFMG	33,466	33,594	33,577	33,617	33,689	33,761	34,005	34,077	34,149	34,222	34,146	34,070	406,373
CHCN	119,514	121,703	122,696	123,666	124,059	124,454	135,070	135,521	135,974	136,430	136,024	135,617	1,550,728
Kaiser	47,525	47,851	48,218	48,545	48,700	48,855	53,193	53,372	53,552	53,732	53,571	53,410	610,524
Delegated Subtotal	200,505	203,148	204,491	205,828	206,448	207,070	222,268	222,970	223,675	224,384	223,741	223,097	2,567,625
Total	**317,629**	**319,256**	**321,333**	**323,198**	**324,216**	**325,237**	**355,095**	**356,270**	**357,450**	**358,634**	**357,585**	**356,535**	**4,072,438**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	6,018	(1,016)	734	528	398	399	14,660	473	475	475	(406)	(406)	22,332
Delegated:													
CFMG	2,058	128	(17)	40	72	72	244	72	72	73	(76)	(76)	2,662
CHCN	13,283	2,189	993	970	393	395	10,616	451	453	456	(406)	(407)	29,386
Kaiser	4,574	326	367	327	155	155	4,338	179	180	180	(161)	(161)	10,459
Delegated Subtotal	19,915	2,643	1,343	1,337	620	622	15,198	702	705	709	(643)	(644)	42,507
Total	**25,933**	**1,627**	**2,077**	**1,865**	**1,018**	**1,021**	**29,858**	**1,175**	**1,180**	**1,184**	**(1,049)**	**(1,050)**	**64,839**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	36.9%	36.4%	36.4%	36.3%	36.3%	36.3%	37.4%	37.4%	37.4%	37.4%	37.4%	37.4%	37.0%
Delegated:													
CFMG	10.5%	10.5%	10.4%	10.4%	10.4%	10.4%	9.6%	9.6%	9.6%	9.5%	9.5%	9.6%	10.0%
CHCN	37.6%	38.1%	38.2%	38.3%	38.3%	38.3%	38.0%	38.0%	38.0%	38.0%	38.0%	38.0%	38.1%
Kaiser	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%
Delegated Subtotal	63.1%	63.6%	63.6%	63.7%	63.7%	63.7%	62.6%	62.6%	62.6%	62.6%	62.6%	62.6%	63.0%
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 2023

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

	Actual Jul-22	Actual Aug-22	Actual Sep-22	Actual Oct-22	Actual Nov-22	Actual Dec-22	Actual Jan-23	Actual Feb-23	Actual Mar-23	Actual Apr-23	Actual May-23	Actual Jun-23	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	100,903	100,977	101,276	101,323	101,653	101,791	101,914	102,288	102,510	103,173	103,434		1,121,242
Adult	47,707	48,112	48,711	49,162	50,069	50,351	50,687	51,141	51,517	52,050	52,677		552,184
SPD	27,990	28,079	28,200	28,237	28,365	28,452	28,685	30,913	31,021	31,130	31,201		322,273
ACA OE	113,322	114,208	115,018	116,205	117,328	118,397	119,302	120,653	121,852	123,606	124,397		1,304,288
Duals	21,911	22,077	22,319	22,482	22,719	23,028	23,444	40,330	41,245	41,470	41,652		322,677
MCAL LTC	0	0	0	0	0	0	6	129	143	145	148		571
MCAL LTC Duals	0	0	0	0	0	0	15	849	948	983	1,003		3,798
Medi-Cal Program	311,833	313,453	315,524	317,409	320,134	322,019	324,053	346,303	349,236	352,557	354,512		3,627,033
Group Care Program	5,796	5,803	5,809	5,789	5,791	5,776	5,761	5,746	5,723	5,669	5,670		63,333
Total	**317,629**	**319,256**	**321,333**	**323,198**	**325,925**	**327,795**	**329,814**	**352,049**	**354,959**	**358,226**	**360,182**		**3,690,366**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	131	74	299	47	330	138	123	374	222	663	261		2,662
Adult	946	405	599	451	907	282	336	454	376	533	627		5,916
SPD	886	89	121	37	128	87	233	2,228	108	109	71		4,097
ACA OE	2,384	886	810	1,187	1,123	1,069	905	1,351	1,199	1,754	791		13,459
Duals	225	166	242	163	237	309	416	16,886	915	225	182		19,966
MCAL LTC	0	0	0	0	0	0	6	123	14	2	3		148
MCAL LTC Duals	0	0	0	0	0	0	15	834	99	35	20		1,003
Medi-Cal Program	4,572	1,620	2,071	1,885	2,725	1,885	2,034	22,250	2,933	3,321	1,955		47,251
Group Care Program	1	7	6	(20)	2	(15)	(15)	(15)	(23)	(54)	1		(125)
Total	**4,573**	**1,627**	**2,077**	**1,865**	**2,727**	**1,870**	**2,019**	**22,235**	**2,910**	**3,267**	**1,956**		**47,126**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	32.4%	32.2%	32.1%	31.9%	31.8%	31.6%	31.4%	29.5%	29.4%	29.3%	29.2%		30.9%
Adult % of Medi-Cal	15.3%	15.3%	15.4%	15.5%	15.6%	15.6%	15.6%	14.8%	14.8%	14.8%	14.9%		15.2%
SPD % of Medi-Cal	9.0%	9.0%	8.9%	8.9%	8.9%	8.8%	8.9%	8.9%	8.9%	8.8%	8.8%		8.9%
ACA OE % of Medi-Cal	36.3%	36.4%	36.5%	36.6%	36.6%	36.8%	36.8%	34.8%	34.9%	35.1%	35.1%		36.0%
Duals % of Medi-Cal	7.0%	7.0%	7.1%	7.1%	7.1%	7.2%	7.2%	11.6%	11.8%	11.8%	11.7%		8.9%
Medi-Cal Program % of Total	98.2%	98.2%	98.2%	98.2%	98.2%	98.2%	98.3%	98.4%	98.4%	98.4%	98.4%		98.3%
Group Care Program % of Total	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.7%	1.6%	1.6%	1.6%	1.6%		1.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**		**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2023

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

	Actual Jul-22	Actual Aug-22	Actual Sep-22	Actual Oct-22	Actual Nov-22	Actual Dec-22	Actual Jan-23	Actual Feb-23	Actual Mar-23	Actual Apr-23	Actual May-23	Actual Jun-23	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	54,340	52,198	52,418	52,571	53,736	53,143	53,870	72,569	73,153	74,713	74,016		666,727
Alameda Health System	62,784	63,910	64,424	64,799	65,216	65,771	66,052	65,896	66,276	66,552	67,113		718,793
	117,124	116,108	116,842	117,370	118,952	118,914	119,922	138,465	139,429	141,265	141,129		1,385,520
Delegated:													
CFMG	33,466	33,594	33,577	33,617	33,498	33,648	33,741	33,983	34,547	34,644	35,138		373,453
CHCN	119,514	121,703	122,696	123,666	124,637	126,009	126,433	129,265	129,908	130,508	131,489		1,385,828
Kaiser	47,525	47,851	48,218	48,545	48,838	49,224	49,718	50,336	51,075	51,809	52,426		545,565
Delegated Subtotal	200,505	203,148	204,491	205,828	206,973	208,881	209,892	213,584	215,530	216,961	219,053		2,304,846
Total	**317,629**	**319,256**	**321,333**	**323,198**	**325,925**	**327,795**	**329,814**	**352,049**	**354,959**	**358,226**	**360,182**		**3,690,366**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	2,973	(1,016)	734	528	1,582	(38)	1,008	18,543	964	1,836	(136)		26,978
Delegated:													
CFMG	58	128	(17)	40	(119)	150	93	242	564	97	494		1,730
CHCN	1,103	2,189	993	970	971	1,372	424	2,832	643	600	981		13,078
Kaiser	439	326	367	327	293	386	494	618	739	734	617		5,340
Delegated Subtotal	1,600	2,643	1,343	1,337	1,145	1,908	1,011	3,692	1,946	1,431	2,092		20,148
Total	**4,573**	**1,627**	**2,077**	**1,865**	**2,727**	**1,870**	**2,019**	**22,235**	**2,910**	**3,267**	**1,956**		**47,126**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	36.9%	36.4%	36.4%	36.3%	36.5%	36.3%	36.4%	39.3%	39.3%	39.4%	39.2%		37.5%
Delegated:													
CFMG	10.5%	10.5%	10.4%	10.4%	10.3%	10.3%	10.2%	9.7%	9.7%	9.7%	9.8%		10.1%
CHCN	37.6%	38.1%	38.2%	38.3%	38.2%	38.4%	38.3%	36.7%	36.6%	36.4%	36.5%		37.6%
Kaiser	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.1%	14.3%	14.4%	14.5%	14.6%		14.8%
Delegated Subtotal	63.1%	63.6%	63.6%	63.7%	63.5%	63.7%	63.6%	60.7%	60.7%	60.6%	60.8%		62.5%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**		**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2023

	Variance Jul-22	Variance Aug-22	Variance Sep-22	Variance Oct-22	Variance Nov-22	Variance Dec-22	Variance Jan-23	Variance Feb-23	Variance Mar-23	Variance Apr-23	Variance May-23	Variance Jun-23	YTD Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	0	0	0	0	127	62	(118)	52	70	528	1,007		1,728
Adult	0	0	0	0	661	696	619	823	947	1,227	2,105		7,078
SPD	0	0	0	0	43	45	(2,852)	(719)	(706)	(692)	(665)		(5,546)
ACA OE	0	0	0	0	774	1,493	(654)	337	1,175	2,567	4,123		9,815
Duals	0	0	0	0	102	275	(20,932)	(4,312)	(3,665)	(3,709)	(3,668)		(35,909)
MCAL LTC	0	0	0	0	0	0	(147)	(24)	(10)	(8)	(5)		(194)
MCAL LTC Duals	0	0	0	0	0	0	(1,169)	(335)	(236)	(201)	(181)		(2,122)
Medi-Cal Program	0	0	0	0	1,707	2,571	(25,253)	(4,178)	(2,425)	(288)	2,716		(25,150)
Group Care Program	0	0	0	0	2	(13)	(28)	(43)	(66)	(120)	(119)		(387)
Total	**0**	**0**	**0**	**0**	**1,709**	**2,558**	**(25,281)**	**(4,221)**	**(2,491)**	**(408)**	**2,597**		**(25,537)**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted	0	0	0	0	1,184	747	(12,905)	5,165	5,654	7,015	7,285		14,145
Delegated:													
CFMG	0	0	0	0	(191)	(113)	(264)	(94)	398	422	992		1,150
CHCN	0	0	0	0	578	1,555	(8,637)	(6,256)	(6,066)	(5,922)	(4,535)		(29,283)
Kaiser	0	0	0	0	138	369	(3,475)	(3,036)	(2,477)	(1,923)	(1,145)		(11,549)
Delegated Subtotal	0	0	0	0	525	1,811	(12,376)	(9,386)	(8,145)	(7,423)	(4,688)		(39,682)
Total	**0**	**0**	**0**	**0**	**1,709**	**2,558**	**(25,281)**	**(4,221)**	**(2,491)**	**(408)**	**2,597**		**(25,537)**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED May 31, 2023

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES:				
$1,178,947	$1,150,395	($28,552)	(2.5%)	PCP-Capitation	$12,613,305	$12,563,895	($49,410)	(0.4%)
4,496,251	4,806,230	309,979	6.4%	PCP-Capitation - FQHC	46,254,496	49,513,703	3,259,207	6.6%
303,537	296,699	(6,838)	(2.3%)	Specialty-Capitation	3,241,013	3,234,037	(6,976)	(0.2%)
3,875,527	4,154,828	279,301	6.7%	Specialty-Capitation FQHC	41,210,012	42,305,955	1,095,943	2.6%
496,772	485,701	(11,072)	(2.3%)	Laboratory-Capitation	5,042,015	5,039,480	(2,535)	(0.1%)
0	0	0	0.0%	Transportation (Ambulance)-Cap	7,211,489	4,820,922	(2,390,567)	(49.6%)
257,951	254,529	(3,422)	(1.3%)	Vision Cap	2,663,990	2,670,128	6,137	0.2%
88,345	86,407	(1,938)	(2.2%)	CFMG Capitation	943,709	941,828	(1,881)	(0.2%)
192,440	206,287	13,848	6.7%	Anc IPA Admin Capitation FQHC	2,873,445	2,108,697	(764,748)	(36.3%)
14,070,365	15,429,726	1,359,361	8.8%	Kaiser Capitation	135,161,442	143,887,475	8,726,033	6.1%
0	0	0	0.0%	BHT Supplemental Expense	5,811,772	4,099,732	(1,712,040)	(41.8%)
0	0	0	0.0%	Hep-C Supplemental Expense	(15,082)	(15,349)	(267)	1.7%
502,806	608,736	105,929	17.4%	Maternity Supplemental Expense	4,033,142	5,481,123	1,447,981	26.4%
726,397	775,761	49,364	6.4%	DME - Cap	6,982,726	7,434,117	451,390	6.1%
$26,189,339	**$28,255,299**	**$2,065,960**	**7.3%**	**5 - TOTAL CAPITATED EXPENSES**	**$274,027,474**	**$284,085,742**	**$10,058,269**	**3.5%**
				FEE FOR SERVICE MEDICAL EXPENSES:				
(1,974,571)	0	1,974,571	0.0%	IBNP-Inpatient Services	5,906,408	2,799,249	(3,107,159)	(111.0%)
(59,237)	0	59,237	0.0%	IBNP-Settlement (IP)	177,196	83,979	(93,217)	(111.0%)
(157,965)	0	157,965	0.0%	IBNP-Claims Fluctuation (IP)	472,511	223,940	(248,571)	(111.0%)
36,163,711	36,587,662	423,950	1.2%	Inpatient Hospitalization-FFS	303,836,704	343,654,919	39,818,215	11.6%
2,212,437	0	(2,212,437)	0.0%	IP OB - Mom & NB	17,349,094	5,348,714	(12,000,380)	(224.4%)
31,478	0	(31,478)	0.0%	IP Behavioral Health	2,276,652	982,572	(1,294,081)	(131.7%)
613,972	0	(613,972)	0.0%	IP - Facility Rehab FFS	8,431,676	3,142,653	(5,289,022)	(168.3%)
$36,829,825	**$36,587,662**	**($242,164)**	**(0.7%)**	**6 - Inpatient Hospital & SNF FFS Expense**	**$338,450,241**	**$356,236,026**	**$17,785,785**	**5.0%**
(317,416)	0	317,416	0.0%	IBNP-PCP	1,209,149	628,624	(580,525)	(92.3%)
(9,523)	0	9,523	0.0%	IBNP-Settlement (PCP)	36,277	18,862	(17,415)	(92.3%)
(25,392)	0	25,392	0.0%	IBNP-Claims Fluctuation (PCP)	96,738	50,291	(46,447)	(92.4%)
2,148,123	1,571,355	(576,768)	(36.7%)	Primary Care Non-Contracted FF	17,622,126	15,748,636	(1,873,490)	(11.9%)
329,505	103,887	(225,618)	(217.2%)	PCP FQHC FFS	2,104,108	1,216,010	(888,097)	(73.0%)
(1,442,167)	2,993,402	4,435,570	148.2%	Prop 56 Direct Payment Expenses	19,805,895	28,695,617	8,889,722	31.0%
14,889	0	(14,889)	0.0%	Prop 56 Hyde Direct Payment Expenses	158,477	57,389	(101,088)	(176.1%)
(292,500)	0	292,500	0.0%	Prop 56-Trauma Expense	499,451	310,921	(188,530)	(60.6%)
(480,053)	0	480,053	0.0%	Prop 56-Dev. Screening Exp.	509,507	396,554	(112,953)	(28.5%)
(2,034,302)	0	2,034,302	0.0%	Prop 56-Fam. Planning Exp.	5,023,862	2,777,346	(2,246,516)	(80.9%)
(5,422,432)	0	5,422,432	0.0%	Prop 56-Value Based Purchasing	(5,426,490)	(1,293)	5,425,197	(419,653.5%)
($7,531,267)	**$4,668,645**	**$12,199,911**	**261.3%**	**7 - Primary Care Physician FFS Expense**	**$41,639,099**	**$49,898,957**	**$8,259,857**	**16.6%**
(593,936)	0	593,936	0.0%	IBNP-Specialist	392,946	479,524	86,578	18.1%
176,380	0	(176,380)	0.0%	Psychiatrist - FFS	176,380	0	(176,380)	0.0%
2,756,577	5,753,672	2,997,096	52.1%	Specialty Care-FFS	24,862,634	47,668,675	22,806,040	47.8%
200,500	0	(200,500)	0.0%	Anesthesiology - FFS	1,597,088	546,925	(1,050,163)	(192.0%)
1,272,950	0	(1,272,950)	0.0%	Spec Rad Therapy - FFS	10,008,363	3,377,385	(6,630,978)	(196.3%)
20,067	0	(20,067)	0.0%	Obstetrics-FFS	374,237	269,748	(104,489)	(38.7%)
472,468	0	(472,468)	0.0%	Spec IP Surgery - FFS	3,632,596	1,351,027	(2,281,569)	(168.9%)
764,781	0	(764,781)	0.0%	Spec OP Surgery - FFS	6,328,848	2,234,372	(4,094,476)	(183.2%)
599,257	0	(599,257)	0.0%	Spec IP Physician	4,398,094	1,438,762	(2,959,333)	(205.7%)
79,239	59,061	(20,177)	(34.2%)	SCP FQHC FFS	638,836	595,925	(42,911)	(7.2%)
(17,817)	0	17,817	0.0%	IBNP-Settlement (SCP)	11,786	14,383	2,597	18.1%
(47,515)	0	47,515	0.0%	IBNP-Claims Fluctuation (SCP)	31,435	38,359	6,924	18.1%
$5,682,950	**$5,812,734**	**$129,783**	**2.2%**	**8 - Specialty Care Physician Expense**	**$52,453,243**	**$58,015,084**	**$5,561,840**	**9.6%**
(93,610)	0	93,610	0.0%	IBNP-Ancillary	3,106,177	321,732	(2,784,445)	(865.5%)
(2,808)	0	2,808	0.0%	IBNP Settlement (ANC)	93,186	9,649	(83,537)	(865.8%)
(7,488)	0	7,488	0.0%	IBNP Claims Fluctuation (ANC)	248,496	25,737	(222,759)	(865.5%)
43,246	0	(43,246)	0.0%	IBNR Transportation FFS Expense	1,445,953	0	(1,445,953)	0.0%
741,817	0	(741,817)	0.0%	Behavioral Health Therapy - FFS	10,905,702	4,559,994	(6,345,708)	(139.2%)
509,409	0	(509,409)	0.0%	Psychologist & Other MH Prof.	509,529	0	(509,529)	0.0%
342,751	0	(342,751)	0.0%	Acupuncture/Biofeedback	2,824,607	1,141,414	(1,683,193)	(147.5%)
121,131	0	(121,131)	0.0%	Hearing Devices	1,168,326	465,938	(702,389)	(150.7%)
32,267	0	(32,267)	0.0%	Imaging/MRI/CT Global	396,921	161,874	(235,047)	(145.2%)
55,385	0	(55,385)	0.0%	Vision FFS	526,555	184,029	(342,526)	(186.1%)
10	0	(10)	0.0%	Family Planning	47,148	47,111	(37)	(0.1%)
529,391	0	(529,391)	0.0%	Laboratory-FFS	6,617,592	2,694,430	(3,923,162)	(145.6%)
121,330	0	(121,330)	0.0%	ANC Therapist	1,186,396	443,518	(742,877)	(167.5%)
1,030,576	0	(1,030,576)	0.0%	Transportation (Ambulance)-FFS	8,180,028	2,305,579	(5,874,449)	(254.8%)
1,516,453	0	(1,516,453)	0.0%	Transportation (Other)-FFS	4,642,427	533,749	(4,108,678)	(769.8%)
1,315,099	0	(1,315,099)	0.0%	Hospice	6,894,968	1,554,127	(5,340,841)	(343.7%)
1,114,300	0	(1,114,300)	0.0%	Home Health Services	10,279,305	3,120,909	(7,158,396)	(229.4%)
0	7,558,936	7,558,936	100.0%	Other Medical-FFS	2,526	46,427,281	46,424,755	100.0%
225,649	0	(225,649)	0.0%	HMS Medical Refunds	(171,494)	84,120	255,613	303.9%
(419,790)	0	419,790	0.0%	Refunds-Medical Payments	(1,047,717)	(69)	1,047,648	(1,520,754.7%)
5,710	0	(5,710)	0.0%	DME & Medical Supplies	1,122,567	1,126,912	4,345	0.4%

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED May 31, 2023

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
0	601,977	601,977	100.0%	GEMT Direct Payment Expense	0	4,338,811	4,338,811	100.0%
0	0	0	0.0%	COVID Vaccination Incentive	4,460	0	(4,460)	0.0%
1,473,362	1,362,443	(110,918)	(8.1%)	ECM Base/Outreach FFS Anc.	12,507,427	12,063,673	(443,754)	(3.7%)
0	0	0	0.0%	ECM Outreach FFS Ancillary	0	9,825	9,825	100.0%
23,612	159,766	136,155	85.2%	CS - Housing Deposits FFS Ancillary	2,854,491	2,515,646	(338,845)	(13.5%)
223,718	1,095,168	871,450	79.6%	CS - Housing Tenancy FFS Ancillary	3,036,430	8,131,872	5,095,442	62.7%
45,874	246,182	200,308	81.4%	CS - Housing Navigation Services FFS Ancillary	1,888,771	2,360,775	472,004	20.0%
57,330	204,877	147,547	72.0%	CS - Medical Respite FFS Ancillary	2,216,333	2,721,008	504,675	18.5%
13,595	136,018	122,423	90.0%	CS - Medically Tailored Meals FFS Ancillary	1,440,053	1,620,665	180,612	11.1%
3,560	37,159	33,599	90.4%	CS - Asthma Remediation FFS Ancillary	291,004	420,689	129,685	30.8%
0	10,964	10,964	100.0%	MOT- Wrap Around (Non Medical MOT Cost)	8,674	85,420	76,746	89.8%
223,390	0	(223,390)	0.0%	Community Based Adult Services (CBAS)	4,683,586	1,783,368	(2,900,218)	(162.6%)
$9,245,270	**$11,413,490**	**$2,168,220**	**19.0%**	**9 - Ancillary Medical Expense**	**$87,910,426**	**$101,259,785**	**$13,349,359**	**13.2%**
(835,029)	0	835,029	0.0%	IBNP-Outpatient	1,825,909	1,712,767	(113,142)	(6.6%)
(25,051)	0	25,051	0.0%	IBNP Settlement (OP)	54,774	51,384	(3,390)	(6.6%)
(66,801)	0	66,801	0.0%	IBNP Claims Fluctuation (OP)	146,075	137,022	(9,053)	(6.6%)
1,827,566	10,434,940	8,607,374	82.5%	Out-Patient FFS	15,905,906	73,556,773	57,650,867	78.4%
1,792,096	0	(1,792,096)	0.0%	OP Ambul Surgery - FFS	17,295,728	6,320,713	(10,975,015)	(173.6%)
2,375,652	0	(2,375,652)	0.0%	OP Fac Imaging Services-FFS	15,839,730	4,151,392	(11,688,338)	(281.6%)
(68,712)	0	68,712	0.0%	Behav Health - FFS	6,951,198	3,072,756	(3,878,442)	(126.2%)
0	0	0	0.0%	Write-Offs	(15)	0	15	0.0%
546,239	0	(546,239)	0.0%	OP Facility - Lab FFS	5,595,235	1,978,515	(3,616,720)	(182.8%)
156,759	0	(156,759)	0.0%	OP Facility - Cardio FFS	1,338,756	419,692	(919,064)	(219.0%)
73,837	0	(73,837)	0.0%	OP Facility - PT/OT/ST FFS	559,745	185,180	(374,565)	(202.3%)
2,265,187	0	(2,265,187)	0.0%	OP Facility - Dialysis FFS	22,130,869	7,656,130	(14,474,739)	(189.1%)
$8,041,744	**$10,434,940**	**$2,393,196**	**22.9%**	**10 - Outpatient Medical Expense Medical Expense**	**$87,643,910**	**$99,242,324**	**$11,598,414**	**11.7%**
(18,265)	0	18,265	0.0%	IBNP-Emergency	1,077,152	337,708	(739,444)	(219.0%)
(547)	0	547	0.0%	IBNP Settlement (ER)	32,314	10,128	(22,186)	(219.1%)
(1,462)	0	1,462	0.0%	IBNP Claims Fluctuation (ER)	86,171	27,018	(59,153)	(218.9%)
858,061	0	(858,061)	0.0%	Special ER Physician-FFS	7,179,942	2,522,209	(4,657,733)	(184.7%)
4,935,034	5,840,069	905,035	15.5%	ER-Facility	46,307,140	55,003,413	8,696,273	15.8%
$5,772,821	**$5,840,069**	**$67,249**	**1.2%**	**11 - Emergency Expense**	**$54,682,719**	**$57,900,476**	**$3,217,757**	**5.6%**
(1,228,551)	0	1,228,551	0.0%	IBNP-Pharmacy	1,945,592	955,216	(990,376)	(103.7%)
(36,856)	0	36,856	0.0%	IBNP Settlement (RX)	58,370	28,657	(29,713)	(103.7%)
(98,286)	0	98,286	0.0%	IBNP Claims Fluctuation (RX)	155,643	76,415	(79,228)	(103.7%)
318,672	346,990	28,318	8.2%	Pharmacy-FFS	3,514,710	4,231,679	716,969	16.9%
308,898	7,419,919	7,111,022	95.8%	Pharmacy- Non-PBM FFS-Other Anc	14,244,150	62,494,525	48,250,374	77.2%
6,355,183	0	(6,355,183)	0.0%	Pharmacy- Non-PBM FFS-OP FAC	44,209,342	7,474,895	(36,734,447)	(491.4%)
176,804	0	(176,804)	0.0%	Pharmacy- Non-PBM FFS-PCP	1,200,040	222,232	(977,808)	(440.0%)
2,307,164	0	(2,307,164)	0.0%	Pharmacy- Non-PBM FFS-SCP	18,564,309	3,401,156	(15,163,152)	(445.8%)
15,586	0	(15,586)	0.0%	Pharmacy- Non-PBM FFS-FQHC	80,146	11,510	(68,636)	(596.3%)
8,046	0	(8,046)	0.0%	Pharmacy- Non-PBM FFS-HH	241,020	100,717	(140,303)	(139.3%)
0	0	0	0.0%	HMS RX Refunds	(66,029)	(59,403)	6,626	(11.2%)
0	32,854	32,854	100.0%	Pharmacy-Rebate	(79,254)	225,670	304,925	135.1%
$8,126,659	**$7,799,763**	**($326,896)**	**(4.2%)**	**12 - Pharmacy Expense**	**$84,068,039**	**$79,163,269**	**($4,904,770)**	**(6.2%)**
(6,987,806)	0	6,987,806	0.0%	IBNR LTC	19,220,124	0	(19,220,124)	0.0%
(209,634)	0	209,634	0.0%	IBNR Settlement (LTC)	576,604	0	(576,604)	0.0%
(559,026)	0	559,026	0.0%	IBNR Claims Fluctuation (LTC)	1,537,609	0	(1,537,609)	0.0%
17,427,959	0	(17,427,959)	0.0%	LTC-Custodial Care	31,644,187	0	(31,644,187)	0.0%
3,343,083	15,948,324	12,605,241	79.0%	LTC SNF	17,236,658	84,582,411	67,345,754	79.6%
$13,014,575	**$15,948,324**	**$2,933,748**	**18.4%**	**13 - Long Term Care FFS Expense**	**$70,215,182**	**$84,582,411**	**$14,367,230**	**17.0%**
$79,182,578	**$98,505,625**	**$19,323,047**	**19.6%**	**14 - TOTAL FFS MEDICAL EXPENSES**	**$817,062,859**	**$886,298,332**	**$69,235,473**	**7.8%**
0	27,270	27,270	100.0%	Clinical Vacancy	0	(191,491)	(191,491)	100.0%
80,579	136,429	55,850	40.9%	Quality Analytics	892,088	1,213,136	321,047	26.5%
660,911	603,386	(57,524)	(9.5%)	Health Plan Services Department Total	5,827,699	6,408,991	581,293	9.1%
540,046	448,577	(91,470)	(20.4%)	Case & Disease Management Department Total	5,130,155	5,162,428	32,273	0.6%
19,374,493	2,484,268	(16,890,226)	(679.9%)	Medical Services Department Total	47,955,819	29,766,167	(18,189,652)	(61.1%)
666,835	640,132	(26,703)	(4.2%)	Quality Management Department Total	6,633,791	7,710,000	1,076,209	14.0%
148,646	180,643	31,998	17.7%	HCS Behavioral Health Department Total	1,523,854	1,773,960	250,107	14.1%
146,432	148,133	1,702	1.1%	Pharmacy Services Department Total	1,397,168	1,600,554	203,386	12.7%
51,882	75,624	23,743	31.4%	Regulatory Readiness Total	366,432	596,672	230,240	38.6%
$21,669,823	**$4,744,463**	**($16,925,360)**	**(356.7%)**	**15 - Other Benefits & Services**	**$69,727,007**	**$54,040,418**	**($15,686,589)**	**(29.0%)**
(711,000)	(663,653)	47,347	(7.1%)	Reinsurance Recoveries	(8,713,840)	(8,502,800)	211,040	(2.5%)
889,519	884,871	(4,648)	(0.5%)	Stop-Loss Expense	9,246,505	9,296,982	50,477	0.5%
$178,519	**$221,218**	**$42,699**	**19.3%**	**16 - Reinsurance Expense**	**$532,665**	**$794,182**	**$261,518**	**32.9%**
$127,220,259	**$131,726,605**	**$4,506,346**	**3.4%**	**17 - TOTAL MEDICAL EXPENSES**	**$1,161,350,005**	**$1,225,218,675**	**$63,868,670**	**5.2%**

Proposed Finance Committee Schedule

ALAMEDA Alliance FOR HEALTH

Mandatory Meeting Months

October	December	June
• Moss-Adams Audit Review	• Final Budget Review	• Preliminary Budget Review

Proposed Schedule

In-Person

- July
- September
- October
- December
- February
- May
- June

Recess

- August
- November
- January
- March
- April

Financial Metrics Warranting In-Person Meeting

- Net Loss > $10M in one month
- Reduction in TNE >100% in one month
- MLR above 110% cumulatively or in one month
- Current Ratio at or below 1.1
- Two or more metrics above near minimum limits
- At the discretion of Board Chair, Finance Chair or CEO

RESOLUTION NO. 2023-06

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH AMENDING THE COMPOSITION AND MEETING FREQUENCY OF ITS STANDING FINANCE COMMITTEE

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

WHEREAS, Section 7.A.1 of the Bylaws requires that the frequency, composition, compensation, terms, and nomination of members of standing committees shall be as set forth by resolution; and

WHEREAS, the Board approved Resolution No. 94-04[1] on July 14th, 1994, which created the Finance Committee as a standing committee of the Board; and

WHEREAS, the Board approved Resolution No. 94-08[2] on August 25th, 1994 which changed the Board composition of the Finance Committee to five (5) Board members; and

WHEREAS, Section 7.C.4 of the Bylaws states that the Alliance Chief Financial Officer shall serve, ex officio, as a voting member on the Finance Committee and shall be counted towards a quorum; and

WHEREAS, the Board at this time desires to amend both the meeting frequency and composition of the Finance Committee; and

WHEREAS, the Board desires, for the sake of clarity, to restate the Finance Committee member compensation, term length and nomination process.

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

SECTION 1. The Finance Committee will hold meetings in February, May, June, July, September, October and December.

SECTION 2. The Finance Committee may, at the discretion of the Board, Finance Committee Chair, or Alliance Chief Executive Officer, cancel meetings deemed to be unnecessary or schedule additional meetings to address any pressing matters.

[1] 94-04 Resolution Appointing Standing Finance Committee of the Alameda Alliance for Health Board of Governors.
[2] 94-08 Resolution to Amend Resolution 94-04 Appointing Standing Finance Committee of the Alameda Alliance for Health Board of Governors.

SECTION 3. The Finance Committee will consist of no less than three (3) Board members, and no more than five (5) Board members.

SECTION 4. Finance Committee members shall be recommended to the Board and shall be approved by majority vote of the Board of Governors.

SECTION 5. Appointments to the Finance Committee shall be for a term of two (2) years and members may be reappointed to additional terms with the Board's approval.

SECTION 6. As stated in the Bylaws section 7.C.4, the Chair and Vice Chair of the Committee shall be Board members selected and approved by the Board.

SECTION 7. The Chief Financial Officer of the Alliance shall serve ex officio as a voting member on the Finance Committee and shall be counted towards a quorum in compliance with the Bylaws.

SECTION 8. Members of the Finance Committee shall not receive compensation.

PASSED AND ADOPTED by Alliance's Board of Governors at a meeting held on the 14th day of July 2023.

_____
CHAIR, BOARD OF GOVERNORS

ATTEST:

_____
Secretary

Presentation to the Board of Governors

Matthew Woodruff, Chief Executive Officer

July 14th, 2023

ALAMEDA Alliance FOR HEALTH

Proposed Recess Months

- **August Recess**
  - Alameda County Recess
- **November Recess**
  - Holidays
    - Veterans Day
    - Thanksgiving Day
- **February Recess**
  - Short Month
- **April Recess**
  - Audit Month
    - DHCS
    - DMHC

Board of Governors Retreat

- Propose the last Friday of January for the Board Retreat from 10:30 AM to 4:00 PM.

Board of Governors Meeting

- Proposal to meet eight times a year, with one meeting being the Board Retreat.
- Board packets will be distributed in recess months on the second Friday of the month.
  - The exception is January and the Board retreat. January packets will be distributed three (3) days in advance of the retreat date.

RESOLUTION NO. 2023-01

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH CHANGING THE FREQUENCY, AND RESTATING THE DATE, TIME, AND LOCATION FOR MEETINGS OF THE BOARD OF GOVERNORS OF ALAMEDA ALLIANCE FOR HEALTH

WHEREAS, California open meeting laws provide that all regular meetings of the Alameda Alliance for Health ("Alliance") Board of Governors ("Board") shall be at a specified date, time and location; and

WHEREAS, the Board adopted bylaws providing that the Board shall set forth, by resolution, the date, time, location and frequency for holding its regular meetings; and

WHEREAS, the Board has previously established the date, time, location and frequency of regular meetings by resolution; and

WHEREAS, the Alliance was under conservatorship from May 2014 through October 2015; and

WHEREAS, beginning during the conservatorship and continuing until the present the Board has held regular meetings once per month at least eleven (11) times per year, with these regular meetings taking place on the second Friday of the month from 12:00 p.m. to 2:00 p.m., with August being a recess month; and

WHEREAS, the Board now finds it necessary to change the frequency of regular meetings and to restate the date, time and location of these meetings.

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

SECTION 1. The regular meetings of the Board shall occur in January, March, May, June, July, September, October, and December; during the months of February, April, August, and November the Board will be at recess, and will only meet if deemed necessary by the Board.

SECTION 2. The January meeting shall be a Board retreat, and shall occur on the last Friday of January, from 10:30 a.m. to 4:00 p.m.; all other regular meetings of the Board shall occur on the second Friday of each month listed above, from 12:00 p.m. to 2:00 p.m., and as a matter of rule will end by 2:30 p.m.; an extension of the meeting beyond 2:30 p.m. must be by majority vote of the members present.

SECTION 3. If the second Friday of the month falls on a legal holiday, the meeting shall occur on the third Friday of the same month.

SECTION 4. The January meeting location will be determined annually by Board vote; all other regular meetings of the Board shall be held at the Alliance's executive offices located at 1240 South Loop Road, Alameda, CA 94502.

SECTION 5. The Alliance Secretary shall certify the adoption of this resolution.

PASSED AND ADOPTED by the Board at a meeting held on the 14th day of July 2023.

_____
VICE CHAIR, BOARD OF GOVERNORS

ATTEST:

_____
Secretary

Medicare Update

Matthew Woodruff, Chief Executive Officer

and

Ruth Watson, Chief Operating Officer

July 14th, 2023

ALAMEDA Alliance FOR HEALTH

Background

- DSNP vs MA Plan
- Health Plan San Mateo Proposed Model
- Alliance Process

Regional Model

- Review of Proposed Model

Local Initiatives Proposed Regional DSNP Model

- CareAdvantage (the Health Plan San Mateo (HPSM) 501c3 LLC) would be responsible for all Medicare and Medi-Cal covered services for members enrolled in the plan.
- CareAdvantage would fully integrate all benefits for members and payments to providers.
- Each local plan would fully delegate most/all Medi-Cal covered services to CareAdvantage.

Proposed Governance Structure

- Limited Liability Companies (LLCs) have Members, which serve as governance for the entity. Each Member would consist of a participating Medi-Cal plan.
- Each Member Organization will appoint three individuals to serve as voting Board Members for LLC governance. Details would be described in the articles of incorporation and by-laws. The individuals are:
  - CEO from each Medi-Cal plan
  - Consumer or community representative from each Medi-Cal plan
  - Participating provider representative from each Medi-Cal plan
- If two or four organizations participate, the CEOs from each Medi-Cal plan will confer and collectively nominate one additional Board Member. Most items will be approved by the majority of Board Members, except for specific exclusions, such as adding new Member Organizations, in which a unanimous or super-majority would apply.

Financing Model – Reserves and Start-Up

Reserve Policy:

- The LLC will sustain a reserve range between 400-600% of Tangible Net Equity(TNE), as defined by DMHC.

Initial Contributions:

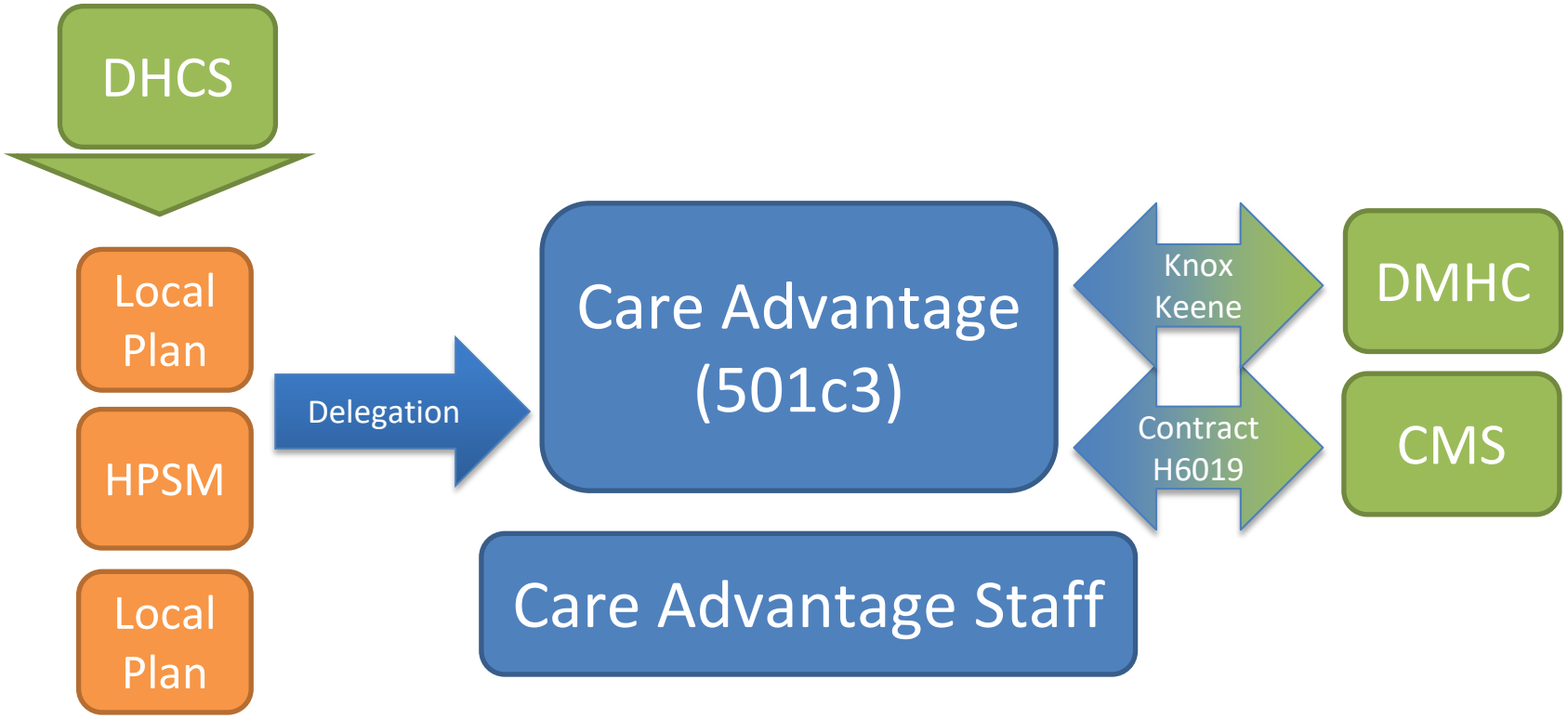
- HPSM will make an initial contribution of 600% of TNE* to the entity and make additional contributions if needed to sustain that level until December 2025.
- Other Local Plans will contribute $10M** initially to join the LLC and $1M*** additional contribution in January 2025 for additional staff start-up costs before go-live in January 2026.

* TNE will now need to be calculated based upon both Medicare and Medi-Cal services.

** Milliman can help advise the best approach to initial reserve contribution. It may be different for each plan. For example, we may set the criteria as the dollars needed to cover the best estimate of membership growth and potential operational losses for two years.

*** The start-up costs have not been fully evaluated, so $1M is a placeholder.

Fully Integrated DNSP Model



Financial and Operational Coordination

Auditing and Oversight

Financing Model – Contributions

- On October 1st, starting in 2026, each plan will jointly make annual contributions to the LLC if needed to attain 500% of TNE, and more frequently if TNE drops below 400% for two consecutive quarters, based on the following formula:
  - *75% based on percentage of total membership and 25% based on performance for the plan county over the last 12 months.*

Timeline

- Exploration of local plan interest and identification of regulatory barriers, if any: March 2023
- HPSM Commission approval to create subsidiary (based on results of initial exploration): August 2023
- Creation of LLC: September-October 2023
- Initiate filing Knox Keene License for new entity: October 2023
- Deadline for local plans to join: April 2024
- CMS and DMHC Service Area Expansion applications: November 2024
- CMS bid submission for newly expanded service area: June 2025
- DHCS demonstration
- Go-live date for expanded service area: January 2026

Local Model

- Review of Proposed Model

D-SNP Implementation

- RFP issued February 2023
  - 5 respondents, 3 Finalists
- Vendor selected April 2023 to assist staff with:
  - Feasibility Study, Application Process, Planning & Implementation - 6/2023 - 6/2026
- Vendor Selection – Rebellis Group
- Kick-off 6/2023
- System Evaluation in progress

Rebellis Group LLC

- Senior Leaders with deep industry experience
  - Expertise – HealthPlan, Medi-Cal Managed Care, Medicare Advantage, D-SNP
  - Regulators - CMS, DHCS, & DMHC
  - Successful track record implementing all aspects of D-SNP

Regional vs Local Model

Regional

- Previous experience with D-SNP, 8,300 Members – AAH ramp up not as costly
- Care Advantage new entity – CEO, CFO, staffing, etc.
- One set of benefits for all counties
- Lower cost to implement – shared costs and expertise
- AAH not Decision Maker
- AAH Members delegated to Care Advantage
- Alameda County Medicare D-SNP Provider Network not connected to Medi-Cal Network

Local

- Start-up plans granted 3.5 stars for 3 years; existing plan is 3-star plan = reduced rates at start-up
- AAH retains its members
- AAH is decision maker
- Unique benefit plan for Alameda County members
  - Health equity, advocacy & delivery of services based on Alameda county resident experience & needs
- If AAH should decide later to bring in-house, would start from scratch and compete with Care Advantage
- Less confusing for Members and Providers

Recommendation

- Establish a local D-SNP under AAH for Alameda County dual eligible members
  - AAH knows the community and will continue to partner with local agencies, providers & stakeholders that serve the dual population
  - Provides mechanism for maintaining members as they “age-in”
  - Revenue loss – 3.5 to 3 stars
  - CEO, COO and staff members have Medicare D-SNP experience
  - Will utilize experienced D-SNP vender to aid in the development & implementation of the Alliance’s MA/D-SNP Plan
    - Vendor training and knowledge transfer will develop AAH MA/D-SNP expertise

Questions?

ALAMEDA Alliance FOR HEALTH

Major Organ Transplant Update

Presented to the Alameda Alliance Board of Governors
Steve O'Brien, CMO

July 14th, 2023

ALAMEDA Alliance FOR HEALTH

What Can Be Transplanted?

- **Solid organs (39,717 in 2019 in US)**
  - Kidney (23,401)
  - Liver (8,896)
  - Heart (3,551)
  - Lung(s) (2,714)
  - Pancreas (143)
  - Small intestines (81)
  - Dual/ triple organs
    (K/P 872, H/L 45)

- **Other:**
  - Corneas
  - Bone Marrow
  - Tendons/ cartilage/skin/ bone
  - Vascular Composite
    - Upper Limbs Bilat (17)
    - Upper Limbs Unilat (18)
    - Face (15)
    - Uterus 29)
    - Penile (2)

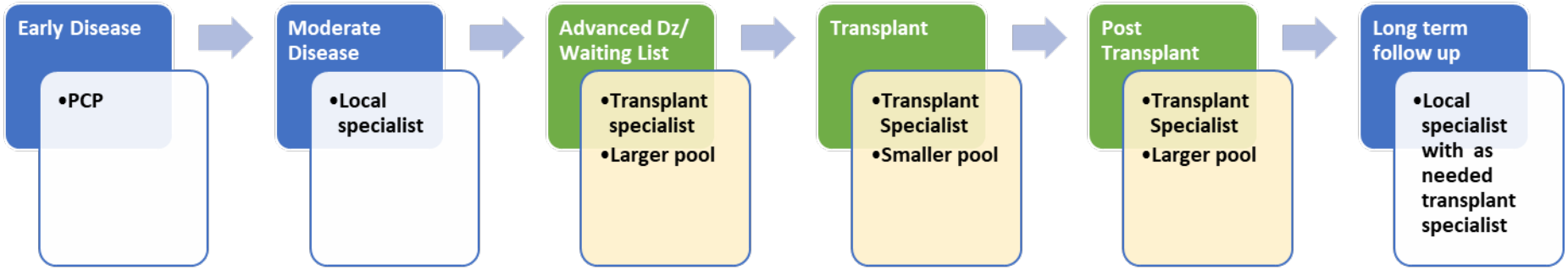
*Data available at www.unos.org
**Kidney, cornea, tendon administered by AAH before 2022

Who Can Do Transplants for Alliance Members?

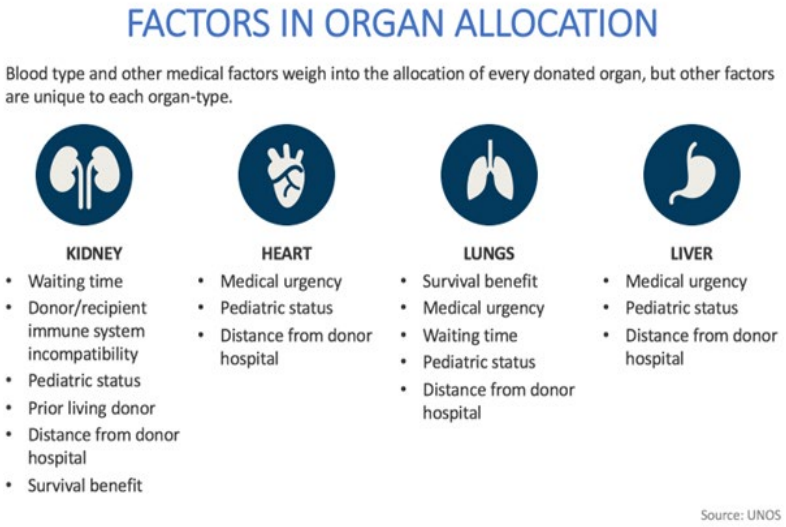
- **Solid organs ***
  - Kidney (UCSF, Stanford, Sutter**)
  - Liver (UCSF, Stanford)
  - Heart (UCSF, Stanford)
  - Lung(s) (UCSF, Stanford)
  - Pancreas (UCSF, Stanford)
  - Small intestines (UCSF, Stanford)
  - Dual/ triple organs (UCSF, Stanford)
- **Other:**
  - Corneas (many)
  - Bone Marrow (UCSF, Stanford)

*Solid organ transplants required to be at Center of Excellence
**Did not move members already in care

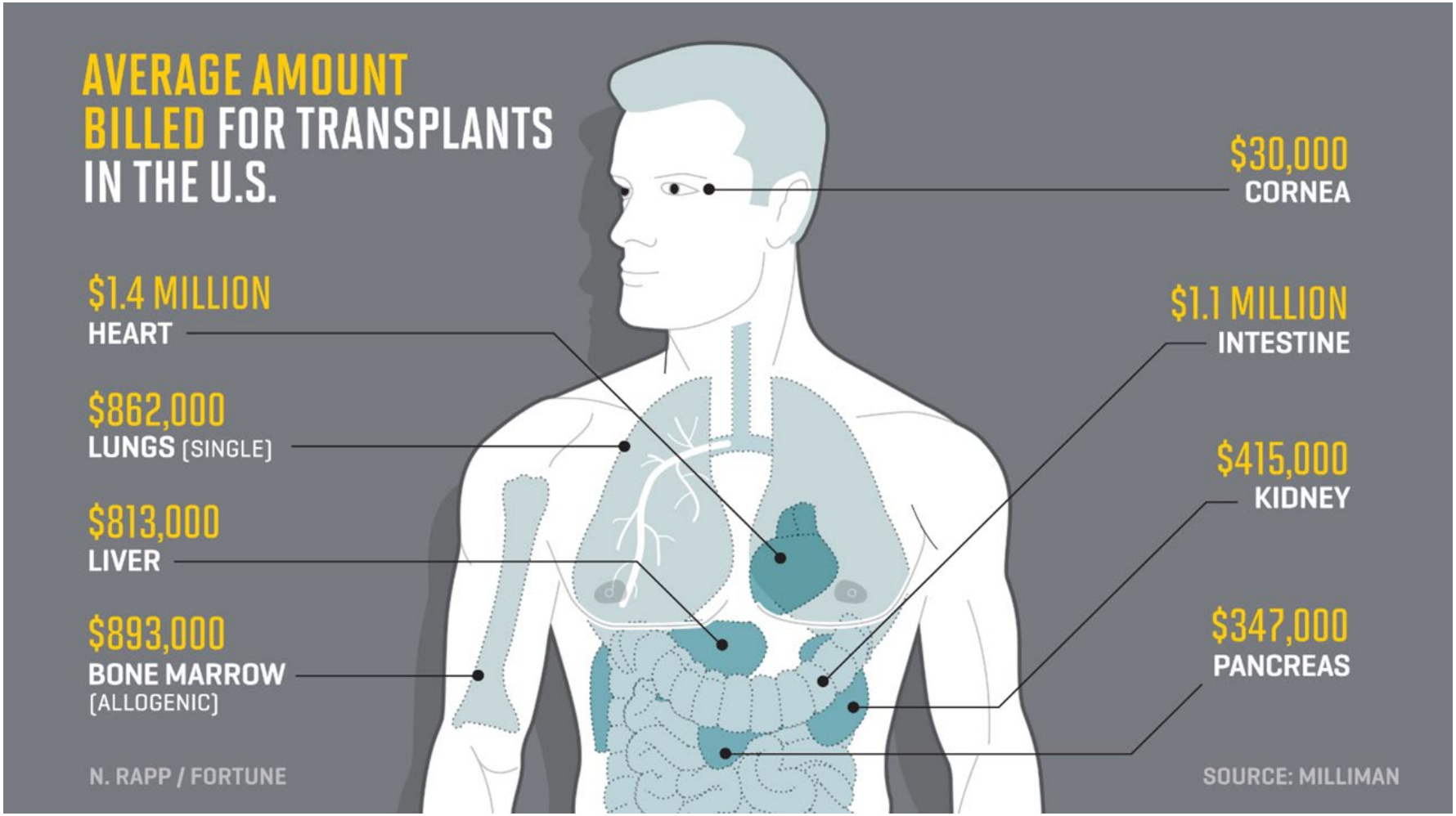
Phases of Transplants



- **Waiting list is**
  - not first come-first served
  - giant pool of patients
    - When organ is identified, national computer system (UNOS) generates a ranked list of transplant candidates from the waiting list who are suitable for the organ



Cost Can Be Significant



Alliance MOT Cost Data 2022

Alliance MOT Costs

January 2022- December 2022

Overall Cost for Major Organ Transplant Services	
Total Number of Unique Members	230
Total Number of Encounters	3320
Total Cost	$16,919,944

Delegate	Number of Members	Number of Encounters	Total Cost
CHCN	90	833	$6,760,109
AHS	87	1296	$5,069,112
Alliance	78	1191	$5,090,723

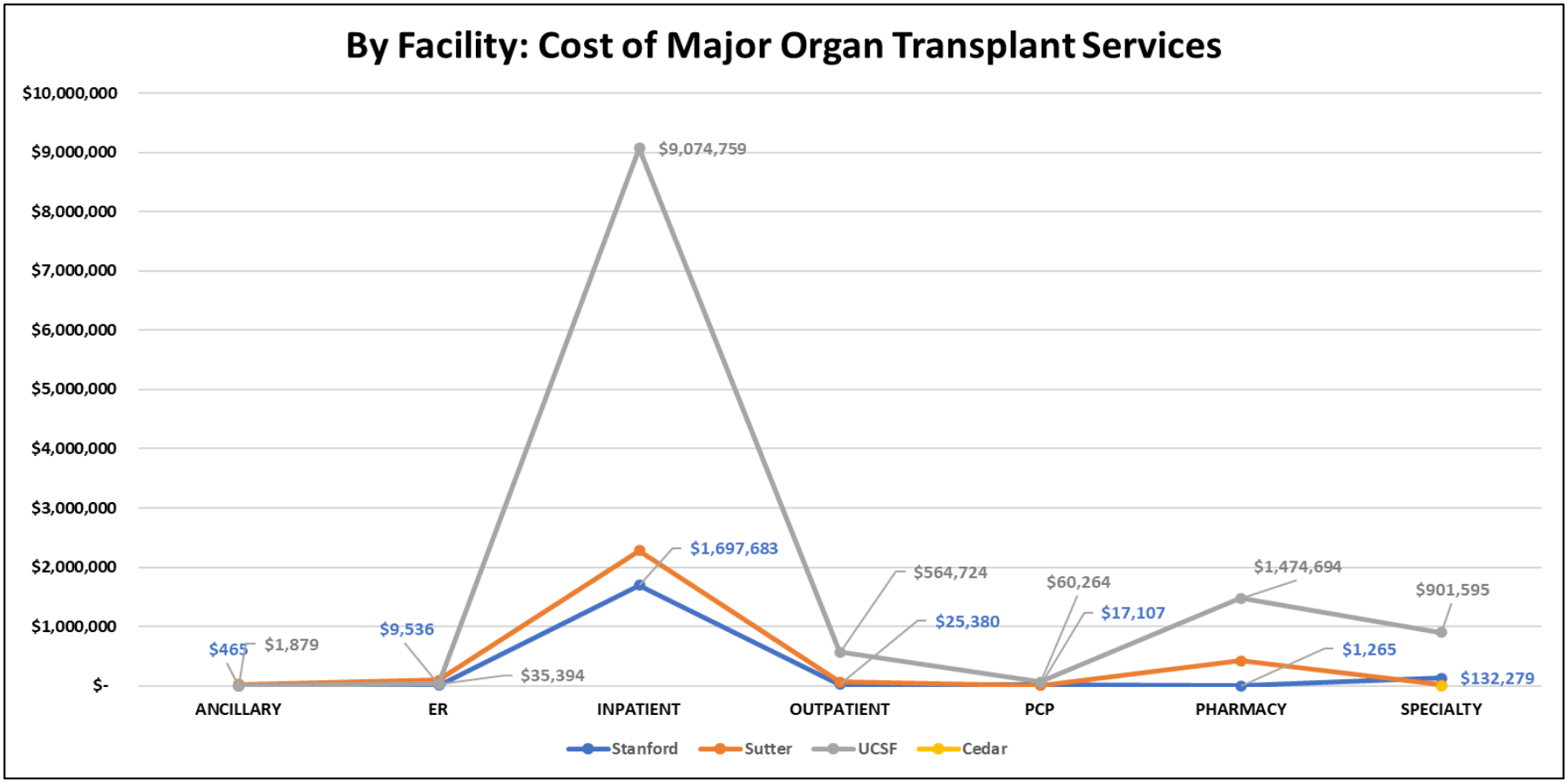
MOT by Network

Major Organ Transplant Services by Network						
Network	**Volume**	**Facility**	**Pre-Transplant**	**Waitlist**	**Post-Transplant**	**Organ Type**
CHCN	90	UCSF (70) Sutter (46) Stanford (7) Cedar (1)	50	6	*24	*Kidney (52) *Bone Marrow (15) Liver (12) Heart (4) Kidney-Pancreas (3) Cornea (2) N/A (1) Pancreas (1)
AHS	87	UCSF (71) Sutter (22) Stanford (15)	33	7	*40	*Kidney (49) *Liver (15) Bone Marrow (8) Lung (6) Cornea (3) Kidney-Pancreas (3) Heart (2) Small Bowel (1)
Alliance	78	UCSF (66) Sutter (29) Stanford (12)	28	8	*39	Kidney (36) *Liver (15) *Bone Marrow (11) Heart (7) Kidney-Pancreas (3) Lung (3) N/A (2) Cornea (1)
TOTAL	**230** (↑ from 151 in 6/22)	**339** UCSF (207) Sutter (97) SHC (34)	**111**	**21**	**103**	**255**

MOT by Facility

MOT by Centers of Excellence					
Facility	**Volume**	**Pre-Transplant**	**Waitlist**	**Post-Transplant**	**Organ Type**
UCSF	193	74	10	65	Kidney (108) Liver (28) Bone Marrow (25) Heart (9) Kidney-Pancreas (7) Cornea (6) Lung (6) N/A (3) Small Bowel(1)
Sutter	92	30	10	34	Kidney (56) Bone Marrow (14) Liver (10) Kidney-Pancreas (5) Heart (3) Cornea (2) N/A (1) Pancreas (1)
Stanford	27	7	1	8	Liver (8) Kidney (7) Bone Marrow (4) Heart (3) Lung (2) Cornea (1) N/A (1) Small Bowel (1)
TOTAL	**339**	**111**	**21**	**103**	**255**

MOT Costs by Facility

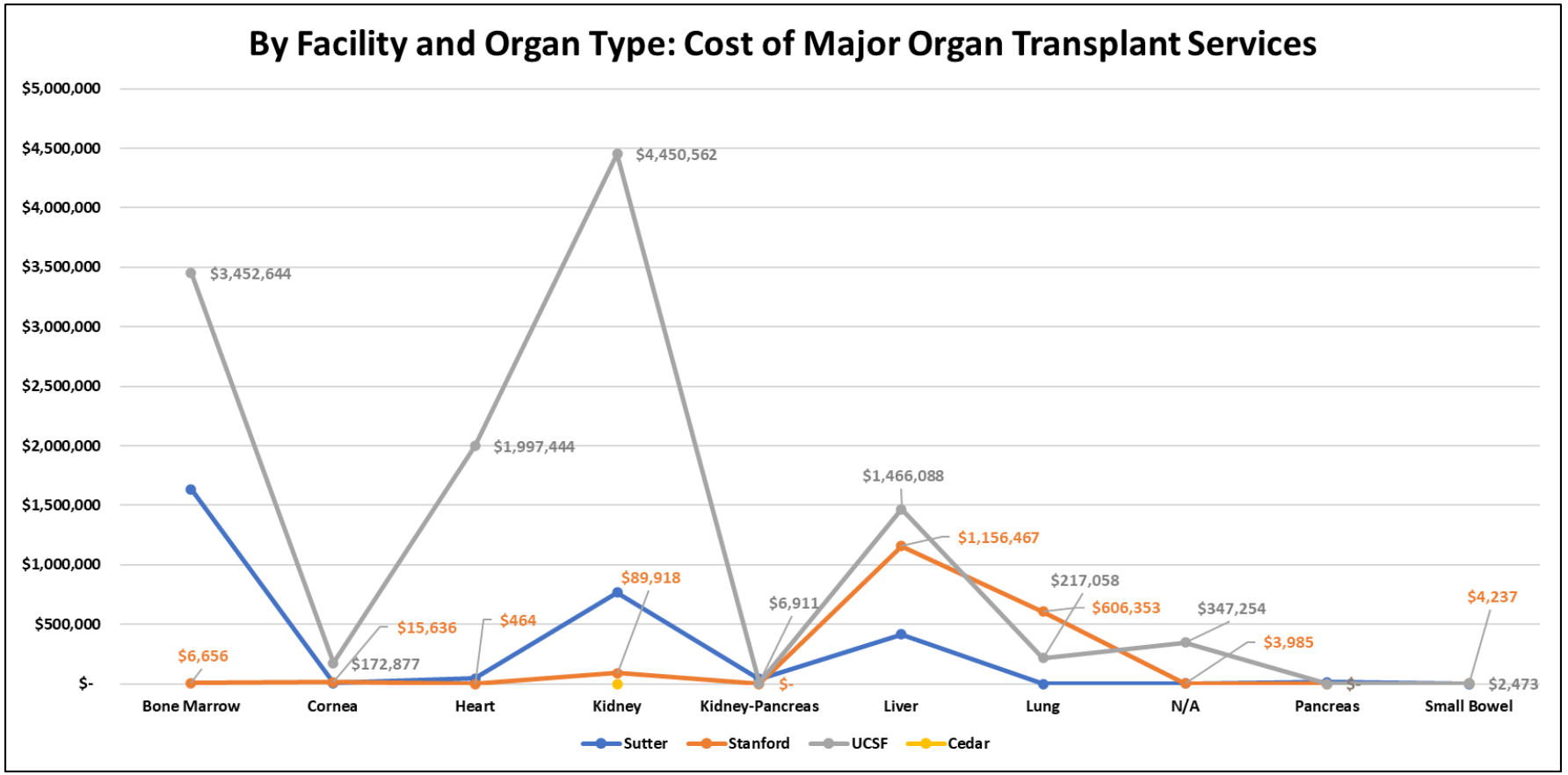


Costs by Organ Type

ALAMEDA Alliance FOR HEALTH

Organ Type	Members	Encounters	Cost by Organ Type	Average Cost Per Member
Kidney	129	1,224	$ 5,309,097	$ 41,156
Bone Marrow	29	703	$ 5,095,850	$ 175,719
Liver	36	687	$ 3,036,258	$ 84,341
Heart	11	271	$ 2,040,554	$ 185,505
Lung	7	226	$ 823,411	$ 117,630
N/A	3	57	$ 351,888	$ 117,296
Cornea	6	77	$ 195,157	$ 32,526
Kidney-Pancreas	7	55	$ 48,447	$ 6,921
Pancreas	1	2	$ 12,572	$ 12,572
Small Bowel	1	18	$ 6,709	$ 6,709
Total	**230**	**3,320**	**$ 16,919,944**	**$ 73,565**

Costs by Facility & Organ Type



MOT Members Can Be High Cost

2022 High Cost PHYSICAL TRANSPLANTS by Centers of Excellence			
Facility	**Volume**	**Post-Transplant examples**	**Organ Type**
UCSF	21	Kidney GVHD on chemo + IVIG injections	Kidney (8) Heart (6) Liver (4) *mostly due to alcoholic cirrhosis* Bone Marrow (3) Lung (2)
Sutter	0	AML oncology mgt s/p BMT at UCSF	N/A
Stanford	5	2 Post BMTs: 1 member with CML not in remission; 1 member in myelodysplastic syndrome requiring chemotherapy.	Liver (3) Lung (2)
TOTAL	**26**		**26**

MOT at AAH:
First Year - Key Points

- Access
  - Alliance members have access to excellent Centers of Excellence
  - UCSF the large leader in member volume
  - Sutter still with high volume due to not moving established patients
  - Limited use of Stanford thus far
- Cost
  - Most members in pre or post-transplant
  - Relatively few on waiting list and fewer yet got physical transplant
  - Largest cost on inpatient and on kidney and BMT

Questions?

ALAMEDA Alliance FOR HEALTH

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

Operations

Ruth Watson

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

From: **Ruth Watson, Chief Operating Officer**

Date: **July 14th, 2023**

Subject: **Operations Report**

Member Services

- 12-Month Trend Blended Summary:

    - The Member Services Department received a thirty-nine percent (39%) increase in calls in June 2023, totaling 21,054 compared to 12,790 in June 2022. Call volume pre-pandemic in June 2019 was 13,740, which is thirty-five percent (35%) lower than the current call volume. Medi-Cal Redeterminations, member mailings, and non-utilizer outreach calls impacted the increase in call volumes for June 2023.
    - The abandonment rate for June 2023 was twenty-one percent (21%), compared to thirteen percent (13%) in June 2022.
    - The Department's service level was sixty-three percent (63%) in June 2023, compared to forty-eight percent (48%) in June 2022. The Department continues to recruit to fill open positions. Customer Service support service vendor continues to provide overflow call center support.
    - The average talk time (ATT) was six minutes and twenty-one seconds (06:21) for June 2023 compared to six minutes and fifty-three seconds (06:53) for June 2022.
    - Ninety-seven percent (97%) of calls were answered within 10 minutes for June 2023 compared to eighty-three (83%) in June 2022.
    - The top five call reasons for June 2023 were: 1). Eligibility/Enrollment, 2). Change of PCP 3). Benefits, 4). Kaiser, 5). ID Card Request. The top five call reasons for June 2022 were: 1). Change of PCP, 2). Eligibility/Enrollment, 3). Kaiser, 4 Benefits, 5). ID Card Requests.
    - June utilization for the member automated eligibility IVR system totaled fifteen hundred fifty-one (1551) in June 2023 compared to seventy-seven (77) in June 2022.
    - The Department continues to service members via multiple communication channels (telephonic, email, online, web-based requests and in-person) while honoring the organization's policies. The Department responded to eight hundred eighty (882) web-based requests in June 2023 compared to five hundred eighty-one (581) in June 2022. The top three web reason requests for June 2023 were: 1). Change of PCP 2). ID Card Requests, 3).

Update Contact Information. Twenty-six (26) members were assisted in-person in June 2023.

- MS BH:
    - The Member Services Behavioral Health Unit received a total of fourteen hundred twenty-four (1,424) calls in June 2023.
    - The abandonment rate was eleven percent (11%).
    - The service level was eighty-three percent (83%).
    - The Average Talk Time (ATT) was nine minutes and forty-two seconds (09:42). ATT are impacted by the DHCS requirements to complete a screening for all members initiating MH services for the first time.
    - Three thousand eighteen (3018) outreach calls were made in June 2023.
    - Two hundred thirty-four (234) screenings were completed in June 2023.
    - Forty-one (41) referrals were made to the County (ACCESS) in June 2023.
    - Fourteen (14) members were referred to CenterPoint for SUD services in June 2023.

Claims

- 12-Month Trend Summary:
    - The Claims Department received 267,437 claims in June 2023 compared to 173,269 in June 2022.
    - Auto Adjudication was 79.3% in June 2023 compared to 84% in June 2022.
    - Claims compliance for the 30-day turnaround time was 90% in June 2023 compared to 97.8% in June 2022. The 45-day turnaround time was 99.9% in June 2023 compared to 99.9% in June 2022.

- Monthly Analysis:
    - In June 2023, we received a total of 267,437 claims in the HEALTHsuite system. This represents an increase of 6.19% from May and is higher, by 94,168 claims, than the number of claims received in June 2022; the higher volume of received claims remains attributed to an increased membership.
    - We received 88.37% of claims via EDI and 11.37% of claims via paper.
    - During June, 99.9% of our claims were processed within 45 working days.
    - The Auto Adjudication rate was 79.3% for June.

Provider Services

- 12-Month Trend Summary:
    - The Provider Services department's call volume in June 2023 was 8,013 calls compared to 5,215 calls in June 2022.
    - Provider Services continuously work to achieve first call resolution and reduction of the abandonment rates. Efforts to promote provider satisfaction is our priority.
    - The Provider Services department completed 209 calls/visits during June 2023.
    - The Provider Services department answered 4,415 calls for June 2023 and made 828 outbound calls.

Credentialing

- 12-Month Trend Summary:
    - At the Peer Review and Credentialing (PRCC) meeting held on June 20, 2023, there were eighty-five (85) initial network providers approved; seven (7) primary care providers, eleven (11) specialists, five (5) ancillary providers, eight (8) midlevel providers, and fifty-four (54) behavioral health providers. Additionally, thirty (30) providers were re-credentialed at this meeting; eight (8) primary care providers, fourteen (14) specialists, one (1) ancillary provider, and seven (7) midlevel providers.

    - Please refer to the Credentialing charts and graphs located in the Operations supporting documentation for more information.

Provider Dispute Resolution

- 12-Month Trend Summary:
    - In June 2023, the Provider Dispute Resolution (PDR) team received 1453 PDRs versus 1573 in June 2022.
    - The PDR team resolved 1519 cases in June 2023 compared to 872 cases in June 2022.
    - In June 2023, the PDR team upheld 78% of cases versus 69% in June 2022.
    - The PDR team resolved 99.8% of cases within the compliance standard of 95% within 45 working days in June 2023 compared to 99.8% in June 2022.

- Monthly Analysis:
    - AAH received 1453 PDRs in June 2023.
    - In June 2023, 1519, PDRs were resolved. Out of the 1519 PDRs, 1183 were upheld and 336 were overturned.
    - The overturn rate for PDRs was 22%, which met our goal of 25% or less.
    - 1516 out of 1519 cases were resolved within 45 working days resulting in a 99.8% compliance rate.
    - The average turnaround time for resolving PDRs in June was 42 days.
    - There were 2080 PDRs pending resolution as of 06/30/2023; with no cases older than 45 working days.

Community Relations and Outreach

- 12-Month Trend Summary:
    - In Q4 2023, the Alliance completed 2,430-member orientation outreach calls and 390 member orientations by phone.
    - The C&O Department reached 1,293 people, 58.3% identified as Alliance members, compared to 396 individuals who identified as Alliance members in Q4 2022.
    - The C&O Department spent a total of $160 in donations, fees, and/or sponsorships, compared to $0 in Q4 2022.
    - The C&O Department reached members in 13 cities/unincorporated areas throughout Alameda County, Bay Area, and the U.S., compared to 17 locations in Q4 2022.

- Quarterly Analysis:
    - In Q4 2023, the C&O Department completed 2,430-member orientation outreach calls and 390 member orientations by phone.
    - Among the 1,293 people reached, 58.3% identified as Alliance members.
    - In Q4 2023, the C&O Department reached members in 13 locations throughout Alameda County, Bay Area, and the U.S.

- Monthly Analysis:
    - In June 2023, the C&O Department completed 1,019-member orientation outreach calls and 156 member orientations by phone, and 48 Alliance website inquiries.

- Among the 468 people reached, 75% identified as Alliance members.
- In June 2023, the C&O Department reached members in 13 locations throughout Alameda County, Bay Area, and the U.S.
- Please see attached **Addendum A**.

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	June 2023
Incoming Calls (R/V)	2,1054
Abandoned Rate (R/V)	21%
Answered Calls (R/V)	1,6428
Average Speed to Answer (ASA)	1:29
Calls Answered in 30 Seconds (R/V)	63%
Average Talk Time (ATT)	06:21
Calls Answered in 10 minutes	97%
Outbound Calls	7,849

Top 5 Call Reasons (Medi-Cal and Group Care) June 2023
Eligibility/Enrollment
Change of PCP
Benefits
Kaiser
ID Card Requests

Top 3 Web-Based Request Reasons (Medi-Cal and Group Care) June 2023
Change of PCP
ID Card Requests
Update Contact Info

Claims Department
May 2023 Final and June 2023 Final

METRICS		
Claims Compliance	**May-23**	**Jun-23**
90% of clean claims processed within 30 calendar days	95.4%	90.0%
95% of all claims processed within 45 working days	99.8%	99.9%
Claims Volume (Received)	**May-23**	**Jun-23**
Paper claims	28,724	31,106
EDI claims	223,134	236,331
Claim Volume Total	**251,858**	**267,437**
Percentage of Claims Volume by Submission Method	**May-23**	**Jun-23**
% Paper	11.40%	11.63%
% EDI	88.60%	88.37%
Claims Processed	**May-23**	**Jun-23**
HEALTHsuite Paid (original claims)	181,267	151,948
HEALTHsuite Denied (original claims)	72,208	66,302
HEALTHsuite Original Claims Sub-Total	**253,475**	**218,250**
HEALTHsuite Adjustments	6,507	3,195
HEALTHsuite Total	**259,982**	**221,445**
Claims Expense	**May-23**	**Jun-23**
Medical Claims Paid	$99,325,961	$81,756,949
Interest Paid	$64,040	$48,965
Auto Adjudication	**May-23**	**Jun-23**
Claims Auto Adjudicated	208,148	173,048
% Auto Adjudicated	82.1%	79.3%
Average Days from Receipt to Payment	**May-23**	**Jun-23**
HEALTHsuite	19	20
Pended Claim Age	**May-23**	**Jun-23**
0-29 calendar days	31,792	27,955
HEALTHsuite		
30-59 calendar days	1,952	3,259
HEALTHsuite		
Over 60 calendar days	0	2
HEALTHsuite		
Overall Denial Rate	**May-23**	**Jun-23**
Claims denied in HEALTHsuite	72,208	66,302
% Denied	27.8%	29.9%

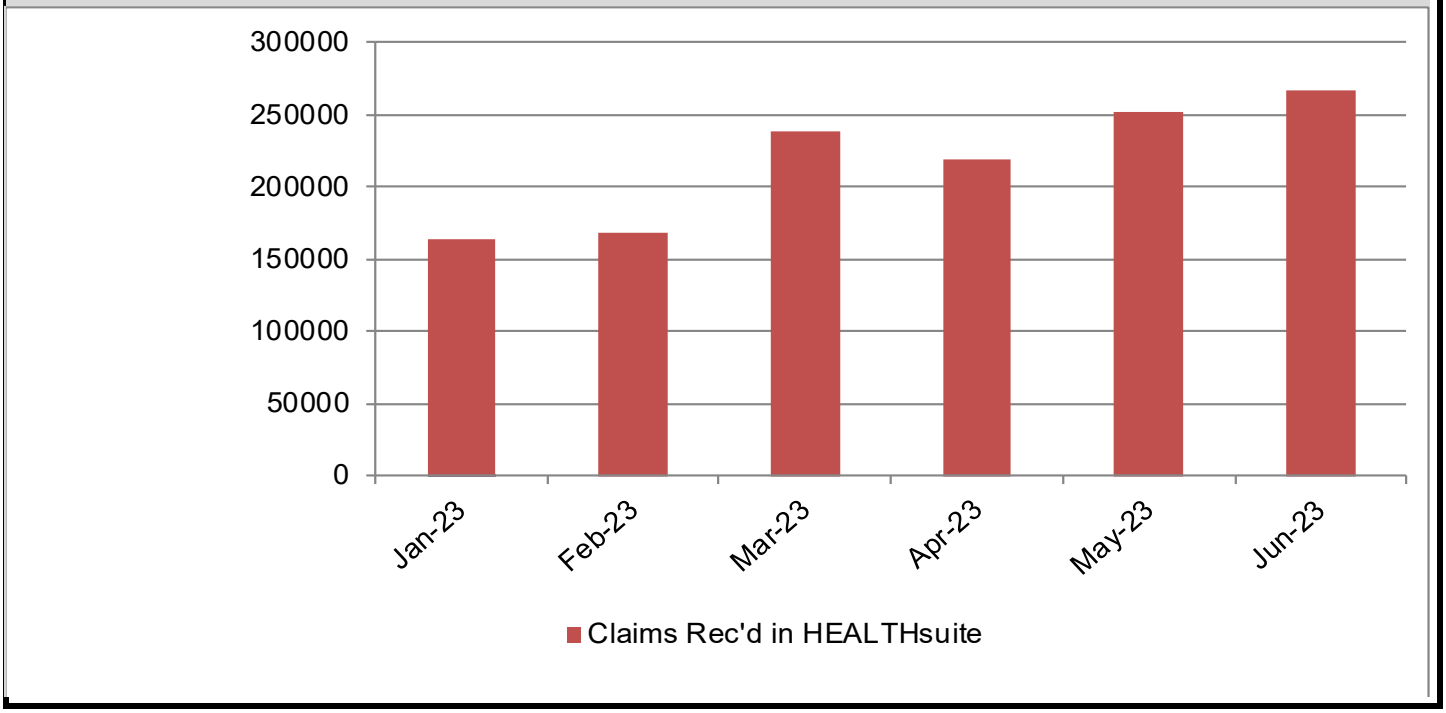
Claims Department
May 2023 Final and June 2023 Final

Jun-23

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	21%
Non-Covered Benefit For This Plan	14%
Duplicate Claim	11%
No Benefits Found For Dates of Service	10%
Must Submit Paper Claim With Copy of Primary Payor EOB	8%
% Total of all denials	**64%**

Claims Received By Month

Run Date	2/1/2023	3/1/2023	4/1/2023	5/1/2023	6/1/2023	7/1/2023
Claims Received Through	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**
Claims Rec'd in HEALTHsuite	163,764	167,475	238,283	218,296	251,858	267,437



Provider Relations Dashboard June 2023

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	5588	5936	6283	6245	8056	8013						
Abandoned Calls	1698	1904	1557	1808	3594	3598						
Answered Calls (PR)	3890	4032	4726	4437	4462	4415						
Recordings/Voicemails	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Incoming Calls (R/V)	1231	953	986	849	1611	1883						
Abandoned Calls (R/V)												
Answered Calls (R/V)	1231	953	983	849	1611	1883						
Outbound Calls	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Outbound Calls	741	758	910	855	904	828						
N/A												
Outbound Calls	741	758	910	855	904	828						
Totals	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Total Incoming, R/V, Outbound Calls	7560	7647	8179	7949	10568	10724						
Abandoned Calls	1698	1904	1557	1808	3594	3598						
Total Answered Incoming, R/V, Outbound Calls	5862	5743	6622	6141	6974	7126						

Provider Relations Dashboard June 2023

Call Reasons (Medi-Cal and Group Care)

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	5.3%	4.8%	5.3%	5.3%	5.9%	5.8%						
Benefits	3.6%	3.4%	3.1%	3.6%	3.4%	5.1%						
Claims Inquiry	46.7%	46.0%	48.8%	47.6%	49.0%	49.5%						
Change of PCP	4.9%	3.8%	3.4%	3.1%	3.3%	3.1%						
Complaint/Grievance (includes PDR's)	2.9%	1.7%	2.9%	3.4%	3.4%	3.6%						
Contracts/Credentialing	0.9%	0.7%	0.9%	0.8%	0.7%	0.7%						
Demographic Change	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%						
Eligibility - Call from Provider	19.4%	20.6%	17.2%	15.7%	14.3%	13.2%						
Exempt Grievance/ G&A	0.0%	0.0%	0.0%	3.5%	3.4%	0.1%						
General Inquiry/Non member	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%						
Health Education	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%						
Intrepreter Services Request	0.7%	0.9%	0.4%	0.6%	0.4%	0.6%						
Kaiser	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%						
Member bill	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%						
Provider Portal Assistance	2.7%	2.9%	2.5%	3.3%	4.3%	4.2%						
Pharmacy	0.2%	0.1%	0.2%	0.1%	0.1%	0.1%						
Prop 56	0.4%	0.5%	0.4%	0.5%	0.6%	0.6%						
Provider Network Info	0.0%	0.1%	0.0%	0.1%	0.0%	0.1%						
Transportation Services	0.2%	0.4%	0.1%	0.1%	0.1%	0.2%						
Transferred Call	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%						
All Other Calls	12.2%	14.0%	14.7%	12.4%	11.2%	13.3%						
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Field Visit Activity Details

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Claims Issues	30	28	47	42	64	17						
Contracting/Credentialing	29	18	34	31	28	27						
Drop-ins	142	96	100	107	161	90						
JOM's	0	2	2	1	4	2						
New Provider Orientation	0	20	32	703	89	70						
Quarterly Visits	0	0	0	0	0	0						
UM Issues	13	18	0	9	3	3						
Total Field Visits	214	182	215	893	349	209	0	0	0	0	0	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS

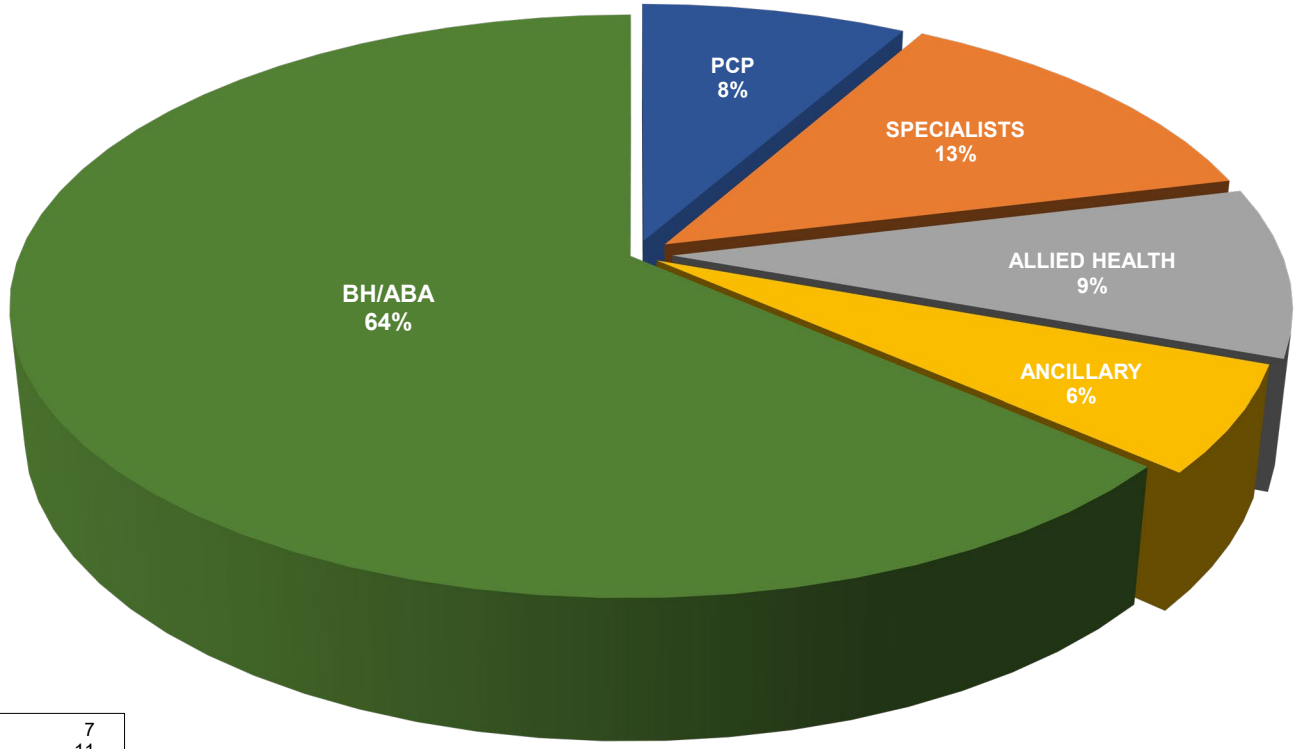
Practitioners		BH/ABA 993	AHP 458	PCP 364	SPEC 671	PCP/SPEC 11
AAH/AHS/CHCN Breakdown			AAH 1329	AHS 250	CHCN 545	COMBINATION OF GROUPS 373
Facilities	**362**					
VENDOR SUMMARY						
Credentialing Verification Organization, Symply CVO						
	Number		**Average Calendar Days in Process**	**Goal - Business Days**	**Goal - 98% Accuracy**	**Compliant**
Initial Files in Process	102		23	25	Y	Y
Recred Files in Process	93		70	25	Y	N
Expirables updated Insurance, License, DEA, Board Certifications						Y
Files currently in process	**195**					
CAQH Applications Processed in June 2023						
Standard Providers and Allied Health	**Invoice not received**					
June 2023 Peer Review and Credentialing Committee Approvals						
Initial Credentialing	**Number**					
PCP	7					
SPEC	11					
ANCILLARY	5					
MIDLEVEL/AHP	8					
BH/ABA	54					
	85					
Recredentialing						
PCP	8					
SPEC	14					
ANCILLARY	1					
MIDLEVEL/AHP	7					
BH/ABA	0					
	30					
TOTAL	**115**					
June 2023 Facility Approvals						
Initial Credentialing	13					
Recredentialing	6					
	19					
Facility Files in Process	**33**					
June 2023 Employee Metrics	5					
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/RE-CRED	CRED DATE
Abraham	Jennifer	BH	INITIAL	6/20/2023
Acevedo	Diana	BH	INITIAL	6/20/2023
Addiego-Hutton	Megan	ABA	INITIAL	6/20/2023
Ahmed	Hiba	Ancillary	INITIAL	6/20/2023
Anderson	Portia	BH	INITIAL	6/20/2023
Apriletti	Tara	Allied Health	INITIAL	6/20/2023
Avise	Jennifer	Specialist	INITIAL	6/20/2023
Baxter	Carson	ABA	INITIAL	6/20/2023
Beal	Madison	Allied Health	INITIAL	6/20/2023
Behera	Sujata	Ancillary	INITIAL	6/20/2023
Behrman	Victoria	Primary Care Physician	INITIAL	6/20/2023
Boldt	Elisa	ABA	INITIAL	6/20/2023
Bost	Christina	ABA	INITIAL	6/20/2023
Bravo	Maria	BH	INITIAL	6/20/2023
Budayr	Amer	Specialist	INITIAL	6/20/2023
Bullard	Madelyn	BH	INITIAL	6/20/2023
Cain	Ke'Aarre	ABA	INITIAL	6/20/2023
Canlas	John Patrick	Ancillary	INITIAL	6/20/2023
Castillo	Lisa	ABA	INITIAL	6/20/2023
Castillo	Lydia	ABA	INITIAL	6/20/2023
Chacon	Elizabeth	Allied Health	INITIAL	6/20/2023
Dawkins-Padigela	Mary Ann	BH	INITIAL	6/20/2023
Dawson	Martin	BH-Telehealth	INITIAL	6/20/2023
Dobroff	Christie	ABA	INITIAL	6/20/2023
Evans Oneal	Alexandrea	BH	INITIAL	6/20/2023
Ewing	Mya	ABA	INITIAL	6/20/2023
Ferrer	Jennifer	ABA	INITIAL	6/20/2023
Franco	Diana	ABA	INITIAL	6/20/2023
Fujimoto	Deborah	BH	INITIAL	6/20/2023
Ganti	Shashi	Specialist	INITIAL	6/20/2023
Goldberg	Shira	BH	INITIAL	6/20/2023
Gonzalez	Catalina	Allied Health	INITIAL	6/20/2023
Grawert	Lauren	BH-Telehealth	INITIAL	6/20/2023
Guo	Yanhong	ABA	INITIAL	6/20/2023
Guzman	Luz	BH	INITIAL	6/20/2023
Hull	Candy	BH-Telehealth	INITIAL	6/20/2023
Huynh	Vivian	ABA	INITIAL	6/20/2023
Ikekwere	Joseph	BH	INITIAL	6/20/2023
Jaros	Allegra	BH-Telehealth	INITIAL	6/20/2023
Kane	Alexandra	ABA	INITIAL	6/20/2023
Kapila	Yagya	Specialist	INITIAL	6/20/2023
Kaur	Inderjeet	Allied Health	INITIAL	6/20/2023
Kaur	Manmeet	ABA	INITIAL	6/20/2023
Kavali	Leena	Primary Care Physician	INITIAL	6/20/2023
Kiang	Esther	Allied Health	INITIAL	6/20/2023
Kim	Haesook	Allied Health	INITIAL	6/20/2023
Lam	Wingsze	ABA	INITIAL	6/20/2023
Lang	John	BH	INITIAL	6/20/2023
Latta	Dana	BH	INITIAL	6/20/2023
Le	Crystal	Specialist	INITIAL	6/20/2023
Leung	Karla	ABA	INITIAL	6/20/2023
Mancao	MariLisa	Primary Care Physician	INITIAL	6/20/2023
Martin Palley	Emile	ABA	INITIAL	6/20/2023
Mejias Lafontaine	Emanuel	Specialist	INITIAL	6/20/2023

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Mendoza	Denisse	BH-Telehealth	INITIAL	6/20/2023
Miller	Julie	BH-Telehealth	INITIAL	6/20/2023
Mojarro	Alyssa	ABA	INITIAL	6/20/2023
Morris	Caretta	BH	INITIAL	6/20/2023
Muk	Jenny	ABA-Telehealth	INITIAL	6/20/2023
Nguyen	Catherine	Ancillary	INITIAL	6/20/2023
Nicolaou	Daemeon	Specialist	INITIAL	6/20/2023
Nolen	Latreasha	ABA-Telehealth	INITIAL	6/20/2023
Noorani	Ghulam	BH	INITIAL	6/20/2023
Okeke	Ogechi	Ancillary	INITIAL	6/20/2023
Ortiz	Ofelia	Specialist	INITIAL	6/20/2023
Otterson	Brooke	BH	INITIAL	6/20/2023
Panjwani	Amreen	ABA	INITIAL	6/20/2023
Patel	Shivani	ABA-Telehealth	INITIAL	6/20/2023
Patino Trier	Pamela	Allied Health	INITIAL	6/20/2023
Perry	Alison	Primary Care Physician	INITIAL	6/20/2023
Rosenow	Chandler	ABA-Telehealth	INITIAL	6/20/2023
Sands	Sophie	ABA	INITIAL	6/20/2023
Shankar	Vikram	Specialist	INITIAL	6/20/2023
Sheth	Sonali	Primary Care Physician	INITIAL	6/20/2023
Stallsmith	Joelle	BH	INITIAL	6/20/2023
Tamura	Eddy	Specialist	INITIAL	6/20/2023
Tenold	Patricia	Primary Care Physician	INITIAL	6/20/2023
Thomas	Marshell	ABA	INITIAL	6/20/2023
To	Pandora	ABA	INITIAL	6/20/2023
Vanjani	Rachna	Specialist	INITIAL	6/20/2023
Velazquez-Hernandez	Marlen	ABA-Telehealth	INITIAL	6/20/2023
Waldo	Stephanie	ABA	INITIAL	6/20/2023
Ward	Elizabeth	BH-Telehealth	INITIAL	6/20/2023
Weber	Armeen	BH	INITIAL	6/20/2023
Wu	Diana	Primary Care Physician	INITIAL	6/20/2023
Chung	Christine	Specialist	RE-CRED	6/20/2023
Danishwar	Shireen	Ancillary	RE-CRED	6/20/2023
Drury	Jessica	Allied Health	RE-CRED	6/20/2023
Edmunds	Magdalen	Primary Care Physician	RE-CRED	6/20/2023
Elias	Christine	Specialist	RE-CRED	6/20/2023
Falik	Rebecca	Specialist	RE-CRED	6/20/2023
Ford	Emma	Allied Health	RE-CRED	6/20/2023
Gorman	Jodi	Allied Health	RE-CRED	6/20/2023
Greene	Robert	Specialist	RE-CRED	6/20/2023
Huang	Susan	Primary Care Physician	RE-CRED	6/20/2023
Hung	Sammy	Specialist	RE-CRED	6/20/2023
Kasberger	Kate	Primary Care Physician	RE-CRED	6/20/2023
Keyashian	Brian	Specialist	RE-CRED	6/20/2023
Khade	Ushakiran	Primary Care Physician	RE-CRED	6/20/2023
Kim	Amy	Allied Health	RE-CRED	6/20/2023
Kumelachew	Hiruth	Allied Health	RE-CRED	6/20/2023
Lai	Eric	Specialist	RE-CRED	6/20/2023
McCleary-Alley	Theresa	Allied Health	RE-CRED	6/20/2023
McDonald	Alden	Specialist	RE-CRED	6/20/2023
Murphy	Aileen	Specialist	RE-CRED	6/20/2023
Nguyen	Hien	Primary Care Physician	RE-CRED	6/20/2023
Nogue	Sophia	Allied Health	RE-CRED	6/20/2023
Obnial	Gonzalo	Specialist	RE-CRED	6/20/2023

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Otero	Fernando	Specialist	RE-CRED	6/20/2023
Patel	Bijal	Specialist	RE-CRED	6/20/2023
Ramakrishnan	Sampath	Primary Care Physician	RE-CRED	6/20/2023
Seven	Nigar	Primary Care Physician	RE-CRED	6/20/2023
Sharma	Amita	Primary Care Physician	RE-CRED	6/20/2023
Suri	Vikram	Specialist	RE-CRED	6/20/2023
Yu	Anne	Specialist	RE-CRED	6/20/2023

JUNE PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY



PCP	7
Specialists	11
Allied Health	8
Ancillary	5
BH/ABA	54
Total	85

Provider Dispute Resolution
May 2023 and June 2023

METRICS

PDR Compliance	May-23	Jun-23
# of PDRs Resolved	947	1,519
# Resolved Within 45 Working Days	944	1,516
% of PDRs Resolved Within 45 Working Days	99.7%	99.8%

PDRs Received	May-23	Jun-23
# of PDRs Received	1,322	1,453
PDR Volume Total	**1,322**	**1,453**

PDRs Resolved	May-23	Jun-23
# of PDRs Upheld	735	1,183
% of PDRs Upheld	78%	78%
# of PDRs Overturned	212	336
% of PDRs Overturned	22%	22%
Total # of PDRs Resolved	**947**	**1,519**

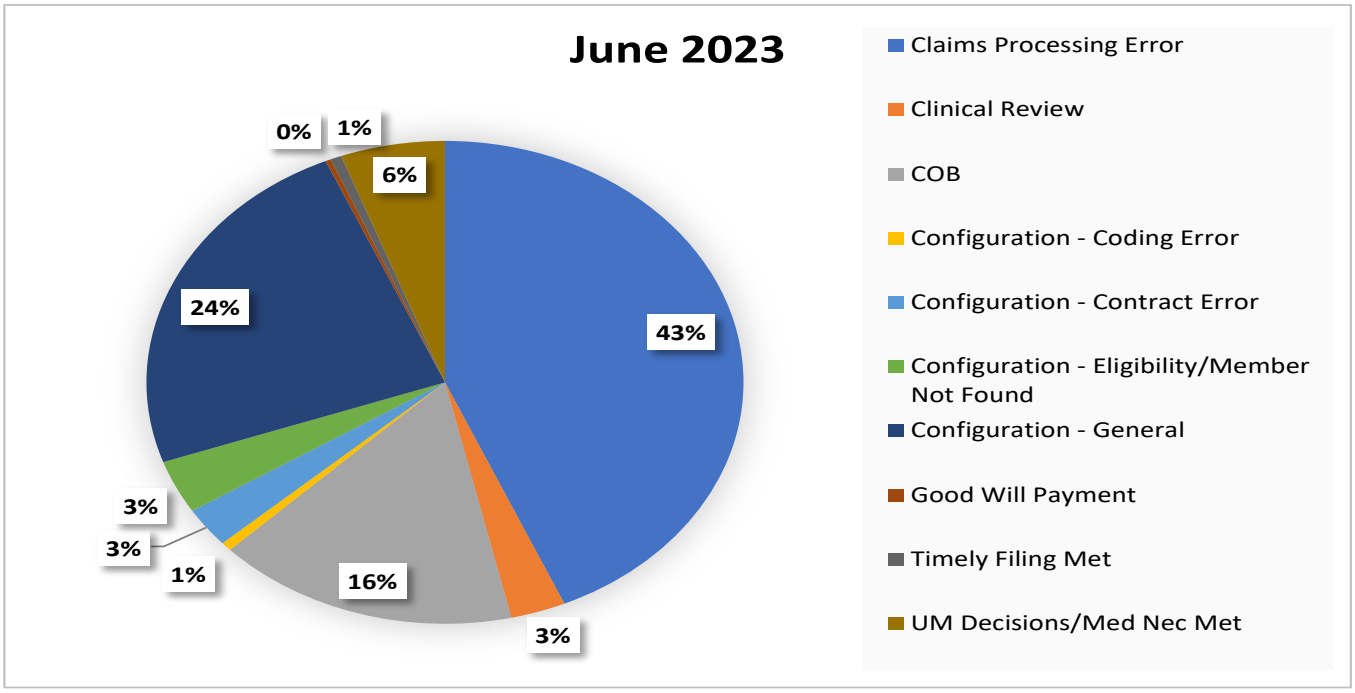
Average Turnaround Time	May-23	Jun-23
Average # of Days to Resolve PDRs	39	42
Oldest Unresolved PDR in Days	52	45

Unresolved PDR Age	May-23	Jun-23
0-45 Working Days	2,491	2,080
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**2,491**	**2,080**

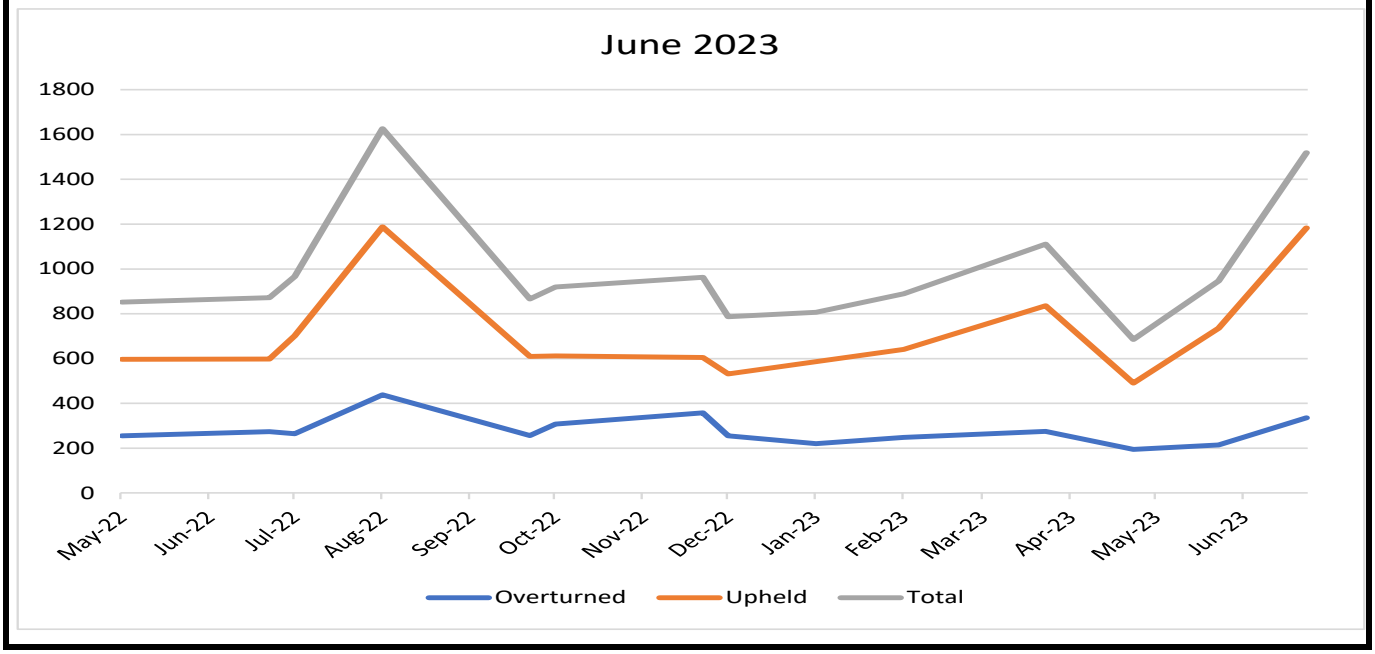
Provider Dispute Resolution
May 2023 and June 2023

Jun-23

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



Between April 2023 and June 2023, the Alliance completed **2,430** member orientation outreach calls among net new members and non-utilizers and conducted **390** member orientations (**16%** member participation rate). The Alliance Outreach Team also completed **10** Service Requests, and **139** Website Inquires in Q4. The Alliance reached a total of **903** people and spent a total of $160 in donations, fees, and/or sponsorships at the 2023 Spring Extravaganza, AHS Food Distribution, San Leandro Cherry Festival, and the Summer Health Block Party community and member education events.**

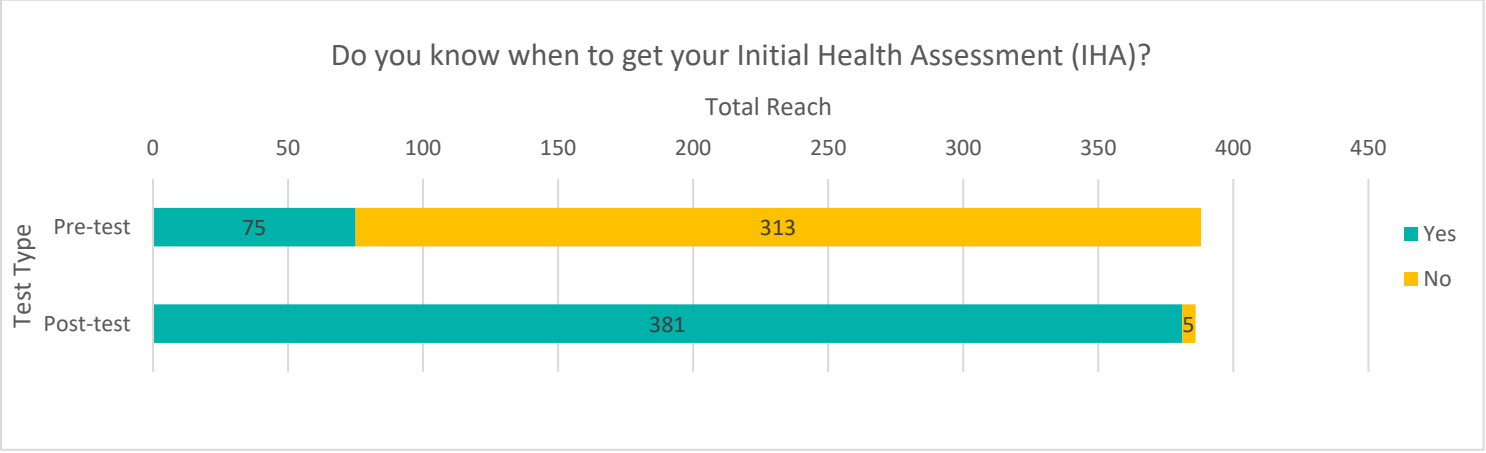
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **27,645** self-identified Alliance members have been reached during outreach activities.

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

On **Wednesday, March 18, 2020,** the Alliance began conducting member orientations by phone. As of **Friday, June 30, 2023**, the Outreach Team completed 27,185 member orientation outreach calls and conducted 7,100 member orientations (26.1%-member participation rate).

The Alliance Member Orientation (MO) program has been in place since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Assessment, by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between March 18, 2020, through June 30, 2023 – **7,100** members completed our MO program by phone.

After completing a MO **98.7%** of members who completed the post-test survey in Q4 FY 22-23 reported knowing when to get their IHA, compared to only **19.3%** 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 22-23\Q4\3. June 2023**

Q4 FY 2022-2023 TOTALS

2 COMMUNITY EVENTS	**623** TOTAL REACHED AT COMMUNITY EVENTS
2 MEMBER EDUCATION EVENTS	**280** TOTAL REACHED AT MEMBER EDUCATION EVENTS
390 MEMBER ORIENTATIONS	**390** TOTAL REACHED AT MEMBER ORIENTATIONS
0 MEETINGS/ PRESENTATIONS	**0** TOTAL REACHED AT MEETINGS/PRESENTATIONS
10 TOTAL INITIATED/INVITED EVENTS	**754** TOTAL MEMBERS REACHED AT EVENTS
394 TOTAL EVENTS	**1,293** TOTAL REACHED AT ALL EVENTS

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

TOTAL REACH 13 CITIES

**Cities represent the mailing addresses for members who completed a Member Orientation by phone. The italicized cities are outside of Alameda County. The following cities had <1% reach during Q4 2023: El Dorado Hills. The C&O Department started including these cities in the Q4 FY21 Outreach Report.*

$160

TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

** Includes refundable deposit.*

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

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

Date: **July 14th, 2023**

Subject: **Compliance Division Report**

Compliance Audit Updates

- 2023 DHCS Routine Medical Survey:
    - The onsite virtual interview took place from April 17th, 2023, through April 28th, 2023. A Focused Audit was conducted concurrently during the Routine Survey. The Plan is awaiting a final report which is expected by August 2023.

- 2022 DHCS Routine Medical Survey:
    - The 2022 DHCS Routine Medical Survey was held on April 4th, 2022, and completed April 13th, 2022. On September 13th, 2022, the Plan received the Final Audit Report which detailed 15 findings, 9 of which were repeat findings from the previous audit year. The DHCS requires the Plan to provide a monthly update of the CAP progress. The updates are due to the DHCS every 15th of the month. To date the Plan has submitted all requests, with the last requested item sent out on June 1st, 2023. DHCS has completed review of 8 out of the 15 findings. At present, the Plan is awaiting further guidance from DHCS.

- 2021 DMHC Follow-up Routine Survey
    - On June 26th, 2023, the Plan received notification from the DMHC that the department will be conducting a Follow-Up Review (Survey) of the outstanding deficiencies identified in the October 23rd, 2022, Final Report of the 2021 DMHC Routine Survey of the Plan. This audit will be conducted via desktop review and telephonic interviews. The department will be evaluating the following: General Plan Operations; Deficiencies associated with Grievance and Appeals; and Deficiencies associated with Prescription Drug Coverage. The review period covers November 1st, 2022, through May 31st, 2023. The pre-audit materials are divided into two sets and are due back to the DMHC on July 10th, 2023, and July 26th, 2023. The audit notice has been distributed to Plan staff and the Plan is preparing to compile responses and pre-audit materials for submission.

- Compliance Risk Assessment:
    - The compliance department has completed the RGP risk assessment. This risk assessment was a systematic evaluation of potential risks and vulnerabilities within the compliance department. Its primary purpose is to identify, analyze and mitigate risks that could have adverse effects on compliance and overall operational efficiency. This assessment provided valuable insights into the organization's current risk landscape and helps inform risk management strategies and decision-making processes. RGP included a list of items that are working well which is included below.
    - What Is Working Well?
        - Exec Leadership Support- The Alliance Leadership team is supportive of Compliance and committed to its success. Leadership is taking on the role of 2nd line of defense to help Compliance during external audits vs Compliance Leadership, due to a shortage of experienced staff.
        - Goals and Objectives- CEO has Goals and Objectives related to Compliance.
        - Approved Budget for Compliance- With an approved budget for additional staff in Compliance, this allows the Alliance to create a new team and culture.
        - External Audit Reporting- There are dashboards and tracking of audits being conducted from California Auditors
    - Recommendations
        - Risk Assessment- This should include Fraud Waste and Abuse (FWA), Healthcare Service and HIPAA to support the development of an actional Compliance Program.
        - Develop a Compliance Strategy Plan- The strategy plan incorporates the roadmap for a robust Compliance Program and Maturing the Compliance Program.
        - Compliance and Quality Assurance (Quality and Appeals and Grievances) need to create a tighter coordination of monitoring and testing efforts.
        - Improve Effectiveness Transparency- Create a dashboard of Compliance Effectiveness both to monitor remediation of existing Compliance Program gaps.
        - Improve Compliance Monitoring Processes Facilitate Tracking, Auditing and Monitoring efforts beyond External Audit Performance. Incorporate Quality Assurance monitoring with Compliance.
        - The compliance department is analyzing the takeaways from RGP's report and will share the detailed findings at the September Compliance Advisory Committee meeting.

- 2022 DMHC Risk Bearing Organization (RBO) Audits:

    - In 2022, the DMHC examined the claims settlement practices and the provider dispute resolution mechanism of Children First Medical Group, Inc. (CFMG) and Community Health Center Network, Inc. (CHCN). The Plan received the audit report from DMHC in December 2022. Deficiencies were found in the following areas:

        - CFMG
            - Claims Payment Accuracy: 1 deficiency
            - Misdirected Claims: 1 deficiency
            - Reimbursement of Claim Overpayments: 1 deficiency
        - CHCN
            - Claims Payment Accuracy: 2 deficiencies
            - Incorrect Claim Denials: 1 deficiency

    - The Plan's oversight of these RBOs includes quarterly audits of the RBOs claims settlement practices beginning with Q1 2023 dates of service. On May 31st, 2023, the Plan sent the audit notification letters to both CHCN and CFMG for their 1st quarterly audit. The Plan received CHCN's claims documents on June 21st, 2023. Documents are under review by the Claims Department to select the case files to be included in the audit. The Plan received CFMG's claims documents on June 13th, 2023. The Plan continues to receive case files for review.

- 2022 Beacon Delegation Audit

    - On June 30th, 2023, the Plan issued notification" Closure Letter – 2022 Annual Delegation Audit" to Beacon informing them of the formal closure of all oversight activities, such as performance reviews, audits and financial monitoring as a result of the March 31st, 2023, contract termination. Effective April 1st, 2023 the Plan has insourced behavioral health services and is rendering these services directly to members in Alameda County. The Plan did provide details of the audit deficiencies found within each area to Beacon, under separate cover, however due to the contract termination, no further responses or corrective actions are required from Beacon for that audit.

Compliance Activity Updates

- 2022 RFP Contract Update:
    - 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. Implementation is to take place through December 31st, 2023, for the majority of the contract's requirements. The State has noted that the Emergency Preparedness and Response Plan will have an extended implementation date of January 1st, 2025. The Plan has identified an internal target implementation date of October 27th, 2023, for all other requirements.
    - The Plan will be submitting seven (7) deliverables on July 14th, 2023, and nine (9) deliverables on August 11th, 2023. The State has provided updated checklists for a number of the deliverables, which were distributed to the Plan's subject-matter experts. On July 6th ,2023, the State notified the Plan that sixty-eight percent (68%) of deliverables required for Operational Readiness have been submitted, and there are thirty-two percent (32%) of requirements pending submission. The Plan is continuing its efforts in implementing new requirements and monitoring potential Business Process Impacts as a result of the changes. The State is expected to provide more information on the remaining undisclosed nineteen (19) deliverables this summer.
- 2022 Corporate Compliance Training – Board of Governors & Staff:
    - The Board of Governors Corporate Compliance Training was assigned on March 21st Board members had ninety (90) days or until June 21st, to complete the assigned training, 40% of Board Members have completed the training.
- 2022 Corporate Compliance Supplemental Department Training:
    - The Privacy Office in collaboration with the Special Investigation Unit began Supplemental Department Training for FY 2023. As of June 30th, the training is 95% complete.

Behavioral Health Insourcing:

- Although the Alliance has received approval from the Departments of Managed Health Care (DMHC) and Health Care Services (DHCS), as expected, DMHC's approval was subject to and conditioned upon the Alliance's full performance to the Department's satisfaction of eight Undertakings. Six of the eight Undertakings require deliverables to the DMHC. Compliance is coordinating with internal stakeholders to gather responses for timely and complete submission of the deliverables.

Undertakings Chart:

Undertaking Number	Deliverable	Initial Due Date	Current Status	Progress
No. 1	Report detailing compliance with SB 855 Section 1374.721(e)(1)[1], when the trainings have been completed. The report must include evidence that training courses by contracted Non-Profit Associations have been completed. If by the due date, the plan has not completed the trainings, AAH must provide a detailed explanation of the efforts and include a detailed timeline for completing the trainings.	By April 28th, 2023	**First Report sent April 28th, 2023.** **See Filing No. 20232102**	DMHC completed its review & closed the filing on May 25th, 2023.
No. 2	Submit regular reports detailing the Plan's efforts to recruit and fill positions identified to support the insourcing of MH/SUD services. The initial report is due no later than 30 days following the date of the Order of Approval. Each subsequent report must be submitted within 30 days of the prior report, until all positions have been filled.	By April 28th, 2023, and every 30 days thereafter.	**First Report sent April 24th, 2023** Received close out of 1st submission on April 27th, 2023. See Filing No. 20232017.	Compliance submitted 2nd report on May 24th, 2023. DMHC completed its review & closed the filing on June 23rd, 2023 (see Filing No. 20232500).

No. 3	Submit the fully executed Memorandum of Understanding (MOU) between the Plan and Alameda County Behavioral Health Services.	By April 28th, 2023	**Filing No. 20231868 submitted to DMHC on April 13th, 2023.**	DMHC completed its review & closed the filing on April 27th, 2023
No. 4	If applicable, submit Grievance and Appeals policies updated as a result of insourcing and administering mental health, substance abuse disorder, and behavioral health services.	By April 28th, 2023	**Filing No. 20232045 submitted to DMHC on April 25th, 2023.** Received a comment from DMHC on May 15th, 2023. Response due June 15th, 2023	Regulatory Affairs & Compliance submitted response on May 30th, 2023, as 20232551 Awaiting DMHC response or closure of the filing
No. 5	If applicable, submit Claims policies updated as a result of insourcing and administering mental health, substance abuse disorder, and behavioral health services.	By April 28th, 2023	**Filing No. 20232024 submitted to DMHC on April 24th, 2023.** **Response to DMHC May 5th, Comment letter due to DMHC by <u>Sunday June 4th, 2023</u>**	Received comment table from DMHC. AAH's response due 7/6/2023.
No. 6	Submit electronically an Amendment filing to demonstrate compliance with the federal Mental Health Parity and Addiction Equity Act ("MHPAEA") (42 USC § 300 gg-26) and its regulations (45 CFR § 146.136) and Section 1374.76 of the Act. Before submitting the Amendment, the Plan shall contact the Department's MHPAEA review team by May 28th, 2023, to obtain	By July 12th, 2023	AAH requested detailed filing instructions & templates from DMHC on April 19th, 2023. May 5th, 2023 received filing instructions and worksheets from DMHC. May 9th, 2023 saved documents on	May 22nd, 2023 – Met with SMEs. Will leverage the documents from BH Investigation to populate the J-12 NQTL table.

	detailed filing instructions and DMHC MHPAEA template worksheets for completion as part of the MHPAEA compliance filing.		teams UT #6 MHPAEA and distributed to BH SMEs & Soli	
No. 7	Legal template language describing the enforceability.	No Deliverable	N/A	N/A
No. 8	Legal template language describing the terms & conditions under which the Undertakings are subject, including that the undertakings will be effective even if the plan changes hands and the date the undertakings are set to expire.	No Deliverable	N/A	N/A

The Compliance Department will track each of the deliverables related to the Undertakings. The Compliance Department will coordinate with the applicable AAH stakeholders to address each of the Undertakings.

2023 APL/PL IMPLEMENTATION TRACKING LIST						
#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
1	DMHC	23-001	01/05/23	Large Group Renewal Notice Requirements	GROUP CARE	This letter provides guidance to plans on the timing and content requirements for renewal notices to large group contractholders under HSC section 1374.21 and HSC section 1385.046. For purposes of this section, large group plans include In Home Supportive Services (IHSS) products.
2	DHCS	23-001	01/06/23	Network Certification Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) on the Annual Network certification (ANC) requirements pursuant to Title 42 of the Code of Federal Regulations (CFR) sections 438.68, 438.206, and 438.207, and Welfare and Institutions Code (WIC) section 14197. This APL also advises MCPs of the new requirements pertaining to good faith contracting requirements with certain cancer centers and referral requirements pursuant to WIC section 14197.45, as set forth by Senate Bill (SB) 987 (Portantino, Chapter 608, Statutes of 2022).
3	DMHC	23-002	01/12/23	Senate Bill 979 – Health Emergencies Guidance	MEDI-CAL & GROUP CARE	This All Plan Letter (APL) sets forth the Department's guidance regarding how plans shall demonstrate compliance with SB 979. The department expects plans to comply with SB 979 effective January 1, 2023. On September 18, 2022, Governor Gavin Newsom signed Senate Bill (SB) 979. SB 979 requires health care service plans (health plans or plans) to provide an enrollee who has been displaced or whose health may otherwise be affected by a state of emergency, as declared by the Governor, or a health emergency, as declared by the State Public Health Officer, access to medically necessary health care services. SB 979 also authorizes the Department of Managed Health Care (Department) to issue guidance to plans regarding compliance with the bill's requirements during the first three years following the declaration of emergency, or until the emergency is terminated, whichever occurs first.
4	DHCS	23-002	01/17/23	2023-2024 Medi-Cal MCP 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 2023-2024 Medi-Cal Eligibility Data System (MEDS)/834 cutoff and processing schedule.
5	DMHC	23-003	01/24/23	AB 1982 Telehealth Dental Care	N/A	Assembly Bill (AB) 1982 (Santiago, Ch. 525, Stats. 2022) adds Health and Safety Code section 1374.142 to the Knox-Keene Health Care Service Plan Act of 1975, effective January 1, 2023. Requires a plan offering a product covering dental services that offers a service via telehealth through a third-party corporate telehealth provider to report certain information to the Department for each product offering the service. This All Plan Letter (APL) sets forth the Department of Managed Health Care's (DMHC or Department) guidance regarding how health care service plans (plans) shall comply with AB 1982.
6	DMHC	23-004	2/7/2023	Plan Year 2024 QHP, QDP, and Off-Exchange Filing Requirements	N/A	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 23-004 to assist in the preparation of Plan Year 2024 regulatory submissions, in compliance with the Knox- Keene Act at California Health and Safety Code sections 1340 et seq. (Act) and regulations promulgated by the Department at California Code of Regulations, title 28 (Rules). The Department offers current and prospective Qualified Health and Dental 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 California), guidance to assist in the preparation of Plan Year 2024 regulatory submissions, in compliance with the Knox- Keene Act at California Health and Safety Code sections 1340 et seq. (Act) and regulations promulgated by the Department at California Code of Regulations, title 28 (Rules).
7	DMHC	23-005	2/13/2023	Network Service Area Confirmation Process	MEDI-CAL	DMHC is establishing the NSACP to ensure that all network service areas on file as part of the Plan's license are consistent with network service areas submitted for Timely Access Compliance and Annual Network Reporting. DMHC will transmit NSACP Workbook to all Reporting Plans (June 2023), including a summary of all reported network service areas in the RY 2023 Annual Network Report submission. The transmittal will include a specific due date for the health plan's response.
8	DMHC	23-006	2/24/2023	Independent Medical Review (IMR) Application/Complaint Form (DMHC 20-224)	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (Department) issues this All-Plan Letter (APL) to inform all licensed health care service plans that the Department has revised the Independent Medical Review Application/Complaint Form (DMHC 20-224).
9	DHCS	23-003	3/8/2023	California Advancing and Innovating Medi-Cal Incentive Payment 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 Payment Program implemented by the California Advancing and Innovating Medi-Cal (CalAIM) initiative.

#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
10	DHCS	23-004	3/14/2023	Skilled Nursing Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (Supersedes APL 22-018)	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide requirements to all Medi-Cal managed care health plans (MCPs) on Skilled Nursing Facility (SNF) Long Term Care (LTC) benefit standardization provisions of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, including the mandatory transition of beneficiaries to managed care.
11	DHCS	23-005	3/16/2023	Requirements For Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (Supersedes APL 19-010)	MEDI-CAL	The purpose of this All Plan Letter (APL) is to clarify the responsibilities of Medi-Cal managed care health plans (MCPs) to provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to eligible Members under the age of 21. This policy applies to all Members under the age of 21 who are enrolled in MCPs. This guidance is intended to reinforce existing state and federal laws and regulations regarding the provisions of Medi-Cal services, including EPSDT. This guidance is also intended to outline requirements for MCPs to ensure Members have access to information on EPSDT and Network Providers receive standardized training on EPSDT utilizing the newly developed DHCS Medi-Cal for Kids and Teens Outreach and Education Toolkit.
12	DMHC	23-007	3/23/2023	Provider Directory Annual Filing Requirements (2023)	MEDI-CAL & GROUP CARE	This All Plan Letter (APL) reminds health care service plans of California Health and Safety Code section 1367.27, subdivision (m)'s requirement to annually submit provider directory policies and procedures to the Department of Managed Health Care.
13	DMHC	23-008	3/24/2023	Health Plan Requirements to Timely Pay Claims	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 23-008 to highlight and remind plans of timely payment and utilization management obligations with respect to hospitals.
14	DHCS	23-006	3/28/2023	Delegation and Subcontractor Network Certification	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance on the requirements for delegation and monitoring of Subcontractors. This APL also details the Subcontractor Network Certification (SNC) process wherein MCPs must provide assurances that each Subcontractor's and Downstream Subcontractor's Provider Network meets state and federal Network adequacy and access requirements.
15	DMHC	23-009	3/30/2023	Health Plan Coverage of Preventive Services	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 23-009 reminding California health plans of their obligation to cover preventive services as required by the Knox-Keene Health Care Service Plan Act.
16	DHCS	20-004	4/4/2023	Emergency Guidance for Medi-Cal Managed Care Health Plans in Response to COVID-19 (REVISED)	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide information to Medi-Cal managed care health plans (MCPs) on temporary changes to federal requirements as a result of the ongoing global COVID-19 pandemic. As the Department of Health Care Services (DHCS) continues to respond to concerns and changing circumstances resulting from the pandemic, DHCS will provide updated guidance to MCPs.
17	DHCS	21-011	4/4/2023	(Supplement to APL 21-011) Emergency State Fair Hearing Timeframe Changes	MEDI-CAL	The purpose of this supplement to All Plan Letter (APL) 21-011 is to provide Medi-Cal managed care health plans (MCPs) with information regarding the Centers for Medicare and Medicaid Services' (CMS) approval of portions of the Department of Health Care Services' (DHCS) Section 1135 Waiver request as related to the Novel Coronavirus Disease (COVID-19) public health emergency (PHE).
18	DHCS	23-007	4/10/2023	Telehealth Services Policy	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care health plans (MCPs) on the Department of Health Care Services' (DHCS) policy on Covered Services offered through Telehealth modalities as outlined in the Medi-Cal Provider Manual. This includes clarification on those Covered Services which can be provided via Telehealth and the expectations related to documentation for Telehealth.
19	DMHC	23-010	4/10/2023	Coverage of Misoprostol-Only Abortion Care	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 23-010 based on potential disruptions to the availability of mifepristone due to the recently issued federal district court decisions.
20	DMHC	23-011	4/10/2023	Annual Segregation Fund Report	N/A	Assembly Bill (AB) 2205 added California Health and Safety Code (HSC) section 1347.8. Effective July 1, 2023 and annually thereafter, a health plan that offers a qualified health plan through the California Health Benefit Exchange (Exchange) shall report to the director the total amount of funds maintained in a segregated account for abortion services pursuant to subdivision (a) of Section 1303 of the federal Patient protection and Affordable Care Act (Public Law 111-148). This APL provides guidance to health plans on the timing and content requirements for submitting annual segregation fund reports.
21	DMHC	23-012	4/17/2023	Health Plan Annual Assessments	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) 23-012 to provide information to health care service plans (health plans) pertaining to the DMHC's fiscal year (FY) 2023- 24 annual assessment. Health plans are required to file the Report of enrollment Plan on the DMHC eFiling web portal by May 15, 2023.

#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
22	DHCS	20-021	4/19/2023	Acute Hospital Care at Home (REVISED)	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with policy guidance regarding hospitals participating in the Centers for Medicare & Medicaid Services' (CMS) Acute Hospital Care at Home program. The APL was revised to indicate that on December 29, 2022, President Biden signed into law the Consolidated Appropriations Act of 2023. This legislation included an extension of the Acute Hospital Care at Home program waiver that was initiated during the federal public health emergency. The Acute Hospital Care at Home program has been extended to December 31, 2024.
23	DMHC	23-013	4/20/2023	Large Group Coverage of Association Health Plans: Extension of Phase Out and Guidance	GROUP CARE	On December 9, 2019, the Department of Managed Health Care (DMHC) issued All Plan Letter (APL) 19-024 reminding health plans, solicitors, brokers and others of the law codified in Senate Bill 1375 (Stats 2018 ch 700 §3). The DMHC recognizes that some health plans and MEWAs continued to renew large group coverage while the DMHC reviewed compliance submissions for SB 255 and SB 718. As such, health plans contracting with MEWAs may continue to renew large group coverage for up to one year until December 31, 2023, if the health plan submits the required information to the DMHC on or before May 19, 2023.
24	DMHC	23-014	4/24/2023	Health Care Service Plans Are Mandatory Signatories to the CalHHS Data Exchange Framework	MEDI-CAL & GROUP CARE	The purpose of this All Plan Letter (APL) is to inform all health care service plans of their requirement to sign the Health and Human Services Data Exchange Framework (DxF) Data Sharing Agreement (DSA). This DSA defines the parties that are subject to the DxF's new data exchange rules and establishes a common set of terms, conditions, and obligations to support the secure exchange of and access to health and social services information in compliance with applicable laws, regulations, and policies.
25	DHCS	23-008	4/28/2023	Proposition 56 Directed Payments for Family Planning Services	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed health care plans (MCPs) with guidance on directed payments, funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), for the provision of specified family planning services.
26	DHCS	23-009	5/3/2023	Authorization for Post-Stabilization Care Services	MEDI-CAL	The purpose of this All Plan Letter (APL) is to clarify Medi-Cal managed care health plans (MCPs) contractual obligations for authorizing post-stabilization care services. In accordance with Title 28 CCR section 1300.71.4, when a Member is stabilized, but the health care Provider believes that they require additional Medically Necessary Covered Services and may not be discharged safely, the MCP, "shall approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one half hour of the request." To clarify, the "health care provider" as referenced herein refers to both Out-of-Network Providers (i.e., non-contracting Providers) and Network Providers.
27	DHCS	23-010	5/4/2023	Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) about the provision of Medically Necessary Behavioral Health Treatment (BHT) services for Members under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, as outlined in APL 19-010 or any superseding APL, and in accordance with mental health parity requirements. This APL clarifies that the MCP has primary responsibility for ensuring that all of a Member's needs for Medically Necessary BHT services are met across environments, including on-site at school or during virtual school sessions. For example, if educational BHT services provided to a Member by school-based Providers have been discontinued during the COVID-19 Public Health Emergency (PHE), the MCP must ensure that Medically Necessary BHT services are provided. The MCP is responsible for coordinating with other entities and covering any gap in Medically Necessary BHT services for the Member.
28	DHCS	23-011	5/8/2023	Treatment of Recoveries Made by the Managed Care Health Plan of Overpayments to Providers	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) relating to an MCP's recovery of all overpayments to providers.
29	DHCS	23-012	5/12/2023	Enforcement Actions: Administrative and Monetary Sanctions	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care health plans (MCPs) of the Department of Health Care Services' (DHCS) policy regarding the imposition of administrative and monetary sanctions, which are among the enforcement actions DHCS may take to enforce compliance with MCP contractual provisions and applicable state and federal laws. This APL supersedes APL 22-015.
30	DMHCS	23-015	5/16/2023	Supplemental Provider Directory Annual Filing Requirements	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 23-015, as a supplement to APL 23-007 (OPL) – Provider Directory Annual Filing Requirements (2023), to provide additional guidance and a filing extension to health care service plans (plans) regarding the Section 1367.27 Annual Compliance (2023) filing.

#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
31	DHCS	23-013	5/18/2023	Mandatory Signatories to the CalHHS Data Exchange Framework	MEDI-CAL	The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (MCPs) of their requirement to sign the California Health and Human Services Agency (CalHHS) Data Exchange Framework (DxF) Data Sharing Agreement (DSA). This DSA defines the parties that are subject to the DxF's new data exchange rules and establishes a common set of terms, conditions, and obligations to support the secure exchange of and access to health and social services information in compliance with applicable laws, regulations, and policies.
32	DHCS	21-004	5/24/2023	Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services (REVISED)	MEDI-CAL	This All Plan Letter (APL) serves to inform all Medi-Cal managed care health plans (MCPs) of the dataset for threshold and concentration languages and clarifies the threshold and concentration standards specified in state and federal law and MCP contracts. This dataset identifies the threshold and concentration languages in which, at a minimum, MCPs must provide written translated member information.
33	DHCS	23-014	6/9/2023	Proposition 56 Value-Based Payment Program Directed Payments	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with guidance on value-based directed payments, funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), to Network Providers for qualifying services tied to performance on designated health care quality measures in the domains of prenatal and postpartum care, early childhood prevention, chronic disease management, and behavioral health care.
34	DHCS	23-015	6/9/2023	Proposition 56 Directed Payments For Private Services	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information on required directed payments, funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), for the provision of specified state-funded medical pregnancy termination services.
35	DHCS	23-016	6/9/2023	Directed Payments for Developmental Screening Services	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with guidance on directed payments, initially funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), for the provision of standardized developmental screening services for children.
36	DHCS	23-017	6/13/2023	Directed Payments for Adverse Childhood Experiences Screening Services	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with guidance on directed payments, initially funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), for the provision of standardized Adverse Childhood Experiences (ACE) screening services for adults (through 64 years of age) and children.
37	DHCS	23-018	6/23/2023	Managed Care Health Plan Transition Policy Guide	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to all Medi-Cal managed care health plans (MCPs) regarding the 2024 MCP Transition effective January 1, 2024. The 2024 Managed Care Plan Transition Policy Guide (Policy Guide) establishes and details the requirements for the implementation of the 2024 MCP Transition.
38	DMHC	23-016	6/29/2023	Implementation of SB 1338 (2022) - Community Assistance, Recovery, and Empowerment (CARE)	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 23-016 to set out the Department's guidance about how health plans shall ensure they identify enrollees who are involved in CARE implemented by SB 1338 (the CARE Act) and how health plans shall process and pay claims arising from their enrollees' CARE agreements or CARE plans.

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

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

Date: **July 14th, 2023**

Subject: **Health Care Services Report**

Utilization Management: Outpatient

- Effective 1/1/23 DHCS expanded the Continuity of Care (CoC) program for all members. CoC ensures new members with the Alliance to have access to services consistent with the access they previously were receiving. Workflows have been designed and socialized for all applicable internal departments. Training for delegates was completed in June.

- There will be a second phase expansion 1/1/24 as AAH transitions into a Single Plan Model. The expansion includes:
  a. Expansion of special populations in 15 categories (examples IHSS, foster youth, TB, immunosuppressive meds, biologics, immunomodulators, ESRD, dementia, transplant, MH)
  b. Transferring supportive information from previous MCP to AAH for case management to ensure continuity and avoid disruption in care.
  c. For members receiving inpatient hospital care on 1/1/24, AAH will initiate contact with the hospitals and coordinate Transitional Care Services.
  d. Gap analysis of the AAH network to initiate provider agreements for identified OON providers currently managing Anthem/HealthPac members.

- Authorizations for referrals to Tertiary/Quaternary (T/Q) centers were implemented on 1/1/23. Initial data will begin to be available Q2. The UM Medical Director will begin to analyze trends to identify the level of referral appropriateness.

- OP UM has completed general UM training for the new Long Term Care UM team in outpatient referral management to ensure standard UM practices across the Alliance.

- Pharmacy referrals through the UM Medical benefit is on track to transition to the Pharmacy department for full PA management on 7/17/23. This allows for additional specialized focus overview with subject matter experts.

- To guide the growing UM lines of business, a new UM Director started May 15th

Outpatient Authorization Denial Rates			
Denial Rate Type	**April 2023**	**May 2023**	**June 2023**
Overall Denial Rate	3.2%	3.5%	2.9%
Denial Rate Excluding Partial Denials	2.9%	3.3%	2.7%
Partial Denials	0.3%	0.2%	0.2%

Turn Around Time Compliance			
Line of Business	**April 2023**	**May 2023**	**June 2023**
Overall	**95%**	**95%**	**95%**
Medi-Cal	**95%**	**95%**	**95%**
IHSS	**98%**	**98%**	**98%**
Benchmark	***95%***	***95%***	***95%***

Utilization Management: Inpatient

- In Q2 2023 AAH continued to manage a 40% volume increase in SNF admissions related to 2023 volume increases from both the Long Term Care carve-in and the dually eligible (MediCare and Medi-Cal) population. Both the dually eligible and the members in long term care have a higher hospitalization rate, which contributed to increases in acute inpatient admissions for these vulnerable members.

- As part of the Transitional Care Services requirement for Population Health Management, the IP UM team continues to identify high risk members admitted to a hospital, conducts discharge assessment, provides the name of Care Manager for inclusion in the discharge summary, and refers to Case Management department for follow up.

- In collaboration with CM, IP UM is working with hospital partners and community based TCS programs to focus on readmission reduction, aligning with their readmission reduction goals.

- IP UM department meets weekly for rounds with contracted hospital providers Alameda Health System, Sutter, Kindred LTACH, Kentfield LTACH, and Washington, to discuss UM issues, address discharge barriers, and improve throughput and real time communication. These meetings provide a forum for discussing new requirements, such as PASRR (Pre Admission Screening and Resident Review).

- IP UM team conducted staff training regarding PQIs for appropriate identification of Provider Preventable Conditions, Health Care-Acquired Conditions such as infections that may lead to adverse events, extended lengths of stay, or preventable readmissions. PQIs are submitted to the Alliance Quality Team for review to help ensure our members' care is of the highest quality, and all reportable cases and potential issues are investigated.

Inpatient Med-Surg Utilization Total All Aid Categories **Actuals (excludes Maternity)**			
Metric	**March 2023**	**April 2023**	**May 2023**
Authorized LOS	**5.7**	**5.2**	**5.5**
Admits/1,000	**53.8**	**53.9**	**51.6**
Days/1,000	**308.1**	**279.9**	**282.6**

Turn Around Time Compliance			
Line of Business	**March 2023**	**April 2023**	**May 2023**
Overall	**96%**	**95%**	**95%**
Medi-Cal	**96%**	**95%**	**95%**
IHSS	**100%**	**98%**	**98%**
Benchmark	***95%***	***95%***	***95%***

Inpatient Authorization Denial Rates			
Denial Rate Type	**April 2023**	**May 2023**	**June 2023**
Full Denials Rate	**0.7%**	**0.7%**	**2.9%**
Partial Denials	**0.0%**	**0.7%%**	**0%**
All Types of Denials Rate	**0. 7%**	**0.14%**	**2.9%**

Utilization Management: Long Term Care

- As of July 1, 2023, there are 1980 AAH Members in Long Term Care nursing facilities, 79% of LTC population are duals (Medi/Medi).
- LTC team is working with IT to create a banner identifying members as LTC in TruCare to easily identify this population and minimize work drift to other teams.
- ICF-DD carve-in planning continues with IPD and key stakeholders.
- Subacute carve-in APL was received for 1/1/24 transition from FFS. Comments are being gathered for submission to DHCS.
- LTC team is working with IT on provider portal interactive form for ancillary and professional services. Development is currently 80% complete.
- Q2 Post Transition Monitoring report to DHCS being prepared for submission due 7/28/23.
- As of May 31, 2023, there are 1850 AAH Members in Long Term Care nursing facilities.
- LTC team is working with IT, Inpatient UM, Outpatient UM & Integrated Planning Department (IPD) to streamline authorization request inputs for providers on AAH website.

- ICF-DD carve-in Network Readiness documents were received from DHCS. The LTC team is working with IPD and key stakeholders on planning. Collaborative meetings with the Regional Center of East Bay are happening monthly. LTC Team met with ICF company CCI to understand current processes and remove barriers to a smooth carve-in.

- LTC team is working with IT on provider portal interactive form for ancillary and professional services. Expected deployment is 6/6/23.

- LTC UM team is receiving training from OP team on ancillary/professional services authorization processing.

- Post-Implementation Townhall provider education sessions are underway with good feedback from providers. Next session is 6/7/23.

Pharmacy

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

Decisions	Number of PAs Processed
Approved	38
Denied	50
Closed	95
Total	**183**

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

- Medications for weight management, pain, acne, diabetes, migraine, high blood pressure, asthma and iron overload are in the top ten categories for denials.

Rank	Drug Name	Common Use	Common Denial Reason
1	WEGOVY 0.25 MG/0.5 ML PEN	Weight Management	Criteria for approval not met
2	WEGOVY 1 MG/0.5 ML PEN	Weight Management	Criteria for approval not met
3	LIDOCAINE 5% PATCH	Pain	Criteria for approval not met
4	TRETINOIN 0.05% CREAM	Acne	Criteria for approval not met
5	JARDIANCE 10 MG TABLET	Diabetes	Criteria for approval not met
6	WEGOVY 0.5 MG/0.5 ML PEN	Weight Management	Criteria for approval not met
7	QULIPTA 60 MG TABLET	Migraine	Criteria for approval not met
8	ALTACE 1.25 MG CAPSULE	High Blood Pressure	Criteria for approval not met
9	FLUTICASONE-VILANTEROL 200-25	Asthma	Criteria for approval not met
10	DEFERASIROX 360 MG TABLET	Iron Overload	Criteria for approval not met

- Pharmacy is leading initiatives on PAD (physician administered drugs) focused internal and external partnership and reviewed PAD related UM authorizations as follows. Note one auth is per drug:

Month	Number of Auth
January 2023	309
February 2023	291
March 2023	482
April 2023	301
May 2023	417

- The Alameda Alliance for Health (AAH) Pharmacy Department has successfully carried out Medi-Cal RX go-live as of 1/1/2022 and continues to serve its members with the same high standards of care.
    - As of June 30, 2023, approximately 85.37 million point-of-sale pharmacy paid claims to participating pharmacies totaling approximately $8.36 billion in payments.
    - Processed 275,708 prior authorization requests.
    - Answered 291,145 calls and 100 percent of virtual hold calls and voicemails have been returned.
    - We have closed submitting Medi-Cal PAs and informing doctor offices to submit to Medi-Cal RX:

Month	Number of Total PA Closed
January 2023	30
February 2023	39
March 2023	60
April 2023	50
May 2023	60
June 2023	57

- Pharmacy is collaborating with multiple healthcare services departments:
    - Pharmacy is collaborating with multiple departments within healthcare services as well as in-network Intermediate Care Facilities (ICF) partners to help support Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF DD) Carve-In implementation.
    - Pharmacy's TOC (Transition of Care) Program continues collaborating with the AAH Inpatient UM Department and Case Management Disease Management (CMDM) Department to help reduce the number of re-admissions after members are discharged from hospitals through education to the members as well as filling potential gaps between providers and their patients.
    - At the start of 2023, DHCS is requiring all MCPs to perform medication reconciliations for their highest risk TOC members based on new criteria from the state. Referred cases from the CMDM daily feed are evaluated to determine if Pharmacy is required for each case. Pharmacy is focusing on lower volume, higher need cases where pharmacy may have the greatest impact on member outcomes.
    - Pharmacy is collaborating with CDPH, QI and HealthEd for additional asthma intervention strategies (e.g., data sharing, toolkit exchange and community worker training materials/programs).
    - Pharmacy is collaborating with QI on an educational campaign to providers on untreated hepatitis B and C.
    - Pharmacy continues to monitor members on use of opioids:

MME	IHSS	MCAL	Total
March 2023			
50-89	6	279	285
90-119	0	17	17
120-199	1	26	27
200-299	0	10	10
300-399	0	4	4
>400	0	14	14
April 2023			
50-89	7	236	243
90-119	0	14	17
120-199	0	25	29
200-299	0	9	16
300-399	0	7	2
>400	0	11	13
May 2023			
50-89	7	254	261
90-119	2	22	24
120-199	0	28	28
200-299	0	16	16
300-399	0	4	4
>400	0	9	9
June 2023			
50-89	7	247	254
90-119	0	15	15
120-199	1	28	29
200-299	1	16	17
300-399	0	5	5
>400	0	16	16

Case and Disease Management

- Transitional Care Services (TCS) (formerly known as Transitions of Care) went live 1/1/23 for high-risk members. CM collaborated with IP UM, LTC and ECM to incorporate DHCS's new requirements. The requirements include an assigned care manager, completion of a discharge risk assessment and discharge documentation to ensure the member understands their discharge plan.
  CM has been working closely with CHCN to provide consistent TCS care for high-risk members assigned to CHCN.
  Talks have started in preparation for TCS for all members in January of 2024.

- Major Organ Transplant (MOT) CM Bundle continues to be offered to members. The volume continues to increase (363 members). All nurses in case management support members throughout the MOT process.

- CM in partnership with Population Health Management is working to enhance Disease Management in alignment with DHCS regulations. The first to go live will be Asthma, followed by Diabetes. Planning for Cardiovascular and Depression Disease Management programs has begun with the hopes of commencement in Q3 and Q4 of 2023.

- CM continues to collaborate with UM and Pharmacy regarding high-risk utilizers. CM has improved the workflow to increase CM engagement with high utilizers. The workgroup continues to do deep dives into previous high utilizer cases to understand the drivers of high utilization and identify areas for improvement.

- CM continues to acquire Physician Certification Statement (PCS) forms to better align with DHCS requirements for members who need a higher level of transportation. The transportation coordinators have been able to increase PCS form acquisition from 60% to 85% since hiring occurred in March.

Case Type	Cases Opened in May 2023	Total Open Cases as of May 2023	Cases Opened in June 2023	Total Open Cases as of June 2023
Care Coordination	591	1057	442	834
Complex Case Management	32	92	26	70
Transitions of Care (TCS)	277	497	243	400

CalAIM

Enhanced Case Management

- ECM worked with IPD, Analytics and Provider Services to launch Populations of Focus (Children/Youth) on 07/01/23.

- AAH hosting an onsite joint ECM/CS Provider Summit on 07/28/23.

- California Children's Services (CCS) launch moved 09/01/23 to accommodate Board of Supervisors meeting.

- Kick off meeting for the Justice Involved Pilot with ROOTS scheduled on 07/17/23.

- Meeting regularly with ECM providers to discuss graduation criteria, new populations of focus, communication between ECM and CS service providers to improve members care across the continuum.

- Children/Youth Populations of focus launched 07/01/23. The ECM team worked to bring on 6 new providers:

New Providers	Sub-Contractors
California Childrens Services (CCS)	
Full Circle (with sub-contractors)	A Better Way Alameda Family Services Alternative Family Services Fred Finch Youth & Family Services East Bay Agency for Children Lincoln Stars, Inc. West Coast Children's Clinic
La Familia	
Med Zed*	
Seneca	
Titanium Health Care*	

*Current Anthem providers in the county

Case Type	ECM Outreach in March 2023	Total Open Cases as of March 2023	ECM Outreach in April 2023	Total Open Cases as of April 2023	ECM Outreach in May 2023	Total Open Cases as of May 2023
ECM	457	1019	544	1047	591	1037

Community Supports (CS)

- 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

- CS went live with 3 additional services 7/1/23:
  - (Caregiver) Respite Services
  - Personal Care & Homemaker Services
  - Environmental Accessibility Adaptations (Home Modifications)

- East Bay Innovations (EBI) is the CS Provider engaged in the Self-Funded Pilot for 2 additional Community Supports-like Services. The Self-Funded Pilot complements the incoming ECM Populations of Focus (January of 2023) and contributes to the success of the members' management:
    - Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities
    - Community Transition Services/Nursing Facility Transition to a Home

- AAH CS staff team continues to meet regularly with each CS provider to work through logistical issues as they arise, including referral management, claims payment and member throughput.

- The CS team is spearheading the use of FindHelp. This platform will be used to better align with DHCS' requirements to establish a closed loop referral process. CS is working closely with each CS provider to bring them onto the platform.

Community Supports	Services Authorized in Feb 2023	Services Authorized in Mar 2023	Services Authorized in Apr 2023	Services Authorized in May 2023
Housing Navigation	324	343	368	362
Housing Deposits	175	155	147	133
Housing Tenancy	863	893	904	884
Asthma Remediation	47	52	51	48
Meals	613	733	868	1088
Medical Respite	43	47	56	70

Grievances & Appeals

- All cases were resolved within the goal of 95% within regulatory timeframes.
- Total grievances resolved in June were 7.45 complaints per 1,000 members.
- The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of June 2023; we did meet our goal at 17.2% overturn rate.

June 2023 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	934	30 Calendar Days	95% compliance within standard	889	95.18%	2.59
Expedited Grievance	0	72 Hours	95% compliance within standard	NA	NA	NA
Exempt Grievance	1,726	Next Business Day	95% compliance within standard	1,726	100.0%	4.78
Standard Appeal	28	30 Calendar Days	95% compliance within standard	28	100.0%	0.08
Expedited Appeal	0	72 Hours	95% compliance within standard	NA	NA	NA
Total Cases:	2,688		95% compliance within standard	2,643	98.32%	7.45

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

Quality

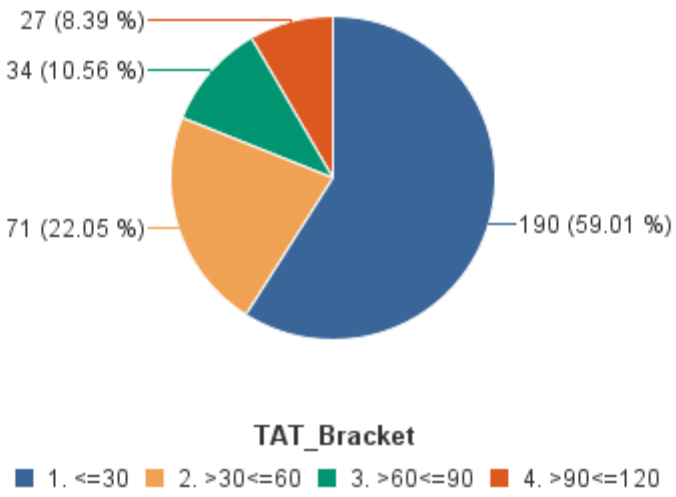
- Quality Improvement continues to track and trend PQI Turn-Around-Time (TAT) compliance. Our goal is closure of PQIs cases within 120 days from receipt to resolution via nurse investigation and procurement of medical records and/or provider responses followed by final MD review when applicable.

- As part of an effort to streamline the PQI review process, Quality of Access issues are reviewed by the Access & Availability team and Quality of Language issues by the Cultural & Linguistics team after they are triaged by the QI Clinical team. Quality of Care and Service issues continue to be reviewed by the QI Clinical staff.

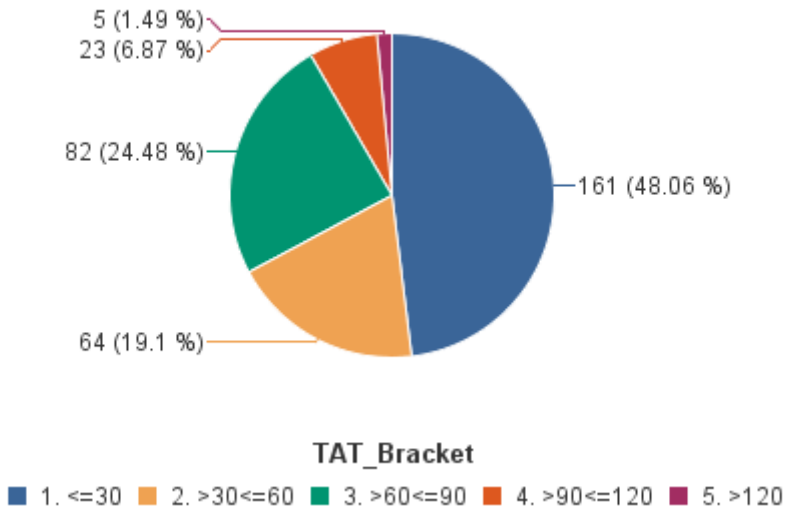
- PQI cases open > 120 days made up 1.49% in May and no cases open >120 days in June. Therefore, turnaround times for case review and closure remain well under the benchmark of 5% per PQI P&P QI-104 in May and 100% compliance in June.

- Cases open for >120 days continues to be primarily related to delay in submission of medical records or provider responses by specific providers. Measures to identify barriers and close these gaps continue to be a priority as reflected in the ongoing decrease in cases open greater than 120 days over the past year.

PQI Aging Report as of 06/30/2023 N= 322



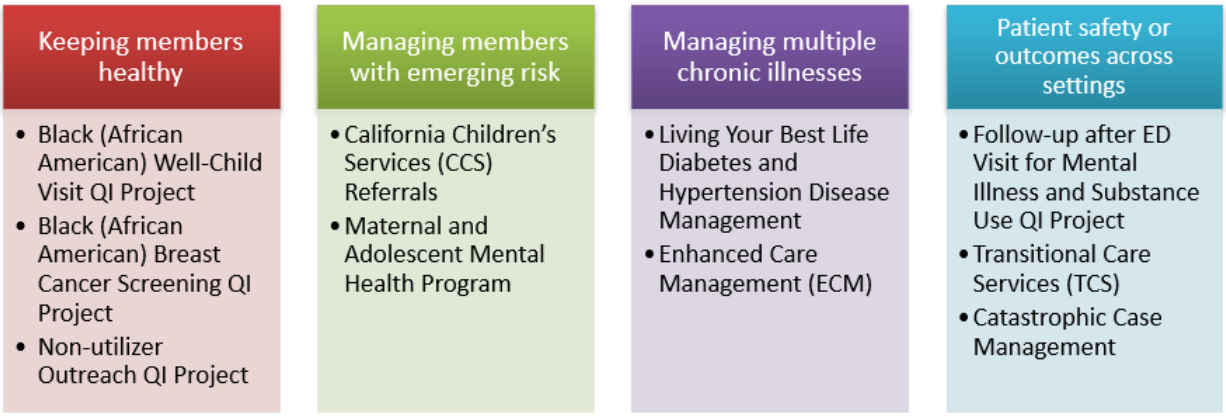
PQI Aging Report as of 05/31/2023 N= 335



Population Health Management (PHM)

- The Alliance Population Health Management program follows the DHCS PHM Policy Guide and National Committee for Quality Assurance (NCQA) standards with the aim of improved health outcomes for all members through assessment of member needs and equitable access to necessary wellness and prevention services, care coordination and care management.

- Completed annual update of the Alliance population health assessment, evaluation of 2022 PHM strategy, and NCQA compliant PHM Strategy. The 2023 PHM Strategy includes the following core programs by NCQA areas of focus. The programs address disparities and gaps in services identified in our population health assessment.



- Created policies and procedures that align with the DHCS All Plan Letter 22-024 Population Health Management Policy Guide. The policies document our population health management program, basic population health management services, and population risk stratification and segmentation process. The policies were submitted to DHCS on 3/08/2023 and responses to AIRs were submitted on 6/13/2023.

- Currently creating PHM monitoring strategy, which includes DHCS-required Key Performance Indicators (KPIs) to be stratified by race, ethnicity, language, and age and reported quarterly to DHCS. PHM KPIs measure, 1) ED versus PCP, primary care, and complex case management utilization, 2) transitional care services access, 3) enhanced care management, 4) incentive payment programs, and 5) HEDIS measures related to children's preventive care, maternal and birth outcomes, and behavioral health.

- Scheduled to begin regular meetings with Alameda County Health Care Services Agency (HCSA) to discuss collaboration on PHM activities.

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

From: **Lao Paul Vang, Chief Health Equity Officer**

Date: **July 14th, 2023**

Subject: **Health Equity Report**

Staffing Plan and Selection Processes:

- **Senior Analyst of Health Equity –** The Senior Analyst of Health Equity has been selected and started her assignment on 07/03/2023.

- **Senior Manager of Health Equity –** The selection process for this position is paused, pending the results from the health equity data assessments and analyses conducted by the Health Equity and Diversity, Equity, and Inclusion Consultant. The selection process for this position is anticipated to resume in a few months.

- **Consultant** – Continuing collaboration with Vendor Management to complete the selection process for the Health Equity (HE) and Diversity, Equity, and Inclusion (DEI) Consultant with a tentative starting date of September 1, 2023. Met with Population Health Management, Quality Improvement, and Utilization Management to gather lists of specific health equity data that these units would like the HE and DEI Consultant to review and analyze for them as part of their annual reviews and strategic planning for health equity strategies.

Internal Collaboration:

- **Meetings and check-ins** – Conduct ongoing 1:1 meetings with the CEO and all Division Chiefs to ensure collaboration and alignment of work-related activities.

- **Population Health Management** – Collaborated with the Population Health Management team to complete the 2023 Population Health Management Strategy.

External Collaboration:

- **Bi-Weekly Meetings with other Local Health Plans' Chief Health Equity Officers (CHEOs**) – Attended bi-weekly meetings with other CHEOs to discuss and exchange ideas, lessons learned, and best practices for Health Equity and Diversity, Equity, and Inclusion.

- **Meetings with External Stakeholders** – Continued participation in regular meetings with external stakeholders (i.e., Alameda County Safety Net Coordination, Alameda Alliance for Health/Alameda Health System Leadership, Housing and Homelessness Incentive Programs, Community of Care, etc., to discuss health equity and DEI related issues.

Policy Development:

- **Stipend Policy** – Developed a draft policy for the stipend payments for the Values in Action and Diversity, Equity, Inclusion, and Belong Committees to ensure fair and transparent stipend payments to committee members.

Diversity, Equity, Inclusion, and Belonging (DEIB) and Values in Action (VIA) Committees:

- **DEIB Committee** – Chaired the monthly meeting of the DEIB Committee. Reviews and revisions of several sections of the Charter are near completion. Henceforth, the Charter will be reviewed annually in alignment with other committees' charters.

- **VIA Committee** – Chaired the monthly meeting of the VIA Committee. Collaborated with committee members to review the draft Charter with the aim of having an approved charter.

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

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

Date: **July 14th, 2023**

Subject: **Information Technology Report**

Call Center System Availability

- AAH phone systems and call center applications performed at 100% availability during the month of June 2023 despite supporting 97% of staff working remotely.

IT Security Program

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

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

    - **Key initiatives include:**

        - Remediating issues from security assessments. (e.g., Cyber, Microsoft Office 365, & Azure Cloud).

        - Create, update, and implement policies and procedures to operationalize and maintain security level after remediation.

        - Set up extended support for monitoring, alerting and supplementary support in cases of security issues.

        - Implement Security Information and Event Management (SIEM) tool for the enterprise to provide real-time visibility across the organization's information security systems.

- Cyber Security remains at 95% and overall, 100% complete for high-severity items as the remaining tasks require comprehensive testing, scheduling, and coordination. A new phase will begin once the remaining tasks are completed.

    - SQLAdmin password change completed as scheduled on June 11th, 2023.
    - Remaining items will carryover for the next phase of the project which is expected to kick-off before the end of July 2023.

- Immutable Backup Implementation project has kicked-off. This project has disaster recovery and IT security impacts to ensure the protection and isolation of the Alliance's data backup from ransomware attacks.

    - Immutable backup testing has been completed successfully.
    - Initial Veeam and CommVault backup sets are now in progress.
        - This process will take 4-6 weeks based on the amount of data.

- Implementation of Single Sign-On and Multi-Factor Authentication for Shared Service Applications. This program focuses on protecting shared cloud applications with Multi-Factor Authentication and Single Sign-On.

    - Completed 100% of the deployments in June 2023.

- The Server Patching Project started with 2 deployments with a total of 59 non-production servers in the month of June 2023.

Fax Services

- The Alliance continued to experience an 80% failure rate for incoming faxes due to a carrier circuit issue with TelePacific during the month of June 2023.

    - The Alliance's top 20 department fax accounts have been migrated to a modern fax solution (EtherFax). This covers all Authorization related faxes which improved the success rate to 95%.
    - An emergency migration of all local fax numbers to EtherFax has been expedited.
        - All 600 local fax numbers were successfully migrated to EtherFax cloud gateway on June 29th, 2023.
    - All incoming/outgoing faxes are now 98% successful transmissions.
    - 40 Toll-Free fax numbers will be scheduled for migration to EtherFax by August 2023.

Encounter Data

- In the month of June 2023, the Alliance submitted 204 encounter files to the Department of Health Care Services (DHCS) with a total of 322,137 encounters.

Enrollment

- The Medi-Cal Enrollment file for the month of June 2023 was received and was slightly delayed loading due to an error with the ID Card file. The enrollment file completed loading to HEALTHsuite on June 30th, 2023.

HealthSuite

- A total of 218,250 claims were processed in the month of June 2023 out of which 173,048 claims auto adjudicated. This sets the auto-adjudication rate for this period to 79.3%.

- HEALTHsuite experienced multiple outages in the month of June, resulting in 4 hours of downtime. The application operated with an uptime of 98%.

TruCare

- A total of 16,541 authorizations were loaded and processed in the TruCare application.

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

Consumer Portal

- In May 2022, the Alliance started the consumer portal enhancement. This consumer portal shall enable the Providers to submit prior authorizations, referrals, claims, and encounters to the Alliance, plus improve authorization and claim processing metrics.

- In June 2023, we made significant progress in developing the forms to directly accept our providers' Long-Term Care Authorization, Referral forms, and Behavioural Health provider forms. Other forms are being added to support Behavioural Health and Long-Term Care programs.

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 “Summary of Medi-Cal and Group Care member enrollment in the month of June 2023”.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of June 2023”.
- The following tables 1-1 and 1-2 are supporting documents from the enrollment summary section.

Table 1-1 Summary of Medi-Cal and Group Care Member enrollment in the month of June 2023

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
June	355,230	3,987	2,680	5,684	117	104

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

Table 1-2 Summary of Primary Care Physician (PCP) Auto-Assignment For the Month of June 2023

Auto-Assignments	Member Count
Auto-assignments MC	1,110
Auto-assignments Expansion	1,372
Auto-assignments GC	45
PCP Changes (PCP Change Tool) Total	2,927

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of June 2023”.
- There were 16,541 authorizations processed within the TruCare application.
- TruCare Application Uptime – 99.99%.
- The following table 2-1 is a supporting document from the TruCare summary section.

Table 2-1 Summary of TruCare Authorizations for the Month of June 2023*

Transaction Type	Inbound EDI Auths	Errored	Total Auths Loaded in TruCare
Paper to EDI	2,636	2,000	1,436
Provider Portal	3,777	770	3,722
EDI	4,023	454	4,026
Long Term Care	40	19	36
Behavioral Health	248	3	248
Manual Entry	N/A	N/A	1,447
Total			10,915

Key: EDI – Electronic Data Interchange

Web Portal Consumer Platform

- The following table 3-1 is a supporting document from the Web Portal summary section. (Portal reports always one month behind current month)

Table 3-1 Web Portal Usage for the Month of May 2023

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	6,421	4,535	207,858	643
MCAL	96,424	3,000	7,174	991
IHSS	3,434	101	102	23
Total	**106,279**	**7,636**	**215,134**	**1,657**

Table 3-2 Top Pages Viewed for the Month of May 2023

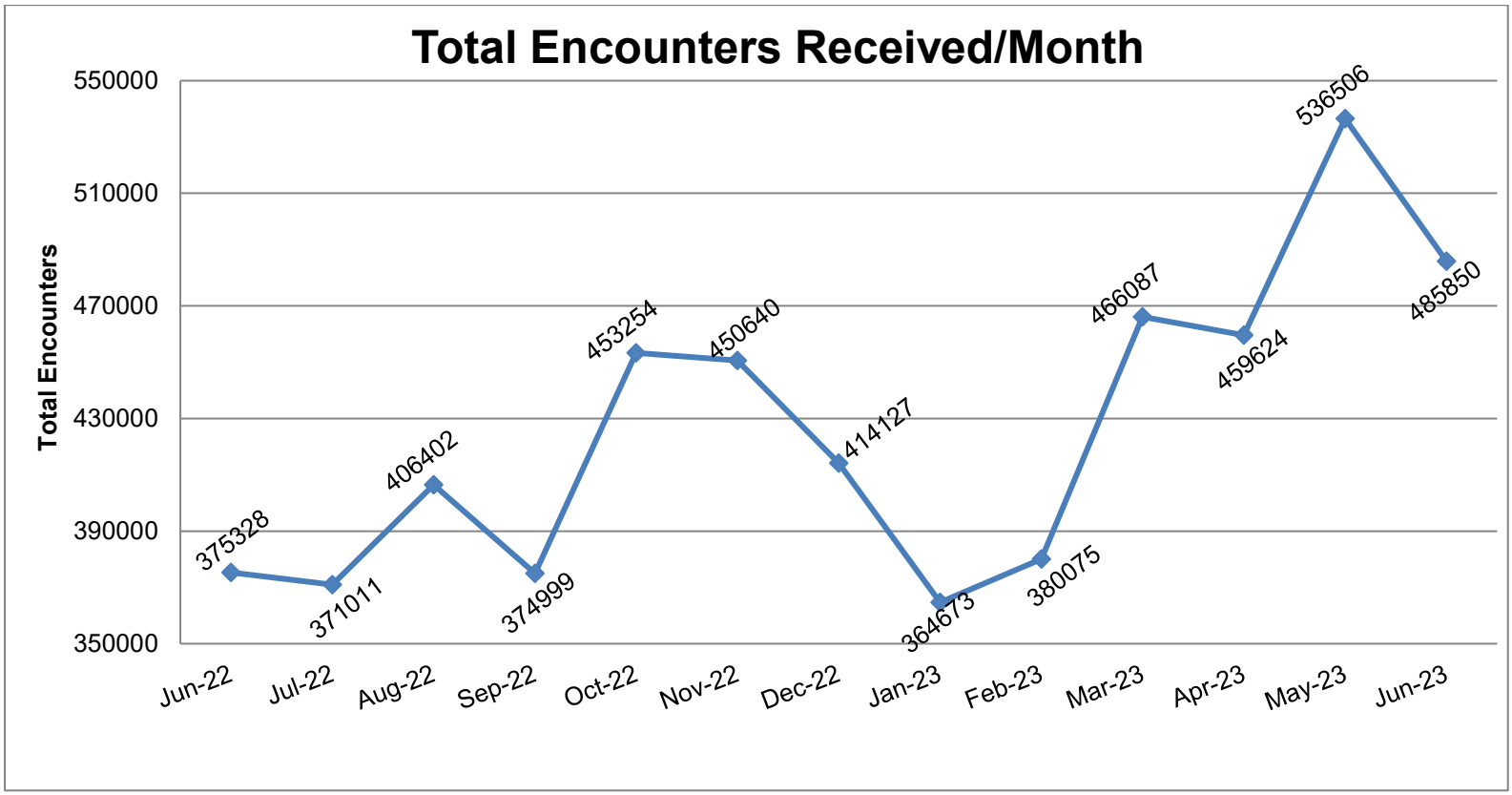
Top 20 Pages Viewed		
Category	**Page Name**	**May-23**
Provider	Member Eligibility	846501
Provider	Claim Status	265831
Provider - Authorizations	Auth Submit	12419
Provider - Authorizations	Auth Search	6867
Member	Member Eligibility	3864
Member - Home	MC ID Card	1128
Member	Find a Doctor or Facility	1948
Provider	Member Roster	2487
Member	Select or Change Your PCP	1293
Provider - Provider Directory	Provider Directory	518
Member - Help & Resources	Member ID Card	1991
Member	My Claims Services	984
Provider - Reports	Reports	824
Member	Request Kaiser as my Provider	639
Member – My Care	Authorization	527
Member	My Pharmacy Medication Benefits	362
Provider - Home	Forms	506
Provider - Home	Behavior Health Forms SSO (auth request)	269
Member - Help & Resources	Authorizations & Referrals	243
Member - EXR	Contact Us	73

Encounter Data from Trading Partners 2023

- **ACBH**: June monthly files (0 records).
    - No longer receiving encounter files but through HCSA.
- **AHS**: June weekly files (6,250 records) were received on time.
- **BAC**: June monthly file (37 records) were received on time.
- **Beacon**: June weekly files (4,559 records) were received on time.
- **CHCN**: June weekly files (90,418 records) were received on time.
- **CHME**: June monthly file (5,692 records) were received on time.
- **CFMG**: June weekly files (9,986 records) were received on time.
- **Docustream**: June monthly files (607 records) were received on time.
- **EBI**: June monthly files (910 records) were received on time.
- **HCSA**: June monthly files (5,573 records) were received on time.
- **IOA**: June monthly files (974 records) were received on time.
- **Kaiser**: June bi-weekly files (53,820 records) were received on time.
- **LogistiCare**: June weekly files (20,859 records) were received on time.
- **March Vision**: June monthly file (5,101 records) were received on time.
- **Quest Diagnostics**: June weekly files (13,627 records) were received on time.
- **Teladoc**: June monthly files (0 records).
    - Teladoc has switched to submitting claims as of July 2022.
- **Magellan**: June monthly files (354,382 records) were received on time.

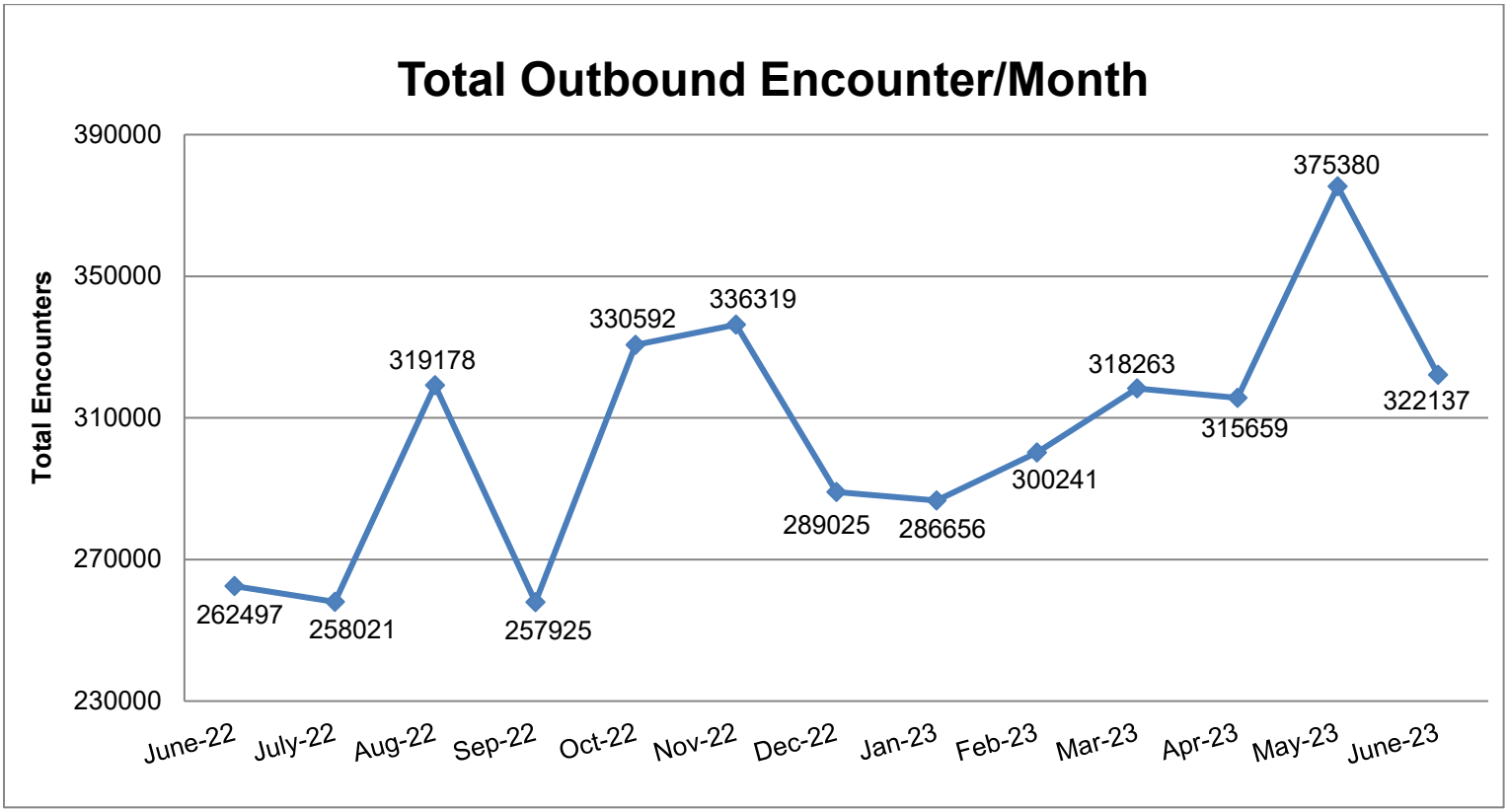
Trading Partner Medical Encounter Inbound Submission History

Trading Partners	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Health Suite	173269	176217	177945	175955	171386	174429	177828	163764	167475	238283	218296	251858	267437
ACBH					8	51	87	86	39	95			0
AHS	5486	5742	5482	5609	5589	6015	6332	4568	5377	5088	6353	5380	6250
BAC	53	66	53	37	39	38	35	199	34	32	38	40	37
Beacon	18340	15678	21310	16040	13490	12883	10437	13824	11036	12159	15799	5822	4559
CHCN	67339	69636	84302	75234	136445	108148	83258	87182	83191	82394	84654	117764	90418
CHME	4578	4853	4722	5191	5214	5152	4822	4574	5303	4729	5277	4987	5692
Claimsnet	10300	7744	10631	6940	15668	19173	12790	9679	11694	8851	16155	12526	9986
Docustream	1263	1236	1149	1715	1294	1435	1487	1327	1794	1361	865	575	607
EBI											976	15	910
HCSA	1880	3366	1869	4440	2098	3734	1781	1825	1976	590	78	72	5573
IOA									172	156	201	325	974
Kaiser	62952	47584	62477	48613	63341	76637	81333	35798	56965	73095	68883	91196	53820
Logisticare	14590	20981	20200	19257	19041	23451	16946	24456	18034	21647	20558	28628	20859
March Vision	3188	3040	2708	3824	3693	3497	4427	3598	3434	3281	4275	3647	5101
Quest	12058	14868	13554	12144	15948	15997	12564	13793	13551	14326	17216	13671	13627
Teladoc	32												
Total	375328	371011	406402	374999	453254	450640	414127	364673	380075	466087	459624	536506	485850



Outbound Medical Encounter Submission

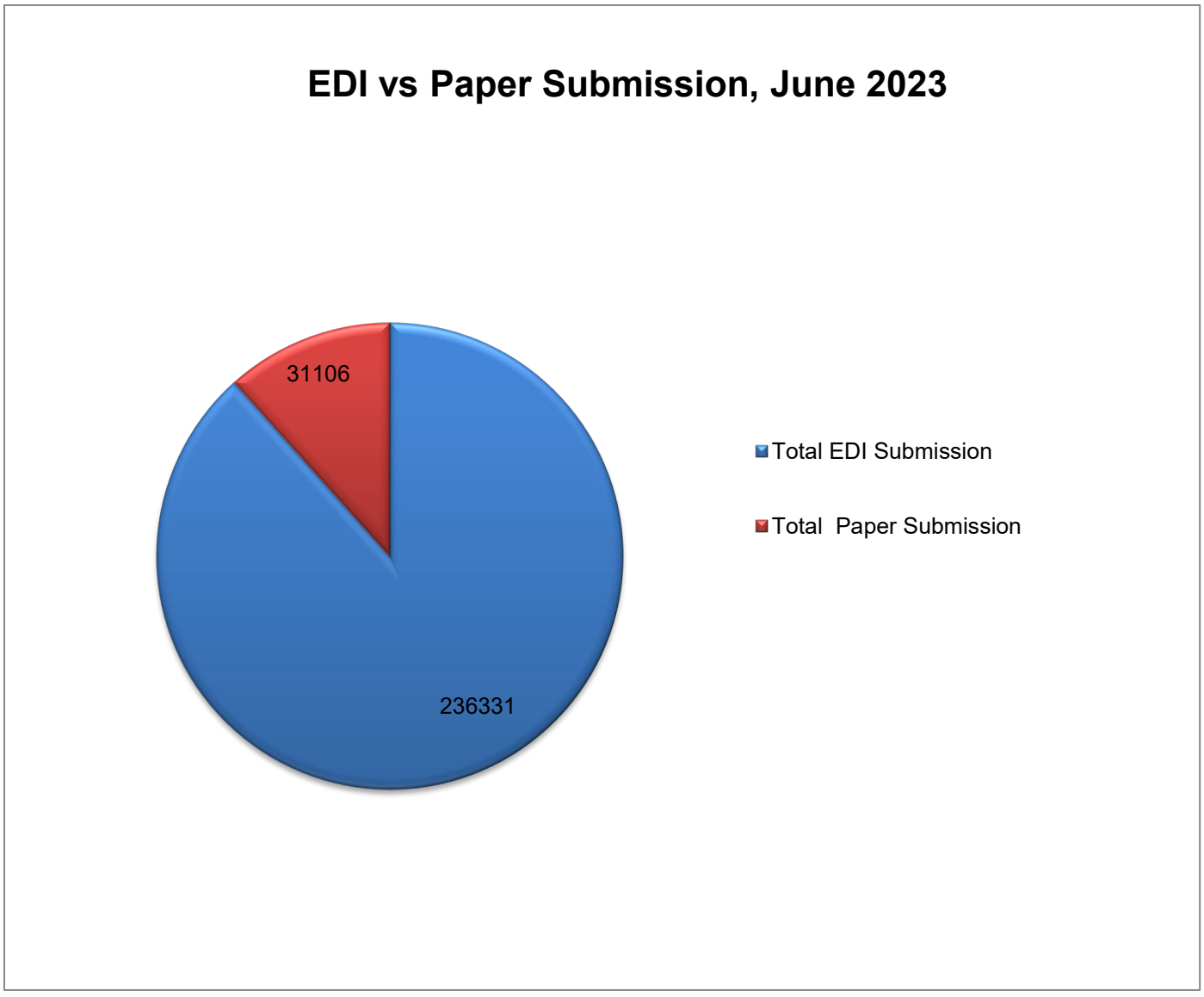
Trading Partners	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Health Suite	90605	92682	121957	96495	121299	95516	97435	114224	128102	117672	117823	151866	126674
ACBH					4	36	60	56	21	73	0	0	0
AHS	5363	5702	5168	4360	6626	5915	5208	5439	5260	3845	7300	5236	5070
BAC	52	63	50	37	37	38	33	196	33	32	38	40	37
Beacon	9534	14711	17246	12054	10967	10172	8001	11282	8910	9674	11927	2879	2233
CHCN	51060	49003	60678	50714	74449	92283	55698	58881	58279	59074	60373	79256	65595
CHME	4470	4714	4618	5069	5016	4843	4729	4470	5181	4606	5159	4864	5577
Claimsnet	7985	7209	7248	4614	10491	11118	8983	8241	8334	6361	9834	10891	7445
Docustream	854	1070	964	1436	1060	1134	1268	1117	1521	1232	481	411	378
EBI											906	15	872
HCSA	1719	1579	1770	2368	2013	2001	1725	1777	1304	287	52	55	1781
IOA									168	152	45	276	751
Kaiser	62562	47331	61831	47861	62682	75808	80464	35360	55930	72409	65652	72893	68887
Logisticare	14677	20828	20022	19001	18457	23178	16729	24291	12223	27071	20411	28455	20787
March Vision	2392	2206	1969	2631	2601	2396	2938	2454	2308	2400	3006	2366	3408
Quest	11192	10923	15657	11285	14890	11881	5754	18868	12667	13375	12652	15877	12642
Teladoc	32												
Total	262497	258021	319178	257925	330592	336319	289025	286656	300241	318263	315659	375380	322137



HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total Claims
23-Jun	236331	31106	267437

Key: EDI – Electronic Data Interchange

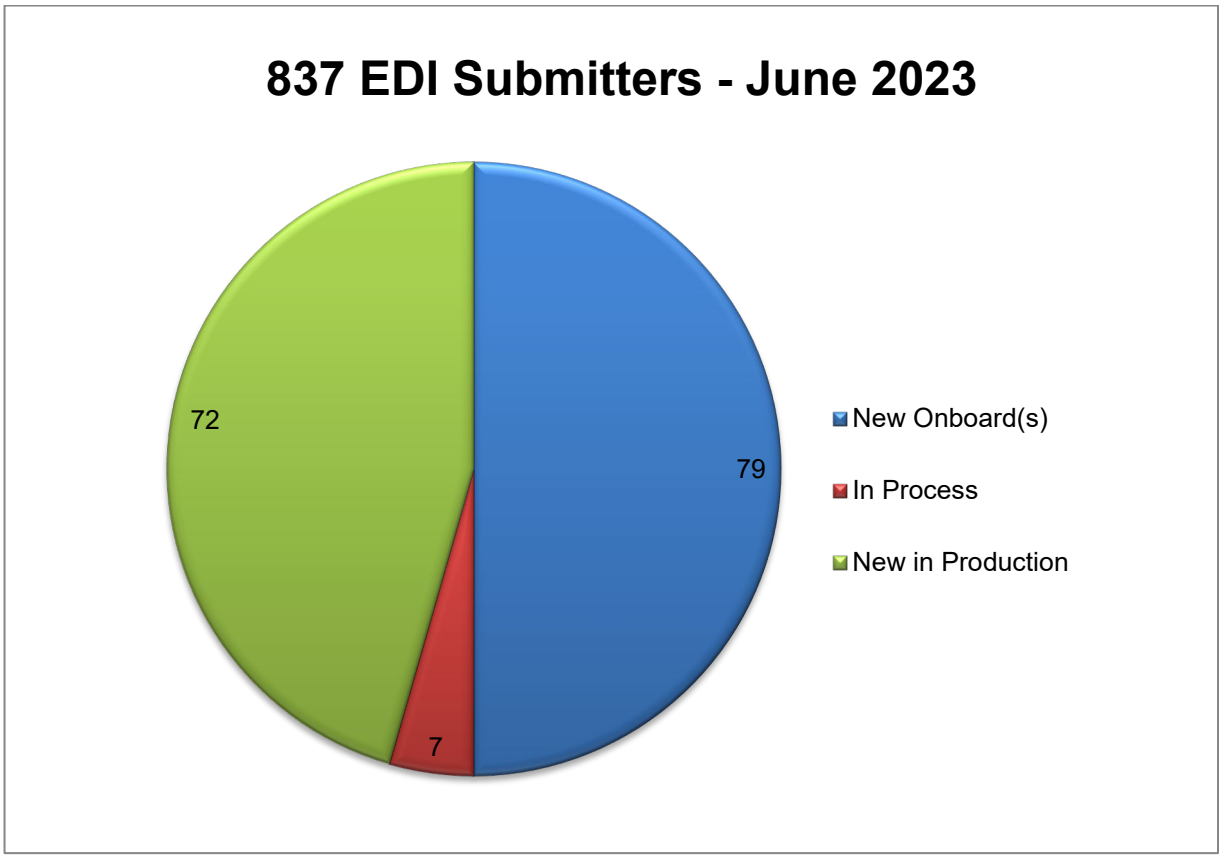


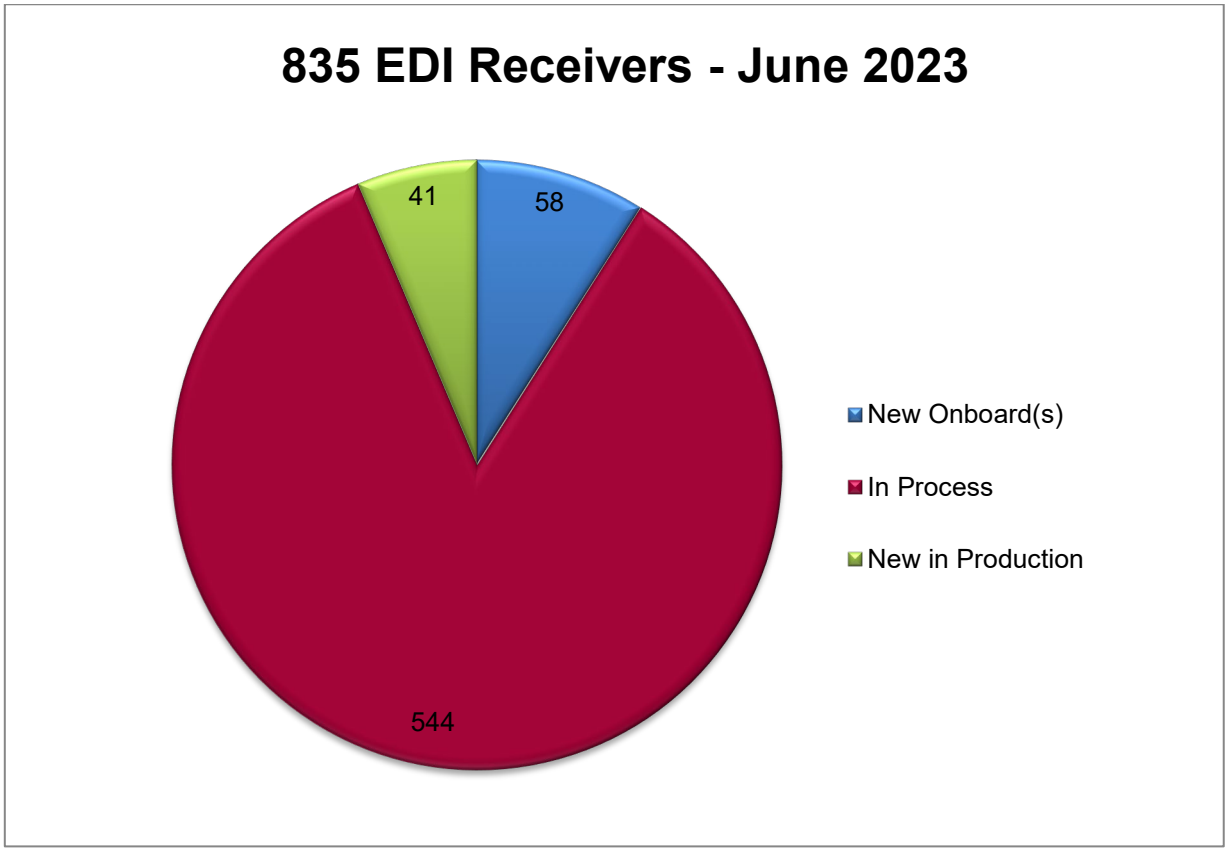
Onboarding EDI Providers - Updates

- June 2023 EDI Claims:
  - A total of 1732 new EDI submitters have been added since October 2015, with 72 added in June 2023.
  - The total number of EDI submitters is 2472 providers.

- June 2023 EDI Remittances (ERA):
  - A total of 747 new ERA receivers have been added since October 2015, with 41 added in June 2023.
  - The total number of ERA receivers is 763 providers.

	837				835			
	New On Boards	In Process	New In Production	Total In Production	New On Boards	In Process	New In Production	Total In Production
Jul-22	38	1	27	2113	54	339	16	485
Aug-22	26	0	26	2139	46	354	31	516
Sep-22	11	0	11	2150	57	385	26	542
Oct-22	17	0	17	2167	48	407	26	568
Nov-22	49	2	47	2214	50	410	47	615
Dec-22	19	0	19	2233	20	421	9	624
Jan-23	13	2	11	2244	21	423	19	643
Feb-23	24	0	24	2268	37	457	3	646
Mar-23	55	0	55	2323	78	472	63	709
Apr-23	50	3	47	2370	24	491	5	714
May-23	35	5	30	2400	44	527	8	722
Jun-23	79	7	72	2472	58	544	41	763


837 EDI Submitters - June 2023
72
79
7
New Onboard(s)
In Process
New in Production


835 EDI Receivers - June 2023
41
58
544
New Onboard(s)
In Process
New in Production

Encounter Data Submission Reconciliation Form (EDSRF) and File Reconciliations

- EDSRF Submission: Below is the total number of encounter files that AAH submitted in the month of June 2023.

File Type	June-23
837 I Files	36
837 P Files	168
Total Files	204

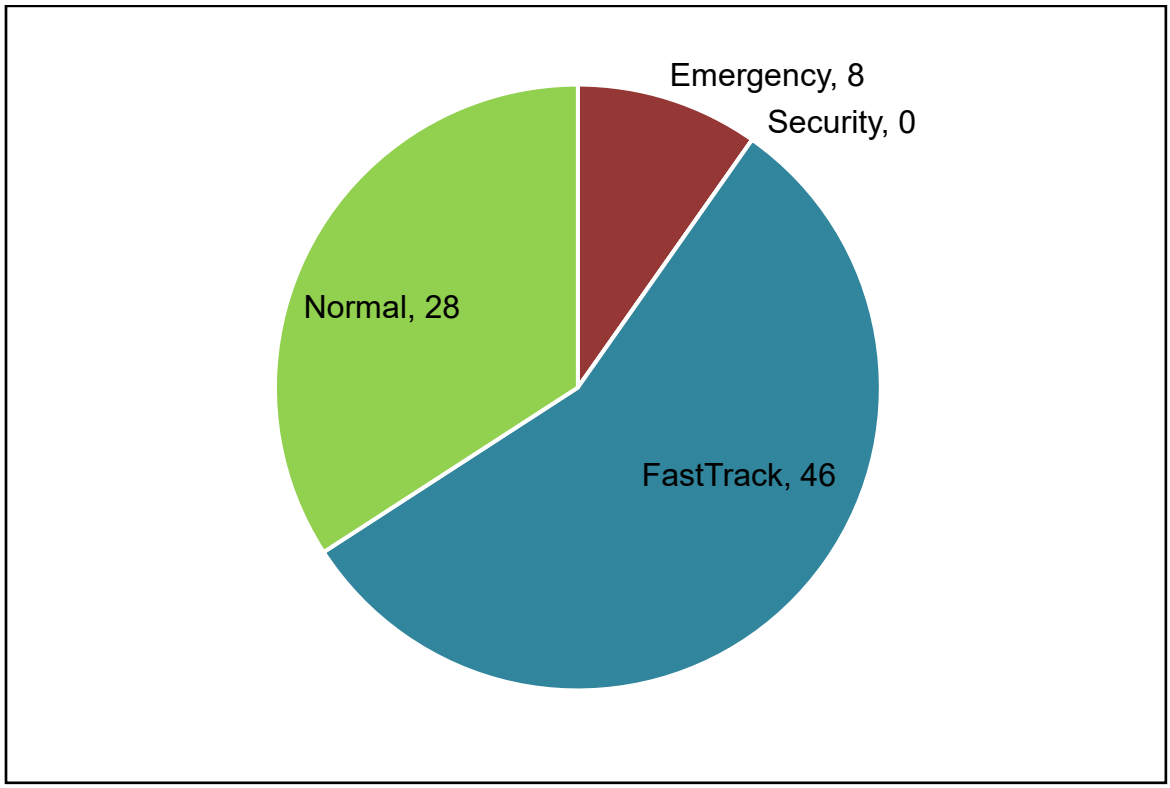
Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	June-23	Target
Timeliness-% Within Lag Time – Institutional 0-90 days	93%	60%
Timeliness-% Within Lag Time – Institutional 0-180 days	98%	80%
Timeliness-% Within Lag Time – Professional 0-90 days	93%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	99%	80%

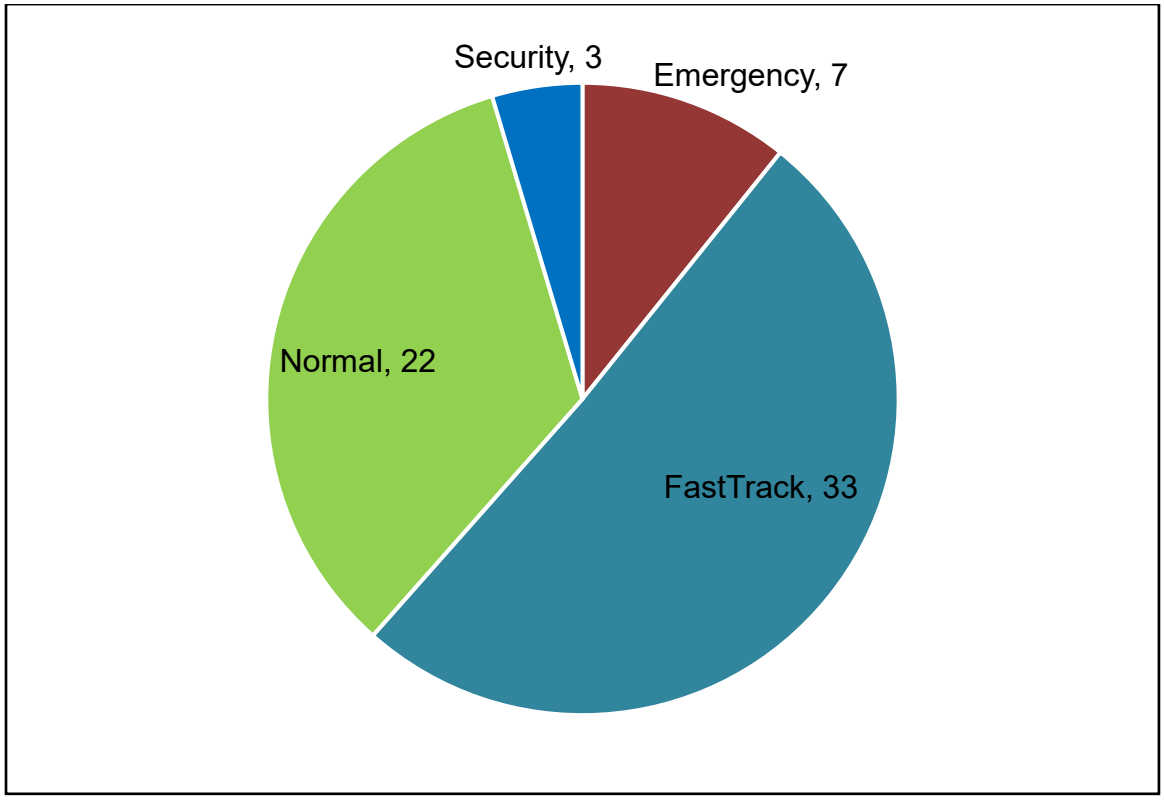
Change Management Key Performance Indicator (KPI)

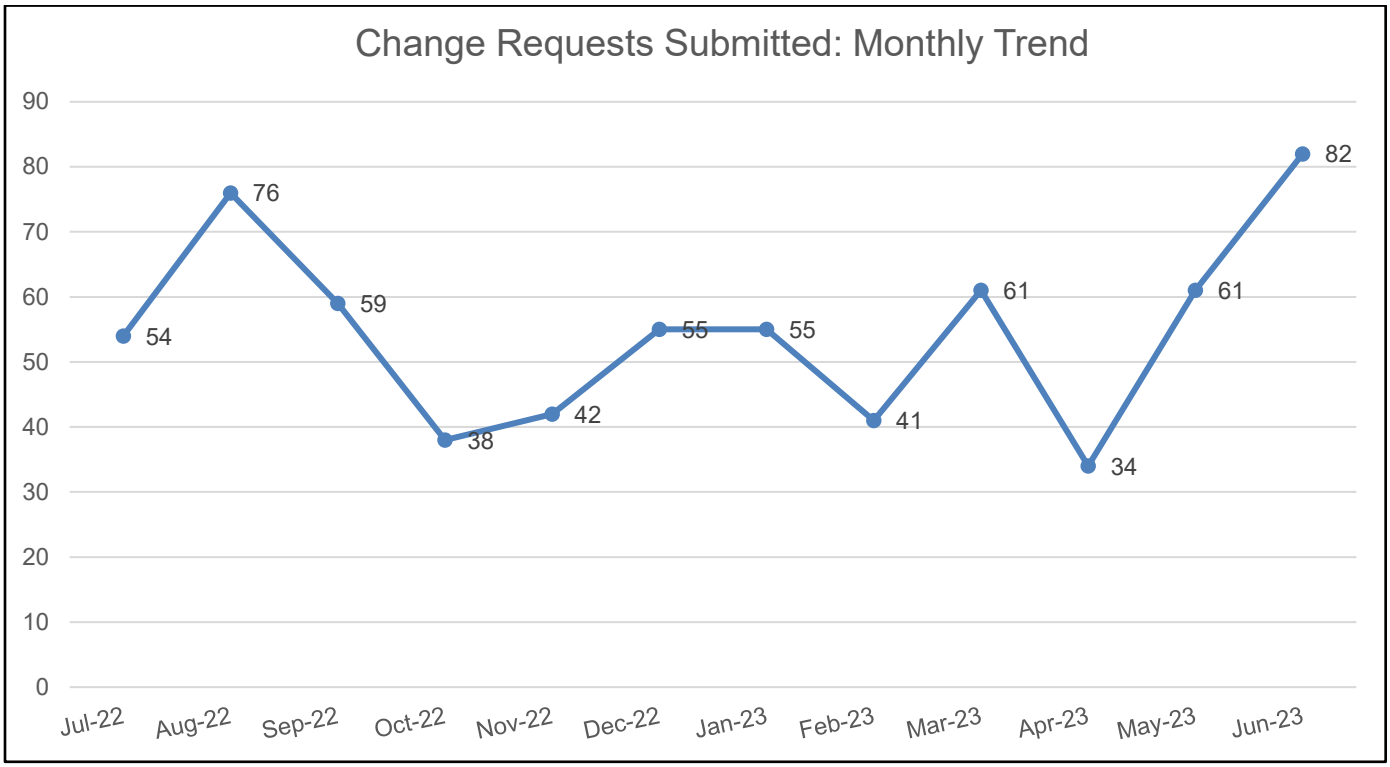
- Change Request Overall Summary in the month of June 2023 KPI:
  - 82 Changes Submitted.
  - 65 Changes Completed and Closed.
  - 167 Active Change Requests in pipeline.
  - 2 Change Requests Cancelled or Rejected.

- 82 Change Requests Submitted/Logged in the month of June 2023



- 65 Change Requests Closed in the month of June 2023




Change Requests Submitted: Monthly Trend
90
80
70
60
50
40
30
20
10
0
54
76
59
38
42
55
55
41
61
34
61
82
Jul-22
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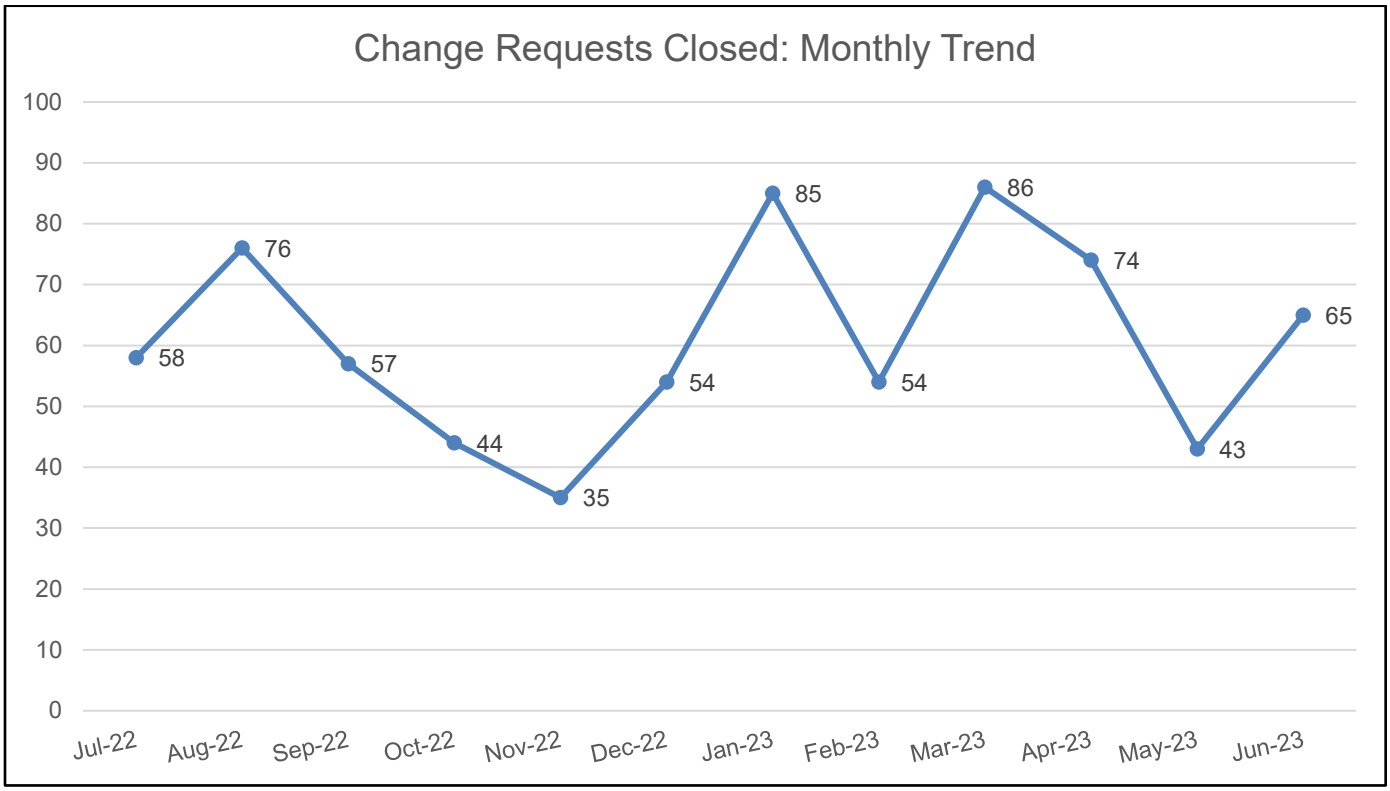
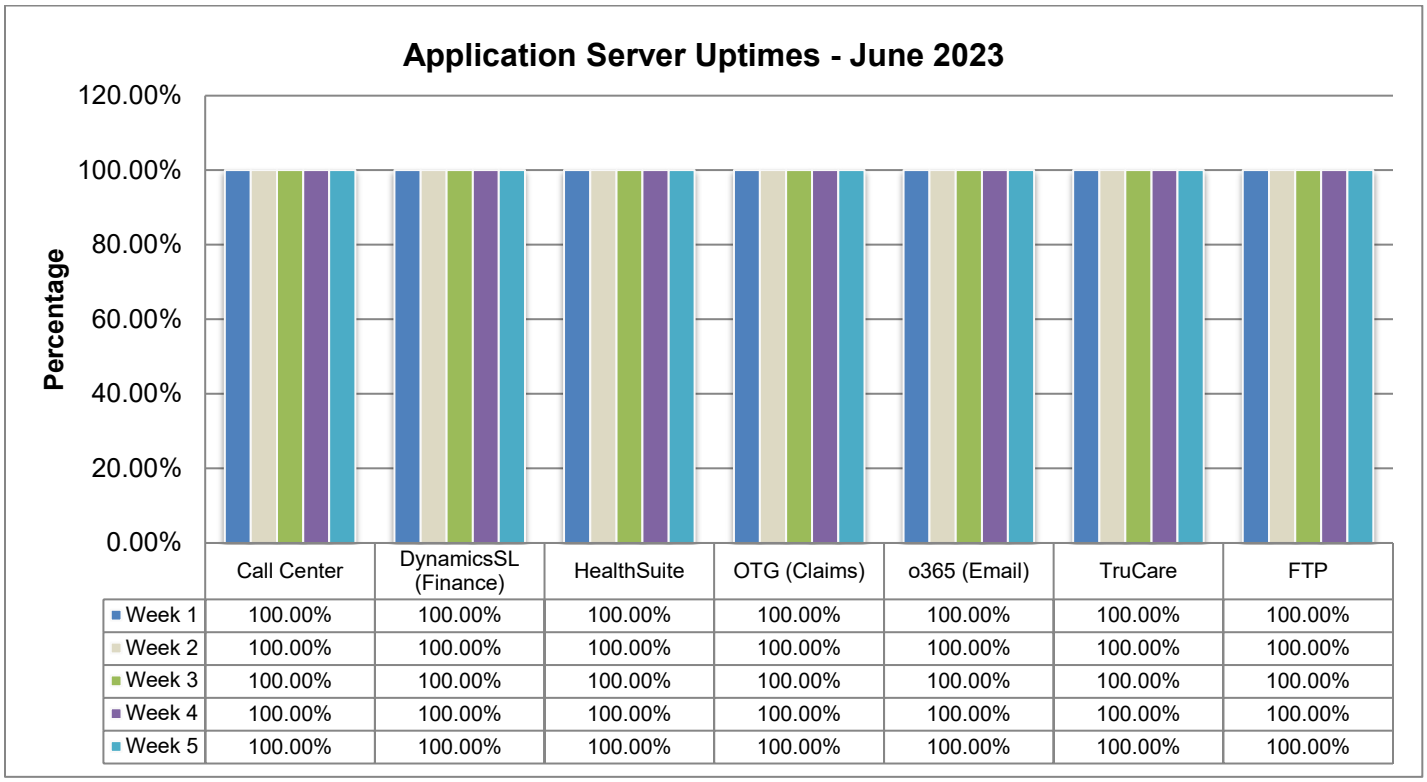
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23


Change Requests Closed: Monthly Trend
100
90
80
70
60
50
40
30
20
10
0
58
76
57
44
35
54
85
54
86
74
43
65
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23

IT Stats: Infrastructure



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

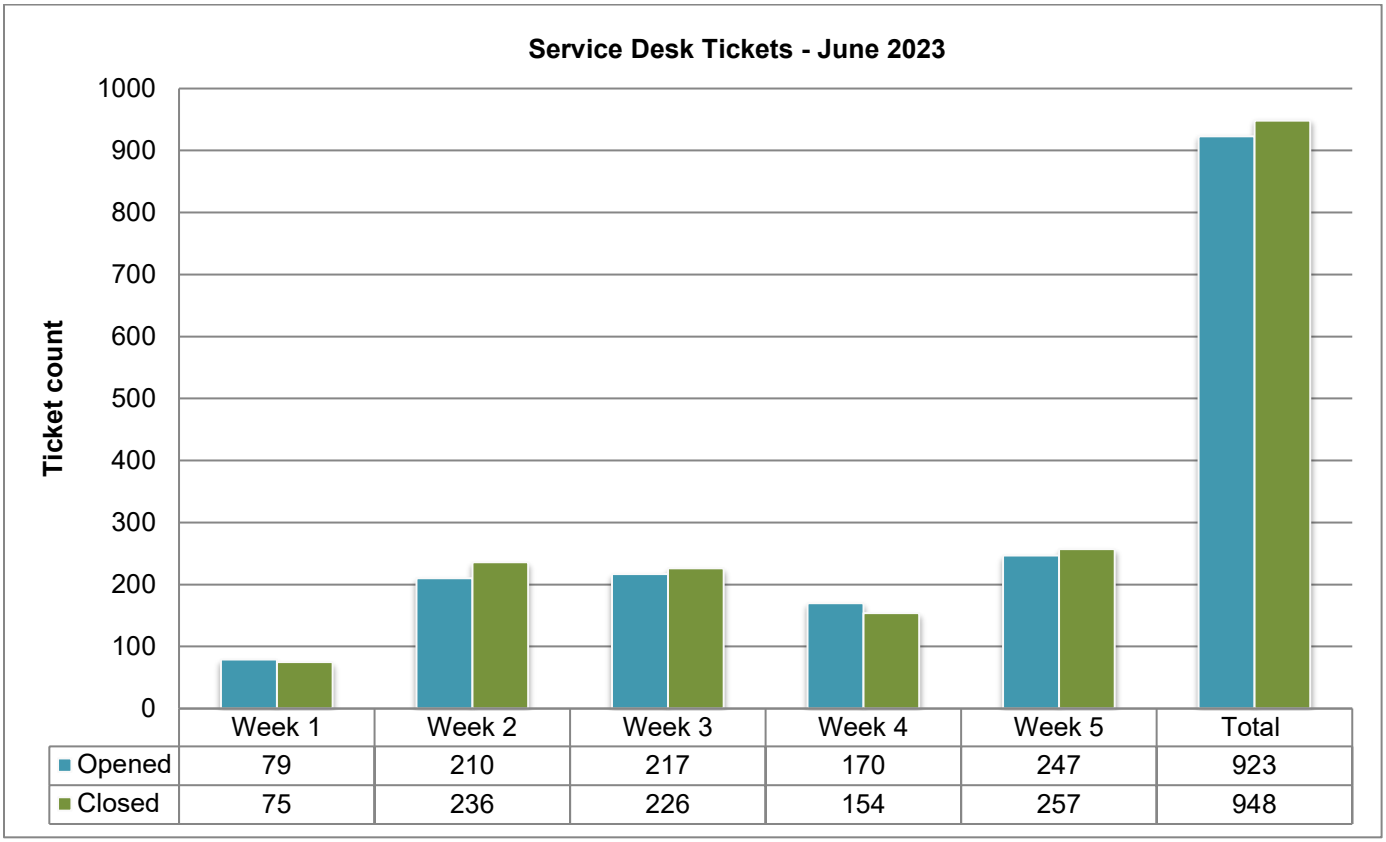
- All mission critical applications are monitored and managed thoroughly.

- Fax Services continued to experience 80% failure rate for incoming faxes due to carrier circuit issue with TelePacific during the month of June 2023.

    - The Alliance's top 20 department fax accounts have been migrated to a modern fax solution (EtherFax). This covers all Authorization related faxes which improved the success rate to 95%.
    - An emergency migration of all local fax numbers to EtherFax has been expedited.
        - All 600 local fax numbers were successfully migrated to EtherFax cloud gateway on June 29th, 2023.
    - All incoming/outgoing faxes are now 98% successful transmissions.
    - 40 Toll-Free fax numbers will be scheduled for migration to EtherFax by August 2023.

- Experienced Multiple HealthSuite Outages that totalled to 4 hours of downtime.

    - *Friday, June 2nd, 2023, at 3:00pm*
    - *Friday, June 23rd, 2023, at 3:28pm*
    - There is a joint effort with multiple vendors (including application and hardware) to understand the root cause of the issues which we plan to mitigate by September 2023.



	Week 1	Week 2	Week 3	Week 4	Week 5	Total
Opened	79	210	217	170	247	923
Closed	75	236	226	154	257	948

- **923** Service Desk tickets were opened in the month of June 2023, which is **14.6%** higher than the previous month and **948** Service Desk tickets were closed, which is **20.3%** higher than the previous month.

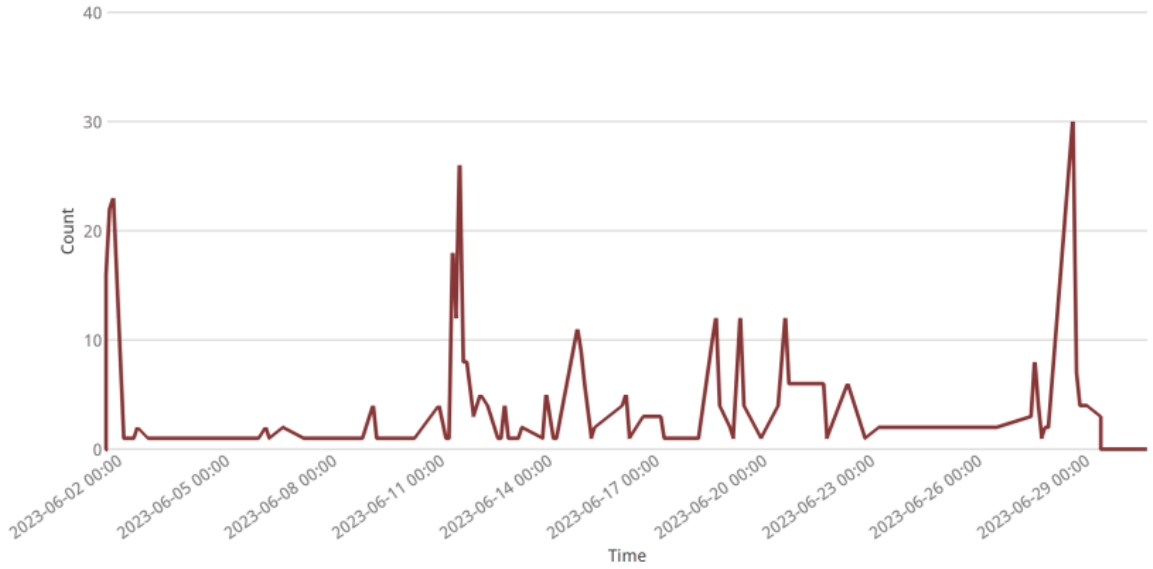
- The opened ticket count for the month of June is **923** which is **8.4%** higher than the previous 3-month average of **853**.

- The closed ticket count for the month of June is **948** which is **9.9%** higher than the previous 3-month average of **859**.

June 2023

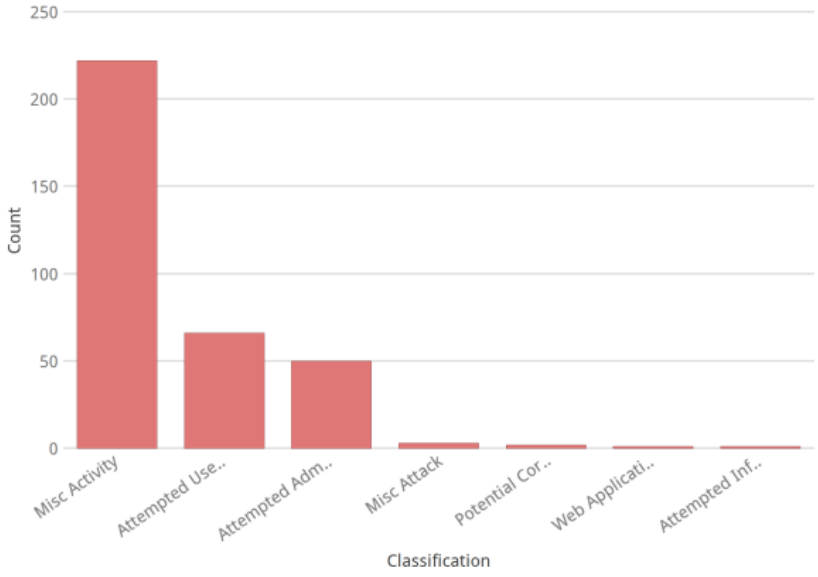
All Intrusion Events

Time Window: *2023-06-01 09:29:00 - 2023-06-30 09:29:00*



Dropped Intrusion Events

Time Window: *2023-06-01 09:30:00 - 2023-06-30 09:30:00*
Constraints: *Inline Result = dropped*



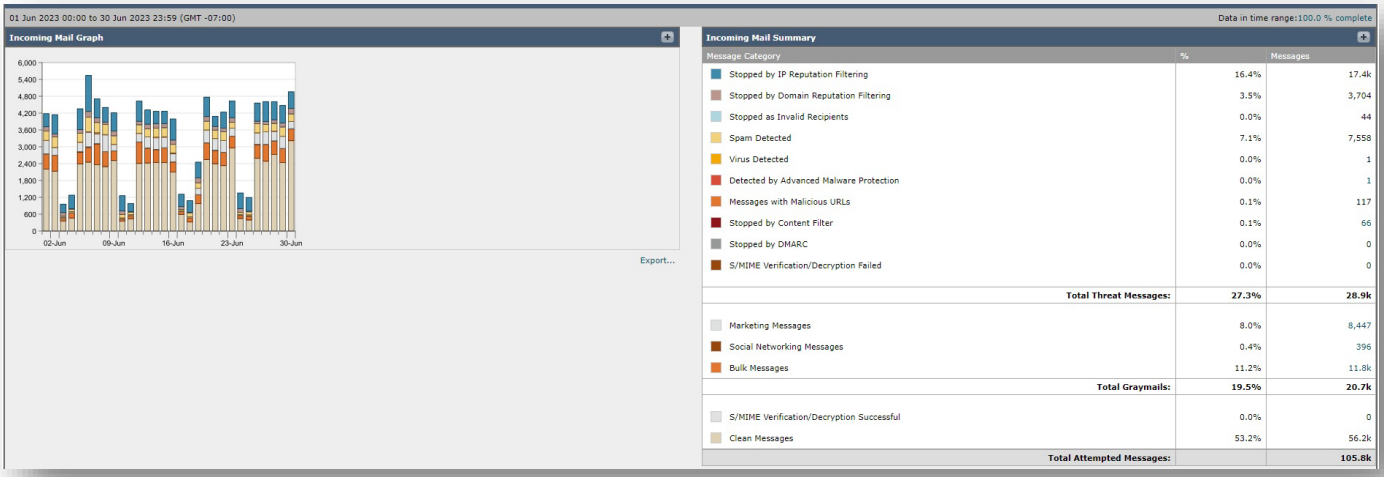
Classification	Count
Misc Activity	222
Attempted User Privilege Gain	66
Attempted Administrator Privilege Gain	50
Misc Attack	3
Potential Corporate Policy Violation	2
Web Application Attack	1
Attempted Information Leak	1

IronPort Email Security Gateways
Email Filters

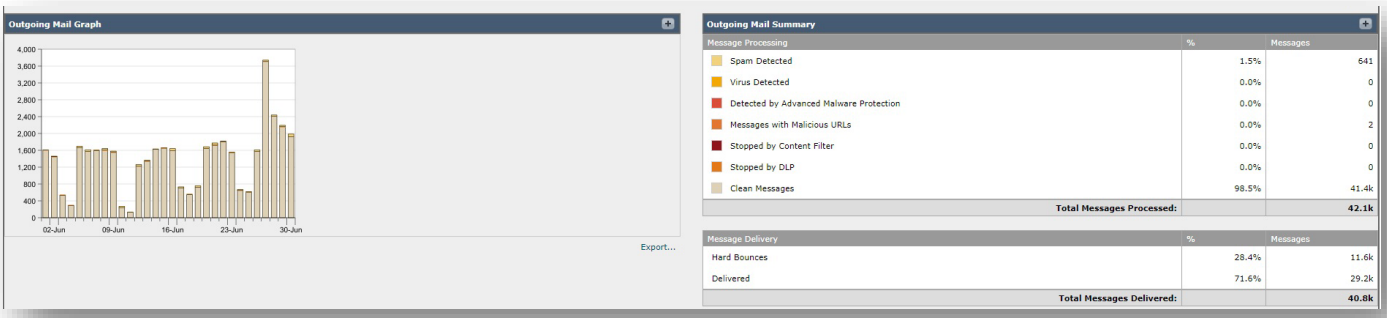
June 2023

MX4

Inbound Mail



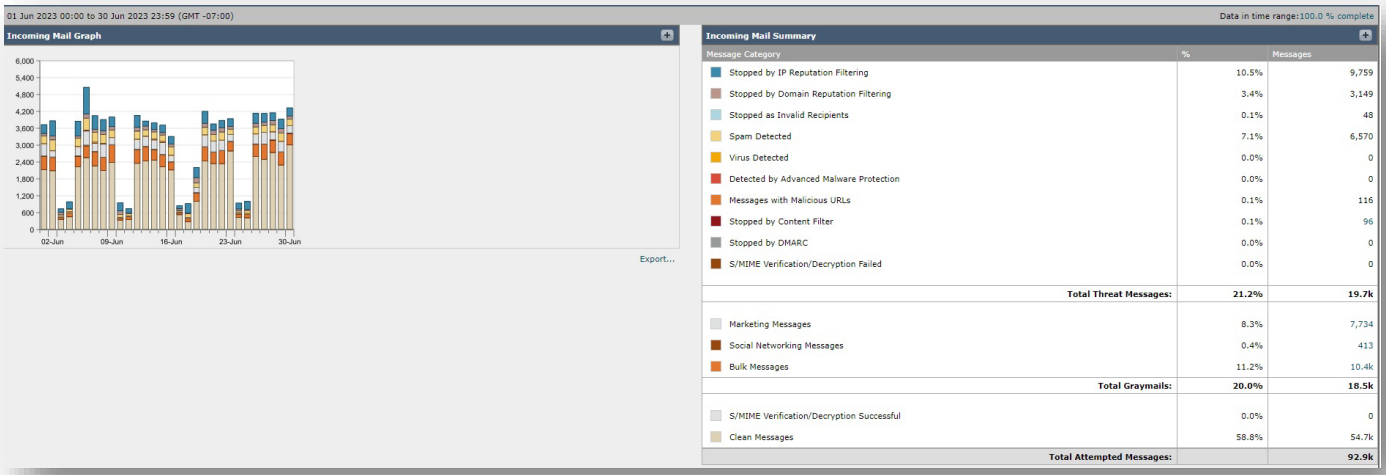
Outbound Mail



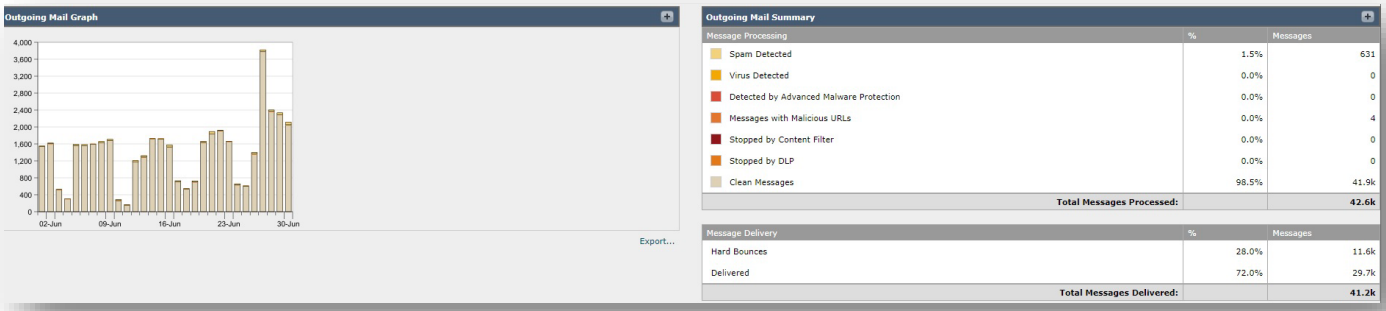
June 2023

MX9

Inbound Mail



Outbound Mail



Item / Date	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	*Jun-23*
Stopped By Reputation	34.7k	28.2k	27.6k	43.6k	20.9k	23k	53.9k	41.9k	65.3k	60.9k	31.7k	33.2k	***27.1k***
Invalid Recipients	119	78	117	71	94	87	184	204	68	75	97	113	***92***
Spam Detected	13.9k	11.6k	13.3k	14.6k	10.9k	10.9k	10.8k	10.1k	12.5k	15.4k	14.5k	13.7k	***14.1k***
Virus Detected	18	1	0	2	3	3	2	1	3	0	2	9	***1***
Advanced Malware	0	0	1	2	0	0	0	1	1	0	0	3	***1***
Malicious URLs	187	93	448	226	102	61	14	35	34	27	6	478	***233***
Content Filter	125	119	79	111	171	77	23	37	33	40	115	127	***162***
Marketing Messages	12.5k	12.6k	14.5k	13.7k	13.9k	16.1k	13.4k	13.7k	13.9k	15.5k	15.5k	18.5k	***16.1k***
Attempted Admin Privilege Gain	215	215	210	151	68	40	112	61	61	115	170	4	***50***
Attempted User Privilege Gain	157	153	722	395	180	324	797	107	307	87	428	42	***66***
Attempted Information Leak	7,839	18,414	12,210	10,748	12,942	12.3k	78.9k	17.8k	17.1k	12.5k	24.4k	5	***1***
Potential Corp Policy Violation	0	277	0	0	0	0	1	0	0	0	0	4	***2***
Network Scans Detected	0	0	0	0	0	0	0	0	0	0	0	0	***0***
Web Application Attack	0	0	4	0	0	0	0	19	1	2	2	7	***1***
Attempted Denial of Service	86	218	215	436	0	214	117	0	0	2.9k	109	0	***0***
Misc. Attack	88	407	733	3,295	469	87	111	240	1,288	2	521	2	***3***

- 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 decreased with a return to a reputation-based block for a total of 27.1k.

- Attempted information leaks detected and blocked at the firewall is at 1 for the month of June 2023.

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

- Attempted User Privilege Gain is slightly higher at 66 from a previous six-month average of 172.

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

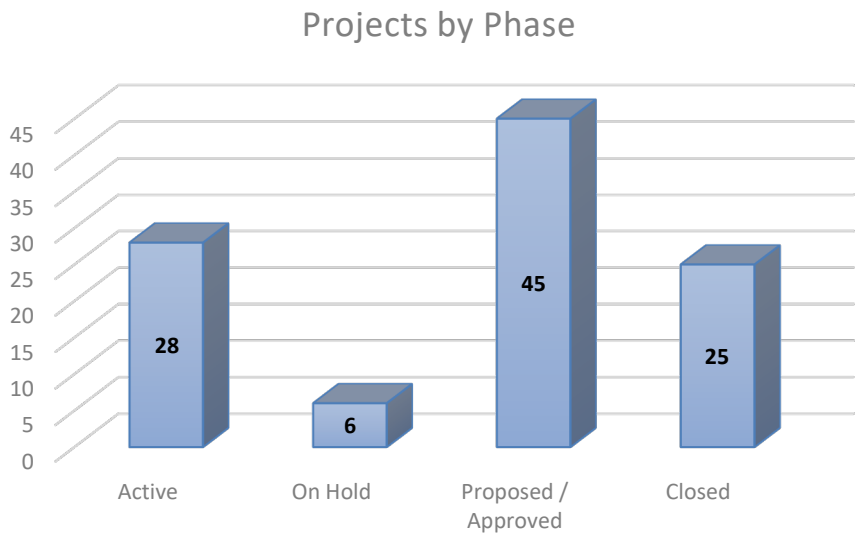
From: **Ruth Watson, Chief Operating Officer**

Date: **July 14th, 2023**

Subject: **Integrated Planning Division Report – June 2023 Activities**

Project Management Office

- 104 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
    - 28 Active projects (discovery, initiation, planning, execution, warranty)
    - 6 On Hold projects
    - 45 Proposed and Approved Projects
    - 25 Closed projects



Integrated Planning

CalAIM Initiatives

- Enhanced Care Management and Community Supports
    - Enhanced Care Management (ECM)
        - July 2023 ECM Populations of Focus (PoF) – Children and Youth
            - ECM Model of Care (MOC) Addendum II was submitted to DHCS on February 15th, 2023, and approved on May 19th
        - January 2024 ECM Populations of Focus
            - Individuals Transitioning from Incarceration
            - Pregnant and Postpartum Individuals At Risk for Adverse Perinatal Outcomes

        - ECM MOC Addendum III template released by DHCS on June 12th and will be due to DHCS September 1st, 2023
    - Community Supports (CS)
        - Submitted CS MOC for July 2023 elections to DHCS on February 15th, 2023, and approved on May 31st
        - MOC for January 2024 CS elections is due to DHCS on July 5th, 2023
            - AAH is adding three (3) additional CS services effective January 1st, 2024
                - Sobering Centers
                - Nursing Facility Transition/Diversion to Assisted Living Facilities
                - Community Transition Services/Nursing Facility to a Home

- Justice-Involved Initiative
    - DHCS received approval from CMS on January 26th to provide up to 90 Days of pre-release services
    - Go-live date for implementation is April 2024
    - Correctional facilities will have the ability to select their go-live date within a 24-month phase-in period (4/1/2024 – 3/31/2026)
        - Managed Care Plans (MCPs) must be prepared to coordinate with correctional facilities as of April 1st, 2024, even if facilities in their county are not going live until a later date
    - AAH is launching a pilot for post-release services in July 2023 in preparation for the 2024 programs related to this population
        - Pilot extends the existing Roots program for 6-12 months

- Long Term Care (LTC) Carve-In – AAH became responsible for all members residing in LTC facilities as of January 1st, 2023, with the exception of Pediatric and Adult Subacute Facilities and Intermediate Care Facilities-Developmentally Disabled (ICF-DD), which will go live in January 2024
    - AAH continues to identify attributed members
        - LTC Team continues to outreach to facilities to encourage incorrect Aid Code reporting to the Social Services Agency (SSA)
        - Approximately 50 members with incorrect Aid codes have been converted to the appropriate LTC Aid code
        - The finance department is compiling a LTC-related medical expense report to calculate net cost
    - Draft All Plan Letter (APL) for ICF-DD and Sub-acute population received in June 2023
        - AAH has identified approximately 150-200 members in ICF-DD homes
        - Volume of members in the Sub-acute facilities is yet to be determined by the state
        - APL Focus:
            - Quality monitoring and oversight

- Close management of transition of members throughout the continuum
- Foster collaboration with Regional centers, other health plans, and advocacy groups
- Identification of additional support and interventions through Population Health Management
- Claims and Billing support for the ICF-DD homes

- Population Health Management (PHM) Program – effective January 1st, 2023
  - 2023 DHCS PHM Monitoring requirements
    - Received updated guidance from DHCS regarding required PHM monitoring data points and stratification
    - Development of PHM monitoring processes to meet DHCS requirement in process for completion by August 2023
  - Disease Management
    - Development of programs for Asthma and Diabetes, with anticipated launch date of 09/2023
    - Next Steps: will begin development of programs for Depression and Cardiovascular Disease, with an anticipated launch date of December 2023
  - Memorandums of Understanding (MOUs): Community and public agency 2024 single contract and Population Health Management requirements
    - Attended working session with Provider Services to define Scope of Work
    - PHM team provided feedback to DHCS on MOU templates

- Community Health Worker Benefit – Medi-Cal benefit effective July 1st, 2022, designed to promote the MCP's contractual obligations to meet DHCS broader Population Health Management standards
  - Internal CHW strategy completed and approved
    - Identified programs and interventions to effectively impact AAH population added to Strategy document
    - Benefits to adding CHW to our network of providers and its impact from a care perspective to AAH population identified
    - Identified methodology and approaches on network buildout
  - AAH continues to participate in the CHW Practice Design Workgroup which includes County staff as well as representatives from organizations throughout the state who utilize CHWs
  - Engagement with Community Partners
    - Roots – Met with ECM team to discuss possible opportunities to combine efforts with outreach to Roots regarding the Justice Involved Pilot but concluded there is not enough overlap so CHW team will approach Roots independently
    - Next steps include outreach to the following organizations:
      - La Clinica De La Raza
      - Lifelong Medical Care
      - Tiburcio Vasquez Health Center

- Inspire Communities
- First 5 Alameda County

- CalAIM Incentive Payment Program (IPP) – three-year DHCS program to provide funding for the support of ECM and CS in 1) Delivery System Infrastructure, 2) ECM Provider Capacity Building, and 3) Community Supports Provider Capacity Building and Community Supports Take-Up
    - As of June 30th, the following activities have been completed:
        - Seven (7) Memorandums of Understanding (MOUs) have been fully executed and one (1) MOU was terminated due to an ECM provider leaving the network
        - Six (6) initial payments have been issued to providers
    - AAH continues to work with the remaining three (3) applicants to address outstanding questions, finalize the MOUs, and/or award the initial payment
    - AAH is in the process of completing the Submission 3 narrative and quantitative response that is due to DHCS on September 1st
    - AAH is currently working with Anthem in preparation for the January transition to a single plan model

- Dual Eligible Special Needs Plan (D-SNP) Implementation – All Medi-Cal MCPs will be required to implement a Medicare Medi-Cal Plan (MMP) as of January 1st, 2026
    - Rebellis and AAH Project Kickoff scheduled for July 28th, 2023
    - Rebelllis will perform an evaluation of AAH information systems to determine clinical operational readiness
    - Development of project work plan is underway

Other Initiatives

Mental Health (Mild to Moderate/Autism Spectrum Disorder) Insourcing – services previously performed by Beacon Health Options were brought in-house on April 1st, 2023

- Reports for Day 2
    - Regulatory Reports – Two (2) reports in development
    - Management Reports – Requirements gathering in progress
        - Awaiting Sign Off from Leadership to finalize list
        - Case Management/Utilization Management (Daily/Weekly/Monthly) – in progress
- Comprehensive Diagnostic Evaluation (CDE) – member backlog has been rectified and continues to be monitored by the Behavioral Health (BH) Department
    - Status regarding volume addressed by BH Leadership with Senior Leadership at weekly Senior Leadership Team (SLT) Meeting
- Mental Health Initial Evaluation Form – forecasting reimplementation at end of July to remediate provider access issue
    - Requirements for User Interface frozen and signed off by Provider Services, Communications, and BH Director
    - Changes to the User Interface in progress and pending approval by stakeholders
- Identification of business system process improvements and automations where necessary and feasible

    - TruCare – Automated Notification requirements gathering in progress
    - Provider Portal – Online Forms
        - Initial Evaluation Form (Priority 1)
        - Coordination of Care Update Form (Priority 2)
            - Requirements gathered and approved
            - Development of online form in progress
        - ABA Referral Form (Priority 3)
            - Requirements gathering scheduled to begin week of July 10th
        - MH Referral Form (Priority 4)
- Post go-live support by Beacon ended June 30th
- Post go-live project management support will continue for 120 days

Behavioral Health Integration (BHI) Incentive Program – Program ended December 31st, 2022

- Final payment of $300,150 for PY2, Q4 milestone completion received on June 22nd
- DHCS program close-out survey completed and submitted to DHCS on June 23rd
- All activities for this program are now complete

Student Behavioral Health Incentive Program (SBHIP) – DHCS program commenced January 1st, 2022, and continues through December 31st, 2024

- AAH SBHIP deliverables:
    - Needs Assessment and four Targeted Interventions Project Plans submitted to DHCS on December 30th, 2022
        - Approval for the Targeted Interventions Project Plans was received on February 24th, 2023, resulting in successful achievement of 50% of the Targeted Interventions allocation ($4.4M)
        - Approval for the comprehensive Needs Assessment was received on March 8th, 2023, resulting in successful achievement of the remaining 50% of the Needs Assessment allocation ($381K)
        - Funding for these two deliverables ($4.8M) was received from DHCS on May 4th, 2023
        - Payments for the remaining Needs Assessment allocation ($265k) were made to the LEAs in May 2023
    - The first Bi-Quarterly Report (BQR) for the measurement period of January 1st, 2023 – June 30th, 2023, was submitted June 30th, 2023, and associated funding (up to $1.1M) is expected in October 2023
- Partner meetings continue with Local Education Agencies (LEAs) to further refine project plan activities for successful completion of the milestones related to the January 1st – June 30th, 2023, measurement period
- An Alameda County SBHIP Steering Group has been formed, which includes Alameda Alliance, Anthem, Alameda County Office of Education (ACOE), and Alameda County Center for Healthy Schools and Communities (CHSC) to provide strategic program direction
    - The Steering Group will advise in the development of an Alameda County Learning Exchange (LE) which will support targeted interventions and development of sustainability resources for LEAs

- The Alliance has hosted two SBHIP LEs; participants include LEAs and Steering Group Partners, with a focus on program updates, LEA project plan sharing, current school-based behavioral landscape, and goals for future LE sessions
- MOUs outlining Targeted Interventions activities and SBHIP program requirements were delivered to all eleven (11) participating LEAs on April 11th, 2023, and payments for the first 50% of the Targeted Interventions Allocation was made to nine (9) LEAs totaling $2.7M

Housing and Homelessness Incentive Program (HHIP) – DHCS program commenced January 1st, 2022, and continues through December 31st, 2023

- The Submission 1 (S1) Report for reporting period May 1st, 2022 – December 31st, 2022, was submitted to DHCS on March 10th, 2023
    - Received notification on June 1st that the Alliance had earned $13.7M or 88.6% of earnable dollars for our S1 Report, resulting in 92% of HHIP funds being earned to-date
- MOU between AAH and HCSA to define deliverables and milestones that must be met to receive funding was fully executed December 30th, 2022
    - HCSA has submitted seven (7) deliverables related to:
        - HHIP data reporting deliverable (received on February 15th, 2023)
        - Housing Financial Supports Progress Report (received on March 30th, 2023)
        - Street Medicine Data (received on January 13th and March 30th, 2023)
        - 2023 Q1 Housing Community Supports Capacity Building progress report (received April 20th, 2023)
    - As of June 30th, $6,008,000 in total payments has been delivered to HCSA for HHIP milestone completion
- Workgroup meetings continue with HCSA and Anthem Blue Cross, as well as internally, to implement Investment Plan initiatives related to street health, recuperative care coordination, medical respite, medically frail beds, data needs, and a recently approved housing community supports legal services pilot program

2024 Single Plan Model – activities related to the conversion from a two-plan model to a single plan model are being included under one comprehensive program

- Managed Care Contract Operational Readiness
    - Group 2 Deliverables Status
        - Total Deliverables submitted to DHCS – 171
            - Approved by DHCS – 161
            - In Review – 9
            - Additional Information Requests (AIR) – 1
        - Upcoming Q2 2023 Operational Readiness Deliverable Dates
            - Deliverables due 7/14/2023 – 7 total deliverables
            - Deliverables due 7/24/23 – 13 total deliverables
            - Deliverables due 8/4/23 – 14 total deliverables
            - Deliverables due 8/11/2023 – 9 total deliverables
            - Deliverables due 8/18/2023 – 4 total deliverables
- Anthem Member Transition – members currently assigned to Anthem will transition to AAH effective January 1st, 2024

- Planning for work related to member notification, provider contracting, data sharing, and Continuity of Care (CoC) has begun
- Kaiser Direct Contract – members currently assigned to AAH but delegated to Kaiser will transition to Kaiser effective January 1st, 2024
- Business Continuity Plan – required as part of our 2024 Operational Readiness
- Disaster Recovery Plan – required as part of our 2024 Operational Readiness

Portfolio Project Management (PPM) Tool – Team Dynamix (TDX) is the selected tool being implemented in a phased approach and started January 2023

- Implementation Phase
    - Reporting
        - Created procedures for building status and desktop reports
    - Security
        - Deployed Multi-Factor Authentication and Single Sign-on
    - Resource and Capacity Planning
        - Obtained TDX Process Consulting
- Work in Progress
    - Reporting
        - Review options for status report with management
        - Deploy status and desktop reports for active projects
    - Resource and Capacity Planning
        - Review setup for resource and capacity planning
        - Propose functional roles for groups that have reported resource capacity

Recruiting and Staffing

Project Management Open position(s):

- All positions have been filled

Integrated Planning

Supporting Documents

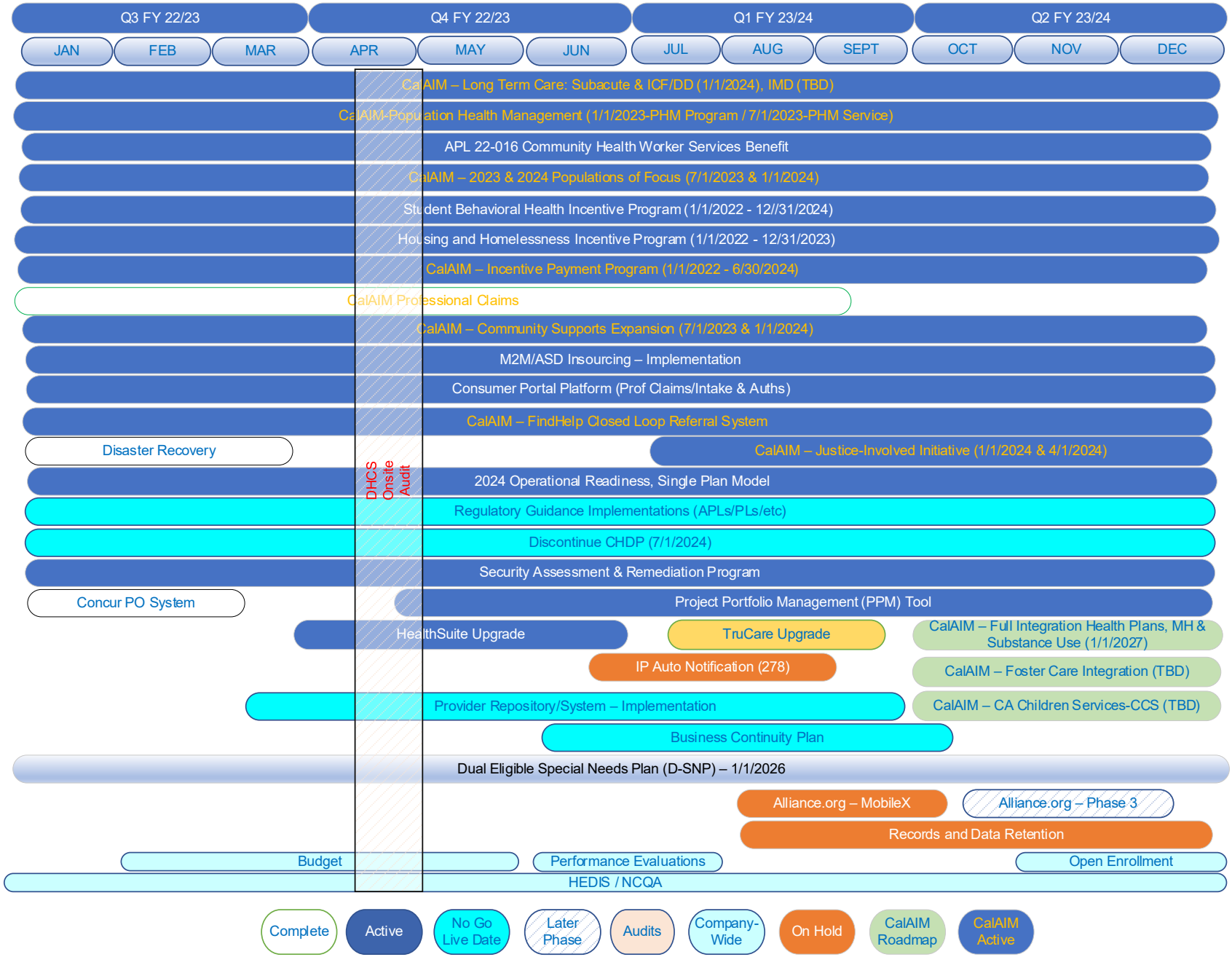
Project Descriptions

Key projects currently in-flight:

- California Advancing and Innovating Medi-Cal (CalAIM) – program to provide targeted and coordinated care for vulnerable populations with complex health needs
  - Enhanced Care Management (ECM) – ECM will target eight (8) 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 PoF became effective on January 1st, 2023
    - One (1) PoF will become effective on July 1st, 2023
    - Two (2) PoF will become effective on January 1st, 2024
  - 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
    - Three (3) additional CS services will be implemented on July 1st, 2023
    - Two (2) CS services that support the two LTC PoF that were effective January 2023 are being piloted in 2023 and scheduled for full implementation on January 1st, 2024
    - One (1) additional CS service is also targeted for implementation on January 1st, 2024
  - 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 - benefit was carved into all MCPs effective January 1st, 2023, with the exception of Subacute and ICF-DD facilities which are scheduled for implementation January 1st, 2024; IMD facilities implementation date TBD
  - Justice Involved Initiative – adults and children/youth transitioning from incarceration or juvenile facilities will be enrolled into Medi-Cal upon release
    - DHCS is finalizing policy and operational requirements for MCPs to implement the CalAIM Justice-Involved Initiative
      - MCPs must be prepared to go live with ECM for the Individuals Transitioning from Incarceration as of January 1st, 2024
      - MCPs must be prepared to coordinate with correctional facilities to support reentry of members as the return to the community by April 1st, 2024

        - Correctional facilities will have two years from 4/1/2024-3/31/2026 to go live based on readiness
    - Population Health Management (PHM) – all Medi-Cal managed care plans were required to develop and maintain a whole system, person-centered population health management strategy effective January 1st, 2023. PHM is a comprehensive, accountable plan of action for addressing Member needs and preferences, and building on their strengths and resiliencies across the continuum of care that:
        - Builds trust and meaningfully engages with Members;
        - Gathers, shares, and assesses timely and accurate data on Member preferences and needs to identify efficient and effective opportunities for intervention through processes such as data-driven risk stratification, predictive analytics, identification of gaps in care, and standardized assessment processes;
        - Addresses upstream factors that link to public health and social services;
        - Supports all Members staying healthy;
        - Provides care management for Members at higher risk of poor outcomes;
        - Provides transitional care services for Members transferring from one setting or level of care to another; and
        - Identifies and mitigates social drivers of health to reduce disparities
    - Dual Eligible Special Needs Plan (D-SNP) Implementation – All Medi-Cal MCPs will be required to operate Medicare Medi-Cal Plans (MMPs), the California-specific program name for Exclusively Aligned Enrollment Dual Eligible Special Needs Plans (EAE D-SNPs) by January 2026 in order to provide better coordination of care and improve care integration and person-centered care. Additionally, this transition will create both program and financial alignment, simplify administration and billing for providers and plans, and provide a more seamless experience for dual eligible beneficiaries by having one plan manage both sets of benefits for the beneficiary.
- Mental Health (Mild to Moderate/Autism Spectrum Disorder) Insourcing – services currently performed by Beacon Health Options were brought in-house effective April 1st, 2023
- Community Health Worker Services Benefit – Community Health Worker (CHW) services became a billable Medi-Cal benefit effective July 1st, 2022. CHW services are covered as preventive services on the written recommendation of a physician or other licensed practitioner of the healing arts within their scope of practice under state law for individuals who need such services to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and well-being
- 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
- 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
- 2024 Managed Care Plan Contract Operational Readiness – new MCP contract developed as part of Procurement RFP
    - All MCPs must adhere to new contract effective January 1, 2024
- Project Portfolio Management (PPM) Tool - Implementation of a PPM tool to support portfolio planning, resource capacity and demand planning and project scheduling


Q3 FY 22/23
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JAN
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CalAIM – Long Term Care: Subacute & ICF/DD (1/1/2024), IMD (TBD)
CalAIM-Population Health Management (1/1/2023-PHM Program / 7/1/2023-PHM Service)
APL 22-016 Community Health Worker Services Benefit
CalAIM – 2023 & 2024 Populations of Focus (7/1/2023 & 1/1/2024)
Student Behavioral Health Incentive Program (1/1/2022 - 12//31/2024)
Housing and Homelessness Incentive Program (1/1/2022 - 12/31/2023)
CalAIM – Incentive Payment Program (1/1/2022 - 6/30/2024)
CalAIM Professional Claims
CalAIM – Community Supports Expansion (7/1/2023 & 1/1/2024)
M2M/ASD Insourcing – Implementation
Consumer Portal Platform (Prof Claims/Intake & Auths)
CalAIM – FindHelp Closed Loop Referral System
Disaster Recovery
CalAIM – Justice-Involved Initiative (1/1/2024 & 4/1/2024)
DHCS Onsite Audit
2024 Operational Readiness, Single Plan Model
Regulatory Guidance Implementations (APLs/PLs/etc)
Discontinue CHDP (7/1/2024)
Security Assessment & Remediation Program
Concur PO System
Project Portfolio Management (PPM) Tool
HealthSuite Upgrade
TruCare Upgrade
CalAIM – Full Integration Health Plans, MH & Substance Use (1/1/2027)
IP Auto Notification (278)
CalAIM – Foster Care Integration (TBD)
Provider Repository/System – Implementation
CalAIM – CA Children Services-CCS (TBD)
Business Continuity Plan
Dual Eligible Special Needs Plan (D-SNP) – 1/1/2026
Alliance.org – MobileX
Alliance.org – Phase 3
Records and Data Retention
Budget
Performance Evaluations
Open Enrollment
HEDIS / NCQA
Complete
Active
No Go Live Date
Later Phase
Audits
Company-Wide
On Hold
CalAIM Roadmap
CalAIM Active

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

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

Date: **July 14th, 2023**

Subject: **Performance & Analytics Report**

Member Cost Analysis

The Member Cost Analysis below is based on the following 12 month rolling periods:

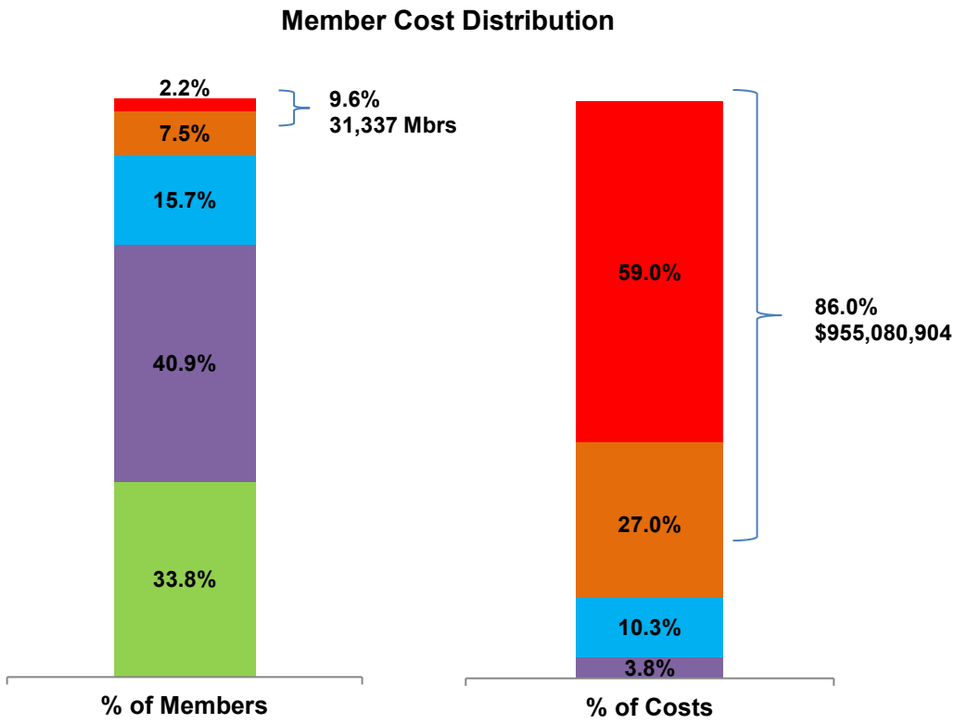
Current reporting period: April 2022 – March 2023 dates of service Prior reporting period: April 2021 – March 2022 dates of service (Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 9.6% of members account for 86.0% of total costs.
- In comparison, the Prior reporting period was lower at 9.1% of members accounting for 83.6% of total costs.
- Characteristics of the top utilizing population remained fairly consistent between the reporting periods:
    - The SPD (non duals) and ACA OE categories of aid decreased to account for 59.2% of the members, with SPDs accounting for 25.5% and ACA OE's at 33.7%.
    - The percent of members with costs >= $30K slightly increased from 1.9% to 2.2%.
    - Of those members with costs >= $100K, the percentage of total members remained consistent at 0.5%.
        - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 44.3%.
    - Demographics for member city and gender for members with costs >= $30K follow the same distribution as the overall Alliance population.
    - However, the age distribution of the top 9.6% is more concentrated in the 45-66 year old category (39.5%) compared to the overall population (20.6%).

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Apr 2022 - Mar 2023

Note: Data incomplete due to claims lag

Run Date: 06/29/2023



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	7,033	2.2%	$ 655,590,944	59.0%
$5K - $30K	24,304	7.5%	$ 299,489,960	27.0%
$1K - $5K	51,194	15.7%	$ 113,837,421	10.3%
< $1K	133,385	40.9%	$ 41,650,969	3.8%
$0	110,215	33.8%	$ -	0.0%
Totals	**326,131**	**100.0%**	**$ 1,110,569,294**	**100.0%**

Top 9.6% of Members = 86.0% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	1,694	0.5%	$ 381,638,645	34.4%
$75K to $100K	740	0.2%	$ 64,075,500	5.8%
$50K to $75K	1,475	0.5%	$ 89,831,382	8.1%
$40K to $50K	1,227	0.4%	$ 54,617,148	4.9%
$30K to $40K	1,897	0.6%	$ 65,428,268	5.9%
SubTotal	***7,033***	***2.2%***	***$ 655,590,944***	***59.0%***
$20K to $30K	3,387	1.0%	$ 82,614,172	7.4%
$10K to $20K	9,496	2.9%	$ 135,386,045	12.2%
$5K to $10K	11,421	3.5%	$ 81,489,743	7.3%
SubTotal	***24,304***	***7.5%***	***$ 299,489,960***	***27.0%***
Total	**31,337**	***9.6%***	**$ 955,080,904**	***86.0%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Mar 2023	303,353	$ 1,015,215,181
Dis-Enrolled During Year	22,778	$ 95,354,113
Totals	**326,131**	**$ 1,110,569,294**

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

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
9.6% of Members = 86.0% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Apr 2022 - Mar 2023
Note: Data incomplete due to claims lag
Run Date: 06/29/2023

9.6% of Members = 86.0% of Costs
25.5% of members are SPDs and account for 31.8% of costs.
33.7% of members are ACA OE and account for 34.5% of costs.
5.2% of members disenrolled as of Mar 2023 and account for 9.3% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	135	616	751	2.4%
MCAL	MCAL - ADULT	790	4,406	5,196	16.6%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	356	1,986	2,342	7.5%
	MCAL - ACA OE	2,441	8,121	10,562	33.7%
	MCAL - SPD	2,499	5,489	7,988	25.5%
	MCAL - DUALS	154	1,915	2,069	6.6%
	MCAL - LTC	32	79	111	0.4%
	MCAL - LTC-DUAL	23	672	695	2.2%
Not Eligible	Not Eligible	603	1,020	1,623	5.2%
Total		**7,033**	**24,304**	**31,337**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 10,860,027	$ 6,933,819	$ 17,793,847	1.9%
MCAL	MCAL - ADULT	$ 68,149,189	$ 51,012,042	$ 119,161,231	12.5%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 24,052,496	$ 23,238,234	$ 47,290,730	5.0%
	MCAL - ACA OE	$ 230,854,443	$ 98,387,581	$ 329,242,024	34.5%
	MCAL - SPD	$ 231,712,280	$ 71,759,091	$ 303,471,371	31.8%
	MCAL - DUALS	$ 11,628,121	$ 23,879,940	$ 35,508,062	3.7%
	MCAL - LTC	$ 1,322,449	$ 1,354,536	$ 2,676,985	0.3%
	MCAL - LTC-DUAL	$ 808,456	$ 10,036,532	$ 10,844,989	1.1%
Not Eligible	Not Eligible	$ 76,203,482	$ 12,888,183	$ 89,091,666	9.3%
Total		**$ 655,590,944**	**$ 299,489,960**	**$ 955,080,904**	**100.0%**

Highest Cost Members; Cost Per Member >= $100K
37.0% of members are SPDs and account for 35.3% of costs.
34.2% of members are ACA OE and account for 35.5% of costs.
14.0% of members disenrolled as of Mar 2023 and account for 14.5% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	28	1.7%
MCAL	MCAL - ADULT	156	9.2%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	39	2.3%
	MCAL - ACA OE	579	34.2%
	MCAL - SPD	627	37.0%
	MCAL - DUALS	27	1.6%
	MCAL - LTC	-	0.0%
	MCAL - LTC-DUAL	-	0.0%
Not Eligible	Not Eligible	238	14.0%
Total		**1,694**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 5,307,564	1.4%
MCAL	MCAL - ADULT	$ 36,740,236	9.6%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 8,960,018	2.3%
	MCAL - ACA OE	$ 135,380,117	35.5%
	MCAL - SPD	$ 134,803,089	35.3%
	MCAL - DUALS	$ 4,996,990	1.3%
	MCAL - LTC	$ -	0.0%
	MCAL - LTC-DUAL	$ -	0.0%
Not Eligible	Not Eligible	$ 55,450,630	14.5%
Total		**$ 381,638,645**	**100.0%**

% of Total Costs By Service Type

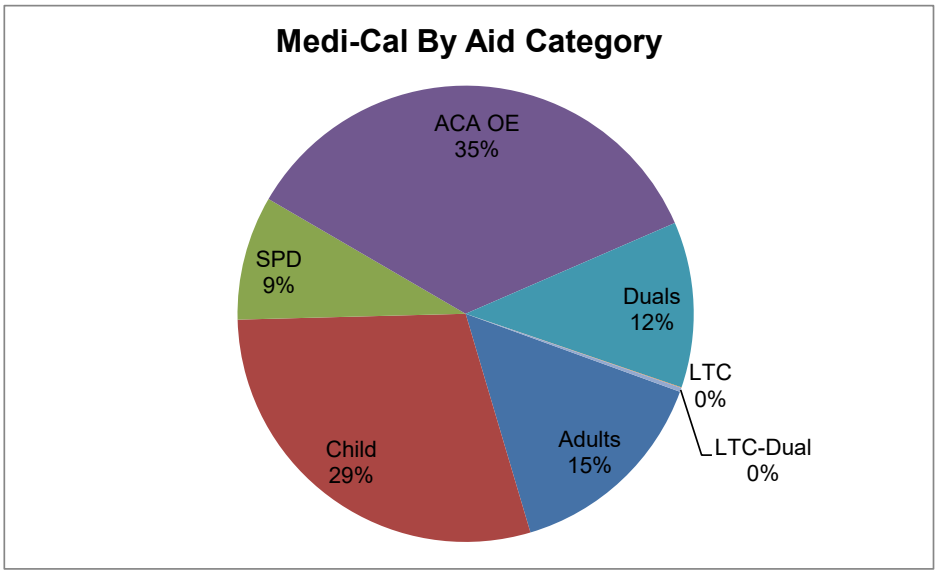
Breakout by Service Type/Location

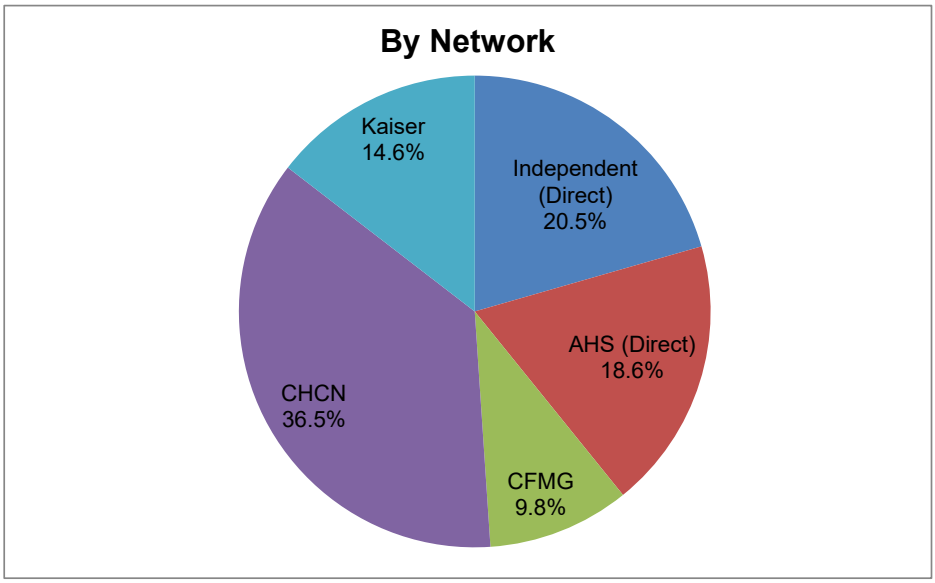
Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
$100K+	8%	0%	1%	0%	53%	1%	14%	5%	2%	6%
$75K to $100K	6%	0%	1%	1%	41%	3%	7%	4%	8%	13%
$50K to $75K	5%	0%	2%	1%	36%	3%	8%	7%	6%	13%
$40K to $50K	6%	0%	2%	1%	36%	5%	5%	5%	2%	14%
$30K to $40K	10%	0%	3%	0%	26%	11%	6%	6%	1%	16%
$20K to $30K	3%	1%	4%	0%	26%	6%	7%	6%	1%	19%
$10K to $20K	1%	0%	10%	1%	24%	5%	9%	8%	2%	21%
$5K to $10K	0%	0%	10%	1%	18%	7%	11%	13%	1%	19%
Total	**6%**	**0%**	**3%**	**0%**	**39%**	**4%**	**11%**	**6%**	**2%**	**13%**

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

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Current Membership by Network By Category of Aid							
Category of Aid	**May 2023**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	52,677	15%	9,986	10,125	852	22,060	9,654
Child	103,434	29%	7,353	9,463	31,831	35,443	19,344
SPD	31,201	9%	10,166	4,567	1,106	13,094	2,268
ACA OE	124,397	35%	18,046	39,551	1,346	48,620	16,834
Duals	41,652	12%	25,088	2,565	3	9,670	4,326
LTC	148	0%	148	-	-	-	-
LTC-Dual	1,003	0%	1,003	-	-	-	-
Medi-Cal	354,512		71,790	66,271	35,138	128,887	52,426
Group Care	5,670		2,226	842	-	2,602	-
Total	**360,182**	**100%**	**74,016**	**67,113**	**35,138**	**131,489**	**52,426**
Medi-Cal %	98.4%		97.0%	98.7%	100.0%	98.0%	100.0%
Group Care %	1.6%		3.0%	1.3%	0.0%	2.0%	0.0%
	Network Distribution		*20.5%*	*18.6%*	*9.8%*	*36.5%*	*14.6%*
			% Direct:	**39%**		**% Delegated:**	**61%**

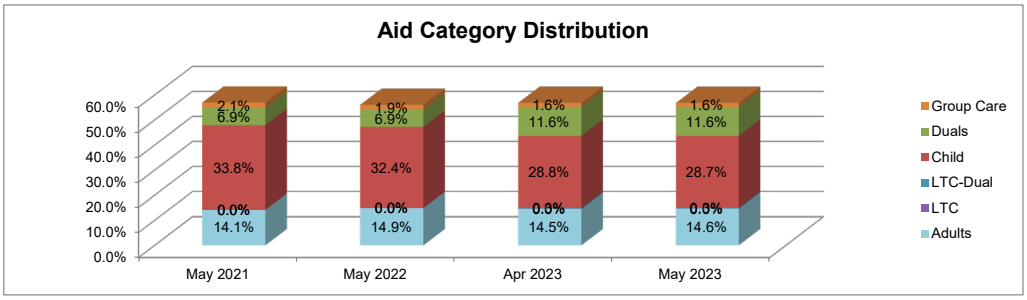




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

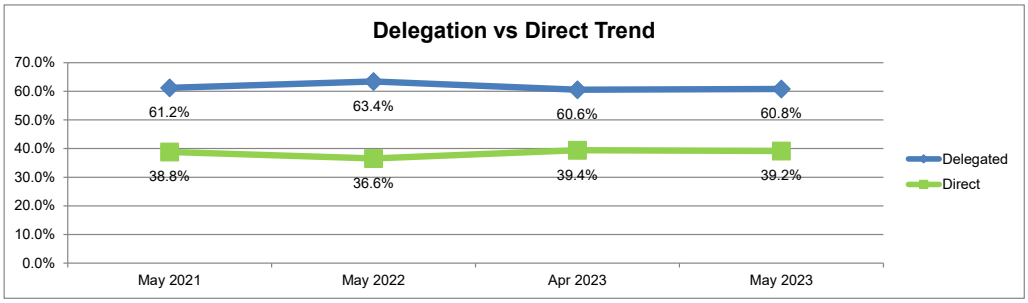
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	May 2021	May 2022	Apr 2023	May 2023	May 2021	May 2022	Apr 2023	May 2023	May 2021 to May 2022	May 2022 to May 2023	Apr 2023 to May 2023
Adults	40,561	46,171	52,047	52,677	14.1%	14.9%	14.5%	14.6%	13.8%	14.1%	1.2%
Child	96,782	100,560	103,173	103,434	33.8%	32.4%	28.8%	28.7%	3.9%	2.9%	0.3%
SPD	26,289	26,958	31,130	31,201	9.2%	8.7%	8.7%	8.7%	2.5%	15.7%	0.2%
ACA OE	97,325	109,734	123,606	124,397	33.9%	35.3%	34.5%	34.5%	12.8%	13.4%	0.6%
Duals	19,851	21,527	41,473	41,652	6.9%	6.9%	11.6%	11.6%	8.4%	93.5%	0.4%
LTC	-	-	145	148	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.1%
LTC-Dual	-	-	983	1,003	0.0%	0.0%	0.3%	0.3%	0.0%	0.0%	2.0%
Medi-Cal Total	280,808	304,950	352,557	354,512	97.9%	98.1%	98.4%	98.4%	8.6%	16.3%	0.6%
Group Care	5,949	5,808	5,669	5,670	2.1%	1.9%	1.6%	1.6%	-2.4%	-2.4%	0.0%
Total	**286,757**	**310,758**	**358,226**	**360,182**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**8.4%**	**15.9%**	**0.5%**



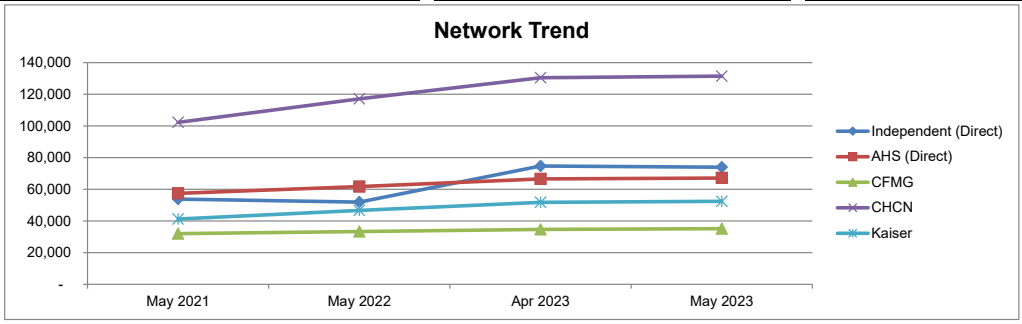
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	May 2021	May 2022	Apr 2023	May 2023	May 2021	May 2022	Apr 2023	May 2023	May 2021 to May 2022	May 2022 to May 2023	Apr 2023 to May 2023
Delegated	175,503	197,155	216,961	219,053	61.2%	63.4%	60.6%	60.8%	12.3%	11.1%	1.0%
Direct	111,254	113,603	141,265	141,129	38.8%	36.6%	39.4%	39.2%	2.1%	24.2%	-0.1%
Total	**286,757**	**310,758**	**358,226**	**360,182**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**8.4%**	**15.9%**	**0.5%**



Network Trend

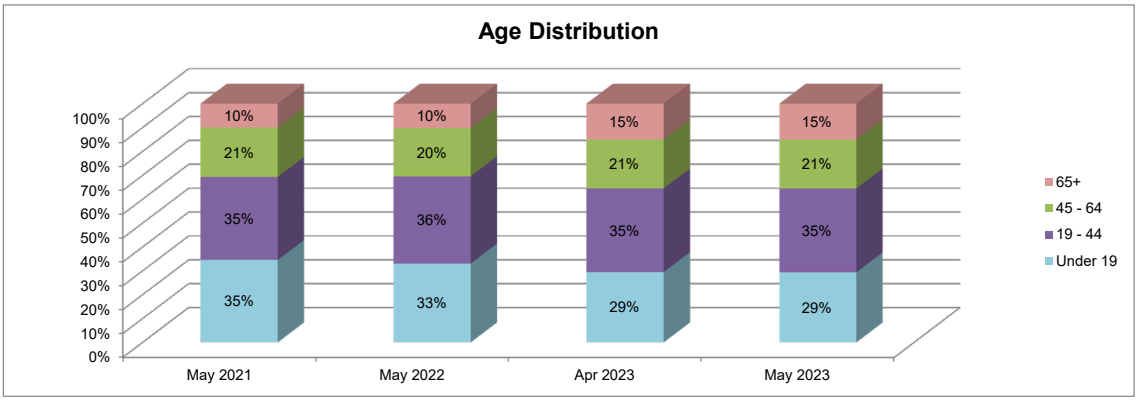
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	May 2021	May 2022	Apr 2023	May 2023	May 2021	May 2022	Apr 2023	May 2023	May 2021 to May 2022	May 2022 to May 2023	Apr 2023 to May 2023
Independent (Direct)	53,817	51,910	74,713	74,016	18.8%	16.7%	20.9%	20.5%	-3.5%	42.6%	-0.9%
AHS (Direct)	57,437	61,693	66,552	67,113	20.0%	19.9%	18.6%	18.6%	7.4%	8.8%	0.8%
CFMG	32,001	33,378	34,644	35,138	11.2%	10.7%	9.7%	9.8%	4.3%	5.3%	1.4%
CHCN	102,275	117,163	130,508	131,489	35.7%	37.7%	36.4%	36.5%	14.6%	12.2%	0.8%
Kaiser	41,227	46,614	51,809	52,426	14.4%	15.0%	14.5%	14.6%	13.1%	12.5%	1.2%
Total	**286,757**	**310,758**	**358,226**	**360,182**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**8.4%**	**15.9%**	**0.5%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

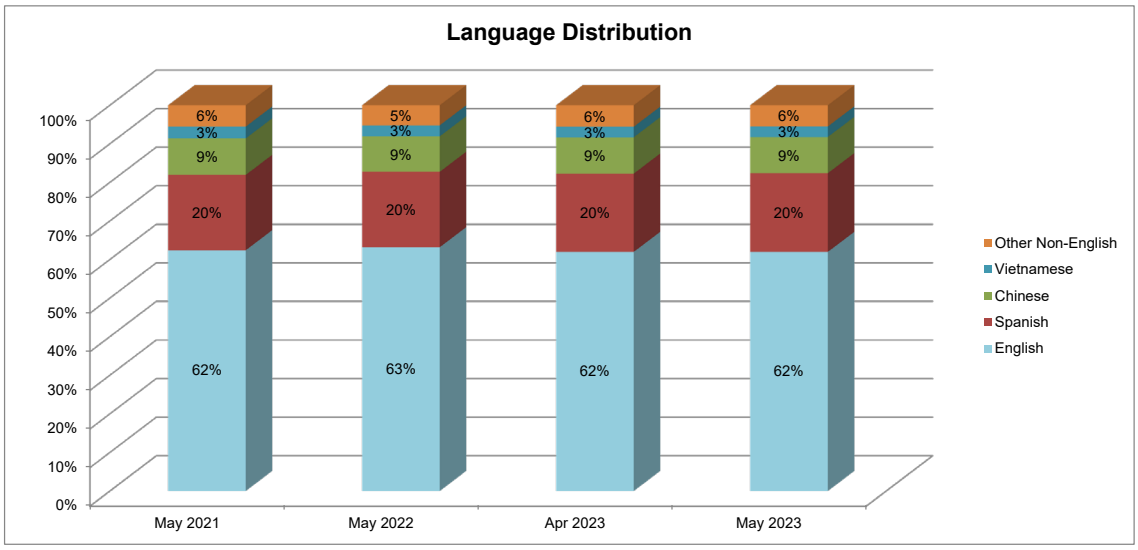
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	May 2021	May 2022	Apr 2023	May 2023	May 2021	May 2022	Apr 2023	May 2023	May 2021 to May 2022	May 2022 to May 2023	Apr 2023 to May 2023
Under 19	99,140	102,823	105,525	105,787	35%	33%	29%	29%	4%	3%	0%
19 - 44	99,528	113,325	125,496	126,401	35%	36%	35%	35%	14%	12%	1%
45 - 64	59,512	63,061	73,669	74,095	21%	20%	21%	21%	6%	17%	1%
65+	28,577	31,549	53,536	53,899	10%	10%	15%	15%	10%	71%	1%
Total	**286,757**	**310,758**	**358,226**	**360,182**	**100%**	**100%**	**100%**	**100%**	**8%**	**16%**	**1%**



Language Trend

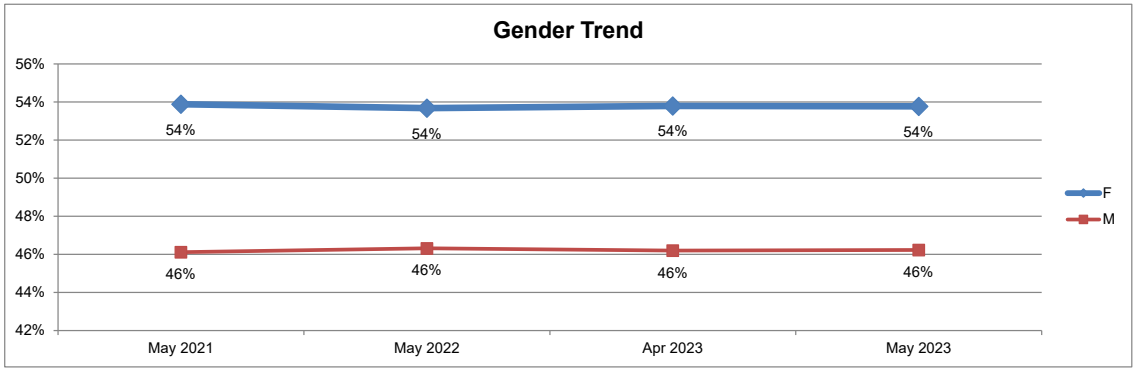
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	May 2021	May 2022	Apr 2023	May 2023	May 2021	May 2022	Apr 2023	May 2023	May 2021 to May 2022	May 2022 to May 2023	Apr 2023 to May 2023
English	178,901	196,309	221,974	223,164	62%	63%	62%	62%	10%	14%	1%
Spanish	56,029	60,778	72,728	73,539	20%	20%	20%	20%	8%	21%	1%
Chinese	27,121	28,583	33,747	33,819	9%	9%	9%	9%	5%	18%	0%
Vietnamese	8,787	8,868	9,787	9,828	3%	3%	3%	3%	1%	11%	0%
Other Non-English	15,919	16,220	19,990	19,832	6%	5%	6%	6%	2%	22%	-1%
Total	**286,757**	**310,758**	**358,226**	**360,182**	**100%**	**100%**	**100%**	**100%**	**8%**	**16%**	**1%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

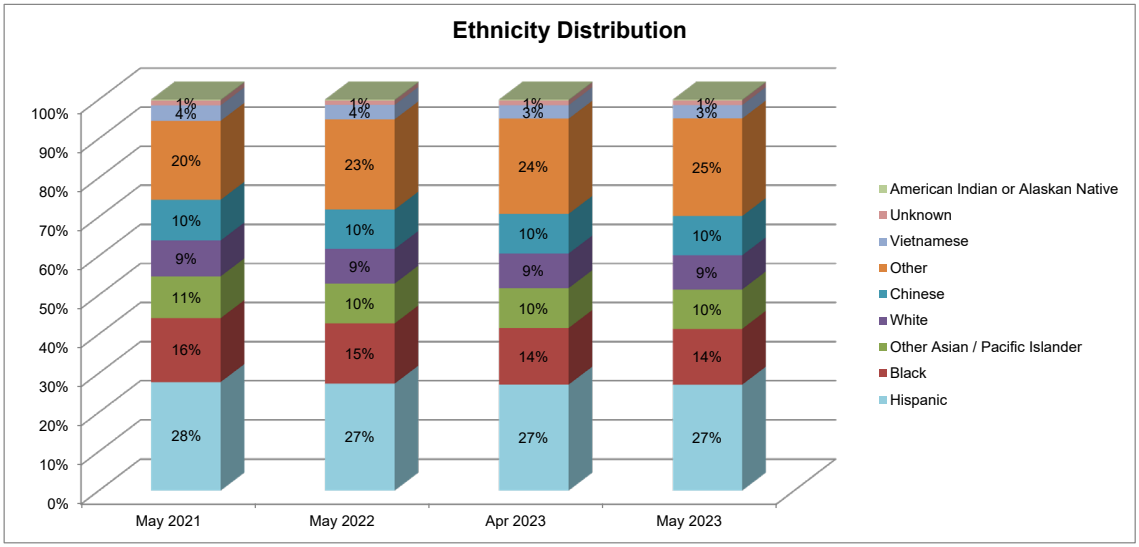
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	May 2021	May 2022	Apr 2023	May 2023	May 2021	May 2022	Apr 2023	May 2023	May 2021 to May 2022	May 2022 to May 2023	Apr 2023 to May 2023
F	154,516	166,816	192,712	193,677	54%	54%	54%	54%	8%	16%	1%
M	132,241	143,942	165,514	166,505	46%	46%	46%	46%	9%	16%	1%
Total	**286,757**	**310,758**	**358,226**	**360,182**	**100%**	**100%**	**100%**	**100%**	**8%**	**16%**	**1%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	May 2021	May 2022	Apr 2023	May 2023	May 2021	May 2022	Apr 2023	May 2023	May 2021 to May 2022	May 2022 to May 2023	Apr 2023 to May 2023
Hispanic	79,509	84,892	96,968	97,427	28%	27%	27%	27%	7%	15%	0%
Black	46,929	47,883	51,913	51,493	16%	15%	14%	14%	2%	8%	-1%
Other Asian / Pacific Islander	30,597	31,631	36,482	36,245	11%	10%	10%	10%	3%	15%	-1%
White	26,358	27,619	31,763	31,499	9%	9%	9%	9%	5%	14%	-1%
Chinese	29,855	31,216	36,306	36,159	10%	10%	10%	10%	5%	16%	0%
Other	57,913	71,778	87,251	89,867	20%	23%	24%	25%	24%	25%	3%
Vietnamese	11,322	11,444	12,333	12,326	4%	4%	3%	3%	1%	8%	0%
Unknown	3,648	3,620	4,471	4,425	1%	1%	1%	1%	-1%	22%	-1%
American Indian or Alaskan Native	626	675	739	741	0%	0%	0%	0%	8%	10%	0%
Total	**286,757**	**310,758**	**358,226**	**360,182**	**100%**	**100%**	**100%**	**100%**	**8%**	**16%**	**1%**



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

Medi-Cal By City

City	May 2023	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	136,686	39%	19,550	30,877	14,502	56,964	14,793
Hayward	55,713	16%	10,591	12,026	5,813	17,866	9,417
Fremont	33,176	9%	12,887	4,938	1,230	8,871	5,250
San Leandro	31,967	9%	6,447	4,442	3,588	11,638	5,852
Union City	15,136	4%	5,356	2,279	627	4,102	2,772
Alameda	13,634	4%	2,889	2,124	1,731	4,682	2,208
Berkeley	13,556	4%	2,587	1,864	1,367	5,708	2,030
Livermore	10,906	3%	1,614	683	1,982	4,711	1,916
Newark	8,424	2%	2,520	2,630	294	1,523	1,457
Castro Valley	8,960	3%	1,880	1,334	1,132	2,706	1,908
San Lorenzo	7,394	2%	1,286	1,252	724	2,658	1,474
Pleasanton	6,210	2%	1,479	396	563	2,719	1,053
Dublin	6,588	2%	1,522	430	697	2,744	1,195
Emeryville	2,464	1%	514	445	317	766	422
Albany	2,199	1%	328	228	420	792	431
Piedmont	462	0%	94	129	28	101	110
Sunol	79	0%	20	9	6	27	17
Antioch	30	0%	3	7	9	8	3
Other	928	0%	223	178	108	301	118
Total	**354,512**	**100%**	**71,790**	**66,271**	**35,138**	**128,887**	**52,426**

Group Care By City

City	May 2023	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	1,817	32%	412	332	-	1,073	-
Hayward	632	11%	302	139	-	191	-
Fremont	612	11%	426	51	-	135	-
San Leandro	570	10%	216	87	-	267	-
Union City	308	5%	203	32	-	73	-
Alameda	282	5%	104	17	-	161	-
Berkeley	164	3%	52	12	-	100	-
Livermore	89	2%	29	3	-	57	-
Newark	140	2%	84	35	-	21	-
Castro Valley	189	3%	83	25	-	81	-
San Lorenzo	129	2%	49	15	-	65	-
Pleasanton	62	1%	24	3	-	35	-
Dublin	109	2%	38	8	-	63	-
Emeryville	33	1%	13	5	-	15	-
Albany	18	0%	5	1	-	12	-
Piedmont	13	0%	3	-	-	10	-
Sunol	-	0%	-	-	-	-	-
Antioch	22	0%	6	6	-	10	-
Other	481	8%	177	71	-	233	-
Total	**5,670**	**100%**	**2,226**	**842**	**-**	**2,602**	**-**

Total By City

City	May 2023	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	138,503	38%	19,962	31,209	14,502	58,037	14,793
Hayward	56,345	16%	10,893	12,165	5,813	18,057	9,417
Fremont	33,788	9%	13,313	4,989	1,230	9,006	5,250
San Leandro	32,537	9%	6,663	4,529	3,588	11,905	5,852
Union City	15,444	4%	5,559	2,311	627	4,175	2,772
Alameda	13,916	4%	2,993	2,141	1,731	4,843	2,208
Berkeley	13,720	4%	2,639	1,876	1,367	5,808	2,030
Livermore	10,995	3%	1,643	686	1,982	4,768	1,916
Newark	8,564	2%	2,604	2,665	294	1,544	1,457
Castro Valley	9,149	3%	1,963	1,359	1,132	2,787	1,908
San Lorenzo	7,523	2%	1,335	1,267	724	2,723	1,474
Pleasanton	6,272	2%	1,503	399	563	2,754	1,053
Dublin	6,697	2%	1,560	438	697	2,807	1,195
Emeryville	2,497	1%	527	450	317	781	422
Albany	2,217	1%	333	229	420	804	431
Piedmont	475	0%	97	129	28	111	110
Sunol	79	0%	20	9	6	27	17
Antioch	52	0%	9	13	9	18	3
Other	1,409	0%	400	249	108	534	118
Total	**360,182**	**100%**	**74,016**	**67,113**	**35,138**	**131,489**	**52,426**

ALAMEDA Alliance FOR HEALTH

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Human Resources

Anastacia Swift

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

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

Date: **July 14th, 2023**

Subject: **Human Resources Report**

Staffing

- As of July 1st, 2023, the Alliance had 479 full time employees and 1-part time employee.

- On July 1st, 2023, the Alliance had 39 open positions in which 9 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 30 positions open to date. The Alliance is actively recruiting for the remaining 30 positions and several of these positions are in the interviewing or job offer stage.

- Summary of open positions by department:

Department	Open Positions July 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	11	4	7
Operations	16	2	14
Healthcare Analytics	5	2	3
Information Technology	3	0	3
Finance	2	0	2
Compliance & Legal	0	0	0
Human Resources	1	1	0
Health Equity	1	0	1
Integrated Planning	0	0	0
Total	39	9	30

- Our current recruitment rate is 8%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in June 2023 included:
    - 6 years:
        - Judith Foster (Member Services)
        - Karen Mejia (Case/Disease Management)
        - Brittany Nielsen (Healthcare Analytics)
    - 7 years:
        - Sherry Roces (Utilization Management)
    - 8 years:
        - Tiana Rivas (Provider Services)
        - Latrice Allen (Claims)
        - Jeanette Murray (Health Equity)
    - 11 years:
        - Marcie Sperling-Bullock (Claims)
        - Thuan Le (Claims)
    - 12 years:
        - Eileen Ahn (Regulatory Readiness)
        - Elisea Toscano Cochrane (Case/Disease Management)
    - 15 years:
        - Annie Wong (Healthcare Analytics)
    - 16 years:
        - Cindy Brazil (Quality Management)
    - 26 years:
        - Monina Malonzo Rayo (Claims)
    - 27 years:
        - Angie Vaziri (Member Services)

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DETAILED APPENDIX

Please click on the hyperlink(s) below to direct you to corresponding material for each item.

Legislative Tracking	Page 617
Finance Supporting Documents	Page 456
Operations Supporting Documents	Page 529
Information Technology Supporting Documents	Page 574
Integrated Planning Supporting Documents	Page 600
Analytics Supporting Documents	Page 606

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Legislative Tracking

July 2023 Legislative Tracking List

The California State Legislature reconvened the 2023-2024 Legislative Session the first week of January 2023. Summer Recess will begin on July 14th, 2023 which will be the last day for policy committees to meet and report bills before the Legislature reconvenes on August 14th, 2023. The following is a list of state bills tracked by the Public Affairs and Compliance Departments that have been introduced during the 2023 Legislative Session. These bills are of interest to and could have a direct impact on Alameda Alliance for Health and its membership.

AB 4 **(Arambula D) Covered California: expansion.**
Current Text: Amended: 6/27/2023 html pdf
Last Amend: 6/27/2023
Status: 6/27/2023-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.
Location: 6/7/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Current state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under the Patient Protection and Affordable Care Act (PPACA). Current law requires the Exchange to apply for a federal waiver to allow persons otherwise not able to obtain coverage through the Exchange because of their immigration status to obtain coverage from the Exchange. This bill would delete that requirement and would instead require the Exchange, in consultation with stakeholders and the Legislature, to develop options for expanding access to affordable health care coverage to Californians regardless of immigration status. The bill would require the Exchange to report those options to the Legislature and Governor on or before February 1st, 2024, and would require the Exchange to post the report publicly on its internet website.

AB 33 **(Bains D) Fentanyl Addiction and Overdose Prevention Task Force.**
Current Text: Amended: 6/14/2023 html pdf
Last Amend: 6/14/2023
Status: 6/28/2023-From committee: Do pass and re-refer to Com. on APPR with recommendation: To Consent Calendar. (Ayes 5. Noes 0.) (June 27). Re-referred to Com. on APPR.
Location: 6/27/2023-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Would, subject to an appropriation, establish the Fentanyl Addiction and Overdose Prevention Task Force to undertake various duties relating to fentanyl abuse, including, among others, collecting and organizing data on the nature and extent of fentanyl abuse in California and evaluating approaches to increase public awareness of fentanyl abuse. The bill would require the task force to be cochaired by the Attorney General and the Surgeon General, or their designees, and would specify the membership of the task force.

AB 47 **(Boerner D) Pelvic floor physical therapy coverage.**
Current Text: Introduced: 12/5/2022 html pdf
Status: 4/28/2023-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 12/5/2022)(May be acted upon Jan 2024)
Location: 4/28/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1st, 2024, to provide coverage for pelvic floor physical therapy after pregnancy. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

AB 48 **(Aguiar-Curry D) Nursing Facility Resident Informed Consent Protection Act of 2023.**
Current Text: Amended: 3/16/2023 html pdf
Last Amend: 3/16/2023
Status: 6/28/2023-From committee: Do pass and re-refer to Com. on APPR with recommendation: To Consent Calendar. (Ayes 11. Noes 0.) (June 27). Re-referred to Com. on APPR.
Location: 6/28/2023-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law provides for the licensure and regulation of health facilities, including skilled nursing facilities and intermediate care facilities, by the State Department of Public Health. Current law requires skilled nursing facilities and intermediate care facilities to have written policies regarding the rights of patients. This bill would add to these rights the right of every resident to receive the information that is material to an individual's informed consent decision concerning whether to accept or refuse the administration of psychotherapeutic drugs, as specified. This bill would also add the right to be free from psychotherapeutic drugs used for the purpose of resident discipline, convenience, or chemical restraint, except in an emergency that threatens to cause immediate injury to the resident or others. This bill would make the prescriber responsible for disclosing the material information relating to psychotherapeutic drugs to the resident and obtaining their informed consent, as defined.

AB 55 **(Rodriguez D) Medi-Cal: workforce adjustment for ground ambulance transports.**
Current Text: Amended: 4/27/2023 html pdf
Last Amend: 4/27/2023
Status: 5/19/2023-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/10/2023)(May be acted upon Jan 2024)
Location: 5/19/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law requires, with exceptions, that Medi-Cal reimbursement to providers of emergency medical transports be increased by application of an add-on to the associated Medi-Cal fee-for-service payment schedule. Under current law, those increased payments are funded solely

from a quality assurance fee (QAF), which emergency medical transport providers are required to pay based on a specified formula, and from federal reimbursement and any other related federal funds. Current law sets forth separate provisions for increased Medi-Cal reimbursement to providers of ground emergency medical transportation services that are owned or operated by certain types of public entities. This bill would establish, for dates of service on or after July 1st, 2024, a workforce adjustment, serving as an additional payment, for each ground ambulance transport performed by a provider of medical transportation services, excluding the above-described public entity providers. The bill would vary the rate of adjustment depending on the point of pickup and whether the service was for an emergency or nonemergency, with the workforce adjustment being equal to 80% of the lowest maximum allowance established by the federal Medicare Program reduced by the fee-for-service payment schedule amount, as specified.

AB 85 **(Weber D) Social determinants of health: screening and outreach.**
Current Text: Amended: 7/3/2023 html pdf
Last Amend: 7/3/2023
Status: 7/3/2023-Read second time and amended. Re-referred to Com. on APPR.
Location: 6/29/2023-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would, upon specified appropriations by the Legislature, require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to include coverage for screenings for social determinants of health, as defined. The bill would require providers to use specified tools or protocols when documenting patient responses to questions asked in these screenings.

AB 90 **(Petrie-Norris D) Family PACT Program: contraceptive device coverage.**
Current Text: Introduced: 1/5/2023 html pdf
Status: 6/7/2023-Referred to Com. on HEALTH.
Location: 6/7/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law establishes the Family Planning, Access, Care, and Treatment (Family PACT) Program, administered by the Office of Family Planning within the State Department of Health Care Services, 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. Under current law, those comprehensive clinical family planning services include coverage for contraceptive devices approved by the federal Food and Drug Administration. This bill would clarify that Family PACT comprehensive clinical family planning services include inpatient services relating to the placement or insertion of a contraceptive device.

AB 101 **(Ting D) Budget Act of 2023.**
Current Text: Amended: 6/11/2023 html pdf
Last Amend: 6/11/2023
Status: 6/15/2023-Read second time. Ordered to third reading.

Location: 6/15/2023-S. THIRD READING

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: This bill would make appropriations for the support of state government for the 2023–24 fiscal year. This bill contains other related provisions.

AB 102 **(Ting D) Budget Act of 2023.**
Current Text: Enrollment: 6/27/2023 html pdf
Last Amend: 6/24/2023
Status: 6/27/2023-Read second time. Ordered to third reading. Senate Rules Suspended (32-8) Read third time. Passed. Ordered to the Assembly. (Ayes 32. Noes 6.). In Assembly. Concurrence in Senate amendments pending. May be considered on or after June 29 pursuant to Assembly Rule 77. Assembly Rule 63 suspended. Assembly Rule 77 suspended. Senate amendments concurred in. To Engrossing and Enrolling. (Ayes 62. Noes 14.). Enrolled and presented to the Governor at 4:30 p.m.
Location: 6/27/2023-A. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would amend the Budget Act of 2023 by amending, adding, and repealing items of appropriation and making other changes. This bill would declare that it is to take effect immediately as a Budget Bill.

AB 103 **(Ting D) Budget Acts of 2021 and 2022.**
Current Text: Chaptered: 6/30/2023 html pdf
Last Amend: 6/24/2023
Status: 6/30/2023-Approved by the Governor. Chaptered by Secretary of State - Chapter 33, Statutes of 2023.
Location: 6/30/2023-A. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would amend the Budget Act of 2021 and Budget Act of 2022 by amending and adding items of appropriation and making other changes. The bill would declare that it is to take effect immediately as a Budget Bill.

AB 118 **(Committee on Budget) Budget Act of 2023: health.**
Current Text: Enrollment: 6/27/2023 html pdf
Last Amend: 6/24/2023
Status: 6/27/2023-Read second time. Ordered to third reading. Senate Rules Suspended (32-8) Read third time. Passed. Ordered to the Assembly. (Ayes 34. Noes 2.). In Assembly. Concurrence in Senate amendments pending. May be considered on or after June 29 pursuant to Assembly Rule 77. Assembly Rule 63 suspended. Assembly Rule 77 suspended. Senate amendments concurred in. To Engrossing and Enrolling. (Ayes 64. Noes 9.). Enrolled and presented to the Governor at 4:30 p.m.
Location: 6/27/2023-A. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

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 a health care service plan to provide disclosures regarding the benefits, services, and terms of the plan contract, as specified, to provide the public, subscribers, and enrollees with a full and fair disclosure of the provisions of the plan. This bill would require the department to develop standard templates for the disclosure form and evidence of coverage, to include, among other things, standard definitions, benefit descriptions, and any other information that the director determines, consistent with the goals of providing fair disclosures of the provisions of a health care service plan. The bill would require the department to consult with the Department of Insurance and interested stakeholders in developing the standard templates. The bill would require health care service plans, beginning January 1, 2025, to use the standard templates for any disclosure form or evidence of coverage published or distributed, except as specified. Because a willful violation of these requirements is a crime, the bill would impose a state-mandated local program.

AB 119 **(Committee on Budget) Medi-Cal: managed care organization provider tax.**
Current Text: Chaptered: 6/29/2023 html pdf
Last Amend: 6/24/2023
Status: 6/29/2023-Approved by the Governor. Chaptered by Secretary of State - Chapter 13, Statutes of 2023.
Location: 6/29/2023-A. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law, inoperative on January 1st, 2023, and to be repealed on January 1st, 2024, imposed a managed care organization (MCO) provider tax, administered and assessed by the department, on licensed health care service plans and managed care plans contracted with the State Department of Health Care Services to provide full-scope Medi-Cal services. Those provisions set forth taxing tiers and corresponding per enrollee tax amounts for the 2019–20, 2020–21, and 2021–22 fiscal years, and the first 6 months of the 2022–23 fiscal year. Under those provisions, all revenues, less refunds, derived from the tax were deposited into the State Treasury to the credit of the Health Care Services Special Fund, and continuously appropriated to the department for purposes of funding the nonfederal share of Medi-Cal managed care rates, as specified. Those inoperative provisions authorized the department, subject to certain conditions, to modify or make adjustments to any methodology, tax amount, taxing tier, or other provision relating to the MCO provider tax to the extent the department deemed necessary to meet federal requirements, to obtain or maintain federal approval, or to ensure federal financial participation was available or was not otherwise jeopardized. Those provisions required the department to request approval from the federal Centers for Medicare and Medicaid Services (CMS) as was necessary to implement those provisions. This bill would repeal those inoperative provisions. The bill would restructure the MCO provider tax, with certain modifications to the above-described provisions, including changes to the taxing tiers and tax amounts, for purposes of the tax periods of April 1st, 2023, through December 31st, 2023, and the 2024, 2025, and 2026 calendar years. The bill would create the Managed Care Enrollment Fund to

replace the Health Care Services Special Fund.

AB 120 **(Committee on Budget) Human services.**
Current Text: Enrollment: 6/27/2023 html pdf
Last Amend: 6/24/2023
Status: 6/27/2023-Read second time. Ordered to third reading. Senate Rules Suspended (32-8) Read third time. Passed. Ordered to the Assembly. (Ayes 32. Noes 6.). In Assembly. Concurrence in Senate amendments pending. May be considered on or after June 29 pursuant to Assembly Rule 77. Assembly Rule 63 suspended. Assembly Rule 77 suspended. Senate amendments concurred in. To Engrossing and Enrolling. (Ayes 61. Noes 10.). Enrolled and presented to the Governor at 4:30 p.m.
Location: 6/27/2023-A. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The California Community Care Facilities Act provides for the licensing and regulation of community care facilities, including group home facilities, short-term residential therapeutic programs (STRTPs), and adult residential facilities (ARFs), by the State Department of Social Services. Under existing law, the department similarly regulates residential care facilities for the elderly. A violation of provisions relating to these facilities is a misdemeanor. Current law requires administrators of these facilities, with specified exemptions, to complete a department-approved certification program, uniformly referred to as administrator certification training programs. Under existing law, these programs require a specified minimum number of hours, depending on the facility type, of classroom instruction that provides training on a uniform core of knowledge in specified areas. Current law also requires administrator certificates to be renewed every 2 years, conditional upon the certificate holder submitting documentation of a specified number of hours of continuing education, based on the facility type. Current law permits up to one-half of the required continuing education hours to be satisfied through online courses, and the remainder to be completed in a classroom instructional setting, as prescribed. This bill would revise those provisions by deleting the classroom instruction requirement for initial certification and continuing education purposes, and instead would require instruction that is conducive to learning and allows participants to simultaneously interact with each other as well as with the instructor.

AB 221 **(Ting D) Budget Act of 2023.**
Current Text: Introduced: 1/10/2023 html pdf
Status: 1/26/2023-Referred to Com. on BUDGET.
Location: 1/26/2023-A. BUDGET

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would make appropriations for the support of state government for the 2023–24 fiscal year.

AB 236 **(Holden D) Health care coverage: provider directories.**
Current Text: Amended: 3/20/2023 html pdf
Last Amend: 3/20/2023
Status: 5/19/2023-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE

FILE on 4/19/2023)(May be acted upon Jan 2024)
Location: 5/19/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law requires a health care service plan and a health insurer that contracts with providers for alternative rates of payment to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services enrollees or insureds, and requires a health care service plan and health insurer to regularly update its printed and online provider directory or directories, as specified. This bill would require a plan or insurer to annually audit and delete inaccurate listings from its provider directories, and would require a provider directory to be 60% accurate on January 1st, 2024, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before January 1, 2027. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks and for each inaccurate listing in its directories. If a plan or insurer has not financially compensated a provider in the prior year, the bill would require the plan or insurer to delete the provider from its directory beginning July 1st, 2024, unless specified criteria applies. The bill would require a plan or insurer to provide information about in-network providers to enrollees and insureds upon request, and would limit the cost-sharing amounts an enrollee or insured is required to pay for services from those providers under specified circumstances.

AB 242 **(Wood D) Critical access hospitals: employment.**
Current Text: Introduced: 1/13/2023 html pdf
Status: 6/29/2023-From committee: Do pass and re-refer to Com. on APPR. (Ayes 12. Noes 0.) (June 28). Re-referred to Com. on APPR.
Location: 6/29/2023-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The Medical Practice Act authorizes the Medical Board of California to grant approval of the employment of licensees on a salary basis by licensed charitable institutions, foundations, or clinics if no charge for professional services is made, in accordance with specified requirements. Current law provides an exception to the prohibition on charging for professional services for a federally certified critical access hospital that employs licensees and charges for professional services rendered by those licensees to patients under specified conditions, including that the medical staff concur by an affirmative vote that the licensee's employment is in the best interest of the communities served by the hospital. Current law makes that exception operative only until January 1st, 2024. This bill would delete the provision making the above-specified exception inoperative on January 1st, 2024.

AB 253 **(Maienschein D) Child death investigations: review teams.**
Current Text: Amended: 2/22/2023 html pdf
Last Amend: 2/22/2023
Status: 5/19/2023-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 3/29/2023)(May be acted upon Jan 2024)
Location: 5/19/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law authorizes each county to establish an interagency child death review team to assist local agencies in identifying and reviewing suspicious child deaths and facilitating communication among persons who perform autopsies and the various persons and agencies involved in child abuse or neglect cases. Current law requires each child death review team to, no less than once each year, make available to the public findings, conclusions, and recommendations of the team, including aggregate statistical data on the incidences and causes of child deaths. This bill would instead require each child death review team to meet these requirements no later than July 1st of each year and to post this report on the internet website of the county.

AB 254 **(Bauer-Kahan D) Confidentiality of Medical Information Act: reproductive or sexual health application information.**

Current Text: Amended: 4/17/2023 html pdf

Last Amend: 4/17/2023

Status: 6/14/2023-From committee: Do pass and re-refer to Com. on HEALTH. (Ayes 9. Noes 0.) (June 13). Re-referred to Com. on HEALTH.

Location: 6/13/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The Confidentiality of Medical Information Act (CMIA) makes a business that offers software or hardware to consumers, including a mobile application or other related device that is designed to maintain medical information in order to make the information available to an individual or a provider of health care at the request of the individual or a provider of health care, for purposes of allowing the individual to manage the individual's information or for the diagnosis, treatment, or management of a medical condition of the individual, a provider of health care subject to the requirements of the CMIA. Current law makes a violation of these provisions that results in economic loss or personal injury to a patient punishable as a misdemeanor. This bill would revise the definition of "medical information" to include reproductive or sexual health application information, which the bill would define to mean information about a consumer's reproductive or sexual health collected by a reproductive or sexual health digital service, as specified. The bill would make a business that offers a reproductive or sexual health digital service to a consumer for the purpose of allowing the individual to manage the individual's information, or for the diagnosis, treatment, or management of a medical condition of the individual, a provider of health care subject to the requirements of the CMIA.

AB 268 **(Weber D) Board of State and Community Corrections.**

Current Text: Amended: 6/28/2023 html pdf

Last Amend: 6/28/2023

Status: 6/28/2023-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on PUB S.

Location: 6/14/2023-S. PUB. S.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law establishes the Board of State and Community Corrections to provide statewide leadership, coordination, and technical assistance to promote effective state and local efforts and partnerships in California's adult and juvenile criminal justice system. The duties of the board, among others, include establishing standards for local correctional facilities and correctional officers. Under current law, the board is composed of 13 members, as specified. This bill would, commencing July 1st, 2024, add 2 additional members to the board, the Secretary of California Health and Human Services, or their designee that has a medical degree, and a licensed mental or behavioral health care specialist, appointed by the Governor and subject to confirmation by the Senate.

AB 273 **(Ramos D) Foster care: missing children and nonminor dependents.**
Current Text: Amended: 6/23/2023 html pdf
Last Amend: 6/23/2023
Status: 6/23/2023-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on JUD.
Location: 6/20/2023-S. JUD.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law generally provides for the placement of foster youth in various placement settings and governs the provision of child welfare services, as specified. Current law requires county child welfare agencies and probation departments to develop and implement specific protocols to expeditiously locate any child or nonminor dependent missing from foster care, including, but not limited to, the timeframe for reporting missing youth and the individuals or entities entitled to notice that a youth is missing, and requires the social worker or probation officer to determine the primary factors that contributed to the child or nonminor dependent running away or otherwise being absent from care, among other things. This bill, the Luke Madrigal Act, would, among other things, additionally require the social worker or probation officer, when they receive information that a child receiving child welfare services is absent from foster care to, among other things, engage in ongoing and intensive due diligence efforts, as defined, to locate, place, and stabilize the child, request that the juvenile court schedule a hearing to review the placement and the ongoing and intensive due diligence efforts to locate and return the child, notify specified individuals whose whereabouts are known about the hearing, and prepare, submit, and serve a report at the hearing and any subsequent hearings describing their ongoing and intensive due diligence efforts to locate, place, and stabilize the child. The bill would require the court to consider the safety of the child receiving child welfare services who is absent from foster care to determine the extent of the activities and compliance of the county with the case plan in making ongoing and intensive due diligence efforts to locate and return the child to a safe placement, and to continue to periodically review their case at least every 30 calendars days, as specified. The bill would define "absent from foster care" to mean when the whereabouts of a child receiving child welfare services is unknown to the county child welfare agency or probation department or when the county child welfare agency or probation department has located the child receiving child welfare services in a location not approved by the court that may pose a risk to the child.

AB 283 **(Patterson, Jim R) Mental Health Services Oversight and Accountability Commission.**
Current Text: Introduced: 1/24/2023 html pdf

Status: 6/12/2023-From Consent Calendar. Ordered to third reading.
Location: 6/12/2023-S. THIRD READING

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the Mental Health Oversight and Accountability Commission to oversee the implementation of the MHSA. Current law specifies the composition of the 16-member commission, including the Attorney General or their designee, the Superintendent of Public Instruction or their designee, specified members of the Legislature, and 12 members appointed by the Governor, as prescribed. Current law authorizes the MHSA to be amended by a 2/3 vote of the Legislature if the amendments are consistent with, and further the purposes of, the MHSA, or by a majority vote to clarify procedures and terms. This bill would urge the Governor, in making appointments, to consider ensuring geographic representation among the 10 regions of California defined by the 2020 census.

AB 288 **(Maienschein D) Revocable transfer on death deeds.**
Current Text: Enrollment: 7/3/2023 html pdf
Last Amend: 3/16/2023
Status: 7/3/2023-Enrolled and presented to the Governor at 3 p.m.
Location: 7/3/2023-A. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law, until January 1st, 2032, governs the execution, revocation, and effectiveness of a revocable transfer on death (TOD) deed, which is an instrument that makes a donative transfer of real property to a named beneficiary that becomes operative on the transferor's death, but remains revocable until the transferor's death. Under current law, a separate interest in a stock cooperative is not real property that may be transferred by a revocable TOD deed. This bill would authorize the transfer of real property by revocable TOD deed even if ownership is not typically evidenced or transferred by use of a deed, and would authorize the transfer of an interest in a stock cooperative by revocable TOD deed subject to any limitation on the transferor's interest. If a stock cooperative exercises an option to purchase property transferred by revocable TOD deed on the transferor's death, the bill would specify that the property is transferred to the stock cooperative and the purchase price is paid to the beneficiary.

AB 289 **(Holden D) Mental health services: representation.**
Current Text: Amended: 3/7/2023 html pdf
Last Amend: 3/7/2023
Status: 6/7/2023-From committee: Do pass and re-refer to Com. on APPR with recommendation: To Consent Calendar. (Ayes 12. Noes 0.) (June 7). Re-referred to Com. on APPR.
Location: 6/7/2023-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The Bronzan-McCorquodale Act may be amended by the Legislature only by a 2/3 vote

of both houses and only so long as the amendment is consistent with and furthers the intent of the act. The Legislature may clarify procedures and terms of the act by majority vote. Current law establishes the Mental Health Services Oversight and Accountability Commission and requires counties to prepare and submit a 3-year program and expenditure plan, and annual updates, as specified, to the commission and the State Department of Health Care Services. Current law requires the plan to be developed with specified local stakeholders, along with other important interests. This bill would require stakeholders to include sufficient participation of individuals representing diverse viewpoints, including representatives from youth from historically marginalized communities, representatives from organizations specializing in working with underserved racially and ethnically diverse communities, and representatives from LGBTQ+ communities.

AB 310 **(Arambula D) CalWORKs.**
Current Text: Amended: 3/23/2023 html pdf
Last Amend: 3/23/2023
Status: 6/27/2023-In committee: Set, first hearing. Hearing canceled at the request of author.
Location: 6/14/2023-S. HUM. S.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current federal law provides for allocation of federal funds through the federal Temporary Assistance for Needy Families (TANF) block grant program to eligible states. Current law establishes the California Work Opportunity and Responsibility to Kids (CalWORKs) program, under which, through a combination of state and county funds and federal funds received through the TANF program, each county provides cash assistance and other benefits to qualified low-income families. Current law imposes various eligibility requirements for the CalWORKs program, including that a child is deprived of parental support or care, a child has received all age-appropriate immunizations, and specified applicants or recipients who are apparently eligible for unemployment insurance shall meet the conditions of eligibility for and accept any unemployment insurance benefits for which they are eligible. This bill would, among other things, repeal the parental deprivation and immunization requirements, and would instead only require that those specified applicants and recipients whom the county has evidence that they are eligible for unemployment insurance to apply for, but not meet the conditions of, unemployment insurance benefits.

AB 317 **(Weber D) Pharmacist service coverage.**
Current Text: Amended: 6/8/2023 html pdf
Last Amend: 6/8/2023
Status: 6/29/2023-Read third time. Passed. Ordered to the Assembly. (Ayes 39. Noes 0.). In Assembly. Concurrence in Senate amendments pending. May be considered on or after July 1 pursuant to Assembly Rule 77.
Location: 6/29/2023-A. CONCURRENCE

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current law authorizes health care service plans and certain disability insurers, that offer coverage for a service that is within the scope of practice of a duly licensed pharmacist, to pay or reimburse the

cost of the service performed by a pharmacist for the plan or insurer if the pharmacist otherwise provides services for the plan or insurer. This bill would instead require a health care service plan and certain disability insurers that offer coverage for a service that is within the scope of practice of a duly licensed pharmacist to pay or reimburse the cost of services performed by a pharmacist at an in-network pharmacy or by a pharmacist at an out-of-network pharmacy if the health care service plan or insurer has an out-of-network pharmacy benefit. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

AB 352 **(Bauer-Kahan D) Health information.**
Current Text: Amended: 5/18/2023 html pdf
Last Amend: 5/18/2023
Status: 6/28/2023-From committee: Do pass and re-refer to Com. on HEALTH. (Ayes 10. Noes 1.) (June 27). Re-referred to Com. on HEALTH.
Location: 6/28/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The Confidentiality of Medical Information Act (CMIA), generally prohibits a provider of health care, a health care service plan, or a contractor from disclosing medical information regarding a patient, enrollee, or subscriber without first obtaining an authorization, unless a specified exception applies. The CMIA requires every provider of health care, health care service plan, pharmaceutical company, or contractor who, among other things, maintains or stores medical information to do so in a manner that preserves the confidentiality of the information contained therein. The CMIA also prohibits a provider of health care, a health care service plan, a contractor, or an employer from releasing medical information that would identify an individual or related to an individual seeking or obtaining an abortion in response to a subpoena or a request or to law enforcement if that subpoena, request, or the purpose of law enforcement for the medical information is based on, or for the purpose of enforcement of, either another state's laws that interfere with a person's rights to choose or obtain an abortion or a foreign penal civil action. Existing law makes a violation of the CMIA that results in economic loss or personal injury to a patient punishable as a misdemeanor. This bill would require specified businesses that electronically store or maintain medical information on the provision of sensitive services on behalf of a provider of health care, health care service plan, pharmaceutical company, contractor, or employer to develop capabilities, policies, and procedures, on or before July 1, 2024, to enable certain security features, including limiting user access privileges and segregating medical information related to sensitive services, as specified.

AB 365 **(Aguiar-Curry D) Medi-Cal: diabetes management.**
Current Text: Amended: 3/15/2023 html pdf
Last Amend: 3/15/2023
Status: 6/22/2023-From committee: Do pass and re-refer to Com. on APPR with recommendation: To Consent Calendar. (Ayes 12. Noes 0.) (June 21). Re-referred to Com. on APPR.
Location: 6/21/2023-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law sets forth a schedule of benefits under the Medi-Cal program. This bill would add continuous glucose monitors and related supplies required for use with those monitors as a covered benefit under the Medi-Cal program, subject to utilization controls. The bill would require the department, by July 1st, 2024, to review and update, as appropriate, coverage policies for continuous glucose monitors, as specified. The bill would authorize the department to require a manufacturer of a continuous glucose monitor to enter into a rebate agreement with the department. The bill would limit its implementation to the extent that any necessary federal approvals are obtained and federal financial participation is not otherwise jeopardized.

AB 408 **(Wilson D) Climate-resilient Farms, Sustainable Healthy Food Access, and Farmworker Protection Bond Act of 2024.**
Current Text: Amended: 5/25/2023 html pdf
Last Amend: 5/25/2023
Status: 7/5/2023-From committee: Do pass and re-refer to Com. on GOV. & F. (Ayes 3. Noes 0.) (July 3). Re-referred to Com. on GOV. & F.
Location: 7/3/2023-S. GOV. & F.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would enact the Climate-resilient Farms, Sustainable Healthy Food Access, and Farmworker Protection Bond Act of 2024, which, if approved by the voters, would authorize the issuance of bonds in the amount of $3,365,000,000 pursuant to the State General Obligation Bond Law, to finance programs related to, among other things, agricultural lands, food and fiber infrastructure, climate resilience, agricultural professionals, including farmers, ranchers, and farmworkers, workforce development and training, air quality, tribes, disadvantaged communities, nutrition, food aid, meat processing facilities, and fishing facilities.

AB 423 **(Maienschein D) Department of Justice: missing persons.**
Current Text: Introduced: 2/6/2023 html pdf
Status: 5/19/2023-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/19/2023)(May be acted upon Jan 2024)
Location: 5/19/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require the Attorney General to convene a working group, as specified, within the Department of Justice Missing and Unidentified Persons Section, to study and propose legislative solutions to the problem of “wandering,” described as the phenomenon of cognitively impaired persons, including those with Alzheimer’s disease, dementia, or autism, wandering away from home, care facilities, or other familiar surroundings and becoming lost or confused about their surroundings. The bill would require the working group to prepare and submit a report to the Legislature, as specified.

AB 425 **(Alvarez D) Medi-Cal: pharmacogenomic testing.**
Current Text: Amended: 3/30/2023 html pdf
Last Amend: 3/30/2023

Status: 6/29/2023-From committee: Do pass and re-refer to Com. on APPR with recommendation: To Consent Calendar. (Ayes 11. Noes 0.) (June 28). Re-referred to Com. on APPR.
Location: 6/29/2023-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would add pharmacogenomic testing as a covered benefit under Medi-Cal, as specified. The bill would define pharmacogenomic testing as laboratory genetic testing that includes, but is not limited to, a panel test, to identify how a person's genetics may impact the efficacy, toxicity, and safety of medications, including medications prescribed for behavioral or mental health, oncology, hematology, pain management, infectious disease, urology, reproductive or sexual health, neurology, gastroenterology, or cardiovascular diseases.

AB 428 **(Waldron R) California Department of Reentry.**
Current Text: Amended: 4/20/2023 html pdf
Last Amend: 4/20/2023
Status: 5/19/2023-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/3/2023)(May be acted upon Jan 2024)
Location: 5/19/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would establish the California Department of Reentry, independent from the Department of Corrections and Rehabilitation (CDCR), to provide statewide leadership, coordination, and technical assistance to promote effective state and local efforts to ensure successful reentry services are provided to incarcerated individuals. The bill would require the department to focus on programming through the period of incarceration that supports successful reentry to society, facilitate the smooth transition of individuals from prison to release by developing individualized reentry plans for each individual, and oversee continuity of care for incarcerated individuals with health and substance use disorders during community supervision and parole, among other things.

AB 459 **(Haney D) California Behavioral Health Outcomes and Accountability Review.**
Current Text: Amended: 4/13/2023 html pdf
Last Amend: 4/13/2023
Status: 6/27/2023-In committee: Set, first hearing. Hearing canceled at the request of author.
Location: 6/14/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require the California Health and Human Services Agency, by July 1st, 2026, to establish the California Behavioral Health Outcomes and Accountability Review (CBH-OAR), consisting of performance indicators, county self-assessments, and county and health plan improvement plans, to facilitate an accountability system that fosters continuous quality improvement in county and commercial behavioral health services and in the collection and dissemination of best practices in service delivery by the agency. The bill would require the agency to convene a workgroup, as specified, to establish a workplan by which the CBH-OAR shall be conducted. The bill would

require the agency to establish specific process measures and uniform elements for the county and health plan improvement plan updates. The bill would require the agency to report to the Legislature, as specified. By imposing new requirements on counties, this bill would impose a state-mandated local program.

AB 482 **(Wilson D) Air ambulance services.**
Current Text: Amended: 3/9/2023 html pdf
Last Amend: 3/9/2023
Status: 4/4/2023-In committee: Hearing postponed by committee.
Location: 3/9/2023-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: The Emergency Medical Air Transportation Act imposed a penalty of $4 until December 31st, 2022, upon every conviction for a violation of the Vehicle Code or a local ordinance adopted pursuant to the Vehicle Code, other than a parking offense. The act requires the county or court that imposed the fine to transfer the revenues collected to the Treasurer for deposit into the Emergency Medical Air Transportation and Children's Coverage Fund. Current law requires the assessed penalty to continue to be collected, administered, and distributed until exhausted or until December 31st, 2023, whichever occurs first. Current law establishes the Aeronautics Account in the State Transportation Fund, and continuously appropriates the moneys in the account for expenditure for airport purposes by the Division of Aeronautics within the Department of Transportation and the California Transportation Commission. This bill would annually transfer $8,000,000 from the Aeronautics Account to the Emergency Medical Air Transportation and Children's Coverage Fund and continuously appropriate those moneys to augment Medi-Cal reimbursement for emergency medical air transportation and related costs.

AB 483 **(Muratsuchi D) Local educational agency: Medi-Cal billing option.**
Current Text: Introduced: 2/7/2023 html pdf
Status: 7/3/2023-In committee: Hearing postponed by committee.
Location: 6/14/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Would require the State Department of Health Care Services to revise the state plan to establish a revised audit process for Medi-Cal Billing Option claims submitted for dates of service on or after January 1st, 2025, pursuant to specified requirements and limitations. The bill would require the department to report to the relevant policy committees and post on its internet website any changes made to the state plan pursuant to the requirement to revise the state plan. The bill would require the department to provide technical assistance to the LEA or to complete appeals by the LEA within 180 days if an audit requires a specified percentage of an LEA's total value of claims to be paid back. The bill would prohibit an auditor from determining that an LEA is required to pay back reimbursement for certain claims, except as specified. The bill would require the department's summary of activities in the above-described report to also include training for LEAs and a summary of the number of audits conducted of Medi-Cal Billing Option claims, as specified. The bill would require the department to ensure, for those claims, that "medical necessity" for a beneficiary under

21 years of age has a specified meaning.

AB 488 **(Nguyen, Stephanie D) Medi-Cal: skilled nursing facilities: vision loss.**
Current Text: Introduced: 2/7/2023 html pdf
Status: 4/28/2023-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 2/17/2023)(May be acted upon Jan 2024)
Location: 4/28/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law requires the State Department of Health Care Services, subject to any necessary federal approvals, for managed care rating periods that begin between January 1, 2023, and December 31st, 2026, inclusive, to establish and implement the Workforce and Quality Incentive Program under which a network provider furnishing skilled nursing facility services to a Medi-Cal managed care enrollee may earn performance-based directed payments from the Medi-Cal managed care plan with which they contract, as specified. Current law, subject to an appropriation, requires the department to set the amounts of those directed payments under a specified formula. Current law requires the department to establish the methodology or methodologies, parameters, and eligibility criteria for the directed payments, including the milestones and metrics that network providers of skilled nursing facility services must meet in order to receive a directed payment from a Medi-Cal managed care plan, with at least 2 of these milestones and metrics tied to workforce measures. This bill would require that the measures and milestones include program access, staff training, and capital improvement measures aimed at addressing the needs of skilled nursing facility residents with vision loss.

AB 492 **(Pellerin D) Medi-Cal: reproductive and behavioral health integration pilot programs.**
Current Text: Amended: 3/23/2023 html pdf
Last Amend: 3/23/2023
Status: 6/14/2023-Referred to Com. on HEALTH.
Location: 6/14/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law establishes the Family Planning, Access, Care, and Treatment (Family PACT) Program pursuant to a federal waiver, as part of the schedule of Medi-Cal benefits. Under existing law, the Family PACT Program provides comprehensive clinical family planning services to a person who has a family income at or below 200% of the federal poverty level and who is eligible to receive those services pursuant to the waiver. Under the Family PACT Program, comprehensive clinical family planning services include, among other things, contraception and general reproductive health care, and exclude abortion. Abortion services are covered under the Medi-Cal program. This bill would, on or before July 1st, 2024, subject to an appropriation, require the department to make grants, incentive payments, or other financial support available to Medi-Cal managed care plans to develop and implement reproductive and behavioral health integration pilot programs in partnership with identified qualified providers, in order to improve access to behavioral health services for beneficiaries with mild-to-moderate behavioral health conditions.

AB 494 **(Arambula D) Robert F. Kennedy Farm Workers Medical Plan.**
Current Text: Amended: 3/23/2023 html pdf
Last Amend: 3/23/2023
Status: 6/29/2023-From committee: Do pass and re-refer to Com. on APPR. (Ayes 10. Noes 1.) (June 28). Re-referred to Com. on APPR.
Location: 6/29/2023-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law, until January 1st, 2026, requires the State Department of Health Care Services to annually reimburse the Robert F. Kennedy Farm Workers Medical Plan up to $3,000,000 per year for claim payments that exceed $70,000 made by the plan on behalf of an eligible employee or dependent for a single episode of care on or after September 1st, 2016. The Robert F. Kennedy Farm Workers Medical Plan is a nonprofit voluntary employees beneficiary association, organized under federal law, that provides payments for health care and other benefits to its members. This bill would require the department to annually reimburse the Robert F. Kennedy Farm Workers Medical Plan up to $4,000,000 per year instead of $3,000,000 per year.

AB 503 **(Carrillo, Juan D) Health care: organ donation enrollment.**
Current Text: Amended: 4/13/2023 html pdf
Last Amend: 4/13/2023
Status: 5/19/2023-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/3/2023)(May be acted upon Jan 2024)
Location: 5/19/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The Uniform Anatomical Gift Act authorizes the creation of a not-for-profit entity to be designated as the California Organ and Tissue Donor Registrar and requires that entity to establish and maintain the Donate Life California Organ and Tissue Donor Registry for persons who have identified themselves as organ and tissue donors upon their death. Current law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Current law requires the department, in consultation with the board governing the California Health Benefit Exchange, to develop a single paper, electronic, and telephone application for insurance affordability programs, including Medi-Cal. This bill would require the department to modify the electronic application for insurance affordability programs to add an option for individuals to enroll in the Donate Life California Organ and Tissue Donor Registry. The bill would require the option to include specified check boxes for an applicant to indicate whether to add the applicant's name to the registry. The bill would require the option to be voluntary to complete and to not be a required part of the application.

AB 524 **(Wicks D) Discrimination: family caregiver status.**
Current Text: Amended: 6/29/2023 html pdf
Last Amend: 6/29/2023
Status: 6/29/2023-Read second time and amended. Re-referred to Com. on L., P.E. & R. (Amended

6/29/2023)
Location: 6/28/2023-S. L., P.E. & R.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The California Fair Employment and Housing Act (FEHA), which is enforced by the Civil Rights Department, prohibits various forms of employment discrimination and recognizes the opportunity to seek, obtain, and hold employment without specified forms of discrimination as a civil right. The act also makes it an unlawful employment practice for an employer, among other things, to refuse to hire or employ a person because of various personal characteristics, conditions, or traits. This bill would prohibit employment discrimination on account of family caregiver status, as defined, and would recognize the opportunity to seek, obtain, and hold employment without discrimination because of family caregiver status as a civil right, as specified.

AB 531 **(Irwin D) The Behavioral Health Infrastructure Bond Act of 2023.**
Current Text: Amended: 6/19/2023 html pdf
Last Amend: 6/19/2023
Status: 6/21/2023-Re-referred to Coms. on HOUSING and GOV. & F.
Location: 6/21/2023-S. HOUSING

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would enact the Behavioral Health Infrastructure Bond Act of 2023 which, if approved by the voters, would authorize the issuance of bonds in the amount of $4,680,000,000 to finance grants for the acquisition of capital assets for, and the construction and rehabilitation of, unlocked, voluntary, and community-based treatment settings and residential care settings and also for housing for veterans and others who are experiencing homelessness or are at risk of homelessness and are living with a behavioral health challenge. The bill would provide for the submission of the bond act to the voters at the March 5, 2024, statewide primary election.

AB 549 **(Wilson D) Gender discrimination.**
Current Text: Amended: 3/8/2023 html pdf
Last Amend: 3/8/2023
Status: 5/19/2023-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/19/2023)(May be acted upon Jan 2024)
Location: 5/19/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require all state agencies, in consultation with the Commission on the Status of Women and Girls, to conduct an evaluation of their own departments to ensure that the state does not discriminate against women through the allocation of funding and the delivery of services. The bill, on or before January 1st, 2025, and on or before January 1st every 2 years thereafter, would require state agencies to report their findings and recommendations, as specified, to the commission.

AB 551 **(Bennett D) Medi-Cal: specialty mental health services: foster children.**

Current Text: Amended: 4/27/2023 html pdf
Last Amend: 4/27/2023
Status: 7/5/2023-From committee: Do pass and re-refer to Com. on APPR with recommendation: To Consent Calendar. (Ayes 5. Noes 0.) (July 3). Re-referred to Com. on APPR.
Location: 7/5/2023-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Under current law, specialty mental health services include federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services provided to eligible Medi-Cal beneficiaries under 21 years of age. Current law requires each local mental health plan to establish a procedure to ensure access to outpatient specialty mental health services, as required by the EPSDT program standards, for youth in foster care who have been placed outside their county of adjudication, as described. Current law requires the department to issue policy guidance on the conditions for, and exceptions to, presumptive transfer of responsibility for providing or arranging for specialty mental health services to a foster youth from the county of original jurisdiction to the county in which the foster youth resides, as prescribed. On a case-by-case basis, and when consistent with the medical rights of children in foster care, current law authorizes the waiver of presumptive transfer, with the responsibility for the provision of specialty mental health services remaining with the county of original jurisdiction if certain exceptions exist. Under current law, the county probation agency or the child welfare services agency is responsible for determining whether waiver of the presumptive transfer is appropriate, with notice provided to the person requesting the exception. Under Current law, commencing July 1st, 2023, in the case of placement of foster children in short-term residential therapeutic programs, community treatment facilities, or group homes, or in the case of admission of foster children to children's crisis residential programs, the county of original jurisdiction is required to retain responsibility and presumptive transfer provisions apply only if certain circumstances exist. This bill, for purposes of foster children placed or admitted in those specific settings, would delay, until July 1, 2024, the requirement on the county of original jurisdiction to retain responsibility and the limitation on the presumptive transfer provisions.

AB 557 (Hart D) Open meetings: local agencies: teleconferences.

Current Text: Amended: 6/19/2023 html pdf
Last Amend: 6/19/2023
Status: 6/29/2023-Read second time. Ordered to third reading.
Location: 6/29/2023-S. THIRD READING

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

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 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 the authority of a legislative body to hold a teleconference meeting under those abbreviated teleconferencing procedures when a declared state of emergency is in effect. Specifically, the bill would extend indefinitely that authority in the circumstances under which the legislative body either (1) meets for the purpose of determining whether, as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees, or (2) has previously made that determination.

AB 564 **(Villapudua D) Medi-Cal: claim or remittance forms: signature.**
Current Text: Amended: 4/5/2023 html pdf
Last Amend: 4/5/2023
Status: 6/14/2023-Referred to Com. on HEALTH.
Location: 6/14/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. Current law requires the Director of Health Care Services to develop and implement standards for the timely processing and payment of each claim type. Current law requires that the standards be sufficient to meet minimal federal requirements for the timely processing of claims. Current law states the intent of the Legislature that claim forms for use by physicians and hospitals be the same as claim forms in general use by other payors, as specified. This bill would require the department to allow a provider to submit an electronic signature for a claim or remittance form under the Medi-Cal program, to the extent not in conflict with federal law.

AB 576 **(Weber D) Medi-Cal: reimbursement for abortion.**
Current Text: Amended: 3/30/2023 html pdf
Last Amend: 3/30/2023
Status: 6/29/2023-From committee: Do pass and re-refer to Com. on APPR. (Ayes 10. Noes 0.) (June 28). Re-referred to Com. on APPR.
Location: 6/29/2023-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Would require the State Department of Health Care Services, by March 1st, 2024, to review and update Medi-Cal coverage policies for medication abortion to align with current evidence-based clinical guidelines. After the initial review, the bill would require the department to update its Medi-Cal coverage policies for medication abortion as needed to align with evidence-based clinical guidelines. The bill would require the department to allow flexibility for providers to exercise their clinical judgment when services are performed in a manner that aligns with one or more evidence-based clinical guidelines.

AB 583 **(Wicks D) Birthing Justice for California Families Pilot Project.**
Current Text: Amended: 4/13/2023 html pdf

Last Amend: 4/13/2023
Status: 5/19/2023-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/3/2023)(May be acted upon Jan 2024)
Location: 5/19/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would establish the Birthing Justice for California Families Pilot Project, which would include a 3-year grant program administered by the Department of Health Care Access and Information to provide grants to specified entities, including community-based doula groups, to provide full-spectrum doula care to pregnant and birthing people who are low income and do not qualify for Medi-Cal or who are from communities that experience high rates of negative birth outcomes. The bill would require the department to take specified actions with regard to awarding grants, including awarding grants to selected entities on or before January 1st, 2025. The bill would require a grant recipient to use grants funds to pay for the costs associated with providing full-spectrum doula care to eligible individuals and establishing and managing doula services. The bill would require a grant recipient, in setting the payment rate for a doula being paid with grant funds, to comply with specified parameters, including that the payment rate not be less than the Medi-Cal reimbursement rate for doulas or the median rate paid for doula care in existing local pilot projects providing doula care in California, whichever is higher. The bill would require the department, on or before January 1st, 2028, to submit a report to the appropriate policy and fiscal committees of the Legislature on the expenditure of funds and relevant outcome data for the pilot project. The bill would repeal these provisions on January 1st, 2029.

AB 586 **(Calderon D) Medi-Cal: community supports: climate change or environmental remediation devices.**
Current Text: Amended: 3/30/2023 html pdf
Last Amend: 3/30/2023
Status: 5/19/2023-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/3/2023)(May be acted upon Jan 2024)
Location: 5/19/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under existing law, community supports that the State Department of Health Care Services is authorized to approve include, among other things, housing deposits, environmental accessibility adaptations or home modifications, and asthma remediation. This bill would add climate change or environmental remediation devices to the above-described list of community supports. For purposes of these provisions, the bill would define “climate change or environmental remediation devices” as coverage of devices and installation of those devices, as necessary, to address health-related complications, barriers, or other factors linked to extreme weather, poor air quality, or climate events, including air conditioners, electric heaters, air filters, or backup power sources, among other specified devices for certain purposes.

AB 608 (Schiavo D) **Medi-Cal: comprehensive perinatal services.**
Current Text: Amended: 4/17/2023 html pdf
Last Amend: 4/17/2023
Status: 6/14/2023-Referred to Coms. on HEALTH and G.O.
Location: 6/14/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: 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 postpregnancy 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 postpregnancy period in effect on that date. The bill would require the department to consider input from the State Department of Public Health and certain stakeholders, as specified, in determining the specific number of additional comprehensive perinatal assessments, individualized care plans, visits, and units of services to be covered.

AB 614 (Wood D) **Medi-Cal.**
Current Text: Amended: 4/19/2023 html pdf
Last Amend: 4/19/2023
Status: 5/31/2023-Referred to Com. on HEALTH.
Location: 5/31/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would make a change to an obsolete reference to the former Healthy Families Program, whose health services for children have been transitioned to the Medi-Cal program. The bill would make a change to an obsolete reference to the former Access for Infants and Mothers Program and would revise a related provision to instead refer to the successor Medi-Cal Access Program. The bill would delete, within certain Medi-Cal provisions, obsolete references to a repealed provision relating to nonprofit hospital service plans.

AB 616 (Rodriguez D) **Medical Group Financial Transparency Act.**
Current Text: Amended: 3/28/2023 html pdf
Last Amend: 3/28/2023
Status: 6/14/2023-Referred to Coms. on HEALTH and JUD.
Location: 6/14/2023-S. JUD.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law establishes the Office of Health Care Affordability within the Department of

Health Care Access and Information to analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs for consumers and purchasers, and create a state strategy for controlling the cost of health care. Current law requires the office to collect data and other information it deems necessary from health care entities to carry out the functions of the office, and requires the office to require providers and physician organizations to submit audited financial reports or comprehensive financial statements, as specified. Current law requires those reports and statements to be kept confidential, and specifies that they are not required to be disclosed under the California Public Records Act. Current law requires the office to obtain information about health care service plans from the Department of Managed Health Care. This bill, the Medical Group Financial Transparency Act, would authorize the disclosure of audited financial reports and comprehensive financial statements of providers and physician organizations collected by the Office of Health Care Affordability and financial and other records of risk-bearing organizations made available to the Department of Managed Health Care. This bill would authorize the board, members of the board, the office, the department, and the employees, contractors, and advisors of the office and the department to use confidential audited financial reports and comprehensive financial statements only as necessary to carry out functions of the office. The bill would also require certain physician organizations, as specified, to produce or disclose audited financial reports and comprehensive financial statements to the office, subject to these provisions. The bill would require the audited financial reports and comprehensive financial statements produced or disclosed to the office to be made available to the public, by the office, as specified. The bill would also make related findings and declarations.

AB 620 **(Connolly D) Health care coverage for metabolic disorders.**
Current Text: Amended: 6/20/2023 html pdf
Last Amend: 6/20/2023
Status: 6/29/2023-From committee: Do pass and re-refer to Com. on APPR. (Ayes 11. Noes 0.) (June 28). Re-referred to Com. on APPR.
Location: 6/29/2023-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require a health care service plan contract and disability insurance policy that provides coverage for hospital, medical, or surgical expenses and is issued, amended, delivered, or renewed on and after January 1st, 2024, to provide coverage for the testing and treatment of other chronic digestive diseases and inherited metabolic disorders, as specified. 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 632 **(Gipson D) Health care coverage: prostate cancer screening.**
Current Text: Amended: 6/15/2023 html pdf
Last Amend: 6/15/2023
Status: 6/26/2023-In committee: Referred to APPR. suspense file.
Location: 6/26/2023-S. APPR. SUSPENSE FILE

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law requires an individual and group health care service plan contract or health insurance policy to provide coverage for the screening and diagnosis of prostate cancer when medically necessary and consistent with good professional practice. Under current law, the application of a deductible or copayment for those services is not prohibited. This bill would instead require that coverage when medically necessary and consistent with nationally recognized, evidence-based clinical guidelines. The bill would prohibit a health care service plan or a health insurance policy issued, amended, renewed, or delivered on or after January 1st, 2024, from applying a deductible, copayment, or coinsurance to coverage for prostate cancer screening services for an enrollee or insured who is at a high risk of prostate cancer, consistent with specified guidelines and is either 55 years of age or older or 40 years of age or older and high risk, as determined by the attending or treating health care provider. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 649 **(Wilson D) Developmental services.**
Current Text: Amended: 5/18/2023 html pdf
Last Amend: 5/18/2023
Status: 7/3/2023-In committee: Referred to APPR suspense file.
Location: 7/3/2023-S. APPR. SUSPENSE FILE

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The Lanterman Developmental Disabilities Services Act makes the State Department of Developmental Services responsible for providing various services and supports to individuals with developmental disabilities, and for ensuring the appropriateness and quality of those services and supports. Pursuant to that law, the department contracts with regional centers to provide services and supports to persons with developmental disabilities. Current law prohibits regional centers from purchasing any service that would otherwise be available from Medi-Cal, Medicare, and private insurance, among other sources, when a consumer or a consumer's family meets the criteria of this coverage, but chooses not to pursue that coverage. Current law also prohibits regional centers from purchasing medical or dental services for a consumer 3 years of age or older unless the regional center is provided with documentation of a Medi-Cal, private insurance, or health care service plan denial, and the regional center determines that an appeal of the denial by the consumer or the consumer's family does not have merit. This bill would remove the requirement for the regional center to determine that the appeal of the denial by the consumer or the consumer's family does not have merit.

AB 659 **(Aguiar-Curry D) Cancer Prevention Act.**
Current Text: Amended: 7/3/2023 html pdf
Last Amend: 7/3/2023
Status: 7/3/2023-Read second time and amended. Re-referred to Com. on ED.
Location: 6/29/2023-S. ED.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would enact the Cancer Prevention Act and declare the public policy of the state that pupils are recommended to be fully immunized against human papillomavirus (HPV) before admission

or advancement to the 8th grade level of any private or public elementary or secondary school. The bill would, upon a pupil's admission or advancement to the 6th grade level, require the governing authority to submit to the pupil and their parent or guardian a notification containing a statement about that public policy and advising that the pupil be fully immunized against HPV before admission or advancement to the 8th grade level. The bill would incorporate that notification into existing provisions relating to notifications by school districts. By creating new notification duties for school districts, the bill would impose a state-mandated local program.

AB 666 **(Arambula D) Health systems: community benefits plans.**
Current Text: Amended: 4/6/2023 html pdf
Last Amend: 4/6/2023
Status: 4/28/2023-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 3/23/2023)(May be acted upon Jan 2024)
Location: 4/28/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law requires a private, not-for-profit hospital to adopt and update a community benefits plan that describes the activities the hospital has undertaken to address identified community needs within its mission and financial capacity, including health care services rendered to vulnerable populations. Current law defines the term "community" as the service areas or patient populations for which the hospital provides health care services, defines "vulnerable populations" for these purposes to include a population that is exposed to medical or financial risk by virtue of being uninsured, underinsured, or eligible for Medi-Cal, Medicare, California Children's Services Program, or county indigent programs, and defines "community benefit" to mean the hospital's activities that are intended to address community needs, such as support to local health departments, among other things. Current law requires a hospital to conduct a community needs assessment to evaluate the health needs of the community and to update that assessment at least once every 3 years. Current law requires a hospital to annually submit a community benefits plan to the department not later than 150 days after the hospital's fiscal year ends. Current law authorizes the department to impose a fine not to exceed $5,000 against a hospital that fails to adopt, update, or submit a community benefits plan, and requires the department to annually report on its internet website the amount of community benefit spending and list those that failed to report community benefit spending, among other things. This bill would require the department to define the term "community" by regulation within certain parameters, would redefine the term "community benefit" to mean services rendered to those eligible for, but not enrolled in the above-described programs, the unreimbursed costs as reported in specified tax filings, and the support to local health departments as documented by those local health departments, among other things, and would redefine the term "vulnerable populations" to include those eligible for, but not enrolled in the above-described programs, those below median income experiencing economic disparities, and certain socially disadvantaged groups, such as those who are incarcerated.

AB 677 **(Addis D) Confidentiality of Medical Information Act.**
Current Text: Introduced: 2/13/2023 html pdf
Status: 5/5/2023-Failed Deadline pursuant to Rule 61(a)(3). (Last location was PRINT on 2/13/2023)(May be acted upon Jan 2024)

Location: 5/5/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The Confidentiality of Medical Information Act, among other things, prohibits a health care provider, a contractor, or a health care service plan from disclosing medical information, as defined, regarding a patient of the provider or an enrollee or subscriber of the health care service plan without first obtaining an authorization, except as specified. This bill would make nonsubstantive changes to the title provision of the act.

AB 716 **(Boerner D) Emergency ground medical transportation.**
Current Text: Amended: 6/26/2023 html pdf
Last Amend: 6/26/2023
Status: 6/26/2023-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.
Location: 6/7/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law creates the Emergency Medical Services Authority to coordinate various state activities concerning emergency medical services. Current law requires the authority to report specified information, including reporting ambulance patient offload time twice per year to the Commission on Emergency Medical Services. This bill would require the authority to annually report the allowable maximum rates for ground ambulance transportation services in each county, including trending the rates by county, as specified. This bill contains other related provisions and other existing laws.

AB 719 **(Boerner D) Medi-Cal: nonmedical and nonemergency medical transportation.**
Current Text: Amended: 6/26/2023 html pdf
Last Amend: 6/26/2023
Status: 6/26/2023-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.
Location: 6/7/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require the State Department of Health Care Services to require Medi-Cal managed care plans to contract with public paratransit service operators for the purpose of establishing reimbursement rates for nonmedical and nonemergency medical transportation trips provided by a public paratransit service operator. The bill would require the rates reimbursed by the managed care plan to the public paratransit service operator to be based on the department's fee-for-service rates for nonmedical and nonemergency medical transportation service, as specified.

AB 722 **(Bonta D) Alameda Health System Hospital Authority.**
Current Text: Amended: 4/24/2023 html pdf
Last Amend: 4/24/2023

Status: 6/21/2023-From committee: Do pass and re-refer to Com. on HEALTH. (Ayes 7. Noes 0.) (June 21). Re-referred to Com. on HEALTH.
Location: 6/21/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law authorizes the Board of Supervisors of Alameda County to establish the Alameda Health System Hospital Authority for the management, administration, and control of the medical center in that county. Current law prohibits the hospital authority, before January 1st, 2024, from entering into a contract with any other person or entity to replace services being provided by physicians and surgeons who are employed by the hospital authority and in a recognized collective bargaining unit, with services provided by that other person or entity without clear and convincing evidence that the needed medical care can only be delivered cost effectively by that other person or entity. This bill would prohibit the hospital authority, before January 1st, 2035, from entering into those contracts.

AB 815 **(Wood D) Health care coverage: provider credentials.**
Current Text: Amended: 4/20/2023 html pdf
Last Amend: 4/20/2023
Status: 6/7/2023-Referred to Com. on HEALTH.
Location: 6/7/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require the California Health and Human Services Agency to create and maintain a provider credentialing board, with specified membership, to certify private and public entities for purposes of credentialing physicians and surgeons in lieu of a health care service plan's or health insurer's credentialing process. The bill would require the board to convene by July 1st, 2024, develop criteria for the certification of public and private credentialing entities by January 1st, 2025, and develop an application process for certification by July 1st, 2025.

AB 845 **(Alvarez D) Behavioral health: older adults.**
Current Text: Amended: 4/13/2023 html pdf
Last Amend: 4/13/2023
Status: 5/18/2023-Joint Rule 62(a), file notice suspended. In committee: Held under submission.
Location: 5/17/2023-A. APPR. SUSPENSE FILE

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would establish within the State Department of Health Care Services an Older Adult Behavioral Health Services Administrator to oversee behavioral health services for older adults. The bill would require that position to be funded with administrative funds from the Mental Health Services Fund. The bill would prescribe the functions of the administrator and their responsibilities, including, but not limited to, developing outcome and related indicators for older adults for the purpose of assessing the status of behavioral health services for older adults, monitoring the quality of programs for those adults, and guiding decisionmaking on how to improve those services. The bill would require

the administrator to receive data from other state agencies and departments to implement these provisions, subject to existing state or federal confidentiality requirements. The bill would require the administrator to report to the entities that administer the MHSA on those outcome and related indicators by July 1st, 2024, and would require the report to be posted on the department's internet website.

AB 847 **(Rivas, Luz D) Medi-Cal: pediatric palliative care services.**
Current Text: Amended: 6/26/2023 html pdf
Last Amend: 6/26/2023
Status: 6/26/2023-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.
Location: 6/7/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law requires the State Department of Health Care Services to develop a pediatric palliative care benefit as a pilot program to Medi-Cal beneficiaries under 21 years of age, to be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available. Current law requires that program to include, among other things, hospice services to individuals whose conditions may result in death, regardless of the estimated length of the individual's remaining period of life. Pursuant to the above-described provisions, the department established the Pediatric Palliative Care (PPC) Waiver in 2009, upon receiving federal approval in December 2008. After the waiver ended on December 31st, 2018, the department implemented a plan in 2019 to transition some pediatric palliative care services to the Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefit, which is available to Medi-Cal beneficiaries under 21 years of age, as specified. This bill, Sophia's Act, would extend eligibility for pediatric palliative care services for those individuals who have been determined eligible for those services prior to 21 years of age, until 26 years of age and would extend eligibility for hospice services after 21 years of age.

AB 874 **(Weber D) Health care coverage: out-of-pocket expenses.**
Current Text: Introduced: 2/14/2023 html pdf
Status: 4/28/2023-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 2/23/2023)(May be acted upon Jan 2024)
Location: 4/28/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require a health care service plan, health insurance policy, other health coverage carrier, or pharmacy benefit manager that administers pharmacy benefits to apply any amounts paid by the enrollee, insured, or another source pursuant to a discount, repayment, product voucher, or other reduction to the enrollee's or insured's out-of-pocket expenses toward the enrollee's or insured's overall contribution to any out-of-pocket maximum, deductible, copayment, coinsurance, or applicable cost-sharing requirement under the enrollee's or insured's health care service plan, health insurance policy, or other health care coverage. The bill would make a willful violation of that requirement by a health care service plan a crime. The bill would limit the application of the section to health care

service plans and health insurance policies issued, amended, delivered, or renewed on or after January 1st, 2024. Because a willful violation of these requirements by a health care service plan would be a crime, this bill would impose a state-mandated local program.

AB 904 **(Calderon D) Health care coverage: doulas.**
Current Text: Amended: 6/26/2023 html pdf
Last Amend: 6/26/2023
Status: 7/3/2023-In committee: Referred to APPR suspense file.
Location: 7/3/2023-S. APPR. SUSPENSE FILE

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require a health care service plan or health insurer, on or before January 1, 2025, to develop a maternal and infant health equity program that addresses racial health disparities in maternal and infant health outcomes through the use of doulas. The bill would require the Department of Managed Health Care, in consultation with the Department of insurance, to collect data and submit a report describing the doula coverage and the above-described programs to the Legislature by January 1st, 2027. Because a willful violation of the provisions relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

AB 907 **(Lowenthal D) Coverage for PANDAS and PANS.**
Current Text: Amended: 7/3/2023 html pdf
Last Amend: 7/3/2023
Status: 7/3/2023-Read second time and amended. Re-referred to Com. on APPR.
Location: 6/29/2023-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1st, 2024, to provide coverage for the prophylaxis, diagnosis, and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) that is prescribed or ordered by the treating physician and surgeon. The bill would prohibit coverage for PANDAS and PANS from being subject to a copayment, coinsurance, deductible, or other cost sharing that is greater than that applied to other benefits. The bill would prohibit a plan or insurer from denying or delaying coverage for PANDAS or PANS therapies because the enrollee or insured previously received treatment for PANDAS or PANS or was diagnosed with or received treatment for the condition under a different diagnostic name. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 912 **(Jones-Sawyer D) Strategic Anti-Violence Funding Efforts Act.**
Current Text: Amended: 5/18/2023 html pdf
Last Amend: 5/18/2023
Status: 6/20/2023-From committee: Do pass and re-refer to Com. on HEALTH. (Ayes 5. Noes 0.) (June 20). Re-referred to Com. on HEALTH.
Location: 6/20/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: (1)Existing law establishes the Youth Reinvestment Grant Program within the Board of State and Community Corrections to grant funds, upon appropriation, to local jurisdictions and Indian tribes for the purpose of implementing trauma-informed diversion programs for minors, as specified. This bill would repeal these provisions. The bill would reestablish the Youth Reinvestment Grant Program, to be administered by the Office of Youth and Community Restoration, for the purpose of implementing a mixed-delivery system of trauma-informed health and development diversion programs for youth, as specified. The bill would create the Youth Reinvestment Fund to be used, upon appropriation by the Legislature, by the office for the purposes of the program. The bill would require applicants for the program to be nongovernmental agencies or tribal governments, as specified. The bill would provide that an applicant under this program be awarded no less than $50,000, and no more than $2,000,000, and would specify the requirements of diversion programs to qualify for funding under these provisions. This bill contains other related provisions and other existing laws.

AB 931 **(Irwin D) Prior authorization: physical therapy.**
Current Text: Amended: 6/15/2023 html pdf
Last Amend: 6/15/2023
Status: 6/26/2023-In committee: Referred to APPR. suspense file.
Location: 6/26/2023-S. APPR. SUSPENSE FILE

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1st, 2025, that provides coverage for physical therapy from imposing prior authorization for the initial 12 treatment visits for a new episode of care for physical therapy. The bill would require a physical therapy provider to verify an enrollee's or an insured's coverage and disclose their share of the cost of care, as specified. The bill would require a physical therapy provider to disclose if the provider is not in the network of the enrollee's plan or the insured's policy, and if so, to obtain the enrollee's or the insured's consent in writing to receive services from the noncontracting provider prior to initiating care. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 948 **(Berman D) Prescription drugs.**
Current Text: Amended: 6/12/2023 html pdf
Last Amend: 6/12/2023
Status: 6/27/2023-Read second time. Ordered to third reading.
Location: 6/27/2023-S. THIRD READING

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law prohibits the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription from exceeding $250 for a supply of up to 30 days, except as specified. Current law requires a health care service plan contract or

health insurance policy for a nongrandfathered individual or small group product that maintains a drug formulary grouped into tiers, and that includes a 4th tier, to define each tier of the drug formulary, as specified. Current law defines Tier 4 to include, among others, drugs that are biologics. Existing law repeals these provisions on January 1st, 2024. This bill would delete drugs that are biologics from the definition of Tier 4. The bill would require a health care service plan or a health insurer, if there is a generic equivalent to a brand name drug, to ensure that an enrollee or insured is subject to the lowest cost sharing that would be applied, whether or not both the generic equivalent and the brand name drug are on the formulary. The bill also would delete the January 1st, 2024, repeal date of the above provisions, thus making them operative indefinitely.

AB 952 **(Wood D) Dental coverage disclosures.**
Current Text: Amended: 6/6/2023 html pdf
Last Amend: 6/6/2023
Status: 6/29/2023-Read third time. Passed. Ordered to the Assembly. (Ayes 39. Noes 0.). In Assembly. Concurrence in Senate amendments pending. May be considered on or after July 1st pursuant to Assembly Rule 77.
Location: 6/29/2023-A. CONCURRENCE

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require a health care service plan or health insurer that issues, sells, renews, or offers a contract covering dental services, including a specialized health care service plan or specialized health insurer covering dental services, to disclose whether an enrollee's or insured's dental coverage is "State Regulated" through a provider portal, if available, or otherwise upon request, on or after January 1st, 2025. The bill would require a plan or insurer to include the statement "State Regulated," if the enrollee's or insured's dental coverage is subject to regulation by the appropriate department, on an electronic or physical identification card, or both if available, for contracts covering dental services issued on or after January 1st, 2025. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 991 **(Alvarez D) Public social services: reporting and verification.**
Current Text: Introduced: 2/15/2023 html pdf
Status: 5/19/2023-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/17/2023)(May be acted upon Jan 2024)
Location: 5/19/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law provides for various public social services programs administered by the State Department of Social Services, State Department of Health Care Services, and counties, including, among others, the California Work Opportunity and Responsibility to Kids (CalWORKs) program, under which each county provides cash assistance and other benefits to qualified low-income families and individuals, CalFresh, under which supplemental nutrition assistance benefits allocated to the state by the federal government are distributed to eligible individuals by each county, and the Medi-Cal program, under which qualified low-income individuals receive health care service. Current law imposes various reporting and verification requirements on applicants and recipients of these public

social services programs relating to identity, income, and assets, among other things. This bill would, to the extent permitted under federal law, require state and county agencies to accept the reporting by an applicant or recipient of public social services of any lawfully required information, changes, and verification required by law that affect eligibility and benefit amounts, by any means available to the applicant or recipient, including, but not limited to, in person, by telephone, through facsimile, by email, or by any other electronic means.

AB 1001 (Haney D) **Health facilities: behavioral health response.**

Current Text: Amended: 4/13/2023 html pdf
Last Amend: 4/13/2023
Status: 6/28/2023-In committee: Set, first hearing. Hearing canceled at the request of author.
Location: 6/14/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Would require a general acute care hospital to adopt policies for behavioral health personnel to respond to patients with a mental health or substance use crisis. The bill would require that these protocols meet standards established by the State Department of Public Health and consist of various parameters such as minimum staffing requirements for behavioral health responses, procedures for response by behavioral health personnel in a timely manner, and annual training, as specified. The bill would require the department to adopt regulations on standards for general acute care hospitals related to behavioral health response. The bill would require all general acute care hospitals to maintain records on each patient who receives care from behavioral health response personnel and the number of hours of services provided for a period of 3 years. The bill would require hospitals to include related data in their quarterly summary utilization data reported to the department.

AB 1006 (McKinnor D) **Aging and Disability Resource Connection program: No Wrong Door System.**

Current Text: Amended: 4/27/2023 html pdf
Last Amend: 4/27/2023
Status: 7/3/2023-In committee: Referred to APPR suspense file.
Location: 7/3/2023-S. APPR. SUSPENSE FILE

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Current law establishes an Aging and Disability Resource Connection (ADRC) program, administered by the California Department of Aging, to provide information to consumers and their families on available long-term services and supports (LTSS) programs and to assist older adults, caregivers, and persons with disabilities in accessing LTSS programs at the local level. Current law requires the California Department of Aging to administer the Aging and Disability Resource Connection (ADRC) Infrastructure Grants Program for the purpose of implementing a No Wrong Door System, a system that enables consumers to access all long-term services and supports (LTSS) through one agency, organization, coordinated network, or portal. Current law makes related legislative intent statements regarding the No Wrong Door System, including that it is the intent to provide consumers and their caregivers access to information and services, regardless of income or benefit level. Current law also establishes the Aging and Disability Resource Connection Advisory Committee, within the California Department of Aging, as the primary adviser in the implementation

of the No Wrong Door System. Current law authorizes the committee to use the staff of the California Department of Aging to accomplish its purposes. This bill would instead require the committee to use the staff of the California Department of Aging.

AB 1011 (**Weber** D) **Social care: data privacy.**

Current Text: Amended: 6/29/2023 html pdf

Last Amend: 6/29/2023

Status: 6/29/2023-Read second time and amended. Re-referred to Com. on APPR. (Amended 6/29/2023)

Location: 6/28/2023-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Current federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), establishes certain requirements relating to the provision of health insurance, including provisions relating to the confidentiality of health records. Current state law, the Confidentiality of Medical Information Act, prohibits a provider of health care, a health care service plan, a contractor, a corporation and its subsidiaries and affiliates, or any business that offers software or hardware to consumers, including a mobile application or other related device, as defined, from intentionally sharing, selling, using for marketing, or otherwise using any medical information, as defined, for any purpose not necessary to provide health care services to a patient, except as provided. This bill would prohibit a participating entity of a closed-loop referral system (CLRS) from selling, renting, releasing, disclosing, disseminating, making available, transferring, or otherwise communicating orally, in writing, or by electronic or other means, social care information stored in or transmitted through a CLRS in exchange for monetary or other valuable consideration. The bill would further prohibit a participating entity from using social care information stored in, or transmitted through, a CLRS for any purpose or purposes other than the social care purpose or purposes for which that social care information was collected or generated, except as specified.

AB 1022 (**Mathis** R) **Medi-Cal: Program of All-Inclusive Care for the Elderly.**

Current Text: Introduced: 2/15/2023 html pdf

Status: 4/28/2023-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 3/2/2023)(May be acted upon Jan 2024)

Location: 4/28/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Current federal law establishes the Program of All-Inclusive Care for the Elderly (PACE), which provides specified services for older individuals at a PACE center so that they may continue living in the community. Federal law authorizes states to implement PACE as a Medicaid state option. Current state law establishes the California Program of All-Inclusive Care for the Elderly (PACE program) to provide community-based, risk-based, and capitated long-term care services as optional services under the state's Medi-Cal state plan. Current law requires the department to develop and pay capitation rates to entities contracted through the PACE program using actuarial methods and that reflect the level of care associated with the specific populations served pursuant to the contract. Current law authorizes a PACE organization approved by the department to use video telehealth to

conduct initial assessments and annual reassessments for eligibility for enrollment in the PACE program. This bill, among other things relating to the PACE program, would require those capitation rates to also reflect the frailty level and risk associated with those populations. The bill would also expand an approved PACE organization's authority to use video telehealth to conduct all assessments, as specified.

AB 1036 (Bryan D) Health care coverage: emergency medical transport.

Current Text: Introduced: 2/15/2023 html pdf

Status: 4/28/2023-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 3/2/2023)(May be acted upon Jan 2024)

Location: 4/28/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law requires a policy of disability insurance issued, amended, delivered, or renewed in this state on or after January 1st, 1999, that provides hospital, medical, or surgical coverage with coverage for emergency health care services to include coverage for emergency medical transportation services without regard to whether or not the emergency provider contracts with the insurer or to prior authorization. Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Current law establishes a schedule of benefits under the Medi-Cal program, including various emergency medical services. This bill would require a physician, upon an individual's arrival to an emergency department of a hospital, to certify in the treatment record whether an emergency medical condition existed, or was reasonably believed to have existed, and required emergency medical transportation services, as specified. This bill would, if a physician has certified that emergency medical transportation services according to these provisions, require a health care service plan, disability insurance policy, and Medi-Cal managed care plan, to provide coverage for emergency medical transport, consistent with an individual's plan or policy. The bill would specify that the indication by a physician pursuant to these provisions is limited to an assessment of the medical necessity of the emergency medical transport services, and does not apply or otherwise impact provisions regarding coverage for care provided following completion of the emergency medical transport. The bill would specify for Medi-Cal benefits, these provisions do not apply to various specified provisions relating to nonemergency transport services or any other law or regulation related to reimbursement or authorization requirements for services provided for emergency services and care.

AB 1048 (Wicks D) Dental benefits and rate review.

Current Text: Amended: 7/3/2023 html pdf

Last Amend: 7/3/2023

Status: 7/3/2023-Read second time and amended. Re-referred to Com. on APPR.

Location: 6/29/2023-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would, on and after January 1st, 2024, prohibit a health care service plan or health insurer

that covers dental services, including a specialized health care service plan or health insurer that covers dental services, from issuing, amending, renewing, or offering a plan contract or policy that imposes a dental waiting period provision or preexisting condition provision, as specified. Because a violation of these requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 1060 (Ortega D) Health care coverage: naloxone hydrochloride.
Current Text: Amended: 6/12/2023 html pdf
Last Amend: 6/12/2023
Status: 6/29/2023-From committee: Do pass and re-refer to Com. on APPR. (Ayes 12. Noes 0.) (June 28). Re-referred to Com. on APPR.
Location: 6/29/2023-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Under current law, the pharmacist service of furnishing naloxone hydrochloride is a covered Medi-Cal benefit. The Medi-Cal program also covers certain medications to treat opioid use disorders as part of narcotic treatment program services, or as part of medication-assisted treatment services within the Drug Medi-Cal Treatment Program, as specified. This bill would make legislative findings relating to the United States Food and Drug Administration (FDA) approving a certain naloxone hydrochloride nasal spray for nonprescription use.

AB 1085 (Maienschein D) Medi-Cal: housing support services.
Current Text: Amended: 6/15/2023 html pdf
Last Amend: 6/15/2023
Status: 6/26/2023-In committee: Referred to APPR. suspense file.
Location: 6/26/2023-S. APPR. SUSPENSE FILE

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the State Department of Health Care Services as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under existing law, community supports that the department is authorized to approve include, among other things, housing transition navigation services, housing deposits, and housing tenancy and sustaining services. Current law, subject to an appropriation, requires the State Department of Health Care Services to complete an independent analysis to determine whether network adequacy exists to obtain federal approval for a covered Medi-Cal benefit that provides housing support services. Current law requires that the analysis take into consideration specified information, including the number of providers in relation to each region's or county's number of people experiencing homelessness. Current law requires the department to report the outcomes of the analysis to the Legislature by January 1st, 2024.This bill would require the department, if the independent analysis finds that the state has sufficient network capacity to meet state and federal guidelines to create a new housing support services benefit, to seek any necessary federal approvals for a Medi-Cal benefit to cover housing support services within 6 months of the completion of the analysis. The bill would

require the department to report the outcomes of the analysis to the Legislature by July 1st, 2024. Under the bill, subject to receipt of those federal approvals, a Medi-Cal beneficiary would be eligible for those services if they either experience homelessness or are at risk of homelessness, as specified.

AB 1091 (Wood D) Health Care Consolidation and Contracting Fairness Act of 2023.

Current Text: Introduced: 2/15/2023 html pdf

Status: 4/28/2023-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 3/2/2023)(May be acted upon Jan 2024)

Location: 4/28/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: This bill, the Health Care Consolidation and Contracting Fairness Act of 2023, would prohibit a contract issued, amended, or renewed on or after January 1st, 2024, between a health care service plan or health insurer and a health care provider or health facility from containing terms that, among other things, restrict the plan or insurer from steering an enrollee or insured to another provider or facility or require the plan or insurer to contract with other affiliated providers or facilities. The bill would authorize the appropriate regulating department to refer a plan's or insurer's contract to the Attorney General, and would authorize the Attorney General or state entity charged with reviewing health care market competition to review a health care practitioner's or health facility's entrance into a contract that contains specified terms. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 1092 (Wood D) Health care service plans: consolidation.

Current Text: Amended: 6/28/2023 html pdf

Last Amend: 6/28/2023

Status: 6/28/2023-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.

Location: 6/7/2023-S. JUD.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law requires a health care service plan that intends to merge with, consolidate with, or enter into an agreement resulting in its purchase, acquisition, or control by, an entity, to give notice to, and secure prior approval from, the Director of the Department of Managed Health Care. Current law authorizes the director to disapprove the transaction or agreement if the director finds it would substantially lessen competition in health care service plan products or create a monopoly in this state. Current law authorizes the director to conditionally approve the transaction or agreement, contingent upon the health care service plan's agreement to fulfill one or more conditions to benefit subscribers and enrollees of the health care service plan, provide for a stable health care delivery system, and impose other conditions specific to the transaction or agreement, as specified. This bill would additionally require a health care service plan that intends to acquire or obtain control of an entity, as specified, to give notice to, and secure prior approval from, the director. Because a willful violation of this provision would be a crime, the bill would impose a state-mandated local program.

AB 1122 (Bains D) Medi-Cal provider applications.

Current Text: Amended: 4/20/2023 html pdf
Last Amend: 4/20/2023
Status: 6/7/2023-Referred to Com. on HEALTH.
Location: 6/7/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law generally requires an applicant that currently is not enrolled in the Medi-Cal program, a provider applying for continued enrollment, or a provider not currently enrolled at a location where the provider intends to provide services, goods, supplies, or merchandise to a Medi-Cal beneficiary, to submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location or a change in location, as specified. Current law requires an applicant or provider, for new or continued enrollment in the Medi-Cal program, to disclose all information as required in federal Medicaid regulations and any other information required by the State Department of Health Care Services, as specified. This bill would require the Director of Health Care Services to develop a process to allow an applicant or provider to submit an alternative type of primary, authoritative source documentation to meet the requirement of submitting the above-described information. The bill would require the department to document each case of an applicant or provider submitting an alternative type of primary, authoritative source documentation, as specified. The bill would condition implementation of these provisions on lack of conflict with federal law or regulation, federal financial participation not being jeopardized, and receipt of any necessary federal approvals.

AB 1130 (Berman D) Substance use disorder.
Current Text: Chaptered: 6/29/2023 html pdf
Status: 6/29/2023-Approved by the Governor. Chaptered by Secretary of State - Chapter 21, Statutes of 2023.
Location: 6/29/2023-A. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law, the California Uniform Controlled Substances Act, regulates the distribution and use of controlled substances, as defined. Under the act, the State Department of Health Care Services is responsible for the administration of prevention, treatment, and recovery services for alcohol and drug abuse. Existing law, the Medical Practice Act, provides for the licensing and regulation of physicians and surgeons by the Medical Board of California. Current law authorizes a physician and surgeon to prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under their treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances and under specified conditions to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances.This bill would revise and recast these provisions, among others, to delete the reference to an “addict” and instead replace it with the term “a person with substance use disorder,” among other technical nonsubstantive changes.

AB 1147 (Addis D) Disability Equity and Accountability Act of 2023.
Current Text: Amended: 5/19/2023 html pdf
Last Amend: 5/19/2023

Status: 7/5/2023-From committee: Do pass and re-refer to Com. on JUD. (Ayes 5. Noes 0.) (July 3). Re-referred to Com. on JUD.
Location: 6/14/2023-S. JUD.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would enact the Disability Equity and Accountability of 2023, which would make various changes to the Lanterman Developmental Disabilities Services Act for purposes including gathering relevant data and providing increased oversight of regional center operations and performance. The bill would require an evaluation of regional center performance by the State Department of Developmental Services, which would be implemented using a common set of performance measures. The bill would require the assessments to use performance measures in 7 specific domains: community integration, employment, equity in access, case management, client and family choice, experience and satisfaction, human and civil rights, and health and safety. The bill would require the department to establish standards for these performance measures, as specified, by July 1st, 2024. The bill would require the department, in consultation with stakeholders, including consumers and family members, to annually establish, update, and review a uniform process to be used by regional centers to develop corrective action plans that respond to below standard performance. The bill would require the department to oversee the process to develop a corrective action plan and assess corrective action undertaken by a regional center.

AB 1157 (Ortega D) Rehabilitative and habilitative services: durable medical equipment and services.
Current Text: Introduced: 2/16/2023 html pdf
Status: 6/14/2023-Referred to Com. on HEALTH.
Location: 6/14/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would specify that coverage of rehabilitative and habilitative services and devices under a health care service plan or health insurance policy includes durable medical equipment, services, and repairs, if the equipment, services, or repairs are prescribed or ordered by a physician, surgeon, or other health professional acting within the scope of their license. The bill would define “durable medical equipment” to mean devices, including replacement devices, that are designed for repeated use, and that are used for the treatment or monitoring of a medical condition or injury in order to help a person to partially or fully acquire, improve, keep, or learn, or minimize the loss of, skills and functioning of daily living. The bill would prohibit coverage of durable medical equipment and services from being subject to financial or treatment limitations, as specified. Because a violation of the bill’s provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 1163 (Rivas, Luz D) Lesbian, Gay, Bisexual, and Transgender Disparities Reduction Act.
Current Text: Amended: 6/28/2023 html pdf
Last Amend: 6/28/2023
Status: 6/28/2023-Read second time and amended. Re-referred to Com. on JUD.
Location: 6/27/2023-S. JUD.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The Lesbian, Gay, Bisexual, and Transgender Disparities Reduction Act requires prescribed state entities, including the State Department of Health Care Services and the Civil Rights Department, in the course of collecting demographic data directly or by contract as to the ancestry or ethnic origin of Californians, to collect voluntary self-identification information pertaining to sexual orientation and gender identity, except as specified. Existing law prohibits these state entities from reporting demographic data that would permit identification of individuals or would result in statistical unreliability and limits the use of the collected data by those entities, as specified. Current law requires these state entities to report to the Legislature specified information related to the data and make the data available to the public, except for personally identifiable information, which existing law deems confidential and prohibits disclosure of that information. This bill would impose the provisions of the above-described act on the Business, Consumer Services, and Housing Agency, the California Health and Human Services Agency, and the Department of Housing and Community Development, and would require these state entities to comply with the bill's provisions as early as possible following the effective date of this bill, but no later than July 1st, 2025.

AB 1194 (Carrillo, Wendy D) California Privacy Rights Act of 2020: exemptions: abortion services.
Current Text: Introduced: 2/16/2023 html pdf
Status: 6/21/2023-From committee: Do pass and re-refer to Com. on APPR. (Ayes 10. Noes 0.) (June 20). Re-referred to Com. on APPR.
Location: 6/20/2023-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The California Privacy Rights Act of 2020 (CPRA), approved by the voters as Proposition 24 at the November 3, 2020, statewide general election, grants a consumer various rights with respect to personal information, as defined, that is collected or sold by a business, as defined, including the right to require the business to delete personal information about the consumer, as specified, unless those obligations restrict a business' ability to, among other things, comply with federal, state, or local laws or comply with a court order or subpoena to provide information, or cooperate with a government agency request for emergency access to a consumer's personal information if a natural person is at risk or danger of death or serious physical injury, as provided. This bill would, if the consumer's personal information contains information related to accessing, procuring, or searching for services regarding contraception, pregnancy care, and perinatal care, including, but not limited to, abortion services, require a business to comply with the obligations imposed by the CPRA. The bill would specify that a consumer accessing, procuring, or searching for those services does not constitute a natural person being at risk or danger of death or serious physical injury.

AB 1202 (Lackey R) Medi-Cal: time or distance standards: children's health care services.
Current Text: Amended: 3/29/2023 html pdf
Last Amend: 3/29/2023
Status: 6/14/2023-Referred to Com. on HEALTH.
Location: 6/14/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing 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 health care 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, no later than January 1st, 2025, require each Medi-Cal managed care plan to conduct, and report to the department the results of, an analysis to identify the number and, as appropriate, the geographic distribution of Medi-Cal providers needed to ensure the Medi-Cal managed care plan's compliance with the above-described time or distance and appointment time standards for pediatric primary care, across all service areas of the plan. The bill would, no later than January 1st, 2026, require the department to prepare and submit a report to the Legislature that includes certain information, including a summary of the results reported by Medi-Cal managed care plans, specific steps for Medi-Cal managed care plan accountability, evidence of progress and compliance, and level of accuracy of provider directories, as specified. This bill contains other related provisions and other existing laws.

AB 1233 (Waldron R) Substance abuse: Naloxone Distribution Project: tribal governments.
Current Text: Amended: 3/23/2023 html pdf
Last Amend: 3/23/2023
Status: 6/26/2023-In committee: Referred to APPR. suspense file.
Location: 6/26/2023-S. APPR. SUSPENSE FILE

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require the State Department of Health Care Services to conduct outreach to each of the tribal governments in California for the purpose of advising them of the availability of naloxone hydrochloride or another opioid antagonist through the NDP. The bill would require the department to provide technical assistance to the tribal entities applying for naloxone kits through the NDP if requested to do so by the tribal government. The bill would require the department to report to the Legislature and to the Assembly and Senate Health Committees, the results of the outreach program, as specified, annually on or before March 31st, of each year, beginning on March 31st, 2025. The bill would repeal these provisions on March 31st, 2027.

AB 1239 (Calderon D) Incarcerated persons: Family Planning, Access, Care, and Treatment Program.
Current Text: Amended: 3/23/2023 html pdf
Last Amend: 3/23/2023
Status: 6/29/2023-From committee: Do pass and re-refer to Com. on PUB S. with recommendation: To Consent Calendar. (Ayes 11. Noes 0.) (June 28). Re-referred to Com. on PUB S.
Location: 6/7/2023-S. PUB. S.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require the State Department of Health Care Services, no later than September 1st, 2025, to issue a list of Family PACT Program providers and clinics to an entity designated by the

Department of Corrections and Rehabilitation for voluntary partnership with the department to assist a prison inmate with continuing and receiving specified health care services upon their release. The bill would impose a similar requirement on the State Department of Health Care Services for purposes of a list of Family PACT Program providers and clinics to assist county jail inmates, with the list being issued to an entity designated by county jails. Under the bill, any assistance provided to inmates would be provided only to the extent that the inmate elects to apply for the program and receive assistance, as specified.

AB 1241 (Weber D) Medi-Cal: telehealth.

Current Text: Amended: 5/24/2023 html pdf

Last Amend: 5/24/2023

Status: 6/29/2023-Read third time. Passed. Ordered to the Assembly. (Ayes 39. Noes 0.). In Assembly. Concurrence in Senate amendments pending. May be considered on or after July 1 pursuant to Assembly Rule 77.

Location: 6/29/2023-A. CONCURRENCE

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Under current law, in-person, face-to-face contact is not required when covered health care services by the Medi-Cal Program are provided by video synchronous interaction, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those services and settings meet certain criteria. Current law requires a provider furnishing services through video synchronous interaction or audio-only synchronous interaction, by a date set by the State Department of Health Care Services, no sooner than January 1st, 2024, to also either offer those services via in-person contact or arrange for a referral to, and a facilitation of, in-person care, as specified. This bill would instead require, under the above-described circumstance, a provider to maintain and follow protocols to either offer those services via in-person contact or arrange for a referral to, and a facilitation of, in-person care. The bill would specify that the referral and facilitation arrangement would not require a provider to schedule an appointment with a different provider on behalf of a patient.

AB 1282 (Lowenthal D) Mental health: impacts of social media.

Current Text: Amended: 6/13/2023 html pdf

Last Amend: 6/13/2023

Status: 6/22/2023-From committee: Do pass and re-refer to Com. on JUD. with recommendation: To Consent Calendar. (Ayes 12. Noes 0.) (June 21). Re-referred to Com. on JUD.

Location: 6/21/2023-S. JUD.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require the Mental Health Services Oversight and Accountability Commission to report to specified policy committees of the Legislature, on or before July 1st, 2025, a statewide strategy to understand, communicate, and mitigate mental health risks associated with the use of social media by children and youth. The bill would require the report to include, among other things, (1) the degree to which individuals negatively impacted by social media are accessing and receiving mental health services and (2) recommendations to strengthen children and youth resiliency

strategies and California's use of mental health services to reduce the negative outcomes that may result from untreated mental illness, as specified. The bill would require the commission to explore, among other things, the persons and populations that use social media and the negative mental health risks associated with social media and artificial intelligence, as defined. The bill would repeal these provisions on January 1st, 2029.

AB 1286 (Haney D) Pharmacy.

Current Text: Amended: 7/5/2023 html pdf

Last Amend: 7/5/2023

Status: 7/5/2023-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on JUD.

Location: 7/3/2023-S. JUD.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The Pharmacy Law requires every pharmacy to designate a pharmacist-in-charge who is responsible for a pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy. This bill would authorize a pharmacist-in-charge to make staffing decisions to ensure sufficient personnel are present in the pharmacy to prevent fatigue, distraction, or other conditions that may interfere with a pharmacist's ability to practice competently and safely. The bill would authorize a pharmacist on duty, if the pharmacist-in-charge is not available, to adjust staffing according to workload if needed. The bill would require a pharmacist-in-charge or pharmacist on duty to immediately notify store management of any conditions that present an immediate risk of death, illness, or irreparable harm to patients, personnel, or pharmacy staff. The bill would require store management to take immediate and reasonable steps to address and resolve those conditions, and, if those conditions are not resolved within 24 hours, would require the pharmacist-in-charge or pharmacist on duty to ensure the California State Board of Pharmacy is notified. The bill would require the executive officer, upon a reasonable belief that conditions within a pharmacy exist that present an immediate risk of death, illness, or irreparable harm to patients, personnel, or pharmacy staff, to issue a cease and desist order, as specified. The bill would make a failure to comply with the cease and desist order unprofessional conduct for a pharmacy corporation.

AB 1288 (Rendon D) Health care coverage: Medication-assisted treatment.

Current Text: Amended: 7/5/2023 html pdf

Last Amend: 7/5/2023

Status: 7/5/2023-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.

Location: 5/31/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would prohibit a medical service plan and a health insurer from subjecting a naloxone product, buprenorphine product, methadone, or long-acting injectable naltrexone for detoxification or maintenance treatment of a substance use disorder to prior authorization or step therapy. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program.

AB 1300 (Flora R) **Health care service plans.**

Current Text: Introduced: 2/16/2023 html pdf

Status: 5/5/2023-Failed Deadline pursuant to Rule 61(a)(3). (Last location was PRINT on 2/16/2023)(May be acted upon Jan 2024)

Location: 5/5/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Current law charges the department with the execution of the laws of this state relating to health care service plans to ensure that health care service plans provide enrollees with access to quality health care services. This bill would make technical, nonsubstantive changes to those provisions.

AB 1309 (Reyes D) **Long-term health care facilities: admission contracts.**

Current Text: Amended: 4/27/2023 html pdf

Last Amend: 4/27/2023

Status: 6/22/2023-From committee: Do pass and re-refer to Com. on APPR with recommendation: To Consent Calendar. (Ayes 12. Noes 0.) (June 21). Re-referred to Com. on APPR.

Location: 6/21/2023-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law provides for the licensing and regulation of health facilities, including, but not limited to, long-term health care facilities, as defined, by the State Department of Health Care Services. Current law requires a contract for admission to a long-term care facility to state that a resident shall not be involuntarily transferred within, or discharged from, a long-term health care facility unless the resident is given reasonable notice in writing, and transfer or discharge planning, as specified. Current law requires the notice to state the reason for the transfer or discharge. This bill would require the written notice to additionally be provided to the resident's representative, if applicable. The bill would require the facility to provide, within 48 hours of the written notice above, a copy of the resident's discharge needs and discharge plan. The bill would require the facility to provide a copy of the resident's discharge summary prior to the proposed transfer or discharge date. The bill would require the facility to provide these documents at no cost to the resident. If the resident requests a transfer or discharge appeal hearing, the bill would require both the resident and the facility to provide all documents and records to be used by the party at the hearing, as specified.

AB 1316 (Irwin D) **Emergency services: psychiatric emergency medical conditions.**

Current Text: Introduced: 2/16/2023 html pdf

Status: 4/28/2023-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 3/2/2023)(May be acted upon Jan 2024)

Location: 4/28/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would revise the definition of “psychiatric emergency medical condition” to make that definition applicable regardless of whether the patient is voluntary, or is involuntarily detained for evaluation and treatment. The bill would make conforming changes to provisions requiring facilities to provide that treatment. By expanding the definition of a crime with respect to those facilities, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 1325 (Waldron R) Microenterprise home kitchen operations.
Current Text: Enrolled: 7/5/2023 html pdf
Last Amend: 6/15/2023
Status: 7/3/2023-Urgency clause adopted. Senate amendments concurred in. To Engrossing and Enrolling. (Ayes 67. Noes 0.).
Location: 7/3/2023-A. ENROLLMENT

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Current law, under the California Retail Food Code, requires an microenterprise home kitchen operations (MHKO), as a restricted food service facility, to meet specified food safety standards, including, among others things, that the food is prepared, cooked, and served on the same day. Under current law, the food preparation is limited to no more than 30 individual meals per day, or the approximate equivalent of meal components when sold separately, and no more than 60 individual meals, or the approximate equivalent of meal components when sold separately, per week. Current law also requires an MHKO to have no more than $50,000 in verifiable gross annual sales, as adjusted annually for inflation. A violation of the code is a misdemeanor. This bill would require the food preparation to be limited to no more than 90 individual meals, as defined, or the approximate equivalent of meal components when sold separately, per week. The bill would also allow an MHKO to have no more than $100,000 in verifiable gross annual sales, adjusted for inflation.

AB 1331 (Wood D) California Health and Human Services Data Exchange Framework.
Current Text: Amended: 6/27/2023 html pdf
Last Amend: 6/27/2023
Status: 7/3/2023-In committee: Hearing postponed by committee.
Location: 5/31/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Current law establishes the Center for Data Insights and Innovation within the California Health and Human Services Agency to ensure the enforcement of state law mandating the confidentiality of medical information. Current law, subject to an appropriation in the annual Budget Act, requires the California Health and Human Services Agency to establish the California Health and Human Services Data Exchange Framework on or before July 1st, 2022, to govern and require the exchange of health information among health care entities and government agencies. This bill would require the Center for Data Insights and Innovation to take over establishment, implementation, and all the functions related to the California Health and Human Services Data Exchange Framework on or before July 1st, 2023, subject to an appropriation in the annual Budget Act. The bill would require the center to establish the CalHHS Data Exchange Board, with specified membership, to develop

recommendations and to approve any modifications to the Data Exchange Framework data sharing agreement, among other things.

AB 1338 (Petrie-Norris D) **Medi-Cal: community supports.**
Current Text: Amended: 4/20/2023 html pdf
Last Amend: 4/20/2023
Status: 5/19/2023-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/3/2023)(May be acted upon Jan 2024)
Location: 5/19/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under current law, community supports that the department is authorized to approve include, among other things, housing transition navigation services, recuperative care, respite, day habilitation programs, and medically supportive food and nutrition services.

AB 1339 (Haney D) **Discrimination: disability: medication-assisted treatment.**
Current Text: Amended: 4/12/2023 html pdf
Last Amend: 4/12/2023
Status: 5/19/2023-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/10/2023)(May be acted upon Jan 2024)
Location: 5/19/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law requires the State Department of Health Care Services to license narcotic treatment programs to use narcotic replacement therapy and medication-assisted treatment (MAT) of addicted persons. Current law specifies the medications a licensed narcotic treatment program may use for narcotic treatment replacement therapy and MAT by a licensed narcotic treatment program. Current law prohibits the unlawful denial of full and equal access to the benefits of, or the unlawful discrimination under, any program or activity that is conducted, operated, or administered by the state or by any state agency, that is funded directly by the state, or that receives any financial assistance from the state, for a person on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, or sexual orientation. This bill would prohibit a state-funded program, as defined, from discriminating against, or denying access to housing or housing services to, individuals because they are currently undergoing MAT or taking authorized medications.

AB 1344 (Santiago D) **Surviving child benefits.**
Current Text: Amended: 3/30/2023 html pdf
Last Amend: 3/30/2023
Status: 5/19/2023-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE

FILE on 4/26/2023)(May be acted upon Jan 2024)
Location: 5/19/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current federal law establishes the federal Old-Age, Survivors, and Disability Insurance (OASDI) program to provide monthly benefits to qualified retired and disabled workers and their spouses, dependents, and survivors. Current federal law provides various benefits to veterans, their dependents, and their survivors administered by the United States Department of Veterans Affairs (USDVA). This bill would require the Department of Child Support Services to issue guidance to local child support agencies directing them to, and would require local child support agencies to, inform a custodial parent or guardian of benefits under the federal OASDI program and benefits provided to survivors of veterans by the USDVA when the local child support agency becomes aware that a child's noncustodial parent has died and the local child support agency has information that suggests that the child may be eligible for either of those programs.

AB 1360 (McCarty D) Hope California: Secured Residential Treatment Pilot Program.
Current Text: Amended: 7/5/2023 html pdf
Last Amend: 7/5/2023
Status: 7/5/2023-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.
Location: 6/20/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would, until July 1st, 2029, authorize the Counties of Sacramento and Yolo to offer secured residential treatment pilot programs, known as Hope California, for individuals suffering from substance use disorders (SUDs) who have been convicted of qualifying drug-motivated felony crimes, as specified. The bill would require the program to meet certain conditions relating to, among other things, a risk, needs, and biopsychosocial assessment, a comprehensive curriculum, a determination by a judge of the length of treatment, data collection, licensing and monitoring of the facility by the State Department of Health Care Services, and reporting to the department and the Legislature.

AB 1369 (Bauer-Kahan D) Out-of-state physicians and surgeons: telehealth: license exemption.
Current Text: Amended: 3/23/2023 html pdf
Last Amend: 3/23/2023
Status: 6/26/2023-From committee: Do pass and re-refer to Com. on APPR. (Ayes 10. Noes 1.) (June 26). Re-referred to Com. on APPR.
Location: 6/26/2023-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law defines "telehealth " as the delivery of health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care, and that telehealth includes synchronous interactions and asynchronous store and forward transfers. Under this bill, a

person licensed as a physician and surgeon in another state, as specified, who does not possess a certificate issued by the Medical Board of California would be authorized to deliver health care via telehealth to a patient who, among other requirements, has a disease or condition that is immediately life-threatening.

AB 1379 (Papan D) **Open meetings: local agencies: teleconferences.**
Current Text: Amended: 3/23/2023 html pdf
Last Amend: 3/23/2023
Status: 4/28/2023-Failed Deadline pursuant to Rule 61(a)(2). (Last location was L. GOV. on 3/23/2023)(May be acted upon Jan 2024)
Location: 4/28/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body be open and public, and that all persons be permitted to attend unless a closed session is authorized. The act generally requires for teleconferencing that the legislative body of a local agency that elects to use teleconferencing post agendas at all teleconference locations, identify each teleconference location in the notice and agenda of the meeting or proceeding, and have each teleconference location be accessible to the public. Current law also requires that, during the teleconference, at least a quorum of the members of the legislative body participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction. This bill, with respect to those general provisions on teleconferencing, would require a legislative body electing to use teleconferencing to instead post agendas at a singular designated physical meeting location, as defined, rather than at all teleconference locations. The bill would remove the requirements for the legislative body of the local agency to identify each teleconference location in the notice and agenda, that each teleconference location be accessible to the public, and that at least a quorum of the members participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction.

AB 1387 (Ting D) **In-Home Supportive Services Program: provider shortage: grant-based outreach program.**
Current Text: Introduced: 2/17/2023 html pdf
Status: 5/19/2023-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/10/2023)(May be acted upon Jan 2024)
Location: 5/19/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require the State Department of Health Care Services, by March 1st, 2024, to issue a request for proposals for a 3-year, grant-based program to support outreach and education to encourage immigrants to become in-home supportive services (IHSS) providers, contingent upon an appropriation by the Legislature for that purpose. The bill would require eligible grantees for the program to include nonprofit, community-based agencies that engage with immigrant populations, counties administering the IHSS program, and county public authorities. The bill would set forth eligible outreach activities, including developing educational and outreach materials, and providing

community outreach workers. The bill would require grantees to report to the department, at least semiannually, on the outcomes achieved by the outreach campaign, including, but not limited to, activities and methods utilized to reach and recruit providers. If the grantee reporting requirements result in additional workload for counties, those provisions would be implemented only if funding for that purpose is provided in the State Budget. The bill would require the department to report to the Legislature, within 6 months after the conclusion of the program, on the effectiveness of the program, including the extent to which the outreach campaign resulted in an increase in the IHSS provider workforce. The provisions of the bill would be repealed on January 1st, 2028.

AB 1432 (Carrillo, Wendy D) Health care coverage.
Current Text: Amended: 4/3/2023 html pdf
Last Amend: 4/3/2023
Status: 6/22/2023-From committee: Do pass and re-refer to Com. on APPR. (Ayes 10. Noes 2.) (June 21). Re-referred to Com. on APPR.
Location: 6/21/2023-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would subject a group health care service plan contract, policy, or certificate of group health insurance that is marketed, issued, or delivered to a California resident to all provisions of the Health and Safety Code and Insurance Code requiring coverage of abortion, abortion-related services, and gender-affirming care, regardless of the situs of the contract, subscriber, or master group policyholder. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 1437 (Irwin D) Medi-Cal: serious mental illness.
Current Text: Amended: 4/13/2023 html pdf
Last Amend: 4/13/2023
Status: 7/3/2023-In committee: Referred to APPR suspense file.
Location: 7/3/2023-S. APPR. SUSPENSE FILE

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law sets forth a schedule of benefits under the Medi-Cal program, including specialty and nonspecialty mental health services through different delivery systems, in certain cases subject to utilization controls, such as prior authorization. Under current law, prior authorization is approval of a specified service in advance of the rendering of that service based upon a determination of medical necessity. Current law sets forth various provisions relating to processing, or appealing the decision of, treatment authorization requests, and provisions relating to certain services requiring or not requiring a treatment authorization request. After a determination of cost benefit, current law requires the Director of Health Care Services to modify or eliminate the requirement of prior authorization as a control for treatment, supplies, or equipment that costs less than $100, except for prescribed drugs, as specified. Under this bill, a prescription refill for a drug for serious mental illness would automatically be approved for a period of 365 days after the initial prescription is dispensed. The bill would condition the above-described provisions on the prescription being for a person 18 years of age or over, and on the person not being within the transition jurisdiction of the juvenile court,

as specified.

AB 1450 (Jackson D) **Pupil health: universal screenings: adverse childhood experiences and dyslexia.**
Current Text: Introduced: 2/17/2023 html pdf
Status: 4/28/2023-Failed Deadline pursuant to Rule 61(a)(2). (Last location was ED. on 3/9/2023)(May be acted upon Jan 2024)
Location: 4/28/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: This bill would require a school district, county office of education, or charter school to employ or contract with at least one mental health clinician, as defined, and at least one case manager, as defined, for each schoolsite of the local educational agency, and to conduct universal screenings for adverse childhood experiences, as defined, and dyslexia, pursuant to a graduated schedule by grade span, as specified. The bill would require a mental health clinician who conducts a screening to develop, and provide to the pupil and their parent or guardian, an action plan based upon findings from the screening, as appropriate, and would require case managers to help implement approved action plans. By imposing additional requirements on local educational agencies, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 1451 (Jackson D) **Urgent and emergency mental health and substance use disorder treatment.**
Current Text: Amended: 5/18/2023 html pdf
Last Amend: 5/18/2023
Status: 6/14/2023-Referred to Com. on HEALTH.
Location: 6/14/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, 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. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer that provides hospital, medical, or surgical coverage shall 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. Existing law also includes requirements for timely access to care, including mental health services, including a requirement that a health care service plan or health insurer provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's or insured's condition consistent with good professional practice. This bill would require a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after January 1st, 2024, to provide coverage for treatment of urgent and emergency mental health and substance use disorders. The bill would require the treatment to be provided without preauthorization, and to be reimbursed in a timely manner, pursuant to specified provisions. The bill's provisions would only be implemented upon appropriation by the Legislature. 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. This bill contains other related

provisions and other existing laws.

AB 1470 (Quirk-Silva D) **Medi-Cal: behavioral health services: documentation standards.**
Current Text: Amended: 7/3/2023 html pdf
Last Amend: 7/3/2023
Status: 7/3/2023-Read second time and amended. Re-referred to Com. on APPR.
Location: 6/29/2023-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Current law establishes the California Advancing and Innovating Medi-Cal (CalAIM) initiative, subject to receipt of any necessary federal approvals and the availability of federal financial participation, in order to, among other things, improve quality outcomes and reduce health disparities. The bill, as part of CalAIM, and with respect to behavioral health services provided under the Medi-Cal program, would require the State Department of Health Care Services to standardize data elements relating to documentation requirements, including, but not limited to, medically necessary criteria, and would require the department to develop standard forms containing information necessary to properly adjudicate claims pursuant to CalAIM Terms and Conditions. The bill would require the department to consult with representatives of specified associations and programs for purposes of implementing these provisions.

AB 1481 (Boerner D) **Medi-Cal: presumptive eligibility.**
Current Text: Amended: 4/20/2023 html pdf
Last Amend: 4/20/2023
Status: 6/12/2023-In committee: Set, first hearing. Hearing canceled at the request of author.
Location: 6/7/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Current federal law, as a condition of receiving federal Medicaid funds, requires states to provide health care services to specified individuals. Current federal law authorizes states to provide presumptive eligibility to pregnant women or children, and existing state law requires the department to provide presumptive eligibility to pregnant women and children, as specified. This bill would expand the presumptive eligibility for pregnant women to all pregnant people, renaming the program "Presumptive Eligibility for Pregnant People" (PE4PP). The bill would also require the department to ensure that a pregnant person receiving coverage under PE4PP who applies for full-scope Medi-Cal benefits within 60 days receives coverage under PE4PP until their full-scope Medi-Cal application is approved or denied, as specified.

AB 1502 (Schiavo D) **Health care coverage: discrimination.**
Current Text: Introduced: 2/17/2023 html pdf
Status: 4/28/2023-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 3/9/2023)(May be acted upon Jan 2024)
Location: 4/28/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered

1st House	2nd House	Conc.			

Summary: This bill would prohibit a health care service plan or health insurer from discriminating on the basis of race, color, national origin, sex, age, or disability through the use of clinical algorithms in its decisionmaking. 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. This bill contains other related provisions and other existing laws.

AB 1537 (Wood D) Skilled nursing facilities: direct care spending requirement.

Current Text: Introduced: 2/17/2023 html pdf
Status: 6/14/2023-Referred to Com. on HEALTH.
Location: 6/14/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law provides for the licensure and regulation of health facilities, including skilled nursing facilities, by the State Department of Public Health. A violation of those provisions is a crime. Existing law requires health facilities to submit specified financial reports to the Department of Health Care Access and Information. Existing 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. This bill would require, no later than July 1st, 2024, the establishment of a direct patient-related services spending, reporting, and rebate requirement for skilled nursing facilities, with exceptions. Under the direct patient-related services spending requirement, the bill would require that a minimum of 85% of a facility's total non-Medicare health revenues from all payer sources in each fiscal year be expended on residents' direct patient-related services, as defined. This bill contains other related provisions and other existing laws.

AB 1549 (Carrillo, Wendy D) Medi-Cal: federally qualified health centers and rural health clinics.

Current Text: Amended: 4/27/2023 html pdf
Last Amend: 4/27/2023
Status: 5/19/2023-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/17/2023)(May be acted upon Jan 2024)
Location: 5/19/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

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, including federally qualified health center services and rural health clinic services. Under current law, to the extent that federal financial participation is available, FQHC and RHC services are reimbursed on a per-visit basis, as specified. This bill would, among other things, require that per-visit rate to account for the costs of the FQHC or RHC that are reasonable and related to the provision of covered services, including the specific staffing and care delivery models used by the FQHC and RHC to deliver those services. The bill would also require the rate for any newly qualified health center to include the cost of care coordination services provided by the health center, as specified.

AB 1601 (Alvarez D) **Cannabis: enforcement by local jurisdictions.**

Current Text: Amended: 4/18/2023 html pdf

Last Amend: 4/18/2023

Status: 4/28/2023-Failed Deadline pursuant to Rule 61(a)(2). (Last location was B.&P. on 5/1/2023)(May be acted upon Jan 2024)

Location: 4/28/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would provide that grounds for disciplinary actions under the Medicinal and Adult-Use Cannabis Regulation and Safety Act (MAUCRSA) against a licensee include concealment of illegal business activities, including tax evasion and money laundering, by a licensee, or by an officer, director, owner, or authorized agent acting on behalf of the licensee. The bill would authorize a local jurisdiction to take disciplinary action against a licensee for illegal business activities by the licensee, or for concealment of illegal business activities, by a licensee, or by an officer, director, owner, or authorized agent acting on behalf of the licensee.

AB 1608 (Patterson, Joe R) **Medi-Cal: managed care plans.**

Current Text: Amended: 3/23/2023 html pdf

Last Amend: 3/23/2023

Status: 4/28/2023-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 3/23/2023)(May be acted upon Jan 2024)

Location: 4/28/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The Lanterman Developmental Disabilities Services Act makes the State Department of Developmental Services responsible for providing various services and supports to individuals with developmental disabilities, and for ensuring the appropriateness and quality of those services and supports. Pursuant to that law, the department contracts with regional centers to provide services and supports to persons with developmental disabilities. The act requires regional centers to pursue all possible sources of funding for consumers receiving regional center services, including, among others, Medi-Cal. This bill contains other existing laws.

AB 1644 (Bonta D) **Medi-Cal: medically supportive food and nutrition services.**

Current Text: Amended: 4/27/2023 html pdf

Last Amend: 4/27/2023

Status: 5/19/2023-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/17/2023)(May be acted upon Jan 2024)

Location: 5/19/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would make medically supportive food and nutrition interventions, as defined, a covered benefit under the Medi-Cal program, upon issuance of final guidance by the State Department of Health Care Services. The bill would require medically supportive food and nutrition interventions to

be covered when determined to be medically necessary by a health care provider or health care plan, as specified. In order to qualify for coverage under the Medi-Cal program, the bill would require a patient to be offered at least 3 of 6 specified medically supportive food and nutrition interventions and for the interventions to be provided for a minimum duration of 12 weeks, as specified. The bill would only provide coverage for nutrition support interventions when paired with the provision of food through one of the 3 offered interventions. The bill would require a health care provider to match the acuity of a patient's condition to the intensity and duration of the medically supportive food and nutrition intervention and include culturally appropriate foods whenever possible.

AB 1645 (Zbur D) Health care coverage: cost sharing.

Current Text: Amended: 7/3/2023 html pdf

Last Amend: 7/3/2023

Status: 7/3/2023-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.

Location: 6/14/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current law requires a group or individual nongrandfathered health care service plan contract or health insurance policy to provide coverage for, and prohibits a contract or policy from imposing cost-sharing requirements for, specified preventive care services and screenings. This bill would prohibit a group or individual health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1st, 2024, from imposing a cost-sharing requirement for office visits for the above-described preventive care services and screenings and for items or services that are integral to their provision. The bill would prohibit contracts and policies from imposing a cost-sharing requirement, utilization review, or other specified limits on a recommended sexually transmitted infections screening, and from imposing a cost-sharing requirement for any items and services integral to a sexually transmitted infections screening, as specified. The bill would require a plan or insurer to directly reimburse a nonparticipating provider or facility of sexually transmitted infections screening that meets specified criteria for screening tests and integral items and services rendered, as specified, and would prohibit a nonparticipating provider from billing or collecting a cost-sharing amount for a sexually transmitted infections screening from an enrollee or insured.

AB 1670 (Gipson D) Medical referral services: treatment referrals.

Current Text: Amended: 4/20/2023 html pdf

Last Amend: 4/20/2023

Status: 5/19/2023-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. on 4/25/2023)(May be acted upon Jan 2024)

Location: 5/19/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law prohibits a person or business from referring or recommending a person for any form of medical care or treatment for profit and creates a presumption that the referral or recommendation is for profit if a fee or charge is imposed. Current law makes a violation of this

provision a misdemeanor, punishable by imprisonment in county jail for not longer than one year, or of a fine not exceeding $5,000, or by both that fine and imprisonment. This bill would increase the maximum fine from $5,000 to $10,000.

AB 1675 (Alanis R) Foster care: enrichment activities.
Current Text: Amended: 3/29/2023 html pdf
Last Amend: 3/29/2023
Status: 5/19/2023-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/17/2023)(May be acted upon Jan 2024)
Location: 5/19/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would, if the State Department of Health Care Services's application for a federal Medicaid demonstration project, known as the California Behavioral Health Community-Based Continuum Demonstration (CalBH-CBC), is granted by the federal Centers for Medicare and Medicaid Services, require the State Department of Health Care Services, in collaboration with the State Department of Social Services, to convene a stakeholder workgroup, as specified, to assist in developing how the activity stipend benefit for current and former foster youth and children who have received or are receiving family maintenance services under the project will be implemented.

AB 1690 (Kalra D) Universal health care coverage.
Current Text: Introduced: 2/17/2023 html pdf
Status: 5/5/2023-Failed Deadline pursuant to Rule 61(a)(3). (Last location was PRINT on 2/17/2023)(May be acted upon Jan 2024)
Location: 5/5/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would state the intent of the Legislature to guarantee accessible, affordable, equitable, and high-quality health care for all Californians through a comprehensive universal single-payer health care program that benefits every resident of the state.

AB 1697 (Schiavo D) Uniform Electronic Transactions Act.
Current Text: Amended: 4/27/2023 html pdf
Last Amend: 4/27/2023
Status: 5/17/2023-Referred to Com. on JUD.
Location: 5/17/2023-S. JUD.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The Uniform Electronic Transactions Act provides that a record or signature may not be denied legal effect or enforceability solely because it is in electronic form. The act exempts from its provisions, among other things, specific transactions, including an authorization for the release of medical information by a provider of health care, health care service plan, pharmaceutical company, or contractor and an authorization for the release of genetic test results by a health care service plan

under the Confidentiality of Medical Information Act. This bill would delete the exemption for the above-described authorizations under the Confidentiality of Medical Information Act and would make conforming changes.

AB 1698 (Wood D) **Medi-Cal.**
Current Text: Introduced: 2/17/2023 html pdf
Status: 5/5/2023-Failed Deadline pursuant to Rule 61(a)(3). (Last location was PRINT on 2/17/2023)(May be acted upon Jan 2024)
Location: 5/5/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would make specified findings and would express the intent of the Legislature to enact future legislation relating to Medi-Cal.

AB 1712 (Irwin D) **Personal information: data breaches.**
Current Text: Amended: 4/27/2023 html pdf
Last Amend: 4/27/2023
Status: 6/14/2023-Referred to Com. on JUD.
Location: 6/14/2023-S. JUD.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: The Information Practices Act of 1977 requires any agency that owns or licenses computerized data that includes personal information to disclose any breach of the security of the system following discovery or notification of the breach, as specified. The act also requires any agency that maintains computerized data that includes personal information that the agency does not own to notify the owner or licensee of the information of any breach of the security of the data, in accordance with certain procedures. Current law requires the security breach notification to include specified information, including, among other things, the names and addresses of the major credit reporting agencies. Current law authorizes the security breach notification to include, at the discretion of the agency, among other things, advice on steps that people whose information has been breached may take to protect themselves. This bill would additionally require the security breach notification to include the internet websites of the major credit reporting agencies and the Uniform Resource Locator for the main internet website operated by the Federal Trade Commission to provide information for victims of identity theft.

AB 1722 (Dahle, Megan R) **Pupil health: credentialed school nurses, registered nurses, and licensed vocational nurses.**
Current Text: Amended: 7/5/2023 html pdf
Last Amend: 7/5/2023
Status: 7/5/2023-Read second time and amended. Re-referred to Com. on APPR.
Location: 6/28/2023-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law authorizes a school nurse, subject to approval by the governing board of the school district, to perform various pupil health care services. Current law requires a school nurse to be currently licensed as a registered nurse, as provided, and to have met the minimum requirements for a credential in school nursing, as specified. This bill would require a licensed vocational nurse, as defined, hired pursuant to this bill to be supervised by a credentialed school nurse, as defined, who is employed as a school nurse at the same local educational agency (LEA) or at another LEA. The bill would prohibit interpreting that provision to allow a licensed vocational nurse to go beyond the approved scope of practice pursuant to the Vocational Nursing Practice Act. The bill would require an LEA employing a credentialed school nurse who is supervising a licensed vocational nurse at another LEA, and a credentialed school nurse who is supervising a licensed vocational nurse at another LEA, pursuant to these provisions to have indemnification for the supervisorial liability, as specified. The bill would require certain LEAs to enter into a written agreement containing specified information, including, among other information, a communication policy delineating how the licensed vocational nurse and the credentialed school nurse are to communicate, as provided. The bill would require an LEA to only hire a licensed vocational nurse if a diligent search has been conducted for a suitable credentialed school nurse each school year, as provided. The bill would require a local educational agency to seek approval from its governing board or body before hiring a licensed vocational nurse, including by submitting a declaration to its governing board or body containing certain information.

AB 1751 (Gipson D) **Opioid prescriptions: information: nonpharmacological treatments for pain.**
Current Text: Amended: 4/13/2023 html pdf
Last Amend: 4/13/2023
Status: 4/28/2023-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 3/9/2023)(May be acted upon Jan 2024)
Location: 4/28/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law requires a prescriber, with certain exceptions, before directly dispensing or issuing for a minor the first prescription for a controlled substance containing an opioid in a single course of treatment, to discuss specified information with the minor, the minor's parent or guardian, or another adult authorized to consent to the minor's medical treatment. This bill would extend that requirement for the prescriber by applying it to any patient, not only a minor, under those circumstances. The bill would also require the prescriber to discuss the availability of nonpharmacological treatments for pain, as defined.

AJR 4 (Schiavo D) **Medicare: ACO REACH Model.**
Current Text: Amended: 5/25/2023 html pdf
Last Amend: 5/25/2023
Status: 6/14/2023-Referred to Com. on HEALTH.
Location: 6/14/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered

1st House	2nd House	Conc.			

Summary: Would request the President of the United States to immediately end the Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) Model under the federal Medicare Program, with the stated goal of eliminating corporate profiteering and expanding consumer-directed access to care established through Traditional Medicare.

SB 9 **(Cortese D) Raising the Age for Extended Foster Care Pilot Program Act of 2023.**
Current Text: Amended: 5/18/2023 html pdf
Last Amend: 5/18/2023
Status: 6/27/2023-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To consent calendar. (Ayes 11. Noes 0.) (June 27). Re-referred to Com. on APPR.
Location: 6/27/2023-A. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would, subject to an appropriation by the Legislature in the annual Budget Act or another statute for this purpose, require the State Department of Social Services to administer a 3-year pilot program in at least 3 counties that choose to participate to extend foster care services to nonminor dependents up to 22 years of age if the nonminor dependent is experiencing homelessness or is at reasonable risk of homelessness if they are not under the jurisdiction of the juvenile court. Under the pilot program, the bill would expand the jurisdiction of the juvenile court to include, as a nonminor dependent, a nonminor who is 21 years of age and who was previously under the jurisdiction of the juvenile court if the juvenile court makes a finding on the record by a preponderance of the evidence that the nonminor is experiencing homelessness or is at reasonable risk of homelessness if they are not under the jurisdiction of the juvenile court, among other requirements, would expand the eligibility of foster care by revising the definition of nonminor dependent to include a foster child who meets the above-described requirements and is 21 years of age if the court makes that same finding, and would make these nonminor dependents eligible for benefits under AFDC-FC, CalWORKs, Kin-GAP, and AAP.

SB 35 **(Umberg D) Community Assistance, Recovery, and Empowerment (CARE) Court Program.**
Current Text: Amended: 6/12/2023 html pdf
Last Amend: 6/12/2023
Status: 6/15/2023-Re-referred to Com. on JUD. pursuant to Assembly Rule 96.
Location: 6/15/2023-A. JUD.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The Community Assistance, Recovery, and Empowerment (CARE) Act authorizes specified adult persons to petition a civil court to create a voluntary CARE agreement or a court-ordered CARE plan and implement services, to be provided by county behavioral health agencies, to provide behavioral health care, including stabilization medication, housing, and other enumerated services, to adults who are currently experiencing a severe mental illness and have a diagnosis identified in the disorder class schizophrenia and other psychotic disorders, and who meet other specified criteria. This bill would authorize CARE Act proceedings to be conducted by a superior court judge or by a court-appointed commissioner or other subordinate judicial officer. The bill would require

that there is no fee for filing a petition nor any fees charged by any public officer for services in filing or serving papers or for the performance of any duty enjoined by the CARE Act.

SB 43 **(Eggman D) Behavioral health.**
Current Text: Amended: 6/30/2023 html pdf
Last Amend: 6/30/2023
Status: 6/30/2023-From committee with author's amendments. Read second time and amended. Re-referred to Com. on JUD.
Location: 6/27/2023-A. JUD.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The Lanterman-Petris-Short Act, provides for the involuntary commitment and treatment of a person who is a danger to themselves or others or who is gravely disabled. Current law, for purposes of involuntary commitment, defines “gravely disabled” as either a condition in which a person, as a result of a mental health disorder, is unable to provide for their basic personal needs for food, clothing, or shelter or has been found mentally incompetent, as specified. This bill expands the definition of “gravely disabled” to also include a condition in which a person, as a result of a severe substance use disorder, or a cooccurring mental health disorder and a severe substance use disorder, is, in addition to the basic personal needs described above, unable to provide for their personal safety or necessary medical care, as defined. The bill would authorize counties to defer implementation of these provisions to January 1st, 2025, as specified.

SB 70 **(Wiener D) Prescription drug coverage.**
Current Text: Amended: 6/29/2023 html pdf
Last Amend: 6/29/2023
Status: 6/29/2023-Read second time and amended. Re-referred to Com. on APPR. (Amended 6/29/2023)
Location: 6/27/2023-A. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

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 additionally prohibit limiting or excluding coverage of a drug, dose of a drug, or dosage form of a drug that is prescribed for off-label use if the drug has been previously covered for a chronic condition or cancer, as specified, regardless of whether or not the drug, dose, or dosage form is on the plan’s or insurer’s formulary. The bill would prohibit a health care service plan contract or health insurance policy from requiring additional cost

sharing not already imposed for a drug that was previously approved for coverage.

SB 72 **(Skinner D) Budget Act of 2023.**
Current Text: Introduced: 1/10/2023 html pdf
Status: 1/11/2023-From printer.
Location: 1/10/2023-S. BUDGET & F.R.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would make appropriations for the support of state government for the 2023–24 fiscal year.

SB 90 **(Wiener D) Health care coverage: insulin affordability.**
Current Text: Amended: 5/1/2023 html pdf
Last Amend: 5/1/2023
Status: 6/21/2023-From committee: Do pass and re-refer to Com. on APPR. (Ayes 14. Noes 0.) (June 20). Re-referred to Com. on APPR.
Location: 6/20/2023-A. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would prohibit a health care service plan contract or a disability insurance policy, as specified, issued, amended, delivered, or renewed on or after January 1st, 2024, or a contract or policy offered in the individual or small group market on or after January 1st, 2025, from imposing a copayment of more than $35 for a 30-day supply of an insulin prescription drug or imposing a deductible, coinsurance, or other cost sharing on an insulin prescription drug, and would prohibit a high deductible health plan from imposing a deductible, coinsurance, or other cost sharing on an insulin prescription drug, 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 100 **(Skinner D) Budget Acts of 2021 and 2022.**
Current Text: Amended: 5/1/2023 html pdf
Last Amend: 5/1/2023
Status: 5/8/2023-Re-referred to Com. on BUDGET pursuant to Assembly Rule 97.
Location: 5/8/2023-A. BUDGET

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The Budget Act of 2021 and Budget Act of 2022 made appropriations for the support of state government for the 2021–22 and 2022–23 fiscal years. This bill would amend the Budget Act of 2021 and Budget Act of 2022 by amending and adding items of appropriation and making other changes.

SB 101 **(Skinner D) Budget Act of 2023.**
Current Text: Chaptered: 6/27/2023 html pdf
Last Amend: 6/12/2023

Status: 6/27/2023-Approved by the Governor. Chaptered by Secretary of State. Chapter 12, Statutes of 2023.
Location: 6/27/2023-S. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: This bill would make appropriations for the support of state government for the 2023–24 fiscal year. This bill contains other related provisions.

SB 102 **(Skinner D) Budget Act of 2023.**
Current Text: Amended: 6/26/2023 html pdf
Last Amend: 6/26/2023
Status: 6/29/2023-Re-referred to Com. on BUDGET.
Location: 6/29/2023-A. BUDGET

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would amend the Budget Act of 2023 by amending, adding, and repealing items of appropriation and making other changes. This bill contains other related provisions.

SB 103 **(Skinner D) Budget Acts of 2021 and 2022.**
Current Text: Amended: 6/26/2023 html pdf
Last Amend: 6/26/2023
Status: 6/29/2023-Re-referred to Com. on BUDGET.
Location: 6/29/2023-A. BUDGET

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would amend the Budget Act of 2021 and Budget Act of 2022 by amending and adding items of appropriation and making other changes. The bill would declare that it is to take effect immediately as a Budget Bill.

SB 118 **(Committee on Budget and Fiscal Review) Budget Act of 2023: health.**
Current Text: Amended: 6/26/2023 html pdf
Last Amend: 6/26/2023
Status: 6/29/2023-Re-referred to Com. on BUDGET.
Location: 6/29/2023-A. BUDGET

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law requires a health care service plan to provide disclosures regarding the benefits, services, and terms of the plan contract, as specified, to provide the public, subscribers, and enrollees with a full and fair disclosure of the provisions of the plan. This bill would require the Department of Managed Health Care to develop standard templates for the disclosure form and evidence of coverage, to include, among other things, standard definitions, benefit descriptions, and any other information that the director determines, consistent with the goals of providing fair

disclosures of the provisions of a health care service plan. The bill would require the department to consult with the Department of Insurance and interested stakeholders in developing the standard templates. The bill would require health care service plans, beginning January 1, 2025, to use the standard templates for any disclosure form or evidence of coverage published or distributed, except as specified. Because a willful violation of these requirements is a crime, the bill would impose a state-mandated local program.

SB 119 **(Committee on Budget and Fiscal Review) Medi-Cal: managed care organization provider tax.**
Current Text: Amended: 6/26/2023 html pdf
Last Amend: 6/26/2023
Status: 6/29/2023-Re-referred to Com. on BUDGET.
Location: 6/29/2023-A. BUDGET

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Under current law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans. Current law, inoperative on January 1st, 2023, and to be repealed on January 1st, 2024, imposed a managed care organization (MCO) provider tax, administered and assessed by the department, on licensed health care service plans and managed care plans contracted with the State Department of Health Care Services to provide full-scope Medi-Cal services. Those provisions set forth taxing tiers and corresponding per enrollee tax amounts for the 2019–20, 2020–21, and 2021–22 fiscal years, and the first 6 months of the 2022–23 fiscal year. Under those provisions, all revenues, less refunds, derived from the tax were deposited into the State Treasury to the credit of the Health Care Services Special Fund, and continuously appropriated to the department for purposes of funding the nonfederal share of Medi-Cal managed care rates, as specified. Those inoperative provisions authorized the department, subject to certain conditions, to modify or make adjustments to any methodology, tax amount, taxing tier, or other provision relating to the MCO provider tax to the extent the department deemed necessary to meet federal requirements, to obtain or maintain federal approval, or to ensure federal financial participation was available or was not otherwise jeopardized. Those provisions required the department to request approval from the federal Centers for Medicare and Medicaid Services (CMS) as was necessary to implement those provisions. This bill would repeal those inoperative provisions. The bill would restructure the MCO provider tax, with certain modifications to the above-described provisions, including changes to the taxing tiers and tax amounts, for purposes of the tax periods of April 1st, 2023, through December 31st, 2023, and the 2024, 2025, and 2026 calendar years. The bill would create the Managed Care Enrollment Fund to replace the Health Care Services Special Fund.

SB 120 **(Committee on Budget and Fiscal Review) Human services.**
Current Text: Amended: 6/26/2023 html pdf
Last Amend: 6/26/2023
Status: 6/29/2023-Re-referred to Com. on BUDGET.
Location: 6/29/2023-A. BUDGET

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: The California Community Care Facilities Act provides for the licensing and regulation of

community care facilities, including group home facilities, short-term residential therapeutic programs (STRTPs), and adult residential facilities (ARFs), by the State Department of Social Services. Under current law, the department similarly regulates residential care facilities for the elderly. Current law requires administrators of these facilities, with specified exemptions, to complete a department-approved certification program, uniformly referred to as administrator certification training programs. Under current law, these programs require a specified minimum number of hours, depending on the facility type, of classroom instruction that provides training on a uniform core of knowledge in specified areas. Current law also requires administrator certificates to be renewed every 2 years, conditional upon the certificate holder submitting documentation of a specified number of hours of continuing education, based on the facility type. Current law permits up to one-half of the required continuing education hours to be satisfied through online courses, and the remainder to be completed in a classroom instructional setting, as prescribed. This bill would revise those provisions by deleting the classroom instruction requirement for initial certification and continuing education purposes, and instead would require instruction that is conducive to learning and allows participants to simultaneously interact with each other as well as with the instructor.

SB 121 **(Committee on Budget and Fiscal Review) Developmental services.**
Current Text: Amended: 6/26/2023 html pdf
Last Amend: 6/26/2023
Status: 6/29/2023-Re-referred to Com. on BUDGET.
Location: 6/29/2023-A. BUDGET

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: A free appropriate public education is required to be made available to individuals with exceptional needs in accordance with specified federal regulations adopted pursuant to the federal Individuals with Disabilities Education Act. Current law recognizes that individuals with exceptional needs of mandated schoolage residing in California's state hospitals and developmental centers are entitled, under specified federal law, to have the same access to educational programs as is provided for individuals with exceptional needs residing in the community, and establishes contracting and funding provisions for that purpose. Current law requires the Superintendent of Public Instruction, the Director of Developmental Services, and the Director of State Hospitals to develop written interagency agreements to carry out the provisions relating to educational programs for individuals with exceptional needs residing in those facilities. Current law requires the transfer of pupils in state hospital school programs whose individualized education programs indicate that a community school program is appropriate to be transferred to schools located in the community. Current law authorizes waivers to that requirement only when approved by both the Superintendent of Public Instruction and the Director of Developmental Services. Current law requires the State Department of Developmental Services, on the first day of each month, upon submission of an invoice by the county superintendent of schools, to pay to the county superintendent of schools 8% of the amount projected to cover the cost of hospital pupils educated in community school programs, as specified. Current law requires the county superintendent of schools to calculate the actual cost of educating those pupils and, if the actual cost is more or less than the projected amount, requires the following year's distribution to be adjusted accordingly. This bill would authorize waivers described above to be approved by the State Superintendent of Public Instruction and either the State Department of Developmental Services, for individuals receiving developmental disability services, or the State Department of State Hospitals,

for individuals receiving mental health services, as specified. The bill would require the State Department of State Hospitals, rather than the State Department of Developmental Services, to make payments to county superintendents of schools with respect to pupils under the State Department of State Hospital's jurisdiction who are being educated in community school programs.

SB 238 **(Wiener D) Health care coverage: independent medical review.**
Current Text: Amended: 6/19/2023 html pdf
Last Amend: 6/19/2023
Status: 6/28/2023-From committee: Do pass and re-refer to Com. on APPR. (Ayes 12. Noes 3.) (June 27). Re-referred to Com. on APPR.
Location: 6/27/2023-A. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law provides for the regulation of disability insurers by the Department of Insurance. Current law establishes the Independent Medical Review System within each department, under which an enrollee or insured may seek review if a health care service has been denied, modified, or delayed by a health care service plan or disability insurer and the enrollee or insured has previously filed a grievance that remains unresolved after 30 days. This bill, commencing July 1st, 2024, would require a health care service plan or a disability insurer that modifies, delays, or denies a health care service, based in whole or in part on medical necessity, to automatically submit within 24 hours a decision regarding a disputed health care service to the Independent Medical Review System, as well as the information that informed its decision, without requiring an enrollee or insured to submit a grievance, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. The bill would require a health care service plan or disability insurer, within 24 hours after submitting its decision to the Independent Medical Review System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee's or insured's provider. The bill would require the notice to include notification to the enrollee or insured that they or their representative may cancel the independent medical review at any time before a determination, as specified. The bill would apply specified existing provisions relating to mental health and substance use disorders for purposes of its provisions, and would be subject to relevant provisions relating to the Independent Medical Review System that do not otherwise conflict with the express requirements of the bill. With respect to health care service plans, the bill would specify that its provisions do not apply to Medi-Cal managed care plan contracts.

SB 257 **(Portantino D) Health care coverage: diagnostic imaging.**
Current Text: Introduced: 1/30/2023 html pdf
Status: 6/28/2023-From committee: Do pass and re-refer to Com. on APPR. (Ayes 15. Noes 0.) (June 27). Re-referred to Com. on APPR.
Location: 6/27/2023-A. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require a health care service plan contract, a 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, 2025, to provide coverage without imposing cost sharing for, among other things, 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, except as specified.

SB 282 **(Eggman D) Medi-Cal: federally qualified health centers and rural health clinics.**
Current Text: Amended: 3/13/2023 html pdf
Last Amend: 3/13/2023
Status: 6/8/2023-Referred to Com. on HEALTH.
Location: 6/8/2023-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

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, including federally qualified health center (FQHC) services and rural health clinic (RHC) services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under current 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 a patient of an FQHC or RHC and a physician or other specified health care professionals. Under current law, “visit” also includes an encounter using video or audio-only synchronous interaction or an asynchronous store and forward modality, as specified. This bill would authorize reimbursement for a maximum of 2 visits that take place on the same day at a single site, whether through a face-to-face or telehealth-based encounter, if after the first visit the patient suffers illness or injury that requires additional diagnosis or treatment, or if the patient has a medical visit and either a mental health visit or a dental visit, as defined. The bill would require the department, by July 1st, 2024, to submit a state plan amendment to the federal Centers for Medicare and Medicaid Services reflecting those provisions.

SB 299 **(Limón D) Voter registration: California New Motor Voter Program.**
Current Text: Amended: 6/13/2023 html pdf
Last Amend: 6/13/2023
Status: 6/13/2023-From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
Location: 6/1/2023-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law requires, in conformance with federal law, that the Secretary of State and the Department of Motor Vehicles establish and implement the California New Motor Voter Program for the purpose of increasing opportunities for voter registration for qualified voters. Current law requires the department to transmit to the Secretary of State specified information related to a person’s eligibility to vote, which the person provides when applying for a driver’s license or identification card or when the person notifies the department of an address change. Current law requires that if this information transmitted to the Secretary of State constitutes a completed affidavit of registration, the

Secretary of State must register or preregister the person to vote, as applicable, unless the person affirmatively declines to register or is ineligible to vote, as specified. This bill would additionally require the Department of Motor Vehicles to transmit specified information to the Secretary of State for a person submitting a driver's license application who provides documentation demonstrating United States citizenship and that the person is of an eligible age to register or preregister to vote. The bill would deem this information to constitute a completed affidavit of registration for such persons, and require the Secretary of State to register or preregister the person to vote, unless the Secretary of State determines they are ineligible. The bill would require, if a person is registered or preregistered to vote in this manner, that the county elections official send a notice to the person advising that they may decline to register or preregister to vote and providing additional information. The bill would also require the county elections official to send a notice to a person who is already registered to vote, but for whom the Secretary of State changes their registration information after receiving updated name or address information from the department.

SB 311 **(Eggman D) Medi-Cal: Part A buy-in.**
Current Text: Introduced: 2/6/2023 html pdf
Status: 6/13/2023-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To consent calendar. (Ayes 15. Noes 0.) (June 13). Re-referred to Com. on APPR.
Location: 6/13/2023-A. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law requires the State Department of Health Care Services, to the extent required by federal law, for Medi–Cal recipients who are qualified Medicare beneficiaries, to pay the Medicare premiums, deductibles, and coinsurance for certain elderly and disabled persons. Current federal law authorizes states to pay for Medicare benefits for specified enrollees pursuant to either a buy-in agreement to directly enroll and pay premiums or a group payer arrangement to pay premiums. This bill would require the department to submit a state plan amendment no later than January 1, 2024, to enter into a Medicare Part A buy-in agreement with the federal Centers for Medicare and Medicaid Services. To the extent that the bill would increase duties for a county, the bill would create a state-mandated local program.

SB 324 **(Limón D) Health care coverage: endometriosis.**
Current Text: Amended: 3/30/2023 html pdf
Last Amend: 3/30/2023
Status: 6/28/2023-From committee: Do pass and re-refer to Com. on APPR. (Ayes 12. Noes 2.) (June 27). Re-referred to Com. on APPR.
Location: 6/27/2023-A. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would prohibit a health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after January 1st, 2024, from requiring prior authorization or other utilization review for any clinically indicated treatment for endometriosis, as determined by the treating physician and consistent with nationally recognized evidence-based clinical guidelines. 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. This bill contains other related provisions and other existing laws.

SB 326 **(Eggman D) The Behavioral Health Services Act.**
Current Text: Amended: 6/19/2023 html pdf
Last Amend: 6/19/2023
Status: 6/19/2023-From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
Location: 6/1/2023-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would, if approved by the voters at the March 5, 2024, statewide primary election, would delete the provision that establishes vote requirements to amend the MHSA, requiring all amendments of the Mental Health Services Act (MHSA) to be approved by the voters. The bill would recast the MHSA by, among other things, renaming it the Behavioral Health Services Act (BHSA), expanding it to include treatment of substance use disorders, changing the county planning process, and expanding services for which counties and the state can use funds. The bill would revise the distribution of MHSA moneys, including allocating up to $36,000,000 to the State Department of Health Care Services for behavioral health workforce funding. The bill would authorize the department to require a county to implement specific evidence-based practices.

SB 338 **(Nguyen R) Health care service plans: health equity and quality.**
Current Text: Amended: 3/16/2023 html pdf
Last Amend: 3/16/2023
Status: 4/28/2023-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 3/29/2023)(May be acted upon Jan 2024)
Location: 4/28/2023-S. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law requires the Department of Managed Health Care to convene a Health Equity and Quality Committee to recommend quality and benchmark standards for reviewing the equity and quality in health care delivery. Current law permits the department to contract with consultants who will assist the committee with the implementation and administration of its duties. Current law exempts these contracts from review and approval, as specified, until January 1st, 2024. Existing law requires the director, as part of the committee appointment process, to consider the relevant experience or expertise of appointees, including, but not limited to, racial, ethnic, or sexual orientation. Current law required the department, on or before September 30, 2022, to make quality and benchmark recommendations. This bill would require the director to appoint to the committee at least one individual with an intellectual or developmental disability, or the parent or guardian of such an individual. This bill would also require the department to reconvene the committee at least once annually to review and revisit quality and benchmark standards. This bill would also exempt contracts entered into pursuant to these provisions from the review and approval processes, as specified, until January 1st, 2026.

SB 340 **(Eggman D) Medi-Cal: eyeglasses: Prison Industry Authority.**
Current Text: Introduced: 2/7/2023 html pdf
Status: 6/27/2023-June 27 set for first hearing canceled at the request of author.
Location: 6/15/2023-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would 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 a purchase of eyeglasses from the Prison Industry Authority. The bill would condition implementation of this provision on the availability of federal financial participation.

SB 345 **(Skinner D) Health care services: legally protected health care activities.**
Current Text: Amended: 6/19/2023 html pdf
Last Amend: 6/19/2023
Status: 7/5/2023-VOTE: Do pass and be re-referred to the Committee on [Public Safety] (PASS)
Location: 7/5/2023-A. PUB. S.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law provides for the licensure and regulation of various categories of medical professionals by boards within the Department of Consumer Affairs, including, among others, the Medical Board of California and the Dental Board of California. Current law makes specified actions by licensed health care providers unprofessional conduct and, in certain cases, a criminal offense. This bill would prohibit a board from suspending or revoking the license of a person regulated under the above healing arts provisions solely because the person provided a legally protected health care activity. In this connection, the bill would define a “legally protected health care activity” to mean specified acts, including exercising rights related to reproductive health care services or gender-affirming health care services secured by the Constitution or the provision of insurance coverage for those services.

SB 408 **(Ashby D) Foster youth with complex needs: regional health teams.**
Current Text: Amended: 5/18/2023 html pdf
Last Amend: 5/18/2023
Status: 6/21/2023-Coauthors revised. From committee: Do pass and re-refer to Com. on HEALTH. (Ayes 8. Noes 0.) (June 20). Re-referred to Com. on HEALTH.
Location: 6/20/2023-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require the State Department of Health Care Services, in consultation with the State Department of Social Services, to establish up to 10 regional health teams throughout the state, to serve foster youth and youth who may be at risk of entering foster care. The bill would require the department to submit a state plan amendment to the federal Centers for Medicare and Medicaid Services no later than July 1st, 2024, to implement the Medicaid Health Home State Plan Option, as specified, in establishing the regional health teams. The bill would require the department to

coordinate with the State Department of Social Services and the State Department of Developmental Services, and to convene and engage specified stakeholders, to develop the regional health teams.

SB 421 (Limón D) **Health care coverage: cancer treatment.**
Current Text: Introduced: 2/13/2023 html pdf
Status: 6/26/2023-From consent calendar on motion of Assembly Member Reyes. Ordered to third reading.
Location: 6/26/2023-A. THIRD READING

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, 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. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits, until January 1st, 2024, an individual or group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1st, 2015, that provides coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells from requiring an enrollee or insured to pay a total amount of copayments and coinsurance that exceeds $250 for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medication, as specified.This bill would extend the duration of that prohibition indefinitely. By indefinitely extending the operation of the prohibition, and thus indefinitely extending the applicability of a crime for a willful violation by a health care service plan, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

SB 424 (Durazo D) **Medi-Cal: Whole Child Model program.**
Current Text: Amended: 5/25/2023 html pdf
Last Amend: 5/25/2023
Status: 6/8/2023-Referred to Com. on HEALTH.
Location: 6/8/2023-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law establishes the California Children's Services (CCS) Program, administered by the State Department of Health Care Services and a designated agency of each county, to provide medically necessary services for persons under 21 years of age who have any of specified medical conditions and who meet certain financial eligibility requirements. Current law establishes the Medi-Cal program, which is administered by the department and under which qualified low-income individuals receive health care services. Current law requires the department to establish a statewide Whole Child Model program stakeholder advisory group that includes specified persons, including CCS case managers, and to consult with that advisory group on prescribed matters. Current law terminates the advisory group on December 31st, 2023. This bill would extend the operation of the advisory group until December 31st, 2026.

SB 427 (Portantino D) **Health care coverage: antiretroviral drugs, devices, and products.**
Current Text: Amended: 6/13/2023 html pdf

Last Amend: 6/13/2023
Status: 6/13/2023-From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
Location: 6/1/2023-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would prohibit a health care service plan or health insurer from subjecting antiretroviral drugs, devices, or products that are either approved by the United States Food and Drug Administration (FDA) or recommended by the federal Centers for Disease Control and Prevention (CDC) for the prevention of HIV/AIDS, to prior authorization or step therapy, but would authorize prior authorization or step therapy if at least one therapeutically equivalent version is covered without prior authorization or step therapy and the insurer provides coverage for a noncovered therapeutic equivalent antiretroviral drug, device, or product without cost sharing pursuant to an exception request. The bill would prohibit a nongrandfathered or grandfathered health care service plan contract or health insurance policy from imposing any cost-sharing or utilization review requirements for antiretroviral drugs, devices, or products that are either approved by the FDA or recommended by the CDC for the prevention of HIV/AIDS. The bill would require a nongrandfathered or grandfathered health care service plan contract or health insurance policy to provide coverage for those drugs, devices, or products, and would require a plan or insurer to provide coverage under the outpatient prescription drug benefit for those drugs, devices, or products, including by supplying participating providers directly with a drug, device, or product, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program.

SB 487 **(Atkins D) Abortion: provider protections.**
Current Text: Amended: 6/22/2023 html pdf
Last Amend: 6/22/2023
Status: 6/28/2023-Coauthors revised. From committee: Do pass and re-refer to Com. on JUD. (Ayes 11. Noes 4.) (June 27). Re-referred to Com. on JUD.
Location: 6/27/2023-A. JUD.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law declares another state's law authorizing a civil action against a person or entity that receives or seeks, performs or induces, or aids or abets the performance of an abortion, or who attempts or intends to engage in those actions, to be contrary to the public policy of this state, and prohibits the application of that law to a controversy in state court and the enforcement or satisfaction of a civil judgment received under that law. This bill would specifically include within these provisions, in addition to abortion performers, abortion providers.

SB 491 **(Durazo D) Public social services: county departments: mail programs.**
Current Text: Amended: 7/3/2023 html pdf
Last Amend: 7/3/2023
Status: 7/3/2023-From committee with author's amendments. Read second time and amended. Re-referred to Com. on HUM. S.

Location: 6/8/2023-A. HUM. S.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Would require a local county entity that administers public benefits to develop and implement a program to ensure that, at a minimum, homeless residents of a county can pick up and receive government-related mail addressed to them at a place designated by the local county entity. The bill would make the program participation optional for homeless residents. The bill would also require the local county entity to provide program participants with specified information regarding the program, including hours of operation. The bill would clarify that program participation would not establish residency. The bill would define what qualifies as government-related mail. The bill would also require, on or before January 1st, 2025, the State Department of Social Services to adopt specified regulations regarding the mail program, with input from stakeholders. The bill would require the department to implement and administer these provisions through all-county letters or similar instructions until regulations are adopted. By imposing new duties on counties, the bill would impose a state-mandated local program.

SB 496 **(Limón D) Biomarker testing.**
Current Text: Amended: 4/25/2023 html pdf
Last Amend: 4/25/2023
Status: 6/1/2023-Referred to Com. on HEALTH.
Location: 6/1/2023-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1st, 2024, to provide coverage for medically necessary biomarker testing, as prescribed, 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 to guide treatment decisions if the test is supported by medical and scientific evidence, as prescribed. The bill would specify that it does not require a health care service plan or health insurer to cover biomarker testing for screening purposes unless otherwise required by law. The bill would subject restricted use of biomarker testing for the purpose of diagnosis, treatment, or ongoing monitoring of a medical condition to state and federal grievance and appeal processes. 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 502 **(Allen D) Medi-Cal: children: mobile optometric office.**
Current Text: Amended: 6/30/2023 html pdf
Last Amend: 6/30/2023
Status: 6/30/2023-Read second time and amended. Re-referred to Com. on APPR.
Location: 6/27/2023-A. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions, with specified coverage for eligible children and pregnant persons funded by the federal Children's Health Insurance Program (CHIP). Current federal CHIP provisions require federal payment to a state with an approved child health plan for expenditures for health services initiatives (HSI) under the plan for improving the health of children, as specified. As part of limitations on expenditures not used for Medicaid or health insurance assistance, Current federal law, with exceptions, prohibits the amount of payment that may be made for a fiscal year for HSI expenditures and other certain costs from exceeding 10% of the total amount of CHIP expenditures, as specified. Pursuant to current state law, the State Department of Health Care Services established a 3-year pilot program, from 2015 through 2017, in the County of Los Angeles that enabled school districts to allow students enrolled in Medi-Cal managed care plans to receive vision care services at the schoolsite through the use of a mobile vision service provider, limited to vision examinations and providing eyeglasses. Current law authorizes an applicant or provider that meets the requirements to qualify as a mobile optometric office to be enrolled in the Medi-Cal program as either a mobile optometric office or within any other provider category for which the applicant or provider qualifies. Under current law, the ownership and operation of a mobile optometric office is limited to a nonprofit or charitable organization, as specified, with the owner and operator registering with the State Board of Optometry. This bill would require the department to file all necessary state plan amendments to exercise the HSI option made available under CHIP provisions to cover vision services provided to low-income children statewide through a mobile optometric office, as specified. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and the availability of federal financial participation. Under the bill, the federal financial participation would be limited to no more than 3% of the total federal dollars available for expenditures not used for Medicaid or health insurance assistance, as specified.

SB 524 **(Caballero D) Pharmacists: furnishing prescription medications.**
Current Text: Amended: 5/1/2023 html pdf
Last Amend: 5/1/2023
Status: 5/19/2023-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/15/2023)(May be acted upon Jan 2024)
Location: 5/19/2023-S. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law generally authorizes a pharmacist to dispense or furnish drugs only pursuant to a valid prescription, with prescribed exceptions. Current law authorizes a pharmacist or a pharmacy to perform skin puncture in the course of performing routine patient assessment procedures, as defined, or in the course of performing prescribed clinical laboratory tests or examinations. Under current law, the definition of "routine patient assessment procedures" includes clinical laboratory tests that are classified as waived pursuant to the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and specified regulations adopted pursuant to the CLIA. Current law also authorizes a pharmacist to perform any aspect of a test approved or authorized by the United States Food and Drug Administration (FDA) that is classified as waived pursuant to the CLIA, under specified conditions. This bill, with respect to the conditional performance of tests approved or authorized by the FDA and classified as waived pursuant to the CLIA, would instead authorize a pharmacist to order, perform, and report those tests. The bill, until January 1st, 2034, would authorize a pharmacist to

furnish prescription medications pursuant to the results from a test classified as waived pursuant to the CLIA performed by the pharmacist that is used to guide diagnosis or clinical decisionmaking for SARS-CoV-2, Influenza, Streptococcal pharyngitis, or conjunctivitis, in accordance with specified requirements. The bill would require a pharmacist, in providing these patient care services, to utilize specified evidence-based clinical guidelines or other clinically recognized recommendations, and in accordance with standardized procedures or protocol designed and approved by the board and the Medical Board of California.

SB 535 **(Nguyen R) Knox-Keene Health Care Service Plan Act of 1975.**
Current Text: Introduced: 2/14/2023 html pdf
Status: 2/22/2023-Referred to Com. on RLS.
Location: 2/14/2023-S. RLS.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

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. Among other provisions, current law requires a health care service plan to meet specified requirements, including, but not limited to, furnishing services in a manner providing continuity of care, ready referral of patients to other providers at appropriate times, and making services readily accessible to all enrollees, as specified. This bill would make technical, nonsubstantive changes to those provisions.

SB 537 **(Becker D) Open meetings: multijurisdictional, cross-county agencies: teleconferences.**
Current Text: Amended: 4/24/2023 html pdf
Last Amend: 4/24/2023
Status: 6/15/2023-Referred to Com. on L. GOV.
Location: 6/15/2023-A. L. GOV.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law, under the Ralph M. Brown Act, requires that, during a teleconference, at least a quorum of the members of the legislative body participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined. Current law, until January 1st, 2024, authorizes the legislative body of a local agency to use alternate teleconferencing provisions during a proclaimed state of emergency or in other situations related to public health that exempt a legislative body from the general requirements (emergency provisions) and impose different requirements for notice, agenda, and public participation, as prescribed. The emergency provisions specify that they do not require a legislative body to provide a physical location from which the public may attend or comment. Current law, until January 1st, 2026, authorizes the legislative body of a local agency to use alternative teleconferencing in certain circumstances related to the particular member if at least a quorum of its members participate from a singular physical location that is open to the public and situated within the agency's jurisdiction and other requirements are met, including restrictions on remote participation by a member of the legislative body. These circumstances include if a member shows "just cause," including for a childcare or caregiving need of a relative that requires the member to participate remotely. This bill would expand the circumstances of "just cause" to apply to the

situation in which an immunocompromised child, parent, grandparent, or other specified relative requires the member to participate remotely.

SB 541 **(Menjivar D) Sexual health: contraceptives: immunization.**
Current Text: Amended: 6/30/2023 html pdf
Last Amend: 6/30/2023
Status: 6/30/2023-Read second time and amended. Re-referred to Com. on HEALTH.
Location: 6/29/2023-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The California Healthy Youth Act requires school districts, defined to include county boards of education, county superintendents of schools, the California School for the Deaf, the California School for the Blind, and charter schools, to ensure that all pupils in grades 7 to 12, inclusive, receive comprehensive sexual health education and human immunodeficiency virus (HIV) prevention education, as specified. This bill would, in order to prevent and reduce unintended pregnancies and sexually transmitted infections, on or before the start of the 2024–25 school year, require each public school, including schools operated by a school district or county office of education, charter schools, and state special schools, to make internal and external condoms available to all pupils in grades 9 to 12, inclusive, free of charge, as provided. The bill would require these public schools to, at the beginning of each school year, inform pupils through existing school communication channels that free condoms are available and where the condoms can be obtained on school grounds. The bill would require a public school to post at least one notice regarding these requirements, as specified. The bill would require this notice to include certain information, including, among other information, information about how to use condoms properly.

SB 582 **(Becker D) Health information.**
Current Text: Amended: 6/29/2023 html pdf
Last Amend: 6/29/2023
Status: 6/29/2023-Read second time and amended. Re-referred to Com. on APPR. (Amended 6/29/2023)
Location: 6/27/2023-A. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current law requires health care service plans and health insurers to establish and maintain specified application programming interfaces (API), including patient access API, to facilitate patient and provider access to health information and for the benefit of enrollees, insureds, and contracted providers. Current law authorizes the Department of Managed Health Care and the Department of Insurance to require a plan or insurer to establish and maintain specified API, including provider access API. This bill would instead require the departments to require the plans and insurers to establish and maintain these specified API. The bill would exclude from the requirements of these provisions dental or vision benefits offered by a plan or insurer, including a specialized plan or insurer. 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 595 **(Roth D) Covered California: data sharing.**
Current Text: Amended: 6/29/2023 html pdf
Last Amend: 6/29/2023
Status: 6/29/2023-Read second time and amended. Re-referred to Com. on HEALTH. (Amended 6/29/2023)
Location: 6/27/2023-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Current federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Current state law creates the California Health Benefit Exchange (Exchange), also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Current law requires the Exchange, beginning no later than September 1, 2023, and at least monthly thereafter, to request from the Employment Development Department (EDD) specified information of each new applicant for unemployment compensation, state disability, and paid family leave. Current law requires the EDD to provide that information in a manner prescribed by the Exchange. Current law requires the Exchange to market and publicize the availability of health care coverage through the Exchange, and engage in outreach activities, to the individuals whose contact information is received by the Exchange from the EDD, as specified. Existing law prohibits the Exchange from disclosing the personal information obtained from the EDD without the consent of the applicant. This bill would prohibit the disclosure of information by the Exchange to a certified insurance agent, a certified employment counselor, or any other entity without the consent of the applicant, except as provided. The bill would authorize the Exchange to disclose information obtained from the EDD to outreach and marketing vendors under contract to the Exchange. The bill would require outreach and marketing conducted pursuant to these provisions to include, in a conspicuous and easy to access manner, the ability for individuals to decline all future outreach and marketing. The bill would require the Exchange to only request from the Employment Development Department, use, or disclose the minimum amount of information necessary to accomplish the purposes for which it was obtained.

SB 598 **(Skinner D) Health care coverage: prior authorization.**
Current Text: Amended: 4/17/2023 html pdf
Last Amend: 4/17/2023
Status: 6/1/2023-Referred to Com. on HEALTH.
Location: 6/1/2023-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Would, on or after January 1st, 2025, prohibit a health care service plan or health insurer from requiring a contracted health professional to complete or obtain a prior authorization for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent one-year contracted period. The bill would set standards for this exemption and its denial, rescission, and appeal. The bill would

authorize a plan or insurer to evaluate the continuation of an exemption not more than once every 12 months, and would authorize a plan or insurer to rescind an exemption only at the end of the 12-month period and only if specified criteria are met. The bill would require a plan or insurer to provide an electronic prior authorization process. The bill would also require a plan or insurer to have a process for annually monitoring prior authorization approval, modification, appeal, and denial rates to identify services, items, and supplies that are regularly approved, and to discontinue prior authorization on those services, items, and supplies that are approved 95% of the time. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

SB 621 **(Caballero D) Health care coverage: biosimilar drugs.**
Current Text: Amended: 5/2/2023 html pdf
Last Amend: 5/2/2023
Status: 6/21/2023-From committee: Do pass and re-refer to Com. on APPR. (Ayes 14. Noes 0.) (June 20). Re-referred to Com. on APPR.
Location: 6/20/2023-A. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law authorizes a health care service plan or health insurer that provides coverage for prescription drugs to require step therapy if there is more than one drug that is clinically appropriate for the treatment of a medical condition, but requires a plan or insurer to expeditiously grant a step therapy exception request if specified criteria are met. Current law does not prohibit a plan, insurer, or utilization review organization from requiring an enrollee or insured to try an AB-rated generic equivalent or interchangeable biological product before providing coverage for the equivalent branded prescription drug. This bill would specify that a plan, insurer, or utilization review organization is also not prohibited from requiring an enrollee or insured to try a biosimilar before providing coverage for the equivalent branded prescription drug, but that the requirement to try biosimilar, generic, and interchangeable drugs does not prohibit or supersede a step therapy exception request.

SB 635 **(Menjivar D) Health care coverage: hearing aids.**
Current Text: Amended: 6/8/2023 html pdf
Last Amend: 6/8/2023
Status: 6/8/2023-Referred to Com. on HEALTH. From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
Location: 6/8/2023-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1st, 2024, to include coverage for hearing aids for enrollees and insureds under 21 years of age, if medically necessary. The bill would limit the maximum required coverage amount to $3,000 per individual hearing aid, as specified. Because a willful violation of the bill's requirements relative to a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish

procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

SB 694 **(Eggman D) Medi-Cal: self-measured blood pressure devices and services.**
Current Text: Amended: 6/12/2023 html pdf
Last Amend: 6/12/2023
Status: 6/21/2023-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To consent calendar. (Ayes 14. Noes 0.) (June 20). Re-referred to Com. on APPR.
Location: 6/20/2023-A. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law sets forth a schedule of benefits under the Medi-Cal program, including pharmacy benefits (Medi-Cal Rx) and durable medical equipment. The State Department of Health Care Services announced that, effective June 1st, 2022, personal home blood pressure monitoring devices, and blood pressure cuffs for use with those devices, are a covered benefit under Medi-Cal Rx as a pharmacy-billed item. This bill would make self-measured blood pressure (SMBP) devices and SMBP services, as defined, covered benefits under the Medi-Cal program subject to utilization controls. The bill would state the intent of the Legislature that those covered devices and services be no less in scope than the devices and services that are recognized under specified existing billing codes or their successors. The bill would condition implementation of that coverage on receipt of any necessary federal approvals and the availability of federal financial participation.

SB 717 **(Stern D) County mental health services.**
Current Text: Amended: 7/5/2023 html pdf
Last Amend: 7/5/2023
Status: 7/5/2023-From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
Location: 6/8/2023-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law prohibits a person from being tried or adjudged to punishment while that person is mentally incompetent. If a defendant who has been charged with a misdemeanor has been determined to be mentally incompetent, existing law authorizes the court to either grant diversion for a period of one year, refer the defendant to treatment, or dismiss the charge. The Bronzan-McCorquodale Act governs the organization and financing of community mental health services for persons with mental disorders in every county through locally administered and locally controlled community mental health programs. This bill would require the court to notify an individual of their ongoing need for mental health services if the individual has been found incompetent to stand trial and is not receiving court directed services. The bill would require the court to provide the individual with specified information, including the name, address, and telephone number of the county behavioral health department. The bill would require a county behavioral health department, in collaboration and coordination with community-based organizations, to attempt to make first contact with an individual within 48 hours of release, to track outreach attempts for an individual for at least 60 days following their release, and to offer mental health services and treatment, as appropriate, and

assist with facilitating an individual's access to private insurance, if applicable.

SB 729 **(Menjivar D) Health care coverage: treatment for infertility and fertility services.**
Current Text: Amended: 5/18/2023 html pdf
Last Amend: 5/18/2023
Status: 6/1/2023-Referred to Com. on HEALTH.
Location: 6/1/2023-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require large group, small group, and individual health care service plan contracts and disability insurance policies issued, amended, or renewed on or after January 1st, 2024, to provide coverage for the diagnosis and treatment of infertility and fertility services. 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 disability insurance policy provide infertility treatment under agreed-upon terms that are communicated to all group contractholders and policyholders. The bill would prohibit a health care service plan or disability insurer from placing different conditions or coverage limitations on fertility medications or services, or the diagnosis and treatment of infertility and fertility services, than would apply to other conditions, as specified.

SB 779 **(Stern D) Primary Care Clinic Data Modernization Act.**
Current Text: Amended: 4/17/2023 html pdf
Last Amend: 4/17/2023
Status: 6/15/2023-Referred to Com. on HEALTH.
Location: 6/15/2023-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law provides for the licensure and regulation of clinics, including primary care clinics, by the State Department of Public Health. Current law excludes certain facilities from those provisions, including a clinic that is operated by a primary care community or free clinic and that is operated on separate premises from the licensed clinic and is only open for limited services of no more than 40 hours a week, also referred to as an intermittent clinic. Current law imposes various reporting requirements on clinics, including requiring a clinic to provide a verified report to the Department of Health Care Access and Information including information relating to the previous calendar year, such as the number of patients served and specified descriptive information, medical and other health services provided, total clinic operating expenses, and gross patient charges by payer category. Current law specifies that the reporting requirements apply to all primary care clinics. This bill would revise those reporting requirements, including specifying the type of descriptive information required to be reported. The bill would extend application of the reporting requirements to intermittent clinics, as specified.

SB 805 **(Portantino D) Health care coverage: pervasive developmental disorders or autism.**
Current Text: Amended: 4/24/2023 html pdf
Last Amend: 4/24/2023

Status: 6/28/2023-From committee: Do pass and re-refer to Com. on HUM. S. (Ayes 15. Noes 0.) (June 27). Re-referred to Com. on HUM. S.
Location: 6/27/2023-A. HUM. S.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law requires a health care service plan contract or a health insurance policy to provide coverage for behavioral health treatment for pervasive developmental disorder or autism, and defines “behavioral health treatment” to mean specified services and treatment programs, including treatment provided pursuant to a treatment plan that is prescribed by a qualified autism service provider and administered either by a qualified autism service provider or by a qualified autism service professional or qualified autism service paraprofessional who is supervised as specified. Current law defines a “qualified autism service professional” to refer to a person who meets specified educational, training, and other requirements and is supervised and employed by a qualified autism service provider. Current law defines a “qualified autism service paraprofessional” to mean an unlicensed and uncertified individual who meets specified educational, training, and other criteria, is supervised by a qualified autism service provider or a qualified autism service professional, and is employed by the qualified autism service provider. This bill would expand the criteria for a qualified autism service professional to include a behavioral health professional and a psychology associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as specified. The bill would expand the criteria for a qualified autism service paraprofessional to include a behavioral health paraprofessional, as specified.

SB 819 **(Eggman D) Medi-Cal: certification.**
Current Text: Amended: 6/26/2023 html pdf
Last Amend: 6/26/2023
Status: 6/26/2023-From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
Location: 5/11/2023-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law requires the State Department of Public Health to license and regulate clinics. Current aw exempts from those licensing provisions certain clinics that are directly conducted, maintained, or operated by federal, state, or local governmental entities, as specified. Current law also exempts from those licensing provisions a clinic that is operated by a primary care community or free clinic, that is operated on separate premises from the licensed clinic, and that is only open for limited services of no more than 40 hours per week. Current law sets forth various procedures, including the submission of an application package, for providers to enroll in the Medi-Cal program. Under current law, an applicant or provider that is a government-run license-exempt clinic as described above is required to comply with those Medi-Cal enrollment procedures. Under current law, an applicant or provider that is operated on separate premises and is license exempt, including an intermittent site or mobile health care unit that is operated by a licensed primary care clinic that provides all staffing, protocols, equipment, supplies, and billing services, is not required to enroll in the Medi-Cal program as a separate provider or comply with the above-described enrollment procedures, if the licensed primary care clinic has notified the department of its separate locations,

premises, intermittent sites, or mobile health care units. This bill would additionally exempt from the Medi-Cal enrollment procedures an intermittent site or mobile health care unit that is operated by the above-described government-run license-exempt clinic if that clinic has notified the department of its separate locations, premises, sites, or units.

SB 839 **(Bradford D) Obesity Treatment Parity Act.**
Current Text: Amended: 5/10/2023 html pdf
Last Amend: 5/10/2023
Status: 5/10/2023-From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
Location: 5/10/2023-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require an individual or group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1st, 2025, to include comprehensive coverage for the treatment of obesity in the same manner as any other illness, condition, or disorder for purposes of determining deductibles, copayment and coinsurance factors, and benefit year maximums for deductibles and copayment and coinsurance factors.

SB 870 **(Caballero D) Medi-Cal: managed care organization provider tax.**
Current Text: Amended: 4/17/2023 html pdf
Last Amend: 4/17/2023
Status: 5/18/2023-May 18 hearing: Held in committee and under submission.
Location: 5/8/2023-S. APPR. SUSPENSE FILE

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law, inoperative on January 1st, 2023, and to be repealed on January 1st, 2024, imposed a managed care organization (MCO) provider tax, administered and assessed by the State Department of Health Care Services, on licensed health care service plans and managed care plans contracted with the department to provide full-scope Medi-Cal services. Those provisions set forth taxing tiers and corresponding per enrollee tax amounts for the 2019–20, 2020–21, and 2021–22, fiscal years, and the first 6 months of the 2022–23 fiscal year. Under those provisions, all revenues, less refunds, derived from the tax were deposited into the State Treasury to the credit of the Health Care Services Special Fund, and continuously appropriated to the department for purposes of funding the nonfederal share of Medi-Cal managed care rates, as specified. Those inoperative provisions authorized the department, subject to certain conditions, to modify or make adjustments to any methodology, tax amount, taxing tier, or other provision relating to the MCO provider tax to the extent the department deemed necessary to meet federal requirements, to obtain or maintain federal approval, or to ensure federal financial participation was available or was not otherwise jeopardized. Those provisions required the department to request approval from the federal Centers for Medicare and Medicaid Services (CMS) as was necessary to implement those provisions. In April 2020, CMS approved a modified tax structure that the department had submitted as part of a waiver request, involving taxing tiers that were based on cumulative Medi-Cal or other member months for certain fiscal years. This bill would extend the above-described MCO provider tax to an unspecified date and

would make conforming changes to the timeline of related provisions by incorporating other unspecified dates.

SB 873 **(Bradford D) Prescription drugs: cost sharing.**
Current Text: Introduced: 2/17/2023 html pdf
Status: 6/15/2023-Referred to Com. on HEALTH.
Location: 6/15/2023-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: This bill, commencing no later than January 1st, 2025, 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. The bill would require the department and the commissioner to submit an annual report on the impact of these provisions to the appropriate policy committees of the Legislature, as specified. The bill would make these provisions inoperative on January 1st, 2027. This bill contains other related provisions and other existing laws.