Board of Governors

Regular Meeting

Friday, October 14th, 2022
12:00 p.m. – 2:00 p.m.

1240 South Loop Road, Alameda, CA 94502
or Video Conference Call

AGENDA

BOARD OF GOVERNORS
Regular Meeting
Friday, October 14th, 2022
12:00 p.m. – 2:00 p.m.

Video Conference Call or

1240 S. Loop Road

Alameda, CA 94502

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

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

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

YOU MAY SUBMIT COMMENTS ON ANY AGENDA ITEM OR ON ANY ITEM NOT ON THE AGENDA, IN WRITING VIA MAIL TO "ATTN: ALLIANCE BOARD," 1240 SOUTH LOOP ROAD, ALAMEDA, CA 94502; OR THROUGH E-COMMENT AT jmurray@alamedaalliance.org. YOU MAY WATCH THE MEETING LIVE BY LOGGING IN VIA COMPUTER AT THE FOLLOWING LINK: Click here to join the meeting OR MAY LISTEN TO THE MEETING BY CALLING IN TO THE FOLLOWING TELEPHONE NUMBER: 1-510-210-0967 Conference ID 8650745#. IF YOU USE THE LINK AND PARTICIPATE VIA COMPUTER, YOU MAY, THROUGH THE USE OF THE CHAT FUNCTION, REQUEST AN OPPORTUNITY TO SPEAK ON ANY AGENDIZED ITEM, INCLUDING GENERAL PUBLIC COMMENT. YOUR REQUEST TO SPEAK MUST BE RECEIVED BEFORE THE ITEM IS CALLED ON THE AGENDA. IF YOU PARTICIPATE BY TELEPHONE, YOU MAY SUBMIT ANY COMMENTS VIA THE E-COMMENT EMAIL ADDRESS DESCRIBED ABOVE OR PROVIDE COMMENTS DURING THE MEETING AT THE END OF EACH TOPIC.

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

1. **CALL TO ORDER**

   (A regular meeting of the Alameda Alliance for Health Board of Governors will be called to order on October 14th, 2022, at 12:00 p.m. in Alameda County, California, by Dr. Evan Seevak, Presiding Officer. This meeting is to take place by video conference call.)

2. **ROLL CALL**

3. **AGENDA APPROVAL OR MODIFICATIONS**

4. **INTRODUCTIONS**

5. **CONSENT CALENDAR**

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

   a) **JULY 8th, 2022, BOARD OF GOVERNORS MEETING MINUTES**

   b) **SEPTEMBER 29th, BOARD OF GOVERNORS RETREAT MINUTES**

   c) **SEPTEMBER 6th, 2022, FINANCE COMMITTEE MEETING MINUTES**

   d) **OCTOBER 11th, 2022, FINANCE COMMITTEE MEETING MINUTES**

6. **BOARD MEMBER REPORTS**

   a) **COMPLIANCE ADVISORY COMMITTEE**

   b) **FINANCE COMMITTEE**

7. **CEO UPDATE**

8. **BOARD BUSINESS**

   a) **REVIEW AND APPROVE MOSS ADAMS FISCAL YEAR 2022 AUDIT RESULTS**

   b) **REVIEW AND APPROVE JUNE 2022 MONTHLY FINANCIAL STATEMENTS**

   c) **REVIEW AND APPROVE JULY 2022 MONTHLY FINANCIAL STATEMENTS**

   d) **REVIEW AND APPROVE AUGUST 2022 MONTHLY FINANCIAL STATEMENTS**

   e) **REVIEW AND APPROVE RESOLUTION #2022-03 AD HOC EXECUTIVE SEARCH SUBCOMMITTEE**

   f) **REVIEW THE CURRENT BOARD OF GOVERNORS COMPOSITION AND DISCUSS FOUR (4) ADDED SEATS.**

g) **CALAIM IMPLEMENTATION UPDATE**

h) **INSOURCING OF MENTAL HEALTH AND AUTISM SPECTRUM UPDATE**

9. STANDING COMMITTEE UPDATES

a) **PEER REVIEW AND CREDENTIALING COMMITTEE**

b) **HEALTH CARE QUALITY COMMITTEE**

c) **PHARMACY AND THERAPEUTICS COMMITTEE**

d) **MEMBERS ADVISORY COMMITTEE**

10. STAFF UPDATES

11. UNFINISHED BUSINESS

12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

13. PUBLIC COMMENT (NON-AGENDA ITEMS)

14. ADJOURNMENT

NOTICE TO THE PUBLIC

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

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

NOTICE TO THE PUBLIC

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

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

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

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

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

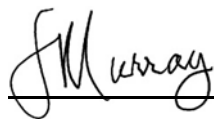
Public Input: If you are interested in addressing the Board, you may submit comments on any agenda item or on any item not on the agenda, in writing via mail to "Attn: Alliance Board," 1240 S. Loop Road, Alameda, CA 94502; or through e-comment at jmurray@alamedaalliance.org. You may also provide comments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

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

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

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

I hereby certify that the agenda for the Board of Governors was posted on the Alameda Alliance for Health's web page at www.alamedaalliance.org on October 10th, 2022, by 12:00 p.m.



Clerk of the Board – Jeanette Murray

Consent Calendar

Board of Governors Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
BOARD OF GOVERNORS
REGULAR MEETING
July 8th, 2022
12:00 pm – 2:00 pm
(Video Conference Call)
Alameda, CA

SUMMARY OF PROCEEDINGS

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

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

Guests Present on Conference Call:

Excused: Supervisor Dave Brown

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
1. CALL TO ORDER			
Dr. Evan Seevak	The regular board meeting was called to order by Dr. Seevak at 12:02 pm. The following public announcement was read. "The Board recognizes that there is a proclaimed state of emergency at both the State and the local Alameda County levels, and there are recommended measures to promote social distancing in place. The Board shall therefore conduct its meetings via teleconference in accordance with Assembly Bill 361 for the duration of the proclaimed State of emergency." "Audience, during each agenda item, you will be provided a reasonable amount of time to provide public comment."	None	None

2. ROLL CALL			
Dr. Evan Seevak	A telephonic roll call was taken of the Board Members, and a quorum was confirmed.	None	None
3. AGENDA APPROVAL OR MODIFICATIONS			
Dr. Evan Seevak	None	None	None
4. INTRODUCTIONS			
Dr. Evan Seevak	None	None	None
5. CONSENT CALENDAR			
Dr. Evan Seevak	Dr. Seevak presented the July 8th, 2022, Consent Calendar. a) June 10th, 2022, Board of Governors Meeting Minutes b) July 5th, 2022, Finance Committee Meeting Minutes Motion to Approve July 8th, 2022, Board of Governors Consent Calendar. A roll call vote was taken, and the motion passed.	Motion to Approve July 8th, 2022, Board of Governors Consent Calendar. Motion: Dr. Rollington Ferguson Second: Dr. Kelley Meade Vote: Yes No opposed or abstained.	None

6. a. BOARD MEMBER REPORT – COMPLIANCE ADVISORY COMMITTEE			
Rebecca Gebhart	The Compliance Advisory Committee (CAC) was held telephonically on July 8th, 2022, at 10:30 am. Rebecca Gebhart gave the following Compliance Advisory Committee updates. 2022 DMHC Behavioral Health Investigation: • Pertains to the commercial line and is now actively in the pre-audit phase. This is a Mental Health Parity and Addiction Equity Act (MHPAEA) audit. The audit is complex, and the State has undertaken now for a second year and applies only to our commercial lines and group care. • The State has requested, and we have submitted over one thousand (1,000) documents. The pre-audit phase ends today. • A question was asked about how they are going to establish the Chief of Health Equity, and the answer was that they are reviewing files from multiple parts of the system, both on the behavioral health side and on the medical side, in order to establish parity or lack-there-of. • This is an extremely comprehensive audit, which includes interviews of our local providers. The State may also be interested in gauging how the local initiatives and commercial plans differ in dealing with parity issues. This audit will be going into the regular audit phase soon, and in the next couple of months, we will get information about the audit outcomes. Question: This is a standard audit, and it isn't the result of a complaint? Answer: No, this is not the result of a complaint. This is from the State, and they are doing it systematically; we just happen to be in the second batch, and it is not due to a complaint against the Plan. Internal Delegation Oversight Committee: • The internal delegation oversight committee within the Plan oversees the performance and ensures compliance and accreditation and many other requirements of our delegates.	Informational update to the Board of Governors. Vote not required.	

	• In their meeting, they review the status of the various audits, and anything that may have come up as a rebuild of something going on with the delegates. • There is a document, "Delegation Grid" which lists all of our delegates and specifically what they are delegated for. For example, Kaiser is a closed system, so they are not delegated – they are delegated to handle their own grievance, whereas we handle grievances for other delegates. Delegation Audit Schedule: • We looked at the delegation audit schedule, which is where we are auditing our delegates in the same way that our regulatory agencies are auditing us. • This is used as a planning tool that provides which delegates will be audited and when. The Committee reviews this at the beginning of the year; it is a helpful and comprehensive planning tool on the delegate audit side. • The delegate audit process occurs concurrently with our own regulatory audit process and general audit season, so at the same time that we have multiple audits with our delegates, we are also in audits with our regulatory agencies. Delegation Reporting and Escalation Protocols: • The document differentiates between routine issues and egregious issues. It also provides examples of routine issues, which generally are no system-wide implications, and a non-systemic infraction; for example, it could be a lack of record-keeping in particular situations. • Egregious issues require immediate escalation. Egregious issues are systemic deficiency with system-wide implications or a specific situation surrounding a death, etc., and utilization management issues impacting members. • The document also addresses escalation protocols for egregious issues, such that the compliance director must report to the CEO with five (5) calendar days, and the CEO must report to the Board within seven (7) calendar days. The agency then has twenty-one (21) calendar days to report to the regulatory agency.		

	Informational update to the Board of Governors. Vote not required.		
6. b. BOARD MEMBER REPORT – FINANCE COMMITTEE			
Dr. R. Ferguson	The Finance Committee was held telephonically on Tuesday, July 5th, 2022. Since Dr. Ferguson was not present for the meeting, Dr. Marchiano provided the following updates: Highlights: • Our enrollment has increased by over two thousand (2,000) members since April 2022, and by over twenty-two thousand (22,000) members over the past year. Higher enrollment is partly due to the Public Health Emergency, which is expected to end in October 2022. • For the fiscal year-to-date (YTD) ending May 31st, 2022, actual revenue was $1.1B and the budgeted revenue was also $1.1B • We looked at the TNE and MLR parameters to help the organization remain favorable. Our TNE exceeds the DMHC's requirement. Informational update to the Board of Governors. Vote not required.	Informational update to the Board of Governors. Vote not required.	None
7. CEO UPDATE			
Scott Coffin	Scott Coffin, Chief Executive Officer, presented the following updates:	Informational update to the Board of Governors.	None

	Scott began by thanking the Alliance staff for their hard work in reaching one hundred percent (100%) compliance on regulatory metrics in the month of May. Key Performance Indicators: • Regulatory Metrics: The regulatory metrics were fully met. • Non-Regulatory Metrics: We are continuing the work on non-regulatory metrics. The member services team and our call center team have been stepping up to answer the calls that come in, nearly thirteen thousand (13,000) calls per month. • Customer service is a key component of our operations, and the team has been working very hard to reduce the wait time for our members and the abandonment rate each month. Anastacia Swift, Chief Human Resource Officer, provided the following update on Staffing: • Our current recruitment rate is at eighteen percent (18%). From last month, we have added approximately twenty-four new positions (24) among which we have budgeted for the different programs. We have a timeline to start recruitment efforts for these positions. • Over the past month, we have had twenty-four (24) new hires, many of which had start dates in June, and some in July. • We are working on filling our recruiter positions internally for the Alliance. Additionally, the external recruiters we are working with are receiving our listings for them to source for candidates for the upcoming programs. These recruiters understand the timelines and start dates we are following, and we are giving them sufficient time to source within those timelines. • Furthermore, our hiring managers internally are aware of the timelines corresponding to both sourcing for candidates through external as well as internal efforts. Preliminary Budget – Fiscal Year 2023: • As previously stated last month, for FY2023, we have seventy-eight positions that have been approved.	Vote not required.	

- We are not hiring for all these positions in the first quarter of the fiscal year; however, we have initiated the recruiting efforts.

Program Implementations:

- During each Board meeting, we present on the highest priority Medi-Cal initiatives, one of which is on the insourcing of Mental Health and Autism Spectrum Services. The insourcing for the Mental Health Services is November 1st, 2022.
- Quality/Quality Improvement: The Department of Health Care Services (DHCS) announced a Medi-Cal quality component that will be applied to the base Medi-Cal rates starting in the Calendar Year 2023.
- For the 2023 Implementation of Quality component, the requirement will be based on a proposed set of HEDIS measures of Calendar Year 2021. We have a projected score of seventy-five percent (75%) that is yet to be validated by the State.
- The quality component is being highlighted to the Board Members for purposes of discussion, as we present the final budget as we are factoring in the potential impact to the rates. We will go more into the details when the State finalizes the proposed set of ten to fifteen (10-15) HEDIS measures.

Question: Your understanding is that this is a withhold for not meeting metrics, and not a bonus for doing well?
Answer: Correct, however, there is a defined amount of funding that is based on our rates being paid. For example, if one Plan does better than the other in a two-plan county, the Plan that did better will gain more of those dollars as a bonus in addition to the base rate.

Question: To clarify, if we do well on our metrics, we can get more funding, and if we don't, we get less?
Answer: Yes, there is a comparison between the two plans. There will also be a baseline that is established for single-plan counties.

Single Plan Model:

- The Department of Health Care Services (DHCS) has provided a deliverable submission timeline for the next eighteen (18) months. We are currently working on the first submission, due August 12th, 2022. A series of documents are being prepared and going through our Compliance division. We will keep the Board apprised as we go through the Single Plan Model process.
- Effective on January 1st, 2024: Implementation of the Single Plan Model.

Question: Are the deliverables solely from the Plan, or are there any from Alameda County?
Answer: There are two-hundred-forty-six (246) deliverables and based on the review of the deliverables due in Phase 1 and Phase 2, the assessment is whether the Plan has existing infrastructure to submit those deliverables. We have not completed a review of whether deliverables would be required from the County or any other entity. We will expand our review and report back to the Board.

CalAIM Incentives:

- Last month we distributed a table showing our incentive programs; we will update this table each time there is an action taken in terms of dollar allocations.
- Item number three, which is the CalAIM Incentive Program reflects the activities between last month and this month. We have advanced through the first wave of funding, which is also an application process where we invite our community-based organizations here in Alameda County to participate. They go through an evaluation process that examines the compliance of the request to the parameters for the CalAIM Incentive Program.
- We have three-point-seven million dollars ($3.7M) that is approved. We have a second wave of funding that is beginning – Tiffany Cheang and her team are coordinating across the organization.
- There is required criteria defined by the State that we are following. Additionally, we have developed a process for how we are doing the evaluations, including the scoring, and awarding. The Team has done a great job on the CalAIM Incentive Program.
- The Housing and Homelessness initiative also provides significant opportunity; there is a lot of work involved with this one, and we are using

	the same process and framework that has yielded results for these other incentive programs. • We will be reporting on these incentive programs to demonstrate full transparency – the money that we receive from the State for these programs and goes into the community is very important to the organization. Therefore, we will be keeping close optics on that. • We will be forecasting administrative costs associated with the incentive programs; we will be transparent in showing what money we received and what money was paid out. Question: Can you please clarify the difference between awarded and approved? Answer: (Tiffany Cheang) The awarded amount is what comes directly from the State. The approved amount is what we approved for distribution. Question: The way we did with the vaccine – will there be descriptions where we listed the grants our partners received? Answer: Yes, we will be making that available. Informational update to the Board of Governors. Vote not required.		
8. a. BOARD BUSINESS – REVIEW AND APPROVE MAY 2022 MONTHLY FINANCIAL STATEMENTS			
Gil Riojas	Gil Riojas gave the following May 2022 Finance updates: Enrollment: • For the month ending May 31st, 2022, the Alliance had an enrollment over 310,000 members, a net income of $5.2M, and the Tangible Net Equity (TNE) was 594% of the required amount. • Our enrollment has increased by over 2,000 members since April 2022, and on a fiscal YTD, we gained over 22,000 members since June 2021. This is primarily due to the Public Health Emergency and the extension of it. We are expecting the Public Health Emergency to end in October;	Motion to Approve May 2022 Monthly Financial Statements as presented. Motion: Dr. Rollington Ferguson Second: Dr. Michael Marchiano Vote: Yes	None

	however, it may be extended. If it is extended, it will have implications on our membership in FY2023. • Our seniors and persons with disabilities enrollment is going up slightly, and our group care line of business has remained flat for twelve (12) months. Net Operating Results: • For the fiscal YTD ending May 31st, 2022, the actual net income was $20.3M. We have done well this past fiscal year in part due to savings on administrative expenses. Revenue: • For the month ending May 31st, 2022, the actual revenue was $99.4M vs. the budgeted revenue of $96.8M. • For the fiscal year ending May 31st, 2022, the actual revenue was $1.1B vs. the budgeted revenue of $1.1B. • For the month ending May 31st, 2022, the favorable revenue variance of $2.6M is largely due to favorable $1.5M CalAIM Incentive Revenue, favorable $470,000 Medi-Cal Base Capitation Revenue, and favorable $381,000 Student Behavioral Incentive Revenue, offset by unfavorable $378,000 Behavioral Health Supplemental Revenue. The favorable Medi-Cal Base Capitation Revenue variance of $470,000 is net of unfavorable $1.4M DHCS recoupment resulting from Date of Death Audit. Question: The first recoupment was $2.6M, and the second recoupment was $1.4M? And it was the same timeframe when they went back to 2011? Answer: Correct. They went back to 2011 and went forward to calendar year 2022. Medical Expense: • For the month ending May 31st, 2022, the actual medical expense was $89.1M, and the budgeted medical expense was $86.8M. • For the fiscal year ending May 31st, 2022, the actual medical expense was $1.0B vs. the budgeted medical expense of $992.4M.	No opposed or abstained.	

	• We had a slight decrease in our Incurred-But-Not-Paid (IBNP) claims estimate of $750,000, that reduced our Medical Expenses slightly. • We are about thirteen million ($13.0M) over our budget in terms of medical expenses, primarily driven by increase in enrollment. • On a PMPM basis, medical expense is 0.8% favorable to the budget. Medical Loss Ratio (MLR): • For the month ending May 31st, 2022, the MLR was 89.6% and 92.7% for the fiscal year-to-date. • Ideally, we would like to maintain our MLR between 90.0% and 95.0%. Administrative Expense: • For the month ending May 31st, 2022, the actual administrative expense was $5.6M vs. the budgeted administrative expense of $6.7M. • For the fiscal YTD ending May 31st, 2022, the actual administrative expense was $59.1M vs. the budgeted administrative expense $74.5M. • For FY2023, we will be doing significant hiring – we are anticipating in our budget to hire seventy-eight (78) people. The goal is to narrow the gap between actual and budgeted, particularly for employee expense since this is a category that is of significant expense for FY2023. • Our administrative loss ratio (ALR) for the month was 5.6% of net revenue and 5.4% of net revenue year-to-date. • Our budget target for FY2022 was about seven percent (~7%) – we are below that, which is positive. Other Income / (Expense): • As of May 31st, 2022, our fiscal year-to-date net investment revenue reported an eighty-two-thousand-dollar loss ($82,000). We anticipate this number to change. • Fiscal-year-to-date claims interest expense from July 2021 to May 2022 is three-hundred-sixty-three thousand dollars ($363,000).		

	Tangible Net Equity (TNE): • The Department of Managed Health Care (DMHC) requires TNE to be thirty-eight million dollars ($38.0M). • We reported an actual TNE of two-hundred-twenty-five-million-dollars ($225.8M), and an excess TNE of one-hundred-eighty-seven-million-dollars ($187.8M). • Of the required TNE, we have five-hundred-ninety four percent (594%). Cash Position and Assets: • For the month ending May 31st, 2022, the Alliance reported $297.9M in cash; $196.7M in uncommitted cash. Our current ratio is above the minimum required at 1.72 compared to the regulatory minimum of 1.0. Capital Investment: • Fiscal year-to-date capital assets acquired: $234,000. • Annual capital budget: $1.4M. • For FY2022, capital investments are primarily related to our generator this year that we installed in the office building. We also continue to acquire IT assets as we increase our memory and storage. Question: Do you have a sense of how June is going to be? Answer: Right now, we are going through our Moss Adams audit; I would suspect the results to be favorable, over the last several months we've seen favorability in our trends in both revenue and expenses. I anticipate this will continue. Motion to Approve May 2022 Monthly Financial Statements as presented. A roll call vote was taken, and the motion passed.		

8. b. BOARD BUSINESS – REVIEW AND APPROVE RESOLUTION #2022-02 NOMINATING YEON PARK FOR APPOINTMENT TO DESIGNATED AT LARGE LABOR SEAT			
Scott Coffin	Staff Report: • Due to the resignation of Nicholas Peraino, the Alameda Alliance for Health "Alliance" Board of Governors has a vacancy for the At-Large Labor Seat (Regular #4). • The Executive Committee of the Board has recommended Yeon Park, a labor union leader, from SEIU Local 1021, as the nominee for this vacant seat. Motion to Approve Resolution #2022-02 Nominating Yeon Park for Appointment to Designated At Large Labor Seat as presented. A roll call vote was taken, and the motion passed.	Motion to Approve Resolution #2022-02 Nominating Yeon Park for Appointment to Designated At Large Labor Seat as presented. Motion: Dr. Evan Seevak Second: Dr. Marty Lynch Vote: Yes No opposed or abstained.	None

8. c. LONG TERM CARE INSOURCING UPDATE, MENTAL HEALTH MILD-TO-MODERATE & AUTISM SPECTRUM DISORDER SERVICES			
Ruth Watson	Presented by the Integrated Planning, Health Care Services, and Operations Division Leadership Teams. CalAIM Long Term Care Carve in Agenda: • This is an enterprise-wide program and involves our partners from outside of the organization. • The Program Scope encompasses the Critical Path and requires us to have the following: Provider Contracting and Credentialing, Workflows and	Informational update to the Board of Governors. Vote not required.	None

Matthew Woodruff	Process Requirements, System Development and Configuration, Staffing, Cultural Competency, and Financial Forecast. • We will also review the timeline, risks, and mitigation, as well as have a discussion. Program Scope: • Long Term Care (LTC) is currently not the responsibility of Alameda Alliance; however, the Plan will be responsible for LTC Skilled Nursing Facility (SNF) and Custodial Care, effective January 1st, 2023. • The Alliance is currently responsible for the month of admission and the month after for a sixty (60) day period. • The LTC Sub-acute, Intermediate Care Facilities (ICF) and Institutions for Mental Disease (IMD) will transition to MCPs no earlier than July 1st, 2023. • The transition with two LTC Populations of Focus that also go live on January 1st, 2023: (1) Adults Living in the Community at Risk for LTC Institutionalization and (2) Nursing Facility Residents Transitioning to the Community. Critical Path: • Provider Contracting and Credentialing: Ensuring Continuity of Care is critical for all transitioning members making contracting/credentialing an essential and expansive effort. We currently contract with sixty-four (64) SNF facilities, and contracts will be amended to include the new requirements. • We have nearly nineteen hundred members currently with LTC Aid Codes (1,891). Member-specific data is expected from DHCS in November. The data will provide information on which facility each member resides in, and the implementation team will utilize the data to address any gaps in the SNF network. Additionally, we are contracting with SNF medical providers as well as other providers serving LTC members. Question: There are six hundred long-term care facilities in the county, do you have to have amendments for all of them? Answer: The six hundred encompasses everything discussed in the previous slide. What we are focusing on right now are the sixty-four (64) SNF facilities we are contracting with. On June 27th, we received data estimates from DHCS. There is		

Tami Lewis	a chance that the beneficiaries are not listed accurately. We will know more when we receive the specific data in the coming months. Question: When a patient is discharged from the hospital to a long-term care facility – doesn't that sometimes occur across a county line? If this happens, how does the Plan handle that request? Answer: Yes, that does happen. We have a policy and plan for dealing with such requests. How we handle the request depends on the facility – for some members with certain complexities, they must go to a specific facility, and we go through an agreement basis where we contact the facility, negotiate the rate, how long the member will be staying and other logistics. Workflow & Process Design Requirements: • The development of business processes and understanding how we are going to manage all the various processes is key in successfully executing this insourcing. • As previously stated, this is an enterprise-wide initiative and encompasses multiple departments – Utilization and Case Management, Claims, Member and Provider Services. System Development & Configurations: • We need to understand what our business requirements are to develop systems and configurations. For example, we will be developing custom codes so that providers will be able to submit claims and process the information in our system and be able to report the information to the State in industry-standard coding. Staffing & Recruitment: • There will be a new long-term care department that is being created to support this initiative once we bring this in-house. Initially, there will be five (5) dedicated positions in Heath Care Services; however, other departments will also have supporting positions.		

Annjanette Dixon Gil Riojas	• Finance has estimated that the total staffing cost for this new department will be one-point-five to one-point-six million dollars ($1.5M - $1.6M) annually. Development of Cultural Competency for Older Adults & Long-Term Care Patients: • We will be expanding our understanding of the unique needs of Older Adults and physically disabled long-term care residents to support them both in terms of their clinical needs as well as their emotional needs. • In order to accomplish this level of understanding, we will schedule listening sessions with targeted stakeholders and create a Long-Term Care Collaborative as part of the countywide CalAIM Stakeholder Committee provide input from the community regarding the transition of this population to managed Medi-Cal. Provider Focus: • Additionally, we want to focus on the providers, and provider education and engage on the transition and timing, authorization request process, and new coding requirements. AAH Utilization & Clinical Impact: • The long-term care population is largely unmanaged since it is handled by Fee-for-Service Medi-Cal. • However, with this transition, there will be an increase in the number of members in acute care facilities; an increase in the number and complexity of Transitions of Care; an increase in focus on quality of care, palliative care and end of life issues for some of our most ill members; and adhering to regulatory recommendations for Continuity of Care requirements and Member Rights. Financial Forecast 2023: • In our preliminary budget, we anticipated around fifteen hundred (1500) members in total of long-term care, three hundred (300) of which are Medi-Cal only members and twelve hundred (1200) of which are long-term care duals. We will have additional information from the State in November.		

Tami Lewis Ruth Watson	• We have budgeted around eighty million in revenue ($79.3M) and around seventy-eight million in expense ($77.7M) for the first part of the calendar year, from January to June of calendar year 2023. • The forecasted Medical Loss Ratio (MLR) is 98%. We anticipate our total cost will potentially be over the revenue that we receive. • The Department of Health Care Services (DHCS) has not established a risk corridor for long-term care. This may cause potential risk because our expenses could be significantly over our revenue. We don't anticipate that happening, however, we don't have the risk corridor that we do for other initiatives, such as major organ transplant. Timeline & Implementation Phases – CalAIM Long Term Care Carve-In: • Long-Term Care Provider Contracting is commencing, for the duration of July 15th, 2022 – November 1st, 2022. • The Training and Testing will be ongoing for the duration of October 1st, 2022 – December 31st, 2022. • We will go live with the Long-Term Care and Population Health initiative January 1st, 2023. • Once we have gone live, we will start the work for the remaining population that is scheduled to go live no earlier than July 2023 – this would be the Sub-acute, ICF, IMD, starting with provider contracting and credentialing. These are the members that we don't know what facilities they are in; therefore, we will have to determine whether we have contracts with these facilities or not. We will repeat the training and testing cycle, and then go live with that population no earlier than July 1st, 2023. Risks & Mitigation Plan: • With this transition, there are inherent risks that we identify on a regular basis as we manage the project. • One area of concern is Contracting and Credentialing. As stated previously, we have sixty-four (64) facilities requiring contract amendments and Providers Credentialing. Our Mitigation Plan is we are adding Contracting Specialist Consultants to work on Contracting. • Another area of concern is that DHCS will not be providing us with identified Member data with facility location until November 2022. There		

	could be potential delays in getting Members loaded into our Systems to support care. This may also cause members to be placed in non-contracted facilities. Our mitigation plan is to use historical utilization and encounter data to try to predict location and volume, as well as have strong LOA process in place for missed facilities. • Lastly, we have staffing concerns as we need to hire for five (5) positions, which involves recruiting, onboarding, and training. A recruitment firm has been hired to support Long-Term Care and other hiring efforts. • There are many competing priorities, with risks of human resource and system constraints. However, we will continue to meet on a weekly basis to monitor performance and just resource assignments. • Our goal is to ensure everything goes smoothly as this transition impacts our most vulnerable members. Question: What if the Provider does not sign the contract or letter of agreement? Answer: Most of them already have a contract with the State of California.		
Dr. Peter Currie	Mental Health Mild-to-Moderate & Autism Spectrum Disorders Service Domains: • There are seven (7) service domains that we transition from Beacon – we are about halfway through the process in preparing for the launch November 1st, 2022. • Care Transitions with some improvements in order to be compliant with new APLs, No Wrong Door which requires us to coordinate closely with the county around care transitions and care coordination. • Utilization Management – we have studied their processes and will be building it into our existing systems and ensuring our systems can support UM Management for behavioral health. • Quality Improvement – we have a very robust Quality Improvement program within the Alliance; we have mapped the Policy and Procedures that Beacon has in place under delegation through us and ensure we could transition any Beacon policies to us while making sure they work in our existing Quality Improvement framework. • For Provider Network, the contracting is in progress and got underway this week; we have sent out multiple credentialing packages and contracts to the top-tier providers that are actively seeing our members. There are		

Anastacia Swift	about three hundred (300) in that target network that we believe we see as a priority. • Credentialing is commencing – we received our first Credentialing package in Behavioral Health Provider this week and will be following the process to get them credentialed. • Customer Service also transitions to us – we are building the positions both in Member Services as well as the navigators of positions within the Behavioral Health departments. We are actively interviewing and selecting that team. We hope to have most of the team onboarded by mid-August. We are making great progress and identifying the key Behavioral Health team members to perform customer service and all the other workflows in the Behavioral Health department. • Claims Processing and Payment is being mapped and I believe we will be in good shape to take on all of these responsibilities. Contracting & Credentialing: • We have prioritized a network that Beacon has of approximately eleven hundred (1100) providers. • We have prioritized them by volume and the first wave of contracts is being sent to the Providers treating the most of our members. We hope to have the first tier of Providers receive the package of contracts by the end of next week. Workflow Design Requirements: • In progress and going well – we have met with our IT team and are on target to implement workflows. • Our design will be to bring on the new Behavioral Health team – the licensed clinicians and the new capacity that will be coming into the Alliance to begin their training in August in preparation for the November 1st effective date. Staffing Update: • We are interviewing for the positions required for this insourcing transition.		

Tami Lewis	• As of this morning, we have made another verbal offer to a candidate and started another background check. Risks & Mitigation Plan: • An area of concern for this insourcing transition is Contracting and Credentialing. The risk is there are over two-hundred Providers requiring contract amendments. We have brought on additional consultant resources to assist with this process. • Competing priorities is also a concern; we are continuing to monitor that and ensure we have the appropriate resources and system capabilities to insource. Other Constraints: • The competing priorities include all CalAIM initiatives that are going live in January 2023 and the Incentive Programs that we continue to work on. • The Operational Readiness for the 2024 DHCS MCP Contract for the Single Plan Model will also be a heavy lift enterprise wide. • We are also in the midst of multiple audits, as well as performance evaluations. Question: As a primary care physician, access has always been an issue in the past. With this new system and bringing it in-house, access should not be a problem, especially expedited access for those who need an appointment as soon as possible – will bringing this in-house make access an issue? Answer: We understand this is one of the things we need to look at. We are prioritizing continuity of care; therefore, we are focusing on the providers that are treating our members. We will be working on improving access and watching what we can do to facilitate expedited appointments. We are building a foundation to build a much more responsive network than we are accustomed to. Informational update to the Board of Governors. Vote not required.		

9. STANDING COMMITTEE UPDATES			
Dr. Steve O'Brien	The Peer Review & Credentialing Committee (PRRC) and the Pharmacy & Therapeutics Committee (P&T) were held on June 21st, 2022 . Dr. Steve O'Brien provided the following Committee updates: • At PRRC, fifteen (15) initial providers were credentialed, and forty-three (43) providers were re-credentialed. • Twenty-nine (29) providers left the Alliance, however, twenty-three (23) of them were from CHCN. • We are anxiously awaiting our behavioral health providers, and the Committee has prepared to process those applications. • At P&T, there were five (5) therapeutic categories and drug monographs reviewed, sixty-two (62) formulary modifications, thirteen (13) prior authorization guidelines reviewed with no updates, and thirteen (13) prior authorization guidelines were reviewed with updates. The Health Care Quality Committee was held June 24th, 2022: • We welcomed Dr. Tornabene, the Chief Medical Officer at Alameda Health System to the Committee. • Also, the Committee moved to a daytime because of the virtual presence of the meeting at the request of Committee members. • Additionally, we discussed the new quality factor and rates that were discussed earlier today, and we had our routine Utilization Management (UM) policy updates, and we had a future presentation was the QI (quality improvement) work plan.	None	None

Scott Coffin	The Member Advisory Committee (MAC) was held on June 16th, 2022. CEO Scott Coffin provided the following Committee updates: • There was an update from the CEO on the operations and financial performance of the health plan. • The leadership team presented on the insourcing of Mental Health and Autism Spectrum Disorders Services, similar to what we presented today. • Additionally, there was a report delivered by a member of the Grievances and Appeals team on an activity from the first quarter of 2022 and our Community Outreach team. Informational update to the Board of Governors. Vote not required.		
10. STAFF UPDATES			
Scott Coffin	None	None	None
11. UNFINISHED BUSINESS			
Scott Coffin	None	None	None
12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS			
Dr. Evan Seevak	None	None	None

13. PUBLIC COMMENT (NON-AGENDA ITEMS)			
Dr. Evan Seevak	None	None	None
14. CLOSED SESSION			
Dr. Evan Seevak	DISCUSSION REGARDING REVIEW OF EXTERNAL PRELIMINARY AUDIT OBSERVATIONS AND FEEDBACK (CALIFORNIA CODE, GOVERNMENT CODE SECTION 8545.1); PROTECTION OF CONFIDENTIAL AUDIT INFORMATION AND POTENTIAL REMEDIAL PLAN OF THE HEALTH AUTHORITY. ESTIMATED PUBLIC DISCLOSURE WILL OCCUR IN THE MONTH OF NOVEMBER 2022.	None	None
15. ADJOURNMENT			
Dr. Evan Seevak	Dr. Evan Seevak adjourned the meeting at 1:48 pm.	None	None

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

ALAMEDA ALLIANCE FOR HEALTH
BOARD OF GOVERNORS
RETREAT MEETING
September 29th, 2022
12:00 pm – 2:00 pm
(Video Conference Call)
Alameda, CA

SUMMARY OF PROCEEDINGS

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

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

Excused: Dr. Kelley Meade, Yeon Park

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
1. CALL TO ORDER			
Dr. Evan Seevak	The retreat meeting was called to order by Dr. Seevak at 12:10 pm. The following public announcement was read. "The Board recognizes that there is a proclaimed state of emergency at both the State and the local Alameda County levels, and there are recommended measures to promote social distancing in place. The Board shall therefore conduct its meetings via teleconference in accordance with Assembly Bill 361 for the duration of the proclaimed State of emergency." "Audience, during each agenda item, you will be provided a reasonable amount of time to provide public comment."	None	None

2. ROLL CALL			
Dr. Evan Seevak	A telephonic roll call was taken of the Board Members, and a quorum was confirmed.	None	None
3. AGENDA APPROVAL OR MODIFICATIONS			
Dr. Evan Seevak	Dr. Seevak announced there would be an agenda modification: Item 14(a) will be removed from the agenda, and the general subject matter that was part of item 14(a) – new board positions will be discussed in connection with item 8(a) – Roles of the Board of Governors. This will be in an open session. Motion to Modify the Agenda: A roll call vote was taken, and the motion passed.	Motion to Approve Agenda Modification September 29th, 2022, Board of Governors Retreat Meeting Agenda Motion: Dr. Evan Seevak Second: Dr. Michael Marchiano	None
4. INTRODUCTIONS			
Dr. Evan Seevak	None	None	None
5. BOARD BUSINESS – ROLES OF THE BOARD OF GOVERNORS			
Dr. Evan Seevak	None	None	None
6. BOARD MEMBER REPORTS			
Rebecca Gebhart	None	None	None

7. CEO UPDATE			
Scott Coffin	None	None	None
8. a. BOARD BUSINESS – ROLES OF THE BOARD OF GOVERNORS			
Bobbie Wunsch Dr. Evan Seevak Dr. Rollington Ferguson Supervisor Dave Brown	Being an Effective Board of Directors: • The first question up for Board Discussion: What do you think are the three (3) most important functions and roles of the Alameda Alliance Board of Governors? Dr. Seevak responded by stating the following to the discussion question: • (1) Supporting and evaluating the CEO. • (2) Ensuring adequate financial resources. • (3) Ensuring effective planning. Dr. Ferguson responded by stating the following to the discussion question: • There is overlap in what I would consider the three (3) most important functions. • (1) It is important for the Board to seek the Executive Team, focus on the mission of the Alliance, and guide the Executive Team on the purpose of the Alliance. • (2) The second most important role of the Board is to help the CEO and the Alliance maintain its governance role. • (3) That we continue to maintain financial viability. Supervisor Dave Brown responded by stating the following to the discussion question: • I agree with the comments made; however, I would add that it is important that the Board members conduct themselves as ambassadors of the Alliance and communicate the mission and vision.		None

	• Fiscal responsibility, supporting the CEO, and adequately planning are things I agree with.		
Dr. Noha Aboelata	Dr. Aboelata responded by stating the following to the discussion question: • An important role of the Board is to assist with decision points or strategic direction questions that may arise.		
Dr. Marty Lynch	Dr. Lynch responded by stating the following to the discussion question: • I agree with Dr. Aboelata - setting policy and direction of the organization, as well as strategic direction. • A second point I would add is assuring our members receive the absolute best and most appropriate care from the Alliance's network. Also, ensuring we pay attention to the quality reports we receive from Scott Coffin (CEO) and Dr. Steve O'Brien (CMO). Additionally, the case management care coordination and how care is coordinated – paying attention to these things and providing feedback.		
Andrea Schwab-Galindo	Andrea Schwab-Galindo responded by stating the following to the discussion question: • In terms of adequate representation, I would say that ensuring that we have a voice at the table and are sharing concerns. Additionally, areas of opportunity in the community and representing the Alliance well. Another area that is very important to me is advocacy – both from a legislative standpoint and as a Board member.		
Rebecca Gebhart	Rebecca Gebhart responded by stating the following to the discussion question: • I want to endorse the selection, support, and evaluate the CEO, and financial oversight. However, I also want to add that because of this plan's regulatory environment; I think the Board or at least some Board members should focus on monitoring compliance. Additionally, there should be sufficient compliance infrastructure and all staff training. • If there are issues or material weaknesses, the Board should be aware of them to support the CEO in addressing them.		
Dr. Marchiano	Dr. Marchiano responded by stating the following to the discussion question:		

	• Regarding selection of the next CEO – that person needs to have the qualities necessary to do the job. It is a special position that needs to be carefully looked at. The selection criteria need to be closely applied. • Collaborating with Board members will also be very important – having the openness to foster education.		
Byron Lopez	Byron Lopez responded by stating the following to the discussion question: • I think being deliberate about listening closely, as there are a lot of initiatives, such as the ending of the public health emergency and how that can impact the Plan, CalAIM, and Medicare. The combination of listening and speaking up is very important.		
James Jackson	James Jackson responded by stating the following to the discussion question: • I want to emphasize representation and ensure an appropriate representation based on the community we serve. • To the extent possible, we should add diversity, equity, and inclusive principles to our work. Bobbie Wunsch: Anything anyone wants to add that we have not discussed?		
Dr. Aboelata	Dr. Aboelata provided the following comment: • Where does our role in compliance pick up – what are triggers or events for the Board as it relates to compliance? We have a lot of work in compliance in the organization consistently, but it's important to distinguish what kind of events must come to the Board on compliance issues.		
Dr. Seevak	Dr. Seevak provided the following comment: • I agree with everything that has been said thus far. I want to emphasize that the Board needs to express the voice of our members as well as our providers and consider them with all our decisions and advocate on their behalf when appropriate. • As James said, we need to adequately represent our clients from various backgrounds and continue our efforts with equity, diversity, and inclusion.		

Dr. Marty Lynch Bobbie Wunsch	Dr. Marty Lynch provided the following comment: • I fully support the comments on diversity, equity, and inclusion. I also want to add that one of the strengths of the Alliance has been its involvement with the community, and the Board should continue its efforts to keep it this way. Being Effective as a Board: Hearts and Minds: • A Board member's role should combine hearts and minds, the emotion and commitment that a Board member brings to an organization's mission, and the intellectual rigor you bring. • Part of this is the quality of the dialogue and debate during the meeting and the Board's ability to ask tough questions within their role. • Another great part of the effectiveness is the diversity of the Board's own experiences, and the thought they put into all of the issues. • The preparation of the meetings and materials also plays a role in effectiveness. • The Board Chair's role is to manage the Board and keep the Board together. The members should also feel that they are well-integrated and oriented. • Lastly, everyone must be committed to participating and remain engaged; attendance is one factor of this commitment. In the Spirit of Service: • The Board Bylaws has an organization's legal and financial oversight responsibility – this is not an operational role. • Additionally, the Board has a strategic leadership role within the organization, and in the important role in selecting, supporting, and evaluating the CEO. Selecting the CEO is the most important responsibility the Board has and requires leadership experience, which everyone on this Board has. • As discussed earlier, there is much to address and think about regulatory oversight. A large portion of what the Board does is risk management and working with the CEO to identify potential risk mitigation opportunities. • As Supervisor Brown mentioned, the ambassador role and enhancing the organization's public stand are important; furthermore, ensuring the community knows the members of the Board and that the members of the Board are proud to be a member.		

- Evaluating the organization's performance is a major responsibility. Furthermore, the Board's conflicts of interest and perceived conflicts of interest are of utmost importance – there needs to be a distinction between actual and perceived conflicts of interest.
- Lastly, board development is an important, ongoing role for Board members, one that the Board Chair generally leads. This encompasses ensuring the Board has the right tools and education to operate effectively.

Relationship with CEO and Executive Staff:

- The Board hires and has only one employee – the CEO. The CEO hires all other employees.
- The Board has the responsibility of advising and guiding the CEO. The CEO has this responsibility with the executive team, and they in turn have this responsibility with their staff.
- The best relationship between the Board and the CEO is a collaborative one.

CEO Scott Coffin provided the following comment:

- There is a consulting side to this collaboration. What I value with the Board members is the way they consult and provide wisdom. I'm grateful for their advice because it is not a paid role that they do – it takes dedication. Asking those tough questions and participating in our governance is very important. Many of our Board members participate in our Standing Committees and have taken in active role in our governance. There are many subtle ways that the Board members show their commitment to the Alliance and our community.

Allocation of Authority:

- At the Alliance, the way contracts responsibilities are divided is that the Board develops and approves contract policies. The Board does not approve individual contracts to avoid conflicts of interest. The CEO approves contracts based on policies that the Board developed, and the Executive Team prepares contracts for the CEO's approval with the staff's support.

	• In the compliance area, the Board monitors the regulatory performance, the CEO oversees the performance, and the Executive Staff administers the performance, and this comes through the committee process. • As demonstrated in this list, there is a clear division of responsibilities between the Board, CEO, and Executive Staff. Question: What is the difference between monitoring and overseeing? Answer: From a monitoring perspective, the Board's job is to look at what the performance standards might be and monitor the performance against the standards or objectives. Where we are meeting our performance standards, where we are exceeding – these would be the questions asked in monitoring. The CEO is the one with the Executive Team and their staffs who would be developing the indicators for the Board's review and approval; this encompasses inquiring into what the performance is, and why it is going in one direction as opposed to another – this would be the CEO's oversight. Dr. Ferguson provided the following comment: • I would see the Board more in the role of providing oversight. The CEO is more interactive, not solely monitoring or overseeing. The distinction I am making is that both monitoring and overseeing are more passive consultative roles, whereas the CEO is more interactive than consultative. Dr. Seevak agreed with Dr. Ferguson's feedback and provided the following comment: • The Executive Staff are more active; they are implementing, not so much overseeing. James Jackson provided the following comments: • Under operations, I wonder if we should call out public and media relations. They are a part of operations, but I think it is important to understand who is responsible for them. • We as leaders of this community, need to be proactive in trying to address the violence we see in the community. In 2021 and in 2022, we have seen a doubling of victims of violence. This is a dramatic uptake, and something has changed in our community in the past couple of years. We cannot just watch this and allow it to continue to happen. We need to do more in a proactive way to break the cycle of violence. There is more we could do		

	than just receiving and treating the victims of violence, there are great programs in the community that are really trying to break the cycle of violence which is disproportionately impacting communities of color. I want to emphasize the importance of us being mindful of the health disparities that exist, and how we can intervene early on and provide resources to help so people feel safe, empowered, and invested in. Allocation of Authority (Continued): • We will add to the chart public and media relations as James Jackson suggested, and from Dr. Ferguson's feedback, we will add language to make the CEO's role more interactive and distinguish it from the CEO's work. • We will also add planning and strategic direction to the chart. Andrea Schwab-Galindo provided the following comment: • I think adding policy and advocacy would also be helpful. Dr. Marchiano provided the following comment: • I think adding New Board Member Education and Orientation to the chart would be useful. Where We Can Improve: • What areas can our Board improve performance in? • What responsibilities can we carry out more effectively? Dr. Ferguson provided the following comment: • I think a long-term plan for our facility. I think we don't pay enough attention to that kind of planning. Dr. Aboelata provided the following comments: • I want to highlight that if we are of the opinion that it is the Board's responsibility to ensure equity or that we are monitoring equity, we would need to define what that means to us and how we are doing that with more clarity.		

	• I would encourage us to build structure on how we are addressing diversity, equity, and inclusion; this would tie into compliance as well since these will be measures, we will have to meet going forward. Rebecca Gebhart provided the following comment: • I'm glad Dr. Aboelata raised this point. I think in our CEO search, candidates know this is a priority for us. Putting it on the chart and attending to it more, potentially having the language there and the definition by the time we are interviewing candidates. Scott Coffin (CEO) provided the following comments: • S. Coffin stated that AAH is actively recruiting right now for a new executive role that will report to me, and that is the Chief of Health Equity. • Adding that AAH's Diversity, Equity and Inclusion Committee was formed nearly two years ago and is comprised of staff from each division in the company. The Board has received presentations from this Committee; however, they are going beyond these statements opposing violence and inequities – diversity, equity and inclusion is being embedded into the corporate culture and into the communities we serve. The Chief of Health Equity will be involved with the population health and health equity initiatives that are being launched next year by the DHCS, State of California. Question: What is the timeline for that person (Chief of Health Equity) to be hired? Answer: We have a robust pool of candidates right now; my goal is to hire for Chief of Health Equity before the end of this year. Question: Is this a clinical position? Answer: The job description does not mandate a clinical certification, however, the candidates include a blend of clinical and non-clinical. Dr. Marchiano provided the following comment: • We might want to enlist the expertise of this person assuming this new role in development and getting more granular.		

Dr. Evan Seevak	Dr. Seevak provided the following comment: • For areas we can improve – repeatedly, we have heard that we need to do more education and training for the Board Members. We have been trying and doing some, but I think it is an area in which we can improve. Andrea Schwab-Galindo provided the following comment: • I think we can ensure efficient planning, and ensure we are doing our due diligence in learning – how we can make the learning practical and tangible. Moving Forward as a Single Plan and Expanding Board Seats: Proposed Changes to the Board of Governors Guiding Principles: • The Alliance Board is operating effectively today based on the Board effectiveness assessment. • We do not want to remove anyone from the current Board based on our assessment that the Board is functioning well currently. • We have At-Large members that have worked well historically, and we want to continue to have an uneven number of Board members for decision-making purposes. • Additionally, we want to continue and maintain the diversity of provider and community representation. Factors to Consider Moving Ahead to Proposed Changes: • As we move from a Two Plan managed care county to a Single Plan county, consideration should be given to our three (3) year strategic plan and ten (10) year road map; the CalAIM priorities including Medicare business line; diversity, equity, and inclusion values; the addition of three (3) additional seats to Alameda County Board of Supervisors, County HCSA Director, County Social Services Director, and CEO of Community Health Clinic Network (CHCN). • We also want to think about what our membership will look like in 2024 under the Single Plan model.		

	Process and Timeline: • The Alliance Board Executive Committee will incorporate today's feedback and present a revised proposal at the October Board meeting. • Additionally, we will vote on changes and additions at the October Alliance Board meeting. • At the end of the year, we will make changes in the County ordinance and the Alliance Bylaws. • We want to seat our new Board members in early Q1 – 2023 and be ready to participate in readiness and planning for the Single Plan model starting as early as January 2023. Question: How did we arrive at the decision on the CHCN admission? Answer: Given the number of our members that are enrolled in CHCN clinics, a second seat would be warranted. Looking at our member enrollment, there are over one-hundred-thousand adults and children that are assigned to community health network centers. Question: We anticipate that number to grow significantly, right? Answer: Yes, we do – as the transition of the Single Plan model occurs, there are adults and children that are currently enrolled in Anthem Blue Cross that would transition into Alameda Alliance. We will know what the numbers are at a later point, but it is a significant number. Question: Scott, can you talk about Social Services? Answer: Bobbie had done some research looking at other Single Plan county models and how they are structured – the intersection we have with Social Services is through enrollment. One of the changes with Medi-Cal managed care is this will be with Social Services. Social Services handles all the eligibility and enrollment for Medi-Cal managed care. Question: Regarding CHCN – is there a threshold we would have for that? Answer: The ratios have not been codified; in looking at where our membership is assigned today, that is how we identified this seat. However, we do not have a process currently designed around that.		

	Existing Board of Governors: • We currently have two (2) openings. We have someone who will start in the Consumer Seat relatively soon. Yeon Park will be in the At-Lage Labor seat, beginning in November. Question: Why isn't the CHCN seat represented by Andrea, when she represents the private and public clinics; I'm not sure if I see the need for the CHCN seat when Andrea represents that? Answer: (Answered by Andrea-Schwab Galindo later in the meeting – see below). Proposed Changes: • Increasing the Board size from fifteen (15) to nineteen (19) seats. • Additionally, we are recommending changing the three (3) at large seats to designated seats. The labor seat that Yeon will be stepping into –is currently an at-large seat that we want to designate as a labor seat. The ancillary/pharmacy seat that Aaron is currently in, we want to designate this as ancillary/pharmacy. The senior/persons with disabilities seat that Marty is currently in – we want to designate this to reflect someone with expertise working with seniors and persons with disabilities. • We want to continue to maintain two (2) at-large seats to provide us some flexibility with Board composition. • The Alameda Health System seat in the past had usually been filled by physicians – we are recommending that Seat for the CEO. James is currently in this seat; we will codify that. • We are recommending four (4) new seats. Some of the possibilities would be adding a seat for someone who works in housing and helping people who are unhoused, or formerly incarcerated, someone with expertise with mental health/substance use disorders, someone with a disability, or potentially someone with long-term care experience. Question: What is the difference between an at-large seat and a designated seat? Answer: The Alliance originally had ten (10) designated seats, and five (5) At-Large were added. There is no difference in voting rights, and everyone at the		

	table has an equal voice. It was distinguished and used in the context of subject experts that are not designated but are experts in their field. One of the things that struck me is that other plans did not have At-Large seats. Some of this is nomenclature in a sense. It is time for us to consider making changes to the Board structure. When we look at the services we are getting into, such as Housing and Homelessness, this is not in our area of expertise. Long Term Care, mental health, substance abuse – the integration of these services. It is important that we structure the Board complementary to these; we need that support to make these successful. Regarding CHCN, Andrea Schwab-Galindo provided the following comment: • The delegate networks are unique in the way that we do business. Therefore, having someone represent the CHCN At-Large would also provide a new perspective. Question for Dr. Seevak: Why did you wish the Board would be smaller rather than larger? Answer: I agree with the proposal to make the Board larger. However, my initial gut reaction was that it is a pretty big number, and it is generally more complicated to coordinate a larger group of people. Dr. Marty Lynch provided the following comment: • I would argue that primary care is even more crucial to our direction. Overall, I am in support of the proposal. Dr. Aboelata provided the following comment: • I like the proposals; however, I do think some clarity should be provided on the specifications and characterizations attached to the seats. For example, what is senior persons with disability? For ancillary/pharmacy, do we need someone who is a pharmacist? The clarity of how we define the different roles is important.		

	Dr. Seevak responded by stating the following: • I agree the at-large seat for Senior/Persons with Disabilities can be specified. However, I think it also provides us some flexibility to leave some of these definitions subjective. Aaron Basrai provided the following comment: • I think it is important that for the fourth seat we have that is not defined that we have a stakeholder that is going to be in one of our new projects such as long-term care, and mental health. I think this is one of the most important seats in my position; from what I see because I had a stakeholder as a pharmacist and had a lot of insight on what we did – it is not as much now since we have carved out, but I think someone in the long-term care space, in mental health/substance use – I think these all need a voice. These are four separate seats in my opinion; that is one concern I have. Rebecca Gebhart provided the following comment: • There are a lot of overlaps; for example, the Agency Director for the Health Care Services Agency also can wear a hat for behavioral health. Question: Do we have someone in mind for the additional seat for Homelessness and Housing? Answer: There are several individuals that have been identified – we want someone who will be committed to giving back in this aspect. Question: Which one of these seats would have the most financial impact? Answer: Long-term care has the highest fiscal impact. Rebecca Gebhart provided the following comments: • For the additional, undefined seat, I lean towards long-term care, I think it would have the most significant impact. • Maybe we could broaden the term to be long-term care continuum and think about the expertise in the continuum.		

	Dr. Aboelata provided the following comment: • Rather than the for-profit side of things, we are more interested in integration; increasing the number of people who can age in place and at home and supports within the community, while also understanding what those transitions are. I think transitions are always the complex part. I'm not sure if there is something that combines the community with long-term care; something where we can ensure that our members can move seamlessly. That is where the mental health/substance use comes in – I agree with Rebecca – having Health Care Services Agency representation is very important. I think many of us on the Board need to be thinking about that continuum as well. It may not be that we need a seat per se but ensuring that we are lifting that part up for the current Board composition that we have. CEO Scott Coffin provided the following comments: • Given what we know about the number of financial resources in the long-term care facility, we do think it is going to play a major part and we will need the support to move forward. • The Department of Health Care Services is leaving a lot of the system transformation to us. One of our advantages is we have a lot of teamwork, and we are bringing on new team members to assist. • We will come back with a more detailed presentation on this topic; we have discussed the long-term care program in previous Board meetings. We have the first phase starting in January 2023, and subsequent phases in the middle of 2023, and beyond that, we need to manage long-term care in court, which will take place sometime in 2026. • We want to ensure we get this first wave on facilities and custodial care in January right; it will expand in July 2023. We must build cultural competence, and this is where having an expanded Board will assist with this initiative. Dr. O'Brien provided the following comment: • In July 2023, the institutions for mental disorders and subacute facilities will also commence.		

	Dr. Marchiano provided the following comment: • Major organ transplant is also on the rise. Dr. O'Brien responded with the following comment: • For major organ transplant, we don't have that many individual members impacted by that, but the cost of that is significant and we are watching it closely. Question: It sounds like the Board has a preference to have this fourth seat for someone with expertise in the long-term care continuum, correct? Answer: (Dr. Seevak) Yes, that is exactly what I heard.		
9. STANDING COMMITTEE UPDATES			
Dr. Steve O'Brien	None	None	None
10. STAFF UPDATES			
Scott Coffin	None	None	None
11. UNFINISHED BUSINESS			
Scott Coffin	None	None	None
12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS			
Dr. Evan Seevak	None	None	None

13. PUBLIC COMMENT (NON-AGENDA ITEMS)			
Dr. Evan Seevak	None	None	None
14. CLOSED SESSION			
Dr. Evan Seevak	PUBLIC EMPLOYEE APPOINTMENT WILL CONCERN THE CHIEF EXECUTIVE OFFICER (CEO) DISCUSSION (CALIFORNIA CODE, GOVERNMENT CODE SECTION 54957(b)(1), PROTECTION OF CONFIDENTIAL INFORMATION. ESTIMATED PUBLIC DISCLOSURE WILL OCCUR IN THE MONTH OF MAY 2023. DISCUSSION AND DELIBERATION REGARDING TRADE SECRETS (WELFARE & INSTITUTIONS CODE SECTION 14087.35). DISCUSSION WILL CONCERN A NEW LINE OF BUSINESS, AND PROTECTION OF ECONOMIC BENEFIT TO THE HEALTH AUTHORITY. ESTIMATED PUBLIC DISCLOSURE WILL OCCUR IN THE MONTH OF JANUARY 2024.	None	None
15. ADJOURNMENT			
Dr. Evan Seevak	Dr. Evan Seevak adjourned the meeting at 1:55 pm.	None	None

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

Finance Committee Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

September 6th, 2022
8:00 am – 9:00 am

SUMMARY OF PROCEEDINGS

Meeting Conducted by Teleconference

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

Board of Governor members on Conference Call:

Alliance Staff on Conference Call: Scott Coffin, Richard Golfin III, Sasi Karaiyan, Dr. Steve O'Brien, Ruth Watson, Matthew Woodruff, Carol van Oosterwijk, Shulin Lin, Linda Ly, Danube Serri, Christine Corpus

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
CALL TO ORDER			
Dr. Michael Marchiano	Scott Coffin asked Dr. Michael Marchiano (Vice Chairperson), as the senior Finance Committee member, to lead the meeting in Dr. Ferguson's (Chairperson) absence. Dr. Marchiano called the meeting to order at 8:08 am. The following public announcement was read. "The Board recognizes that there is a proclaimed state of emergency at both the State and the local Alameda County level, and there are recommended measures to promote social distancing in place. The Board shall therefore conduct its meetings via teleconference in accordance with Assembly Bill 361 for the duration of the proclaimed state of emergency." A telephonic Roll Call was then conducted.	Quorum was not achieved. Meeting conducted for informational purposes only.	

CONSENT CALENDAR			
Dr. Michael Marchiano	Dr. Marchiano presented the Consent Calendar	No vote was taken due to no-quorum status.	
COMMITTEE BUSINESS **a.) CEO Update**			
Scott Coffin	Scott Coffin, CEO, provided updates to the Committee on the following: **Department of Managed Health Care (DMHC) Audit:** Our routine DMHC audit for Finance and Claims begins this week. For Finance, the lookback is at our March 2022 Quarterly Financial Statement. For Claims processing, the lookback period is three years from March 2019 through March 2022. We will report the status of the audit at the October Compliance Committee. **DMHC Enforcement Matter:** The Alliance received an enforcement matter from DMHC in the month of August. For the period 2017 through 2018, the Alliance had six deficiencies resulting in a $200K fine. This is currently being negotiated with the DMHC. We will have further discussion regarding the statewide increases related to enforcement matters and the potential for financial impacts in the future. **Question:** Dr. Marchiano asked if there was a specific area of interest that the State will find discrepancies. Richard Golfin III, Chief Compliance & Privacy Officer, answered that the AAH Health Care Services Division is typically where we see the most opportunity for deficiency. Particularly surrounding authorizations, denials, and timeliness of responses. **Annual Board Retreat:** The annual Board Retreat is scheduled for Thursday, September 29th, 2022.	Informational update to the Finance Committee Vote not required	

	Behavioral Health Services Insourcing: The insourcing of the Behavioral Health Services, including Autism Spectrum Services, has been moved from November 1st, 2022, to March 31st, 2023. The costs associated with the additional five months will be presented to the Finance Committee next month. **Updates at October Committee and Board:** A CalAIM Incentives update will be presented to the Finance Committee in October. This is a requested periodic update. Our Board of Governor's update in October will include June, July, and August Financials for a vote. Fiscal year end 2022 is completed in the month of June and the first month of the fiscal year 2023 is being presented to the Finance Committee today.		
b.) Review June 2022 Monthly Financial Statements			
Gil Riojas	<u>**June 2022 Financial Statement Summary**</u> **Enrollment:** Current enrollment is 313,056 and continues to trend upward. Total enrollment has increased by 2,298 members from May 2022, and 24,502 members since June 2021. Increases were primarily in the Child, Adult, and Optional Expansion categories of aid, and included slight increases in the Duals and SPD categories of aid. Group Care had a slight decline for the month. Monthly enrollment trends are projected to increase as the Public Health Emergency (PHE) is currently expected to be extended through October 2022. **Net-Income:** For the month ending June 30th, 2022, the Alliance reported a Net Income of $3.3 million (versus a budgeted Net Income of $2.4 million). The favorable variance is attributed to higher than anticipated Revenue and lower than		

anticipated Administrative Expense. This was slightly offset by higher than anticipated Total Other Income, and higher than anticipated Medical Expense. For the year-to-date, the Alliance recorded a Net Income of $23.7 million versus a budgeted Net Income of $3.5 million.

Revenue:
For the month ending June 30th, 2022, actual Revenue was at $96.5 million vs. our budgeted amount of $95.9 million. The favorable revenue variance of $530,000 is primarily due to favorable CalAIM Incentive Payment Program and CalAIM Community Supports Revenue, offset by a $4 million unfavorable accrual for an anticipated member health acuity adjustment by DHCS, FY-19 Prop 56 Minimum Medical Expenditure recoupment, and timing of Maternity and Behavioral Health payments. For the year-to-date, the Alliance recorded a Revenue at Budget of $1.2 billion.

Medical-Expense:
Actual Medical Expenses for the month were $87.6 million, vs. our budgeted amount of $86.1 million. For the year-to-date, actual Medical Expenses were on budget at $1.1 billion. Details are provided on the tables on page 10 with further explanation of the variances can be seen on pages 11 and 12.

Medical-Loss-Ratio:
Our MLR ratio for this month was reported at 90.8%. Year-to-date MLR was at 92.5%.

Administrative-Expense:
Actual Administrative Expenses for the month ending June 30th, 2022 were $5.4 million vs. our budgeted amount of $7.5 million. For the year-to-date, the actual Administrative Expenses were $64.5 million vs. a budgeted $82.0 million.

Our Administrative Expense represents 5.6% of our Revenue for the month, and 5.4% of Net Revenue for year-to-date.

Reasons for the favorable month-end variances, as well as the favorable year-to-date variances, can be seen on page 13 of the packet.

	Other-Income-(Expense): As of June 30th, 2022, YTD Investment Interest Revenue realized a $162,000 Net Loss. There are a lot of changes in the market, particularly to interest rates, and we are hopeful that as we roll some of our investments off of lower interest rate earning investment vehicles to higher ones, our return will go up. YTD claims interest expense is $396,000. **Tangible Net Equity (TNE):** We reported a TNE of 601%, with an excess of $191.0 million. This remains a healthy number in terms of our reserves. **Cash-and-Cash-Equivalents:** We reported $307.4 million in cash; $192.7 million is uncommitted. Our current ratio is above the minimum required at 1.72 compared to the regulatory minimum of 1.0. **Capital Investments:** We have spent $421,000 in Capital Assets year-to-date. Our annual capital budget is $1.4 million.	No vote was taken due to no-quorum status.	
c.) Review July 2022 Monthly Financial Statements			
Gil Riojas	**<u>July 2022 Financial Statement Summary</u>** **Enrollment:** Current enrollment is 317,629 and continues to trend upward. Total enrollment has increased by 4,573 members from June 2022. Increases were primarily in the Child, Adult, Optional Expansion, and Duals categories of aid, including a fairly large increase in our SPD category of aid. Group Care remains relatively flat. A significant portion of the SPD increase is related to the initial addition of Undocumented Older Adults. Monthly enrollment trends are projected to increase as the Public Health Emergency (PHE) is currently expected to be extended through October 2022. The disenrollment process is scheduled to start in early 2023.		

	Net-Income: For the month ending July 31st, 2022, the Alliance reported a Net Income of \$5.7 million (versus budgeted Net Loss of \$3.4 million). The favorable variance is attributed to lower than anticipated Medical Expense, lower than anticipated Administrative Expense, and higher than anticipated Total Other Income. This was slightly offset by lower than anticipated Revenue. **Revenue:** For the month ending July 31st, 2022, actual Revenue was at \$100.8 million vs. our budgeted amount of \$101.8 million. The slight unfavorable is primarily due to an unfavorable accrual to Medi-Cal Base Capitation Revenue for an anticipated member health acuity adjustment by DHCS, unfavorable Prop 56 Revenue, and unfavorable Behavioral Health Revenue, partially offset by favorable Maternity Revenue. **Medical Expense:** Actual Medical Expenses for the month were \$90.9 million, vs. our budgeted amount of \$98.8 million. Drivers leading to this variance can be seen on the tables on page 10 and 11. Further explanation of the variances can be seen on pages 11 and 12. **Medical Loss Ratio:** Our MLR ratio for this month was reported at 90.1%. **Administrative Expense:** Actual Administrative Expenses for the month ending July 31st, 2022 were \$4.7 million vs. our budgeted amount of \$6.5 million. Our Administrative Expense represents 4.7% of our Revenue. Reasons for the favorable month-end variances is due to delayed timing of new project start dates for Consultants, Computer Support Services and Purchased Services. **Other Income / (Expense):** As of July 31st, 2022, YTD Investment Interest Revenue realized a \$466,000 Net Gain. As the market changes and the Federal interest rates go up, we should continue to see a positive result in our investments.		

	YTD claims interest expense is $24,000. **Tangible-Net-Equity-(TNE):** We reported a TNE of 625%, with an excess of $198.6 million. This remains a healthy number in terms of our reserves. **Cash-and-Cash-Equivalents:** We reported $300.8 million in cash; $204.8 million is uncommitted. Our current ratio is above the minimum required at 1.72 compared to the regulatory minimum of 1.0. **Capital-Investments:** For the month ending July 31st, 2022, we did not add any Capital Assets. Our annual capital budget is $979,000.	No vote was taken due to no-quorum status.	
ADJOURNMENT			
Dr. Michael Marchiano	The meeting adjourned at 8:45 am.		

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

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

October 11th, 2022
8:00 am – 9:00 am

SUMMARY OF PROCEEDINGS

Meeting Conducted by Teleconference

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

Board of Governor Members on Conference Call: None

Alliance Staff on Conference Call: Scott Coffin, Tiffany Cheang, Dr. Steve O'Brien, Ruth Watson, Matthew Woodruff, Carol van Oosterwijk, Shulin Lin, Linda Ly, Jennifer Vo, Danube Serri, Christine Corpus

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
CALL TO ORDER			
Dr. Michael Marchiano	Scott Coffin asked Dr. Michael Marchiano to lead the meeting. Dr. Marchiano called the meeting to order at 8:04 am. The following public announcement was read aloud. *"The Board recognizes that there is a proclaimed state of emergency at both the State and the local Alameda County level, and there are recommended measures to promote social distancing in place. The Board shall therefore conduct its meetings via teleconference in accordance with Assembly Bill 361 for the duration of the proclaimed state of emergency."* A telephonic Roll Call was then conducted.		
INTRODUCTIONS			
Gil Riojas	Gil Riojas introduced the audit team, Chris Pritchard, Rianne Suico, and Gordon Lam, from Moss Adams.		

CONSENT CALENDAR			
Dr. Michael Marchiano	Dr. Marchiano presented the Consent Calendar		
COMMITTEE BUSINESS **a.) Review Moss Adams Fiscal Year 2022 Audit Results**			
Chris Pritchard Rianne Suico, and Gordon Lamb; representing Moss Adams	Following a comprehensive presentation explaining their audit process and results, Moss Adams issued the Alliance an Unmodified Opinion which is "Combined financial statements are presented fairly and in accordance with generally accepted accounting principles". This is the highest level of assurance that can be issued by the audit firm. The composition of assets were confirmed (cash and cash equivalents, premiums receivable, investments, reinsurance, capital assets), and noted that the Financial Statements are free of material misstatements. In addition, investments were tested to make sure that Management has recorded them at their fair market value as required by the Accounting Standards. Liabilities and net position balance were confirmed (accounts payable, accrued expenses, claims payable, payable to other governmental agencies and hospital fee, net position, etc.) and were consistent. The Accounting estimates are reasonable; no audit adjustments, no issues discussed prior to our retention as auditors, no disagreements with management and there were no adjustments or issues completing work. In final, there is no awareness of any instances of fraud or noncompliance with your applicable loss and regulations.	Informational update to the Finance Committee Vote not required	
b.) CEO Update			
Scott Coffin	Scott Coffin provided updates to the Committee on the following: **Final Budget Update** – The Final Budget for Fiscal Year 2023 will be presented at the December Finance Committee and Board of Governors meetings.	Informational update to the Finance Committee Vote not required	

c.) Review June 2022 Monthly Financial Statements			
Gil Riojas	**<u>June 2022 Financial Statement Summary</u>** **Enrollment:** Current enrollment is 313,056 and continues to trend upward. Total enrollment has increased by 2,298 members from May 2022, and 24,502 members since June 2021. Increases were primarily in the Child, Adult, and Optional Expansion categories of aid, and included slight increases in the Duals and SPD categories of aid. Group Care had a slight decline for the month. Monthly enrollment trends are projected to increase as the Public Health Emergency (PHE) is currently expected to be extended through October 2022. **Net Income:** For the month ending June 30th, 2022, the Alliance reported a Net Income of $3.3 million (versus budgeted Net Income of $2.4 million). The favorable variance is attributed to higher than anticipated Revenue and lower than anticipated Administrative Expense. This was slightly offset by higher than anticipated Total Other Income, and higher than anticipated Medical Expense. For the year-to-date, the Alliance recorded a Pre-audit Net Income of $23.7 million versus a budgeted Net Income of $3.5 million. **Revenue:** For the month ending June 30th, 2022, actual Revenue was at $96.5 million vs. our budgeted amount of $95.9 million. The favorable revenue variance of $530,000 is primarily due to favorable CalAIM Incentive Payment Program and CalAIM Community Supports Revenue, offset by a $4 million unfavorable accrual for an anticipated member health acuity adjustment by DHCS, FY-19 Prop 56 Minimum Medical Expenditure recoupment, and timing of Maternity and Behavioral Health payments. For the year-to-date, the Alliance recorded a Revenue at Budget of $1.2 billion. **Medical Expense:** Actual Medical Expenses for the month were $87.6 million, vs. our budgeted amount of $86.1 million. For the year-to-date, actual Medical Expenses were on budget at $1.1 billion. Details are provided on the tables on page 26 with further explanation of the variances can be seen on pages 26 and 27.		

Medical Loss Ratio:
Our MLR ratio for this month was reported at 90.8%. Year-to-date MLR was at 92.5%.

Administrative Expense:
Actual Administrative Expenses for the month ending June 30th, 2022 were $5.4 million vs. our budgeted amount of $7.5 million. For the year-to-date, the actual Administrative Expenses were $64.5 million vs.budgeted $82.0 million.

Our Administrative Expense represents 5.6% of our Revenue for the month, and 5.4% of Net Revenue for year-to-date.

Reasons for the favorable month-end variances, as well as the favorable year-to-date variances can be seen on page 13 of the packet.

Other Income / (Expense):
As of June 30th, 2022, YTD Investment Interest Revenue realized a $162,000 Net Loss. Due to market changes our year to date interest revenue was negative. We expect a reversal of this as we move into fiscal year 2023 as short term interest rates are increasing rapidly.

YTD claims interest expense is $396,000.

Tangible Net Equity (TNE):
We reported a TNE of 601%, with an excess of $191.0 million. This remains a healthy number in terms of our reserves.

Cash and Cash Equivalents:
We reported $307.4 million in cash; $192.7 million is uncommitted. Our current ratio is above the minimum required at 1.72 compared to regulatory minimum of 1.0.

Capital Investments:
We have spent $421,000 in Capital Assets year-to-date. Our annual capital budget is $1.4 million.

Motion to accept **June 2022, July 2022, and August 2022 Financial Statements** made at end of presentation of all months.

d.) Review July 2022 Monthly Financial Statements			
Gil Riojas	<u>**July 2022 Financial Statement Summary**</u> **Enrollment:** Current enrollment is 317,629 and continues to trend upward. Total enrollment has increased by 4,573 members from June 2022. Increases were primarily in the Child, Adult, Optional Expansion, and Duals categories of aid, including a fairly large increase in our SPD category of aid. Group Care remains relatively flat. A significant portion of the SPD increase is related to the initial addition of Undocumented Older Adults. Monthly enrollment trends are projected to increase as the Public Health Emergency (PHE) is currently expected to be extended through October 2022. The disenrollment process is scheduled to start in early 2023. **Net Income:** For the month ending July 31st, 2022, the Alliance reported a Net Income of $5.7 million (versus budgeted Net Loss of $3.4 million). The favorable variance is attributed to lower than anticipated Medical Expense, lower than anticipated Administrative Expense, and higher than anticipated Total Other Income. This was slightly offset by lower than anticipated Revenue. **Revenue:** For the month ending July 31st, 2022, actual Revenue was at $100.8 million vs. our budgeted amount of $101.8 million. The slight unfavorable is primarily due to an unfavorable accrual to Medi-Cal Base Capitation Revenue for an anticipated member health acuity adjustment by DHCS, unfavorable Prop 56 Revenue, and unfavorable Behavioral Health Revenue, partially offset by favorable Maternity Revenue. **Medical Expense:** Actual Medical Expenses for the month were $90.9 million, vs. our budgeted amount of $98.8 million. Drivers leading to this variance can be seen on the tables on pages 63 and 64. Further explanation of the variances can be seen on pages 64 and 65. **Medical Loss Ratio:** Our MLR ratio for this month was reported at 90.1%.		

	Administrative Expense: Actual Administrative Expenses for the month ending July 31st, 2022 were $4.7 million vs. our budgeted amount of $6.5 million. Our Administrative Expense represents 4.7% of our Revenue. Reasons for the favorable month-end variances are due to delayed timing of new project start dates for Consultants, Computer Support Services and Purchased Services. **Other Income / (Expense):** As of July 31st, 2022, YTD Investment Interest Revenue realized a $466,000 Net Gain. As the market changes and the Federal interest rates go up, we should continue to see a positive result in our investments. YTD claims interest expense is $24,000. **Tangible Net Equity (TNE):** We reported a TNE of 625%, with an excess of $198.6 million. This remains a healthy number in terms of our reserves. **Cash and Cash Equivalents:** We reported $300.8 million in cash; $204.8 million is uncommitted. Our current ratio is above the minimum required at 1.72 compared to the regulatory minimum of 1.0. **Capital Investments:** For the month ending July 31st, 2022, we did not add any Capital Assets. Our annual capital budget is $979,000. **Question:** Dr. Marchiano asked how the budget will be impacted the most with the new programs coming online. Gil Riojas answered that he anticipates Long-Term Care will have the greatest impact as it has financial implications for both our Medical Expense as well as our Administrative Expense. Dr. Marchiano further asked where the Alliance TNE and reserves compare to other plans. Gil answered that we are in the middle as compared to our peer plans.	Motion to accept **June 2022, July 2022, and August 2022 Financial Statements** made at end of the presentation of all months.	

e.) Review and Approve August 2022 Monthly Financials			
Gil Riojas	**August 2022 Financial Statement Summary** **Enrollment:** Current enrollment is 319,256 and continues to trend upward, Total enrollment has increased by 1,627 members from July 2022, and 6,200 members since June 2022. Consistent increases were primarily in the Child, Adult, and Optional Expansion categories of aid, and included slight increases in the Duals, SPD, and Group Care categories of aid. Monthly enrollment trends are projected to increase as the Public Health Emergency (PHE) is currently expected to be extended through October 2022. The disenrollment process is scheduled to start in early 2023. **Net Income:** For the month ending August 31st, 2022, the Alliance reported a Net Income of $2.3 million (versus budgeted Net Income of $2.1 million). For the year-to-date, the Alliance recorded a Net Income of $8.0 million versus a budgeted Net Income of $5.5 million. The favorable variance is explained on page 98. **Revenue:** For the month ending August 31st, 2022, actual Revenue was $101.0 million vs. our budgeted amount of $102.3 million. Unfavorable Revenue variance is mainly due to unfavorable accrual to Medi-Cal Base Capitation Revenue for anticipated member health acuity adjustment by DHCS, unfavorable Prop 56 Revenue, and unfavorable Behavioral Health supplemental revenue. **Question:** Dr. Ferguson asked for clarification of the acuity adjustment. Gil Riojas explained that DHCS determined that the acuity level of our membership was lower than they anticipated as a result, they made an adjustment to our calendar year 2022 rates. This impact on our revenue for the year is approximately $4.0 million, which we are taking as a $700,000 per month reduction to our revenue from June to December 2022. **Medical Expense:** Actual Medical Expenses for the month were $93.3 million vs. our budgeted amount of $97.4 million. Drivers leading to the favorable variance can be seen on the tables on page 100, with further explanation on pages 100 and 101		

	Medical Loss Ratio: Our MLR ratio for this month was reported at 92.4%. Year-to-date MLR was at 91.3%. **Administrative Expense:** Actual Administrative Expenses for the month ending August 31st, 2022 were $5.7 million vs. our budgeted amount of $7.0 million. Our Administrative Expense represents 5.6% of our Revenue for the month, and 5.2% of Net Revenue for year-to-date. Reasons for the favorable month-end variances, as well as the favorable year-to-date variances are outlined on page 102 of the presentation. **Other Income / (Expense):** As of August 31st, 2022, our YTD interest income from investments was $859,000. YTD claims interest expense is $52,000. **Tangible Net Equity (TNE):** We reported a TNE of 627%, with an excess of $200.6 million. This remains a healthy number in terms of our reserves. **Cash and Cash Equivalents:** We reported $322.4 million in cash; $147.9 million is uncommitted. Our current ratio is above the minimum required at 1.55 compared to the regulatory minimum of 1.0. **Capital Investments:** For the month ending August 31st, 2022, we added $24,000 in Capital Assets. Our annual capital budget is $1.0 million.	Motion to accept **June 2022, July 2022, and August 2022 Financial Statements** Motion: Dr. Ferguson Seconded: Dr. Marchiano Motion Carried No opposed or abstained	
ADJOURNMENT			
Dr. Michael Marchiano	The meeting adjourned at 8:56 am.		

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

CEO Update

Scott Coffin

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

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

Date: **October 14th, 2022**

Subject: **CEO Report**

- **Financials:**
  - The Board of Governors is reviewing and approving three (3) months of financial statements in the month of October 2022. The Board of Governors is being presented with financial statements for the months of June 2022, July 2022, and August 2022. The reporting consolidation is due to the Board Recess in August and the Board Strategic Retreat in September, which resulted in deferring the routine reporting to the October 2022 Board of Governors meeting.
  - The Alliance implemented a system configuration change in the month of June 2022 that resulted in 567 claims being denied inappropriately over a 90-day period. The claims were correctly processed and paid in the month of September, totaling approximately $3.5 million. The paid amount includes $4,105 in interest, which will be recognized in the September 2022 financial report and presented as an adjustment in the November 2022 financial report.
  - **Fiscal Year Ending 2022**. Moss Adams completed the annual financial audit and adjusted the net income for fiscal year 2023 upward by nearly $2 million, resulting in a revised net income of $25.2 million for the fiscal year ($21.7 million favorable as compared to final budget).
  - **Fiscal Year 2023:** Net Operating Performance by Line of Business for the month of August 2022 and Year-To-Date (YTD):

	August	YTD
Medi-Cal	$1.5M	$6.9M
Group Care	$889K	$835K
Totals	$2.3M	$8.0M

- Revenue $101 million in August 2022, and $201.8 million Year-to-Date (YTD).
  - Medical expenses for August were $93.3 million, and $184.2 million year-to-date (two months); medical loss ratio is 92.4% for the month, and averages 91.3% for the first two months of the fiscal year.
  - Administrative expenses for August were $5.7 million for the month, and $10.4 million year-to-date; 5.6% of revenue for the month, and averages 5.2% for the first two months in the fiscal year.
- Tangible Net Equity (TNE): Financial reserves are 627% above the regulatory requirement, representing $200.6 million in excess TNE.
- Total enrollment 319,256 in August 2022, increasing by more than 1,600 Medi-Cal members as compared to July. Preliminary enrollment in the month of October exceeds 324,000 members, led by Medi-Cal growth due to the public health emergency.
- The public health emergency is approved through the month of November and is anticipated to be extended to January 31st, 2023. During the public health emergency, the Medi-Cal re-determination process is suspended, and will resume 60 days after the termination of the public health emergency.

- **Final Budget – Fiscal Year (FY) 2023:**
  - Fiscal Year 2023 preliminary budget approved by the Board of Governors on June 10th, 2022.
  - DHCS has announced that final Medi-Cal rates will be issued two months later than normal this year (November vs. September).
  - The final budget for FY2023 will be presented to the Finance Committee and Board of Governors in December 2022.

- **Key Performance Indicators:**
  - Regulatory Metrics:

    The turnaround time for Member Grievances (standard and expedited) did not meet the minimum threshold in the month of September. A total of 654 of 789 (83%) standard grievances were processed within the 30 calendar days; the expedited grievance turnaround time was 50% based on 1 of 2 expedited grievances being processed within the 72-hour period. The regulatory threshold

is 95% for both turnaround metrics. The low denominator for the expedited grievances significantly impacts the ability to meet the regulatory requirement; however, steps are being taken to monitor and manage the workloads.

- Non-Regulatory Metrics:

  The Member Services call center reported an abandonment rate of 15% and a 52% service level for the month of September. The results are 6% and 18% below the internal thresholds and are related to the growing membership and available staff to support the volumes of incoming calls. The average wait time to speak with a Member Services Representative was 3 minutes and 42 seconds.

  The Human Resources Division is reporting 17% vacancy rate in the month of September due to the high volume of open positions related to projects and operations initiatives funded in the fiscal year 2023 budget.

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

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

  Medi-Cal and Group Care:
  - Insourcing of mental health & autism spectrum services on 3/31/2023

  Medi-Cal Only:
  - CalAIM: ECM and Community Supports launched in January 2022; Additional Community Support (Recipe4Health) launched in September 2022
  - CalAIM: Behavioral health in schools begins 12/31/22
  - CalAIM: Additional ECM Populations of Focus in 2023
  - CalAIM: Long-Term Care begins 1/1/23
  - CalAIM: Justice Involved begins in Q3-2023 (policy changes announced by the DHCS)
  - CalAIM: Population health begins 1/1/23

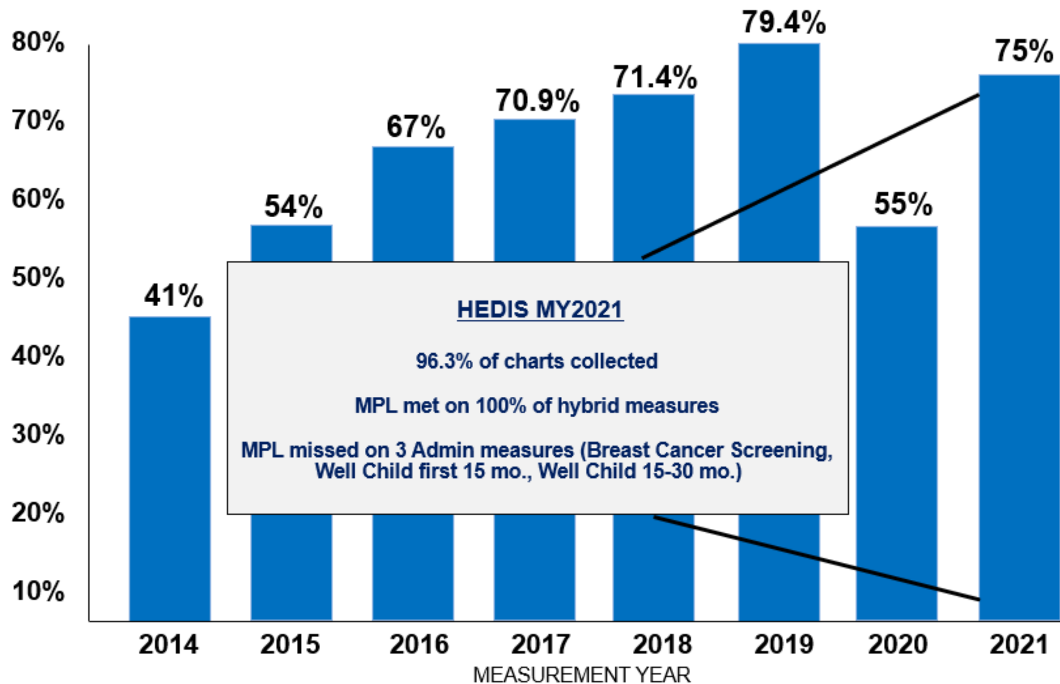
- **CalAIM Incentives**

    - The Housing & Homelessness Incentive Plan (HHIP) investment plan was submitted by Alameda Alliance to the DHCS on September 30th, 2022. In total, $44.3M was allocated to the Alameda Alliance for Health for a two-year period.
        - $19.9 million is allotted for calendar year 2022, and
        - $24.4 million is allotted for calendar year 2023.
        - Payments issued for eligible expenses will be issued by the DHCS in September 2022, June 2023, and March 2024.
    - As a result of the DHCS' reimbursement criteria, approximately $26.5M (60%) of the available $44.3M was identified as the targeted spending for initiatives relating to local housing & homeless initiatives in calendar years 2022-2023.
    - Approximately six percent (6.0%) of the funding, or $1.5 million, is being applied to infrastructure and staffing expenses related to the administration of this investment plan.
    - The investment plan is a non-binding document to the State of California that includes an estimated spend of $26.5M by the Alameda Alliance in the next 12 months. The Alliance will release funds into the community and the DHCS will determine the eligibility for reimbursements as outlined above. The initiatives are measured by goals and outcomes, and the benefits must be demonstrated by October 2023. The HHIP does not cover investments in housing solutions that result in outcomes beyond October 2023. **Therefore, the Alliance is at risk for investing in housing and homeless initiatives in 2022 and 2023, up to the specified amount of $26.5M.**
    - The intersections of housing services funded through the Homeless Housing, Assistance and Prevention (HHAP) grant program are considered by the DHCS, as well as the alignment to the overall housing strategy.
    - Alameda County Health Care Services Agency (HCSA) presented their HHIP investment recommendations to the Continuum of Care (CoC) Leadership Board in the month of August, and the CoC endorsed the investment plan on September 27th, 2022.
    - Alameda Alliance is forecasting administrative costs for each incentive program to oversee the management of the funding, and outcomes-based reporting, over the life of each incentive program.

- **Quality Improvement, HEDIS, and Medi-Cal Rate Development**

    - DHCS announced a Medi-Cal quality component is being added in calendar year 2023 that compares HEDIS scores between Alameda Alliance and Anthem Blue Cross (Elevance).

- The quality component is based on a proposed set of 10-15 HEDIS measures and uses actual HEDIS scores from calendar year 2021.
- Weightings for each measure is applied to the calculation and includes achievement and improvement as part of the scoring component.
- The DHCS has not issued the final HEDIS rates for calendar year 2021. The following graph illustrates the Alliance's actual HEDIS scores for calendar years 2014 through 2020, and the projected HEDIS score for calendar year 2021:



*MPL is the minimum performance level for a HEDIS measure, defined by NCQA.

- **Regulatory Audits & Accreditation**

  - The NCQA re-accreditation survey completed, and the Alliance earned accreditation status for both lines of business, Medicaid and Commercial (Group Care). A corrective action plan has been applied to the commercial line of business and will be addressed by the Alliance. In Q4-2022, the Alliance is conducting an independent audit to assess NCQA policies and workflows, and to identify opportunities for improvement.

  - The DMHC routine financial survey started in mid-August, and follow-up documents are being provided to the DMHC.

- The DMHC focused mental health parity audit, referred to as the Behavioral Health Investigation, was conducted in the month of August.

- **Single Plan Model**

    - The California DHCS has issued a single plan transition timeline for calendar years 2022 and 2023.
    - The first set of deliverables were submitted on August 12th, and a second set on September 12th. As part of the work-plan changes by DHCS, the next set will be submitted November 28th.
    - The Alliance's Integrated Planning & Compliance Divisions are coordinating resources to meet the regulatory timelines.
    - Alameda County begins the single plan model for Medi-Cal managed care on January 1st, 2024. Please refer to the Compliance Report on page 276 for more information.

Executive Dashboard

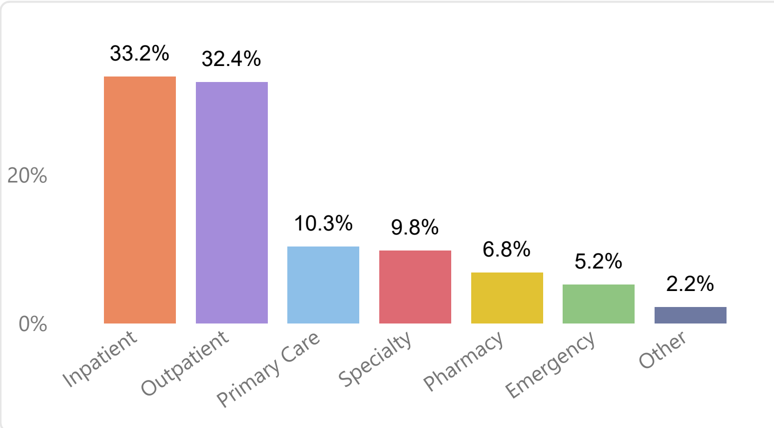
Financials

Income & Expenses

	AUGUST 2022	FISCAL YTD
REVENUE	$ 101.0 M	$ 201.8 M
MEDICAL EXPENSE	$ (93.3) M	$ (184.2) M
ADMIN EXPENSE	$ (5.7) M	$ (10.4) M
OTHER	$ 394 K	$ 859 K
NET INCOME	$ 2.3 M	$ 8.0 M

Gross Margin %
8.7%

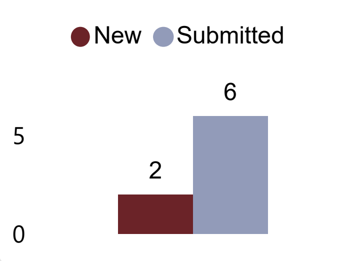
Medical Expenses



Liquid Reserves

MLR Net %
91.3%
TNE %
626.7%
TNE $
$238.7M

Reinsurance Cases



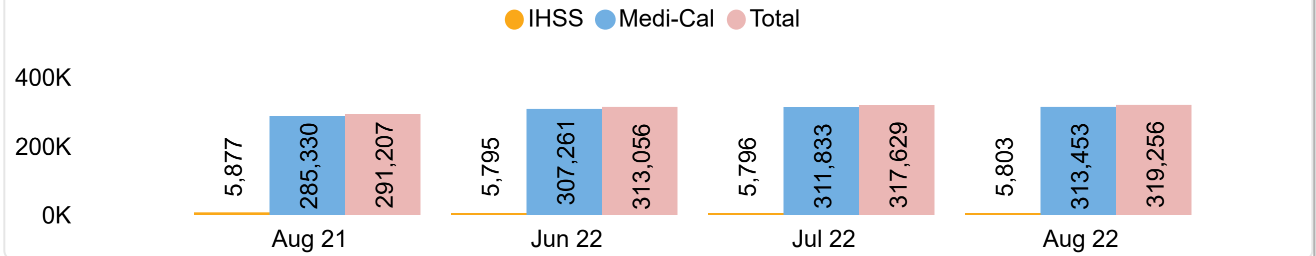
Balance Sheet

Cash Equivalents	$322.4M
Pass-Through Liabilities	$174.5M
Uncommitted Cash	$147.8M
Working Capital	$194.8M

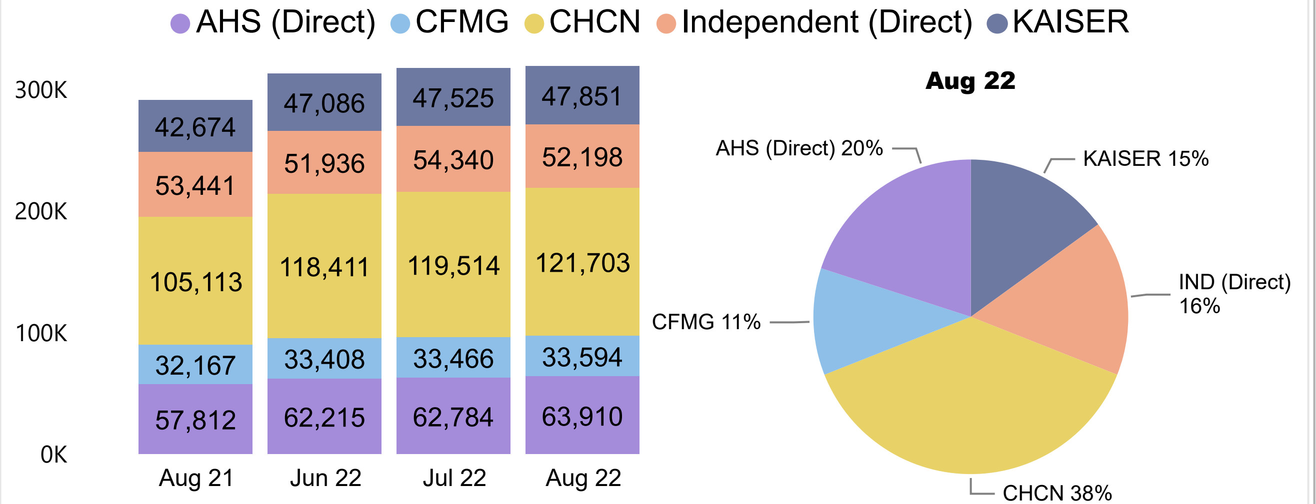
Current Ratio
1.55

Membership

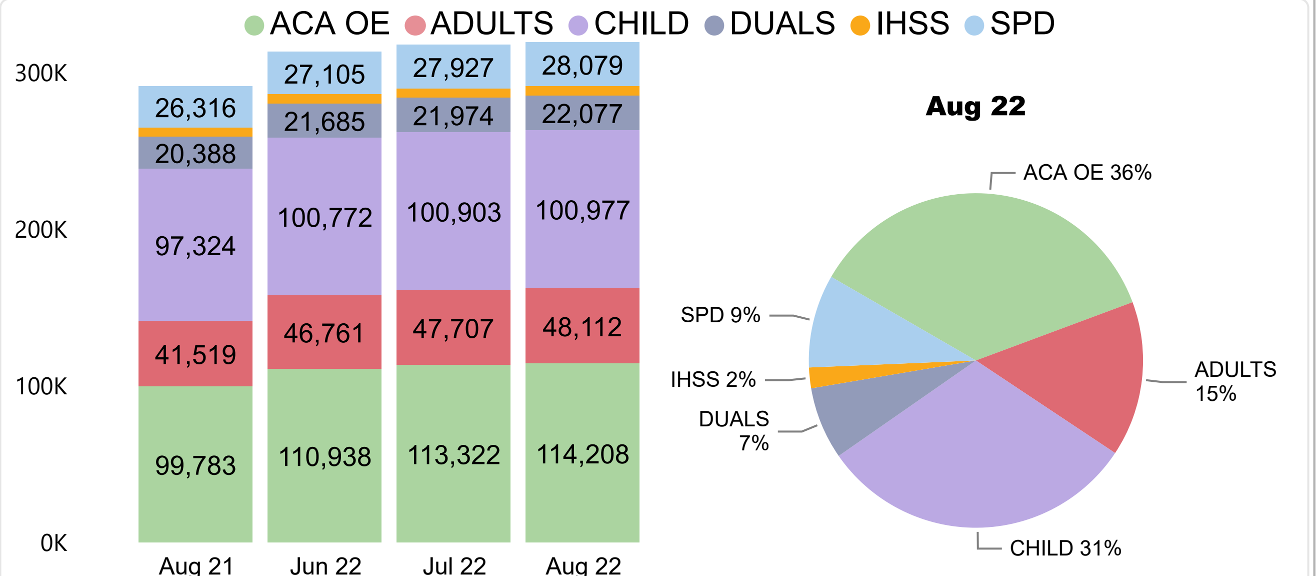
By Plan



By Network

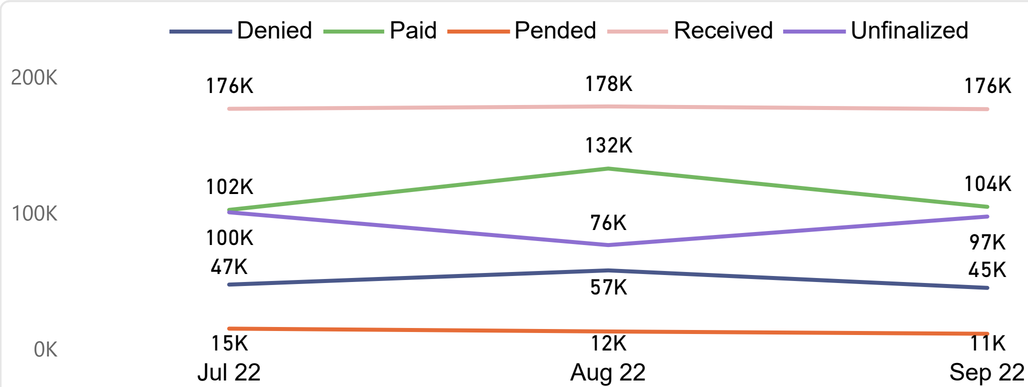


By Category

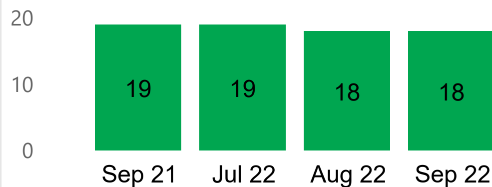


Claims

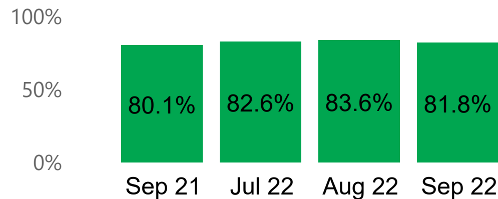
Claims Processing



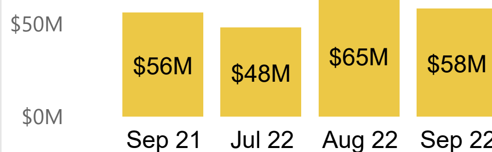
Average Payment TAT (Days)



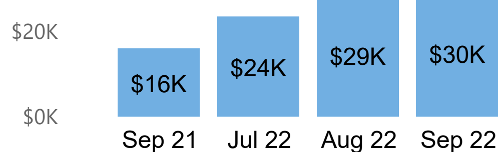
Auto Adjudication Rate (%)



Claims Paid ($)

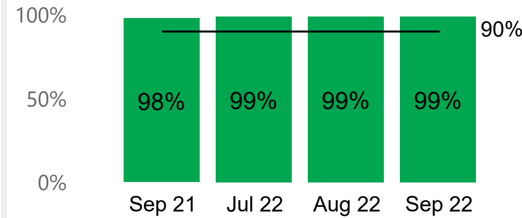


Interest Paid ($)

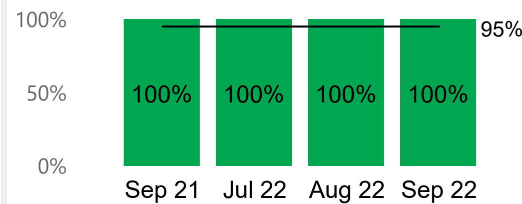


Claims Compliance

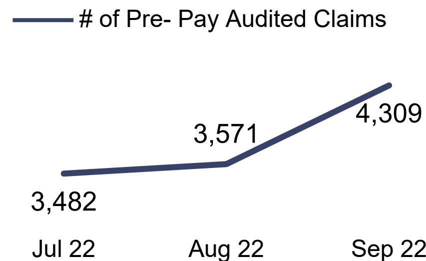
Processed 30 Cal Days (%)



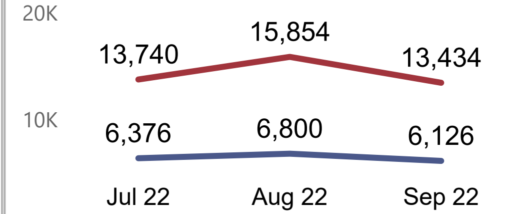
Processed 45 Work Days (%)



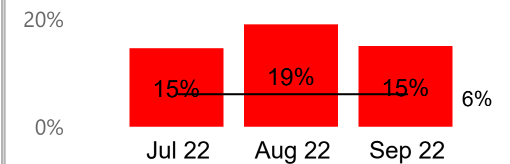
Claims Auditing



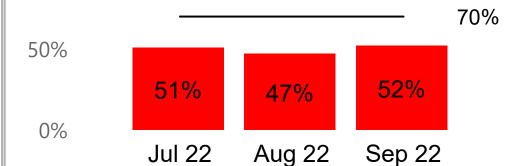
Member Services



Abandoned Call Rate (%)

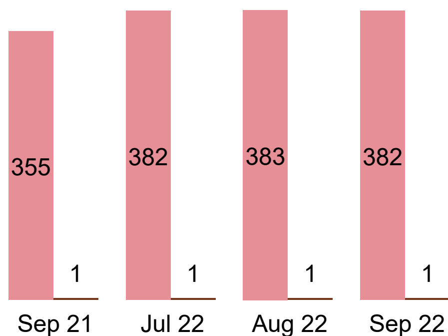


Calls Answered in 60 Seconds (%)

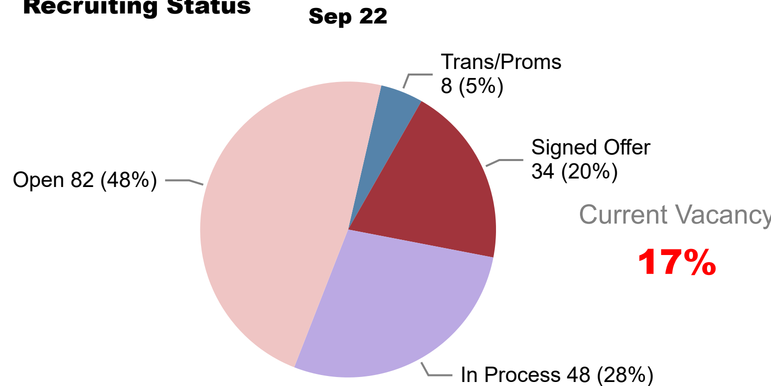


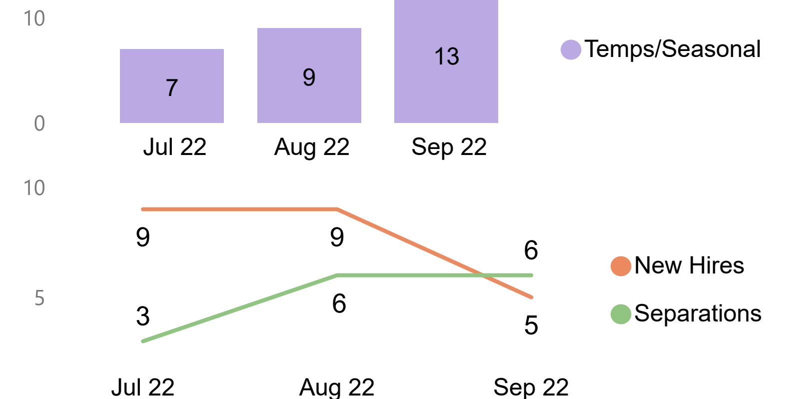
Average Call Times	Jul 22	Aug 22	Sep 22
Wait Time	03:35	05:02	03:42
Call Duration	06:26	06:36	07:25

Human Resources



Recruiting Status





Provider Services

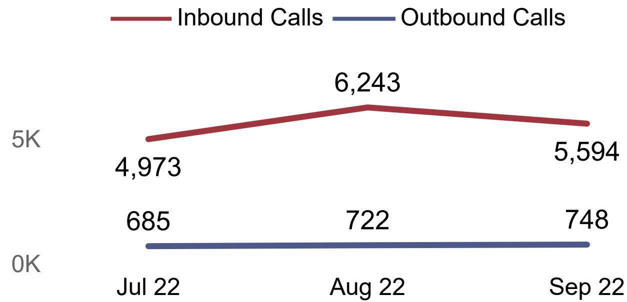
Provider Network

Hospital	17
Specialist	9,085
Primary Care Physician	732
Skilled Nursing Facility	66
Urgent Care	8
Health Centers (FQHCs and Non-FQHCs)	68
Transportation	380
TOTAL	**10,356**

Provider Credentialing

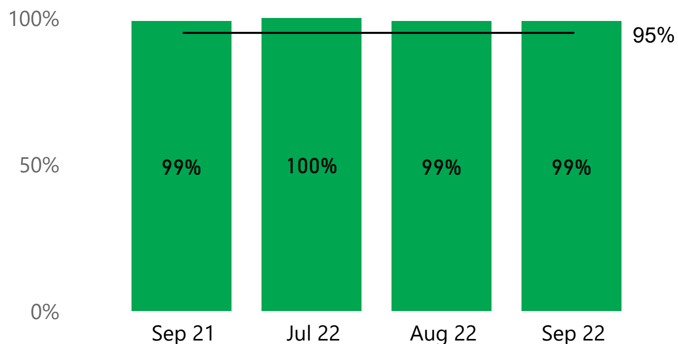
1,474

Provider Call Center



Provider Disputes & Resolutions

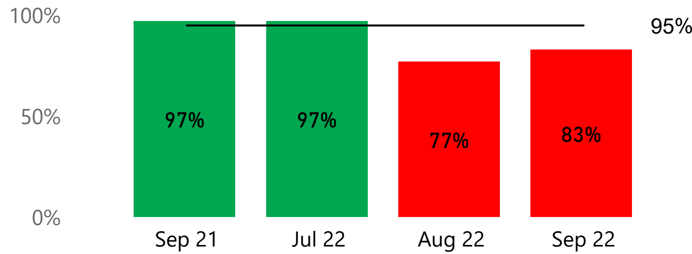
Turnaround Compliance (45 business days)



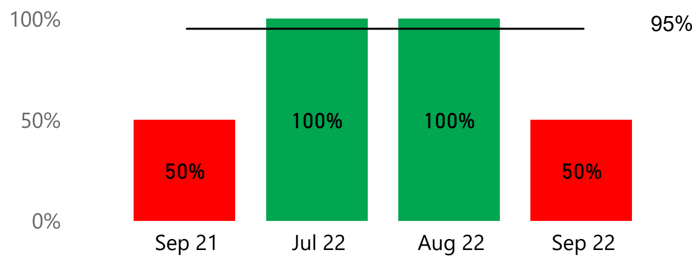
Compliance

Member Grievances

Standard (30 calendar days)

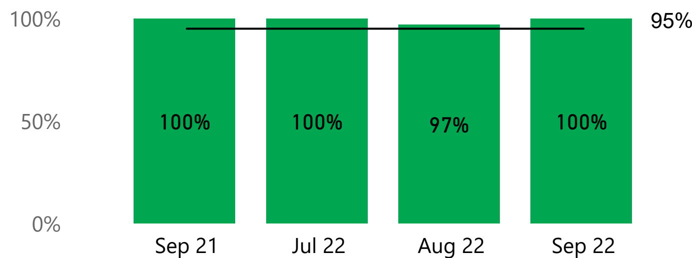


Expedited (3 calendar days)

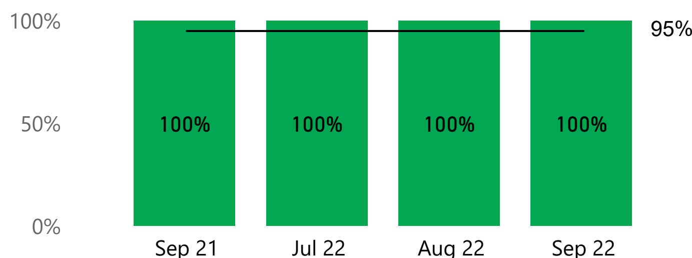


Member Appeals

Standard (30 calendar days)

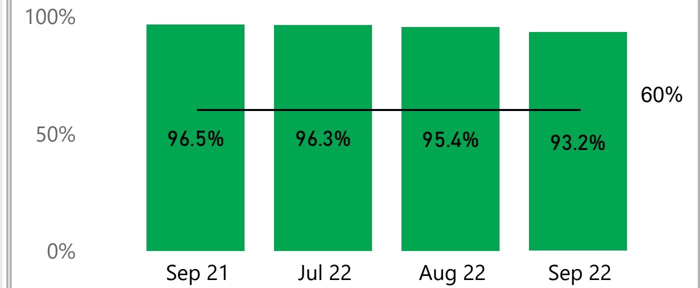


Expedited (3 calendar days)

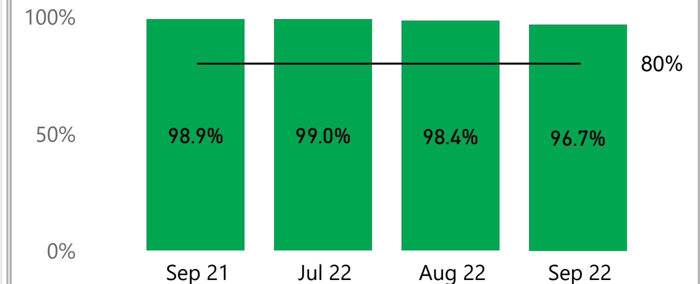


Encounter Data

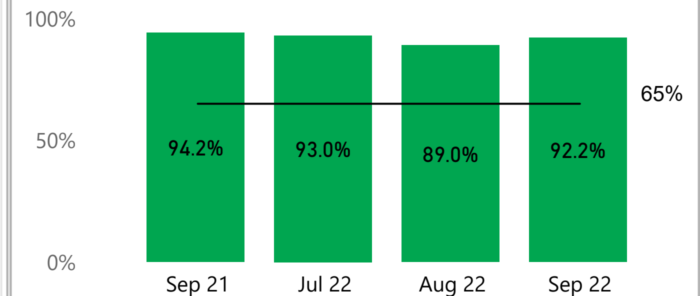
Institutional 0-90 days



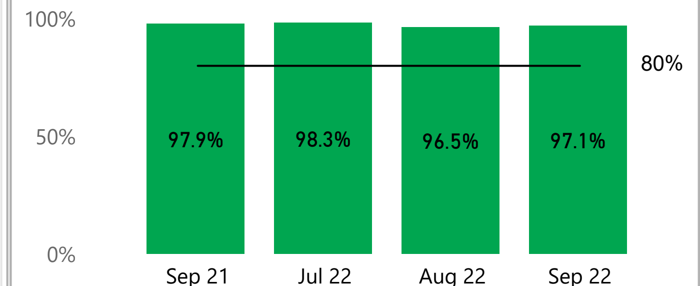
Institutional 0-180 days



Professional 0-90 days



Professional 0-180 days



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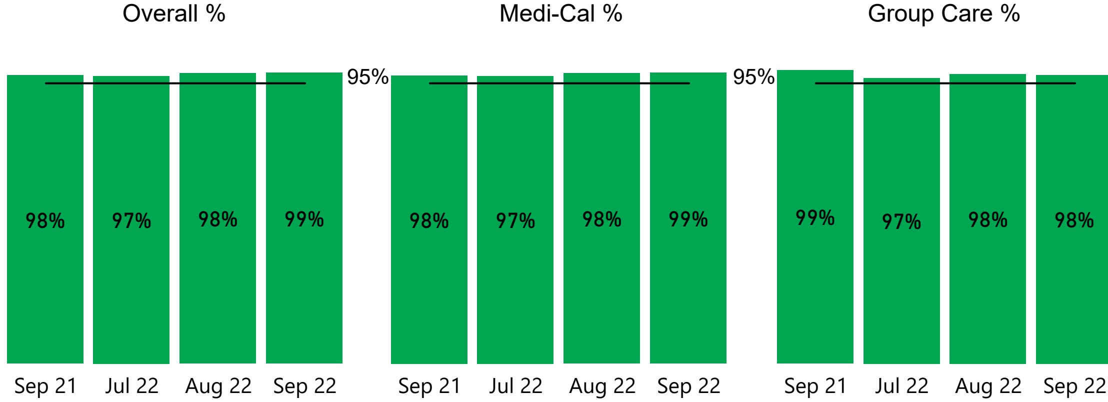
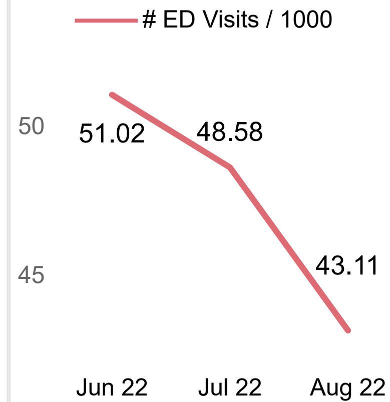
Health Care Services

Authorization Turnaround



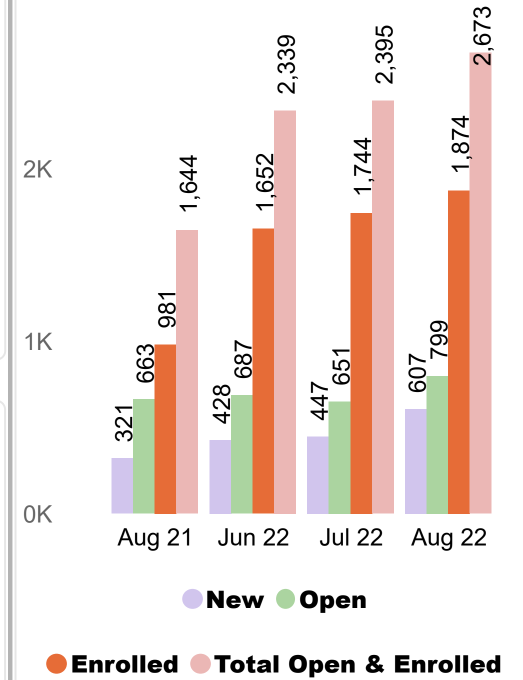
ED Utilization



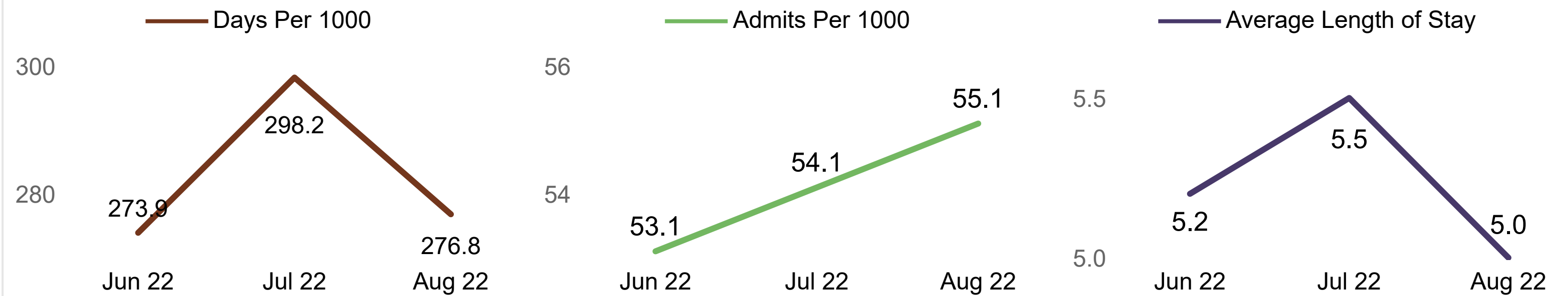
Case Management

Total Cases^

^ ECM Metrics since 2022



Inpatient Utilization

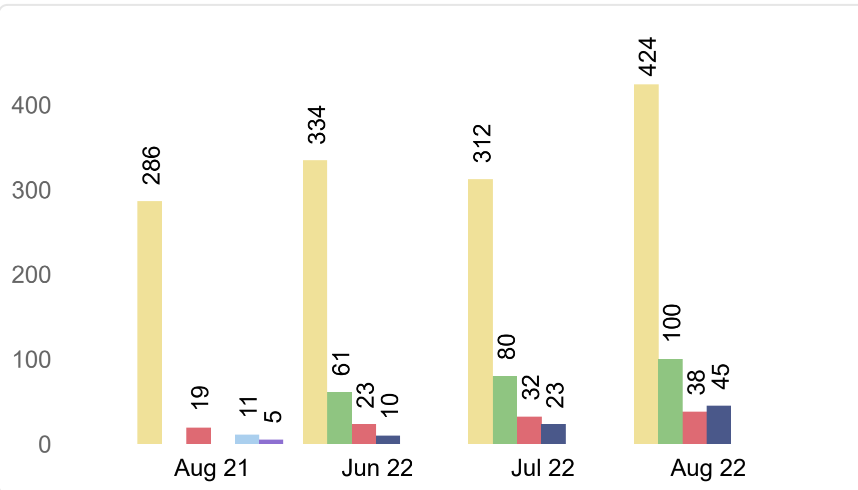


Case Management^

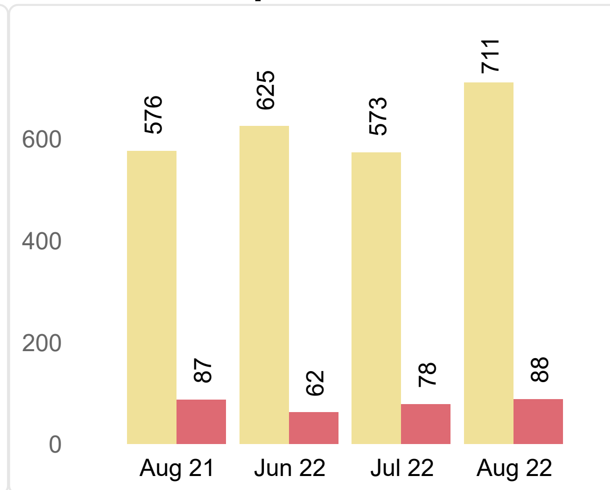
Care Coordination Complex Cases Health Homes Whole Person Care Community Supports Enhanced Case Management

^ ECM Metrics since 2022

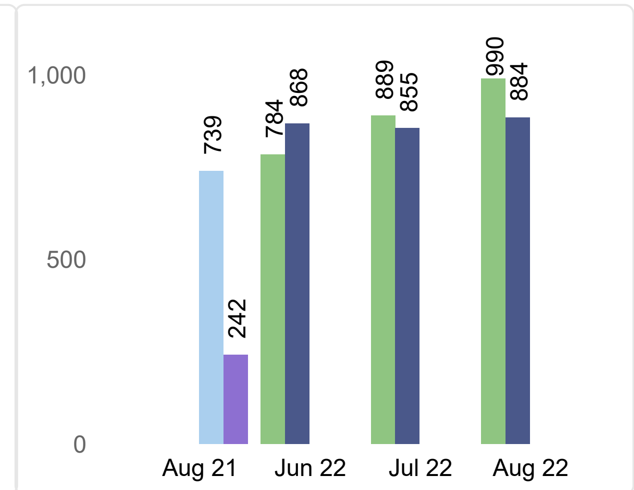
New Cases



Open Cases



Enrolled Cases



Technology (Business Availability)

Applications	Sep 21	Jul 22	Aug 22	Sep 22
HEALTHsuite System	100.0%	96.0%	100.0%	100.0%
Other Applications	100.0%	100.0%	100.0%	100.0%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Sep 21	Jul 22	Aug 22	Sep 22
Denial Rate Excluding Partial Denials (%)	4.3%	4.5%	3.5%	3.2%
Overall Denial Rate (%)	4.8%	5.0%	3.8%	3.6%
Partial Denial Rate (%)	0.6%	0.5%	0.3%	0.4%

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

Pharmacy Authorizations

Authorizations	Sep 21	Jul 22	Aug 22	Sep 22
Approved Prior Authorizations	808	19	33	35
Closed Prior Authorizations	672	53	78	110
Denied Prior Authorizations	624	37	39	29
Total Prior Authorizations	2,104	109	150	174

Legislative Tracking

2022 Legislative Tracking List

The following is a list of state bills tracked by the Public Affairs Department that were introduced during the 2021 and 2022 Legislative Sessions. This list includes 2-year bills introduced in 2021 that did not make it through the legislature and have moved through the legislature in 2022, as well as bills introduced in 2022. These bills are of interest to and could have a direct impact on Alameda Alliance for Health and its membership. **The bills on this list are updated as of 10/7/2022.**

On August 31st, the state legislature officially adjourned the 2021-2022 session. All bills that made it through the legislative process went to the Governor's desk and were either signed or vetoed by the Governor as of September 30th.

Medi-Cal (Medicaid)

- **AB 1355 (Levine – D) Medi-Cal: Independent medical review system**
  - **Introduced:** 2/19/2021
  - **Status:** 9/30/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 944, Statues of 2022.
  - **Summary:** Current law establishes hearing procedures for an applicant for, or recipient of, public social services who is dissatisfied with certain actions regarding those services to request a hearing from the State Department of Social Services or the State Department of Health Care Services, as applicable, under specified circumstances. After an administrative law judge has held a hearing and issued a proposed decision, within 30 days after the department has received a copy of the administrative law judge's proposed decision, or within the 3 business days for an expedited resolution of an appeal of an adverse benefit determination for a Medi-Cal managed care plan beneficiary, as specified, current law authorizes the director to take specified action under prescribed timeframes. These actions include adopting the decision in its entirety, deciding the matter themselves on the record, including the transcript, with or without taking additional evidence, or ordering a further hearing to be conducted by the director or another administrative law judge on their behalf. Under current law, the failure of the director to take certain actions is deemed an affirmation of the proposed decision. This bill would instead authorize the director to adopt the decision in its entirety, decide the matter on the record after reviewing the transcript or recording of the hearing without taking additional evidence, or order a further hearing to be conducted by the director or another administrative law judge on their behalf that affords the parties the opportunity to present and respond to additional evidence. The bill would clarify that a proposed decision would be deemed affirmed and adopted if the director fails to take prescribed action and would require the director's alternated decision to contain a statement of the facts and evidence, including references to the applicable provisions of law and regulations, and the analysis that supports their decision.

- **AB 1859 (Levine – D) Mental health and substance use disorder treatment**
  - **Introduced:** 2/8/2022
  - **Status:** 9/9/2022 Vetoed by Governor
  - **Summary:** Would require a health care service plan or a health insurer for a health care service plan contract or a health insurance policy issued, amended, or renewed on or after July 1st, 2023, that includes coverage for mental health services to, among other things, approve the provision of medically necessary treatment of a mental health or substance use disorder for persons who

are screened, evaluated, and detained for treatment and evaluation under the Lanterman-Petris-Short Act. The bill would prohibit a noncontracting provider of covered mental health or substance use disorder treatment from billing the previously described enrollee or insured more than the cost-sharing amount the enrollee or insured would pay to a contracting provider for that treatment. Under the bill, if an enrolled or insured is referred for a follow-up appointment for mental health services on a voluntary basis pursuant to the Lanterman-Petris-Short Act, the bill would require the health care service plan or health insurer to process the referral as a request for an appointment and offer appointments within specified timeframes, and if an appointment is not available in the network that meets the geographic and timely access standards set by law, arrange coverage to ensure the delivery of medically necessary out-of-network services, to the extent possible, to meet those geographic and timely access standards. Because a willful violation of the bill's requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program.

- **AB 1880 (Arambula – D) Prior authorization and step therapy**
  - **Introduced:** 1/24/2022
  - **Status:** 9/25/2022 Vetoed by Governor
  - **Summary:** Current law permits a health care provider or prescribing provider to appeal a denial of a step therapy exception request for coverage of a nonformulary drug, a prior authorization request, or a step therapy exception request, consistent with the current utilization management processes of the health care service plan or health insurer. Current law also permits an enrollee or insured, or the enrollee's or insured's designee or guardian, to appeal a denial of a step therapy exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request by filing a grievance under a specified provision. This bill would require health care service plan's or health insurer's utilization management process to ensure that an appeal of a denial of an exception request is reviewed by a clinical peer of the health care provider or prescribing provider, as specified. The bill would define the term "clinical peer" for these purposes.

- **AB 1892 (Flora - R) Medi-Cal: orthotic and prosthetic appliances**
  - **Introduced:** 2/9/2022
  - **Status:** 8/12/2022-Failed Deadline pursuant to Rule 61(b)(15). (Last location was APPR. SUSPENSE FILE on 6/20/2022)
  - **Summary:** Under the Medi-Cal program, current law requires the State Department of Health Care Services to establish a list of covered services and maximum allowable reimbursement rates for prosthetic and orthotic appliances and requires that the list be published in provider manuals. Current law prohibits reimbursement for prosthetic and orthotic appliances from exceeding 80% of the lowest maximum allowance for California established by the federal Medicare Program for the same or similar services. This bill would instead require reimbursement for these appliances to be set at least at 80% of the lowest maximum allowance for California established by the federal Medicare Program and would require that reimbursement to be adjusted annually, as specified.

- **AB 1900 (Arambula – D): Medi-Cal: income level for maintenance**
  - **Introduced:** 2/9/2022
  - **Status:** 8/12/2022-Failed Deadline pursuant to Rule 61(b)(15). (Last location was APPR. SUSPENSE FILE on 6/27/2022)
  - **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 to receive health care services. Current law requires the department to establish income levels for maintenance at the lowest levels that reasonably permit a medically needy person to meet their

basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. Under current law, for a single individual, the amount of the income level for maintenance per month is based on a calculation of 80% of the highest amount that would ordinarily be paid to a family of 2 persons, without any income or resources, under specified cash assistance provisions, multiplied by the federal financial participation rate, adjusted as specified. To the extent that any necessary federal authorization is obtained, and effective no sooner than January 1st, 2024, this bill would increase the above-described income level for maintenance per month to be equal to the income limit for Medi-Cal without a share of cost for individuals who are 65 years of age or older or are disabled, generally totaling 138% of the federal poverty level. The bill would require the department to seek any necessary federal authorization for maintaining that income level for maintenance and would make conforming changes to related provisions. The bill would authorize the department to implement those provisions by various means, including all-county letters, and would require the department to implement those changes by regulatory action within 2 years of the operation of the above-described increase.

- **AB 1929 (Gabriel - D) Medi-Cal: violence preventive services**
    - **Introduced:** 2/10/2022
    - **Status:** 8/22/2022-Approved by the Governor. Chaptered by Secretary of State - Chapter 154, Statutes of 2022.
    - **Summary:** Current law establishes a schedule of benefits under the Medi-Cal program, including various mental health services. Current federal law authorizes, at the option of the state, preventive services, as defined, that is recommended by a physician or other licensed practitioner of the healing arts. This bill would add violence prevention services, as defined, as a covered benefit under Medi-Cal, subject to medical necessity and utilization controls. The bill would authorize the department to implement, interpret, or make specific that provision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until regulations are adopted. The bill would limit its implementation only to the extent that any necessary federal approvals are obtained, and federal financial participation is not otherwise jeopardized. The bill would require the department to post on its Internet website the date upon which violence prevention services may be provided and billed.

- **AB 1930 (Arambula - D) Medi-Cal: comprehensive perinatal services**
    - **Introduced:** 2/10/2022
    - **Status:** 9/27/2022 Vetoed by Governor
    - **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 post pregnancy eligibility period, and as part of comprehensive perinatal services under Medi-Cal, would require the department to cover additional comprehensive perinatal assessments and individualized care plans and to provide additional visits and units of services in an amount, duration, and scope that are at least proportional to those available on July 27th, 2021, during pregnancy and the initial 60-day post pregnancy period in effect on that date. The bill would require the department to collaborate with the State Department of Public Health and a broad stakeholder group to determine the specific number of additional comprehensive perinatal assessments, individualized care plans, visits, and units of services to be covered.

- **AB 1937 (Patterson - R) Medi-Cal: out-of-pocket pregnancy costs**
    - **Introduced:** 2/10/2022

- **Status:** 4/29/2022 Failed Deadline pursuant to Rule 61(b)(5). (Last location was HEALTH on 2/18/2022)
- **Summary:** Would require the State Department of Health Care Services, on or before July 1st, 2023, to establish a health expense account program for pregnant Medi-Cal beneficiaries and pregnant subscribers of the Medi-Cal Access Program. The bill would make a Medi-Cal beneficiary who is pregnant or a pregnant subscriber of the Medi-Cal Access Program eligible for reimbursement for "out-of-pocket pregnancy-related costs," as specified, in an amount not to exceed $1,250. The bill would require the person to submit the request for reimbursement within 3 months of the end of the pregnancy in order to be reimbursed. The bill would require the department to seek to maximize federal financial participation in implementing the program. The bill would require the department, to the extent federal financial participation is unavailable, to implement the program only with state funds. The bill would require the department to contract out for purposes of implementing the health expense account program, as specified. The bill would authorize the department to implement the above-described provisions through all-county or plan letters or similar instructions and would require regulatory action no later than January 1st, 2026.

- **AB 1944 (Lee – D) Local governments: open and public meetings**
  - **Introduced:** 1/24/2022
  - **Status:** 7/5/2022-Failed Deadline pursuant to Rule 61(b)(14). (Last location was S. GOV. & F. on 6/8/2022)
  - **Summary:** The Ralph M. Brown Act requires, with specified exceptions, that all meetings of a legislative body of a local agency, as those terms are defined, be open and public and that all persons be permitted to attend and participate. The act contains specified provisions regarding the timelines for posting an agenda and providing for the ability of the public to observe and provide comments. The act allows for meetings to occur via teleconferencing subject to certain requirements, particularly that the legislative body notice each teleconference location of each member that will be participating in the public meeting, that each teleconference location be accessible to the public, that members of the public be allowed to address the legislative body at each teleconference location, that the legislative body post an agenda at each teleconference location, and that at least a quorum of the legislative body participate from locations within the boundaries of the local agency's jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined. This bill would require the agenda to identify any member of the legislative body that will participate in the meeting remotely.

- **AB 1995 (Arambula - D) Medi-Cal: premiums, contributions or copayments**
  - **Introduced:** 1/24/2022
  - **Status:** 8/12/2022-Failed Deadline pursuant to Rule 61(b)(15). (Last location was APPR. SUSPENSE FILE on 6/27/2022
  - **Summary:** Current law requires that Medi-Cal benefits be provided to optional targeted low-income children, as defined, based on a certain income eligibility threshold. Current law also establishes the Medi-Cal Access Program, which provides health care services to a woman who is pregnant or in her postpartum period and whose household income is between certain thresholds, and to a child under 2 years of age who is delivered by a mother enrolled in the program, as specified. Current law also establishes a program under which certain employed persons with disabilities are eligible for Medi-Cal benefits based on income and other criteria. Existing law requires the department to exercise the option available to the state under federal law to impose specified monthly premiums, based on income level, for the above-described children and employed persons with disabilities. Existing law requires the department to determine schedules for subscriber contribution amounts for persons enrolled in the Medi-Cal

Access Program. This bill would eliminate the premiums and subscriber contributions for the above-described populations.

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

- **AB 2024 (Friedman - D) Health care coverage: diagnostic imaging**
  - **Introduced:** 2/14/2022
  - **Status:** 8/12/2022-Failed Deadline pursuant to Rule 61(b)(15). (Last location was APPR. SUSPENSE FILE on 8/8/2022)
  - **Summary:** Would require a health care service plan contract, health insurance policy, or self-insured employee welfare benefit plan issued, amended, or renewed on or after January 1st, 2023, to provide coverage for screening mammography, medically necessary diagnostic, or supplemental breast examinations, or testing for screening or diagnostic purposes upon referral by specified professionals. The bill would prohibit a health care service plan contract, health insurance policy, or self-insured employee welfare benefit plan issued, amended, or renewed on or after January 1st, 2023, from imposing cost sharing for screening mammography, medically necessary or supplemental breast examinations, or testing, unless the contract or policy is a high deductible health plan and the deductible has not been satisfied for the year.

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

- **AB 2077 (Calderon - D) Medi-Cal: monthly maintenance amount: personal and incidental needs**
  - **Introduced:** 2/14/2022
  - **Status:** 9/27/2022 Vetoed by Governor
  - **Summary:** Qualified individuals under the Medi-Cal program include medically needy persons and medically needy family persons who meet the required eligibility criteria, including applicable income requirements. Current law requires the State Department of Health Care Services to establish income levels for maintenance needs at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. In calculating the income of a medically needy person in a medical institution or nursing facility, or a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization, the required monthly maintenance amount includes an amount providing for personal and incidental needs in the amount of not less than $35 per month while a patient. Current law authorizes the department to increase, by regulation, this amount as necessitated by increasing costs of personal and incidental needs. This bill would increase the monthly maintenance amount for personal and incidental needs from $35 to $80, commencing on July 1st, 2024, or on the date that any necessary federal approvals are obtained, whichever is later.

- **AB 2117 (Gipson – D) Mobile stroke units**
  - **Introduced:** 2/14/2022
  - **Status:** 9/29/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 772, Statues of 2022.
  - **Summary:** The Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act (act) establishes the Emergency Medical Services Authority, which is responsible for the coordination of various state activities concerning emergency medical services (EMS), including the development of planning and implementation guidelines for EMS systems. The act authorizes a county to develop an EMS program by designating a local EMS agency. This bill would define, under the act, “mobile stroke unit” to mean a multijurisdictional mobile facility that serves as an emergency response critical care ambulance under the direction and approval of a local EMS agency and as a diagnostic, evaluation, and treatment unit, providing radiographic imaging, laboratory testing, and medical treatment under the supervision of a physician in person or by telehealth, for patients with symptoms of a stroke, to the extent consistent with any federal definition of a mobile stroke unit, as specified.

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

- **AB 2304 (Bonta – D) Nutrition Assistance: “Food as Medicine”**
  - **Introduced:** 2/16/2022

- **Status:** 5/6/22 Failed Deadline pursuant to Rule 61(b)(6). (Last location was A. PRINT on 2/16/2022)
- **Summary:** Current law provides for the California Health and Human Services Agency, which includes the State Department of Health Care Services, the State Department of Public Health, and the State Department of Social Services. Current law establishes various programs and services under those departments, including the Medi-Cal program, under which qualified low-income individuals to receive health care services, such as enteral nutrition products, the California Special Supplemental Nutrition Program for Women, Infants, and Children, which is administered by the State Department of Public Health and counties and under which nutrition and other assistance are provided to eligible individuals who have been determined to be at nutritional risk, and the CalFresh program, under which supplemental nutrition assistance benefits allocated to the state by the federal government are distributed to eligible individuals by each county. This bill would declare the intent of the Legislature to enact the Wilma Chan Food as Medicine Act of 2022.

- **AB 2352 (Nazarian - D) Prescription drug coverage**
  - **Introduced:** 2/16/2022
  - **Status:** 9/27/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 590, Statues of 2022.
  - **Summary:** Would require a health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after July 1st, 2023, that provides prescription drug benefits and maintains one or more drug formularies to furnish specified information about a prescription drug upon request by an enrollee or insured, or their prescribing provider. The bill would require the plan or insurer to respond in real-time to that request and ensure the information is current no later than one business day after a change is made. The bill would prohibit a health care service plan or health insurer from, among other things, restricting a prescribing provider from sharing the information furnished about the prescription drug or penalizing a provider for prescribing, administering, or ordering a lower-cost or clinically appropriate alternative drug. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

- **AB 2402 (Rubio, Blanca - D) Medi-Cal: continuous eligibility**
  - **Introduced:** 2/17/2022
  - **Status:** 8/31/2022-Failed Deadline pursuant to Rule 61(b)(18). (Last location was INACTIVE FILE on 8/30/2022)
  - **Summary:** Would prohibit the redetermination of Medi-Cal eligibility before the child reaches 5 years of age unless the department or county possesses facts indicating that the family has requested the child's voluntary disenrollment, the child is deceased, the child is no longer a state resident, or the child's original enrollment was based on a state or county error or on fraud, abuse, or perjury, as specified. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and, except as specified, on the availability of federal financial participation.

- **AB 2449 (Rubio, Blanca – D) Open meetings: local agencies: teleconferences**
  - **Introduced:** 1/24/2022
  - **Status:** 9/13/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 285, Statues of 2022.
  - **Summary:** Current law, 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 generally requires posting an

agenda at least 72 hours before a regular meeting that contains a brief general description of each item of business to be transacted or discussed at the meeting and prohibits any action or discussion from being undertaken on any item not appearing on the posted agenda. This bill would revise and recast those teleconferencing provisions and, until January 1st, 2026, would authorize a local agency to use teleconferencing without complying with the teleconferencing requirements that each teleconference location be identified in the notice and agenda and that each teleconference location be accessible to the public if at least a quorum of the members of the legislative body participates in person from a singular physical location clearly identified on the agenda that is open to the public and situated within the local agency's jurisdiction.

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

- **AB 2516 (Aguiar-Curry - D) Health care coverage: human papillomavirus**
    - **Introduced:** 2/17/2022
    - **Status:** 9/25/2022 Vetoed by Governor
    - **Summary:** This bill would expand the coverage requirement for an annual cervical cancer screening test to disability insurance policies that provide coverage for hospital, medical, or surgical benefits and would require a health care service plan contract or disability insurance policy that provides coverage for hospital, medical, or surgical benefits issued, amended, or renewed on or after January 1st, 2023, to provide coverage without cost sharing for the HPV vaccine for persons for whom the vaccine is FDA approved. 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. The bill would also expand comprehensive clinical family planning services under the Family PACT Program to include the HPV vaccine for persons for whom it is FDA approved. This bill contains other related provisions and other existing laws.

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

- **AB 2581 (Salas – D) Health Care Service Plans: Mental Health and Substance Use Disorders: Provider Credentials**
    - **Introduced:** 2/18/2022
    - **Status:** 9/25/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 533, Statues of 2022.

- **Summary:** The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Current law also provides for the regulation of disability insurers by the Department of Insurance. Current law requires a health care service plan contract or disability insurance policy issued, amended, or renewed on or after January 1st, 2021, that provides hospital, medical, or surgical coverage to provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions, as specified. For provider contracts issued, amended, or renewed on and after January 1st, 2023, this bill would require a health care service plan or disability insurer that provides coverage for mental health and substance use disorders and credentials health care providers of those services for the health care service plan's or disability insurer's networks, to assess and verify the qualifications of a health care provider within 60 days after receiving a completed provider credentialing application.

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

- **AB 2680 (Arambula - D) Medi-Cal: Community Health Navigator Program**
  - **Introduced:** 2/19/2022
  - **Status:** 8/31/2022-Failed Deadline pursuant to Rule 61(b)(18). (Last location was INACTIVE FILE on 8/23/2022)
  - **Summary:** Would, commencing January 1st, 2023, require the State Department of Health Care Services to create the Community Health Navigator Program to make direct grants to qualified community-based organizations, as defined, to conduct targeted outreach, enrollment, retention, and access activities for Medi-Cal-eligible individuals and families. The bill would specify the basis for issuing a grant, including specified factors in the applicant's service area. The bill would authorize the department to contract with one or more private foundations to assist the department with administering the grant application and allocation process. The bill would require the department to contract with specified providers to furnish training and technical assistance to grant recipients. The bill would also require the department to coordinate and partner with Covered California and counties that elect to participate in an approach for outreach, enrollment, retention, and access activities for marketing to eligible individuals, including facilitation of quarterly meetings on enrollment and access barriers and solutions, among other requirements.

The bill would become operative only upon an express appropriation in the annual Budget Act or another statute for the purposes of the bill.

- **AB 2724 (Arambula – D) Medi-Cal: alternate health care service plan**
  - **Introduced:** 2/18/2022
  - **Status:** 6/30/2022-Chaptered by Secretary of State- Chapter 73, Statutes of 2022
  - **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 to receive health care services through various delivery systems, including managed care pursuant to Medi-Cal managed care plan contracts. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would authorize the department to enter into one or more comprehensive risk contracts with an alternate health care service plan (AHCSP), as defined, to serve as a primary Medi-Cal managed care plan for certain eligible beneficiaries in geographic regions designated by the department, as specified. The bill would authorize the department to contract with an AHCSP as a Medi-Cal managed care plan in any geographic region of the state for which federal approval is available, for which the AHCSP maintains appropriate licensure or an approved exemption from the Department of Managed Health Care, and in which the AHCSP already provides commercial coverage in the individual, small group, or large group market.

- **AB 2727 (Wood – D) Medi-Cal: Eligibility**
  - **Introduced:** 1/24/2022
  - **Status:** 9/13/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 291, Statues of 2022.
  - **Summary:** Current law prohibits the use of resources, including property or other assets, to determine Medi-Cal eligibility for applicants or beneficiaries whose eligibility is not determined using the MAGI-based financial methods, and requires the department to seek federal authority to disregard all resources as authorized by the flexibilities provided under federal law. Current law conditions implementation of that provision on the Director of Health Care Services determines that systems have been programmed for those disregards and they are communicating that determination in writing to the Department of Finance no sooner than January 1st, 2024. Current law also conditions implementation of that provision on receipt of any necessary federal approvals and the availability of federal financial participation. Current law states the intent of the Legislature to provide, to the extent practicable, through the Medi-Cal program, for health care for those aged and other persons, including family persons who lack the sufficient annual income to meet the costs of health care and whose other assets are so limited that their application toward the costs of that care would jeopardize the person or family's future minimum self-maintenance and security. This bill would commence on the date that the resource disregards are implemented and remove from that statement of legislative intent the above-described assets as an eligibility criterion.

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

and the board to administer the program using proceeds from the fund. The bill would require an individual to have paid into the fund for an unspecified number of years to be eligible to receive benefits pursuant to the program.

- **AB 2833 (Irwin – D) COVID-19 testing capacity**
  - **Introduced:** 2/18/2022
  - **Status:** 7/5/22 Failed Deadline pursuant to Rule 61(b)(14). (Last location was S. HEALTH on 6/1/2022)
  - **Summary:** Current law sets forth various provisions specific to COVID-19 testing, including, among others, provisions relating to healthcare coverage for testing and certain programs or requirements for the workplace or educational setting. This bill would require the State Department of Public Health to make plans to ensure that the laboratory infrastructure in the state is sufficient and prepared for COVID-19 testing capacity to be scaled, within a period of 2 calendar weeks, to 500,000 tests per day and for results of at least 90% of those COVID-19 tests to be returned to the individuals tested and to the department within 24 hours of collection of the testing samples. The bill would require the department, for purposes of making these plans, to prioritize local public health laboratories and the state laboratory and to consider sufficient staffing.

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

- **SB 184 Health Trailor Bill**
  - **Introduced:** 1/08/2022
  - **Status:** 6/30/2022 Chaptered by Secretary of State – Chapter 47, Statues of 2022
  - **Summary:** SB 184 is an omnibus health trailer bill that makes statutory revisions affecting health programs necessary to implement the Budget Act of 2022. ***See addendum for a complete summary on this bill.***

- **SB 245 (Gonzalez – D) Health Care Coverage: Abortion Services: Cost of Sharing**
  - **Introduced:** 1/24/2022
  - **Status:** 3/22/2022 Chaptered by Secretary of State – Chapter 11, Statutes of 2022
  - **Summary:** Would prohibit a health care service plan or an individual or group policy or certificate of health insurance or student blanket disability insurance that is issued, amended, renewed, or delivered on or after January 1st, 2023, from imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement on coverage for all abortion and abortion-related services, as specified. The bill would prohibit a health care service plan and an insurer subject to these requirements from imposing utilization management or utilization review on the coverage for outpatient abortion services. The bill would require that for a contract, certificate, or policy that is

a high deductible health plan, the cost-sharing prohibition would apply once the enrollee's or insured's deductible has been satisfied for the benefit year. The bill would not require an individual or group contract or policy to cover an experimental or investigational treatment. The bill's requirements would also apply to Medi-Cal managed care plans and their providers, independent practice associations, preferred provider groups, and all delegated entities that provide physician services, utilization management, or utilization review. The bill would require the Department of Managed Health Care and the Department of Insurance to adopt related regulations on or before January 1st, 2026.

- **SB 853 (Wiener – D) Prescription drug coverage**
  - **Introduced:** 1/19/2022
  - **Status:** 8/12/2022-Failed Deadline pursuant to Rule 61(b)(15). (Last location was APPR. SUSPENSE FILE on 8/3/2022)
  - **Summary:** Current law generally authorizes a health care service plan or health insurer to use utilization review, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Current law prohibits a health care service plan contract that covers prescription drug benefits or a specified health insurance policy from limiting or excluding coverage for a drug on the basis that the drug is prescribed for a use that is different from the use for which it was approved by the federal Food and Drug Administration if specified conditions are met. Current law also prohibits a health care service plan that covers prescription drug benefits from limiting or excluding coverage for a drug that was previously approved for coverage if an enrollee continues to be prescribed that drug, as specified. This bill would expand the above-described prohibitions to prohibit limiting or excluding coverage of a drug, dose, or dosage form, and would apply the prohibition to blanket disability insurance policies and certificates. The bill would prohibit a health care service plan or disability insurer that provides coverage for prescription drugs from limiting or declining to cover a drug or dose of a drug as prescribed or imposing additional cost sharing for covering a drug as prescribed if specified criteria apply.

- **SB 858 (Wiener – D) Health care service plans: discipline: civil penalties.**
  - **Introduced:** 1/19/2022
  - **Status:** 9/30/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 291, Statues of 2022.
  - **Summary:** The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Current law authorizes the Director of the Department of Managed Health Care to take disciplinary measures, including the imposition of civil penalties, against a licensee when the director determines that the licensee has committed an act or omission constituting grounds for disciplinary action, as specified. Under current law, a person who violates the act, or a rule or order adopted or issued under the act, is generally liable for a civil penalty not to exceed $2,500 per violation. Current law also includes various provisions that assess specific civil and administrative penalties for certain violations. Fines and penalties under the act are deposited into the Managed Care Administrative Fines and Penalties Fund, and used, upon appropriation by the Legislature, for designated purposes. This bill would increase the base amount of the civil penalty from $2,500 per violation to not more than $25,000 per violation and would authorize a lower, proportionate penalty for specialized dental and vision health care service plans. Under the bill, the civil penalty base amount would be adjusted annually commencing January 1st, 2028, and every 5 years thereafter, as specified.

- **SB 871 (Pan – D) Public Health: Immunization**
  - **Introduced:** 4/29/22 Failed Deadline pursuant to Rule 61(b)(5). (Last location was JUD. on 2/24/2022)
  - **Status:** 2/24/2022 Referral to Com on JUD. Rescinded because of the limitation placed on committee hearings due to ongoing health and safety risks of the COVID-19 virus.
  - **Summary:** Current law prohibits the governing authority of a school or other institution from unconditionally admitting any person as a pupil of any public or private elementary or secondary school, childcare center, day nursery, nursery school, family day care home, or development center, unless prior to their admission to that institution they have been fully immunized against various diseases, including measles, mumps, pertussis, hepatitis B, and any other disease deemed appropriate by the State Department of Public Health, as specified. Current law authorizes an exemption from those provisions for medical reasons. Under existing law, notwithstanding the above-described prohibition, full immunization against hepatitis B is not a condition by which the governing authority admits or advances a pupil to the 7th grade level of a public or private elementary or secondary school. This bill would remove the above-described exception relating to hepatitis B. The bill would additionally prohibit the governing authority of a school or other institution from unconditionally admitting any person as a pupil of any public or private elementary or secondary school, childcare center, day nursery, nursery school, family day care home, or development center unless prior to their admission to that institution they have been fully immunized against COVID-19.

- **SB 912 (Limon – D) Biomarker testing**
  - **Introduced:** 2/3/2022
  - **Status:** 9/29/2022 Vetoed by the Governor. In Senate. Consideration of Governor's veto pending.
  - **Summary:** Current law applies the provisions relating to biomarker testing to Medi-Cal managed care plans, as prescribed. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1st, 2023, to provide coverage for biomarker testing, including whole genome sequencing, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's or insured's disease or condition if the test is supported by medical and scientific evidence, as prescribed. 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 the 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 923 (Wiener – D) Gender- affirming care**
  - **Introduced:** 1/25/2022
  - **Status:** 9/29/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 822, Statues of 2022.
  - **Summary:** Would require a Medi-Cal managed care plan, a PACE organization, a health care service plan, or a health insurer, and delegated entities, as specified, to require its staff to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care, as defined, for individuals who identify as transgender, gender diverse, or intersex (TGI). The bill would specify the required components of the training and would make use of any training curricula subject to approval by the respective departments. The bill would require an individual to complete a refresher course if a complaint has been filed and a decision

has been made in favor of the complainant against that individual for not providing trans-inclusive health care or on a more frequent basis if deemed necessary.

- **SB 958 (Limon - D) Medication and Patient Safety Act of 2022**
  - **Introduced:** 2/09/2022
  - **Status:** 7/5/2022-Failed Deadline pursuant to Rule 61(b)(14). (Last location was A. HEALTH on 5/27/2022)
  - **Summary:** Would prohibit a health care service plan or health insurer, or its designee, from requiring a vendor to dispense an infused or injected medication directly to a patient with the intent that the patient will transport the medication to a health care provider for administration. The bill would authorize a plan or insurer, or its designee, to arrange for an infused or injected medication to be administered in an enrollee's or insured's home when the treating health care provider and patient determine home administration is in the best interest of the patient. The bill would prohibit a plan or insurer, or its designee, from requiring an infused or injected medication to be supplied by a vendor specified by the plan or insurer, or its designee, as a condition of coverage unless specified criteria are met.

- **SB 966 (Limon – D) Federally qualified health centers and rural health clinics**
  - **Introduced:** 2/09/2022
  - **Status:** 9/27/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 607, Statues of 2022.
  - **Summary:** 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, federally qualified health center (FQHC) services and rural health clinic (RHC) services are reimbursed on a per-visit basis, as specified. This bill would require the State Department of Health Care Services to seek any necessary federal approvals and issue appropriate guidance to allow an FQHC or RHC to bill, under a supervising licensed behavioral health practitioner, for an encounter between an FQHC or RHC patient and an associate clinical social worker or associate marriage and family therapist when certain requirements are met, including that the visit is billed under the supervising licensed behavioral health practitioner of the FQHC or RHC.

- **SB 974 (Portantino - D) Health care coverage: diagnostic imaging**
  - **Introduced:** 2/10/2022
  - **Status:** 9/27/2022 Vetoed by the Governor. In Senate. Consideration of Governor's veto pending.
  - **Summary:** Current law requires a health care service plan contract issued, amended, delivered, or renewed on or after January 1st, 2000, or an individual or group policy of disability insurance or self-insured employee welfare benefit plan to provide coverage for mammography for screening or diagnostic purposes upon referral by specified professionals. Under current law, mammography performed pursuant to those requirements or that meets the current recommendations of the United States Preventive Services Task Force is provided to an enrollee or an insured without cost sharing. This bill 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, 2024, 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 987 (Portantino – D) California Cancer Care Equity Act**
  - **Introduced:** 2/14/2022

- **Status:** 9/27/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 608, Statues of 2022.
- **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 to 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, for covered benefits under its contract, require a Medi-Cal managed care plan to, among other things, make a good faith effort to contract with at least one National Cancer Institute (NCI)-designated comprehensive cancer center, site affiliated with the NCI Community Oncology Research Program (NCORP), or qualifying academic cancer center, as specified within each county in which the Medi-Cal managed care plan operates, and authorize any eligible enrollee diagnosed with a complex cancer diagnosis to request a referral to any of those centers to receive medically necessary services unless the enrollee chooses a different cancer treatment provider. The bill would require a Medi-Cal managed care plan to notify all enrollees of their right to request a referral to access to care through any of those centers. This bill contains other related provisions.

- **SB 1019 (Gonzalez – D) Medi-Ca managed care plans: mental health benefits**
  - **Introduced:** 2/14/2022
  - **Status:** 9/30/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 879, Statues of 2022.
  - **Summary:** Current law requires a Medi-Cal managed care plan to provide mental health benefits covered in the state plan, excluding those benefits provided by county mental health plans under the Specialty Mental Health Services Waiver. Under current law, non-specialty mental health services covered by a Medi-Cal managed care plan include, among other things, individual and group mental health evaluation and treatment, psychological testing, and psychiatric consultation, as specified. This bill would require a Medi-Cal managed care plan, no later than January 1st, 2025, to conduct annual outreach and education for its enrollees based on a plan that the Medi-Cal managed care plan develops and submits to the State Department of Health Care Services, as specified, regarding the mental health benefits that are covered by the Medi-Cal managed care plan. The bill would require a Medi-Cal managed care plan to also conduct annual outreach and education, based on a plan that it develops, to inform primary care providers regarding those mental health benefits.

- **SB 1033 (Pan – D) Health care coverage**
  - **Introduced:** 2/15/2022
  - **Status:** 8/12/2022-Failed Deadline pursuant to Rule 61(b)(15). (Last location was APPR. SUSPENSE FILE on 8/10/2022)
  - **Summary:** Current law requires the Department of Managed Health Care and the commissioner to develop and adopt regulations establishing standards and requirements to provide enrollees and insureds with appropriate access to language assistance in obtaining health care services and covered benefits. Current law requires the Department of Managed Health Care and the Insurance Commissioner, in developing the regulations, to require health care service plans and health insurers to assess the linguistic needs of the enrollee and insured population and to provide for translation and interpretation for medical services, as indicated. Current law requires the regulations to include, among other things, requirements for conducting assessments of the enrollees and insured groups. This bill would require the Department of Managed Health Care and the commissioner to revise these regulations and develop and adopt regulations establishing demographic data collection standards no later than July 1st, 2024. The bill would require healthcare service plans and health insurers to assess the individual cultural, linguistic, and

health-related social needs of enrollees and insureds for the purpose of identifying and addressing health disparities, improving healthcare quality and outcomes, and addressing population health.

- **SB 1180 (Pan – D) Medi-Cal: time and distance standards for managed care services**
  - **Introduced:** 2/17/2022
  - **Status:** 8/31/2022-Failed Deadline pursuant to Rule 61(b)(18). (Last location was INACTIVE FILE on 8/25/2022)
  - **Summary:** Current law establishes, until January 1st, 2023, certain time and distance and appointment time standards for specified Medi-Cal managed care covered services, consistent with federal regulations relating to network adequacy standards, to ensure that those services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as specified. This bill would extend the operation of those standards to January 1st, 2026, and would require the department to seek input from stakeholders, as specified, prior to January 1st, 2025, to determine what changes are needed to these provisions.

- **SB 1184 (Cortese - D) Confidentiality of Medical Information Act: school-linked services coordinators**
  - **Introduced:** 2/17/2022
  - **Status:** 9/30/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 993, Statues of 2022.
  - **Summary:** The Confidentiality of Medical Information Act prohibits a provider of health care, a health care service plan, or a contractor from disclosing medical information, as defined, regarding a patient of the provider of health care or an enrollee or subscriber of the health care service plan without first obtaining an authorization, except as prescribed. The act authorizes a provider of health care or a health care service plan to disclose medical information in certain circumstances, including by authorizing disclosure to providers of health care, health care service plans, contractors, or other health care professionals or facilities for purposes of diagnosis or treatment of the patient. This bill would additionally authorize a provider of health care or a health care service plan to disclose medical information to a school-linked services coordinator, as prescribed.

- **SB 1207 (Portantino – D) Health care coverage: maternal and pandemic-related mental health conditions**
  - **Introduced:** 2/17/2022
  - **Status:** 9/27/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 618, Statues of 2022.
  - **Summary:** Would make findings and declarations relating to the effect of the COVID-19 pandemic on mental health in California and the importance of outreach, education, and access to quality mental health treatment. The bill would extend the deadline for the establishment of the maternal mental health program to July 1st, 2023. The bill would revise the requirements of the program to include quality measures to encourage screening, diagnosis, treatment, and referral. The bill also would encourage health care service plans, and health insurers to improve screening, treatment, and referral to maternal mental health services, including coverage for doulas, incentivize training opportunities for contracting obstetric providers and educate enrollees and insureds about the program. The bill would define “health care service plan” to include specified Medi-Cal managed health care plans, as specified, and would require those plans to continue to comply with any quality measures required or adopted by the State Department of Health Care Services, notwithstanding the requirements of the bill. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program.

- **SB 1298 (Ochoa Bogh - R) Behavioral Health Continuum Infrastructure Program**
    - **Introduced:** 2/18/2022
    - **Status:** 58/31/22 Failed Deadline pursuant to Rule 61(b)(18). (Last location was APPR. SUSPENSE FILE on 5/2/2022)
    - **Summary:** Current law authorizes the State Department of Health Care Services to, subject to an appropriation, establish a Behavioral Health Continuum Infrastructure Program. Current law authorizes the department, pursuant to this program, to award competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets or to invest in needed mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources to build or expand the capacity of various treatment and rehabilitation options for persons with behavioral health disorders, as specified. This bill would authorize the department, in awarding the above-described grants, to give preference to qualified entities that intend to place their projects in specified facilities or properties.

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

- **SB 1379 (Ochoa Bogh - R) Pharmacy: remote services**
    - **Introduced:** 2/18/2022
    - **Status:** 4/29/2022 Failed Deadline pursuant to Rule 61(b)(5). (Last location was B., P. & E.D. on 3/9/2022)
    - **Summary:** The Controlled Substances Act regulates, among other matters, the dispensing by prescription of controlled substances, which are classified into schedules, and the Pharmacy Law regulates, among other matters, the dispensing by prescription of dangerous drugs and dangerous devices, which also include controlled substances. Current law authorizes a prescriber, a prescriber's authorized agent, or a pharmacist to electronically enter a prescription or order from outside of a pharmacy or hospital, as specified, except for prescriptions for controlled substances classified in Schedules II, III, IV, or V. Under current law, a violation of these provisions is a crime. This bill would extend the authority to remotely enter a prescription or order to include prescriptions for controlled substances classified in Schedules II, III, IV, or V. The bill would also authorize a pharmacist to perform various services remotely, as specified, on behalf of a pharmacy located in California and under the written authorization of a pharmacist-in-charge.

SB 184 – Health Trailer Bill Summary

Addendum to 2022 Legislative Tracking List
10/10/22

SB 184 is an omnibus health trailer bill that makes statutory revisions affecting health programs necessary to implement the Budget Act of 2022.

This bill was signed by the Governor and chaptered by the Secretary of State on June 30th, 2022. The following summary highlights items included in the bill.

California Premium Subsidy Program (Covered California)

Eliminates programs' sunset of January 1st, 2023 and extends indefinitely a program of health care coverage financial assistance to help low-income and middle-income Californians, and permanently exempts the program from the requirements of the Administrative Procedure Act.

Office of Health Care Affordability

Establishes the Office of Health Care Affordability to analyze the healthcare market for cost trends and drivers of spending to develop data-informed policies with the goal of lowering healthcare costs and providing affordable health care to Californians. Also establishes the Health Care Affordability Board, composed of 8 members, appointed as prescribed, and the Health Care Affordability Advisory Committee.

Commencing in 2026 will require the office to take progressive actions against healthcare entities for failing to meet the cost targets, including performance improvement plans and escalating administrative penalties. Will establish the Health Care Affordability Fund for the purpose of receiving and, upon appropriation by the Legislature, expending revenues collected pursuant to the provisions of the bill.

Will require healthcare service plans and health insurers, in submitting rates for review, to demonstrate the impact of any changes in the rate of growth of healthcare costs resulting from the health care cost targets. Because a willful violation of the bill's requirements relative to healthcare service plans would be a crime, the bill will impose a state-mandated local program.

Medi-Cal Expansion for individuals between 26 to 49 years old regardless of immigration status

Extends Medi-Cal eligibility for full scope Medi-Cal benefits to individuals 26 to 49 years of age, inclusive, and who do not have satisfactory immigrant status if they are otherwise eligible for those benefits. The bill will make the expansion no later than January 1st, 2024.

Will require the eligibility and enrollment plan to enable, to the maximum extent possible, as determined by the DHCS, an individual to maintain their primary care provider or medical home. The bill will require the DHCS to work with counties, Medi-Cal managed care health plans, health care providers, and consumer advocations, among others, to identify and maintain such linkage.

Reform Medi-Cal Share of Cost in 2025

The budget puts a placeholder for a future allocation (January 2025) to reform the Medi-Cal Share of Cost programs maintenance need income level to 138% of the federal poverty level for individuals who are 65 years of age or older or are disabled. This change will mean that fewer older and disabled adults will have to spend 60% of their income on healthcare before they can access Medi-Cal coverage.

Continuous Medi-Cal Coverage for Children

Establishes that a child under five years of age shall be continuously eligible for Medi-Cal, including without regard to income until the child reaches five years of age. Will prohibit the redetermination of Medi-Cal eligibility before the child reaches 5 years of age, unless the family has requested the child's voluntary disenrollment, the child is deceased, the child is no longer a state resident, or the child's original enrollment was based on a state or county error. It will require the DHCS to implement those provisions on January 1st, 2025.

Expansion of Medi-Cal Benefit to Pregnant Women

Expands the scope of Medi-Cal benefits to pregnant individuals to full-scope benefits for individuals with an effective income between 138 and 213 percent of the federal poverty level (FPL), effective January 1st, 2024.

Premiums for Low-Income Children and Disabled People

Authorizes the DHCS, effective July 1st, 2022, to elect not to impose Medi-Cal premiums, or subscriber contributions, on select beneficiaries, with household incomes between 160 and 261 percent of the federal poverty level, within specified programs within the Medi-Cal program, including low-income children, Medi-Cal Access program, and employed individuals with disabilities

Discontinue CHDP

Requires DHCS to discontinue the Child Health and Disability Prevention (CHDP) Program, as of July 1st, 2024, and transition CHDP services to other Medi-Cal services or programs. All qualified providers enrolled in the CHDP Program will be automatically enrolled as providers under the Children's Presumptive Eligibility Program on July 1st, 2024. It will require the DHCS, to take steps, including developing a transition plan to transition the CHDP Program, conducting a stakeholder engagement process to inform the DHCS in the development and implementation of the transition plan, and requiring the DHCS to seek federal approval to implement the transition plan. It will make the CHDP Program inoperative on July 1st, 2024.

Healthy Families Program

Beginning January 1st, 2025, or on a date certified by the DHCS as specified, will require that a child be continuously eligible for the Healthy Families Program up to five years of age. The bill will delete obsolete provisions relating to the former Healthy Families Program and the former Managed Risk Medical Insurance Board, and will make technical, non-substantive changes.

Medi-Cal Redeterminations Forms

Deletes certain requirements related to re-determining eligibility of Medi-Cal beneficiaries to align with federal guidelines, including the requirement on counties to prepopulate the redetermination form (if additional information is needed to complete redetermination), and the requirement on beneficiaries to sign or return the form. Also, requires the DHCS to develop future revisions to the form.

Clinical Trials

Expands, effective July 1st, 2022, the routine patient care coverage requirements for qualifying clinical cancer trials for purposes of the Medi-Cal program, to conform to the federal Medicaid definition of a qualifying clinical trial. Requires treatment to be provided in a qualifying clinical trial, which means a clinical trial, in any clinical phase of development, that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition.

Medi-Cal Telehealth Policy

Does not require face-to-face contact when covered Medi-Cal services are provided by video

synchronous interaction, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities. Requires providers offering these services to also offer services through in-person, face-to-face contact or arrange for a referral to in-person care. Authorizes and limits a provider establishing a new patient relationship with the Medi-Cal beneficiary through telehealth, to use video synchronous interaction only.

Expands the definition of a “visit” for FQHCs and RHCs to include specified telehealth modalities when applicable conditions and standards of care are met.

Authorizes reimbursement for additional medically necessary Drug Medi-Cal services to authorized individuals through video synchronous interaction or audio-only synchronous interaction. Requires the DHCS to adopt regulations by July 1st, 2024, to implement telehealth provisions specific to Drug Medi-Cal.

Extends time and distance standards for specified services from January 1st, 2023, to January 1st, 2026. Authorizes managed care plans to use video synchronous interaction to demonstrate compliance of time and distance standards as part of an alternate access standards requests. Changes the frequency of alternative access standards request submissions made by managed care plans.

MLR

Applies the 85 percent medical loss ratio (MLR) requirement, to subcontracting Medi-Cal MCMC, effective July 1st, 2022, by repealing the exemption for subcontracting MCMC plans in existing law.

Extends the requirement that DHCS post the MLR of each MCMC plan to also include posting the MLR of each subcontractor plan or other delegated entity, under contract with the MCMC plan, that is required to report an MLR pursuant to the CalAIM Terms and Conditions.

Extends the remittance requirement, which is the amount owed by each MCMC plan for failure to meet the 85 percent MLR, to each subcontractor plan or other delegated entity to that MCMC care plan pursuant to the CalAIM Terms and Conditions.

Deletes the exemption from the MLR remittance requirement in existing law for Denti-Cal managed care plans, effective January 1st, 2024, thereby applying the remittance requirement to these plans

FQHC Alternative Payment

Makes various changes to the Medi-Cal alternative payment methodology (APM) for FQHCs, with implementation of new provisions under the existing APM pilot project to begin no sooner than January 1st, 2024, subject to any necessary federal approvals, and no longer limited to a period of up to three years.

Children and Youth Behavioral Health Initiative

Expands the purposes of the Behavioral Health Quality Improvement Program, which provides grants to Medi-Cal behavioral health delivery systems for the purpose of preparing those entities and their contracting providers for implementation of the CalAIM changes and broadens the purpose to being “other purposes related to Medi-Cal behavioral health delivery systems as specified in an annual Budget Act or enacted legislation providing appropriations related to those acts.”

CalAIM – Long Term Care

Requires the DHCS, starting July 1st, 2023, and subject to CalAIM implementation, to include or continue to include institutional long-term care services (other than skilled nursing facility services), as capitated benefits in the comprehensive risk contract with each Medi-Cal managed care plan, as specified.

CalAIM – CS

Renames “in lieu of services” as “community supports” and defines “community supports” as those alternative services and settings approved in the CalAIM Terms and Conditions that are administered pursuant to federal Medicaid managed care regulation; community supports are services that Medi-Cal managed care plans are authorized to offer as an optional benefit for Medi-Cal beneficiaries in plans that are “in lieu of” a covered Medi-Cal service.

CalAIM – Suspension of Medi-Cal Benefits for Incarcerated Individuals

Suspends an adult’s Medi-Cal benefits on the date the adult becomes an inmate of a public institution, consistent with current law, and ends the suspension of those benefits on the date that the individual is no longer an inmate of a public institution, if otherwise eligible, effective January 1st, 2023. Expands eligibility for a qualifying inmate of a public institution to receive targeted Medi-Cal services for 90 days, or the number of days approved in the CalAIM Terms and Conditions if fewer than 90 days, before the date they are released from a public institution.

Specialty Mental Health Program

Will authorize the DHCS, as a component of the Specialty Mental Health Program, to seek federal approval for a demonstration project to receive federal financial participation for services furnished to Medi-Cal beneficiaries during short-term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as institutions for mental diseases, as defined.

Specialty Mental Health Facility Written Record

Deletes the requirement that a specialty mental health facility’s written record, of a voluntarily admitted patient’s consent to receive antipsychotic medications, include the patient’s signature.

Presumptive Eligibility Rule

Authorizes qualified hospitals to make presumptive eligibility determinations for individuals who are 65 years of age or older, blind, or disabled, who meet certain income criteria.

Record Retention Requirement

Extends the length of time, from three to ten years, for which every primary supplier of pharmaceuticals, medical equipment, or supplies is required to maintain accounting records subject to audit by the DHCS.

Intermediate Care Reimbursement Rate

Continues the current Medi-Cal reimbursement rate for intermediate care facilities for the developmentally disabled or facilities providing continuous skilled nursing care to developmentally disabled individuals for dates of services on or after August 21st, 2021st, including Prop 56 supplemental payments and increased payments associated with the COVID-19 Public Health Emergency.

Dental Managed Care

Will require the DHCS to conduct a competitive bid and procurement process to award new dental managed care contracts, commencing January 1st, 2024, as specified. Extends the existing dental managed care contracts through December 31st, 2023, or through the calendar day immediately preceding the effective date of the new contracts, whichever is later. Requires, if the new dental managed care contracts have not taken effect on or before July 1st, 2024, the DHCS to provide an update to the Legislature detailing the specific circumstances that contributed to the delay and an expected commencement date for the new contracts.

Medi-Cal Reimbursement Reduction Exemptions

Exempts the following providers from 10 percent Medi-Cal reimbursement reductions that took effect June 1st, 2011: nurses, alternative birth centers, audiologists, hearing aid dispensers, respiratory care providers, durable medical equipment, chronic dialysis clinics, emergency medical air transportation services, nonemergency medical transportation services, doula services, community health worker services, durable medical equipment, health care services delivered via remote patient monitoring, asthma prevention services, dyadic services, clinical laboratory services, medication therapy management services, blood banks, occupational therapists, orthotists, podiatrists and prosthetists, psychologists, medical social workers, speech pathologists, free clinics, outpatient heroin detoxification centers, dispensing opticians, optometrists and optometry groups, acupuncturists, portable imagine services, California Children's Services and Genetically Handicapped Persons Program services, and community clinics, free clinics, surgical clinics, rehabilitation clinics, and non-hospital county-operated community clinics.

Oxygen and Respiratory Equipment

Effective July 1st, 2022, requires that Medi-Cal reimbursement for oxygen and respiratory equipment, as determined by the DHCS, not exceed 100 percent of the lowest maximum allowance for California established by the federal Medicare Program for the same.

Continuous Glucose Monitors Reimbursement

Amends the definition of medical supplies under the Medi-Cal pharmacy benefit to be inclusive of diabetic products, allowing for the implementation of a revised reimbursement methodology for continuous glucose monitoring, from the current estimated acquisition cost, plus the pharmacy professional dispensing fee, to a Maximum Acquisition Cost plus 23 percent, starting July 1st, 2022.

COVID-19-Vaccine

Requires the DHCS to reimburse the administration of a COVID-19 vaccine at 100% of the Medicare national equivalent rate in effect at the time of administration without geographic adjustment.

Drug Medi-Cal Treatment Program

Expands reimbursement for other medically necessary Drug Medi-Cal services and to other authorized individuals, as specified, when those services are delivered through video synchronous interaction or audio-only synchronous interaction. Also, sets certain requirements relating to privacy and security compliance and the establishment of new patient relationships through telehealth modalities. Requires the DHCS to adopt regulations by July 1st, 2024, to implement these provisions.

Medication Assisted Treatment

Requires alcohol and other drug programs and alcoholism or drug abuse recovery or treatment facilities to either offer medications for addiction treatment (MAT) directly to clients or have an effective referral process in place with narcotic treatment programs, community health centers, or other MAT providers.

Requires the DHCS to establish a program for the operation and regulation of mobile narcotic treatment programs. Requires those programs to meet specified requirements, including that they operate under the license of a primary narcotic treatment program and receive approval from the DHCS before operating a mobile narcotic treatment program.

Community-based Mobile Crisis Intervention Services

Requires the DHCS to seek federal approval to provide qualifying community-based mobile crisis intervention services to eligible Medi-Cal beneficiaries experiencing a mental health or substance use disorder crisis. Services will be available exclusively through a Medi-Cal behavioral health delivery system and require the DHCS to establish requirements for the receipt of the services by eligible Medi-Cal

beneficiaries and for authorized service providers and to oversee and enforce the requirements and guidelines. These provisions will be implemented no sooner than January 1st, 2023, up to the end of the 5-year period specified under federal law.

Incompetent to Stand Trial Solutions
Revises the roles of a licensed psychologist or psychiatrist in the process of determining a defendant's mental competency to stand trial.

Requires, effective July 1st, 2023, that a mentally incompetent defendant first be considered for placement in an outpatient treatment program, a community treatment program, or a diversion program, if available, unless the court finds that the clinical needs of the defendant, or the risk to community safety, warrant placement in a State Hospital.

Revises the requirement that a court, prior to ordering a defendant to be committed to a treatment facility, hear and determine whether the defendant lacks the capacity to make decisions regarding the administration of antipsychotic medication and increases documentation.

Will authorize a court to order the involuntary administration of antipsychotic medication based upon a reevaluation, as specified. Will also require local county jails to cooperate with evaluators, as specified. It will authorize the State Department of State Hospitals to contract for medical, evaluation, and other services for felony defendants in county jail deemed incompetent to stand trial.

Repeals the authorization for the administration of antipsychotic medications in a county jail. Authorizes DSH to contract for medical, evaluation, and other services for felony defendants in county jail deemed incompetent to stand trial. Authorizes DSH to conduct reevaluations of those defendants awaiting admission any time after the commitment has been ordered. Authorizes a court to order the involuntary administration of antipsychotic medication based upon a reevaluation. Requires local county jails to cooperate with evaluators.

Requires DSH to implement a cap on the number of mentally incompetent persons committed to State Hospitals in each county per year and assess a penalty rate for commitments exceeding that cap.

Until June 30th, 2026, establishes a statewide panel of independent evaluators, as specified, to identify and evaluate state hospital patients that are appropriate for participation in the Forensic Conditional Release Program.

Mental Health Services Oversight and Accountability Commission
Will authorize the authority and the commission to use sole source contracting processes to increase capacity for services within the Investment in Mental Health Wellness Act of 2013. Expands the types of entities that qualify for these grants from just county and city health departments to also include other local government agencies, community-based organizations, health care providers, hospitals, health systems, childcare providers, and other entities.

Sexually Transmitted Diseases
Modifies the requirement that at least 50 percent of funds allocated to local health jurisdictions be provided to community base organizations or non-profit health care providers, to now require those funds to be allocated to, "or be used to support activities in partnership with," community-based organizations, or non-profit health care providers.

Expands innovative and impactful prevention and control activities to also include Integrated services for STIs, viral hepatitis, HIV, and drug overdose, to the extent they improve health outcomes for people living with, or at risk for, STIs. Material support, including, but not limited to, sleeping bags, tarps, shelter, clothing items, and hygiene kits, to people living with, or at risk for STIs.

Allows CDPH to use funds to support capacity building assistance for purposes consistent with this section, including integrated services for STIs, viral hepatitis, HIV, and drug overdose to the extent they improve health outcomes for people living with, or at risk for, STIs.

Opioid Settlement Fund

Establishes the Opioid Settlement Fund, to be administered by the State Treasury. Will require the moneys in the fund to be used for opioid remediation in accordance with the terms of the judgment or settlement from which the funds were received.

Department of State Hospitals – Cost of Care

Requires DSH to develop and implement a financial assistance program that may reduce or cancel the amount that a patient owes for the cost of care and treatment at a state hospital and to make its financial assistance program policy available to the public on DSH’s internet website. Authorizes DSH to develop reasonable payment plans suitable to the patient’s ability to pay. Deletes certain statutory provisions.

California Health Workforce Education and Training Council

Revises various provisions related to the establishment of the council, including adding the Secretary of Labor and Workforce Development onto the council.

Department of Health Care Access and Information (HCAI)

Will require the director of HCAI to develop application and contract criteria based on health care workforce needs and priorities and add programs that train midwives to the list of programs eligible to contract with the state under the Song-Brown Health Care Workforce Training Act.

Will establish the Abortion Practical Support Fund and require HCAI to administer the fund for the purpose of providing grants to nonprofit organizations that either specialize in assisting pregnant people who are low income, or who face other financial barriers, with direct practical support services to access and obtain an abortion or that provide abortion services to those persons.

Will require HCAI, on or before July 1st, 2023, to develop and approve statewide requirements for community health worker certificate programs and to approve the curriculum required for programs to certify community health workers.

Will require the DHCS, subject to appropriation by the Legislature, to provide funding to specified employers for retention payments to their eligible employees or physicians for the public purpose of promoting stability and retention in California’s health care workforce.

Support for Vital Public Health Services

Requires the CDPH to develop and implement a program to fund and support vital public health activities and services provided by local health jurisdictions. Each local health jurisdiction will be required to submit a public health plan to CDPH, and that it be informed by the most recent community health assessment, community health improvement plan, or strategic plan, and shall include proposed evaluation methods and metrics.

Will require the State Public Health Officer, on or before February 1st of every other year, to submit a report to the Governor and Legislature on the state of public health in California and require the report to include,

among other things, data on the prevalence of morbidity and mortality related to mental illness and substance abuse. Local health jurisdictions will be required to present annual updates on the public health status to the city council or board of supervisors, including an update on the progress addressing these issues through the strategies and programs identified by the local health jurisdiction.

Public Health Nursing in Child Welfare Services Program

Shifts responsibility for seeking federal financial participation from the Department of Social Services to the DHCS, for a public health nursing program within child welfare services, and requires the DHCS, counties, and cities to maximize the use of federal funds in implementing this program.

California Affordable Drug Manufacturing Act of 2020

For purposes of implementing the California Affordable Drug Manufacturing Act of 2020, this bill will authorize CHHSA or its departments to enter exclusive or nonexclusive contracts on a bid or negotiated basis and exempt these contracts from review or approval by the Department of General Services until December 31st, 2027, as specified. Will extend the deadline for the report describing the status of the drugs targeted for manufacture and the related impacts until December 31st, 2022 and will extend the deadline for the report assessing the feasibility of directly manufacturing generic prescription drugs until December 31st, 2023. Will additionally exempt all nonpublic information and documents prepared under the California Affordable Drug Manufacturing Act of 2020 from disclosure under the California Public Records Act.

Suicide Prevention Contribution

Shifts revenue collected through the Suicide Prevention Voluntary Tax Contribution Fund from the Mental Health Services Oversight and Accountability Commission to the DHCS. Eliminates the requirement that 50 percent of these funds be awarded as grants to provide suicide prevention services to rural and desert communities and that 50 percent of the funds be disbursed on a proportional basis to crisis centers based on the number of calls answered by the crisis centers. Requires these funds to be disbursed to crisis centers located in the state that are active members of the National Suicide Prevention Lifeline, with priority given to those crisis centers located in rural and desert communities.

California Health Facilities Financing Authority Act

Will change the definition of “working capital” to include 2 years’ worth of interest on any loan for working capital. The bill will also extend the time for a participating health institution that is a private nonprofit corporation or association to repay and discharge a loan for working capital to 24 months.

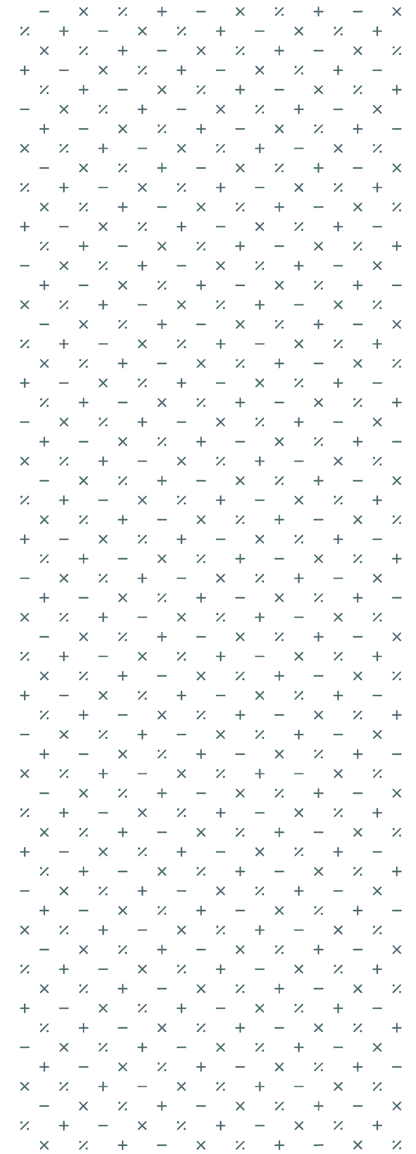
Board Business

Finance

Gil Riojas

Moss Adams

2022 Alliance Audit Results



2022 Audit Results: Alameda Alliance for Health

Rianne Suico
Health Care and Insurance Services Partner

Chris Pritchard
Health Care and Insurance Services Partner

2022 Audit Objectives

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

- Consideration of internal controls and compliance.

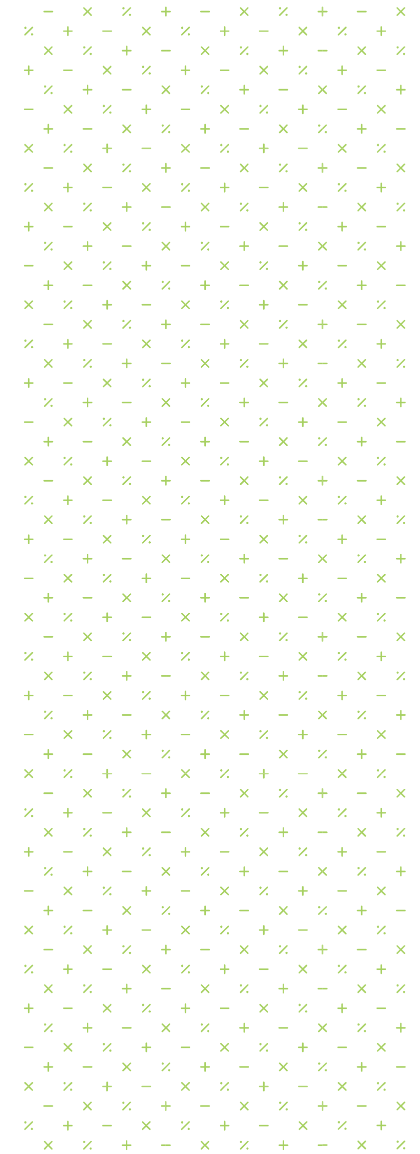
Report of Independent Auditors

Unmodified Opinion

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

MOSSADAMS

Combined Statements of Net Positions



Assets and Deferred Outflows of Resources Composition (in thousands)

	2020 = $546,486	2021 = $457,494	2022 = $566,963
Cash and cash equivalents	40,706	37,087	12,246
Premiums receivable	242,555	123,244	188,674
Investments	238,969	263,948	330,234
Reinsurance recoveries receivable/other receivables/prepaid expenses/restricted cash/lease assets/net pension asset/deferred outflows of resources	14,244	26,943	30,136
Capital assets, net	10,012	6,272	5,673

$350,000
$300,000
$250,000
$200,000
$150,000
$100,000
$50,000
$0

4

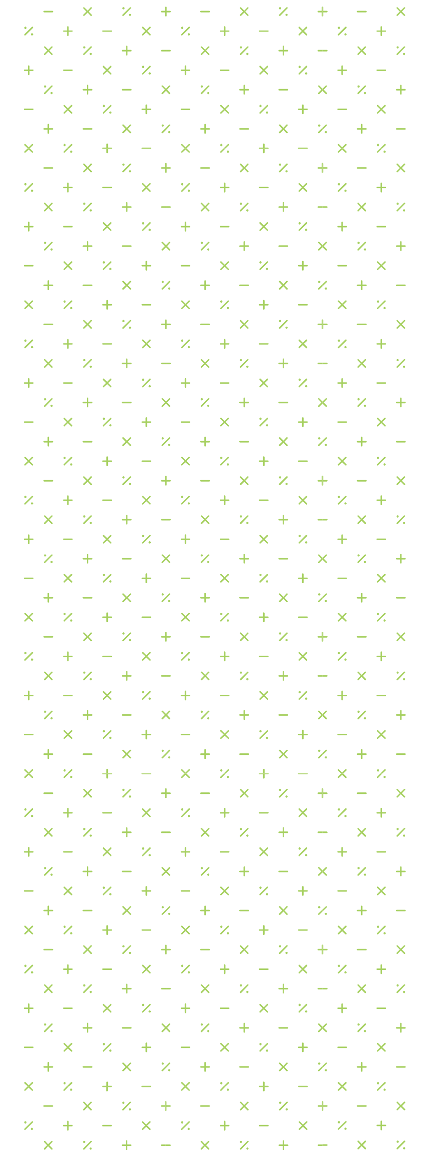
Liabilities, Deferred Inflows of Resources and Net Position Balance (in thousands)

	2020 = $546,486	2021 = $457,494	2022 = $566,963
Accounts payable and accrued expenses//net pension liability/lease liabilities/deferred inflows of resources/other liabilities	23,223	25,146	23,744
Claims payable	88,696	132,105	121,862
Payable to other governmental agencies and hospital fee payable	228,392	94,833	190,733
Net position	206,175	205,410	230,624

$250,000
$200,000
$150,000
$100,000
$50,000
$0

MOSSADAMS

Operations



Operating Expenses (in thousands)

June 30, 2022
$1,294,271

- 84% Medical services
- 5% Marketing, general, and administrative expenses
- 1% Depreciation and amortization expense
- 10% Premium tax

June 30, 2021
$1,193,599

- 85% Medical services
- 4% Marketing, general, and administrative expenses
- 1% Depreciation and amortization expense
- 10% Premium tax

June 30, 2020
$994,634

- 88% Medical services
- 6% Marketing, general, and administrative expenses
- 1% Depreciation and amortization expense
- 5% Premium tax

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

$120,000
$100,000
$80,000
$60,000
$40,000
$20,000
$0

2017 2018 2019 2020 2021

Estimated Claims Liability* — Actual Claims Liability*

8

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

Source: Alliance's internal reports

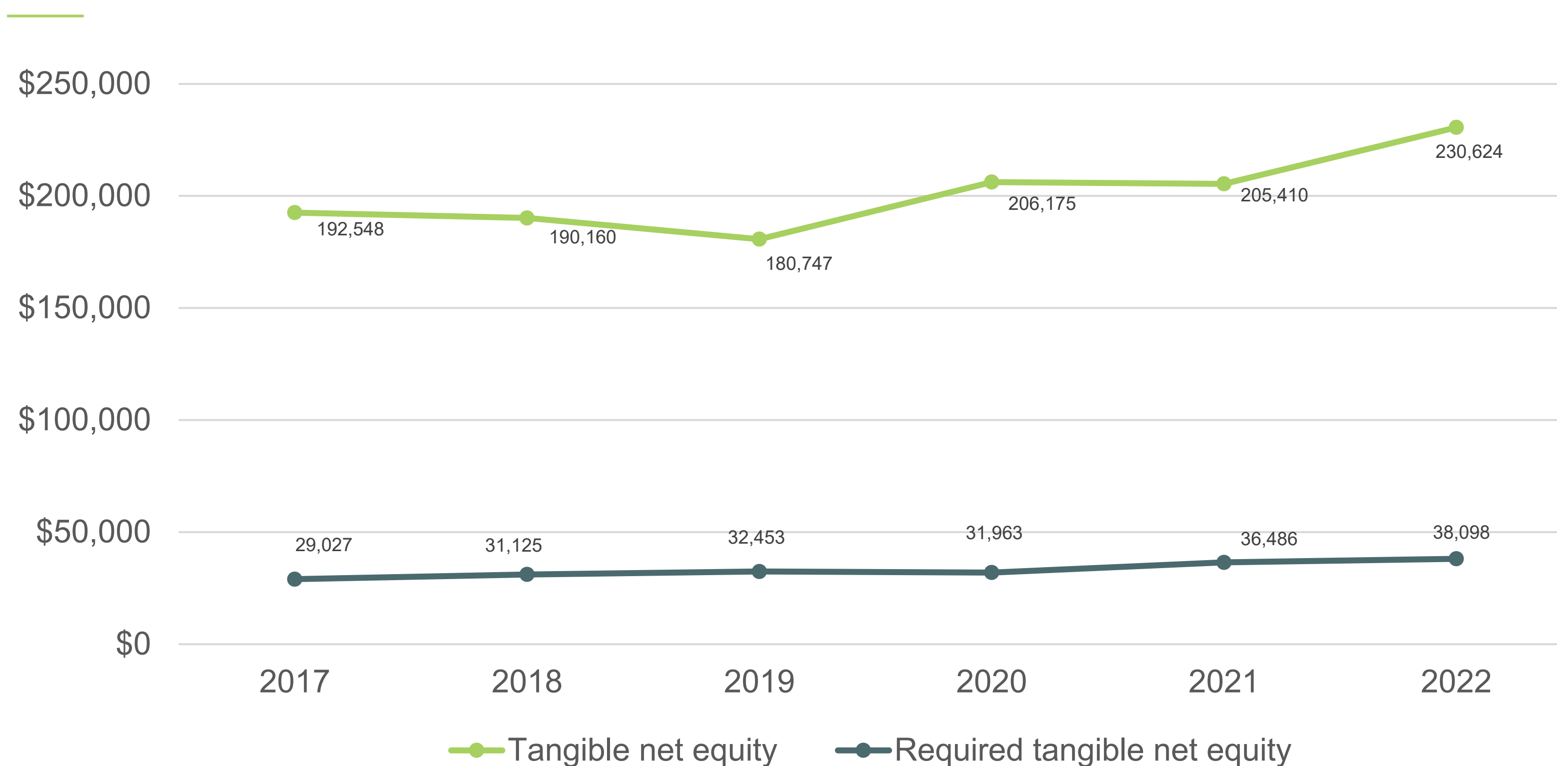
Historic Actual Claims Liability* as a % of Capitation and Premium Revenues

Year	Actual Claims Liability as % of Capitation and Premium Revenues
2017	9.30%
2018	8.22%
2019	7.77%
2020	7.79%
2021	7.13%

* Actual claims liability excludes non-hospital claims.

Source: Alliance's internal reports

Tangible Net Equity (in thousands)



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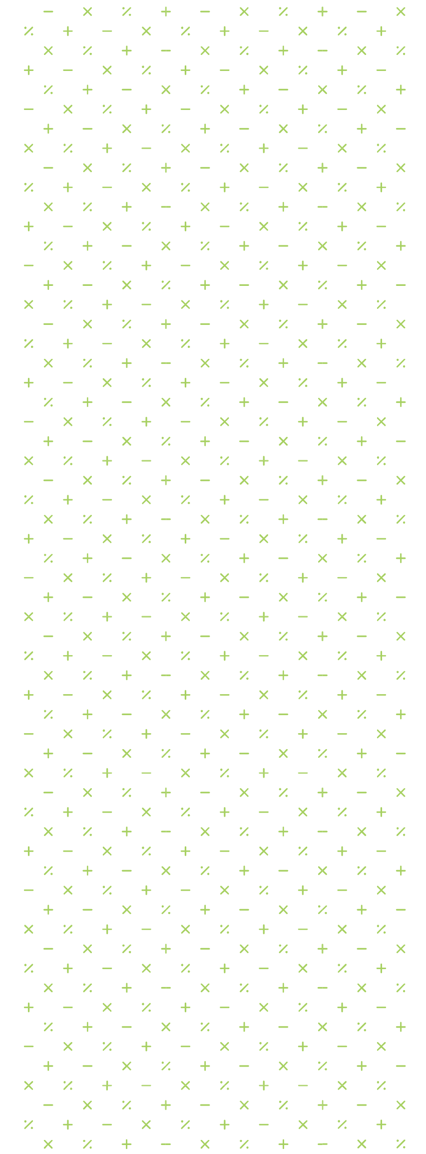
Source: Annual Department of Managed Health Care Filing

Important Board Communications

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

Questions?



Finance Committee Report

For the month of

June 2022

To: Alameda Alliance for Health Board of Governors

From: Gil Riojas, Chief Financial Officer

Date: October 14th, 2022u

Subject: Finance Report – June 2022

Executive Summary

- For the month ended June 30th, 2022, the Alliance had enrollment of 313,056 members, a Net Income of $3.3 million and 601% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$96,461	$1,186,885
Medical Expense	87,572	1,098,118
Admin. Expense	5,445	64,534
Other Inc. / (Exp.)	(112)	(558)
Net Income	**$3,332**	**$23,675**

Net Income by Program:

	Month	YTD
Medi-Cal	$3,969	$25,250
Group Care	(637)	(1,575)
	$3,332	**$23,675**

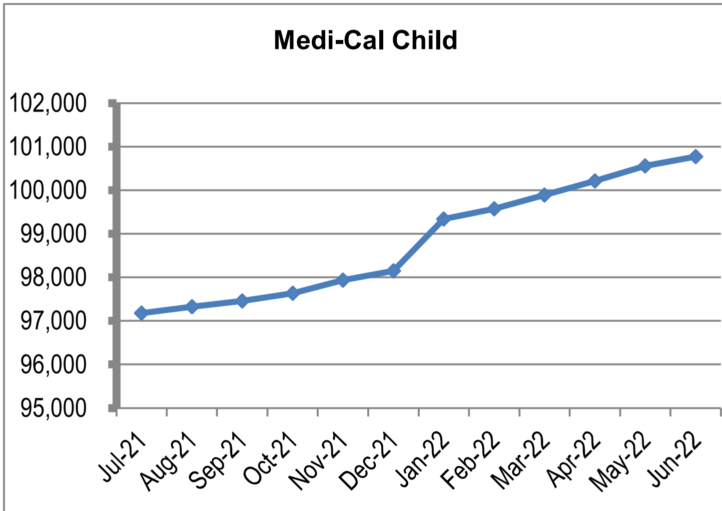
Enrollment

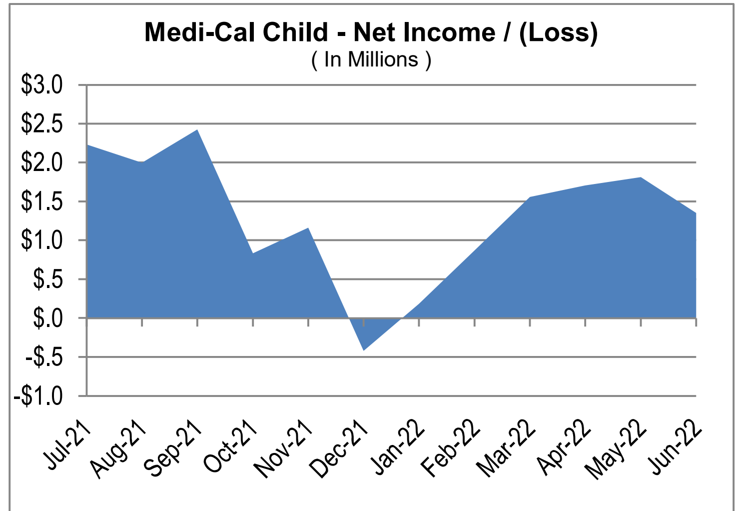
- Total enrollment increased by 2,298 members since May 2022.
- Total enrollment increased by 24,502 members since June 2021.
- Higher enrollment compared to Budget is due to the extension of the Public Health Emergency.

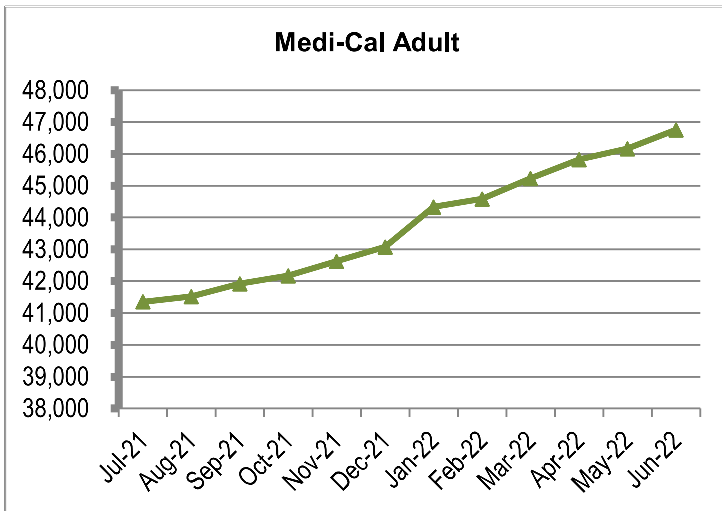
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

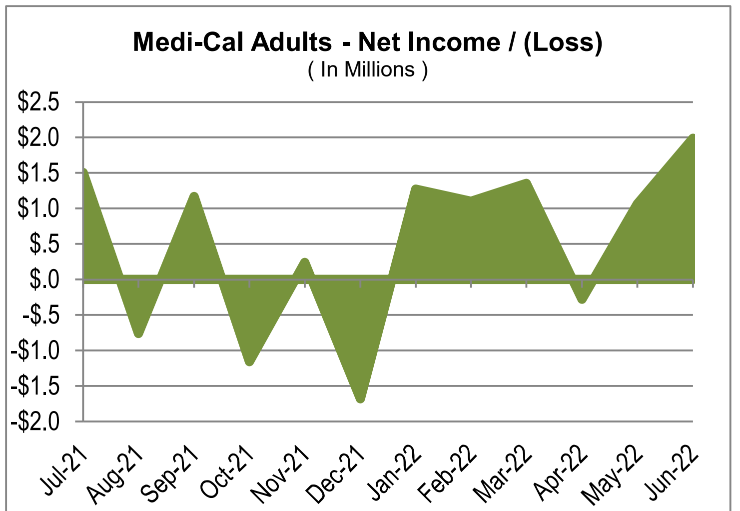
Enrollment June-2022 Actual	Budget	Variance	Variance %		Member Months Year-to-Date Actual	Budget	Variance	Variance %
				Medi-Cal:				
46,761	41,076	5,685	13.8%	Adult	525,591	504,754	20,837	4.1%
100,772	94,811	5,961	6.3%	Child	1,186,030	1,168,536	17,494	1.5%
27,105	26,745	360	1.3%	SPD	319,248	316,311	2,937	0.9%
21,685	19,776	1,909	9.7%	Duals	251,996	245,360	6,636	2.7%
110,938	103,436	7,502	7.3%	ACA OE	1,253,315	1,212,389	40,926	3.4%
307,261	**285,844**	**21,417**	**7.5%**	**Medi-Cal Total**	**3,536,180**	**3,447,350**	**88,830**	**2.6%**
5,795	5,852	(57)	-1.0%	Group Care	70,191	70,433	(242)	-0.3%
313,056	**291,696**	**21,360**	**7.3%**	**Total**	**3,606,371**	**3,517,783**	**88,588**	**2.5%**

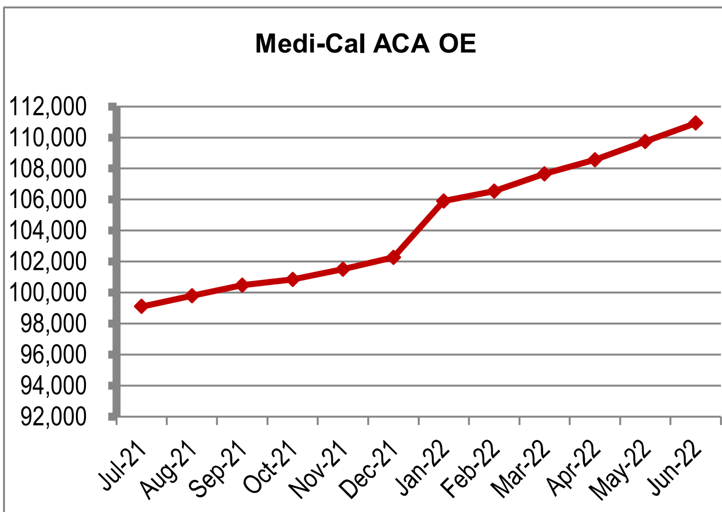
Enrollment and Profitability by Program and Category of Aid

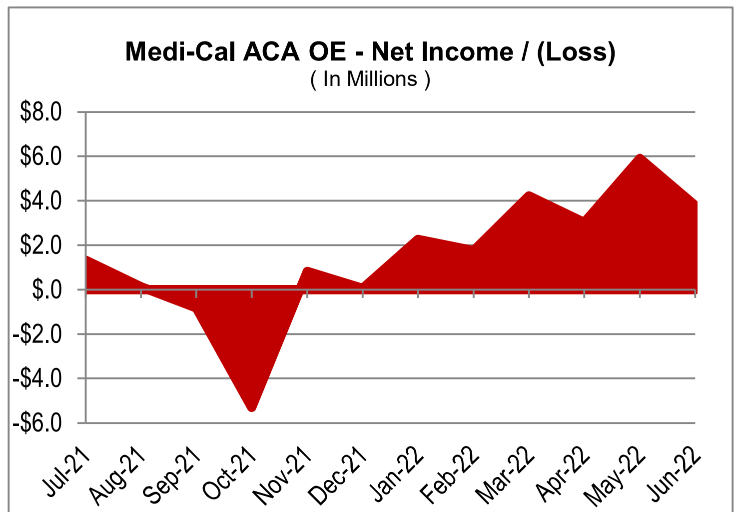




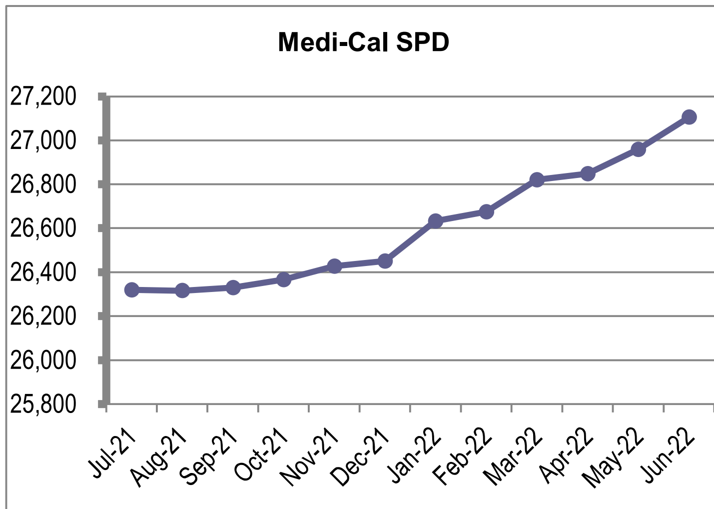


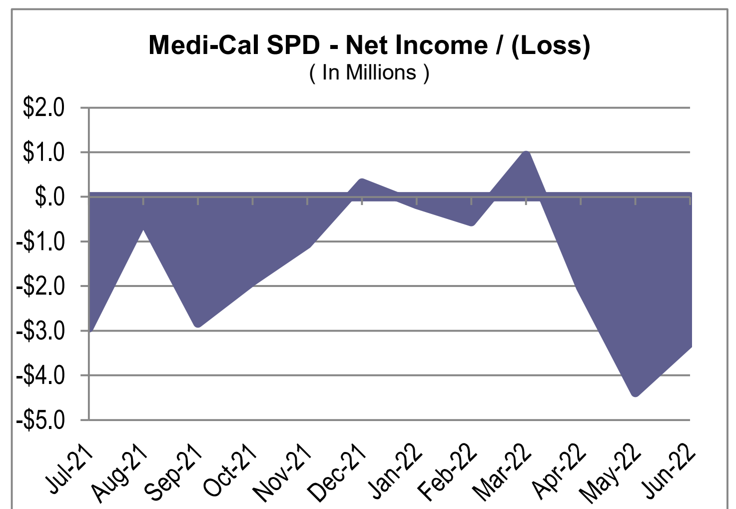


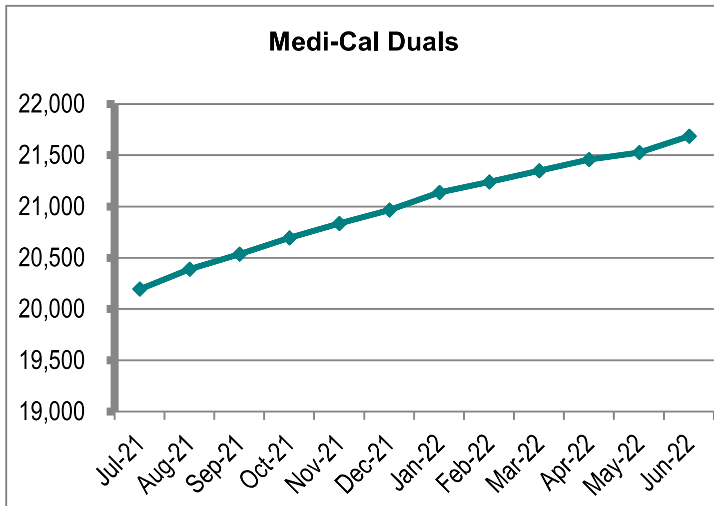


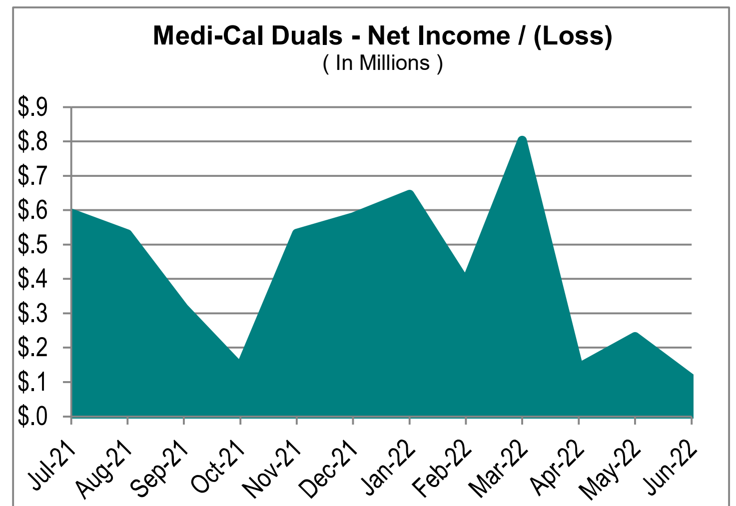


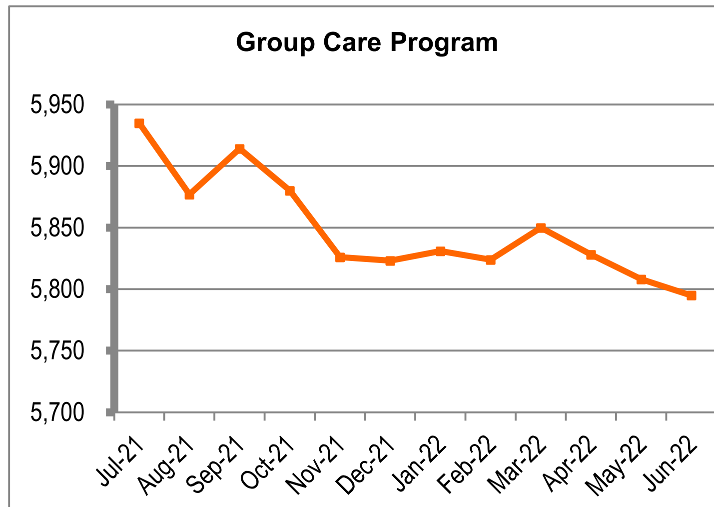
Enrollment and Profitability by Program and Category of Aid

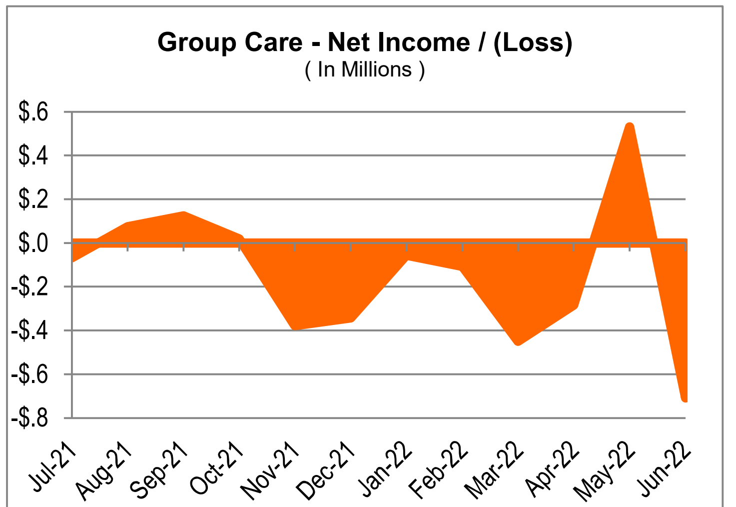




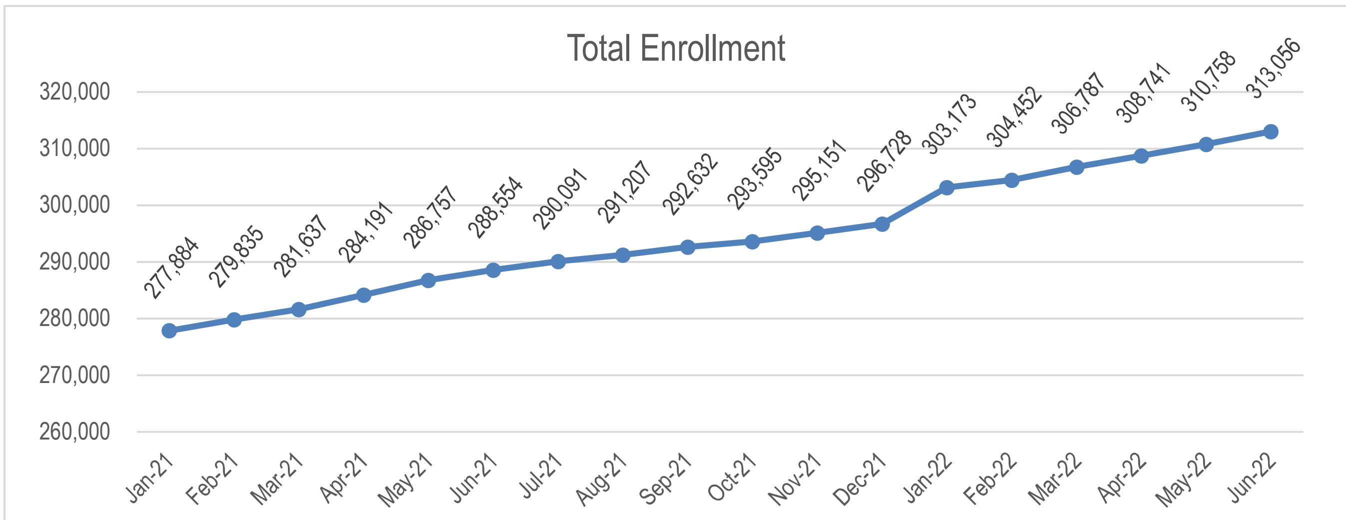


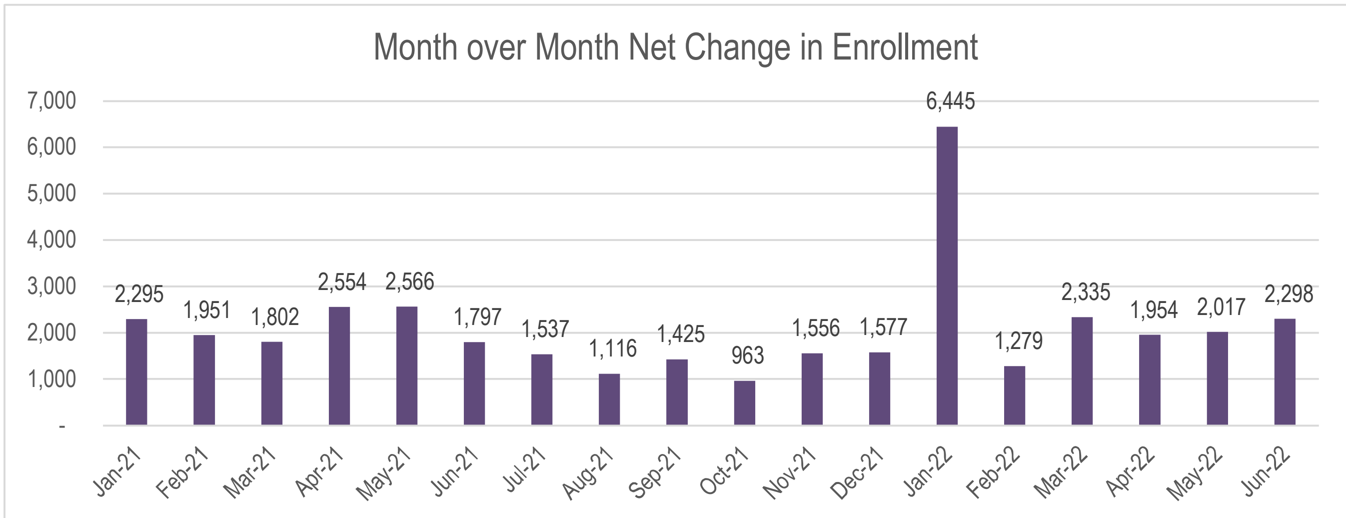






Net Change in Enrollment



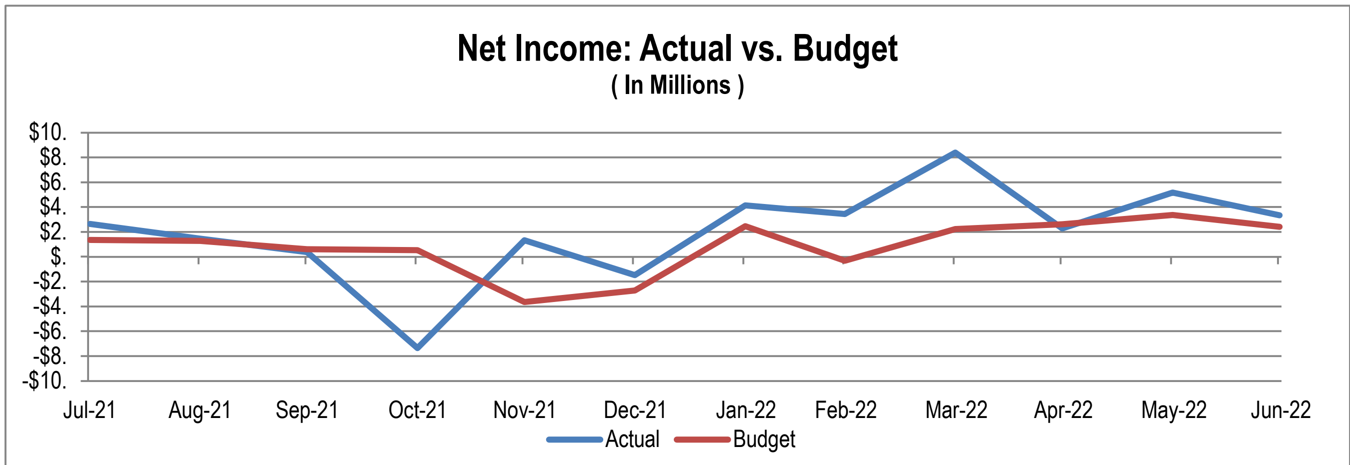


- The Public Health Emergency (PHE) is currently expected to be extended through October 2022.

<u>Net Income</u>

- For the month ended June 30th, 2022:
  - Actual Net Income: $3.3 million.
  - Budgeted Net Income: $2.4 million.

- For the fiscal YTD ended June 30th, 2022:
  - Actual Net Income: $23.7 million.
  - Budgeted Net Income: $3.5 million.

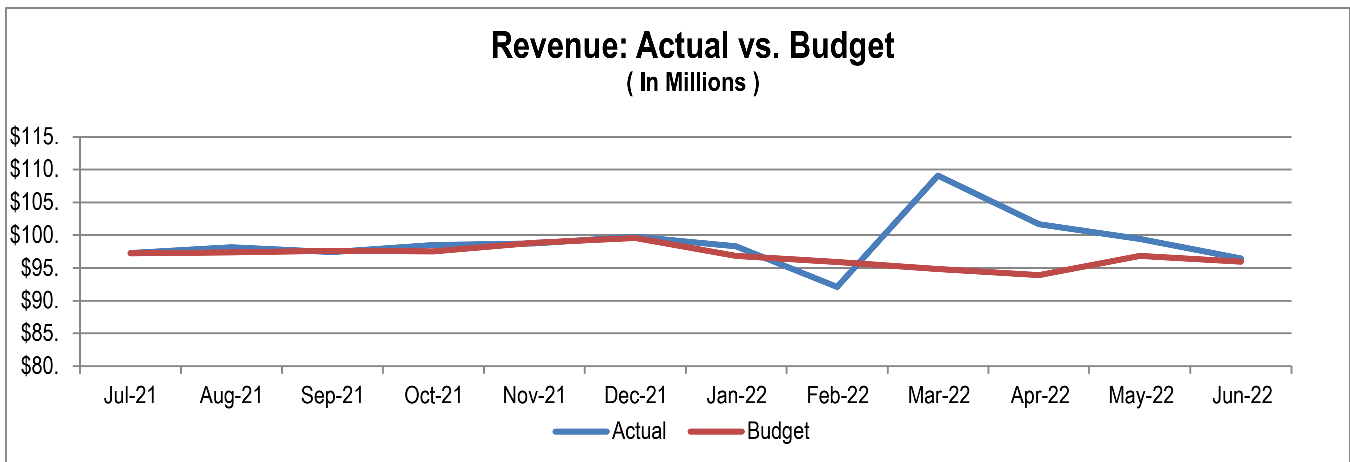


- The favorable variance of $932,000 in the current month is primarily due to:
  - Favorable $530,000 higher than anticipated Revenue.
  - Unfavorable $1.5 million higher than anticipated Medical Expense.
  - Favorable $2.0 million lower than anticipated Administrative Expense.
  - Unfavorable $121,000 lower than anticipated Total Other Income.

Revenue

- For the month ended June 30th, 2022:
  - Actual Revenue: $96.5 million.
  - Budgeted Revenue: $95.9 million.

- For the fiscal YTD ended June 30th, 2022:
  - Actual Revenue: $1.2 billion.
  - Budgeted Revenue: $1.2 billion.

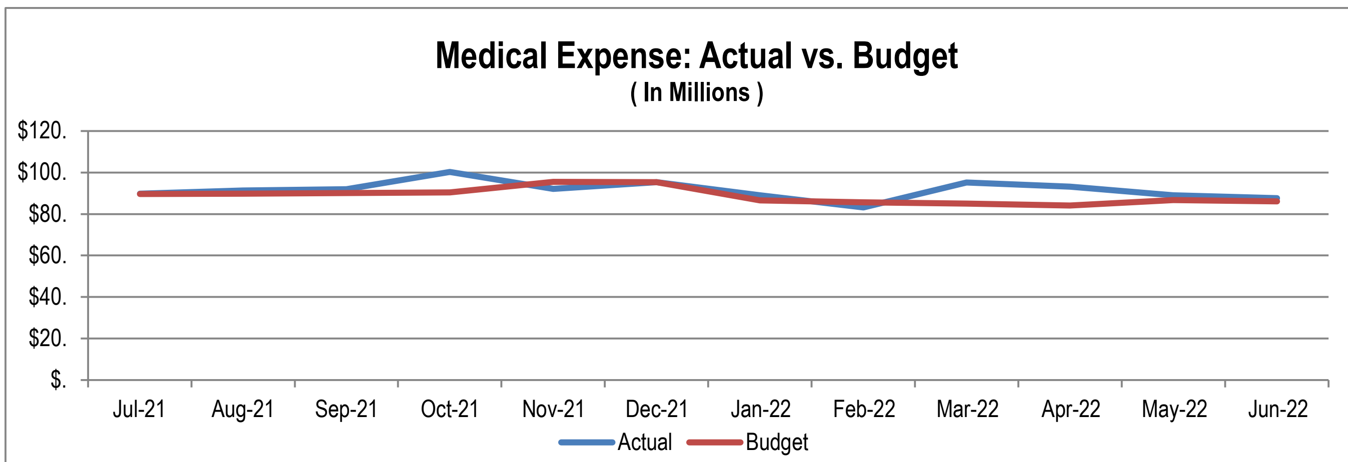


- For the month ended June 30th, 2022, the favorable revenue variance of $530,000 is primarily due to favorable CalAIM Incentive Payment Program and CalAIM Community Supports Revenue, offset by a $4 million unfavorable accrual for an anticipated member health acuity adjustment by DHCS, FY-19 Prop 56 Minimum Medical Expenditure recoupment, and timing of Maternity and Behavioral Health payments.

Medical Expense

- For the month ended June 30th, 2022:
  - Actual Medical Expense: $87.6 million.
  - Budgeted Medical Expense: $86.1 million.

- For the fiscal YTD ended June 30th, 2022:
  - Actual Medical Expense: $1.1 billion.
  - Budgeted Medical Expense: $1.1 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 on a quarterly basis by the company's external actuaries.

- For June, updates to Fee-For-Service (FFS) decreased the estimate for prior period unpaid Medical Expenses by $792,000. The estimate for prior years increased by $5.1 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	$270,335,546	$0	$270,335,546	$267,221,804	($3,113,742)	-1.2%
Primary Care FFS	53,142,390	$33,609	$53,175,999	54,094,952	$952,562	1.8%
Specialty Care FFS	56,677,515	$223,741	$56,901,256	56,076,320	($601,195)	-1.1%
Outpatient FFS	98,769,069	$577,338	$99,346,407	99,937,470	$1,168,401	1.2%
Ancillary FFS	69,589,815	$255,590	$69,845,406	64,144,743	($5,445,072)	-8.5%
Pharmacy FFS	129,860,630	$1,604,716	$131,465,345	125,037,781	($4,822,849)	-3.9%
ER Services FFS	53,862,707	$259,035	$54,121,742	53,202,050	($660,657)	-1.2%
Inpatient Hospital & SNF FFS	335,416,579	$2,186,740	$337,603,319	331,501,226	($3,915,353)	-1.2%
Other Benefits & Services	26,944,699	$0	$26,944,699	26,251,672	($693,027)	-2.6%
Net Reinsurance	(1,621,466)	$0	($1,621,466)	1,044,315	$2,665,781	255.3%
	$1,092,977,484	**$5,140,769**	**$1,098,118,254**	**$1,078,512,333**	**($14,465,151)**	**-1.3%**

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

Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

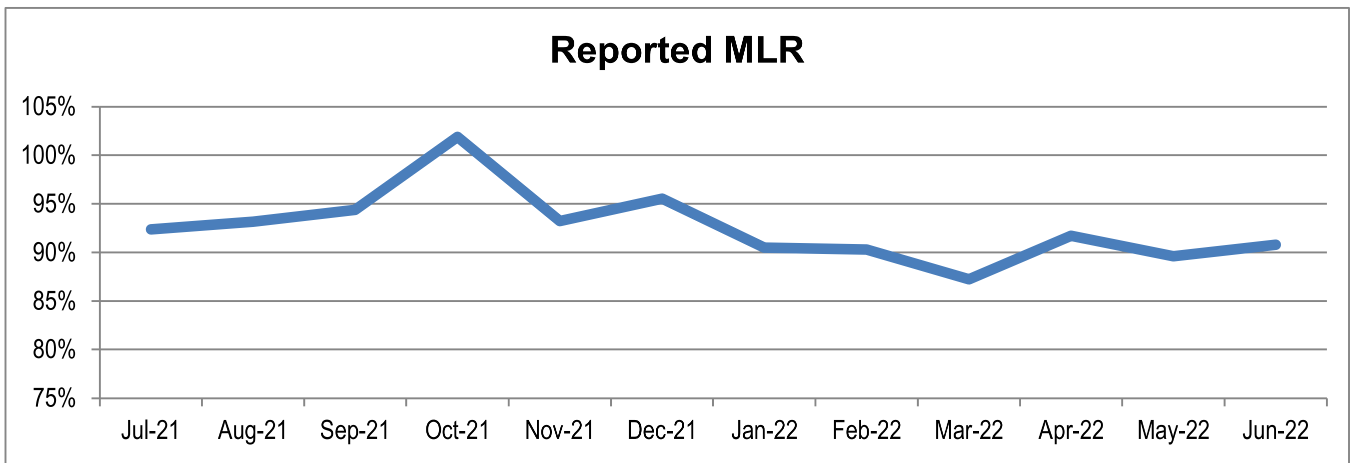
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$74.96	$0.00	$74.96	$75.96	$1.00	1.3%
Primary Care FFS	$14.74	$0.01	$14.75	$15.38	$0.64	4.2%
Specialty Care FFS	$15.72	$0.06	$15.78	$15.94	$0.22	1.4%
Outpatient FFS	$27.39	$0.16	$27.55	$28.41	$1.02	3.6%
Ancillary FFS	$19.30	$0.07	$19.37	$18.23	($1.06)	-5.8%
Pharmacy FFS	$36.01	$0.44	$36.45	$35.54	($0.46)	-1.3%
ER Services FFS	$14.94	$0.07	$15.01	$15.12	$0.19	1.2%
Inpatient Hospital & SNF FFS	$93.01	$0.61	$93.61	$94.24	$1.23	1.3%
Other Benefits & Services	$7.47	$0.00	$7.47	$7.46	($0.01)	-0.1%
Net Reinsurance	($0.45)	$0.00	($0.45)	$0.30	$0.75	251.5%
	$303.07	**$1.43**	**$304.49**	**$306.59**	**$3.52**	**1.1%**

- Excluding the effect of prior year estimates for IBNP, year-to-date medical expense variance is $14.5 million unfavorable to final budget, primarily due to higher enrollment. On a PMPM basis, medical expense is 1.1% favorable to budget. For per-member-per-month expense:
  - Capitated Expense overall is under budget. Unfavorable global delegate expense and unfavorable PCP Capitation expense is offset by favorable Supplemental Maternity expense.

- Primary Care Expense is below budget, driven by favorable unit cost in the SPD and Dual populations and favorable utilization in the ACA OE and Adult populations.
- Specialty Care Expense is favorable compared to budget, which is generally driven by favorable utilization in the ACA OE, Adult and Child populations.
- Outpatient Expense is under budget, driven by favorable utilization offset by unfavorable unit cost.
- Ancillary Expense is over budget due to Home Heath, DME, Outpatient Therapy, Laboratory and Radiology, CBAS, Non-Emergency Transportation, ECM and Community Supports offset by Other Medical Professional, Ambulance and Hospice service categories. Overall utilization is unfavorable offset by favorable unit cost.
- Pharmacy Expense is over budget due to unfavorable Non-PBM expense, driven mostly by unfavorable unit cost in the ACA OE, Adult and Group Care populations.
- Emergency Room Expense is under budget driven by favorable unit cost in the ACA OE and Dual populations and favorable utilization for Adults.
- Inpatient Expense is under budget, driven by favorable utilization in the ACA OE, and Child populations, and favorable unit cost and utilization in the Adult and Group Care populations.
- Other Benefits & Services are unfavorable to budget, primarily due to CalAIM incentive expenses, which were not included in the budget as information was not available at the time.
- Net Reinsurance year-to-date is favorable, driven by higher than anticipated recoveries.

Medical Loss Ratio (MLR)

- The Medical Loss Ratio (total reported medical expense divided by operating revenue) was 90.8% for the month and 92.5% for the fiscal year-to-date.



Administrative Expense

- For the month ended June 30th, 2022:
  - Actual Administrative Expense: $5.4 million.
  - Budgeted Administrative Expense: $7.5 million.
- For the fiscal YTD ended June 30th, 2022:
  - Actual Administrative Expense: $64.5 million.
  - Budgeted Administrative Expense: $82.0 million.

Summary of Administrative Expense (In Dollars) For the Month and Fiscal Year-to-Date Favorable/(Unfavorable)								
Month					Year-to-Date			
Actual	Budget	Variance $	Variance %		Actual	Budget	Variance $	Variance %
$3,154,137	$3,947,850	$793,713	20.1%	Employee Expense	$36,459,916	$40,956,667	$4,496,751	11.0%
312,717	311,972	(745)	-0.2%	Medical Benefits Admin Expense	5,917,895	5,920,126	2,231	0.0%
1,024,983	1,831,406	806,423	44.0%	Purchased & Professional Services	9,081,832	16,409,376	7,327,544	44.7%
953,059	1,384,663	431,604	31.2%	Other Admin Expense	13,073,856	18,694,406	5,620,550	30.1%
$5,444,895	$7,475,891	$2,030,995	27.2%	Total Administrative Expense	$64,533,497	$81,980,575	$17,447,076	21.3%

The year-to-date variances include:

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

Administrative loss ratio (ALR) represented 5.6% of net revenue for the month and 5.4% of net revenue year-to-date.

Other Income / (Expense)

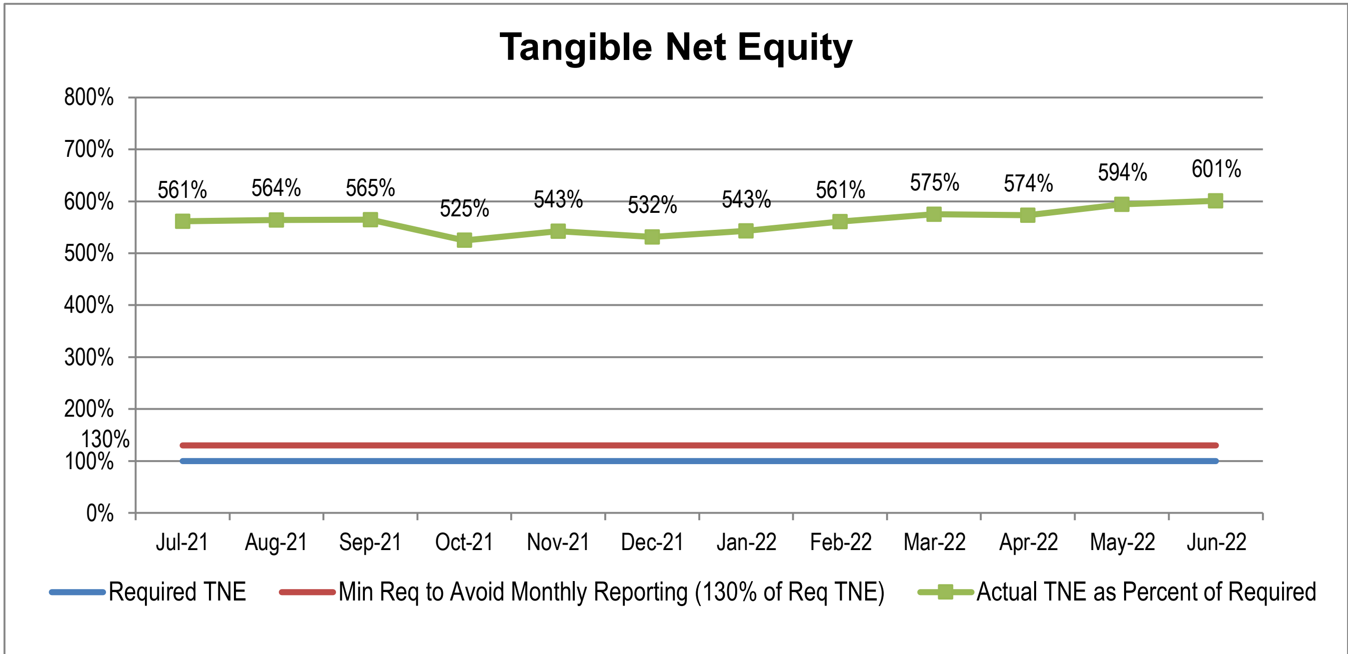
Other Income & Expense is comprised of investment income and claims interest.

- Fiscal year-to-date net investments show a loss of $162,000.
- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $396,000.

Tangible Net Equity (TNE)

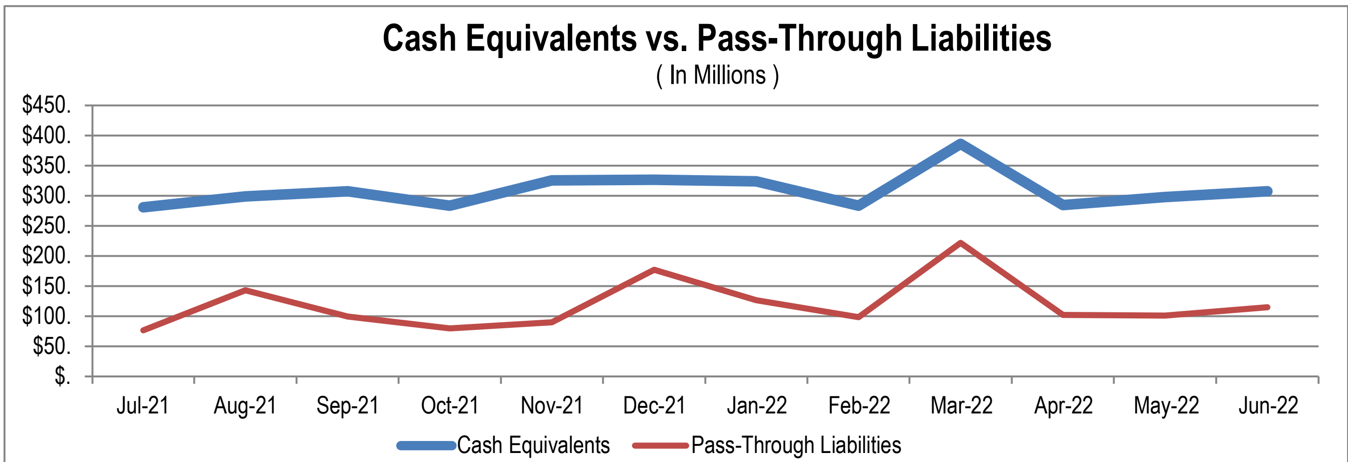
- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to consumers. TNE is a calculation of a company's total tangible assets minus the company's total liabilities. The Alliance exceeds DMHC's required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

- Required TNE $38.1 million
- Actual TNE $229.1 million
- Excess TNE $191.0 million
- TNE % of Required TNE 601%



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

- Key Metrics
  - Cash & Cash Equivalents $307.4 million
  - Pass-Through Liabilities $114.7million
  - Uncommitted Cash $192.7 million
  - Working Capital $188.0 million
  - Current Ratio 1.72 (regulatory minimum is 1.0)



Capital Investment

- Fiscal year-to-date capital assets acquired: $421,000.
- Annual capital budget: $1.4 million.
- A summary of year-to-date capital asset acquisitions is included in this monthly financial statement package.

Caveats to Financial Statements

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

Finance

Supporting Documents

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				MEMBERSHIP				
307,261	285,844	21,417	7.5%	1 - Medi-Cal	3,536,180	3,447,350	88,830	2.6%
5,795	5,852	(57)	(1.0%)	2 - Group Care	70,191	70,433	(242)	(0.3%)
313,056	**291,696**	**21,360**	**7.3%**	**3 - Total Member Months**	**3,606,371**	**3,517,783**	**88,588**	**2.5%**
				REVENUE				
$96,460,822	**$95,931,287**	**$529,535**	**0.6%**	**4 - TOTAL REVENUE**	**$1,186,884,990**	**$1,163,893,000**	**$22,991,990**	**2.0%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses:				
23,157,341	22,134,288	(1,023,053)	(4.6%)	5 - Capitated Medical Expense	270,335,546	267,221,822	(3,113,724)	(1.2%)
				Fee for Service Medical Expenses:				
28,619,403	28,071,190	(548,213)	(2.0%)	6 - Inpatient Hospital & SNF FFS Expense	337,603,319	331,501,228	(6,102,091)	(1.8%)
4,052,579	4,553,417	500,838	11.0%	7 - Primary Care Physician FFS Expense	53,175,999	54,094,948	918,949	1.7%
5,210,658	4,721,693	(488,965)	(10.4%)	8 - Specialty Care Physician Expense	56,901,256	56,076,320	(824,936)	(1.5%)
5,974,906	6,409,049	434,142	6.8%	9 - Ancillary Medical Expense	69,845,406	64,144,738	(5,700,668)	(8.9%)
8,150,330	8,184,228	33,898	0.4%	10 - Outpatient Medical Expense	99,346,407	99,937,467	591,060	0.6%
4,134,023	4,334,454	200,431	4.6%	11 - Emergency Expense	54,121,742	53,202,051	(919,691)	(1.7%)
6,285,403	5,237,643	(1,047,760)	(20.0%)	12 - Pharmacy Expense	131,465,345	125,037,790	(6,427,555)	(5.1%)
62,427,302	61,511,674	(915,628)	(1.5%)	13 - Total Fee for Service Expense	802,459,475	783,994,542	(18,464,933)	(2.4%)
3,237,256	2,281,610	(955,646)	(41.9%)	14 - Other Benefits & Services	26,944,699	26,251,661	(693,037)	(2.6%)
(1,250,088)	136,976	1,387,064	1,012.6%	15 - Reinsurance Expense	(1,621,466)	1,044,315	2,665,781	255.3%
87,571,811	**86,064,548**	**(1,507,263)**	**(1.8%)**	**17 - TOTAL MEDICAL EXPENSES**	**1,098,118,254**	**1,078,512,340**	**(19,605,914)**	**(1.8%)**
8,889,011	**9,866,740**	**(977,729)**	**(9.9%)**	**18 - GROSS MARGIN**	**88,766,736**	**85,380,660**	**3,386,076**	**4.0%**
				ADMINISTRATIVE EXPENSES				
3,154,136	3,947,849	793,713	20.1%	19 - Personnel Expense	36,459,915	40,956,666	4,496,751	11.0%
312,717	311,972	(745)	(0.2%)	20 - Benefits Administration Expense	5,917,895	5,920,126	2,231	0.0%
1,024,980	1,831,406	806,426	44.0%	21 - Purchased & Professional Services	9,081,833	16,409,376	7,327,543	44.7%
953,061	1,384,663	431,603	31.2%	22 - Other Administrative Expense	13,073,858	18,694,407	5,620,549	30.1%
5,444,894	**7,475,891**	**2,030,997**	**27.2%**	**23 -Total Administrative Expense**	**64,533,501**	**81,980,575**	**17,447,074**	**21.3%**
3,444,116	**2,390,848**	**1,053,268**	**44.1%**	**24 - NET OPERATING INCOME / (LOSS)**	**24,233,235**	**3,400,085**	**20,833,150**	**612.7%**
				OTHER INCOME / EXPENSE				
(112,198)	**8,751**	**(120,949)**	**(1,382.1%)**	**25 - Total Other Income / (Expense)**	**(557,898)**	**67,693**	**(625,591)**	**(924.2%)**
$3,331,919	**$2,399,599**	**$932,320**	**38.9%**	**26 - NET INCOME / (LOSS)**	**$23,675,337**	**$3,467,778**	**$20,207,559**	**582.7%**
5.6%	7.8%	2.1%	27.6%	27 - Admin Exp % of Revenue	5.4%	7.0%	1.6%	22.8%

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

	June	May	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	$12,245,640	$35,616,120	($23,370,480)	-65.62%
Short-Term Investments	295,164,712	262,319,385	32,845,327	12.52%
Interest Receivable	278,437	275,251	3,186	1.16%
Other Receivables - Net	135,021,327	136,544,658	(1,523,332)	-1.12%
Prepaid Expenses	5,133,863	4,617,782	516,080	11.18%
Prepaid Inventoried Items	21,760	24,200	(2,440)	-10.08%
CalPERS Net Pension Asset	(1,665,176)	(1,665,176)	0	0.00%
Deferred CalPERS Outflow	4,501,849	4,501,849	0	0.00%
TOTAL CURRENT ASSETS	**450,702,410**	**442,234,069**	**8,468,341**	**1.91%**
OTHER ASSETS:				
Long-Term Investments	35,068,850	35,383,898	(315,048)	-0.89%
Restricted Assets	350,000	350,000	0	0.00%
TOTAL OTHER ASSETS	**35,418,850**	**35,733,898**	**(315,048)**	**-0.88%**
PROPERTY AND EQUIPMENT:				
Land, Building & Improvements	10,089,578	9,626,797	462,782	4.81%
Furniture And Equipment	11,540,223	11,540,223	0	0.00%
Leasehold Improvement	902,447	902,447	0	0.00%
Construction in Process	0	275,666	(275,666)	-100.00%
Internally-Developed Software	14,824,002	14,824,002	0	0.00%
Fixed Assets at Cost	37,356,250	37,169,134	187,116	0.50%
Less: Accumulated Depreciation	(31,683,019)	(31,549,532)	(133,487)	0.42%
NET PROPERTY AND EQUIPMENT	**5,673,231**	**5,619,602**	**53,629**	**0.95%**
TOTAL ASSETS	**$491,794,490**	**$483,587,569**	**$8,206,921**	**1.70%**
CURRENT LIABILITIES:				
Accounts Payable	$2,197,168	$1,822,944	$374,225	20.53%
Pass-Through Liabilities	114,669,827	101,166,651	13,503,176	13.35%
Claims Payable	19,569,612	21,722,991	(2,153,379)	-9.91%
IBNP Reserves	113,104,374	116,135,862	(3,031,488)	-2.61%
Payroll Liabilities	4,707,435	6,303,657	(1,596,222)	-25.32%
CalPERS Deferred Inflow	859,093	859,093	0	0.00%
Risk Sharing	7,374,932	8,124,932	(750,000)	-9.23%
Provider Grants/ New Health Program	226,672	237,981	(11,309)	-4.75%
Deferred Revenue	0	1,460,000	(1,460,000)	-100.00%
TOTAL CURRENT LIABILITIES	**262,709,112**	**257,834,109**	**4,875,002**	**1.89%**
TOTAL LIABILITIES	**262,709,112**	**257,834,109**	**4,875,002**	**1.89%**
NET WORTH:				
Contributed Capital	840,233	840,233	0	0.00%
Restricted & Unrestricted Funds	204,569,809	204,569,809	0	0.00%
Year-to Date Net Income / (Loss)	23,675,337	20,343,418	3,331,919	16.38%
TOTAL NET WORTH	**229,085,379**	**225,753,460**	**3,331,919**	**1.48%**
TOTAL LIABILITIES AND NET WORTH	**$491,794,490**	**$483,587,569**	**$8,206,921**	**1.70%**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 6/30/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$2,168,551	$6,551,190	$13,094,822	$26,309,908
Total	2,168,551	6,551,190	13,094,822	26,309,908
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	94,292,197	290,880,126	583,542,410	1,158,367,518
Allowance for Doubtful Accounts	0	0	0	0
Deferred Premium Revenue	(1,460,000)	0	0	0
Premium Receivable	183,212	12,812,403	40,337,074	(7,829,254)
Total	93,015,409	303,692,529	623,879,484	1,150,538,264
Investment & Other Income Cash Flows				
Other Revenue (Grants)	(27,483)	7,388	283,239	2,033,361
Interest Income	(51,942)	169,708	(189,528)	12,368
Interest Receivable	(3,186)	13,731	(235,265)	(268,866)
Total	(82,611)	190,827	(141,554)	1,776,863
Medical & Hospital Cash Flows				
Total Medical Expenses	(87,571,812)	(269,871,765)	(537,216,922)	(1,098,118,259)
Other Receivable	1,340,122	2,463,306	2,483,860	9,202,581
Claims Payable	(2,153,379)	(1,411,117)	1,730,285	(13,894,658)
IBNP Payable	(3,031,488)	4,035,242	3,695,109	14,463,816
Risk Share Payable	(750,000)	(750,000)	(750,000)	(2,974,917)
Health Program	(11,309)	(33,834)	(64,802)	(224,471)
Other Liabilities	0	0	0	0
Total	(92,177,866)	(265,568,168)	(530,122,470)	(1,091,545,908)
Administrative Cash Flows				
Total Administrative Expenses	(5,477,591)	(16,969,716)	(32,777,475)	(64,929,561)
Prepaid Expenses	(513,640)	642	545,850	1,018,503
CalPERS Pension Asset	0	0	0	0
CalPERS Deferred Outflow	0	0	0	0
Trade Accounts Payable	374,225	(1,502,254)	(922,339)	(2,101,971)
Other Accrued Liabilities	0	0	0	0
Payroll Liabilities	(1,596,222)	(751,320)	(297,958)	(58,832)
Depreciation Expense	133,488	266,945	487,119	1,019,678
Total	(7,079,740)	(18,955,703)	(32,964,803)	(65,052,183)
Interest Paid				
Debt Interest Expense	0	0	0	0
Total Cash Flows from Operating Activities	**(4,156,257)**	**25,910,675**	**73,745,479**	**22,026,944**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 6/30/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	315,048	2,918,769	(30,098,732)	(35,068,850)
	315,048	2,918,769	(30,098,732)	(35,068,850)
Restricted Cash & Other Asset Cash Flows				
Provider Pass-Thru-Liabilities	13,503,176	(107,448,403)	(62,467,149)	19,837,292
Restricted Cash	0	0	0	0
	13,503,176	(107,448,403)	(62,467,149)	19,837,292
Fixed Asset Cash Flows				
Depreciation expense	133,488	266,945	487,119	1,019,678
Fixed Asset Acquisitions	(187,116)	(187,116)	(308,407)	(420,773)
Change in A/D	(133,488)	(266,945)	(487,119)	(1,019,678)
	(187,116)	(187,116)	(308,407)	(420,773)
Total Cash Flows from Investing Activities	**13,631,108**	**(104,716,750)**	**(92,874,288)**	**(15,652,331)**
Financing Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Total Cash Flows	**9,474,851**	**(78,806,075)**	**(19,128,809)**	**6,374,613**
Rounding	(3)	(5)	1	4
Cash @ Beginning of Period	297,935,504	386,216,432	326,539,160	301,035,735
Cash @ End of Period	**$307,410,352**	**$307,410,352**	**$307,410,352**	**$307,410,352**
Difference (rounding)	0	0	0	0

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 6/30/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$3,331,917	$10,766,925	$26,736,548	$23,675,337
Add back: Depreciation	133,488	266,945	487,119	1,019,678
Receivables				
Premiums Receivable	183,212	12,812,403	40,337,074	(7,829,254)
First Care Receivable	0	0	0	0
Family Care Receivable	0	0	0	0
Healthy Kids Receivable	0	0	0	0
Interest Receivable	(3,186)	13,731	(235,265)	(268,866)
Other Receivable	1,340,122	2,463,306	2,483,860	9,202,581
FQHC Receivable	0	0	0	0
Allowance for Doubtful Accounts	0	0	0	0
Total	1,520,148	15,289,440	42,585,669	1,104,461
Prepaid Expenses	(513,640)	642	545,850	1,018,503
Trade Payables	374,225	(1,502,254)	(922,339)	(2,101,971)
Claims Payable, IBNR & Risk Share				
IBNP	(3,031,488)	4,035,242	3,695,109	14,463,816
Claims Payable	(2,153,379)	(1,411,117)	1,730,285	(13,894,658)
Risk Share Payable	(750,000)	(750,000)	(750,000)	(2,974,917)
Other Liabilities	0	0	0	0
Total	(5,934,867)	1,874,125	4,675,394	(2,405,759)
Unearned Revenue				
Total	(1,460,000)	0	0	0
Other Liabilities				
Accrued Expenses	0	0	0	0
Payroll Liabilities	(1,596,222)	(751,320)	(297,958)	(58,832)
Health Program	(11,309)	(33,834)	(64,802)	(224,471)
Accrued Sub Debt Interest	0	0	0	0
Total Change in Other Liabilities	(1,607,531)	(785,154)	(362,760)	(283,303)
Cash Flows from Operating Activities	**($4,156,260)**	**$25,910,669**	**$73,745,481**	**$22,026,946**
Difference (rounding)	(3)	(6)	2	2

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 6/30/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received From:				
Capitation Received from State of CA	$93,015,409	$303,692,529	$623,879,484	$1,150,538,264
Commercial Premium Revenue	2,168,551	6,551,190	13,094,822	26,309,908
Other Income	(27,483)	7,388	283,239	2,033,361
Investment Income	(55,128)	183,439	(424,793)	(256,498)
Cash Paid To:				
Medical Expenses	(92,177,866)	(265,568,168)	(530,122,470)	(1,091,545,908)
Vendor & Employee Expenses	(7,079,740)	(18,955,703)	(32,964,803)	(65,052,183)
Interest Paid	0	0	0	0
Net Cash Provided By (Used In) Operating Activities	(4,156,257)	25,910,675	73,745,479	22,026,944
Cash Flows from Financing Activities:				
Purchases of Fixed Assets	(187,116)	(187,116)	(308,407)	(420,773)
Net Cash Provided By (Used In) Financing Activities	(187,116)	(187,116)	(308,407)	(420,773)
Cash Flows from Investing Activities:				
Changes in Investments	315,048	2,918,769	(30,098,732)	(35,068,850)
Restricted Cash	13,503,176	(107,448,403)	(62,467,149)	19,837,292
Net Cash Provided By (Used In) Investing Activities	13,818,224	(104,529,634)	(92,565,881)	(15,231,558)
Financial Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Net Change in Cash	**9,474,851**	**(78,806,075)**	**(19,128,809)**	**6,374,613**
Cash @ Beginning of Period	297,935,504	386,216,432	326,539,160	301,035,735
Subtotal	$307,410,355	$307,410,357	$307,410,351	$307,410,348
Rounding	(3)	(5)	1	4
Cash @ End of Period	**$307,410,352**	**$307,410,352**	**$307,410,352**	**$307,410,352**
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	$3,331,917	$10,766,925	$26,736,548	$23,675,337
Depreciation	133,488	266,945	487,119	1,019,678
Net Change in Operating Assets & Liabilities:				
Premium & Other Receivables	1,520,148	15,289,440	42,585,669	1,104,461
Prepaid Expenses	(513,640)	642	545,850	1,018,503
Trade Payables	374,225	(1,502,254)	(922,339)	(2,101,971)
Claims payable & IBNP	(5,934,867)	1,874,125	4,675,394	(2,405,759)
Deferred Revenue	(1,460,000)	0	0	0
Accrued Interest	0	0	0	0
Other Liabilities	(1,607,531)	(785,154)	(362,760)	(283,303)
Subtotal	(4,156,260)	25,910,669	73,745,481	22,026,946
Rounding	3	6	(2)	(2)
Cash Flows from Operating Activities	**($4,156,257)**	**$25,910,675**	**$73,745,479**	**$22,026,944**
Rounding Difference	3	6	(2)	(2)

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OFJUNE 2022

	Child	Adult	Medi-Cal SPD	ACA OE	Duals	Medi-Cal Total	Group Care	Grand Total
Enrollment	100,772	46,761	27,105	110,938	21,685	307,261	5,795	313,056
Net Revenue	$12,288,529	$14,394,094	$24,837,403	$38,706,708	$4,077,316	$94,304,049	$2,156,773	$96,460,822
Medical Expense	$10,488,968	$11,651,345	$26,169,841	$32,880,421	$3,789,321	$84,979,895	$2,591,915	$87,571,811
Gross Margin	$1,799,561	$2,742,749	($1,332,438)	$5,826,287	$287,995	$9,324,154	($435,143)	$8,889,011
Administrative Expense	$444,393	$737,585	$1,896,487	$1,993,643	$174,083	$5,246,190	$198,704	$5,444,894
Operating Income / (Expense)	$1,355,168	$2,005,164	($3,228,924)	$3,832,644	$113,911	$4,077,963	($633,847)	$3,444,116
Other Income / (Expense)	($5,742)	($13,710)	($36,563)	($48,504)	($4,637)	($109,155)	($3,043)	($112,198)
Net Income / (Loss)	$1,349,426	$1,991,454	($3,265,487)	$3,784,140	$109,275	$3,968,809	($636,890)	$3,331,919
Revenue PMPM	$121.94	$307.82	$916.34	$348.90	$188.02	$306.92	$372.18	$308.13
Medical Expense PMPM	$104.09	$249.17	$965.50	$296.39	$174.74	$276.57	$447.27	$279.73
Gross Margin PMPM	$17.86	$58.65	($49.16)	$52.52	$13.28	$30.35	($75.09)	$28.39
Administrative Expense PMPM	$4.41	$15.77	$69.97	$17.97	$8.03	$17.07	$34.29	$17.39
Operating Income / (Expense) PMPM	$13.45	$42.88	($119.13)	$34.55	$5.25	$13.27	($109.38)	$11.00
Other Income / (Expense) PMPM	($0.06)	($0.29)	($1.35)	($0.44)	($0.21)	($0.36)	($0.53)	($0.36)
Net Income / (Loss) PMPM	$13.39	$42.59	($120.48)	$34.11	$5.04	$12.92	($109.90)	$10.64
Medical Loss Ratio	85.4%	80.9%	105.4%	84.9%	92.9%	90.1%	120.2%	90.8%
Gross Margin Ratio	14.6%	19.1%	-5.4%	15.1%	7.1%	9.9%	-20.2%	9.2%
Administrative Expense Ratio	3.6%	5.1%	7.6%	5.2%	4.3%	5.6%	9.2%	5.6%
Net Income Ratio	11.0%	13.8%	-13.1%	9.8%	2.7%	4.2%	-29.5%	3.5%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE -JUNE 2022

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal Total	Group Care	Grand Total
Member Months	1,186,030	525,591	319,248	1,253,315	251,996	3,536,180	70,191	3,606,371
Net Revenue	$151,113,621	$172,271,992	$325,599,204	$465,183,641	$46,405,404	$1,160,573,861	$26,311,129	$1,186,884,990
Medical Expense	$130,093,256	$157,613,812	$321,266,639	$424,186,195	$39,300,141	$1,072,460,043	$25,658,211	$1,098,118,254
Gross Margin	$21,020,365	$14,658,180	$4,332,565	$40,997,446	$7,105,263	$88,113,818	$652,918	$88,766,736
Administrative Expense	$5,282,401	$8,748,716	$22,553,960	$23,665,133	$2,069,030	$62,319,240	$2,214,261	$64,533,501
Operating Income / (Expense)	$15,737,964	$5,909,463	($18,221,395)	$17,332,313	$5,036,232	$25,794,578	($1,561,343)	$24,233,235
Other Income / (Expense)	($30,178)	($95,925)	($185,658)	($207,124)	($25,200)	($544,085)	($13,813)	($557,898)
Net Income / (Loss)	$15,707,786	$5,813,538	($18,407,054)	$17,125,189	$5,011,033	$25,250,492	($1,575,156)	$23,675,337
Revenue PMPM	$127.41	$327.77	$1,019.89	$371.16	$184.15	$328.20	$374.85	$329.11
Medical Expense PMPM	$109.69	$299.88	$1,006.32	$338.45	$155.96	$303.28	$365.55	$304.49
Gross Margin PMPM	$17.72	$27.89	$13.57	$32.71	$28.20	$24.92	$9.30	$24.61
Administrative Expense PMPM	$4.45	$16.65	$70.65	$18.88	$8.21	$17.62	$31.55	$17.89
Operating Income / (Expense) PMPM	$13.27	$11.24	($57.08)	$13.83	$19.99	$7.29	($22.24)	$6.72
Other Income / (Expense) PMPM	($0.03)	($0.18)	($0.58)	($0.17)	($0.10)	($0.15)	($0.20)	($0.15)
Net Income / (Loss) PMPM	$13.24	$11.06	($57.66)	$13.66	$19.89	$7.14	($22.44)	$6.56
Medical Loss Ratio	86.1%	91.5%	98.7%	91.2%	84.7%	92.4%	97.5%	92.5%
Gross Margin Ratio	13.9%	8.5%	1.3%	8.8%	15.3%	7.6%	2.5%	7.5%
Administrative Expense Ratio	3.5%	5.1%	6.9%	5.1%	4.5%	5.4%	8.4%	5.4%
Net Income Ratio	10.4%	3.4%	-5.7%	3.7%	10.8%	2.2%	-6.0%	2.0%

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSE SUMMARY				
$3,154,136	$3,947,849	$793,713	20.1%	Personnel Expenses	$36,459,915	$40,956,666	$4,496,751	11.0%
312,717	311,972	(745)	(0.2%)	Benefits Administration Expense	5,917,895	5,920,126	2,231	0.0%
1,024,980	1,831,406	806,426	44.0%	Purchased & Professional Services	9,081,833	16,409,376	7,327,543	44.7%
375,450	288,381	(87,069)	(30.2%)	Occupancy	3,179,526	3,320,951	141,425	4.3%
(39,602)	353,891	393,493	111.2%	Printing Postage & Promotion	2,148,426	2,746,250	597,824	21.8%
598,646	721,389	122,743	17.0%	Licenses Insurance & Fees	6,100,657	7,726,441	1,625,784	21.0%
18,567	21,002	2,435	11.6%	Supplies & Other Expenses	1,645,248	4,900,764	3,255,516	66.4%
2,290,758	3,528,042	1,237,284	35.1%	Total Other Administrative Expense	28,073,586	41,023,909	12,950,323	31.6%
$5,444,894	**$7,475,891**	**$2,030,997**	**27.2%**	**Total Administrative Expenses**	**$64,533,501**	**$81,980,575**	**$17,447,074**	**21.3%**

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
$2,153,020	$2,240,956	$87,936	3.9%	Salaries & Wages	$24,257,149	$25,106,647	$849,498	3.4%
179,154	249,034	69,880	28.1%	Paid Time Off	2,435,169	2,738,478	303,309	11.1%
5,650	271,196	265,546	97.9%	Incentives	26,258	301,534	275,276	91.3%
0	25,000	25,000	100.0%	Severance Pay	0	200,000	200,000	100.0%
38,927	36,966	(1,961)	(5.3%)	Payroll Taxes	474,163	594,645	120,481	20.3%
9,872	15,418	5,546	36.0%	Overtime	302,925	277,330	(25,595)	(9.2%)
161,807	190,262	28,455	15.0%	CalPERS ER Match	1,920,360	2,070,954	150,594	7.3%
0	0	0	0.0%	Mandated Covid -19 Supplemental Sick Leave	10,398	10,400	2	0.0%
517,169	718,405	201,236	28.0%	Employee Benefits	5,908,996	7,189,880	1,280,884	17.8%
122	0	(122)	0.0%	Personal Floating Holiday	103,853	112,983	9,130	8.1%
10,304	18,351	8,047	43.9%	Employee Relations	56,532	168,728	112,196	66.5%
7,710	9,691	1,981	20.4%	Work from Home Stipend	86,520	101,892	15,372	15.1%
341	5,341	5,000	93.6%	Transportation Reimbursement	1,223	22,247	21,024	94.5%
1,458	24,394	22,936	94.0%	Travel & Lodging	6,414	104,975	98,561	93.9%
27,849	52,543	24,694	47.0%	Temporary Help Services	603,730	937,575	333,845	35.6%
31,016	75,587	44,571	59.0%	Staff Development/Training	124,711	600,349	475,638	79.2%
9,738	14,706	4,968	33.8%	Staff Recruitment/Advertising	141,514	418,050	276,536	66.1%
3,154,136	**3,947,849**	**793,713**	**20.1%**	**Total Employee Expenses**	**36,459,915**	**40,956,666**	**4,496,751**	**11.0%**
				Benefit Administration Expense				
16,751	52,434	35,683	68.1%	RX Administration Expense	2,597,290	2,764,727	167,437	6.1%
277,424	242,950	(34,474)	(14.2%)	Behavioral Hlth Administration Fees	3,105,698	2,951,505	(154,193)	(5.2%)
18,542	16,588	(1,954)	(11.8%)	Telemedicine Admin Fees	214,908	203,894	(11,014)	(5.4%)
312,717	**311,972**	**(745)**	**(0.2%)**	**Total Employee Expenses**	**5,917,895**	**5,920,126**	**2,231**	**0.0%**
				Purchased & Professional Services				
380,304	589,269	208,965	35.5%	Consulting Services	3,104,115	5,390,277	2,286,162	42.4%
244,733	617,447	372,714	60.4%	Computer Support Services	3,374,097	6,051,161	2,677,063	44.2%
3,669	11,583	7,914	68.3%	Professional Fees-Accounting	139,205	142,988	3,783	2.6%
0	72,260	72,260	100.0%	Professional Fees-Medical	95	72,330	72,235	99.9%
91,157	304,114	212,958	70.0%	Other Purchased Services	592,338	2,103,378	1,511,040	71.8%
0	5,000	5,000	100.0%	Maint.& Repair-Office Equipment	9,103	61,809	52,706	85.3%
108,445	121,732	13,287	10.9%	HMS Recovery Fees	1,036,915	1,103,639	66,724	6.0%
12,852	0	(12,852)	0.0%	MIS Software (Non-Capital)	12,852	250,002	237,151	94.9%
154,204	8,000	(146,204)	(1,827.5%)	Hardware (Non-Capital)	360,971	384,813	23,842	6.2%
9,491	21,492	12,001	55.8%	Provider Relations-Credentialing	146,784	216,682	69,898	32.3%
20,126	80,509	60,384	75.0%	Legal Fees	305,357	632,297	326,940	51.7%
1,024,980	**1,831,406**	**806,426**	**44.0%**	**Total Purchased & Professional Services**	**9,081,833**	**16,409,376**	**7,327,543**	**44.7%**
				Occupancy				
133,487	90,207	(43,280)	(48.0%)	Depreciation	1,019,679	1,105,617	85,938	7.8%
66,051	72,294	6,243	8.6%	Building Lease	840,778	847,813	7,035	0.8%
5,083	2,006	(3,077)	(153.4%)	Leased and Rented Office Equipment	63,318	24,170	(39,148)	(162.0%)
12,248	14,004	1,756	12.5%	Utilities	149,524	171,106	21,582	12.6%
117,562	71,401	(46,161)	(64.7%)	Telephone	913,717	860,609	(53,108)	(6.2%)
41,018	38,469	(2,549)	(6.6%)	Building Maintenance	192,510	311,636	119,126	38.2%

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
$375,450	**$288,381**	**($87,069)**	**(30.2%)**	**Total Occupancy**	**$3,179,526**	**$3,320,951**	**$141,425**	**4.3%**
				Printing Postage & Promotion				
21,581	46,851	25,270	53.9%	Postage	360,705	513,135	152,430	29.7%
2,665	7,000	4,335	61.9%	Design & Layout	32,355	97,888	65,533	66.9%
(33,213)	44,731	77,944	174.3%	Printing Services	649,916	631,191	(18,725)	(3.0%)
(7,883)	2,500	10,383	415.3%	Mailing Services	57,150	30,894	(26,256)	(85.0%)
4,515	3,225	(1,290)	(40.0%)	Courier/Delivery Service	50,561	42,028	(8,533)	(20.3%)
75	334	259	77.5%	Pre-Printed Materials and Publications	1,056	5,605	4,549	81.2%
946	15,000	14,054	93.7%	Promotional Products	946	20,000	19,054	95.3%
0	250	250	100.0%	Promotional Services	0	700	700	100.0%
(35,431)	225,500	260,931	115.7%	Community Relations	808,575	1,235,175	426,601	34.5%
67	0	(67)	0.0%	Health Education-Member	0	0	0	0.0%
7,076	8,500	1,424	16.8%	Translation - Non-Clinical	187,162	169,634	(17,528)	(10.3%)
(39,602)	**353,891**	**393,493**	**111.2%**	**Total Printing Postage & Promotion**	**2,148,426**	**2,746,250**	**597,824**	**21.8%**
				Licenses Insurance & Fees				
0	0	0	0.0%	Regulatory Penalties	0	250,001	250,001	100.0%
21,006	20,800	(206)	(1.0%)	Bank Fees	249,322	248,065	(1,257)	(0.5%)
61,920	61,377	(543)	(0.9%)	Insurance	740,325	736,522	(3,803)	(0.5%)
360,368	558,400	198,032	35.5%	Licenses, Permits and Fees	4,135,087	5,400,359	1,265,272	23.4%
155,352	80,812	(74,540)	(92.2%)	Subscriptions & Dues	975,922	1,091,494	115,572	10.6%
598,646	**721,389**	**122,743**	**17.0%**	**Total Licenses Insurance & Postage**	**6,100,657**	**7,726,441**	**1,625,784**	**21.0%**
				Supplies & Other Expenses				
15,980	5,816	(10,164)	(174.8%)	Office and Other Supplies	63,758	156,004	92,246	59.1%
1,295	2,399	1,104	46.0%	Ergonomic Supplies	25,867	66,329	40,462	61.0%
1,295	8,371	7,077	84.5%	Commissary-Food & Beverage	10,671	49,348	38,677	78.4%
0	0	0	0.0%	Miscellaneous Expense	534	0	(534)	0.0%
0	4,150	4,150	100.0%	Member Incentive Expense	4,850	40,100	35,250	87.9%
(4)	0	4	0.0%	Covid-19 Vaccination Incentive Expense	1,538,771	4,581,255	3,042,484	66.4%
0	100	100	100.0%	Covid-19 IT Expenses	0	800	800	100.0%
0	166	166	100.0%	Covid-19 Non IT Expenses	797	6,928	6,131	88.5%
18,567	**21,002**	**2,435**	**11.6%**	**Total Supplies & Other Expense**	**1,645,248**	**4,900,764**	**3,255,516**	**66.4%**
$5,444,894	**$7,475,891**	**$2,030,997**	**27.2%**	**TOTAL ADMINISTRATIVE EXPENSE**	**$64,533,501**	**$81,980,575**	**$17,447,074**	**21.3%**

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

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco Network Hardware	IT-FY22-07	$ -	$ -	**$ -**	$ 150,000	$ 150,000
	Cisco UCS Blade	IT-FY22-08	$ -		**$ -**	$ 100,000	$ 100,000
	Veeam Backup	IT-FY22-10	$ -		**$ -**	$ 60,000	$ 60,000
	Call Center Hardware	IT-FY22-11	$ -		**$ -**	$ 100,000	$ 100,000
	Network / AV Cabling	IT-FY22-13	$ -		**$ -**	$ 150,000	$ 150,000
Hardware Subtotal			**$ -**	**$ -**	**$ -**	**$ 560,000**	**$ 560,000**
2. Software:							
	Patch Management	AC-FY22-01	$ -		**$ -**	$ 20,000	$ 20,000
	Zerto Licenses (DR - Replication Orchestration)	AC-FY22-02	$ -		**$ -**	$ 50,000	$ 50,000
	Monitoring Software	AC-FY22-03	$ -		**$ -**	$ 40,000	$ 40,000
	Identity and Access Management (Security)	AC-FY22-04	$ -		**$ -**	$ 40,000	$ 40,000
Software Subtotal			**$ -**	**$ -**	**$ -**	**$ 150,000**	**$ 150,000**
3. Building Improvement:							
	1240 Emergency Generator (carryover from FY21)	FA-FY22-06	**$ 227,316**	$ 187,116	**$ 414,432**	$ 360,800	$ (53,632)
	1240 Electrical Requirements for EV Charging Stations (est.)	FA-FY22-07	$ -		**$ -**	$ 20,000	$ 20,000
	1240 EV Charging stations installation, fees (est. only)	FA-FY22-08	$ -		**$ -**	$ 50,000	$ 50,000
	1240 Seismic Improvements (carryover from FY21)	FA-FY22-09	$ -		**$ -**	$ 50,000	$ 50,000
	Contingency	FA-FY22-16	**$ 6,341**		**$ 6,341**	$ 100,000	$ 93,659
Building Improvement Subtotal			**$ 233,657**	**$ 187,116**	**$ 420,773**	**$ 580,800**	**$ 160,027**
4. Furniture & Equipment:							
	Replace, reconfigure, re-design workstations/add barriers or plexiglass	FA-FY22-20	$ -		**$ -**	$ 125,000	$ 125,000
Furniture & Equipment Subtotal			**$ -**	**$ -**	**$ -**	**$ 125,000**	**$ 125,000**
GRAND TOTAL			**$ 233,657**	**$ 187,116**	**$ 420,773**	**$ 1,415,800**	**$ 995,027**
5. Reconciliation to Balance Sheet:							
	Fixed Assets @ Cost - 6/30/22				**$ 37,356,250**		
	Fixed Assets @ Cost - 6/30/21				**$ 36,935,477**		
	Fixed Assets Acquired YTD				**$ 420,773**		

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

TANGIBLE NET EQUITY (TNE)

	Jul-21	Aug-21	QTR. END Sep-21	Oct-21	Nov-21	QTR. END Dec-21	Jan-22	Feb-22	QTR. END Mar-22	Apr-22	May-22	QTR. END Jun-22
Current Month Net Income / (Loss)	$2,645,613	$1,455,041	$370,178	($7,350,897)	$1,314,900	($1,496,048)	$4,122,017	$3,443,438	$8,404,167	$2,267,503	$5,167,507	$3,331,919
YTD Net Income / (Loss)	$2,645,613	$4,100,654	$4,470,832	($2,880,065)	($1,565,165)	($3,061,213)	$1,060,804	$4,504,242	$12,908,409	$15,175,912	$20,343,419	$23,675,338
Actual TNE												
Net Assets	$208,055,654	$209,510,696	$209,880,873	$202,529,977	$203,844,876	$202,348,828	$206,470,845	$209,914,283	$218,318,450	$220,585,953	$225,753,460	$229,085,379
Subordinated Debt & Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Actual TNE	**$208,055,654**	**$209,510,696**	**$209,880,873**	**$202,529,977**	**$203,844,876**	**$202,348,828**	**$206,470,845**	**$209,914,283**	**$218,318,450**	**$220,585,953**	**$225,753,460**	**$229,085,379**
Increase/(Decrease) in Actual TNE	$3,467,237	$1,455,042	$370,177	($7,350,896)	$1,314,899	($1,496,048)	$4,122,017	$3,443,438	$8,404,167	$2,267,503	$5,167,507	$3,331,919
Required TNE[1]	**$37,061,269**	**$37,134,762**	**$37,155,961**	**$38,560,140**	**$37,568,385**	**$38,067,278**	**$38,019,954**	**$37,402,476**	**$37,954,630**	**$38,456,012**	**$37,976,096**	**$38,098,379**
Min. Req'd to Avoid Monthly Reporting (130% of Required TNE)	$48,179,650	$48,275,191	$48,302,749	$50,128,181	$48,838,900	$49,487,461	$49,425,940	$48,623,218	$49,341,019	$49,992,815	$49,368,925	$49,527,893
TNE Excess / (Deficiency)	$170,994,385	$172,375,934	$172,724,912	$163,969,837	$166,276,491	$164,281,550	$168,450,891	$172,511,807	$180,363,820	$182,129,941	$187,777,364	$190,987,000
Actual TNE as a Multiple of Required	**5.61**	**5.64**	**5.65**	**5.25**	**5.43**	**5.32**	**5.43**	**5.61**	**5.75**	**5.74**	**5.94**	**6.01**

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

	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Net Assets	$208,055,654	$209,510,696	$209,880,873	$202,529,977	$203,844,876	$202,348,828	$206,470,845	$209,914,283	$218,318,450	$220,585,953	$225,753,460	$229,085,379
Fixed Assets at Net Book Value	(6,161,088)	(6,073,778)	(6,093,339)	(6,013,994)	(5,931,375)	(5,851,942)	(5,774,186)	(5,821,605)	(5,753,060)	(5,686,094)	(5,619,604)	(5,673,231)
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)	(350,000)
Liquid TNE (Liquid Reserves)	**$201,544,566**	**$203,086,918**	**$203,437,534**	**$196,165,983**	**$197,563,501**	**$196,146,886**	**$200,346,659**	**$203,742,678**	**$212,215,390**	**$214,549,859**	**$219,783,856**	**$223,062,148**
Liquid TNE as Multiple of Required	**5.44**	**5.47**	**5.48**	**5.09**	**5.26**	**5.15**	**5.27**	**5.45**	**5.59**	**5.58**	**5.79**	**5.85**

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

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

	Actual Jul-21	Actual Aug-21	Actual Sep-21	Actual Oct-21	Actual Nov-21	Actual Dec-21	Actual Jan-22	Actual Feb-22	Actual Mar-22	Actual Apr-22	Actual May-22	Actual Jun-22	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	97,179	97,324	97,460	97,636	97,935	98,150	99,337	99,573	99,889	100,215	100,560	100,772	1,186,030
Adult	41,358	41,519	41,924	42,177	42,623	43,077	44,340	44,588	45,227	45,826	46,171	46,761	525,591
SPD	26,320	26,316	26,330	26,366	26,427	26,450	26,633	26,675	26,820	26,848	26,958	27,105	319,248
ACA OE	99,105	99,783	100,469	100,844	101,508	102,264	105,897	106,553	107,652	108,568	109,734	110,938	1,253,315
Duals	20,194	20,388	20,535	20,692	20,832	20,964	21,135	21,239	21,349	21,456	21,527	21,685	251,996
Medi-Cal Program	284,156	285,330	286,718	287,715	289,325	290,905	297,342	298,628	300,937	302,913	304,950	307,261	3,536,180
Group Care Program	5,935	5,877	5,914	5,880	5,826	5,823	5,831	5,824	5,850	5,828	5,808	5,795	70,191
Total	**290,091**	**291,207**	**292,632**	**293,595**	**295,151**	**296,728**	**303,173**	**304,452**	**306,787**	**308,741**	**310,758**	**313,056**	**3,606,371**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	131	145	136	176	299	215	1,187	236	316	326	345	212	3,724
Adult	392	161	405	253	446	454	1,263	248	639	599	345	590	5,795
SPD	(3)	(4)	14	36	61	23	183	42	145	28	110	147	782
ACA OE	824	678	686	375	664	756	3,633	656	1,099	916	1,166	1,204	12,657
Duals	206	194	147	157	140	132	171	104	110	107	71	158	1,697
Medi-Cal Program	1,550	1,174	1,388	997	1,610	1,580	6,437	1,286	2,309	1,976	2,037	2,311	24,655
Group Care Program	(13)	(58)	37	(34)	(54)	(3)	8	(7)	26	(22)	(20)	(13)	(153)
Total	**1,537**	**1,116**	**1,425**	**963**	**1,556**	**1,577**	**6,445**	**1,279**	**2,335**	**1,954**	**2,017**	**2,298**	**24,502**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	34.2%	34.1%	34.0%	33.9%	33.8%	33.7%	33.4%	33.3%	33.2%	33.1%	33.0%	32.8%	33.5%
Adult % of Medi-Cal	14.6%	14.6%	14.6%	14.7%	14.7%	14.8%	14.9%	14.9%	15.0%	15.1%	15.1%	15.2%	14.9%
SPD % of Medi-Cal	9.3%	9.2%	9.2%	9.2%	9.1%	9.1%	9.0%	8.9%	8.9%	8.9%	8.8%	8.8%	9.0%
ACA OE % of Medi-Cal	34.9%	35.0%	35.0%	35.0%	35.1%	35.2%	35.6%	35.7%	35.8%	35.8%	36.0%	36.1%	35.4%
Duals % of Medi-Cal	7.1%	7.1%	7.2%	7.2%	7.2%	7.2%	7.1%	7.1%	7.1%	7.1%	7.1%	7.1%	7.1%
Medi-Cal Program % of Total	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.1%	98.1%	98.1%	98.1%	98.1%	98.1%	98.1%
Group Care Program % of Total	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%
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%**

REPORT #9

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

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

	Actual Jul-21	**Actual Aug-21**	**Actual Sep-21**	**Actual Oct-21**	**Actual Nov-21**	**Actual Dec-21**	**Actual Jan-22**	**Actual Feb-22**	**Actual Mar-22**	**Actual Apr-22**	**Actual May-22**	**Actual Jun-22**	**YTD Member Months**
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	53,189	53,441	53,246	53,081	53,438	52,288	57,046	51,053	51,767	51,662	51,910	51,936	634,057
Alameda Health System	58,045	57,812	58,060	58,049	58,073	58,590	58,927	60,699	60,974	61,442	61,693	62,215	714,579
	111,234	111,253	111,306	111,130	111,511	110,878	115,973	111,752	112,741	113,104	113,603	114,151	1,348,636
Delegated:													
CFMG	32,217	32,167	32,217	32,232	32,266	32,573	32,689	33,319	33,293	33,333	33,378	33,408	393,092
CHCN	104,433	105,113	106,050	106,808	107,583	109,059	109,878	114,264	115,125	116,169	117,163	118,411	1,330,056
Kaiser	42,207	42,674	43,059	43,425	43,791	44,218	44,633	45,117	45,628	46,135	46,614	47,086	534,587
Delegated Subtotal	178,857	179,954	181,326	182,465	183,640	185,850	187,200	192,700	194,046	195,637	197,155	198,905	2,257,735
Total	**290,091**	**291,207**	**292,632**	**293,595**	**295,151**	**296,728**	**303,173**	**304,452**	**306,787**	**308,741**	**310,758**	**313,056**	**3,606,371**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(24)	19	53	(176)	381	(633)	5,095	(4,221)	989	363	499	548	2,893
Delegated:													
CFMG	20	(50)	50	15	34	307	116	630	(26)	40	45	30	1,211
CHCN	1,094	680	937	758	775	1,476	819	4,386	861	1,044	994	1,248	15,072
Kaiser	447	467	385	366	366	427	415	484	511	507	479	472	5,326
Delegated Subtotal	1,561	1,097	1,372	1,139	1,175	2,210	1,350	5,500	1,346	1,591	1,518	1,750	21,609
Total	**1,537**	**1,116**	**1,425**	**963**	**1,556**	**1,577**	**6,445**	**1,279**	**2,335**	**1,954**	**2,017**	**2,298**	**24,502**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	38.3%	38.2%	38.0%	37.9%	37.8%	37.4%	38.3%	36.7%	36.7%	36.6%	36.6%	36.5%	37.4%
Delegated:													
CFMG	11.1%	11.0%	11.0%	11.0%	10.9%	11.0%	10.8%	10.9%	10.9%	10.8%	10.7%	10.7%	10.9%
CHCN	36.0%	36.1%	36.2%	36.4%	36.5%	36.8%	36.2%	37.5%	37.5%	37.6%	37.7%	37.8%	36.9%
Kaiser	14.5%	14.7%	14.7%	14.8%	14.8%	14.9%	14.7%	14.8%	14.9%	14.9%	15.0%	15.0%	14.8%
Delegated Subtotal	61.7%	61.8%	62.0%	62.1%	62.2%	62.6%	61.7%	63.3%	63.3%	63.4%	63.4%	63.5%	62.6%
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%**

REPORT #9

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

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

REPORT #9

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

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

REPORT #9

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

	Variance Jul-21	Variance Aug-21	Variance Sep-21	Variance Oct-21	Variance Nov-21	Variance Dec-21	Variance Jan-22	Variance Feb-22	Variance Mar-22	Variance Apr-22	Variance May-22	Variance Jun-22	Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	0	0	0	0	123	162	(254)	952	2,228	3,505	4,817	5,961	17,494
Adult	0	0	0	0	193	394	1,184	1,855	2,912	3,925	4,689	5,685	20,837
SPD	0	0	0	0	25	12	166	455	844	1,114	(39)	360	2,937
ACA OE	0	0	0	0	289	670	4,110	5,708	7,739	9,578	5,330	7,502	40,926
Duals	0	0	0	0	(17)	(42)	339	651	967	1,278	1,551	1,909	6,636
Medi-Cal Program	0	0	0	0	613	1,196	5,545	9,621	14,690	19,400	16,348	21,417	88,830
Group Care Program	0	0	0	0	(37)	(29)	(21)	(28)	(2)	(24)	(44)	(57)	(242)
Total	**0**	**0**	**0**	**0**	**576**	**1,167**	**5,524**	**9,593**	**14,688**	**19,376**	**16,304**	**21,360**	**88,588**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted	0	0	0	0	(28)	(1,073)	3,524	341	2,355	3,734	1,461	3,045	13,359
Delegated:													
CFMG	0	0	0	0	(28)	217	(159)	790	1,079	1,431	1,662	2,000	6,992
CHCN	0	0	0	0	418	1,534	1,628	7,024	8,885	10,919	9,933	12,180	52,521
Kaiser	0	0	0	0	214	489	531	1,438	2,369	3,292	3,248	4,135	15,716
Delegated Subtotal	0	0	0	0	604	2,240	2,000	9,252	12,333	15,642	14,843	18,315	75,229
Total	**0**	**0**	**0**	**0**	**576**	**1,167**	**5,524**	**9,593**	**14,688**	**19,376**	**16,304**	**21,360**	**88,588**

REPORT #9

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

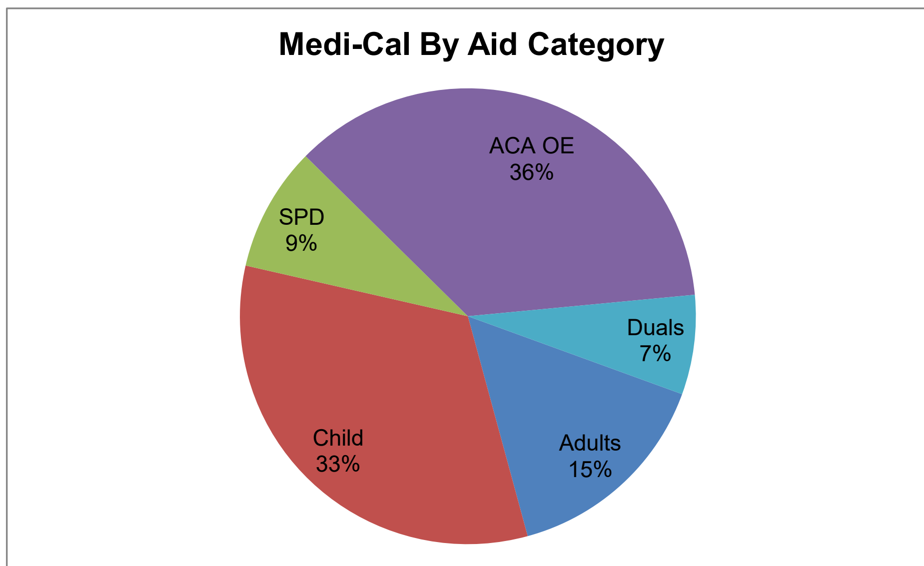
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES:				
$1,117,378	$1,799,361	$681,983	37.9%	PCP-Capitation	$13,346,535	$22,067,388	$8,720,853	39.5%
4,110,157	3,160,099	(950,058)	(30.1%)	PCP-Capitation - FQHC	46,539,304	36,887,184	(9,652,120)	(26.2%)
289,909	265,064	(24,845)	(9.4%)	Specialty-Capitation	3,413,179	3,304,592	(108,587)	(3.3%)
3,424,184	3,343,963	(80,221)	(2.4%)	Specialty-Capitation FQHC	38,640,591	38,552,756	(87,835)	(0.2%)
385,554	360,743	(24,811)	(6.9%)	Laboratory-Capitation	4,467,519	4,361,432	(106,087)	(2.4%)
832,532	875,088	42,556	4.9%	Transportation (Ambulance)-Cap	11,063,674	10,647,157	(416,517)	(3.9%)
227,236	212,786	(14,450)	(6.8%)	Vision Cap	2,635,093	2,575,153	(59,940)	(2.3%)
84,438	77,226	(7,212)	(9.3%)	CFMG Capitation	994,436	962,832	(31,604)	(3.3%)
172,177	166,984	(5,193)	(3.1%)	Anc IPA Admin Capitation FQHC	1,945,831	1,936,874	(8,957)	(0.5%)
10,768,702	10,071,518	(697,184)	(6.9%)	Kaiser Capitation	127,088,409	125,065,831	(2,022,578)	(1.6%)
825,155	751,668	(73,487)	(9.8%)	BHT Supplemental Expense	9,505,463	8,881,706	(623,757)	(7.0%)
0	0	0	0.0%	Hep-C Supplemental Expense	102,679	100,877	(1,802)	(1.8%)
357,958	473,181	115,223	24.4%	Maternity Supplemental Expense	4,001,876	5,105,738	1,103,862	21.6%
561,962	576,607	14,645	2.5%	DME - Cap	6,590,956	6,772,302	181,346	2.7%
23,157,341	**22,134,288**	**(1,023,053)**	**(4.6%)**	**5-TOTAL CAPITATED EXPENSES**	**270,335,546**	**267,221,822**	**(3,113,724)**	**(1.2%)**
				FEE FOR SERVICE MEDICAL EXPENSES:				
(861,322)	0	861,322	0.0%	IBNP-Inpatient Services	9,198,463	0	(9,198,463)	0.0%
(25,839)	0	25,839	0.0%	IBNP-Settlement (IP)	275,951	0	(275,951)	0.0%
(68,906)	0	68,906	0.0%	IBNP-Claims Fluctuation (IP)	735,872	0	(735,872)	0.0%
25,645,564	26,732,153	1,086,589	4.1%	Inpatient Hospitalization-FFS	286,775,058	320,995,322	34,220,264	10.7%
1,336,529	0	(1,336,529)	0.0%	IP OB - Mom & NB	14,743,893	0	(14,743,893)	0.0%
334,226	0	(334,226)	0.0%	IP Behavioral Health	2,827,603	0	(2,827,603)	0.0%
1,353,080	1,339,037	(14,043)	(1.0%)	IP - Long Term Care	13,227,829	10,505,906	(2,721,923)	(25.9%)
906,070	0	(906,070)	0.0%	IP - Facility Rehab FFS	9,818,651	0	(9,818,651)	0.0%
28,619,403	**28,071,190**	**(548,213)**	**(2.0%)**	**6-Inpatient Hospital & SNF FFS Expense**	**337,603,319**	**331,501,228**	**(6,102,091)**	**(1.8%)**
(34,136)	0	34,136	0.0%	IBNP-PCP	(136,771)	0	136,771	0.0%
(1,024)	0	1,024	0.0%	IBNP-Settlement (PCP)	(4,101)	0	4,101	0.0%
(2,731)	0	2,731	0.0%	IBNP-Claims Fluctuation (PCP)	(10,938)	0	10,938	0.0%
0	0	0	0.0%	Telemedicine FFS	9,450	0	(9,450)	0.0%
1,404,649	1,327,829	(76,820)	(5.8%)	Primary Care Non-Contracted FF	14,439,756	28,235,110	13,795,354	48.9%
67,440	80,973	13,533	16.7%	PCP FQHC FFS	629,159	648,876	19,717	3.0%
1,172,357	3,144,615	1,972,258	62.7%	Prop 56 Direct Payment Expenses	21,579,940	25,210,962	3,631,022	14.4%
13,848	0	(13,848)	0.0%	Prop 56 Hyde Direct Payment Expenses	81,082	0	(81,082)	0.0%
76,652	0	(76,652)	0.0%	Prop 56-Trauma Expense	907,443	0	(907,443)	0.0%
98,568	0	(98,568)	0.0%	Prop 56-Dev. Screening Exp.	1,187,540	0	(1,187,540)	0.0%
670,361	0	(670,361)	0.0%	Prop 56-Fam. Planning Exp.	7,756,255	0	(7,756,255)	0.0%
586,594	0	(586,594)	0.0%	Prop 56-Value Based Purchasing	6,737,185	0	(6,737,185)	0.0%
4,052,579	**4,553,417**	**500,838**	**11.0%**	**7-Primary Care Physician FFS Expense**	**53,175,999**	**54,094,948**	**918,949**	**1.7%**
(239,966)	0	239,966	0.0%	IBNP-Specialist	401,655	0	(401,655)	0.0%
3,003,568	4,716,689	1,713,121	36.3%	Specialty Care-FFS	29,894,781	56,036,672	26,141,891	46.7%
104,875	0	(104,875)	0.0%	Anesthesiology - FFS	1,518,353	0	(1,518,353)	0.0%
996,577	0	(996,577)	0.0%	Spec Rad Therapy - FFS	9,319,771	0	(9,319,771)	0.0%
140,422	0	(140,422)	0.0%	Obstetrics-FFS	1,373,688	0	(1,373,688)	0.0%
266,200	0	(266,200)	0.0%	Spec IP Surgery - FFS	3,138,958	0	(3,138,958)	0.0%
514,574	0	(514,574)	0.0%	Spec OP Surgery - FFS	6,172,477	0	(6,172,477)	0.0%
396,099	0	(396,099)	0.0%	Spec IP Physician	4,513,232	0	(4,513,232)	0.0%
54,706	5,004	(49,702)	(993.2%)	SCP FQHC FFS	524,159	39,648	(484,511)	(1,222.0%)
(7,198)	0	7,198	0.0%	IBNP-Settlement (SCP)	12,050	0	(12,050)	0.0%
(19,198)	0	19,198	0.0%	IBNP-Claims Fluctuation (SCP)	32,133	0	(32,133)	0.0%
5,210,658	**4,721,693**	**(488,965)**	**(10.4%)**	**8-Specialty Care Physician Expense**	**56,901,256**	**56,076,320**	**(824,936)**	**(1.5%)**
(468,690)	0	468,690	0.0%	IBNP-Ancillary	1,258,122	0	(1,258,122)	0.0%
(14,060)	0	14,060	0.0%	IBNP Settlement (ANC)	37,747	0	(37,747)	0.0%
(37,496)	0	37,496	0.0%	IBNP Claims Fluctuation (ANC)	100,647	0	(100,647)	0.0%
384,927	0	(384,927)	0.0%	Acupuncture/Biofeedback	5,138,020	0	(5,138,020)	0.0%
93,256	0	(93,256)	0.0%	Hearing Devices	1,154,826	0	(1,154,826)	0.0%
32,484	0	(32,484)	0.0%	Imaging/MRI/CT Global	378,508	0	(378,508)	0.0%
44,859	0	(44,859)	0.0%	Vision FFS	571,485	0	(571,485)	0.0%
24,406	0	(24,406)	0.0%	Family Planning	266,039	0	(266,039)	0.0%
299,104	0	(299,104)	0.0%	Laboratory-FFS	9,016,182	0	(9,016,182)	0.0%
98,614	0	(98,614)	0.0%	ANC Therapist	1,135,154	0	(1,135,154)	0.0%
0	0	0	0.0%	ANC Diagnostic Procedures	(166)	0	166	0.0%
344,653	0	(344,653)	0.0%	Transportation (Ambulance)-FFS	3,546,175	0	(3,546,175)	0.0%
165,598	0	(165,598)	0.0%	Transportation (Other)-FFS	1,609,130	0	(1,609,130)	0.0%
459,928	0	(459,928)	0.0%	Hospice	5,989,850	0	(5,989,850)	0.0%
818,147	0	(818,147)	0.0%	Home Health Services	7,987,096	0	(7,987,096)	0.0%
0	3,471,407	3,471,407	100.0%	Other Medical-FFS	0	45,408,785	45,408,785	100.0%

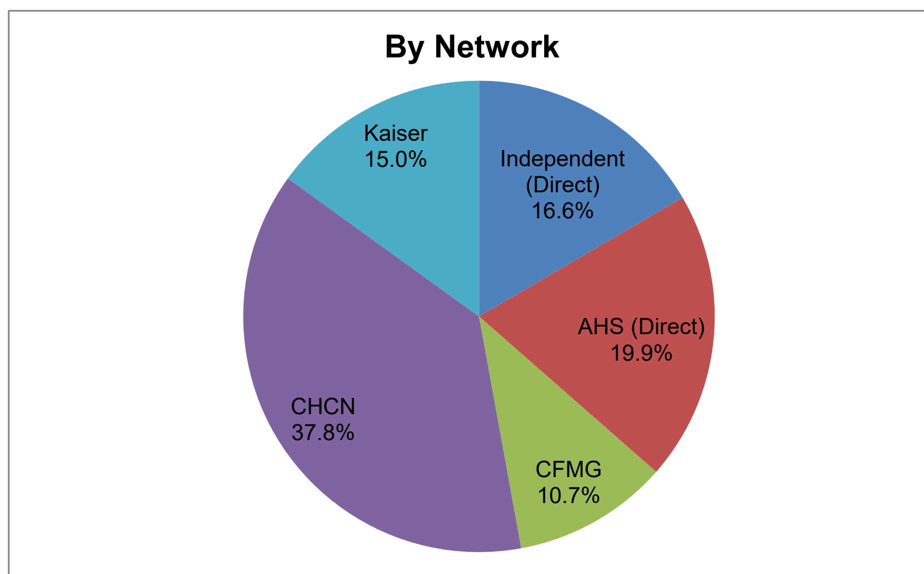
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED June 30, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	**Budget**	**$ Variance (Unfavorable)**	**% Variance (Unfavorable)**	**Account Description**	**Actual**	**Budget**	**$ Variance (Unfavorable)**	**% Variance (Unfavorable)**
$2,552	$0	($2,552)	0.0%	HMS Medical Refunds	($11,019)	$0	$11,019	0.0%
(2,960)	0	2,960	0.0%	Refunds-Medical Payments	(2,961)	0	2,961	0.0%
518,472	0	(518,472)	0.0%	DME & Medical Supplies	5,622,666	0	(5,622,666)	0.0%
0	0	0	0.0%	Denials	167	0	(167)	0.0%
(62,131)	593,041	655,172	110.5%	GEMT Direct Payment Expense	5,352,576	4,695,789	(656,787)	(14.0%)
794,459	0	(794,459)	0.0%	Community Based Adult Services (CBAS)	5,863,219	0	(5,863,219)	0.0%
0	0	0	0.0%	COVID Vaccination Incentive	50,541	0	(50,541)	0.0%
866,906	722,732	(144,174)	(19.9%)	ECM Base FFS Ancillary	5,103,664	4,308,957	(794,707)	(18.4%)
1,135	10,001	8,866	88.7%	ECM Outreach FFS Ancillary	5,890	60,000	54,110	90.2%
397,484	398,608	1,124	0.3%	CS - Housing Deposits FFS Ancillary	2,391,647	2,391,647	0	0.0%
407,667	407,667	0	0.0%	CS - Housing Tenancy FFS Ancillary	2,446,002	2,446,002	0	0.0%
298,956	298,956	0	0.0%	CS - Housing Navigation Services FFS Ancillary	1,793,735	1,793,736	1	0.0%
241,313	241,312	(1)	0.0%	CS - Medical Respite FFS Ancillary	1,447,875	1,447,872	(3)	0.0%
230,081	230,081	0	0.0%	CS - Medically Tailored Meals FFS Ancillary	1,380,488	1,380,486	(2)	0.0%
35,244	35,244	0	0.0%	CS - Asthma Remediation FFS Ancillary	211,467	211,464	(3)	0.0%
0	0	0	0.0%	MOT- Wrap Around (Non Medical MOT Cost)	634	0	(634)	0.0%
5,974,906	**6,409,049**	**434,142**	**6.8%**	**9-Ancillary Medical Expense**	**69,845,406**	**64,144,738**	**(5,700,668)**	**(8.9%)**
(253,146)	0	253,146	0.0%	IBNP-Outpatient	963,612	0	(963,612)	0.0%
(7,594)	0	7,594	0.0%	IBNP Settlement (OP)	28,910	0	(28,910)	0.0%
(20,252)	0	20,252	0.0%	IBNP Claims Fluctuation (OP)	77,088	0	(77,088)	0.0%
1,513,464	8,184,228	6,670,764	81.5%	Out-Patient FFS	15,965,208	99,937,467	83,972,259	84.0%
1,397,256	0	(1,397,256)	0.0%	OP Ambul Surgery - FFS	15,826,875	0	(15,826,875)	0.0%
1,198,681	0	(1,198,681)	0.0%	OP Fac Imaging Services-FFS	13,874,919	0	(13,874,919)	0.0%
733,055	0	(733,055)	0.0%	Behav Health - FFS	17,792,200	0	(17,792,200)	0.0%
1,284,985	0	(1,284,985)	0.0%	Behavioral Health Therapy - FFS	7,305,543	0	(7,305,543)	0.0%
547,706	0	(547,706)	0.0%	OP Facility - Lab FFS	5,716,271	0	(5,716,271)	0.0%
132,723	0	(132,723)	0.0%	OP Facility - Cardio FFS	1,270,467	0	(1,270,467)	0.0%
42,901	0	(42,901)	0.0%	OP Facility - PT/OT/ST FFS	567,925	0	(567,925)	0.0%
1,580,551	0	(1,580,551)	0.0%	OP Facility - Dialysis FFS	19,957,392	0	(19,957,392)	0.0%
8,150,330	**8,184,228**	**33,898**	**0.4%**	**10-Outpatient Medical Expense Medical Expense**	**99,346,407**	**99,937,467**	**591,060**	**0.6%**
(604,902)	0	604,902	0.0%	IBNP-Emergency	1,078,406	0	(1,078,406)	0.0%
(18,147)	0	18,147	0.0%	IBNP Settlement (ER)	32,353	0	(32,353)	0.0%
(48,393)	0	48,393	0.0%	IBNP Claims Fluctuation (ER)	86,276	0	(86,276)	0.0%
690,138	0	(690,138)	0.0%	Special ER Physician-FFS	7,400,192	0	(7,400,192)	0.0%
4,115,326	4,334,454	219,128	5.1%	ER-Facility	45,524,516	53,202,051	7,677,535	14.4%
4,134,023	**4,334,454**	**200,431**	**4.6%**	**11-Emergency Expense**	**54,121,742**	**53,202,051**	**(919,691)**	**(1.7%)**
(268,908)	0	268,908	0.0%	IBNP-Pharmacy	266,971	0	(266,971)	0.0%
(8,067)	0	8,067	0.0%	IBNP Settlement (RX)	8,010	0	(8,010)	0.0%
(21,513)	0	21,513	0.0%	IBNP Claims Fluctuation (RX)	21,360	0	(21,360)	0.0%
368,554	376,129	7,575	2.0%	Pharmacy-FFS	72,481,960	71,529,235	(952,725)	(1.3%)
6,407,663	4,879,646	(1,528,017)	(31.3%)	Pharmacy- Non-PBM FFS-Other Anc	63,056,832	57,045,503	(6,011,329)	(10.5%)
(663)	0	663	0.0%	HMS RX Refunds	(752,996)	0	752,996	0.0%
(191,663)	(18,132)	173,531	(957.0%)	Pharmacy-Rebate	(3,616,791)	(3,536,948)	79,843	(2.3%)
6,285,403	**5,237,643**	**(1,047,760)**	**(20.0%)**	**12-Pharmacy Expense**	**131,465,345**	**125,037,790**	**(6,427,555)**	**(5.1%)**
62,427,302	**61,511,674**	**(915,628)**	**(1.5%)**	**13-TOTAL FFS MEDICAL EXPENSES**	**802,459,475**	**783,994,542**	**(18,464,933)**	**(2.4%)**
0	(47,122)	(47,122)	100.0%	Clinical Vacancy	0	(433,222)	(433,222)	100.0%
98,478	116,982	18,504	15.8%	Quality Analytics	979,197	1,101,049	121,852	11.1%
453,672	468,535	14,863	3.2%	Health Plan Services Department Total	4,938,674	5,765,777	827,103	14.3%
192,530	421,167	228,637	54.3%	Case & Disease Management Department Total	3,167,986	6,297,258	3,129,272	49.7%
1,763,379	254,512	(1,508,867)	(592.8%)	Medical Services Department Total	9,989,817	2,324,198	(7,665,619)	(329.8%)
434,993	750,033	315,040	42.0%	Quality Management Department Total	5,253,945	8,249,560	2,995,615	36.3%
60,762	123,536	62,774	50.8%	HCS Behavioral Health Department Total	455,727	842,831	387,104	45.9%
127,747	128,070	323	0.3%	Pharmacy Services Department Total	1,452,656	1,547,043	94,387	6.1%
105,695	65,897	(39,798)	(60.4%)	Regulatory Readiness Total	706,696	557,167	(149,529)	(26.8%)
3,237,256	**2,281,610**	**(955,646)**	**(41.9%)**	**14-Other Benefits & Services**	**26,944,699**	**26,251,661**	**(693,037)**	**(2.6%)**
				Reinsurance Expense				
(1,819,289)	(410,927)	1,408,362	(342.7%)	Reinsurance Recoveries	(8,237,001)	(5,460,682)	2,776,319	(50.8%)
569,201	547,903	(21,298)	(3.9%)	Stop-Loss Expense	6,615,535	6,504,997	(110,538)	(1.7%)
(1,250,088)	**136,976**	**1,387,064**	**1,012.6%**	**15-Reinsurance Expense**	**(1,621,466)**	**1,044,315**	**2,665,781**	**255.3%**
87,571,811	**86,064,548**	**(1,507,263)**	**(1.8%)**	**17-TOTAL MEDICAL EXPENSES**	**1,098,118,254**	**1,078,512,340**	**(19,605,914)**	**(1.8%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Current Membership by Network By Category of Aid							
Category of Aid	**Jun 2022**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	46,761	15%	9,159	9,418	744	18,874	8,566
Child	100,772	33%	7,437	9,224	30,447	35,205	18,459
SPD	27,105	9%	8,297	4,250	1,020	11,436	2,102
ACA OE	110,938	36%	16,505	36,076	1,197	42,489	14,671
Duals	21,685	7%	8,196	2,378	-	7,823	3,288
Medi-Cal	307,261		49,594	61,346	33,408	115,827	47,086
Group Care	5,795		2,342	869	-	2,584	-
Total	**313,056**	**100%**	**51,936**	**62,215**	**33,408**	**118,411**	**47,086**
Medi-Cal %	98.1%		95.5%	98.6%	100.0%	97.8%	100.0%
Group Care %	1.9%		4.5%	1.4%	0.0%	2.2%	0.0%
		Network Distribution	*16.6%*	*19.9%*	*10.7%*	*37.8%*	*15.0%*
			% Direct:	**36%**		**% Delegated:**	**64%**

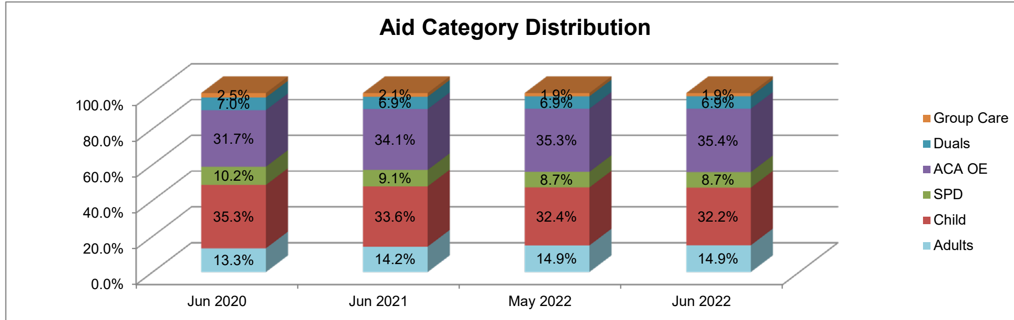




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

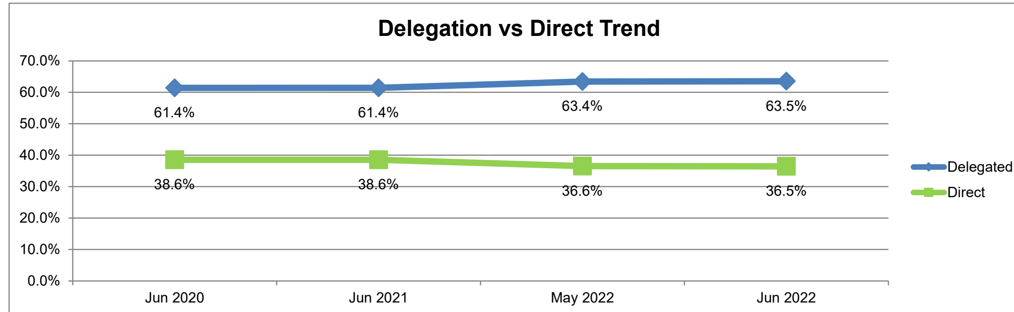
Category of Aid Trend

Category of Aid	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jun 2020	Jun 2021	May 2022	Jun 2022	Jun 2020	Jun 2021	May 2022	Jun 2022	Jun 2020 to Jun 2021	Jun 2021 to Jun 2022	May 2022 to Jun 2022
Adults	34,087	40,966	46,171	46,761	13.3%	14.2%	14.9%	14.9%	20.2%	14.1%	1.3%
Child	90,745	97,048	100,560	100,772	35.3%	33.6%	32.4%	32.2%	6.9%	3.8%	0.2%
SPD	26,111	26,323	26,958	27,105	10.2%	9.1%	8.7%	8.7%	0.8%	3.0%	0.5%
ACA OE	81,296	98,281	109,734	110,938	31.7%	34.1%	35.3%	35.4%	20.9%	12.9%	1.1%
Duals	18,069	19,988	21,527	21,685	7.0%	6.9%	6.9%	6.9%	10.6%	8.5%	0.7%
Medi-Cal Total	250,308	282,606	304,950	307,261	97.5%	97.9%	98.1%	98.1%	12.9%	8.7%	0.8%
Group Care	6,437	5,948	5,808	5,795	2.5%	2.1%	1.9%	1.9%	-7.6%	-2.6%	-0.2%
Total	**256,745**	**288,554**	**310,758**	**313,056**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**12.4%**	**8.5%**	**0.7%**



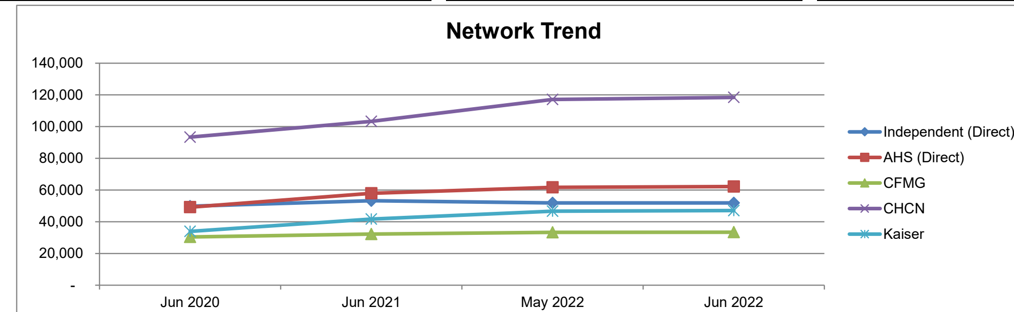
Delegation vs Direct Trend

Members	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jun 2020	Jun 2021	May 2022	Jun 2022	Jun 2020	Jun 2021	May 2022	Jun 2022	Jun 2020 to Jun 2021	Jun 2021 to Jun 2022	May 2022 to Jun 2022
Delegated	157,755	177,296	197,155	198,905	61.4%	61.4%	63.4%	63.5%	12.4%	12.2%	0.9%
Direct	98,990	111,258	113,603	114,151	38.6%	38.6%	36.6%	36.5%	12.4%	2.6%	0.5%
Total	**256,745**	**288,554**	**310,758**	**313,056**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**12.4%**	**8.5%**	**0.7%**



Network Trend

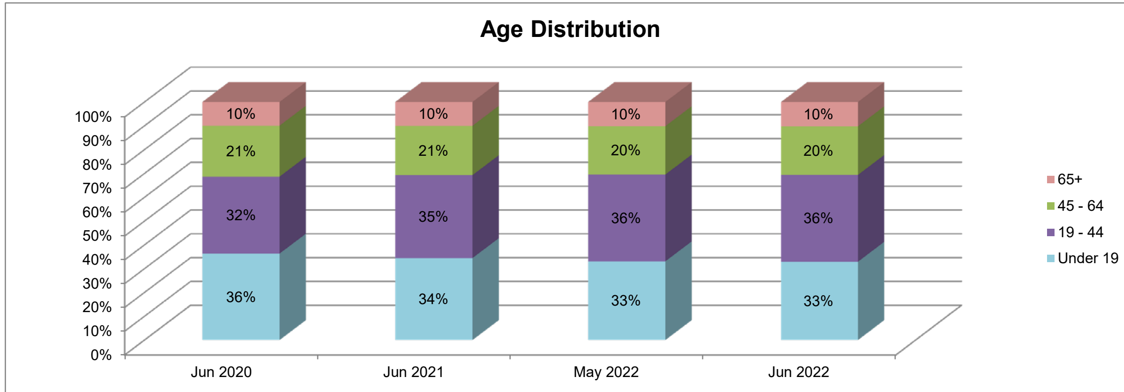
Network	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jun 2020	Jun 2021	May 2022	Jun 2022	Jun 2020	Jun 2021	May 2022	Jun 2022	Jun 2020 to Jun 2021	Jun 2021 to Jun 2022	May 2022 to Jun 2022
Independent (Direct)	49,813	53,280	51,910	51,936	19.4%	18.5%	16.7%	16.6%	7.0%	-2.5%	0.1%
AHS (Direct)	49,177	57,978	61,693	62,215	19.2%	20.1%	19.9%	19.9%	17.9%	7.3%	0.8%
CFMG	30,425	32,197	33,378	33,408	11.9%	11.2%	10.7%	10.7%	5.8%	3.8%	0.1%
CHCN	93,392	103,339	117,163	118,411	36.4%	35.8%	37.7%	37.8%	10.7%	14.6%	1.1%
Kaiser	33,938	41,760	46,614	47,086	13.2%	14.5%	15.0%	15.0%	23.0%	12.8%	1.0%
Total	**256,745**	**288,554**	**310,758**	**313,056**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**12.4%**	**8.5%**	**0.7%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

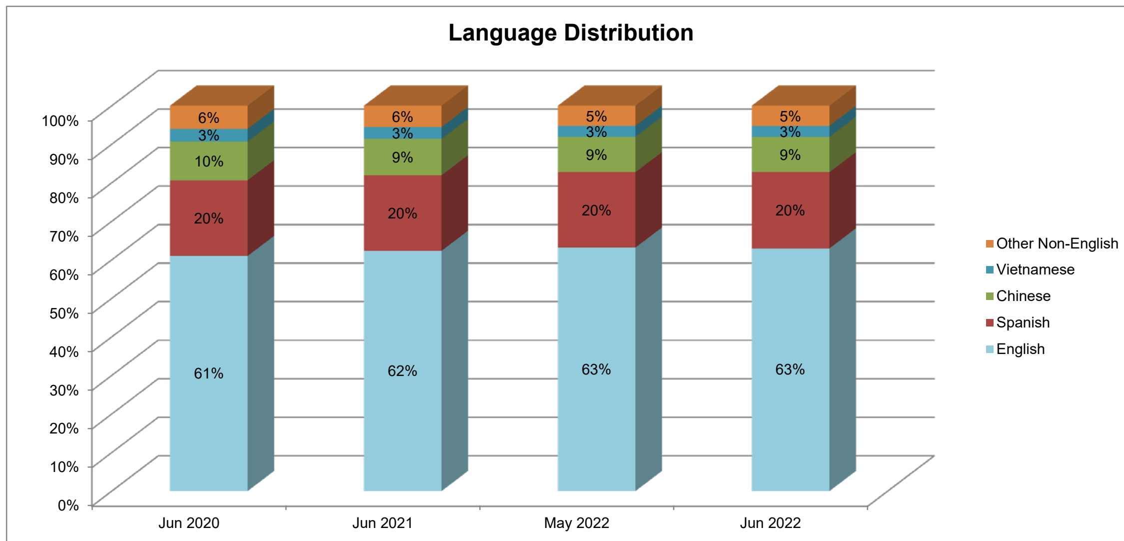
Age Category Trend

Age Category	Members: Jun 2020	Jun 2021	May 2022	Jun 2022	% of Total (ie.Distribution): Jun 2020	Jun 2021	May 2022	Jun 2022	% Growth (Loss): Jun 2020 to Jun 2021	Jun 2021 to Jun 2022	May 2022 to Jun 2022
Under 19	93,270	99,380	102,823	103,026	36%	34%	33%	33%	7%	4%	0%
19 - 44	83,006	100,530	113,325	114,184	32%	35%	36%	36%	21%	14%	1%
45 - 64	54,927	59,806	63,061	63,899	21%	21%	20%	20%	9%	7%	1%
65+	25,542	28,838	31,549	31,947	10%	10%	10%	10%	13%	11%	1%
Total	**256,745**	**288,554**	**310,758**	**313,056**	**100%**	**100%**	**100%**	**100%**	**12%**	**8%**	**1%**



Language Trend

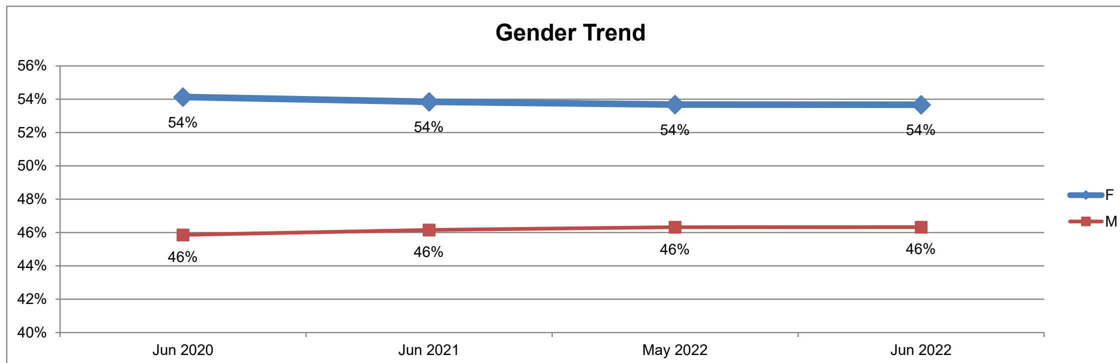
Language	Members: Jun 2020	Jun 2021	May 2022	Jun 2022	% of Total (ie.Distribution): Jun 2020	Jun 2021	May 2022	Jun 2022	% Growth (Loss): Jun 2020 to Jun 2021	Jun 2021 to Jun 2022	May 2022 to Jun 2022
English	156,593	179,840	196,309	197,106	61%	62%	63%	63%	15%	10%	0%
Spanish	50,437	56,529	60,778	61,849	20%	20%	20%	20%	12%	9%	2%
Chinese	25,843	27,322	28,583	28,802	10%	9%	9%	9%	6%	5%	1%
Vietnamese	8,437	8,826	8,868	8,868	3%	3%	3%	3%	5%	0%	0%
Other Non-English	15,435	16,037	16,220	16,431	6%	6%	5%	5%	4%	2%	1%
Total	**256,745**	**288,554**	**310,758**	**313,056**	**100%**	**100%**	**100%**	**100%**	**12%**	**8%**	**1%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

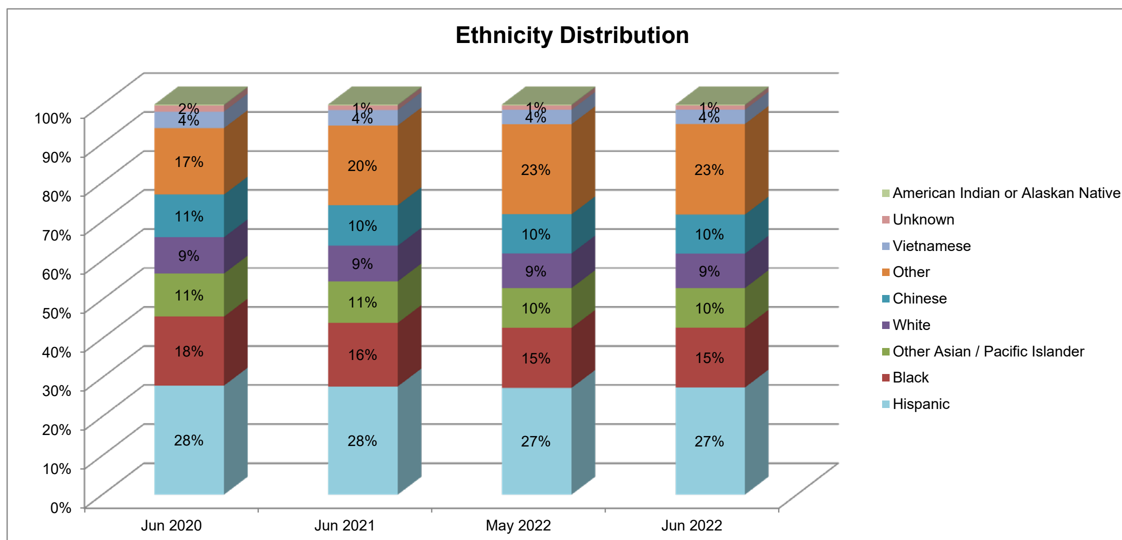
Gender Trend

Gender	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jun 2020	Jun 2021	May 2022	Jun 2022	Jun 2020	Jun 2021	May 2022	Jun 2022	Jun 2020 to Jun 2021	Jun 2021 to Jun 2022	May 2022 to Jun 2022
F	138,995	155,381	166,816	168,023	54%	54%	54%	54%	12%	8%	1%
M	117,750	133,173	143,942	145,033	46%	46%	46%	46%	13%	9%	1%
Total	**256,745**	**288,554**	**310,758**	**313,056**	**100%**	**100%**	**100%**	**100%**	**12%**	**8%**	**1%**



Ethnicity Trend

Ethnicity	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jun 2020	Jun 2021	May 2022	Jun 2022	Jun 2020	Jun 2021	May 2022	Jun 2022	Jun 2020 to Jun 2021	Jun 2021 to Jun 2022	May 2022 to Jun 2022
Hispanic	71,641	79,920	84,892	85,824	28%	28%	27%	27%	12%	7%	1%
Black	45,453	47,000	47,883	48,031	18%	16%	15%	15%	3%	2%	0%
Other Asian / Pacific Islander	28,304	30,688	31,631	31,777	11%	11%	10%	10%	8%	4%	0%
White	23,922	26,407	27,619	27,666	9%	9%	9%	9%	10%	5%	0%
Chinese	28,101	30,015	31,216	31,360	11%	10%	10%	10%	7%	4%	0%
Other	43,770	59,005	71,778	72,720	17%	20%	23%	23%	35%	23%	1%
Vietnamese	10,860	11,343	11,444	11,426	4%	4%	4%	4%	4%	1%	0%
Unknown	4,102	3,549	3,620	3,570	2%	1%	1%	1%	-13%	1%	-1%
American Indian or Alaskan Native	592	627	675	682	0%	0%	0%	0%	6%	9%	1%
Total	**256,745**	**288,554**	**310,758**	**313,056**	**100%**	**100%**	**100%**	**100%**	**12%**	**8%**	**1%**



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

Medi-Cal By City

City	Jun 2022	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	120,794	39%	12,889	29,376	14,145	51,043	13,341
Hayward	47,939	16%	7,204	10,549	5,448	16,145	8,593
Fremont	27,919	9%	9,830	4,378	966	8,030	4,715
San Leandro	27,852	9%	4,427	4,188	3,498	10,559	5,180
Union City	12,879	4%	3,911	2,022	521	3,922	2,503
Alameda	11,748	4%	2,045	1,933	1,643	4,199	1,928
Berkeley	11,476	4%	1,479	1,711	1,312	5,193	1,781
Livermore	9,426	3%	1,065	740	1,882	4,013	1,726
Newark	7,131	2%	1,853	2,299	232	1,393	1,354
Castro Valley	7,699	3%	1,276	1,246	1,076	2,472	1,629
San Lorenzo	6,485	2%	834	1,126	719	2,415	1,391
Pleasanton	5,173	2%	978	425	512	2,336	922
Dublin	5,555	2%	995	443	685	2,367	1,065
Emeryville	2,078	1%	323	412	297	676	370
Albany	1,936	1%	266	222	368	684	396
Piedmont	373	0%	51	106	21	98	97
Sunol	61	0%	10	10	6	21	14
Antioch	18	0%	8	3	1	4	2
Other	719	0%	150	157	76	257	79
Total	**307,261**	**100%**	**49,594**	**61,346**	**33,408**	**115,827**	**47,086**

Group Care By City

City	Jun 2022	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	1,915	33%	454	366	-	1,095	-
Hayward	648	11%	323	137	-	188	-
Fremont	621	11%	453	46	-	122	-
San Leandro	580	10%	224	93	-	263	-
Union City	311	5%	218	28	-	65	-
Alameda	276	5%	99	17	-	160	-
Berkeley	169	3%	48	11	-	110	-
Livermore	83	1%	27	1	-	55	-
Newark	150	3%	89	40	-	21	-
Castro Valley	185	3%	83	17	-	85	-
San Lorenzo	124	2%	48	17	-	59	-
Pleasanton	58	1%	24	3	-	31	-
Dublin	104	2%	34	11	-	59	-
Emeryville	34	1%	13	6	-	15	-
Albany	15	0%	6	1	-	8	-
Piedmont	14	0%	4	-	-	10	-
Sunol	-	0%	-	-	-	-	-
Antioch	24	0%	5	6	-	13	-
Other	484	8%	190	69	-	225	-
Total	**5,795**	**100%**	**2,342**	**869**	**-**	**2,584**	**-**

Total By City

City	Jun 2022	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	122,709	39%	13,343	29,742	14,145	52,138	13,341
Hayward	48,587	16%	7,527	10,686	5,448	16,333	8,593
Fremont	28,540	9%	10,283	4,424	966	8,152	4,715
San Leandro	28,432	9%	4,651	4,281	3,498	10,822	5,180
Union City	13,190	4%	4,129	2,050	521	3,987	2,503
Alameda	12,024	4%	2,144	1,950	1,643	4,359	1,928
Berkeley	11,645	4%	1,527	1,722	1,312	5,303	1,781
Livermore	9,509	3%	1,092	741	1,882	4,068	1,726
Newark	7,281	2%	1,942	2,339	232	1,414	1,354
Castro Valley	7,884	3%	1,359	1,263	1,076	2,557	1,629
San Lorenzo	6,609	2%	882	1,143	719	2,474	1,391
Pleasanton	5,231	2%	1,002	428	512	2,367	922
Dublin	5,659	2%	1,029	454	685	2,426	1,065
Emeryville	2,112	1%	336	418	297	691	370
Albany	1,951	1%	272	223	368	692	396
Piedmont	387	0%	55	106	21	108	97
Sunol	61	0%	10	10	6	21	14
Antioch	42	0%	13	9	1	17	2
Other	1,203	0%	340	226	76	482	79
Total	**313,056**	**100%**	**51,936**	**62,215**	**33,408**	**118,411**	**47,086**

Finance Committee Report

For the month of July 2022

To: Alameda Alliance for Health Board of Governors

From: Gil Riojas, Chief Financial Officer

Date: October 14th, 2022

Subject: Finance Report - July 2022

Executive Summary

- For the month ended July 31st, 2022, the Alliance had enrollment of 317,629 members, a Net Income of $5.7 million and 625% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$100,828	$100,828
Medical Expense	90,861	90,861
Admin. Expense	4,728	4,728
Other Inc. / (Exp.)	466	466
Net Income	**$5,705**	**$5,705**

Net Income by Program:

	Month	YTD
Medi-Cal	$5,428	$5,428
Group Care	276	276
	$5,705	**$5,705**

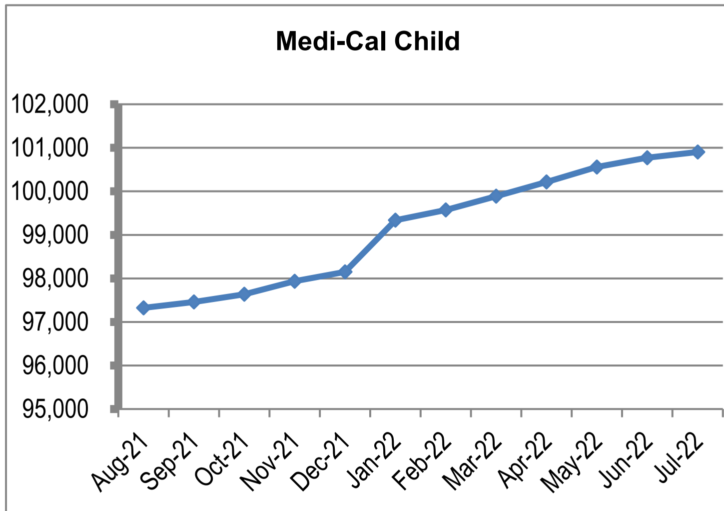
Enrollment

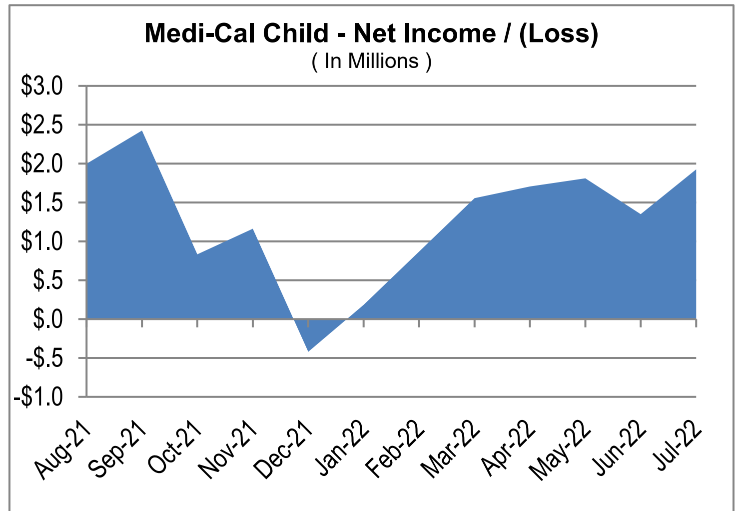
- Total enrollment increased by 4,573 members since June 2022.

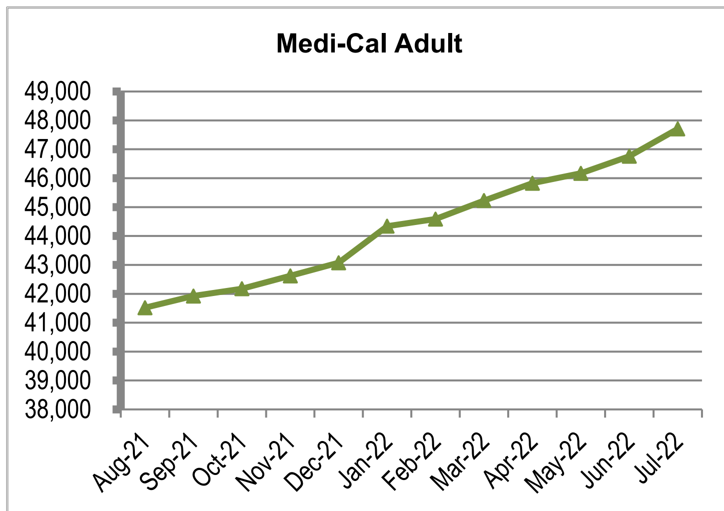
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

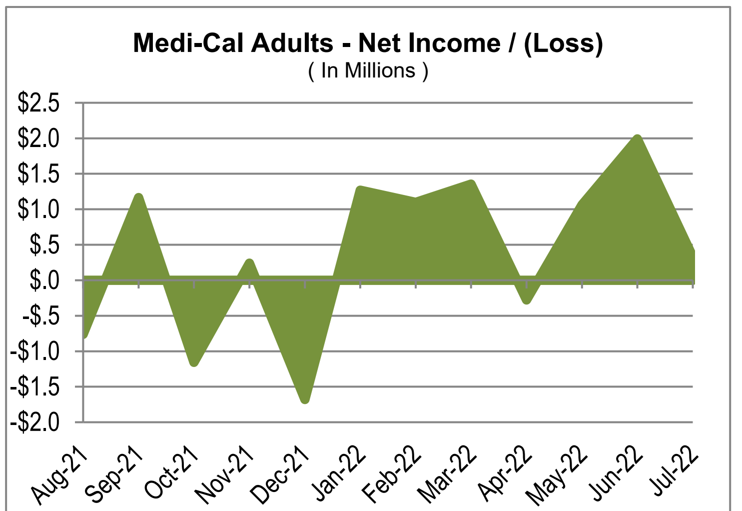
Enrollment					Member Months			
July-2022					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
47,707	46,703	1,004	2.1%	Adult	47,707	46,703	1,004	2.1%
100,903	101,120	(217)	-0.2%	Child	100,903	101,120	(217)	-0.2%
27,991	28,283	(292)	-1.0%	SPD	27,991	28,283	(292)	-1.0%
21,910	21,650	260	1.2%	Duals	21,910	21,650	260	1.2%
113,322	113,561	(239)	-0.2%	ACA OE	113,322	113,561	(239)	-0.2%
311,833	**311,317**	**516**	**0.2%**	**Medi-Cal Total**	**311,833**	**311,317**	**516**	**0.2%**
5,796	5,828	(32)	-0.5%	Group Care	5,796	5,828	(32)	-0.5%
317,629	**317,145**	**484**	**0.2%**	**Total**	**317,629**	**317,145**	**484**	**0.2%**

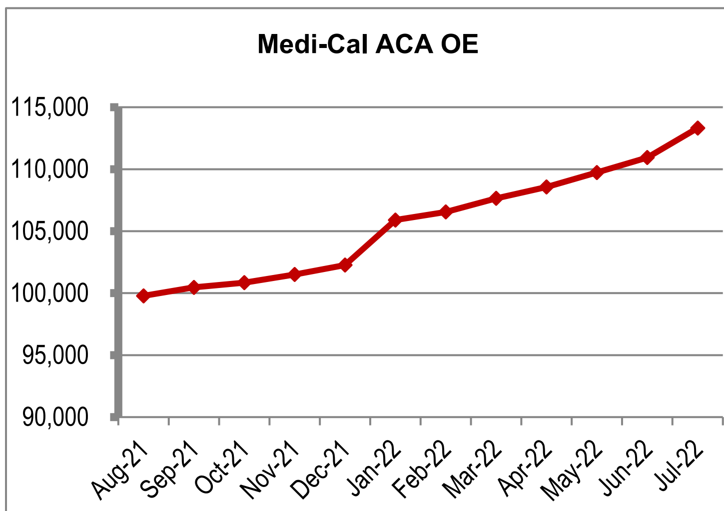
Enrollment and Profitability by Program and Category of Aid

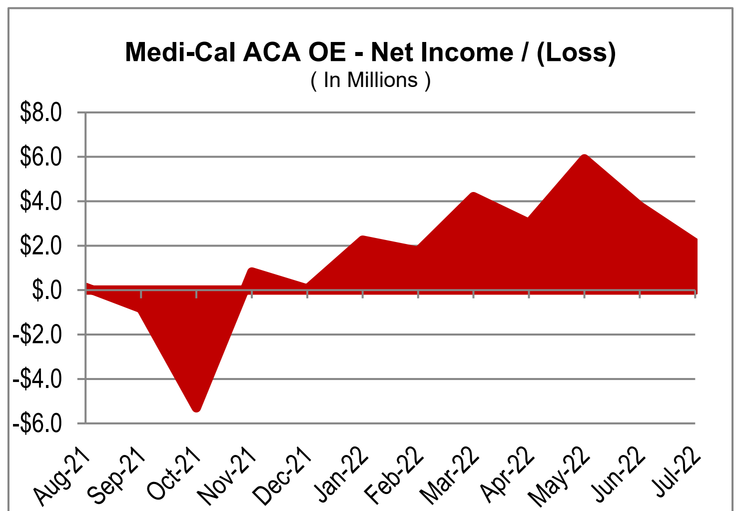




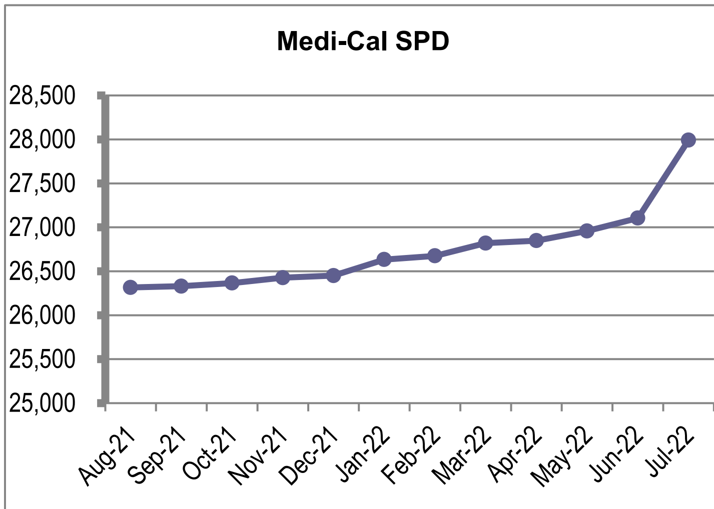


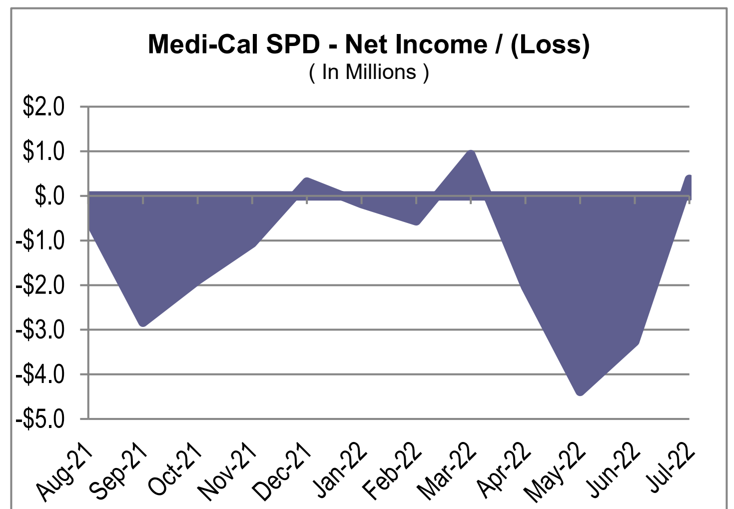


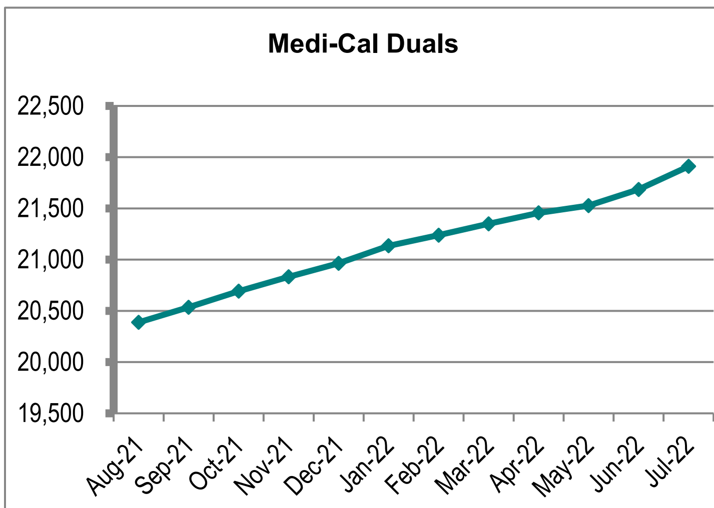


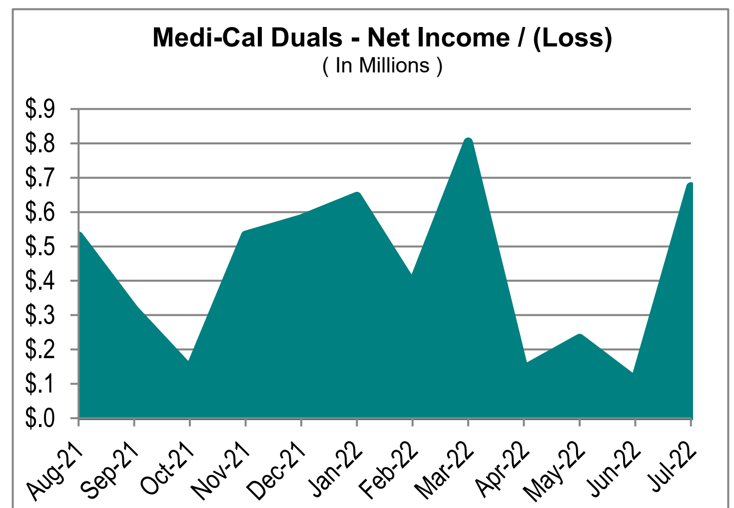


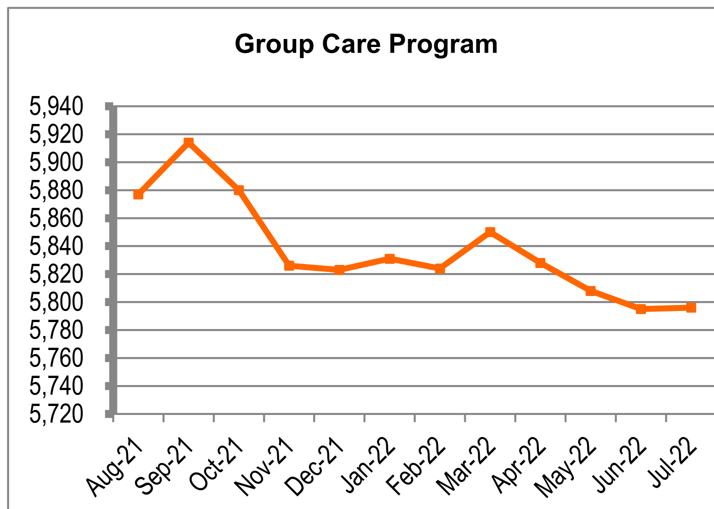
Enrollment and Profitability by Program and Category of Aid

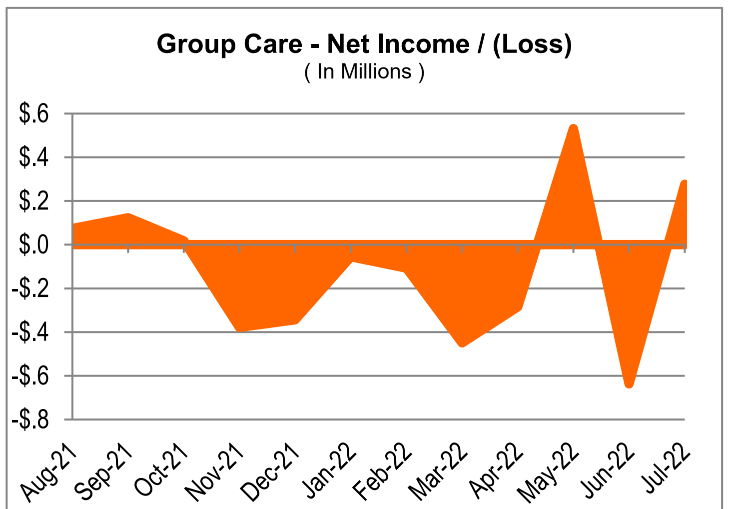




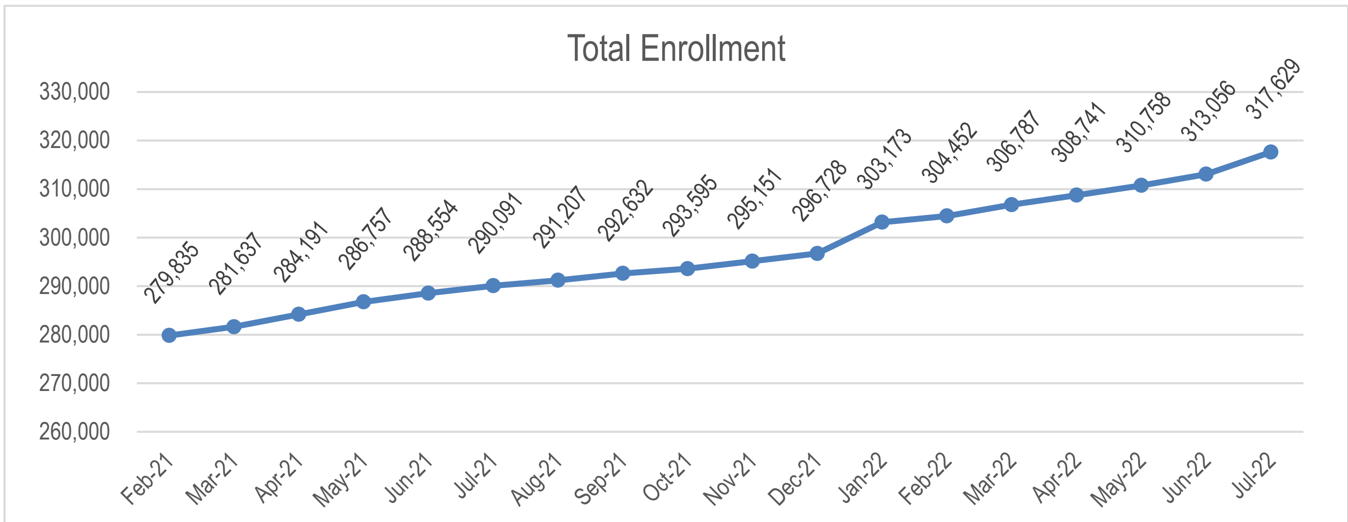


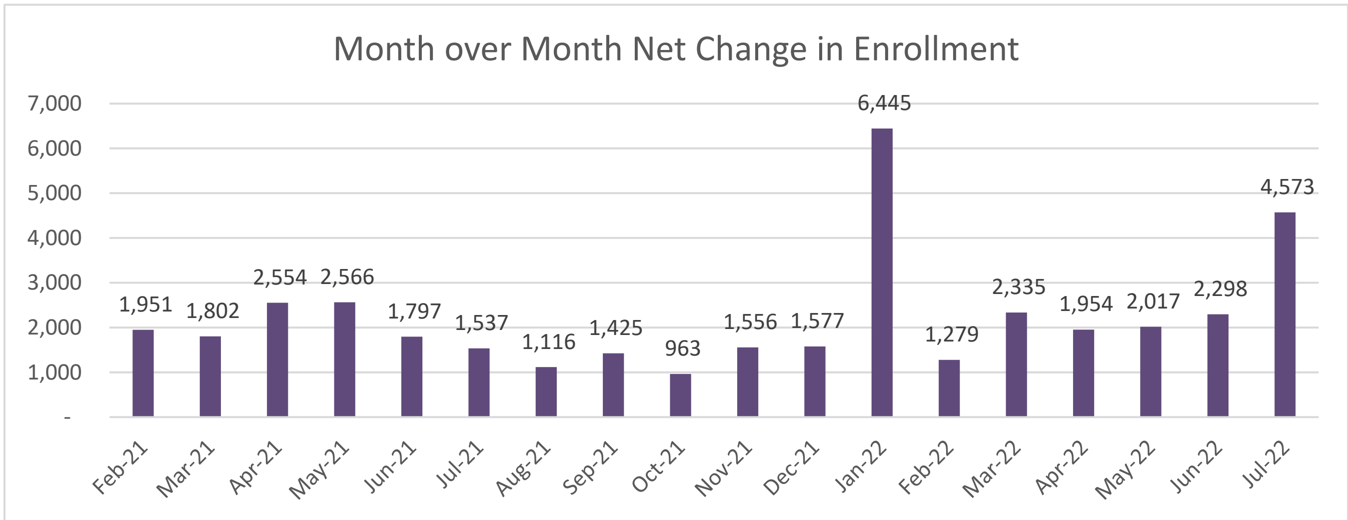






Net Change in Enrollment

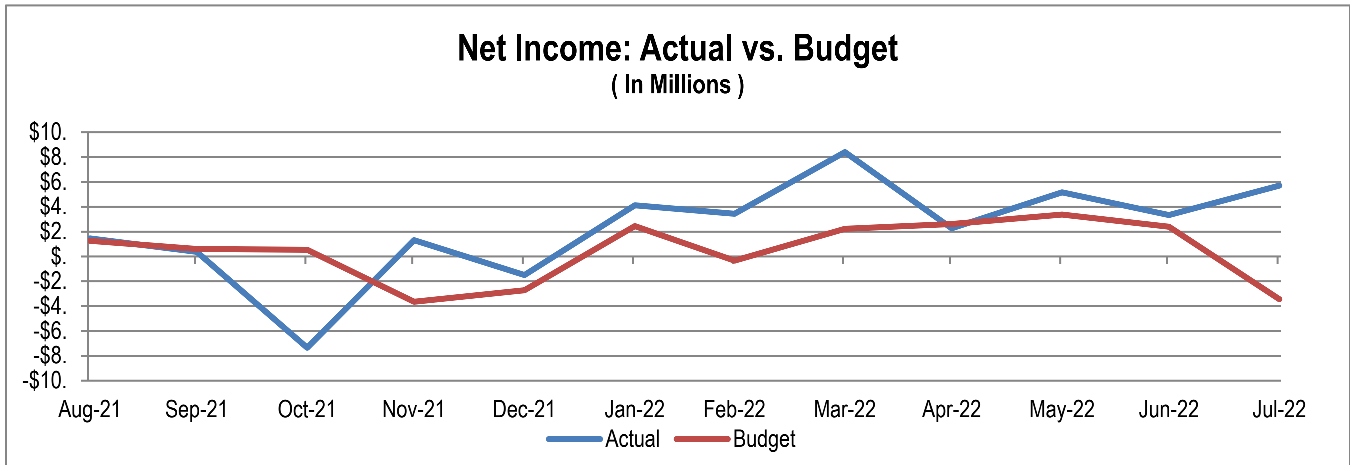




- The disenrollment process associated with the Public Health Emergency (PHE) is projected to restart in early calendar year 2023.

Net Income

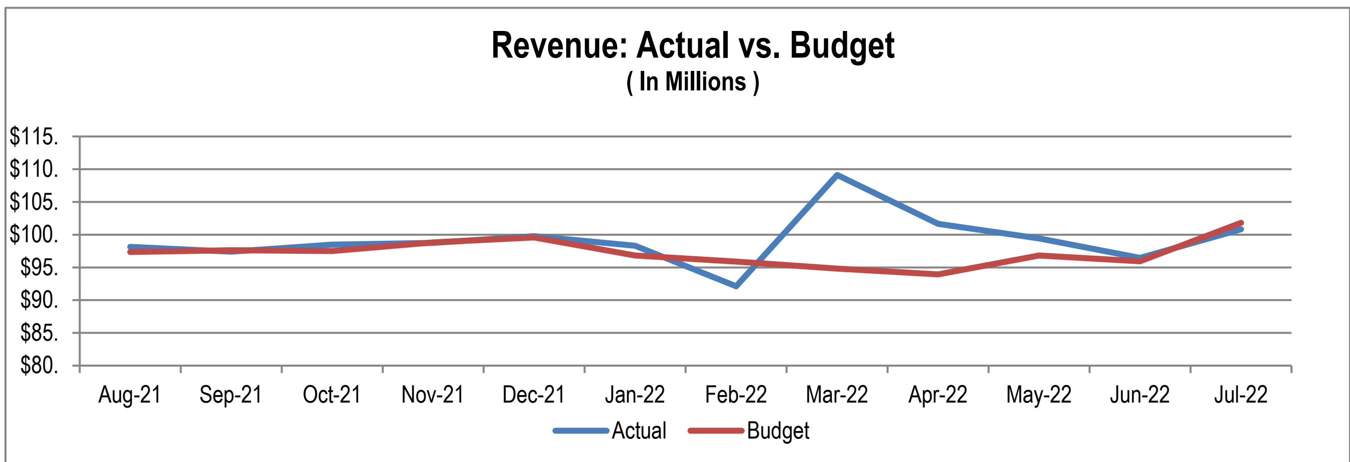
- For the month and fiscal YTD ended July 31st, 2022:
  - Actual Net Income: $5.7 million.
  - Budgeted Net Loss: $3.4 million.



- The favorable variance of $9.1 million in the current month is primarily due to:
    - Favorable $7.9 million lower than anticipated Medical Expense.
    - Favorable $1.8 million lower than anticipated Administrative Expense.
    - Favorable $417,000 higher than anticipated Total Other Income.
    - Offset by unfavorable $986,000 lower than anticipated Revenue.

Revenue

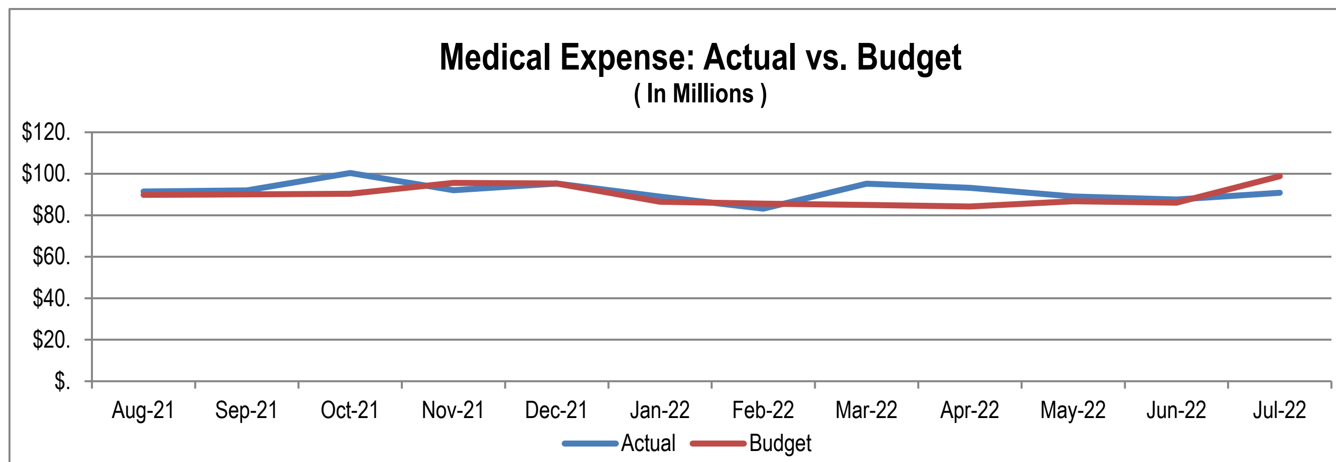
- For the month and fiscal YTD ended July 31st, 2022:
    - Actual Revenue: $100.8 million.
    - Budgeted Revenue: $101.8 million.



- For the month ended July 31st, 2022, the unfavorable revenue variance of $985,000 is primarily due to an unfavorable $700,000 accrual to Medi-Cal Base Capitation Revenue for an anticipated member health acuity adjustment by DHCS, unfavorable Prop 56 Revenue, and unfavorable Behavioral Health Revenue, partially offset by favorable Maternity Revenue.

Medical Expense

- For the month and fiscal YTD ended July 31st, 2022:
  - Actual Medical Expense: $90.9 million.
  - Budgeted Medical Expense: $98.8 million.



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

- Updates to Fee-For-Service (FFS) decreased the estimate for unpaid Medical Expenses prior months by $2.5 million (per table below).

Medical Expense - Actual vs. Budget (In Dollars)
Adjusted to Eliminate the Impact of Prior Period IBNP Estimates

	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$24,103,109	$0	$24,103,109	$23,870,528	($232,581)	-1.0%
Primary Care FFS	4,240,252	($33,019)	$4,207,233	4,183,752	($56,501)	-1.4%
Specialty Care FFS	5,031,645	($10,962)	$5,020,683	5,160,134	$128,489	2.5%
Outpatient FFS	8,925,359	($509,970)	$8,415,389	9,021,351	$95,992	1.1%
Ancillary FFS	7,273,937	($473,656)	$6,800,281	7,272,498	($1,439)	0.0%
Pharmacy FFS	5,840,730	($427,622)	$5,413,108	6,466,783	$626,053	9.7%
ER Services FFS	4,722,624	$134,721	$4,857,346	5,499,897	$777,272	14.1%
Inpatient Hospital & SNF FFS	31,290,947	($1,156,387)	$30,134,560	32,992,713	$1,701,766	5.2%
Other Benefits & Services	1,758,107	$0	$1,758,107	4,121,926	$2,363,819	57.3%
Net Reinsurance	151,115	$0	$151,115	217,220	$66,104	30.4%
	$93,337,825	**($2,476,895)**	**$90,860,931**	**$98,806,801**	**$5,468,976**	**5.5%**

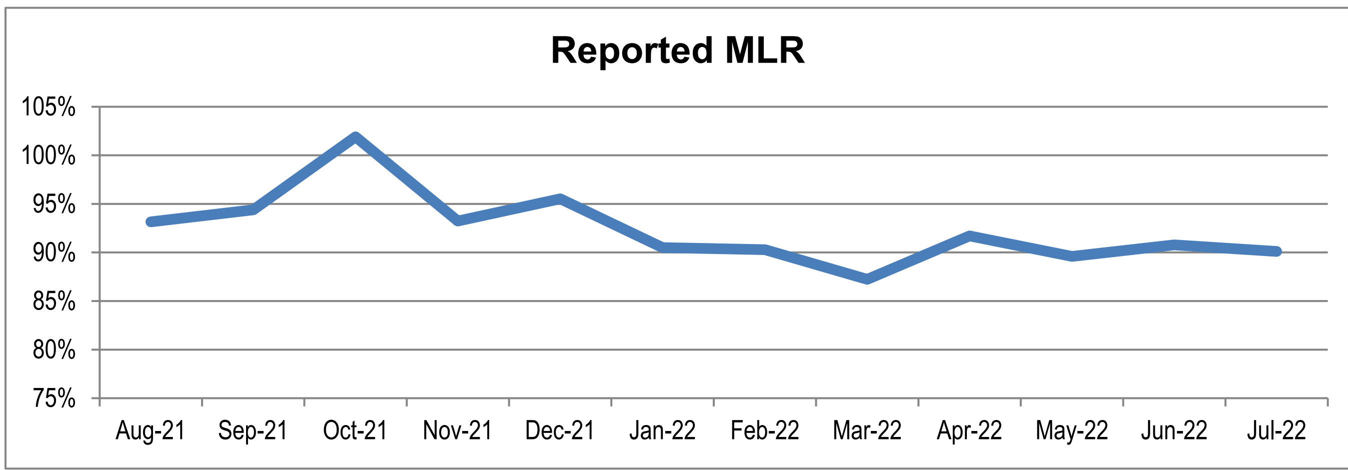
Medical Expense - Actual vs. Budget (Per Member Per Month) Adjusted to Eliminate the Impact of Prior Year IBNP Estimates						
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$75.88	$0.00	$75.88	$75.27	($0.62)	-0.8%
Primary Care FFS	$13.35	($0.10)	$13.25	$13.19	($0.16)	-1.2%
Specialty Care FFS	$15.84	($0.03)	$15.81	$16.27	$0.43	2.6%
Outpatient FFS	$28.10	($1.61)	$26.49	$28.45	$0.35	1.2%
Ancillary FFS	$22.90	($1.49)	$21.41	$22.93	$0.03	0.1%
Pharmacy FFS	$18.39	($1.35)	$17.04	$20.39	$2.00	9.8%
ER Services FFS	$14.87	$0.42	$15.29	$17.34	$2.47	14.3%
Inpatient Hospital & SNF FFS	$98.51	($3.64)	$94.87	$104.03	$5.52	5.3%
Other Benefits & Services	$5.54	$0.00	$5.54	$13.00	$7.46	57.4%
Net Reinsurance	$0.48	$0.00	$0.48	$0.68	$0.21	30.5%
	$293.86	**($7.80)**	**$286.06**	**$311.55**	**$17.69**	**5.7%**

- Excluding the effect of prior year estimates for IBNP, year-to-date medical expense variance is $5.5 million favorable to preliminary budget. On a PMPM basis, medical expense is 5.7% favorable to budget. For per-member-per-month expense:
  - Capitated Expense is unfavorable to budget. Unfavorable Maternity and BHT Expenses are partially offset by favorable global delegate expense.
  - Primary Care Expense is above budget, driven by unfavorable utilization in the ACA OE and SPD populations and unfavorable unit cost in the Group Care population.
  - Specialty Care Expense is favorable to budget, which is generally driven by favorable unit cost in the ACA OE and Adult populations and favorable utilization in the Duals population.
  - Outpatient Expense is under budget, driven by favorable unit cost offset by unfavorable utilization.
  - Ancillary Expense is over budget due to Home Heath, DME, Outpatient Therapy, Laboratory and Radiology, CBAS, Non-Emergency Transportation and ECM, offset by Other Medical Professional, Ambulance and Hospice service categories. Overall utilization is unfavorable, offset by favorable unit cost.
  - Pharmacy Expense is under budget due to favorable Non-PBM expense, driven by favorable utilization across all populations except for Group Care.
  - Emergency Room Expense is under budget driven by favorable unit cost across all populations except for Group Care.
  - Inpatient Expense is under budget, driven by favorable utilization in the SPD, ACA OE, Adult and Child populations.

- Other Benefits & Services are favorable to budget, primarily due to favorable purchased and professional, printing/postage/promotion and employee expense.
- 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 90.1% for the month and 90.1% for the fiscal year-to-date.



Administrative Expense

- For the month and fiscal YTD ended July 31st, 2022:
  - Actual Administrative Expense: $4.7 million.
  - Budgeted Administrative Expense: $6.5 million.

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

Month					Year-to-Date			
Actual	**Budget**	**Variance $**	**Variance %**		**Actual**	**Budget**	**Variance $**	**Variance %**
$3,079,402	$3,623,030	$543,628	15.0%	Employee Expense	$3,079,402	$3,623,030	$543,628	15.0%
299,172	314,648	15,476	4.9%	Medical Benefits Admin Expense	299,172	314,648	15,476	4.9%
526,842	1,479,926	953,084	64.4%	Purchased & Professional Services	526,842	1,479,926	953,084	64.4%
822,830	1,081,213	258,383	23.9%	Other Admin Expense	822,830	1,081,213	258,383	23.9%
$4,728,246	$6,498,817	$1,770,571	27.2%	Total Administrative Expense	$4,728,246	$6,498,817	$1,770,571	27.2%

Favorable $1.8 million variance is primarily due to:

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

- Delayed hiring of new employees.

Administrative loss ratio (ALR) represented 4.7% of net revenue for the month and year-to-date.

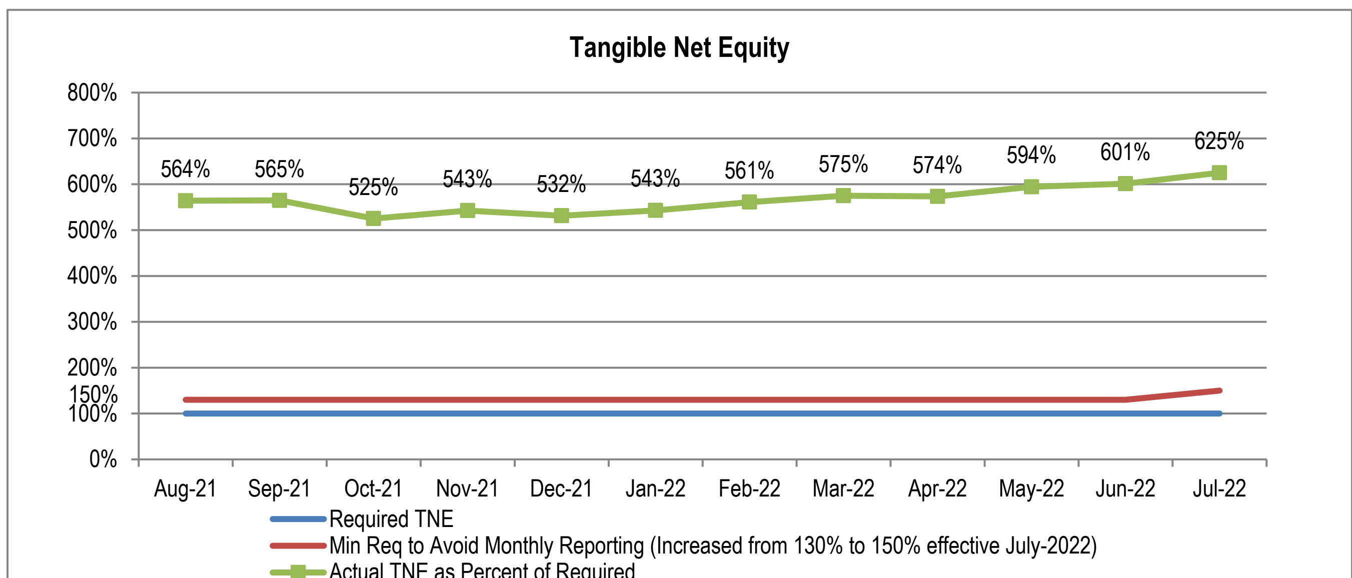
Other Income / (Expense)

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

- Fiscal year-to-date net investments total $466,000.
- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $24,000.

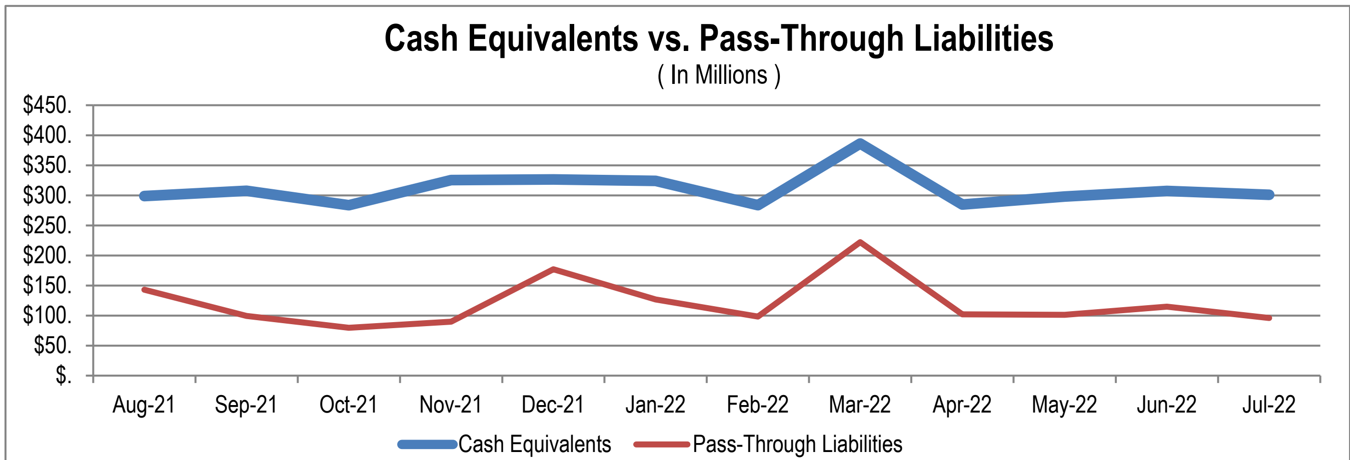
Tangible Net Equity (TNE)

- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to consumers. TNE is a calculation of a company's total tangible assets minus the company's total liabilities. The Alliance exceeds DMHC's required TNE.
  - Required TNE $37.8 million
  - Actual TNE $236.4 million
  - Excess TNE $198.6 million
  - TNE % of Required TNE 625%



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

- Key Metrics
    - Cash & Cash Equivalents $300.8 million
    - Pass-Through Liabilities $96.0 million
    - Uncommitted Cash $204.8 million
    - Working Capital $189.8 million
    - Current Ratio 1.72 (regulatory minimum is 1.0)



Capital Investment

- Fiscal year-to-date capital assets acquired: $0.

- Annual capital budget: $979,000.

- A summary of year-to-date capital asset acquisitions is included in this monthly financial statement package.

Caveats to Financial Statements

- We continue to caveat these financial statements that, due to challenges of projecting medical expense and liabilities based on incomplete claims experience, financial results are subject to revision.

- The full set of financial statements and reports are included in the Board of Governors Report. This is a high-level summary of key components of those statements, which are unaudited.

Finance

Supporting Documents

ALAMEDA ALLIANCE FOR HEALTH
STATEMENT OF REVENUE & EXPENSES
ACTUAL VS. BUDGET (WITH MEDICAL EXPENSE BY PAYMENT TYPE)
COMBINED BASIS (RESTRICTED & UNRESTRICTED FUNDS)
FOR THE MONTH AND FISCAL YTD ENDED July 31, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				MEMBERSHIP				
311,833	311,317	516	0.2%	1 - Medi-Cal	311,833	311,317	516	0.2%
5,796	5,828	(32)	(0.5%)	2 - Group Care	5,796	5,828	(32)	(0.5%)
317,629	**317,145**	**484**	**0.2%**	**3 - TOTAL MEMBER MONTHS**	**317,629**	**317,145**	**484**	**0.2%**
				REVENUE				
$100,828,452	**$101,813,708**	**($985,256)**	**(1.0%)**	**4 - TOTAL REVENUE**	**$100,828,452**	**$101,813,708**	**($985,256)**	**(1.0%)**
				MEDICAL EXPENSES				
				Capitated Medical Expenses:				
$24,103,109	$23,870,525	($232,584)	(1.0%)	5 - Capitated Medical Expense	$24,103,109	$23,870,525	($232,584)	(1.0%)
				Fee for Service Medical Expenses:				
$30,134,560	$32,992,714	$2,858,154	8.7%	6 - Inpatient Hospital & SNF FFS Expense	$30,134,560	$32,992,714	$2,858,154	8.7%
$4,207,233	$4,183,751	($23,482)	(0.6%)	7 - Primary Care Physician FFS Expense	$4,207,233	$4,183,751	($23,482)	(0.6%)
$5,020,683	$5,160,132	$139,449	2.7%	8 - Specialty Care Physician Expense	$5,020,683	$5,160,132	$139,449	2.7%
$6,800,281	$7,272,494	$472,213	6.5%	9 - Ancillary Medical Expense	$6,800,281	$7,272,494	$472,213	6.5%
$8,415,389	$9,021,352	$605,963	6.7%	10 - Outpatient Medical Expense	$8,415,389	$9,021,352	$605,963	6.7%
$4,857,346	$5,499,896	$642,550	11.7%	11 - Emergency Expense	$4,857,346	$5,499,896	$642,550	11.7%
$5,413,108	$6,466,782	$1,053,674	16.3%	12 - Pharmacy Expense	$5,413,108	$6,466,782	$1,053,674	16.3%
$64,848,600	$70,597,121	$5,748,521	8.1%	13 - Total Fee for Service Expense	$64,848,600	$70,597,121	$5,748,521	8.1%
$1,758,107	$4,121,928	$2,363,821	57.3%	14 - Other Benefits & Services	$1,758,107	$4,121,928	$2,363,821	57.3%
$151,115	$217,219	$66,104	30.4%	15 - Reinsurance Expense	$151,115	$217,219	$66,104	30.4%
$90,860,931	**$98,806,793**	**$7,945,862**	**8.0%**	**17 - TOTAL MEDICAL EXPENSES**	**$90,860,931**	**$98,806,793**	**$7,945,862**	**8.0%**
9,967,521	**3,006,915**	**6,960,606**	**231.5%**	**18 - GROSS MARGIN**	**9,967,521**	**3,006,915**	**6,960,606**	**231.5%**
				ADMINISTRATIVE EXPENSES				
$3,079,402	$3,623,030	$543,628	15.0%	19 - Personnel Expense	$3,079,402	$3,623,030	$543,628	15.0%
$299,172	$314,648	$15,476	4.9%	20 - Benefits Administration Expense	$299,172	$314,648	$15,476	4.9%
$526,842	$1,479,926	$953,084	64.4%	21 - Purchased & Professional Services	$526,842	$1,479,926	$953,084	64.4%
$822,830	$1,081,213	$258,383	23.9%	22 - Other Administrative Expense	$822,830	$1,081,213	$258,383	23.9%
$4,728,246	**$6,498,817**	**$1,770,571**	**27.2%**	**23 - TOTAL ADMINISTRATIVE EXPENSE**	**$4,728,246**	**$6,498,817**	**$1,770,571**	**27.2%**
$5,239,275	**($3,491,902)**	**$8,731,177**	**250.0%**	**24 - NET OPERATING INCOME / (LOSS)**	**$5,239,275**	**($3,491,902)**	**$8,731,177**	**250.0%**
				OTHER INCOME / EXPENSE				
$465,553	**$48,750**	**$416,803**	**855.0%**	**25 - Total Other Income / (Expense)**	**$465,553**	**$48,750**	**$416,803**	**855.0%**
$5,704,828	**($3,443,152)**	**$9,147,980**	**265.7%**	**26 - NET INCOME / (LOSS)**	**$5,704,828**	**($3,443,152)**	**$9,147,980**	**265.7%**
4.7%	**6.4%**	**1.7%**	**26.6%**	**27 - Admin Exp % of Revenue**	**4.7%**	**6.4%**	**1.7%**	**26.6%**

ALAMEDA ALLIANCE FOR HEALTH
BALANCE SHEETS
CURRENT MONTH VS. PRIOR MONTH
FOR THE MONTH AND FISCAL YTD ENDED July 31, 2022

	July	June	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	$51,457,654	$12,245,640	$39,212,014	320.21%
Short-Term Investments	249,368,193	295,164,712	(45,796,518)	-15.52%
Interest Receivable	290,103	278,437	11,666	4.19%
Other Receivables - Net	137,140,036	135,034,494	2,105,541	1.56%
Prepaid Expenses	5,221,582	5,325,435	(103,854)	-1.95%
Prepaid Inventoried Items	16,910	21,760	(4,850)	-22.29%
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	**$454,227,418**	**$458,803,419**	**($4,576,001)**	**-1.00%**
OTHER ASSETS:				
Long-Term Investments	39,988,833	35,068,850	4,919,984	14.03%
Restricted Assets	350,000	350,000	0	0.00%
Lease Asset - Office Space (Net)	2,224,601	2,290,031	(65,429)	-2.86%
Lease Asset - Office Equipment (Net)	106,290	111,273	(4,983)	-4.48%
TOTAL OTHER ASSETS	**$42,669,725**	**$37,820,154**	**$4,849,571**	**12.82%**
PROPERTY AND EQUIPMENT:				
Land, Building & Improvements	10,089,578	10,089,578	0	0.00%
Furniture And Equipment	11,540,223	11,540,223	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	37,356,250	37,356,250	0	0.00%
Less: Accumulated Depreciation	(31,751,692)	(31,683,019)	(68,673)	0.22%
NET PROPERTY AND EQUIPMENT	**$5,604,558**	**$5,673,231**	**($68,673)**	**-1.21%**
TOTAL ASSETS	**$502,501,701**	**$502,296,804**	**$204,898**	**0.04%**
CURRENT LIABILITIES:				
Accounts Payable	1,310,888	1,547,018	(236,130)	-15.26%
Other Accrued Expenses	880,228	1,183,823	(303,596)	-25.65%
Interest Payable	(11,724)	(12,035)	312	-2.59%
Pass-Through Liabilities	95,980,358	114,574,951	(18,594,594)	-16.23%
Claims Payable	22,747,661	19,588,722	3,158,938	16.13%
IBNP Reserves	123,488,607	113,104,374	10,384,233	9.18%
Payroll Liabilities	4,875,537	4,707,435	168,102	3.57%
CalPERS Deferred Inflow	6,781,898	6,781,898	0	0.00%
Risk Sharing	7,374,932	7,374,932	0	0.00%
Provider Grants/ New Health Program	214,761	226,672	(11,911)	-5.25%
ST Lease Liability - Office Space	752,285	746,487	5,799	0.78%
ST Lease Liability - Office Equipment	59,209	59,253	(44)	-0.07%
TOTAL CURRENT LIABILITIES	**$264,454,640**	**$269,883,530**	**($5,428,890)**	**-2.01%**
LONG TERM LIABILITIES:				
LT Lease Liability - Office Space	1,567,869	1,634,049	(66,180)	-4.05%
LT Lease Liability - Office Equipment	46,180	51,041	(4,861)	-9.52%
TOTAL LONG TERM LIABILITIES	**$1,614,049**	**$1,685,090**	**($71,041)**	**-4.22%**
TOTAL LIABILITIES	**$266,068,689**	**$271,568,620**	**($5,499,931)**	**-2.03%**
NET WORTH:				
Contributed Capital	840,233	840,233	0	0.00%
Restricted & Unrestricted Funds	229,887,951	204,569,809	25,318,142	12.38%
Year-to Date Net Income / (Loss)	5,704,828	25,318,142	(19,613,313)	-77.47%
TOTAL NET WORTH	**$236,433,012**	**$230,728,184**	**$5,704,828**	**2.47%**
TOTAL LIABILITIES AND NET WORTH	**$502,501,701**	**$502,296,804**	**$204,897**	**0.04%**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 7/31/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$2,646,648	$7,013,060	$13,557,676	$2,646,648
Total	2,646,648	7,013,060	13,557,676	2,646,648
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	98,181,650	289,596,569	585,781,325	98,181,650
Allowance for Doubtful Accounts	0	0	0	0
Deferred Premium Revenue	0	0	(200,000)	0
Premium Receivable	(3,571,499)	(1,543,415)	(14,234,181)	(3,571,498)
Total	94,610,151	288,053,154	571,347,144	94,610,152
Investment & Other Income Cash Flows				
Other Revenue (Grants)	(12,715)	(70,160)	(8,427)	(12,715)
Investment Income	513,657	937,469	386,266	513,657
Interest Receivable	(11,666)	(26,237)	(187,308)	(11,666)
Total	489,276	841,072	190,531	489,276
Medical & Hospital Cash Flows				
Total Medical Expenses	(90,860,939)	(267,492,296)	(539,086,473)	(90,860,939)
Other Receivable	1,465,956	2,312,559	3,477,677	1,465,957
Claims Payable	3,158,938	(600,893)	8,596,679	3,158,938
IBNP Payable	10,384,233	11,490,278	7,717,701	10,384,233
Risk Share Payable	0	(750,000)	(750,000)	0
Health Program	(11,911)	(23,220)	(65,899)	(11,911)
Other Liabilities	0	(1)	0	0
Total	(75,863,723)	(255,063,573)	(520,110,315)	(75,863,722)
Administrative Cash Flows				
Total Administrative Expenses	(4,763,484)	(14,137,583)	(30,668,199)	(4,763,484)
Prepaid Expenses	108,704	(7,856,762)	(7,170,327)	108,704
CalPERS Pension Asset	0	0	0	0
CalPERS Deferred Outflow	0	0	0	0
Trade Accounts Payable	(539,101)	385,522	(10,082)	(539,101)
Other Accrued Liabilities	(312)	11,724	11,724	(312)
Payroll Liabilities	168,103	5,140,909	5,646,066	168,102
Net Lease Assets/Liabilities (Short term & Long term)	5,126	94,651	94,651	5,126
Depreciation Expense	68,673	268,652	478,035	68,673
Total	(4,952,291)	(16,092,887)	(31,618,132)	(4,952,292)
Interest Paid				
Debt Interest Expense	0	0	0	0
Total Cash Flows from Operating Activities	**16,930,061**	**24,750,826**	**33,366,904**	**16,930,062**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 7/31/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	(4,919,984)	(2,354,701)	(25,530,029)	(4,919,984)
	(4,919,984)	(2,354,701)	(25,530,029)	(4,919,984)
Restricted Cash & Other Asset Cash Flows				
Provider Pass-Thru-Liabilities	(18,594,593)	(6,076,565)	(30,794,927)	(18,594,594)
Restricted Cash	0	0	0	0
	(18,594,593)	(6,076,565)	(30,794,927)	(18,594,594)
Fixed Asset Cash Flows				
Depreciation expense	68,673	268,652	478,035	68,673
Fixed Asset Acquisitions	0	(187,116)	(308,407)	0
Change in A/D	(68,673)	(268,652)	(478,035)	(68,673)
	0	(187,116)	(308,407)	0
Total Cash Flows from Investing Activities	**(23,514,577)**	**(8,618,382)**	**(56,633,363)**	**(23,514,578)**
Financing Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Total Cash Flows	**(6,584,516)**	**16,132,444**	**(23,266,459)**	**(6,584,516)**
Rounding	12	0	(1)	12
Cash @ Beginning of Period	307,410,351	284,693,403	324,092,307	307,410,351
Cash @ End of Period	**$300,825,847**	**$300,825,847**	**$300,825,847**	**$300,825,847**
Difference (rounding)	0	0	0	0

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 7/31/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$5,704,829	$15,847,059	$29,962,167	$5,704,829
Add back: Depreciation	68,673	268,652	478,035	68,673
Receivables				
Premiums Receivable	(3,571,499)	(1,543,415)	(14,234,181)	(3,571,498)
First Care Receivable	0	0	0	0
Family Care Receivable	0	0	0	0
Healthy Kids Receivable	0	0	0	0
Interest Receivable	(11,666)	(26,237)	(187,308)	(11,666)
Other Receivable	1,465,956	2,312,559	3,477,677	1,465,957
FQHC Receivable	0	0	0	0
Allowance for Doubtful Accounts	0	0	0	0
Total	(2,117,209)	742,907	(10,943,812)	(2,117,207)
Prepaid Expenses	108,704	(7,856,762)	(7,170,327)	108,704
Trade Payables	(539,101)	385,522	(10,082)	(539,101)
Claims Payable, IBNR & Risk Share				
IBNP	10,384,233	11,490,278	7,717,701	10,384,233
Claims Payable	3,158,938	(600,893)	8,596,679	3,158,938
Risk Share Payable	0	(750,000)	(750,000)	0
Other Liabilities	0	(1)	0	0
Total	13,543,171	10,139,384	15,564,380	13,543,171
Unearned Revenue				
Total	0	0	(200,000)	0
Other Liabilities				
Accrued Expenses	(312)	11,724	11,724	(312)
Payroll Liabilities	168,103	5,140,909	5,646,066	168,102
Net Lease Assets/Liabilities (Short term & Long term)	5,126	94,651	94,651	5,126
Health Program	(11,911)	(23,220)	(65,899)	(11,911)
Accrued Sub Debt Interest	0	0	0	0
Total Change in Other Liabilities	161,006	5,224,064	5,686,542	161,005
Cash Flows from Operating Activities	**$16,930,073**	**$24,750,826**	**$33,366,903**	**$16,930,074**
Difference (rounding)	12	0	(1)	12

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 7/31/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received From:				
Capitation Received from State of CA	$94,610,151	$288,053,154	$571,347,144	$94,610,152
Commercial Premium Revenue	2,646,648	7,013,060	13,557,676	2,646,648
Other Income	(12,715)	(70,160)	(8,427)	(12,715)
Investment Income	501,991	911,232	198,958	501,991
Cash Paid To:				
Medical Expenses	(75,863,723)	(255,063,573)	(520,110,315)	(75,863,722)
Vendor & Employee Expenses	(4,952,291)	(16,092,887)	(31,618,132)	(4,952,292)
Interest Paid	0	0	0	0
Net Cash Provided By (Used In) Operating Activities	16,930,061	24,750,826	33,366,904	16,930,062
Cash Flows from Financing Activities:				
Purchases of Fixed Assets	0	(187,116)	(308,407)	0
Net Cash Provided By (Used In) Financing Activities	0	(187,116)	(308,407)	0
Cash Flows from Investing Activities:				
Changes in Investments	(4,919,984)	(2,354,701)	(25,530,029)	(4,919,984)
Restricted Cash	(18,594,593)	(6,076,565)	(30,794,927)	(18,594,594)
Net Cash Provided By (Used In) Investing Activities	(23,514,577)	(8,431,266)	(56,324,956)	(23,514,578)
Financial Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Net Change in Cash	**(6,584,516)**	**16,132,444**	**(23,266,459)**	**(6,584,516)**
Cash @ Beginning of Period	307,410,351	284,693,403	324,092,307	307,410,351
Subtotal	$300,825,835	$300,825,847	$300,825,848	$300,825,835
Rounding	12	0	(1)	12
Cash @ End of Period	**$300,825,847**	**$300,825,847**	**$300,825,847**	**$300,825,847**
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	$5,704,829	$15,847,059	$29,962,167	$5,704,829
Depreciation	68,673	268,652	478,035	68,673
Net Change in Operating Assets & Liabilities:				
Premium & Other Receivables	(2,117,209)	742,907	(10,943,812)	(2,117,207)
Prepaid Expenses	108,704	(7,856,762)	(7,170,327)	108,704
Trade Payables	(539,101)	385,522	(10,082)	(539,101)
Claims payable & IBNP	13,543,171	10,139,384	15,564,380	13,543,171
Deferred Revenue	0	0	(200,000)	0
Accrued Interest	0	0	0	0
Other Liabilities	161,006	5,224,064	5,686,542	161,005
Subtotal	16,930,073	24,750,826	33,366,903	16,930,074
Rounding	(12)	0	1	(12)
Cash Flows from Operating Activities	**$16,930,061**	**$24,750,826**	**$33,366,904**	**$16,930,062**
Rounding Difference	(12)	0	1	(12)

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH AND FISCAL YEAR TO DATE - JULY 2022

	Child	Adult	Medi-Cal SPD	ACA OE	Duals	Medi-Cal Total	Group Care	Grand Total
Enrollment	100,903	47,707	27,991	113,322	21,910	311,833	5,796	317,629
Net Revenue	$12,583,586	$15,319,540	$25,960,192	$40,192,758	$4,125,728	$98,181,804	$2,646,648	$100,828,452
Medical Expense	$10,293,662	$14,396,647	$24,196,850	$36,408,317	$3,307,768	$88,603,244	$2,257,687	$90,860,931
Gross Margin	$2,289,924	$922,893	$1,763,342	$3,784,441	$817,961	$9,578,561	$388,961	$9,967,521
Administrative Expense	$394,966	$653,970	$1,549,244	$1,848,517	$156,417	$4,603,114	$125,132	$4,728,246
Operating Income / (Expense)	$1,894,958	$268,923	$214,097	$1,935,924	$661,544	$4,975,446	$263,829	$5,239,275
Other Income / (Expense)	$31,319	$62,093	$157,351	$190,431	$11,810	$453,004	$12,550	$465,553
Net Income / (Loss)	$1,926,277	$331,016	$371,448	$2,126,356	$673,353	$5,428,450	$276,379	$5,704,828
Revenue PMPM	$124.71	$321.12	$927.45	$354.68	$188.30	$314.85	$456.63	$317.44
Medical Expense PMPM	$102.02	$301.77	$864.45	$321.28	$150.97	$284.14	$389.53	$286.06
Gross Margin PMPM	$22.69	$19.35	$63.00	$33.40	$37.33	$30.72	$67.11	$31.38
Administrative Expense PMPM	$3.91	$13.71	$55.35	$16.31	$7.14	$14.76	$21.59	$14.89
Operating Income / (Expense) PMPM	$18.78	$5.64	$7.65	$17.08	$30.19	$15.96	$45.52	$16.49
Other Income / (Expense) PMPM	$0.31	$1.30	$5.62	$1.68	$0.54	$1.45	$2.17	$1.47
Net Income / (Loss) PMPM	$19.09	$6.94	$13.27	$18.76	$30.73	$17.41	$47.68	$17.96
Medical Loss Ratio	81.8%	94.0%	93.2%	90.6%	80.2%	90.2%	85.3%	90.1%
Gross Margin Ratio	18.2%	6.0%	6.8%	9.4%	19.8%	9.8%	14.7%	9.9%
Administrative Expense Ratio	3.1%	4.3%	6.0%	4.6%	3.8%	4.7%	4.7%	4.7%
Net Income Ratio	15.3%	2.2%	1.4%	5.3%	16.3%	5.5%	10.4%	5.7%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED July 31, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSE SUMMARY				
$3,079,402	**$3,623,030**	**$543,628**	**15.0%**	**Personnel Expenses**	**$3,079,402**	**$3,623,030**	**$543,628**	**15.0%**
299,172	314,648	15,476	4.9%	Benefits Administration Expense	299,172	314,648	15,476	4.9%
526,842	1,479,926	953,084	64.4%	Purchased & Professional Services	526,842	1,479,926	953,084	64.4%
240,481	271,110	30,629	11.3%	Occupancy	240,481	271,110	30,629	11.3%
69,771	96,184	26,413	27.5%	Printing Postage & Promotion	69,771	96,184	26,413	27.5%
507,892	691,576	183,684	26.6%	Licenses Insurance & Fees	507,892	691,576	183,684	26.6%
4,685	22,343	17,658	79.0%	Supplies & Other Expenses	4,685	22,343	17,658	79.0%
$1,648,844	**$2,875,787**	**$1,226,943**	**42.7%**	**Total Other Administrative Expense**	**$1,648,844**	**$2,875,787**	**$1,226,943**	**42.7%**
$4,728,246	**$6,498,817**	**$1,770,571**	**27.2%**	**Total Administrative Expenses**	**$4,728,246**	**$6,498,817**	**$1,770,571**	**27.2%**

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED July 31, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
2,013,110	2,121,085	107,975	5.1%	Salaries & Wages	2,013,110	2,121,085	107,975	5.1%
236,970	230,275	(6,695)	(2.9%)	Paid Time Off	236,970	230,275	(6,695)	(2.9%)
3,412	2,770	(642)	(23.2%)	Incentives	3,412	2,770	(642)	(23.2%)
0	28,846	28,846	100.0%	Severance Pay	0	28,846	28,846	100.0%
31,997	90,516	58,519	64.7%	Payroll Taxes	31,997	90,516	58,519	64.7%
18,366	16,671	(1,695)	(10.2%)	Overtime	18,366	16,671	(1,695)	(10.2%)
154,738	179,669	24,931	13.9%	CalPERS ER Match	154,738	179,669	24,931	13.9%
558,521	617,399	58,878	9.5%	Employee Benefits	558,521	617,399	58,878	9.5%
23,688	28,521	4,833	16.9%	Employee Relations	23,688	28,521	4,833	16.9%
7,770	14,953	7,183	48.0%	Work from Home Stipend	7,770	14,953	7,183	48.0%
219	2,165	1,946	89.9%	Transportation Reimbursement	219	2,165	1,946	89.9%
2,103	14,657	12,554	85.7%	Travel & Lodging	2,103	14,657	12,554	85.7%
18,119	112,964	94,846	84.0%	Temporary Help Services	18,119	112,964	94,846	84.0%
2,542	54,255	51,713	95.3%	Staff Development/Training	2,542	54,255	51,713	95.3%
7,850	108,284	100,434	92.8%	Staff Recruitment/Advertising	7,850	108,284	100,434	92.8%
$3,079,402	**$3,623,030**	**$543,628**	**15.0%**	**Total Employee Expenses**	**$3,079,402**	**$3,623,030**	**$543,628**	**15.0%**
				Benefit Administration Expense				
(2,513)	13,225	15,738	119.0%	RX Administration Expense	(2,513)	13,225	15,738	119.0%
282,775	282,531	(244)	(0.1%)	Behavioral Hlth Administration Fees	282,775	282,531	(244)	(0.1%)
18,910	18,892	(18)	(0.1%)	Telemedicine Admin Fees	18,910	18,892	(18)	(0.1%)
$299,172	**$314,648**	**$15,476**	**4.9%**	**Total Employee Expenses**	**$299,172**	**$314,648**	**$15,476**	**4.9%**
				Purchased & Professional Services				
160,620	764,553	603,933	79.0%	Consulting Services	160,620	764,553	603,933	79.0%
228,127	347,869	119,742	34.4%	Computer Support Services	228,127	347,869	119,742	34.4%
9,916	9,915	(1)	0.0%	Professional Fees-Accounting	9,916	9,915	(1)	0.0%
0	17	17	100.0%	Professional Fees-Medical	0	17	17	100.0%
44,506	122,803	78,297	63.8%	Other Purchased Services	44,506	122,803	78,297	63.8%
0	1,400	1,400	100.0%	Maint.& Repair-Office Equipment	0	1,400	1,400	100.0%
71,302	67,374	(3,928)	(5.8%)	HMS Recovery Fees	71,302	67,374	(3,928)	(5.8%)
242	21,194	20,952	98.9%	Hardware (Non-Capital)	242	21,194	20,952	98.9%
14,129	31,467	17,338	55.1%	Provider Relations-Credentialing	14,129	31,467	17,338	55.1%
(2,000)	113,334	115,334	101.8%	Legal Fees	(2,000)	113,334	115,334	101.8%
$526,842	**$1,479,926**	**$953,084**	**64.4%**	**Total Purchased & Professional Services**	**$526,842**	**$1,479,926**	**$953,084**	**64.4%**
				Occupancy				
68,673	63,609	(5,064)	(8.0%)	Depreciation	68,673	63,609	(5,064)	(8.0%)
65,429	71,986	6,557	9.1%	Building Lease	65,429	71,986	6,557	9.1%
4,983	5,916	933	15.8%	Leased and Rented Office Equipment	4,983	5,916	933	15.8%
11,889	16,892	5,003	29.6%	Utilities	11,889	16,892	5,003	29.6%
70,137	79,700	9,563	12.0%	Telephone	70,137	79,700	9,563	12.0%
19,370	33,007	13,637	41.3%	Building Maintenance	19,370	33,007	13,637	41.3%
$240,481	**$271,110**	**$30,629**	**11.3%**	**Total Occupancy**	**$240,481**	**$271,110**	**$30,629**	**11.3%**
				Printing Postage & Promotion				

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED July 31, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
9,914	28,281	18,367	64.9%	Postage	9,914	28,281	18,367	64.9%
5,800	5,501	(299)	(5.4%)	Design & Layout	5,800	5,501	(299)	(5.4%)
25,150	38,791	13,641	35.2%	Printing Services	25,150	38,791	13,641	35.2%
0	2,500	2,500	100.0%	Mailing Services	0	2,500	2,500	100.0%
4,736	5,077	341	6.7%	Courier/Delivery Service	4,736	5,077	341	6.7%
0	1,217	1,217	100.0%	Pre-Printed Materials and Publications	0	1,217	1,217	100.0%
0	150	150	100.0%	Promotional Services	0	150	150	100.0%
11,000	6,500	(4,500)	(69.2%)	Community Relations	11,000	6,500	(4,500)	(69.2%)
13,171	8,167	(5,004)	(61.3%)	Translation - Non-Clinical	13,171	8,167	(5,004)	(61.3%)
$69,771	**$96,184**	**$26,413**	**27.5%**	**Total Printing Postage & Promotion**	**$69,771**	**$96,184**	**$26,413**	**27.5%**
				Licenses Insurance & Fees				
23,105	26,350	3,245	12.3%	Bank Fees	23,105	26,350	3,245	12.3%
60,861	94,366	33,505	35.5%	Insurance	60,861	94,366	33,505	35.5%
350,010	481,272	131,262	27.3%	Licenses, Permits and Fees	350,010	481,272	131,262	27.3%
73,915	89,588	15,673	17.5%	Subscriptions & Dues	73,915	89,588	15,673	17.5%
$507,892	**$691,576**	**$183,684**	**26.6%**	**Total Licenses Insurance & Postage**	**$507,892**	**$691,576**	**$183,684**	**26.6%**
				Supplies & Other Expenses				
1,024	4,002	2,978	74.4%	Office and Other Supplies	1,024	4,002	2,978	74.4%
2,538	4,099	1,561	38.1%	Ergonomic Supplies	2,538	4,099	1,561	38.1%
1,049	4,694	3,645	77.7%	Commissary-Food & Beverage	1,049	4,694	3,645	77.7%
0	150	150	100.0%	Member Incentive Expense	0	150	150	100.0%
75	4,167	4,092	98.2%	Covid-19 Vaccination Incentive Expense	75	4,167	4,092	98.2%
0	100	100	100.0%	Covid-19 IT Expenses	0	100	100	100.0%
0	5,131	5,131	100.0%	Covid-19 Non IT Expenses	0	5,131	5,131	100.0%
$4,685	**$22,343**	**$17,658**	**79.0%**	**Total Supplies & Other Expense**	**$4,685**	**$22,343**	**$17,658**	**79.0%**
$4,728,246	**$6,498,817**	**$1,770,571**	**27.2%**	**TOTAL ADMINISTRATIVE EXPENSE**	**$4,728,246**	**$6,498,817**	**$1,770,571**	**27.2%**

ALAMEDA ALLIANCE FOR HEALTH
CAPITAL SPENDING INCLUDING CONSTRUCTION-IN-PROCESS
ACTUAL VS. BUDGET
FOR THE FISCAL YEAR-TO-DATE ENDED JULY 31, 2022

		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	$ -	$ -	$ -	$ 100,000	$ 100,000
	Veeam Backup Shelf	IT-FY23-02	$ -		$ -	$ 70,000	$ 70,000
	Cisco Nexus 9k	IT-FY23-03	$ -		$ -	$ 60,000	$ 60,000
	Pure Storage Shelf	IT-FY23-04	$ -		$ -	$ 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	$ -		$ -	$ 60,000	$ 60,000
Hardware Subtotal			**$ -**	**$ -**	**$ -**	**$ 560,000**	**$ 560,000**
2. Software:							
	Zerto	AC-FY23-01	$ -		$ -	$ 80,000	$ 80,000
Software Subtotal			**$ -**	**$ -**	**$ -**	**$ 80,000**	**$ 80,000**
3. Building Improvement:							
	ADT (ACME) Security: Readers, HID Boxes, Doors - Planned/Unplanned requirements or repairs	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	$ -		$ -	$ 38,992	$ 38,992
	Contingencies	FA-FY23-16	$ -		$ -	$ 100,000	$ 100,000
Building Improvement Subtotal			**$ -**	**$ -**	**$ -**	**$ 338,992**	**$ 338,992**
4. Furniture & Equipment:							
			$ -		$ -	$ -	$ -
Furniture & Equipment Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
GRAND TOTAL			**$ -**	**$ -**	**$ -**	**$ 978,992**	**$ 978,992**
5. Reconciliation to Balance Sheet:							
	Fixed Assets @ Cost - 7/31/22				**$ 37,356,250**		
	Fixed Assets @ Cost - 6/30/22				**$ 37,356,250**		
	Fixed Assets Acquired YTD				**$ -**		

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
SUMMARY - FISCAL YEAR 2023

TANGIBLE NET EQUITY (TNE)

	Jul-22
Current Month Net Income / (Loss)	$5,704,828
YTD Net Income / (Loss)	$5,704,828
Actual TNE	
Net Assets	$236,433,012
Subordinated Debt & Interest	$0
Total Actual TNE	**$236,433,012**
Increase/(Decrease) in Actual TNE	$7,347,633
Required TNE[(1)]	**$37,821,118**
Min. Req'd to Avoid Monthly Reporting (Increased from 130% to 150% of Required TNE effective July-2022)	$56,731,678
TNE Excess / (Deficiency)	$198,611,894
Actual TNE as a Multiple of Required	**6.25**

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	$236,433,012
Fixed Assets at Net Book Value	(5,604,558)
Net Lease Assets/Liabilities/Interest	106,376
CD Pledged to DMHC	(350,000)
Liquid TNE (Liquid Reserves)	**$230,584,830**
Liquid TNE as Multiple of Required	**6.10**

REPORT #8

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												100,903
Adult	47,707												47,707
SPD	27,991												27,991
ACA OE	113,322												113,322
Duals	21,910												21,910
MCAL LTC	0												0
MCAL LTC Duals	0												0
Medi-Cal Program	311,833												311,833
Group Care Program	5,796												5,796
Total	**317,629**												**317,629**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	131												131
Adult	946												946
SPD	886												886
ACA OE	2,384												2,384
Duals	225												225
MCAL LTC	0												0
MCAL LTC Duals	0												0
Medi-Cal Program	4,572												4,572
Group Care Program	1												1
Total	**4,573**												**4,573**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	32.4%												32.4%
Adult % of Medi-Cal	15.3%												15.3%
SPD % of Medi-Cal	9.0%												9.0%
ACA OE % of Medi-Cal	36.3%												36.3%
Duals % of Medi-Cal	7.0%												7.0%
Medi-Cal Program % of Total	98.2%												98.2%
Group Care Program % of Total	1.8%												1.8%
Total	**100.0%**												**100.0%**

REPORT #9

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												54,340
Alameda Health System	62,784												62,784
	117,124												117,124
Delegated:													
CFMG	33,466												33,466
CHCN	119,514												119,514
Kaiser	47,525												47,525
Delegated Subtotal	200,505												200,505
Total	**317,629**												**317,629**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	2,973												2,973
Delegated:													
CFMG	58												58
CHCN	1,103												1,103
Kaiser	439												439
Delegated Subtotal	1,600												1,600
Total	**4,573**												**4,573**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	36.9%												36.9%
Delegated:													
CFMG	10.5%												10.5%
CHCN	37.6%												37.6%
Kaiser	15.0%												15.0%
Delegated Subtotal	63.1%												63.1%
Total	**100.0%**												**100.0%**

REPORT #9

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2023

	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	101,120	101,423	101,727	101,930	102,134	102,338	101,787	101,043	100,298	99,552	98,806	98,059	1,210,217
Adult	46,703	47,030	47,359	47,501	47,644	47,787	46,980	45,856	44,731	43,605	42,478	41,349	549,023
SPD	28,283	28,368	28,453	28,510	28,567	28,624	29,006	28,941	28,876	28,811	28,746	28,681	343,866
ACA OE	113,561	114,129	114,700	115,044	115,389	115,735	114,009	111,510	109,009	106,505	103,999	101,490	1,335,080
Duals	21,650	21,715	21,780	21,824	21,868	21,912	21,781	21,488	21,194	20,900	20,606	20,312	257,030
MCAL LTC	0	0	0	0	0	0	300	300	300	300	300	300	1,800
MCAL LTC Duals	0	0	0	0	0	0	1,200	1,200	1,200	1,200	1,200	1,200	7,200
Medi-Cal Program	311,317	312,665	314,019	314,809	315,602	316,396	315,063	310,338	305,608	300,873	296,135	291,391	3,704,216
Group Care Program	5,828	5,828	5,828	5,828	5,828	5,828	5,828	5,828	5,828	5,828	5,828	5,828	69,936
Total	**317,145**	**318,493**	**319,847**	**320,637**	**321,430**	**322,224**	**320,891**	**316,166**	**311,436**	**306,701**	**301,963**	**297,219**	**3,774,152**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	6,309	303	304	203	204	204	(551)	(744)	(745)	(746)	(746)	(747)	3,248
Adult	5,627	327	329	142	143	143	(807)	(1,124)	(1,125)	(1,126)	(1,127)	(1,129)	273
SPD	1,538	85	85	57	57	57	382	(65)	(65)	(65)	(65)	(65)	1,936
ACA OE	10,125	568	571	344	345	346	(1,726)	(2,499)	(2,501)	(2,504)	(2,506)	(2,509)	(1,946)
Duals	1,874	65	65	44	44	44	(131)	(293)	(294)	(294)	(294)	(294)	536
MCAL LTC	0	0	0	0	0	0	300	0	0	0	0	0	300
MCAL LTC Duals	0	0	0	0	0	0	1,200	0	0	0	0	0	1,200
Medi-Cal Program	25,473	1,348	1,354	790	793	794	(1,333)	(4,725)	(4,730)	(4,735)	(4,738)	(4,744)	5,547
Group Care Program	(24)	0	0	0	0	0	0	0	0	0	0	0	(24)
Total	**25,449**	**1,348**	**1,354**	**790**	**793**	**794**	**(1,333)**	**(4,725)**	**(4,730)**	**(4,735)**	**(4,738)**	**(4,744)**	**5,523**
Enrollment Percentages:													
Medi-Cal Program:													
Child % (Medi-Cal)	32.5%	32.4%	32.4%	32.4%	32.4%	32.3%	32.3%	32.6%	32.8%	33.1%	33.4%	33.7%	32.7%
Adult % (Medi-Cal)	15.0%	15.0%	15.1%	15.1%	15.1%	15.1%	14.9%	14.8%	14.6%	14.5%	14.3%	14.2%	14.8%
SPD % (Medi-Cal)	9.1%	9.1%	9.1%	9.1%	9.1%	9.0%	9.2%	9.3%	9.4%	9.6%	9.7%	9.8%	9.3%
ACA OE % (Medi-Cal)	36.5%	36.5%	36.5%	36.5%	36.6%	36.6%	36.2%	35.9%	35.7%	35.4%	35.1%	34.8%	36.0%
Duals % (Medi-Cal)	7.0%	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%	7.0%	7.0%	6.9%
MCAL LTC % (Medi-Cal)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%
MCAL LTC Duals % (Medi-Cal)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.2%
Medi-Cal Program % of Total	98.2%	98.2%	98.2%	98.2%	98.2%	98.2%	98.2%	98.2%	98.1%	98.1%	98.1%	98.0%	98.1%
Group Care Program % of Total	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.9%	1.9%	1.9%	2.0%	1.9%
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%**

REPORT #9

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2023

	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	116,747	117,272	117,799	118,102	118,406	118,710	118,871	116,928	114,985	113,037	111,088	109,138	1,391,083
Delegated:													
CFMG	33,731	33,837	33,943	34,013	34,083	34,153	33,970	33,696	33,422	33,148	32,874	32,599	403,469
CHCN	119,411	119,921	120,435	120,733	121,033	121,334	120,278	118,487	116,693	114,899	113,103	111,305	1,417,632
Kaiser	47,256	47,463	47,670	47,789	47,908	48,027	47,772	47,055	46,336	45,617	44,898	44,177	561,968
Delegated Subtotal	200,398	201,221	202,048	202,535	203,024	203,514	202,020	199,238	196,451	193,664	190,875	188,081	2,383,069
Total	**317,145**	**318,493**	**319,847**	**320,637**	**321,430**	**322,224**	**320,891**	**316,166**	**311,436**	**306,701**	**301,963**	**297,219**	**3,774,152**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	5,641	525	527	303	304	304	161	(1,943)	(1,943)	(1,948)	(1,949)	(1,950)	(1,968)
Delegated:													
CFMG	2,323	106	106	70	70	70	(183)	(274)	(274)	(274)	(274)	(275)	1,191
CHCN	13,180	510	514	298	300	301	(1,056)	(1,791)	(1,794)	(1,794)	(1,796)	(1,798)	5,074
Kaiser	4,305	207	207	119	119	119	(255)	(717)	(719)	(719)	(719)	(721)	1,226
Delegated Subtotal	19,808	823	827	487	489	490	(1,494)	(2,782)	(2,787)	(2,787)	(2,789)	(2,794)	7,491
Total	**25,449**	**1,348**	**1,354**	**790**	**793**	**794**	**(1,333)**	**(4,725)**	**(4,730)**	**(4,735)**	**(4,738)**	**(4,744)**	**5,523**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	36.8%	36.8%	36.8%	36.8%	36.8%	36.8%	37.0%	37.0%	36.9%	36.9%	36.8%	36.7%	36.9%
Delegated:													
CFMG	10.6%	10.6%	10.6%	10.6%	10.6%	10.6%	10.6%	10.7%	10.7%	10.8%	10.9%	11.0%	10.7%
CHCN	37.7%	37.7%	37.7%	37.7%	37.7%	37.7%	37.5%	37.5%	37.5%	37.5%	37.5%	37.4%	37.6%
Kaiser	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%
Delegated Subtotal	63.2%	63.2%	63.2%	63.2%	63.2%	63.2%	63.0%	63.0%	63.1%	63.1%	63.2%	63.3%	63.1%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

REPORT #9

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	Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	(217)	0	0	0	0	0	0	0	0	0	0	0	(217)
Adult	1,004	0	0	0	0	0	0	0	0	0	0	0	1,004
SPD	(292)	0	0	0	0	0	0	0	0	0	0	0	(292)
ACA OE	(239)	0	0	0	0	0	0	0	0	0	0	0	(239)
Duals	260	0	0	0	0	0	0	0	0	0	0	0	260
MCAL LTC	0	0	0	0	0	0	0	0	0	0	0	0	0
MCAL LTC Duals	0	0	0	0	0	0	0	0	0	0	0	0	0
Medi-Cal Program	516	0	0	0	0	0	0	0	0	0	0	0	516
Group Care Program	(32)	0	0	0	0	0	0	0	0	0	0	0	(32)
Total	**484**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**484**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted	377	0	0	0	0	0	0	0	0	0	0	0	377
Delegated:													
CFMG	(265)	0	0	0	0	0	0	0	0	0	0	0	(265)
CHCN	103	0	0	0	0	0	0	0	0	0	0	0	103
Kaiser	269	0	0	0	0	0	0	0	0	0	0	0	269
Delegated Subtotal	107	0	0	0	0	0	0	0	0	0	0	0	107
Total	**484**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**484**

REPORT #9

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED July 31, 2022

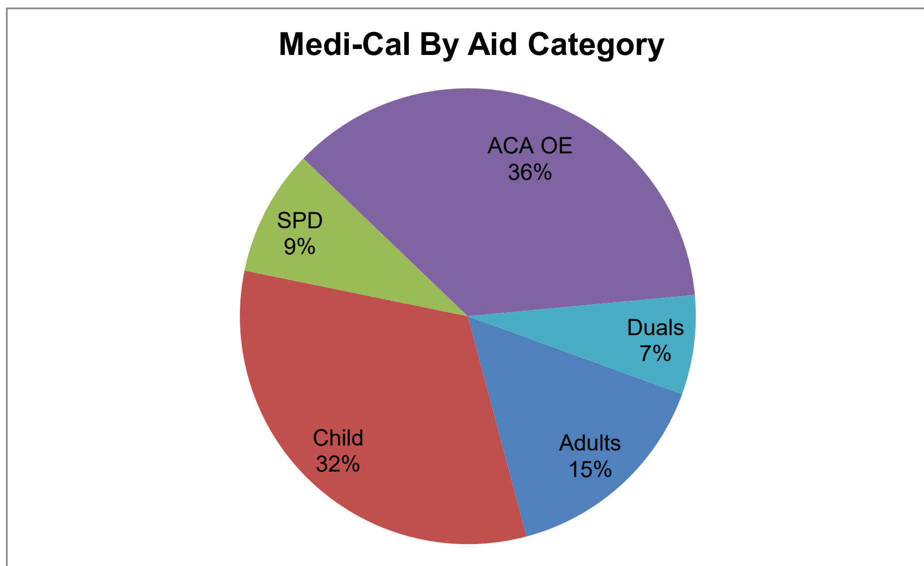
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES:				
$1,131,294	$1,972,020	$840,726	42.6%	PCP-Capitation	$1,131,294	$1,972,020	$840,726	42.6%
4,142,893	3,344,019	(798,874)	(23.9%)	PCP-Capitation - FQHC	4,142,893	3,344,019	(798,874)	(23.9%)
290,083	293,192	3,109	1.1%	Specialty-Capitation	290,083	293,192	3,109	1.1%
3,470,298	3,517,704	47,406	1.3%	Specialty-Capitation FQHC	3,470,298	3,517,704	47,406	1.3%
433,421	391,015	(42,406)	(10.8%)	Laboratory-Capitation	433,421	391,015	(42,406)	(10.8%)
954,981	951,435	(3,546)	(0.4%)	Transportation (Ambulance)-Cap	954,981	951,435	(3,546)	(0.4%)
231,113	230,576	(537)	(0.2%)	Vision Cap	231,113	230,576	(537)	(0.2%)
84,499	85,448	949	1.1%	CFMG Capitation	84,499	85,448	949	1.1%
174,329	176,168	1,839	1.0%	Anc IPA Admin Capitation FQHC	174,329	176,168	1,839	1.0%
10,864,093	10,964,104	100,011	0.9%	Kaiser Capitation	10,864,093	10,964,104	100,011	0.9%
984,133	789,352	(194,781)	(24.7%)	BHT Supplemental Expense	984,133	789,352	(194,781)	(24.7%)
764,165	539,450	(224,715)	(41.7%)	Maternity Supplemental Expense	764,165	539,450	(224,715)	(41.7%)
577,807	616,042	38,235	6.2%	DME - Cap	577,807	616,042	38,235	6.2%
$24,103,109	**$23,870,525**	**($232,584)**	**(1.0%)**	**5-TOTAL CAPITATED EXPENSES**	**$24,103,109**	**$23,870,525**	**($232,584)**	**(1.0%)**
				FEE FOR SERVICE MEDICAL EXPENSES:				
6,011,597	0	(6,011,597)	0.0%	IBNP-Inpatient Services	6,011,597	0	(6,011,597)	0.0%
180,348	0	(180,348)	0.0%	IBNP-Settlement (IP)	180,348	0	(180,348)	0.0%
480,926	0	(480,926)	0.0%	IBNP-Claims Fluctuation (IP)	480,926	0	(480,926)	0.0%
20,729,673	31,629,280	10,899,607	34.5%	Inpatient Hospitalization-FFS	20,729,673	31,629,280	10,899,607	34.5%
867,947	0	(867,947)	0.0%	IP OB - Mom & NB	867,947	0	(867,947)	0.0%
120,774	0	(120,774)	0.0%	IP Behavioral Health	120,774	0	(120,774)	0.0%
1,054,134	1,363,434	309,300	22.7%	IP - Long Term Care	1,054,134	1,363,434	309,300	22.7%
689,161	0	(689,161)	0.0%	IP - Facility Rehab FFS	689,161	0	(689,161)	0.0%
$30,134,560	**$32,992,714**	**$2,858,154**	**8.7%**	**6-Inpatient Hospital & SNF FFS Expense**	**$30,134,560**	**$32,992,714**	**$2,858,154**	**8.7%**
271,427	0	(271,427)	0.0%	IBNP-PCP	271,427	0	(271,427)	0.0%
8,143	0	(8,143)	0.0%	IBNP-Settlement (PCP)	8,143	0	(8,143)	0.0%
21,713	0	(21,713)	0.0%	IBNP-Claims Fluctuation (PCP)	21,713	0	(21,713)	0.0%
1,011,890	1,298,195	286,305	22.1%	Primary Care Non-Contracted FF	1,011,890	1,298,195	286,305	22.1%
46,945	65,182	18,237	28.0%	PCP FQHC FFS	46,945	65,182	18,237	28.0%
1,972,326	2,820,374	848,048	30.1%	Prop 56 Direct Payment Expenses	1,972,326	2,820,374	848,048	30.1%
14,160	0	(14,160)	0.0%	Prop 56 Hyde Direct Payment Expenses	14,160	0	(14,160)	0.0%
77,408	0	(77,408)	0.0%	Prop 56-Trauma Expense	77,408	0	(77,408)	0.0%
98,984	0	(98,984)	0.0%	Prop 56-Dev. Screening Exp.	98,984	0	(98,984)	0.0%
685,544	0	(685,544)	0.0%	Prop 56-Fam. Planning Exp.	685,544	0	(685,544)	0.0%
(1,305)	0	1,305	0.0%	Prop 56-Value Based Purchasing	(1,305)	0	1,305	0.0%
$4,207,233	**$4,183,751**	**($23,482)**	**(0.6%)**	**7-Primary Care Physician FFS Expense**	**$4,207,233**	**$4,183,751**	**($23,482)**	**(0.6%)**
452,052	0	(452,052)	0.0%	IBNP-Specialist	452,052	0	(452,052)	0.0%
2,397,527	5,151,623	2,754,096	53.5%	Specialty Care-FFS	2,397,527	5,151,623	2,754,096	53.5%
98,550	0	(98,550)	0.0%	Anesthesiology - FFS	98,550	0	(98,550)	0.0%
812,868	0	(812,868)	0.0%	Spec Rad Therapy - FFS	812,868	0	(812,868)	0.0%
111,646	0	(111,646)	0.0%	Obstetrics-FFS	111,646	0	(111,646)	0.0%
269,601	0	(269,601)	0.0%	Spec IP Surgery - FFS	269,601	0	(269,601)	0.0%
476,240	0	(476,240)	0.0%	Spec OP Surgery - FFS	476,240	0	(476,240)	0.0%
313,418	0	(313,418)	0.0%	Spec IP Physician	313,418	0	(313,418)	0.0%
39,060	8,509	(30,551)	(359.0%)	SCP FQHC FFS	39,060	8,509	(30,551)	(359.0%)
13,560	0	(13,560)	0.0%	IBNP-Settlement (SCP)	13,560	0	(13,560)	0.0%
36,163	0	(36,163)	0.0%	IBNP-Claims Fluctuation (SCP)	36,163	0	(36,163)	0.0%
$5,020,683	**$5,160,132**	**$139,449**	**2.7%**	**8-Specialty Care Physician Expense**	**$5,020,683**	**$5,160,132**	**$139,449**	**2.7%**
919,392	0	(919,392)	0.0%	IBNP-Ancillary	919,392	0	(919,392)	0.0%
27,581	0	(27,581)	0.0%	IBNP Settlement (ANC)	27,581	0	(27,581)	0.0%
73,551	0	(73,551)	0.0%	IBNP Claims Fluctuation (ANC)	73,551	0	(73,551)	0.0%
264,339	0	(264,339)	0.0%	Acupuncture/Biofeedback	264,339	0	(264,339)	0.0%
116,187	0	(116,187)	0.0%	Hearing Devices	116,187	0	(116,187)	0.0%
35,773	0	(35,773)	0.0%	Imaging/MRI/CT Global	35,773	0	(35,773)	0.0%
37,728	0	(37,728)	0.0%	Vision FFS	37,728	0	(37,728)	0.0%
18,246	0	(18,246)	0.0%	Family Planning	18,246	0	(18,246)	0.0%
832,435	0	(832,435)	0.0%	Laboratory-FFS	832,435	0	(832,435)	0.0%
112,810	0	(112,810)	0.0%	ANC Therapist	112,810	0	(112,810)	0.0%
242,454	0	(242,454)	0.0%	Transportation (Ambulance)-FFS	242,454	0	(242,454)	0.0%
151,364	0	(151,364)	0.0%	Transportation (Other)-FFS	151,364	0	(151,364)	0.0%
332,409	0	(332,409)	0.0%	Hospice	332,409	0	(332,409)	0.0%
458,800	0	(458,800)	0.0%	Home Health Services	458,800	0	(458,800)	0.0%
0	4,279,256	4,279,256	100.0%	Other Medical-FFS	0	4,279,256	4,279,256	100.0%
22,938	0	(22,938)	0.0%	HMS Medical Refunds	22,938	0	(22,938)	0.0%

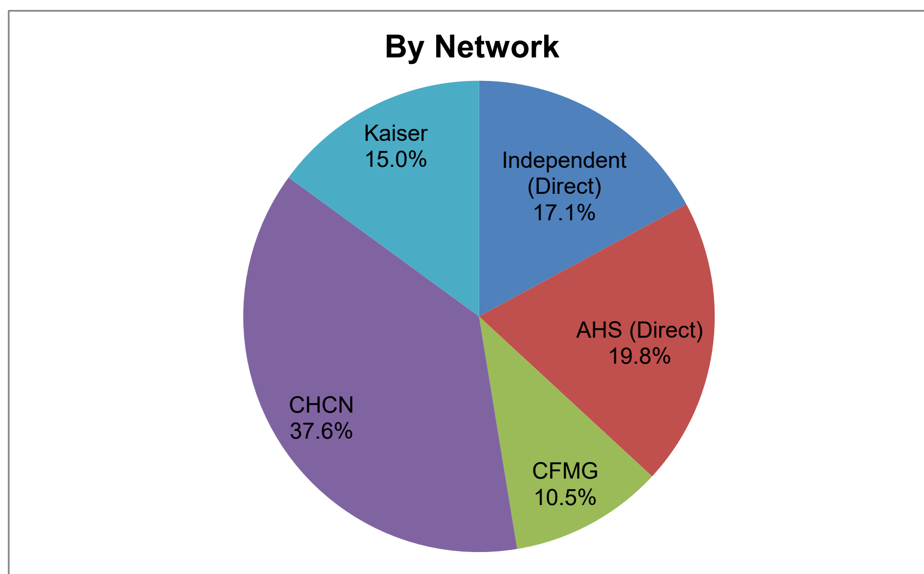
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED July 31, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	**Budget**	**$ Variance (Unfavorable)**	**% Variance (Unfavorable)**	**Account Description**	**Actual**	**Budget**	**$ Variance (Unfavorable)**	**% Variance (Unfavorable)**
404,888	0	(404,888)	0.0%	DME & Medical Supplies	404,888	0	(404,888)	0.0%
0	652,743	652,743	100.0%	GEMT Direct Payment Expense	0	652,743	652,743	100.0%
233,612	0	(233,612)	0.0%	Community Based Adult Services (CBAS)	233,612	0	(233,612)	0.0%
888,276	705,592	(182,684)	(25.9%)	ECM Base FFS Ancillary	888,276	705,592	(182,684)	(25.9%)
495	5,227	4,732	90.5%	ECM Outreach FFS Ancillary	495	5,227	4,732	90.5%
328,055	328,054	(1)	0.0%	CS - Housing Deposits FFS Ancillary	328,055	328,054	(1)	0.0%
580,032	580,031	(1)	0.0%	CS - Housing Tenancy FFS Ancillary	580,032	580,031	(1)	0.0%
220,282	220,281	(1)	0.0%	CS - Housing Navigation Services FFS Ancillary	220,282	220,281	(1)	0.0%
325,580	325,580	0	0.0%	CS - Medical Respite FFS Ancillary	325,580	325,580	0	0.0%
128,573	128,572	(1)	0.0%	CS - Medically Tailored Meals FFS Ancillary	128,573	128,572	(1)	0.0%
37,159	37,159	0	0.0%	CS - Asthma Remediation FFS Ancillary	37,159	37,159	0	0.0%
7,324	9,999	2,675	26.8%	MOT- Wrap Around (Non Medical MOT Cost)	7,324	9,999	2,675	26.8%
$6,800,281	**$7,272,494**	**$472,213**	**6.5%**	**9-Ancillary Medical Expense**	**$6,800,281**	**$7,272,494**	**$472,213**	**6.5%**
1,304,878	0	(1,304,878)	0.0%	IBNP-Outpatient	1,304,878	0	(1,304,878)	0.0%
39,147	0	(39,147)	0.0%	IBNP Settlement (OP)	39,147	0	(39,147)	0.0%
104,389	0	(104,389)	0.0%	IBNP Claims Fluctuation (OP)	104,389	0	(104,389)	0.0%
991,780	9,021,352	8,029,572	89.0%	Out-Patient FFS	991,780	9,021,352	8,029,572	89.0%
1,359,546	0	(1,359,546)	0.0%	OP Ambul Surgery - FFS	1,359,546	0	(1,359,546)	0.0%
823,147	0	(823,147)	0.0%	OP Fac Imaging Services-FFS	823,147	0	(823,147)	0.0%
704,074	0	(704,074)	0.0%	Behav Health - FFS	704,074	0	(704,074)	0.0%
1,039,190	0	(1,039,190)	0.0%	Behavioral Health Therapy - FFS	1,039,190	0	(1,039,190)	0.0%
450,917	0	(450,917)	0.0%	OP Facility - Lab FFS	450,917	0	(450,917)	0.0%
85,490	0	(85,490)	0.0%	OP Facility - Cardio FFS	85,490	0	(85,490)	0.0%
43,238	0	(43,238)	0.0%	OP Facility - PT/OT/ST FFS	43,238	0	(43,238)	0.0%
1,469,594	0	(1,469,594)	0.0%	OP Facility - Dialysis FFS	1,469,594	0	(1,469,594)	0.0%
$8,415,389	**$9,021,352**	**$605,963**	**6.7%**	**10-Outpatient Medical Expense Medical Expense**	**$8,415,389**	**$9,021,352**	**$605,963**	**6.7%**
469,917	0	(469,917)	0.0%	IBNP-Emergency	469,917	0	(469,917)	0.0%
14,096	0	(14,096)	0.0%	IBNP Settlement (ER)	14,096	0	(14,096)	0.0%
37,594	0	(37,594)	0.0%	IBNP Claims Fluctuation (ER)	37,594	0	(37,594)	0.0%
600,756	0	(600,756)	0.0%	Special ER Physician-FFS	600,756	0	(600,756)	0.0%
3,734,983	5,499,896	1,764,913	32.1%	ER-Facility	3,734,983	5,499,896	1,764,913	32.1%
$4,857,346	**$5,499,896**	**$642,550**	**11.7%**	**11-Emergency Expense**	**$4,857,346**	**$5,499,896**	**$642,550**	**11.7%**
(74,090)	0	74,090	0.0%	IBNP-Pharmacy	(74,090)	0	74,090	0.0%
(2,223)	0	2,223	0.0%	IBNP Settlement (RX)	(2,223)	0	2,223	0.0%
(5,928)	0	5,928	0.0%	IBNP Claims Fluctuation (RX)	(5,928)	0	5,928	0.0%
397,089	373,039	(24,050)	(6.4%)	Pharmacy-FFS	397,089	373,039	(24,050)	(6.4%)
5,101,031	6,092,771	991,740	16.3%	Pharmacy- Non-PBM FFS-Other Anc	5,101,031	6,092,771	991,740	16.3%
(2,771)	0	2,771	0.0%	HMS RX Refunds	(2,771)	0	2,771	0.0%
0	972	972	100.0%	Pharmacy-Rebate	0	972	972	100.0%
$5,413,108	**$6,466,782**	**$1,053,674**	**16.3%**	**12-Pharmacy Expense**	**$5,413,108**	**$6,466,782**	**$1,053,674**	**16.3%**
$64,848,600	**$70,597,121**	**$5,748,521**	**8.1%**	**13-TOTAL FFS MEDICAL EXPENSES**	**$64,848,600**	**$70,597,121**	**$5,748,521**	**8.1%**
0	(151,918)	(151,918)	100.0%	Clinical Vacancy	0	(151,918)	(151,918)	100.0%
83,154	121,466	38,312	31.5%	Quality Analytics	83,154	121,466	38,312	31.5%
408,506	475,272	66,766	14.0%	Health Plan Services Department Total	408,506	475,272	66,766	14.0%
326,948	425,483	98,535	23.2%	Case & Disease Management Department Total	326,948	425,483	98,535	23.2%
340,741	2,199,725	1,858,984	84.5%	Medical Services Department Total	340,741	2,199,725	1,858,984	84.5%
410,208	690,971	280,763	40.6%	Quality Management Department Total	410,208	690,971	280,763	40.6%
53,171	138,441	85,270	61.6%	HCS Behavioral Health Department Total	53,171	138,441	85,270	61.6%
118,598	126,350	7,752	6.1%	Pharmacy Services Department Total	118,598	126,350	7,752	6.1%
16,782	96,138	79,356	82.5%	Regulatory Readiness Total	16,782	96,138	79,356	82.5%
$1,758,107	**$4,121,928**	**$2,363,821**	**57.3%**	**14-Other Benefits & Services**	**$1,758,107**	**$4,121,928**	**$2,363,821**	**57.3%**
				Reinsurance Expense				
(651,659)	(651,659)	0	0.0%	Reinsurance Recoveries	(651,659)	(651,659)	0	0.0%
802,774	868,878	66,104	7.6%	Stop-Loss Expense	802,774	868,878	66,104	7.6%
$151,115	**$217,219**	**$66,104**	**30.4%**	**15-Reinsurance Expense**	**$151,115**	**$217,219**	**$66,104**	**30.4%**
$90,860,931	**$98,806,793**	**$7,945,862**	**8.0%**	**17-TOTAL MEDICAL EXPENSES**	**$90,860,931**	**$98,806,793**	**$7,945,862**	**8.0%**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Current Membership by Network By Category of Aid							
Category of Aid	**Jul 2022**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	47,707	15%	9,536	9,535	788	19,121	8,727
Child	100,903	32%	7,372	9,236	30,460	35,313	18,522
SPD	27,927	9%	9,009	4,261	1,016	11,548	2,093
ACA OE	113,322	36%	17,844	36,463	1,201	42,984	14,830
Duals	21,974	7%	8,253	2,432	1	7,935	3,353
Medi-Cal	311,833		52,014	61,927	33,466	116,901	47,525
Group Care	5,796		2,326	857	-	2,613	-
Total	**317,629**	**100%**	**54,340**	**62,784**	**33,466**	**119,514**	**47,525**
Medi-Cal %	98.2%		95.7%	98.6%	100.0%	97.8%	100.0%
Group Care %	1.8%		4.3%	1.4%	0.0%	2.2%	0.0%
		Network Distribution	*17.1%*	*19.8%*	*10.5%*	*37.6%*	*15.0%*
			% Direct:	**37%**		**% Delegated:**	**63%**

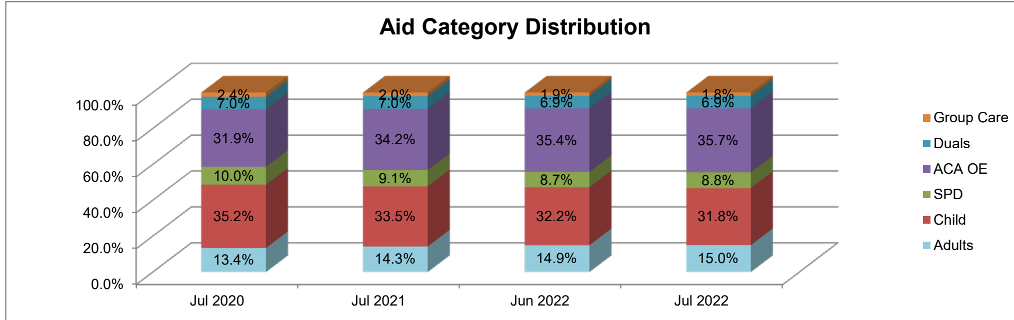




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

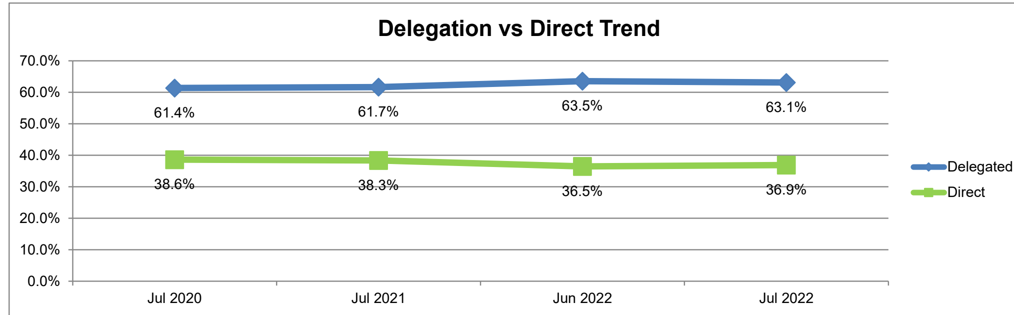
Category of Aid Trend

Category of Aid	Members Jul 2020	Members Jul 2021	Members Jun 2022	Members Jul 2022	% of Total (ie.Distribution) Jul 2020	Jul 2021	Jun 2022	Jul 2022	% Growth (Loss) Jul 2020 to Jul 2021	Jul 2021 to Jul 2022	Jun 2022 to Jul 2022
Adults	34,909	41,358	46,761	47,707	13.4%	14.3%	14.9%	15.0%	18.5%	15.4%	2.0%
Child	91,570	97,179	100,772	100,903	35.2%	33.5%	32.2%	31.8%	6.1%	3.8%	0.1%
SPD	26,044	26,320	27,105	27,927	10.0%	9.1%	8.7%	8.8%	1.1%	6.1%	3.0%
ACA OE	82,989	99,105	110,938	113,322	31.9%	34.2%	35.4%	35.7%	19.4%	14.3%	2.1%
Duals	18,297	20,194	21,685	21,974	7.0%	7.0%	6.9%	6.9%	10.4%	8.8%	1.3%
Medi-Cal Total	253,809	284,156	307,261	311,833	97.6%	98.0%	98.1%	98.2%	12.0%	9.7%	1.5%
Group Care	6,109	5,935	5,795	5,796	2.4%	2.0%	1.9%	1.8%	-2.8%	-2.3%	0.0%
Total	**259,918**	**290,091**	**313,056**	**317,629**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**11.6%**	**9.5%**	**1.5%**



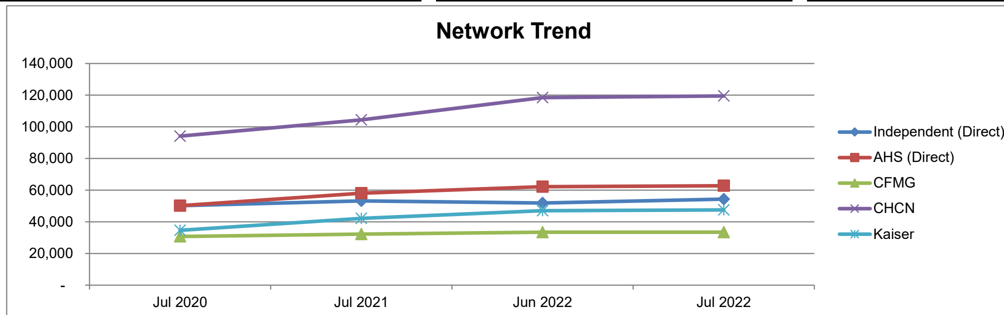
Delegation vs Direct Trend

Members	Members Jul 2020	Members Jul 2021	Members Jun 2022	Members Jul 2022	% of Total (ie.Distribution) Jul 2020	Jul 2021	Jun 2022	Jul 2022	% Growth (Loss) Jul 2020 to Jul 2021	Jul 2021 to Jul 2022	Jun 2022 to Jul 2022
Delegated	159,526	178,857	198,905	200,505	61.4%	61.7%	63.5%	63.1%	12.1%	12.1%	0.8%
Direct	100,392	111,234	114,151	117,124	38.6%	38.3%	36.5%	36.9%	10.8%	5.3%	2.6%
Total	**259,918**	**290,091**	**313,056**	**317,629**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**11.6%**	**9.5%**	**1.5%**



Network Trend

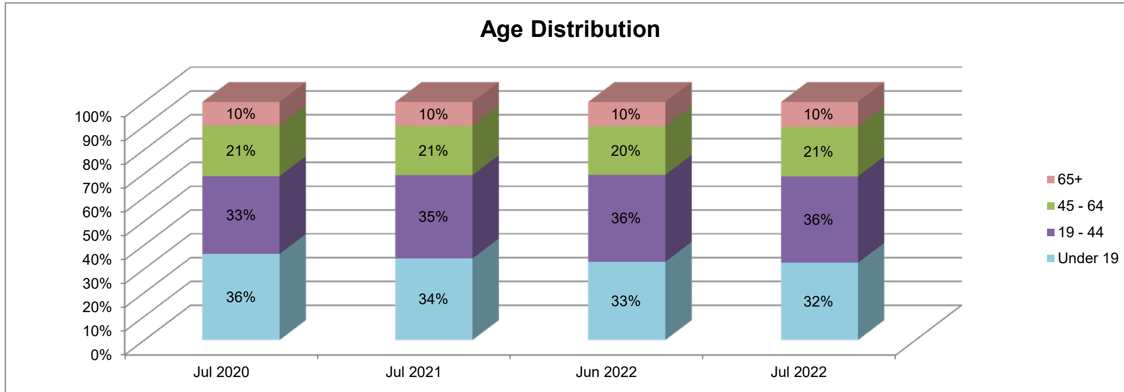
Network	Members Jul 2020	Members Jul 2021	Members Jun 2022	Members Jul 2022	% of Total (ie.Distribution) Jul 2020	Jul 2021	Jun 2022	Jul 2022	% Growth (Loss) Jul 2020 to Jul 2021	Jul 2021 to Jul 2022	Jun 2022 to Jul 2022
Independent (Direct)	50,199	53,189	51,936	54,340	19.3%	18.3%	16.6%	17.1%	6.0%	2.2%	4.6%
AHS (Direct)	50,193	58,045	62,215	62,784	19.3%	20.0%	19.9%	19.8%	15.6%	8.2%	0.9%
CFMG	30,742	32,217	33,408	33,466	11.8%	11.1%	10.7%	10.5%	4.8%	3.9%	0.2%
CHCN	94,144	104,433	118,411	119,514	36.2%	36.0%	37.8%	37.6%	10.9%	14.4%	0.9%
Kaiser	34,640	42,207	47,086	47,525	13.3%	14.5%	15.0%	15.0%	21.8%	12.6%	0.9%
Total	**259,918**	**290,091**	**313,056**	**317,629**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**11.6%**	**9.5%**	**1.5%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

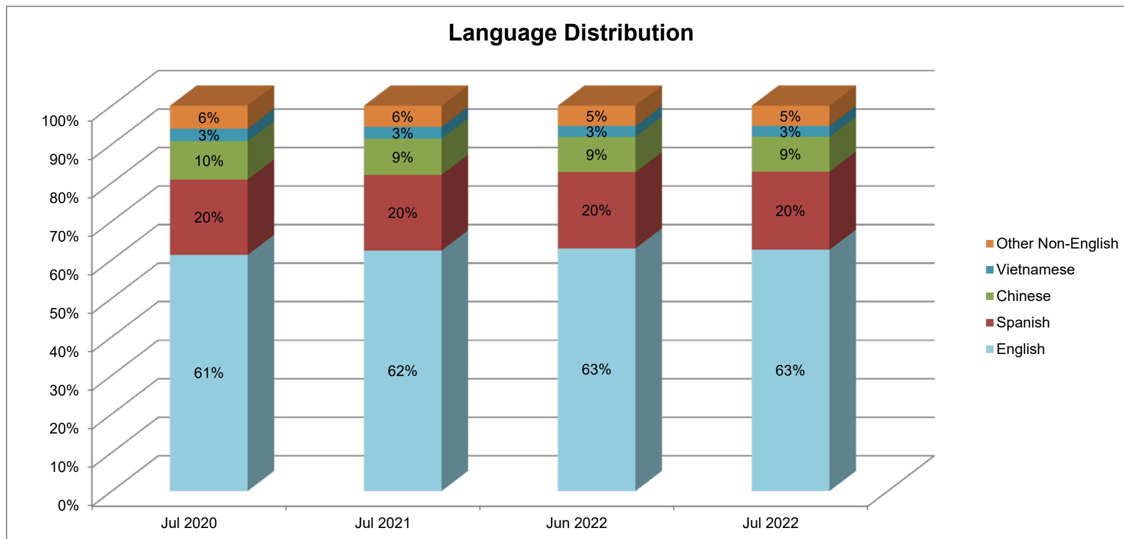
Age Category Trend

Age Category	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jul 2020	Jul 2021	Jun 2022	Jul 2022	Jul 2020	Jul 2021	Jun 2022	Jul 2022	Jul 2020 to Jul 2021	Jul 2021 to Jul 2022	Jun 2022 to Jul 2022
Under 19	94,074	99,517	103,026	103,148	36%	34%	33%	32%	6%	4%	0%
19 - 44	84,828	101,407	114,184	115,171	33%	35%	36%	36%	20%	14%	1%
45 - 64	55,293	60,069	63,899	66,174	21%	21%	20%	21%	9%	10%	4%
65+	25,723	29,098	31,947	33,136	10%	10%	10%	10%	13%	14%	4%
Total	**259,918**	**290,091**	**313,056**	**317,629**	**100%**	**100%**	**100%**	**100%**	**12%**	**9%**	**1%**



Language Trend

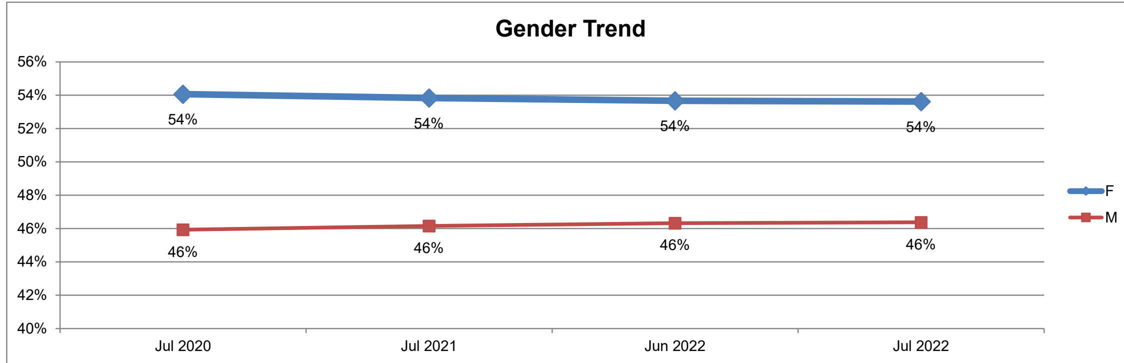
Language	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jul 2020	Jul 2021	Jun 2022	Jul 2022	Jul 2020	Jul 2021	Jun 2022	Jul 2022	Jul 2020 to Jul 2021	Jul 2021 to Jul 2022	Jun 2022 to Jul 2022
English	159,176	181,065	197,106	198,847	61%	62%	63%	63%	14%	10%	1%
Spanish	50,932	56,862	61,849	64,363	20%	20%	20%	20%	12%	13%	4%
Chinese	25,833	27,378	28,802	28,906	10%	9%	9%	9%	6%	6%	0%
Vietnamese	8,463	8,828	8,868	8,884	3%	3%	3%	3%	4%	1%	0%
Other Non-English	15,514	15,958	16,431	16,629	6%	6%	5%	5%	3%	4%	1%
Total	**259,918**	**290,091**	**313,056**	**317,629**	**100%**	**100%**	**100%**	**100%**	**12%**	**9%**	**1%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

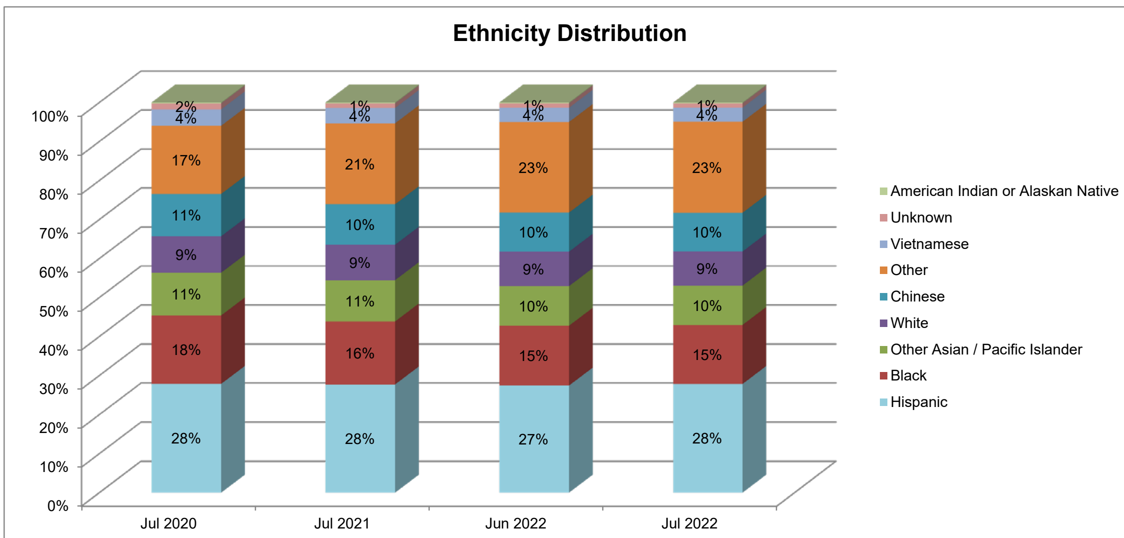
Gender Trend

Gender	Members Jul 2020	Members Jul 2021	Members Jun 2022	Members Jul 2022	% of Total (ie.Distribution) Jul 2020	Jul 2021	Jun 2022	Jul 2022	% Growth (Loss) Jul 2020 to Jul 2021	Jul 2021 to Jul 2022	Jun 2022 to Jul 2022
F	140,532	156,178	168,023	170,323	54%	54%	54%	54%	11%	9%	1%
M	119,386	133,913	145,033	147,306	46%	46%	46%	46%	12%	10%	2%
Total	**259,918**	**290,091**	**313,056**	**317,629**	**100%**	**100%**	**100%**	**100%**	**12%**	**9%**	**1%**



Ethnicity Trend

Ethnicity	Members Jul 2020	Members Jul 2021	Members Jun 2022	Members Jul 2022	% of Total (ie.Distribution) Jul 2020	Jul 2021	Jun 2022	Jul 2022	% Growth (Loss) Jul 2020 to Jul 2021	Jul 2021 to Jul 2022	Jun 2022 to Jul 2022
Hispanic	72,376	80,361	85,824	88,368	28%	28%	27%	28%	11%	10%	3%
Black	45,622	46,843	48,031	48,090	18%	16%	15%	15%	3%	3%	0%
Other Asian / Pacific Islander	28,453	30,700	31,777	32,015	11%	11%	10%	10%	8%	4%	1%
White	24,309	26,392	27,666	27,805	9%	9%	9%	9%	9%	5%	1%
Chinese	28,189	30,090	31,360	31,505	11%	10%	10%	10%	7%	5%	0%
Other	45,429	60,195	72,720	74,128	17%	21%	23%	23%	33%	23%	2%
Vietnamese	10,933	11,369	11,426	11,461	4%	4%	4%	4%	4%	1%	0%
Unknown	4,020	3,523	3,570	3,574	2%	1%	1%	1%	-12%	1%	0%
American Indian or Alaskan Native	587	618	682	683	0%	0%	0%	0%	5%	11%	0%
Total	**259,918**	**290,091**	**313,056**	**317,629**	**100%**	**100%**	**100%**	**100%**	**12%**	**9%**	**1%**



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

Medi-Cal By City

City	Jul 2022	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	122,458	39%	13,869	29,589	14,122	51,417	13,461
Hayward	48,841	16%	7,716	10,704	5,454	16,277	8,690
Fremont	28,316	9%	10,044	4,389	988	8,136	4,759
San Leandro	28,222	9%	4,684	4,220	3,489	10,614	5,215
Union City	12,991	4%	3,985	2,046	512	3,932	2,516
Alameda	11,873	4%	2,076	1,967	1,641	4,241	1,948
Berkeley	11,609	4%	1,522	1,732	1,321	5,231	1,803
Livermore	9,619	3%	1,149	733	1,884	4,114	1,739
Newark	7,247	2%	1,928	2,334	232	1,397	1,356
Castro Valley	7,805	3%	1,304	1,265	1,084	2,499	1,653
San Lorenzo	6,562	2%	885	1,131	723	2,430	1,393
Pleasanton	5,234	2%	997	418	514	2,385	920
Dublin	5,617	2%	1,002	447	687	2,407	1,074
Emeryville	2,121	1%	347	414	295	693	372
Albany	1,958	1%	277	230	369	678	404
Piedmont	380	0%	47	109	25	99	100
Sunol	71	0%	20	10	6	21	14
Antioch	35	0%	8	7	8	7	5
Other	874	0%	154	182	112	323	103
Total	**311,833**	**100%**	**52,014**	**61,927**	**33,466**	**116,901**	**47,525**

Group Care By City

City	Jul 2022	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	1,910	33%	437	364	-	1,109	-
Hayward	655	11%	326	136	-	193	-
Fremont	618	11%	450	46	-	122	-
San Leandro	578	10%	224	87	-	267	-
Union City	308	5%	219	27	-	62	-
Alameda	277	5%	100	18	-	159	-
Berkeley	172	3%	47	11	-	114	-
Livermore	83	1%	26	1	-	56	-
Newark	147	3%	89	37	-	21	-
Castro Valley	181	3%	77	19	-	85	-
San Lorenzo	121	2%	46	17	-	58	-
Pleasanton	59	1%	25	3	-	31	-
Dublin	105	2%	36	10	-	59	-
Emeryville	37	1%	14	6	-	17	-
Albany	17	0%	7	1	-	9	-
Piedmont	14	0%	4	-	-	10	-
Sunol	-	0%	-	-	-	-	-
Antioch	24	0%	5	6	-	13	-
Other	490	8%	194	68	-	228	-
Total	**5,796**	**100%**	**2,326**	**857**	**-**	**2,613**	**-**

Total By City

City	Jul 2022	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	124,368	39%	14,306	29,953	14,122	52,526	13,461
Hayward	49,496	16%	8,042	10,840	5,454	16,470	8,690
Fremont	28,934	9%	10,494	4,435	988	8,258	4,759
San Leandro	28,800	9%	4,908	4,307	3,489	10,881	5,215
Union City	13,299	4%	4,204	2,073	512	3,994	2,516
Alameda	12,150	4%	2,176	1,985	1,641	4,400	1,948
Berkeley	11,781	4%	1,569	1,743	1,321	5,345	1,803
Livermore	9,702	3%	1,175	734	1,884	4,170	1,739
Newark	7,394	2%	2,017	2,371	232	1,418	1,356
Castro Valley	7,986	3%	1,381	1,284	1,084	2,584	1,653
San Lorenzo	6,683	2%	931	1,148	723	2,488	1,393
Pleasanton	5,293	2%	1,022	421	514	2,416	920
Dublin	5,722	2%	1,038	457	687	2,466	1,074
Emeryville	2,158	1%	361	420	295	710	372
Albany	1,975	1%	284	231	369	687	404
Piedmont	394	0%	51	109	25	109	100
Sunol	71	0%	20	10	6	21	14
Antioch	59	0%	13	13	8	20	5
Other	1,364	0%	348	250	112	551	103
Total	**317,629**	**100%**	**54,340**	**62,784**	**33,466**	**119,514**	**47,525**

Finance Committee Report

For the month of
August 2022

To: Alameda Alliance for Health Board of Governors

From: Gil Riojas, Chief Financial Officer

Date: October 14th, 2022

Subject: Finance Report – August 2022

Executive Summary

- For the month ended August 31st, 2022, the Alliance had enrollment of 319,256 members, a Net Income of $2.3 million and 627% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$100,982	$201,810
Medical Expense	93,340	184,201
Admin. Expense	5,698	10,426
Other Inc. / (Exp.)	394	859
Net Income	**$2,338**	**$8,043**

Net Income by Program:

	Month	YTD
Medi-Cal	$1,449	$6,878
Group Care	889	1,165
	$2,338	**$8,043**

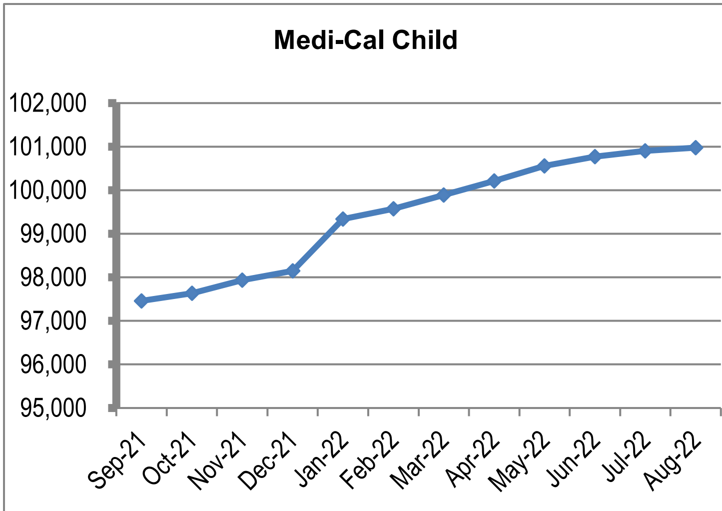
Enrollment

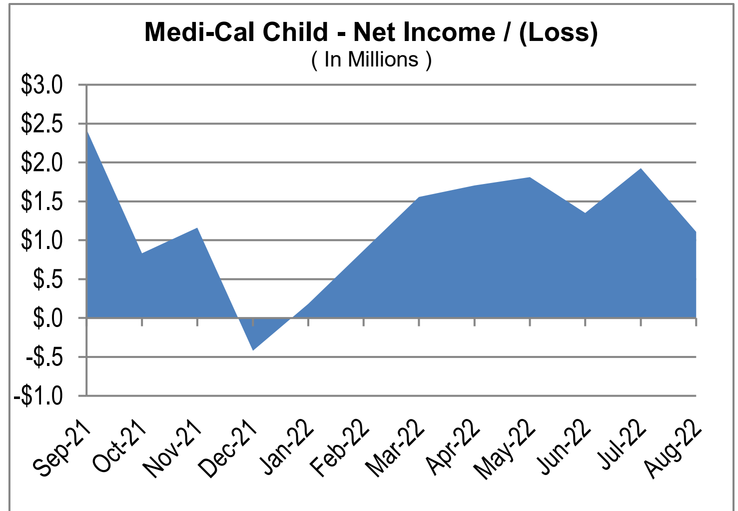
- Total enrollment increased by 1,627 members since July 2022.
- Total enrollment increased by 6,200 members since June 2022.

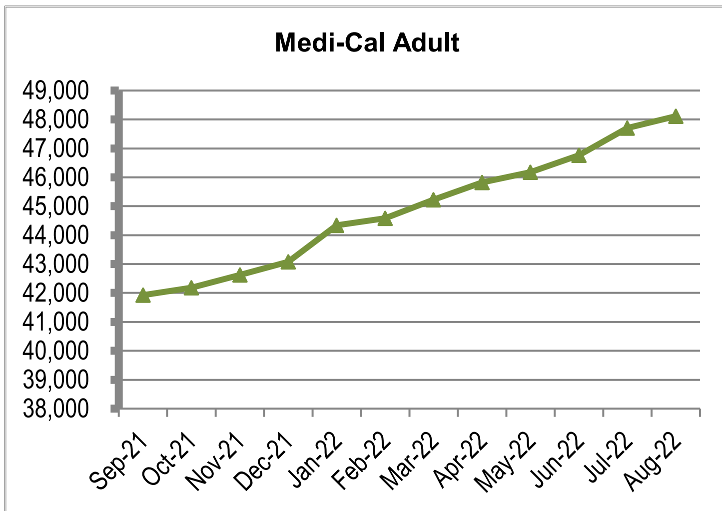
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

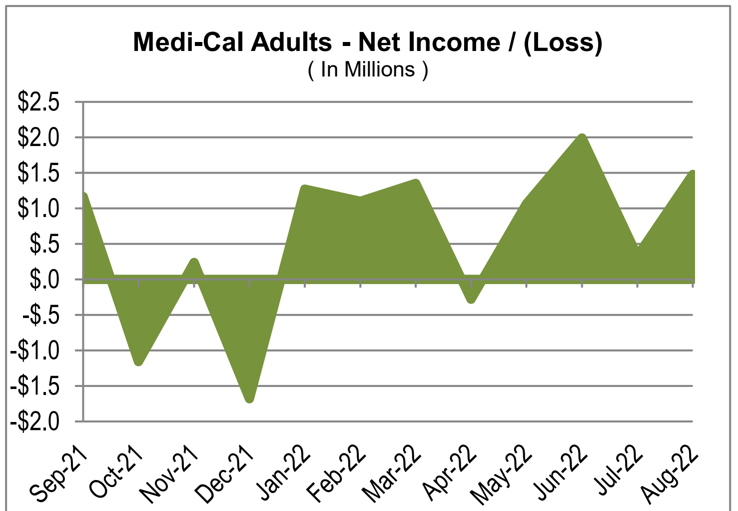
Enrollment August-2022					Member Months Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
48,112	47,030	1,082	2.3%	Adult	95,819	47,030	48,789	103.7%
100,977	101,423	(446)	-0.4%	Child	201,880	101,423	100,457	99.0%
28,079	28,368	(289)	-1.0%	SPD	56,070	28,368	27,702	97.7%
22,077	21,715	362	1.7%	Duals	43,987	21,715	22,272	102.6%
114,208	114,129	79	0.1%	ACA OE	227,530	114,129	113,401	99.4%
313,453	**312,665**	**788**	**0.3%**	**Medi-Cal Total**	**625,286**	**312,665**	**312,621**	**100.0%**
5,803	5,828	(25)	-0.4%	Group Care	11,599	5,828	5,771	99.0%
319,256	**318,493**	**763**	**0.2%**	**Total**	**636,885**	**318,493**	**318,392**	**100.0%**

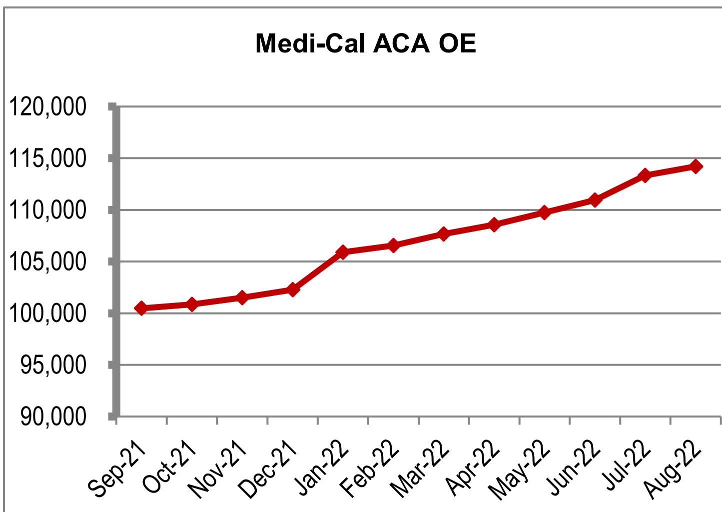
Enrollment and Profitability by Program and Category of Aid

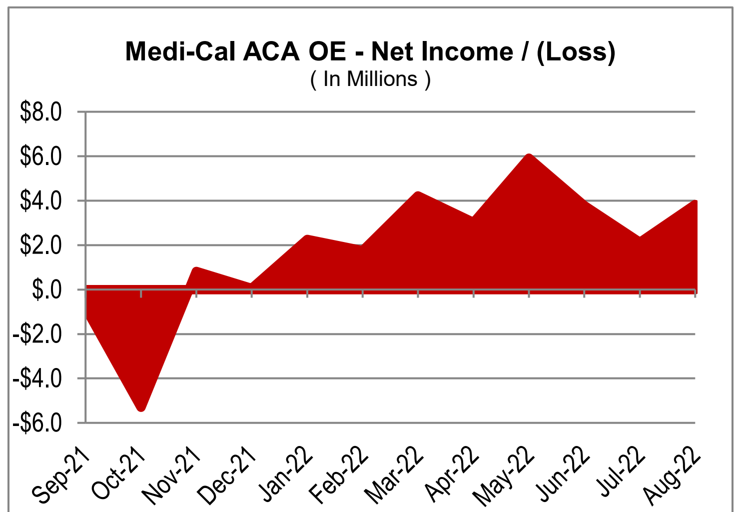




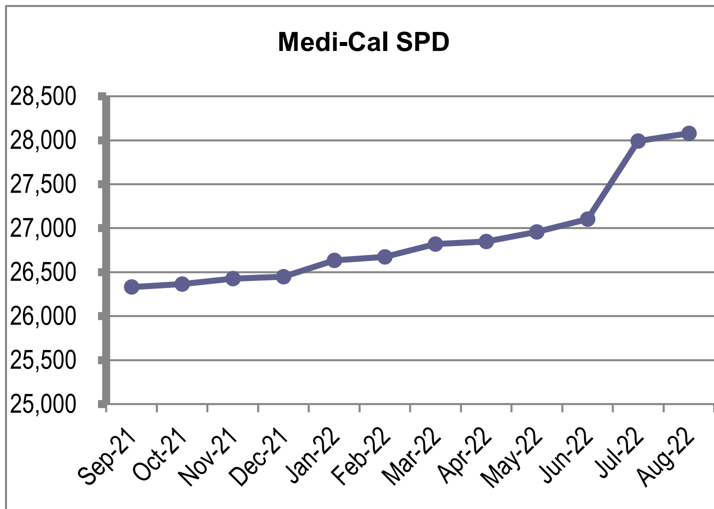


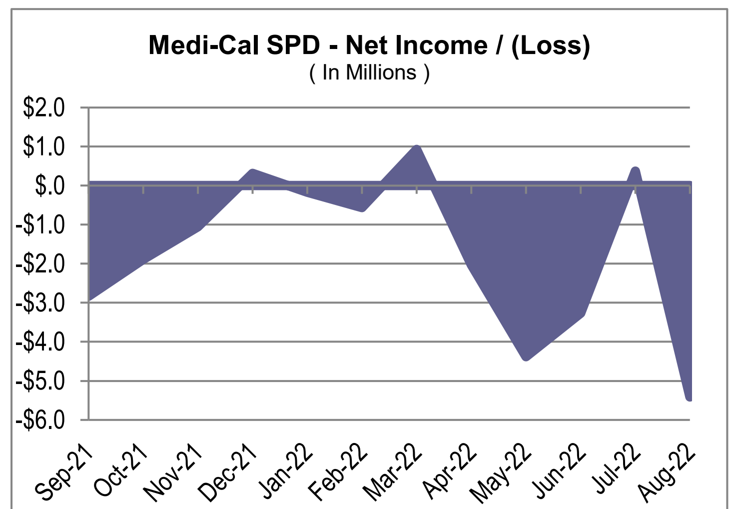


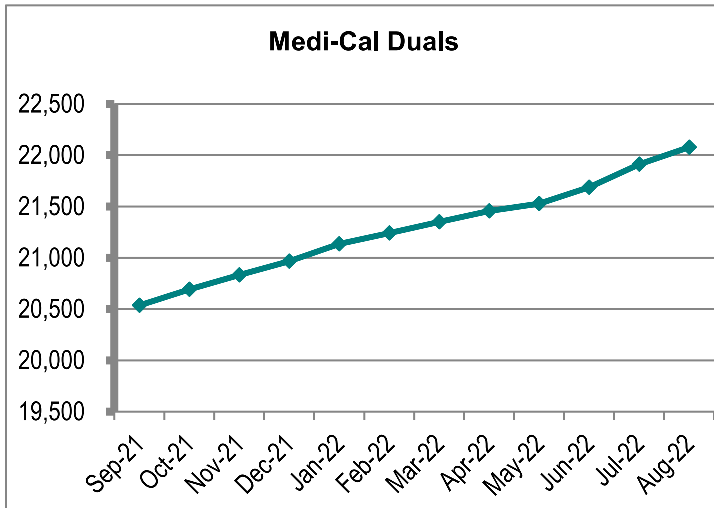


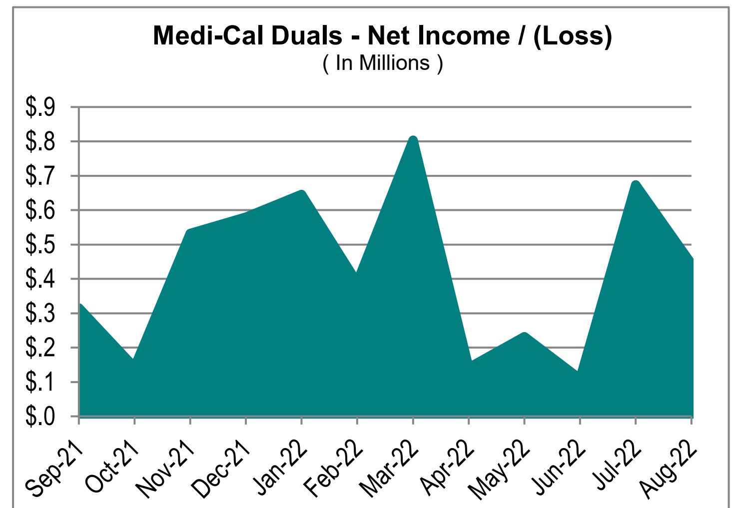


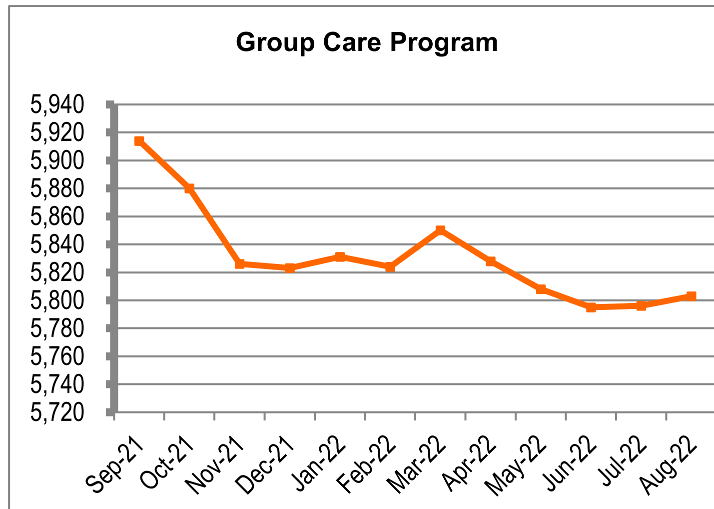
Enrollment and Profitability by Program and Category of Aid

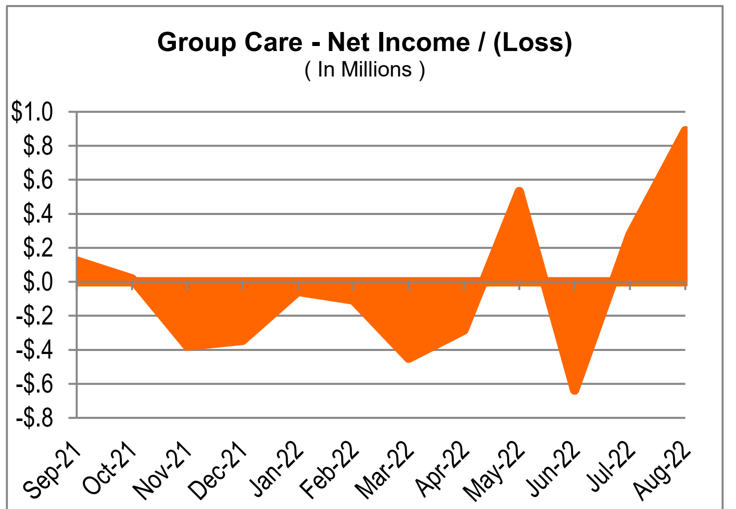




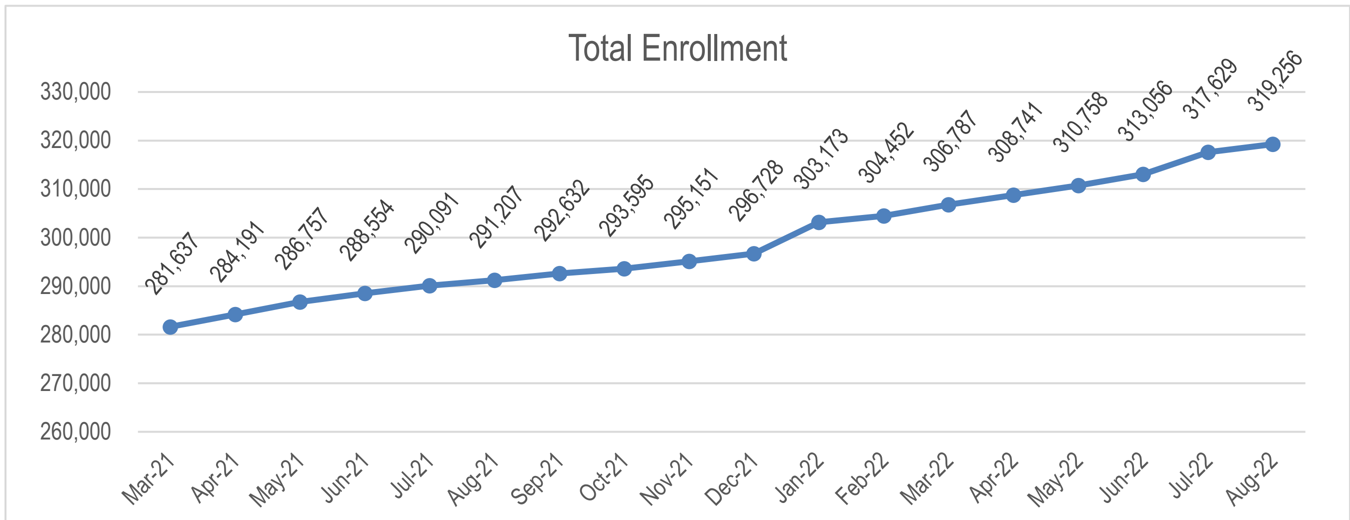


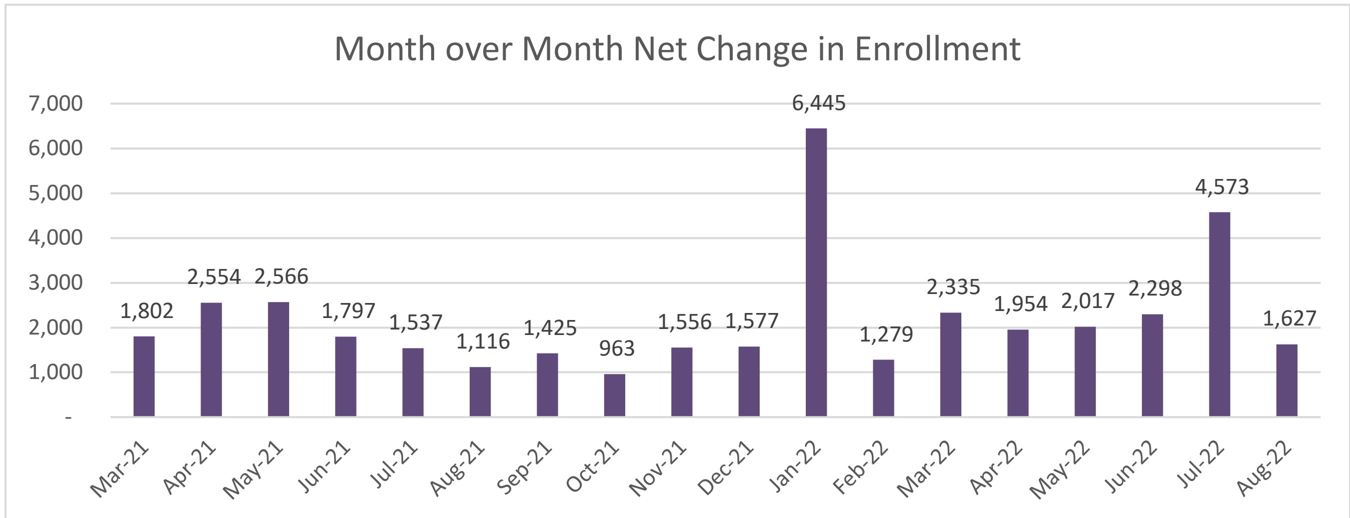






Net Change in Enrollment



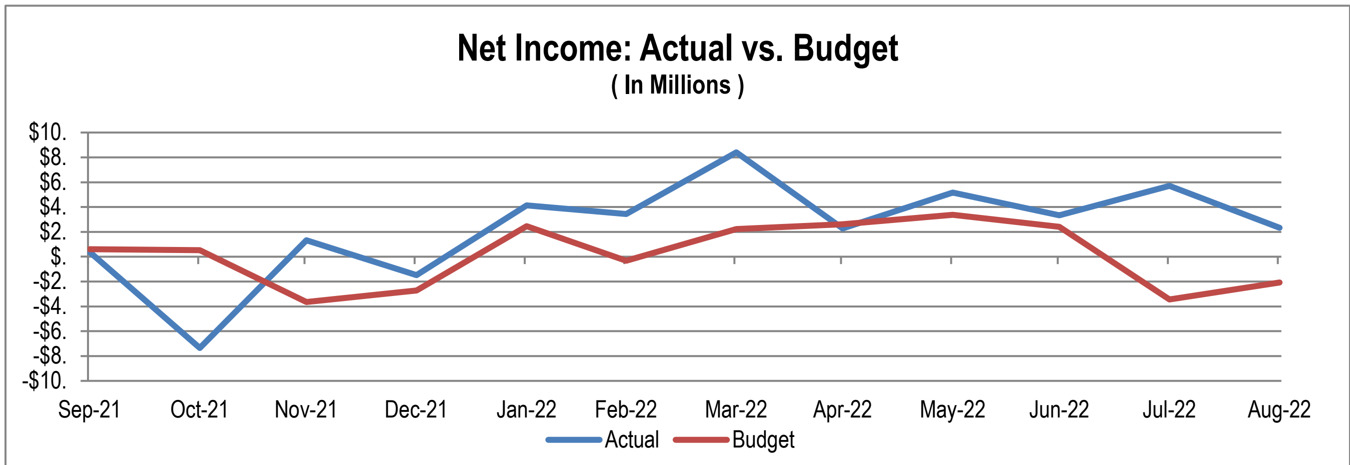


- The disenrollment process associated with the Public Health Emergency (PHE) is projected to restart in early calendar year 2023.

Net Income

- For the month ended August 31st, 2022:
  - Actual Net Income: $2.3 million.
  - Budgeted Net Loss: $2.1 million.

- For the fiscal YTD ended August 31st, 2022:
  - Actual Net Income: $8.0 million.
  - Budgeted Net Loss: $5.5 million.

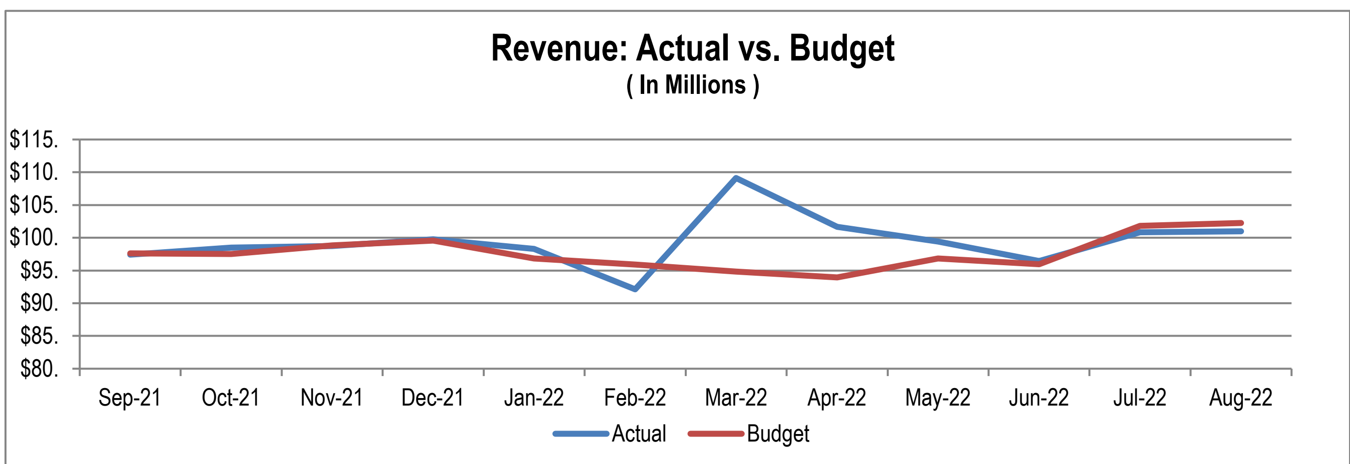


- The favorable variance of $4.4 million in the current month is primarily due to:
  - Unfavorable $1.3 million lower than anticipated Revenue.
  - Favorable $4.1 million lower than anticipated Medical Expense.
  - Favorable $1.3 million lower than anticipated Administrative Expense.
  - Favorable $345,000 higher than anticipated Total Other Income.

Revenue

- For the month ended August 31st, 2022:
  - Actual Revenue: $101.0 million.
  - Budgeted Revenue: $102.3 million.

- For the fiscal YTD ended August 31st, 2022:
  - Actual Revenue: $201.8 million.
  - Budgeted Revenue: $204.1 million.



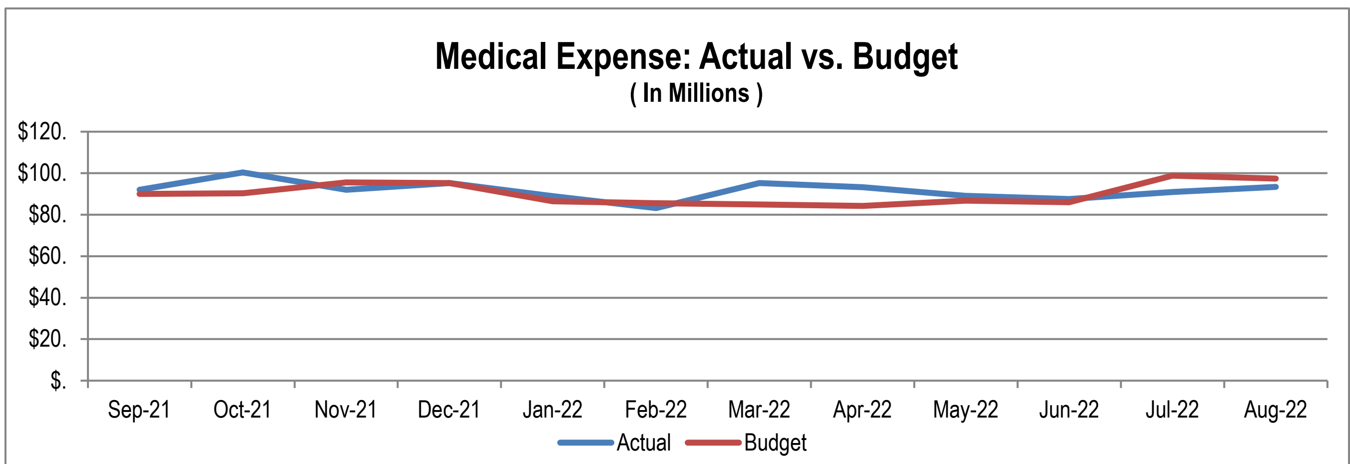
- For the month ended August 31st, 2022, the unfavorable revenue variance of $1.3 million is primarily due to unfavorable $700,000 accrual to Medi-Cal Base Capitation Revenue for an anticipated member health acuity adjustment by DHCS,

unfavorable Prop 56 Revenue, and unfavorable Behavioral Health Supplemental Revenue.

Medical Expense

- For the month ended August 31st, 2022:
  - Actual Medical Expense: $93.3 million.
  - Budgeted Medical Expense: $97.4 million.

- For the fiscal YTD ended August 31st, 2022:
  - Actual Medical Expense: $184.2 million.
  - Budgeted Medical Expense: $196.2 million.



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

- For August, updates to Fee-For-Service (FFS) decreased the estimate for prior period unpaid Medical Expenses by $1.6 million. The estimate for prior years decreased by $6.2 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	$48,207,575	$0	$48,207,575	$47,845,962	($361,612)	-0.8%
Primary Care FFS	8,396,361	$26,286	$8,422,646	8,388,615	($7,746)	-0.1%
Specialty Care FFS	10,152,023	$243,309	$10,395,332	10,342,534	$190,511	1.8%
Outpatient FFS	17,064,626	($943,369)	$16,121,257	18,044,092	$979,466	5.4%
Ancillary FFS	14,374,756	($690,400)	$13,684,356	14,575,201	$200,445	1.4%
Pharmacy FFS	12,660,227	($48,246)	$12,611,981	12,974,292	$314,065	2.4%
ER Services FFS	9,715,153	($113,190)	$9,601,963	10,993,314	$1,278,160	11.6%
Inpatient Hospital & SNF FFS	65,766,771	($4,652,936)	$61,113,834	66,142,318	$375,547	0.6%
Other Benefits & Services	3,781,406	$0	$3,781,406	6,479,746	$2,698,341	41.6%
Net Reinsurance	260,204	$0	$260,204	435,268	$175,063	40.2%
	$190,379,101	**($6,178,547)**	**$184,200,554**	**$196,221,341**	**$5,842,240**	**3.0%**

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

Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

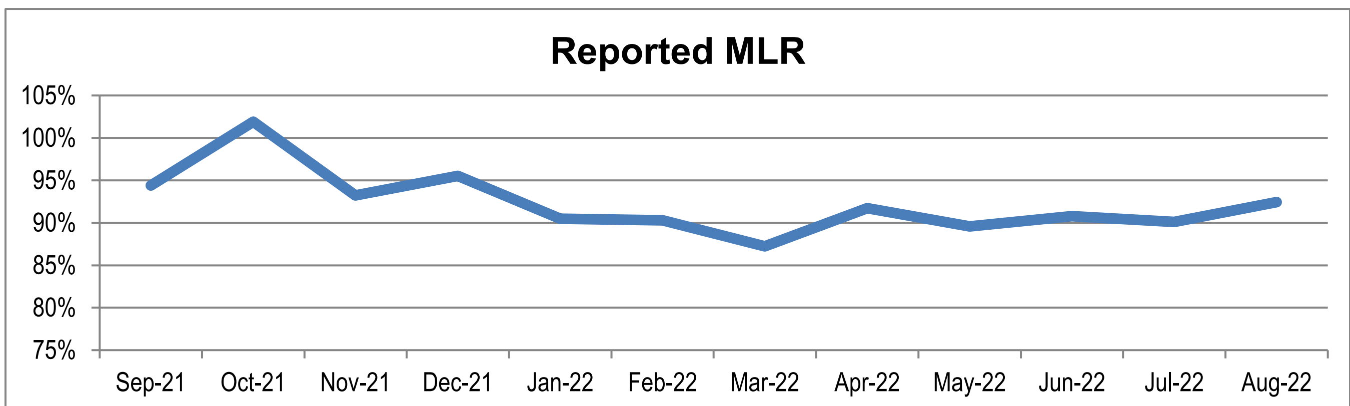
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$75.69	$0.00	$75.69	$75.27	($0.42)	-0.6%
Primary Care FFS	$13.18	$0.04	$13.22	$13.20	$0.01	0.1%
Specialty Care FFS	$15.94	$0.38	$16.32	$16.27	$0.33	2.0%
Outpatient FFS	$26.79	($1.48)	$25.31	$28.39	$1.59	5.6%
Ancillary FFS	$22.57	($1.08)	$21.49	$22.93	$0.36	1.6%
Pharmacy FFS	$19.88	($0.08)	$19.80	$20.41	$0.53	2.6%
ER Services FFS	$15.25	($0.18)	$15.08	$17.29	$2.04	11.8%
Inpatient Hospital & SNF FFS	$103.26	($7.31)	$95.96	$104.06	$0.79	0.8%
Other Benefits & Services	$5.94	$0.00	$5.94	$10.19	$4.26	41.8%
Net Reinsurance	$0.41	$0.00	$0.41	$0.68	$0.28	40.3%
	$298.92	**($9.70)**	**$289.22**	**$308.70**	**$9.78**	**3.2%**

- Excluding the effect of prior year estimates for IBNP, year-to-date medical expense variance is $5.8 million favorable to final budget, primarily due to higher enrollment. On a PMPM basis, medical expense is 3.2% favorable to budget. For per-member-per-month expense:
  - Capitated Expense overall is slightly unfavorable to budget.
  - Primary Care Expense is favorable compared to budget, driven by favorable utilization in the Adult, Child, and Dual populations, offset by unfavorable utilization in SPD, ACA OE, and Group Care populations.

- Specialty Care Expense is less than budget, generally driven by favorable utilization in the ACA OE, Adult, Child, and Dual populations, offset by unfavorable utilization in the SPD and Group Care populations.
- Outpatient Expense is under budget, driven by favorable utilization, offset by unfavorable unit cost.
- Ancillary Expense is favorable to budget due to Hospice, Other Medical Professional, Ambulance, Non-Emergency Transportation, and transplant wrap around expense offset by unfavorable Home Heath, DME, ECM, Outpatient Therapy, Laboratory and Radiology and CBAS expense. Unit cost is favorable offset, by unfavorable utilization.
- Pharmacy Expense is under budget due to favorable Outpatient Pharmacy expense, driven by favorable utilization across all populations, except for the ACE OE, for which expense is driven by unfavorable unit cost.
- Emergency Room Expense is under budget driven by favorable unit cost across all populations except for the Child population, which is driven by unfavorable utilization.
- Inpatient Expense is under budget, driven by favorable utilization in the ACA OE, Adult and Child populations.
- Other Benefits & Services are under budget, primarily due to favorable purchased and professional, printing/postage/promotion and employee expense.
- 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 92.4% for the month and 91.3% for the fiscal year-to-date.



Administrative Expense

- For the month ended August 31st, 2022:
    - Actual Administrative Expense: $5.7 million.
    - Budgeted Administrative Expense: $7.0 million.
- For the fiscal YTD ended August 31st, 2022:
    - Actual Administrative Expense: $10.4 million.
    - Budgeted Administrative Expense: $13.5 million.

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

Month					Year-to-Date			
Actual	**Budget**	**Variance $**	**Variance %**		**Actual**	**Budget**	**Variance $**	**Variance %**
$3,762,034	$3,977,318	$215,284	5.4%	Employee Expense	$6,841,436	$7,600,348	$758,912	10.0%
320,243	315,853	(4,390)	-1.4%	Medical Benefits Admin Expense	619,415	630,501	11,086	1.8%
803,352	1,485,330	681,978	45.9%	Purchased & Professional Services	1,330,193	2,965,256	1,635,063	55.1%
812,002	1,174,848	362,846	30.9%	Other Admin Expense	1,634,832	2,256,061	621,229	27.5%
$5,697,631	$6,953,349	$1,255,718	18.1%	Total Administrative Expense	$10,425,877	$13,452,166	$3,026,290	22.5%

The year-to-date variances include:

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

Administrative loss ratio (ALR) represented 5.6% of net revenue for the month and 5.2% of net revenue year-to-date.

Other Income / (Expense)

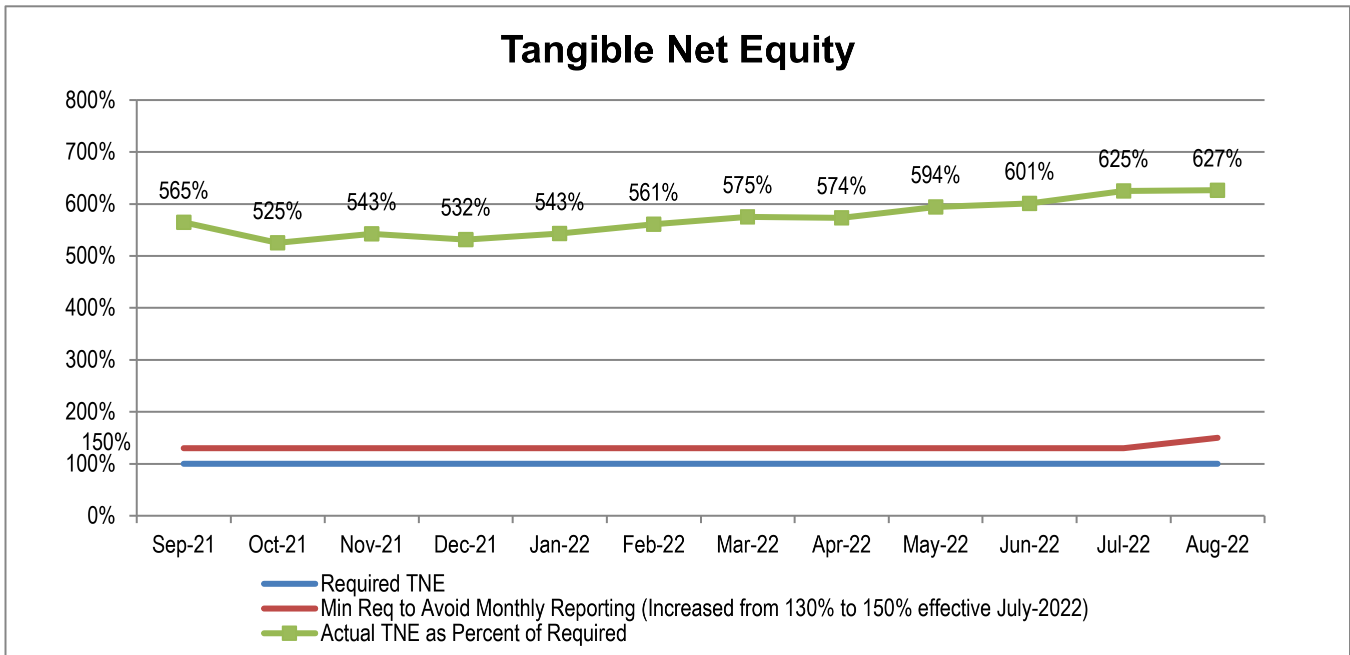
Other Income & Expense is comprised of investment income and claims interest.

- Fiscal year-to-date net investments show a gain of $859,000.
- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $52,000.

Tangible Net Equity (TNE)

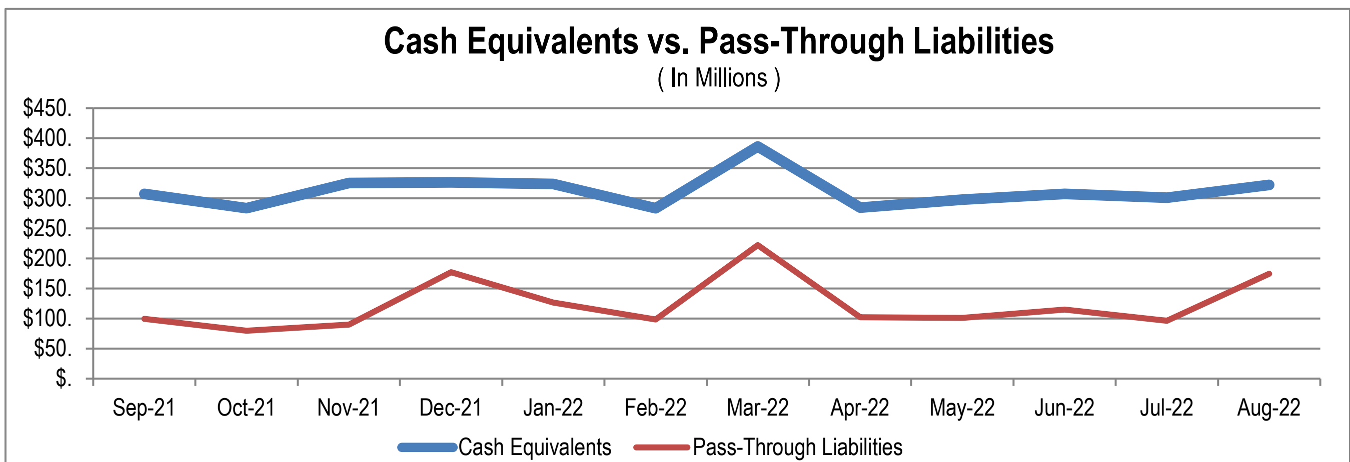
- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to consumers. TNE is a calculation of a company's total tangible assets minus the company's total liabilities. The Alliance exceeds DMHC's required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

- Required TNE $38.1 million
- Actual TNE $238.7 million
- Excess TNE $200.6 million
- TNE % of Required TNE 627%



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

- Key Metrics
  - Cash & Cash Equivalents $322.4 million
  - Pass-Through Liabilities $174.5 million
  - Uncommitted Cash $147.9 million
  - Working Capital $194.8 million
  - Current Ratio 1.55 (regulatory minimum is 1.0)



Capital Investment

- Fiscal year-to-date capital assets acquired: $24,000.
- Annual capital budget: $1.0 million.
- A summary of year-to-date capital asset acquisitions is included in this monthly financial statement package.

Caveats to Financial Statements

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

Finance

Supporting Documents

ALAMEDA ALLIANCE FOR HEALTH
STATEMENT OF REVENUE & EXPENSES
ACTUAL VS. BUDGET (WITH MEDICAL EXPENSE BY PAYMENT TYPE)
COMBINED BASIS (RESTRICTED & UNRESTRICTED FUNDS)
FOR THE MONTH AND FISCAL YTD ENDED August 31, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				MEMBERSHIP				
313,453	312,665	788	0.3%	1 - Medi-Cal	625,286	623,982	1,304	0.2%
5,803	5,828	(25)	0.4%	2 - Group Care	11,599	11,656	(57)	0.5%
319,256	**318,493**	**763**	**0.2%**	**3 - TOTAL MEMBER MONTHS**	**636,885**	**635,638**	**1,247**	**0.2%**
				REVENUE				
$100,981,650	**$102,252,054**	**($1,270,404)**	**(1.2%)**	**4 - TOTAL REVENUE**	**$201,810,102**	**$204,065,762**	**($2,255,660)**	**(1.1%)**
				MEDICAL EXPENSES				
				Capitated Medical Expenses:				
$24,104,466	$23,975,436	($129,030)	(0.5%)	5 - Capitated Medical Expense	$48,207,575	$47,845,961	($361,614)	(0.8%)
				Fee for Service Medical Expenses:				
$30,979,274	$33,149,605	$2,170,331	6.5%	6 - Inpatient Hospital & SNF FFS Expense	$61,113,834	$66,142,319	$5,028,485	7.6%
$4,215,413	$4,204,865	($10,548)	(0.3%)	7 - Primary Care Physician FFS Expense	$8,422,646	$8,388,616	($34,030)	(0.4%)
$5,374,649	$5,182,399	($192,250)	(3.7%)	8 - Specialty Care Physician Expense	$10,395,332	$10,342,531	($52,801)	(0.5%)
$6,884,075	$7,302,698	$418,623	5.7%	9 - Ancillary Medical Expense	$13,684,356	$14,575,192	$890,836	6.1%
$7,705,868	$9,022,741	$1,316,873	14.6%	10 - Outpatient Medical Expense	$16,121,257	$18,044,093	$1,922,836	10.7%
$4,744,617	$5,493,416	$748,799	13.6%	11 - Emergency Expense	$9,601,963	$10,993,312	$1,391,349	12.7%
$7,198,873	$6,507,509	($691,364)	(10.6%)	12 - Pharmacy Expense	$12,611,981	$12,974,291	$362,310	2.8%
$67,102,770	$70,863,233	$3,760,463	5.3%	13 - Total Fee for Service Expense	$131,951,370	$141,460,354	$9,508,984	6.7%
$2,023,299	$2,357,807	$334,508	14.2%	14 - Other Benefits & Services	$3,781,406	$6,479,735	$2,698,329	41.6%
$109,089	$218,048	$108,959	50.0%	15 - Reinsurance Expense	$260,204	$435,267	$175,063	40.2%
$93,339,624	**$97,414,524**	**$4,074,900**	**4.2%**	**17 - TOTAL MEDICAL EXPENSES**	**$184,200,554**	**$196,221,317**	**$12,020,763**	**6.1%**
7,642,026	**4,837,530**	**2,804,496**	**58.0%**	**18 - GROSS MARGIN**	**17,609,548**	**7,844,445**	**9,765,103**	**124.5%**
				ADMINISTRATIVE EXPENSES				
$3,762,034	$3,977,318	$215,284	5.4%	19 - Personnel Expense	$6,841,436	$7,600,348	$758,912	10.0%
$320,243	$315,853	($4,390)	(1.4%)	20 - Benefits Administration Expense	$619,415	$630,501	$11,086	1.8%
$803,352	$1,485,330	$681,978	45.9%	21 - Purchased & Professional Services	$1,330,193	$2,965,256	$1,635,063	55.1%
$812,002	$1,174,848	$362,846	30.9%	22 - Other Administrative Expense	$1,634,832	$2,256,061	$621,229	27.5%
$5,697,631	**$6,953,349**	**$1,255,718**	**18.1%**	**23 - TOTAL ADMINISTRATIVE EXPENSE**	**$10,425,877**	**$13,452,166**	**$3,026,289**	**22.5%**
$1,944,395	**($2,115,819)**	**$4,060,214**	**191.9%**	**24 - NET OPERATING INCOME / (LOSS)**	**$7,183,671**	**($5,607,721)**	**$12,791,392**	**228.1%**
				OTHER INCOME / EXPENSE				
$393,579	**$48,750**	**$344,829**	**707.3%**	**25 - TOTAL OTHER INCOME / (EXPENSE)**	**$859,132**	**$97,500**	**$761,632**	**781.2%**
$2,337,974	**($2,067,069)**	**$4,405,043**	**213.1%**	**26 - NET INCOME / (LOSS)**	**$8,042,802**	**($5,510,221)**	**$13,553,023**	**246.0%**
5.6%	**6.8%**	**1.2%**	**17.6%**	**27 - Admin Exp % of Revenue**	**5.2%**	**6.6%**	**1.4%**	**21.2%**

ALAMEDA ALLIANCE FOR HEALTH
BALANCE SHEETS
CURRENT MONTH VS. PRIOR MONTH
FOR THE MONTH AND FISCAL YTD ENDED August 31, 2022

	August	July	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	$24,597,319	$51,457,654	($26,860,335)	-52.20%
Short-Term Investments	297,760,158	249,368,193	48,391,965	19.41%
Interest Receivable	305,785	290,103	15,682	5.41%
Other Receivables - Net	210,740,990	137,140,036	73,600,955	53.67%
Prepaid Expenses	5,822,225	5,221,582	600,644	11.50%
Prepaid Inventoried Items	5,385	16,910	(11,525)	-68.15%
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	**$549,964,804**	**$454,227,418**	**$95,737,385**	**21.08%**
OTHER ASSETS:				
Long-Term Investments	37,306,236	39,988,833	(2,682,597)	-6.71%
Restricted Assets	350,000	350,000	0	0.00%
Lease Asset - Office Space (Net)	2,067,070	2,126,917	(59,848)	-2.81%
Lease Asset - Office Equipment (Net)	238,174	241,784	(3,610)	-1.49%
TOTAL OTHER ASSETS	**$39,961,480**	**$42,707,534**	**($2,746,054)**	**-6.43%**
PROPERTY AND EQUIPMENT:				
Land, Building & Improvements	10,113,570	10,089,578	23,992	0.24%
Furniture And Equipment	11,540,223	11,540,223	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	37,380,242	37,356,250	23,992	0.06%
Less: Accumulated Depreciation	(31,819,830)	(31,751,692)	(68,138)	0.21%
NET PROPERTY AND EQUIPMENT	**$5,560,412**	**$5,604,558**	**($44,146)**	**-0.79%**
TOTAL ASSETS	**$595,486,695**	**$502,539,510**	**$92,947,185**	**18.50%**
CURRENT LIABILITIES:				
Accounts Payable	769,298	1,286,429	(517,131)	-40.20%
Other Accrued Expenses	903,442	880,228	23,215	2.64%
Interest Payable	11,871	12,205	(335)	-2.74%
Pass-Through Liabilities	174,549,300	95,980,358	78,568,943	81.86%
Claims Payable	40,160,356	22,747,661	17,412,695	76.55%
IBNP Reserves	118,007,599	123,488,607	(5,481,008)	-4.44%
Payroll Liabilities	5,559,420	4,875,537	683,883	14.03%
CalPERS Deferred Inflow	6,781,898	6,781,898	0	0.00%
Risk Sharing	7,374,932	7,374,932	0	0.00%
Provider Grants/ New Health Program	203,381	214,761	(11,380)	-5.30%
ST Lease Liability - Office Space	758,526	752,285	6,241	0.83%
ST Lease Liability - Office Equipment	49,027	48,641	386	0.79%
TOTAL CURRENT LIABILITIES	**$355,129,049**	**$264,443,541**	**$90,685,508**	**34.29%**
LONG TERM LIABILITIES:				
LT Lease Liability - Office Space	1,495,153	1,567,869	(72,715)	-4.64%
LT Lease Liability - Office Equipment	195,389	198,971	(3,582)	-1.80%
TOTAL LONG TERM LIABILITIES	**$1,690,543**	**$1,766,840**	**($76,297)**	**-4.32%**
TOTAL LIABILITIES	**$356,819,591**	**$266,210,381**	**$90,609,211**	**34.04%**
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)	8,042,802	5,704,828	2,337,974	40.98%
TOTAL NET WORTH	**$238,667,104**	**$236,329,130**	**$2,337,974**	**0.99%**
TOTAL LIABILITIES AND NET WORTH	**$595,486,695**	**$502,539,510**	**$92,947,185**	**18.50%**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 8/31/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$2,655,884	$7,471,083	$14,037,232	$5,302,532
Total	2,655,884	7,471,083	14,037,232	5,302,532
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	98,325,707	290,697,946	594,226,957	196,507,356
Allowance for Doubtful Accounts	0	0	0	0
Deferred Premium Revenue	0	(1,460,000)	0	0
Premium Receivable	(73,691,067)	(77,011,813)	(83,222,018)	(11,935,550)
Total	24,634,640	212,226,133	511,004,939	184,571,806
Investment & Other Income Cash Flows				
Other Revenue (Grants)	4,313	(35,884)	(38,684)	(8,401)
Investment Income	426,727	888,441	865,758	940,382
Interest Receivable	(15,682)	(30,534)	(32,432)	(27,348)
Total	415,358	822,023	794,642	904,633
Medical & Hospital Cash Flows				
Total Medical Expenses	(93,339,626)	(271,753,526)	(549,246,473)	(184,200,554)
Other Receivable	90,113	2,815,481	4,122,878	1,556,069
Claims Payable	17,412,695	18,437,365	23,993,987	20,571,633
IBNP Payable	(5,481,008)	1,871,737	1,053,850	4,903,225
Risk Share Payable	0	(750,000)	(750,000)	0
Health Program	(11,380)	(34,601)	(66,678)	(23,291)
Other Liabilities	0	(1)	(1)	0
Total	(81,329,206)	(249,413,545)	(520,892,437)	(157,192,918)
Administrative Cash Flows				
Total Administrative Expenses	(5,735,031)	(14,354,416)	(31,091,969)	(10,498,513)
Prepaid Expenses	(589,119)	(9,081,897)	(8,290,071)	(480,415)
CalPERS Pension Asset	0	0	0	0
CalPERS Deferred Outflow	0	0	0	0
Trade Accounts Payable	(493,916)	(150,203)	(1,301,401)	(1,033,017)
Other Accrued Liabilities	(335)	11,871	11,871	(646)
Payroll Liabilities	683,882	5,178,568	6,232,053	851,985
Net Lease Assets/Liabilities (Short term & Long term)	(6,212)	192,852	192,852	(1,089)
Depreciation Expense	68,138	270,299	472,301	136,811
Total	(6,072,593)	(17,932,926)	(33,774,364)	(11,024,884)
Interest Paid				
Debt Interest Expense	0	0	0	0
Total Cash Flows from Operating Activities	**(59,695,917)**	**(46,827,232)**	**(28,829,988)**	**22,561,169**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 8/31/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	2,682,597	(1,922,338)	(8,565,539)	(2,237,387)
	2,682,597	(1,922,338)	(8,565,539)	(2,237,387)
Restricted Cash & Other Asset Cash Flows				
Provider Pass-Thru-Liabilities	78,568,944	73,382,650	76,295,548	(5,352,666)
Restricted Cash	0	0	0	0
	78,568,944	73,382,650	76,295,548	(5,352,666)
Fixed Asset Cash Flows				
Depreciation expense	68,138	270,299	472,301	136,811
Fixed Asset Acquisitions	(23,992)	(211,108)	(211,108)	(23,992)
Change in A/D	(68,138)	(270,299)	(472,301)	(136,811)
	(23,992)	(211,108)	(211,108)	(23,992)
Total Cash Flows from Investing Activities	**81,227,549**	**71,249,204**	**67,518,901**	**(7,614,045)**
Financing Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Total Cash Flows	**21,531,632**	**24,421,972**	**38,688,913**	**14,947,124**
Rounding	(2)	0	0	1
Cash @ Beginning of Period	300,825,847	297,935,505	283,668,564	307,410,352
Cash @ End of Period	**$322,357,477**	**$322,357,477**	**$322,357,477**	**$322,357,477**
Difference (rounding)	0	0	0	0

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 8/31/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$2,337,972	$12,913,644	$28,752,821	$8,042,803
Add back: Depreciation	68,138	270,299	472,301	136,811
Receivables				
Premiums Receivable	(73,691,067)	(77,011,813)	(83,222,018)	(11,935,550)
First Care Receivable	0	0	0	0
Family Care Receivable	0	0	0	0
Healthy Kids Receivable	0	0	0	0
Interest Receivable	(15,682)	(30,534)	(32,432)	(27,348)
Other Receivable	90,113	2,815,481	4,122,878	1,556,069
FQHC Receivable	0	0	0	0
Allowance for Doubtful Accounts	0	0	0	0
Total	(73,616,636)	(74,226,866)	(79,131,572)	(10,406,829)
Prepaid Expenses	(589,119)	(9,081,897)	(8,290,071)	(480,415)
Trade Payables	(493,916)	(150,203)	(1,301,401)	(1,033,017)
Claims Payable, IBNR & Risk Share				
IBNP	(5,481,008)	1,871,737	1,053,850	4,903,225
Claims Payable	17,412,695	18,437,365	23,993,987	20,571,633
Risk Share Payable	0	(750,000)	(750,000)	0
Other Liabilities	0	(1)	(1)	0
Total	11,931,687	19,559,101	24,297,836	25,474,858
Unearned Revenue				
Total	0	(1,460,000)	0	0
Other Liabilities				
Accrued Expenses	(335)	11,871	11,871	(646)
Payroll Liabilities	683,882	5,178,568	6,232,053	851,985
Net Lease Assets/Liabilities (Short term & Long term)	(6,212)	192,852	192,852	(1,089)
Health Program	(11,380)	(34,601)	(66,678)	(23,291)
Accrued Sub Debt Interest	0	0	0	0
Total Change in Other Liabilities	665,955	5,348,690	6,370,098	826,959
Cash Flows from Operating Activities	**($59,695,919)**	**($46,827,232)**	**($28,829,988)**	**$22,561,170**
Difference (rounding)	(2)	0	0	1

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 8/31/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received From:				
Capitation Received from State of CA	$24,634,640	$212,226,133	$511,004,939	$184,571,806
Commercial Premium Revenue	2,655,884	7,471,083	14,037,232	5,302,532
Other Income	4,313	(35,884)	(38,684)	(8,401)
Investment Income	411,045	857,907	833,326	913,034
Cash Paid To:				
Medical Expenses	(81,329,206)	(249,413,545)	(520,892,437)	(157,192,918)
Vendor & Employee Expenses	(6,072,593)	(17,932,926)	(33,774,364)	(11,024,884)
Interest Paid	0	0	0	0
Net Cash Provided By (Used In) Operating Activities	(59,695,917)	(46,827,232)	(28,829,988)	22,561,169
Cash Flows from Financing Activities:				
Purchases of Fixed Assets	(23,992)	(211,108)	(211,108)	(23,992)
Net Cash Provided By (Used In) Financing Activities	(23,992)	(211,108)	(211,108)	(23,992)
Cash Flows from Investing Activities:				
Changes in Investments	2,682,597	(1,922,338)	(8,565,539)	(2,237,387)
Restricted Cash	78,568,944	73,382,650	76,295,548	(5,352,666)
Net Cash Provided By (Used In) Investing Activities	81,251,541	71,460,312	67,730,009	(7,590,053)
Financial Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Net Change in Cash	**21,531,632**	**24,421,972**	**38,688,913**	**14,947,124**
Cash @ Beginning of Period	300,825,847	297,935,505	283,668,564	307,410,352
Subtotal	$322,357,479	$322,357,477	$322,357,477	$322,357,476
Rounding	(2)	0	0	1
Cash @ End of Period	**$322,357,477**	**$322,357,477**	**$322,357,477**	**$322,357,477**
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	$2,337,972	$12,913,644	$28,752,821	$8,042,803
Depreciation	68,138	270,299	472,301	136,811
Net Change in Operating Assets & Liabilities:				
Premium & Other Receivables	(73,616,636)	(74,226,866)	(79,131,572)	(10,406,829)
Prepaid Expenses	(589,119)	(9,081,897)	(8,290,071)	(480,415)
Trade Payables	(493,916)	(150,203)	(1,301,401)	(1,033,017)
Claims payable & IBNP	11,931,687	19,559,101	24,297,836	25,474,858
Deferred Revenue	0	(1,460,000)	0	0
Accrued Interest	0	0	0	0
Other Liabilities	665,955	5,348,690	6,370,098	826,959
Subtotal	(59,695,919)	(46,827,232)	(28,829,988)	22,561,170
Rounding	2	0	0	(1)
Cash Flows from Operating Activities	**($59,695,917)**	**($46,827,232)**	**($28,829,988)**	**$22,561,169**
Rounding Difference	2	0	0	(1)

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF AUGUST 2022

	Child	Adult	Medi-Cal SPD	ACA OE	Duals	Medi-Cal Total	Group Care	Grand Total
Enrollment	100,977	48,112	28,079	114,208	22,077	313,453	5,803	319,256
Net Revenue	$12,582,442	$15,064,943	$25,892,308	$40,623,742	$4,162,331	$98,325,766	$2,655,885	$100,981,650
Medical Expense	$11,035,281	$12,857,179	$29,572,168	$34,729,509	$3,545,990	$91,740,127	$1,599,497	$93,339,624
Gross Margin	$1,547,160	$2,207,765	($3,679,859)	$5,894,232	$616,341	$6,585,638	$1,056,388	$7,642,026
Administrative Expense	$456,136	$783,534	$1,874,741	$2,219,189	$184,902	$5,518,503	$179,128	$5,697,631
Operating Income / (Expense)	$1,091,025	$1,424,231	($5,554,601)	$3,675,043	$431,438	$1,067,136	$877,260	$1,944,395
Other Income / (Expense)	$18,050	$56,077	$142,443	$153,408	$12,157	$382,135	$11,443	$393,579
Net Income / (Loss)	$1,109,075	$1,480,308	($5,412,158)	$3,828,451	$443,596	$1,449,271	$888,703	$2,337,974
Revenue PMPM	$124.61	$313.12	$922.12	$355.70	$188.54	$313.69	$457.67	$316.30
Medical Expense PMPM	$109.29	$267.23	$1,053.18	$304.09	$160.62	$292.68	$275.63	$292.37
Gross Margin PMPM	$15.32	$45.89	($131.05)	$51.61	$27.92	$21.01	$182.04	$23.94
Administrative Expense PMPM	$4.52	$16.29	$66.77	$19.43	$8.38	$17.61	$30.87	$17.85
Operating Income / (Expense) PMPM	$10.80	$29.60	($197.82)	$32.18	$19.54	$3.40	$151.17	$6.09
Other Income / (Expense) PMPM	$0.18	$1.17	$5.07	$1.34	$0.55	$1.22	$1.97	$1.23
Net Income / (Loss) PMPM	$10.98	$30.77	($192.75)	$33.52	$20.09	$4.62	$153.15	$7.32
Medical Loss Ratio	87.7%	85.3%	114.2%	85.5%	85.2%	93.3%	60.2%	92.4%
Gross Margin Ratio	12.3%	14.7%	-14.2%	14.5%	14.8%	6.7%	39.8%	7.6%
Administrative Expense Ratio	3.6%	5.2%	7.2%	5.5%	4.4%	5.6%	6.7%	5.6%
Net Income Ratio	8.8%	9.8%	-20.9%	9.4%	10.7%	1.5%	33.5%	2.3%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE - AUGUST 2022

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal Total	Group Care	Grand Total
Member Months	201,880	95,819	56,070	227,530	43,987	625,286	11,599	636,885
Net Revenue	$25,166,028	$30,384,484	$51,852,500	$80,816,499	$8,288,059	$196,507,570	$5,302,532	$201,810,102
Medical Expense	$21,328,943	$27,253,826	$53,769,018	$71,137,826	$6,853,758	$180,343,371	$3,857,184	$184,200,554
Gross Margin	$3,837,085	$3,130,658	($1,916,518)	$9,678,673	$1,434,301	$16,164,199	$1,445,349	$17,609,548
Administrative Expense	$851,102	$1,437,505	$3,423,985	$4,067,706	$341,319	$10,121,617	$304,260	$10,425,877
Operating Income / (Expense)	$2,985,983	$1,693,153	($5,340,503)	$5,610,967	$1,092,982	$6,042,582	$1,141,089	$7,183,671
Other Income / (Expense)	$49,369	$118,170	$299,794	$343,839	$23,967	$835,139	$23,993	$859,132
Net Income / (Loss)	$3,035,351	$1,811,324	($5,040,710)	$5,954,807	$1,116,949	$6,877,721	$1,165,082	$8,042,802
Revenue PMPM	$124.66	$317.10	$924.78	$355.19	$188.42	$314.27	$457.15	$316.87
Medical Expense PMPM	$105.65	$284.43	$958.96	$312.65	$155.81	$288.42	$332.54	$289.22
Gross Margin PMPM	$19.01	$32.67	($34.18)	$42.54	$32.61	$25.85	$124.61	$27.65
Administrative Expense PMPM	$4.22	$15.00	$61.07	$17.88	$7.76	$16.19	$26.23	$16.37
Operating Income / (Expense) PMPM	$14.79	$17.67	($95.25)	$24.66	$24.85	$9.66	$98.38	$11.28
Other Income / (Expense) PMPM	$0.24	$1.23	$5.35	$1.51	$0.54	$1.34	$2.07	$1.35
Net Income / (Loss) PMPM	$15.04	$18.90	($89.90)	$26.17	$25.39	$11.00	$100.45	$12.63
Medical Loss Ratio	84.8%	89.7%	103.7%	88.0%	82.7%	91.8%	72.7%	91.3%
Gross Margin Ratio	15.2%	10.3%	-3.7%	12.0%	17.3%	8.2%	27.3%	8.7%
Administrative Expense Ratio	3.4%	4.7%	6.6%	5.0%	4.1%	5.2%	5.7%	5.2%
Net Income Ratio	12.1%	6.0%	-9.7%	7.4%	13.5%	3.5%	22.0%	4.0%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED August 31, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSE SUMMARY				
$3,762,034	**$3,977,318**	**$215,284**	**5.4%**	**Personnel Expenses**	**$6,841,436**	**$7,600,348**	**$758,912**	**10.0%**
320,243	315,853	(4,390)	(1.4%)	Benefits Administration Expense	619,415	630,501	11,086	1.8%
803,352	1,485,330	681,978	45.9%	Purchased & Professional Services	1,330,193	2,965,256	1,635,063	55.1%
246,127	265,627	19,500	7.3%	Occupancy	486,609	536,737	50,128	9.3%
24,405	158,895	134,490	84.6%	Printing Postage & Promotion	94,176	255,079	160,903	63.1%
534,753	705,035	170,282	24.2%	Licenses Insurance & Fees	1,042,645	1,396,611	353,966	25.3%
6,717	45,291	38,574	85.2%	Supplies & Other Expenses	11,403	67,634	56,231	83.1%
$1,935,597	**$2,976,031**	**$1,040,434**	**35.0%**	**Total Other Administrative Expense**	**$3,584,441**	**$5,851,818**	**$2,267,377**	**38.7%**
$5,697,631	**$6,953,349**	**$1,255,718**	**18.1%**	**Total Administrative Expenses**	**$10,425,877**	**$13,452,166**	**$3,026,289**	**22.5%**

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED August 31, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
2,472,697	2,382,775	(89,922)	(3.8%)	Salaries & Wages	4,485,806	4,503,860	18,054	0.4%
380,880	263,429	(117,451)	(44.6%)	Paid Time Off	617,850	493,704	(124,146)	(25.1%)
200	3,375	3,175	94.1%	Incentives	3,612	6,145	2,533	41.2%
0	23,077	23,077	100.0%	Severance Pay	0	51,923	51,923	100.0%
41,090	65,532	24,442	37.3%	Payroll Taxes	73,086	156,048	82,962	53.2%
48,750	17,145	(31,605)	(184.3%)	Overtime	67,116	33,816	(33,300)	(98.5%)
192,439	202,201	9,762	4.8%	CalPERS ER Match	347,177	381,870	34,693	9.1%
542,426	699,621	157,195	22.5%	Employee Benefits	1,100,947	1,317,020	216,073	16.4%
1,832	0	(1,832)	0.0%	Personal Floating Holiday	1,832	0	(1,832)	0.0%
2,510	28,490	25,980	91.2%	Employee Relations	26,198	57,011	30,813	54.0%
7,950	16,053	8,103	50.5%	Work from Home Stipend	15,720	31,006	15,286	49.3%
571	2,722	2,151	79.0%	Transportation Reimbursement	790	4,887	4,097	83.8%
5,943	10,200	4,257	41.7%	Travel & Lodging	8,046	24,857	16,811	67.6%
47,186	103,363	56,177	54.3%	Temporary Help Services	65,305	216,327	151,022	69.8%
9,096	51,051	41,955	82.2%	Staff Development/Training	11,637	105,306	93,669	88.9%
8,463	108,284	99,821	92.2%	Staff Recruitment/Advertising	16,313	216,568	200,255	92.5%
$3,762,034	**$3,977,318**	**$215,284**	**5.4%**	**Total Employee Expenses**	**$6,841,436**	**$7,600,348**	**$758,912**	**10.0%**
				Benefit Administration Expense				
17,670	13,173	(4,497)	(34.1%)	RX Administration Expense	15,157	26,398	11,241	42.6%
283,606	283,707	101	0.0%	Behavioral Hlth Administration Fees	566,381	566,238	(143)	0.0%
18,967	18,973	6	0.0%	Telemedicine Admin Fees	37,877	37,865	(12)	0.0%
$320,243	**$315,853**	**($4,390)**	**(1.4%)**	**Total Employee Expenses**	**$619,415**	**$630,501**	**$11,086**	**1.8%**
				Purchased & Professional Services				
314,726	720,319	405,593	56.3%	Consulting Services	475,345	1,484,872	1,009,527	68.0%
318,195	346,870	28,675	8.3%	Computer Support Services	546,322	694,739	148,417	21.4%
9,916	9,915	(1)	0.0%	Professional Fees-Accounting	19,832	19,830	(2)	0.0%
0	17	17	100.0%	Professional Fees-Medical	0	34	34	100.0%
41,111	165,308	124,197	75.1%	Other Purchased Services	85,618	288,111	202,493	70.3%
628	1,400	772	55.1%	Maint.& Repair-Office Equipment	628	2,800	2,172	77.6%
72,862	87,506	14,644	16.7%	HMS Recovery Fees	144,165	154,880	10,715	6.9%
8,667	21,194	12,528	59.1%	Hardware (Non-Capital)	8,908	42,388	33,480	79.0%
21,398	31,467	10,069	32.0%	Provider Relations-Credentialing	35,527	62,934	27,407	43.5%
15,849	101,334	85,485	84.4%	Legal Fees	13,849	214,668	200,819	93.5%
$803,352	**$1,485,330**	**$681,978**	**45.9%**	**Total Purchased & Professional Services**	**$1,330,193**	**$2,965,256**	**$1,635,063**	**55.1%**
				Occupancy				
68,138	63,241	(4,897)	(7.7%)	Depreciation	136,811	126,850	(9,961)	(7.9%)
57,688	72,145	14,457	20.0%	Building Lease	123,117	144,131	21,014	14.6%
3,915	5,916	2,001	33.8%	Leased and Rented Office Equipment	8,898	11,832	2,934	24.8%
14,160	16,892	2,732	16.2%	Utilities	26,049	33,784	7,735	22.9%
77,696	79,700	2,004	2.5%	Telephone	147,833	159,400	11,567	7.3%
24,530	27,733	3,203	11.6%	Building Maintenance	43,900	60,740	16,840	27.7%
$246,127	**$265,627**	**$19,500**	**7.3%**	**Total Occupancy**	**$486,609**	**$536,737**	**$50,128**	**9.3%**

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED August 31, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Printing Postage & Promotion				
1,391	68,013	66,622	98.0%	Postage	11,305	96,294	84,989	88.3%
3,490	6,427	2,937	45.7%	Design & Layout	9,290	11,928	2,638	22.1%
0	66,544	66,544	100.0%	Printing Services	25,150	105,335	80,185	76.1%
6,500	2,500	(4,000)	(160.0%)	Mailing Services	6,500	5,000	(1,500)	(30.0%)
5,211	5,077	(134)	(2.6%)	Courier/Delivery Service	9,947	10,154	207	2.0%
0	517	517	100.0%	Pre-Printed Materials and Publications	0	1,734	1,734	100.0%
0	150	150	100.0%	Promotional Services	0	300	300	100.0%
600	1,500	900	60.0%	Community Relations	11,600	8,000	(3,600)	(45.0%)
7,213	8,167	954	11.7%	Translation - Non-Clinical	20,384	16,334	(4,050)	(24.8%)
$24,405	**$158,895**	**$134,490**	**84.6%**	**Total Printing Postage & Promotion**	**$94,176**	**$255,079**	**$160,903**	**63.1%**
				Licenses Insurance & Fees				
23,243	26,350	3,107	11.8%	Bank Fees	46,349	52,700	6,351	12.1%
94,321	94,366	45	0.0%	Insurance	155,183	188,732	33,549	17.8%
344,089	495,548	151,459	30.6%	Licenses, Permits and Fees	694,100	976,820	282,720	28.9%
73,099	88,771	15,672	17.7%	Subscriptions & Dues	147,014	178,359	31,345	17.6%
$534,753	**$705,035**	**$170,282**	**24.2%**	**Total Licenses Insurance & Postage**	**$1,042,645**	**$1,396,611**	**$353,966**	**25.3%**
				Supplies & Other Expenses				
3,641	22,916	19,275	84.1%	Office and Other Supplies	4,664	26,918	22,254	82.7%
904	4,000	3,096	77.4%	Ergonomic Supplies	3,442	8,099	4,657	57.5%
786	9,175	8,389	91.4%	Commissary-Food & Beverage	1,835	13,869	12,034	86.8%
0	150	150	100.0%	Member Incentive Expense	0	300	300	100.0%
0	4,167	4,167	100.0%	Covid-19 Vaccination Incentive Expense	75	8,334	8,259	99.1%
0	100	100	100.0%	Covid-19 IT Expenses	0	200	200	100.0%
1,386	4,783	3,397	71.0%	Covid-19 Non IT Expenses	1,386	9,914	8,528	86.0%
$6,717	**$45,291**	**$38,574**	**85.2%**	**Total Supplies & Other Expense**	**$11,403**	**$67,634**	**$56,231**	**83.1%**
$5,697,631	**$6,953,349**	**$1,255,718**	**18.1%**	**TOTAL ADMINISTRATIVE EXPENSE**	**$10,425,877**	**$13,452,166**	**$3,026,289**	**22.5%**

ALAMEDA ALLIANCE FOR HEALTH
CAPITAL SPENDING INCLUDING CONSTRUCTION-IN-PROCESS
ACTUAL VS. BUDGET
FOR THE FISCAL YEAR-TO-DATE ENDED AUGUST 31, 2022

		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	$ -	$ -	$ -	$ 100,000	$ 100,000
	Veeam Backup Shelf	IT-FY23-02	$ -		$ -	$ 70,000	$ 70,000
	Cisco Nexus 9k	IT-FY23-03	$ -		$ -	$ 60,000	$ 60,000
	Pure Storage Shelf	IT-FY23-04	$ -		$ -	$ 70,000	$ 70,000
	Call Center Hardware	IT-FY23-05	$ -		$ -	$ 60,000	$ 60,000
	FAX DMG	IT-FY23-06	$ -		$ -	$ 80,000	$ 80,000
	Wireless)	IT-FY23-07	$ -		$ -	$ 60,000	$ 60,000
	Network / AV Cabling	IT-FY23-08	$ -		$ -	$ 60,000	$ 60,000
Hardware Subtotal			**$ -**	**$ -**	**$ -**	**$ 560,000**	**$ 560,000**
2. Software:							
	Zerto	AC-FY23-01	$ -		$ -	$ 80,000	$ 80,000
Software Subtotal			**$ -**	**$ -**	**$ -**	**$ 80,000**	**$ 80,000**
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			**$ -**	**$ 23,992**	**$ 23,992**	**$ 978,992**	**$ 955,000**
5. Reconciliation to Balance Sheet:							
	Fixed Assets @ Cost - 8/31/22				**$ 37,380,242**		
	Fixed Assets @ Cost - 6/30/22				**$ 37,356,250**		
	Fixed Assets Acquired YTD				**$ 23,992**		

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
SUMMARY - FISCAL YEAR 2023

TANGIBLE NET EQUITY (TNE)

	Jul-22	Aug-22
Current Month Net Income / (Loss)	$5,704,828	$2,337,974
YTD Net Income / (Loss)	$5,704,828	$8,042,802
Actual TNE		
Net Assets	$236,433,012	$238,667,103
Subordinated Debt & Interest	$0	$0
Total Actual TNE	**$236,433,012**	**$238,667,103**
Increase/(Decrease) in Actual TNE	$5,808,710	$2,234,091
Required TNE[1]	**$37,812,719**	**$38,083,218**
Min. Req'd to Avoid Monthly Reporting (Increased from 130% to 150% of Required TNE effective July-2022)	$56,719,078	$57,124,827
TNE Excess / (Deficiency)	$198,620,293	$200,583,885
Actual TNE as a Multiple of Required	**6.25**	**6.27**

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

	Jul-22	Aug-22
Net Assets	$236,433,012	$238,667,103
Fixed Assets at Net Book Value	(5,604,558)	(5,560,412)
Net Lease Assets/Liabilities/Interest	106,376	204,722
CD Pledged to DMHC	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$230,584,830**	**$232,961,413**
Liquid TNE as Multiple of Required	**6.10**	**6.12**

REPORT #8

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											201,880
Adult	47,707	48,112											95,819
SPD	27,991	28,079											56,070
ACA OE	113,322	114,208											227,530
Duals	21,910	22,077											43,987
MCAL LTC	0	0											0
MCAL LTC Duals	0	0											0
Medi-Cal Program	311,833	313,453											625,286
Group Care Program	5,796	5,803											11,599
Total	**317,629**	**319,256**											**636,885**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	131	74											205
Adult	946	405											1,351
SPD	886	88											974
ACA OE	2,384	886											3,270
Duals	225	167											392
MCAL LTC	0	0											0
MCAL LTC Duals	0	0											0
Medi-Cal Program	4,572	1,620											6,192
Group Care Program	1	7											8
Total	**4,573**	**1,627**											**6,200**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	32.4%	32.2%											32.3%
Adult % of Medi-Cal	15.3%	15.3%											15.3%
SPD % of Medi-Cal	9.0%	9.0%											9.0%
ACA OE % of Medi-Cal	36.3%	36.4%											36.4%
Duals % of Medi-Cal	7.0%	7.0%											7.0%
Medi-Cal Program % of Total	98.2%	98.2%											98.2%
Group Care Program % of Total	1.8%	1.8%											1.8%
Total	**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											106,538
Alameda Health System	62,784	63,910											126,694
	117,124	116,108											233,232
Delegated:													
CFMG	33,466	33,594											67,060
CHCN	119,514	121,703											241,217
Kaiser	47,525	47,851											95,376
Delegated Subtotal	200,505	203,148											403,653
Total	**317,629**	**319,256**											**636,885**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	2,973	(1,016)											1,957
Delegated:													
CFMG	58	128											186
CHCN	1,103	2,189											3,292
Kaiser	439	326											765
Delegated Subtotal	1,600	2,643											4,243
Total	**4,573**	**1,627**											**6,200**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	36.9%	36.4%											36.6%
Delegated:													
CFMG	10.5%	10.5%											10.5%
CHCN	37.6%	38.1%											37.9%
Kaiser	15.0%	15.0%											15.0%
Delegated Subtotal	63.1%	63.6%											63.4%
Total	**100.0%**	**100.0%**											**100.0%**

REPORT #9

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2023

	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	101,120	101,423	101,727	101,930	102,134	102,338	101,787	101,043	100,298	99,552	98,806	98,059	1,210,217
Adult	46,703	47,030	47,359	47,501	47,644	47,787	46,980	45,856	44,731	43,605	42,478	41,349	549,023
SPD	28,283	28,368	28,453	28,510	28,567	28,624	29,006	28,941	28,876	28,811	28,746	28,681	343,866
ACA OE	113,561	114,129	114,700	115,044	115,389	115,735	114,009	111,510	109,009	106,505	103,999	101,490	1,335,080
Duals	21,650	21,715	21,780	21,824	21,868	21,912	21,781	21,488	21,194	20,900	20,606	20,312	257,030
MCAL LTC	0	0	0	0	0	0	300	300	300	300	300	300	1,800
MCAL LTC Duals	0	0	0	0	0	0	1,200	1,200	1,200	1,200	1,200	1,200	7,200
Medi-Cal Program	311,317	312,665	314,019	314,809	315,602	316,396	315,063	310,338	305,608	300,873	296,135	291,391	3,704,216
Group Care Program	5,828	5,828	5,828	5,828	5,828	5,828	5,828	5,828	5,828	5,828	5,828	5,828	69,936
Total	**317,145**	**318,493**	**319,847**	**320,637**	**321,430**	**322,224**	**320,891**	**316,166**	**311,436**	**306,701**	**301,963**	**297,219**	**3,774,152**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	6,309	303	304	203	204	204	(551)	(744)	(745)	(746)	(746)	(747)	3,248
Adult	5,627	327	329	142	143	143	(807)	(1,124)	(1,125)	(1,126)	(1,127)	(1,129)	273
SPD	1,538	85	85	57	57	57	382	(65)	(65)	(65)	(65)	(65)	1,936
ACA OE	10,125	568	571	344	345	346	(1,726)	(2,499)	(2,501)	(2,504)	(2,506)	(2,509)	(1,946)
Duals	1,874	65	65	44	44	44	(131)	(293)	(294)	(294)	(294)	(294)	536
MCAL LTC	0	0	0	0	0	0	300	0	0	0	0	0	300
MCAL LTC Duals	0	0	0	0	0	0	1,200	0	0	0	0	0	1,200
Medi-Cal Program	25,473	1,348	1,354	790	793	794	(1,333)	(4,725)	(4,730)	(4,735)	(4,738)	(4,744)	5,547
Group Care Program	(24)	0	0	0	0	0	0	0	0	0	0	0	(24)
Total	**25,449**	**1,348**	**1,354**	**790**	**793**	**794**	**(1,333)**	**(4,725)**	**(4,730)**	**(4,735)**	**(4,738)**	**(4,744)**	**5,523**
Enrollment Percentages:													
Medi-Cal Program:													
Child % (Medi-Cal)	32.5%	32.4%	32.4%	32.4%	32.4%	32.3%	32.3%	32.6%	32.8%	33.1%	33.4%	33.7%	32.7%
Adult % (Medi-Cal)	15.0%	15.0%	15.1%	15.1%	15.1%	15.1%	14.9%	14.8%	14.6%	14.5%	14.3%	14.2%	14.8%
SPD % (Medi-Cal)	9.1%	9.1%	9.1%	9.1%	9.1%	9.0%	9.2%	9.3%	9.4%	9.6%	9.7%	9.8%	9.3%
ACA OE % (Medi-Cal)	36.5%	36.5%	36.5%	36.5%	36.6%	36.6%	36.2%	35.9%	35.7%	35.4%	35.1%	34.8%	36.0%
Duals % (Medi-Cal)	7.0%	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%	7.0%	7.0%	6.9%
MCAL LTC % (Medi-Cal)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%
MCAL LTC Duals % (Medi-Cal)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.2%
Medi-Cal Program % of Total	98.2%	98.2%	98.2%	98.2%	98.2%	98.2%	98.2%	98.2%	98.1%	98.1%	98.1%	98.0%	98.1%
Group Care Program % of Total	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.9%	1.9%	1.9%	2.0%	1.9%
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%**

REPORT #9

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2023

	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	116,747	117,272	117,799	118,102	118,406	118,710	118,871	116,928	114,985	113,037	111,088	109,138	1,391,083
Delegated:													
CFMG	33,731	33,837	33,943	34,013	34,083	34,153	33,970	33,696	33,422	33,148	32,874	32,599	403,469
CHCN	119,411	119,921	120,435	120,733	121,033	121,334	120,278	118,487	116,693	114,899	113,103	111,305	1,417,632
Kaiser	47,256	47,463	47,670	47,789	47,908	48,027	47,772	47,055	46,336	45,617	44,898	44,177	561,968
Delegated Subtotal	200,398	201,221	202,048	202,535	203,024	203,514	202,020	199,238	196,451	193,664	190,875	188,081	2,383,069
Total	**317,145**	**318,493**	**319,847**	**320,637**	**321,430**	**322,224**	**320,891**	**316,166**	**311,436**	**306,701**	**301,963**	**297,219**	**3,774,152**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	5,641	525	527	303	304	304	161	(1,943)	(1,943)	(1,948)	(1,949)	(1,950)	(1,968)
Delegated:													
CFMG	2,323	106	106	70	70	70	(183)	(274)	(274)	(274)	(274)	(275)	1,191
CHCN	13,180	510	514	298	300	301	(1,056)	(1,791)	(1,794)	(1,794)	(1,796)	(1,798)	5,074
Kaiser	4,305	207	207	119	119	119	(255)	(717)	(719)	(719)	(719)	(721)	1,226
Delegated Subtotal	19,808	823	827	487	489	490	(1,494)	(2,782)	(2,787)	(2,787)	(2,789)	(2,794)	7,491
Total	**25,449**	**1,348**	**1,354**	**790**	**793**	**794**	**(1,333)**	**(4,725)**	**(4,730)**	**(4,735)**	**(4,738)**	**(4,744)**	**5,523**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	36.8%	36.8%	36.8%	36.8%	36.8%	36.8%	37.0%	37.0%	36.9%	36.9%	36.8%	36.7%	36.9%
Delegated:													
CFMG	10.6%	10.6%	10.6%	10.6%	10.6%	10.6%	10.6%	10.7%	10.7%	10.8%	10.9%	11.0%	10.7%
CHCN	37.7%	37.7%	37.7%	37.7%	37.7%	37.7%	37.5%	37.5%	37.5%	37.5%	37.5%	37.4%	37.6%
Kaiser	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%
Delegated Subtotal	63.2%	63.2%	63.2%	63.2%	63.2%	63.2%	63.0%	63.0%	63.1%	63.1%	63.2%	63.3%	63.1%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

REPORT #9

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	Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	(217)	(446)											(663)
Adult	1,004	1,082											2,086
SPD	(292)	(289)											(581)
ACA OE	(239)	79											(160)
Duals	260	362											622
MCAL LTC	0	0											0
MCAL LTC Duals	0	0											0
Medi-Cal Program	516	788											1,304
Group Care Program	(32)	(25)											(57)
Total	**484**	**763**											**1,247**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted	377	(1,164)											(787)
Delegated:													
CFMG	(265)	(243)											(508)
CHCN	103	1,782											1,885
Kaiser	269	388											657
Delegated Subtotal	107	1,927											2,034
Total	**484**	**763**											**1,247**

REPORT #9

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED August 31, 2022

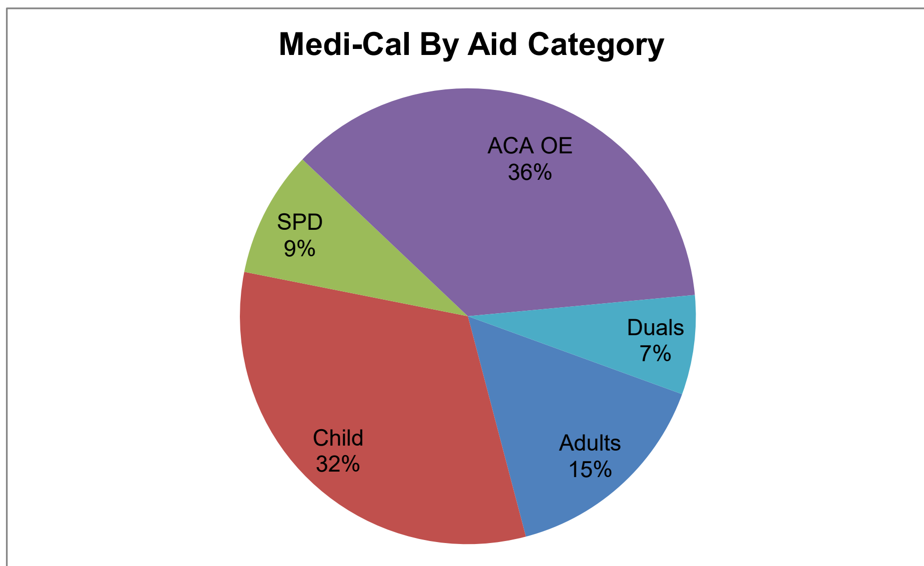
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES:				
$1,141,457	$1,979,232	$837,775	42.3%	PCP-Capitation	$2,272,751	$3,951,252	$1,678,501	42.5%
4,222,324	3,357,999	(864,325)	(25.7%)	PCP-Capitation - FQHC	8,365,217	6,702,018	(1,663,199)	(24.8%)
292,760	294,117	1,358	0.5%	Specialty-Capitation	582,843	587,309	4,466	0.8%
3,566,331	3,533,364	(32,967)	(0.9%)	Specialty-Capitation FQHC	7,036,629	7,051,068	14,439	0.2%
432,231	392,608	(39,623)	(10.1%)	Laboratory-Capitation	865,652	783,623	(82,029)	(10.5%)
958,794	955,479	(3,315)	(0.3%)	Transportation (Ambulance)-Cap	1,913,775	1,906,914	(6,861)	(0.4%)
231,652	231,529	(123)	(0.1%)	Vision Cap	462,764	462,105	(659)	(0.1%)
85,234	85,717	483	0.6%	CFMG Capitation	169,733	171,165	1,432	0.8%
178,434	176,928	(1,506)	(0.9%)	Anc IPA Admin Capitation FQHC	352,763	353,096	333	0.1%
11,127,093	11,015,484	(111,609)	(1.0%)	Kaiser Capitation	21,991,186	21,979,588	(11,598)	(0.1%)
866,708	791,789	(74,919)	(9.5%)	BHT Supplemental Expense	1,850,841	1,581,141	(269,700)	(17.1%)
421,253	543,081	121,828	22.4%	Maternity Supplemental Expense	1,185,417	1,082,531	(102,886)	(9.5%)
580,196	618,109	37,913	6.1%	DME - Cap	1,158,003	1,234,151	76,148	6.2%
$24,104,466	**$23,975,436**	**($129,030)**	**(0.5%)**	**5-TOTAL CAPITATED EXPENSES**	**$48,207,575**	**$47,845,961**	**($361,614)**	**(0.8%)**
				FEE FOR SERVICE MEDICAL EXPENSES:				
(572,918)	0	572,918	0.0%	IBNP-Inpatient Services	5,438,679	0	(5,438,679)	0.0%
(17,187)	0	17,187	0.0%	IBNP-Settlement (IP)	163,161	0	(163,161)	0.0%
(45,834)	0	45,834	0.0%	IBNP-Claims Fluctuation (IP)	435,092	0	(435,092)	0.0%
28,445,424	31,776,814	3,331,391	10.5%	Inpatient Hospitalization-FFS	49,175,096	63,406,094	14,230,998	22.4%
1,409,131	0	(1,409,131)	0.0%	IP OB - Mom & NB	2,277,078	0	(2,277,078)	0.0%
446,519	0	(446,519)	0.0%	IP Behavioral Health	567,293	0	(567,293)	0.0%
927,975	1,372,791	444,816	32.4%	IP - Long Term Care	1,982,110	2,736,225	754,115	27.6%
386,165	0	(386,165)	0.0%	IP - Facility Rehab FFS	1,075,326	0	(1,075,326)	0.0%
$30,979,274	**$33,149,605**	**$2,170,331**	**6.5%**	**6-Inpatient Hospital & SNF FFS Expense**	**$61,113,834**	**$66,142,319**	**$5,028,485**	**7.6%**
(266,521)	0	266,521	0.0%	IBNP-PCP	4,906	0	(4,906)	0.0%
(7,995)	0	7,995	0.0%	IBNP-Settlement (PCP)	148	0	(148)	0.0%
(21,320)	0	21,320	0.0%	IBNP-Claims Fluctuation (PCP)	393	0	(393)	0.0%
1,533,788	1,305,704	(228,084)	(17.5%)	Primary Care Non-Contracted FF	2,545,677	2,603,899	58,222	2.2%
116,561	65,607	(50,954)	(77.7%)	PCP FQHC FFS	163,505	130,789	(32,716)	(25.0%)
1,981,434	2,833,554	852,120	30.1%	Prop 56 Direct Payment Expenses	3,953,760	5,653,928	1,700,168	30.1%
14,224	0	(14,224)	0.0%	Prop 56 Hyde Direct Payment Expenses	28,383	0	(28,383)	0.0%
77,546	0	(77,546)	0.0%	Prop 56-Trauma Expense	154,954	0	(154,954)	0.0%
98,999	0	(98,999)	0.0%	Prop 56-Dev. Screening Exp.	197,983	0	(197,983)	0.0%
688,871	0	(688,871)	0.0%	Prop 56-Fam. Planning Exp.	1,374,415	0	(1,374,415)	0.0%
(172)	0	172	0.0%	Prop 56-Value Based Purchasing	(1,478)	0	1,478	0.0%
$4,215,413	**$4,204,865**	**($10,548)**	**(0.3%)**	**7-Primary Care Physician FFS Expense**	**$8,422,646**	**$8,388,616**	**($34,030)**	**(0.4%)**
(691,061)	0	691,061	0.0%	IBNP-Specialist	(239,009)	0	239,009	0.0%
3,234,763	5,173,849	1,939,086	37.5%	Specialty Care-FFS	5,632,289	10,325,472	4,693,183	45.5%
170,835	0	(170,835)	0.0%	Anesthesiology - FFS	269,385	0	(269,385)	0.0%
1,001,518	0	(1,001,518)	0.0%	Spec Rad Therapy - FFS	1,814,386	0	(1,814,386)	0.0%
107,610	0	(107,610)	0.0%	Obstetrics-FFS	219,256	0	(219,256)	0.0%
475,852	0	(475,852)	0.0%	Spec IP Surgery - FFS	745,452	0	(745,452)	0.0%
653,770	0	(653,770)	0.0%	Spec OP Surgery - FFS	1,130,010	0	(1,130,010)	0.0%
434,560	0	(434,560)	0.0%	Spec IP Physician	747,977	0	(747,977)	0.0%
62,821	8,550	(54,271)	(634.7%)	SCP FQHC FFS	101,881	17,059	(84,822)	(497.2%)
(20,733)	0	20,733	0.0%	IBNP-Settlement (SCP)	(7,173)	0	7,173	0.0%
(55,285)	0	55,285	0.0%	IBNP-Claims Fluctuation (SCP)	(19,122)	0	19,122	0.0%
$5,374,649	**$5,182,399**	**($192,250)**	**(3.7%)**	**8-Specialty Care Physician Expense**	**$10,395,332**	**$10,342,531**	**($52,801)**	**(0.5%)**
(851,923)	0	851,923	0.0%	IBNP-Ancillary	67,469	0	(67,469)	0.0%
(25,557)	0	25,557	0.0%	IBNP Settlement (ANC)	2,024	0	(2,024)	0.0%
(68,154)	0	68,154	0.0%	IBNP Claims Fluctuation (ANC)	5,397	0	(5,397)	0.0%
433,172	0	(433,172)	0.0%	Acupuncture/Biofeedback	697,511	0	(697,511)	0.0%
148,078	0	(148,078)	0.0%	Hearing Devices	264,265	0	(264,265)	0.0%
44,378	0	(44,378)	0.0%	Imaging/MRI/CT Global	80,151	0	(80,151)	0.0%
47,796	0	(47,796)	0.0%	Vision FFS	85,523	0	(85,523)	0.0%
22,919	0	(22,919)	0.0%	Family Planning	41,165	0	(41,165)	0.0%
916,406	0	(916,406)	0.0%	Laboratory-FFS	1,748,841	0	(1,748,841)	0.0%
119,177	0	(119,177)	0.0%	ANC Therapist	231,987	0	(231,987)	0.0%
807,122	0	(807,122)	0.0%	Transportation (Ambulance)-FFS	1,049,576	0	(1,049,576)	0.0%
18,200	0	(18,200)	0.0%	Transportation (Other)-FFS	169,564	0	(169,564)	0.0%
444,101	0	(444,101)	0.0%	Hospice	776,510	0	(776,510)	0.0%
729,760	0	(729,760)	0.0%	Home Health Services	1,188,560	0	(1,188,560)	0.0%
2	4,306,605	4,306,603	100.0%	Other Medical-FFS	2	8,585,861	8,585,859	100.0%
6,359	0	(6,359)	0.0%	HMS Medical Refunds	29,298	0	(29,298)	0.0%

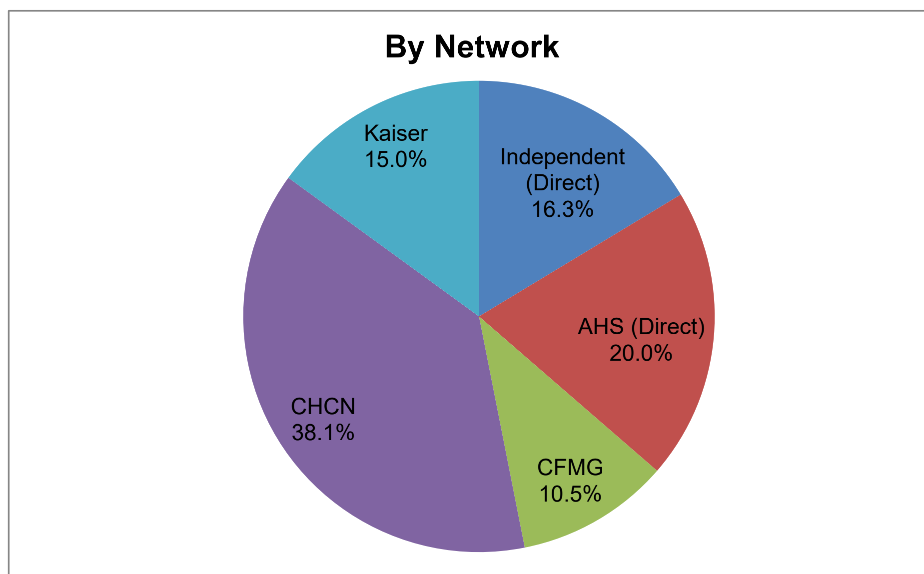
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED August 31, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
(69)	0	69	0.0%	Refunds-Medical Payments	(69)	0	69	0.0%
613,404	0	(613,404)	0.0%	DME & Medical Supplies	1,018,292	0	(1,018,292)	0.0%
0	655,598	655,598	100.0%	GEMT Direct Payment Expense	0	1,308,341	1,308,341	100.0%
961,940	0	(961,940)	0.0%	Community Based Adult Services (CBAS)	1,195,552	0	(1,195,552)	0.0%
894,887	705,592	(189,295)	(26.8%)	ECM Base FFS Ancillary	1,783,163	1,411,184	(371,979)	(26.4%)
2,395	5,227	2,832	54.2%	ECM Outreach FFS Ancillary	2,890	10,454	7,564	72.4%
328,055	328,054	(1)	0.0%	CS - Housing Deposits FFS Ancillary	656,110	656,108	(2)	0.0%
580,032	580,031	(1)	0.0%	CS - Housing Tenancy FFS Ancillary	1,160,063	1,160,062	(1)	0.0%
220,282	220,281	(1)	0.0%	CS - Housing Navigation Services FFS Ancillary	440,564	440,562	(2)	0.0%
325,580	325,580	0	0.0%	CS - Medical Respite FFS Ancillary	651,160	651,160	0	0.0%
128,573	128,572	(1)	0.0%	CS - Medically Tailored Meals FFS Ancillary	257,146	257,144	(2)	0.0%
37,159	37,159	0	0.0%	CS - Asthma Remediation FFS Ancillary	74,319	74,318	(1)	0.0%
0	9,999	9,999	100.0%	MOT- Wrap Around (Non Medical MOT Cost)	7,324	19,998	12,674	63.4%
$6,884,075	**$7,302,698**	**$418,623**	**5.7%**	**9-Ancillary Medical Expense**	**$13,684,356**	**$14,575,192**	**$890,836**	**6.1%**
(1,408,519)	0	1,408,519	0.0%	IBNP-Outpatient	(103,641)	0	103,641	0.0%
(42,256)	0	42,256	0.0%	IBNP Settlement (OP)	(3,109)	0	3,109	0.0%
(112,680)	0	112,680	0.0%	IBNP Claims Fluctuation (OP)	(8,291)	0	8,291	0.0%
1,610,230	9,022,741	7,412,511	82.2%	Out-Patient FFS	2,602,009	18,044,093	15,442,084	85.6%
1,849,434	0	(1,849,434)	0.0%	OP Ambul Surgery - FFS	3,208,980	0	(3,208,980)	0.0%
1,031,266	0	(1,031,266)	0.0%	OP Fac Imaging Services-FFS	1,854,413	0	(1,854,413)	0.0%
754,680	0	(754,680)	0.0%	Behav Health - FFS	1,458,754	0	(1,458,754)	0.0%
1,137,406	0	(1,137,406)	0.0%	Behavioral Health Therapy - FFS	2,176,596	0	(2,176,596)	0.0%
614,497	0	(614,497)	0.0%	OP Facility - Lab FFS	1,065,414	0	(1,065,414)	0.0%
122,208	0	(122,208)	0.0%	OP Facility - Cardio FFS	207,698	0	(207,698)	0.0%
45,825	0	(45,825)	0.0%	OP Facility - PT/OT/ST FFS	89,063	0	(89,063)	0.0%
2,103,777	0	(2,103,777)	0.0%	OP Facility - Dialysis FFS	3,573,370	0	(3,573,370)	0.0%
$7,705,868	**$9,022,741**	**$1,316,873**	**14.6%**	**10-Outpatient Medical Expense Medical Expense**	**$16,121,257**	**$18,044,093**	**$1,922,836**	**10.7%**
(595,420)	0	595,420	0.0%	IBNP-Emergency	(125,503)	0	125,503	0.0%
(17,864)	0	17,864	0.0%	IBNP Settlement (ER)	(3,768)	0	3,768	0.0%
(47,634)	0	47,634	0.0%	IBNP Claims Fluctuation (ER)	(10,040)	0	10,040	0.0%
720,207	0	(720,207)	0.0%	Special ER Physician-FFS	1,320,964	0	(1,320,964)	0.0%
4,685,328	5,493,416	808,088	14.7%	ER-Facility	8,420,311	10,993,312	2,573,001	23.4%
$4,744,617	**$5,493,416**	**$748,799**	**13.6%**	**11-Emergency Expense**	**$9,601,963**	**$10,993,312**	**$1,391,349**	**12.7%**
(551,484)	0	551,484	0.0%	IBNP-Pharmacy	(625,574)	0	625,574	0.0%
(16,543)	0	16,543	0.0%	IBNP Settlement (RX)	(18,766)	0	18,766	0.0%
(44,120)	0	44,120	0.0%	IBNP Claims Fluctuation (RX)	(50,048)	0	50,048	0.0%
474,118	363,424	(110,694)	(30.5%)	Pharmacy-FFS	871,208	736,463	(134,745)	(18.3%)
7,349,631	6,132,296	(1,217,335)	(19.9%)	Pharmacy- Non-PBM FFS-Other Anc	12,450,662	12,225,067	(225,595)	(1.8%)
(12,730)	0	12,730	0.0%	HMS RX Refunds	(15,501)	0	15,501	0.0%
0	11,789	11,789	100.0%	Pharmacy-Rebate	0	12,761	12,761	100.0%
$7,198,873	**$6,507,509**	**($691,364)**	**(10.6%)**	**12-Pharmacy Expense**	**$12,611,981**	**$12,974,291**	**$362,310**	**2.8%**
$67,102,770	**$70,863,233**	**$3,760,463**	**5.3%**	**13-TOTAL FFS MEDICAL EXPENSES**	**$131,951,370**	**$141,460,354**	**$9,508,984**	**6.7%**
0	(346,227)	(346,227)	100.0%	Clinical Vacancy	0	(498,145)	(498,145)	100.0%
108,588	120,064	11,476	9.6%	Quality Analytics	191,742	241,530	49,788	20.6%
483,539	542,049	58,510	10.8%	Health Plan Services Department Total	892,044	1,017,321	125,277	12.3%
384,849	478,650	93,801	19.6%	Case & Disease Management Department Total	711,797	904,133	192,336	21.3%
366,846	389,452	22,606	5.8%	Medical Services Department Total	707,587	2,589,177	1,881,590	72.7%
414,051	719,390	305,339	42.4%	Quality Management Department Total	824,259	1,410,361	586,102	41.6%
100,310	179,338	79,028	44.1%	HCS Behavioral Health Department Total	153,481	317,779	164,298	51.7%
141,580	149,311	7,731	5.2%	Pharmacy Services Department Total	260,177	275,661	15,484	5.6%
23,536	125,780	102,244	81.3%	Regulatory Readiness Total	40,318	221,918	181,600	81.8%
$2,023,299	**$2,357,807**	**$334,508**	**14.2%**	**14-Other Benefits & Services**	**$3,781,406**	**$6,479,735**	**$2,698,329**	**41.6%**
				Reinsurance Expense				
(697,875)	(654,145)	43,730	(6.7%)	Reinsurance Recoveries	(1,349,534)	(1,305,804)	43,730	(3.3%)
806,964	872,193	65,229	7.5%	Stop-Loss Expense	1,609,738	1,741,071	131,333	7.5%
$109,089	**$218,048**	**$108,959**	**50.0%**	**15-Reinsurance Expense**	**$260,204**	**$435,267**	**$175,063**	**40.2%**
$93,339,624	**$97,414,524**	**$4,074,900**	**4.2%**	**17-TOTAL MEDICAL EXPENSES**	**$184,200,554**	**$196,221,317**	**$12,020,763**	**6.1%**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Current Membership by Network By Category of Aid							
Category of Aid	**Aug 2022**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	48,112	15%	9,222	9,596	825	19,632	8,837
Child	100,977	32%	7,412	9,230	30,547	35,214	18,574
SPD	28,079	9%	8,391	4,407	1,025	12,148	2,108
ACA OE	114,208	36%	16,621	37,362	1,195	44,084	14,946
Duals	22,077	7%	8,223	2,450	2	8,016	3,386
Medi-Cal	313,453		49,869	63,045	33,594	119,094	47,851
Group Care	5,803		2,329	865	-	2,609	-
Total	**319,256**	**100%**	**52,198**	**63,910**	**33,594**	**121,703**	**47,851**
Medi-Cal %	98.2%		95.5%	98.6%	100.0%	97.9%	100.0%
Group Care %	1.8%		4.5%	1.4%	0.0%	2.1%	0.0%
		Network Distribution	*16.3%*	*20.0%*	*10.5%*	*38.1%*	*15.0%*
			% Direct:	**36%**		**% Delegated:**	**64%**

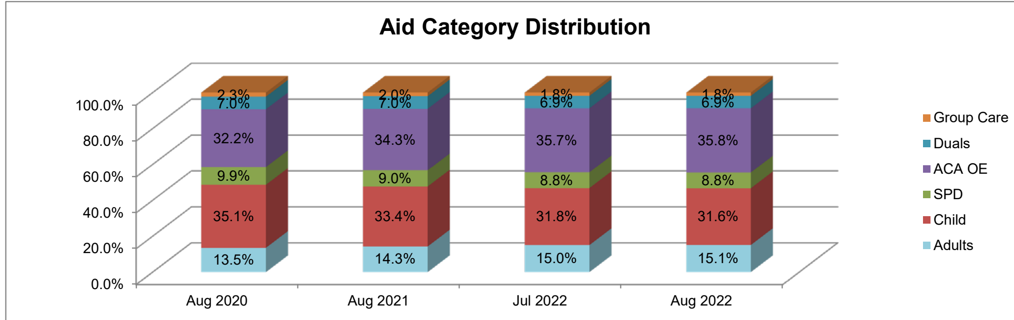




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

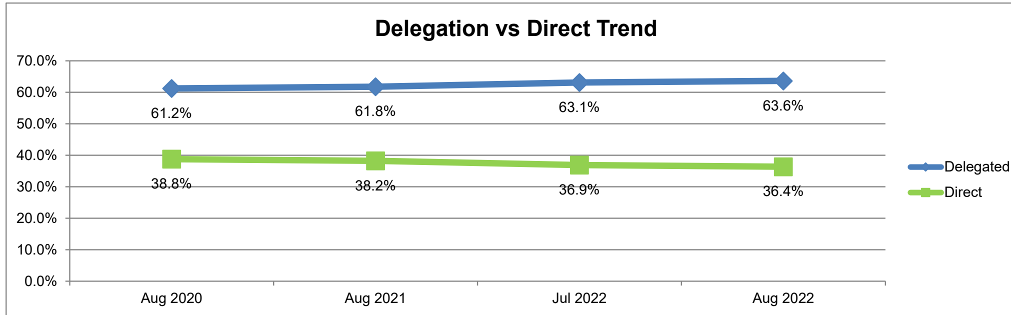
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Aug 2020	Aug 2021	Jul 2022	Aug 2022	Aug 2020	Aug 2021	Jul 2022	Aug 2022	Aug 2020 to Aug 2021	Aug 2021 to Aug 2022	Jul 2022 to Aug 2022
Adults	35,689	41,519	47,707	48,112	13.5%	14.3%	15.0%	15.1%	16.3%	15.9%	0.8%
Child	92,692	97,324	100,903	100,977	35.1%	33.4%	31.8%	31.6%	5.0%	3.8%	0.1%
SPD	26,094	26,316	27,927	28,079	9.9%	9.0%	8.8%	8.8%	0.9%	6.7%	0.5%
ACA OE	85,081	99,783	113,322	114,208	32.2%	34.3%	35.7%	35.8%	17.3%	14.5%	0.8%
Duals	18,495	20,388	21,974	22,077	7.0%	7.0%	6.9%	6.9%	10.2%	8.3%	0.5%
Medi-Cal Total	258,051	285,330	311,833	313,453	97.7%	98.0%	98.2%	98.2%	10.6%	9.9%	0.5%
Group Care	6,007	5,877	5,796	5,803	2.3%	2.0%	1.8%	1.8%	-2.2%	-1.3%	0.1%
Total	**264,058**	**291,207**	**317,629**	**319,256**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**10.3%**	**9.6%**	**0.5%**



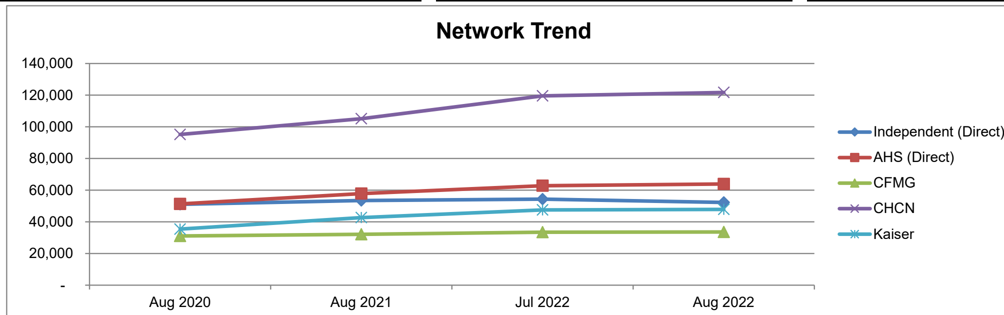
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Aug 2020	Aug 2021	Jul 2022	Aug 2022	Aug 2020	Aug 2021	Jul 2022	Aug 2022	Aug 2020 to Aug 2021	Aug 2021 to Aug 2022	Jul 2022 to Aug 2022
Delegated	161,689	179,954	200,505	203,148	61.2%	61.8%	63.1%	63.6%	11.3%	12.9%	1.3%
Direct	102,369	111,253	117,124	116,108	38.8%	38.2%	36.9%	36.4%	8.7%	4.4%	-0.9%
Total	**264,058**	**291,207**	**317,629**	**319,256**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**10.3%**	**9.6%**	**0.5%**



Network Trend

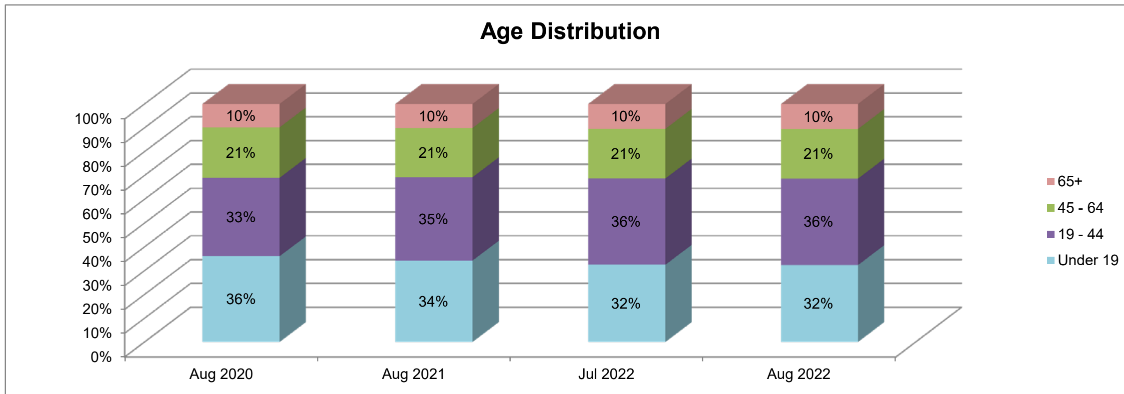
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Aug 2020	Aug 2021	Jul 2022	Aug 2022	Aug 2020	Aug 2021	Jul 2022	Aug 2022	Aug 2020 to Aug 2021	Aug 2021 to Aug 2022	Jul 2022 to Aug 2022
Independent (Direct)	51,057	53,441	54,340	52,198	19.3%	18.4%	17.1%	16.3%	4.7%	-2.3%	-3.9%
AHS (Direct)	51,312	57,812	62,784	63,910	19.4%	19.9%	19.8%	20.0%	12.7%	10.5%	1.8%
CFMG	31,072	32,167	33,466	33,594	11.8%	11.0%	10.5%	10.5%	3.5%	4.4%	0.4%
CHCN	95,194	105,113	119,514	121,703	36.1%	36.1%	37.6%	38.1%	10.4%	15.8%	1.8%
Kaiser	35,423	42,674	47,525	47,851	13.4%	14.7%	15.0%	15.0%	20.5%	12.1%	0.7%
Total	**264,058**	**291,207**	**317,629**	**319,256**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**10.3%**	**9.6%**	**0.5%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

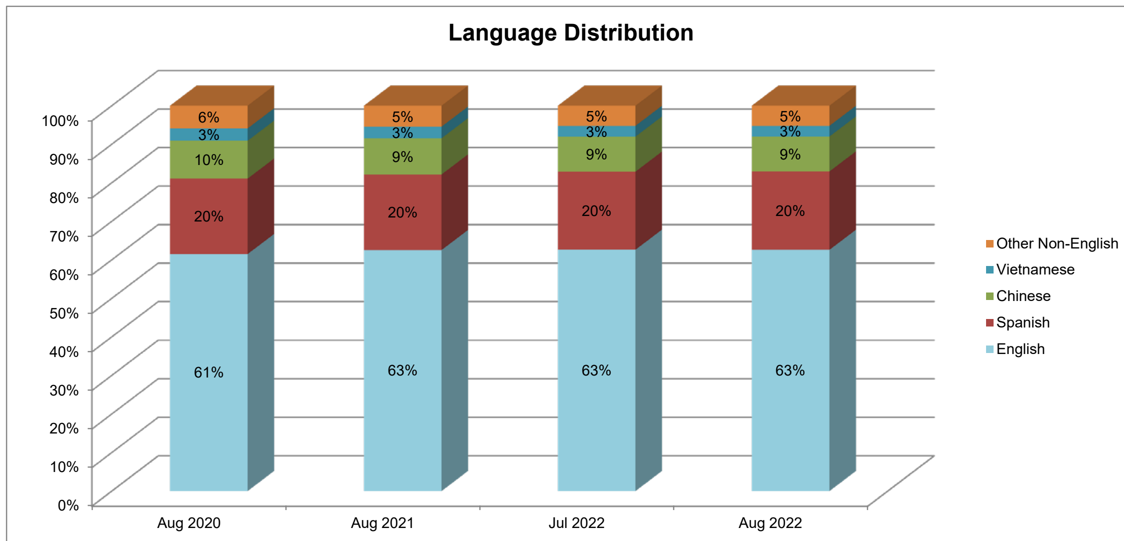
Age Category Trend

Age Category	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Aug 2020	Aug 2021	Jul 2022	Aug 2022	Aug 2020	Aug 2021	Jul 2022	Aug 2022	Aug 2020 to Aug 2021	Aug 2021 to Aug 2022	Jul 2022 to Aug 2022
Under 19	95,188	99,634	103,148	103,223	36%	34%	32%	32%	5%	4%	0%
19 - 44	87,011	102,009	115,171	116,003	33%	35%	36%	36%	17%	14%	1%
45 - 64	55,910	60,200	66,174	66,526	21%	21%	21%	21%	8%	11%	1%
65+	25,949	29,364	33,136	33,504	10%	10%	10%	10%	13%	14%	1%
Total	**264,058**	**291,207**	**317,629**	**319,256**	**100%**	**100%**	**100%**	**100%**	**10%**	**10%**	**1%**



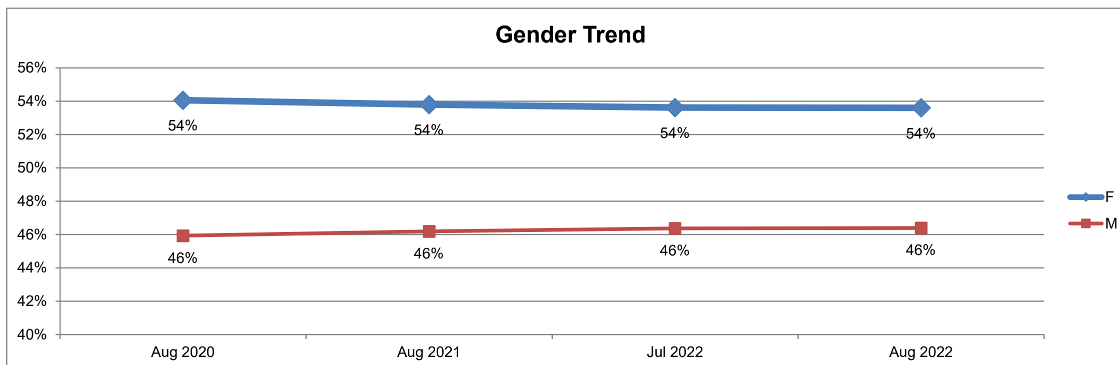
Language Trend

Language	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Aug 2020	Aug 2021	Jul 2022	Aug 2022	Aug 2020	Aug 2021	Jul 2022	Aug 2022	Aug 2020 to Aug 2021	Aug 2021 to Aug 2022	Jul 2022 to Aug 2022
English	162,321	182,065	198,847	199,798	61%	63%	63%	63%	12%	10%	0%
Spanish	51,725	57,124	64,363	64,967	20%	20%	20%	20%	10%	14%	1%
Chinese	25,941	27,385	28,906	28,938	10%	9%	9%	9%	6%	6%	0%
Vietnamese	8,470	8,772	8,884	8,869	3%	3%	3%	3%	4%	1%	0%
Other Non-English	15,601	15,861	16,629	16,684	6%	5%	5%	5%	2%	5%	0%
Total	**264,058**	**291,207**	**317,629**	**319,256**	**100%**	**100%**	**100%**	**100%**	**10%**	**10%**	**1%**

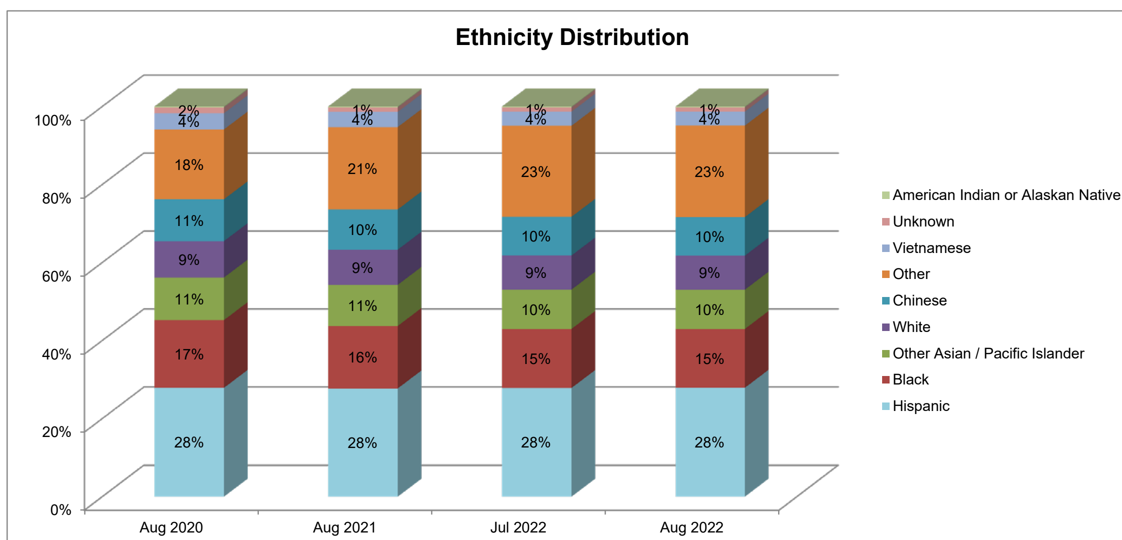


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Gender Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Aug 2020	Aug 2021	Jul 2022	Aug 2022	Aug 2020	Aug 2021	Jul 2022	Aug 2022	Aug 2020 to Aug 2021	Aug 2021 to Aug 2022	Jul 2022 to Aug 2022
F	142,759	156,688	170,323	171,141	54%	54%	54%	54%	10%	9%	0%
M	121,299	134,519	147,306	148,115	46%	46%	46%	46%	11%	10%	1%
Total	**264,058**	**291,207**	**317,629**	**319,256**	**100%**	**100%**	**100%**	**100%**	**10%**	**10%**	**1%**



Ethnicity Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Aug 2020	Aug 2021	Jul 2022	Aug 2022	Aug 2020	Aug 2021	Jul 2022	Aug 2022	Aug 2020 to Aug 2021	Aug 2021 to Aug 2022	Jul 2022 to Aug 2022
Hispanic	73,556	80,668	88,368	88,998	28%	28%	28%	28%	10%	10%	1%
Black	45,864	46,640	48,090	48,133	17%	16%	15%	15%	2%	3%	0%
Other Asian / Pacific Islander	28,805	30,667	32,015	32,123	11%	11%	10%	10%	6%	5%	0%
White	24,655	26,303	27,805	27,887	9%	9%	9%	9%	7%	6%	0%
Chinese	28,346	30,056	31,505	31,586	11%	10%	10%	10%	6%	5%	0%
Other	47,252	61,466	74,128	74,839	18%	21%	23%	23%	30%	22%	1%
Vietnamese	10,987	11,324	11,461	11,428	4%	4%	4%	4%	3%	1%	0%
Unknown	3,991	3,468	3,574	3,579	2%	1%	1%	1%	-13%	3%	0%
American Indian or Alaskan Native	602	615	683	683	0%	0%	0%	0%	2%	11%	0%
Total	**264,058**	**291,207**	**317,629**	**319,256**	**100%**	**100%**	**100%**	**100%**	**10%**	**10%**	**1%**



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

Medi-Cal By City

City	Aug 2022	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	123,034	39%	12,755	30,036	14,156	52,503	13,584
Hayward	49,104	16%	7,265	11,086	5,491	16,538	8,724
Fremont	28,478	9%	9,965	4,444	1,012	8,280	4,777
San Leandro	28,440	9%	4,622	4,270	3,500	10,803	5,245
Union City	13,038	4%	3,929	2,110	526	3,944	2,529
Alameda	11,924	4%	2,025	2,010	1,626	4,296	1,967
Berkeley	11,722	4%	1,506	1,743	1,325	5,332	1,816
Livermore	9,668	3%	1,020	725	1,904	4,258	1,761
Newark	7,286	2%	1,860	2,407	236	1,408	1,375
Castro Valley	7,831	2%	1,274	1,263	1,085	2,548	1,661
San Lorenzo	6,598	2%	854	1,152	714	2,480	1,398
Pleasanton	5,255	2%	962	413	515	2,442	923
Dublin	5,678	2%	1,017	448	682	2,448	1,083
Emeryville	2,121	1%	324	417	292	709	379
Albany	1,954	1%	253	229	373	695	404
Piedmont	383	0%	50	107	26	98	102
Sunol	65	0%	11	12	4	24	14
Antioch	30	0%	6	8	5	7	4
Other	844	0%	171	165	122	281	105
Total	**313,453**	**100%**	**49,869**	**63,045**	**33,594**	**119,094**	**47,851**

Group Care By City

City	Aug 2022	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	1,895	33%	431	366	-	1,098	-
Hayward	649	11%	325	136	-	188	-
Fremont	621	11%	452	45	-	124	-
San Leandro	590	10%	229	88	-	273	-
Union City	307	5%	216	28	-	63	-
Alameda	280	5%	100	18	-	162	-
Berkeley	166	3%	45	10	-	111	-
Livermore	86	1%	29	1	-	56	-
Newark	147	3%	88	37	-	22	-
Castro Valley	182	3%	80	20	-	82	-
San Lorenzo	123	2%	48	17	-	58	-
Pleasanton	62	1%	27	3	-	32	-
Dublin	105	2%	35	10	-	60	-
Emeryville	36	1%	13	6	-	17	-
Albany	18	0%	7	1	-	10	-
Piedmont	14	0%	4	-	-	10	-
Sunol	-	0%	-	-	-	-	-
Antioch	26	0%	6	7	-	13	-
Other	496	9%	194	72	-	230	-
Total	**5,803**	**100%**	**2,329**	**865**	**-**	**2,609**	**-**

Total By City

City	Aug 2022	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	124,929	39%	13,186	30,402	14,156	53,601	13,584
Hayward	49,753	16%	7,590	11,222	5,491	16,726	8,724
Fremont	29,099	9%	10,417	4,489	1,012	8,404	4,777
San Leandro	29,030	9%	4,851	4,358	3,500	11,076	5,245
Union City	13,345	4%	4,145	2,138	526	4,007	2,529
Alameda	12,204	4%	2,125	2,028	1,626	4,458	1,967
Berkeley	11,888	4%	1,551	1,753	1,325	5,443	1,816
Livermore	9,754	3%	1,049	726	1,904	4,314	1,761
Newark	7,433	2%	1,948	2,444	236	1,430	1,375
Castro Valley	8,013	3%	1,354	1,283	1,085	2,630	1,661
San Lorenzo	6,721	2%	902	1,169	714	2,538	1,398
Pleasanton	5,317	2%	989	416	515	2,474	923
Dublin	5,783	2%	1,052	458	682	2,508	1,083
Emeryville	2,157	1%	337	423	292	726	379
Albany	1,972	1%	260	230	373	705	404
Piedmont	397	0%	54	107	26	108	102
Sunol	65	0%	11	12	4	24	14
Antioch	56	0%	12	15	5	20	4
Other	1,340	0%	365	237	122	511	105
Total	**319,256**	**100%**	**52,198**	**63,910**	**33,594**	**121,703**	**47,851**

Staff Report and Resolution

TO: Alameda Alliance for Health Board of Governors

FROM: Dr. Evan Seevak, Chair

DATE: October 14th, 2022

SUBJECT: Formation of an Ad Hoc Executive Search Subcommittee Pursuant to Section 7.A.2 of the Alliance Bylaws

RECOMMENDED ACTION

1. Adopt Resolution No. 2022-03 titled "A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH CREATING AN AD HOC EXECUTIVE SEARCH SUBCOMMITTEE"
2. Approve a motion to nominate the following six (6) Alliance Board members to the Ad Hoc Executive Search Subcommittee:

    - Dr. Evan Seevak (Chair)
    - Rebecca Gebhart (Vice Chair)
    - Dr. Rollington Ferguson
    - Andrea Schwab-Galindo
    - Dr. Marty Lynch
    - James Jackson

DISCUSSION

Alameda Alliance for Health (Alliance) CEO Scott Coffin has informed the Board of Governors of his intent to retire effective May 31st, 2023. The search, selection, and hiring of a new CEO is a collaborative process involving many parties, including the Alliance Board and Alliance Staff, as well as outside search firms. A subcommittee is therefore needed to meet often and on short notice, interfacing with the parties, and advising, updating, and making recommendations to the full Board.

Resolution 2022-03:

- Establishes an Ad Hoc Executive Search Subcommittee, as an advisory subcommittee of the standing Executive Committee, to advise as necessary on the search, selection, and hiring of a new Alliance CEO.

- The Ad Hoc Executive Search Subcommittee will consist of no more than six (6) Board members as appointed by the Board of Governors.
- Gives the Ad Hoc Executive Search Subcommittee discretion to meet as its members deem necessary under the Bylaws of Article 7.A.1.

As an advisory subcommittee with a limited purpose, whose body is composed solely of Alliance Board Members who number less than a quorum, and whose meeting schedule is not set by the Board of Governors, the Ad Hoc Executive Search Subcommittee will not be subject to Brown Act open meeting requirements pursuant to the Alliance Bylaws and will dissolve once the recruitment process is complete (CEO search is expected to end by May 2023).

FISCAL IMPACT

Adoption of the resolution will have no fiscal impact.

ATTACHMENTS

1. Resolution No. 2022-03 titled “A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH CREATING AN AD HOC EXECUTIVE SEARCH SUBCOMMITTEE.”

RESOLUTION NO. 2022-03

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH CREATING AN AD HOC EXECUTIVE SEARCH SUBCOMMITTEE

WHEREAS, the Alameda Alliance for Health (Alliance) Chief Executive Officer (CEO), Scott Coffin, has informed the Board of Governors of his intent to retire effective May 31st, 2023; and

WHEREAS, the Alliance has a standing Executive Committee to take up administrative issues affecting the Alliance and make recommendations to the Board of Governors; and

WHEREAS, Article 7 of the Alliance Bylaws allows for the creation of ad hoc subcommittees to standing committees to carry out the purposes of the Board of Governors; and

WHEREAS, the Board of Governors has determined that the creation of an Ad Hoc Executive Search Subcommittee, a subcommittee of the standing Executive Committee, is necessary to advise on the search, selection, and hiring of a new Alliance CEO.

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

SECTION 1. The creation of an Ad Hoc Executive Search Subcommittee of the standing Executive Committee is approved by the Board of Governors pursuant to Article 7 of the Bylaws.

SECTION 2. The Ad Hoc Executive Search Subcommittee shall be advisory only and will work with Alliance staff, outside recruiting firms, and other parties as needed to identify and evaluate potential CEO candidates before making recommendations to the Board of Governors.

SECTION 3. The Ad Hoc Executive Search Subcommittee shall be composed of no more than six (6) Board members to be appointed by the Board of Governors.

SECTION 4. Meetings of the Ad Hoc Executive Search Subcommittee shall be determined by its members and scheduled as needed.

SECTION 5. The Alliance Secretary shall certify the adoption of this resolution.

PASSED AND ADOPTED by the Board of Governors at a meeting held on the 14th day of October 2022.

CHAIR, BOARD OF GOVERNORS

ATTEST:

Secretary

Project Updates

Presented to the Alameda Alliance Board of Governors

Presented by Ruth Watson,
Chief Integrated Planning Officer

October 14th, 2022

Agenda

ALAMEDA Alliance FOR HEALTH

CalAIM
- Enhanced Care Management
- Community Supports
- Long Term Care Carve-In

Mental Health Insourcing

Incentive Programs
- CalAIM Incentive Payment Program (IPP)
- Student Behavioral Health Incentive Program (SBHIP)
- Housing and Homelessness Incentive Program (HHIP)

ALAMEDA Alliance FOR HEALTH

CalAIM – Enhanced Care Management

- Enhanced Care Management (ECM) by the numbers
  - Eligible members across all Populations of Focus (PoF) – 9,126
  - Members currently enrolled in ECM – 988
  - ECM Providers - 8
- New Populations of Focus effective January 1, 2023
  - Members Eligible for Long Term Care and At-Risk of Institutionalization
  - Nursing Home Residents Transitioning to Community

CalAIM – Community Supports

ALAMEDA Alliance FOR HEALTH

- Community Supports (CS) by the numbers
- CS services currently offered – 6
  - Housing (Navigation, Deposits, Tenancy & Sustaining Services)
  - Recuperative Care (Medical Respite)
  - Asthma Remediation
  - Medically Supportive Food/Meals/Medically Tailored Meals
- Unique Members Served – 1,135
- CS Providers – 6

	Authorizations	Authorizations with Claims/Encounters	Claims/Encounters
All Housing	1,584	1,185	9,939
Recuperative Care	81	52	1,167
Asthma Remediation	40	26	59
Meals	111	63	180
	1,816	1,326	11,345

*data through August 2022

CalAIM – Community Supports

ALAMEDA Alliance FOR HEALTH

Community Support Auths - Utlization Analysis (6 months Pre/Post CS Elig Date)

Time Period - 202201

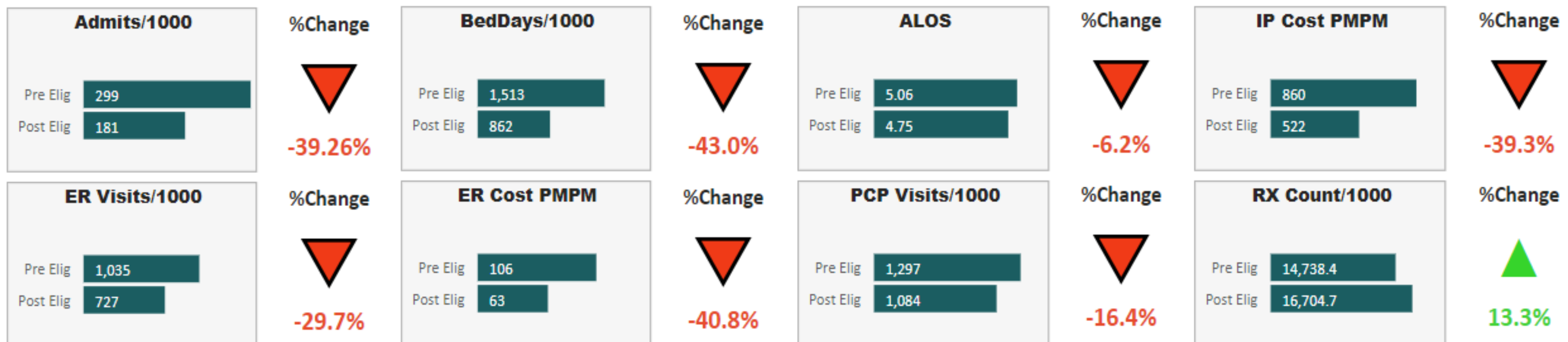
Data Refreshed on: 8/15/2022 5:21:38 PM

Total Community Support Auths

1,816

Note - Please note that we have 2-3 months data lag for Claims

Clear All



Pre/Post CS Elig FLG	Member Months	Admits	Admits/1000	BedDays	BedDays/1000	ALOS	IPCost	IP Cost PMPM	ERVisits	ERVisits/1000	ERCost	ERCost PMPM	PCPVisits	PCPVisits/1000	RXCount	RXCount/1000	RX Cost	RX Cost PMPM
Pre Elig	10,401	518	299	2,623	1,513	5.06	8,939,914	860	1,794	1,035	1,102,982	106	2,248	1,297	25,549	14,738.4	1,873,916	180
Post Elig	9,422	285	181	1,354	862	4.75	4,913,979	522	1,142	727	591,532	63	1,703	1,084	26,232	16,704.7	2,910,911	309

CS Program Performance - % Difference

Admits/1000	BedDays/1000	ALOS	IP Cost PMPM	ER Visits/1000	ER Cost PMPM	PCP Visits/1000	RX Count/1000	RX Cost PMPM
-39.26%	-43.0%	-6.2%	-39.3%	-29.7%	-40.8%	-16.4%	13.3%	71.5%

CalAIM – Long Term Care Carve-In

ALAMEDA Alliance FOR HEALTH

- Long Term Care (LTC) Readiness Deliverables - DHCS
  - Skilled Nursing Facility (SNF) Network Readiness Template submitted 9/1
    - Resubmission due 10/12/2022 with minor edits
    - DHCS Network Goal of 60% met, currently at 60.2%
    - LTC Member Materials submitted and approved by DHCS
- APL 22-018-SNF- LTC Benefit Standardization released 9/28/2022
  - Additional DHCS Deliverables due 11/28/2022
    - P&Ps, Program Description and other artifacts updated with DHCS requirements
- Contracting and Credentialing
  - Contracted with 57 facilities - Custodial Level of Care
    - 34 of 57 facilities credentialed
  - 64 PCP Providers identified; 23 contracts signed
  - Out of Area Facilities- 45 total
    - 36 contracts pending and 9 signed

CalAIM – Long Term Care Carve-In

ALAMEDA Alliance FOR HEALTH

- LTC Provider Town Halls beginning late October
  - LTC training for all long-term care providers and facilities
- DHCS Member Data
  - Expected November 2022
  - Contingency plan for data impact underway
  - Existing authorizations data will be provided at this time
- LTC Staffing Resources
  - RN Manager (1), RN Reviewer/Case Manager (2), Social Worker, and Non-Clinical Navigator(1)
  - Interviews underway for all positions

CalAIM – LTC and Managed Long-Term Services and Supports (MLTSS)

ALAMEDA Alliance FOR HEALTH

Go-Live Date	Initiative	Go-Live Description
January 2023	Mandatory Managed Care Enrollment - LTC Transition from Medi-Cal FFS into Managed Care	Statewide mandatory enrollment of full dual eligible beneficiaries into MCPs for Medi-Cal benefits, including dual eligible LTC residents ➢ MCPs will be fully responsible for LTC Skilled Nursing Facility (SNF) resident6s ➢ Currently responsible for month of admit and month after
July 2023	Mandatory Managed Care Enrollment - LTC Transition from Medi-Cal FFS into Managed Care	Medi-Cal Members residing in Sub-acute or Pediatric Subacutes, Intermediate Care Facilities (ICF) and Institutions for Mental Disease (IMD) will transition to MCPs no earlier than July 1, 2023
January 2025/26	Transition to Dual Eligible Special Needs Plan (D-SNP)	All Medi-Cal MCPs required to operate Medicare Dual Eligible Special Needs Plans (D-SNPs), unless determined otherwise by 2022 D-SNP Feasibility Study. ➢ Exclusively aligned enrollment (EAE) required in all counties.
January 2026/27	Transition to Statewide Managed Long-Term Support Service (MLTSS)	Managed long-term services and supports (MLTSS) implemented statewide in Medi-Cal managed care

Mental Health Insourcing

ALAMEDA Alliance FOR HEALTH

- Material Modification is required and must be approved by the Department of Managed Health Care (DMHC)
  - Submission #1 submitted 9/2/2022 and included:
    - → Narrative to DMHC (E-1 Exhibit)
    - → Evidence of Coverage (EOC) – Medi-Cal and Group Care
    - → Member and Provider Notices
    - → Medi-Cal and Group Care Notifications
  - Submission #2 submitted 9/30/2022 and included:
    - → Narrative to DMHC (E-1 Exhibit)
    - → Policies & Procedures
    - → Financial Assumptions
  - Submission #3 targeted for 10/12/2022 and will include:
    - → Narrative to DMHC (E-1 Exhibit)
    - → Full Network Analysis by Provider Services

Mental Health Insourcing Material Modification Cont'd

ALAMEDA Alliance FOR HEALTH

- DMHC BH Filing Comment Table - Due: 10/18
  - Received 10/5/22
  - Internal Responses due 10/13/22

- ASAs Filed – 10/5/22
  - Crisis Help Line
  - SPH Surveys
  - MCG Health
    - Awaiting countersigned contract

- Redlined Provider Directory
  - Internal Counsel requesting clarification on requirements from DMHC on behalf of Provider Services

Mental Health Insourcing cont'd…

ALAMEDA Alliance FOR HEALTH

- Provider Services
  - Boilerplate Contract and Cover Letter
    - DHCS – Submitted 7/7/2022
      - Additional Information Request (AIR) received from DHCS; response was sent to DHCS on 8/12/2022
      - AIR2 from DHCS received on 9/12/2022; response submitted to DHCS on 10/10/2022
    - DMHC – included with September 2nd submission (previous slide)
    - Contract distribution to providers continues and follow-up with providers who haven't returned contracts is on-going
    - Contract and Credentialing – Peer Review & Credentialing Committee (PRCC) met on 9/20/2022 and each 3rd Tuesday of the Month thereafter
      - Credentialed
        - Behavioral Health Providers – 30
        - Applied Behavioral Analysis (ABA) Providers – 42
        - Specialists - 4
      - Contracts Received and Pending
        - AHS Contract – total of 73 providers
        - CHCN Contracts (8) – total of 129 providers
          - Contracts may be signed but not considered executed until credentialing application is approved

Mental Health Insourcing cont'd…

ALAMEDA Alliance FOR HEALTH

- Communications
  - Member Notification
    - 60/30 Day Member Notice and FAQs approved by DHCS on 7/8/2022
    - Impacted Member Letter – Initially submitted to DHCS in July
      - Additional Information Request (AIR) received; response submitted to DHCS on 8/23/2022
      - AIR2 received on 9/8/2022 and response submitted to DHCS on 9/26/2022
    - Group Care Letters –submitted to DMHC on 9/2/2022 (same letter submitted to DHCS was used for submission to DMHC for the Group Care Member Notification
  - Provider Notification
    - Provider Notification submitted to DMHC on 9/2/2022
    - Provider FAQs developed and submitted
    - Provider Training and Townhall Meetings – planning deferred to December for forecasted meetings in early February 2023
    - Member Services call script approved by DHCS on 8/5/2022

ALAMEDA Alliance FOR HEALTH

Incentive Programs

- CalAIM Incentive Payment Program (IPP)
  - AAH has received ten (10) applications for IPP Funding to date
    - As of September, initial payments totaling over $4.69M have been distributed to the applicants who were awarded IPP Funding for:
      - Delivery System Infrastructure
      - ECM/CS Provider Capacity Building for New Hire Ramp-Up
      - ECM/CS Provider Training
    - AAH is currently reviewing the Status Reports submitted by the IPP Funding Recipients to review their progress prior to releasing their final payment
    - Program Payment 2 report submitted to DHCS on 9/1/2022
      - This will determine DHCS payout of remaining 50% of PY1 funding

Incentive Programs

ALAMEDA Alliance FOR HEALTH

- Student Behavioral Health Incentive Program (SBHIP)
  - MOUs completed with Alameda County Office of Education, Health Care Services Agency, Local Education Agencies (school districts)
  - First Needs Assessment incentive payments distributed; $265k disbursed
  - Needs Assessment to be completed by 10/17/2022
  - Identify Targeted Interventions (minimum of four) by 11/30/2022
  - Submit consolidated Needs Assessment and Projects Plans for Targeted Interventions by 12/31/2022

Incentive Programs

ALAMEDA Alliance FOR HEALTH

- Housing and Homelessness Incentive Program
  - Alameda Alliance earnable dollars - $44.3M
    - Submission and approval of Local Homelessness Plan (LHP) - $2.2M (5% of earnable dollars)
    - Submission and approval of Investment Plan - $4.4M (10% of earnable dollars
    - Reporting period 1 - $15.5M (35% of earnable dollars)
    - Reporting period 2 - $22.1M (50% of earnable dollars)
  - Local Homelessness Plan submitted to DHCS on 8/12/2022
  - Investment Plan submitted to DHCS on 9/30/2022
    - ~$26.5M in proposed investments; includes an estimated $1.5M to build internal housing infrastructure at AAH
    - Measures must be met by 10/31/2023 to be eligible for earned dollars

ALAMEDA Alliance FOR HEALTH

Questions?

Operations

Matt Woodruff

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

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

Date: **October 14th, 2022**

Subject: **Operations Report**

<u>Member Services</u>

- 12-Month Trend Summary:

    - The Member Services Department received less than one percent (.06%) in calls in September 2022, totaling 13,434 compared to 13,521 in September 2021. Call volume pre-pandemic in September 2019 was 13,661, which is two percent (2%) higher than the current call volume.
    - The abandonment rate for September 2022 was fifteen percent (15%), compared to sixteen percent (16%) in September 2021.
    - The Department's service level was fifty-two percent (52%) in September 2022, compared to forty-two percent (42%) in September 2021. Service levels continue to be directly impacted due to staffing challenges (unplanned/unscheduled absences related to COVID-19). The Department continues to recruit to fill open positions and has made great progress in filling open positions. The Customer Service support service vendor continues to provide overflow call center support.
    - The average talk time (ATT) was seven minutes and twenty-five seconds (07:25) for September 2022 compared to six minutes and eighteen seconds (06:18) for September 2021.
    - Member utilization of self-service phone options totaled fifteen-hundred and five (1,502) in September 2022, which includes eight hundred-two (802) for the member automated eligibility IVR system. The Department continues to analyze IVR prompt utilization and employs member feedback to improve the member's experience and meet the ever-changing needs of our members.
    - The top five call reasons for September 2022 were: 1). Change of PCP, 2). Eligibility/Enrollment, 3) Kaiser, 4). Benefits, 5). Provider Network Information. The top five call reasons for September 2021 were: 1). Eligibility/Enrollment, 2). Kaiser, 3). Change of PCP, 4). Benefits, 5). ID Card/Member Materials Request.
    - The Department continues to service members via multiple non-contact communication channels (telephonic, email, web-based requests, and in-person, effective 7/5/22). The Department responded to five hundred thirty-

eight (538) web-based requests in September 2022 compared to six hundred sixty-six (666) in September 2021. The top three web reason requests for September 2022 were: 1). Change of PCP, 2). ID Card Requests, 3). Update Contact Information.

Claims

- 12-Month Trend Summary:
    - The Claims Department received 175,955 claims in September 2022 compared to 159,558 in September 2021.
    - The Auto Adjudication was 81.8% in September 2022 compared to 80.1% in September 2021.
    - Claims compliance for the 30-day turn-around time was 99.2% in September 2022 compared to 98.0% in September 2021. The 45-day turn-around time was 99.9% in September 2022 compared to 99.9% in September 2021.

- Monthly Analysis:
    - In September, we received a total of 175,955 claims in the HEALTHsuite system. This represents a decrease of -1.12% from August and is higher, by 16,397 claims, than the number of claims received in September 2021; the higher volume of received claims remains attributed increased membership.
    - We received 86.6% of claims via EDI and 13.4% of claims via paper.
    - During September, 99.9% of our claims were processed within 45 working days.
    - The Auto Adjudication rate was 81.8% for September.

Provider Services

- 12-Month Trend Summary:
    - The Provider Services department's call volume in September 2022 was 5,594 calls compared to 4,936 calls in September 2021.
    - Provider Services continuously works to achieve first call resolution and reduction of the abandonment rates. Efforts to promote provider satisfaction is our first priority.
    - The Provider Services department completed 211 calls/visits during September 2022.
    - The Provider Services department answered 3,501 calls for September 2022 and made 748 outbound calls.

Credentialing

- 12-Month Trend Summary:
    - At the Peer Review and Credentialing (PRCC) meeting held on September 20th, 2022, there were ninety-six (96) initial network providers approved; three (3) primary care providers, seven (7) specialists, zero (0) ancillary providers, ten (10) midlevel providers, and seventy-six (76) behavioral health providers. Additionally, twenty-seven (27) providers were re-credentialed at this meeting; ten (10) primary care providers, twelve (12) specialists, one (1) ancillary provider, and four (4) 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 September 2022, the Provider Dispute Resolution (PDR) team received 642 PDRs versus 662 in September 2021.
    - The PDR team resolved 866 cases in September 2022, compared to 860 cases in September 2021.
    - In September 2022, the PDR team upheld 70% of cases versus 63% in September 2021.
    - The PDR team resolved 99.0% of cases within the compliance standard of 95% within 45 working days in September 2022 compared to 99.4% in September 2021.

- Monthly Analysis:
    - AAH received 642 PDRs in September 2022.
    - In September, 866 PDRs were resolved. Out of the 866 PDRs, 610 were upheld, and 256 were overturned.
    - The overturn rate for PDRs was 30% which did not meet our goal of 25% or less.

Community Relations and Outreach

- 12-Month Trend Summary:
  - In the first Quarter of 2022, the Alliance completed 2,370-member orientation outreach calls and 545 member orientations by phone.
  - The C&O Department reached 1,357 people, 91% identified as Alliance members, compared to 556 individuals who identified as Alliance members.
  - The C&O Department spent a total of $770 in donations, fees, and/or sponsorships, compared to $2,500.
  - The C&O Department reached members in 17 cities/unincorporated areas throughout Alameda County, and Bay Area, compared to 26 locations.

- Quarterly Analysis:
  - In the first Quarter of 2022, the C&O Department completed 2,370-member orientation outreach calls, 545 member orientations by phone, and 2 community events.
  - Among the 1,357 people reached, 91% identified as Alliance members.
  - In the first Quarter of 2022, the C&O Department reached members in 17 locations throughout Alameda County and Bay Area.

- Monthly Analysis:
  - In October 2022, the C&O Department completed 853-member orientation outreach calls and 173 member orientations by phone, and 31 Alliance website inquiries.
  - Among the 685 people reached, 40% identified as Alliance members.
  - In October 2022, the C&O Department reached members in 14 locations throughout Alameda County and Bay Area.
  - Please see attached **Addendum A**.

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	Sept 2022
Incoming Calls (R/V)	13,434
Abandoned Rate (R/V)	15%
Answered Calls (R/V)	11,417
Average Speed to Answer (ASA)	03:42
Calls Answered in 60 Seconds (R/V)	52%
Average Talk Time (ATT)	07:25
Outbound Calls	6,126

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

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

Claims Department
August 2022 Final and September 2022 Final

METRICS		
Claims Compliance	**Aug-22**	**Sep-22**
90% of clean claims processed within 30 calendar days	99.1%	99.2%
95% of all claims processed within 45 working days	99.9%	99.9%
Claims Volume (Received)	**Aug-22**	**Sep-22**
Paper claims	27,055	23,572
EDI claims	150,890	152,383
Claim Volume Total	**177,945**	**175,955**
Percentage of Claims Volume by Submission Method	**Aug-22**	**Sep-22**
% Paper	15.20%	13.40%
% EDI	84.80%	86.60%
Claims Processed	**Aug-22**	**Sep-22**
HEALTHsuite Paid (original claims)	132,261	104,137
HEALTHsuite Denied (original claims)	57,389	44,539
HEALTHsuite Original Claims Sub-Total	**189,650**	**148,676**
HEALTHsuite Adjustments	3,738	1,994
HEALTHsuite Total	**193,388**	**150,670**
Claims Expense	**Aug-22**	**Sep-22**
Medical Claims Paid	$65,460,024	$58,297,687
Interest Paid	$28,811	$29,767
Auto Adjudication	**Aug-22**	**Sep-22**
Claims Auto Adjudicated	158,554	121,587
% Auto Adjudicated	83.6%	81.8%
Average Days from Receipt to Payment	**Aug-22**	**Sep-22**
HEALTHsuite	18	18
Pended Claim Age	**Aug-22**	**Sep-22**
0-29 calendar days	12,399	10650
HEALTHsuite		
30-59 calendar days	75	132
HEALTHsuite		
Over 60 calendar days	1	0
HEALTHsuite		
Overall Denial Rate	**Aug-22**	**Sep-22**
Claims denied in HEALTHsuite	57,389	44,539
% Denied	29.7%	29.6%

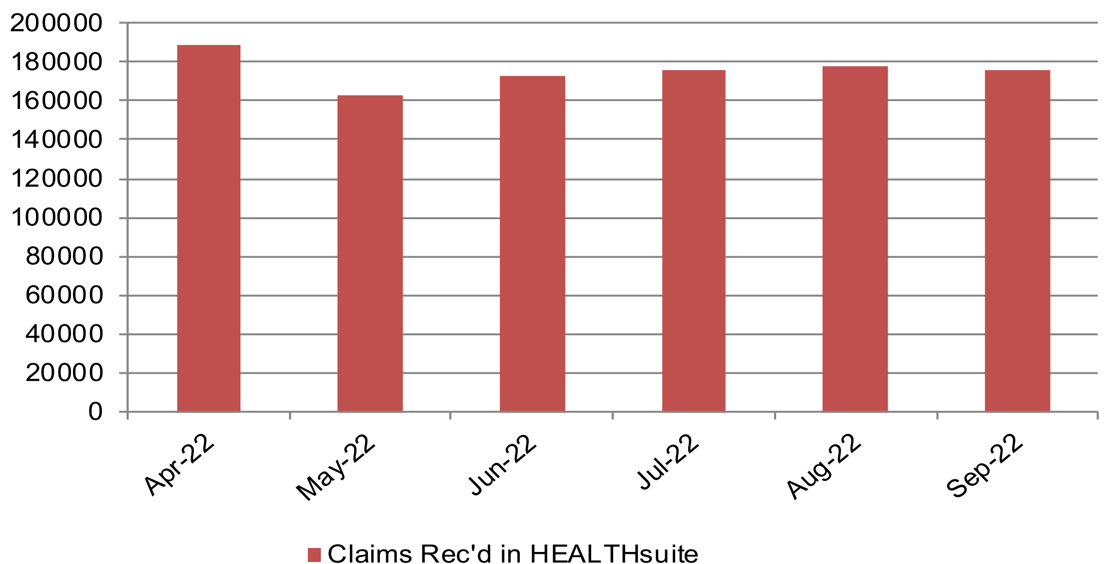
Claims Department
August 2022 Final and September 2022 Final

Sep-22

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	25%
No Benefits Found For Dates of Service	15%
Non-Covered Benefit for this Plan	13%
Duplicate Claim	11%
Please submit a copy of primary payer paper EOB	5%
% Total of all denials	**69%**

Claims Received By Month

Run Date	5/1/2022	6/1/2022	7/1/2022	8/1/2022	9/1/2022	10/1/2022
Claims Received Through	**Apr-22**	**May-22**	**Jun-22**	**Jul-22**	**Aug-22**	**Sep-22**
Claims Rec'd in HEALTHsuite	189,172	163,272	173,269	176,217	177,945	175,955



Provider Relations Dashboard September 2022

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	4810	4334	6078	5767	5236	5215	4973	6243	5594			
Abandoned Calls	626	586	2149	2219	1333	1512	1454	2083	2093			
Answered Calls (PR)	4184	3748	3929	3548	3903	3703	3519	4160	3501			
Recordings/Voicemails	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Incoming Calls (R/V)	332	373	1067	1309	677	807	665	756	950			
Abandoned Calls (R/V)												
Answered Calls (R/V)	332	373	1067	1309	677	807	665	756	950			
Outbound Calls	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Outbound Calls	624	680	664	640	677	573	685	722	748			
N/A												
Outbound Calls	624	680	664	640	677	573	685	722	748			
Totals	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Total Incoming, R/V, Outbound Calls	5766	5387	7809	7716	6590	6595	6323	7721	7292			
Abandoned Calls	626	586	2149	2219	1333	1512	1454	2083	2093			
Total Answered Incoming, R/V, Outbound Calls	5140	4801	5660	5497	5257	5083	4869	5638	5199			

Provider Relations Dashboard September 2022

Call Reasons (Medi-Cal and Group Care)

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	3.4%	4.2%	3.4%	3.0%	3.3%	3.4%	3.7%	3.5%	4.3%			
Benefits	4.1%	3.4%	3.1%	3.8%	3.9%	3.1%	2.9%	2.9%	1.6%			
Claims Inquiry	40.2%	41.5%	40.8%	48.8%	44.8%	47.8%	48.2%	49.5%	50.5%			
Change of PCP	2.4%	4.0%	4.8%	4.1%	5.0%	4.2%	3.6%	4.2%	4.2%			
Complaint/Grievance (includes PDR's)	4.9%	5.3%	4.8%	4.2%	3.8%	3.5%	3.9%	3.4%	2.3%			
Contracts	0.5%	0.7%	0.8%	0.7%	1.1%	1.2%	1.0%	0.9%	1.0%			
Correspondence Question/Followup	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%			
Demographic Change	0.1%	0.3%	0.0%	0.1%	0.0%	0.1%	0.1%	0.1%	0.0%			
Eligibility - Call from Provider	25.3%	23.2%	22.6%	21.4%	23.2%	18.8%	19.0%	17.9%	19.8%			
Exempt Grievance/ G&A	0.0%	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%	0.2%			
General Inquiry/Non member	0.0%	0.0%	0.0%	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%	0.0%	0.0%	0.0%			
Intrepreter Services Request	0.8%	0.4%	0.8%	0.7%	1.0%	0.8%	0.1%	0.8%	1.0%			
Kaiser	0.0%	0.1%	0.1%	0.7%	0.1%	0.0%	0.0%	0.0%	0.0%			
Member bill	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			
Mystery Shopper Call	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			
Provider Portal Assistance	4.5%	5.4%	4.9%	3.9%	4.2%	4.0%	4.9%	4.9%	3.9%			
Pharmacy	1.2%	0.3%	0.3%	0.3%	0.2%	0.1%	0.2%	0.2%	0.2%			
Provider Network Info	0.1%	0.1%	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%	0.2%			
Transferred Call	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			
All Other Calls	12.3%	10.8%	13.4%	8.2%	9.2%	12.8%	12.5%	11.4%	10.8%			
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	#DIV/0!	#DIV/0!	#DIV/0!

Field Visit Activity Details

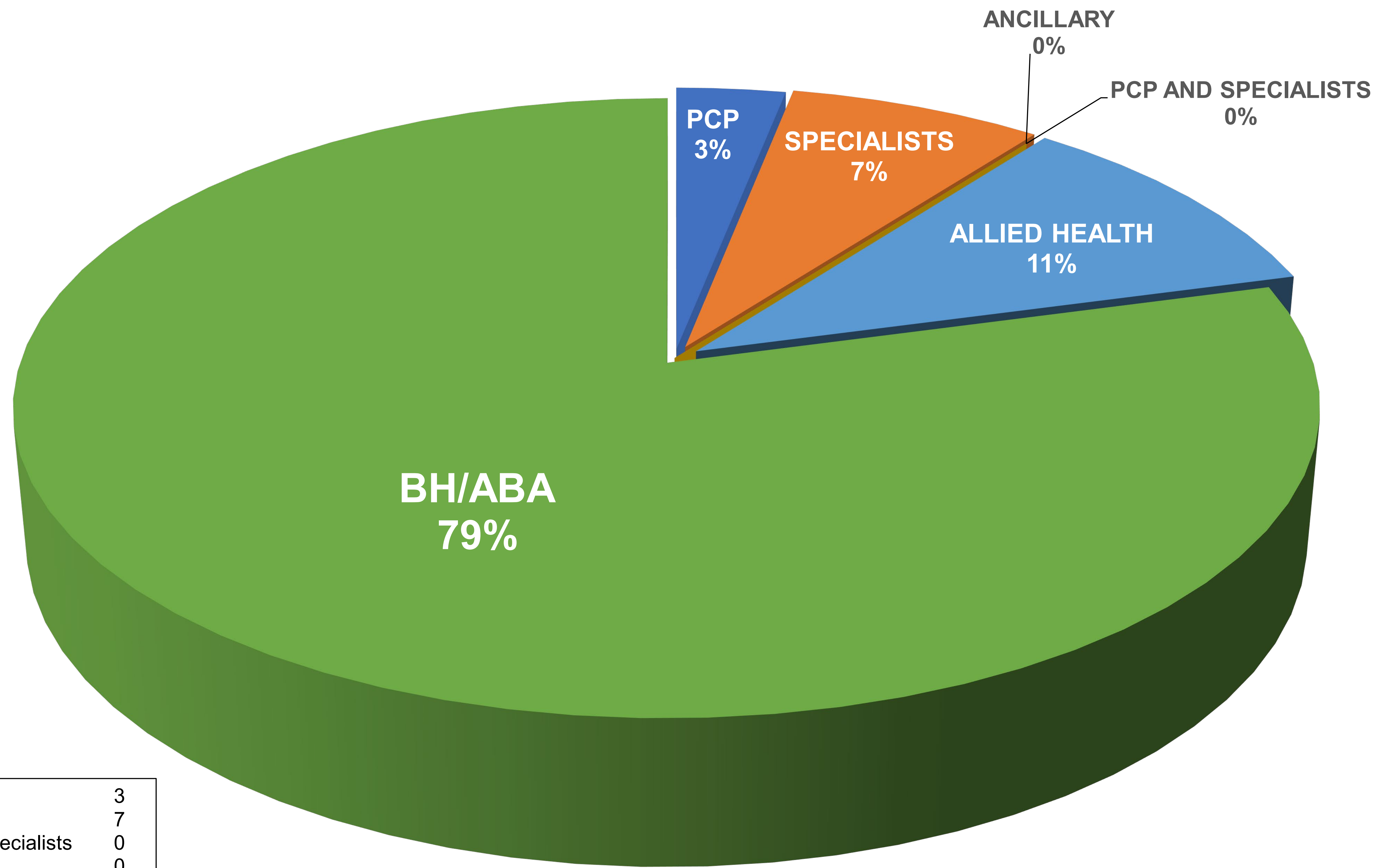
Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Claims Issues	9	18	17	12	7	15	7	10	47			
Contracting/Credentialing	8	10	28	20	12	14	11	9	31			
Drop-ins	0	0	0	0	0	0	0	0	104			
JOM's	1	2	3	1	4	2	3	4	0			
New Provider Orientation	22	15	34	22	22	5	15	10	6			
Quarterly Visits	211	274	159	175	201	149	182	240	3			
UM Issues	2	4	2	1	2	0	0	2	20			
Total Field Visits	253	323	243	231	248	185	218	275	211	0	0	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS						
Practitioners		BH/ABA 76	AHP 412	PCP 346	SPEC 625	PCP/SPEC 15
AAH/AHS/CHCN Breakdown			AAH 489	AHS 176	CHCN 417	COMBINATION OF GROUPS 392
Facilities	**30**					
VENDOR SUMMARY **Credentialing Verification Organization, Symply CVO**						
	Number		**Average Calendar Days in Process**	**Goal - Business Days**	**Goal - 98% Accuracy**	**Compliant**
Initial Files in Process	460		28	25	Y	Y
Recred Files in Process	7		15	25	Y	Y
Expirables updated **Insurance, License, DEA, Board Certifications**						Y
Files currently in process	**467**					
CAQH Applications Processed in September 2022						
Standard Providers and Allied Health	**Invoice not received**					
September 2022 Peer Review and Credentialing Committee Approvals						
Initial Credentialing	**Number**					
PCP	3					
SPEC	7					
ANCILLARY	0					
MIDLEVEL/AHP	10					
BH/ABA	76					
	96					
Recredentialing						
PCP	10					
SPEC	12					
ANCILLARY	1					
MIDLEVEL/AHP	4					
BH/ABA	0					
	27					
TOTAL	**123**					
September 2022 Facility Approvals						
Initial Credentialing	5					
Recredentialing	12					
	17					
Facility Files in Process	**300**					
September 2022 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/RECRED	CRED DATE
Abhari	Bahareh	BH/ABA-Telehealth	INITIAL	9/20/2022
Aceves	Berenice	BH/ABA-Telehealth	INITIAL	9/20/2022
Adkins	Shawna	BH/ABA	INITIAL	9/20/2022
Arpaci	Carol	BH/ABA	INITIAL	9/20/2022
Asher	Ava	BH/ABA	INITIAL	9/20/2022
Azghadi	Soheila	Specialist	INITIAL	9/20/2022
Bakshi	Nandini	Specialist	INITIAL	9/20/2022
Ben-Zvy	Leigh	Primary Care Physician	INITIAL	9/20/2022
Beyer	Yvonne	BH/ABA	INITIAL	9/20/2022
Boisvert	Alexandria	BH/ABA-Telehealth	INITIAL	9/20/2022
Bowden	Haydee	BH/ABA	INITIAL	9/20/2022
Caldwell	Alicia	BH/ABA	INITIAL	9/20/2022
Camarena	Evangelina	BH/ABA	INITIAL	9/20/2022
Canfield	Jasmin	BH/ABA	INITIAL	9/20/2022
Carter	Jack	BH/ABA-Telehealth	INITIAL	9/20/2022
Chandran	Jessica	BH/ABA	INITIAL	9/20/2022
Chang	Hanna	BH/ABA-Telehealth	INITIAL	9/20/2022
Chavez Carrera	Alejandra	Primary Care Physician	INITIAL	9/20/2022
Cochran	Colleen	BH/ABA-Telehealth	INITIAL	9/20/2022
De La Torre Villegas	Lorena	BH/ABA	INITIAL	9/20/2022
Di Gregorio	Allison	BH/ABA-Telehealth	INITIAL	9/20/2022
Eddy	Julia	BH/ABA	INITIAL	9/20/2022
Escobar Correa	Adriana	BH/ABA	INITIAL	9/20/2022
Farrohi	Parisa	BH/ABA	INITIAL	9/20/2022
Fleminger	Dawn	BH/ABA-Telehealth	INITIAL	9/20/2022
Flores	Jessica	BH/ABA	INITIAL	9/20/2022
Forsberg	Michael	BH/ABA-Telehealth	INITIAL	9/20/2022
Gill	Ammara	Specialist	INITIAL	9/20/2022
Guardado	Luana	BH/ABA-Telehealth	INITIAL	9/20/2022
Haimowitz	Carla	BH/ABA-Telehealth	INITIAL	9/20/2022
Hall	Darah	BH/ABA-Telehealth	INITIAL	9/20/2022
Hansra	Haramrit	Specialist	INITIAL	9/20/2022
Hart	Naima	BH/ABA	INITIAL	9/20/2022
Ibarra	Amanda	BH/ABA-Telehealth	INITIAL	9/20/2022
Iqbal	Wurda	BH/ABA-Telehealth	INITIAL	9/20/2022
Jaramillo	Briana	BH/ABA-Telehealth	INITIAL	9/20/2022
Jensen	McKenna	BH/ABA-Telehealth	INITIAL	9/20/2022
Kamper	Lorraine	BH/ABA-Telehealth	INITIAL	9/20/2022
Kapoor	Shilpa	BH/ABA	INITIAL	9/20/2022
Kashem	Sakeen	Specialist	INITIAL	9/20/2022
Kern	Anna	BH/ABA	INITIAL	9/20/2022
Kim	Grace	BH/ABA	INITIAL	9/20/2022
Kulkarni	Gauri	BH/ABA-Telehealth	INITIAL	9/20/2022
Lawrence	Alison	BH/ABA-Telehealth	INITIAL	9/20/2022
Lazarin	Margaux	Specialist	INITIAL	9/20/2022
Le	Vincent	Primary Care Physician	INITIAL	9/20/2022
Leslie	Kathleen	BH/ABA	INITIAL	9/20/2022
Liao	Xing	BH/ABA-Telehealth	INITIAL	9/20/2022
Liu	Samantha	BH/ABA	INITIAL	9/20/2022
Lopez	Ana	BH/ABA-Telehealth	INITIAL	9/20/2022
Ly	Jessica	BH/ABA-Telehealth	INITIAL	9/20/2022
Lyandres	Polina	BH/ABA-Telehealth	INITIAL	9/20/2022
Marcella	Hillary	BH/ABA-Telehealth	INITIAL	9/20/2022
McCabe	Patrick	Specialist	INITIAL	9/20/2022
Misso	Nicole	BH/ABA	INITIAL	9/20/2022
Montarella	Amberlee	Allied Health	INITIAL	9/20/2022
Montiel	Kelly	BH/ABA	INITIAL	9/20/2022
Nguyen	Minh-Thu	Allied Health	INITIAL	9/20/2022

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RECRED	CRED DATE
Ni	Huan	Allied Health	INITIAL	9/20/2022
Nordhues	Juliana	BH/ABA	INITIAL	9/20/2022
Norris	Claire	BH/ABA	INITIAL	9/20/2022
Palencia Diaz	Ivy	BH/ABA-Telehealth	INITIAL	9/20/2022
Patterson	Amy	BH/ABA-Telehealth	INITIAL	9/20/2022
Patterson	Rosa	BH/ABA-Telehealth	INITIAL	9/20/2022
Perry	Barbara	BH/ABA	INITIAL	9/20/2022
Perswain	Lorena	BH/ABA-Telehealth	INITIAL	9/20/2022
Phan	Cattuong	BH/ABA-Telehealth	INITIAL	9/20/2022
Piazza	Fred	BH/ABA	INITIAL	9/20/2022
Pitochelli	Ysabella	BH/ABA-Telehealth	INITIAL	9/20/2022
Pittman	Keegan	BH/ABA	INITIAL	9/20/2022
Quevedo	Stacia	BH/ABA	INITIAL	9/20/2022
Quirk	Lorien	BH/ABA	INITIAL	9/20/2022
Reese	Lyndsay	BH/ABA	INITIAL	9/20/2022
Richer	Katelyn	Allied Health	INITIAL	9/20/2022
Roychoudhury	Sunita	BH/ABA	INITIAL	9/20/2022
Sachdev	Janak	BH/ABA-Telehealth	INITIAL	9/20/2022
Sachkar	Nicole	Allied Health	INITIAL	9/20/2022
Sanchez	Saul	BH/ABA	INITIAL	9/20/2022
Schoenborn	Brian	BH/ABA-Telehealth	INITIAL	9/20/2022
Shem	Tiffany	Allied Health	INITIAL	9/20/2022
Solomon	Theodore	BH/ABA-Telehealth	INITIAL	9/20/2022
Spatz	Tenley	Allied Health	INITIAL	9/20/2022
Specht	Amanda	BH/ABA	INITIAL	9/20/2022
Spielvogel	Brianna	BH/ABA-Telehealth	INITIAL	9/20/2022
Stauffer	Stephen	BH/ABA	INITIAL	9/20/2022
Taguchi-Solorio	Natalie	BH/ABA-Telehealth	INITIAL	9/20/2022
Thakur	Sonica	BH/ABA-Telehealth	INITIAL	9/20/2022
Van Osch	Matthew	BH/ABA-Telehealth	INITIAL	9/20/2022
Victoria	Enrique	Allied Health	INITIAL	9/20/2022
Walia	Monika	Allied Health	INITIAL	9/20/2022
Wolfe	Martha	BH/ABA	INITIAL	9/20/2022
Wright-Fong	Taryn	BH/ABA	INITIAL	9/20/2022
Yagudayeva	Svetlana	Allied Health	INITIAL	9/20/2022
Yeo	Monica	BH/ABA-Telehealth	INITIAL	9/20/2022
Yoon	Jin Hee	BH/ABA	INITIAL	9/20/2022
Zlotowski	Steven	BH/ABA	INITIAL	9/20/2022
Adler	Ronald	Specialist	RECRED	9/20/2022
Barua	Upama	Primary Care Physician	RECRED	9/20/2022
Chen	Arthur	Primary Care Physician	RECRED	9/20/2022
Chen	Judy	Specialist	RECRED	9/20/2022
Chentanez	Teera	Specialist	RECRED	9/20/2022
Diamond	Jan	Primary Care Physician	RECRED	9/20/2022
Dubois	Robert	Ancillary	RECRED	9/20/2022
Fleisig	Sarah	Specialist	RECRED	9/20/2022
Gersten-Rothenberg	Karen	Allied Health	RECRED	9/20/2022
Goldrich	Michael	Primary Care Physician	RECRED	9/20/2022
Gutierrez	Vanessa	Allied Health	RECRED	9/20/2022
Hoang	Sylvia	Primary Care Physician	RECRED	9/20/2022
Iota-Herbei	Claudia	Specialist	RECRED	9/20/2022
Kamlot	Andreas	Specialist	RECRED	9/20/2022
King-Angell	Joan	Primary Care Physician	RECRED	9/20/2022
Lopez-Arredondo	Yahaira	Primary Care Physician	RECRED	9/20/2022
Mcglashan	Kate	Allied Health	RECRED	9/20/2022
Mehra	Soniya	Primary Care Physician	RECRED	9/20/2022
Melton	Clifford	Specialist	RECRED	9/20/2022
Navani	Annu	Specialist	RECRED	9/20/2022
Oommen	Santosh	Specialist	RECRED	9/20/2022
Rasheed	Sabiha	Specialist	RECRED	9/20/2022
Roisman	Debra	Allied Health	RECRED	9/20/2022
Taylor	Nicholas	Primary Care Physician	RECRED	9/20/2022
Tseng	Yu-Tzu	Primary Care Physician	RECRED	9/20/2022
Waissbluth	Alvaro	Specialist	RECRED	9/20/2022
Yan	Yan	Specialist	RECRED	9/20/2022

SEPTEMBER PEER REVIEW AND CREDENTIALING INITIAL APPROVALS BY SPECIALTY



PCP	3
Specialists	7
PCP and Specialists	0
Ancillary	0
Allied Health	10
BH/ABA	6
Total	96

Provider Dispute Resolution
August 2022 and September 2022

METRICS

PDR Compliance	Aug-22	Sep-22
# of PDRs Resolved	1,626	866
# Resolved Within 45 Working Days	1,617	857
% of PDRs Resolved Within 45 Working Days	99.4%	99.0%

PDRs Received	Aug-22	Sep-22
# of PDRs Received	904	642
PDR Volume Total	**904**	**642**

PDRs Resolved	Aug-22	Sep-22
# of PDRs Upheld	1,188	610
% of PDRs Upheld	73%	70%
# of PDRs Overturned	438	256
% of PDRs Overturned	27%	30%
Total # of PDRs Resolved	**1,626**	**866**

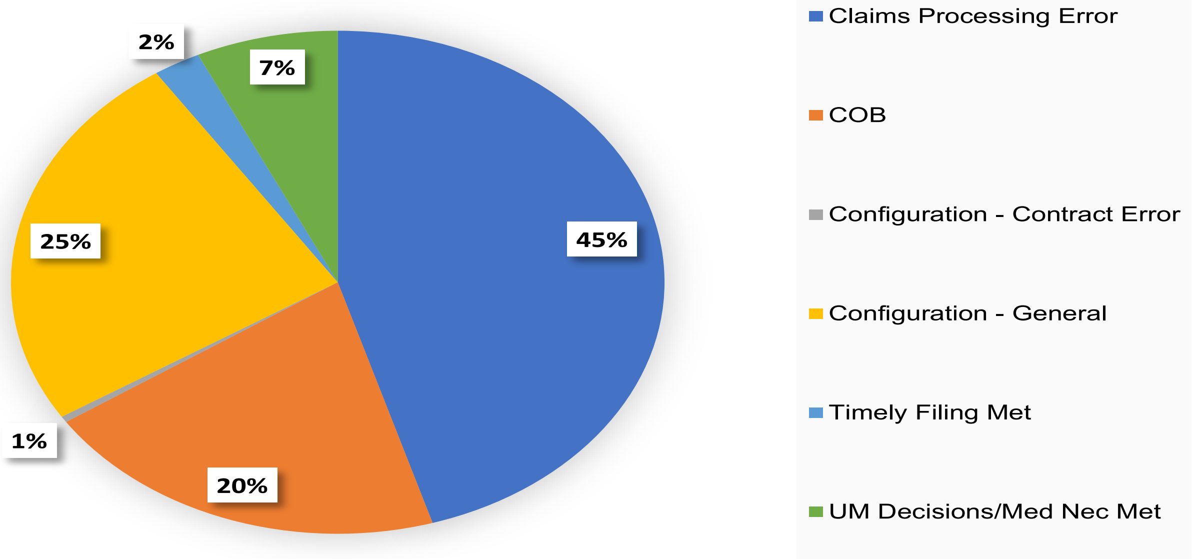
Average Turnaround Time	Aug-22	Sep-22
Average # of Days to Resolve PDRs	36	29
Oldest Unresolved PDR in Days	45	76

Unresolved PDR Age	Aug-22	Sep-22
0-45 Working Days	900	789
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**900**	**789**

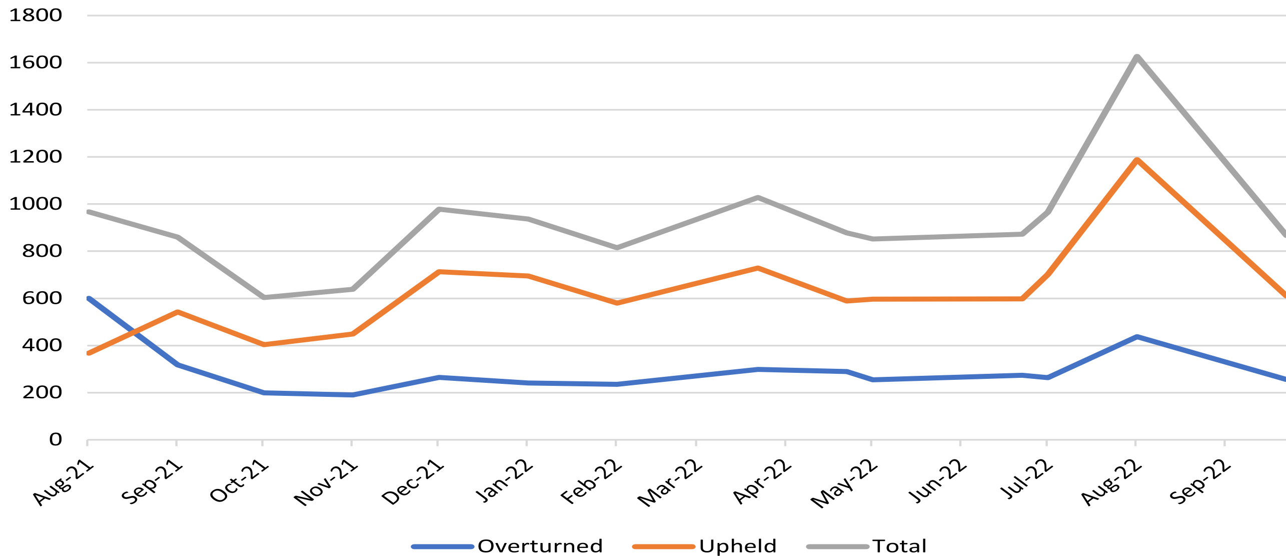
Provider Dispute Resolution
August 2022 and September 2022

Sep-22

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



Between July 2022 and September 2022, the Alliance completed **2,370** member orientation outreach calls and conducted **545** member orientations (**23%** member participation rate). The Alliance also completed **31** Service Requests, and **144** Website Inquires in Q1. The Alliance reached a total of **1,357** people and spent a total of $770 in donations, fees, and/or sponsorships at the Oakland Chinatown Chamber of Commerce and the 19th Annual Healthy Living Festival community events.**

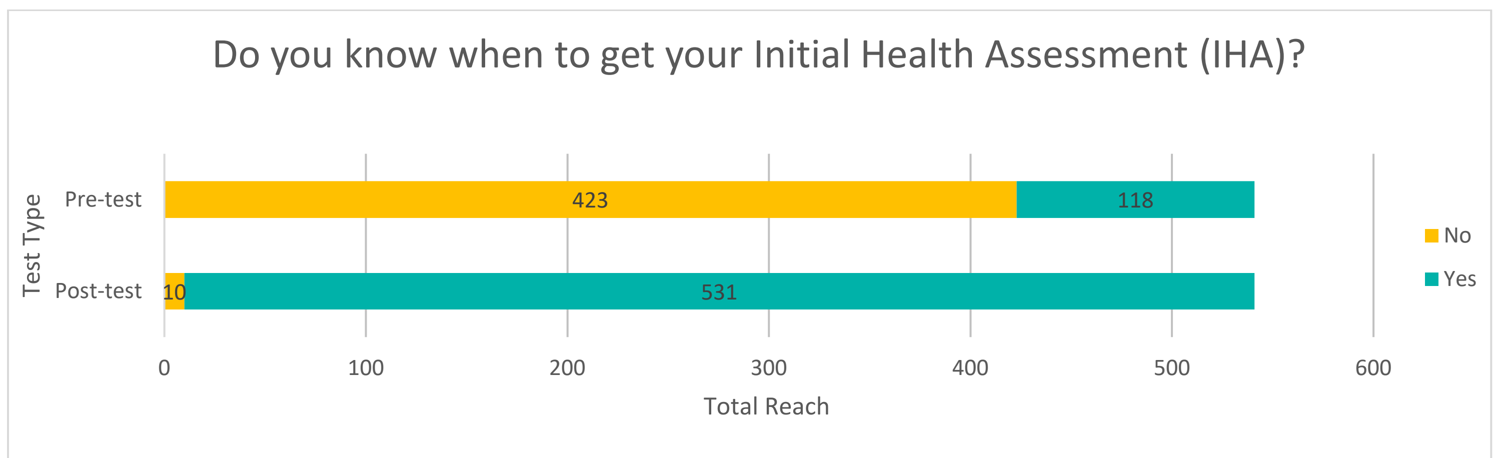
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **25,839** self-identified Alliance members have been reached during outreach activities.

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

On **Wednesday, March 18, 2020,** the Alliance began conducting member orientations by phone. As of September 30, 2022, the Outreach Team completed **21,669**-member orientation outreach calls and conducted **6,014** member orientations (**28%-member** participation rate).

The Alliance Member Orientation (MO) program has been in place since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Assessment, by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between March 18, 2020, through September 30, 2022 – **6,014** members completed our MO program by phone.

After completing a MO **98.2%** of members who completed the post-test survey in Q1 FY 22-23 reported knowing when to get their IHA, compared to only **21.8%** 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\Q1\3. September 2022**

Q1 FY 2022-2023 TOTALS

2	COMMUNITY EVENTS	1357	TOTAL REACHED AT COMMUNITY EVENTS
0	MEMBER EDUCATION EVENTS	0	TOTAL REACHED AT MEMBER EDUCATION EVENTS
545	MEMBER ORIENTATIONS	545	TOTAL REACHED AT MEMBER ORIENTATIONS
0	MEETINGS/ PRESENTATIONS	0	TOTAL REACHED AT MEETINGS/PRESENTATIONS
2	TOTAL INITIATED/INVITED EVENTS	1230	TOTAL MEMBERS REACHED AT EVENTS
547	TOTAL EVENTS	**1902**	TOTAL REACHED AT ALL EVENTS

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

TOTAL REACH 17 CITIES

**Cities represent the mailing addresses for members who completed a Member Orientation by phone and CE. The italicized cities are outside of Alameda County. The following cities had <1% reach during Q1 2022: Emeryville, Concord, and Richmond. The C&O Department started including these cities in the Q3 FY21 Outreach Report.*

$770

TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

*** Includes refundable deposit.*

Compliance

Richard Golfin III

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

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

Date: **October 14th, 2022**

Subject: **Compliance Division Report**

Compliance Audit Updates

- 2022 DHCS Routine Medical Survey:
  - The 2022 DHCS Routine Medical Survey was held on April 4th, 2022 and completed April 13th, 2022. The review period was April 1st, 2021, through March 31st, 2022. On September 13th, 2022, the Plan received the Final Audit Report, Cover Letter and CAP Response Form which will be used to outline the Plan's detailed response to findings within the Final Report. The Final Report detailed 15-findings, 9 of which were repeat findings from the previous audit year. The Plan's CAP response is due back to the Department by October 14th, 2022.

- 2022 DMHC Routine Financial Examination:
  - On February 25th, 2022, the DMHC sent notice to the Plan of the 2022 DMHC Routine Financial Examination beginning August 15th, 2022. The audit began with virtual interviews of Claims and Finance Staff. The audit reviewed the Plan's fiscal and administrative affairs and activities through the quarter-ending March 31st, 2022. The Plan continues to manage Agency requests for Claims and Finance deliverables and is evaluating potential findings.

- 2022 DMHC Behavioral Health Investigation [MHPAEA]:
  - In 2021, the DMHC began investigating full-service commercial health plans to evaluate and assess barriers providers experience in providing behavioral health services. Pre-audit submission concluded in July with more than 1,100 documents provided to DMHC auditors. The onsite review was held from September 7th, through September 8th, 2022. The Plan continues to manage Agency requests through the month of October. The Plan has not yet developed an assessment of potential findings from the Agency's review and looks forward to either a preliminary or final report, when ready.

- 2021 DMHC Routine Full Medical Survey:
  - The 2021 DMHC Routine Medical Survey, virtual audit took place from April 13th, 2021, through April 16th, 2021. On May 25th, 2022, the Plan received its 2021 Preliminary Audit Report and survey results. The preliminary report had a total of six (6) findings: three (3) in Grievances and Appeals; and three (3) in Prescription Drug Coverage. The Plan returned its CAP responses and supporting documentation to the Department on July 8th, 2022, with the remaining CAP items due to the Agency by December 30th, 2022.

- 2021 DHCS Routine Full Medical Survey:
  - On January 13th, 2021, the DHCS sent notice of the 2021 DHCS Routine Medical Survey beginning April 12th, 2021. The audit was conducted jointly with the DMHC from April 13th, 2021, through April 23rd, 2021.The review period was June 1st, 2019, through March 31st, 2021. The Plan received the final audit report on August 24th, 2021, which had a total of thirty-three (33) findings and four (4) repeat findings. The Plan's final response to the findings were completed and provided to the State on September 23rd, 2022.

<u>Compliance Activity Updates</u>

- 2022 RFP Contract Award & Review:
  - On February 9th, 2022, the DHCS released Request for Proposal (RFP) #20-10029 soliciting submissions for the 2024 Contract for the provision of managed health care services to Medi-Cal beneficiaries. The contract award is expected in the coming months following CMS approval of State model transitions, with implementation to take place through December 31st, 2023.
  - On September 15th, 2022, the State notified the Plan that the next deliverable submission date will be November 28th, 2022. The Plan was also notified that there will be a new workplan, which extended our deliverable submission requirements from two-hundred-forty-five (245) to a total of four-hundred-seventy-one (471) for the duration of the Operational Readiness contract. The State will provide more information on the remaining requirements in Spring 2023. To date, two-hunded-thirty-three (233) of the four-hundred-seventy-one (471) have been identified.
  - On September 22nd, 2022, the State provided the new workplan and deliverable submission phases as follows:

    - Wave 4 will take place through January 31st, 2023, with sixty-four (64) deliverables submitted during this period.
    - Wave 5 will take place from February 21st, 2023, through May 31st, 2023, with one-hundred-seven (107) deliverables to be submitted during this period.
    - Wave 6 will take place from May 22nd, 2023, through September 15th, 2023, with sixty-two (62) deliverables to be submitted during this period.

- 2022 Corporate Compliance Training – Board of Governors & Staff:
    - The Board of Governors began their Corporate Compliance Training on August 15th. with a completion date of November 15th, 2022. At this time, 11% of the group has completed the training.

        - Health Insurance Portability and Accountability Act (HIPAA)
        - Fraud Waste and Abuse

    - All Plan Staff were assigned Annual Corporate Compliance Training on September 16th with a completion date of December 6th, 2022. At this time, 26% of staff have completed the assigned training.

        - Health Insurance Portability and Accountability Act (HIPAA)
        - Fraud Waste and Abuse
        - Cultural Competency and Sensitivity

Health Care Services

Steve O'Brien, MD

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

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

Date: **October 14th, 2022**

Subject: **Health Care Services Report**

Utilization Management: Outpatient

- The carve in of Major Organ Transplant/Bone Marrow Transplant (MOT/BMT) went live on 1/1/2022. So far 211 members are in various stages of the Transplant process: 87 in Pre-Transplant, 12 on a Waitlist, 79 are post-Transplant, 32 have stopped being eligible with AAH. Most cases are going to UCSF, with a few to Stanford and other Centers of Excellence.

- Progress continues with UM/Claims configuration alignment, including Pharmacy claims. Providers are informed of the coding alignment changes so that they can bill and receive payment in a timely manner. Most recently the Rehabilitation claims have been re-configured. The standardization improves accuracy and timeliness of claims payment through appropriate data integration between the authorization process and the claims processing. This project also supports accurate reporting of data to the state for a variety of initiatives.

- CCS process enhancements continue to integrate into the larger EPSDT strategy. Reports to identify members who may qualify for CCS have been developed, and many members referred to CCS for services, enabling them to receive care through the CCS Special Care Centers. Through this process, 146 children with CCS qualifying diagnoses have been identified, and they are being evaluated for referral to CCS for potential care.

- The process to refer members to Tertiary/Quaternary (T/Q) centers for specialized care has been revised to ensure that members appropriate for this higher-level care receive it in the most appropriate setting. Go live for implementation is set for 12/1/22, after communication with all stakeholders.

- Progress on UM Corrective Action Plans from DHCS surveys is continuing, with required changes being monitored to ensure fidelity to regulatory requirements.

Outpatient Authorization Denial Rates			
Denial Rate Type	**June 2022**	**July 2022**	**Aug 2022**
Overall Denial Rate	**4.5%**	**4.7%**	**3.3%**
Denial Rate Excluding Partial Denials	**4.1%**	**4.3%**	**3.0%**
Partial Denial Rate	**0.4%**	**0.4%**	**0.3%**

Turn Around Time Compliance			
Line of Business	**June 2022**	**July 2022**	**Aug 2022**
Overall	**97%**	**97%**	**98%**
Medi-Cal	**97%**	**97%**	**98%**
IHSS	**98%**	**97%**	**98%**
Benchmark	***95%***	***95%***	***95%***

Utilization Management: Inpatient

- The IP department continues with process improvements in the IP program to align with the carve in of Long-Term Care, close management of high-risk members, and to optimize departmental functioning. Sub-processes under improvement are staffing and coverage, (completed,) development of additional standard work, (ongoing,) training/monitoring, and integration with AAH initiatives.

- On January 1st, 2023, FFS Medi-Cal members currently residing in Long Term Care SNFs will join AAH. Preparation for the influx of these1500 to 1800 new members are underway, involving all departments in AAH, led by the Integrated Planning Department.

- IP Team implemented Unsafe Discharge and Administrative Day Review workflow, conducted staff training on inpatient admissions that meet criteria for review and standard practice for escalation to Medical Directors. These processes have been shared with delegates to ensure that members receive the same assessment for medical necessity across the entire network.

- Inpatient department continues to track COVID admissions: Covid admissions increased slightly in July, and then declined to only 16 in September, with the average LOS hovering around 9-10 days. Overall, the rate continues to remain low, consistent with Alameda County data.

- Readmission reduction: CM continuing to collaborate with hospital partners and with their community-based TOC programs to focus on readmission reduction, aligning with their readmission reduction goals. There has been CM leadership

changes at AHS, and AAH has re-established the partnership with Dr. Borneo and Mark Brown, leadership of their Case Management and Ambulatory Transitions care team.

Inpatient Med-Surg Utilization Total All Aid Categories **Actuals (excludes Maternity)**			
Metric	**May 2022**	**June 2022**	**July 2022**
Authorized LOS	5.4	5.0	5.2
Admits/1,000	57	53	54
Days/1,000	305.5	268.1	280.7

Pharmacy

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

Decisions	Number of PAs Processed
Approved	35
Denied	29
Closed	110
Total	**174**

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

- Medications for Diabetes, Nerve Pain, Hepatitis B, Diabetes, Asthma, Eye Pain, Skin Disease and Cold Sores are top ten categories for denials.

Rank	Drug Name	Common Use	Common Denial Reason
1	JARDIANCE 10 MG TABLET	Diabetes	Criteria for approval not met
2	LIDOCAINE 5% PATCH	Nerve Pain	Criteria for approval not met
3	VEMLIDY 25MG TABLET	Hepatitis B	Criteria for approval not met
4	JARDIANCE 25 MG TABLET	Diabetes	Criteria for approval not met
5	NUCALA 100 MG VIAL	Asthma	Criteria for approval not met
6	SEMGLEE (YFGN) 100 UNIT/ML PEN	Diabetes	Criteria for approval not met
7	PROLENSA 0.07% EYE DROPS	Eye Pain	Criteria for approval not met
8	HUMIRA(CF) PEN 40 MG/0.4 ML	Skin Disease	Criteria for approval not met
9	ZOVIRAX 5% CREAM	Cold Sores	Criteria for approval not met
10	HUMIRA(CF) PEN PS-UV-AHS 80-40	Skin Disease	Criteria for approval not met

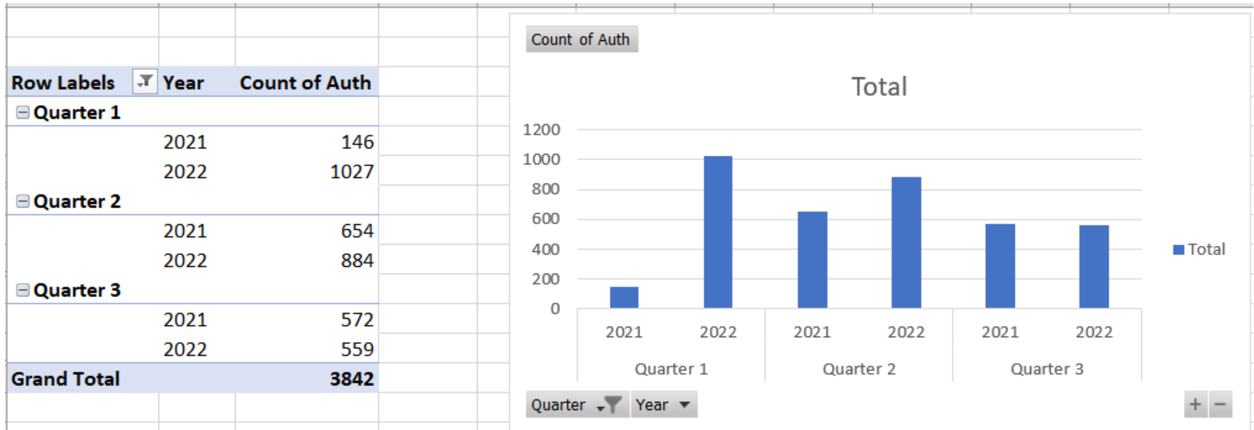
- The Alameda Alliance for Health (AAH) Pharmacy Department has successfully carried out Medi-Cal RX go-live as of 1/1/2022 and continues to serve its members with the same high standards of care.
    - As of September 23rd, 2022, processed approximately 90.58 million point-of-sale pharmacy paid claims to participating pharmacies totaling approximately $11.20 billion in payments
    - Processed 244,250 prior authorization requests
    - Answered 401,200 calls and 100 percent of virtual hold calls and voicemails have been returned
    - We have closed submitted Medi-Cal PAs and informing doctor offices to submitted to Medi-Cal RX:

Month	Number of Total PA Closed
January 2022	169
February 2022	44
March 2022	31
April 2022	25
May 2022	7
June 2022	8
July 2022	27
August 2022	44
September 2022	66

- The AAH Pharmacy Department is collaborating with QI/health education on providing input on diabetes assessment for future pharmacy referral.
    - The AAH Pharmacy Department is working with its Inpatient Department and Case Management Disease Management (CMDM) Department.
    - The Pharmacy team participates in the TOC (Transition of Care) Program and 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. The inclusion criteria are members with heart failure, diabetes, sepsis, asthma/COPD, and use of anti-coagulants.
    - Referred cases from the CMDM daily feed are evaluated to determine if the AAH Pharmacy Dept is required for each case. The pharmacy department is focusing on lower volume, higher need cases where pharmacy may have the greatest impact on member outcomes:

Month	Number of TOC Cases
January 2022	8
February 2022	38
March 2022	21
April 2022	22
May 2022	0
June 2022	1
July 2022	2
August 2022	12
September 2022	6

- 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:



Row Labels	Year	Count of Auth
⊟ Quarter 1		
	2021	146
	2022	1027
⊟ Quarter 2		
	2021	654
	2022	884
⊟ Quarter 3		
	2021	572
	2022	559
Grand Total		3842

- Biosimilar utilization average was 70% during July 2021 to June 2022
    - Savings achieved was $1.88 million

- Pharmacy has issued pharmacist-prescribed access to Nicotine Replacement Therapy (NRT) at in-network dispensing pharmacies. This can help support smoking cessation initiatives in our at-risk populations in conjunction with QI.

Case and Disease Management

- Population health-driven, disease-specific case management bundles (standard sets of actions developed to address the specific needs of members with significant diseases,) continue development. Current bundles are Heme-Oncology, Dialysis, Asthma and Diabetes. CM's collaboration with the Quality Department on the implementation of the new Population Health Management (PHM) standards, include further expansion of Disease Management to include cardiovascular disease and Depression.

- CM is working with the Quality and Analytics Departments on updating the current Risk Stratification of AAH members as guided by the implementation of the new Population Health Management (PHM) standards. The new Risk Stratification will be used to evaluate and improve AAH's approach to connect members to appropriate interventions and services.

- CM in collaboration with UM is working to prepare for Long-Term Care's Go-Live date of January 1, 2023. This includes creating workflows and internal processes to address members transition(s) through the care continuum.

- Major Organ Transplant (MOT) CM Bundle was deployed, and the volume continues to increase, (211 cases YTD.) Processes to support members throughout the continuum of care, from Pre-Transplant, Transplantation, and Post-Transplant are in place.

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

- CM is working closely with the Behavioral Health (BH) team to train BH on internal CM processes. CM will continue to integrate the BH team as Behavioral Health is carved-in to the Alliance.

Case Type	Cases Opened in July 2022	Total Open Cases as of July 2022	Cases Opened in August 2022	Total Open Cases as of August 2022
Care Coordination	312	573	424	711
Complex Case Management	32	78	38	88
Transitions of Care (TOC)	239	439	214	426

Enhanced Case Management and Community Supports Services

- ACBH launched as an ECM provider on September 1st, 2022.
- Work with IPD, Analytics and Provider Service teams continues for next Populations of Focus (LTC to home; LTC diversion) to launch 01/01/23.
- As part of expansion of ECM Providers, the ECM Entity Interest forms were reviewed for Jan 1 Populations of Focus. Recommendations for potential providers presented at CalAIM Core (Planning) Team. Moving forward with discussions with potential providers.
- Plans to meet with Parole Board to discuss current ECM referral process for current Populations of Focus. Inservice for them will be scheduled on CM, ECM, & Community Supports.
- An ECM Dashboard has been developed which provides real time access to outcomes of ECM program, including member outcomes, utilization, and change in outcomes over time. ECM program is showing 33% reductions in admissions and 29% reduction in ED usage before and after members were enrolled, and an approximately 25% reduction in ED/IP costs PMPM before and after members were enrolled.

Case Type	ECM Outreach in July 2022	Total Open Cases as of July 2022	ECM Outreach in August 2022	Total Open Cases as of August 2022
ECM	226	796	244	844

- 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

- CalAIM Community Supports (CS): The planned staff for the CS program have been hired and are authorizing care and are tracking program metrics.

- A CS dashboard has been completed to provide real time data review and reporting on the processes and outcomes of the CS program. Early evaluation is showing a decrease in Admits/1000, Bed Days/1000, Average Length of Stay, ER Visits/1000.

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

- Recipe for Health (R4H) successfully launched as a Medically Supportive Food CS provider on 9/1/22.

- CS, ECM, Finance and Provider Relations are collaborating to consider a Self-Funded Pilot for 2 additional Community Supports Services. The Self-Funded Pilot would complement the incoming ECM Populations of Focus (January of 2023) and contribute 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

Community Supports	Services Authorized in Apr 2022	Services Authorized in May 2022	Services Authorized in Jun 2022	Services Authorized in Jul 2022
Housing Navigation	253	274	294	315
Housing Deposits	148	136	179	215
Housing Tenancy	806	850	874	934
Asthma Remediation	23	28	25	21
Meals	64	70	62	64
Medical Respite	53	22	36	35

Grievances & Appeals

- Cases were resolved within the goal of 95% within regulatory timeframes except for standard grievances and expedited grievances, which were not resolved within the goal of 95%.
  - Standard Grievances: The goal was not met due to the G & A Department completing a systematic review and closure of remaining unresolved cases awaiting provider responses. This effort began in August and was completed in September. The G & A Department closed an additional 135 out of compliance cases; resulting in a low compliance rate of 82.89% for the month of September.
    The G&A team has been retrained on escalation processes, including partnering with compliance and provider services, and regular weekly reviews by management will keep us accumulating cases and maintain compliance moving forward.
  - Expedited grievances: The goal was not met because of a G&A staff error one of the two cases was not presented to the Medical Director timely

- Total grievances resolved in September were 7.73 complaints per 1,000 members.

- The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of September 2022; we did meet our goal at 19% overturn rate.

September 2022	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	789	30 Calendar Days	95% compliance within standard	654	82.89%	2.45
Expedited Grievance	2	72 Hours	95% compliance within standard	1	50%	0.01
Exempt Grievance	1667	Next Business Day	95% compliance within standard	1667	100%	5.18
Standard Appeal	29	30 Calendar Days	95% compliance within standard	29	100%	0.09
Expedited Appeal	0	72 Hours	95% compliance within standard	NA	NA	NA
Total Cases:	2,487		95% compliance within standard	2,351		7.73

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

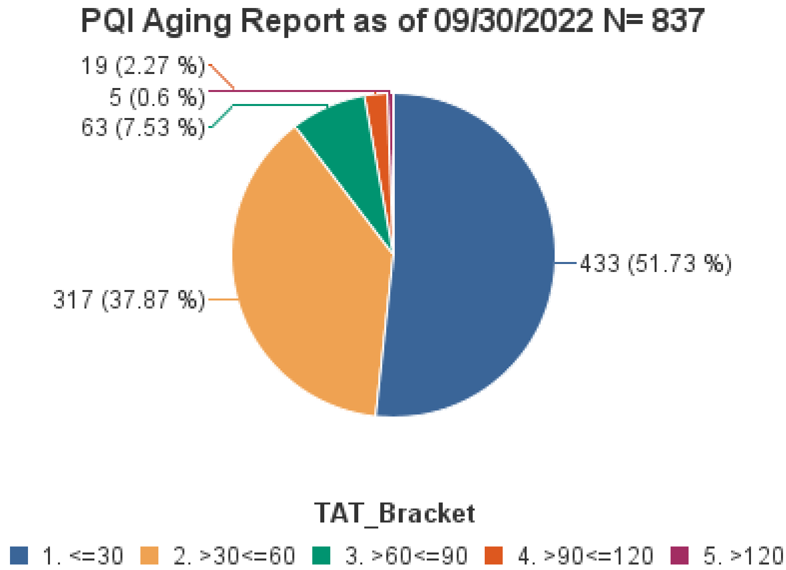
Quality

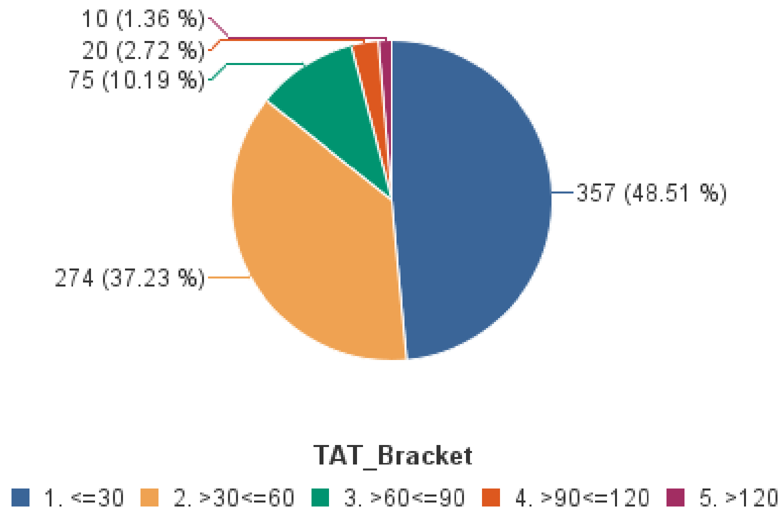
- Quality Improvement continues to track and trend PQI Turn-Around-Time (TAT) compliance. Our goal is closure of PQIs cases within 120 days from receipt to resolution via nurse investigation and procurement of medical records followed by final MD review when applicable.

- As part of an effort to streamline the PQI review process, Quality of Access issues are now being reviewed by the Access & Availability team. PQI cases open > 120 days made up 1.36% of total cases for August and 0.6% in September. Cases open for >120 days continues to be primarily related to delay in submission of

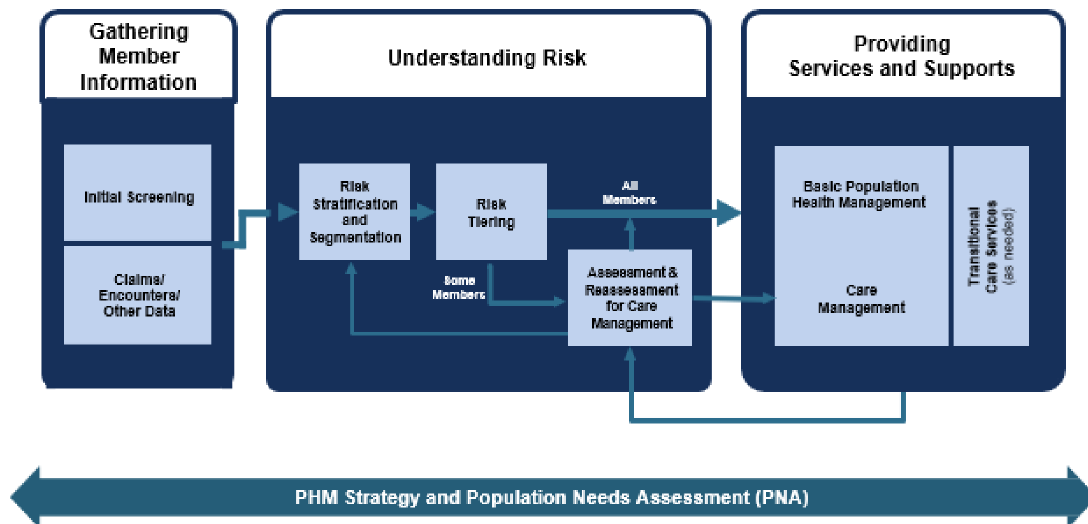
medical records by specific providers. Measures to close these cases continues to be a priority with evidence of success as seen in the reduction in open cases from August to September by 0.76%.

- It was also noted that for cases open >90 days, the percentage remains below 3%. Overall, the rate of case closure within 120 days is below the 5% benchmark as required by the PQI P&P QI-104.





- The Alliance is developing responses to a DHCS Population Health Management (PHM) Program deliverable due October 21, 2022. Our responses will demonstrate to DHCS our strategy and readiness to implement the state's requirements for Population Health Management starting January 1, 2023. We are on track for timely submission. The DHCS PHM strategy includes the following components:



- The PHM Readiness Document also asks that the Alliance address:
  - What relationships we have with community entities
  - How we will implement closed loop referrals
  - Integration of community health workers into our PHM strategy

Information Technology

Sasikumar Karaiyan

To: Alameda Alliance for Health Board of Governors

From: Sasi Karaiyan, Chief Information & Security Officer

Date: October 14th, 2022

Subject: Information Technology Report

Call Center System Availability

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

Disaster Recovery and Business Continuity

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

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

- The Business Continuity Plan document has been drafted and completed. This document will serve as a playbook to help ensure the safety of our employees, to keep the organization and members informed through communication designed channels and restore business functions in the event of a disaster.

- The Discovery and Design phase of the project for all tier 1 applications has been completed. The Implementation phase of the project is now in progress and 85% of the tier 1 servers have been successfully seeded and are now replicating to our backup data center in Roseville. Part of this phase also includes the runbook creation for each application which will incorporate the recovery procedures.

- The initial Disaster Recovery tabletop test for all tier 1 application has been completed successfully on Friday, September 30th, 2022.

- The project team is working diligently to update the recovery procedures within the runbook to 95% by the end of October 2022 and schedule the final tabletop test before the end of November 2022.

IT Security Program

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

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

    - **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 is at 85% complete, M365 is at 90% complete, Azure 100% complete and overall, 85% complete for high-severity items.

- Protecting shared cloud applications with Multi-Factor Authentication and Single Sign-On has been included in the overall project. The design modeling phase of each cloud application has been completed. Testing phase is now in-progress and will be scheduled during non-business hours.

- The Extended 24/7 Security Support project is in progress and the portal onboarding and configuration has been completed. The Arctic Wolf sensor appliances have been delivered and the first appliance has been installed in our main data center in Alameda. The second appliance has been installed in the backup data center in Roseville on September 16th, 2022. Hardware configuration is now in progress and expected to complete the overall project by the end of October 2022.

Encounter Data

- In the month of September 2022, the Alliance submitted 139 encounter files to the Department of Health Care Services (DHCS) with a total of 257,925 encounters.

Enrollment

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

HealthSuite

- A total of 148,676 claims were processed in the month of September 2022 out of which 121,587 claims auto adjudicated. This sets the auto-adjudication rate for this period to 81.8%.

TruCare

- A total of 13,481 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 and improve authorization and claim processing metrics.

- In September 2022, we made significant progress in building the portal foundation to support accepting the Behavioural Health provider forms and the Professional Services Claim Form.

Enrollment

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

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

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
September	315, 486	4,211	2,430	5,804	128	120

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 September 2022

Auto-Assignments	Member Count
Auto-assignments MC	1,479
Auto-assignments Expansion	1,307
Auto-assignments GC	48
PCP Changes (PCP Change Tool) Total	2,568

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of September 2022”.
- There were 13, 481 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 September 2022

Transaction Type	Inbound EDI Auths	Errored	Total Auths Loaded in TruCare
EDI	4,251	445	4,295
Paper to EDI	2,827	1,828	1,657
Provider Portal	2,458	548	2,395
Manual Entry	N/A	N/A	1,587
Total			9,934

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 August 2022

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	7,777	3,638	165,411	450
MCAL	86,728	2,590	6,463	949
IHSS	3,186	82	196	29
AAH Staff	176	53	1,022	3
Total	**97,867**	**6,363**	**173,092**	**1,431**

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

Top 25 Pages Viewed		
Category	**Page Name**	**August - 22**
Provider	Member Eligibility	746,002
Provider	Claim Status	165,570
Provider - Authorizations	Auth Submit	9, 481
Provider - Authorizations	Auth Search	4,158
Member My Care	Member Eligibility	3,692
Provider	Member Roster	1,941
Member Help Resources	Find a Doctor or Hospital	1,918
Member Help Resources	ID Card	1,659
Member Help Resources	Select or Change Your PCP	1,236
Member My Care	MC ID Card	954
Provider - Provider Directory	Provider Directory	796
Member My Care	My Claims Services	900
Member Help Resources	Request Kaiser as my Provider	581
Provider - Home	Forms	349
Member My Care	Authorization	472
Member My Care	My Pharmacy Medication Benefits	311
Provider - Provider Directory	Manual	230
Provider - Provider Directory	Instruction Guide	236
Member Help Resources	FAQs	203
Member Help Resources	Authorizations Referrals	166
Member Help Resources	Forms Resources	220
Member My Care	Member Benefits Materials	262
Member Help Resources	Contact Us	201

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

Member Portal Preferred Languages		
Member Group	**# of Individual User Accounts Accessed**	**Total Logins**
MCAL - English	2,590	6,463
MCAL - Spanish	-	-
MCAL - Vietnamese	-	-
MCAL - Tagalog	-	-
MCAL - Chinese	-	-
IHSS - English	82	196
IHSS - Spanish	-	-
IHSS - Vietnamese	-	-
IHSS - Tagalog	-	-
IHSS - Chinese	-	-
Total	**2,672**	**6,659**

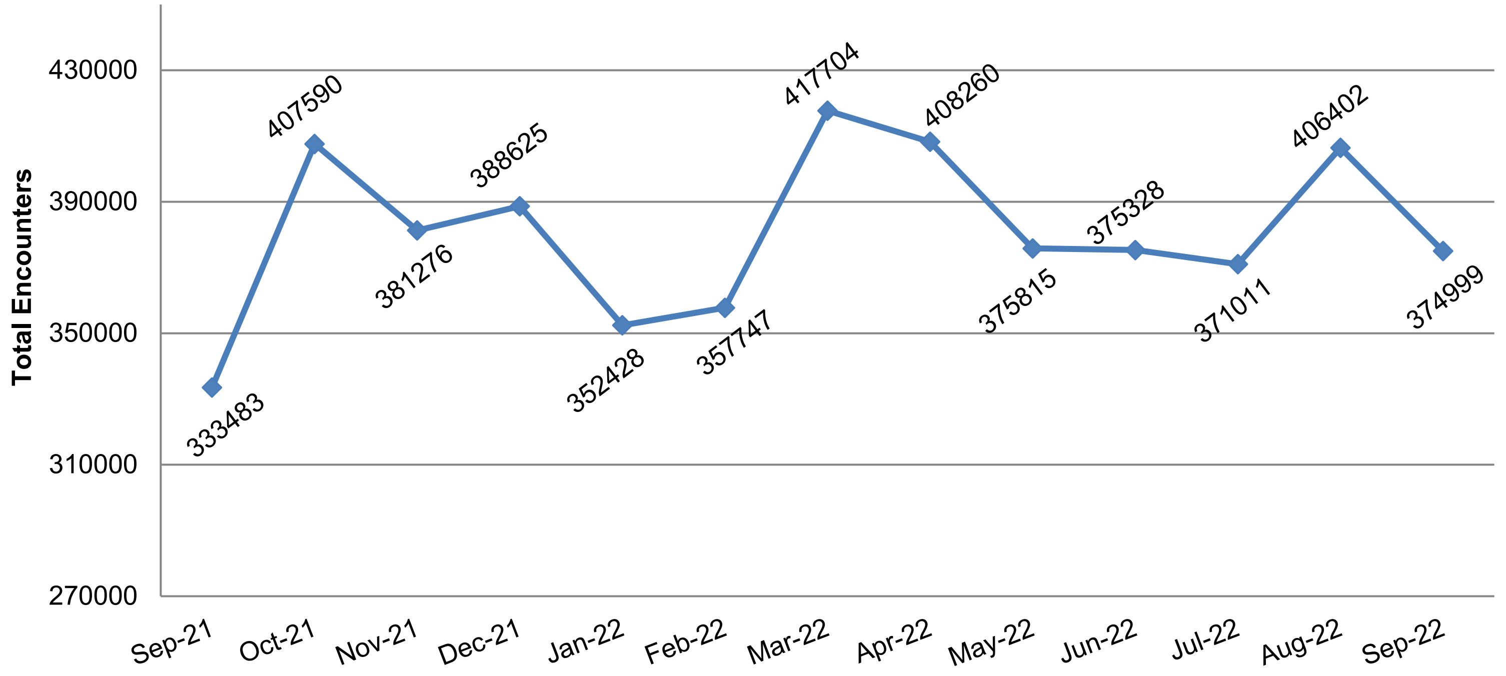
Encounter Data from Trading Partners 2022

- **AHS**: September weekly files (5,609 records) were received on time.
- **BAC**: September monthly file (37 records) were received on time.
- **Beacon**: September weekly files (16,040 records) were received on time
- **CHCN**: September weekly files (75,234 records) were received on time.
- **CHME**: September monthly file (5,191 records) were received on time.
- **CFMG**: September weekly files (6,940 records) were received on time.
- **Docustream**: September monthly files (1,715 records) were received on time.
- **HCSA**: September monthly files (4,440 records) were received on time.
- **Kaiser**: September bi-weekly files (48,613 records) were received on time.
- **LogistiCare**: September weekly files (19,257 records) were received on time.
- **March Vision**: September monthly file (3,824 records) were received on time.
- **Quest Diagnostics**: September weekly files (12,144 records) were received on time.
- **Teladoc:** September monthly files (0 records) were NOT received on time.
  - The Data Exchange team continued to reach out and escalate to its contacts with Teladoc regarding their lack of submissions.

- **Magellan**: September monthly files (309,191 records) were received on time.

Trading Partner Medical Encounter Inbound Submission History

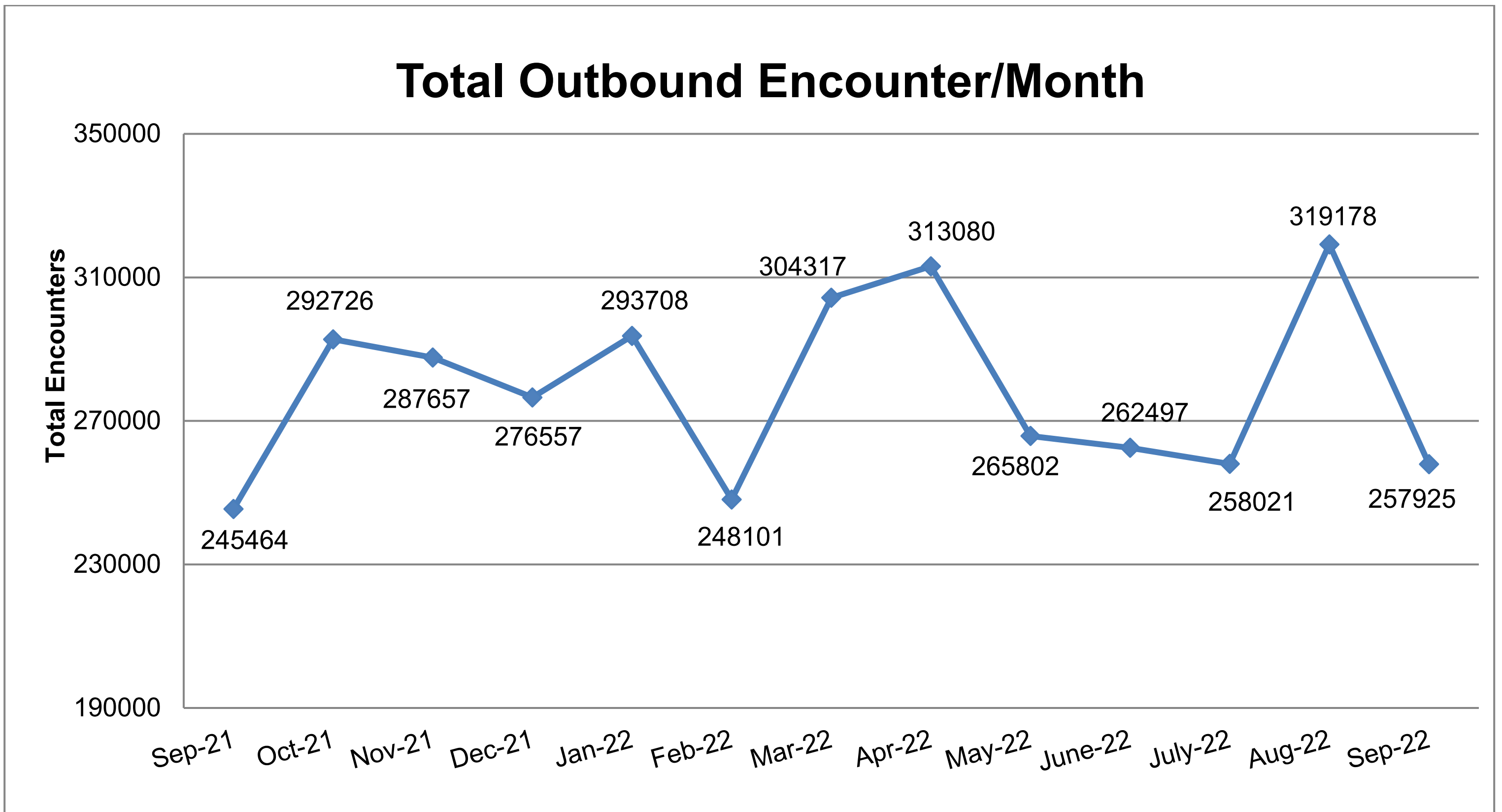
Trading Partners	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
HealthSuite	159558	177483	167057	175441	162201	162433	185738	189172	163272	173269	176217	177945	175955
AHS	7640	10625	8791	9314	6944	5630	6215	7717	6105	5486	5742	5482	5609
BAC						34	12	45	63	53	66	53	37
Beacon	14618	13693	12456	14899	9796	10966	16088	14303	13796	18340	15678	21310	16040
CHCN	60227	71581	99117	73269	75302	77276	79363	74683	80340	67339	69636	84302	75234
CHME	5393	4814	5003	4908	9254	4706	4778	4955	4551	4578	4853	4722	5191
Claimsnet	9880	15598	11032	12410	8643	13228	13522	10943	14075	10300	7744	10631	6940
Docustream	1594	1474	1185	1586	1703	1304	2130	2220	1140	1263	1236	1149	1715
HCSA							3630	2029	1824	1880	3366	1869	4440
Kaiser	44366	75112	38085	63939	46458	52179	68530	69174	51214	62952	47584	62477	48613
Logisticare	13803	16977	22403	17125	16536	16393	19841	16232	20299	14590	20981	20200	19257
March Vision	3297	3377	3584	3220	2872	1445	3559	3425	3345	3188	3040	2708	3824
Quest	13084	16841	12542	12494	12696	12121	14268	13330	15757	12058	14868	13554	12144
Teladoc	23	15	21	20	23	32	30	32	34	32	0	0	0
Total	333483	407590	381276	388625	352428	357747	417704	408260	375815	375328	371011	406402	374999



Total Encounters Received/Month
Total Encounters
430000
390000
350000
310000
270000
333483
407590
381276
388625
352428
357747
417704
408260
375815
375328
371011
406402
374999
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22

Outbound Medical Encounter Submission

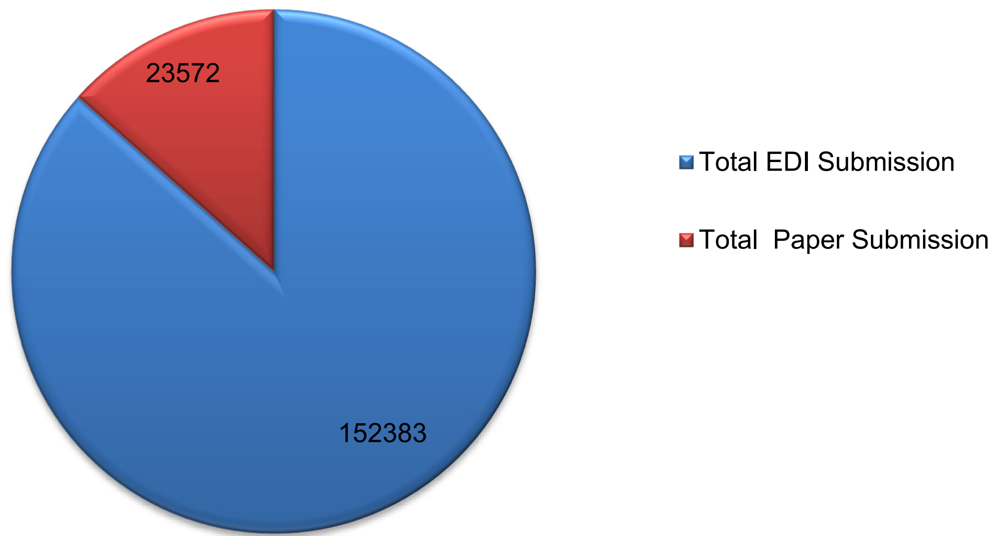
Trading Partners	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
HealthSuite	83690	100925	114507	95489	139452	97141	103843	133252	93919	90605	92682	121957	96495
AHS	7476	10176	8541	7728	7943	5524	6142	6251	7156	5363	5702	5168	4360
BAC						34	12	45	61	52	63	50	37
Beacon	9355	11423	9969	12659	7566	8140	12332	11273	9221	9534	14711	17246	12054
CHCN	54958	49171	67383	49080	52531	44745	58795	49365	49911	51060	49003	60678	50714
CHME	5280	4587	4849	4691	4496	4585	4702	4686	4448	4470	4714	4618	5069
Claimsnet	7452	10829	7406	8465	6114	9917	9677	8100	8410	7985	7209	7248	4614
Docustream	1209	1094	981	1185	1176	66	72	14	3406	854	1070	964	1436
HCSA							3112	1810	1518	1719	1579	1770	2368
Kaiser	43779	73264	37473	63433	44248	51831	67559	67177	50894	62562	47331	61831	47861
Logisticare	17657	16231	19240	19787	16309	16242	19700	16123	19777	14677	20828	20022	19001
March Vision	2483	2608	2831	2490	2175	1072	2724	2575	2464	2392	2206	1969	2631
Quest	12102	12403	14457	11531	11676	8774	15620	12378	14602	11192	10923	15657	11285
Teladoc	23	15	20	19	22	30	27	31	15	32	0	0	0
Total	245464	292726	287657	276557	293708	248101	304317	313080	265802	262497	258021	319178	257925



HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total Claims
22-Sep	152383	23572	175955

Key: EDI – Electronic Data Interchange

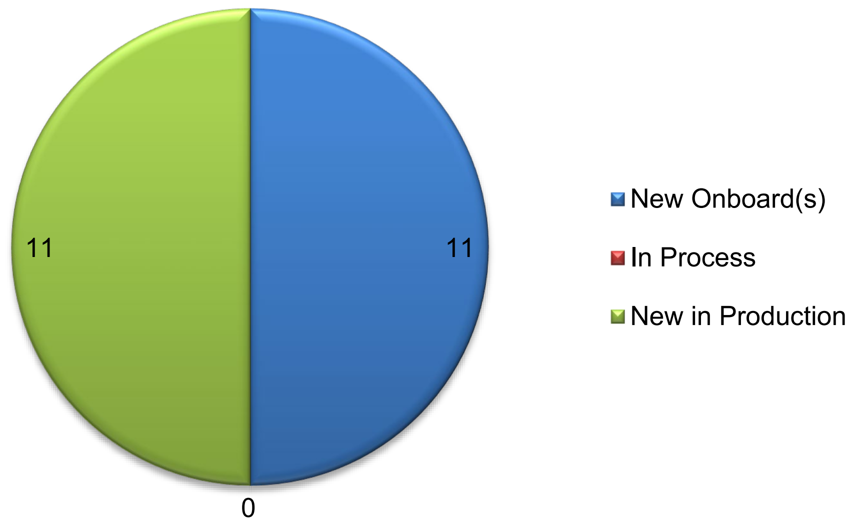


Onboarding EDI Providers - Updates

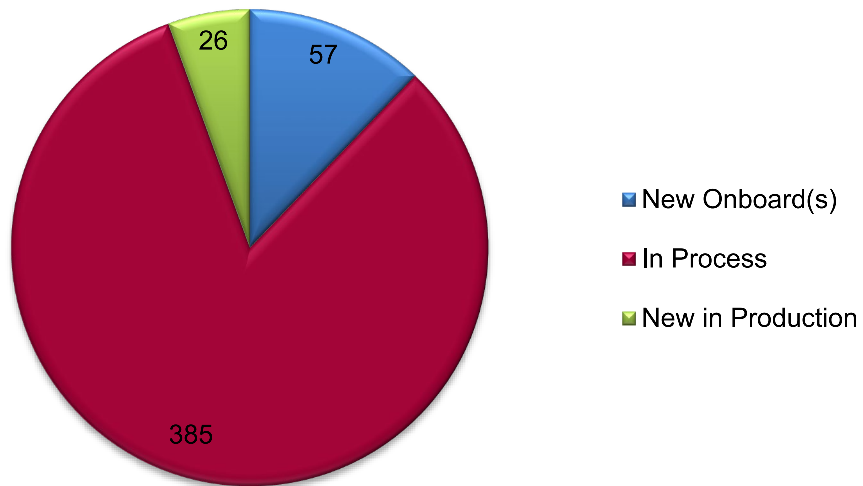
- September 2022 EDI Claims:
  - A total of 1410 new EDI submitters have been added since October 2015, with 11 added in September 2022.
  - The total number of EDI submitters is 2150 providers.

- September 2022 EDI Remittances (ERA):
  - A total of 515 new ERA receivers have been added since October 2015, with 26 added in September 2022.

	837				835			
	New On Boards	In Process	New In Production	Total In Production	New On Boards	In Process	New In Production	Total In Production
Oct-21	17	0	17	1956	30	205	18	381
Nov-21	14	0	14	1970	19	210	14	395
Dec-21	8	0	8	1978	18	223	5	400
Jan-22	29	1	28	2006	44	253	14	414
Feb-22	17	2	15	2021	20	258	15	429
Mar-22	36	0	36	2057	22	268	12	441
Apr-22	11	3	8	2065	19	275	12	453
May-22	17	3	14	2079	13	285	3	456
Jun-22	8	1	7	2086	29	301	13	469
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



837 EDI Submitters - September 2022
11
11
0
New Onboard(s)
In Process
New in Production



835 EDI Receivers - September 2022
26
57
385
New Onboard(s)
In Process
New in Production

Encounter Data Submission Reconciliation Form (EDSRF) and File Reconciliations

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

File Type	Sep-22
837 I Files	20
837 P Files	119
Total Files	139

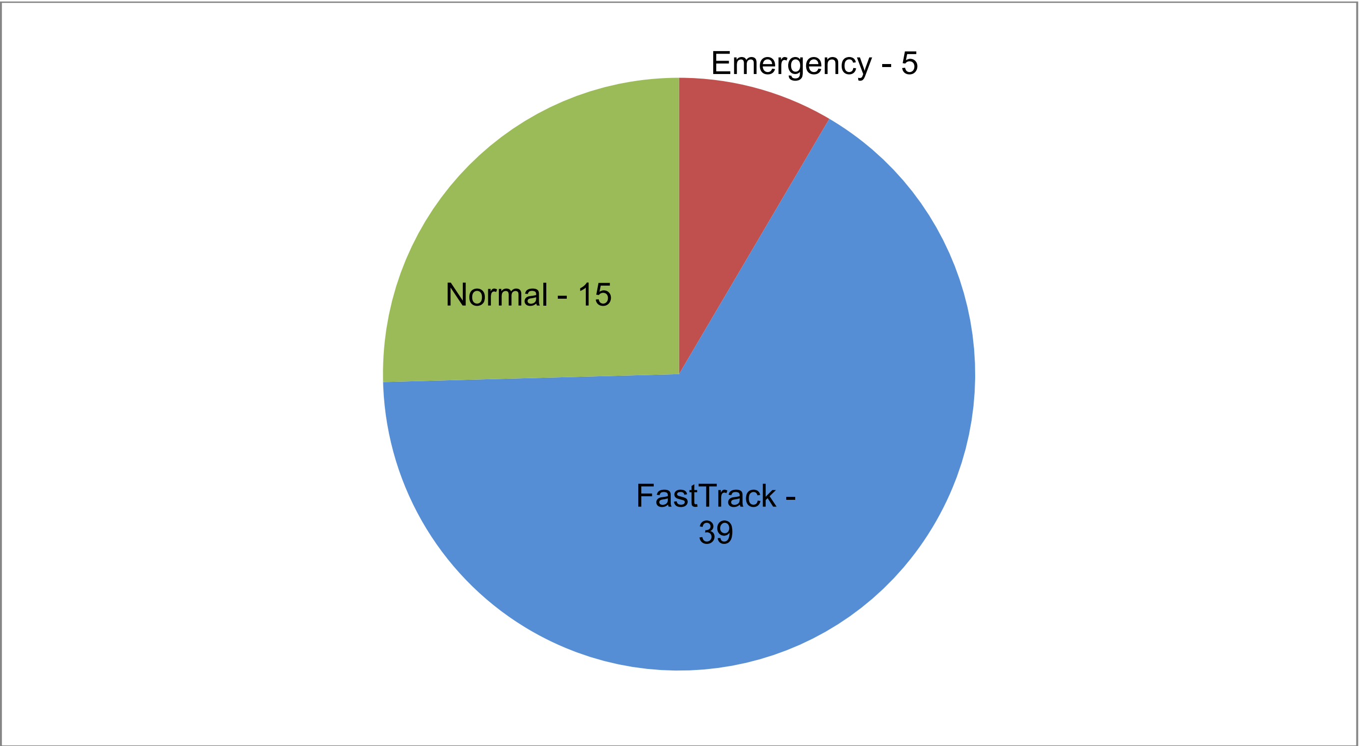
Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	Sep-22	Target
Timeliness-% Within Lag Time – Institutional 0-90 days	93%	60%
Timeliness-% Within Lag Time – Institutional 0-180 days	97%	80%
Timeliness-% Within Lag Time – Professional 0-90 days	92%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	97%	80%

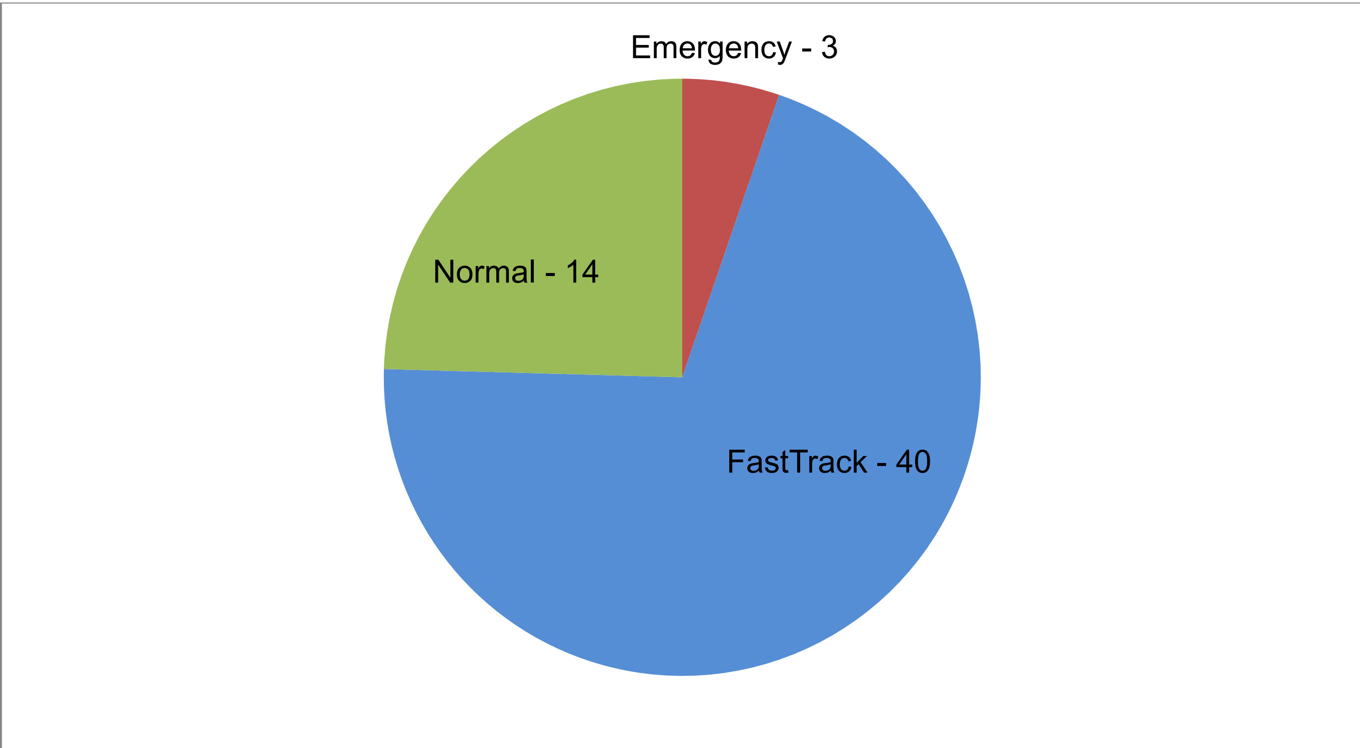
Change Management Key Performance Indicator (KPI)

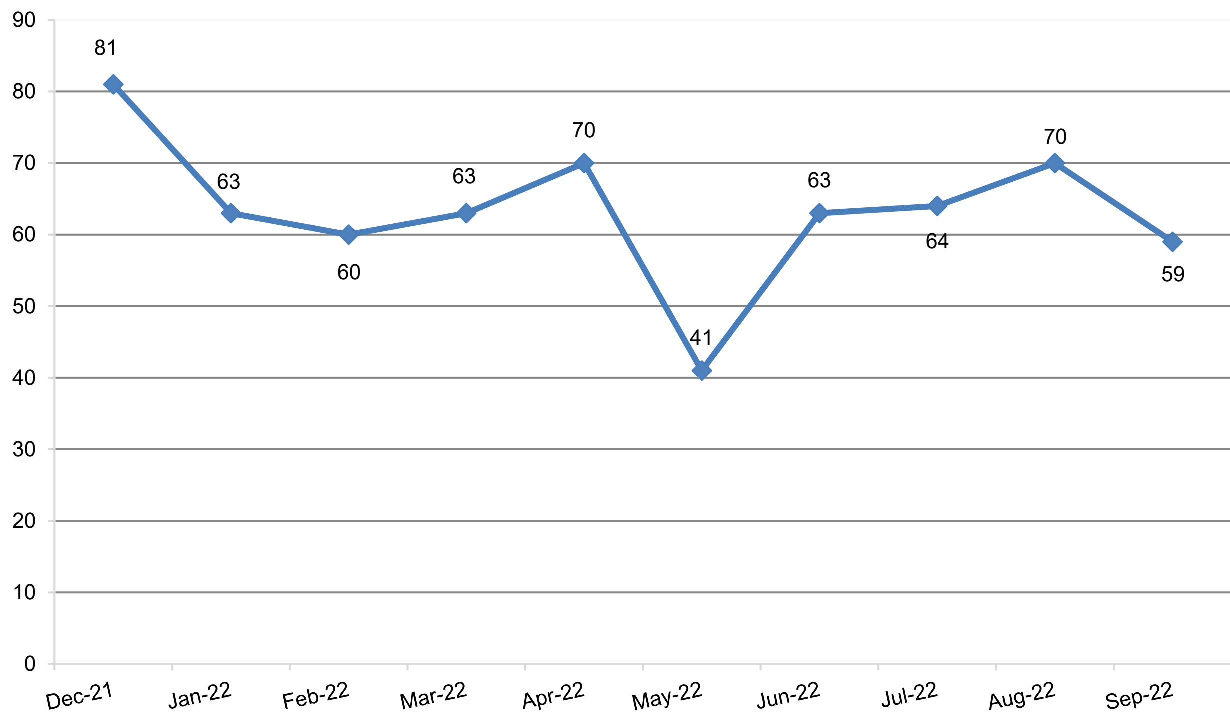
- Change Request Overall Summary in the month of September 2022 KPI:
  - 59 Changes Submitted.
  - 57 Changes Completed and Closed.
  - 166 Active Change Requests in pipeline.
  - 5 Change Requests Cancelled or Rejected.

- 59 Change Requests Submitted/Logged in the month of September 2022

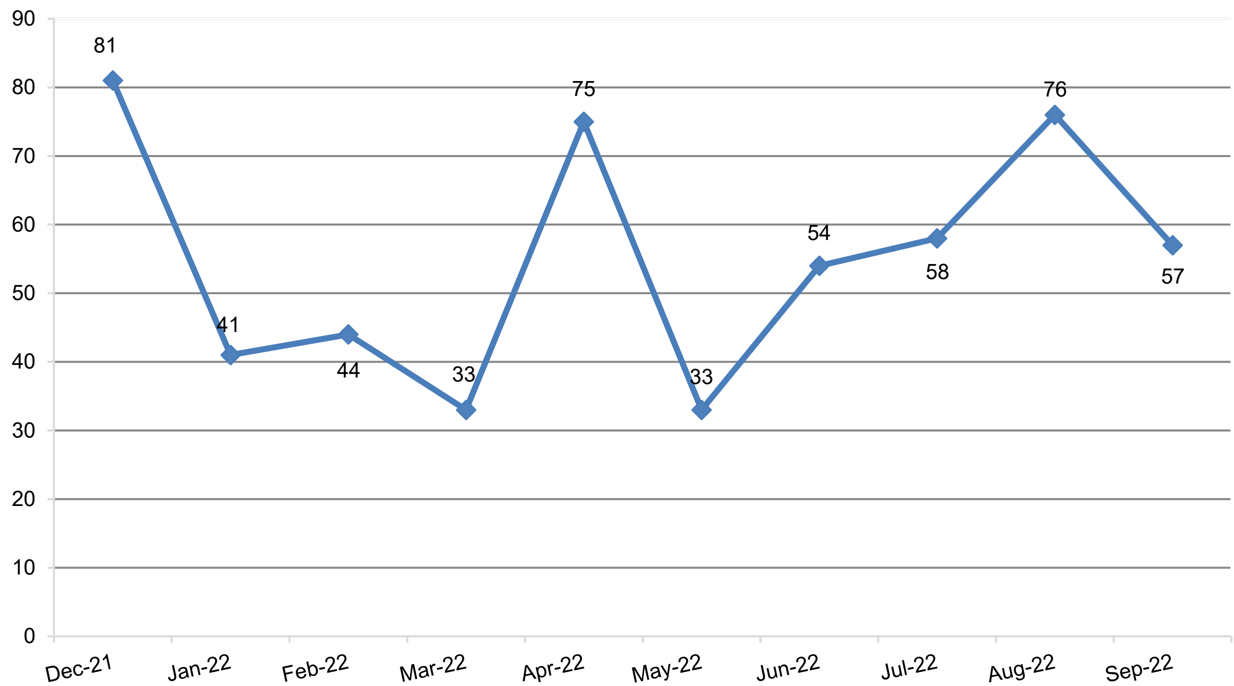


- 57 Change Requests Closed in the month of September 2022



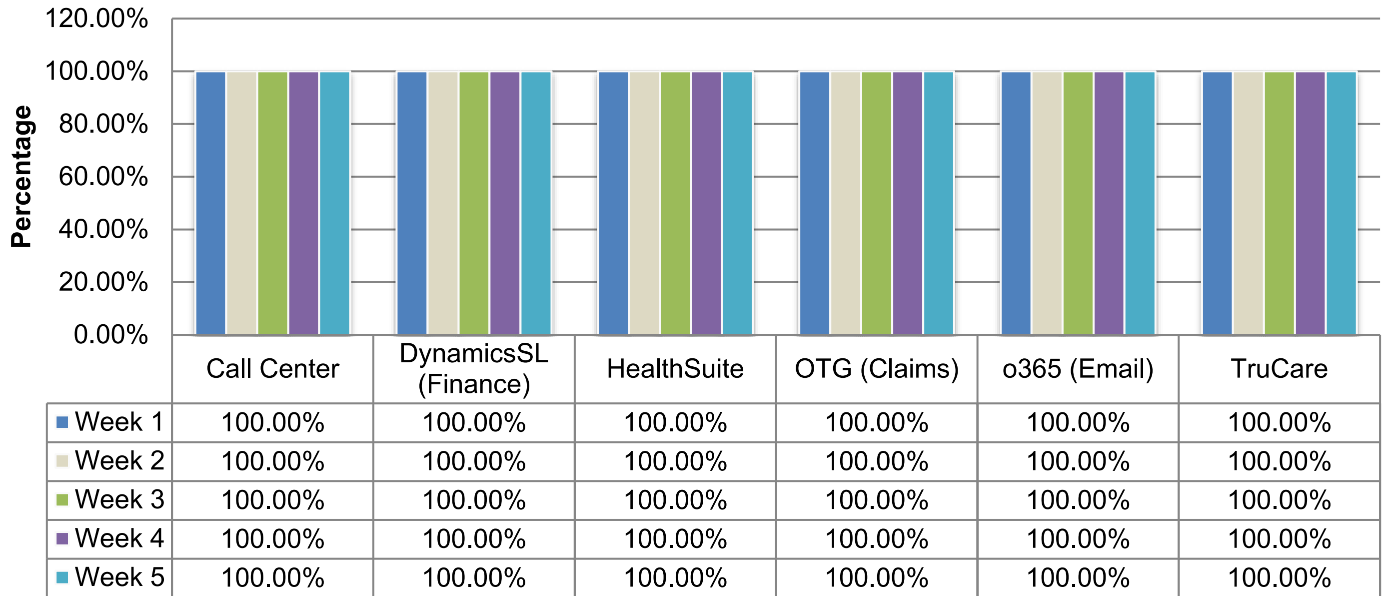


• Change Requests Submitted: Monthly Trend
90
80
70
60
50
40
30
20
10
0
81
63
60
63
70
41
63
64
70
59
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22



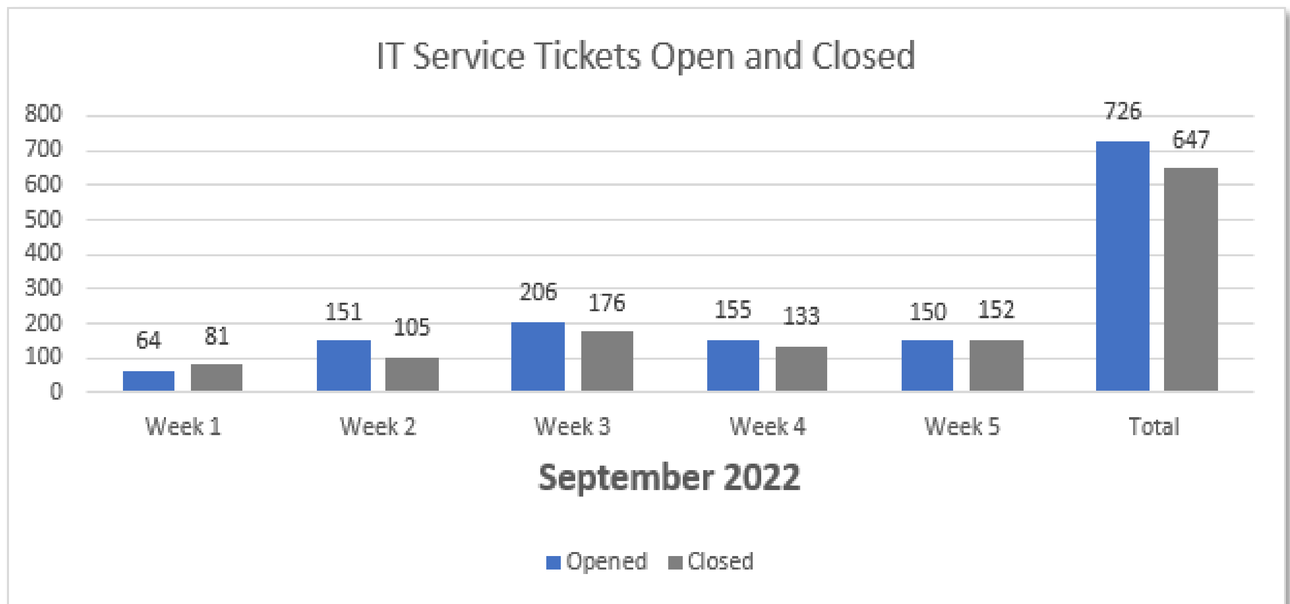
• Change Requests Closed: Monthly Trend
90
80
70
60
50
40
30
20
10
0
81
41
44
33
75
33
54
58
76
57
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22

IT Stats: Infrastructure



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

- All mission critical applications are monitored and managed thoroughly.
- There were no outages experienced in the month of September 2022.



	Week 1 (9/1 -9/4)	Week 2 (9/5- 9/11)	Week 3 (9/12- 9/18)	Week 4 (9/19 - 9/25)	Week 5 (9/26 - 9/30)	Total
Opened	64	151	206	155	150	726
Closed	81	105	176	133	152	647

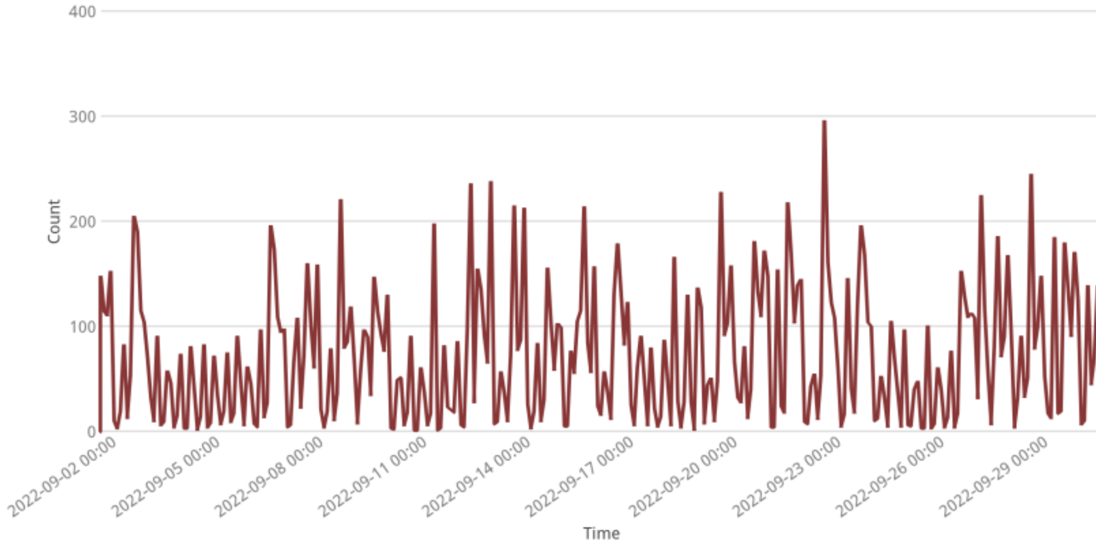
- 726 Service Desk tickets were opened in the month of September 2022, which is 11.6% higher than the previous month and 647 Service Desk tickets were closed, which is .4% lower than the previous month.

- The open ticket count for the month of September is slightly higher than the previous 3-month average of 700.

September 2022

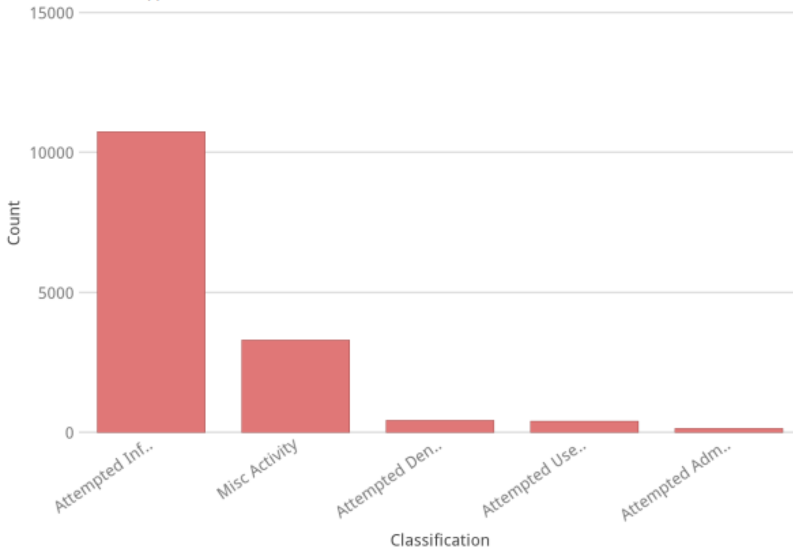
All Intrusion Events

Time Window: *2022-09-01 09:29:00 - 2022-09-30 09:29:00*



Dropped Intrusion Events

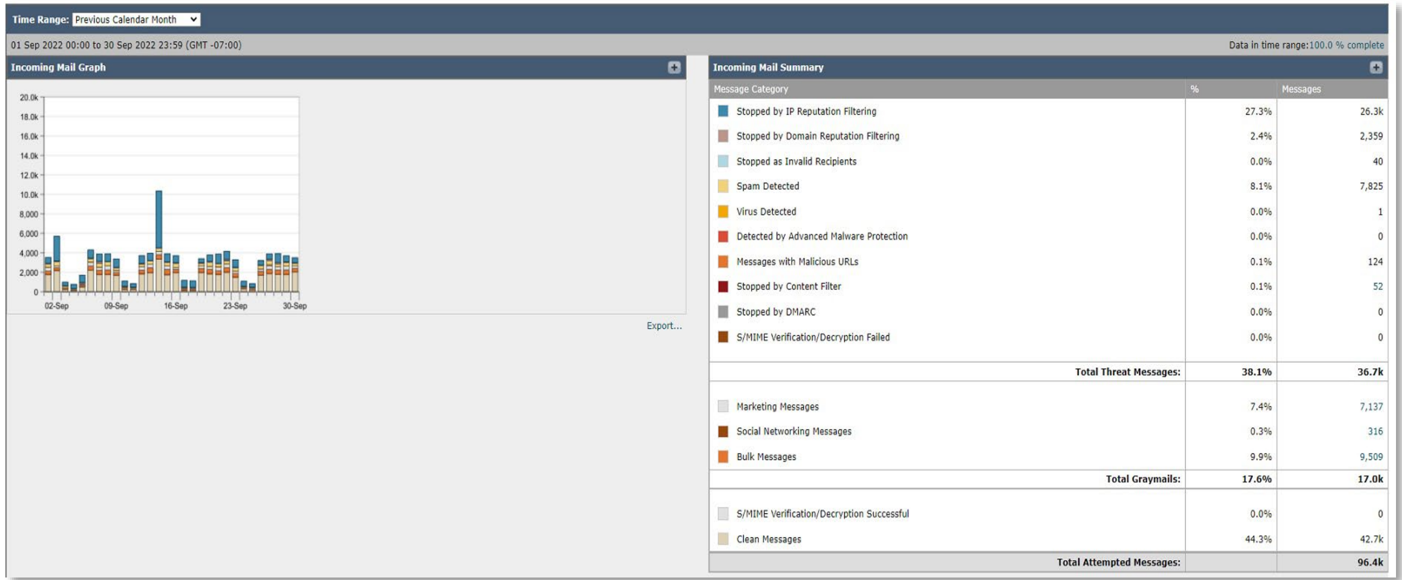
Time Window: *2022-09-01 09:30:00 - 2022-09-30 09:30:00*
Constraints: *Inline Result = dropped*



Classification	Count
Attempted Information Leak	10,748
Misc Activity	3,295
Attempted Denial of Service	436
Attempted User Privilege Gain	395
Attempted Administrator Privilege Gain	151

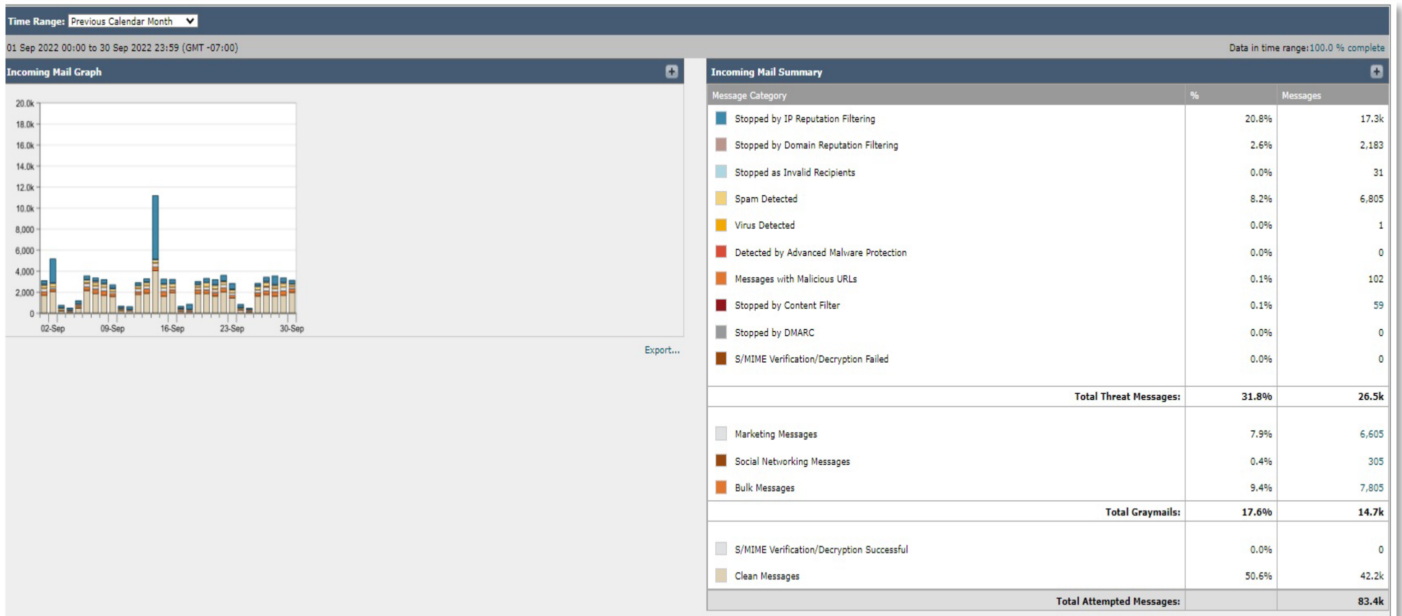
September 2022

MX4



Message Category	%	Messages
Stopped by IP Reputation Filtering	27.3%	26.3k
Stopped by Domain Reputation Filtering	2.4%	2,359
Stopped as Invalid Recipients	0.0%	40
Spam Detected	8.1%	7,825
Virus Detected	0.0%	1
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.1%	124
Stopped by Content Filter	0.1%	52
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**38.1%**	**36.7k**
Marketing Messages	7.4%	7,137
Social Networking Messages	0.3%	316
Bulk Messages	9.9%	9,509
Total Graymails:	**17.6%**	**17.0k**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	44.3%	42.7k
Total Attempted Messages:		**96.4k**

MX9



Message Category	%	Messages
Stopped by IP Reputation Filtering	20.8%	17.3k
Stopped by Domain Reputation Filtering	2.6%	2,183
Stopped as Invalid Recipients	0.0%	31
Spam Detected	8.2%	6,805
Virus Detected	0.0%	1
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.1%	102
Stopped by Content Filter	0.1%	59
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**31.8%**	**26.5k**
Marketing Messages	7.9%	6,605
Social Networking Messages	0.4%	305
Bulk Messages	9.4%	7,805
Total Graymails:	**17.6%**	**14.7k**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	50.6%	42.2k
Total Attempted Messages:		**83.4k**

Item / Date	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	**Sep-22**
Stopped By Reputation	41.5k	24.3k	39.3k	69.7k	42.4k	329.9k	52.8k	36k	36k	34.7k	28.2k	27.6k	**43.6k**
Invalid Recipients	132	82	92	153	185	69	389	117	100	119	78	117	**71**
Spam Detected	10.8k	5.6k	9,684	13.2k	10.3k	10.3k	15k	13.7k	13.9k	13.9k	11.6k	13.3k	**14.6k**
Virus Detected	14	0	1	1	5	13	1	4	18	18	1	0	**2**
Advanced Malware	2	0	0	9	0	4	2	1	0	0	0	1	**2**
Malicious URLs	7	6	43	39	16	89	41	159	296	187	93	448	**226**
Content Filter	89	27	27	8	371	54	39	115	39	125	119	79	**111**
Marketing Messages	7,383	4,489	9,221	6,147	8,864	9,588	8,864	11.3k	10.7k	12.5k	12.6k	14.5k	**13.7k**
Attempted Admin Privilege Gain	157	128	124	116	103	116	132	143	113	215	215	210	**151**
Attempted User Privilege Gain	6	6	13	49	117	663	789	401	549	157	153	722	**395**
Attempted Information Leak	3,700	7,782	9,376	13.7k	13.7k	5,813	5,192	5,207	5,924	7,839	18,414	12,210	**10,748**
Potential Corp Policy Violation	0	0	0	0	0	0	0	0	0	0	277	0	**0**
Network Scans Detected	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Web Application Attack	0	0	0	0	0	1	0	0	0	0	0	4	**0**
Attempted Denial of Service	0	0	0	0	0	0	0	50	0	86	218	215	**436**
Misc. Attack	5,733	8,550	76	161	275	626	308	78	874	88	407	733	**3,295**

- All security activity data is based on the current month’s metrics as a percentage. This is compared to the previous three month’s average, except as noted.
- Email based metrics currently monitored have increased with a return to a reputation-based block for a total of 43.6k.
- Attempted information leaks detected and blocked at the firewall is at 10,748 for the month of September 2022.
- Network scans returned a value of 0, which is in line with previous month’s data.
- Attempted User Privilege Gain is higher at 395 from a previous six-month average of 396.

Integrated Planning

Ruth Watson

To: Alameda Alliance for Health Board of Governors

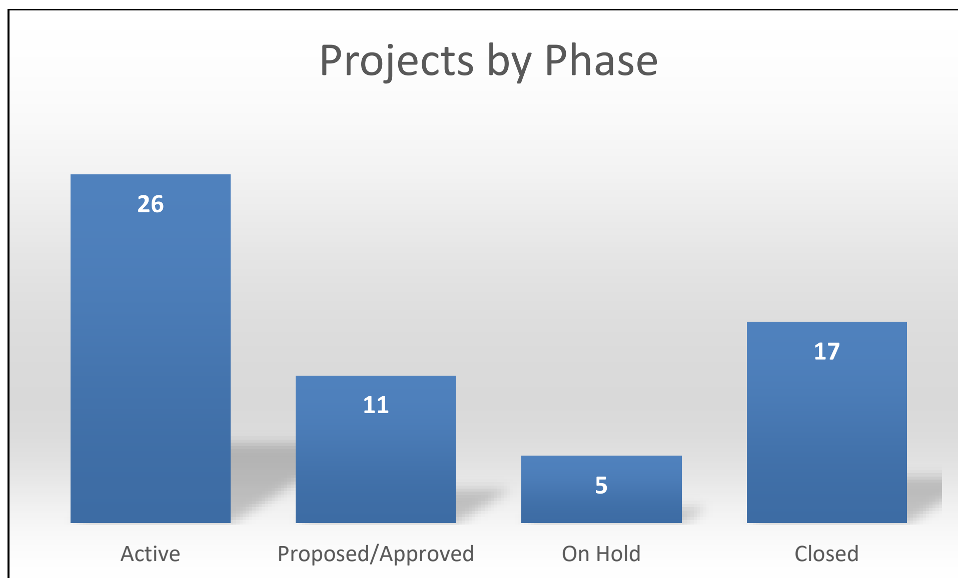
From: Ruth Watson, Chief of Integrated Planning

Date: October 14th, 2022

Subject: Integrated Planning Report

Project Management Office

- 42 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
    - 26 Active projects (discovery, initiation, planning, execution, warranty)
    - 5 On Hold projects
    - 11 Proposed and Approved Projects
    - 17 Closed projects



Integrated Planning – CalAIM Initiatives

- Enhanced Care Management (ECM) and Community Supports (CS):
    - January 2023 ECM Populations of Focus (PoF)
        - Adults Living in the Community Who Are At-Risk for LTC Institutionalization
        - Nursing Facility Residents Transitioning to the Community
        - Model of Care (MOC) Addendums
    - ECM MOC approved by DHCS on August 22nd
    - Pending approval of CS MOC

  - Submitted additional CS MOC update to DHCS on September 30th.
  - ECM MOC update due to DHCS on October 28th.

- July 2023 ECM Populations of Focus:
  - Children and Youth
    - Individuals Transitioning from Incarceration, originally scheduled for implementation in January 2023, has been re-scheduled with an implementation date of July 2023.
    - DHCS is considering adding an additional PoF of High Risk Pregnant and Postpartum Individuals."
    - MOCs for these PoF will be due to DHCS in January and March 2023.
  - Two existing ECM Providers will add the two new PoF being implemented January 2023.

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

- Long Term Care (LTC) Carve-In – AAH will be responsible for all members residing in LTC facilities as of January 1st, 2023.
  - Does not include Pediatric and Adult Subacute Facilities, Intermediate Care Facilities (ICF), or Institutions for Mental Disease (IMD) which will be implemented no earlier than July 1st, 2023.
  - Contracting and Credentialing:
    - Currently contracted with 57 facilities - Custodial Level of Care - 34 of the 57 facilities credentialed.
    - 33 PCP Providers identified; 13 contracts signed
    - Out of Area Facilities - 57 total – 12 contracts pending and 5 signed.
  - Communications:
    - Member notifications
      - Benefit Change letter will be sent to impacted members by DHCS 30 & 60 days before go live.
      - LTC Member Welcome letters, Member FAQs and Member Portal update notices will be sent by AAH.
    - Provider notifications
      - Provider FAQs, LTC Resource Guide, Provider Manual and call scripts.
      - Provider Townhall training series will occur late October, November.

- 2 LTC Utilization Management Forms being created to be uploaded on Consumer Portal.
- Individual workstreams meetings continue weekly.

- Population Health Management (PHM) Program – effective January 1st, 2023:
  - MCP 2023 PHM Readiness Submission guidance and template provided by DHCS on September 2nd.
  - Readiness Submission due to DHCS on October 21st.

- Community Health Worker Benefit – new benefit effective July 1st, 2022, to promote the MCP's contractual obligations to meet DHCS broader Population Health Management standards:
  - Initial impact assessment underway.
  - Intersects with PHM Readiness Submission due in October.

- CalAIM Incentive Payment Program (IPP) – three-year DHCS program to provide funding for the support of ECM and CS in the following areas:
  - 1) Delivery System Infrastructure
  - 2) ECM Provider Capacity Building
  - 3) Community Supports Provider Capacity Building and Community Supports Take-Up
  - Program Year 1 (PY1), Payment 1 of $7.4M (50% of PY1 funding) received from DHCS
  - AAH has received ten (10) applications for IPP Funding to date
    - $6.1M out of the $7.4M has been approved for distribution
    - As of September, initial payments totaling over $4.69M have been distributed to the applicants who were awarded IPP Funding for:
      - Delivery System Infrastructure
      - ECM/CS Provider Capacity Building for New Hire Ramp-Up
      - ECM/CS Provider Training
    - AAH is currently reviewing the Status Reports submitted by the IPP Funding Recipients to review their progress prior to releasing their final payment.
  - Program Payment 2 report submitted to DHCS on 9/1/22
    - This will determine DHCS payout of remaining 50% of PY1 funding.

Other Initiatives

- Mental Health (Mild to Moderate/Autism Spectrum Disorder) Insourcing – services currently performed by Beacon Health Options will be brought in-house as of March 31st, 2023
- Material Modification is required for submission and approval by the Department of Managed Health Care (DMHC)
  - Submission #1 submitted September 2nd and included:
    - Narrative to DMHC (E-1 Exhibit)
    - Evidence of Coverage (EOC) – Group Care and Medi-Cal
    - Member and Provider Notices
    - Medi-Cal Notifications
    - Group Care Notifications

- Submission #2 submitted September 30th and included:
  - Narrative to DMHC (E-1 Exhibit)
  - Policies & Procedures
  - Financial Assumptions
- Submission #3 targeted for October 7th and will include:
  - Full Network Analysis by Provider Services
- Boilerplate Contract and Cover Letter
  - DHCS – Submitted July 7th
    - Additional Information Request (AIR) received from DHCS; response was sent to DHCS on August 12th
    - AIR2 from DHCS was received on September 12th; response is due to DHCS on October 7th and is on track
  - DMHC – included with September 2nd submission
  - Contract distribution to providers continues and follow-up with providers who haven't returned contracts is on-going
  - Contract and Credentialing – Peer Review & Credentialing Committee (PRCC) met on September 20th
    - Credentialed:
      - Behavioral Health providers – 30
      - Applied Behavioral Analysis (ABA) providers – 42
    - Received and Pending:
      - AHS Contract – total of 73 providers
      - CHCN Contracts (8) – total of 129 providers
  - Contracts may be signed but not considered executed until credentialing application is approved.

- Communications:
  - Member Notification:
    - 60/30 Day Member Notice and FAQs approved by DHCS on July 8th
    - Impacted Member Letter – Initially submitted to DHCS in July
      - AIR1 received and response submitted to DHCS on August 22nd.
      - AIR2 received on September 8th and response submitted to DHCS on September 26th.
    - Group Care Letters –submitted to DMHC on September 2nd (same letter submitted to DHCS was used for submission to DMHC for the Group Care Member Notification
  - Provider Notification – developing FAQs and call scripts
    - Provider Notification submitted to DMHC on September 2nd
    - Provider FAQs developed and submitted
    - Provider Training and Townhall Meetings – planning deferred to December for forecasted meetings in early February
    - Member Services call script created and approved by DHCS on August 5th.
      - Identified additional edits needed by Member Services and will be resubmitted to DHCS; submission date TBD.
- Work in progress:
  - Development of Behavioral Health Initial Evaluation Web Form

- Development of business requirements:
  - HealthSuite claims requirements
  - TruCare authorization requirements
  - Portal Single Sign On for providers - Completed in Test environment and currently in QA
  - Individual workstream meetings continue.
- Deliverables, timelines, and risks will continue to be assessed frequently.
- Behavioral Health Integration (BHI) Incentive Program – DHCS pilot program commenced January 1st, 2021, and continues through December 31st, 2022
- Program Year 2, Q1 milestone payment of $320,550 expected from DHCS late September.

- Student Behavioral Health Incentive Program (SBHIP) – DHCS program commenced January 1st, 2022, and continues through December 31st, 2024:
  - MOU for Alameda County Office of Education (ACOE) approved on September 30th and has been fully executed.
  - MOUs for the Local Education Agencies (LEAs) fully executed, and the first Needs Assessment incentive payment sent to all LEAs.
  - Continued to work with Center for Healthy Schools and Communities and individual LEAs on completion of the Needs Assessment which are due October 17th.

- Housing and Homelessness Incentive Program (HHIP) – DHCS program commenced January 1st, 2022 and continues through December 31st, 2023.
- Provided high-level overview of Investment Plan (IP) to Continuum of Care (CoC) on September 22nd and received Letter of Support on September 27th
- Submitted Investment Plan (IP) to DHCS on September 30th
  - ~$26.5M in proposed investments consisting of capacity building, infrastructure support, and engagement with street medicine.

- Justice-Involved/Coordinated Re-Entry
  - January 2023 implementation has been delayed by DHCS; awaiting additional program guidance

- 2024 Managed Care Contract Operational Readiness:
  - 245 deliverables due to DHCS in three (3) phases with multiple packages included in each phase
  - Submitted Phase 1 deliverables due to DHCS on 8/12/2022 and 9/12/2022.
  - AAH moved to Group 2 for remainder of the deliverables; next submission not due until November 28th.

Recruiting and Staffing

- Project Management Open position(s):
  - Recruitment to commence or continues for the following positions:
  - Manager, Project Management Office (PMO)

- Senior Business Analyst – offer accepted and candidate scheduled to start 10/31/2022.
- Director, Incentives and Reporting
- Technical Business Analyst
- Project Manager
- Senior Program Manager, Portfolio Programs

Projects and Programs

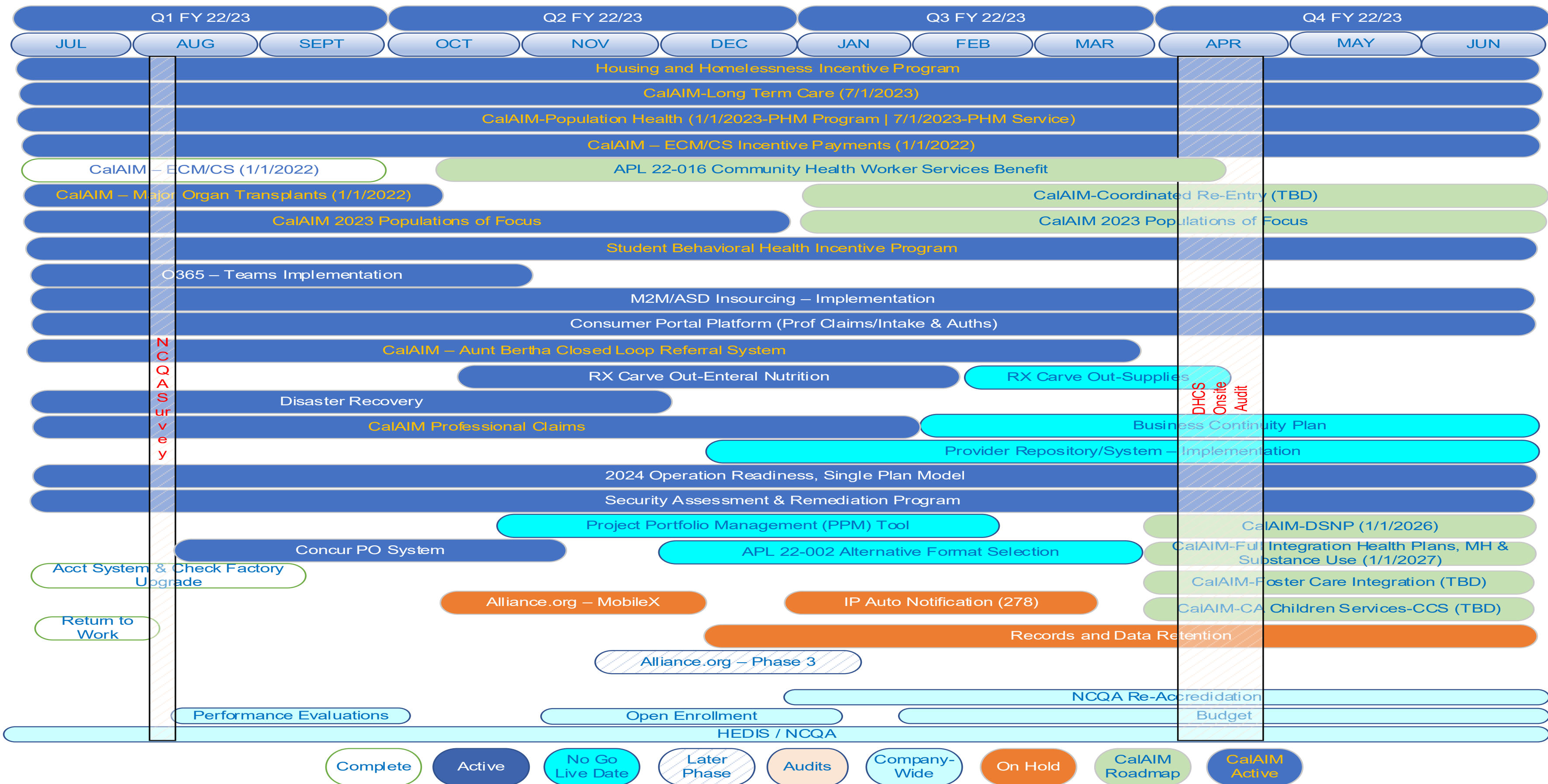
Supporting Documents

Project Descriptions

Key projects currently in-flight:

- California Advancing and Innovating Medi-Cal (CalAIM) – program to provide targeted and coordinated care for vulnerable populations with complex health needs
  - Enhanced Care Management (ECM) – ECM will target seven (7) specific populations of vulnerable and high-risk children and adults
    - Three (3) Populations of Focus (PoF) transitioned from HHP and/or WPC on January 1st, 2022.
    - Two (2) additional PoF will become effective on January 1st, 2023.
    - Two (2) PoF will become effective on July 1st, 2023.
  - Community Supports (CS) effective January 1st, 2022 – menu of optional services, including housing-related and flexible wraparound services, to avoid costlier alternatives to hospitalization, skilled nursing facility admission and/or discharge delays
    - Six (6) Community Supports were implemented on January 1st, 2022
    - Two (2) additional CS services are targeted for implementation by January 1st, 2024
    - Additional CS services may be required to be implemented to support the two LTC PoF that are effective January 2023
  - Major Organ Transplants (MOT) – currently not within the scope of many Medi-Cal managed care plans (MCPs); carved into all MCPs effective January 1st, 2022
    - Applicable to all adults as well as children if the transplant is not covered by California Children's Services
  - CalAIM Incentive Payment Program (IPP) – The CalAIM ECM and CS programs will require significant new investments in care management capabilities, ECM and CS infrastructure, information technology (IT) and data exchange, and workforce capacity across MCPs, city and county agencies, providers and other community-based organizations. CalAIM incentive payments are intended to:
    - Build appropriate and sustainable ECM and ILOS capacity.
    - Drive MCP investment in necessary delivery system infrastructure
    - Incentivize MCP take-up of ILOS.
    - Bridge current silos across physical and behavioral health care service delivery.
    - Reduce health disparities and promote health equity.
    - Achieve improvements in quality performance.
  - Long Term Care - currently not within the scope of many Medi-Cal MCPs; will be carved into all MCPs effective January 1st, 2023.
    - ICF, IMD and Subacute facilities will be implemented July 1st, 2023
  - Justice Involved/Coordinated Re-Entry – adults and children/youth transitioning from incarceration or juvenile facilities will be enrolled into Medi-Cal upon release.
    - Originally scheduled for January 1st, 2023, but has now been delayed by DHCS with a targeted implementation date of July 2023
  - Population Health Management (PHM) – all Medi-Cal managed care plans will be required to develop and maintain a whole system, person-centered population health management strategy effective January 1st, 2023.

        - PHM is a cohesive plan of action for addressing member needs across the continuum of care based on data driven risk stratification, predictive analytics, and standardized assessment processes.
- 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.
- Project Portfolio Management (PPM) Tool – vendor demonstrations complete and tool selected; target implementation in FY 2022-23.
- 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.
    - Meetings completed with Alameda County Office of Education (ACOE), Center for Healthy Schools and Communities (CHSC) and interested Local Education Agencies (LEAs) to begin work on Needs Assessment which will identify which of the fourteen (14) Targeted Interventions are a priority for Alameda County.
    - Needs Assessment and Project Plans for the selected Targeted Interventions are due to DHCS by December 31st, 2022.
- Housing and Homelessness Incentive Program (HHIP) – program launched in January 2022 and is part of the Home and Community-Based (HCBS) Spending Plan
    - Enables MCPs to earn incentive funds for making progress in addressing homelessness and housing insecurity as social determinants of health
    - MCPs must collaborate with local homeless Continuums of Care (CoCs) and submit a Local Homelessness Plan (LHP) to be eligible for HHIP funding
        - LHP submitted to DHCS on June 30th, 2022.
        - LHP is expected to be in alignment with local Homeless Housing, Assistance and Prevention (HHAP) grant application.
        - In counties with more than one MCP, MCPs need to work together to submit one LHP per county.
        - Investment Plan due to DHCS by September 30th, 2022.
- 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 1st, 2024.


Q1 FY 22/23
Q2 FY 22/23
Q3 FY 22/23
Q4 FY 22/23
JUL
AUG
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APR
MAY
JUN
Housing and Homelessness Incentive Program
CalAIM-Long Term Care (7/1/2023)
CalAIM-Population Health (1/1/2023-PHM Program | 7/1/2023-PHM Service)
CalAIM – ECM/CS Incentive Payments (1/1/2022)
CalAIM – ECM/CS (1/1/2022)
APL 22-016 Community Health Worker Services Benefit
CalAIM – Major Organ Transplants (1/1/2022)
CalAIM-Coordinated Re-Entry (TBD)
CalAIM 2023 Populations of Focus
CalAIM 2023 Populations of Focus
Student Behavioral Health Incentive Program
O365 – Teams Implementation
M2M/ASD Insourcing – Implementation
Consumer Portal Platform (Prof Claims/Intake & Auths)
CalAIM – Aunt Bertha Closed Loop Referral System
RX Carve Out-Enteral Nutrition
RX Carve Out-Supplies
Disaster Recovery
NCQA Survey
DHCS Onsite Audit
CalAIM Professional Claims
Business Continuity Plan
Provider Repository/System – Implementation
2024 Operation Readiness, Single Plan Model
Security Assessment & Remediation Program
Project Portfolio Management (PPM) Tool
CalAIM-DSNP (1/1/2026)
Concur PO System
APL 22-002 Alternative Format Selection
CalAIM-Full Integration Health Plans, MH & Substance Use (1/1/2027)
Acct System & Check Factory Upgrade
CalAIM-Foster Care Integration (TBD)
Alliance.org – MobileX
IP Auto Notification (278)
CalAIM-CA Children Services-CCS (TBD)
Return to Work
Records and Data Retention
Alliance.org – Phase 3
NCQA Re-Accredidation
Performance Evaluations
Open Enrollment
Budget
HEDIS / NCQA
Complete
Active
No Go Live Date
Later Phase
Audits
Company-Wide
On Hold
CalAIM Roadmap
CalAIM Active

Performance & Analytics

Tiffany Cheang

To: Alameda Alliance for Health Board of Governors

From: Tiffany Cheang, Chief Analytics Officer

Date: October 14th, 2022

Subject: Performance & Analytics Report

Member Cost Analysis

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

- For the Current reporting period, the top 9.3% of members account for 84.4% of total costs.

- In comparison, the Prior reporting period was lower at 8.5% of members accounting for 83.6% of total costs.

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

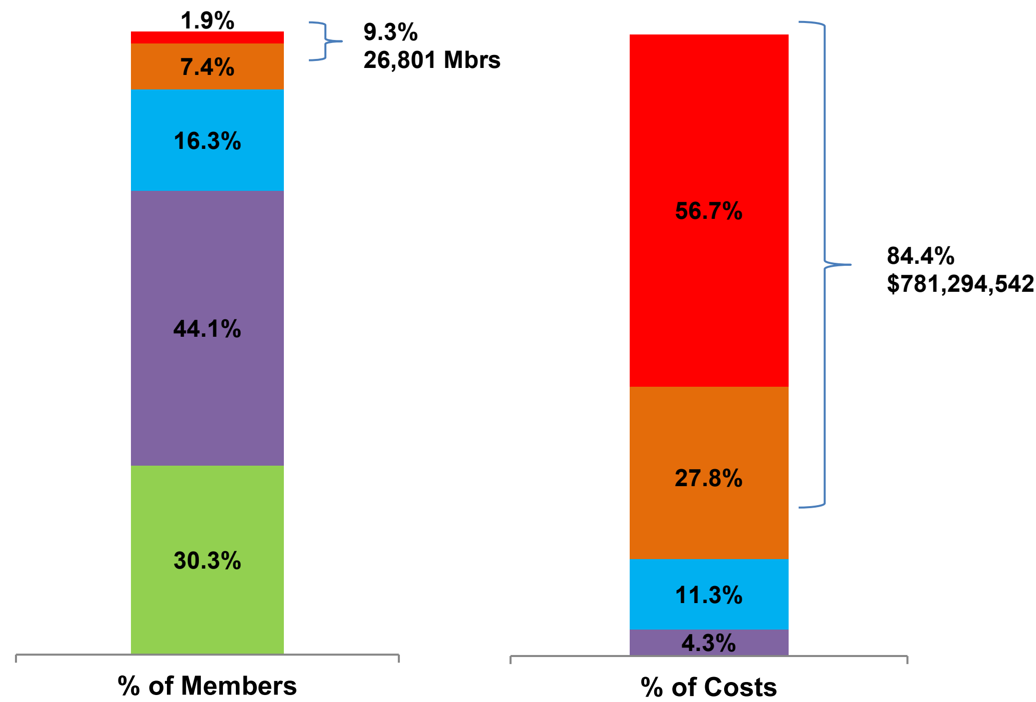
  - The SPD (non-duals) and ACA OE categories of aid slightly increased to account for 60.8% of the members, with SPDs accounting for 26.7% and ACA OE's at 34.1%.
  - The percent of members with costs >= $30K slightly increased from 1.8% to 1.9%.
  - Of those members with costs >= $100K, the percentage of total members has slightly increased to 0.5%.
    - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 48.8%.

- Demographics for member city and gender for members with costs >= $30K follow the same distribution as the overall Alliance population.
  - However, the age distribution of the top 9.3% is more concentrated in the 45–66-year-old category (40.0%) compared to the overall population (20.8%).

Analytics

Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Jul 2021 - Jun 2022
Note: Data incomplete due to claims lag
Run Date: 09/29/2022



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	5,586	1.9%	$ 524,432,491	56.7%
$5K - $30K	21,215	7.4%	$ 256,862,051	27.8%
$1K - $5K	47,028	16.3%	$ 104,422,253	11.3%
< $1K	127,084	44.1%	$ 39,487,542	4.3%
$0	87,432	30.3%	$ -	0.0%
Totals	**288,345**	**100.0%**	**$ 925,204,337**	**100.0%**

Top 9.3% of Members = 84.4% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	1,339	0.5%	$ 299,296,414	32.3%
$75K to $100K	690	0.2%	$ 59,547,328	6.4%
$50K to $75K	1,277	0.4%	$ 78,037,192	8.4%
$40K to $50K	887	0.3%	$ 39,578,219	4.3%
$30K to $40K	1,393	0.5%	$ 47,973,338	5.2%
SubTotal	***5,586***	***1.9%***	***$ 524,432,491***	***56.7%***
$20K to $30K	2,953	1.0%	$ 71,837,213	7.8%
$10K to $20K	8,009	2.8%	$ 111,702,931	12.1%
$5K to $10K	10,253	3.6%	$ 73,321,906	7.9%
SubTotal	***21,215***	***7.4%***	***$ 256,862,051***	***27.8%***
Total	**26,801**	***9.3%***	**$ 781,294,542**	***84.4%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Jun 2022	265,620	$ 830,136,696
Dis-Enrolled During Year	22,725	$ 95,067,641
Totals	**288,345**	**$ 925,204,337**

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
9.3% of Members = 84.4% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Jul 2021 - Jun 2022
Note: Data incomplete due to claims lag
Run Date: 09/29/2022

9.3% of Members = 84.4% of Costs
26.7% of members are SPDs and account for 32.4% of costs.
34.1% of members are ACA OE and account for 33.8% of costs.
6.5% of members disenrolled as of Jun 2022 and account for 11.4% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	138	614	752	2.8%
MCAL	MCAL - ADULT	629	3,885	4,514	16.8%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	275	1,763	2,038	7.6%
	MCAL - ACA OE	1,828	7,320	9,148	34.1%
	MCAL - SPD	1,976	5,181	7,157	26.7%
	MCAL - DUALS	101	1,343	1,444	5.4%
Not Eligible	Not Eligible	639	1,109	1,748	6.5%
Total		**5,586**	**21,215**	**26,801**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 9,929,984	$ 6,679,953	$ 16,609,937	2.1%
MCAL	MCAL - ADULT	$ 51,978,088	$ 45,228,387	$ 97,206,476	12.4%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 16,242,926	$ 20,097,241	$ 36,340,167	4.7%
	MCAL - ACA OE	$ 176,234,211	$ 87,971,121	$ 264,205,332	33.8%
	MCAL - SPD	$ 186,622,806	$ 66,874,991	$ 253,497,797	32.4%
	MCAL - DUALS	$ 7,989,924	$ 16,115,293	$ 24,105,216	3.1%
Not Eligible	Not Eligible	$ 75,434,552	$ 13,895,064	$ 89,329,616	11.4%
Total		**$ 524,432,491**	**$ 256,862,051**	**$ 781,294,542**	**100.0%**

Highest Cost Members; Cost Per Member >= $100K
36.4% of members are SPDs and account for 35.1% of costs.
33.4% of members are ACA OE and account for 34.6% of costs.
15.5% of members disenrolled as of Jun 2022 and account for 17.0% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	22	1.6%
MCAL	MCAL - ADULT	131	9.8%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	25	1.9%
	MCAL - ACA OE	447	33.4%
	MCAL - SPD	488	36.4%
	MCAL - DUALS	18	1.3%
Not Eligible	Not Eligible	208	15.5%
Total		**1,339**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 4,144,095	1.4%
MCAL	MCAL - ADULT	$ 27,164,307	9.1%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 4,687,502	1.6%
	MCAL - ACA OE	$ 103,608,175	34.6%
	MCAL - SPD	$ 104,982,570	35.1%
	MCAL - DUALS	$ 3,749,962	1.3%
Not Eligible	Not Eligible	$ 50,959,803	17.0%
Total		**$ 299,296,414**	**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+	7%	0%	0%	6%	56%	1%	14%	6%	2%	7%
$75K to $100K	7%	0%	1%	9%	43%	3%	8%	5%	8%	12%
$50K to $75K	7%	0%	1%	8%	43%	4%	8%	7%	7%	13%
$40K to $50K	8%	1%	0%	8%	44%	6%	6%	5%	3%	14%
$30K to $40K	13%	1%	1%	7%	33%	14%	8%	6%	1%	16%
$20K to $30K	5%	2%	1%	9%	30%	8%	8%	7%	1%	16%
$10K to $20K	1%	0%	1%	10%	28%	6%	11%	9%	1%	14%
$5K to $10K	0%	0%	0%	10%	17%	8%	12%	14%	1%	18%
Total	**6%**	**0%**	**1%**	**8%**	**42%**	**5%**	**11%**	**7%**	**3%**	**12%**

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

Human Resources

Anastacia Swift

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

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

Date: **October 14th, 2022**

Subject: **Human Resources Report**

Staffing

- As of October 1st, 2022, the Alliance had 382 full time employees and 1-part time employee.
- On October 1st, 2022, the Alliance had 82 open positions in which 34 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 48 positions open to date. The Alliance is actively recruiting for the remaining 48 positions and several of these positions are in the interviewing or job offer stage.
- Summary of open positions by department:

Department	Open Positions October 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	27	13	14
Operations	27	12	15
Healthcare Analytics	2	0	2
Information Technology	3	1	2
Finance	7	1	6
Regulatory Compliance	7	5	2
Human Resources	5	1	4
Integrated Planning	4	1	3
Total	82	34	48

- Our current recruitment rate is 17%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in September 2022 included:
  - 5 years:
    - Jennifer Leung (Facilities & Support Services)
    - Benita Ochoa (Pharmacy Services)
  - 6 years:
    - Natalie McDonald (Utilization Management)
    - Sasi Karaiyan (Information Technology)
    - Ed De Ocampo (IT Infrastructure)
    - Tami Lewis (Integrated Planning)
    - Pandiyarajan Subburaman (IT Development)
    - Sankar Rathnasamy (IT Development)
    - Anthony Taylor (Finance)
  - 7 years:
    - Smita Kaza (IT Ops & Quality Applications Management)
    - Shirish Mallavolu (Healthcare Analytics)
    - Dacheng Peng (IT Development)
  - 9 years:
    - Hellai Momen (Quality Improvement)
    - Alexandra Loza (Complaints & Resolutions)
    - Catherine Patrick (Case & Disease Management)
  - 10 years:
    - BJ Gerona (Information Technology)
  - 18 years:
    - Carol van Oosterwijk (Finance)
  - 20 years:
    - Steve Le (Community Relations)