Board of Governors

Regular Meeting

Friday, May 10, 2019
12:00 p.m. – 2:00 p.m.

1240 South Loop Road, Alameda, CA 94502

AGENDA

BOARD OF GOVERNORS
Regular Meeting
Friday, May 10, 2019
12:00 p.m. – 2:00 p.m.

1240 South Loop Road
Alameda, CA 94502

Speaker's Card/Request to Speak: If you would like to address the Board on a scheduled agenda item, please complete the Request to Speak Form. The card is at the table at the entrance to the Board Room. Please identify on the card your name, address (optional), and the item on which you would like to speak and return to the Clerk of the Board. The Request to Speak Form assists the Chair in ensuring that all persons wishing to address the Board are recognized. Your name will be called at the time the matter is heard by the Board.

1. CALL TO ORDER

A regular meeting of the Alameda Alliance for Health Board of Governors will be called to order on May 10, 2019 at 12:00 p.m. at 1240 South Loop Road, Alameda, California, by Dr. Evan Seevak, Presiding Officer.

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) REVIEW AND APPROVE APRIL 2019 BOARD OF GOVERNORS MEETING MINUTES

b) 2018 UTILIZATION MANAGEMENT PROGRAM EVALUATION

c) 2018 QUALITY IMPROVEMENT PROGRAM EVALUATION

d) 2018 CM - DM EVALUATION

e) 2019 UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

f) 2019 UTILIZATION MANAGEMENT WORK PLAN

g) 2019 QUALITY IMPROVEMENT PROGRAM DESCRIPTION

h) 2019 QUALITY IMPROVEMENT WORK PLAN

i) 2019 CASE MANAGEMENT DESCRIPTION

j) **2019 CASE MANAGEMENT WORK PLAN**

6. **BOARD MEMBER REPORTS**

   a) **COMPLIANCE ADVISORY GROUP**

   b) **FINANCE COMMITTEE**

7. **CEO UPDATE**

8. **BOARD BUSINESS**

   a) **REVIEW AND APPROVE MARCH 2019 MONTHLY FINANCIAL STATEMENTS**

9. **STANDING COMMITTEE UPDATES**

   a) **PEER REVIEW AND CREDENTIALING COMMITTEE**

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

11. **PUBLIC COMMENTS (NON-AGENDA ITEMS)**

12. **ADJOURNMENT**

NOTICE TO THE PUBLIC

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

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

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 in the Alameda Alliance for Health Offices located 1240 S. Loop Road, Alameda, California. 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 list 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 at the Alameda Alliance for Health Offices located 1240 S. Loop Road for public review and copying. Please call the Clerk of the Board at 510-747-6160 for assistance or any additional information.

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.

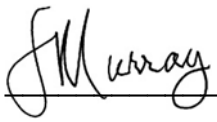
Public Input: If you are interested in addressing the Board, please fill out a form provided at the meeting with your full name and address. These forms are submitted to the Clerk of the Board at the front of the room. The Chair of the Board will call your name to speak when your item is considered. When you speak to the Board, state your full name and address for the record.

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 Alameda Alliance for Health Offices located 1240 S. Loop Road, during normal business hours. In addition, such writings or documents will be made available for public review at the respective public meeting.

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 or at the time he/she addresses the Board of Governors. Please provide 15 copies of the information to be submitted and file with the Clerk of the Board at the time of arrival to the meeting. This information will be disseminated to the Board of Governors 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 meeting was posted in the posting book located at 1240 S. Loop Road, Alameda, California on May 6, 2019 by 12:00 p.m. as well as on the Alameda Alliance for Health's web page at www.alamaedaalliance.org.



Clerk of the Board – Jeanette Murray

ALAMEDA Alliance FOR HEALTH

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

Consent Calendar

ALAMEDA ALLIANCE FOR HEALTH
BOARD OF GOVERNORS
REGULAR MEETING

April 12, 2019
12:00 pm – 2:00 pm
1240 South Loop Road, Alameda, CA

SUMMARY OF PROCEEDINGS

Board Members Present: Dr. Evan Seevak (Chair), Rebecca Gebhart (Vice Chair), Feda Almaliti, Dr. Noha Aboelata, Wilma Chan, Dr. Rollington Ferguson, Delvecchio Finley, Marty Lynch, Dr. Michael Marchiano, Dr. Kelly Meade, Will Scott, Travis Stein
Excused: Aarondeep Basrai, Nick Peraino, David B. Vliet
Alliance Staff Present: Scott Coffin, Tiffany Cheang, Sasikumar Karaiyan, Dr. Steve O'Brien, Gil Riojas, Matt Woodruff

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
1. CALL TO ORDER			
R. Gebhart	The regular board meeting was called to order by R. Gebhart at 12:06 PM. A board quorum was established by a simple majority for the meeting.	None	None
2. ROLL CALL			
R. Gebhart		None	None
3. AGENDA APPROVAL OR MODIFICATIONS			
R. Gebhart	There were no modifications to the agenda.	None	None
4. INTRODUCTIONS			
R. Gebhart	Introductions made for those present	None	None
5. CONSENT CALENDAR			

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
R. Gebhart	R. Gebhart requested a motion to approve the Consent Calendar: • March 8, 2019 Board of Governors Meeting Minutes. o W. Scott moved to approve the Consent Calendar. The motion was seconded by M. Marchiano. The motion passed unanimously.	Meeting Minutes Motion: W. Scott Second: M. Marchiano Motion passed unanimously.	None
6. a. BOARD MEMBER REPORT – COMPLIANCE ADVISORY GROUP			
R. Gebhart	R. Gebhart provided the following updates from the Compliance Advisory Committee. Board member who participated was W. Scott. The committee tracks DHCS, DMHC, and internally identified findings. • All of the Corrective Action Plans have been completed or are in the process of being verified. • The committee spent most of their time discussing the importance of the new focus areas of the DHCS. o Increased focus on quality, including HEDIS and NCQA. The State is adding new measures retroactive to January 2019 in regards to preventative health, specifically pediatric preventative health. o Delegation Oversight – The State is requiring all plans to attend more closely to their delegation oversight to include annual auditing, reporting, and monitoring. They will be checking quality and compliance of our delegates. o Quality, completeness, and accuracy of encounter data. M. Lynch asked if there are different levels of oversight based on levels of capitation. G. Riojas answered that the levels of oversight would be different for those entities that are delegated to do more. R. Gebhart asked if it would be possible to have a presentation on Delegation Oversight at a future meeting. Specifically a grid that shows all the delegates and what program areas are within their		Presentation on Delegation Oversight for purpose of

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	agreements, showing who is responsible for what when it comes to monitoring. E. Seevak asked if the new areas of focus related to quality have changed or if this represents a heightened focus on the same areas of focus. R. Gebhart answered that they are new areas of focus. S. O'Brien added that along with these being new measures, the State has also raised the threshold of accountability and compliance from the top 75% to the top 50%. • Preparations are being made for the DHCS Medical Services Audit in June. This is a full medical services audit, but there will be extra focus on the issues identified in the prior audit. • NCQA accreditation review data will be submitted in July, followed by an onsite review in September. The three main components that NCQA will review are as follows: o Standards and Guidelines. o HEDIS Scores. o Results of NCQA Member Survey. • Our previous NCQA accreditation review was in 2016 and we received designation of "Commendable".		Board edification.
6.b. BOARD MEMBER REPORT– FINANCE COMMITTEE			
R. Ferguson	R. Ferguson reported from the Finance Committee meeting on March 9th. Board members M. Marchiano and N. Peraino also attended this meeting. • TNE continues to remain healthy at 592%. • We had projected a $3.0 million Net Loss for the month of February; instead we had an approximate $3.0 million Net Income. We are currently at a $2.0 million Net Income Year-to-Date vs. our original projection of a $38 million Net Loss. • Membership continues to decline without definitive answers.	Requested to discuss recruitment of additional Board members for Finance Committee during already scheduled closed session	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	• Requested discussion related to increasing Board participation in Finance Committee membership.	following regular meeting.	
7.a. BOARD BUSINESS – REVIEW AND APPROVE FINANCIAL STATEMENTS			
G. Riojas	G. Riojas provided the following financial updates for January: • Enrollment has decreased by 1,605 since January 2019, and has decreased by 6,376 since June 2018. Current enrollment is at 259,921. The most significant decreases have been in the Child, Adult, and Optional Expansion categories of aid. This was discussed at a recent DMHC Financial Solvency Standards Board (FSSB) meeting, and it was shown that as Medi-Cal enrollment has decreased state-wide, there has been a subsequent increase in large and small group commercial enrollment. This could indicate that as the economy and job market flourishes, people are able to receive insurance through employment rather than needed state provided Medi-Cal. • Net Income of $3.0 million; budgeted Net Loss of $2.9 million. Actual YTD Net Income of $2.0 million; budgeted YTD Net Loss of $23.8 million. • Revenue $83.9 million; budgeted revenue $74.7 million. We have tracked very closely the last 12 months on expected Revenue with the exception of the two months that we received Prop 56 revenue (April 2018, and February 2019). This will also result in a corresponding increase in Medical Expense as the funds are paid out to participating Primary Care Providers. M. Lynch asked if the Prop 56 revenue and corresponding Medical Expense is “a wash”. Does the Alliance keep any of the additional revenue? G. Riojas answered that the State puts a threshold that the plans must pay out 95% of the revenue to its providers and if they don’t meet the threshold, we must refund the state the additional		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	funds. The Alliance could potentially benefit from the 5% above the state required threshold, but as this is a risk-based program that is not something we can budget for. • Actual Medical Expenses $77.6 million; budgeted medical expense $73.8 million. As stated above, the additional expense is attributed to Prop 56 payout. Actual YTD Medical Expense of $578.9 million vs. budgeted $592.6 million. W. Scott commented that he has been told by other members that they are receiving letters from Physicians that they are now billing separately from the facilities in order to receive payment more expeditiously and wondered if we need to track that separately. G. Riojas answered that we only pay based on contract. If physicians are contracted with us independently then we pay them directly within 45 working days of receiving the claim per statutory regulation. If they are not contracted with us then the service is not covered by the Alliance at all. • Medical Loss Ratio 92.5% for the month and 94.8% YTD; budgeted 98.9% for YTD. • Administrative Expenses $3.8 million; budgeted $4.4 million. YTD actual administrative expense $33.9 million vs. budgeted $35.7 million. • YTD interest income from investments is $3.9 million, and YTD claims interest expense is $420,000. R. Ferguson asked how our interest expense compares to this time last year. G. Riojas answered that last year we ended at approximately $3.0 million paid which is significantly higher than where we will end up this year. R. Ferguson asked a follow-up question regarding the recent audit that was completed, and wanted to know if we have implemented any corrective actions. M. Woodruff answered that we have implemented or are in the process of		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	implementing several corrective actions. The audit looked at everything from how the contracts are set up, to how authorizations are completed, configurations of systems, and how we pay claims. There were recommendations across the board, but the most significant was in how our systems "talk" to each other and making that more efficient. • Tangible net equity (TNE) continues to remain healthy at 592% of the required amount, with a surplus of $159.7 million. • Balance Sheet: Cash $233.1 million; $162.8 million is uncommitted. E. Seevak asked how our interest income compared to last year. G. Riojas answered that it is better. It is difficult to make a comparison due to the amount of money invested now versus last year, but it has been significant enough to know that the investment strategy approved by the Board last year is indeed making a positive difference.	Motion: R. Ferguson Second: M. Marchiano Motion passed.	
7. b. BOARD BUSINESS – UTILIZATION TRENDS REVIEW			
G. Riojas S. O'Brien	G. Riojas and S. O'Brien provided a brief presentation on Utilization and Cost Trends: • Separate handout measuring trends for Inpatient, Outpatient, ER, and Pharmacy over an approximate 24-month period.	None – Informational Only	None
7. c. BOARD BUSINISS – HEALTH SERVICES UPDATE – EPSDT			
S. O'Brien	S. O'Brien provided the following updates from Health Care Services: • EPSDT (Early Periodic Screening, Diagnosis, and Treatment). o This is a pediatric Medi-Cal benefit and approximately 100,000 of our members are children. Two of our delegated partners manage approximately 2/3 of those		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	members. CHCN oversees approximately 35k, and CFMG oversees approximately 32k. o Major focus in state. o State may be tying some components to Prop 56 incentive payments. o SWOT analysis: ▪ Strength – We have a lot of pediatricians and specialists in our key geographic areas, as well as a great partner in UCSF Benioff Children's Hospital (CHO). ▪ Weakness – Pediatrics is a very competitive market which makes it somewhat tumultuous and a little bit unstable. Additionally, one of our main partners, CFMG, is currently significantly underperforming in quality scores, and we are working very closely with them to bring them up to quality standards. ▪ Opportunities – relate to leveraging our partnerships with CHCN and CFMG. The competitive environment does make things a bit unstable but it also forces people to pay more attention because we are not tied to any particular group. Also, Alameda County intends to incorporate CCS (California Children's Services) into our Managed Care plan in 2022. ▪ Threats – The state has made it clear that they will start to sanction plans that are not doing well with EPSDT. If quality metrics are low there will be financial penalties and other sanctions enforced. • Action steps as a plan o Quality – Review HEDIS measures and CMS core requirements. New measures require Average or above rating in order to avoid being fined. We are currently		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	looking to see where the areas where we are solid, where we are under, and where we are borderline. We will look at those areas and then coordinate with our partners to drive these measures to where we need them to be. o Access – We are looking at our service area to see if we have the right access. o Case Management – CCS has a robust case management and we have to work out how to interface with that, and to understand them more so that we can make that care more seamless. o Utilization Management – We are looking to see if there are any barriers and are there ways we can facilitate access to preventative services. M. Lynch asked if there are other CMS measures not related to EPSDT that the state is interested in or just those mentioned. S. O'Brien answered that along with the pediatric measures, the state is also including in all of the adult CMS core measures into our accountability set. The new measures are retroactive to January 2019, and must meet 50% or better of MPL's (Minimum Performance Levels) versus the previous requirement of 25%. R. Gebhart asked if we find that our current structure of contracted providers doesn't have the capacity that we need for the preventative services and screenings, do we then either incentivize our providers to add those services or we identify new providers that can provide those services and contract with them. S. O'Brien answered yes to this. R. Gebhart followed up asking if we do that, are we then eligible to resubmit for rate change for adding those expanded services? To which S. O'Brien answered no. The state already has an expectation that these services are being provided currently. What has changed is the level of expected compliance to these measures and the penalty associated with failing to do that. He went on to explain that the state		Educational information regarding CMS measures.

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	has not yet defined exactly how to incorporate Prop 56 funds to these measures. K. Meade made the observation that there have been tremendous changes in the data capture systems over the last 10 years and that at the encounter level the work is likely being done, but it is not being captured correctly. Many of the forms previously completed manually have moved to electronic versions and information gets lost in translation in the move from manual platform to electronic. Additionally, in the 18-21 year old range, it is more complicated because they then apply CMS core measures and those are not loaded into most pediatric provider systems. S. O'Brien affirmed these observations. F. Almaliti asked who then would be performing coordination of care. S. O'Brien answered that the PCP would continue to manage simple coordination of care; CCS would provide for the more complex cases, the Alliance does a lot related to the wrap-around services, as well as Beacon. R. Ferguson asked about the substandard quality level of CFMG and asked if we have a timeline for corrective action from them? S. O'Brien answered that there is not a timeline yet, but we are currently in dialogue with them to help them get where they need to be.		
8. CEO UPDATE			
S. Coffin	S. Coffin provided the following updates: • Reported on actual Net Income vs. budgeted Net Loss. • Q3 Forecast will be presented at next meeting and will give us the projection through the remainder of the fiscal year. • Revenue is $11 million higher than budget; Medical Expense is greater than 4% below budget.	None	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	• We continue to work on increasing quality for our members and reduce unnecessary expenses. • The Operations Dashboard (red areas): o Claim payment to providers is currently at 30-days and our target is 25-days. We expect to be corrected in the next 30-45 days. o Claims processed within 90 calendar days are currently at 96%, and the DHCS goal is 99%. We expect to be corrected on this issue in the next 30-45 days as well. o Our average speed to answer and abandonment rates numbers did not meet our internal goals. R. Ferguson commented that it is his perception that we consistently have a problem with member services and phones issues causing customer service levels to dip. Can it be fixed with consistency? S. Coffin answered that we continue to pursue solutions that will help us meet these desired service levels. M. Woodruff further answered that we are in State compliance, we hold ourselves to a higher standard, and it is that higher standard that we are falling short of. • Review of Preliminary Timeline for Reporting of Program Benefits. • Discussed the latest published Dashboard report from DHCS which shows that the Alliance is improving on its timeliness and accuracy for encounter reporting. • Due to time constraints and the need to end early for closed session, S. Coffin tabled the remainder of his update for a future meeting.		
9.a. STANDING COMMITTEE UPDATES – PEER REVIEW AND CREDENTIALING COMMITTEE			**9.a.**
S. O'Brien	S. O'Brien provided a summary of the most recent Peer Review and Credentialing Committee Meeting, which was held on April 16, 2019.		None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	• There were 17 initial providers credentialed. • There were 24 providers re-credentialed.		
9.b. STANDING COMMITTEE UPDATES – HEALTH CARE QUALITY COMMITTEE			
S. O'Brien	S. O'Brien reported that the HCQC met. • The Alliance has added a new Senior Director of Quality, Stephanie Wakefield, as well as new managers for Access and Availability, and Clinical Quality. • Reminder about Performance Improvement Projects: o Access to Primary Care for 12-19 year olds at Tri-City. o Comprehensive Diabetes care at Highland. o Members on persistent medication. o Tdap compliance.		None
9. c. STANDING COMMITTEE UPDATES – PHARMACY AND THERAPEUTICS COMMITTEE			
S. O'Brien	S. O'Brien reported that the Pharmacy and Therapeutics Committee met as well, and provided updates on the following: • Two new pharmacists added to the team. • Discussed Pharmacy cost containment measures. • Pharmacy will be carved back in at state level.		
9. d. STANDING COMMITTEE UPDATES – MEMBERS ADVISORY COMMITTEE			
S. Coffin	S. Coffin provided the following updates from the Member Advisory Committee, which met on March 21, 2019: • Recognized the two members present in the public audience, as well as F. Almaliti, and W. Scott who are Board Members. • 10 members attended in March for discussion about: o Grievances & Appeals – in-network and out-of-network o DME (Durable Medical Equipment) supplier, CHME regarding customer service issues. o Cultural and Linguistics. o Communication and Outreach.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
10. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS			
S. Coffin	None	None	None
11. PUBLIC COMMENTS (NON-AGENDA ITEMS)			
E. Seevak	F. Almaliti announced that April is National Autism Awareness Month and reminded the Board that Autism is the fastest growing pediatric issue in the United States, with 3% of the population currently being diagnosed somewhere on the Autism Spectrum. This surpasses Juvenile Diabetes, and all pediatric cancers combined. Current statistics show that 1:35 boys are diagnosed with Autism, and affects 1:58 births overall. She handed out canvas bags for all those in attendance.	None	None
12. ADJOURNMENT			
E. Seevak	The meeting was adjourned at 1:52 PM for closed session	None	None

Respectfully Submitted By:
Christine E. Corpus, Executive Assistant to the Chief Financial Officer

2018
Utilization Management Program Evaluation

2018 Utilization Management Program

Signature Page

Date _____

Julie Anne Miller, LCSW
Director, Health Care Services

Date _____

Sanjay Bhatt, M.D.
Director, Quality Improvement

Date _____

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

Date _____

Scott Coffin
Chief Executive Officer

Date _____

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

2018
Utilization Management (UM) Program Evaluation

Overview

Under the leadership and strategic direction established by Alameda Alliance for Health (The Alliance) Board of Directors and Quality Management Committee (QMC), senior management and the Health Care Quality Committee (HCQC), the Health Services 2018 Utilization Management Programs were successfully implemented. This report serves as the annual evaluation of the effectiveness of the program activities.

The processes and data reported covers activities conducted from January 1, 2018 through December 31, 2018.

Membership and Provider Network

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

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

Figure 1. 2018 Trended Enrollment by Network and Age Group

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Current Membership by Network By Category of Aid

Category of Aid	Dec 2018	% Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN	KAISER
ADULTS	35,559	14%	9,163	6,892	351	13,447	5,706
CHILD	95,322	37%	9,459	8,355	29,880	31,404	16,224
SPD	26,006	10%	8,918	3,576	1,350	10,309	1,853
MCE	85,345	33%	15,620	27,478	929	32,656	8,662
DUALS	16,072	6%	6,297	1,812	10	6,167	1,786
Medi-Cal	258,304		49,457	48,113	32,520	93,983	34,231
Group Care	5,886		2,695	760	0	2,431	0
Total	**264,190**	**100%**	**52,152**	**48,873**	**32,520**	**96,414**	**34,231**
Medi-Cal %	97.8%		94.8%	98.4%	100.0%	97.5%	100.0%
Group Care %	2.2%		5.2%	1.6%	0.0%	2.5%	0.0%
	Network Distribution		***19.7%***	***18.5%***	***12.3%***	***36.5%***	***13.0%***
			% Direct:	**38%**		**% Delegated:**	**62%**

Age Category Trend				
	Members			
Age Category	Dec 2016	Dec 2017	Nov 2018	Dec 2018
Under 19	101,385	103,264	98,950	98,122
19 - 44	86,207	87,080	84,900	84,866
45 - 64	59,141	58,915	57,493	57,340
65+	20,317	22,538	23,789	23,862
Total	267,050	271,797	265,132	264,190

For 2018, The Alliance membership remained relatively flat, as seen in Figure 1. The Alliance lost a small number of members in 2018 compared to 2017, (from 271,797 down to 264,190) from the Adult and Child members.

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

Figure 2 Provider Network by Type, Enrollment and Percentage

Provider Network	Provider Type	Members (Enrollment)	% of Enrollment to Network
Independent (Direct)	Independent	52,152	19.7%
Alliance Health Systems	Managed Care Organization	48,873	18.5%
Children First Medical Group (CFMG)	Medical Group	32,520	12.3%
Community Health Clinic Network (CHCN)	Medical Group	96,414	36.5%
KAISER	HMO	34,231	13.0%
Total		**264,190**	**100.0%**

The percentage of members within each network has been steady from 2017 to 2018.

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

- Ambulatory care
- Hospital care
- Emergency services
- Behavioral health (mental health and addiction medicine)
- Home health care
- Hospice
- Palliative Care
- Rehabilitation services
- Skilled nursing services - Skilled
- Managed long term services and support (MLTSS)
    - Community based adult services
    - Long Term SNF Care (limited)
- Transportation
- Pharmacy

- Care coordination along the continuum of care including arrangements for linked and carved out services, programs, and agencies.

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

Figure 3 The Alliance Ancillary Network

The Alliance Ancillary Network	
Hospitals	15
Behavioral Health Network	1
DME Vendor	1
Transportation Vendor	1
Pharmacies/Pharmacy Benefit Manager (PBM)	Over 200
Radiology/Delegate	1

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

Delegation

The Alliance delegates UM activities to provider groups, networks and healthcare organizations that meet delegation standards. The contractual agreements between The Alliance and delegated groups specify the responsibilities of both parties; the functions or activities that are delegated; the frequency of reporting on those functions and responsibilities; how performance is evaluated; and corrective action plan expectations, if applicable. The Alliance conducts a pre-contractual evaluation of delegated functions to assure capacity to meet standards and requirements. The Alliance's Compliance Department is responsible for the oversight of delegated activities. The Compliance Department works with the UM Department and other respective departments to conduct the annual delegation oversight audits. When delegation occurs, The Alliance requires the delegated entity to comply with the NCQA standards and present quarterly and semiannual reports of services provided to Alliance members. The Alliance's Compliance Department is responsible for the oversight of delegated activities and completes an annual performance evaluation of all delegates. Results of the annual evaluation and any audit results are reviewed by the Compliance and Delegation Oversight Committee. The UM Department works with delegates on operational issues to ensure that members receive services from delegates that are in line with the Alliance's established policies and procedures.

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

Figure 4 – 2017 The Alliance Delegated Network

Delegate	NCQA Accreditation or Certification	Provider Type	Delegated Activity -UM	Delegated Activity – Grievance and Appeals	Exceptions
Kaiser	Yes	HMO	X	X	
(CHCN)	No	Medical Group	X		
(CFMG)	No	Medical Group	X		
California Home Medical	No	Vendor - DME	X*		* Not

Equipment (CHME)					delegated for denials
Beacon/College Health IPA (CHIPA)	Yes	BH	X		
eviCore Healthcare	Yes	Specialty Services	X		

Overall, the network was sufficient to meet the needs of The Alliance membership and provider network throughout 2018. The organization clarifies issues related to delegated activities and responsibilities as needed. The issues have led to additional clarification in contractual documents as well as additional training to delegates on roles and expectations. In 2018, more frequent Joint Operation Meetings (JOMs) facilitated communication and operational alignment. These JOMs, which are collaborative meetings between The Alliance and Delegates/Vendors to address operations and performance outcomes are also used to identify joint opportunities for improvement. For 2019, there is an opportunity to continue to improve the level of oversight, monitoring, reporting and training of delegates.

UM Program Structure

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

Responsibility, Authority and Accountability/ Governing Committee

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

Committee Structure

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

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

HCQC charters a sub-committee, the Utilization Management Committee (UMC) which meets at least once every 2 months, serving as a forum for the Alliance to evaluate current UM activities, processes, and metrics. The UMC also

evaluates the impact of UM programs on other key stakeholders within various departments and when needed, assesses and plans for the implementation of any needed changes. HCQC assumes responsibility for oversight of the UMC activities and monitoring its areas of accountability as needed. The structure of the committee meetings was redesigned to increase engagement from all participants.

In 2018 the HCQC approved the UM Department 2017 Evaluation on March 1, the UM Program 2018 Description and UM 2018 Workplan on April 12, 2018, for Board of Directors approval. The committee was chaired by the Chief Medical Officer with support of the Director of Quality Management, external physicians and key organizational staff. The UM Committee had seven meetings in 2018.

In 2019 the UM Subcommittee of HCQC will continue to support the focus on UM activities, oversight for delegated UM activities, case management/care coordination, population health, integration of behavioral health and medical as well as regulatory compliance.

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

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

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

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

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

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

- Setting UM behavioral healthcare policies
- Reviewing UM behavioral healthcare cases, as needed
- Participating in the various UM Committees
- Evaluation of the overall effectiveness of the UM Program (Beacon)

Program Scope and Structure

The Alliance UM Program encompasses the management and evaluation of care across the scope of UM. This includes prior authorization, concurrent and retrospective review of institutional care, acute care, behavioral health and chemical dependency, rehabilitation, skilled nursing, pharmaceuticals, ambulatory services. The UM Program involves the medical and behavioral management of all members at the most appropriate site and level of care. (For behavioral

health activities, refer to The Managed Behavioral Health Organization's [Beacon Health Strategies] UM Program for a description of delegated behavioral health UM activities.

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

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

Utilization Management Resources

The Alliance UM Department is staffed with physicians, nurses and non-clinical support staff including clerical support and clinical support coordinators. A full description of staff roles and responsibilities is provided in the 2018 UM Program Description.

The assignment of work to the team, whether working on site or remotely, for both clinical and non-clinical activities, is seamless to the process as it did not change the team member's job responsibilities or job description. The job descriptions with assigned tasks and responsibilities remained the same regardless of the geographical location of the team member.

During 2018 several key leadership roles in Health Services were hired:

- Chief Medical Officer
- Director of Health Care Services
- Manager of UM

In 2018, based on the established staffing ratios and roles, the UM Department continued to struggle in timely hiring for both department and leadership roles. As a result, staff were often called to perform in those missing roles. With the onboarding of new leadership, the Health Care Services Department teams will be reviewing the current organization goals and restructuring the Departments to achieve those goals.

Delegated Utilization Management

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

The Alliance has several levels of UM delegation: For NCQA accredited or Knox Keene licensed Health Plans, UM is fully delegated. For certain medical groups, UM decision making is a shared risk; the Medical Group are delegated for the performance of outpatient referral management and UM decision making while The Alliance UM Department maintains responsibility for high cost outpatient services and inpatient care. All delegates perform certain levels of UM decision making based on their contracts. The Alliance maintains responsibility for UM decision making associated with transportation, MLTSS, pharmacy and certain radiological services. The resolution of clinical grievance and appeals are only delegated to Knox Keene licensed Health Plans (Kaiser.) For care management and complex case management, the Alliance delegates basic care management and care coordination to network providers. Currently, the Alliance only delegates complex case management to Kaiser and Beacon.

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

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

In 2018, the UM staff conducted annual audits on the six (6) delegates. The threshold for UM audit compliance is 90%. For entities that do not meet the threshold, the UM staff may require a corrective action plan which is tracked for compliance with the resolution of the deficiency. Entity audit results for 2018 were:

- Five groups pass UM audit (≥ 90.0%), 1 failed with corrective actions required.
- Two provider networks were required to complete CAPs as a result of the annual audit.

Figure #5 The Alliance Network – 2018 Annual Audit Score

Delegate	Provider Type	Delegated Activity -UM	2018 Audit Results	Corrective Action Required
Kaiser	**HMO**	**X**	**Pass: UM files 99%**	**None**
(CHCN)	**Medical Group**	**X**	**Pass: UM files 91%**	**Yes; NOA did not provide clear and concise reason for decision.**
(CFMG)	**Medical Group**	**X**	**Pass: UM files 99%**	**None**
California Home Medical Equipment (CHME)	**Vendor - DME**	**X* * Not delegated for denials**	**Failed: (85%)**	**Yes; timeliness of decision making**
Beacon/College Health IPA (CHIPA)	**BH**	**X**	**Pass: 99%**	**None**
EviCore Healthcare	**Specialty Services**	**X**	**Pass*: 100% Routine Outpatient Denials Only**	**None; 2017 file audit resulted in a focused file audit in 2018.**

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

During summer 2017, DHCS apprised The Alliance of a concern with a delegate, eviCore, who displayed a higher than expected appeal overturn rate. It was identified that this issue may be related to inappropriate UM clinical decision making or policies as well as denials to out-out-network services. The Alliance UM Department clinical team worked with the delegate in 2018 to identify the root cause and implement corrective actions to mitigate the issue. Despite the UM Department's increased level of oversight, monitoring and 2018 Q1 clinical training of eviCore, the overturn rate continued to be unacceptably high. Therefore, delegate termination procedures were initiated to end the contract with EviCore. The contract is expected to end by Q2 of 2019, once the Alliance UM department is ready to assume the responsibility.

For 2018, the rest of the current UM delegates continue to meet the program's scope of activities. The individual issues of compliance to delegation requirements are addressed with the delegate through the Compliance Department. The UM team works collaboratively with the Compliance Department on identifying potential process improvement activities and monitoring corrective action plans. In 2018, the team:

- Collaborated with Senior Health Care Services Leadership and Compliance staff to resolve on-going corrective actions identified during regulatory audits.
- Used the new Out of Network / LOA workflow that resulted in better oversight for referrals and access associated with out of network request.

Recommend Actions/Next Steps

For 2019, there are opportunities to improve the oversight of delegated UM activities. The UM Department leadership is continuing the development of a robust level of delegate oversight and performance monitoring. The activities will include dedicated staff monitoring activities, performance management, delegate feedback and UM training. In particular, additional staff and training will be required to take on authorizations and denials for radiology services currently delegated to EviCore.

Utilization Management Processes and Information Sources

Utilization Management Decision Making

Decision and screening criteria are designed to assist UM staff and delegates in assessing the appropriateness of care for clinical and behavioral health situations encountered in the clinical setting. Application of the criteria is not absolute, but based upon the individual health care needs of the member and in accordance with the member's specific benefits plan and capacity of the health care delivery systems. The decision criteria are made available to the member, providers or public upon request by contacting the UM Department. A full description of the criteria utilized for UM decision making is available in the 2018 UM Program.

For 2018, The Alliance UM Department utilized the clinical criteria as defined in the UM Program. In 2018, The Alliance used the Milliman's CareWebQI® interactive software tools which integrate the MCG® guidelines into the core information system and the 21stEdition MCG® criteria. Upon review of member needs and the requirement to use alternative criteria as appropriate, there were no changes to the clinical criteria. In 2018 there were two requests from members for copies of the decision making clinical criteria, and they were referred to the Alliance web portal to obtain it.

In July 2017, DHCS revised a Medi-Cal Managed Care Division All Plan Letter (APL 17-010) for Non-Emergency Medical and Non-Medical Transportation (Revised 17-010) to include specific criteria for access to the Medi-Cal benefit for transportation services. In addition, the benefit has additional requirements for accessing a new benefit. Effective October 1, 2017, Managed Care Health Plans (MCP) were also required to provide non-medical transportation for Medi-Cal services that are not covered under the MCP contract. The Alliance UM staff collaborated with Senior Leadership to develop processes to operationalize the new benefit. In 2018, the Alliance operationalized all requirements of the APL to include the non-medical transportation benefits through contract with Logisticare. The Alliance monitors the performance of Logisticare provision of this benefit by regular review of G&As and performance metrics.

While the standard hierarchy of medical criteria met the membership needs, DHCS issued a key new benefit which integrated new regulatory guidance and specific criteria to access the Palliative Care benefit. In December 2018, DHCS revised a Medi-Cal Managed Care Division All Plan Letter (APL) 18-020 to extend the Palliative Care benefit to members under age 21, to begin January 1, 2019. The Alliance reviewed the current members under age 21 who were using the Palliative Care benefit through California Childrens' Services, (CCS) and developed a transition plan to administer the benefit through the Alliance. The Alliance contracted with CCS and Hospice of the East Bay Kids to provide the Palliative Care benefit without a break in continuity. Members were notified of the change per the requirements of the APL, both written and verbally. The new benefit will be operationalized in 2019 and the Alliance has made preparations to administer the benefit on behalf of members.

In late 2018, a new role, Director of Quality Assurance, was created to ensure smooth processing of APLs into Alliance clinical operations, policies and procedures, as well as regulatory compliance. For 2019, The Alliance will develop a formal documentation process to review and update existing policies and workflows to address regulatory changes based on specific criteria. This will include any internal and delegate training or regulatory reporting needs.

Consistency in Application of Criteria

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

Figure #6 Inter-rater Reliability Thresholds

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

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

All new hire staff are trained and participate in the IRR process upon completion of their training. Results will be tallied as they complete the process and corrective actions implemented as needed. When opportunities for improving the consistency in applying criteria, UM staff addresses corrective actions through requiring global or individualized training or completing additional IRR case reviews.

For 2018, IRR testing was performed for UM clinical staff and non-clinical staff to establish consistency in practice and outcomes for members. Of the two outpatient clinical nurses, one passed on 1st review with 100% and one passed on the 2nd review with 100%. For the seven inpatient clinical nurses, two passed on 1st review with 100% and the remaining four scored in the medium range and in the process of additional training and oversight by the Manager. The four clinical nurses will be required to repeat the IRR during 2nd Quarter 2019. Of the three Medical Directors, all three passed with 100% on the 1st attempt.

The results from the staff that scored below 90% found opportunities to improve consistency in the application of criteria:

- Review and revise UM Policy for IRR to ensure clarity on the staff oversight process and corrective actions necessary for poor performance.
- Increase training frequency on clinical decision making, which includes application of criteria. The training should be done every quarter for all staff. For staff scoring below 90%, Management may require up to additional focused training on clinical decision-making.

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

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

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

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

- Hospital services, including acute, long-term acute and acute rehabilitation
- Skilled Nursing Facilities services
- Sub-Acute Facility services
- Durable Medical Equipment
- Prosthetics/Orthotics/Medical Supplies
- Outpatient Facility Based Services (i.e. specialized radiology or diagnostic procedures, dialysis, etc.)
- Hospice
- Out of Network, Tertiary
- Out of Area Services (Per Contract)

- Managed Long Term Services and Support/Community Based Adult Services (CBAS)
- Long Term Care, month of admission plus the following month
- Transgender Services
- Transportation
- Major Organ Transplant Services
- Acupuncture
- Home Health
- Medications covered under the pharmacy benefit - i.e., non-formulary, some self- injectable medications
- Experimental/investigational procedure/services determination
- Cancer clinical trial determinations

UM Information Systems

The Alliance maintains a core information system, TruCare, that is utilized by both UM and case management. During summer 2017, UM staff identified opportunities to enhance the functionality of the system to assist in managing UM referrals and case management functions. TruCare was upgraded to version 6.1.3 in 2018 and staff training occurred in Q3 2018.

UM DETERMINATIONS

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

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

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

Referrals are tracked and reported by:

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

Denials are reported in relationship to:

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

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

Usage of specialty referrals are monitored to ensure members have o

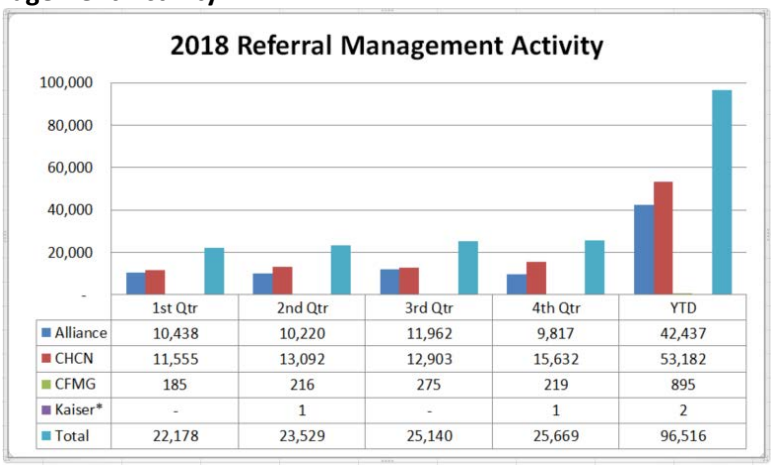
As discussed in a previous section, The Alliance manages two products, Medi-Cal and Commercial (Group Care). For the purpose of data analysis, as the commercial network, IHSS, represents only 2.2% of the total membership and 4.1% of the referral activities, the data is aggregated for reporting. In key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

Utilization Management Referral Management Data

Quantitative Analysis

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

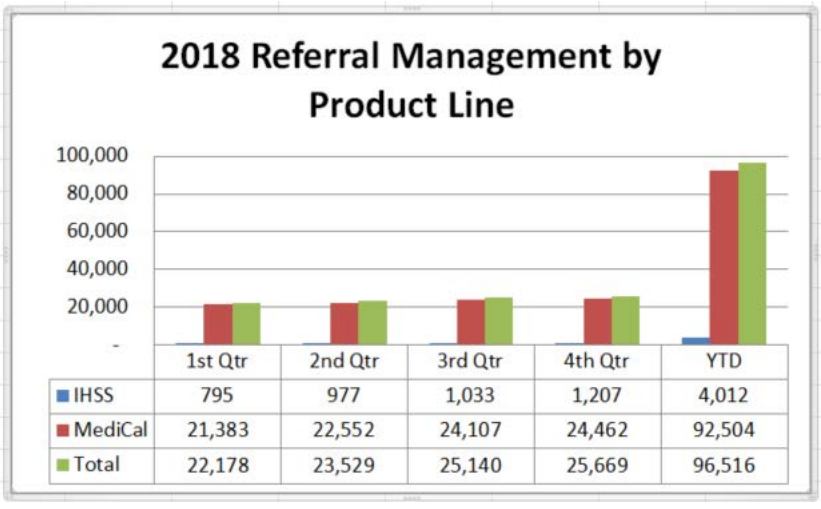
Figure #7 2018 Referral Management Activity



	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	YTD
Alliance	10,438	10,220	11,962	9,817	42,437
CHCN	11,555	13,092	12,903	15,632	53,182
CFMG	185	216	275	219	895
Kaiser*	-	1	-	1	2
Total	22,178	23,529	25,140	25,669	96,516

Outpatient Referral Management data by quarter based on number of authorizations managed by The Alliance by date of service; Reporting period is January 1 through December 31, 2018 for All Delegates and all products.

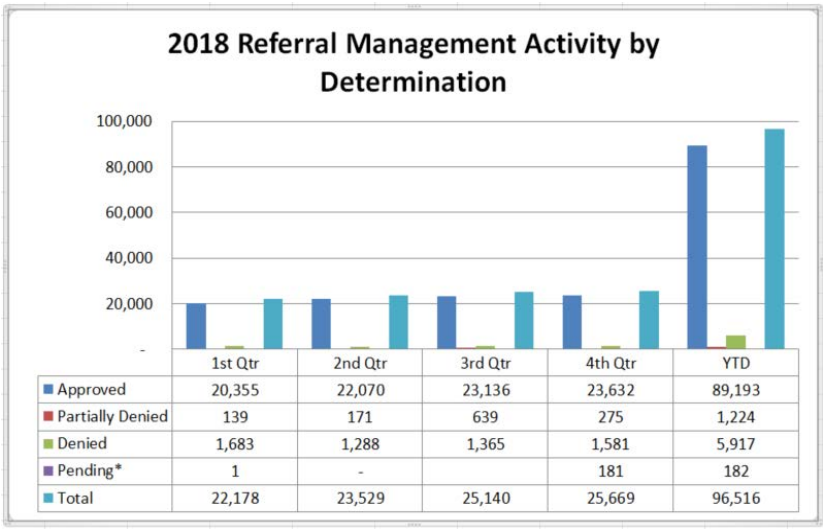
Figure #8 2018 Referral Management Activity by Product Line



	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	YTD
IHSS	795	977	1,033	1,207	4,012
MediCal	21,383	22,552	24,107	24,462	92,504
Total	22,178	23,529	25,140	25,669	96,516

Outpatient Referral Management data by quarter based on number of authorizations managed by The Alliance by date of service; Reporting period is January 1 through December 31, 2018 by products.

Figure #9 2018 Referral Management Activity by Determination



	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	YTD
Approved	20,355	22,070	23,136	23,632	89,193
Partially Denied	139	171	639	275	1,224
Denied	1,683	1,288	1,365	1,581	5,917
Pending*	1	-		181	182
Total	22,178	23,529	25,140	25,669	96,516

Outpatient Referral Management data using the final determination, reported by quarter based on number of authorizations managed by The Alliance by date of service; Reporting period is January 1 through December 31, 2018 for all Delegates and all products.

Figure #10 Comparisons of 2017 and 2018 Outpatient Referral Denial Rate

OP Denial Rate by %	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
2017	5.4%	5.6%	6.4%	6.8%	6.6%	6.4%	5.5%	5.8%	6.3%	6.5%	6.8%	6.7%	6.2%
2018	7.4%	6.9%	5.8%	6.1%	6.5%	7.1%	7.0%	7.0%	8.8%	6.9%	6.2%	5.8%	6.8%

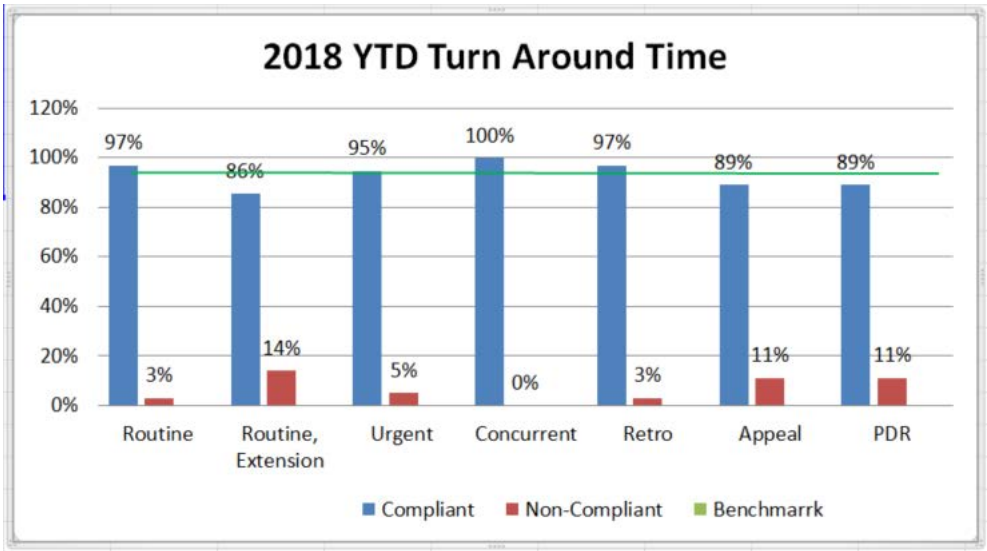
Outpatient Referral Management Denial Rate by month based on number of authorizations by date of service through December 31, 2018 for all Delegates. The 2018 Year to Date (YTD) denial rate was 6.8%, which is an increase of 0.6 percentage points from 2017.

Referrals are also monitored to ensure staff process requests within the required timeframes or Turn-Around Times (TAT). The Compliance Department monitors turn-around time performance and reports it to the HCQA. The performance goal for TAT is 95%. For 2018, TAT performance was as follows:

Figure#11a 2018 Referral Management TAT Reports

2018 Performance Referral Management TAT						
	Q1	Q2	Q3	Q4	YTD	Goal
Overall	97%	98%	98%	97%	98%	95%
MediCal	97%	98%	98%	97%	98%	95%
Group Care	95%	98%	95%	98%	97%	95%

Figure#11b 2018 Referral Management TAT Reports



Qualitative Analysis

The overall referral volume managed by network (96,596) slightly increased across the year in 2018. The volume of referrals by network provider aligns with the volume of enrollment with CHCN having the highest volume of referrals (53,182) and the largest membership (96,414) which includes adults, MCE and SPD members; CFMG having the lowest referrals (895) and lowest membership (32,520) which includes primarily children and adolescents. The referral analysis by product line shows the largest volume of referrals being submitted for Medi-Cal, again not unusual as Medi-Cal is the largest membership for The Alliance.

The 2018 Year to Date (YTD) denial rate of 6.8% is above the established performance threshold of 5%. The rise in the denial rate from 6.2% to 6.8% is attributable to an increase in denials for OON requests when there was appropriate and accessible comparable service in the Alliance network. UM will continue to analyze opportunities to further identify denial types to further understand the appropriateness of decision making. In addition, in 2019, UM staff will be retrained in standard work for utilization management.

Overall authorization Turnaround Time for 2018 for both Medi-Cal (98%) and Group Care (97%) met the established goal.

While the volume of referrals is reported in terms of product, ancillary network and determination, there is an additional opportunity to further assess the types of services by requested services and by type of authorizations, auto approved or clinical review. In 2019, the program will analyze opportunities to increase the number of requests that may appropriately be automatically authorized, thus improving throughput for members' care. This will also assist in validating an appropriate staffing ratio for the department.

Tracking of Unused Specialty Care Authorizations

DHCS requires The Alliance to establish a specialty referral system to track and monitor referrals requiring prior authorizations. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system should include non-contracting providers. The Alliance is also required to ensure that all delegates and contracting health care practitioners are aware of the referral processes and tracking procedures

In 2018, The Alliance developed the program for management and oversight of unused specialty referrals that require prior authorization. The program includes updates the UM policies, revisions to the tracking report, development of member communications and staff training. The program will be implemented in 2nd Qtr 2019.

Recommendations/Next Steps for 2019:

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

TRANSPORTATION

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

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

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

Currently, The Alliance maintains four types of transportation:

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

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

QUANTITATIVE ANALYSIS

Figure#12 – 2018 Transportation Utilization

2018	Description		Q1 Ave	% of Total	Q2 Ave	% of Total	Q3 Ave	% of Total	Q4 Ave	% of Total	YTD Ave	YTD Totals
Members	Members Served	Number of unique members utilizing transportation	**884**		**1,045**		**1,175**		**1,379**		1,121	1,121
	Enrollment	Total number of eligible members	264,849		267,115		263,900		262,324			
Trip Mode	**Ambulatory**	Trips provided by sedan	**6,397**	65.5%	**7,382**	67.7%	**8,329**	70.1%	**9,722**	71.6%	69.0%	95,489
	Wheelchair	Trips provided by vehicle equipped to transport wheelchair	**1,608**	16.5%	**1,866**	17.1%	**1,971**	16.6%	**2,276**	16.8%	16.7%	23,165
	Advance Life Support	Trips provided by vehicle equipped to transport ALS	2	0.0%	1	0.0%	1	0.0%	2	0.0%	0.0%	19
	Stretcher	Trips provided by vehicle equipped to transport Stretcher	314	3.2%	312	2.9%	369	3.1%	540	4.0%	3.3%	4,604
	Basic Life Support	Trips provided by vehicle equipped to transport BLS	32	0.3%	69	0.6%	45	0.4%	97	0.7%	0.5%	727
	Specialty Care Transport	Trips provided by vehicle equipped to transport SCT	8	0.1%	4	0.0%	5	0.0%	9	0.1%	0.1%	79
	Mass Transit	Trips provided by public transport	1,404	14.4%	1,286	11.8%	1,161	9.8%	923	6.8%	10.3%	14,320
Call Center	Average Hold Time	Average hold time should be less than 3 min for 90% of calls	81.9%		82.9%		83.4%		84.9%		83.3%	
	Service Level	Goal: 80% of calls answered within 30 seconds	79.6%		90.1%		88.7%		0.9%		64.8%	
Time	On Time Performance*	Goal: 90% on time for all legs	93.9%		93.3%		93.5%		92.3%		93.2%	
Missed Trips	Member Missed Appointments	Less than 1% of gross reservations	0.06%		0.09%		0.09%		0.08%		0.08%	

The amount of Ambulatory transport has increased over the course of 2018, reflecting the increased use of the NMT benefit.

QUALITATIVE ANALYSIS

In 2018, the Alliance fully implemented the requirements for the transportation benefits, using Logisticare as the provider. The Alliance UM Department developed a set of criteria to allow certain members in need of non-medical transportation to access services, policies, training materials and program monitoring reports for the new transportation benefits. This also included monitoring for the appropriateness of services with the transportation vendor.

Recommendations/Next Steps for 2019:
The Alliance UM Department will continue to monitor provision of the transportation benefit using criteria to allow appropriate members in need of non-medical transportation to access the transportation benefits. Revise the transportation report to include reporting by age to allow analysis of the use of NMT transport for EPSDT and non-EPSDT services.

Monitoring of Over/Under Utilization

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

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

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

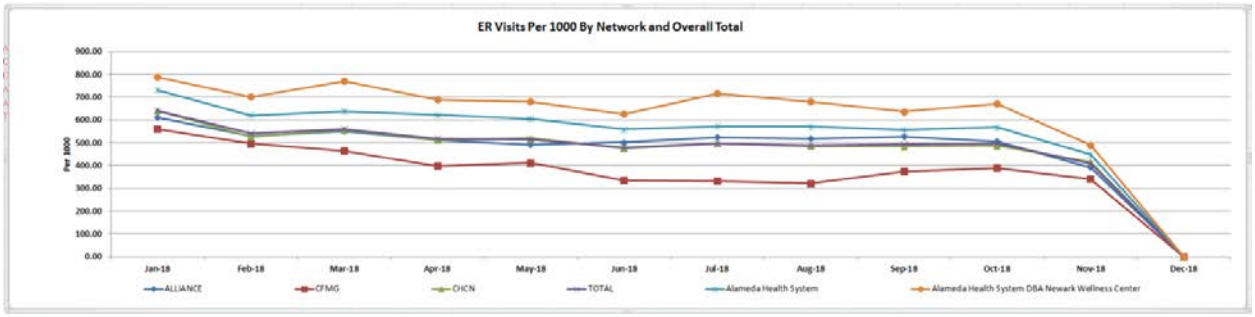
The UM Department has established monitoring activities to include:

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

Acute Hospitalization

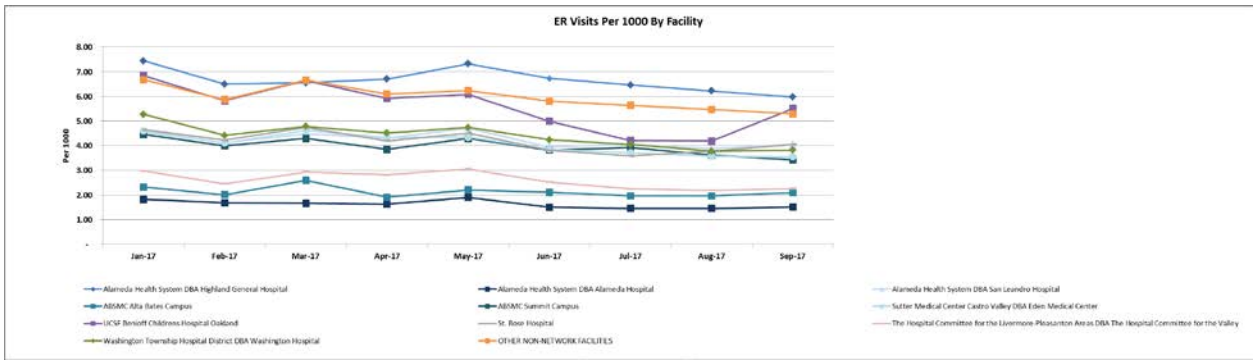
Emergency Room

Figure #13 depicts ER utilization by product from January to December 2018.



The data in Figure 13 show ER utilization across all products. The data appears to align with ER utilization seasonality, higher in winter months and lower in late spring, summer and early autumn.

Figure #14 depicts ER utilization by facility from January to September 2018.



The data in Figure 14 show ER utilization across ER facilities/hospitals.

Qualitative Analysis

The ER visits remain flat performance specific to the network. The reporting data appears to run parallel to the seasonality of ER utilization. In reviewing the CDC Flu Portal Dashboard for the 2017-2018 Flu Season, Influenza activity in the United States began to increase in early-December and remained elevated until April 2017. This aligns with activity seen across all networks. After 1st Quarter 2017, the ER utilization trended downward, with one spike noted in May 2017. From 2nd Quarter, ER utilization has continued to trend downward.

In reviewing ER visits by facilities, for both 2017 and 2018, the top three centers for ER visits during this nine-month period are 1) Highland General (Alameda Health Systems), 2) Other Non-network ERs, unspecified, and 3) UCSF Benioff Children's Hospital in Oakland. As there is limited information to establish a trend by inappropriate access or limited geographic availability to primary care services, this data should be assessed for potential access issues.

Hospitalization Measures

Concurrent/continued stay review for acute hospitalization focuses on:

- Facilitating timely and efficient provision of services
- Promoting adherence to established standards of care and identifying quality of care issues
- Coordinating timely and efficient transfer to the most appropriate level of care
- Implementing proactive and effective discharge planning
- Identification of ongoing case management needs in the ambulatory setting

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

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

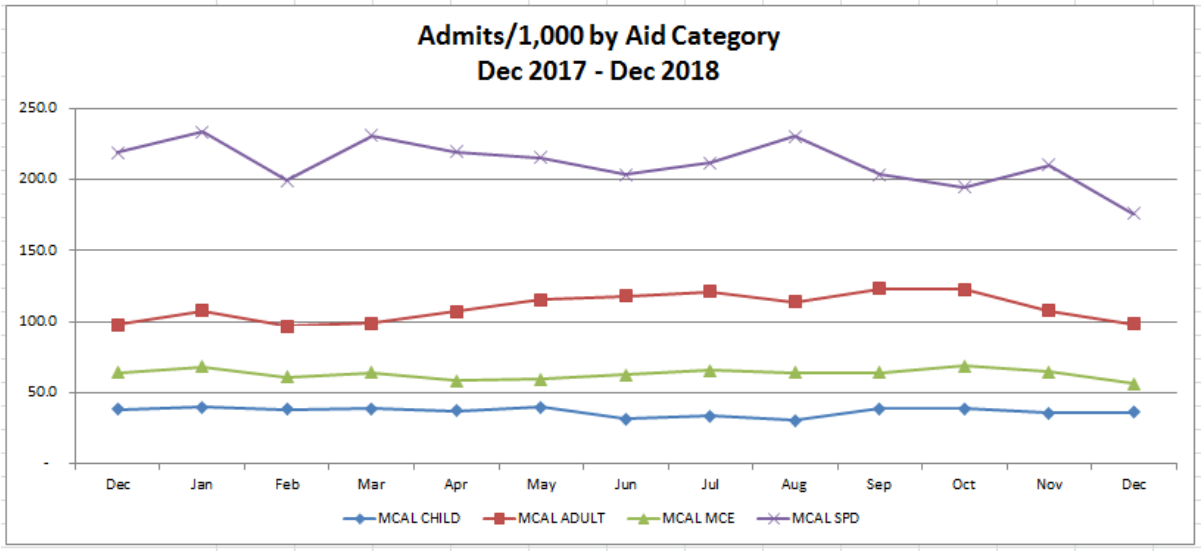
Quantitative Analysis

The Alliance has established benchmarks for inpatient admissions:

Figure #15– 2018 Hospitalization Targets

Inpatient Barometer All Products	
Metric	Target
Admits/1000	84.4
Bed Days/1000	297.8
Average Length of Stay (ALOS)	3.5

Figure #16 2018 Hospitalization admits per thousand by Aid Category.



The data above represents the 2018 performance for all lines of business in inpatient management by admits per thousand. Medi-Cal SPDs continue to have the highest admits per 1000 members while all other member aid categories remain relatively flat. This is as expected.

Figure #17 **2018 Hospital bed days per thousand by Aid category**

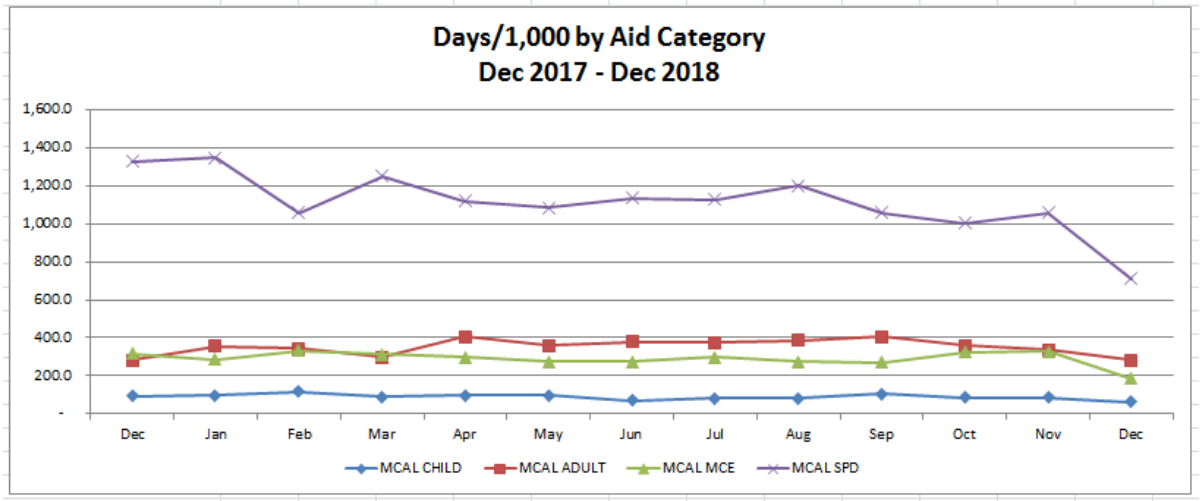
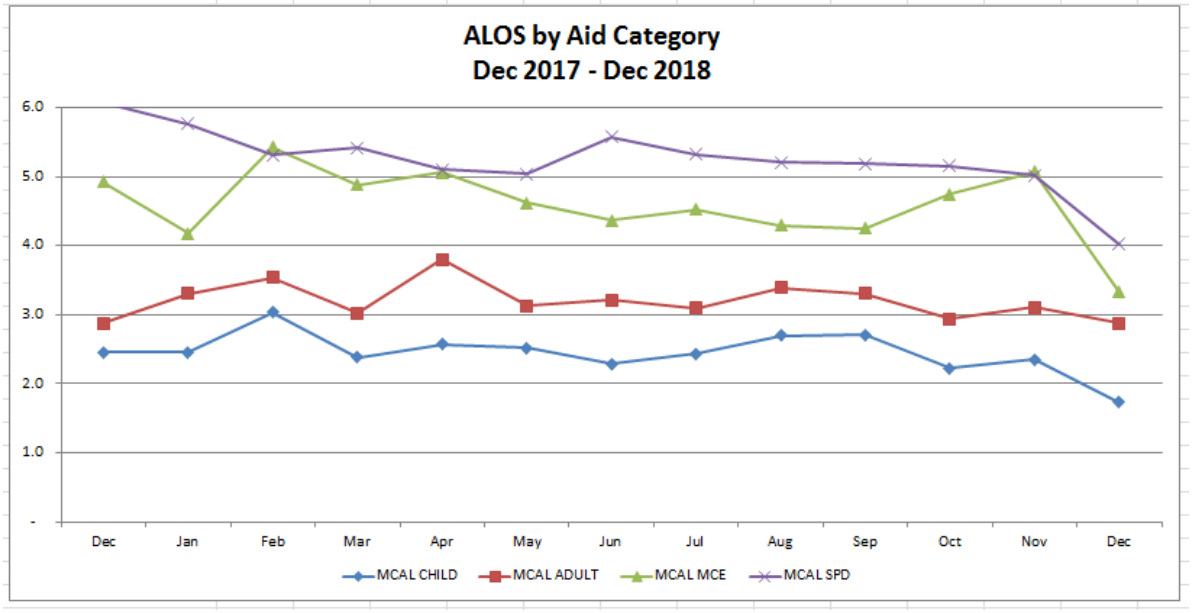


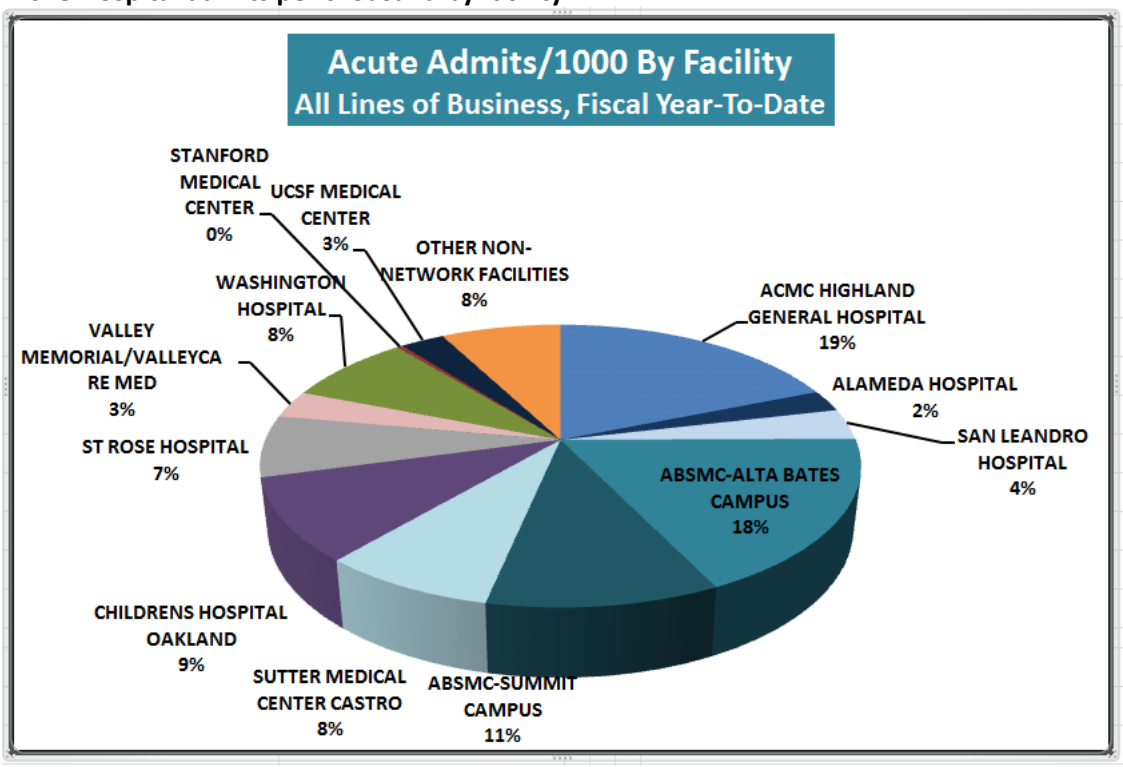
Figure #17 represents the 2018 performance for all lines of business in inpatient management by bed days per thousand. The data above again shows Medi-Cal SPDs as having the highest bed-days per 1000 members while all other member aid categories remain relatively flat.

***Figure #18* 2018 Hospital average length of stay per thousand by Aid Category.**



The data above show Medi-Cal SPD and Medi-Cal Expansion (MCE) has having the longest stays for inpatient hospitalizations.

***Figure #19* 2018 Hospital admits per thousand by facility.**



Qualitative Analysis

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

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

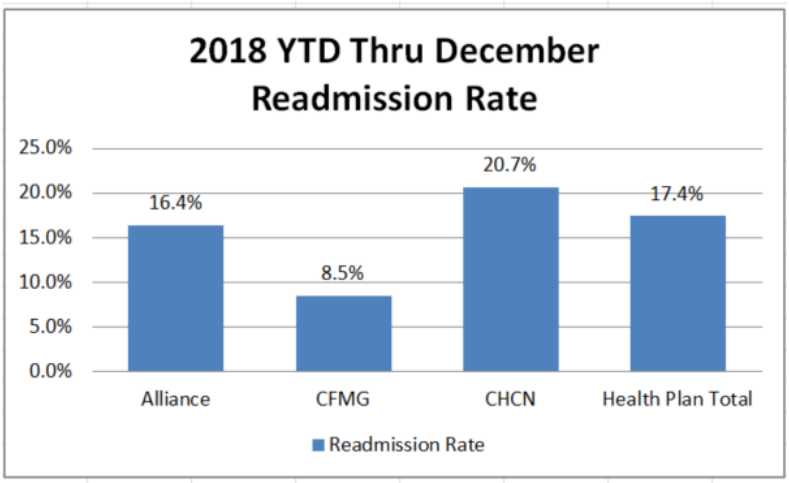
Data provided to assess admissions by facilities, the top three hospitals are 1) Highland General Hospital, 2) ABSMC Facilities (Summit and Alta Bates) and 3) Children's Hospital, Oakland. Two of the three hospitals also align with the ER utilization data by facilities as highly utilized facilities. Given the high number of admissions to Highland General Hospital, in 2019 the Alliance will engage Highland leadership and staff to develop strategies to support throughput and appropriate care transition program for Alliance members.

Readmissions

All Cause Readmission rate, defined as readmission within 30 days of discharge, is trending above goal. The activities included early interventions prior to discharge and co-management with Case Management. The Alliance threshold for readmission is 18 %. For 2018, the overall network readmission rates are:

Quantitative Analysis

Figure #20 **- 2018 Hospital readmission by Provider Group.**



Data identifeid in Figure#20 identiifes readmission rates for the three delegated provider groups and The Alliance UM Department. The overall readmission rate represented by Health Plan total (17.4%) is below the threshold of 18%, Of the three entities, CHCN has a readmission rate (20.7%) that exceeds the threshold of 18%.

Figure #21 2018 **Hospital readmission by Provider Group and AID Category/SPD.**

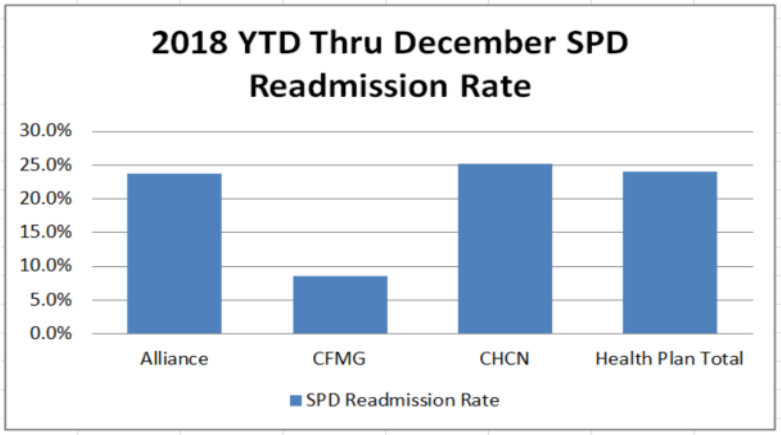
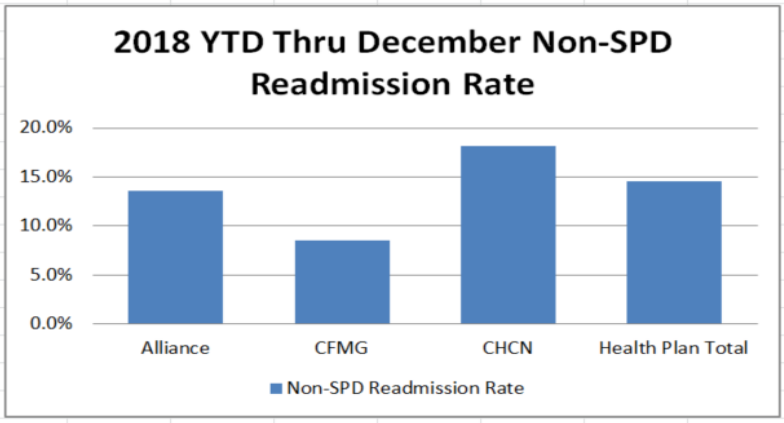


Figure #22 2018 **Hospital readmission by Provider Group and AID Category/Non-SPD.**



Data in Figures 21 and 22 identified readimssion rates by AID category. With the exception of Members assigend to CFMG, Members identified in the AID category of SPD are noted to have a higher readmission rate than non-SPDs. The overall health plan rate for SPD also exceeds the readmission threshold rate. For Members identified as non-SPD are consistently below the threshold rate.

Reduction in readmissions is the focus of a Transitions of Care (TOC) program. In 2018 the Transitions of Care program was in the refinement process, collecting data to capture the disease burden of the Alliance membership, and discussion with CHCN as the Alliance's largest delegate. Due to leadership and staffing changes and competing priorities in the department, the TOC program was not fully implemented. However, leadership is discussing including the TOC program as part of the new hospital strategic initiative activities.

Specialty Referrals

The Alliance analyzes specialty referrals by volume, type and rate of referrals.

Quantitative Analysis

Figure #23 2018 Specialty Network Referrals by Volume and Rate

2018	Q1	Q2	Q3	Q4
ALLIANCE	691	751	871	849
CFMG	11	8	10	14
CHCN	307	275	272	1880
Total	**1,009**	**1,034**	**1,153**	**2,743**
Membership	245,212	245,235	243,140	242,002
Rate	**0.41%**	**0.42%**	**0.47%**	**1.13%**

As noted in Figure #23, the overall network specialty referrals by network significantly remained steady until the last quarter of 2018, when referrals significantly increased for the CHCN delegated members. The overall specialty rate also increased in the last quarter, from .41% to 1.13%. The assessment of activities potentially leading to the trend will be discussed at the 2019 UMC meetings.

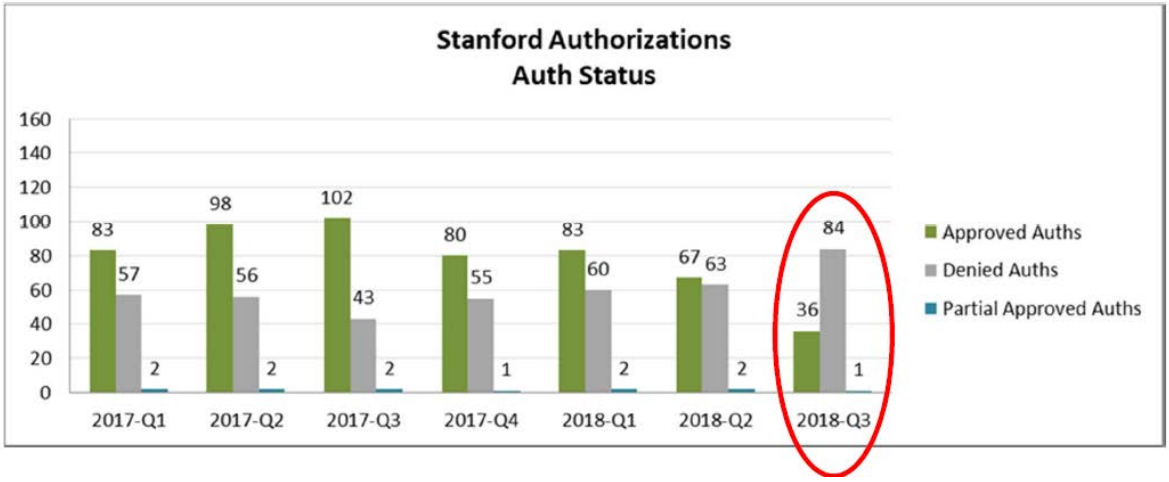
An additional issue noted was the inability to analyze referrals by type with the presented data. Recommendations are made to finalize the algorithm and reporting format to include identification of specialty referral by type.

Out of Network Services

Out of the network services are defined as any service provided by non-participating practitioners or facilities. Members may access OON services either through an emergency or as a direct referral for services not available within the network. The Alliance analyzes data related to OON services to address network deficiencies. This activity is focused at assessing requests for OON specialty services which may indicate the lack of availability of specific specialty types or geographic locations.

In 2018, The Alliance focused on monitoring OON utilization at the highest requested OON provider, Stanford Hospital Systems. The monitoring included a review each OON service request for medical necessity and the appropriateness to re-direct to an in-network provider.

Figure#24 OON UM Determinations - Stanford



Data in Figure 24 show the Authorizations request to Stanford for OON services from Q1 2017 to Q3 2018. The data measures the number of OON referrals to Stanford by the authorization determination, approved, modified and denied. The data for Q3 2018 shows the number of approved requests continued to decrease and the number of denials continues to increase.

Q4 2018 data shows a more detailed by showing inpatient and outpatient requests as well as detailed on the reasons for the approvals.

In addition, Q4 2018 data was provided in a report to the UMC:

- Q4 2018 inpatient: 17 authorization requests cases
    - 15 approvals; these are ER admission
    - 1 denied
    - 1 pending review
- Q4 2018 outpatient: 80 requests*
    - 72 denied
    - 13 approved for continuity of care
    - 1 approved: urgent care network access issue
    - 3 approved as requested

  * The data above does not add up to the total. This will need to be validated in Q1 2019.

Quantitative Analysis

The trend chart in Figure #24 showed continued trending of decreasing approvals and increasing denials. The assumption is more appropriate services are being referred to Stanford. However, there is the need for further analysis of the denials to evaluate medical necessity versus re-direction. This would include a total review of the re-directed services and if the re-directed services are appropriate for the needs of the member. Further analysis is recommended to evaluate the effectiveness of the re-direction program.

<u>Pharmacy Utilization</u>

The management and monitoring of Pharmacy utilization and activities is reported through the Pharmacy and Therapeutics Committee and HCQC. A full review of these activities can be found in the P&T Committee minutes.

Recommendations/Next Steps for 2019:

In 2019, The Alliance UM Department identified opportunities to improve the monitoring and reporting of over/under utilization management activities which included:

- Enhance UM system reporting to capture required elements for over/under utilization monitoring reports, to include access to OON specialty services and primary care,
- Develop a process to ensure receipt and management of the required UM evaluation reports.
- Emergency Room
    - Use monitoring reports identify potential frequent utilizers of ER services
    - Document CM interventions for high utilizers, including ER services
- Hospital Utilization
    - Continue to assess drivers resulting in longer than expected length of hospital stays
    - Review workflows for OON hospital management
    - Full implementation of a Transition of Care Program

- Implement process to support the early identification of members at risk for readmission which will include frailty scores and additional UM parameters such as medication monitoring to identify members at risk for readmission, developing targeted interventions to improve outcomes

- Ambulatory Setting - identify measures to monitor for care in the capitated setting
  - Primary Care and Specialty Care encounters per thousand
  - Primary/Preventive Care in the capitated setting with UM interventions–, i.e. flu vaccine, pneumococcal vaccine. Mammography, Colonoscopy.
- For OON:
  - Develop process to review monthly detailed OON reports that included more specific providers and services to support prospective analysis.
  - Continue efforts to attempt contracting with tertiary and limited availability service providers
  - Continue to explore contracting options for providers who resist conventional contracting
  - Continue to ensure that provider identification and contracting data is correct and timely.
  - Work with Provider Team to ensure that provider identification and contracting data is correctly uploaded and managed in the Alliance system

Behavioral Health

The Alliance provides access to mental health services for the Medi-Cal and Commercial membership in several ways:

- Basic mental health care needs are provided by Primary Care Providers
- Medi-Cal members with "mild to moderate" impairments in mental, emotional or behavioral functioning are referred to the contracted behavioral health delegate, Beacon Health Strategies
- Medi-Cal members diagnosed with a severe persistent mental health is carved-out and managed by Alameda County Behavioral Health Care Services Department (ACBHCS).
- Commercial members access mental health benefits through the contracted BH delegate, Beacon Health Strategies.

The Alliance works closely with both ACBHCS and Beacon to identify members who may benefit from co-management of both medical and behavioral health services.

The UM Department is also responsible for maintaining the relationship with ACBHCS to ensure eligible Medi-Cal members receive services through the Linked and Carve Out mental health programs. The focus of the activities is to ensure contracted providers continue to identify and refer members with serious persistent mental health conditions to the appropriate ACBHCS programs as well as facilitate coordination activities for co-existing medical and behavioral health disorders to assist with their treatment access and follow-up care.

The Alliance contracts with Beacon to administer the applicable Medi-Cal and Commercial mental health benefits.

Beacon and College Health IPA (CHIPA) work collaboratively to perform all behavioral health plan management functions. College Health IPA (CHIPA) is the clinical arm of Beacon performing contracting and any utilization management decisions. CHIPA maintains the NCQA accreditation. The relationship and operations are seamless to members and providers.

Figure #25– 2018 Beacon Health Strategies Agreement

Beacon – CHIPA Division of Responsibility Function	Beacon (Admin)	CHIPA (Clinical)
Contracting for Outpatient Professional services		X
Credentialing	X	
Member Services	X	
Utilization Management		X
Claims Adjudication/Payment	X	

The Alliance has developed multi-disciplinary team to analyze data and identify opportunities for collaboration between medical and behavioral health. A full description of the program activities is defined in the Beacon Behavioral Health Program Evaluation and UM Program Description. The BH documents were presented to The Alliance HCQC in 2nd Quarter 2018.

Integration with Quality Improvement/Management

The UM Department collaborates with the Quality Management on several reports which impact health services. The QM Department provides the data to the UMC for analysis to use for quality improvement activities.

Assessing Members and Practitioners' Experience with the UM Process

Provider satisfaction survey that includes experience with the UM process results were presented to during the HCQC May 3rd, 2018 meeting. The Benchmark is a comparison of the Alliance outcomes to the other plans participating in in the 2018 SPH survey:

Figure #26 2018 Provider Satisfaction with Utilization Management

Provider Satisfaction with Utilization Management				
Question	**2016**	**2017**	**2018**	**Benchmark**
Access to UM Staff	39%	46%	**41%**	33%
Obtaining Pre-Auth Info	40%	45%	**46%**	34%
Timeliness of Pre-Auth Info	38%	44%	**46%**	34%
Facilitation of Care	39%	47%	**46%**	34%
Coverage of Prevention	47%	54%	**53%**	41%

As shown above in Figure #26, the overall scores from 2017 to 2018 are relatively flat for the Provider satisfaction but are noted to be above the established benchmarks. In 2018, the Provider satisfaction with obtaining getting Pre- Auth info (46%), Timeliness of Pre-Auth Info (46%) show slight increases over 2017, they are significantly above the benchmark of 34.1%, In the area of satisfaction with access to knowledgeable UM staff, facilitation of care (46%) and Coverage of Prevention (53%) showed slight decrease over 2017 was significantly above their established benchmarks.

Overall, while the outcome results show surveyed Providers are satisfied with their UM experience, there has been very little movement of over time. Provider satisfaction will need to have increased focus in the future with a more detailed analysis to understand the drivers and how to improve the provider's experience with the UM processes.

Figure #27 2018 Member Satisfaction with Utilization Management

Member Satisfaction with Utilization Management			
CAHPS Question	**2017**	**2018**	**Percentile Rank**
Getting Care Quickly	70%	**73%**	<10th Percentile
Getting Needed Care	75%	**76%**	<10th Percentile
Coordination of Care	79%	**83%**	42nd Percentile

Member experience with the UM process is assessed using established survey Consumer Assessment of Healthcare Providers and Hospital Systems (CAHPS) which measure patient experience across health plans, providers and health care facilities. UM utilizes three questions to assess patient experience with UM, 1) Getting Care Quickly, 2) Getting Needed Care and 3) Coordination of Care. The results were presented to during the April HCQC. A full report can be found in the HCQC minutes and 2018 Quality Program Description.

As identified in Figure #27, the trending shows Member satisfaction with Getting Needed Care went from 75.3% in 2017 to 76.1% in 2018. Getting Care Quickly improved from 70.3% in 2017 to 73.2% and both are below the 10th percentile. Member satisfaction with Coordination of Care improved from 79.3% in 2017 to 83.1% in 2018, which was in the 42nd percentile, showing better performance in this area. Overall, while member satisfaction shows approximately 75% of the surveyed members are satisfied with getting the care from their physicians, these are lower outcomes compared to other health plans. Member satisfaction will need to have increased focus in the future.

Recommended Interventions/Next Steps for 2019:

In 2019, there is an opportunity to ensure the UM Department participate in the analysis of the data and development of activities associated with the member and provider experience with the UM processes. While Provider Satisfaction is above the comparative benchmark, it is still below 50%. Member experience is low compared to other health plans, and specific activities to address this will be required.

As there is continued lack of improvement with both measures, the goal for 2019 is to establish an UM improvement sub-committee to identify a strategy and address the lack of improvement for both Provider and Member experiences with the UM process.

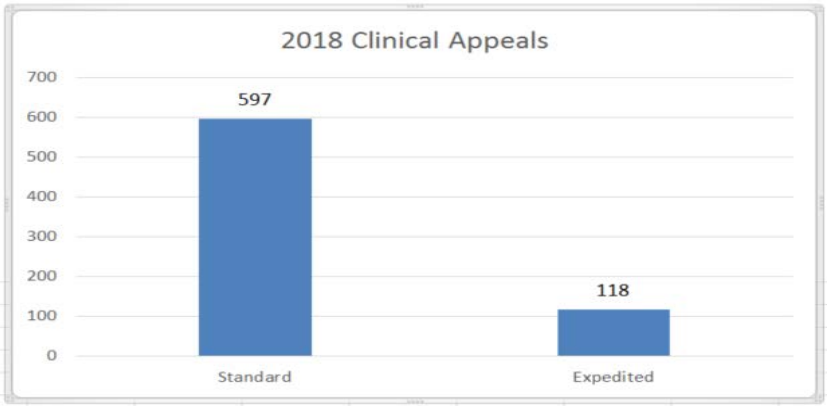
Analysis of Clinical Appeals

Quality integration activities continued with UM involvement in the analysis of member clinical appeals and overturns for medical and pharmacy services. UM participates in the analysis of clinical appeals through the UMC and HCQC. This include analyzing data by provider group responsible for the determination, by product and service type. As The Alliance only delegates the resolution of complaints and appeals to Knox Keene licensed Health Plans, the data below is inclusive of appeals of determinations made by The Alliance UM Department and all delegated provider groups except Kaiser and Beacon Health Strategies.

Clinical Appeals are investigated to determine if the initial UM determination was appropriate. The final appeal is resolved with determinations of upheld, overturn or withdraw (at the request of the member or member's authorized representative). Overturn appeal determinations are considered an opportunity to assess the UM process. The Alliance established a threshold of the overturn determination of 45%.

Quantitative Analysis

Figure #28 – 2018 Clinical Appeals



In Figure #28, The Alliance processed a total of 715 clinical appeals. Of those 597 were processed as standard requests while 118 were expedited. This represents 10% (715/7141) of all UM denial determinations made for the same time period.

Figure #29a – 2018 Clinical Appeals by Resolution/ Overturn – Threshold Compliance

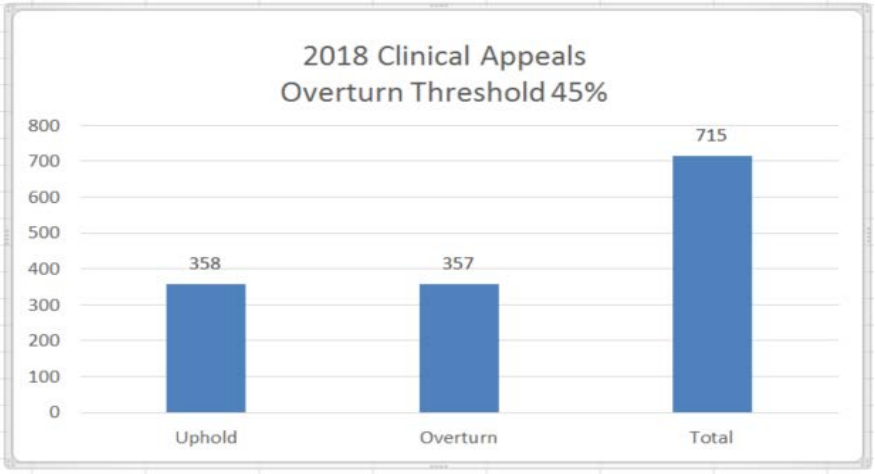
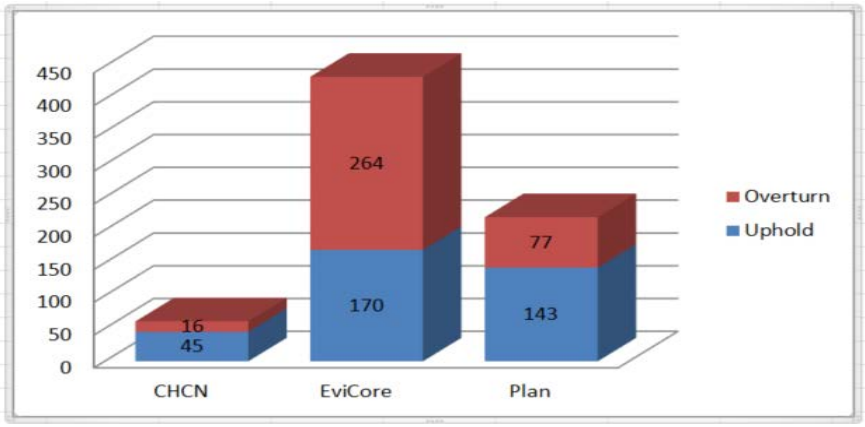


Figure #29b – 2018 Clinical Appeals by Provider Group and Resolution



Data represented in Figure 29a – the overall final determinations for the 715 clinical appeals. Of those, 358/715 or 50% were found to be appropriate thus the determination was to uphold the appeal. The remaining 357 or 50% were found to be inappropriate UM decisions resulting in an overturn of the initial UM decisions. This is above the overall overturn threshold of 45%

Further analysis of the clinical appeals was completed to identify the cases by the Provider Group responsible for the initial decision. Data in Figure 29b identified three provider groups were responsible for the total 715 cases. Of those, CHCN had an overturn rate of 26% (16/61), The Alliance was 35% (77/220) and EviCore was 61% (274/434). As a result of the higher than expected overturn rate with EviCore, The Alliance UM Department worked with EviCore UM staff to identify the areas of concern and opportunities. These outcomes led to a CAP for EviCore, which was unsuccessful in improving performance, such that the contract termination procedures were initiated.

A key finding for the 2018 involves UM clinical decision making. This is highlighted in the findings of the analysis of clinical appeals. There is an opportunity to look at additional elements to identify opportunities for improving the UM process, such as clinical decision making, application of criteria, understanding adequate information to make a determination. This may lead to educational opportunities for additional internal and external staff training on the UM processes.

Recommended Interventions/Next Steps for 2019:

For 2019, the UM Department will collaborate with the Grievance and Appeals Department and HCQC to develop various grievance codes to aid in categorizing appeals as well as a series of standard reports to identify trends. In addition, there will be an aggressive training on the use of UM criteria, hierarchy, internal monitoring and oversight and the Notice of Action. Recommendations are made to increase the IRR to at least two times a year as well the full implementation of the internal monitoring

Integration of medical and behavioral health

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

In 2018, the teams worked on efforts crossing the medical and behavioral health services which included:

- Involvement of Behavioral Health practitioners in the HCQC.
- HEDIS activities related to behavioral health measures
- Enhancing CCM outreach to chronically ill
- Improve coordination of care by increasing clinical oversight and co-management with the medical management teams
- Continued efforts toward improving communication between the primary care physician and behavioral health providers

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

Coordination with Regulatory Compliance

The Alliance UM Department works closely with the Compliance Department in preparation for regulatory audits. In 2018, the department participated in follow up reviews and work from two regulatory audits. As a result of the reviews, several internal workgroups met to identify activities targeted at resolving the identified UM related issues. The workgroups managed these activities via ongoing work-plans. The activities identified are on target for completion within the established timeframes. The activities include mechanisms for ongoing monitoring to mitigate further regulatory deficiencies.

Recommended Interventions/Next Steps for 2019:

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

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

Conclusion

Overall, the 2018 UM Program was effective in maintaining compliance with regulatory and contractual requirements, monitoring of performance within the established benchmarks or goals, identifying opportunities for improvement and enhancing processes and outcomes. The UM program activities have met a majority of the established targets. The Alliance leadership has played an active role in the UM Program structure by participating in various committee meetings, providing input and assistance in resolving barriers and developing effective approaches to achieve improvements.

UM Program Recommendations for 2019

As a result of internal performance monitoring performed in 2018, opportunities for improvement were identified and will be incorporated into the 2019 department goals. Highlights of opportunities for improvement based on the regulatory findings include:

- Develop a process to ensure receipt and management of the required UM evaluation reports.
- Improve monitoring of network utilization (over/under), including out of network authorization requests particularly focus on the Stanford analysis.
- Collaboration with The Alliance Compliance Department on the full implementation of the UM process for internal performance monitoring of UM decisions.
- Strengthen programs around oversight of clinical decision making, both internally and for Delegates.
- Implement a care transition program in partnership with Highland Hospital.
- Develop processes and enhance staffing to assume the Prior Authorizations function on radiology procedures from eviCore.
- Analyze the opportunity and implement the process to increase the number of authorizations that are appropriate for automatic approval.
- Enhance the current transportation benefit reporting to ensure Member access to the transportation benefit.

- Improve reporting and analysis of grievance and appeals activities related to UM decision making and analysis for member and provider experience with UM.
- Establish an UM improvement sub-committee to identify a strategy and address the lack of improvement for both Provider and Member experiences with the UM process.
- Continue implementation for tracking and intervening with unused Authorizations to ensure that members receive appropriate care and follow up.
- Operationalize the Palliative Care benefit for members, members under age 21.
- Completed analysis of hospital data and develop an individual hospital strategy for management of members for appropriate length of stay.
- Develop standardized work and a training program for the UM department staff to ensure regulatory compliance.
- Develop a standard process for policy review and revision that ensures UM processes maintain operational and regulatory compliance.

Quality Improvement Program
Program Evaluation

2018

2018 Quality Improvement Program Evaluation
Signature Page

Date _____

Sanjay Bhatt, M.D.
Medical Director, Quality Improvement
Vice Chair, Health Care Quality Committee

Date _____

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

Date _____

Scott Coffin
Chief Executive Officer

Date _____

Evan Seevak, M.D.
Board Chair

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
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INTRODUCTION

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

Under the leadership and strategic direction established by Alameda Alliance for Health (The Alliance) Board of Directors, senior management and the Health Care Quality Committee (HCQC), the Health Services 2018 Quality Improvement Program was successfully implemented. This report serves as the annual evaluation of the effectiveness of the program activities.

The processes and data reported covers activities conducted from January 1, 2018 through December 31, 2018.

Membership and Provider Network

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

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

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Current Membership by Network By Category of Aid

Category of Aid	Dec 2018	% Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN	KAISER
ADULTS	35,559	14%	9,163	6,892	351	13,447	5,706
CHILD	95,322	37%	9,459	8,355	29,880	31,404	16,224
SPD	26,006	10%	8,918	3,576	1,350	10,309	1,853
MCE	85,345	33%	15,620	27,478	929	32,656	8,662
DUALS	16,072	6%	6,297	1,812	10	6,167	1,786
Medi-Cal	258,304		49,457	48,113	32,520	93,983	34,231
Group Care	5,886		2,695	760	0	2,431	0
Total	**264,190**	**100%**	**52,152**	**48,873**	**32,520**	**96,414**	**34,231**
Medi-Cal %	97.8%		94.8%	98.4%	100.0%	97.5%	100.0%
Group Care %	2.2%		5.2%	1.6%	0.0%	2.5%	0.0%
	Network Distribution		***19.7%***	***18.5%***	***12.3%***	***36.5%***	***13.0%***
			% Direct:	**38%**		**% Delegated:**	**62%**

Age Category Trend

	Members			
Age Category	Dec 2016	Dec 2017	Nov 2018	Dec 2018
Under 19	101,385	103,264	98,950	98,122
19 - 44	86,207	87,080	84,900	84,866
45 - 64	59,141	58,915	57,493	57,340
65+	20,317	22,538	23,789	23,862
Total	267,050	271,797	265,132	264,190

In 2018, the Alliance membership remained relatively steady, as seen in Figure 1. Compared to 2017, the Alliance lost a small number of members in 2018, (271,797 to 264,190) from the Adult and Child members.

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

Provider Network	Provider Type	Members (Enrollment)	% of Enrollment to Network
Independent (Direct)	Independent	52,152	19.7%
Alliance Health Systems	Managed Care Organization	48,873	18.5%
Children First Medical Group (CFMG)	Medical Group	32,520	12.3%
Community Health Clinic Network (CHCN)	Medical Group	96,414	36.5%
KAISER	HMO	34,231	13.0%
Total		**264,190**	**100.0%**

Figure 2 Provider Network by Type, Enrollment and Percentage

From 2017 to 2018, the percentage of members within each network has remained steady.

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

- Ambulatory care
- Hospital care
- Emergency services
- Behavioral health (mental health and addiction medicine)
- Home health care
- Hospice
- Palliative Care
- Rehabilitation services
- Skilled nursing services - Skilled
- Managed long term services and support (MLTSS)
    - Community based adult services
    - Long Term SNF Care (limited)
- Transportation
- Pharmacy
- Care coordination along the continuum of care including arrangements for linked and carved out services, programs, and agencies.

These services are provided through a contracted network of providers that include a hospitals, nursing facilities, ancillary providers and contracted vendors. The providers are responsible for identified services through contractual arrangements and delegation agreements.

The Alliance provider network includes:

The Alliance Ancillary Network	
Hospitals	15
Behavioral Health Network	1
DME Vendor	1
Transportation Vendor	1
Pharmacies/Pharmacy Benefit Manager	Over 200
Radiology Consulting Services	1

Figure 3: Alliance Ancillary Network

Alliance members may choose from a network of over 550 primary care practitioners (PCPs), 6000 specialists, 17 hospitals, 73 health centers, 52 nursing facilities and more than 200 pharmacies throughout Alameda County. The Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan members. Our members' optimal health is always our first priority.

The Alliance Quality Improvement (QI) Program strives to ensure that members have access to quality health care services.

PURPOSE

The Alliance evaluates its QI Program annually to determine the overall effectiveness in meeting the goals and objectives of the QI Program and Work Plan, identifying improvement opportunities, and assessing progress toward improved network practices. The evaluation includes input from multiple departments. The Alliance uses the annual evaluation to identify goals, objectives, and activities for the QI Program in the coming year.

This evaluation assesses the following elements:

- Effectiveness of the QI structure;
- Overall effectiveness of the QI program;
- Completed and ongoing QI activities;
- Performance measure trends;
- Analysis of QI initiatives and barriers to improvement;
- Delegated entities' performance

The annual QI Program Evaluation is reviewed and approved by the Health Care Quality Committee (HCQC) prior to being submitted for review and approval by the BOG. The HCQC and the BOG also review and approve the QI Program Description and Work Plan for the upcoming year.

QI STRUCTURE AND RESOURCES

A. QI Structure

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

B. Governing Committee

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

The HCQC recommends policy decisions, analyzes and evaluates the Quality Improvement, Utilization Management (UM) and Case Management Work Plan activities. HCQC also assesses the overall effectiveness of the QI, UM and CM Programs. The HCQC met a total of 7 times in 2018:

- January 4, 2018
- March 1, 2018
- April 12, 2018
- May 3, 2018
- July 19, 2018
- September 6, 2018
- November 15, 2018

C. Committee Structure

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

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

HCQC charters a sub-committee, the Internal Quality Improvement Sub-Committee (IQIC) which serves as a forum for the Alliance to evaluate current QI activities, processes, and metrics. The IQIC also evaluates the impact of QI programs on other key stakeholders within various departments and when needed, assesses and plans for the implementation of any needed changes. HCQC assumes responsibility for oversight of the IQIC activities and monitoring its areas of accountability as needed. The structure of the committee meetings was redesigned to increase engagement from all participants.

On April 12, 2018, the 2017 QI Program Evaluation was presented to the HCQC and unanimously approved and on May 3, 2018 the 2018 Program Description and Work Plan were both presented to the HCQC and unanimously approved.

The major committees that support the quality and utilization of care and service include the HCQC, Pharmacy and Therapeutics Sub-committee, Utilization Management (UM) Subcommittee, Access and Availability Subcommittee, and Internal Quality Improvement Subcommittee (IQIC). Also, various joint operations meetings (JOMs) support the quality and utilization of care and service. Each committee meets at least quarterly, some monthly, and all committees / sub-committees reports directly to the HCQC. Additionally, the Peer Review and Credentialing Committee supports the quality and utilization of care and service and reports directly to the BOG. Each committee continues to meet the goals set forth in their charters. The HCQC membership includes practitioners, leadership, and staff.

D. **Evaluation of Senior-level Physician and Behavioral Health Practitioners**

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

During 2018 Dr. Aaron Chapman, a psychiatrist and Medical Director of Alameda County Behavioral Health Care Services (ACBHCS), actively participated in the HCQC meetings and provided clinical input ensuring policies and reports considered behavioral health implications.

The active involvement of senior-level physicians including the psychiatrist from ACBHCS has provided consistent input into the quality program. Their participation helped ensure The Alliance is meeting accreditation and regulatory requirements.

E. **Program Scope and Structure**

The Alliance QI Program encompasses the quality of care across the continuum. QI Program activities include the following but are not limited to:

- Effectiveness of the QI structure;
- Overall effectiveness of the QI program;
- Completed and ongoing QI activities;
- Performance measure trends; and
- Analysis of QI initiatives and barriers to improvement.
- Delegated entities' performance.
- Monitoring and auditing delegated entities QI activities for compliance to contractual requirements with implementation of corrective action plans as appropriate
- Internal monitoring and auditing for compliance
- Departmental policies, procedures and processes with implementation of corrective action plans as appropriate

F. **QI Resources**

The Alliance QI Department is staffed with physicians, nurses and non-clinical support staff including clerical support and clinical support coordinators. The assignment of work to the team, whether working on site or remotely, for both clinical and non-clinical activities, is seamless to the process as it did not change the team member's job responsibilities or job description. The job descriptions with assigned tasks and responsibilities remained the same regardless of the geographical location of the team member.

During 2018 several key leadership roles in Health Services were hired:

- Chief Medical Officer
- Medical Director of Quality Improvement
- Director of Health Care Services
- Director of Pharmacy
- Temporary Quality Director
- Temporary Quality Manager
- Outpatient Manager of Utilization Management

The timelines for positions is noted below:

- Q1, 2018:
    - Chief Medical Officer was hired

    - Medical Director of Quality Improvement was hired
    - One Quality Improvement Nurse was hired
    - One Quality Improvement Project Specialist was hired
- Q2, 2018:
    - One Quality Improvement Project Specialist left the Alliance
    - One Quality Improvement Project Specialist was hired
    - Temporary Quality Director and Temporary Quality Manager were hired
    - Previous Interim Quality Director moved into a new role as the Director of Access and Availability at the Alliance
    - Facility Site Review Nurse began long-term leave
    - Certified Facility Site Review Nurse Master Trainer retired
- Q3, 2018:
    - One CM Nurse transferred to the role of QI Project Specialist
    - One Quality Improvement Project Specialist left the Alliance
    - Temporary Facility Site Review Nurse hired
- Q4, 2018:
    - One Quality Improvement Nurse left the Alliance
    - One Facility Site Review Coordinator left the Alliance
    - Facility Site Review Nurse returned from long-term leave
    - Temporary Director of QI completed their maximum hours and left the Alliance
    - Temporary Manager of QI completed their maximum hours and left the Alliance

In 2018, based on the established staffing ratios and roles, the QI Department continued to work towards timelier hiring for both department and leadership roles. As a result, QI staffs outside of their defined roles often performed to complete the necessary tasks. With the onboarding of new leadership, the Health Care Services Department teams will be reviewing the current organization goals and restructuring the Departments to achieve those goals. The Alliance continues to evaluate staff turn-over and strives to provide a positive work environment, thus, creating a more stable work force.

OVERALL PROGRAM EFFECTIVENESS

The Alliance's improvement efforts strive to impact the quality of care and service provided to our members and providers. Review of the Alliance's QI activities as described herein demonstrate the ability to successfully achieve the following:

- Improved focus on the importance of chronic condition management, and accessing appropriate care through initiatives to educate and connect with members, work with providers, and enhance our internal operations.
- Improved focus on the analysis of key drivers of access to care
- Expanded our knowledge of health disparities amongst Alliance members
- Promoted the awareness and concepts of inter-departmental organizational QI, including Plan-Do-Study-Act (PDSA), Inter-Rater Reliability (IRR), to create greater operational efficiency and capacity.
- Invested in quality measurement expertise.
- Identifying and categorizing Potential Quality Issues (PQIs) followed by assisting partners in root-cause analysis to identify and overcome barriers and roadblocks
- Exhibited improvement in HEDIS measures' performance including CCS, CDC, and IMA
- Ensuring that providers regularly are evaluated through the Facilty Site Review Process
- Continued focus on hiring new staff for the QI Department.

The Alliance is invested in a multi-year strategy to ensure that the organization adapts to health plan industry changes now and within 3 - 5 years. An effective QI program with adequate resources is essential to the Alliance's successful adaptation to expected changes and challenges.

A. Serving Members With Complex Conditions

The Alliance continues to identify members in need of supportive services based on complex health conditions. The Alliance links members to Asthma and Diabetes Disease Management, Complex Case Management and Transition of Care.

Members are identified as potential candidates for Asthma Disease Management and are mailed outreach materials explaining their illness and the process to enroll in Disease Management. Disease Management is optional so members who do not pursue Disease Management programs are also provided information related to community resources that support their conditions.

Members are identified as high risk through claims, encounter and referral sources. These members are forwarded to case management for follow up. Complex Case Management staff outreach to high risk members by telephone. When outreach attempts are successful, initial assessments are performed and care plans are developed. Members who agree to care are provided assistance with provision of services and recommendations to support managing their conditions. When outreach is attempted but unsuccessful, the case is closed.

Members are also identified for transition of care assistance. Transition of Care assistance occurs for members who are discharged from Medical or Surgical inpatient care settings. Case and Disease Management processes and outcomes are provided in the Case Management and Disease Management program documents.

PROVIDER OUTREACH

During 2018, the Provider Services department provided their continued outreach to all PCP, Specialists and Ancillary provider offices via in-person visits and the use of fax blasts.

Topics covered in the visits and fax blasts included: use of the provider portal, the announcement of the Member Satisfaction survey, review of HEDIS measures, interpretive services, cultural sensitivity, Health Wellness, Provider Dispute Resolution (PDR) policy and procedure, updated drug formulary schedule change, announcement of the acupuncture benefit, instructions on discharging members from provider practices, Fraud Waste and Abuse reporting, Provider Appointment Availability Survey (PASS), the announcement of the Claims Editing System software, tobacco cessation counseling and Pay For Performance and DHCS' final rule impact on managed Medi-Cal plans.

In addition to ongoing quarterly visits, every newly credentialed provider received a new provider orientation within 10 days of becoming effective with the Alliance. This orientation includes a very detailed summary which includes but not limited to:

- Plan review and summary of Alliance programs
- Review of network and contract information
- How to verify eligibility
- Referrals and how to submit prior authorizations
- How to submit claims
- Filing of complaints and the appeal process
- Initial Health Assessment
- Coordination of Care, CCS, Regional Center, WIC program
- Members Rights and Responsibilities
- Member Grievances

Overall, there were approximately 465 provider visits completed during the 2018 calendar year.

MEMBER OUTREACH AND MEMBER SERVICES

The Alliance Member Services (MS) Department has a strong focus on providing high-quality service. Quarterly call center metrics are presented below in the member services dashboard; the dashboard represents blended (MediCal and Group Care) customer service results.

Alliance Member Services Staff	Q1, 2018	Q2, 2018	Q3, 2018	Q4, 2018
Incoming Calls (MS)	48458	41545	40474	36573
Abandoned Rate (MS)	3%	3%	3%	2%
Answered Calls (MS)	47078	40396	39334	35708
Average Speed to Answer (ASA)	00:25	00:25	00:20	00:16
Calls Answered in 30 Seconds (All)	85.0%	86%	87%	90%
Calls Answered in 10 Minutes (goal: 100%)	100.0%	100.0%	100.0%	100.0%
Recordings/Voicemails	Q1	Q2	Q3	Q4
Incoming Calls (R/V)	7051	6030	2639	2381
Abandoned Rate (R/V)	0.0%	0.0%	0.0%	0.0%
Answered Calls (R/V)	7051	6030	2639	4081
Calls Answered in 30 Seconds (R/V)	100%	100%	100%	100%
Blended Results	Q1	Q2	Q3	Q4
Incoming Calls (R/V)	55599	47575	43113	38954
Abandoned Rate (R/V)	2%	2%	3%	2%
Answered Calls (R/V)	54129	46426	41973	38089
Average Speed to Answer (ASA)	00:25	00:25	00:20	00:16
Calls Answered in 30 Seconds (R/V)	87%	88%	87%	91%

Targets:

1. **To answer 80% or more calls within 30 seconds**
2. **Abandoned Rate of 5% or less.**

In 2018, Member Service staff met target call service metrics to answer 80% or more calls within 30 seconds and experience less than 5% abandonment.

A. Member Advisory Committee (MAC)

The Member Advisory Committee's function is to provide information, advice, and recommendations to the Alliance on educational and operational issues in respect to the administration of the Alliance's cultural and linguistic services. These advisory functions include, but are not limited to, providing input on the following:

1. Culturally appropriate service or program design
2. Priorities for the health education and outreach program
3. Member satisfaction survey results
4. Findings of health education and cultural and linguistic group needs assessment
5. The Alliance's outreach materials and campaigns
6. Communication of needs for provider network development and assessment
7. Community resources and information

The Member Advisory Committee shall also receive information from the Alliance on public policy issues, including financial information and data on the nature and volume of grievances and their disposition.

The MAC met four times in 2018:

- March 15, 2018
- June 14, 2018
- September 20, 2018
- December 20, 2018

Some of the key topics discussed in 2018 include:

- Cultural and Linguistics Work Plan and Report
- Grievances & Appeals
- Health Risk Assessment
- Communications & Outreach collateral, events and activities
- Health Education Report
- Outreach Report
- Quality Improvement and HEDIS results
- Opioids Program
- Member Ambassador Program
- Member Listening Sessions
- Web-based provider survey
- Preventive Care handout review
- Questions & Answers for member concerns

B. Member Newsletter

The Alliance Spring/Summer and Fall/Winter *Member Connect* newsletter was published and shared with more than 165,000 member households and provider offices in 2018. The newsletter contained a variety of disease self-management and preventive care topics such as asthma, diabetes, heart disease, pregnancy, exercise, appropriate ER use, smoking cessation, immunizations, healthy eating, physical activity, blood lead testing and preventive care visits.

SAFETY OF CLINICAL CARE

The Alliance has an organizational focus on maintaining safety of clinical care for its membership.

A. Substance Abuse Disorder

The Alliance is in the process of partnering with our providers and other local leaders to develop an Opioid Management Program. This approach includes a focus on:

1. Developing a comprehensive opioid educational program and materials for Alliance providers
2. Ensure members have access to alternative medications and therapies to reduce opioid use
3. Establish appropriate use criteria for using over 120 milligrams of morphine per day and subsequent dose increases
4. Ensure appropriate use of long-acting opioids and prevention of inappropriate dose escalation
5. Reduce potentially inappropriate use of multiple long-acting opioids together
6. Remove/restrict use of medications commonly abused with opioids that have formulary alternatives
7. Reduce use of opioids for treatment of low-evidence conditions in accordance with CDC Guidelines

The 3 phases of the pharmacy intervention are detailed below:

Phase Ia (1/1/2018): Dose Increase Limitation

- All members who are increasing opioid dose greater than 120 Morphine Equivalent per Day (MED) will be required to provide explanation for dose increase.
    - Prescribers will fill out a standardized form to include with prior authorization request that will highlight patient's:
        - Current MED
        - Proposed MED and explanation for dose increase
        - Diagnosis and duration of treatment
        - Alternative treatments already used (non-narcotic drugs, surgery, acupuncture, physical therapy, etc.)
        - Attestation from prescriber that PDMP was accessed, complete assessment for pain and function performed, and benefits and potential harm of opioids has been discussed with patient
- All members already on 120 MED or greater will not be allowed to have any dose increase without an explanation for it.
- Quantity limit restrictions will be set in place on all formulary opioids for each single-dose strength, not to exceed a maximum daily dose of 120 MED.
    - Given new quantity limit, will convert the following single dose strengths to non-formulary status:
        - Morphine 100mg and 200mg extended-release tablets

- Methadone 40mg soluble tablet

Phase Ib (1/1/2018): Reduction of stable high dose opioids

- Prescribers will be required to provide explanation for all patients on stable, high dose opioids.
- Documentation of a "taper plan" will be required for patients on stable, high dose opioids who do not have a proper justification for continuing on high dose. Taper plan should document exact process on de-escalating patient's opioid dose over a proposed period of time.
- Create a registry to monitor all high dose opioid patients and track progress in reducing daily morphine equivalent doses.

Phase II (4/1/2018): Opioid New Start (Acute Pain)

- Quantity limits will be placed for all patients who are new to opioid therapy
  - Short acting opioids: 30 units per 90 days
  - Liquid/solution/syrup opioids: 240 ml per 90 days
- Prescriptions exceeding these quantity limits will require explanation for higher quantity needed.
- Plan will not allow more than 1 short acting opioid to be prescribed at the same time.

Alongside the pharmacy team, the QI team is in the process of implementation of a 3-prong approach to addressing members with Substance Abuse Disorder along the continuum of care. The 3 Prong approach focuses on:

1. Prevention – includes Provider Education, Community Outreach, Pharmacy Safeguards
   a. Provider Education has / will continue to have a focus on an Introduction Letter specifically addressing Best Practices, encouraging X-Waivers, assisting providers to understand their local network, and upcoming pharmacy UM Limits. Additionally, education will focus on regular provider outlier report that identifies changes in prescribing habits and outliers to under and over-prescribing. Additionally, evidence based use of opioids will be promoted through the planned 2019 Pay-For-Performance Program. This program was finalized in 2018.
   b. Community Outreach with local partnerships (including Emergency Departments, Hospital Leadership, Medical Organizations, Department of Public Health, and County Leadership
   c. Pharmacy Safeguards which includes removing the prior authorization (PA) for most non-opioid pain medications (see below table), removing commonly over-used / abused drugs from the formulary, implementing a pharmacist review of all long-acting opioid PAs to ensure that treatment diagnosis are consistent with CDC guidelines (and does not include chronic lower back pain, migraines, neuropathic pain, osteoarthritis). Pharmacists also ensure the co-prescription of naloxone. Finally, formulary limits were implemented in a step-wise approach; this will continue into 2019.

Below is a table that exhibits AAH step-wise approach to ensure the safe and effective use of opioids.

Substance Abuse Program	2017	Dec, 2017	June, 2018	Dec, 2018	June, 2019
"New Start" SAO Limit	None	None	None	14 days	14 days
SAO QL per month	#180	#180/30d	#180/30d	**#90/30d**	**#60/30d**
PA for all LAOs	No	**Yes**	Yes	Yes	Yes
LAO increase limit	No	**Yes**	Yes	Yes	Yes
Cover Alprazolam	Yes	**No**	No	No	No
Cover Carisoprodol	Yes	**No**	No	No	No
Lorazepam Limits	No	**3/day**	3/day	3/day	3/day
Clonazepam Limits	No	**3/day**	3/day	3/day	3/day
Oxazepam Limits	No	No	**1/day**	1/day	1/day

Key achievements of goals include (see above table):

- Removal of PA for most NSAIDs and neuropathic agents (see below table)
- SAO (Short acting opioids) have a 14 day limit on their initial start.
- SAO have / will continue to have step-wise quantity restriction limits.
- All long acting opioids (LAO) require a prior authorization (PA).
- Concurrent prescription of benzodiazepines and opioids require a PA and the prescription of naloxone.
- LAO require the concurrent prescription of naloxone.
- Monitoring of Member Grievances

Class	Drug	Limit	Notes
NSAIDs	Ibuprofen		No restrictions.
	Naproxen		
	Nabumetone		
	Diclofenac		
	Indomethacin		
	Sulindac		
	Meloxicam		
	Etodolac		
	Celecoxib (Celebrex)	QL	Limited to 60 capsules per 30 days
	Diclofenac Gel (Voltaren)	QL	Limited to 200g (two boxes) per 30 days
	Diclofenac soln. (Pennsaid)	PA	Reserved for trial and failure of Voltaren Gel.
Neuropathic Agents	Gabapentin		
	Amitriptyline, Nortriptyline		
	Venlafaxine IR / XR		
	Duloxetine (Cymbalta)		
	Milnacipran (Savella)	NF	
	Pregabalin (Lyrica)	PA	Reserved for treatment failure of gabapentin at dose larger than 1800mg/day for at 2 months and two other neuropathic pain medications
Other	Lidocaine (Lidoderm) 5% patches	PA	Reserved for treatment failure of gabapentin at dose larger than 1800mg/day for at 2 months and two other neuropathic pain medications

2. Intervention and Treatment – Includes Member Education, Access to MAT and Adjunctive Therapies
3. Recovery Support – Includes Integrated Care and Complex / Care Management – Limited given limited Case Management Staff; see 2018 UM/CM Evaluation

B. Drug Recalls

The Pharmacy Department monitors all drug recalls. In 2018, pharmacy recall information is as below:

Total number of safety notices/recalls	64
Total number of withdrawals	0
The number of notifications where PBM completed a claims data review	25

In 2018, there were 64 recalls. Recalls were monitored for adversely affected members.

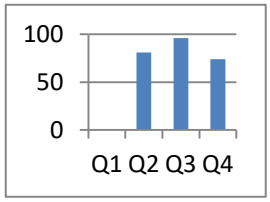
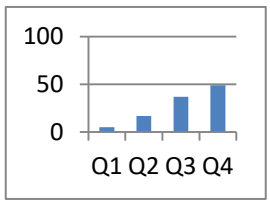
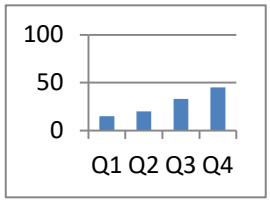
The Alliance website has a continuous flow of safety resources for members and providers and includes FDA recalls, Risk Evaluation and Mitigation Strategies, a Patient Safety Resource Center, and Drug Safety Bulletins.

C. Potenial Quality Issues - Quality of Care

Potential Quality Issues are defined as a suspected deviation from expected provider performance, clinical care or outcome of care which requires further investigation; further investigation can determine whether an actual quality issue exists.

The QI Department investigates all Potential Quality Issues (PQIs). These may be submitted by members, practitioners, or internal staff. When a PQI is identified, it is forwarded to the Quality Department and logged into a database for tracking. Quality Review Nurses investigate the incident and summarize the findings. The Medical Director reviews all PQI summaries where a quality of care issue is identified. A Medical Director will refer cases to the Peer Review and Credentialing Committee (PRCC) for resolution, if found to be a significant quality of care issue (Clinical Severity 3, 4).

Alameda Alliance for Health's Quality department received two-thousand nine-hundred and fifteen (2915) Potential Quality Issues (PQIs), during measurement year 2018. The quarterly frequencies are listed in the table below:

Indicator 1: Compliance with the 90 day turn-around time	**Q1, 2018**** Denominator: N/A Numerator: N/A	**Q2, 2018** Denominator: **107** Numerator: **87** Rate: **81%** Goal Met: **No** Gap to goal: **9**% points	**Q3, 2018** Denominator: **134** Numerator: **128** Rate: **96%** Goal Met: **Yes**	**Q4, 2018** Denominator: **83** Numerator: **63** Rate: **76%** Goal Met: **No** Gap to goal: **14**%	
Indicator 2: QOC PQIs	**Q1, 2018** Denominator: **1135** Numerator: **60*** Rate: **5%** Goal Met: No Gap to goal: **55%** points	**Q2, 2018** Denominator: **1,289** Numerator: **107** Rate: **17%** Goal Met: **No** Gap to goal: **63**% points	**Q3, 2018** Denominator: **358** Numerator: **134** Rate: **37%** Goal Met: **No** Gap to goal: **43%** points	**Q4, 2018** Denominator: **133** Numerator: **65** Rate: **49%** Goal Met: **No** Gap to goal: **11%** points	
Indicator 3: QOC PQIs leveled at severity C2-4	**Q1, 2018** Denominator: **60*** Numerator: **9** Rate: **15**% Goal: N/A	**Q2, 2018** Denominator: **107** Numerator: **21** Rate: **20%** Goal: N/A	**Q3, 2018** Denominator: **134** Numerator: **44** Rate: **33%** Goal: N/A	**Q4, 2018** Denominator: **65** Numerator: **29** Rate: **45%** Goal: N/A	

*Approximate number given changes in data source, reporting, and backlog issue

**2 Backlog issues caused a delay in QI referral; Over an additional 1,000 PQIs were identified through the below mentioned IT backlog glitch.

In 2017, the Quality Improvement (QI) team received about **300** PQIs; in December of 2017, the QI team trained all AAH staff and changed the referral criteria. As a result, in 2018, the QI team received almost **3000** PQIs. Independently, in Q1 of 2018, the team identified an IT glitch that caused 2 backlogs of over 1000 cases. These were identified and disclosed to our auditors; they were then reviewed and closed by the QI team.

In 2018, the QI team has undergone 2 independent PDSA (Plan-Do-See-Act) cycles.

First, the team devised a method to 1) provide oversight of exempt and standard grievances 2) encourages *clinical* referrals and 3) ensures that services and access issues are addressed through other existing channels. Given this change, the QI team is staffed to receive **600** PQIs in 2019 – this number is more consistent with plans of our size.

The second PDSA cycle is around the technological support of the QI team. In 2017 and 2018, the team heavily relied on Microsoft Excel. In Q4 2018, phase 1 of the PQI Application was introduced, and subsequent phases will allow the QI team to transition from Excel to a home-built application.

As quality is our top priority, PQIs that result in potential or actual member harm are a top priority. In the past 1.5 years, the team has undergone significant transitions, however, through 2 PDSA cycles, the team effectively addresses PQIs. It also works closely with partners to perform root-cause-analysis to improve patient care. Finally, it has created a path to ensure that cases that significant deviate from the standard of care are reviewed by our Peer Review Committee.

D. Consistency in Application of Criteria (IRR)

The Alliance QI Department assesses the consistency with which physicians, pharmacist, UM nurses, Retrospective Review nurses and non-physician reviewers apply criteria to evaluate inter-rater reliability (IRR). A full description of the testing methodology is available in the QI Program and Quality Improvement policy 133. QI has set the IRR passing threshold as noted in Figure 6.

Inter-rater Reliability Thresholds

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

The IRR process for PQIs uses actual PQI cases. IRRs included a combination of acute and/or behavioral health IRRs. All new hire staffs are trained and participate in the IRR process upon completion of their training. Results will be tallied as they complete the process and corrective actions implemented as needed. When opportunities for improving the consistency in applying criteria, QI staff addresses corrective actions through requiring global or individualized training or completing additional IRR case reviews.

For 2018, IRR testing was performed for QI clinical staff to establish consistency in practice and outcomes for members. Of the clinical nurses and physician, all passed on the initial review with 100%.

E. Facility Site Review

Facility Site Review (FSR), Medical Record Review (MRR) and Physical Accessibility Review (PAR) is mandated for each Health plan under Plan Letter 14-004 and 15-023 every 3 years. Mid-cycle follow-up

is required for FSR and MRR. Corrective Action Plans are required depending on the site FSR and MRR scores. Site reviews are another way the QI Department ensures safety within the provider office environment. In 2018, the QI Department lost a Master Trainer Review Nurse; while FSRs were completed through a temporary nurse, a new Master Trainer was hired and efficiently and effectively completed the requires FSRs.

In 2018, there were 68 site reviews. The total number of FSR / MRR / Mid-Cycle FSR / Mid-Cycle MRR are as detailed in the table below:

Year: 2018	Q1	Q2	Q3	Q4
FSR: Full Scope	6	1	3	32
FSR: Initial	0	2	4	1
MRR: Initial	0	2	0	0
MRR: Follow Up	1	0	0	0
FSR/MRR: Mid-cycle	8	2	0	5
FSR: Mid-cycle	0	0	0	1
Total Reviews	15	7	7	39

These reviews resulted in 52 corrective action plans and follow-up with the practice sites.

Year: 2018	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Total CAPs	13	5	2	30
Open CAPs	0	1	0	0
Closed CAPs	13	4	2	29

PEER REVIEW AND CREDENTIALING COMMITTEE (PRCC)

The PRCC met monthly and conducted a comprehensive review of each practitioner before credentialing or re-credentialing was complete. If any issues were identified, a thorough review by the committee was completed to ensure that there were not quality or safety issues.

Any practitioner that was not board certified was reviewed by the committee. In 2018, 27 practitioners were reviewed for lack of board certification. If there were complaints about a practitioner's office, facility site reviews were conducted and the outcome was reviewed by the PRCC. There was no site reviews conducted based on complaints in 2018. All grievances, complaints, and PQIs that required investigation were forwarded to this committee for review. In 2018, 62 practitioner grievances, complaints, or PQIs were investigated by the committee. There were no practitioners that required reporting to National Practitioner Data Bank (NPDB) by the Alliance.

In 2018, the PRCC granted one year reappointment for three practitioners and a two year reappointment for grievances filed regarding office procedures. Additionally, one practitioner was terminated from the Alliance network for not disclosing correct information on original attestation and NPDB. The table below shows evidence of practitioner review by the PRCC prior to credentialing and re-credentialing decisions.

Count of Practitioners Reviewed
Quality Issues At PRC in 2018

PRC Date	NPDB Record Identified	Attestation	Malpractice (pending or dismissed)	Facility Site Reviews	Grievance, Complaints, PQI	License Action	Board Certification	Total
1/18/2018	1							1
2/20/2018			4		8		3	15
3/20/2018	4		1		6		2	13
5/15/2018	2		1		7		1	11
6/26/2018	2		1		3		1	7
7/17/2018					4		2	6
8/21/2018	3				8		4	15
9/18/2018	1		1		4		4	10
10/16/2018	2		2		10		1	15
11/27/2018	2	1	2		8		8	21
12/18/2018	1				4		1	6
	18	1	12	0	62	0	27	120

DELEGATION OVERSIGHT

The Alliance conducts quarterly and annual delegation oversight in compliance with Department of Health Care Services (DHCS), DMHC, and the National Committee for Quality Assurance (NCQA) regulations. Annual delegation oversight reviews were conducted in 2018.

Results from the reviews are reported to the Compliance Committee. The QI delegation audit results were also reported to the HCQC.

In addition to the annual oversight audits, the Alliance holds quarterly Joint Operations Meetings with delegates. It also holds regular Executive Team meetings with CHNC and AHS Leadership. Both the Alliance and the delegate contribute to the agenda items. The agenda includes a discussion of claims, information technology, provider relations, member services, quality issues/progress, and new legislation. Also, weekly or biweekly calls are often held with the delegates to resolve any immediate concerns. The Alliance places a high degree of importance on problem solving and communicating with delegates.

The Alliance conducted Joint Operations meetings with the delegated groups to review HEDIS performance specific to their group and to identify opportunities for improvement, strategies for improvement of scores, and HEDIS timelines for reporting year 2019.

The following delegated groups were audited in 2018:

2018 AAH Delegation Audit Schedule											
Delegate Name		Service Type	Product Line		Quality Improvement	Utilization Management	Credentialing/ Re-Credentialing	Rights and Responsibilities	Claims	Case Management	BHT
			MCAL	GC							
1	KAISER	Fully Delegated	X		11/06/18	11/06/18	NCQA	11/06/18	11/06/18	11/06/18	11/06/18
2	BEACON HEALTH STRATEGIES LLC	Mental Health, Partially Delegated	X	X	8/16/18	8/16/18	NCQA	N/A	8/16/18	8/16/18	11/06/18
3	COMMUNITY HEALTH CENTER NETWORK (CHCN)	Partially Delegated	X	X	N/A	10/09/18	N/A	N/A	10/09/18	10/09/18	N/A
4	CHILDREN'S FIRST MEDICAL GROUP (CFMG)	Partially Delegated	X		N/A	9/10/18	7/01/17	N/A	9/10/18	N/A	N/A
5	PERFORMRX	Pharmacy	X	X	N/A	1/01/18	1/01/18	N/A	1/01/18	N/A	N/A
6	MARCH VISION CARE GROUP, INC.*	Vision	X		N/A	N/A	7/01/17	N/A	11/01/18	N/A	N/A
7	CALIFORNIA HOME MEDICAL EQUIPMENT (CHME)	DME	X	X	N/A	8/30/18	N/A	N/A	N/A	N/A	N/A

8	EVICORE*	Specialty Radiology	X	X	N/A	11/01/18	N/A	N/A	N/A	N/A	N/A
9	PHYSICAL THERAPY PROVIDER NETWORK (PTPN)	Physical Therapy	X	X	N/A	N/A	4/01/17	N/A	N/A	N/A	N/A
10	LUCILLE PACKARD	Medical Group	X	X	N/A	N/A	9/01/17	N/A	N/A	N/A	N/A
11	UCSF	Medical Group	X	X	N/A	N/A	10/01/17	N/A	N/A	N/A	N/A

The Alliance will continue to conduct oversight of the delegated groups, review thresholds to ensure they are aligned with industry standards, and will issue corrective actions when warranted. After review of the QI delegates, no actions were specifically identified or taken. The QI Delegates Program Evaluation will be reviewed by the HCQC in Q1 of 2019.

QUALITY IMPROVEMENT PROJECTS

In 2018, the Alliance cooperated with the Department of Health Care Services (DHCS) and Health Services Advisory Group (HSAG) to improve the process for three quality measures. The following quality improvement projects were conceived in late 2017 and have an expected completion date of June 2019. The projects were based on HEDIS 2017 reporting year data. DHCS encourages plans to adopt the Institute for Health Improvement's (IHI) model for improvement. This approach frames the improvement project to clarify and focus the project before the Plan-Do-Study-Act (PDSA) model is used. The project cycle is 18 months and will run through 2018. The outcomes for the quality improvement projects are stated below.

Quality Improvement Projects:

1. HEDIS Measure CDC: Improve the rate of HbA1c Testing in African American Men.

   Each Performance Improvement Project (PIP) cycle, DHCS requires one PIP to be centered on addressing a health disparity. 2016 Census data estimates that approximately 11% of Alameda County population identifies as African American whereas Alameda Alliance data revealed that 22% of our diabetic members are African American, which represents a greater disease burden. For reporting year 2017 (2016 calendar year), Alameda Alliance HbA1c testing rate for African American men of 73.12% was below the total plan rate of 85.89%, Additional communication with provider partners across the network revealed that Alameda Health System was making HbA1c Poor Control (>9.0%) a focus for 2018. Through this partnership, a goal was developed to increase the rate of HbA1c testing among African American men from 73.12% to 79%. The intervention focused on providing point-of-care testing at Highland Outpatient, one of the largest providers of care in the AAH network. During 2018, Alameda Alliance met with Highland clinical staff six times to develop, plan and implement the intervention. Highland began using point-of-care testing in a pilot phase in December 2018. This project will run through June 30, 2019.

2. HEDIS Measure CAP: Increase the Alameda Alliance overall rate of Children and Adolescent Access to Primary Care

   Physicians for ages 12-19 (CAP4). Using MY 2017 data, Alameda Alliance CAP4 rate was 85.47%, which fell under the Minimum Performance Level (MPL) of 85.73%. Additional analysis showed that Tri-City clinics, which include Liberty, Mowry 1 and Mowry 2, had a CAP4 rate of 81.12%, significantly lower than the Alameda Alliance overall rate and well below the MPL. Conversations with Tri-City clinical staff and a thorough literature revealed monetary incentives to be an effective intervention with this age group. Alameda Alliance met with providers and support staff from Tri-City seven times in 2018 to discuss intervention strategies, plan and implementation. Tri-City staff committed to calling all members who were non-compliant with this measure three times and then send them a follow up text if they were not reached by

phone. Alameda Alliance committed to sending these members a mailed letter and providing a $25 gift card to all members who completed a compliant visit during the pilot. Tri-City began outreach phone calls in December 2018. The goal is to increase the rate of primary care visits for 12-19 year olds assigned to Tri-City clinics from 81.12% to 86%. This project will run through June 30, 2019, at which time data collection and analysis will be finalized in order to determine if the intervention should be abandoned or adopted for a larger group of members.

3. HEDIS Measure MPM: Managing members on persistent medications.

   Screening rates for members on persistent medications were below the minimum performance level three years in a row. The rates of screening for members on the following medications: angiotensin converting enzyme (ACE) inhibiters or angiotensin receptor blockers (ARB) and diuretics (DIU) were ACE/ARB= 83.12% in RY 2015,84.27% in RY 2016 and 86.06% in RY 2017 and DIU= 81.67% in RY 2015,83.22% in RY 2016 and 85.14% in RY 2017. Due to consistently falling below the Minimum Performance Level for this measure, DHCS requested that Alameda Alliance participate in a pilot to rapidly improve the rates for this measure using a SWOT methodology: Strengths, Weaknesses, Opportunities and Threats. Alameda Alliance completed a data analysis of delegate performance and reached out to clinics with low performance. Leadership at Tiburcio Vasquez clinics in the Community Health Center Network (CHCN) expressed an interested in partnering on improving this measure. Tiburcio Vasquez clinics had 556 eligible members and a compliance rate of 85.9% for ACE/ARB and 88.9% for diuretics. The interventions developed included texting members to alert them that they were due for a lab and needed to see their provider as well as a 'soft stop' put on members' pharmacy refills to encourage pharmacists to counsel members to get their labs. Alameda Alliance allocated $25 to pharmacies for each member that successfully completed their lab within the measurement period, which is scheduled to run through June 30, 2019. Text messaging was completed through Tiburcio Vasquez using their text messaging application and began in December 2018. Text messaging in December prioritized members who had not seen their provider in over a year and had multiple gaps in care in addition to missing their MPM lab. This intervention will continue and the soft stop will be put in place in 2019 at which time data analysis of results can be completed to determine the efficacy of the interventions.

   Additional Projects:

4. HEDIS Measure None: Increasing rates of Tdap vaccines in pregnant women in the third trimester

   In 2018, over 300 cases of pertussis were identified in Alameda County, five of which were infants younger than 4 months old. Immunizing pregnant women with the Tdap vaccine between 27-36 weeks gestation is the most effective practice to protect infants from pertussis. The Alliance and the Immunization Division of Alameda County's Public Health Department (ACPHD) have partnered to implement a Quality Improvement Project to improve rates of

prenatal Tdap vaccination. The Alliance completed a baseline data analysis of claims submitted for deliveries between 5/1/2017 to 4/30/2018 and claims data for any Tdap received within 10 months prior to delivery. As a result, 19 PCP's were identified with 30 deliveries or more and Tdap vaccination rates of 80% or lower. Among these providers thus far, Ob/Gyn leadership at Lifelong Medical Care and Alameda Health Systems have expressed interest with improving their rates. ACPHD will be presenting best Tdap practices to these sites at upcoming staff meetings between March and June 2019. Next steps include: continued provider outreach and Tdap training by ACPHD, and a repeat data analysis In October 2019 and January 2020 by the Alliance.

5. Improving Initial Health Assessment (IHA) Rates

The past 1 year of IHA rates is outlined below.

Q3, 2017	**Q4, 2017**	**Q1, 2018**	**Q2, 2018**
Denominator: 15489	Denominator: 13358	Denominator:13841	Denominator: 14477
Numerator: 4110	Numerator: 3228	Numerator: 3186	Numerator: 2925
Rate: 27%	Rate: 24%	Rate: 23%	Rate: 20%
Goal Met: N	Goal Met: N	Goal Met: N	Goal Met: N
Gap to goal: 7% points	Gap to goal: 6% points	Gap to goal: 7% points	Gap to goal: 10% points

On average, an IHA is completed for 24% of new members (7/1/17 – 6/30/18); the table below identifies IHA completion rates by network.

Network	New Enrollees	With IHA Completed	IHA Compliant Rate
AHS	17,033	2,819	**17%**
ALLIANCE Excl. AHS	9,821	2,830	**29%**
CFMG	8,182	1,944	**24%**
CHCN	16,208	4,641	**29%**
KAISER	5,921	1,215	**21%**
ALL NETWORK	**57,165**	**13,449**	**24%**

In an effort to improve IHA compliance rates, the Alliance is working to:

- Ensure member education – through mailings and member orientation
- Improve provider education – through faxes, the PR team, provider handbook, and P4P program
- Improve data sharing – by sharing gaps in care lists with our delegates and providers
- Incentivize IHA completion rates – by including IHA completion rates as an incentivized program
- Update claims codes – to ensure proper capture of IHA completion
- Monitor records to ensure compliance with all components of the IHA

Given the 6 month claims lag, data will be reviewed and analyzed in Q3 – Q4 of 2019.

6. Substance Abuse Disorder – see above section on patient safety

CLINICAL IMPROVEMENT TRENDS: HEDIS

The Alliance is committed to ensuring the level of care provided to all enrollees meets professionally recognized standards of care and is not withheld or delayed for any reason. The Alliance adopts and evaluates recognized standards of care for preventive, chronic and behavioral health care conditions. The Alliance also approves the guidelines used by delegated entities. Guidelines are approved through the HCQC. Adherence to practice guidelines and clinical performance is evaluated primarily using standard HEDIS measures. HEDIS is a set of national standardized performance measures used to report on health plan performance in preventive health, chronic condition care, access and utilization measures. DHCS requires all Medicaid plans to report a subset of the HEDIS measures. Three years of Medicaid hybrid and administrative rates are noted below. Reporting year is noted and reflects prior calendar year. Minimum Performance Level and High Performance Level are determined by the Medi-Cal Managed Care Division.

Medicaid Hybrid HEDIS Measures

2018 EAS and Accreditation Measures		2017 Results	2018 Rates	State Metrics	
NCQA Acronym	Measure	Hybrid Final - June 2017	Current Rate	2018 MPL	2018 HPL
ABA	Adult BMI Assessment	86.23%	83.09%	*78.83%*	*93.68%*
CCS	Cervical Cancer Screening	60.34%	60.00%	*51.88%*	*70.80%*
CDC	CDC HbA1c	85.89%	87.59%	*84.32%*	*92.82%*
CIS	CIS - COMBO3	74.45%	73.97%	*65.25%*	*79.32%*
PPC	PPC - Prenatal	84.43%	85.52%	*77.66%*	*91.67%*
W34	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	73.13%	79.27%	*66.18%*	*82.77%*
CBP	Controlling High Blood Pressure	65.21%	65.69%	*47.69%*	*71.69%*
CDC	CDC Poor Control	37.96%	34.31%	*48.57%*	*29.07%*
CDC	CDC Good Control <8	50.12%	53.77%	*41.94%*	*58.82%*
CDC	CDC Eye	55.23%	58.64%	*47.57%*	*68.27%*
CDC	CDC Neph	88.81%	89.54%	*88.56%*	*93.28%*
CDC	CDC BP<140/90	61.80%	61.80%	*52.74%*	*75.91%*
IMA	IMA - Combo 2	30.17%	47.69%	*15.87%*	*30.39%*
PPC	PPC - Postpartum	67.15%	68.31%	*59.59%*	*73.67%*
WCC	WCC - BMI	83.21%	72.27%	*60.19%*	*87.50%*
WCC	WCC - Counseling for Nutrition	79.56%	74.45%	*58.56%*	*82.53%*
WCC	WCC - Counseling for Phys Activity	74.70%	76.01%	*49.06%*	*75.40%*

Medicaid Administrative HEDIS Rates

2018 EAS Measures		2017 Results	2018 Rates	State Metrics	
NCQA Acronym	Measure	Admin Final - April 2017	Current Rate	2018 MPL	2018 HPL
AAB	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	38.05%	41.23 %	*24.91 %*	*39.12 %*
ADD	Initiation Phase	37.55%	40.04 %	*39.02 %*	*57.05 %*
ADD	Continuation and Maintenance (CM) Phase	48.48%	54.55 %	*48.18 %*	*69.47 %*
AMM	Effective Acute Phase Treatment	66.89%	66.70 %	*48.22 %*	*64.15 %*
AMM	Effective Continuation Phase Treatment	52.61%	51.97 %	*32.58 %*	*50.41 %*
AMR	Asthma Medication Ratio	60.65%	62.85 %	*55.33 %*	*72.38 %*
AWC	Adolescent Well-Care Visits	46.04%	48.24 %	*43.06 %*	*68.06 %*
BCS	Breast Cancer Screening	62.52%	63.88 %	*52.71 %*	*70.29 %*
CAP	12-24 Months	92.00%	91.90 %	*93.27 %*	*97.89 %*
CAP	25 Months - 6 Years	84.40%	84.53 %	*84.94 %*	*93.16 %*
CAP	7-11 Years	87.19%	87.55 %	*87.58 %*	*96.09 %*
CAP	12-19 Years	84.75%	85.54 %	*85.73 %*	*94.78 %*
CHL	Chlamydia Screening in Women - Total	56.08%	59.99 %	*50.39 %*	*71.33 %*
CWP	Appropriate Testing for Children With Pharyngitis	60.27%	66.48 %	*67.15 %*	*88.00 %*
LSC	Lead Screening in Children	64.74%	64.50 %	*59.65 %*	*86.37 %*
LBP	Use of Imaging Studies for Low Back Pain	76.28%	81.99 %	*66.23 %*	*78.29 %*
MMA	Total Medication Compliance 50%	64.92%	67.73 %	*51.75 %*	*72.33 %*
MMA	Total Medication Compliance 75%	43.64%	46.12	*27.58*	*51.21*

			%	%	%
			86.52	*85.93*	*92.77*
MPM	ACE Inhibitors or ARBs	86.06%	%	%	%
			85.60	*85.52*	*92.48*
MPM	Diuretics	85.14%	%	%	%
	Non-Recommended Cervical Cancer Screening in Adolescent				
NCS	Females	0.32%	0.27%	*2.83%*	*0.55%*
			77.76	*72.76*	*85.65*
SPC	SPC - Received Statin Therapy 21-75 Male	76.90%	%	%	%
			82.24	*56.00*	*74.04*
SPC	SPC - Statin Adherence 80% 21-75 Male	77.57%	%	%	%
			66.04	*66.82*	*81.82*
SPC	SPC - Received Statin Therapy 40-75 Female	64.72%	%	%	%
			72.49	*53.73*	*73.44*
SPC	SPC - Statin Adherence 80% 40-75 Female	71.94%	%	%	%
			69.16	*57.76*	*67.74*
SPD	SPD - Received Statin Therapy	66.33%	%	%	%
			76.20	*53.07*	*71.41*
SPD	SPD - Statin Adherence 80%	77.77%	%	%	%
	Diabetes Screening for People With Schizophrenia or Bipolar		82.24	*77.48*	*87.41*
SSD	Disorder Who Are Using Antipsychotic Medications	80.34%	%	%	%
	Diabetes Monitoring for People With Diabetes and		63.89	*64.44*	*78.92*
SMD	Schizophrenia	60.48%	%	%	%
	Cardiovascular Monitoring for People With Cardiovascular		68.00	*73.03*	*88.33*
SMC	Disease and Schizophrenia	67.86%	%	%	%
	Adherence to Antipsychotic Medications for Individuals With		28.53	*54.12*	*71.67*
SAA	Schizophrenia	28.61%	%	%	%
			81.30	*76.54*	*89.94*
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack	83.05%	%	%	%
			63.65	*61.82*	*77.72*
PCE	Systemic Corticosteroid	60.88%	%	%	%
			85.82	*78.13*	*88.48*
PCE	Bronchodilator	84.90%	%	%	%
	Appropriate Treatment for Children With Upper Respiratory		97.38	*86.38*	*95.98*
URI	Infection	97.14%	%	%	%
			21.03	*56.11*	*72.46*
W15	W15 - Six or More visits	21.66%	%	%	%

Analysis of HEDIS Medicaid External Accountability Set (EAS)

The above tables represent the Medicaid HEDIS measures for the DHCS Accountability measure set. Of the trended measures (including individual sub measures), 39/53 measures showed improvement while 12 showed a minimal decline. 2 measures (WCC – BMI and WCC – Nutrition) showed more significant decline but continue to be significantly above the MPL.

The Aggregated Quality Factor Score (AQFS) is a single score that accounts for plan performance on all DHCS-selected Health Effectiveness Data and Information Set (HEDIS) indicators. It is a composite rate calculated as a percent of the National High Performance Level (HPL). The Alliance goal is to increase Aggregated Quality Factor Score rates by 5% each year. In 2018, the Alliance met the target goal when evaluated in the aggregate. The Alliance met minimum performance goals for all measures. If a minimum performance level is not met, an in depth analysis occurs to identify barriers to access and care.

Based on the HEDIS data presented, potential focus areas for 2019 may include the following:

-

Clinical Quality Measure Category	
1	Childhood Immunization Status – Combo 3
2*	Children and Adolescents' Access to Primary Care Physicians
3	Children/Adolescents' Weight Assessment and Counseling - Nutrition
4	Asthma Medication Ratio (Total Rate)
5	Cervical Cancer Screening
6	Comprehensive Diabetes Care (18-75 y/o) – HbA1c Testing
7*	Controlling High Blood Pressure
8	Annual Monitoring for Patients on Persistent Medications (>18 y/o) - ACE or ARB
9	Annual Monitoring for Patients on Persistent Medications (>18 y/o) -Diuretics

Other Non-HEDIS related measures of focus may include:

Other Measure Category	
10R*	Opioids Intervention Education
11*	Initial Health Assessment (DHCS measure)
12	ED Visits per 1000 Member
13	Pharmacy Utilization - % of Generic Usage

HEALTH PLAN ACCREDITATION

In September 2016, Alameda Alliance participated in the triennial reaccreditation survey for Health Plan Accreditation (HPA) sponsored by NCQA. NCQA HPA is a voluntary recognition program consisting of a triennial desktop review of program materials, policies and procedures and on-site file review. The standards evaluate Quality Improvement, Utilization Management, Pharmacy, Rights and Responsibilities, Credentialing, Network Management and Member Related Services. Annually, the score and award are reevaluated based on the fixed survey standards score and an annual reevaluation of audited HEDIS and CAHPS scores. NCQA grants the following decisions: Excellent (90-100 points), Commendable (80-89.99 points), Accredited (65-79.99 points), Provisional (55-64.99 points), and Denied (less than 54.99 points).

Based on increased HEDIS and CAHPS scores, Medicaid earned "Commendable" status, both Medicaid and Group Care products were brought forward in 2018.

Medicaid

The total points earned by Medicaid were 81.23/100 points.

Standards score earned by Medicaid were 46.23/50. Medicaid HEDIS scores were 26.6/37 points, and CAHPS scores were 8.4/13 points. In 2018, HEDIS and CAHPS scores will be submitted for annual NCQA reevaluation and added to the Standards score of 46.23.

Group Care

The next triennial standards survey scheduled for September, 2019.

QUALITY OF SERVICE

Analyses of member experience information helps managed care organizations identify aspects of performance that do not meet member and provider expectations and initiate actions to improve performance. Alameda Alliance for Health (AAH) monitors multiple aspects of member and provider experience, including:

- Member Experience Survey
- Member Complaints (Grievances)
- Member Appeals

A. Member Experience Survey

The MediCal and Commercial member experience survey is administered by an NCQA certified HEDIS survey vendor. SPH Analytics was selected by AAH to conduct the 2018 Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.0 survey. The survey method includes mail and phone responses. Members in each population line are surveyed separately.

Survey Response Rates for CY 2017 – 2018

Survey Population	AAH 2018 Response Rate	AAH 2017 Response Rate
MediCal General Child	24.3%	19.5%
MediCal Adult	20.9%	26.1%
Commercial Adult	27.9%	31.6%

MediCal Child Trended Survey Results

Summary Rate Scores – MediCal Child	AAH 2018 Results	2017 Quality Compass All Plans*	AAH 2017 Results	Year Over Year Tend
Getting Needed Care	81.0%	84.5%	81.7%	↔
Getting Care Quickly	82.8%	88.8%	83.6%	↓
How Well Doctors Communicate	91.6%	93.5%	94.4%	↓
Customer Service	84.6%	88.1%	85.2%	↓
Shared Decision Making	75.3%	78.7%	79.7%	↓
Rating of Health Care (8+9+10)	85.9%	86.7%	90.1%	↓
Rating of Personal Doctor (8+9+10)	89.6%	89.3%	92.9%	↓
Rating of Specialist (8+9+10)	86.3%	87.3%	88.7%	↓
Rating of Health Plan (8+9+10)	88.3%	85.8%	88.4%	↔

*The 2017 Quality Compass All Plans benchmark is the mean summary rate from the Medicaid and Commercial samples that submitted to NCQA in 2017.

MediCal Child Trended Survey Results – Delegates

Summary Rate Scores – MediCal Child Delegates	CFMG 2018	CFMG 2017	Year Over Year Trend	CHCN 2018	CHCN 2017	Year Over Year Trend	Kaiser 2018	Kaiser 2017	Year Over Year Trend	2017 Quality Compass All Plans*
Getting Needed Care	81.4%	81.6%	↔	78.9%	75.8%	↑	92.4%	86.5%	↑	81.0%
Getting Care Quickly	89.9%	87.1%	↑	76.8%	82.6%	↓	93.1%	84.6%	↑	82.8%
How Well Doctors Communicate	93.9%	95.8%	↓	86.4%	91.7%	↓	99%	96.8%	↑	91.6%
Rating of Health Care (8+9+10)	86.4%	90.8%	↓	81.4%	86.2%	↓	93.9%	97.7%	↓	85.9%
Rating of Personal Doctor (8+9+10)	93.3%	96.8%	↓	87.2%	90%	↓	94.7%	93.9%	↔	89.6%
Rating of Specialist (8+9+10)	93.8%	95.7%	↓	89.7%	68.8%	↑	83.3%	100%	↓	86.3%
Rating of Health Plan (8+9+10)	85.6%	86.3%	↔	89%	87.2%	↑	92.6%	91%	↔	88.3%

*The 2017 Quality Compass All Plans benchmark is the mean summary rate from the Medicaid and Commercial samples that submitted to NCQA in 2017.

MediCal Adult Trended Survey Results

Summary Rate Scores – MediCal Adult	AAH 2018 Results	2017 Quality Compass All Plans*	AAH 2017 Results	Year Over Year Tend
Getting Needed Care Composite	76.1%	82%	75.3%	↔
Getting Care Quickly	73.2%	81.8%	70.3%	↑
How Well Doctors Communicate	90.5%	91.4%	90.3%	↔
Customer Service	86.7%	88.2%	82.6%	↑
Shared Decision Making	70.8%	79.8%	77.3%	↑
Rating of Health Care (8+9+10)	73.5%	74.4%	66.2%	↑

Rating of Personal Doctor (8+9+10)	80.3%	81.2%	74%	↑
Rating of Specialist (8+9+10)	77.8%	81.8%	86.1%	↓
Rating of Health Plan (8+9+10)	73%	75.9%	69.3%	↑

*The 2017 Quality Compass All Plans benchmark is the mean summary rate from the Medicaid and Commercial samples that submitted to NCQA in 2017.

MediCal Adult Trended Survey Results – Delegates

Summary Rate Scores – MediCal Adult Delegates	CFMG 2018	CFMG 2017	Year Over Year Trend	CHCN 2018	CHCN 2017	Year Over Year Trend	Kaiser 2018	Kaiser 2017	Year Over Year Trend	2017 Quality Compass All Plans*
Getting Needed Care	100%	50%	↓	78.3%	72.3%	↑	88.3%	91.2%	↓	82%
Getting Care Quickly	83.3%	50%	↑	65.7%	70.4%	↓	72.3%	86.4%	↓	81.8%
How Well Doctors Communicate	100%	100%	↔	94.4%	90.5%	↑	85%	100%	↓	91.4%
Rating of Health Care (8+9+10)	100%	100%	↔	70.4%	65.6%	↑	90.9%	100%	↓	74.4%
Rating of Personal Doctor (8+9+10)	100%	100%	↔	79.2%	84.2%	↓	70.6%	81.8%	↓	81.2%
Rating of Specialist (8+9+10)	100%	0%	↑	88.9%	86.4%	↓	57.1%	100%	↓	81.8%
Rating of Health Plan (8+9+10)	50%	0%	↑	74.8%	73.9%	↔	82.6%	87.5%	↓	75.9%

*The 2017 Quality Compass All Plans benchmark is the mean summary rate from the Medicaid and Commercial samples that submitted to NCQA in 2017.

Commercial Adult Trended Survey Results

Summary Rate Scores – Commercial Adult	AAH 2018 Results	2017 Quality Compass All Plans*	AAH 2017 Results	Year Over Year Tend

Getting Needed Care Composite	72.3%	86.3%	65%	↑
Getting Care Quickly	69.5%	84.5%	65.5%	↑
How Well Doctors Communicate	85.8%	95.1%	84.6%	↔
Customer Service	86.5%	88.2%	70%	↑
Claims Processing	91.5%	88.1%	88.3%	↑
Shared Decision Making	84.3%	81.8%	81%	↑
Rating of Health Care (8+9+10)	66.8%	77.2%	62.2%	↑
Rating of Personal Doctor (8+9+10)	73.3%	84.7%	76.6%	↓
Rating of Specialist (8+9+10)	75.9%	84.6%	79.5%	↓
Rating of Health Plan (8+9+10)	66.5%	63.4%	63.4%	↑

*The 2017 Quality Compass All Plans benchmark is the mean summary rate from the Medicaid and Commercial samples that submitted to NCQA in 2017.

MediCal Child Three-Point Scores

CAHPS Results – MediCal Child	AAH Three-Point Scores	CAHPS 25th Percentile	Plan Percentile Threshold
Getting Needed Care	2.36	2.38	<25th
Getting Care Quickly	2.44	2.54	<25th
Customer Service	2.45	2.50	<25th
Coordination of Care	2.37	2.35	25th
Rating of Health Care	2.60	2.49	90th
Rating of Personal Doctor	2.68	2.58	75th
Rating of Specialist	NA	2.53	NA
Rating of Health Plan	2.66	2.51	75th

NA = denominator was less than 100 and the points are redistributed among the remaining required measures.

MediCal Adult Three-Point Scores

CAHPS Results – MediCal Adult	AAH Three-Point Scores	CAHPS 25th Percentile	Plan Percentile Threshold
Getting Needed Care	2.19	2.33	<25th
Getting Care Quickly	2.22	2.37	<25th
Customer Service	NA	2.48	NA
Coordination of Care	NA	2.36	NA
Rating of Health Care	2.36	2.35	25th
Rating of Personal Doctor	2.60	2.43	90th
Rating of Specialist	NA	2.48	NA

Rating of Health Plan	2.42	2.39	25th

NA = denominator was less than 100 and the points are redistributed among the remaining required measures.

Commercial Adult Three-Point Scores

CAHPS Results – Commercial Adult	AAH Three-Point Scores	CAHPS 25th Percentile	Plan Percentile Threshold
Getting Needed Care	2.08	2.37	<25th
Getting Care Quickly	2.07	2.39	<25th
Customer Service	NA	2.44	NA
Claims Processing	NA	2.36	NA
Coordination of Care	2.05	2.29	<25th
Rating of Health Care	2.23	2.33	<25th
Rating of Personal Doctor	2.38	2.47	<25th
Rating of Specialist	2.44	2.49	<25th
Rating of Health Plan	2.25	2.02	75th

NA = denominator was less than 100 and the points are redistributed among the remaining required measures.

Analysis

The 2018 CAHPS survey results year-over-year trends show variation amongst population line. General Child's composite scores saw a majority decrease (7/9); Adult (6/9) and Commercial Adult (7/10) both saw majority increases.

A large percentage of AAH's membership belongs to delegate networks. As of 12/31/17 AAH had a total of 244,206 members. Breakdown of enrollment by delegates is as follows: Children First Medical Group (CFMG) 36%, Community Health Center Network (CHCN) 36%, and Kaiser 13%. CFMG saw majority of decreases with their composite scores for General Child (4/7) and variation within the Adult (3-increased, 3-flat, 1-decreased) population. CHCN saw majority of decreases with their composite scores General Child (4/7) and variation within the Adult (3-increased, 3-decreased, 1-flat) population. Kaiser saw variation within their General Child (3-increased, 2-decreased, 2-flat) and Adult saw all decreases within the composite scores.

Three-point scores are utilized for the annual accreditation score provided by NCQA. AAH usually utilized the General Child survey to address this portion of the annual score. Four composites are at or below the 25th percentile. The others are 75th percentile or above.

Barriers contributing to CAHPS Results

The Quality Improvement and Member Services Departments have experienced vacancies and need to add administrative capacity to better serve the needs of Alameda Alliance members. High turnover and

high vacancies for some of these positions delayed the implementation of new programs in 2018. Quality and Member Services are working collaboratively with Human Resources to recruit and retain resources in these departments.

Moving into 2019, the Alliance will work towards identified barriers including provider and member communication, improving access to care including child services, appropriately addressing grievances, and performing RCAs on PQIs; the goal of 2019 is to see a majority increase in composite scores. Additionally, these items will be brought to the Cross-Functional Workgroup for further analysis and action.

B. Grievance and Appeals

Alameda Alliance for Health reviews and investigates all grievance and appeal information submitted to the plan in an effort to identify quality issues that affect member experience. The grievance and appeals intake process are broken down into two processes, exempt grievances and non-exempt grievances. In both instances, the details of the member's complaints are collected, processed, and reviewed and actions are taken to resolve the issue.

An **Exempt Grievance** is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination received over the telephone that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the close of the next business day. Exempt grievances are tracked via the Informal Complaints Dashboard.

A **Non Exempt Grievance** is a written or oral expression of dissatisfaction regarding the Plan and/or provider, including quality of care or service concerns, including any breaches of confidentiality surrounding protected health information, and may include a complaint, dispute, or a request for reconsideration made by a Member or the Member's authorized representative. Where the Plan is unable to distinguish between a grievance and an inquiry, it will be considered a grievance. The Plan appropriately categorizes appeals by definition. Non Exempt Grievance information is tracked using the Grievance and Appeals Grievance Log.

An **Appeal** is defined as a review of an Adverse Benefit Determination. The state regulations do not explicitly define the term "Appeal", they do delineate specific requirements for types of Grievances that would fall under the new federal definition of Appeal. These types of Grievances involve the delay, modification, or denial of services based on medical necessity, or a determination that the requested service was not a covered benefit.

The Alliance's Grievance and Appeals (G&A) department monitors grievances (complaints) and appeals on a quarterly basis to identify issues affecting quality of care and service within the provider network. Providers exceeding the maximum amount of complaints are subject to disciplinary action.

Medical Grievances:

Medicaid Complaint Volume				
Category	2017 Compliant Total	2017 Complaints per 1,000 Members	2018 Compliant Total	2018 Complaints per 1,000 Members
Quality of Care	767	0.24	2513	0.8
Access	442	0.14	1790	0.57
Attitude/Service	445	0.14	1190	0.57
Billing/Financial	1633	0.52	1175	0.37
Quality of Practitioner Office Site	14	0.004	45	0.014
Total Number per 1,000	3,301	1.04	6,713	2.13

The Alliance initiated an update to our exempt and non-exempt grievance process in 2017 which continued into 2018. We identified that in addition to not reporting exempt grievances to Committee for review we were grossly under reporting exempt grievances in general. Workflows and training was conducted with Member Services and G&A staff to ensure that all expressions of dissatisfaction were being captured. In addition, the Alliance updated the tracking system for capturing exempt grievances effective Q4 2018 to allow for accurate reporting. As a result, all Committee and Joint Operations Meetings will include exempt grievance data along with Non Exempt Grievances and Appeals effective Q4 2018 and onward. We have also seen a significant increase of grievances throughout the quarters due to training and better tracking of grievances.

The Alliance identified a significant trend of increased grievances against our durable medical equipment (DME) vendor, California Home Medical Equipment (CHME). There were a total of 35 grievances in 2017. In January 2018, there were 48 grievances received alone with a total of 444 grievances for all of 2018. The grievances involved customer service, telephone access, and delay in receiving supplies. Grievance data and trends were presented to CHME leadership during Joint Operations Meetings and on an ad-hoc basis. In Q4 2018, the Alliance Compliance Department issued a Corrective Action Plan and the Alliance has begun to meet with CHME bi-weekly starting in 2019 to resolve issues. CHME has reported that they have increased their call center staff and operational team in order to improve telephone wait times. The Alliance continues to monitor grievances against CHME.

Medicaid Appeals

In accordance with 28 CCR 1300.68(a)(1), the Alliance follows the Department of Managed Health Care's definition of a Grievance, which is, "A written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative". Therefore, Alameda Alliance does not distinguish between a complaint and an appeal. Appeals will be included in UM coverage appeals addressed in UM 8–UM 9.

Commerical Grievances

Commercial Complaint Volume				
Category	2017 Compliant Total	2017 Complaints per 1,000 Members	2018 Compliant Total	2018 Complaints per 1,000 Members
Quality of Care	24	0.35	161	2.31
Access	18	0.26	99	1.42
Attitude/Service	18	0.26	51	0.73
Billing/Financial	168	2.45	115	1.65
Quality of Practitioner Office Site	0	0	2	0.03
Total Number per 1,000	228	3.32	428	6.13

The Alliance initiated an update to our exempt and non-exempt grievance process in 2017 which continued into 2018. We identified that in addition to not reporting exempt grievances to Committee for review we were grossly under reporting exempt grievances in general. Workflows and training was conducted with Member Services and G&A staff to ensure that all expressions of dissatisfaction were being captured. In addition, the Alliance updated the tracking system for capturing exempt grievances effective Q4 2018 to allow for accurate reporting. As a result, all Committee and Joint Operations Meetings will include exempt grievance data along with Non Exempt Grievances and Appeals effective Q4 2018 and onward. We have also seen a significant increase of grievances throughout the quarters due to training and better tracking of grievances.

We continue to see a large amount of billing and financial grievances with 168 grievances in 2017 and 115 grievances in 2018 related to commercial members being balanced billed from out-of-network providers for emergency services. The Alliance covers twenty-four (24) hour care for emergencies, both in and outside of Alameda County. Although we cannot avoid these grievances, the Alliance works closely with our claims department and provider service department to resolve the complaints.

Commercial Appeals

In accordance with 28 CCR 1300.68(a)(1), the Alliance follows the Department of Managed Health Care's definition of a Grievance, which is, "A written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative". Therefore, Alameda Alliance does not distinguish between a complaint and an appeal. Appeals will be included in UM coverage appeals addressed in UM 8–UM 9.

QUALITY OF ACCESS

A. Standards and Education of Standards

AAH has adopted, educated providers on, monitored, and enforced the following standards:

Primary Care Physician (PCP) Appointment	
Appointment Type:	**Appointment Within:**
Non-Urgent Appointment	10 Business Days of Request
Initial **OB/Gyn Pre-natal** Appointment	2 Weeks of Request
Urgent Appointment that *requires* Prior Authorization (PA)	96 Hours of Request
Urgent Appointment that *does not* require PA	48 Hours of Request

Specialty / Other Appointment	
Appointment Type:	**Appointment Within:**
Non-Urgent Appointment with a **Specialist** Physician	15 Business Days of Request
Initial **OB/Gyn Pre-natal** Appointment	2 Weeks of Request
Non-Urgent Appointment with a **Behavioral Health** Provider	10 Business Days of Request
Non-Urgent Appointment with an **Ancillary Service**	15 Business Days of Request
Urgent Appointment that *requires* Prior Authorization (PA)	96 Hours of Request
Urgent Appointment that *does not* require PA	48 Hours of Request

All Provider Wait Time / Telephone / Language Practices	
Appointment Type:	**Appointment Within:**
In-Office Wait Times	Within 60 Minutes
Call Return Time	Within 1 Business Day
Time to Answer Call	Within 10 Minutes
After Hours Telephone Access	Provide 24 Hours Coverage
Emergency Instructions	Ensure Proper Emergency Instructions
Language Services	Provide 24 Hour Interpretive Services

Each of these standards are monitored as per the below table. In 2018, the Alliance made changes to the CG-CAHPS instrument to ensure that the collected data was consistent with the Alliance standards. These changes will be implemented in the 2019 Surveys.

Primary Care Physician (PCP) Appointment	
Appointment Type:	**Measured By:**
Non-Urgent Appointment	PAAS, CG-CAHPS (Q8 edited)
Initial OB/Gyn Pre-natal Appointment	PAAS
Urgent Appointment that *requires* Prior Authorization (PA)	PAAS, CG-CAHPS (new question added)
Urgent Appointment that *does not* require PA	PAAS, CG-CAHPS (new question added)

Specialty / Other Appointment	
Appointment Type:	**Measured By:**
Non-Urgent Appointment with a Specialist Physician	PAAS Survey
Initial OB/Gyn Pre-natal Appointment	PAAS Survey
Non-Urgent Appointment with a Behavioral Health Provider	PAAS Survey
Non-Urgent Appointment with an Ancillary Service	PAAS Survey
Urgent Appointment that *requires* Prior Authorization (PA)	PAAS Survey
Urgent Appointment that *does not* require PA	PAAS Survey

All Provider Wait Time / Telephone / Language Practices	
Appointment Type:	**Measured By:**
In-Office Wait Times	Internal Survey, CG-CAHPS (Q32 edited)
Call Return Time	Internal Survey, CG-CAHPS (new question added)
Time to Answer Call	Internal Survey, CG-CAHPS (new question added)
After Hours Telephone Access	After Hours Survey / Confirmatory Survey
Emergency Instructions	After Hours Survey / Confirmatory Survey

Language Services	CG-CAHPS (existing questions 33, 34)

Alameda Alliance and the QI team adopted a PDSA approach to the access standards.

- Plan: The standards were discussed and adopted and surveys were then aligned with our adopted standards
- Do: The surveys were then administered as per our policies and procedures; surveys methodologies, vendors, and processes are outlined in P&Ps
- Study: Survey results along with QI recommendations were brought forward to the A&A sub-committee; the sub-committee formalized recommendations and were forwarded to the HCQC Committee and Board of Governors
- Act: Dependent on non-compliant providers and study / decision of the A&A Sub-Committee, actions included re-education, discussions with providers and delegates, and corrective action plans (CAPs).

B. Cultural and Linguistic Needs of Members

The Alliance QI Department conducts an annual assessment of the Alliance's membership cultural and linguistic makeup as well as the provider network with respect to member accessibility. The assessment is meant to enhance the Alliance's ability to provide access to high quality healthcare to our members and focuses on the following areas:

- Cultural and Linguistic needs of members;
- Provision of interpreter services
- PCP language capacity

The Alliance strives to ensure members have access to a PCP who can speak their language or to appropriate interpreters. For members who have not chosen a PCP upon enrollment, the Alliance will assign a member to a PCP based on characteristics, including language. In 2018, the Alliance identified the following threshold languages.

Medi-Cal	English	155,975	60.91%
	Spanish	49,879	19.48%
	Chinese	24,900	9.72%
	Vietnamese	8,487	3.31%
Group Care	English	3,552	60.36%
	Chinese	1,297	22.04%
	Spanish	278	4.72%*

* Just under threshold criteria, but given variations in membership over the year, the Alliance chooses to treat Spanish as a threshold language for Group Care.

Member Ethnicity

MEDI-CAL	Prior Year	YTD	Difference	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY ETHNICITY	Jan - Dec 2017	Jan - Dec 2018	% YTD Membership in Jan - Dec 2018 (minus) % of Membership in Jan - Dec 2017	Dec 2018	Dec 2018 %
Hispanic	28.82%	28.78%	-0.04%	73,159	28.57%
Black	19.44%	19.09%	-0.35%	49,074	19.17%
Other	12.18%	12.93%	0.75%	33,667	13.15%
Other Asian / Pacific Islander	12.18%	11.89%	-0.29%	30,132	11.77%
Chinese	10.76%	10.95%	0.20%	28,255	11.03%
White	11.23%	10.83%	-0.40%	27,415	10.71%
Vietnamese	4.27%	4.29%	0.03%	11,011	4.30%
Unknown	0.84%	0.96%	0.12%	2,658	1.04%
American Indian Or Alaskan Native	0.29%	0.27%	-0.02%	684	0.27%
Total Members				**256,055**	

Medi-Cal Ethnicity Discussion: 2018 saw only slight changes in ethnicities as a percent of the Medi-Cal membership. Hispanic members make up almost 30%, all Asian members combined make up over 25%, and Black members almost 20% of our Medi-Cal membership.

GROUP CARE	Prior Year	YTD	Difference	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY ETHNICITY	Jan - Dec 2017	Jan - Dec 2018	% YTD Membership in Jan - Dec 2018 (minus) % of Membership in Jan - Dec 2017	Dec 2018	Dec 2018 %
Unknown	43.69%	39.81%	-3.88%	2,232	37.93%
Other Asian / Pacific Islander	22.65%	25.23%	2.58%	1,533	26.05%
Chinese	10.01%	10.93%	0.92%	673	11.44%
Black	10.94%	11.17%	0.23%	670	11.38%
Other	4.79%	4.95%	0.17%	304	5.17%
Hispanic	3.19%	3.16%	-0.03%	192	3.26%
Vietnamese	2.61%	2.70%	0.09%	160	2.72%
White	1.97%	1.94%	-0.03%	116	1.97%
American Indian Or Alaskan Native	0.15%	0.10%	-0.05%	5	0.08%
Total Members				**5,885**	

Group Care Ethnicity Discussion: The largest group who identified their ethnicity was the Other Asian/Pacific Islander, at almost one-fourth of the Group Care membership, of which 21% are of Asian

Indian ethnicity. The percent of Group Care members with unknown ethnicity continues to decline, although still higher than desired.

Member and Provider Languages Spoken

MEDI-CAL	Prior Year	YTD	Difference	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY LANGUAGE	**Jan - Dec 2017**	**Jan - Dec 2018**	**% YTD Membership in Jan - Dec 2018 (minus) % of Membership in Jan - Dec 2017**	**Dec 2018**	**Dec 2018 %**
English	61.92%	61.16%	-0.76%	155,975	60.91%
Spanish	19.04%	19.42%	0.38%	49,879	19.48%
Chinese	9.39%	9.60%	0.21%	24,900	9.72%
Unknown	4.07%	4.11%	0.03%	10,575	4.13%
Vietnamese	3.21%	3.28%	0.06%	8,487	3.31%
Other Non-English	1.71%	1.77%	0.06%	4,514	1.76%
				256,055	

Medi-Cal Language Discussion: Our Medi-cal members are approximately 3/5 English-speaking, 1/5 Spanish-speaking, 1/10 Chinese-speaking 3/100 Vietnamese-speaking.

GROUP CARE	Prior Year	YTD	Difference	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY LANGUAGE	**Jan - Dec 2017**	**Jan - Dec 2018**	**% YTD Membership in Jan - Dec 2018 (minus) % of Membership in Jan - Dec 2017**	**Dec 2018**	**Dec 2018 %**
English	61.58%	60.72%	-0.86%	3,552	60.36%
Chinese	20.53%	21.63%	1.10%	1,297	22.04%
Unknown	5.07%	4.84%	-0.23%	286	4.86%
Spanish	4.74%	4.78%	0.04%	278	4.72%
Vietnamese	3.40%	3.34%	-0.06%	195	3.31%
Other Non-English	2.75%	2.85%	0.10%	173	2.94%
				5,885	

Group Care Language Discussion: Group Care members continue to speak predominately English 2/5 of the Group Care members, followed by Chinese-speaking (almost 1/5) and Spanish-speaking (1/20).

Practitioner Language Capacity

During 2017, the Alliance's Provider Relations staff conducted in-person surveys during provider office visits to verify languages spoken by providers. The chart below is a comparison of identified languages

spoken by the plan's members to its provider network at the end of Quarter 4 2018. Please note, multi-lingual providers are counted for each language spoken by the individual.

	2017Q4			2018Q4			Change			
Language	**PCPs**	**Members**	**Members per PCP**	**PCPs**	**Members**	**Members per PCP**	**# PCPs**	**% PCPs**	**# Members**	**% Members**
English	501	135,124	269	509	131,489	258	8	2%	-3,635	-3%
Spanish	113	45,571	403	115	45,318	394	2	2%	-253	-1%
Chinese	47	23,701	504	78	23,541	301	31	66%	-160	-1%
Unknown	7	10,818	1,545	7	9,785	1,397	0	0%	-1,033	-10%
Vietnamese	16	8,289	518	16	8,218	513	0	0%	-71	-1%
Other Non-English	133	2,212	16	173	2,153	12	40	30%	-59	-3%
Arabic	2	2,069	1,034	3	2,000	666	1	50%	-69	-3%
Farsi	6	1,656	276	7	1,640	234	1	17%	-16	-1%
Total	825	229,440		908	224,144		83	10%	-5,296	-2%

Source: Q4 2017 and Q4 2018 Provider Impact Reports

* A number of PCPs do not have a primary language designated in the data we receive. Also, multi-lingual providers are counted for each language they speak.

The Alliance also identified and reviewed significant changes and trends related to provider language capacity. In 2018 the Plan experienced overall improvement in the ratios of members per provider for all languages. All languages are in a favorable range.

	2017Q4	2018Q4	Change
Language	**Members per PCP**	**Members per PCP**	**Difference**
English	269	258	Improvement ↓11
Spanish	403	394	Improvement ↓9
Chinese	504	301	Improvement ↓203
Vietnamese	518	513	Improvement ↓5
Arabic	1034	666	Improvement ↓ 69
Farsi	276	234	Improvement ↓ 16

In addition, the Alliance continues to monitor provider language capacity levels and trends quarterly though the following:

1. Review of provider and member spoken language capacity comparison
2. Review of grievances related to provider language capacity
3. Monitoring of interpreter services provided

In the absence of a practitioner who speaks a member's preferred language, the Alliance ensures the provision of interpreter services at the time of appointment. In order to meet the language demand increase in 2018, the Alliance contracted with a second interpreter vendor. In 2018, the Alliance

provided over 17,000 telephonic interpreter services. In addition, we completed just under18,000 requests for interpreter services at the time of appointment. This represents over 99.5% fulfillment with prescheduled interpreter requests.

C. Provider Capacity

The Alliance reviews network capacity reports monthly to determine whether primary care providers are reaching network capacity standards of 1:2000. In 2018, no providers exceeded the 2,000 member threshold. The Network Validation department flags the provider at 1900 and above to ensure member assignment does not reach the 2,000 capacity standard. If a provider is close to the threshold, the plan reaches out to confirm if the provider intends to recruit other providers. If not, the panel is closed to new assignment. During this time the plan and the provider are in communication of such changes.

D. Geo Access

The geographic access reports are reviewed quarterly to ensure that the plan is meeting the geographic access standards for provided services in Alameda County. For PCPs, the Alliance has adopted standards of one provider within 30 minutes / 15 miles. For specialists, the Alliance has adopted standards of one provider within 30 minutes / 15 miles.

In 2017, the rural areas near Livermore and the southern border of Alameda were the only areas in which the plan is facing geographic access issues for certain specialties. These areas were in need of access to a hospital which will enable them to meet the geographic access standards for both lines of business (IHSS and Medi-Cal). In the past due to the lack of hospitals located in the rural area, plan submitted an alternative access standard proposal to the Department of Managed Health Care which has been approved for a distance of 25 miles for both Medi-Cal and IHSS networks.

In August of 2018, the Alliance finalized a physician and hospital contract agreement with a local and major health system that will provide geographic access for those members residing in the Livermore and Pleasanton areas.

In the remainder of 2018, the plan met the geographic access standards for provided services in Alameda County.

E. Provider Appointment Availability

The Alliance annual Provider Appointment Availability Survey for MY2018 was used to review appointment wait times for the following provider types:

- Primary Care Physicians
- Specialists:
    - Allergists
    - Cardiologists
    - Endocrinologists
    - Gastroenterologists

    - Psychiatrists
    - Child & Adolescent Psychiatrists
- Non-Physician Mental Health Providers (PhD-level and Masters-level)
- Ancillary Providers offering Mammogram, MRI and/or Physical Therapy appointments

The Alliance reviewed the results of its annual Provider Appointment Availability Survey for MY 2018 in order to identify areas of deficiency and areas of potential improvement. The Alliance defines *deficiency* as a provider group scoring less than seventy-five percent (75%) for the compliance rate on any of the survey questions related to appointment wait times.

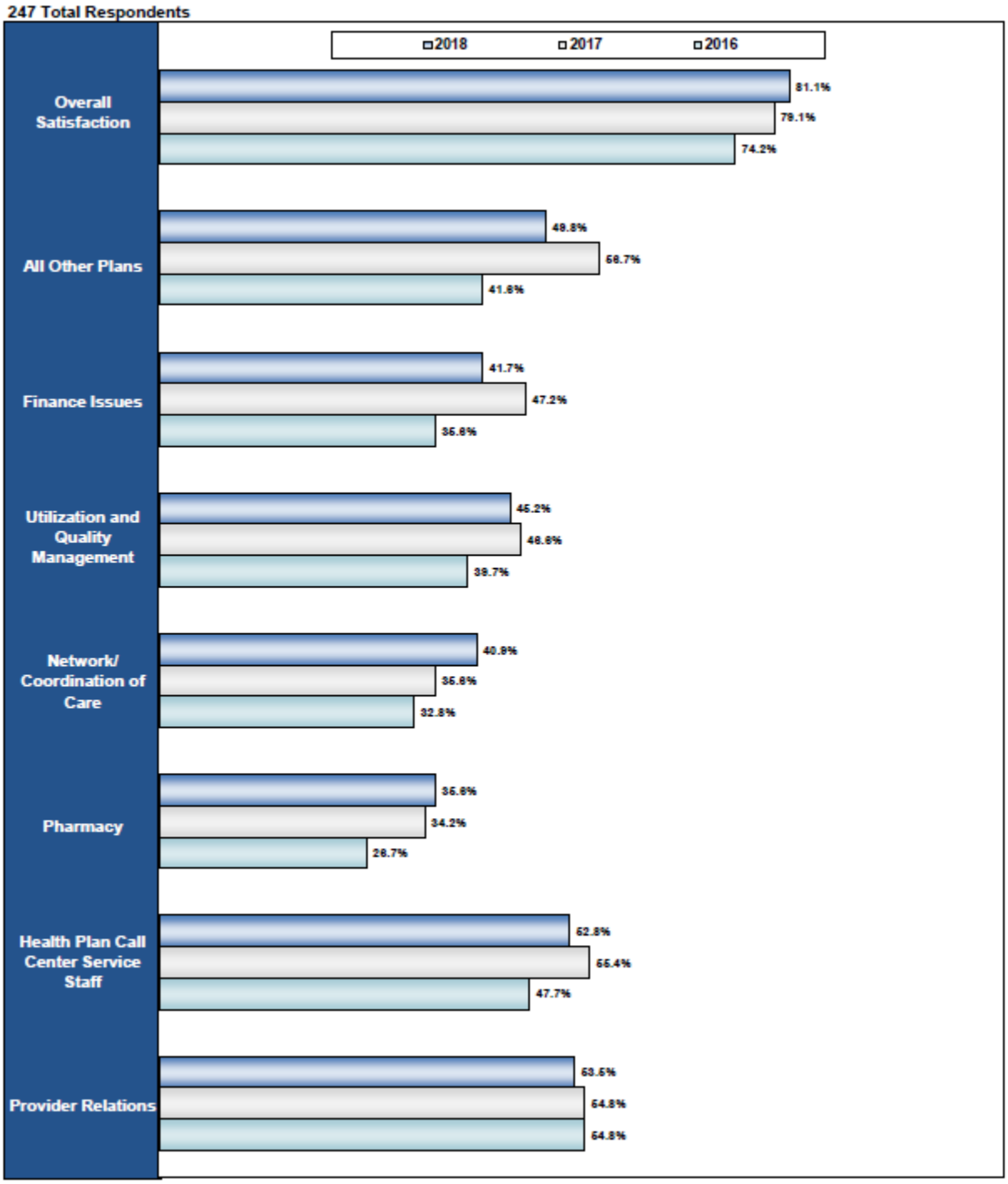
A review and analysis of the data could not be completed as the results have not yet been validated.

PROVIDER SATISFACTION SURVEY OVERVIEW

Alameda Alliance for Health (AAH) contracted to conduct a Provider Satisfaction Surveys for measurement year 2018. AAH provided the vendor with a database of 5,372 Primary Care Physicians, Specialists and Behavioral Health Care Practitioners. The database was cleaned by removing any records with duplicate NPIs. From the database of unique providers, a sample of 815 records was drawn based on specialty. A total of 247 surveys were completed (128 mail, 24 internet and 95 phone), yielding a response rate of 19.9% for the mail/internet component and 30.4% for the phone data component.

Below is an overview of the survey results broken down by provider satisfaction composites.

247 Total Respondents	Current							
Composites and Key Questions	2018		2017		2016		2017 SPH Book of Business Benchmarks**	
	Valid n	Summary Rate*	Valid n	Summary Rate*	Valid n	Summary Rate	Commercial	Aggregate
Overall Satisfaction		81.1%		79.1%		74.2%	76.8%	70.1%
8A. Would you recommend Alameda Alliance for Health to other physicians' practices?	203	87.7%	214	88.8%	201	87.1%	87.4%	82.9%
8B. Please rate your overall satisfaction with Alameda Alliance for Health.	212	81.1%	235	79.1%	209	74.2%	75.9%	70.1%
8C. Please rate your overall satisfaction with Other managed Medi-Cal plans in your county.	160	63.8%	174	60.3%	177	61.0%	73.1%	64.3%
All Other Plans (Comparative Rating)								
1A. How would you rate Alameda Alliance for Health compared to all other health plans you contract with?	238	49.8%	240	56.7%	233	41.6%	44.9%	37.6%
Finance Issues		41.7%		47.2%		36.8%	34.8%	32.0%
2A. Consistency of reimbursement fees with your contract rates.	210	39.5%	219	47.5%	194	33.0%	32.8%	30.0%
2B. Accuracy of claims processing.	204	46.1%	215	50.7%	194	38.7%	37.6%	34.4%
2C. Timeliness of claims processing.	200	43.5%	218	44.5%	192	38.0%	36.4%	34.5%
2D. Resolution of claims payment problems or disputes.	179	38.5%	193	46.1%	181	32.6%	32.3%	29.1%
Utilization and Quality Management		45.2%		48.8%		38.7%	38.7%	34.7%
3A. Access to knowledgeable UM staff.	190	40.5%	184	45.7%	197	38.6%	37.4%	32.5%
3B. Procedures for obtaining pre-certification/referral/authorization information.	199	46.7%	217	44.7%	198	40.4%	38.4%	34.1%
3C. Timeliness of obtaining pre-certification/referral/authorization information.	197	46.7%	214	43.5%	194	37.6%	38.4%	34.2%
3D. The health plan's facilitation/support of appropriate clinical care for patients.	189	46.0%	198	46.5%	186	39.2%	38.4%	33.8%
3E. Access to Case/Care Managers from this health plan.	170	40.6%	159	45.3%	170	35.9%	37.5%	32.3%
3F. Degree to which the plan covers and encourages preventive care and wellness.	170	52.4%	180	53.9%	184	46.7%	47.8%	41.2%
Network/Coordination of Care		40.9%		35.8%		32.8%	38.4%	31.4%
4A. The number of specialists in this health plan's provider network.	178	37.6%	179	30.7%	171	30.4%	36.8%	29.4%
4B. The quality of specialists in this health plan's provider network.	184	44.6%	174	39.1%	176	37.5%	41.8%	34.8%
4C. The timeliness of feedback/reports from specialists in this health plan's provider network.	171	40.4%	160	36.9%	160	30.6%	36.6%	30.1%
Pharmacy		35.8%		34.2%		26.7%	28.8%	24.8%
5A. Consistency of the formulary over time.	168	34.2%	126	34.9%	166	30.1%	30.1%	25.5%
5B. Extent to which formulary reflects current standards of care.	161	37.9%	128	34.4%	163	27.0%	30.2%	26.2%
5C. Variety of branded drugs on the formulary.	163	34.0%	126	32.5%	165	21.8%	27.0%	23.5%
5D. Ease of prescribing your preferred medications within formulary guidelines.	162	37.6%	125	36.8%	167	29.3%	30.4%	25.7%
5E. Availability of comparable drugs to substitute those not included in the formulary.	161	34.4%	123	32.5%	163	25.2%	27.0%	23.5%
Health Plan Call Center Service Staff		52.8%		55.4%		47.7%	42.0%	38.6%
6A. Ease of reaching health plan call center staff over the phone.	197	49.2%	210	51.9%	194	47.9%	37.3%	35.5%
6B. Process of obtaining member information (eligibility, benefit coverage, co-pay amounts).	199	56.8%	208	59.1%	195	55.4%	45.9%	42.3%
6C. Helpfulness of health plan call center staff in obtaining referrals for patients in your care.	190	51.6%	191	53.9%	169	42.0%	43.9%	38.0%
6D. Overall satisfaction with health plan's call center service.	201	54.7%	206	56.8%	200	45.5%	40.9%	38.8%
Provider Relations		63.6%		64.8%		64.8%	40.2%	37.3%
7A. Do you have a Provider Relations representative from this health plan assigned to your practice?	198	64.6%	212	44.3%	195	57.4%	37.8%	45.7%
7B. Provider Relations representative's ability to answer questions and resolve problems.	89	66.7%	89	70.8%	107	68.2%	54.6%	48.6%
7C. Quality of provider orientation process.	145	48.3%	158	46.8%	142	50.7%	31.4%	30.5%
7D. Quality of written communications, policy bulletins, and manuals.	187	46.5%	186	46.8%	174	45.4%	34.6%	32.8%



The above information does recognize an upward trend from 2017 to 2018 in overall provider satisfaction, network, coordination of care, and pharmacy.

The above information does recognize a downward trend from 2017 to 2018 in comparative rating to other plans, finance issues, utilization and quality management, health plan call center service staff, and provider relations.

While our goals were upward trends in the majority of satisfaction composites, this data will be shared with all relevant stake holders to identify and improve future scores and outcomes.

QUALITY PROGRAM BARRIERS

The Alliance has identified the challenges and barriers to improvement throughout the 2018 QI Evaluation. Recommended activities and interventions for the upcoming year consider these challenges and barriers in working towards success and achievement of the Alliance's goals in 2019.

Some of the challenges encountered throughout 2018 included, but are not limited to:

- Vacancies and employee turnover in the QI Department
- Changes in the Grievance and Appeals system
- Reliance on annual HEDIS outcome measurements results impedes rapid and strategic PDSA cycles.
- Mixed results in member experience as measured through CAHPS and grievances.

Some successful outcomes for 2018 include:

- The HCQC met 7 times this year and remained active in ensuring requirements of the QI Program were met
- There continues to be Senior Level Physician involvement and Appropriate External and Internal Leadership
- The QI Program was evaluated and discussed by the HCQC Committee
- Improved HEDIS performance for most measures; above the MPL for all accountable HEDIS metrics
- Focus on provider education - including more frequent visits and regular meetings with network and delegated providers that resulted in Improved 'Overall Satisfaction' of network providers
- Continued focus on health promotion and education that resulted in some of the higher CAHPS scores
- Improved turn-around times and root cause analysis of PQIs
- Introduction of a PQI Application
- Ongoing / successful performance improvement projects
- Robust Health Education and Cultural and Linguistic Programs
- Cost effective approach to quality and safety by utilizing community resources such as:
    - Substance Abuse Disorder Program
    - Ongoing Performance Improvement Projects
    - Early Start Program that serves infants and toddlers who have significant developmental delays.
    - California WIC Program that helps pregnant, breastfeeding or postpartum women and children.
    - Partnering with the Breastfeeding Coalition and Black Infant Health

- Improved Member Services processes and hiring new staff, resulting in improved telephone response times.
- Comprehensive monitoring of all practitioners during credentialing / re-credentialing to ensure high quality network.

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

2018

Case Management/Care Coordination & Disease Management
2018 Program Evaluation

Signature Page

Date _____

Julie Anne Miller, LCSW
Director, Health Care Services

Date _____

Sanjay Bhatt, M.D.
Director, Quality Improvement

Date _____

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

Date _____
Scott Coffin
Chief Executive Officer

Date _____
Evan Seevak, M.D.
Board Chair

2018
Utilization Management (UM) and Case Management (CM)
Program Evaluations
Attachment A: Case Management

Overview

Under the leadership and strategic direction established by Alameda Alliance for Health (The Alliance) Board of Directors and Quality Management Committee (QMC), senior management and the Health Care Quality Committee (HCQC), the Health Services 2018 Utilization Management Programs were successfully implemented. This report serves as the annual evaluation of the effectiveness of the program activities. For 2018, the annual report also includes this evaluation of the Health Care Services Case Management Department which includes care coordination, care management and complex case management.

The processes and data reported covers activities conducted from January 1, 2018 through December 31, 2018.

Membership and Provider Network

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

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

Figure 1. 2018 Trended enrollment by network and age group

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Current Membership by Network By Category of Aid

Category of Aid	Dec 2018	% Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN	KAISER
ADULTS	35,559	14%	9,163	6,892	351	13,447	5,706
CHILD	95,322	37%	9,459	8,355	29,880	31,404	16,224
SPD	26,006	10%	8,918	3,576	1,350	10,309	1,853
MCE	85,345	33%	15,620	27,478	929	32,656	8,662
DUALS	16,072	6%	6,297	1,812	10	6,167	1,786
Medi-Cal	258,304		49,457	48,113	32,520	93,983	34,231
Group Care	5,886		2,695	760	0	2,431	0
Total	**264,190**	**100%**	**52,152**	**48,873**	**32,520**	**96,414**	**34,231**
Medi-Cal %	97.8%		94.8%	98.4%	100.0%	97.5%	100.0%
Group Care %	2.2%		5.2%	1.6%	0.0%	2.5%	0.0%
	Network Distribution		***19.7%***	***18.5%***	***12.3%***	***36.5%***	***13.0%***
			% Direct:	**38%**		**% Delegated:**	**62%**

Age Category Trend

	Members			
Age Category	Dec 2016	Dec 2017	Nov 2018	Dec 2018
Under 19	101,385	103,264	98,950	98,122
19 - 44	86,207	87,080	84,900	84,866
45 - 64	59,141	58,915	57,493	57,340
65+	20,317	22,538	23,789	23,862
Total	267,050	271,797	265,132	264,190

For 2018, The Alliance membership remained relatively flat, as seen in Figure 1, at about 264 thousand members, which is slightly down from 272 thousand members in 2017. This trend is similar to other managed MediCal health plans in California in 2018.

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

Figure 2 Provider Network by Type and Enrollment

Provider Network	Provider Type	Members (Enrollment)	% of Enrollment to Network
Independent (Direct)	Independent	52,152	19.7%
AHS (Direct)	Managed Care Organization	48,873	18.5%
CFMG	Medical Group	32,520	12.3%
CHCN	Managed Care Organization	96,414	36.5%
KAISER	HMO	34,231	13.0%
Total		**264,190**	**100.0%**

The percentage of members within each network has been steady from 2017 to 2018.

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

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

Delegation

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

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

evaluation and any audit results are reviewed by the Compliance and Delegation Oversight Committee.

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

Figure 3 – 2018 the Alliance Delegated Network

2018 Alliance Delegated Network			
Provider Network/Delegate	**Provider Type**	**Delegated Activity- Care Coordination/CM**	**Delegated Activity- CCM**
KAISER	HMO	YES	YES
AHS	Managed Care Organization	NO	NO
CFMG	Medical Group	YES	NO
CHCN	Managed Care Organization	YES	NO
Beacon	Vendor-BH	YES	YES

Delegation vs Direct	Members	% of Total Distribution
Delegated	163,165	61.8%
Direct	101,025	38.2%
Total	**264,190**	**100.0%**

Overall, the network was sufficient to meet the needs of The Alliance membership and provider network through 2018. The organization had identified issues related delegation oversight in 2017, so in 2018 there were improvements in the level of oversight, monitoring, reporting and training of delegates.

Program Structure

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

Responsibility, Authority and Accountability/ Governing Committee

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

Committee Structure

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

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

HCQC charters a sub-committee, the Utilization Management Committee (UMC) which meets at least once every 2 months (7 meetings in 2018,) serving as a forum for the Alliance to evaluate current UM and CM activities, processes, and metrics. The UMC also evaluates the impact of UM and CM programs on other key stakeholders within various departments and when needed, and assesses and plans for the implementation of any needed changes

The 2018 CM Program Evaluation and CM Program Description were developed and presented for documentation into the April 12, 2018 HCQC minutes for Board of Directors approval. The committee was chaired by the interim Chief

Medical Officer with support of the Director of Quality Management, external physicians and key organizational staff.

In 2019 the UM Subcommittee of HCQC will continue to support the focus on CM activities, oversight for delegated CM activities, case management/care coordination, complex case management, population health, integration of behavioral health and medical as well as regulatory compliance.

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

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

During 2018 Dr. Aaron Chapman, a psychiatrist and Medical Director of Alameda County Behavioral Health Care Services, actively participated in the HCQC meetings and provided clinical input ensuring policies and reports considered behavioral health implications .

Program Scope and Structure

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

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

quality case management, client satisfaction and cost efficiency using collaborative communications, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

Case Management Resources

The Alliance CM Department is staffed with physicians, nurses, social workers and non-clinical support staff including clerical support and clinical support coordinators. A full description of staff roles and responsibilities is provided in the 2019 CM Program Description.

The assignment of work to the team, whether working on site or remotely for both clinical and non-clinical activities, is seamless to the process. The job descriptions with assigned tasks and responsibilities remained the same regardless of the geographical location of the team member.

During 2018 several key leadership roles in Health Services were hired:

- Chief Medical Officer,
- Director of Health Care Service,
- Manager of UM, who interfaces closely with CM department activities and services.

In 2018, based on the established staffing ratios and roles, the CM Department struggled in timely hiring for both department and leadership roles. As a result, staff were often called to perform in those missing roles. With the onboarding of new leadership, the Health Care Services Department teams will be reviewing the current organization goals and restructuring the Department as needed to achieve those goals.

Delegated Case Management

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

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

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

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

In 2018, the UM and CM staff conducted annual audits on the six (6) delegates. The threshold for UM and CM audit compliance is 90%. For entities that do not meet the threshold, UM/CM may require a corrective action plan which is tracked for compliance with the resolution of the deficiency. Entity audit results for 2018 were:

- Five groups pass UM audit (≥ 90.0%), 1 failed with corrective actions required.

- Two provider networks were required to complete CAPs as a result of the annual audit.

Figure 5 the Alliance Network – 2018 Annual Audit Score

Delegate	Provider Type	Delegated Activity -UM	2018 Audit Results	Corrective Action Required
Kaiser	HMO	X	Pass: UM files 99%	None
(CHCN)	Medical Group	X	Pass: UM files 91%	Yes; NOA did not provide clear and concise reason for decision.
(CFMG)	Medical Group	X	Pass: UM files 99%	None
California Home Medical Equipment (CHME)	Vendor - DME	X*	Failed: (85%)	Yes; timeliness of decision making * Not delegated for denials
Beacon/College Health IPA (CHIPA)	Vendor - BH	X	Pass: 99%	None

EviCore Healthcare	**Vendor – Specialty Services**	**X**	**Pass*: 100% Routine Outpatient Denials Only**	**None; 2017 file audit resulted in a focused file audit in 2018.**

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

Recommend Actions/Next Steps

For 2019, there is an opportunity to improve the oversight of delegated CM activities. The CM Department leadership continues to develop a robust level of delegate oversight and performance monitoring. The activities include dedicated staff, monitoring activities, performance management, delegate feedback and CM training.

Case Management Processes and Information sources

Case Management Information Systems and Sources

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

Evidence-based clinical guidelines are available to support the Case Managers in conducting assessments, developing care plans, and managing care. The

clinical practice guidelines are based on current published literature, current practice standards, and expert opinion. (Appendix B displays the list of clinical guidelines that support assessment and case management). Whenever possible, guidelines are derived from nationally recognized sources. If a nationally recognized guideline is not available, the Alliance will involve board certified specialists in the development of the appropriate guidelines. Assessment questions were based on evidence-based guidelines from The National Guideline Clearinghouse (www.guideline.gov) until they were no longer available as of July 2018, as well as medical and behavioral healthcare specialty societies and/or Alliance guidelines of care.

In 2017, the CM Department underwent a full review of the functionality in the TruCare system to identify opportunities to improve the workflow and management of identified members. Because of the review, staff identified opportunities to re-engage with the system's training team to focus on current and potential new system enhancements to improve the workflow. The team began meeting in early January 2018 and completed the training at end of 1st Qtr. 2018.

The Alliance CM Department utilized the established evidence based clinical criteria as defined in the CM Program. Based on a review of member needs and require to utilization alternative criteria, there were no changes to the clinical criteria based on the needs of the membership.

While the standard hierarchy of evidence-based criteria met the current membership needs and CM activities, in 2018 the department prepared for the shift to population health management. For 2019, the CM Department continues to collaborate with Senior Leadership to develop program activities, and new clinical criteria will continue to be evaluated to meet the identified needs of those programs.

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

Care Coordination and Case Management Processes

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

- **Basic Case Management** or Low Risk level is provided by the Primary Care Physicians and their staff with a Network Provider Group's Care Management support.

- **Care Coordination/Service Coordination** or Moderate Risk level is provided at the Provider Group level, supporting the PCP.
- **Targeted** Care Management is supported by The Alliance Care Management staff with designated community TCM programs.
- **Complex** Care Management is provided by The Alliance Care Management staff, consistent with NCQA Standards
- **Specialty Programs** such as Transition of Care, Continuity of Care

Basic Care Management

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

Care Coordination

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

Targeted Care Management

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

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

Members eligible for TCM services have generally been identified as moderate or high risk.

Complex Case Management

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

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

Case Management Processes

Health Risk Assessments

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

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

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

In 2017, Department of Health Care Services issued a new MMCD All Plan Letter for Requirements for Health Risk Assessments of MediCal Seniors and Persons with Disabilities. It clarified the Plan's responsibilities for the early identification of members who need early intervention and care planning to prevent adverse outcomes. The new guidance also required development of a process for utilizing the standardized LTSS referral questions to identify and ensure the proper referral of members who may qualify for and benefit from LTSS services.

The Alliance CM Department worked in collaboration with Member Services to complete the HRA process. CM Staff were responsible for the outreach and assessment for Members initially stratified as high risk. Member Services was responsible for the initial outreach process for members stratified as low risk. On a monthly basis, after completing the outbound call attempts, Member Services routed Member files with completed HRA who have scored as Low Risk either by HRA scoring or are initially scored as Low Risk but are Unable to Contact and complete the HRA.

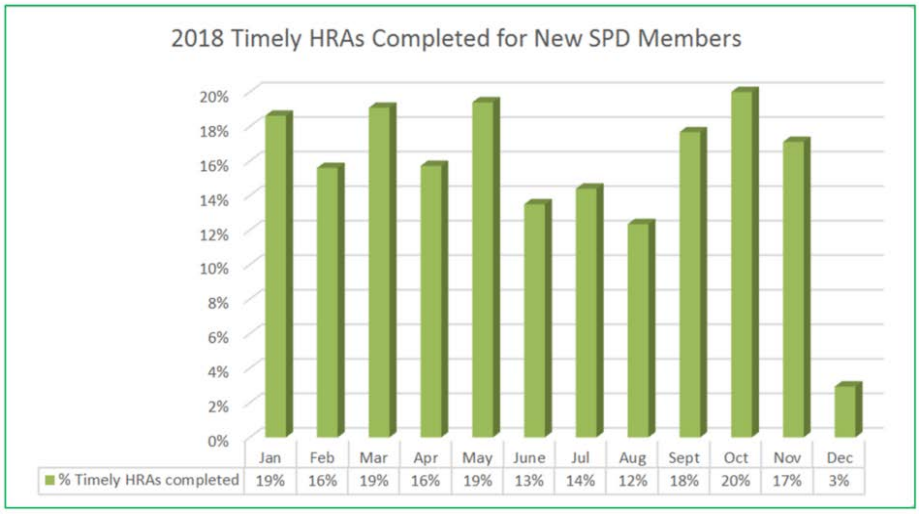
CM staff is responsible for ensuring the Member Care Plan is completed and shared as well as providing any community or health resources. For Members who completed the HRA with a final stratification of Low Risk, CM staff review the HRA responses to identify Member needs, i.e. resources for transportation,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

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

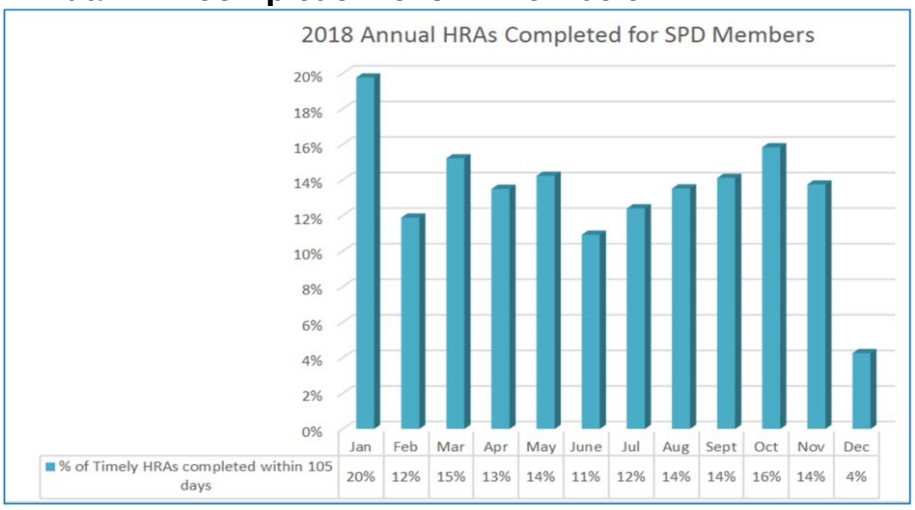
In 2018, when questions were added to the HRA, it was identified that Member Services was having challenges in successfully calling members timely to outreach them after no response to mailed forms. The Alliance contracted with a vendor to make Interactive Voice Response (IVR) calls to members so that the Alliance could give members every opportunity to complete the HRA and have the results acted upon by the CM department.

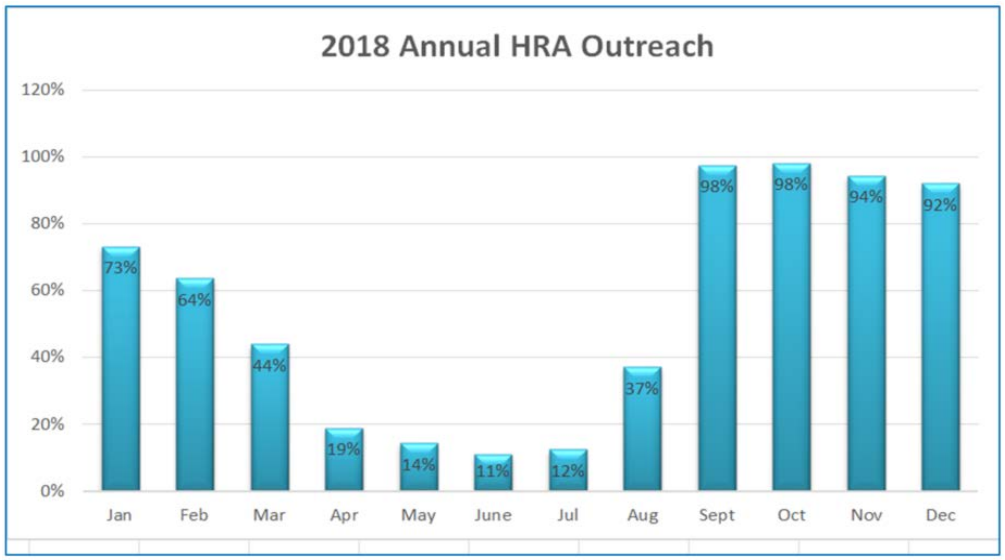
In the last quarter of 2018 CM, in collaboration with Healthcare Analytics, developed a HRA dashboard, which tracks compliance of outreach attempts and timely completion of the HRA for the SPD population.

New HRA completion for SPD Members



Annual HRA completion for SPD Members





The outreach rates for 2018 improved significantly over the course of the year, going from the low of 11% in June to the upper 90%s by the end of the year, reflecting the engagement of the vendor to assist with the HRA process, to ensure that members receive their HRAs timely, and were also responded to timely as well. However, while there was an upward trend in HRA outreach for both the new SPD members and annual SPD members within appropropriate time frames, the completion numbers continue to be relatively low, with the last quarter showing completion rates in the mid teens. To further evaluate this, chart review will part of 2019 plan to futher improve and identify gaps.

CM Referral and Identification

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

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

The Alliance's Care Management program emphasizes that the CM aligns with the members' needs. The three (3) primary level trigger areas used to determine CM identification:

- Health Risk Assessment (HRA),
- Data sources such as Utilization and Predictive Modeling

- Direct referrals to care management.

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

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

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

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

Predictive Model Application

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

In 2017, the CM department collaborated with the Information System team to enhance the data stratification to target members for outreach. Adjusted Clinical Group, or ACGs, are the building blocks of The Johns Hopkins ACG

System methodology. ACGs are a series of mutually exclusive, health status categories defined by morbidity, age, and sex. They are based on the premise that the level of resources necessary for delivering appropriate healthcare to a population is correlated with the illness burden of that population. ACGs are used to determine the morbidity profile of patient populations to more fairly assess provider performance, to reimburse providers based on the health needs of their patients, and to allow for more equitable comparisons of utilization or outcomes across two or more patient or enrollee aggregations. ACGs are a person-focused method of categorizing patients' illnesses. Over time, each person develops numerous conditions. Based on the pattern of these morbidities, the ACG approach assigns each individual to a single ACG category. By adding the Johns Hopkins Resource Utilization Bands (RUBs) to the data sets, the team hoped to improve the sensitivity and specificity of the identified member data. ACGs were designed to represent clinically logical categories for persons expected to require similar levels of healthcare resources (i.e., resource groups). However, enrollees with similar overall utilization may be assigned different ACGs because they have different epidemiological patterns of morbidity. For example, a pregnant woman with significant morbidity, an individual with a serious psychological condition, or someone with two chronic medical conditions may all be expected to use approximately the same level of resources even though they each fall into different ACG categories. In many instances it may be useful to collapse the full set of ACGs into fewer categories, particularly where resource use similarity, and not clinical cogency, is a desired objective.

ACGs are collapsed according to concurrent relative resource use in the creation of Resource Utilization Bands (RUBs). The software automatically assigns six RUB classes:

- 0 - No or Only Invalid Diagnosis
- 1 - Healthy Users
- 2 - Low
- 3 - Moderate
- 4 - High
- 5 - Very High

In addition, the tool was enhanced to capture the Residual Risk Score (RRS) to apply predictability to the data. The enhancement identifies current and predictive changes based on utilization data.

While the changes improved the ability to target the specific membership, the volume of identified members continued to be more than the existing staff could assess.

Figure 6 - 2018 Care Analyzer data for Disease Management and Care Management Services.

Care Analyzer	2018/1	2018/2	2018/3	2018/4	2018/5	2018/6	2018/7	2018/8	2018/9	2018/10	2018/11	2018/12
Asthma	943	1119	1096	815	838	1236	1225	665	862	759	907	761
Diabetes (Excluding CCM)	3193	3475	2893	2536	2487	6390	3355	3182	3471	3000	2553	2727
CCM (Diabetes+Non-Diabetes)	750	744	752	783	798	766	728	676	630	593	603	609
Care Coordination MCAL/Medicare Members	50	50	53	53	52	49	65	64	56	56	69	69
Percentage of CCM												
5%	38	37	38	39	40	38	36	34	32	30	30	30
3%	23	22	23	23	24	23	22	20	19	18	18	18
1%	8	7	8	8	8	8	7	7	6	6	6	6

Figure 6 above shows the number of members identified by CareAnalyzer algorithm for potential candidates for CCM services in 2018. The top volumes were in Diabetes, averaging about 3000 per month, followed by Asthma at around 1000 per month.

For 2018, the CM team worked with Health Care Analytics to identify opportunities to use the RRS current and predictive changes to improve the identification of members with health conditions who are at risk for higher utilization and lower health outcomes. Due to capacity constraints, the CMs focus on outreach to the top 1% of members identified as high risk.

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

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

Methodology:

In 2018 a Case Management Aging report was developed and deployed to staff for tracking of the required CM processes for multiple members. Using the

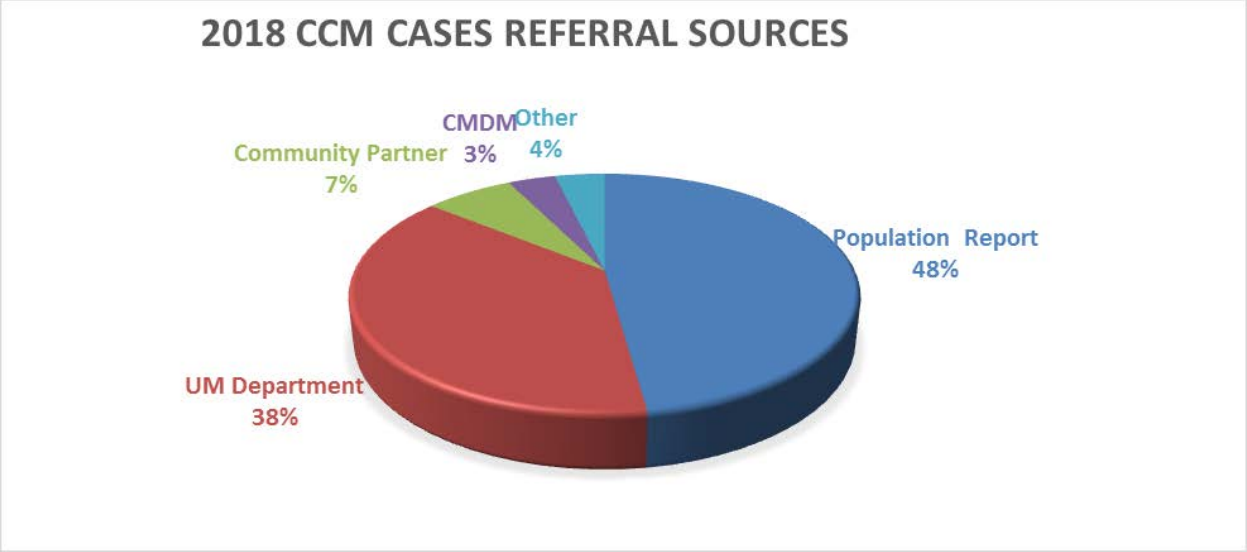
CM Aging report, CCM cases created in 2018 were pulled and separated based on sources. Forty-eight percent (290 out of 607) of CCM cases came from population report. CCM cases referred from Population report were further assessed to identify opportunities.

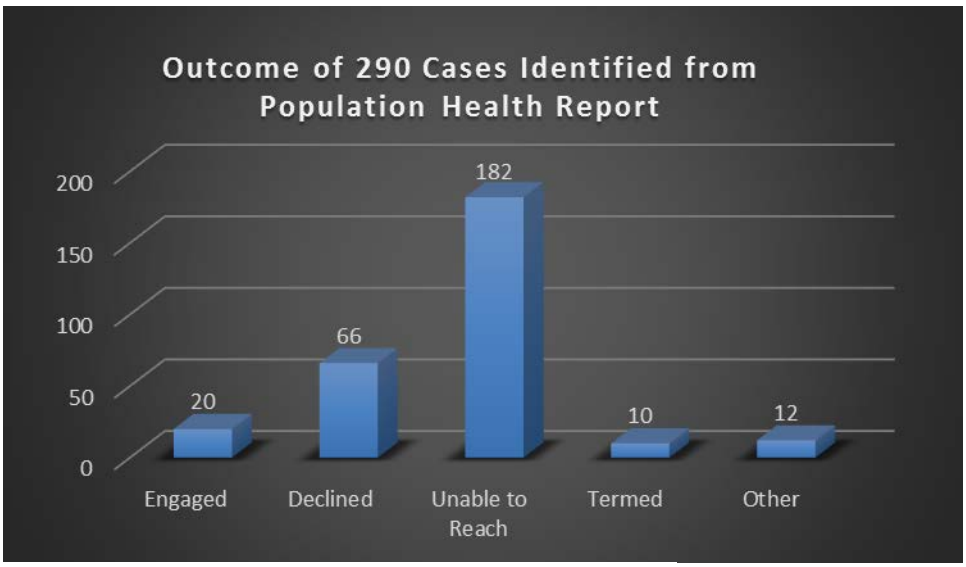
2018 Results:

Complex Case Management

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

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





Outcome of 290 Cases Identified from Population Health Report	Total Cases	%
Engaged	20	7%
Declined	66	23%
Unable to Reach	182	63%
Termed	10	3%
Other	12	4%

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

- Overall for 2018, almost 50% of CCM cases were identified from the Population Health report.
- CM had difficulty engaging members from the Population Health Report in the CCM program, with only 7 % of potential cases successfully engaged in the program.
- Majority of cases identified through population health report were to Unable to Reach or Declined to be in the program.

Qualitative analysis:
The following provides a qualitative analysis of CCM and population health report derived from quantitative analysis of combined CCM aging and population health report, as well as feedback from, but not limited to, committee discussion and focus groups.

- There were members identified in the cost containment initiative but were not pulled from Population Health report.
- There were members identified in both cost containment initiative and Population Health report but not successfully engaged.

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

- Reports may pull from different sources and yield different results
- Issues with CM structure, turnover, and lack of process.
- "Cold calling" members on the Population Health Report has been ineffective to engage members in the program.

2019 Plan

- Clearly define criteria and use of the use of most recent data available to create or revise the Population Health report in 2019.
- Review and approve the new/revised report by the end of Q2 2019.
- Continue to evaluate the new/revised report until the end of the year. Findings will be collected and submitted as part of the 2019 CM program evaluation.

Figure 7 - 2018 CM Care Coordination Program by Referral Source

CARE COORDINATION												
REFERRALS BY REFERRAL SOURCE	201801	201802	201803	201804	201805	201806	201807	201808	201809	201810	201811	201812
Behavioral Health Program	0	0	0	1	0	0	0	0	0	0	0	0
California Children's Services	0	0	1	0	5	4	0	0	2	1	0	0
Care Advisors	0	1	0	0	0	0	0	0	0	0	1	0
CBAS/LTSS	0	0	0	0	0	0	0	0	1	0	0	0
CM/DM	5	4	7	4	1	2	3	9	4	7	3	1
Community Partner/Hospital	5	6	11	7	2	3	6	7	2	17	11	7
Grievance and Appeal	9	6	5	7	8	6	8	10	14	11	7	6
Internal Report	0	1	0	2	2	1	2	1	1	3	1	0
Member Services	4	3	5	5	4	6	3	3	2	6	9	11
NULL	0	0	0	0	0	0	0	0	0	0	0	0
Nurse Advice Line	0	4	2	7	3	2	3	2	1	5	3	9
PCP/Specialty Provider	1	1	5	1	2	2	0	2	0	1	1	0
Provider Services Dept	0	0	0	0	0	0	0	1	0	0	0	0
Self	1	1	0	5	0	2	0	5	1	2	2	2
UM Dept	50	34	66	58	82	75	100	153	125	123	127	139
TOTAL	75	61	102	97	109	103	125	193	153	176	165	175

As identified in Figure 7, the top three referral sources are 1) UM Department at 1,132, 2) Grievance and Appeal Department at 97, and 3) Community Partners/Hospitals at 84. Referrals from PCP/Specialty Providers are low, and may represent an opportunity to work with the Physicians/Physician Offices on the services for care coordination.

Figure 8 - 2018 CM Care Coordination Program by Active Cases

CARE COORDINATION	201801	201802	201803	201804	201805	201806	201807	201808	201809	201810	201811	201812
TOTAL	75	61	102	97	109	103	125	193	153	176	165	175
ACTIVE CASES												
New Cases	97	77	93	100	124	139	154	221	173	230	207	210
Total Cases In Progress	349	349	344	359	403	342	360	463	465	523	499	559
Total Opt Out Assessments	0	0	0	0	0	0	0	0	0	0	0	0
Total Assessments Completed w/in 30 Days of Referral	20	21	46	46	36	49	70	75	94	118	105	115
High Risk Cases In Progress	83	78	78	74	61	48	53	62	62	67	74	72
Medium Risk Cases In Progress	139	128	119	93	91	66	54	55	53	45	48	48
Low Risk Cases In Progress	32	36	27	24	25	11	12	26	9	9	9	8
Active Participation Rate % (Total Assessments Completed w/in 30 Days of Referral / Total Referrals)	27%	34%	45%	47%	33%	48%	56%	39%	61%	67%	64%	66%

Figure 8 above describes the Active case activities by the number of new cases, the total open cases in program and the number of cases in which the members were identified and referred but opted not to engage in the program.

In addition, the data in Figure 8 shows the number of assessments completed and the timeframe for completing the assessment. In this report the completion within the 30 days of referral was well below the 90% goal for the entire year, but improved over the year, going from 27% in January to 66% in December, with an overall average of 52%. The report also tracks the level of risk identified after the assessment. Members identified as High Risk are referred to the CCM program for further care planning.

Figure 9 - 2018 CM Care Coordination Program by Case Closure

CARE COORDINATION	201801	201802	201803	201804	201805	201806	201807	201808	201809	201810	201811	201812
CASE CLOSURE BY CLOSURE REASONS												
Already in program	0	0	0	0	0	0	0	0	0	0	0	0
Condition stable with no further Case Management needs	21	18	17	15	29	25	30	57	43	50	31	75
Condition stable with no further Disease Management needs	0	1	0	0	0	1	0	1	0	0	1	2
Deceased	2	0	1	1	1	1	2	0	2	1	0	3
Duplicate member record	0	0	0	1	0	0	1	1	1	1	0	0
Escalate services to higher level program	2	2	3	1	8	1	5	1	9	18	5	10
Inappropriately identified for program	0	0	1	1	0	1	1	1	1	0	0	2
Member declines continued Case Management services	1	0	1	0	0	0	3	1	1	0	1	2
Member declines continued Disease Management services	0	0	0	0	0	0	0	0	0	0	0	0
Member non-compliant	0	0	0	0	0	0	0	0	0	0	0	0
Member transferred to Delegate/Other	2	1	2	2	14	5	6	2	7	4	5	1
Member/Caregiver refuses services	0	0	0	1	3	2	0	4	3	7	2	1
Other	15	29	14	8	28	15	11	9	18	16	20	36
Readmission	0	2	0	0	0	0	0	0	0	0	1	1
NULL	0	0	0	0	0	0	0	0	0	0	0	0
Referred to Disease Management	0	0	0	0	1	0	0	0	0	0	0	0
Step down to lower level program	0	0	0	0	0	0	0	1	0	0	0	1
Termination of coverage	0	3	0	1	8	0	1	0	0	0	1	1
TruCare cleanup	0	0	0	0	43	2	0	0	0	0	0	0
Unable to contact member	34	42	33	29	44	55	43	68	65	96	60	100
Already in Program	0	0	1	1	3	1	0	3	0	1	1	2
Declined Program	0	0	3	2	7	7	0	5	8	12	8	6
Completed Program	0	0	1	9	4	7	6	10	7	10	5	12
Lost Contact	0	0	7	6	7	9	5	4	5	13	5	13
Member Ineligible	0	0	1	1	0	4	3	3	2	2	4	4
Case still open	0	0	0	1	0	0	1	0	0	0	0	0
TOTAL	77	98	85	80	200	136	118	171	172	231	150	272

As noted in Figure 9, the top three reasons for case closure in 2018 were 1) Unable to Contact at 699 members, 2) Condition Stable with no further need for CM at 411 members and 3) Other reasons not categorized at 219 members. The

high number of members for whom the program was unable to reach warrants additional strategies. In addition, given the high number of cases not categorized, further refinement of the data capture tool or additional staff training may be indicated.

Complex Case Management

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

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

Figure 10 – 2018 Complex Case Management – Referrals by Source

COMPLEX REFERRALS BY REFERRAL SOURCE	201801	201802	201803	201804	201805	201806	201807	201808	201809	201810	201811	201812
Behavioral Health Program	1	0	0	1	0	0	0	0	0	0	0	0
California Children's Services	0	0	0	0	1	0	0	0	0	0	0	0
Care Advisors	0	0	0	0	0	0	0	0	0	0	0	0
CBAS/LTSS	0	0	0	0	1	0	0	0	0	0	0	0
CM/DM	9	2	1	1	7	0	1	6	1	2	4	1
Community Partner/Hospital	2	6	13	8	0	7	6	8	6	13	8	4
Grievance and Appeal	3	3	1	3	4	3	5	5	8	7	4	2
Internal Report	1	1	0	0	54	23	57	34	24	25	33	38
Member Services	2	2	2	3	3	1	3	1	1	1	2	1
NULL	0	0	0	0	0	0	0	0	0	0	0	0
Nurse Advice Line	0	0	0	0	0	0	1	0	0	0	0	0
PCP/Specialty Provider	1	2	0	1	2	2	1	2	1	1	1	0
Provider Services Dept	0	0	0	0	0	0	0	0	0	0	0	0
Self	2	1	0	2	4	1	1	0	0	2	0	0
UM Dept	9	10	19	13	24	60	44	58	35	52	41	33
TOTAL	30	27	36	32	100	97	119	114	76	103	93	79

As identified in Figure 10, the top three referral sources are 1) UM Department at 398, 2) Internal Report (CareAnalyzer) at 290, and 3) Community Partners/Hospitals at 81. It is noted that the referrals from PCP/Specialty Providers is quite low, with only 14 referrals. This may be an area of opportunity to work with the Physicians/Physician Offices on the services for complex case management.

Figure 11 2018 CCM Active Cases and Case Assessments Rates

COMPLEX CASES in 2018	201801	201802	201803	201804	201805	201806	201807	201808	201809	201810	201811	201812	Total
TOTAL REFERRALS	30	27	36	32	100	97	119	114	76	103	93	79	906
ACTIVE CASES													0
New Cases	20	25	31	42	101	79	100	90	46	55	53	43	685
Total Cases In Progress	40	57	62	65	134	142	179	153	109	113	87	81	1,222
Total Opt Out Assessments	0	1	1	0	13	12	12	17	5	12	6	11	90
Total Assessments Completed w/in 30 Days of Referral	17	19	14	14	37	46	53	53	40	69	47	38	447
High Risk Cases In Progress	38	55	57	37	30	38	39	42	35	27	18	8	424
Medium Risk Cases In Progress	0	0	0	1	1	0	0	0	0	0	0	0	2
Low Risk Cases In Progress	0	0	0	2	1	0	0	0	0	0	0	0	3
Active Participation Rate % (Total Assessments Completed w/in 30 Days of Referral / Total Referrals)	57%	70%	39%	44%	37%	47%	45%	46%	53%	67%	51%	48%	49%

Figure 11 above describes the 2018 Active case activities by the number of new cases, (685) the total open cases in program (1,222) and the number of cases in which the members was identified and referred but opted not to engage in the program, (90).

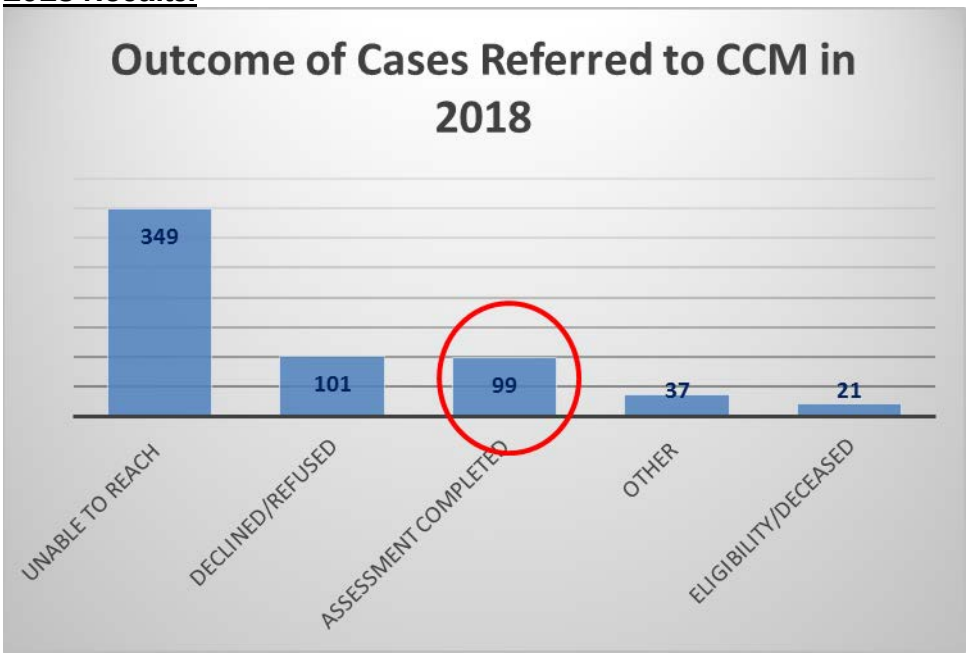
In addition, the data in Figure 11 monitors the number of assessments completed and the timeframe for completing the assessment. In this report the completion within the 30 days of referral was well below the 90% goal for the entire year at 49% and there was no clear trend in the percentages.

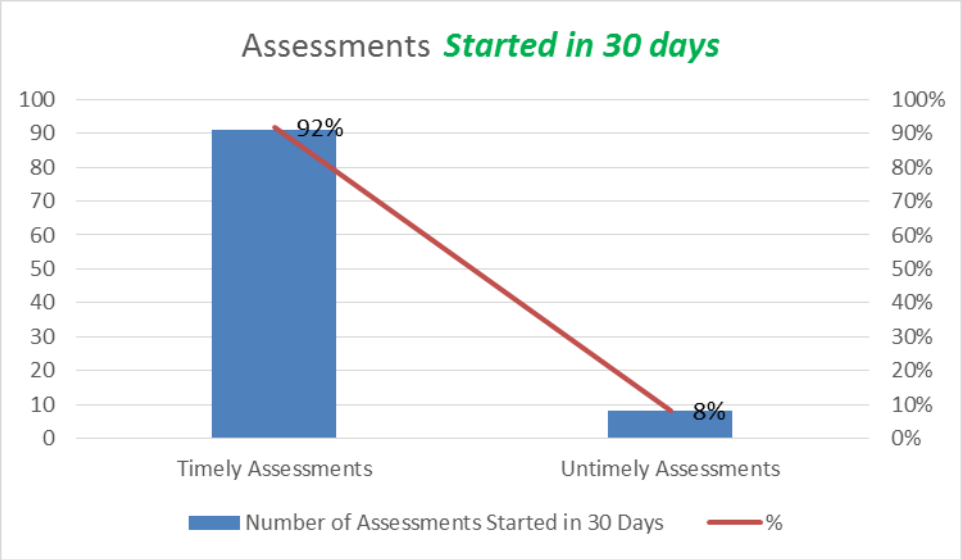
The Case Manager may begin the initial assessment in the first contact call. An initial assessment is performed as expeditiously as the Member's condition requires (and may be completed by multiple calls), but must be created within 30 calendar days and completed within 60 days from date of identification.

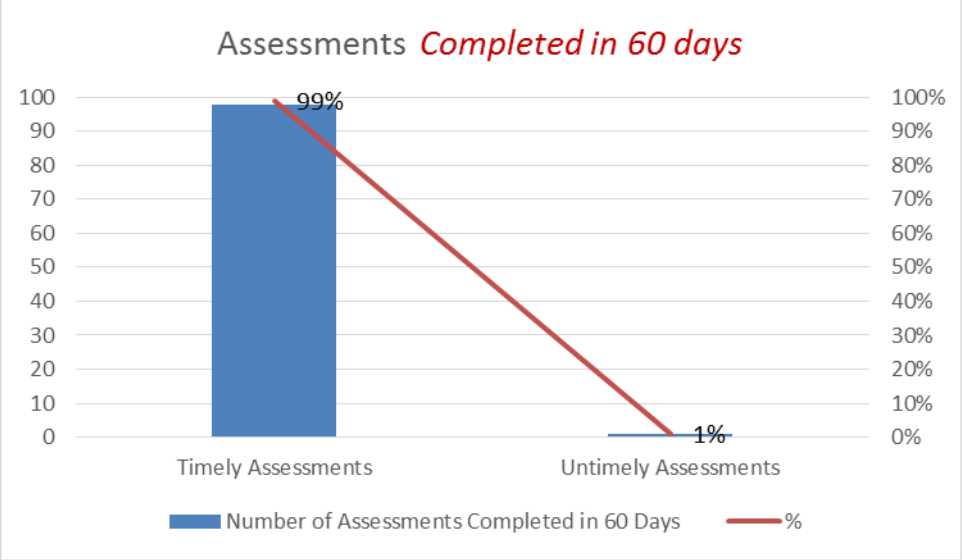
Further review of CCM case timeliness was done, using the Aging Report. The re-review revealed data integrity issues, such that cases less than 30 days were included in the report, and the report also included the members Declining CCM and Unable to Reach members.

Methodology for Data Validation:
Using the Aging report, all 607 cases referred and created in 2018 were pulled to identify the assessment status. CCM assessments completed were pulled and evaluated for timeliness.

2018 Results:







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

- Out of 99 assessments, 91 were started within 30 days and only eight were started after the 30 calendar day timeframe, meeting the goal at 92%.
- Out of 99 assessments, 98 were completed within 60 days and only one was completed after the 60 calendar day timeframe, exceeding the goal at 99%.

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

- Three out of eight cases in which assessments were not started timely were due to member hospitalizations. Cases were started with the care transition program at the time of referral. On a positive note, those three members were assessed within thirty days after hospital discharge.
- Two out of eight cases were started timely but the report logic captured the date when the assessment was completed.
- The remaining three out of eight cases identified as untimely assessments due to untimely outreach.
- The only assessment that was not completed within 60 days was due to member hospitalization.

Though timeliness outcomes were met for the CCM cases, opportunity for process standardization, written workflows and staff training was identified.

Plan for 2019:

- By the end of February 2019, create training materials and workflow which includes CCM and Care transition process.
- By the end of March 2019, train staff on the Care transition and CCM process including timeline.
- By the end of March, 2019, incorporate the slides, workflow in the orientation and competency checklist for staff evaluation.

Individualized Care Team **(ICT)**

Case Management team evaluated the ICT completion rates and timeliness rates for CCM cases equal to or greater than 90 days

Methodology:

The 99 cases that engaged in CCM and had completed the assessment were reviewed to identify only members who stayed in CCM for at least 90 days. CM identified 23 members from the aging report and from chart review.

Results:

CCM cases ≥ 90 days	Outcome of ICT	% of Timely ICT based on **Report**
11	No ICT	48%
8	Timely	35%
4	Untimely	17%

CCM cases ≥ 90 days	Outcome of ICT	% Timely ICT based on **Chart Review**
11	No ICT	48%

11	Timely	48%
1	Untimely	4%

Results show that there is an issue with completing the ICT according to the requirements (only 48% completed at all, or timely.) There is also a data integrity issue that will affect the ability to readily track outcomes, reflected in the different outcomes of the report vs. chart review.

2019 Plan

- Submit intake request to Analytics by end of February, 2019 to change the logic to capture the ICT date accurately on the aging report.
- Incorporate the ICT process in the CM training slides by end of March, 2019
- Train staff on ICT Process by end of April, 2019
- Modify the audit tool to include ICT criteria by end of April, 2019

Figure 12 - 2018 Complex Case Management Case Closures by Reason

CCM CASE CLOSURE REASONS	201801	201802	201803	201804	201805	201806	201807	201808	201809	201810	201811	201812	Total
Already in program	0	0	0	0	0	0	0	0	0	0	0	0	0
Condition stable with no further Case Management needs	0	3	3	2	4	2	4	7	3	10	1	1	40
Condition stable with no further Disease Management needs	0	0	0	0	0	0	0	0	0	0	0	0	0
Deceased	0	0	0	0	2	1	1	6	1	0	0	1	12
Duplicate member record	0	0	0	2	1	0	2	0	1	0	0	0	6
Escalate services to higher level program	0	0	1	0	0	0	0	0	0	1	1	0	3
Inappropriately identified for program	0	0	3	0	1	0	0	0	0	1	0	0	5
Member declines continued Case Management services	0	0	0	0	0	0	1	1	0	0	0	0	2
Member declines continued Disease Management services	0	0	0	0	0	0	0	0	0	0	0	0	0
Member non-compliant	0	0	0	0	0	0	0	0	0	0	0	0	0
Member transferred to Delegate/Other	0	0	0	0	0	2	1	0	0	0	1	0	4
Member/Caregiver refuses services	0	1	1	1	2	4	2	1	0	0	0	0	12
Other	3	3	1	5	3	3	2	4	0	5	1	2	32
Readmission	0	1	0	0	1	0	1	0	0	0	0	0	3
NULL	0	0	0	0	0	0	0	0	0	0	0	0	0
Referred to Disease Management	0	0	0	0	0	0	0	0	0	0	0	0	0
Step down to lower level program	2	1	2	1	3	0	0	0	0	0	2	0	11
Termination of coverage	0	0	0	0	0	0	0	0	0	0	0	0	0
TruCare cleanup	0	0	0	0	0	0	0	0	0	0	0	0	0
Unable to contact member	3	17	18	14	37	30	74	59	33	26	34	34	379
Already in Program	0	0	1	1	0	0	0	0	0	0	0	0	2
Declined Program	0	0	1	0	10	12	13	11	4	24	8	11	94
Completed Program	0	0	1	1	0	1	0	0	0	1	0	0	4
Lost Contact	0	0	6	4	4	7	11	1	7	8	1	1	50
Member Ineligible	0	0	1	1	3	1	4	0	2	3	0	1	16
TOTAL	8	26	39	32	71	63	116	90	51	79	49	51	675

As noted in Figure 12, the top three reasons for case closure in 1) Unable to Contact (379), 2) Member Declined the Program, (94) and 3) Condition Stable with no further need for CM, (40) .

Recommended Interventions/Next Steps for 2019:

An opportunity to continuously improve the quality oversight of the current CM processes has been identified. This will be accomplished by internal monitoring of CM/CCM files on a routine and/or periodic basis. This also includes reviewing

and revising the standardized reports focused at monitoring of CM activities referral management, outreach, case closure and PCP communications.

Performance Measures

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

Figure 13 – CM Performance Measures

	Goal	Measure	Measurement	Performance Goal	2018 Rate	Goal Met?
# 1	Achieve and maintain high level of satisfaction with CM services	Member Satisfaction Rates	High level of satisfaction with CM services	90%	100%	Yes
# 2	Improve member outcomes	All-Cause Admission Rate	Admission rates for all causes for members in CCM with admission within 6 months of enrollment in CCM	None established	17.4% for the entire membership	NA
# 3	Improve member outcomes	Emergency Room Visit Rate	ER rates for members enrolled in CCM	None established	Not Available	NA
# 4	Achieve optimal member functioning	Health Status	% of members in CCM responding that their health status improved because of CCM	None established	Not Available	NA

#5	Use of Appropriate Health Care Services	Use of Services	Improvement in measures of office visits within Alliance Network	None established	Not Available	NA

Figure 13 captures the 2018 Performance Measures. Of the five measures, one had an established benchmark. Only one of the measures had an identified rate. The overall all cause readmission rate was reported at 17.4%, but this is not specific to the CCM population. It is noted that most measures are not specific to members enrolled in CCM. Unless the population measures can be refined to reflect outcomes for members enrolled in CCM, there will need to be consideration of different measures that can capture meaningful CCM outcomes.

Assessing Members Experience with the CM Process

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

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

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

In 2018, out of 20 members mailed surveys, a total of 3 surveys were completed during the time frame allowed, which was a response rate of 15%.

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

Of the three surveys returned, all were 100% satisfied in all areas.

Another way to assess member experience is through review of the filed complaints against Case Management. A review of the 2018 Grievance data shows only one case identified as a member complaint about the CM process.

Figure 14 – 2018 Complaints Filed Regarding CM Process

Grievances Filed Against	Benefits/Coverage	Quality of Care/Service		Referral		Grand Total
	Dispute over Covered Services	Plan Denial of Treatment	Poor Provider/Staff Attitude	Plan Refusal to Refer	Delay in Referral	
Case Management Process					1	1
Grand Total:					**1**	**1**

One complaint does not represent a trend or an opportunity for improvement. Overall, as the department adds staff, customer service communication and member engagement training is provided to all staff.

Recommended Interventions/Next Steps for 2019:

In 2019, there is an opportunity to ensure the CM Department:

- Revises the process on how CM initiates and collects the satisfaction survey.
- Participates in the analysis of the data and development of activities aimed at improving the member experience with the CM processes.
- Identifies CM performance measures, goals and benchmarks.
- Collaborates with Health Care Analytics to ensure the performance measures can be captured and reported at least semi-annually.

Special Programs

Transition of Care

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

In 2018, The Alliance had a TOC program for members identified as potentially having risk for readmission. It changed over the course of the year from a report based program to a referral based program, with most referrals coming from the UM Concurrent Review staff. This change was prompted by the fact that the volume of cases identified by report was more than the staffing could effectively handle. The TOC program may be expanded in 2019 as the Alliance engages hospital partners on initiatives related to readmission reduction and discharge planning.

Figure 15 - 2018 Transition of Care Dashboard

TRANSITION OF CARE												
REFERRALS BY REFERRAL SOURCE	**201801**	**201802**	**201803**	**201804**	**201805**	**201806**	**201807**	**201808**	**201809**	**201810**	**201811**	**201812**
Behavioral Health Program	0	0	0	0	0	0	0	0	0	0	0	0
California Children's Services	0	0	0	0	2	5	0	1	0	0	0	0
Care Advisors	0	0	0	0	0	0	0	0	0	0	0	0
CBAS/LTSS	0	0	0	0	0	0	0	0	0	0	0	0
CM/DM	2	1	0	0	0	0	0	1	0	0	0	0
Community Partner/Hospital	0	0	0	0	0	0	0	0	0	0	0	0
Grievance and Appeal	0	0	0	0	0	0	0	0	0	0	0	0
Internal Report	135	99	42	0	0	0	0	0	0	0	0	0
Member Services	0	0	0	0	0	0	0	0	0	0	0	0
NULL	0	0	0	0	0	0	0	0	0	0	0	0
Nurse Advice Line	0	0	0	0	0	0	0	0	0	0	0	0
PCP/Specialty Provider	0	0	0	0	0	0	0	0	0	0	0	0
Provider Services Dept	0	0	0	0	0	0	0	0	0	0	0	0
Self	0	0	0	0	0	0	0	0	0	0	0	0
UM Dept	11	2	5	12	4	17	10	11	1	9	3	13
TOTAL	**148**	**102**	**47**	**12**	**6**	**22**	**10**	**13**	**1**	**9**	**3**	**13**
ACTIVE CASES												
New Cases	127	75	42	13	10	3	1	1	0	3	2	27
Total Cases In Progress	261	191	141	92	73	9	6	2	1	4	6	32
Total Opt Out Assessments	0	0	0	0	0	0	0	1	0	0	0	0
Total Assessments Completed w/in 30 Days of Referral	66	33	22	11	1	11	10	10	1	7	2	12
High Risk Cases In Progress	125	70	54	46	32	3	2	1	0	3	3	3
Medium Risk Cases In Progress	78	58	32	16	11	1	1	0	0	0	0	0
Low Risk Cases In Progress	38	44	30	16	19	4	1	1	1	1	1	1
Active Participation Rate % (Total Assessments Completed w/in 30 Days of Referral / Total Referrals)	45%	32%	47%	92%	17%	50%	100%	77%	100%	78%	67%	92%

The data noted in Figure 15 shows the majority of referrals to the program were noted to be from the UM Department across the year. This is an expected outcome given the program change. The volume in the program varied across the year as it transitioned from report based to referral based. Once the volume was reduced, the timeliness of assessments came closer to the goal as well. The program completed those assessments on time approximately 66% of the time overall, with rates in the 40% range in first quarter to 84% in the last quarter. Later in 2018, the CM department pulled staff from the TOC program to enhance focus and resources for Complex Case Management. In 2019 there will be more ability to focus resources in both arenas.

Continuity of Care

The CM Department collaborates with the UM Department and Member Services on the management of the continuity of care program. CM is responsible for assisting members who have been approved to see provider's outside of the network and need to be transitioned back in network after the Continuity of Care period has ended as well as members for whom Continuity of Care conditions have not been satisfied (ex. out of network provider not accepting Medi-Cal rates) CM is notified of the need to assist members back in network via a report developed by HealthCare Analytics which captures data from the UM authorization. Staff also provide assistance to members based on direct referrals into the care coordination program.

The CM program is also responsible for assisting members who have exhausted a benefit or who are aging out of a benefit, i.e. California Children Services. The CM Department coordinates these services through the care coordination

referral process and identifies members who are aging out of CCS eligibility in order to ensure that they transition to appropriate providers. In 2019, further refinement of the Continuity of Care and CCS Transitions report process will be needed.

LONG TERM SERVICES AND SUPPORTS (LTSS)

The Alliance is responsible for ensuring Members who are eligible to receive LTSS services are identified and referred. The CM Department works in collaboration with the UM Department to ensure members identified for Community Based Adult Services (CBAS) are identified, referred and assessed appropriately and timely. In 2018 the CM Department was responsible for the assessment and initial referral. The CM Department was also responsible for the re-assessments and re-authorization of services.

Figure 16 - 2018 CBAS Enrollment by Facility by Delegate

CBAS Enrollment By Facility By Delegate - 2018					
Based on Active Approved Authorizations					
Run Date:	3/11/2019				
Number of Members					
Facility Name	Alliance	IHSS	CHCN	Kaiser	Total
Alzheimer Services of The East Bay	46	0	19	0	65
Family Bridges Inc.	166	0	283	1	450
Golden Castle Adult Day Health Care Center	22	0	0	0	22
Grace Adult Day Healthcare	12	0	0	0	12
Silicon Valley Adult Day Health Care	8	0	5	0	13
West Oakland Health Center	1	0	0	0	1
Total	253	0	306	1	560

As seen in the Figure 16, there were a total of 560 members receiving services through one of the six CBAS centers. The Center with the highest volume is Family Bridges, by a considerable margin. The data provided does not assess for the timeliness of the assessments and reassessments. For 2019, the CM Department will collaborate with UM to transition the CBAS program to the UM Department, and the UM department will work to develop the appropriate metrics for the program outcomes.

INTEGRATION OF MEDICAL AND BEHAVIORAL HEALTH

Behavioral health is managed through delegation to Beacon Health Options, the MBHO. The behavioral health practitioners are involved in key aspects of the

delegate's UM/CM program ensuring BH focus in policies and procedures, aligning the medical necessity guidelines with medical necessity guidelines and participation in the UM committee meetings. The MBHO dedicates a clinical team to assist in the co-management of the activities.

In 2018, the teams worked on efforts crossing the medical and behavioral health services which included:

- Enhancing CCM outreach to chronically ill
- Improve coordination of care by increasing clinical oversight and co-management with the medical management teams
- Continued efforts toward improving communication between the primary care physician and behavioral health providers

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

PRE-HEALTH HOMES PROJECT PILOT:

One of the Alliance's three year strategies is to 'Build internal capacity to better coordinate care for members with complex medical, behavioral, autism or social service needs; assist navigation across systems of care; and address social determinants of health in primary care.' As part of this strategy, the Alliance opted to fund and create a Pre- Health Homes pilot program in 2017, modeled after the anticipated state Health Home Program. This decision was felt to help position the Alliance to fully realize the California HHP benefit prior to its initiation in Alameda County in 2019.

Over the course of the last half of 2017 and all of 2018 the Alliance created a network of community based care management entities (CB-CME's) through contracting agreements, developed and disseminated a model of care based on the projected state Health Homes program, and initiated a monthly learning collaborative in partnership with Alameda County's Whole Person Care program. By December 2018, approximately 400 members were enrolled in the Pilot across 15 multiple network CB-CME's.

The state funded Health Homes Program will start in July of 2019 in Alameda County. The Alliance will employ a network of community based care management entities (CB_CME's) to integrate primary, acute, and behavioral health care services as well as community based needs (ex. housing) for the highest risk Medi-Cal enrollees. The HHP includes six core services, delivered through the managed care system: 1) Comprehensive care management; 2)

Care coordination; 3) Health promotion; 4) Comprehensive transitional care; 5) Individual and family support; 6) Referral to community and social support services.

The primary program goal is to achieve improved health outcomes for eligible members by providing them additional supportive ("wrap around") care via the plan's network of CB-CME organizations. In 2019 Alameda Alliance will simultaneously help build and oversee the capacity of CB-CME's to address the needs of the population and orchestrate reporting of encounter data and program results.

Health Homes Patient Characteristics (enrollment criteria)

Eligibility Requirement	Criteria Details
1. Chronic condition criteria (*Must meet at least one of the above to be enrolled.)	· **At least two of the following**: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic renal (kidney) disease, dementia, substance use disorders; OR · **Hypertension and one of the following:** chronic obstructive pulmonary disease, diabetes, coronary artery disease, chronic or congestive heart failure; OR · **One of the following:** major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia); OR · **Asthma**

2. Acuity/Complexity criteria (*Must meet at least one of the above to be enrolled.)	· Has at least 3 or more of the HHP eligible chronic conditions; OR · At least one inpatient hospital stay in the last year; OR · Three or more emergency department visits in the last year; OR · Chronic homelessness.

Staff were identified or hired into the program in 2018, including a Project Manager, a Physician Champion, a Social Worker and a Community Health Worker. A Nurse Liaison is scheduled to be added to the team in 2019.

Program Outcomes: As of 12/31/18, the program has served 176 members at the 15 CB-CME sites in Alameda County:

CB-CME site	Members Served in HHP
AHS Eastmont	5
AHS Highland	10
AHS Hayward	10
Family Bridges	12
Roots	24
Roots STOMP	1
Tri-City	24
Trust/Lifelong	9
EBI (pending Oct, Nov, Dec data)	1
Watson Wellness	40
Bonita House	0
St. Mary's (pending Oct, Nov, Dec data)	0
Davis St.	0
California Cardiovascular Consultants	38
City of Fremont	1
Sum	**176**

Next Steps in 2019

Apply for Health Homes Administrator status
Hire RN Liaison to staff the program
Certify CB-CMEs as appropriate members of our Health Homes network.

Develop and maintain the reporting requirements in collaboration with the CB-CMEs

Meet all state requirements in collaboration with the HHP CB-CMEs

Train and oversee the contracted CB-CME's to ensure compliance and quality.

Coordination with Regulatory Compliance

The Alliance CM Department works closely with the Compliance Department in preparation for regulatory audits. In 2018, the department participated in two follow up regulatory audits. The final report identified the following key findings:

- The Plan did not ensure the provision of CCM services to eligible members. The Plan did not fully implement their policies and procedures regarding the contact, assessment, and triage of potential members who would benefit from the CCM program.
    - As a result, the Alliance developed a report to monitor aging CCM cases and is now able to track and intervene to ensure that members are provided CCM services as indicated.
    - The Plan did not ensure PCP participation in the provision of CCM to each eligible member. A PCP Input Form was developed and implemented in May of 2018.

As a result of the reviews, several internal workgroups have met to identify activities targeted at resolving the identified CM related issues. The workgroups have been managing these activities via ongoing work-plans. The activities identified are on target for completion within the established timeframes. The activities include mechanisms for ongoing monitoring to mitigate further regulatory deficiencies.

Recommended Interventions/Next Steps for 2019:

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

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

Conclusion

Overall, the 2018 CM Program continued to develop into an effective program maintaining compliance with regulatory and contractual requirements, monitoring of performance within the established benchmarks or goals, identifying opportunities for improvement and enhancing processes and outcomes. The CM program activities have met the established targets. The Alliance leadership has played an active role in the CM Program structure by participating in various committee meetings, providing input and assistance in resolving barriers and developing effective approaches to achieve improvements. To effectuate a comprehensive approach to the CM program structure, practicing physicians provided input through the UM Committee and subcommittees.

CM Program Recommendations for 2019

As a result of internal performance monitoring performed in 2018, opportunities for improvement were identified and will be incorporated into the 2019 department goals. Highlights of opportunities for improvement based on the regulatory findings include:

- Redesign the CM program to focus on key CM activities, monitoring through the UM Committee and HCQC.
- Revise the CM staffing model to address operational needs.
- Ensure information systems are accurately reflective of reporting needs for compliance monitoring and oversight both internal and external.
- Identify appropriate performance measures and goals for CM, and develop monitoring reports of performance toward the measures. This includes developing CM related activities to address improvement with the measures.

- Launch the California Health Homes Program with community-based collaborations.
- Develop educational program for PCPs and Network Provider Groups on identification of members in need of CM/CCM, referral processes and engagement with CM team on management of ICPs and ICTs.
- Enhance reporting and analysis of CM activities focused on member experience with CM.
- Develop process for implementing activities addressing improved member experience with CM, including analysis of a member survey and member complaints.
- In collaboration with the Compliance Department, develop a department program focused on monitoring internal compliance and quality review of CM department operations.
- Collaborate with MS to obtain HRA data and information on program activities.
- Revise the continuity of care program to accurately reflect CM involvement and activities, including regulatory reporting and CCS age out program.
- Formalize the Palliative Care benefits for members under age 21
- Enhance delegation oversight activities for CM, Care Coordination and CCM.
- Collaborate with Health Care Analytics on identifying enhancements to the predictive model algorithm to improve the identification of appropriate members for CCM.
- Implement internal auditing of cases for Care Coordination and CCM.

2019
Utilization Management
Program Description

2019 Utilization Management Program

Signature Page

Date _____

Julie Anne Miller, LCSW
Director, Health Care Services

Date _____

Sanjay Bhatt, M.D.
Director, Quality Improvement

Date _____

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

Date _____

Scott Coffin
Chief Executive Officer

Date _____

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

- **<u>Changes in UM Program Description from 2018 Version</u>**
  - **Staff Title Changes**
  - **Outside Agency Name Corrections**
  - **Grammatical corrections**
  - **Pagination corrections**
  - **Removal of terminated special programs**
  - **Clarification of key UM referral activities, i.e. transportation**

Table of Contents

Introduction

Alameda Alliance for Health (The Alliance) is a public, not-for-profit managed care health plan committed to making high quality health care services accessible and affordable to lower-income people of Alameda County. Established in January 1996, the Alliance was created by and for Alameda County residents.

The Alliance provides health care coverage to over 265,000 children and adults through the Medi-Cal and Alliance Group Care programs. Alliance members choose from a network of over 1,700 doctors, 15 hospitals, 29 community health centers, and more than 190 pharmacies throughout Alameda County. The Alliance cares about the health of our community and reflects the community's cultural and linguistic diversity in the health plan's structure, operations and services. In addition, many of the Alliance providers, employees, and Board of Governors (BOG) live in areas that we serve. The Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan members. Our members' optimal health is always our priority.

The Alliance's Utilization Management (UM) Program was established to provide basic and complex care management structures and key processes that enable the health plan to improve the health and health care of its members. The UM Program is a supportive and dynamic tool that the Alliance uses to achieve these objectives as well as respond to the needs and standards of consumers, the healthcare provider community, and regulatory and accrediting organizations. The UM Program is compliant with Health and Safety Code Sections 1363.5, 1367.01, 1368.1, 1374.16, 1374.72 and Title 28, CCR, Sections 1300.1300.67.2, 1300.70(b)(2)(H) & (c).

The UM Program Description includes a discussion of program objectives, structure, scope and processes.

The annual evaluation of the effectiveness of UM processes was conducted and the recommendations were documented in the 2018 UM Program Evaluation. Based on those recommendations, the Alliance will continue its focus on the following areas for 2019:

- Revise the existing UM infrastructure to meet the needs of the members, providers and the organization, including a new staffing model for UM activities.
- Continue to evaluate opportunities to enhance the existing clinical information system reporting capabilities to focus on the improvement of monitoring operational activities, i.e. Turn-around Time monitoring, referral types;
- Focus on strategies and tactics to reduce readmissions;
- Improve monitoring of network utilization (over/under), including out of network
- Enhance reporting and analysis of member and provider complaint data related to UM decision making to improve experiences with UM process.
- Implementing activities to improve member experience with UM, targeting CAHPs measures for "getting needed care" and "getting care quickly" as it relates to primary and specialty care.

- Strengthen internal oversight of UM processes;
- Strengthen oversight of delegates; and
- Continue to focus on activities to mitigate regulatory audit deficiencies related to UM activities.
- Secure staffing and resourcing to support these initiatives.

Section I. Program Objectives & Principles

The purpose of the Alliance UM Program is to objectively monitor and evaluate the appropriateness of utilization management services delivered to members of the Alliance. The UM Program serves Alliance members through the following objectives:

- Ensure that appropriate processes are used to review and approve the provision of Medically Necessary Covered Services;
- Provide continuity of care and coordination of medical services;
- Improve health outcomes; and
- Assure the effectiveness and efficiency of healthcare services.

The Alameda Alliance for Health adheres to the following operating principles for the UM Program:

- Appropriately licensed and qualified health care professionals with clinical care expertise make UM review determinations according to approved clinical review criteria.
- UM decisions are made on appropriateness of care and service, as well as existence of benefit coverage.
- Appropriate processes are used to review and approve provision of medically necessary covered services.
- Prior authorization requirements are not applied to emergency, family planning, preventive, or basic prenatal care, and sexually transmitted disease or HIV testing services.
- The Alliance does not financially reward clinicians or other individuals for issuing denials of coverage, care, or service.
- The Alliance does not encourage UM decisions that result in under-utilization of care to members.
- Members have the right to:
    - Participate with providers in making decisions about their individual health care, including the right to refuse treatment;
    - Discuss candidly with providers the appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage;
    - Receive written notification of a decision to deny, defer, or modify requests for prior authorization;
    - Request a second opinion from a qualified health professional at no cost to the member;
    - Voice grievances or appeals, either verbally or in writing, about the

organization of the care received;
- Request a Medi-Cal state hearing, including information on the circumstances under which an expedited fair hearing is possible;
- Have access to, and where legally appropriate, receive copies of, amend or correct their medical record; and
- Receive information about how to access State resources for investigation and resolution of member complaints, including a description of the DHCS Medi-Cal Managed Care Ombudsman Program and its toll-free number, and the DMHC, Health Maintenance Organization (HMO) Consumer Service and its toll-free number

Section II. Program Structure

A. Program Authority and Accountability

1. Board of Governors

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

2. Committee Structure

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

Alliance committees meet on a regular basis and in accordance with Alliance Bylaws. Alliance Board meetings are open to the public, except for peer review activities, contracting issues, and other proprietary matters of business, which are held in closed session.

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

description of the HCQC Committee responsibilities can be found in the most recent Quality Improvement Program.

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

The HCQC functional responsibilities for the UM Program include:

- Annual review and approval of the UM Program Description.
  Oversight and monitoring of the UM Program, including:
    - Recommend policy decisions;
    - Oversight of interventions to address over and under-utilization of health services;
    - Oversight of the integration of medical and behavioral health activities
    - Guide studies and improvement activities;
    - Review results of improvement activities, HEDIS measures, other studies and profiles and the results of audits; and
    - Recommend necessary actions.

B. Utilization Management Committee

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

1. UM Committee Structure

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

2. Authority and Responsibility

The HCQC is responsible for the overall direction and development of strategies to manage the UM program including but not limited to reviewing all

recommendations and actions taken by the UM Committee.

The HCQC has delegated authority of the following functions to the UM Committee:

- Annual review and approval of the effectiveness of the UM Program
- Annual review and approval of the UM Program,
- UM Policies/Procedures,
- UM Criteria, and
- Other pertinent UM documents such as the UM Delegation Oversight Plan, UM Notice of Action Templates, and
- Case/ Care Management Program and Policies/ Procedures.

3. UM Committee Membership

The UMC is chaired by the Chief Medical Officer.

Members of the UM Committee include:

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

4. UMC Voting Privileges

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

5. UMC Quorum

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

6. UMC Meetings

The UMC meets at least 8 times a year but as frequently as necessary. The meeting dates are established and published each year.

7. UMC Minutes

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

8. UM Committee Functions

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

- Improve quality of care for the Alliance members
- Evaluate and trend utilization data for medical and behavioral health services provided to Alliance members and benchmarks for over/under utilization. This includes in- network and out-of-network utilization data review to ensure services are accessible and available timely to members.
- Provide a feedback mechanism to drive quality improvement efforts in UM.
- Increase cross functional collaboration and provide accountability across all departments in Medical Services.
- Provide mechanism for oversight of delegated UM functions, including review and trend authorization and utilization reports for delegated entities to identify improvement opportunities
- Identify behaviors, practices patterns and processes that may contribute to fraud, waste and abuse with a goal to support the financial stability of our providers and network.

UM Committee responsibilities are to:

- Maintain the annual review and approval of the UM Program, UM Policies/Procedures, UM Criteria, and other pertinent UM documents such as the UM Delegation Oversight Plan, UM Notice of Action Templates, and Case/ Care Management Program and Policies/ Procedures.
- Participate in the utilization management/ continuing care programs aligned with the Program's quality agenda.
- Assist in monitoring for potential areas of over and underutilization and recommend appropriate actions when indicated.
- Review and analysis of utilization data for the identification of trends
- Recommend actions to the Quality Oversight Committee when opportunities for improvement are identified from review of utilization data including, but not limited to, Ambulatory Visits, Emergency Visits, Hospital Utilization Rates, Hospital Admission Rates, Average Length of Stay Rates, and Discharge Rates.
- Review information about New Medical Technologies from the Pharmacy & Therapeutics Committee including new applications of existing technologies for potential addition as a new medical benefit for Members

Based on the decision of the UM Committee and recommendations through the

appropriate Quality Committees, the approval of a new technology or new application of an existing technology by the HCQC shall be deemed to be The Alliance policy on coverage, and where The Alliance does not have the authority to modify the benefit package, the Chief Medical Officer shall notify, in writing, each payer for whom The Alliance manages benefits of its recommendation.

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

C. Program Oversight and Staff Responsibility

The Alliance Health Care Services Department is responsible for management and coordination of programs including the UM Program. The UM Department staff administer the UM Program. Non-clinical staff may receive and log utilization review requests to ensure adequate information is present.

Appropriately qualified and trained clinical staff use approved criteria to conduct utilization reviews and make UM determinations relevant to their positions, e.g. Non-physician staff may only approve services; qualified non-clinical staff may make non-medical necessity denial decisions (example: non-covered benefit); potential denials are referred to physician reviewers. The CMO, Medical Director, or licensed MD staff review requests that require additional clinical interpretation or are potential denials. A qualified physician reviews all denials made, whole or in part, based on medical necessity. The CMO or a Medical Director makes medical necessity denial decisions for medical and pharmacy service requests. The Alliance Pharmacist, a licensed Pharm. D., may approve, defer, modify, or deny prior authorization requests for pharmaceutical services.

1. Chief Medical Officer

The Chief Medical Officer is a designated board-certified physician with responsibility for development, oversight and implementation of the UM Program. The CMO holds a current unrestricted license to practice medicine in California. The CMO serves as the chair of the HCQC and UMC, and makes periodic reports of committee activities, UM Program activities and the annual program evaluation to the BOG. The CMO works collaboratively with Alliance network physicians to continuously improve the services that the UM Program provides to members and providers.

Any changes in the status of the CMO shall be reported to Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) within the required timeframe.

2. Medical Directors

The Medical Directors are licensed physicians with authority and responsibility for providing professional judgment and decision-making regarding matters of UM. The

Medical Directors hold current unrestricted license to practice medicine in California. Medical Directors responsibilities include but are not limited to the following:

- Ensure that medical decisions are rendered by and are not influenced by fiscal or administrative management considerations.
- The decision to deny services based on medical necessity is made only by Medical Directors.
- Ensure that the medical care provided meets the standards for acceptable medical care.
- Ensure that medical protocols and rules of conduct for plan medical personnel are followed.
- The initial reviewer must not review any appeal cases in which they were the decision maker for the authorization.
- Develop and implement medical policy.

The Alliance may also use external specialized physicians to provide specific expertise in conducting reviews. These physicians are currently licensed, and many have board certification in specific areas of medical expertise. The CMO is responsible for managing access and use of specialized physicians.

3. Director, Health Care Services

The Director, Health Care Services is a Licensed Clinical Social Worker and is responsible for overall UM Department operations, staff training, and coordination of services between departments. The Director's management responsibilities include:

- Develop and maintain the UM Program in collaboration with the CMO;
- Coordinate UM activities with the Quality Department and other Alliance units;
- Maintain compliance with the regulatory standards;
- Monitor utilization data for over and under-utilization.
- Coordinate interventions with the CMO to address under and over utilization concerns when appropriate;
- Monitor utilization data and activities for clinical and utilization studies; and maintain professional relationships with colleagues from other Medi-Cal Managed Care Plans, sharing information about requirements and successful evaluation strategies;
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision;
- Monitor documentation for adequacy;
- Available for UM staff on site or by telephone.

4. Pharmacy Services Senior Director

The Pharmacy Services Senior Director is a licensed pharmacist (Pharm.D.) responsible for coordinating daily operations and reviewing and managing pharmacy utilization reports to identify trends and patterns. The Director provides clinical expertise relative to the Pharmacy, Quality and UM components of Alliance plan

management including Member and Provider Services and Claims operations. The scope of responsibilities of the Pharmacy Services Director includes:

- Render pharmaceutical service decisions (approve, defer, modify or deny) pursuant to criteria established for specific line of business by the CMO and the Alliance Pharmacy and Therapeutics Committee;
- Assure that the Alliance maintains a sound pharmacy benefits program;
- Manage the Alliance Medication Formulary on an ongoing basis;
- Manage the Drug Utilization Review program;
- Monitor compliance with delegation requirements and the performance of the Pharmacy Benefits Management and other pharmacy vendor firm's services;
- Provide clinical expertise and advice for the on-going development of pharmacy benefits;
- Review medication utilization reports to identify trends and patterns in medication utilization;
- Develop and manage provider and client education programs to improve medication prescribing patterns and to increase patient compliance;
- Ensure compliance with Federal and State regulatory agencies; and
- Manage the contract with, and delegated activities of, the pharmacy benefits management organization.

5. Utilization Review Clinicians

UM Review Clinicians with a current unrestricted California nursing license, California Physician Assistant license, and/or California Nurse Practitioner are responsible for the review and determinations of medical necessity coverage decisions. Clinicians may approve prospective, concurrent and retrospective inpatient or outpatient medical necessity coverage determinations using established and approved evidenced-based medical criteria, tools and references as well as their own clinical training and education. UM Review Clinicians, who are qualified clinical non-physician staff, may approve non-medical necessity benefit denial decisions. Utilization Review Clinicians also work collaboratively with case managers and assist with member transition of care and discharge planning. For cases that do not satisfy medical necessity guidelines for approval, the UM Review Clinicians are referred to a Medical Director for final determination. The CMO or Medical Directors are available to the nurses for consultation and to make medical necessity denials. All clinical staff involved in the authorization review process must identify and refer any potential quality issues appropriately for further investigation.

6. UM Coordinators

The UM Coordinators are non-clinical staff responsible for performing basic administrative and operational UM functions. Clinical staff provides oversight to the non-clinical staff.

Roles and responsibilities include:

- Outpatient UM Coordinators

- Ensure appropriate UM referral entries into the information system;
- Process UM referrals approvals for selected requests identified as Auto Authorizations or Authorization Scope of Work that do not require clinical interpretation;
- Complete intake functions with the use of established scripted guidelines and
- Manage and complete UM Member and Provider communications.
- Complete administrative denials, as defined in UM Policy 057 – Authorization Requests.

- Inpatient UM Coordinators:
  - monitor and collect facility admissions census data;
  - Complete data entry of initial cases;
  - Maintain member and provider communications;
  - Assist in requesting additional information as needed and;
  - Review of hospital referral to ensure appropriate case closure.
  - Approve inpatients services as defined in UM Policy UM-057 Authorization Requests.
- Ensuring the efficient processing for the authorization process and maintain documentation in support of the on-site and telephonic UM nurse staff.

Section III. Program Scope, Processes & Information Sources

The UM Program consists of comprehensive and systematic functions, services, and processes that provide care management to members and include medical necessity determinations regarding the appropriateness of health care services in accordance with definitions contained in the member evidence of coverage. The UM Program also encompasses delegated utilization management functions, activities and processes for behavioral health and pharmacy services.

A. Utilization Management Activities

Referral Management includes Prior Authorization Review, Concurrent Review, and Post Service Review of requests for authorization:

- Services exempt from Prior Authorization means services for which the health plan cannot require advance approval.
- Pre-service Review means a formal process requiring a requesting health care provider to obtain advance approval to provide specific services or procedures. Preauthorization, Prior Authorization, and Pre-Certification are terms also used to describe Pre-service Review.
- Concurrent Review means a review for an extension of a previously approved, ongoing course of treatment over a period or number of treatments. Concurrent reviews are typically associated with inpatient care, residential behavioral care, intensive outpatient behavioral health care, and ongoing ambulatory care.
- Post Service Review means the assessment of the appropriateness of medical

services after the services have been provided. This is also called Retrospective Review.

- After Hours and Emergency Care

Emergency health care services are available and accessible within the service area 24 hours a day, seven days a week. The Alliance provides 24-hour access for members and providers to obtain timely authorization for medically necessary care, for circumstances where the member has received emergency services and care and is stabilized, but the treating provider believes that the member may not be discharged safely. A Physician is available 24 hours a day to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized Members in an emergency department, if necessary.

Emergency health care services are covered without prior approval:

- to screen and stabilize the member where a prudent layperson, acting reasonably would have believed an emergency medical condition existed;
- when there is an imminent and serious threat to health including, but not limited to, the potential loss of life, limb, or other major bodily function;
- when a delay in decision making would be detrimental to the member's life or health or could jeopardize the member's ability to regain maximum function;
- If an authorized representative, acting for The Alliance, has authorized the provision of emergency services.

A "Prudent Layperson" is a person who is without medical training, and who draws on his/her practical experience when making a decision regarding whether emergency medical treatment is needed. A Prudent layperson is considered to have acted reasonably if other similarly situated laypersons would have believed that emergency medical treatment was necessary

Other Alliance representatives who may direct members to emergency services include the Nurse Advice Line staff, and The Alliance nurse case manager or disease manager, an Alliance Member Services Representative or after-hours call answering service, or a contracted specialist. The Alliance will honor health plan coverage for services when directed by any Alliance staff member or delegated representative.

B. Communication Services for UM Process with Members and Providers

The Alliance members, providers, and the public may contact the UM department to discuss any aspect of the UM program. Members contact the Member Services Department at 510-747-4567 and may be warm transferred to an UM Manager or Director. Providers contact the UM Department directly at 1-877-897-4388. UM staff are available at least 8 hours per normal business day (excludes weekends and

holidays). During scheduled business hours, The Alliance provides access to staff for members and practitioners seeking information about the UM process and the authorization of care. After hours calls are answered by a contracted vendor and non-emergency calls are returned the following business day. After Hour calls requiring clinical decision-making are transferred to a The Alliance on-call nurse for assistance. Staff identify themselves by name, title and as representatives of The Alliance when initiating or returning calls. HIPAA protocols are followed to ensure protection of privacy. Language assistance and TDD/TTY services are available as needed for members to communicate with The Alliance regarding the UM program.

Both the UM staff voice mail phone message line for utilization review information and the computer network system are controlled by a secured password system, accessible only by the individual employee. The facsimile machines used for utilization review purposes are located within the Department to assure monitoring of confidential medical record information by The Alliance's UM staff.

C. Decision Support Tools

The appropriate use of criteria and guidelines require strong clinical assessment skills, sound professional medical judgment, and application of individual case information and local geographical practice patterns. Licensed nursing review staff apply professional judgment during all phases of decision-making regarding The Alliance members.

"Decision Support Tools" are intended for use by qualified licensed nursing review staff as references, resources, screening criteria, and guidelines with respect to the decisions regarding medical necessity of health care services, and not as a substitute for important professional judgment. The Medical Director evaluates cases that do not meet review criteria/guidelines and is responsible for authorization/denial determinations.

UM staff clearly document the Review Criteria/Guidelines utilized to assist with authorization decisions. If a provider questions a medical necessity/appropriateness determination, any criteria, standards, or guidelines applied to the individual case supporting the determination is provided to the provider for reference.

The following describes the approved Department "Decision Support Tools" that have been implemented and are evaluated and updated at least annually.

D. UM Review Criteria, Guidelines and Standards

The Alliance, Provider Groups and Vendors delegated for UM functions must utilize evidenced based nationally recognized criteria for UM decision making. UM criteria are used to determine medical necessity in the Authorization Request review process.

Standards, criteria and guidelines are the foundation of an effective UM Program. The tools are utilized to assist during evaluation of individual cases to determine the following:

- Services are medically necessary
- Services are rendered at the appropriate level of care
- Quality of care meets professionally-recognized industry standards
- UM decision-making is consistent

The following standards, criteria, and guidelines are utilized by UM staff and Medical Directors as resources during the decision-making process:

- UM Medical necessity review criteria and guidelines
- Length of stay criteria and guidelines
- Clinical Practice Guidelines
- Referral Guidelines
- Policies and Procedures

Examples of regulations and guidelines are as follows:

- Regulations:
  - Code of Federal Regulations
  - California Health and Safety Code;
  - California Code of Regulations Title 22;
  - California Code of Regulations Title 28;
  - California Welfare and Institution Code

- Guidelines:
  - Medi-Cal Guidelines (Medi-Cal Provider Manuals)

1. Application of UM Criteria

The Alliance requires that UM criteria be applied in a consistent and appropriate manner by physician and non-physician UM staff based on available medical information and the needs of individual Members. For use in determining the appropriateness of UM determinations at The Alliance Plan level for the direct requests for authorization, The Alliance adopts and maintains approved criteria with current versions of the following UMC approved UM Criteria hierarchy:

- Regulatory contractual requirements, such as DHCS regulations, Provider Manuals, All Plan Letters.
- Evidence based guidelines, such as MCG®, InterQual, ApolloMed, UpToDate. Alliance specific guidelines

- UM Auto Authorization List as approved by the UM Committee
- Other Utilization Management Committee Approved Criteria
- Pharmacy Therapeutics Committee Approved Criteria
- When none of the above criteria are applicable, consider the following and two (2) or more of the following criteria are applicable, then MCG® criteria are to be used as the first choice.
    - MCG® Guidelines
    - Uptodate.com

- National medical association guidelines, such as American Commission of Obstetrics and Gynecology (ACOG), American Association of Pediatrics (AAP), American Diabetes Association (ADA), World Professional Association for Transgender Health (WPATH).
- Definition of Medical Necessity (Product Line specific when the above criteria do not apply to a specific request for an UM decision).
- Other resources

Due to the dynamic state of medical/health care practices, each medical decision must be case specific, and based on current medical knowledge and practice, regardless of available practice guidelines. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition, or the need for a referral.

2. Clinical Review Criteria

Utilization review determinations to approve, defer, modify or deny requested services are made based on a consistently applied, systematic evaluation of utilization management decision criteria. The criteria adopted by The Alliance are reviewed and discussed by the UMC. They are selected based on nationally recognized and evidence-based standards of practice for medical services and are applied based on individual need. Primary criteria used for utilization review decisions are from MCG® Care Guidelines. Other applicable publicly available clinical guidelines from recognized medical authorities are referenced when indicated. Also, when applicable, government manuals, statutes and laws are referenced in the medical necessity decision making process. The UMC annually reviews the MCG® Care Guideline criteria and applicable government and clinical guidelines for changes and updates.

Additionally, the Alliance has a formal mechanism to evaluate and address new developments in technology and new applications of existing technology for inclusion in benefit plans to keep pace with changes and to ensure that members have equitable access to safe and effective care. The UMC reviews and approves all new coverage policies before implementation.

For the Medi-Cal line of business, the term “Medically Necessary” will include all Covered Services that are reasonable and necessary to protect life, prevent

significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. {Title 22, CCR, Section 51303(a)}. When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, “Medical Necessity” is expanded to include the standards set forth in Title 22, CCR, Section 51340 and 51340.1.

The above definition of medically necessary applies to any line of business without a product specific definition.

The Alliance is accredited by the National Committee for Quality Assurance (NCQA) and adheres to the latest NCQA Standards and Guidelines.

NCQA defines medical necessity review as a process to consider whether services that are covered only when medically necessary meet criteria for medical necessity and clinical appropriateness. A medical necessity review requires consideration of the member’s circumstances, relative to appropriate clinical criteria and the organization’s policies.

3. Access to and Disclosure of UM Criteria and UM Procedures and Processes

UM Criteria and UM Procedures and Processes are available to The Alliance practitioners, providers, members, and the public upon request in accordance with established regulatory and contractual requirements.

If criteria are requested, the organization makes them available:

- In person, at The Alliance
- By telephone, mail, fax, or email.

E. Benefits

The Alliance administers health care benefits for members, as defined by contracts. Benefit coverage for requested service is verified by the UM staff during the authorization process as follows:

- Medi-Cal member benefits are developed by the State of California, DHCS and DHCS mandated benefits for Medi-Cal Members. DHCS benefits, available on the DHCS Web site, defined by, but not limited to:
  - Service requests for Medi-Cal beneficiaries.
  - Medi-Cal Manual of Criteria
  - Medi-Cal DME.
  - Medi-Cal Hospice
  - Medi-Cal Waivers.
  - Medi-Cal Linked and Carve Out Programs

- IHSS benefits are developed by Public Authority of Alameda County

Benefit resource guides for all Product Lines are maintained by Member Services Department. Benefits resource guides describe in detail the covered and non-covered services, procedures, and medical equipment for the line of business. These guides are aligned with the applicable product line benefits.

1. Benefit Exclusions

Based on the specific contract requirements and applicable laws, some services are explicitly excluded from coverage. Per contract requirements, specific services may not be covered benefits, unless clinical indicators support medical necessity, as determined by the Medical Directors, in which case the medically needed services will be provided. Every attempt is made by the UM staff to identify additional community programs to provide wrap-around services to enhance The Alliance benefit package.

2. Transition to Other Care when Benefits End

The Alliance assists with, and/or ensures that practitioners assist with, a member's transition to other care, if necessary, when benefits end.

3. New Medical Technology Evaluation Assessment

The Alliance maintains a formal mechanism to evaluate and address new developments in technology and new applications of existing technology for inclusion in its benefits plan to keep pace with changes and to ensure that members have equitable access to safe and effective care. Evaluation of new technology is applied for medical and behavioral health procedures, pharmaceuticals, and devices. The UM Committee is responsible for evaluating and recommending coverage status for a new technology to the UM Committee and to the Quality Oversight Committee. This includes evaluation of medical and behavioral health procedures, pharmaceuticals, and devices. Requests for evaluation of a new technology or a new application of an existing technology may come from a member, practitioner, organization, The Alliance's physician reviewers, or other staff.

The following are evaluated when considering new technology:

- Organizational reviews from appropriate government regulatory bodies, such as FDA or CMS;
- Relevant scientific information from peer-review literature, professional societies, and/or specialists and professionals who have expertise in the technology.

Based on the decision of the UM Committee, P&T Committee and recommendations through the appropriate Quality Committees, the approval of a new technology or new application of an existing technology by the Quality BOG Committee shall be deemed to be The Alliance's policy on coverage. When The Alliance does not have the

authority to modify the benefit package, the Chief Medical Officer shall notify, in writing, each payer for whom The Alliance manages benefits of its recommendation. A full description of the process is defined in UM policy and procedure.

4. Member Eligibility Verification

Authorization is based on member eligibility at the time of service and is verified by the UM staff at the time of the request. Medi-Cal eligibility is on a month-to-month basis. The Alliance Direct members may become eligible retrospectively, in which case their claims would be subject to retrospective review**.**

5. Determination Information Sources

UM clinical staff collects relevant clinical information from health care providers to make prospective, concurrent and retrospective utilization review for medical necessity and health plan benefit coverage determinations. Clinical information is provided to the appropriate clinical reviewers to support the determination review process. Examples of relevant sources of patient clinical data and information used by clinical reviewers to make medical necessity and health plan benefit coverage determinations include the following:

- History and physical examinations;
- Clinical examinations;
- Treatment plans and progress notes;
- Diagnostic and laboratory testing results;
- Consultations and evaluations from other practitioners or providers;
- Office and hospital records;
- Physical therapy notes;
- On-site, telephonic and fax concurrent reviews from inpatient facilities;
- Information regarding benefits for services or procedures;
- Information regarding the local delivery system;
- Patient characteristics and information;
- Information from responsible family members; and
- Independent, unbiased, and evidenced based analyses of new, emerging, and controversial healthcare technologies.

F. UM Determinations

Qualified health professionals supervise review decisions, including service reductions. UM decisions based on medical necessity to deny or authorize an amount, duration, or scope that is less than requested shall be made by qualified physicians or appropriate health care professionals, who have appropriate clinical expertise in treating the condition and disease. Appropriate health care professionals at The Alliance are qualified physicians, qualified doctoral level behavioral health care professionals, and qualified pharmacists. The timeliness of UM decisions shall be commensurate with the seriousness and urgency of the request whether the request is routine or expedited and made in a timely manner and not unduly delayed for medical conditions requiring time

sensitive services. Appropriately licensed and qualified health care professionals with clinical care expertise make UM review determinations according to approved clinical review criteria.
In addition to guidelines and criterion, patient records and conversations with appropriate practitioners are used in the decision-making process. Qualified health care professionals also supervise utilization review decisions. Under the supervision of a licensed medical professional, non-clinical staff collect administrative data or structured clinical data to administratively authorize cases that do not require clinical review.

Only a Medical Director, with a current license to practice without restriction in California, makes medical necessity denial determinations. A Medical Director is available to discuss UM denial determinations with providers. Providers are notified how to contact the Medical Director about determination processes in the denial letter.

In accordance with the DHCS contract, only qualified health care professionals supervise review decisions, including service reductions. A qualified physician will review all denials that are made based on medical necessity. Additionally, a qualified physician or pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the Plan Medical Director in collaboration with the Plan Pharmacy and Therapeutics committee (P&T Committee) or its equivalent.

UM decisions are not based on the outcome of individual authorization decisions or the number and type of non-authorization decisions rendered. UM staff involved in clinical and health plan benefit coverage determination processes are compensated solely based on overall performance and contracted salary and are not financially incentivized by the Alliance based on the outcome of clinical determinations.

Board certified physician advisors are available to the UM Program for consultation on clinical issues as well as consultation for potential denials. The UM Program maintains a list of board-certified physician specialists identified for consultation and documents their involvement in member authorization and appeal records when appropriate.

Decisions affecting care are communicated in writing to the provider and member in a timely manner, in accordance with regulatory guidelines for timeliness, and are not unduly delayed for medical conditions that require time-sensitive services. Reasons for decisions are clearly documented in the member/provider correspondence in easily understandable language. Notification must reference the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request, must be included in the notification.

Providers are informed how to contact and speak with the Medical Director who made the decision. Notification communication includes appeal rights and procedures. Member notifications comply with appropriate contractual and regulatory guidance for each

member's line of business. Member correspondence about authorization decisions includes a statement in each Alliance threshold language instructing the member how to obtain correspondence in their preferred language. Records, including Notice of Action letters, meet contractual retention requirements. Members are informed that they may request copies of their medical records.

G. UM Referral Management and UM Review Processes

The scope of medical management services and activities includes utilization review determinations, referral management, discharge planning, complex case management, and UM documents.

1. Services Exempt from Prior Authorization

Exemptions from Prior Authorization services for members differ by product line and are listed in the member's benefit handbook, online at www.alamedaalliance.org and in the specific provider manuals. Exemptions include:

- Emergency Services, whether in or out of Alameda; except for care provided outside of the United States. Care provided in Canada or Mexico are covered.
- Urgent care, whether in or out of network
- Primary Care Visits
- Preventative Services
- Mental Health Care and Substance Use treatment
- Women's health services – a woman can go directly to any network provider for women's health care such as breast or pelvic exams. This includes care provided by a Certified Nurse Midwife/OB-GYN and Certified Nurse Practitioners
- Basic prenatal care – a woman can go directly to any network provider for basic pre-natal care
- Family planning services, including counseling, pregnancy tests and procedures for the termination of pregnancy (abortion)
- Treatment for Sexually Transmitted Diseases, includes testing, counseling, treatment and prevention
- HIV testing and counseling
- Initial Mental Health Assessments
- Early and Periodic Screening, Diagnostic and Treatment

2. Auto-Authorization

- Services approved on the most recent copy of the Medical Management Auto Authorization Matrix.
- Direct - Services for which UM requests are not required, include but are not limited to:
  - Specialty visits, direct network
  - Preventive health diagnostic services, i.e. mammogram, colonoscopy

3. Services Requiring Prior Authorization

The Alliance develops, reviews, and approves at least annually, lists of auto authorizations. Any procedure, treatment, or service not on these lists requires prior authorization. The Alliance communicates to all contracted health care practitioners the procedures, treatments, and services that require prior authorization and the procedures and timeframes necessary to obtain such prior authorization.

Authorization requirements for medical services are listed on the website, at www.alamedaalliance.org. Providers can also review the approved drug formulary at this website.

The services that currently require prior authorization include, but are not limited to:

- Non-emergency out of area care, outside of Alameda County
- Out of network care, for services not provided by a contracted network doctor
- Inpatient Admissions, non-emergency/elective
- Inpatient Admission to Skilled Nursing Facility or Nursing Home
- Outpatient hospital services/surgery
- Outpatient facilities, non-hospital based, such as surgeries or sleep studies
- Outpatient diagnostic and radiology services, minimally invasive or invasive such as CT Scans, MRIs, cardiac catheterization, PET
- Durable Medical Equipment, standard or customized; rental or purchased
- Medical Supplies
- Prosthetics and Orthotics
- Podiatry services
- Home Health Care, including skilled nursing, nursing aides, rehabilitation therapies, and social workers.
- Transportation
- Transplant Services
- Experimental or Investigational Services
- Cancer Clinical Trials
- Medications not on The Alliance Approved Drug List and/or exceeding the monthly medication limit
- All admissions to LTSS services - CBAS and Long-Term Care (LTC) facilities
- Acupuncture, greater than 4 visits per month.
- Chiropractic Services,
- Radiology Services (i.e. CT, MRI, PET)
- Second Opinions
- Select behavioral health services

The Alliance also routinely analyzes past utilization patterns to determine whether it would be in the member's best interests to remove any of the listed services from the prior authorization requirement or add additional requirements. The Alliance makes any adjustments to this list by amending the Prior Authorization Policies, as appropriate.

4. Medical Director Responsibilities

The Medical Directors are responsible for providing clinical expertise to the UM staff and exercising sound professional judgment during review determinations regarding health care and health services.

The CMO and Medical Directors, with support of the UM Committee, have the authority, accountability, and responsibility for denial determinations. Physician review and determination is required for all final denial decisions based on medical necessity for requested medical services. The review of the denial of a pharmacy prior authorization for medical necessity, however, may be carried out by a qualified Physician or Pharmacist. For those contracted entities that are delegated UM responsibilities, the entity's Medical Director has the sole responsibility and authority to deny coverage; the Medical Director may also provide clarification of policy and procedure issues, and communicate with entity practitioners regarding referral issues, policies and procedures, etc.

5. Appropriate Professionals for UM Decision Process

The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. Only physicians, pharmacist, or doctoral level behavioral health specialists can make decisions/determinations for denial or modification of care based on medical necessity.

6. Timeliness Standards

The Alliance maintains established timeliness standards for UM determinations for routine and urgent Authorization Requests in compliance with Regulatory Standards for each Product Line as described in corresponding Policies/Procedures The timeliness of UM decisions shall be commensurate with the seriousness and urgency of the request whether the request is routine or expedited. Time sensitive requests cannot be delayed waiting for medical information. Response to requests must meet required regulatory timeframes

7. Utilization Review Processes

The UM Program includes the following utilization review processes:

Prospective Review

Prospective (pre-service) review is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted prior to the delivery of a health care service or supply to a member. A prospective review decision is based on the collection of medical information available to the health care provider prior to the time the service or supply is provided.

Concurrent Review

Concurrent review is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted during a member's ongoing stay in a facility or course of outpatient treatment. The frequency of review is based on the member's medical condition with respect to

applicable care guidelines.

Retrospective Review

Retrospective (post-service) review is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted after the health care service or supply is provided to a member.

The Alliance does not except non-emergent/urgent services that required prior authorization after the date of service. There are a few exceptions which a retrospective request will be considered by the Medical Director:

- Requests due to member eligibility issues
- Provision of inpatient services where the facility is unable to confirm enrollment with The Alliance
- Services rendered in an urgent and emergent situation.

The Alliance maintains instructions for the authorization process on the website and provider training which is available to contracted and non-contracted providers. For non-contracted facilities, The Alliance maintains a 24-hour UM contact notification process on the California DMHC website. The Alliance maintains a full list of conditions eligible for retrospective review by the Department and is reviewed annually for any changes.

8. Outpatient Referral Management

Alliance network physicians are the primary care managers for member healthcare services. Based on the member's assignment, referrals may be managed by The Alliance or a delegated Provider Group.

Network Primary Care Physicians (PCPs) may process in-network specialist and facility referrals directly to members as "direct referrals" without administrative pre-authorization from the UM Program or the Provider Group. These referrals are primarily for routine outpatient and diagnostic services and are tracked by the UM Program using claim and encounter data. For services identified as requiring prior authorization, PCPs must submit and coordinate prior authorization for several services that require prior authorization, such as DME, home health and certain radiology services. All elective inpatient surgeries and non-contracted provider referrals require prior authorization.

The UM Program clinical information system tracks all authorized, denied, deferred and modified service requests and includes timeliness records. These processes are outlined in the Provider Manual and in internal policies and procedures.

Practitioners and providers send referrals and requests for prior authorization of services to the UM Department by mail, fax and/or telephone, based on the urgency of

the requested service. Request must include the following information for the requested service:

- Member demographic information (name, date of birth, etc.)
- Provider demographic information (Referring and Referred to)
- Requested service/procedure, including specific CPT/HCPCS Codes
- Member diagnosis (ICD-10 Code and description)
- Pertinent medical history and treatment
- Location where service(s) will be performed
- Clinical indications necessitating service or referral *(See Section: Minimum Clinical Information for Review of UM Requests for Authorization)*

Requests for services are reviewed in accordance with approved UM criteria and the member's benefit structure. When decisions on coverage are based on medical necessity, relevant clinical information is obtained and consultation with the treating practitioner occurs as necessary.

Requests for Authorization determinations related to Medi-Cal and IHSS Product Lines are defined differently as follows**:**

- Pre-Service Determinations for Medi-Cal and IHSS are defined in the following terms:
    - Approval - the determination to provide a service
    - Modification – the determination to either approve less than what was requested or to approve something else in place of what was requested
    - Denial - a determination to not provide the request service
    - Delay – when a determination cannot be made, and additional time is required to obtain relevant clinical information
    - Termination- to not extend an extension of a previously authorized service (e.g. PT visits, SNF days, etc.) (NOTE: must give 10 calendar days' notice of terminations)

UM staff receive requests for authorization of outpatient services and elective procedures prior to admission to ensure that admission to a healthcare facility is appropriate/medically necessary. Non-Clinical UM staff may approve services which can be auto-authorized when the specific elements of the policy are met. Clinical UM staff will review services that require prior authorization based on medical necessity. The medical necessity clinical review is based on the severity and complexity of the individual case, unless there are questions regarding the medical necessity of services.

Should the UM staff question the medical necessity of services to be rendered, or appropriateness of the level of care for service based on review criteria and guidelines, the Medical Director will be consulted for case review. The Medical Director, or physician designee, will contact the attending physician to discuss the case, if necessary.

Should the Medical Director or physician designee determine that proposed services are not medically necessary or indicated, a denial determination may be made by the Medical Director. Denial notification and communication will be made in accordance with current regulatory timeliness standards and denial notification requirements, as established by regulators, including the DHCS and Department of Managed Health Care (DMHC) and national accrediting organizations, such as, NCQA.

9. Second Opinion

The Alliance members may request a second opinion from any qualified primary care provider or specialist within the same medical group. If a qualified specialist is not available within medical group, a referral is provided within The Alliance's network. If the qualified specialist is not available in The Alliance network, staff will assist the medical group to identify an out-of-network specialist. The second opinion from a qualified health professional will be provided at no cost to the member. The Alliance provides a second opinion from a qualified health care professional when a member or a practitioner requests it for reasons that include, but are not limited to, the following:

- The member questions the reasonableness or necessity of recommended surgical procedures.
- The member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including but not limited to, a serious chronic condition.
- The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and requests consultation, or the member requests an additional diagnosis.
- The treatment plan in progress is not improving the medical condition of the member within an appropriate period given the diagnosis and plans of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment.
- The member has attempted to follow the practitioner's advice or consulted with the initial practitioner concerning serious concerns about the diagnosis or plan of care.

The Alliance educates its members and practitioners of the availability of second opinions in annual member publications. Policies regarding second opinions are available to the public upon request. Member rights related to second opinions include:

- To be provided with the names of two physicians who are qualified to give a second opinion
- To obtain a second opinion within 30 calendar days, or if the medical need is emergent or urgent, to obtain an opinion within a timeframe that is appropriate to the member's condition and that does not exceed 72 hours
- To see the second opinion report

10. Standing Referrals

The Alliance maintains process to provide enrollees a standing referral to a specialist. The procedure shall provide for a standing referral if the PCP, in consultation with both the specialist, if any, and The Alliance Medical Director (or designee), determines that the enrollee has a condition or disease that requires continuing specialized medical care from the specialist or SCC.

The Alliance may require the PCP to submit a treatment plan during care or prior to the referral from the enrollee as determined by the Medical Director:

- If a treatment plan is necessary in the course of care and is approved by The Alliance, in consultation with the PCP, specialist, and enrollee, a standing referral shall be made in accordance with the treatment plan.
- A treatment plan may be deemed unnecessary if The Alliance approves a current standing referral to a specialist.
- The treatment plan may limit the number of visits to the specialist, limit the period of time during which visits are authorized, or required that the specialist provide the PCP with regular reports on the care and treatment provided to the enrollee.

The Alliance maintains guidelines for standing referral requests for enrollees that required specialized medical care over a period and who have a life-threatening, degenerative, or disabling condition, to a specialist or SCC that has expertise in treating the condition or disease for having specialist coordinate he enrollee's health care. Standing referral to a specialist or SCC are provided within The Alliance's network to participating providers, unless there is no specialist or SCC within The Alliance's network that is appropriate to provide treatment to enrollee, as determined by the PCP in consultation with the Medical Director and as documented in the treatment plan.

11. Concurrent/Continued Stay Review (Acute, Skilled, Rehabilitation)

The Alliance provides telephonic UM services and on-site UM at a sub-set of network hospitals. Appropriate inpatient medical management is ensured through consistent and coordinated Concurrent Review of members, irrespective of the presence or utilization of a contracted hospitalist. Concurrent/Continued Stay Review is a process coordinated by the UM staff during a member's course of hospitalization, which may include acute hospital, skilled nursing, and acute rehabilitation facilities, to assess the medical necessity and appropriateness of continuation at the requested level of care. Concurrent/Continued Stay review also involves the telephonic or on-site medical record review that occurs after admission if no pre-admission review has occurred.

Additional objectives of continued stay review are to:

- Ensure that services are provided in a timely and efficient manner
- Ensure that established standards of quality care are met
- Implement timely and efficient transfer to lower levels of care when clinically indicated and appropriate
- Implement effective and safe discharge planning

- Identify cases appropriate for Case Management

The Concurrent Review Procedure shall be followed throughout the member's hospitalization, utilizing approved criteria and guidelines. Telephonic, facsimile reviews or on-site are coordinated by the UM staff daily, or on cyclic intervals based on individual case requirements. In the event a scheduled review date falls on a weekend or holiday, the UM staff will coordinate a Concurrent Review on the work day prior to the scheduled review date, or not later than the first work day after the holiday or weekend.

Continued hospital care and/or ancillary services, that does not meet continued stay criteria is referred to the Medical Director, or physician designee, to evaluate and consult with the attending physician, as appropriate. When the Medical Director decides that the case does not meet criteria for continued stay based on medical necessity or appropriateness, the attending physician will be contacted, and discharge planning discussed. When an acceptable discharge plan is mutually agreed upon by the attending physician and the UM Medical Director, a Notice of Action (NOA) letter may be issued immediately by fax or via overnight Certified Mail to the attending physician, hospital and the member, if the member disagrees with the discharge plan.

12. Transition of Care and Discharge Planning

Transition of Care and Discharge Planning management are components of the UM process that assess necessary services and resources available to facilitate member discharge and/or transition to the appropriate level of care. Discharge Planning refers to activities related to planning the discharge of a member out of an inpatient medical facility. Transition of Care refers to activities related to movement of a member from a clinical setting to a home or community setting.

Discharge planning begins as early as possible during an inpatient admission, and is designed to identify and initiate cost effective, quality-driven treatment intervention for post-hospital care needs. It is a cooperative effort between the attending physicians, hospital discharge planner, UM staff, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of medical/psycho-social issues with potential for post-hospital intervention
- Development of an individual care plan involving an appropriate multi-disciplinary team and family members involved in the members care
- Communication to the attending physician and member, when appropriate, to suggest alternate health care resources
- Communication to attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-

covered services and denied days of hospitalization

- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge Planning staff, and UM staff

The UM staff obtains medical record information and identifies the need for discharge to a lower level of care based on discharge review criteria/guidelines. If the attending physician orders discharge to a lower level of care, the UM staff assists the hospital UM/Discharge Planner in coordinating post-hospital care needs. The same process is utilized for continued stay approval or denial determinations by the UM Medical Director, as previously noted in the Concurrent Review Process.

UM Review Clinicians work with facility discharge planners, attending physicians and ancillary and community service providers to assist in making necessary arrangements for member post- discharge needs.

For SPD members, UM Review Clinicians are responsible for ensuring discharge planning is in place ensuring that necessary care, services, and supports are in place in the community for the SPD beneficiary once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the patient and/or caregiver. Minimum criteria for discharge planning activities includes:

A. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, durable medical equipment (DME), and other services received.
B. Documentation of pre-discharge factors, including an understanding of the medical condition by the SPD beneficiary or a representative of the SPD beneficiary as applicable, physical and mental function, financial resources, and social supports.
C. Services needed after discharge, type of placement preferred by the SPD beneficiary/representative of the SPD beneficiary and hospital/institution, type of placement agreed to by the SPD beneficiary/representative of the SPD beneficiary, specific agency/home recommended by the hospital, specific agency/home agreed to by the SPD beneficiary/representative of the SPD beneficiary, and pre-discharge counseling recommended.
D. Summary of the nature and outcome SPD beneficiary/representative of the SPD beneficiary involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital/institution.

13. Denial Notifications

Adverse Benefit Determination letters or/and Notice of Action (NOA) letters for denials are provided to members and their practitioners in compliance with the member's regulatory appeal requirements. All potential denials and/or modifications of service are discussed with the appropriate Medical Director, who makes the final determination.

Services that are denied, modified, delayed shall contain the following elements:

- Clear, concise and easily understandable explanation of the reason for denial in the Notice of Action (NOA) or adverse determination letter
- Reference to the specific benefit, guideline, protocol or other similar criterion on which the denial decision is based
- Statement that members can obtain a copy of the actual benefit, guideline, protocol or other similar criterion on which the decision was based.
- Member Rights
- Appeal Rights and Process

In addition to the above for ongoing services that are terminated for all members, the NOA shall include:

- Agreement to an alternative treatment plan by attending practitioner for hospital concurrent decisions and by the PCP for Ambulatory Concurrent decisions
- In addition to the above for Medi-Cal members:
- Citation to the criteria used to support the decision (Medi-Cal only)
- Information about the member's State Hearing rights and process
- "Aid Paid Pending" process, as applicable for Medi-Cal, must also be included.

In addition, All UM NOA correspondences for pre-service and concurrent denials, modifications, and adverse decisions sent to the Requesting Practitioner shall include a name and phone number for contacting the Peer Reviewer to allow for the Requesting Practitioner to request a reconsider of the UM Determination

14. Peer to Peer Review (Discussing a Denial with a Peer Reviewer)

All UM Notice of Action correspondences for pre-service and concurrent denials, (including modifications, terminations, and adverse decisions) sent to the Requesting Practitioner shall include a name and phone number for contacting the Peer Reviewer to allow the Requesting Practitioner the opportunity to discuss issues or concerns regarding the decision. Following a denial, a practitioner can discuss the decision by calling or writing to supply additional information for discussion with the Peer Reviewer. The Peer Reviewer will make himself/herself available for discussion of the denial decision within one business day of the receipt of the provider telephone call or written request. If the discussion does not result in a fully reversed denial determination, the practitioner can initiate an expedited or standard appeal, as appropriate.

15. Required Internal Reporting for UM Staff

- Potentially fraudulent or abusive practices identified to The Compliance Department
- Potential under and over utilization to the UM Manager
- Coordination of care for results or facilitation to the UM Manager
- Opportunities for improvement to the UM Manager

- Breaches of adherence to confidentiality and HIPAA policies to The Alliance's designated Compliance staff member
- Potential quality issues identified through UM activities to the Quality Improvement Department
- Barriers to accessibility and availability of UM services to their UM Manager

16. UM Documents

In addition to this program description, other documents important in communicating UM policies and procedures include:

- The Provider Manual, available on the Alliance web site and on a CD, provides an overview of operational aspects of the relationship between the Alliance, providers and members. Information about the Alliance's UM Program, referral and tracking procedures, processes, and timeframes necessary to obtain prior authorization are included in the manual. In addition, the Provider Manual describes how providers may obtain a copy of the clinical guidelines used to make medical determinations.

- The Provider Bulletin is a periodic newsletter distributed to all contracted provider sites and delegated groups on topics relevant to the provider community and may include UM policies, procedures and activities.
- The Member Alert is a periodic newsletter distributed to members in all lines of business. Each issue covers different topics of interest and importance to members about their health may include information about UM policies and procedures.

- Evidence of Coverage (EOC) documents are distributed to members based on their product line. Members have the right to submit a complaint or grievance about any plan action. The Evidence of Coverage document directs members to call the Member Service phone number to initiate complaints or grievances involving UM issues and actions. Member complaints or grievances are documented in the data system and forwarded to the UM unit for follow-up response. The Alliance Grievance and Appeal unit coordinates with the UM unit on appropriate responses to member complaints or grievances.

These documents, or summaries of the documents, are available upon request to providers, members and community partners. In addition, the UM Program information is available on the Alliance website.

H. Continuity of Care for Medical and Behavioral Health Services

Continuity of care can be defined as the lack of interruption in the care provided to members when circumstances dictate a change in the member's insurance coverage,

geographic location, entity, or provider assignment.

The Alliance must provide continuity of care with an out-of-network provider when:

- The Alliance can determine that the beneficiary has an existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider);
  - An existing relationship means the beneficiary has seen an out-of-network primary care provider (PCP) or specialist at least once during the 12 months prior to the date of his or her initial enrollment in The Alliance for a non-emergency visit, unless otherwise specified by regulation.
- The provider is willing to accept the higher of The Alliance's contract rates or Medi-Cal FFS rates;
- The provider meets the applicable professional standards and has no disqualifying quality of care issues (a quality of care issue means The Alliance can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other MediCal beneficiaries);
- The provider is a California State Plan approved provider; and
- The provider supplies The Alliance with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, if it is allowable under federal and state privacy laws and regulations.

The Alliance is not required to provide continuity of care for services not covered by Medi-Cal. In addition, provider continuity of care protections does not extend to the following providers: durable medical equipment, transportation, other ancillary services, and carved-out services.

The UM staff works with the member and the member's current treating physician and/or PCP to assist the member in continuity of care. Every effort is made to maintain continuity of care for the member during the transition process. If the current treating physician is not affiliated with any of the existing PGs, or with the member's PG selection, the UM staff works with the PGs to make arrangements with the physician to continue care of the member until the treatment is completed or the member can be safely transitioned to a physician within the PG. The UM staff notifies each PG of its membership qualifying for continuity of care assistance.

When members are identified as possibly benefiting from coordination of care, both within and outside of the network, the case is referred to Case Management for further intervention. The Case Management actively engages in activity that monitors and assesses continuity and coordination of clinical care. Individual registered nurses work closely with the Member, the physicians and any other associated healthcare delivery organization involved in the case, to provide timely, quality-based care meeting the needs of the individual member.

Continuity of care is also evaluated when members are referred from primary care physicians and specialists, including behavioral health specialists, or when a member is transferred or admitted to another level of care, such as a transfer or admittance to a skilled nursing facility (SNF), rehabilitation, chemical dependency, or mental health facility,

where member follow through is a risk.

The Alliance documents all requests for assistance with continuity of care and is responsible for monitoring and oversight of the activities. A full description of the various programs is listed in the applicable policies and procedures.

1. ***New Enrollees***

The Alliance recognizes that a strong doctor-patient relationship, particularly for members with serious medical conditions, may enhance the healing process. Maintaining continuity of care as new enrollees change physicians and health plans are an important aspect of this relationship. Each newly-enrolled Medi-Cal member are placed in a transition group for up to 30 days, during which time they select their Alliance, PG, and PCP.

For a newly enrolled SPD members, The Alliance must honor any active MediCal FFS Treatment Authorization Requests (TARs) for up to 60 days or until a new assessment is completed by The Alliance. A new assessment is considered completed by The Alliance if the beneficiary has been seen by an Alliance -contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. The FFS TAR must be honored as outlined above without a request by the beneficiary or the Provider.

2. ***Terminated Practitioners (Both PCPs and Specialists)***

The Alliance's contracts with delegates establish a mechanism to continue appropriate and timely care for members whose physicians are terminating from the PG. This process includes notification from practitioners of intent to terminate, in accordance with the laws applicable to the line of business. Members under current care, and those with approved prior authorizations, not yet utilized, are identified, so that their care can be managed and coordinated with the receiving entity or with The Alliance physicians. Members, such as those undergoing cancer treatments of chemotherapy or radiation therapy, that are dialysis-dependent, awaiting transplants, in late-term pregnancies, have pending surgeries, or those awaiting transfer or admittance to a skilled nursing facility (SNF), rehabilitation, chemical dependency, or mental health facility, and any other members who might have their ongoing care negatively impacted by the termination of the group are identified.

The Alliance will notify members affected by the termination of a practitioner or practice group in general, family or internal medicine of pediatrics, at least 30 calendar days prior to the effective termination date, and help them select a new practitioner.

For members undergoing active treatment for a chronic or acute medical condition, care may be continued through the current period of active treatment or up to 90 calendar days, whichever is less.**3**. ***Pregnant and Post- Partum Members***

Pregnant and post-partum Medi-Cal beneficiaries who are assigned a mandatory aid

code and are transitioning from Medi-Cal FFS into The Alliance have the right to request out-of-network provider continuity of care for up to 12 months in accordance with The Alliance contracts and the general requirements listed in the regulatory guidance. This requirement is applicable to any existing Medi-Cal FFS provider relationship that is allowed under the general requirements of regulatory guidance.

For Alliance Group Care, continuation of care extends through the postpartum period for members in their second or third trimester of pregnancy.

4. *Medical Exemption Requests*

A Medical Exemption Request (MER) is a request for temporary exemption from enrollment into The Alliance only until the Medi-Cal beneficiary's medical condition has stabilized to a level that would enable the beneficiary to transfer to an Alliance provider of the same specialty without deleterious medical effects. A MER is a temporary exemption from The Alliance enrollment that only applies to beneficiaries transitioning from Medi-Cal FFS to The Alliance. A MER should only be used to preserve continuity of care with a Medi-Cal FFS provider under the circumstances described above in this paragraph. The Alliance is required to consider MERs that have been denied as an automatic continuity of care request to allow the beneficiary to complete a course of treatment with a Medi-Cal FFS provider in accordance with the most recent regulatory guidance.

5. *Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder*

The Alliance is responsible for providing Early and Periodic Screening, Diagnosis, and Treatment services for beneficiaries ages 0 to 21. Effective September 15, 2014, the services include medically necessary Behavioral Health Treatment (BHT) services such as Applied Behavioral Analysis and other evidence-based behavioral intervention services that develop or restore, to the maximum extent practicable, the functioning of beneficiaries diagnosed with Autism Spectrum Disorder (ASD). In accordance with the requirements listed in the most recent DHCS All Plan Letter, The Alliance must provide continued access to out-of-network BHT providers (continuity of care) for up to 12 months.

I. Behavioral Health Management

The provision of behavioral health and substance use services are applied to Alliance members according to their benefit. Group Care members receive a comprehensive benefit for all behavioral health services. Medi-Cal members receive services for mild to moderate behavioral health services. The provision of treatment for moderate to severe behavioral health services for Medi-Cal members is managed under a Memorandum of Understanding with Alameda County Behavioral Health Care Services, as described below.

The Alliance ensures services are provided in a culturally and linguistically appropriate manner.

1. Alameda County Behavioral Health Care Services (ACBHCS)

Specialty behavioral health services for Medi-Cal members excluded from the Alliance contract with DHCS are coordinated under a Memorandum of Understanding executed with ACBHCS. This is a carve-out arrangement for specialty behavioral health management with the State of California directly overseeing and reimbursing the behavioral health services provided to Medi-Cal members.

The referral procedure for Alliance members includes:

- Alliance Primary Care Providers (PCPs) render outpatient behavioral health and substance abuse services within their scope of practice.
- PCPs refer the members to ACBHCS for evaluation and coordination of medically necessary specialty behavioral health services by the Access Team, including inpatient psychiatric care.
- PCPs refer members to qualified Medi-Cal providers for the provision of services not covered by ACBHCS.

2. Behavioral Health

The Alliance contracts with a Managed Behavioral Health Organization (MBHO) NCQA accredited delegate for the provision of behavioral health and substance abuse services not covered through ACBHCS, and for behavioral health and substance abuse services benefits for of all other lines of business. The Alliance delegates behavioral health utilization management activities and the maintenance of the provider network for behavioral health and substance abuse services.

All services are based on a member's benefit plan and the functions delegated to the MBHO by The Alliance. The scope of the program covers behavioral health treatment that may be beyond the customary scope of practice of a primary care physician. Care settings include home and office bases services, free-standing and hospital-based programs, residential treatment programs and facility based acute care treatment units. The MBHO uses information provided by the Alliance to determine member-specific benefit coverage, including plan-specific Evidence of Coverage documents, web-based member eligibility verification systems and direct download of member eligibility information via 834 files exchanges. Medical necessity is determined by applying level of care criteria, while the clinical appropriateness of services are evaluated using Clinical Practice Guidelines. Member specific clinical information is obtained from the member and/or family member or other legal representative, behavioral health medical providers (through verbal case review and/or submission of medical records). Program processes include; triage and referral; prospective; concurrent; post-service review and care coordination. Services include education to members and providers, coordination of care with primary care physicians, linkage and coordination with state and community agencies.

The Alliance reviews and approves the MBHO's LOC criteria through the HCQC. The

Alliance reviews the criteria to ensure its clinical criteria for both medical and behavioral health services are aligned. MBHO's Level of Care criteria (LOC), as adopted by the UMC, were developed from the comparison of national, scientific and evidence-based criteria sets, including but not limited to those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA) and American Academy of Child and Adolescent Psychiatry (AACAP), Substance Abuse and Mental Health Services Administration (SAMHSA), and the American Society of Addiction Medicine (ASAM.)

The MBHO uses the LOC criteria as guidelines, not absolute standards, and considers them in conjunction with other indications of a member's needs, strengths and treatment history in determining the best placement for a member. LOC criteria are applied to determine appropriate care for all members. In general, members will only be certified if they meet the specific medical necessity criteria for a particular LOC. However, the individual's needs and characteristics of the local service delivery system are taken into consideration prior to the making of UM decisions.

3. Alameda Alliance Triage and Referral

The Alliance arranges for triage and screening services available by telephone to members 24 hours per day, 7 days per week. The Alliance ensures that the telephone triage or screening services are provided in a timely manner appropriate for the requesting member's condition.

The Alliance is contingent on its contracted provider network to provide triage services to its members. Primary care providers and mental health care providers provide triage and screening services 24 hours a day, 7 days a week for medical and behavioral health care services.

For cases when the providers are unable to meet the time-elapsed standards, the Plan provides members the Plan's nurse advice line to call as an alternative triage and screening service arrangement. Providers who are unable to provide triage and screening services are required to inform members about the Alliance's nurse advice line information.

4. Monitoring Over and Under Utilization of Medical and Behavioral Health Services

The CMO or its physician designee monitors patterns of over and under-utilization.

Data is reviewed at the UMC and HCQC and when a pattern of under or over utilization is identified an analysis of barriers is conducted and potential interventions are identified. Data is then re-evaluated to determine the efficacy of the interventions.

When a concern over potential over or under-utilization for a specific member is identified, the clinical team including the Primary Care Physician, under the direction of the UM Medical Director, develops a plan to address the utilization issue which may include referral to Behavioral Health Case Management and/or the Alliance's Case

Management or Disease Management programs, physician peer to peer with the inpatient attending physician, referral to the Alameda county mental health authority for additional services and supports.

5. Behavioral Health Integration

Members may contact their appropriate behavioral health organization directly or be referred by the PCP and/or health care professional. The Alliance maintains procedures for providers to coordinate care and services for members in need of behavioral health services including, but not limited to, all medical necessary services across the behavioral health provider network

The Alliance uses a variety of mechanisms that ensure behavioral health services and management processes are actively integrated into the UM Program and include:

- A behavioral healthcare practitioner, who is a behavioral healthcare physician or a doctoral-level behavioral health practitioner, is involved in quarterly HCQC meetings to support, advise and coordinate behavioral healthcare aspects into UM Program policies, procedures and processes.
- There are regular care coordination rounds, in which the staff attending rounds evaluates topics such as access, availability, health management systems, practice guidelines, clinical and service quality improvement activities, member satisfaction, continuity and coordination of care and member's rights and responsibilities.
- The Alliance routinely receives clinical reports from its Behavioral Health provider network which are reviewed by the Chief Medical Officer, the Director of Health Care Services, the Senior Director of Quality Improvement, and the Director, Compliance, or designees.
- The Alliance participates in quarterly operational meetings with the Behavioral Health provider network delegate to review and coordinate administrative, clinical and operational activities.

J. Pharmacy Management

The Alliance ensures the provision of pharmacy management to a pharmacy benefit manager (PBM), PerformRx. The PBM possesses service level guarantees that manages pharmacy services under the delegated arrangement and maintains clinical policies and procedures that are revised at least annually. The Alliance delegates some of its pharmacy utilization management activities to the pharmacy benefit management company;. The PBM supports full prior authorization review services, including confirmation of denials for weekends/holidays/emergency. The PBM provides support to the Alliance's Pharmacy and Therapeutic Committee activities including formulary management, guideline development and trend reviews related to pharmacy services. The Pharmacy and Therapeutics Committee meets quarterly and provides oversight for evidence-based, clinically appropriate pharmacy guideline criteria. Guidelines are developed in conjunction with review of peer-reviewed literature and with consideration

for such factors as safety, efficacy and cost effectiveness; with the input and evaluation of external clinical specialists appropriate to the subject matter.

The PBM receives and processes medication prior authorization requests for medications filled through network retail and specialty pharmacies. The PBM's Prior Authorization Department is comprised of certified technicians and clinical pharmacists who conduct reviews and approve requests that meet prior authorization criteria. All requests that the PBM cannot approve per their protocol are forwarded to Alliance for the final determination. All pharmacy PA requests must be processed, and a decision rendered within the regulatory requirement. Pharmacy UM decision monitoring is reported through the UM Committee.

K. Linked and Carved Out Services

For linked and carved out services The Alliance provides linkages with community programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions, receive wrap-around services that enhance their medical benefits. These linkages are established through special programs, such as The Alliance Community Liaisons, and specific program Memoranda of Understanding (MOU) with other community agencies and programs, such as the California Children's Services, Alameda County Behavioral Health Care Services, and the Regional Center of the East Bay (RCEB). The UM staff and delegated entity practitioners are responsible for identification of such cases, and coordination of referral to appropriate State agencies and specialist care when the benefit coverage of the member dictates. The UM Department coordinates activities with the Case Management Department to assist members with the transition to other care, if necessary, when benefits end. This may include informing the member about ways to obtain continued care through other sources, such as community resources.

A full description of program the identification and referral process as well as the care coordination activities is maintained in the UM department policies and procedures.

Transportation Services

Transportation services are covered benefits. Transportation benefits include:

- Emergency
- Non-emergency medically necessary (NEMT)
- Non-medical transportation (NMT)

Benefits are administered based on the guidance of The Alliance product line. Those products include:

- MediCal
- IHSS

For the administration of the benefit:

- For Members enrolled with Kaiser, The Alliance delegates the responsibility for the provision of transportation services to the contracted Plan Partner.

- For the administration of MediCal Direct and IHSS, The Alliance is responsible for the provision of transportation services.

The Alliance contracts with a vendor, Logisticare, to provide the various modes of transportation. The vendor's UM Department is delegated for the utilization review process to determine medical necessity when required; the vendor is not delegated for potential denials. All potential denials are referred to The Alliance UM Medical Director for final determination. Utilization review is performed using the transportation guidance for the product, and as needed, a Physician Certification Statement (PCS). A full description of the process is defined the most recent policies on transportation services.

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

The Alliance is responsible for the provision of medical and non-medical transportation to eligible children under the age of 21 to access Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. The Alliance is required to provide appointment scheduling assistance and necessary transportation, including non-emergency medical transportation and non-medical transportation, to and from medical appointments for the medically necessary covered services. The Alliance is not responsible for providing non-medical transportation to and from the services that are carved-out, including dental services. DHCS All Plan Letter 14-007 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment of Services for MediCal Beneficiaries Under the Age of Twenty- One, December 12, 2014.

Section IV. Special Programs

A. Long Term Services and Supports

The UM program includes oversight of the UM clinical decision-making review and authorizations for access to Long Term Service and Support benefits including Long Term Care (LTC) and Community Based Adult Services (CBAS). LTSS is responsible for the programmatic management of the LTSS programs. The Alliance administers the LTC and CBAS program elements as defined by the most recent DHCS contract or MMCD letter.

1. Long Term Care

The Long-Term Care (LTC) UM activities includes long term skilled care authorizations for the following facilities: skilled nursing, intermediate care, sub-acute care, intermediate care; developmentally disabled, intermediate care–developmentally disabled—habilitative, and intermediate care–developmentally disabled—nursing, residential care facilities, board and care, and assisted living facilities. LTC excludes Institutes for Mental Disease and special behavioral health treatment programs.

Authorizations are provided based on member's meeting criteria the eligibility and nursing facility admission criteria.

For Medi-Cal members: Long Term Care (LTC) services for eligible MediCal members. The Alliance is responsible for the provision of LTC services for the month of admission plus the following month. The UM Department is responsible for providing the following activities:

- If a Member requires LTC in the facility for longer than the regulatory timeframe for admission, The Alliance shall submit a disenrollment request for the member to DHCS, for approval.
- The Alliance shall provide all Medically Necessary Covered Services to the Member until the disenrollment is effective. For these Members, an approved disenrollment request will become effective the first day of the eligible month, provided Contractor submitted the disenrollment request at least 30 calendar days prior in the appropriate timeframe. If the Alliance submitted the disenrollment request less than 30 calendar days prior to that date, disenrollment will be effective the first day of the month that begins at least 30 calendar days after submission of the disenrollment request. Prior to the disenrollment effective date, The Alliance shall ensure the Member's orderly transfer from The Alliance's Provider to the Medi-Cal Fee-For-Service program. This includes notifying the Member and his or her family or guardian of the disenrollment; assuring the appropriate transfer of medical records or copies from The Alliance's Provider to the Medi-Cal fee-for-service provider; assuring that continuity of care is not interrupted; and, completion of all administrative work necessary to assure a smooth transfer of responsibility for the health care of the Members.
- Admission to a nursing facility of a MediCal Member who has elected hospice services does not affect the Member's eligibility for Enrollment. Hospice services are Covered Services under and are not long-term care services regardless of the Member's expected or actual length of stay in a nursing facility.

2. CBAS

The Alliance administers the CBAS program elements as defined by the most recent DHCS contract or MMCD letter. The Alliance maintains procedures, processes and mechanisms for administering assessments and re-assessments for CBAS services. For providers delegated to perform the CBAS assessments, The Alliance provides the necessary delegation oversight and monitoring activities.

The Alliance administers the CBAS program elements as defined by the most recent DHCS contract or MMCD letter. The Alliance maintains procedures, processes and mechanisms for administering assessments and re-assessments for CBAS services. The Alliance develops mechanism to generate and distribute the required reports to the identified DHCS departments

D. Palliative Care

Palliative care services may be delivered at the hospital, as part of the inpatient care treatment plan, or authorized and delivered in primary care, specialty care clinics, by home

health teams, or by hospice entities. The Alliance offers a network of palliative care services to its members through various provider types.

The Alliance, as part of its palliative care network development, contracts with hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and /or training in palliative care. The Alliance may also contract with different types of providers depending on local provider qualifications and the need to reflect the diversity of their membership. Community-Based Adult Services (CBAS) facilities may be considered as a palliative care partner for facilitating advance care planning or palliative care referrals. The Alliance utilizes qualified providers for palliative care based on setting and needs of the members if the provider complies with the existing Medi-Cal requirements.

The Alliance ensures that palliative care provided in a member's home complies with existing Medi-Cal requirements for in-home providers, services, and authorization, such as physician assessments and care plans.

The Alliance informs and educates its providers regarding availability of the palliative care benefit through its website and education materials.

The Alliance identifies members eligible for palliative care by the following:

- Screening for palliative care eligibility in Complex Case Management referrals
- Referrals from network providers, including through case management, concurrent review, and the general authorization process
- Analysis of member data

Palliative care services follow the general authorization process is outlined in the UM policy and procedures. Through the authorization review and decision process, the type of palliative care (including the location where palliative care services can be delivered) will be determined based on medical necessity. Referral and care coordination for palliative services will be provided to the member within the timely access standard requirements. Alliance's network providers receive instructions of the referral and authorization process for palliative care through the Alliance's provider educational materials and via the Alliance's website.

Section V. Quality Improvement Integration

The UM Program includes a wide variety of quality assurance activities to support positive member outcomes and continuous quality improvement. The CMO guides these activities in collaboration with the Director of Health Care Services, the Directors of Quality and Accreditation, and oversight of the HCQC. Performance results are analyzed and reviewed with opportunities for improvement identified for intervention and performance management. The following quality activities are included in the UM Program:

- Monitoring Under and Over Utilization, including Out of Network and Provider Capacity monitoring;

- Monitoring of Member Experience with the UM process;
- Monitoring UM Appeals for UM Decision Making;
- Potential quality issue referrals;
- Provider Preventable Condition identification and referral;
- Inter-rater reliability assessments;
- Delegation oversight including Corrective Action Plan completion and process improvements if audit findings occur.

The UM data sources and information used for quality monitoring and improvement activities include the following:

- Claims and encounter data;
- Medical records;
- Medical utilization data;
- Behavioral Health utilization data;
- Pharmacy utilization data;
- Appeal, denial, and grievance information;
- Internally developed data and reports;
- Audit findings; and
- Other clinical or administrative data.

A. Monitoring Over and Under Utilization

The Alliance regularly monitors member service utilization using industry standard utilization measures. Medi-Cal contracts require that plans report rates to detect over and under-utilization. Rates for these measures vary based on the relative health of each population. For instance, usage rates for Non-SPD Medi-Cal members tend to be significantly lower than those for SPD Medi-Cal and IHSS members because the former populations are generally younger and healthier. Monitoring reports include changes in membership totals for each line of business in the last 12 months. National and regional benchmarks are not available for every line of business. In the absence of such benchmarks, the Alliance closely monitors monthly, quarterly and annual data for significant changes and trends, reports the results quarterly to the UMC and HCQC, and acts when indicated.

UM data elements are reviewed to assess over/under utilization of services for either medical and/or behavioral health include but are not limited to the following:

- Ambulatory Services – e.g. Outpatient encounters per enrollee per year primary care visits, specialist visits, preventive health care.
- Out of Network Specialty Referrals, e.g. specialists, behavioral health care;
- Acute Hospital Services
    - Emergency room visit rates;

    - Hospital admit rates;
    - Bed days rates;
    - Length of Stay;
    - Re-admission rates;
- Behavioral health utilization data;
- Pharmacy utilization rates;
- HEDIS measures for use of services
- Complaint reports (Grievance & Appeals) that reflect barriers for access to care or delivery of care.

Because of these clinical data analyses, The Alliance identifies opportunities for improvement through root cause analysis, action plans and the continuous improvement cycle ensure the actions taken are improving performance. When appropriate, feedback is provided to both entities and individual practitioners allowing their input into the improvement activities. The Alliance continues to monitor the action plans to ensure the activities improvements in the care delivery process.

B. Experience with Utilization Management

Annually Alliance members and providers are surveyed to assess their experience with the plan's utilization management processes and services. Data is collected and analyzed to identify improvement opportunities. For identified opportunities, Alliance takes actions designed to improve the experience based on the data.

1. Member

Alliance uses survey data to assess the member experience with the UM process. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is administered by mail to Alliance Medi-Cal members. Composite measures display member ratings for: 1) Getting Needed Care – member experience when attempting to get care, tests or treatments; 2) Getting Care Quickly – member experience when receiving care; and 3) Rating the Health Plan. The CAHPS summary rate results are compared to Medicaid benchmarks. A sample of Alliance Group Care members was asked to participate in a brief telephone survey about their satisfaction with utilization management processes and services.

2. Provider

Annually, the Alliance surveys its providers for their experience with the plan's utilization management processes and services. A vendor employed by the plan contacts a sample of network providers by mail and/or internet. Six (6) questions ask providers to rate the plan on:

- Access to knowledgeable UM staff;
- Procedures for obtaining prior-authorization information;
- Timeliness for obtaining prior-authorization information;

- The Plan's facilitation/support of appropriate clinical care for patients;
- Degree to which the Plan covers and encourages preventive care and wellness. Alliance provider survey responses are benchmarked against other Medi-Cal/Medicaid plans that use the same vendor's survey.

Alliance conducts quantitative and qualitative analysis to identify areas for improvement. Outcomes of the assessments are presented to the UMC and HCQC to assist in identifying opportunities for improvement. If the analysis indicated that there are opportunities to improve experience with UM, Alliance UM Department will implement interventions based on the analysis results. Activities identified to improve the member and provider experience with UM are used to update the following years UM Program.

C. Grievances and Appeals

The Alliance maintains an effective member grievance and appeals (G&A) process that follows all regulatory, contractual and accreditation requirements. G&A is managed within Health Care Services, and complaints identified with clinical service needs are supported by UM Nurses and Physicians. Trending data for clinical appeals and fair hearings is reported to the UMC for the identification and recommendations of opportunities to improve the UM experience for members and providers. On a quarterly basis, the UM Department will review and analyze grievance data. The evaluation is reported to the UMC.

Appeal decisions are made by a practitioner who was not involved in the initial decision unless the case is overturned. A same-or similar specialist review is required for all appeals of medical necessity decisions. The details of the appeal process are outlined in The Alliance Appeals Policy and Procedure.

D. Potential Quality of Care/ Provider Preventable Reportable Conditions

At any time during an UM review, staff identify a condition or situation that appears to deviate from the professional standard of care or identified by regulatory guidance as a Potential Quality of Care or Provider Preventable Reportable Condition, are referred to the Quality Improvement Department to be evaluated per policy and procedure.

E. UM Delegation Activities

The Alliance delegates UM activities to provider groups, vendor networks and healthcare organizations that meet delegation agreement standards. The contractual agreements between the Alliance and delegated groups specify: the responsibilities of both parties; the functions or activities that are delegated; the frequency of reporting on those functions and responsibilities to the Alliance; how performance is evaluated; and corrective action plan expectations, if applicable. The Alliance conducts a pre- contractual evaluation of delegated functions to assure capacity to meet standards and requirements. The Alliance's Compliance Department is responsible for the oversight of delegated activities. The Compliance Department will work with other respective departments to

conduct the annual delegation oversight audits. Delegate work plans, reports and evaluations are reviewed by the Alliance and the finding are summarized at HCQC and Compliance Committee meetings, as appropriate. The Compliance Department in conjunction with each respective department monitors the delegated functions of each delegate through reports and annual oversight audits.

As part of delegation responsibilities, delegated providers must:

- Develop, enact, and monitor a UM Program description that addresses all State, Federal, health plan and accreditation requirements;
- Provide encounter information and access to medical records pertaining to Alliance members;
- Submit at least semi-annual ~~quarterly~~ reports, annual evaluations, and program descriptions and work plans; and
- Cooperate with annual audits and complete any corrective actions necessary by the Alliance.
- Participate in performance improvement activities

F. Inter-Rater Reliability Testing

Inter-Rater Reliability (IRR) Testing is a method used at the Alliance to assess the degree of agreement among personnel who make utilization management decisions. It provides a score of how much homogeneity or consensus there is in responses to utilization management cases. The purpose is for The Alliance to provide consistency and accuracy of review criteria applied by all reviewers - physicians and non-physicians and to act on improvement opportunities identified through this testing. This report provides an analysis of The Alliance's testing for each year and fulfills regulatory, contractual and accreditation requirements associated with ensuring the consistency in applying UM criteria and acting on identified improvement opportunities.

IRR testing is conducted following The Alliance internal policy (UM-006 Inter-rater Reliability) for UM, QM and Pharmacy staff that participates in the Health Services medical necessity decision making process. IRR test results are collated and reviewed by management.

Reports on IRR test results are reviewed and approved by the HCQC. The IRR process and reports are reviewed for delegated entities during the annual auditing process.

G. UM Department – Internal Quality Review

To ensure the oversight of the internal UM process, Alliance UM Department conducts ongoing auditing and monitoring of key operational areas to ensure compliance with all federal, state, regulatory, contractual and accreditation standards. Alliance UM Department has implemented a monitoring program for the early identification of potential compliance risks. In addition, the program includes an opportunity to provide quality

oversight of the current UM processes. This is accomplished by internal monitoring of UM authorization files on a routine and/or periodic basis.

1. UM File Review

UM will complete file reviews using a defined methodology for the file selection. Files will be assessed to ensure compliance using the regulatory and accreditation requirements as well as to identify opportunities for process improvement. The process outcomes will also be utilized for staff performance. Elements of the review include, but are not limited to, ensuring the appropriate medical information is obtained, use of criteria, application of clinical decision making, and appropriate referral to physician reviewers as needed. For cases that are denied or modified, the file will assess the NOA requirements for communication to the member and provider.

2. Audit of Authorization Processing Turn-Around-Time (TAT)

An authorization aging report is used to monitor TATs for authorizations. Any opened authorization without a final determination will appear in this report. The UM Manager or designee will work this report daily to ensure all authorization determinations are compliant with UM will complete file reviews using a defined methodology for the file selection. Files will be assessed to ensure compliance using the regulatory and accreditation requirements as well as to identify opportunities for process improvement.

H. Annual UM Workplan

Each year, The Alliance establishes objectives and priorities, and outlines a strategic UM Workplan for the coming year. The UM Workplan incorporates anticipated timeframes, responsible parties and status of activities. The UM Workplan is submitted to the UM Committee for approval annually. See Attachment B – 2019 UM Workplan.

I. Annual UM Evaluation

Members of the UM Program management team annually evaluate and update the UM Program to ensure the overall effectiveness of UM Program objectives, structure, scope and processes. The evaluation includes, at a minimum:

- Review of changes in staffing, reorganization, structure or scope of the program;
- Resources allocated to support the program;
- Review of completed and ongoing UM work plan activities;
- Assessment of performance indicators;
- Review of delegated arrangement activities; and
- Recommendations for program revisions and modifications

The UM Program management team presents a written program evaluation to the UMC and HCQC. The UMC and HCQC reviews and approves the UM Program evaluation on an annual basis. The review and revision of the UM program description may be

conducted more frequently as deemed appropriate by the UMC, HCQC, CMO, CEO, or BOG.

The HCQC's recommendations for revision are incorporated into the UM Program description, as appropriate, which is reviewed and approved by the BOG and submitted to DHCS on an annual basis.

Attachment A

2019 The Alliance Delegated Network or Vendor Relationships

Delegate	Provider Type		Delegated Activity - UM	Delegated Activity – Grievance and Appeals	Exceptions
Kaiser	HMO		X	X	
Alameda Health System	Delivery System		X	NA	
CHCN	Medical Group		X	NA	
CFMG	Medical Group		X	NA	
California Home Medical Equipment (CHME)	Vendor DME		X*	NA	* Not delegated for denials
Beacon/College Health IPA (CHIPA)	~~Vendor – BH~~ MBHO		X	NA	
eviCore Healthcare	~~Vendor –~~ Specialty Services		X	NA	
Logisticare	Vendor - Transportation		NA	NA	* Not delegated for denials
March Vision	Vendor – Vision Services		NA	NA	

Attachment B – 2019 UM Work Plan

See attached document.

2019 Utilization Management Work Plan
Signature Page

Date _____

Sanjay Bhatt, M.D.
Medical Director, Quality Improvement
Vice Chair, Health Care Quality Committee

Date _____

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

Date _____

Scott Coffin
Chief Executive Officer

Date _____

Evan Seevak, M.D.
Board Chair

Performance Measures	2018 Evaluation Level	2019 Goal	Document/Report	Responsible Staff	Timeframe for completion	Reports to:
UM Infrastructure						
Goal: Revise the existing UM infrastructure to meet the needs of the members, providers and the organization, including a new						
Develop a new staffing model	NA	Complete new staffing model for outpatient UM services	Productivity Report	UM Medical Director/Manager, UM	Q3 2019	UMC
Secure staffing and resources to support UM	NA	100% of newly hired staffing in 2019 are retained	Budget Reports	UM Medical Director/Manager, UM	Q4 2019	UMC
Enhance Auto Authorization Process	20% of PA s were Auto Auth'ed	60% of PA requests are Auto Authorized	Report on Auto Auth in development	UM Medical Director/ Manager UM	Q2 2016	UMC
Explore team model vs. cross functional activities.	NA	Develop proposal for team management in UM; operationalize one time in 2019	Productivity Report	UM Medical Director/Manager, UM	Q3 2019	UMC
Monitoring of UM Operational Activities						
Goal: Use the existing clinical information system reporting capabilities to focus on the improvement of monitoring operational						
Referral Management Utilization Activities - AAH UM only	Met	Consistent tracking of trends in Referrals across the year	UM Reports - Total volume of request for authorization request by volume and UM determination	UM Medical Director/Manager, UM	Quarterly	**UMC**
Referral Management Turn-Around Times	97% Meeting TAT	95% of referrals processed within the required timeframe: Routine 5 days; Expedited 72 hours; Retro 30 days	UM Reports -	UM Medical Director/Manager, UM	Quarterly	**UMC**

Denial Rate	6.80%	Benchmark: ≤ to 5%	UM Reports -	UM Medical Director/Manager, UM	Quarterly	**UMC**
Denials by Type	Met	100% of denials will be analyzed to identify top 5 reasons and act on opportunities	UM Reports -	UM Medical Director/Manager, UM	Quarterly	**UMC**
Compliance with NOA Requirements	Not met	90% compliance with UM file review	File Review	UM Medical Director/Manager, UM	Quarterly	**UMC**
Provider Preventable Condition Monitoring	NA	Integrate PPCs into Standard Work for UM Reviewers	Departmental Audit	UM Medical Director/ Manager UM	Quarterly	**UMC**
Pharmacy - Referral Management Turn-Around Times	TBD	90% of referrals processed within the required timeframe: Routine 5 days; Expedited 72 hours; Retro 30 days	Pharmacy Report	Director of Pharmacy	Quarterly	**UMC**
Pharmacy - Denial Rate	TBD	Benchmark: > or equal to 5%?	Pharmacy Report	Director of Pharmacy	Quarterly	**UMC**
Pharmacy - Denials by Type	TBD	100% of denials will be analyzed to identify top 5 reasons and act on opportunities	Pharmacy Report	Director of Pharmacy	Quarterly	**UMC**
Palliative Care	NA	Operationalize Palliative Care benefit for children	UM Reports - Total volume of request for pediatric palliative care	UM Medical Director/Manager, UM	Quarterly	**UMC**
Transportation Activities	Not met	Vendor meets 90% of goals	Vendor Reports	UM Medical Director/Manager, UM	Quarterly	**UMC**

Transportation Activities	93%	90% of requests for NEMT are met within timeframes	UM Reports - Total volume of NEMT and MET transportation	UM Medical Director/Manager, UM	Quarterly	**UMC**
Continuity of Care						
Request for CoC/New Enrollees	TBD	Total number of requests; total number approved, total number denied.	UM Report	Manager, UM	Quarterly	**UMC**
Request for CoC/Term Providers	TBD	Total number of requests; total number approved, total number denied.	UM Report	Manager, UM	Quarterly	**UMC**
CoC/MER Report	48 requests: 4 approved, 44 denied	Total number of requests; total number approved, total number denied.	Regulatory MER reports	Manager, UM	Quarterly	**UMC**
Goal: Strategies to reduce readmissions						
Hospital Services/ MediCal	Dec 2018: Admits/1000 - 54.2; Bed-Days/1000 - 174 ; ALOS - 3.1	Admits/1000 - 84.4; Bed-Days/1000 - 298 ; ALOS - 3.5 Readmission Rate: 18%	Hospital reports for admits, bed days, LOS	UM Medical Director	Quarterly	**UMC**
ED Services/ MediCal	40 / 1000	ED Visits/1000 - 38	Hospital ED reports for Visits	UM Medical Director	Quarterly	**UMC**
Transitions of Care	NA	Members at high risk for readmissions will have TOC assessment and intervention	TOC Report	Manager, CM	Quarterly	**UMC**
Hospital Services/ MediCal	17.40%	All cause readmissions with in 30 days of discharge; < 16%	Hospital reports for readmissions	UM Medical Director	Quarterly	**UMC**
Goal: Improve monitoring of network utilization						

Ambulatory Services/ Medical (Office Visits and ER)		performing within the control limits (25-75%) the national Medicaid HEDIS measures, benchmarks, and performances at or near the identified medians.	Over/ Under Utilization Monitoring -	UM Medical Director	Quarterly	**UMC**
Ambulatory Services/ Medical (Specialty referrals)		Percent of specialty referrals to OON providers	Over/ Under Utilization Monitoring -	UM Medical Director	Quarterly	**UMC**
Ambulatory Services, Preventive Health	64.3%, <10th Percentile	performing within the control limits (25-75%) the national Medicaid HEDIS measures, benchmarks, and performances at or near the identified medians.	CAHPS MAS	UM Medical Director	Quarterly	**UMC**
Auth usage by Members	NA	90% of services authorized are used by members	Auth usage report	UM Manager	Quarterly	**UMC**
OON Services		TBD	Over/Under Utilization Monitoring - Review of OON services	UM Medical Director	Quarterly	**UMC**
Behavioral health, Outpatient		TBD	Over/Under Utilization Monitoring -Review of Behavioral Health services	UM Medical Director	Quarterly	**UMC**
Activities to improve member experience						
Goal: Enhance reporting and analysis of member and provider complaints						

Grievance Analysis	Met	100% of grievances will be analyzed to identify top 5 reasons and act on opportunities	Grievance and Appeal Report	Director G&A	Quarterly Reports	**UMC**
Appeals Analysis	Met	100% of appeals will be analyzed to identify top 5 reasons and act on opportunities	Grievance and Appeal Report	Director G&A	Quarterly Reports	**UMC**
Member Appeal Overturn Rate	40.20%	Benchmark: ≤25%	G&A Reports - Total number of member appeals that are overturned/Total number of member appeals.	Manager, UM & Director of G&A	Quarterly	**UMC**
Goal: Implementing activities to improve member experience with UM, targeting CAHPs measures for primary and specialty care						
Service - *Member Satisfaction*						
Getting Care Quickly						
Q 4 Usually or always got needed care as soon as you thought you needed.	76.70%	84% SPH 2018	**CAHPS MAS**	Manager, UM	Annual	**UMC**: Sept
Q 6 Usually or always got appt for care as soon as you thought you needed.	69.80%	80% SPH 2018	**CAHPS MAS**	Manager, UM	Annual	**UMC**: Sept
Getting Needed Care						

Member satisfaction with UM process Q 25 Usually or always easy to get appts with SCPs	68.80%	80% SPH 2018	**CAHPS MAS**	Manager, UM	Annual	**UMC**: Sept 28
Member satisfaction with UM process Q 14 The process of getting the needed care (tests, therapy, etc.)	83.50%	84% SPH 2018	**CAHPS MAS**	Manager, UM	Annual	**UMC**: Sept 28
Service - *Provider Satisfaction*						
PCP satisfaction with UM process/ Access to knowledgeable UM staff;	40.50%	50% of PCPs will be overall satisfied with Access to knowledgeable UM staff	Provider Satisfaction Survey	Manager, UM	Annual	**UMC:** Nov
PCP satisfaction with UM process/Procedures for obtaining prior-authorization information;	45.70%	50% of PCPs will be overall satisfied with UM process/Procedures for obtaining prior-authorization information; s.	Provider Satisfaction Survey	Manager, UM	Annual	**UMC:** Nov

PCP satisfaction with UM process/Timeliness for obtaining prior-authorization information;	45.70%	50% of PCPs will be overall satisfied UM process/Timeliness for obtaining prior-authorization information	Provider Satisfaction Survey	Manager, UM	Annual	**UMC:** Nov
PCP satisfaction with UM process/ The Plan's facilitation/support of appropriate clinical care for patients;	46.00%	50% of PCPs will be overall satisfied with clinically reasonable decisions for pre-auths.	Provider Satisfaction Survey	Manager, UM	Annual	**UMC:** Nov
PCP satisfaction with UM process/ Access to plan's Case Managers;	40.60%	5 of PCPs will be overall satisfied with UM process/ Access to plan's Case Managers;	Provider Satisfaction Survey	Manager, UM	Annual	**UMC:** Nov

PCP satisfaction with UM process/ Degree to which the Plan covers and encourages preventive care and wellness	52.50%	60% of PCPs will be overall satisfied with UM process/ Degree to which the Plan covers and encourages preventive care and wellness	Provider Satisfaction Survey	Manager, UM	Annual	**UMC:** Nov
Delegation Oversight						
Goal: Strengthen internal oversight of UM processes;						
Delegation Oversight reporting requirements	Met	100% submission of delegates monthly reports	Reporting Submission Updates	Delegation Oversight Staff or Manager UM	Quarterly	**UMC**
Delegation Oversight reporting requirements	Met	100% submission of delegate's quarterly reports	Reporting Submission Updates	Delegation Oversight Staff or Manager UM	Quarterly	**UMC**
Delegation Oversight reporting requirements	Met	100% submission of delegate's corrective action plan reports	Reporting Submission Updates	Delegation Oversight Staff or Manager UM	Quarterly	**UMC**
Delegation Oversight reporting requirements	Met	100% submission of delegate's annual audits/reports. *Presentation of delegates UM Program services as approval of UM processes and criteria.	Reporting Submission Updates	Delegation Oversight Staff or Manager UM	Quarterly	**UMC**
Administrative						

Interrater Reliability	100%	100% of staff will receive at least 90% on IRR	Internal IRR report	Manager, UM	Annually	UMC
Staff Competence Documentation	Not met	Train UM staff on standards of practice and standard workflows	Training Documents	Director, Health Care Services	Annual	UMC
UM Criteria	100%	100% Annual Review of UM Criteria	Review of UM criteria contract(s)	Director, Health Care Services	Annually	UMC
Review of Auto Authorization Criteria	100%	100% Annual Review of UM Criteria	Review of UM Auto Authorization Criteria	Director, Health Care Services	Semi-Annual	UMC
Disclosure of UM Criteria/ Procedures	100%	100% Annual Review of Disclosure of UM Criteria or Procedures	Member or provider Request Log for UM criteria/policies	Director, Health Care Services	Annually	UMC
Annual Review of Policies & Procedure	100%	100% Annual Review of P&Ps	P&Ps	Director, Health Care Services	Annually to the UMC and as needed	UMC
UM Evaluation	Done	Annual UM Evaluation	UM Program Evaluation	Director, Health Care Services	Q1 2019	UMC
UM Program Document	Done	Annual UM Program Description	UM Program Description	Director, Health Care Services	Q1 2019	UMC
UM Work Plan/Calendar	Done	Annual UM Work Plan	UM Workplan	Director, Health Care Services	Quarterly	UMC

Quality Improvement Program
Program Description

2019

2019 Quality Improvement Program Description
Signature Page

Date _____

Sanjay Bhatt, M.D.
Medical Director, Quality Improvement
Vice Chair, Health Care Quality Committee

Date _____

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

Date _____

Scott Coffin
Chief Executive Officer

Date _____

Evan Seevak, M.D.
Board Chair

ALAMEDA Alliance FOR HEALTH

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

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OVERVIEW

Alameda Alliance for Health's (Alliance) Quality Improvement (QI) Program strives to ensure that members have access to quality health care services. The QI Program Description details the scope, goals, and objectives of the program; how the program is organized to meet program objectives; functional areas and their responsibilities; reporting relationships for QI staff; the methodology used within the program; the structure and roles of committees supporting QI; staffing, resources, and data sources; and how improvement activities are conducted within the Alliance.

The Alliance is licensed by the State of California for Medi-Cal and Group Care lines of business. The Alliance QI Program is applicable to all lines of business and is designed to assess, measure, and improve the quality of care that members receive. The participation of all Alliance departments and staff is essential to achieving QI goals.

I. QI PROGRAM GOALS AND SCOPE

The purpose of the Alliance QI Program is to objectively monitor and evaluate the quality, appropriateness, and outcome of care and services delivered to members of the Alliance. The overall goal of the QI Program is to ensure that members have access to quality health care services that are safe, effective, and meet their needs. The QI program is structured to continuously pursue opportunities for improvement and problem resolution. The QI program is organized to meet overall program objectives as described below and as directed each year by the QI and UM Work Plan. Improvement priorities are selected based on volume, opportunities for improvement, risk, and evidence of disparities.

The QI program is designed to ensure that:

- High quality, safe, and appropriate care that meets professionally recognized standards of practice is delivered to all enrollees.
- The plan promotes objective and systematic measurement, monitoring, and evaluation of services and implements QI activities based upon the findings.
- The plan incorporates medical and behavioral health QI aspects.
- Performance improvement activities are developed, implemented, evaluated and reassessed.
- Physicians and other appropriate licensed professionals, including behavioral health, are an integral part of the QI program.
- Appropriate care consistent with professionally recognized standards of practice is not withheld or delayed for any reason, such as potential financial gain or incentive to plan providers.
- A culture of quality exists to ensure continual HEDIS improvement and accreditation readiness.

The scope of the QI program is comprehensive and encompasses the following:

- Access and availability to clinical services and care management
- Cultural and linguistic services
- Patient safety
- Member and provider experience
- Continuity and coordination of care
- Utilization trends, including over-and under-utilization
- Clinical practice guideline development, adoption, distribution and monitoring
- Acute, chronic, and preventive care services for children and adults
- Member and provider education
- Perinatal, primary, specialty, emergency, inpatient, and ancillary care
- Case review of potential quality issues
- Credentialing and re-credentialing activities
- Delegation oversight and monitoring
- Special needs populations including Seniors and Persons with Disabilities and persons with chronic conditions

II. ORGANIZATIONAL STRUCTURE and SUPPORT COMMITTEES RESPONSIBILITY

Overview

The Alliance Board of Governors (BOG) appoints and oversees the Health Care Quality Committee (HCQC), Pharmacy & Therapeutics (P&T) Committee, Peer Review/Credentialing Committee (PRCC), Member Advisory Committee, and Compliance Committee which in turn, provide the authority, direction, guidance, and resources to enable Alliance staff to carry out the QI Program.

The organizational chart in ***Appendix A*** displays the reporting relationships for key staff responsible for QI activities at the Alliance. ***Appendix B*** displays the committee reporting relationship and organizational bodies.

A Board of Governors

The Alliance BOG is appointed by the Alameda County Board of Supervisors and consists of up to 15 members who represent member, provider, and community partner stakeholders. The BOG is the final decision-making authority for the Alliance QI program. Its duties include:

- Reviewing annually, updating and approving the QI program description, defining the scope, objectives, activities, and structure of the program.
- Reviewing annual QI report and evaluation of QI studies, activities, and data on utilization and quality of services.
- Assessing QI program's effectiveness and direct modification of operations as indicated.

- Defining the roles and responsibilities of HCQC.
- Designating a physician member of senior management with the authority and responsibility for the overall operation of the quality management program, who serves on HCQC.
- Appointing and approving the roles of the Chief Medical Officer (CMO) and other management staff in the QI program.
- Receiving a report from the CMO on the agenda and actions of HCQC.

B. **Health Care Quality Committee (HCQC)**

The HCQC is a standing committee of the BOG and meets a minimum of four times per year, and as often as needed, to follow-up on findings and required actions. The HCQC is responsible for the implementation, oversight, and monitoring of the QI Program and Utilization Management (UM) Program. As it relates to the QI Program, the HCQC recommends policy decisions, analyzes and evaluates the QI work plan activities, and assesses the overall effectiveness of the QI program. The HCQC reviews results and outcomes for all QI activities to ensure performance meets standards and makes recommendations to resolve barriers to quality improvement activities. Any quality issues related to the health plan that are identified through the CAHPS survey and health plan service reports are also discussed and addressed at HCQC meetings. The HCQC oversees and reviews all QI delegation summaries reports and evaluates delegate quality program descriptions and work plan activities. The HCQC presents to the Board the annual QI program description, work plan and prior year evaluation. Signed and dated minutes that summarize committee activities and decisions are maintained. The QI Program, Work Plan, annual Evaluation and minutes from the HCQC are submitted to the California Department of Health Care Services (DHCS).

Responsibilities include:

- Approve, select, design, and schedule studies and improvement activities.
- Review results of performance measures, improvement activities and other studies.
- Review CAHPS and other survey results and related improvement initiatives.
- Provide on-going reporting to the BOG.
- Meet at least quarterly and maintaining approved minutes of all committee meetings.
- Approve definitions of outliers and developing corrective action plans.
- Approve Medical Necessity Criteria and Clinical Practice Guidelines and review compliance monitoring.
- Review member grievance and appeals data.
- Oversee the Plan's process for monitoring delegated providers.
- Oversee the Plan's UM Program.
- Review advances in health care technology, and recommend incorporation of new technology into delivery of services as appropriate.
- Provide guidance to staff on quality improvement activities.
- Monitor progress in meeting QI goals.

- Evaluate annually the effectiveness of the QI program.
- Oversee the Plan's complex case management and disease management programs.
- Review and approve annual QI and UM Program Descriptions, Work Plans, and Evaluations.

The HCQC is chaired by the CMO and vice-chaired by the QI Medical Director. The members are representative of the contracted provider network including, those who provide health care services to Seniors and Persons with Disabilities (SPD) and chronic conditions. The HCQC Members are appointed for two year terms. The voting membership consists of:

- Alliance CMO (Chair)
- Medical Director of Quality (Vice-Chair)
- Chief Executive Officer (ex officio)
- Medical Director or designee from each delegated medical group (i.e., Community Health Center Network, Children First Medical Group, Kaiser)
- Physician representative of Alameda County Medical Center
- Physician representative of Alameda County Ambulatory Clinics
- Alliance contracted physicians (3 positions)
- Representative of County Public Health Department
- A Behavioral Health practitioner
- Alliance Medical Directors
- Alliance Senior QI Director

A quorum is established when the majority of the voting membership is present at the meeting. The Chief Executive Officer does not count in the determination of a quorum.

C. **Pharmacy and Therapeutics Committee (P&T)**

The P&T Committee The IQIC assists the HCQC in oversight and assurance of ensuring the promotion of clinically appropriate, safe, and cost-effective drug therapy by managing and approving the Alliance's drug formulary, monitoring drug utilization and developing provider education programs on drug appropriateness. P&T Committee meeting minutes and pharmacy updates are shared at the HCQC meetings.

The voting membership consists of:

- Alliance Chief Medical Officer (Co-Chair) or Designee
- Alliance Pharmacist (Co-Chair/Secretary)
- Practicing physician(s) representing Family Practice and/or Internal Medicine
- Practicing physician(s) representing Pediatrics
- Practicing physician representing a medical specialty in support of agenda
- Practicing community pharmacist(s) contracted with AAH (not to exceed 3)

D. **Peer Review and Credentialing Committee (PRC)**

The PRC is a standing committee of the BOG that meets a minimum of ten times per year.

Responsibilities include:

- Recommending provider credentialing and re-credentialing actions.
- Performing provider-specific clinical quality peer review.
- Reviewing and approving PRCC Program Description.
- Monitoring delegated entity credentialing and re-credentialing.

The voting membership consists of:

- Alliance Chief Medical Officer (Chair) or Designee
- Medical Director/physician designee from Children First Medical Group
- Medical Director/physician designee from Community Health Center Network
- Physician representative for Alameda County Medical Center
- One specialist physician contracted with the Alliance
- Two physicians from the South County area contracted with the Alliance
- Physician representative from the Alliance BOG

E. **Internal Quality Improvement Committee (IQIC)**

The IQIC assists the HCQC in oversight and assurance of the quality of clinical care, patient safety, and customer service provided throughout the AAH organization. Its primary roles are to maintain and improve clinical operational quality, review organization-wide performance against the Alliance quality targets, and report results to the HCQC. All members shall complete a confidentiality and conflict-of-interest form, as required. A quorum, defined as a simple majority of voting members, must be present in order to conduct a meeting. The IQIC shall meet quarterly, at least four times per year. If urgent matters (as determined by the Alliance CMO) arise between meetings, additional meetings will be scheduled. Meetings may be conducted via conference call or webinar. All relevant matters discussed in between meetings will be presented formally at the next meeting. An agenda and supplementary materials, including minutes of the previous meeting, shall be prepared and submitted to the IQIC members prior to the meeting to ensure proper review of the material. IQIC members may request additions, deletions, and modifications to the standard agenda. Minutes of the IQIC proceedings shall be prepared and maintained in the permanent records of the Alliance. Minutes, relevant documents, and reports will be forwarded to HCQC for review.

Responsibilities include:

- Develop, approve and monitor a dashboard of key performance and QI indicators compared to organizational goals and industry benchmarks.
- Oversee and evaluate the effectiveness of AAH's Performance Improvement and Quality Plans.
- Review reports from other sub-committees and, if acceptable, forward for review at the next scheduled HCQC.

- Reviewing plan and delegate corrective plans with regard to negative variances and serious errors.
- Oversee compliance with NCQA accreditation standards.
- Make recommendations to the HCQC on all matters related to:
    - Quality of Care, Patient Safety, and Member/Provider Experience
    - Performance Measurement
    - Preventive services including:
        - Seniors and Persons with Disability (SPD)
        - Members with chronic conditions
        - Medi-Cal Expansion (MCE) members.

The Committee shall be comprised of the following members:

- Alliance Chief Medical Officer(CMO)
- Alliance Medical Director(s)
- Director of Quality
- Clinical Quality Manager
- Access to Care Manager
- Ad Hoc members from Provider Relations, Member Services, Business Analytics and Health Education

F. **Utilization Management Committee (UMC)**

The UMC is a forum for facilitating clinical oversight and direction. Its responsibilities are to:

- Maintain the annual review and approval of the UM Program, UM Policies/Procedures, UM Criteria and other pertinent UM documents such as the UM Delegation Oversight Plan, UM Notice of Action Templates, and Case/Care Management Program and Policies/Procedures.
- Participate in the utilization management/continuing care programs aligned with the Program's quality agenda.
- Assist in monitoring for potential areas of over and under-utilization and recommend appropriate actions when indicated.
- Review and analysis of utilization data for the identification of trends.
- Recommend actions to the Quality Oversight Committee when opportunities for improvement are identified from review of utilization data including, but not limited to Ambulatory Visits, Emergency Visits, Hospital Utilization Rates, Hospital Admission Rates, Average Length of Stay Rates, and Discharge Rates.

Review information about New Medical Technologies from the Pharmacy & Therapeutics Committee including new applications of existing technologies for potential addition as a new medical benefit for Members.

G. **Access and Availability Subcommittee (AASC)**

The AASC reviews the Alliance's access and availability data to evaluate whether the Alliance is meeting regulatory standards and provides corrective actions and recommendations for improvement to departments when needed. The committee identifies opportunities for improvement and provides recommendations to maintain compliance with access and availability regulatory requirements. Membership is comprised of Alliance staff within departments that are involved with access and availability.

The following are the monitoring activities the subcommittee reviews to ensure compliance with access and availability and network adequacy requirements including:

- Provider capacity levels
- Geographic accessibility
- Appointment availability
- High volume and high impact specialists
- Grievances and appeals related to access
- Potential quality issues related to access
- Triage and screening services related to access
- Member and provider satisfaction survey
- After hours care

H. **Joint Operations Committee/Delegation**

The contractual agreements between the Alliance and delegated groups specify:

- The responsibilities of both parties.
- The functions or activities that are delegated.
- The frequency of reporting on those functions and responsibilities to the Alliance and how performance is evaluated.
- Corrective action plan expectations, if applicable.

The Alliance may delegate QI, Credentialing, UM, Case Management, Disease Management and Claims activities to provider groups that meet delegation requirements. Prior to delegation, the Alliance conducts delegation pre-assessments to determine compliance with regulatory and accrediting requirements.

As part of delegation responsibilities, delegated providers must:

- Develop, enact, and monitor quality plans that meet contractual requirements and Alliance standards.
- Provide encounter information and access to medical records pertaining to Alliance members as required for HEDIS and regulatory agencies.
- Provide a representative to the Joint Operations Committee.
- Submit at least semi-annual reports or more frequently if required on delegated functions.
- Cooperate with state/federal regulatory audits as well as annual oversight audits.
- Complete any corrective action judged necessary by the Alliance.

The Alliance collaborates with delegates to formulate and coordinate QI activities and includes these activities in the QI work plan and program evaluation. Delegated activities are a shared function. Delegate program descriptions, work plans, reports, policies and procedures, evaluations and audit results are reviewed by the Compliance and Joint Operations Committee and findings are summarized at HCQC meetings, as appropriate.

The Alliance currently delegates the following functions:

18 AAH Delegation Audit Schedule											
Delegate Name		Service Type	Product Line		QI	UM	Credentialing / Re-Credentialing	Rights and Responsibilities	Claims	Case Mgmt.	BHT
			MCAL	GC							
1	KAISER	Fully Delegate	X		11/06/18	11/06/18	NCQA	11/06/18	11/06/18	11/06/18	11/06/18
2	BEACON HEALTH STRATEGIES LLC	Mental Health, Partially Delegated	X	X	8/16/18	8/16/18	NCQA	N/A	8/16/18	8/16/18	11/06/18
3	COMMUNITY HEALTH CENTER NETWORK (CHCN)	Partially Delegated	X	X	N/A	10/09/18	N/A	N/A	10/09/18	10/09/18	N/A
4	CHILDREN'S FIRST MEDICAL GROUP (CFMG)	Partially Delegated	X		N/A	9/10/18	7/01/17	N/A	9/10/18	N/A	N/A
5	PERFORMRX	Pharmacy	X	X	N/A	1/01/18	1/01/18	N/A	1/01/18	N/A	N/A
6	MARCH VISION CARE GROUP, INC.*	Vision	X		N/A	N/A	7/01/17	N/A	11/01/18	N/A	N/A
7	CALIFORNIA HOME MEDICAL EQUIPMENT (CHME)	DME	X	X	N/A	8/30/18	N/A	N/A	N/A	N/A	N/A
8	EVICORE*	Specialty Radiology	X	X	N/A	11/01/18	N/A	N/A	N/A	N/A	N/A
9	PHYSICAL THERAPY PROVIDER NETWORK (PTPN)	Physical Therapy	X	X	N/A	N/A	4/01/17	N/A	N/A	N/A	N/A
10	LUCILLE PACKARD	Medical Group	X	X	N/A	N/A	9/01/17	N/A	N/A	N/A	N/A
11	UCSF	Medical Group	X	X	N/A	N/A	10/01/17	N/A	N/A	N/A	N/A

III. QUALITY IMPROVEMENT PROGRAM RESOURCES

Responsibilities for QI program activities are an integral part of all Alliance departments. Each department is responsible for setting and monitoring quality goals and activities.

The Alliance QI Department is part of the Health Care Services Department, and responsible for implementing QI activities and monitoring the QI program. The QI Department directs the accreditation process, manages the HEDIS and CAHPS data collection and improvement process, conducts facility site reviews (FSRs), and oversees the quality activities in other departments and those performed by delegated groups.

Resource allocation for the QI Department is determined by recommendations from the HCQC, CMO, and CEO. The Alliance recruits and hires trained staff, and provides resources to support activities required to meet the goals and objectives of the QI program.

The Alliance's commitment to the QI program extends throughout the organization and focuses on QI activities linked to service, access, continuity and coordination of care, and member and provider experience. The Director of Quality with direction from the Medical Director of Quality and CMO, coordinate the QI program.

A. **Chief Medical Officer**

The Alliance CMO is the designated physician who is responsible for, and oversees the QI program. The CMO provides leadership to the QI program through oversight of QI study design, development, and implementation, and chairs the HCQC, PRCC, and P&T committees. The CMO makes periodic reports of committee activities, QI study and activity results, and the annual program evaluation to the BOG.

B. **Medical Director of Quality Improvement**

The Medical Director is part of the medical team and is responsible for strategic direction of the Quality and Program Improvement programs. The Medical Director also forms a dyad partner with the Director of Quality and will serve as an internal expert, consultant, and resource in QI. They are responsible for clinical appropriateness, quality of care, pay for performance, access and availability, provider experience, member experience and cost-effective utilization of services delivered to Alliance members. Responsibilities include participating in the grievance and external medical review procedure process, resolving medically related and potential quality related grievances, and issuing authorizations, appeals, decisions, and denials. The Medical Director holds a Medical Doctorate, Master of Medical Management, a Master of Science in Biomedical Investigations, over 10 years of clinical experience, and 8 years of QI experience.

C. **Director of Quality Improvement**

The Director of Quality is responsible for strategic direction of the Quality and Program Improvement programs. This position has direct responsibility for the development, implementation, and evaluation of HEDIS and CAHPS. This position is responsible for all performance improvement activities, including improving access and availability of network services; developing and managing quality programs as identified by DHCS, DMHC, and NCQA (PIPs, Improvement Programs i.e. EAS measures, QI Standards) as well as managing, tracking, analyzing, and reporting member experience/satisfaction as requested. The Director is also responsible for the oversight of FSR and potential quality issues (PQIs) and will direct performance improvement, FSR, access and availability. The director is also the senior nurse to the organization to augment clinical oversight. This position assists with setting the priorities of the Health Education program and ensures Health Education and Cultural and Linguistic Services are incorporated in to the Quality program. The Director holds a Master of Science in Health Service Administration, 15 years of managed care experience and a clinical license.

D. **Clinical Quality Manager**

This position is currently unfilled. The Clinical Quality Manager is responsible for the day-to-day management of the QI department, including but not limited to the HEDIS measures submissions, Physician Profiling (practice profiling) activities, Performance Improvement Projects, Potential Quality of Care reviews and quality improvement initiatives. The Clinical Manager also acts as

liaison between the Alliance's physician leadership and community practitioners/providers of care across all specialties and delegates. The Manager is also responsible for creating report cards and assessing gaps in care. They work collaboratively throughout the organization to lead and establish appropriate performance management/quality improvement systems.

E. **Access to Care Manager**

This position is currently unfilled. The Access to Care Manager is intended to work collaboratively throughout the organization to lead and establish appropriate access to care systems. The Access to Care Manager ensures the access program is in compliance with timely access standards as regulated by the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA). The Access to Care Manager ensures planning and oversight of access to care surveys, ensures appropriate follow up when compliance monitoring indentifies defeciencies, and daily operations related to Facility Site Reviews (FSRs).

F. **Quality Improvement Clinical Staff (5)**

1.5 / 5 positions are currently unfilled. The QI clinical staff is comprised of licensed registered nurses and have clinical oversight from the Medical Director of Quality and Director of Quality. The QI Supervisor oversees day-to-day activities of the clinical staff within the QI department with direct supervision of Quality Review Nurses. Quality Review Nurses are responsible for investigating Potential Quality Issues initiated from member grievances or front line health care staff, assisting with HEDIS medical record needs and as needed FSRs. QI Nurse Specialists report to the Clinical Quality Manager. The Senior QI Nurse Specialist is a Facility Site Review (FSR) Master Trainer. The FSR Master Trainer is a state required position responsible for ensuring timely facility site review of contracted physicians or physician groups. The QI Nurse Specialist is responsible for provider site review audits, qualitative and quantitative content of the medical records, compliance with quality of care standards, and oversight monitoring of delegated provider organizations. This position reports to the QI Supervisor.

G. **Quality Improvement Project Specialist (5)**

2 / 5 positions are currently unfilled. QI Project Specialists (QIPS) are responsible for providing support for quality assessment and performance improvement activities including quality monitoring, accreditation, access and availability monitoring, evaluation and facilitation of performance improvement projects. They report directly to either the Clinical Quality Manager or Access to Care Manager. The QIPS acts as a liaison between the Alliance and the survey vendors, assist with accreditation needs, collaborate on HEDIS interventions, perform regular assessments of access surveys, provider surveys, CAHPS and grievances. The QIPS ensures accuracy of DHCS performance improvement projects, internal subcommittees and HCQC and subcommittee meeting facilitation. The QIPS have experience in managed care as well as other highly regulated organizations.

H **Facility Site Review/Coordinator**

This position is currently unfilled. The Facility Site Review Coordinator reports to the Access to Care Manager and is responsible for performing facility site review audits and quality improvement activities in conjunction with the QI Nurse Specialists. The position assists with access and availability requirements, provider trainings, HEDIS data collection, disease specific outreach, and preparation for accreditation and compliance surveys by external agencies such as DHCS, CMS and NCQA. \

I **Quality Program Coordinator**

Under the general direction of the Clinical Quality Manager, this position is responsible for helping to plan, organize, and implement Alliance quality programs. Responsibilities include: coordinate quality projects, conduct reminder calls/mailings to targeted members or providers in quality initiatives or programs, represent the Alliance at community meetings/events, create/run periodic departmental reports, maintain departmental worksheets/limited data sets, etc.

J **Director Quality Assurance**

The Director, Quality Assurance is responsible for the operational management of the Alliance Quality Assurance Program under the direction of the Chief Medical Officer. The Director is responsible for Health Care Services internal monitoring activities as well as clinical components of delegation oversight auditing and performance monitoring. The Director is responsible for ensuring Health Care Service's overall regulatory compliance with Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) contractual responsibilities for Health Care Service Departments. The role is also responsible for overseeing ongoing audit readiness activities for DHCS, DMHC and NCQA. The Director is also responsible to coordinate processes, activities, and regulatory compliance involving grievances and appeals for all lines of business. The position identifies, analyzes, and coordinates resolution of grievances and appeals.

K **Utilization Management Staff**

The UM/Medical Services and QI Departments are part of the Alliance Health Care Services Department. These two departments work collaboratively to ensure that quality health care is delivered to members. QI ensures that HCQC is able to identify improvement opportunities regarding: concurrent reviews, tracking key utilization data, and the annual evaluation of UM activities.

L **Pharmacy Staff**

The Pharmacy Department and QI Department work collaboratively on various QI projects. The Pharmacy Department supports patient safety initiatives including working with the Pharmacy Benefit Manager (PerformRx) to inform members, providers and network pharmacies of medication safety alerts. Responsibilities also include review and update of

the formulary through P&T, oversight of the Pharmacy Benefit Manager, and collaboration with HCQC.

M. **Case and Disease Management Staff**

The Case and Disease Management department oversees case management for high-risk members including those identified through the disease management program. Responsibilities include conducting outreach and care coordination activities for members in the programs to ensure the improvement of member outcomes and overall member satisfaction. The staff will also assist the QI department in QI activities through conducting member outreach calls and mailings.

N. **Network Management/Provider Relations**

The Network Management/Provider Relations Department is the primary point of contact for network providers. They assist the QI Department on various QI activities with network providers as appropriate as well as disseminating QI information to practitioners. The Department is responsible for assessing provider satisfaction with Alliance processes and monitoring availability and accessibility standards at physician offices, including after-hours coverage. Provider Services staff also assists the QI Department with practitioners who do not comply with requests from QI including scheduling HEDIS abstraction visits.

O. **Credentialing Staff**

The Credentialing staff support the credentialing and re-credentialing processes for practitioners and network providers. The Credentialing staff conducts ongoing monitoring and evaluation of network practitioners to ensure the safety and quality of services to members. The QI Department provides the Credentialing Department with Facility Site Review and Medical Record audit scores. The Credentialing staff is responsible for coordinating the PRCC meetings.

P. **Member Services Staff**

The Member Services staff fields all member inquiries regarding eligibility, benefits, claims, programs, and access to care. The staff conducts welcome calls to members to educate new members about the health plan benefits. Member Services staff also works with the QI Department on member complaints and appeals in accordance with established policies and procedures. To assist in improving HEDIS scores, the Member Services Department may conduct reminder calls to members to get HEDIS services completed.

Q. **Health Education**

The Health Education Department consists of three full time staff and is inclusive within the QI Department. The staff supports QI in the development and implementation of member and provider educational interventions and community collaborations to address health care quality and access to care. The Health Education Department also manages and monitors the

Cultural and Linguistic programs for the Alliance. The Health Education and Cultural and Linguistic Programs are outlined in a separate document.

R **Healthcare Analytics Staff**

The Healthcare Analytics Department consists of seventeen staff members. This includes: one Chief Analytics Officer, two Directors, one Manager, nine analysts, two Quality Specialists, one Business Administrator, and one Executive Assistant. They perform data analyses involving clinical, financial, provider and member data. The Health Care Analysts are available to the QI department allotting at least 25% of their time to direct QI analysis. They collect and summarize QI data, and work in conjunction with the Information Technology (IT) Department and the QI department to produce analytics and reporting for various QI activities projects including HEDIS. Additionally, some quality analytics and reporting are produced by outside vendors under contract with the Alliance.

S **Utilization Management**

The Alliance's Utilization Management (UM) activities are outlined in the UM Program Description which includes a persons with complex health conditions. The UM Program Description defines how UM decisions are made in a fair and consistent manner. There is also a Case Management (CM) and Complex Case Management Program Description. These programs address serving members with complex health needs, such as, seniors and people with physical or developmental disabilities (SPDs) and/or multiple chronic conditions. There is one staff person dedicated to working with "linked and carved out services" such as East Bay Regional Center, California Children Services (children with complex health care needs), and the Alameda County Behavioral Health Care Department. The UM Program Description is approved by the UMC and HCQC. For additional information, refer to the UM and CM/Complex CM Program Descriptions.

IV. METHODS AND PROCESSES FOR QUALITY IMPROVEMENT

The QI program employs a systematic method for identifying opportunities for improvement and evaluating the results of interventions. All program activities are documented in writing and all quality studies are performed on any product line for which it seems relevant. The Alliance QI Program follows the recommended performance improvement framework used by the Department of Health Care Services (DHCS). In 2017, DHCS adopted a framework based on a modification of the Institute for Health Care Improvement (IHI) Quality Improvement (QI) Model of Improvement. Key concepts for DHCS performance improvement projects (PIP) utilize the following framework:

- PIP Initiation
- SMART Aim Data Collection
- Intervention Determination
- Plan-Do-Study-Act
- PIP Conclusion

A. Identification of Important Aspects of Care

The Alliance uses several methods to identify aspects of care that are the focus of QI activities. Some studies are initiated based on performance measured as part of contractual requirements (e.g., HEDIS). Other studies are initiated based on analyses of the demographic and epidemiologic characteristics of Alliance members and others are identified through surveys and dialogue with our member and provider communities (e.g., CAHPS, provider satisfaction and Group Needs Assessment). Particular attention is paid to those areas in which members are high risk, high volume, high cost, or problem prone.

B. Data Collection and Data Sources

The Alliance uses internal resources and capabilities to design sound studies of clinical and service quality that produce meaningful and actionable information.

Much of the data relevant to QI activities are maintained in a confidential and secure data warehouse named ODS (Operational Data Store). Data integrity is validated annually through the HEDIS reporting audit process, and through adherence to the Alameda Alliance data analysis plan.

Data sources to support the QI program include, but are not limited to the following:

- Data Warehouse (HAL): Houses legacy data from previous system (Diamond).
- ODS (Operational Data Store): This is the main database and the primary source for all data including member, eligibility, encounter, provider, pharmacy data, lab data, vision, encounters, etc. and claims. This database is used for abstracting data required for quality reporting.
- Business Objects: A data mining tool used by staff to create accurate member level reporting.
- HealthSuite: a platform for integrating data from Providers, Members, Medical Records, Encounters, and claims.
- CareAnalyzer (DST): provide care managers access to risk-stratified data that can be effectively applied to target high-risk members for early intervention and improve the overall coordination of care.
- TruCare: in house medical record data storage software.
- HEDIS: Preventive, chronic care, and access measures run through NCQA-certified HEDIS software vendor (Verscend).
- CAHPS 5.0 and CAHPS 3.0: Member experience survey.
- California Immunization Registry (CAIR): Immunization registry information.
- Laboratory supplemental data sources from: Quest, Foundation, Sorian, and NextGen and Novius.
- Credentialing is in Cactus, a credentialing database.
- Provider satisfaction and coordination of care surveys
- Pre-service, concurrent, post-service and utilization review data (TruCare).

- Member and provider grievance and appeal data.
- Potential Quality of Care Issue tracking/trending data.
- Internally developed databases (e.g., asthma and diabetes).
- Provider Appointment Availability Survey (PAAS), as well as after hour access and emergency instructions.
- Other clinical or administrative data.

C. Evaluation

Health care analysts collect and summarize quality data. Quality performance staff analyzes the data to determine variances from established criteria, performance goals, and for clinical issues. Data is analyzed to determine priorities or achievement of a desired outcome. Data is also analyzed to identify disparities based on ethnicity and language. Particular subsets of our membership may also be examined when they are deemed to be particularly vulnerable or at risk.

HEDIS related analyses include investigating trends in provider and member profiling, data preparation (developing business rules for file creation, actual file creation for HEDIS vendors, mapping proprietary data to vendor and NCQA specifications, data quality review and data clean-up). These activities involve both data sets maintained by the Alliance and supplemental files submitted by various trading partners, such as delegated provider organizations and various external health registries and programs (e.g., Kaiser Permanente, Quest Diagnostics and the California Immunization Registry).

Aggregated reports are forwarded to the HCQC. Status and final reports are submitted to regulatory agencies as contractually required. Evaluation is documented in committee minutes and attachments.

D. ACTIONS TAKEN AS RESULT OF QUALITY IMPROMEVEMENT ACTIVITIES

Action plans are developed and implemented when opportunities for improvement are identified. Each performance improvement plan specifies who or what is expected to change, the person responsible for implementing the change, the appropriate action, and when the action is to take place. Actions will be prioritized according to possible impact on the member or provider in terms of urgency and severity. Actions taken are documented in reports, minutes, attachments to minutes, and other similar documents.

An evaluation of the effectiveness of each QI activity is performed. A re-evaluation will take place after an appropriate interval between implementation of an intervention and remeasurement. The evaluation of effectiveness is described quantitatively, in most cases, compared to previous measurement, with an analysis of statistical significance when indicated.

Based on the HEDIS data presented, areas of focus for 2019 include the following:

Clinical Quality Measure Category	
1	Childhood Immunization Status – Combo 3
2*	Children and Adolescents' Access to Primary Care Physicians
3	Children/Adolescents' Weight Assessment and Counseling - Nutrition
4	Asthma Medication Ratio (Total Rate)
5	Cervical Cancer Screening
6	Comprehensive Diabetes Care (18-75 y/o) – HbA1c Testing
7*	Controlling High Blood Pressure
8	Annual Monitoring for Patients on Persistent Medications (>18 y/o) - ACE or ARB
9	Annual Monitoring for Patients on Persistent Medications (>18 y/o) -Diuretics

Other Non-HEDIS related measures of focus will include EPSDT / Pediatric services and also:

Other Measure Category	
10R*	Opioids Intervention Education
11*	Initial Health Assessment (DHCS measure)
12	ED Visits per 1000 Member
13	Pharmacy Utilization - % of Generic Usage

See Appendix C (bottom) for ongoing PIP activities that will continue into 2019.

E. TYPES OF QI MEASURES AND ACTIVITIES

A Healthcare Effectiveness Data Information Set (HEDIS)

The External Accountability Set (EAS) Performance Measures, a subset of HEDIS (Health Effectiveness Data Information Set) are calculated, audited, and reported annually as required by DHCS. Additional measures from HEDIS are also reviewed. A root cause analysis may be performed and improvement activities initiated for measures not meeting benchmarks.

B Consumer Assessment of Health Plan Survey (CAHPS)

The Alliance evaluates member experience periodically. The Consumer Assessment of Health Plan Survey (CAHPS) is conducted by vendors. The Alliance assists in the administration of these surveys, receives and analyzes the results, and follows up with

prioritized improvement initiatives. Survey results are distributed to the HCQC and made available to members and providers upon request. The CAHPS survey is conducted annually for the entire Medi-Cal population and the results from the CAHPS are reported in the annual QI evaluation and used to identify opportunities to improve health care and service for our members.

C. State of California Measures

DHCS has developed several non-HEDIS measures that the Alliance evaluates. These measures, specified in the Alliance contract with DHCS, involve reporting rates for an Under/Over-Utilization Monitoring Measure Set.

D. State Quality Improvement Activities

DHCS requires Medi-Cal Managed Care plans to conduct at least two QI projects each year. Forms provided by DHCS are used for QI project milestones.

Annually, the Alliance submits its QI Program Description, an evaluation of the prior year's QI Work Plan and a QI Work Plan for the next year. The QI Work Plan will be updated throughout the year as QI activities are designed and implemented.

The Alliance complies with the requirements described in MMCD All Plan Letters.

E. Monitoring Satisfaction

The QI program measures member and provider satisfaction using several sources of satisfaction, including the results of the CAHPS survey, the Group Needs Assessment (GNA), the annual DMHC Timely Access survey, plan member and provider satisfaction surveys, complaint and grievance data, disenrollment and retention data, and other data as available. These data sets are presented to the HCQC and BOG at quarterly and annual intervals. The plan may administer topic specific satisfaction surveys depending on findings of other QI studies and activities.

F. Health Education Activities

The Health Education Program at the Alliance operates as part of the Health Care Services Department. The primary goal of Health Education is to improve members' health and well-being through the lifespan through promotion of appropriate use of health care services, prevention, healthy lifestyles and disease self-care and management. The primary goal of Health Education is to provide the means and opportunities for Alameda Alliance members to maintain and support their health.

Health education programs include individual, provider, and community-focused health education activities which cluster around several topic areas. The Alliance also collaborates on a number of community projects to develop and distribute important health education messages for at risk populations.

G. Cultural and Linguistic Activities

The Alliance Cultural and Linguistic Program operates under the Health Care Services

Department. It reflects the Alliance's adherence and commitment to the U.S. Department of Health & Human Services "National Standards for Culturally and Linguistically Appropriate Services". The program conducts activities designed to ensure that all members have access to quality health care services that are culturally and linguistically appropriate. These activities encompass efforts within the organization, as well as with Alliance members, providers, and our community partners.

Objectives include:

- Comply with state and federal guidelines related to assessment of enrollees in order to offer our members culturally and linguistically appropriate services.
- Identify, inform and assist Limited English Proficiency members in accessing quality interpretation services and written informing materials in threshold languages.
- Ensure that all staff, providers and subcontractors are compliant with the cultural and linguistic program through cultural competency training.
- Integrate community input into the development and implementation of Alliance cultural and linguistic accessibility standards and procedures.
- Monitor and continuously improve Alliance activities aimed at achieving cultural competence and reducing health care disparities.

The objectives for cultural and linguistic activities are addressed in the Health Education and Cultural and Linguistic work plans which are updated annually.

H Disease Surveillance

The Alliance has executed a Memoranda of Understanding with DMHC and maintains procedures to ensure accurate, timely, and complete reporting of any disease or condition to public health authorities as required by State law. The Provider Manual describes requirements and lists Public Health Department contact phone and fax numbers.

I Patient Safety and Quality of Care

The Alliance QI process incorporates several mechanisms to review incidents that pose potential risk or safety concerns for members. The following activities are performed to demonstrate the Alliance's commitment to improve quality of care and safety of its members:

- Reviewing complaints and grievances, and determining quality of care impact.
- Monitoring iatrogenic events such as, hospital-acquired infections reported on claims and reviewing encounter submissions.
- Reviewing concurrent inpatient admissions to evaluate and monitor the medical necessity and appropriateness of ongoing care and services. Safety issues may be identified during this review.
- Investigating reported and/or identified potential quality of care issues.
- Auditing Alliance internal processes/systems and delegated providers.
- Credentialing and re-credentialing review of malpractice, license suspension registries, loss of hospital privileges.

- Performing site review of provider offices for compliance with safety, infection control, emergency, and access standards.
- Monitoring operational compliance with local regulatory practices.
- Monitoring medication usage (e.g., monitoring number of rescue medications used by asthmatics).
- Encouraging/reminding providers to use ePocrates to receive information on drug information, side effects and interactions.
- Partnering with the pharmacy benefit management company to notify members and providers of medication recalls and warnings.
- Reviewing hospital readmission reports.
- Improving continuity and coordination of care between practitioners.
- Providing educational outreach to members (e.g., member newsletter, telephonic outreach) on patient safety topics including questions asked prior to surgery and questions asked about drug-drug interaction.

Quality issues are referred to the QI Department to evaluate the issue, develop an intervention and involve the CMO when necessary.

J. **Access and Availability**

The Alliance implements mechanisms to maintain an adequate network of primary care providers (PCP) and high volume and high impact specialty care providers. Alliance policy defines the types of practitioners who may serve as PCPs. Policies and procedures establish standards for the number and geographic distribution of PCPs and high volume specialists. The Alliance monitors and assesses the cultural, ethnic, racial, and linguistic needs and preferences of members, and adjusts availability of network providers, if necessary.

The following services are also monitored for access and availability:

- Children's preventive periodic health assessments/ EPSDT
- Adult initial health assessments
- Standing referrals to HIV/AIDS specialists
- Sexually transmitted disease services
- Minor's consent services
- Pregnant women services
- Chronic pain management specialists.

The QI program collaborates with the Provider Relations Department to monitor access and availability of care including member wait times and access to practitioners for routine, urgent, emergent, and preventive, specialty, and after-hours care. Access to medical care is ensured by monitoring compliance with timely access standards for practitioner office appointments, telephone practices, appointment availability. The HCQC also oversees appropriate access standards for appointment wait times. Alliance appointment access

standards are no longer than DMHC and DHCS established standards. The Provider Manual and periodic fax blasts inform practitioners of these standards.

The HCQC reviews the following data and makes recommendations for intervention and quality activities when network availability and access improvement is indicated:

- Member complaints about access
- CAHPS results for wait times and telephone practices
- HEDIS measures for well child and adolescent primary care visits
- Immunizations
- Emergency room utilization
- Facility site review findings
- The review of specialty care authorization denials and appeals
- Additional studies and surveys may be designed to measure and monitor access.

K Behavioral Health Quality

The Alliance maintains procedures for monitoring the coordination and quality of behavioral healthcare provided to all members including, but not limited to, all medically necessary services across the health care network. The Alliance involves a senior behavioral healthcare physician in quarterly HCQC meetings to monitor, support, and improve behavioral healthcare aspects of QI.

Behavioral Health Services are delegated to Beacon Health Strategies, an NCQA Accredited MBHO, except for Specialty Behavioral Health for Medi-Cal members, excluded from the Alliance contract with DHCS. The Specialty Behavioral Health Services are coordinated under a Memorandum of Understanding between the Alliance and Alameda County Behavioral Health Services (ACBHCS). While behavioral health is delegated, some primary care physicians may choose to treat mild mental health conditions rather than referring to Beacon.

The Alliance includes the involvement of a designated behavioral health physician in program oversight and implementation as discussed in Beacon's QI Program Description. The Alliance annually reviews Beacon's QI Program Description, Work Plan, and Annual Evaluation. The Alliance reviews Beacon behavioral health quality, utilization and member satisfaction quarterly reports in a Joint Operations Meeting (JOM) to ensure members obtain necessary and appropriate behavioral health services.

L Coordination, Continuity of Care and Transitions

Member care transitions present the greatest opportunity to improve quality of care and decrease safety risks by ensuring coordination and continuity of health care as members transfer between different locations or different levels of care within the same location.
The Alliance Health Plan Health Care Services Department focuses on interventions that support planned and unplanned transitions and promote chronic disease self-management. Primary goals of the department are to reduce unplanned transitions, prevent avoidable

transitions and maintain members in the least restrictive setting possible.

Comprehensive case management services are available to each member. It is the PCP's responsibility to act as the primary case manager to all assigned members. Members have access to these services regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability. All services are provided in a culturally and linguistically appropriate manner.

Members who may need or are receiving services from out-of-network providers are identified. Procedures ensure these members receive medically necessary coordinated services and joint case management, if indicated. Written policies and procedures direct the coordination of care for the following:

- Services for Children with Special Health Care Needs (CSHCN).
- California Children's Service (CCS) eligible children are identified and referred to the local CCS program.
- Overall coordination and case management for members who obtain Child Health and Disability Prevention Program (CHDP) services through local school districts or sites.
- Early Start eligible children are identified and referred to the local program.
- Members with developmental difficulties are referred to the Regional Center of the East Bay for evaluation and access to developmental services.

All new Medi-Cal members are expected to receive an Initial Health Assessment (IHA) within 120 days of their enrollment with the plan. The IHA includes an age-appropriate health education and behavioral assessment (IHEBA). Members are informed of the importance of scheduling and receiving an IHA from their PCP. The Provider Manual informs the PCP about the IHA, the HRA, and recommended forms. All new Medi-Cal members also receive a Health Information Form\Member Information Tool (HIF\MET) in the New Member Packet upon enrollment. The Alliance ensures coordination of care with primary care for all members who return the form with a condition that requires follow up within 90 days.

The Alliance coordinates with PCPs to encourage members to schedule their IHA appointment. The medical record audit of the site review process is used to monitor whether baseline assessments and evaluations are sufficient to identify CCS eligible conditions, and if medically necessary follow-up services and referrals are documented in the member's medical record.

M **Complex Case Management Program**

All Alliance members are potentially eligible for participation in the complex case management program. The purpose of the complex case management program is to provide the case management process and structure to a member who has complex health issues and medical conditions. The components of the Alliance complex case management program encompass: member identification and selection; member assessment; care plan

development, implementation and management; evaluation of the member care plan; and closure of the case. Program structure is designed to promote quality case management, client satisfaction and cost efficiency through the use of collaborative communication, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

The objectives of the complex case management program are concrete measures that assess effectiveness and progress toward the overall program goal of making high quality health care services accessible and affordable to Alliance membership. The Chief Medical Officer, Director of Health Care Services, and Manager of Case and Disease Management develop and monitor the objectives. The HCQC reviews and assesses program performance against objectives during the annual program evaluation, and if appropriate, provides recommendations for improvement activities or changes to objectives. The objectives of the program include:

- Preventing and reducing hospital and facility readmissions as measured by admission and readmission rates.
- Preventing and reducing emergency room visits as measured by emergency room visit rates.
- Achieving and maintaining member's high levels of satisfaction with case management services as measured by member satisfaction rates.
- Improving functional health status of complex case management members as measured by member self-reports of health condition.

The complex case management program is a supportive and dynamic resource that the Alliance uses to achieve these objectives as well as respond to the needs and standards of consumers, the healthcare provider community, regulatory and accrediting organizations.

The Alliance annually measures the effectiveness of its complex case management program based on the following measures (detailed information can be found in the Comprehensive Case Management Program Description):

1. Satisfaction with case management services - members are mailed a survey after case closure and are asked to rate experiences and various aspects of the program's service.
2. All-cause admission rates - the Alliance measures admission rates for all causes within six months of being enrolled in complex case management.
3. Emergency room visit rate - the Alliance measures emergency room visit rates among members enrolled in complex case management.
4. Health status rate - the Alliance measures the percentage of members who received complex case management services and responded that their health status improved as a result of complex case management services.
5. Use of appropriate health care services - The Alliance measures enrolled members'

office visit activity, to ensure members seek ongoing clinical care within the Alliance network.

The Chief Medical Officer and the Director of Health Care Services collaboratively conduct an annual evaluation of the Alliance complex case management program. This includes an analysis of performance measures, an evaluation of member satisfaction, a review of policies and program description, analysis of population characteristics and an evaluation of the resources to meet the needs of the population. The results of the annual program evaluation are reported to the HCQC for review and feedback. The HCQC makes recommendations for improvement and interventions to improve program performance, as appropriate. The Director of Clinical Services is responsible for implementing the interventions under the oversight of the Chief Medical Officer.

N. **Disease Management Program**

All Alliance members are eligible for participation in the disease management program. The purpose of the disease management program is to provide disease management services to children who have chronic asthma or adults with diabetes and promote healthy outcomes. This is accomplished through the provision of interventions based on member acuity level. The intervention activities range from case management to those members at high risk to making educational materials available to those members who may have gaps in care. The components of the Alliance disease management program encompass: member identification and risk stratification; provision of case management services; chronic condition monitoring; identification of gaps in care; and education and reminders. Program structure is designed to promote quality condition management, client satisfaction and cost efficiency through the use of collaborative communications, evidence-based clinical guidelines and protocols, patient - centered care plans, and targeted goals and outcomes.

The objectives of the disease management program are concrete measures that assess effectiveness and progress toward the overall program goals of meeting the health care needs of members and actively supporting members and practitioners to manage chronic asthma and diabetes. The Chief Medical Officer and the Director Clinical Services develop and monitor the objectives. The HCQC reviews and assesses program performance against objectives during the annual program evaluation, and if appropriate, provides recommendations for improvement activities or changes to objectives. The objectives of the disease management program include:

- Preventing and reducing hospital and facility readmissions as measured by admission and readmission rates.
- Preventing and reducing emergency room visits as measured by emergency room visit rates.
- Achieving and maintaining member's high levels of satisfaction with disease management services as measured by member satisfaction rates.
- Reducing gaps in care as measured by HEDIS clinical effectiveness measures specific

to the management of asthma and diabetes.

F. SENIORS AND PERSONS WITH DISABILITY (SPD)

The Alliance categories all new SPD members as high risk. High risk members are contacted for a HRA within 45 calendar days and low risk members are contacted within 105 calendar days from their date of enrollment. Existing SPD members receive an annual HRA on their anniversary date. The objectives of a HRA are to assess the health status, estimate health risk, and address members' needs relating to medical, specialty, pharmacy, and community resources. Alliance staff uses the responses to the HRAs, along with any relevant clinical information, to generate care plans with interventions to decrease health risks and improve care management.

DHCS has established performance measures to evaluate the quality of care delivered to the SPD population using HEDIS measures and a hospital readmissions measure.

G. PROVIDER COMMUNICATION

The Alliance contracts with its providers to foster open communication and cooperation with QI activities. Contract language specifically addresses:

- Provider cooperation with QI activities.
- Plan access to provider medical records to the extent permitted by state and federal law.
- Provider maintenance of medical record confidentiality.
- Open provider-patient communication about treatment alternatives for medically necessary and appropriate care.

Provider involvement in the QI program occurs through membership in standing and ad-hoc committees, and attendance at BOG and HCQC meetings. Providers and members may request copies of the QI program description, work plan, and annual evaluation. Provider participation is essential to the success of QI studies including HEDIS and those that focus on improving aspects of member care. Additionally, provider feedback on surveys and questionnaires is encouraged as a means of continuously improving the QI program.

Providers have an opportunity to review the findings of the QI program through a variety of mechanisms. The HCQC reports findings from QI activities to the BOG, at least quarterly. Findings include aggregate results, comparisons to benchmarks, deviation from threshold, drill-down results for provider group or type, race/ethnicity and language, and other demographic or clinical factors. Findings are distributed directly to the provider when data is provider-specific. Findings are included in an annual evaluation of the QI Program and made available to providers and members upon request. The Provider Bulletin contains a calendar of future BOG and standing committee dates and times.

H. EVALUATION OF QUALITY IMPROVEMENT PROGRAM

The HCQC reviews a written evaluation of the overall effectiveness of the QI program on an annual basis. The evaluation includes, at a minimum:

- Changes in staffing, reorganization, structure, or scope of the program during the year.
- Allocation of resources to support the program.
- Comparison of results with goals and targets.
- Tracking and trending of key indicators.
- Description of completed and ongoing QI activities.
- Analysis of the overall effectiveness of the program, including assessment of barriers or opportunities.
- Recommendations for goals, targets, activities, or priorities in subsequent QI Work Plan.

The review and revision of the program may be conducted more frequently as deemed appropriate by the HCQC, CMO, CEO, or BOG. The HCQC's recommendations for revision are incorporated into the QI Program Description, as appropriate, which is reviewed by the BOG and submitted to DHCS on an annual basis.

I. ANNUAL QI WORK PLAN (Separate Document)

A QI Work Plan is received and approved annually by the HCQC. The work plan describes the QI goals and objectives, planned projects, and activities for the year, including continued follow-up on previously identified quality issues, and a mechanism for adding new activities to the plan as needed. The work plan delineates the responsible party and the time frame in which planned activities will be implemented.

The work plan is included as a separate document and addresses the following:

- Quality of clinical care
- Quality of service
- Safety of clinical care
- Members' experience
- Yearly planned activities and objectives
- Time frame within which each activity is to be achieved
- The staff member responsible for each activity
- Monitoring previously identified issues
- Evaluation of the QI program

Progress on completion of activities in the QI work plan is reported to the HCQC quarterly. A summary of this progress will be reported by the CMO to the BOG.

J. QI DOCUMENTS

In addition to this program description, the annual evaluation and work plan, the other additional documents important in communicating QI policies and procedures include:

- "Provider Manual" provides an overview of operational aspects of the relationship between the Alliance, providers, and members. Information about the Alliance's QI Program is included in the provider manual. It is distributed to all contracted provider sites.
- "Provider Bulletin" is a newsletter distributed to all contracted provider sites on topics of relevance to the provider community, and can include QI policies, procedures and activities.
- "Alliance Alert" is the member newsletter that also serves as a vehicle to inform members of QI policies and activities.

These documents, or summaries of the documents, are available upon request to providers, members, and community partners. In addition, the QI program information is available on the Alliance website.

K. CONFIDENTIALITY AND CONFLICT OF INTEREST

All employees, contracted providers, delegated medical groups and sub-contractors of the Alliance maintain the confidentiality of personally identifiable health information, medical records, peer review, internal and external, and internal electronic transmissions and quality improvement records. They will ensure that these records and information are not improperly disclosed, lost, altered, tampered with, destroyed, or misused in any manner. All information used in QI activities is maintained as confidential in compliance with applicable federal and state laws and regulations.

Access to member or provider-specific peer review and other QI information is restricted to individuals and/or committees responsible for these activities. Outside parties asking for information about QI activities must submit a written request to the CMO. Release of all information will be in accordance with state and federal laws.

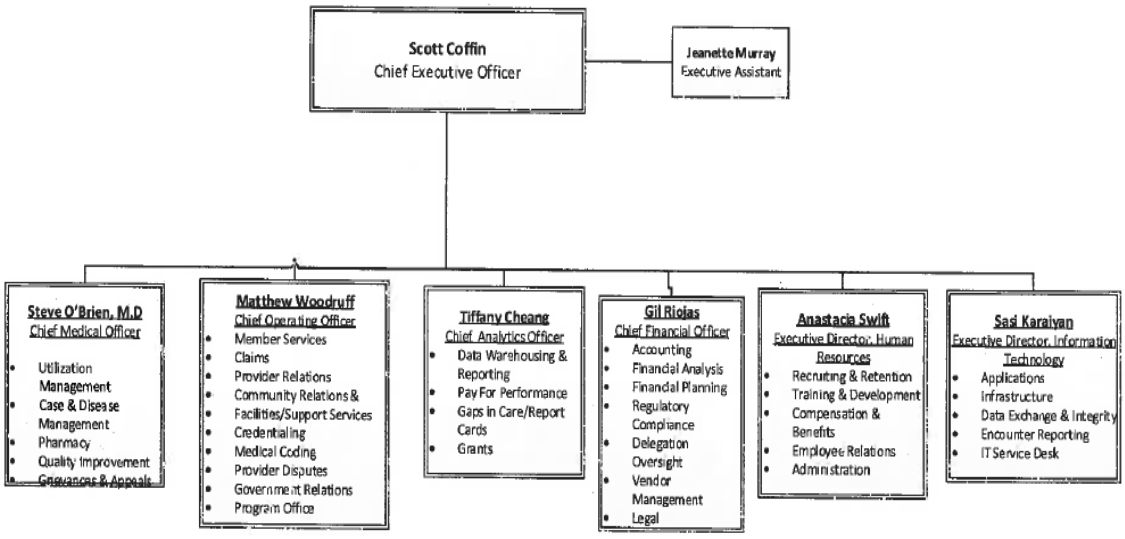
All providers participating in the HCQC or any of its subcommittees, or other QI program activities involving review of member or provider records, will be required to sign and annually renew confidentiality and conflict of interest agreements. Guests or additional Alliance staff attending HCQC meetings will sign a confidentiality agreement.

Committee members may not participate in the review of any case in which they have a direct professional, financial, or personal interest. It is each committee member's obligation to declare actual or potential conflicts of interest.

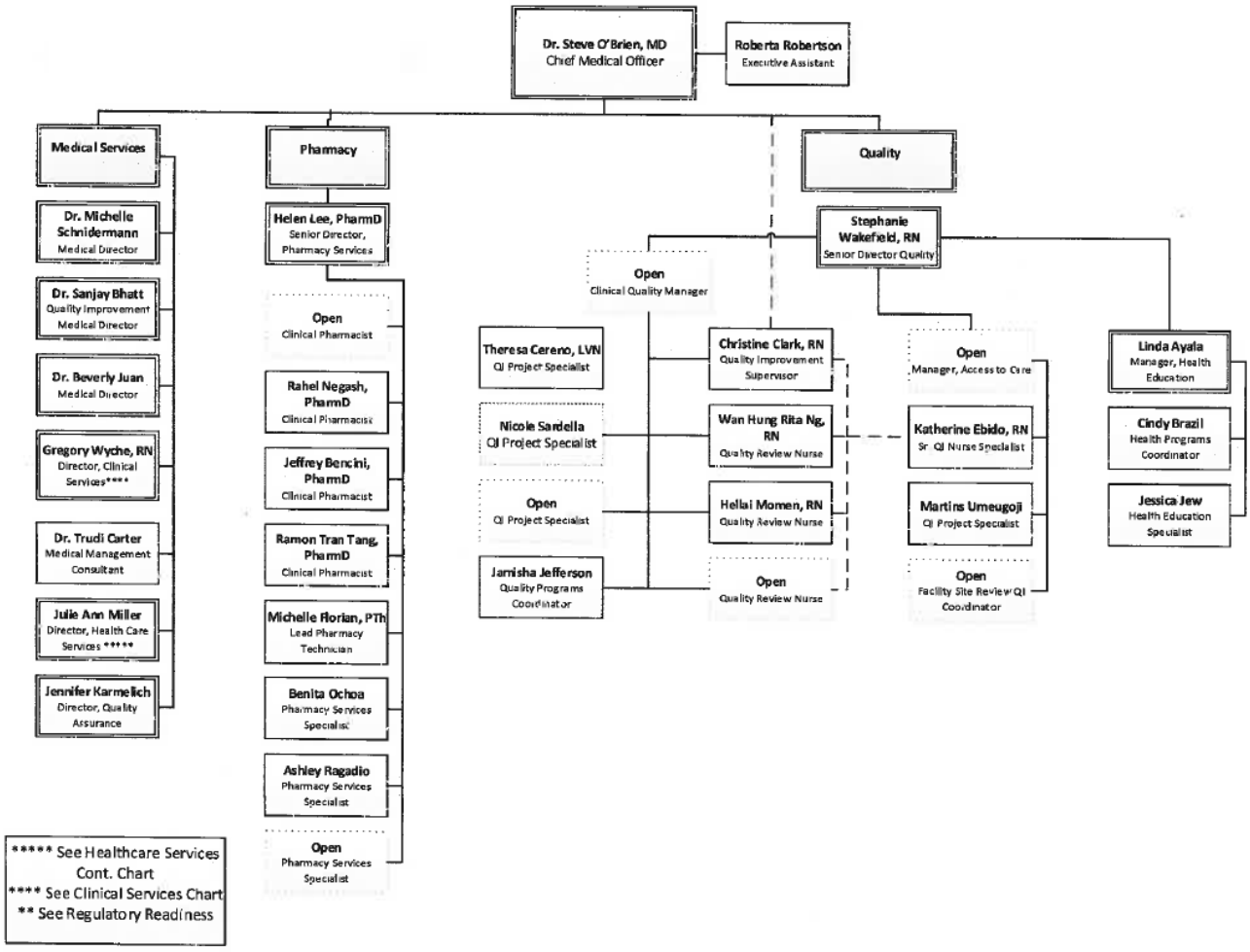
All QI meeting materials and minutes are marked with the statement "Confidential". Copies of QI meeting documents and other QI data are maintained separately and secured to ensure strict confidentiality.

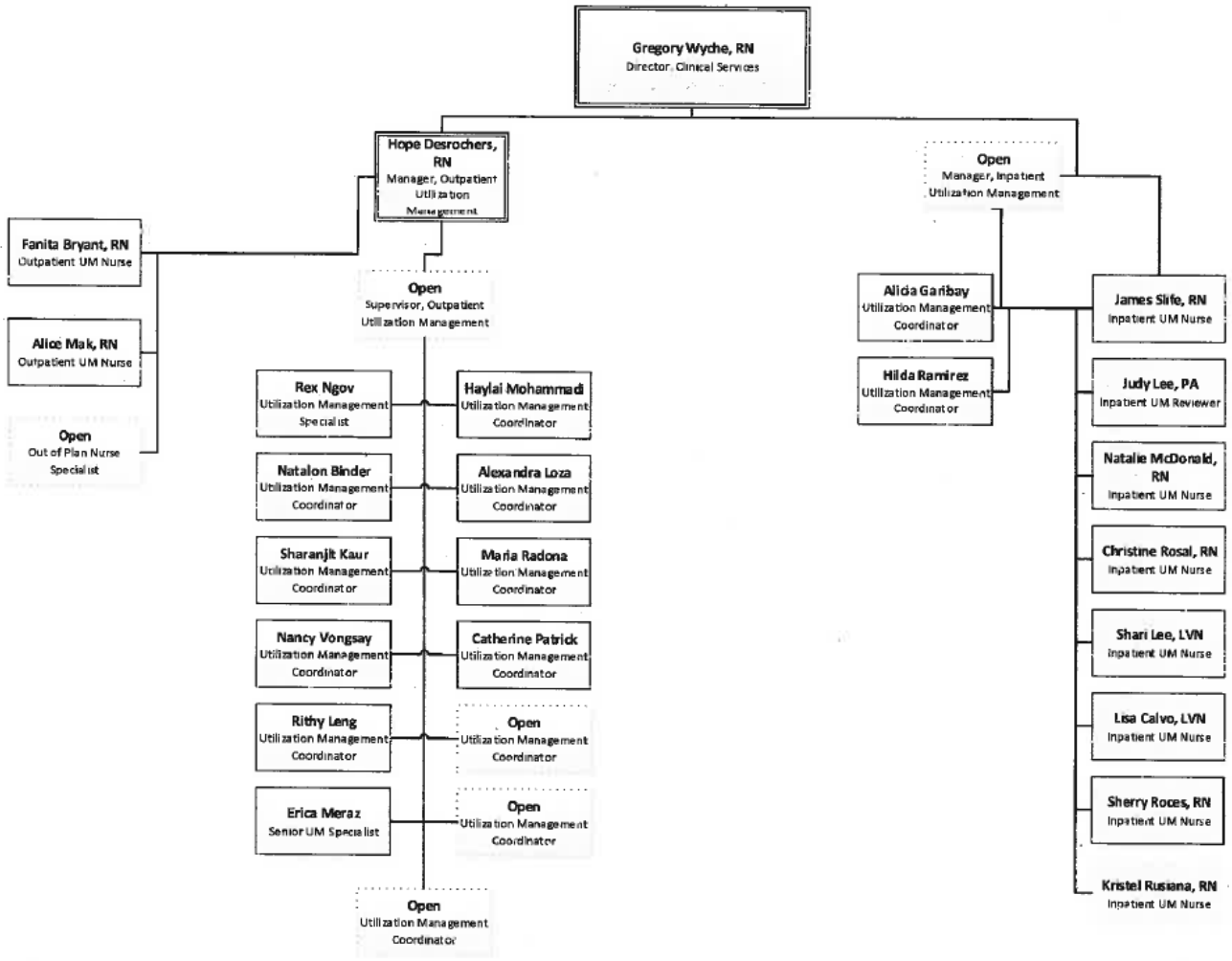
Organizational charts are as follows: Appendix A

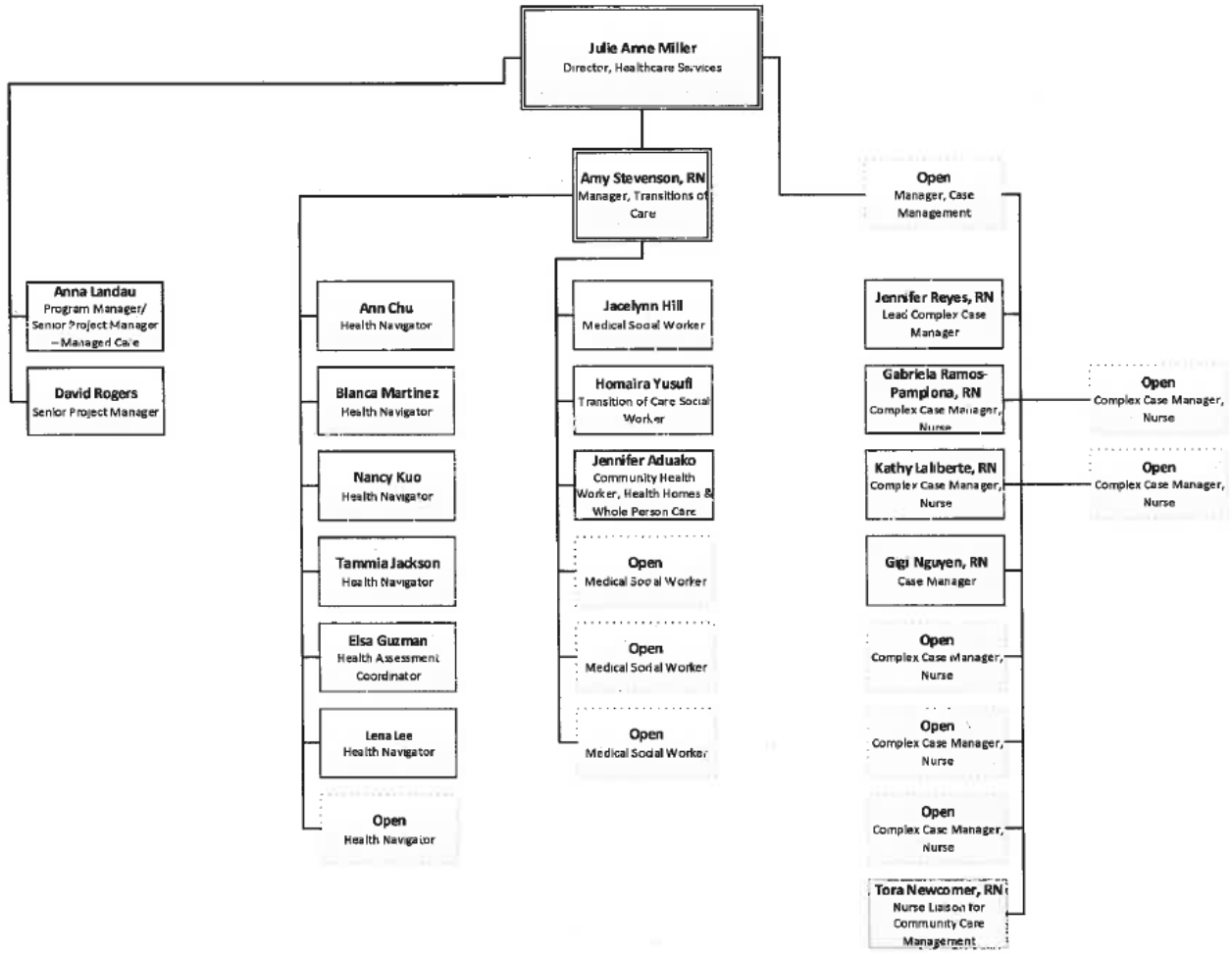
- **Senior Management –**



- **Health Care Services –**




Gregory Wyche, RN
Director, Clinical Services
Hope Desrochers, RN
Manager, Outpatient Utilization Management
Open
Manager, Inpatient Utilization Management
Fanita Bryant, RN
Outpatient UM Nurse
Alice Mak, RN
Outpatient UM Nurse
Open
Out of Plan Nurse Specialist
Open
Supervisor, Outpatient Utilization Management
Rex Ngov
Utilization Management Specialist
Haylai Mohammadi
Utilization Management Coordinator
Natalon Binder
Utilization Management Coordinator
Alexandra Loza
Utilization Management Coordinator
Sharanjit Kaur
Utilization Management Coordinator
Maria Radona
Utilization Management Coordinator
Nancy Vongsay
Utilization Management Coordinator
Catherine Patrick
Utilization Management Coordinator
Rithy Leng
Utilization Management Coordinator
Open
Utilization Management Coordinator
Erica Meraz
Senior UM Specialist
Open
Utilization Management Coordinator
Open
Utilization Management Coordinator
Alicia Garibay
Utilization Management Coordinator
Hilda Ramirez
Utilization Management Coordinator
James Slife, RN
Inpatient UM Nurse
Judy Lee, PA
Inpatient UM Reviewer
Natalie McDonald, RN
Inpatient UM Nurse
Christine Rosal, RN
Inpatient UM Nurse
Shari Lee, LVN
Inpatient UM Nurse
Lisa Calvo, LVN
Inpatient UM Nurse
Sherry Roces, RN
Inpatient UM Nurse
Kristel Rusiana, RN
Inpatient UM Nurse


Julie Anne Miller
Director, Healthcare Services
Amy Stevenson, RN
Manager, Transitions of Care
Open
Manager, Case Management
Anna Landau
Program Manager/ Senior Project Manager – Managed Care
David Rogers
Senior Project Manager
Ann Chu
Health Navigator
Blanca Martinez
Health Navigator
Nancy Kuo
Health Navigator
Tammia Jackson
Health Navigator
Elsa Guzman
Health Assessment Coordinator
Lena Lee
Health Navigator
Open
Health Navigator
Jacelynn Hill
Medical Social Worker
Homaira Yusufi
Transition of Care Social Worker
Jennifer Aduako
Community Health Worker, Health Homes & Whole Person Care
Open
Medical Social Worker
Open
Medical Social Worker
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Medical Social Worker
Jennifer Reyes, RN
Lead Complex Case Manager
Gabriela Ramos-Pamplona, RN
Complex Case Manager, Nurse
Kathy Laliberte, RN
Complex Case Manager, Nurse
Gigi Nguyen, RN
Case Manager
Open
Complex Case Manager, Nurse
Open
Complex Case Manager, Nurse
Open
Complex Case Manager, Nurse
Tora Newcomer, RN
Nurse Liaison for Community Care Management
Open
Complex Case Manager, Nurse
Open
Complex Case Manager, Nurse

APPENDIX B:

ALAMEDA ALLIANCE COMMITTEES

COMMITTEE	ROLE	REPRESENTATION	MEETING FREQUENCY
Health Care Quality Committee (HCQC) *Reports* to *Alliance Board* of *Governors*	• Oversight of QM Program • Oversight of UM Program (including Complex Case Management and Disease Management programs) • Oversight of delegate management • Oversight of regulatory and accreditation compliance • Oversight of review and adoption of clinical practice guidelines and medical necessity criteria • Review and approval of QI and UM policies and procedures, program descriptions, work plans, and evaluations	• Chief Medical Officer (Chair) • Chief Executive Officer • QI Medical Director • UM Medical Director • CM Medical Director • QI Director • Medical Director or physician designee from CFMG • Medical Director or physician designee from Kaiser • Medical Director or physician designee from CHCN • Physician from Alameda County Medical Center • Representative from	Quarterly, additionally as needed

Peer Review Credentialing Committee (PRC) *Reports* to *Alliance Board* of *Governors*	• Oversight of credentialing process and decisions • Management of credentialing performance and analytics • Oversight of delegated entity credentialing	• Chief Medical Officer (Chair) • QI Medical Director (Vice Chair) • Medical Director or physician designee from Children First Medical Group • Medical Director or physician designee from CHCN • Medical Director or physician designee from Alameda County Medical Center • Alliance participating physician (2 positions)	Monthly, up to ten times each year.
Pharmacy & Therapeutics Committee (P&T) *Reports* to *Alliance Board* of *Governors*	• Development and revision of pharmaceutical policies and processes (including formulary review/updates) • Review, revision and approval of pharmacy review criteria	• Chief Medical Officer (Co-Chair) • Director Pharmacy Services (Co-Chair) • Physician representing Family Practice or Internal Medicine • Physician representing Pediatrics • Physician	Quarterly

Appendix C:

QUALITY IMPROVEMENT PROJECTS

1. HEDIS Measure CDC: Improve the rate of HbA1c Testing in African American Men.

Each Performance Improvement Project (PIP) cycle, DHCS requires one PIP to be centered on addressing a health disparity. 2016 Census data estimates that approximately 11% of Alameda County population identifies as African American whereas Alameda Alliance data revealed that 22% of our diabetic members are African American, which represents a greater disease burden. For reporting year 2017 (2016 calendar year), Alameda Alliance HbA1c testing rate for African American men of 73.12% was below the total plan rate of 85.89%, Additional communication with provider partners across the network revealed that Alameda Health System was making HbA1c Poor Control (>9.0%) a focus for 2018. Through this partnership, a goal was developed to increase the rate of HbA1c testing among African American men from 73.12% to 79%. The intervention focused on providing point-of-care testing at Highland Outpatient, one of the largest providers of care in the AAH network. During 2018, Alameda Alliance met with Highland clinical staff six times to develop, plan and implement the intervention. Highland began using point-of-care testing in a pilot phase in December 2018. This project will run through June 30, 2019.

2. HEDIS Measure CAP: Increase the Alameda Alliance overall rate of Children and Adolescent Access to Primary Care

Physicians for ages 12-19 (CAP4). Using MY 2017 data, Alameda Alliance CAP4 rate was 85.47%, which fell under the Minimum Performance Level (MPL) of 85.73%. Additional analysis showed that Tri-City clinics, which include Liberty, Mowry 1 and Mowry 2, had a CAP4 rate of 81.12%, significantly lower than the Alameda Alliance overall rate and well below the MPL. Conversations with Tri-City clinical staff and a thorough literature revealed monetary incentives to be an effective intervention with this age group. Alameda Alliance met with providers and support staff from Tri-City seven times in 2018 to discuss intervention strategies, plan and implementation. Tri-City staff committed to calling all members who were non-compliant with this measure three times and then send them a follow up text if they were not reached by phone. Alameda Alliance committed to sending these members a mailed letter and providing a $25 gift card to all members who completed a compliant visit during the pilot. Tri-City began outreach phone calls in December 2018. The goal is to increase the rate of primary care visits for 12-19 year olds assigned to Tri-City clinics from 81.12% to 86%. This project will run through June 30, 2019, at which time data collection and analysis will be finalized in order to determine if the intervention should be abandoned or adopted for a larger group of members.

3. HEDIS Measure MPM: Managing members on persistent medications.

Screening rates for members on persistent medications were below the minimum performance level three years in a row. The rates of screening for members on the following medications: angiotensin converting enzyme (ACE) inhibiters or angiotensin receptor blockers (ARB) and diuretics (DIU) were ACE/ARB= 83.12% in RY 2015,84.27% in RY 2016 and 86.06% in RY 2017 and DIU= 81.67% in RY 2015,83.22% in RY

2016 and 85.14% in RY 2017. Due to consistently falling below the Minimum Performance Level for this measure, DHCS requested that Alameda Alliance participate in a pilot to rapidly improve the rates for this measure using a SWOT methodology: Strengths, Weaknesses, Opportunities and Threats. Alameda Alliance completed a data analysis of delegate performance and reached out to clinics with low performance. Leadership at Tiburcio Vasquez clinics in the Community Health Center Network (CHCN) expressed an interested in partnering on improving this measure. Tiburcio Vasquez clinics had 556 eligible members and a compliance rate of 85.9% for ACE/ARB and 88.9% for diuretics. The interventions developed included texting members to alert them that they were due for a lab and needed to see their provider as well as a 'soft stop' put on members' pharmacy refills to encourage pharmacists to counsel members to get their labs. Alameda Alliance allocated $25 to pharmacies for each member that successfully completed their lab within the measurement period, which is scheduled to run through June 30, 2019. Text messaging was completed through Tiburcio Vasquez using their text messaging application and began in December 2018. Text messaging in December prioritized members who had not seen their provider in over a year and had multiple gaps in care in addition to missing their MPM lab. This intervention will continue and the soft stop will be put in place in 2019 at which time data analysis of results can be completed to determine the efficacy of the interventions.

4. HEDIS Measure None: Increasing rates of Tdap vaccines in pregnant women in the third trimester

In 2018, over 300 cases of pertussis were identified in Alameda County, five of which were infants younger than 4 months old. Immunizing pregnant women with the Tdap vaccine between 27-36 weeks gestation is the most effective practice to protect infants from pertussis. The Alliance and the Immunization Division of Alameda County's Public Health Department (ACPHD) have partnered to implement a Quality Improvement Project to improve rates of prenatal Tdap vaccination. The Alliance completed a baseline data analysis of claims submitted for deliveries between 5/1/2017 to 4/30/2018 and claims data for any Tdap received within 10 months prior to delivery. As a result, 19 PCP's were identified with 30 deliveries or more and Tdap vaccination rates of 80% or lower. Among these providers thus far, Ob/Gyn leadership at Lifelong Medical Care and Alameda Health Systems have expressed interest with improving their rates. ACPHD will be presenting best Tdap practices to these sites at upcoming staff meetings between March and June 2019. Next steps include: continued provider outreach and Tdap training by ACPHD, and a repeat data analysis In October 2019 and January 2020 by the Alliance.

5. Improving Initial Health Assessment (IHA) Rates

The past 1 year of IHA rates is outlined below.

Q3, 2017	**Q4, 2017**	**Q1, 2018**	**Q2, 2018**
Denominator: 15489 Numerator: 4110 Rate: 27% Goal Met: N Gap to goal: 7% points	Denominator: 13358 Numerator: 3228 Rate: 24% Goal Met: N Gap to goal: 6% points	Denominator:13841 Numerator: 3186 Rate: 23% Goal Met: N Gap to goal: 7% points	Denominator: 14477 Numerator: 2925 Rate: 20% Goal Met: N Gap to goal: 10% points

On average, an IHA is completed for 24% of new members (7/1/17 – 6/30/18); the table below identifies IHA completion rates by network.

Network	New Enrollees	With IHA Completed	IHA Compliant Rate
AHS	17,033	2,819	**17%**
ALLIANCE Excl. AHS	9,821	2,830	**29%**
CFMG	8,182	1,944	**24%**
CHCN	16,208	4,641	**29%**
KAISER	5,921	1,215	**21%**
ALL NETWORK	**57,165**	**13,449**	**24%**

In an effort to improve IHA compliance rates, the Alliance is working to:

- Ensure member education – through mailings and member orientation
- Improve provider education – through faxes, the PR team, provider handbook, and P4P program
- Improve data sharing – by sharing gaps in care lists with our delegates and providers
- Incentivize IHA completion rates – by including IHA completion rates as an incentivized program
- Update claims codes – to ensure proper capture of IHA completion
- Monitor records to ensure compliance with all components of the IHA

Given the 6 month claims lag, data will be reviewed and analyzed in Q3 – Q4 of 2019. This intervention will continue and through 2019 at which time data analysis of results can be completed to determine the efficacy of the interventions.

6. Substance Abuse Disorder –

Alongside the pharmacy team, the QI team is in the process of implementation of a 3-prong approach to addressing members with Substance Abuse Disorder along the continuum of care. The 3 Prong approach focuses on:

1. Prevention – includes Provider Education, Community Outreach, Pharmacy Safeguards
   a. Provider Education has / will continue to have a focus on an Introduction Letter specifically addressing Best Practices, encouraging X-Waivers, assisting providers to understand their local network, and upcoming pharmacy UM Limits. Additionally, education will focus on regular provider outlier report that identifies changes in prescribing habits and outliers to under and over-prescribing. Additionally, evidence based use of opioids will be promoted through the planned 2019 Pay-For-Performance Program. This program was finalized in 2018.
   b. Community Outreach with local partnerships (including Emergency Departments, Hospital Leadership, Medical Organizations, Department of Public Health, and County Leadership
   c. Pharmacy Safeguards which includes removing the prior authorization (PA) for most non-opioid pain medications (see below table), removing commonly over-used / abused drugs

from the formulary, implementing a pharmacist review of all long-acting opioid PAs to ensure that treatment diagnosis are consistent with CDC guidelines (and does not include chronic lower back pain, migraines, neuropathic pain, osteoarthritis). Pharmacists also ensure the co-prescription of naloxone. Finally, formulary limits were implemented in a step-wise approach; this will continue into 2019.

Below is a table that exhibits AAH step-wise approach to ensure the safe and effective use of opioids.

Substance Abuse Program	2017	Dec, 2017	June, 2018	Dec, 2018	June, 2019
"New Start" SAO Limit	None	None	None	14 days	14 days
SAO QL per month	#180	#180/30d	#180/30d	**#90/30d**	**#60/30d**
PA for all LAOs	No	**Yes**	Yes	Yes	Yes
LAO increase limit	No	**Yes**	Yes	Yes	Yes
Cover Alprazolam	Yes	**No**	No	No	No
Cover Carisoprodol	Yes	**No**	No	No	No
Lorazepam Limits	No	**3/day**	3/day	3/day	3/day
Clonazepam Limits	No	**3/day**	3/day	3/day	3/day
Oxazepam Limits	No	No	**1/day**	1/day	1/day

Key achievements of goals include (see above table):

- Removal of PA for most NSAIDs and neuropathic agents (see below table)
- SAO (Short acting opioids) have a 14 day limit on their initial start.
- SAO have / will continue to have step-wise quantity restriction limits.
- All long acting opioids (LAO) require a prior authorization (PA).
- Concurrent prescription of benzodiazepines and opioids require a PA and the prescription of naloxone.
- LAO require the concurrent prescription of naloxone.
- Monitoring of Member Grievances

Class	Drug	Limit	Notes
NSAIDs	Ibuprofen		No restrictions.
	Naproxen		
	Nabumetone		
	Diclofenac		
	Indomethacin		
	Sulindac		
	Meloxicam		
	Etodolac		
	Celecoxib (Celebrex)	QL	Limited to 60 capsules per 30 days
	Diclofenac Gel (Voltaren)	QL	Limited to 200g (two boxes) per 30 days
	Diclofenac soln. (Pennsaid)	PA	Reserved for trial and failure of Voltaren Gel.
Neuropathic Agents	Gabapentin		
	Amitriptyline, Nortriptyline		
	Venlafaxine IR / XR		
	Duloxetine (Cymbalta)		
	Milnacipran (Savella)	NF	
	Pregabalin (Lyrica)	PA	Reserved for treatment failure of gabapentin at dose larger than 1800mg/day for at 2 months and two other neuropathic pain medications
Other	Lidocaine (Lidoderm) 5% patches	PA	Reserved for treatment failure of gabapentin at dose larger than 1800mg/day for at 2 months and two other neuropathic pain medications

2. Intervention and Treatment – Includes Member Education, Access to MAT and Adjunctive Therapies
3. Recovery Support – Includes Integrated Care and Complex / Care Management – Limited given limited Case Management Staff; see 2018 UM/CM Evaluation

This intervention will continue and through 2019 at which time data analysis of results can be completed to determine the efficacy of the interventions.

2019 Quality Improvement Work Plan
Signature Page

Date _____

Sanjay Bhatt, M.D.
Medical Director, Quality Improvement
Vice Chair, Health Care Quality Committee

Date _____

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

Date _____

Scott Coffin
Chief Executive Officer

Date _____

Evan Seevak, M.D.
Board Chair

Quality Improvement Initiatives

Q1 2019 - Workplan

Business Lead	Project Manager	Topic	Goal	Timeframe for Completion	Q2, 2018	Q3, 2018	Q4, 2018	Ongoing, Q1, 2019	Summary	Subcommittee		
QI Director / QI Medical Director	Clinical Quality Manager	**HEDIS Rates**	Increase the HEDIS AQFS rate by 2%	January 2020	No data available	Quality Analytics in collaboration with Quality Department assessed which HEDIS measures to focus on for improvement efforts. Seventeen (17) measures were identified as possible areas for internvetion. Decision on final measures to target will be made in October.	QI Interventions will coincide with P4P measures which will soon be released	Working closely with the quality analytics team, the QI Team will focus on P4P Incentivized measures; these measures include: - HEDIS: CIS, CAP, WCC, AMR, CCS, CDC, CBP, MPM - Other: Opioid Education, IHA, ED Visits / 1000, Pharmacy Generics Utilization	The HEDIS season runs throughout the year; in Q1/Q2, the emphasis is on record retrieval / abstraction / overreads. The entire year focuses on QI initiative and projects that will impact future years rates and positively and clinically impact members.	Internal Quality Improvement Committee		
QI Director / QI Medical Director	Clinical Quality Manager	**QIP #1: Monitoring Members on Persistent Medications PIP**	Improve rate of annual lab testing for members on persistent medication, as defined by HEDIS, assigned to Tiburcio Vasquez clinics Hayward and Union City from 84.19% to 87.85%	December 2019	Quality Improvement team developed a two prong approach of outreach through text messaging and alerts at the pharmacy level to target members and provide education around the need for annual testing.	Pharmacy team continues to work with AAH's Pharmacy Benefits Manager in developing code to alert pharmacists that members are due for their annual lab. Tiburcio Vasquez is developing process for texting members in the gap.	Tiburcio Vaquez began the first round of texting, prioritizing members with multiple gaps in care and those who had not been seen by their PCP in the last year. Alliance Communications Department continues to process fax blast message to pharmacists to begin soft stop intervention.	In order to isolate the effects of the pharmacy internvetion, Tiburcio Vasquez will no longer text members re: lab testing. Pharmacy is gathering billing contacts for involved pharmacies in order to finalize reimbursement work flow. Once work flow is finalized, pharmacies will receive education regarding project and soft stop can be implemented.	This project works with members assigned to Tubercio Vasquez and encourages members on diuretics / ACE-I / ARBs to obtain annual blood screening.	Internal Quality Improvement Committee		
QI Director / QI Medical Director	Clinical Quality Manager	**QIP #2: Improve Adolescent Access to Care PIP**	In compliance with 5 module PIP structure, pilot an intervention to increase the rate of primary care visits among 12-19 year olds assigned to Mowry 1, Mowry 2 and Liberty clinics in the CHCN network from 86.1% to 90%.	September 201 9	Several team meetings between AAH and Tri-City resulted in a data collection plan, process map, failure modes and effects analysis (FMEA) and priority ranking. The team identified member motivation as a key barrier to adolescents seeking care.	The Alliance and Tri-City have developed an intervention strategy combining outreach via phone, text and letter and an incentive to members for completed visits. Member facing material and the process for incentive distribution are underway.	Tri-City call center completed two call attempts for target population with gaps in care. Letter to members remains with the state for approval.	Module 4 update submitted and approved by the state detailing implementation of the intervention. Tri-City is reporting monthly and Data Analytics has developed a tool for AAH to validate teen visits. Anticipated approval for outreach letter shortly at which time, all members remaining in the gap will receive targeted mailer.	This is a DHCS Mandated PIP. It will follow the 5 DHCS required modules. This project works with members assigned to Mowry 1, Mowry 2 and Liberty clinics to encourage children to access their pediatricians for care.	Internal Quality Improvement Committee		
QI Director / QI Medical Director	Clinical Quality Manager	**QIP #3: Improve A1C Testing in AAM**	In compliance with 5 module PIP structure, pilot an intervention to increase the rate of African American men with diabetes assigned to Highland Outpatient Clinic receiving HbA1c testing from 65.6% to 79%.	September 201 9	Several team meetings between AAH and AHS resulted in a data collection plan, process map, failure modes and effects analysis (FMEA) and priority ranking. The team identified a large number of members going to PCP visits and getting lab orders but not going through the lab process.	The Alliance has developed an intervention strategy of implementing point-of-care testing at Highland Hosptial that will serve as a pilot of expanding point-of-care testing viability at high volume clinics.	AHS purchased POC machine, completed callibration of the machine, developed a work flow, trained staff and achieved competency by key staff.	AHS has experience staff shortages that have complicated the implementation of POCT. Leadership are evaluating the viability of POCT at this time. AAH is prepared to do telephone outreach in the event that POCT is not possible.	This project targets African American men with DM assigned to Highland Outpatient Clinic to undergo HbA1c testing annually.	Internal Quality Improvement Committee		
QI Director / QI Medical Director	Clinical Quality Manager	**QIP #4: IHA**	To properly capture IHA completion rates, validate IHA completion, and promote IHA education	August 2019	Review IHA Report	Validate IHA Codes and establish IHA next steps; initiate coversation re: IHA and PSP	IHA Audit completed prior to 12/31/18; compliance rate of ~9% (with SHA) and ~91 (without SHA)	IHA Audit Report to HCQC on 1/17; CAP to be mailed to 19 providers before 2/1/19 FSR IHA Report to IQIC 2/27/19; ensure that 32 CAPs that have been sent regarding FSR IHA have been closed	IHAs (consisting of a history, PE, and SHA) are to be completed within 120 days of new membership. Of recent, IHA Codes have been validated, a P&P has been approved, Gap Lists are being shared, and IHA completion is now a P4P measure. In addition IHA monitoring, CAP, and education has been created and is ongoing.	Internal Quality Improvement Committee		
QI Director / QI Medical Director	Clinical Quality Manager	**QIP #5: Tdap Completion Rates**	Working with DPH, improve Tdap immunization rates identified clinics	January 2020	N/A	Establish relationship with Amy Pine and DPH; initial data request and analysis	Underperforming sites were identified and additional conversation to be had with DPH.	Establish target sites with >30 deliveries and tdap rates < 80%; letter from DPH and AAH to be drafted; meeting between HGH, DPH, and AAH	In conjuntion with the DPH, this projects targets pregnant women in their third trimester and aims to improve Tdap vaccination rates; low performing, high volume delivery sites will be identified and targeted for resources and education.	Internal Quality Improvement Committee		
QI Director / QI Medical Director	Clinical Quality Manager	**QIP #6: Opioid / SUD**	Develop an opioid / SUD continuum of care that supports: 1. Prevention 2. Intervention and Treatment 3. Recovery Support	December 2019 / Ongoing	Prior To Quarter: Remove non-opioid PA, Formualry changes, LAO requires pharmacy oversight and PA Present to MAC Committee	Develop Strategy: Prevention: Provider Education, Community Outreach, Pharmacy Safeguards Intervention and Treatment: Member Education, Access to MAT, Access to Adjunctive Therapies Recovery Support: Integrated Care, Care / Case Improvement	Meet with Key parterns including EDs, Hospital Leadership, Med. Orgs., Public Health, County Leadership Step-Wise Approach to pharmacy safeguards approved through P&T; initial step passed Explore how to monitor data, grievances, provider practices, member usage, ED Data	Additional data analysis re: mortality data (from county), bup / narcan carve out data (from state), membership data (from PerformRx) Closely monitor data, grievances, provider practices, member usage, ED Data Continue monthly review of opioid focused cases with pharmacy team HR 6 Opioid Legislation Overview Focused provider outreach and letter Member letters to be drafted	Develop an opioid / SUD continuum of care that supports: 1. Prevention 2. Intervention and Treatment 3. Recovery Support	Internal Quality Improvement Committee		
QI Director / QI Medical Director	Clinical Quality Manager	**HEDIS Retrieval and Overreads**	Alongside the analytics team, provide HEDIS support related to medical record retrieval, abstraction, and overreads.	May 2019	N/A	Initial weekly HEDIS meetings with QI, Analytics, HDVI	Continue weekly HEDIS meetings with QI, Analytics, HDVI	Continue weekely meetings; schedule and participate in medical records retrieval training, abstraction training, overread training, IT training Ongoing record retrieval has begun; AAH staff - including those from QI - have been retrieving records initally from CHCN. Project is on track. Overreads will begin soon after abstraction is completed.	In conjuntion with the analytics team, the QI team provides HEDIS support related to medical record retrieval, abstraction, and overreads. Project and timeline are co-owned.	Internal Quality Improvement Committee		
QI Director / QI Medical Director	Clinical Quality Manager	**Potential Quality Issues (PQIs)**	Review all PQIs for trends and incidence of quality of care (QOC) with appropriate reporting software.	December 2019 / Ongoing	Discussion began on ways to make reporting more efficient by moving from Excel to a database application.	PQI application project accepted. PMO working with QI to address reporting needs for tracking and trending. Several meetings occurred to address user stories and first demo of application occurred.	Ongoing trial of PQI Application; in the meantime, QI staff continue to utilize the excel sheet; Medical Director involvement	Phase 1 of PQI app has begun; as of 2/3, all cases that are entered in the G&A app Bugs have been identified and will be fixed; phase 1 permits data entry. Phases 2 and 3 that permits a more	Potential Quality Issues are suspected deviation from expected provider performance, clinical care or outcome of care which requires further investigation; further investigation can determine whether an actual quality issue exists.	Internal Quality Improvement Committee		
QI Director / QI Medical Director	Access Manager	**Facility Site Review (FSR)**	Develop a strategy to ensure back up staff to complete FSR tasks	December 2019 / Ongoing	Master Trainer retired in June 2018. Backup staff member on medical leave. Reviewed requirements and options available. Plan is to hire Master Trainer ASAP and have QI RNs trained on FSRs for backup needs.	PQI RNs received FSR didactic training August 28-30. Master Trainer hired and started September 4.	A FTE Master Trainer has been hired; work is ongoing for the 2018 and 2019 year. Master Trainer will work closely with recently trained RN to ensure backup.	A FTE Master Trainer has been hired; work is ongoing for the 2018 and 2019 year. Master Trainer will work closely with recently trained RN to ensure backup.	Facility Site Review (FSR), Medical Record Review (MRR) and Physical Accessibility Review (PAR) is mandated for each Health plan by DHCS. Corrective Action Plans are required depending on the site FSR and MRR scores. Site reviews are another way the QI Department ensures safety within the provider office environment.	Internal Quality Improvement Committee		
QI Director / QI Medical Director	QI Director / QI Medical Director	**Pay For Performance (P4P)**	Incentives providers to improve care through P4P measures	January 2020	Given the delayed publication of the 2018 P4P measures, work closely with the analytics team to identify, choose, and publish 2019 P4P measures by Q4, 2018.	Analyze HEDIS metrics Evaluate 2018 P4P measures Work with the Analytics / PR team on the ability to send out gap lists	Finalize HEDIS measures and metrics Work with Analytics, PR and Comunications to finalize printed brochure P4P measures include: - HEDIS: CIS, CAP, WCC, AMR, CCS, CDC, CBP, MPM - Other: Opioid Education, IHA, ED Visits / 1000, Pharmacy Generics Utilization	Distribute P4P measures / brochure to direct providers (via PR) and delegates Work closely with AHS to encourage IHA completion rates Phone conversations with delegates requesting conversation and also directs with question / enquiries	The 2018 P4P measures were finalized and distributed later than desired; in 2019, the P4P measures were chosen earlier with the goal of early distribution. Also, gap lists are distributed. P4P measures include: CIS, CAP, WCC, AMR, CCS, CDC, CBP, MPM and Opioid Education, IHA, ED Visits / 1000, Pharmacy Generics Utilization. Ongoing conversation and assistance with delegates and direct providers to improve rates year over year.	Internal Quality Improvement Committee		
QI Director / QI Medical Director	QI Director / QI Medical Director	**PDSA Cycle**	Ensure that all divisions within HCS utilize the PDSA cycle and the adopted reporting template to evaluate their processes	December 2019 / Ongoing	N/A	Discussion of initial topic at HCS meetings	Introduction of standardized reporting template to the HCS Team that lists out barriers, interventions, and next steps	Work with divisions in the HCS team to properly utilize reporting template	In order to encourage all divisions within HCS to utilize the PDSA cycle, a reporting template that lists out barriers, interventions, and next steps has been developed. This reporting template has been distributed. QI has worked with each division to encourage the use of this template; sub-committees are encourage to assist in completion of the report -- especially that of the next steps.	All Sub-Committees		
QI Director / QI Medical Director	QI Director / QI Medical Director	**Inter-rater Reliability (IRR)**	Ensure the monitor the consistency and accuracy of review criteria applied by all clinical reviewers - physicians and non-physicians - who are responsible for conducting clinical reviews and to act on improvement opportunities identified through this monitoring.	December 2019 / Ongoing	N/A	Initial project development Understand the workflow of each affected department (Pharmacy, UM, QI, and G&A) Ensure that IRR has been completed in 2018	Develop scoring methodology Draft and approve P&P QI 133 (11/2018)	Work with divisions in the HCS team to properly compete an IRR in 2019	The IRR process aims to ensure the monitor the consistency and accuracy of review criteria applied by all clinical reviewers. QI oversees the IRR process, ensures that QI 133 is followed, and provides support in whatever manner the respective division requires.	All Sub-Committees		
QI Director / QI Medical Director	Access Manager	**CG-CAHPS Survey**	To ensure that the CG-CAHPS survey is effective, direct, and actionable while maintain the avaiability of benchmarking metrics.	August, 2019	N/A	N/A	Work with vendor to analyze and understand results Re-evaluate CG-CAHPS questions to ensure that aligns with goals of effective, direct, and actionable questions Discuss survey with cross-functional workgroup	Finalize adult and child questions Ensure that questions align with timely access standard Work with vendor to ensure translation and publication of CG-CAHPS survey The survey will evaluate non-urgent appts (<10 business days), urgent appt availability, in-office wait times (<60 minutes), call return time (<1 day), time to answer call (<10 minutes), and lanugage services	The CG-CAHPS Survey is a valuable tool that will permit the Alliance to closely monitor timely access standards. The survey will be re-evaluated to ensure consisteny with our internal and external timely access requirements. The questionaire will be simplified to obtain actionable and appropriate data.	Access and Availability Subcommittee		
QI Director / QI Medical Director	Access Manager	**Telephone Practices**	Ensure timely access via telephone using annual and quarterly monitoring surveys. Incidents of non-compliance are trended, continued non-compliance is communicated, repeat non-compliance is CAP'd. Goal: less than 3% of telephone calls not returned.	May 2019	Secret shopper calls were initiated. A random selection of 10 PCP, 10 SCP and 10 BHPs were called after hours to determine whether members are able to receive a returned telephone call. The result was 67% complaince. 10/10 Behavioral Health practitioners were unable to provide telephone access compliant with standards.	Secret shopper calls continued. 18/30 providers were able to provide telephone access compliant with standards. The compliance rate was 60%. The calls showed a mixed response. 7/10 PCP, 9/10 SCP, 2/10 BHP met standards.	CG CAHPS Tool is being explored; conversation with vendor (SPH) is ongoing to modfiy the survey to encourage an additional quarterly monitoring tool. Also, secret shopper survey tool will likely be utilized in Q1, 2019.	Adopt standard for office call wait time (to be discussed at HCQC 1/17/19). Subsequently, providers will be notified, provider manual will be updated, and secret shopper survey will be undertaken. Internal Survey to be performed Present internal survey results to A&A committee	Telephone practices are monitored through traige and screening (Advice Nurse Line) and returned phone call times. Telephone access is monitored through secret shopper calls quarterly. Annually, after hours access is monitored through an After Hours Survey. This survey monitors after hours emergency instruction messaging as well as after hours telephone access.	Access and Availability Subcommittee		

QI Director / QI Medical Director	CMDM Manager	**HRA/HIF-MET**	Ensure timely screening of new members to capture members at greater risk for adverse health events. Health Risk Assessment (HRA) is sent to all new Seniors and Persons with Disabilities (SPDs) and annually thereafter. HIF/MET is sent to all new members.	August 2019	HRA: A backlog developed as AAH staff attempted to complete reminder calls and care plan mailings internally. HIF/MET: Mailings and phone calls completed timely.	HRA: Intervention to control the backlog of phone calls and care plan mailings made a priority by leadership. Process to obtain outside vendors began. HIF/MET: Mailings and phone calls completed timely.	HRA: Vendors completed backlog phone calls and care plan mailings to both members and providers. Regular monthly mailing and phone calls began. HIF/MET: Mailings and phone calls completed timely.	Plans for ongoing improvement: 1) Develop internal capability to perform IVR calls; 2) Develop standardized work flow 3) Automate entry of completed forms into TruCare	The volume of HRAs required outside vendors to maitain standards set out in the APL and for turnaround times. Quality improvement opportunities were identified and QI and UM continue to work together to streamline both HRA and HIF/MET processes.	Utilization Management Subcommittee		

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

2019

2018 Case Management/Care Coordination & Disease Management Program

Signature Page

Date _____

Julie Anne Miller, LCSW
Director, Health Care Services

Date _____

Sanjay Bhatt, M.D.
Director, Quality Improvement

Date _____

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

Date _____

Scott Coffin
Chief Executive Officer

Date _____

Evan Seevak, M.D.
Board Chair

Table of Contents

I. Background

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

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

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

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

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

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

II. Purpose and Scope

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

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

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

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

III. Goals and Objectives

A. Goals

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

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

- Develop and implement a program that meets all regulatory compliance and NCQA accreditation standards.

B. Objectives

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

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

IV. Program Oversight and Staff Responsibility

A. Health Care Quality Committee (HCQC)

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

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

The HCQC functional responsibilities for the CM Program include:

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

B. The Utilization Management Committee

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

UM Committee Structure

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

Authority and Responsibility

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

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

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

UM Committee Membership

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

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

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

UMC Voting Privileges

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

UMC Quorum

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

UMC Meetings

The UMC meets at least 8 times a year but as frequently as necessary. The meeting dates are established and published each year.

UMC Minutes

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

UM Committee Functions

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

- Improve quality of care for the Alliance Members
- Evaluate and trend enrollment data for medical and behavioral health services provided to Alliance Members and benchmarks for care management program utilization.
- Provide a feedback mechanism to drive quality improvement efforts.

- Increase cross functional collaboration and provide accountability across all departments in Medical Services.
- Provide mechanism for oversight of delegated CM functions, including review and trend CM reports for delegated entities to identify improvement opportunities

UM Committee responsibilities are to:

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

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

C. Staff Resources

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

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

1. Chief Medical Officer

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

continuously improve the services that the comprehensive management program provides Members and providers.

2. Medical Director

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

3. Director, Health Care Services

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

4. Manager, Case Management and Disease Management

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

5. Manager of Case Management

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

6. Case Manager

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

7. Social Worker

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

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

Under general supervision from the Manager, Case Management, the Medical Social Worker is responsible to meet the day-to-day care coordination needs between the Alliance and contracted Community Based Care Management Entities (CB-CMEs) for the Health Home Pilot and Alameda County's Whole Person Care initiative. The Medical Social Worker is also responsible for coordinating medical, social and or behavioral health care needs with Alliance contracted providers for Members.

8. Health Navigator

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

9. Health Risk Assessment Coordinator

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

10. Nurse Liaison, Community Care Management

Under the guidance of the Manager, Community Linkages, The Nurse Liaison for Community Care Management is the connector between the Alliance and its network of contracted Community Care Management teams. Under supervision from the Manager, Community Care Management, the Nurse Liaison connects to and collaborates with care teams that target high risk Medi-Cal Members with complex needs such as chronic illness and behavioral health conditions leading to acute care utilization, providing an extra layer of support to help them achieve their health goals. Social determinants of health are also identified and prioritized by the teams. The Nurse Liaison is also responsible for coordinating medical, social and or behavioral health care needs for targeted Members identified by the Alliance.

V. Population and Member Needs Assessment

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

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

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

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

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

VI. Case Management Clinical Systems

A. Clinical Information Systems

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

B. Clinical Decision Support Tools

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

VII. Care Coordination and Case Management Services

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

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

Alameda County Care Connect (AC3) – Whole Person Care Pilot

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

A. Health Risk Assessment

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

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

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

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

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

High Risk Members are referred to Complex Case Management team for completion of the HRA, review of the HIF/MET when available, development of a care plan and completion of care coordination. For Members initially identified as Low Risk, a vendor performs the initial outreach to complete the HRA. Vendors submit the outreach report to AAH every month including those HRAs who have scored as Low Risk either by HRA scoring or are initially scored as Low Risk but are Unable to Contact (UTC) and complete the HRA. The responses from the HRA may result in the Members reclassification of Members as higher or lower risk. (For some Members, this re-classification based on the HRA may be different from their earlier classification based on the stratification tool. Members re-classified/scored as High Risk are routed to the CCM team for review and processing. A full description of the MS procedures for HRA is found in MS policies and procedures. The 2018 HRA and LTSS Questionnaire can be found in Appendix F and G.

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

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

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

B. Case Management

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

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

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

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

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

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

1. Basic Case Management Services

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

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

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

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

2. Initial Health Assessment and Behavioral Risk Assessment

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

C. Care Navigation (Case Management/Care Coordination)

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

1. Case Management/Care Coordination

Alliance Case Management staff maintains procedures to assist Members who are unable to secure and coordinate their own care because of functional, cognitive, or behavioral limitations, or the complexity of the community-based services. Members are assigned to a Case Manager or Health Navigator to

assist with short-term assistance with care coordination. Members, during program enrollment, will also be assessed for long-term care needs provided through Complex Case Management and Disease Management.

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

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

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

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

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

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

2. Targeted Case Management Services

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

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

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

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

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

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

- Screening and enrollment
- Comprehensive clinical assessment
- Development and implementation of an Individualized Care Plan ("ICP") also referred to as a "service plan."
- All care coordination activities – including facilitating communication, referrals, treatment/service authorizations, etc.
- Maintenance of comprehensive, written records based upon assessment and care plan.

- Clear documentation of service delivery, provider communications, Member interactions, etc.
- Periodic review of cases
- Case closure and evaluation as appropriate

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

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

D. Special Programs

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

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

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

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

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

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

Providers and Specialists. A full description of the various CoC programs in found in the relevant UM Policies.

2. California Children Services/Age-Out Program

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

- Who have a chronic, disabling, or life-threatening CCS eligible medical condition
- Who need specialty medical care
- Who meet income requirements (See Eligibility, below)
- Age birth to 21

Referred children are screened for eligibility criteria and referred to a specialized contracted CCS provider. As the program is limited to providing services to children under the age of 21 years, The Alliance has developed a program to identify and provide care coordination of services for children on CCS who are nearing 21 years of age and aging out of pediatric health care services. As CCS children age out of the system, staff will assist with the transitions to appropriate adult specialists in a collaborative manner in order to protect the individual and ensure age appropriate care is provided.

At the start of 2019, the program is managed through The Alliance CM Department; by 1st Quarter 2019, the CCS age out program will transition to UM.

E. Complex Case Management

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

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

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

VIII. Case Management Program Description

A. Case Management

1. Identifying Members for Case Management

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

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

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

Referral Sources

Individual Members may be referred by:

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

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

- Predictive modeling, e.g. Care Analyzer

The cases identified through the data sources or referral sources cited above are reviewed by the CM triage nurses, taking into consideration the known information about the case from claims history, medical records that may be on file for UM purposes, and Member services call

history. The triage nurse verifies Member appropriateness for CCM and if determined as appropriate then a CCM case is opened in the care management information system and assigned to a Case Manager. Members are deemed ineligible if the Member is not in the Plan, has died or entered a hospice program, is in a long term care facility or is receiving transplant services through a contracted center of excellence.

2. Case Management Process

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

A. Intake

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

B. Identification of Care Needs

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

C. Communication with Member

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

A. Coordination of Services

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

B. Monitoring of PCP Services

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

C. Identification of Barriers to Care

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

D. Case Closure

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

- Goals met
- Interventions not successful/All resources exhausted
- Loss of eligibility
- Unable to establish or maintain contact with Member
- Member transferred to another setting and no longer require CCM
- Client refuses necessary psychosocial services and/or medical services
- Member declines CM
- Death of the Member
- Member not compliant with plan of care
- Determination by the Case Manager that he/she is no longer able to perform or provide appropriate case management services

B. Targeted Case Management

1. Identifying Members for Targeted Case Management

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

2. Targeted Case Management Process

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

A. Referral

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

B. Documented Assessment

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

C. Development of Comprehensive Service Plan

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

D. Coordination of Services

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

E. Crisis Assistance

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

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

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

G. Identification of Barriers to Care

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

H. Case Closure

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

- Goals met
- Interventions not successful/All resources exhausted
- Loss of eligibility
- Unable to establish or maintain contact with Member
- Member transferred to another setting and no longer require CCM
- Client refuses necessary psychosocial services and/or medical services
- Member declines CM
- Death of the Member
- Member not compliant with plan of care
- Determination by the Case Manager that he/she is no longer able to perform or provide appropriate case management services

IX. Complex Case Management Program Description

A. Identifying Members for Complex Case Management

1. Criteria

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

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

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

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

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

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

2. Data Sources

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

- Claim and pharmacy data (CDPS and MRx) from the data warehouse and analyzed by the Health Care Analysts. Members are identified monthly from this data source
- Hospital discharge report generated by UM staff
- UM data from preauthorization and concurrent review
- Data from purchasers (Medi-Cal and Commercial)
- Information provided to Alliance from Members, caregivers and community based programs that support the Member
- Data from Member Health Risk Assessment
- Data from practitioners (Referral and Medical Records)

3. Referrals to Complex Case Management

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

A. Health Information Line referral

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

b. DM program referral

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

c. Hospital discharge planner referrals

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

d. UM referral

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

e. Member, caregiver and practitioner referrals

The Member Services Department receives calls from Members, caregivers and practitioners and refers them to case management based on either a request by the caller or if the nature of the call indicates that the Member would benefit from the service. At least annually, Members and Providers are informed about their ability to make referrals in the Provider and Member newsletters.

f. Community-based referrals

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

g. Behavioral health referrals

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

4. Date of Eligibility for Complex Case Management

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

B. Complex Case Management Process

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

1. Referral & Screening

When a Member is identified, as described in Section IX.A ("Identifying Members for Complex Case Management") or a referral is received for case management, the CM staff enters the referral into the care management system and verifies Member health plan enrollment and eligibility. After health plan

eligibility is confirmed the staff submits the referral. The Case Manager then screens and determines program eligibility in complex case management or other appropriate programs by performing the initial screening assessment with the oversight of the Associate Medical Director. If the Member does not meet criteria for complex case management, the Member may be referred to the other Alliance program for coordination of care, assistance in managing risk-factors, referral to community services or assistance in identifying a primary care practitioner. Appendix C & D contain the 2018 Case Management Criteria and Screening Checklist to assist clinical teams in consistency in assessment for CCM services.

2. Assessment of Health Status

The Case Manager conducts a Comprehensive Assessment of the Member health, behavioral, functional and psychosocial status specific to identified health conditions and comorbidities. The assessment also includes:

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

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

3. Documentation of Clinical History Including Medications

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

4. Assessment of Activities of Daily Living

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

5. Assessment of Behavioral Health Status Including Cognitive Functions

During the General Assessment and ongoing evaluations as appropriate, the Case Manager evaluates Member mental health status, including psychosocial factors, cognitive functions, and depression. The Case Manager also completes an alcohol and drug use screen as part of the General Assessment. As part of the assessment of cognitive and communication limitations, CM assess the member's ability to

communicate, understand instructions, and their ability to process information about their illness. Referrals are made to behavioral health clinicians for case management Members that meet specified criteria.

6. Assessment of Social Determinants of Health

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

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

7. Assessment of Life-planning Activities

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

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

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

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

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

10. Evaluation of Caregiver Resources and Involvement

The Case Manager evaluates caregiver resources such as family involvement and decision making about the Member's individualized care plan. The Case Manager collects this information in the General

Assessment and uses the information to determine barriers to care and to identify issues to include in the Member Care Plan.

11. Evaluation of Health Plan Benefits and Community Resources

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

12. Development of Individualized Person-Centered Case Management Plan

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

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

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

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

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

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

The Case Manager addresses the Member's beliefs and concerns about their condition and any perceived or real barriers to their treatment such as access, transportation and financial barriers to obtaining treatment. Additionally, cultural, religious and ethnic beliefs are assessed that may impact the

condition being managed. Based on the assessment of these psychosocial issues, interventions may be modified. Examples of such issues include:

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

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

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

15. Development of Schedule for Follow-up and Communication

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

16. Development and Communication of Member Self-management Plan

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

17. Process to Assess Progress

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

18. Case Closure

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

- Goals met
- Interventions not successful/All resources exhausted
- Loss of eligibility
- Unable to establish or maintain contact with Member
- Member transferred to another setting and no longer require CCM
- Client refuses necessary psychosocial services and/or medical services
- Member declines CM
- Death of the Member
- Member not compliant with plan of care
- Determination by the Case Manager that he/she is no longer able to perform or provide appropriate case management services

19 Patient Safety

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

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

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

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

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

in services. All contact attempts and the letter are documented in the case management system. On the same day the letter is mailed, a CM Health Navigator contacts the Member's PCP office to obtain clinical notes to enable The Alliance to develop a Care Plan to put into effect with the PCP and other Members of the care team such as behavioral health specialist or pharmacist.

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

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

21. Initial Assessment

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

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

22. Individualized Care Plan

Following the initial assessment, the Case Manager develops an Individualized Care Plan (ICP), consisting of goals and interventions. The Case Manager incorporates information from the initial assessment, as well as other assessments such as Health Risk Assessments, Pharmacy profile, specialized assessments, such as PHQ-9 or PH-Q2, that may be included in the Initial Assessment, HRA and Health Information Form/Member Evaluation Tool.

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

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

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

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

Case Managers establish care plan goals with the following characteristics:

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

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

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

23. Ongoing Management

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

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

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

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

24. Case Management Integration

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

25. Inter-Disciplinary Care Teams

The ICT is a team of healthcare professionals from various professional and care management disciplines who work together to manage the physical, psychological and social needs of the Members. The ICT is always comprised of the CM Nurse, the PCP and the Member or caregiver. Internal ICTs are held to review care plans and provide guidance to the CM team caring for the Member. For CM, the core ICT is

comprised of the CM Medical Director, Manager of CM and DM, the assigned CM, assigned CM Health Navigator. Ad hoc Members of the team may be invited to attend based on the needs of the Member. This includes pharmacy, social worker or behavioral health specialist. Formal ICTs are held with invitations to the Member/Member Caregiver and PCP/Specialist as needed.

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

X. Community Based Integration

The Alliance has collaborated with Alameda County Health Care Services Agency's Care Connect to implement the Health Home and Whole Person Care pilot requirements. The purpose of the program is to build community infrastructure to improve integration, reduce unnecessary utilization of health services and improve health outcomes. The Whole Person Care infrastructure includes a community health record, human infrastructure and housing navigation and supports. The goal of the collaboration is to ensure targeted Members and providers can access intensive, community-based care management services by Community Based Care Management Entities (CB-CME's) from anywhere in the care continuum, providing the "right care-right place-right time". The program outcomes focus of providing services that will:

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

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

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

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

The Alliance has dedicated clinical and non-clinical staff to participate in the planning and development of The Alliance activities for Health Homes and AC3 implementation in 2018 and 2019. The Alliance is also committed to piloting a plan-based CB-CME with activities aligning to the HH/WPC projects. Staff works at developing mechanisms to identify Members and provide services to meet the overall goals. The processes are defined in CM Policies and Procedures.

XI. Disease Management

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

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

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

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

XII. Case Management Monitoring and Oversight

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

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

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

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

XIII. Program Effectiveness

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

A. Complex Case Management Performance Measurement

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

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

Measure One - Member Satisfaction Rates

2. Improve Member outcomes

Measure Two - All-Cause Admission Rate

Measure Three – Emergency Room Visit Rate

3. Achieve optimal Member functioning

Measure Four – Health Status Rate

4. Use of Appropriate Health Care Services

Measure Five – Use of Services (Primary Care)

A full description of the measures, goals, methodology and sources is available in Appendix E – 2019 Performance Measures

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

1. Identifies a relevant process or outcome

2. Uses valid methods that provide quantitative results

3. Sets a performance goal

4. Clearly identifies measure specifications

5. Analyzes results

6. Identifies opportunities for improvement, if applicable

7. Develops a plan for intervention and re-measurement

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

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

B. Experience with Case Management

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

XIV. Annual Complex Case Management Program Evaluation

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

XV. Delegation of Case Management Activities

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

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

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

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

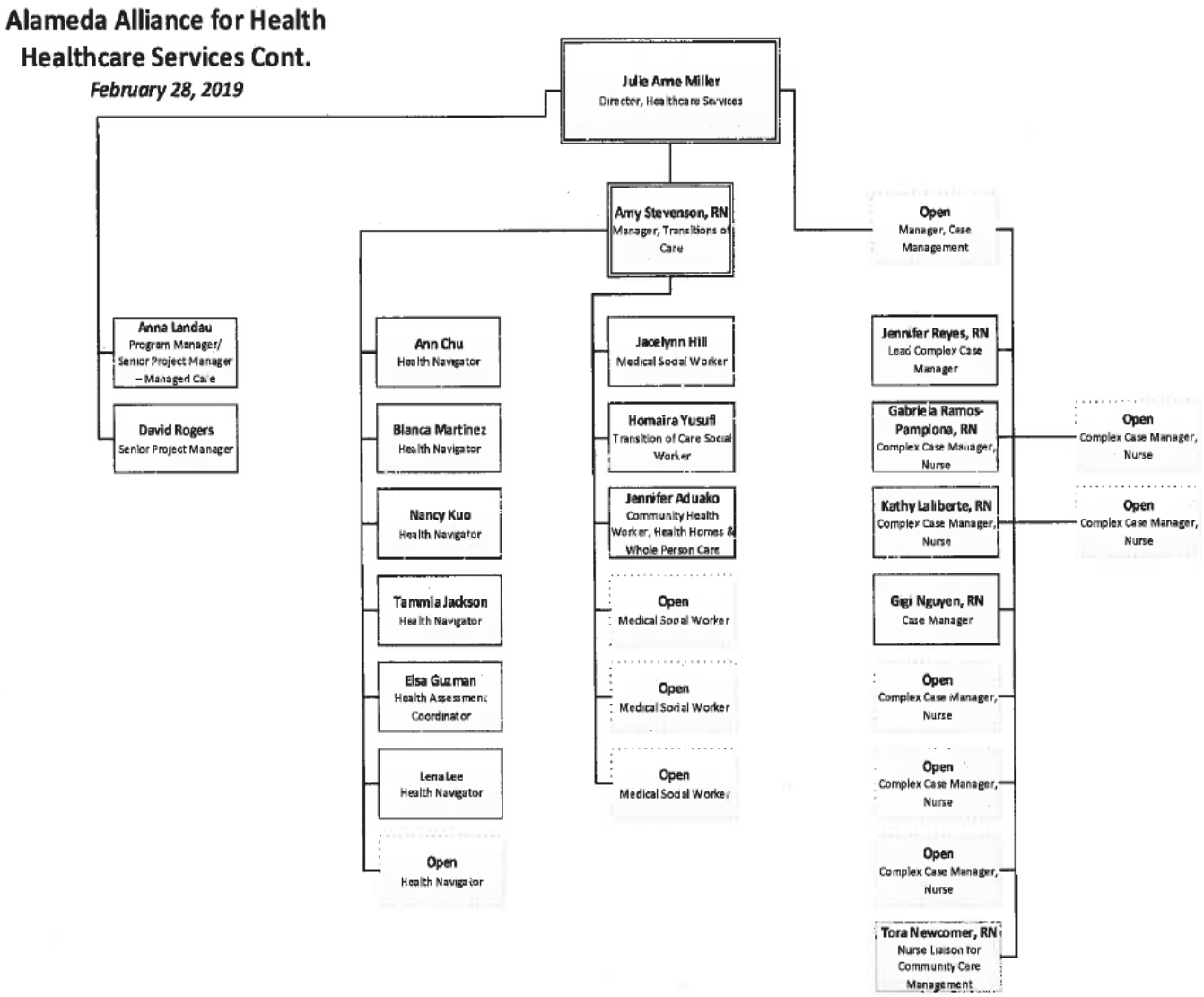
1. Evaluation of the delegate's abilities to perform case management functions prior to delegation in accordance with all regulatory requirements and accreditation standards
2. Review of required reports monthly, quarterly, semi-annually and annually, or as defined by the delegate's contract
3. Annual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

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

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

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

APPENDIX A: Case Management Organization Chart



APPENDIX B: Clinical Care Guidelines

TruCare 4.7 Disease Specific Content References

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Preventive Health Guidelines

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

- **Asymptomatic Healthy Adults**

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

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

- **Members Under 21 Years of Age**

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

- **Perinatal Services**

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

- **Immunizations**

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

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

Appendix C – 2019 Criteria for Case Management

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

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

Referrals that are selected for CCM are not diagnosis-specific, but rather based on the following general criteria:

a. The degree and complexity of the Member's illness is typically severe
    1. Multiple specialties involved
    2. Level of specialty management (tertiary providers)
    3. Primary diagnosis with complication
    4. Higher levels of disease staging
b. The level of management necessary is typically intensive.
    1. Multiple services needing coordination
    2. Frequency of care management contacts needed
    3. Large number of external care coordination services
c. The amount of resources required for the Member to regain optimal health or improved functionality is typically extensive.
    1. Multiple hospitalizations
    2. Multiple ED visits
    3. High cost and utilization of pharmacy

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

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

2. Cancer and possible cancer indicators:
    a. Criteria

i. Lung, brain, head and neck, pancreatic, liver cancer
ii. Metastatic cancer
iii. Malnutrition, dehydration, nausea/vomiting
iv. Chronic pain

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

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

11. Trauma:
    a. Criteria
        i. severe trauma with head injury and/or requiring prolonged facility care or complex home care
        ii. spinal cord injuries
        iii. brain injury
        iv. burns

12. Readmission:
    a. Criteria
        i. readmission to facility within 15 days of discharge due to complications or multiple admissions for same condition

13. Mental health:
    a. Criteria
        i. requests for residential treatment facilities
        ii. multiple psychiatric or chemical dependency admissions within the past 12 months
        iii. history or threat of suicide

14. Other:
    a. Criteria
        i. Any recommendation from Health Services management or direct referral from referral provider

Appendix D- REFERRAL TO COMPLEX CASE MANAGEMENT CHECK LIST

Referrals that are selected for CCM are not diagnosis-specific, but rather based on the following general criteria:

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

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

3. ◯The amount of resources required for the Member to regain optimal health or improved functionality is typically extensive.
    a. ◯Multiple hospitalizations
    b. ◯Multiple ED visits
    c. ◯High cost and utilization of pharmacy

4. ◯Complex social needs (subject to clinical review and must have more than one)
    a. ◯Living situations
    b. ◯Needing assistance with multiple ADL
    c. ◯Nursing home eligible living in the community

5. ◯ Identified automatic referral diagnoses (See above list)
    a. _____Diagnosis
    b. _____Diagnosis

6. ◯ Clinical Determination
    a. ◯ Nurse Reviewer
        a. _____
        _____
    b. ◯ Direct provider referral
        _____

Appendix E - 2019 CCM Performance Measures

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

Appendix F: HRA Questionnaire

ALAMEDA Alliance FOR HEALTH

Health Survey

Name:	Member ID#:
Address:	Phone: ☐ Cell ☐ Home

1. What is your preferred language:

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

2. Where do you live:

   ☐ Own home

   ☐ Rent

   ☐ Temporary housing

   ☐ Staying with friends/family

   ☐ Assisted living

   ☐ Homeless

   ☐ Group home

   ☐ Other _____

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

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

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

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

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

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

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

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8. Are you under the care of any specialists?	☐ Yes	☐ No
9. Are you pregnant?	☐ Yes	☐ No
a. If you are pregnant, are you currently seeing a doctor for this pregnancy?	☐ Yes	☐ No
10. Do you have a condition that limits your activities or what you can do?	☐ Yes	☐ No
11. Do you need help with any of these actions?		
a. Taking a bath or shower	☐ Yes	☐ No
b. Going up stairs	☐ Yes	☐ No
c. Eating	☐ Yes	☐ No
d. Getting dressed	☐ Yes	☐ No
e. Brushing your teeth or hair, or shaving	☐ Yes	☐ No
f. Making meals or cooking	☐ Yes	☐ No
g. Getting out of a bed or a chair	☐ Yes	☐ No
h. Shopping and getting food	☐ Yes	☐ No
i. Using the toilet	☐ Yes	☐ No
j. Walking	☐ Yes	☐ No
k. Washing dishes or clothes	☐ Yes	☐ No
l. Writing checks or keeping track of money	☐ Yes	☐ No
m. Getting a ride to the doctor or to see your friends	☐ Yes	☐ No
n. Doing house or yard work	☐ Yes	☐ No
o. Going out to visit family or friends	☐ Yes	☐ No
p. Using the phone	☐ Yes	☐ No
q. Keeping track of your appointments	☐ Yes	☐ No
If yes, are you getting all the help you need with these actions?	☐ Yes	☐ No

If you get help with any of the tasks listed above, who is helper?

Name of your helper: _____

What is your relationship to the helper: _____

May we contact your helper? ☐ Yes ☐ No

Phone number of helper: _____

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

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

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

Name: _____

Relationship: _____

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

Please list _____

15. Do you need assistive devices that you do not have? ☐ Yes ☐ No

Please list _____

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

a. Home Health Nurse ☐ Yes ☐ No

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

c. Home Care Worker ☐ Yes ☐ No

d. Social Worker ☐ Yes ☐ No

e. Adult Day Care Center ☐ Yes ☐ No

f. Help with Transportation ☐ Yes ☐ No

g. Other (please list): _____

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

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

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

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

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

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

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

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

a. Good lighting ☐ Yes ☐ No

b. Good heating ☐ Yes ☐ No

c. Good cooling ☐ Yes ☐ No

d. Rails for any stairs or ramps ☐ Yes ☐ No

e. Hot water ☐ Yes ☐ No

f. Indoor toilet ☐ Yes ☐ No

g. A door to the outside that locks ☐ Yes ☐ No

h. Stairs to get into your home or stairs inside your home ☐ Yes ☐ No

i. Elevator ☐ Yes ☐ No

j. Space to use a wheelchair ☐ Yes ☐ No

k. Clear ways to exit your home ☐ Yes ☐ No

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

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

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

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

☐ None – I never feel lonely

☐ Less than 5 days

☐ More than half the days (more than 15 days)

☐ Most days – I always feel lonely

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

30. Over the last two (2) weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly everyday
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling asleep, staying asleep, or sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself – or that you're a failure or have let yourself or your family down?	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so slowly that other people have noticed or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

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

32. Do you feel you have a problem with:

a. Alcohol use ☐ Yes ☐ No

b. Drug Use ☐ Yes ☐ No

c. Tobacco use ☐ Yes ☐ No

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

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

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

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

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

If yes, check all that apply:

☐ Asthma ☐ Cancer ☐ Cystic Fibrosis ☐ Diabetes

☐ Heart Problems ☐ Hepatitis ☐ High Blood Pressure ☐ HIV or AIDS

☐ Kidney Disease ☐ Seizures ☐ Sickle Cell Anemia ☐ Tuberculosis

☐ Other: _____

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

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

Name of Medication	Dose (How Much)	How Often Taken

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

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

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

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

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

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

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

Only answer the next three (3) questions if you are over 64 years of age:

47. Do you get a flu shot every year? ☐ Yes ☐ No

48. Have you had a pneumonia shot in the past? ☐ Yes ☐ No

49. Have you had the Zostavax (shingles) shot in the past? ☐ Yes ☐ No

Only answer the next question if you are between 50 -74 years of age:

50. Have you had a test to screen for colon cancer with the following:
    a. FOBT (Fecal Occult Blood Test), testing the stool for presence of blood this year? ☐ Yes ☐ No
    b. Flexible sigmoidoscopy any time in the last four (4) years? ☐ Yes ☐ No
    c. Colonoscopy any time in the last 5-10 years? ☐ Yes ☐ No

This Health Survey is complete. Thank you!

Please return to:

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

If you have questions, please contact us at **1.888.433.1876**.

Appendix G Long-Term Services and Supports Referral Questions

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

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

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

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

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

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

Appendix H – Disease Management Program Activities

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

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

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

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

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

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

Information needed for a DM referral includes:

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

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

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

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

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

DM Risk Stratification

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

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

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

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

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

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

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

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

Enrollment

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

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

Assessment

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

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

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

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

DM Plan Development and Management

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

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

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

d. Development and communication of member self-management plans

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

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

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

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

DM Case Evaluation and Closure

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

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

3. Diabetes DM Program enrollees will also be evaluated for closure to DM services using MED-CM-0003 P&P criteria. However, the length of time in program should not exceed 6 months of participation in the program.

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

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

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

Appendix I – California Health Homes Services Model

http://www.dhcs.ca.gov/services/Documents/HealthHomesForPatients_Final.pdf

A. 2016 Eligibility Criteria

1. Target Population

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

2. HHP Eligibility Criteria and the Targeted Engagement List

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

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

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

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

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

- A chronic condition predictive level above three based on a method to be determined by DHCS **OR**

- At least one inpatient stay in the last year **OR**
- Three or more Emergency Department (ED) visits in the last year **OR**
- Chronic homelessness

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

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

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

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

2019 Case Management Work Plan
Signature Page

Date _____

Sanjay Bhatt, M.D.
Medical Director, Quality Improvement
Vice Chair, Health Care Quality Committee

Date _____

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

Date _____

Scott Coffin
Chief Executive Officer

Date _____

Evan Seevak, M.D.
Board Chair

THE ALLIANCE
UTILIZATION MANAGEMENT DEPARTMENT
2018 WORK PLAN - MEDI-CAL

Performance Measures	2018 Performance	2019 Performance Goal	Document/Report	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	UM - '19 Updates	R=Did Not Meet Goal Y=At Risk G=On Target
Goal: Revise the existing CM infrastructure to meet the needs of the members, providers and the organization, including a new staffing model for CM activities.								
Develop a new staffing model	NA	Complete new staffing model for CM services	Productivity Report	Director, Health Services	Q3 2019	**UMC**		
Secure staffing and resources to support UM	NA	100% of newly hired staffing in 2019 are retained	Budget Reports	Director, Health Services	Q4 2019	**UMC**		
Explore team model vs. cross functional activities.	NA	Develop proposal for team management in CM; operationalize one time in 2019	Productivity Report	Director, Health Services	Q3 2019	**UMC**		
Service - *CM Activitives*								
IHA/HRA								
IHA - Completion Rate of IHA for newly enrolled members within 120 calendar days of enrollment (adults)	NA	TBD	IHA report	Manager, CM	Quarterly	**UMC**		
IHEBA- Completion Rate of IHEBA (SHA) for newly enrolled members within 120 calendar days of enrollment (Adults)	NA	TBD	IHA report	Manager, CM	Quarterly	**UMC**		
IHA - Completion Rate of IHA for newly enrolled members within 120 calendar days of enrollment (Peds - Under 21 years)	NA	TBD	IHA report	Manager, CM	Quarterly	**UMC**		
IHEBA- Completion Rate of IHEBA (SHA) for newly enrolled members within 120 calendar days of enrollment (Peds Under 21 years)	NA	TBD	IHA report	Manager, CM	Quarterly	**UMC**		
HIF/MET - Outreach rate - Newly enrolled SPD - within 90 days of enrollment complete two reminder outreach attempts to complete and return the forms	NA	NA	HIFMET report	Manager, CM	Quarterly	**UMC**		
HIF/MET - Completion rate - use of completed HIF/MET for use in initial screening for newly enrolled SPD members - Due within 90 days of enrollment	NA	TBD	HIFMET report	Manager, CM	Quarterly	**UMC**		
HRA Outreach for HR members; completion with less than three outreach attempts	25%	90%	HRA Report	Manager, CM	Quarterly	**UMC**		
HRA - Completion rate of HRA for newly enrolled SPD members		TBD	HRA Report	Manager, CM	Quarterly	**UMC**		

THE ALLIANCE
UTILIZATION MANAGEMENT DEPARTMENT
2018 WORK PLAN - MEDI-CAL

Performance Measures	2018 Performance	2019 Performance Goal	Document/Report	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	UM - '19 Updates	R=Did Not Meet Goal Y=At Risk G=On Target
HRA - Completion of annual update to HRA for existing SPD members		TBD	HRA Report	Manager, CM	Quarterly	**UMC**		

THE ALLIANCE
UTILIZATION MANAGEMENT DEPARTMENT
2018 WORK PLAN - MEDI-CAL

Performance Measures	2018 Performance	2019 Performance Goal	Document/Report	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	UM - '19 Updates	R=Did Not Meet Goal Y=At Risk G=On Target
Care Coordination								
TCM - Identification and Referrals made to Regional Center	NA	Benchmark -≤ 1%	Referral Tracking Log for Regional Center	Manager, CM	Quarterly	**UMC**		
Out of Plan Services - Referrals made to CCS	NA	Benchmark -≤ 1%	CCS Tracking Log	Manager, CM	Quarterly	**UMC**		
Out of Plan Services - Referrals made for Developmental Disabled/Regional Center	NA	Benchmark -≤ 1%	Regional CenterTracking Log	Manager, CM	Quarterly	**UMC**		
Out of Plan Services - Referrals made for Early Intervention Services/Regional Center	NA	Benchmark -≤ 1%	Regional CenterTracking Log	Manager, CM	Quarterly	**UMC**		
CM								
CM Referral Activity Reporting - AAH CM only		NA	CM Referral Activity Report	Manager, CM	Quarterly	**UMC**		
CM - identified CM referrals engaged into CM		Benchmark 20%	CM Referral Activity Report	Manager, CM	Quarterly	**UMC**		
CM - identified CM referrals unable to contact		Benchmark 40%	CM Referral Activity Report	Manager, CM	Quarterly	**UMC**		
CM - ICT completion for members greater than 90 days in CCM	NA	Benchmark 90%	CM Referral Activity Report	Manager, CM	Quarterly	**UMC**		
CCM								
CCM Referrals from Pop Health Report	50% of referrals came from Pop Health Report; no data available to assess the total of potential referrals	Benchmark: review top 1% for potential CCM referral	AAH Population Health	Manager, CM	Quarterly	**UMC**		
CCM improve outreach efforts for member engagement	7% engagement rate	80%	AAH Population Health	Manager, CM	Quarterly	**UMC**		
CCM - begins the initial assessment within 30 calendar days of identifying a member for complex case management (NCQA)	TBD	TBD	CM Aging Report	Manager, CM	Quarterly	**UMC**		
CCM completes the assessment within 60 calendar days of identification (NCQA)	TBD	TBD	CM Aging Report	Manager, CM	Quarterly	**UMC**		
CCM - cases open greater than 90 calendar days from enrollment.	TBD	Benchmark: ≤1% of CCM referrals open for greater than 90 calendar days	CM Aging Report	Manager, CM	Quarterly	**UMC**		
CCM - identified CCM referrals unable to contact	TBD	Benchmark 40%	CM Aging Report	Manager, CM	Quarterly	**UMC**		
CCM Assessment started in 30 days	92%	95%	CM Aging Report	Manager, CM	Quarterly	**UMC**		
ICT - Rate of completed HRA with ICT within 90 days of CM enrollment	48% timely	80% with ICT	CM Aging Report	Manager, CM	Quarterly	**UMC**		

Performance Measures	2018 Performance	2019 Performance Goal	Document/Report	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	UM - '19 Updates	R=Did Not Meet Goal Y=At Risk G=On Target
Provider Training - appropriateness of CCM referrals	NA	NA	Provider Newsletter	Director, Health Services	Annual	**UMC**		
Member Training on CCM Services	NA	NA	Member Newsletter	Director, Health Services	Annual	**UMC**		

THE ALLIANCE
UTILIZATION MANAGEMENT DEPARTMENT
2018 WORK PLAN - MEDI-CAL

Performance Measures	2018 Performance	2019 Performance Goal	Document/Report	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	UM - '19 Updates	R=Did Not Meet Goal Y=At Risk G=On Target
Enhance the existing clinical information system reporting capabilities								
CM/CCM								
CM Activities - review for consistency and accuracy of reporting elements	NA	100%	CM Aging Report	Director, Health Services	Quarterly	**UMC**		
CM Activities - collaborate with IT to enhance predictive modeling to improve identification of appropriate members for CCM	NA	NA	Predictive Modeling Report	Director, Health Services	Semi-annual	**UMC**		
CM - TruCare - review new features to identify impact to CM proceses	NA	NA	TruCare User Group	Director, Health Services	Semi-annual	**UMC**		
Operationalize Health Home Project								
Develop reporting capabilities to capture HHP requirements - Enrollment	**NA**	Pending final approval from HHP * Source - https://www.dhcs.ca.gov/services/Documents/MCQMD/HHP_Program_Guide_Final_3.06.19.pdf	Health Home Project Report	Director, Health Services	Pending	**UMC**		
Develop reporting capabilities to capture HHP requirements - Member Activities	**NA**	Pending final approval from HHP * Source - https://www.dhcs.ca.gov/services/Documents/MCQMD/HHP_Program_Guide_Final_3.06.19.pdf	Health Home Project Report	Director, Health Services	Pending	**UMC**		
Develop reporting capabilities to capture HHP requirements - CMS Core Activities	**NA**	Pending final approval from HHP * Source - https://www.dhcs.ca.gov/services/Documents/MCQMD/HHP_Program_Guide_Final_3.06.19.pdf	Health Home Project Report	Director, Health Services	Pending	**UMC**		
Special Projects								
Continuity of Care - Number of CoC assistance requests, including OON transfers into network providers.	**NA**	**NA**	CoC Tracking Report	Manager, CM	Quarterly	**UMC**		
CCS Age Out - review of CCS eligible members > 19 yrs and enrolled in Age Out Program	NA	NA	CCS Tracking Report	Manager, CM	Quarterly	**UMC**		
CCM Program Performance measures								
Improve member outcomes - All cause readmissions for CCM enrolleess	18% overall, not CCM specific	10 percentage point reduction	CCM Performance Measures Report	Manager, CM	Quarterly	**UMC**		
Improve member outcomes - ER rates for CCM enrolleess	NA	10 percentage point reduction	CCM Performance Measures Report	Manager, CM	Quarterly	**UMC**		

THE ALLIANCE
UTILIZATION MANAGEMENT DEPARTMENT
2018 WORK PLAN - MEDI-CAL

Performance Measures	2018 Performance	2019 Performance Goal	Document/Report	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	UM - '19 Updates	R=Did Not Meet Goal Y=At Risk G=On Target
Achieve optimal member health - Health status rate (self reported) improvement in overall health status	NA	85% will report improvement in health status	CCM Performance Measures Report	Manager, CM	Quarterly	**UMC**		
Appropriate Use of Health Care Services - PCP visits for Members enrolled in CCM per Member per year	NA	10 percentage point improvement	CCM Performance Measures Report	Manager, CM	Quarterly	**UMC**		

THE ALLIANCE
UTILIZATION MANAGEMENT DEPARTMENT
2018 WORK PLAN - MEDI-CAL

Performance Measures	2018 Performance	2019 Performance Goal	Document/Report	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	UM - '19 Updates	R=Did Not Meet Goal Y=At Risk G=On Target
Improve member experience with CM								
Member Experience with CM Process								
1. Did the case manager help you understand the treatment plan? (NCQA)	**100%**	≥ 90% of members enrolled in CCM understand treatment plan	Member Survey Outcomes	Manager, CM	Annual	**UMC**: Dec 28		
2. Did the case manager help you get the care you needed? (NCQA)	**100%**	≥ 90% of members enrolled in CCM understand how to get needed assistance.	Member Survey Outcomes	Manager, CM	Annual	**UMC**: Dec 28		
3. Did the case manager pay attention to you and help you with problems? (NCQA)	**100%**	≥ 90% members enrolled in CCM report their CM assisted in helping with problems	Member Survey Outcomes	Manager, CM	Annual	**UMC**: Dec 28		
4. Did the case manager treat you with courtesy and respect? (NCQA)	**100%**	≥ 90% member enrolled in CCM reporte CM treated with the courtesy and respect.	Member Survey Outcomes	Manager, CM	Annual	**UMC**: Dec 28		
5. How satisfied are you with the case management program? (NCQA)	**100%**	≥ 90% of members enrolled in CCM reported being satisfied with the CCM program.	Member Survey Outcomes	Manager, CM	Annual	**UMC**: Dec 28		
Analyzing member compliants related to CCM program activities. (NCQA)	1 complaint	Benchmark: < 3% will file G&A related to CM process	G&A Reports -	Manager, CM Director of G&A	Quarterly	**UMC**: Dec 28		
Improve rate of survey responses	3/20 or 15%	Based on total eligible CCM members, 3% margin of error	Member Survey Outcomes	Manager, CM	Annual	**UMC**: Dec 28		
Delegation Oversight reporting requirements (NCQA)		100% submission of delegates monthly reports	Reporting Submission Updates	Delegation Oversight Staff or Manager UM	Quarterly	**UMC**		
Delegation Oversight reporting requirements (NCQA)		100% submission of delegate's quarterly reports	Reporting Submission Updates	Delegation Oversight Staff or Manager UM	Quarterly	**UMC**		
Delegation Oversight reporting requirements (NCQA)		100% submission of delegate's corrective action plan reports	Reporting Submission Updates	Delegation Oversight Staff or Manager UM	Quarterly	**UMC**		
Delegation Oversight reporting requirements (NCQA)		100% submission of delegate's annual audits/reports. *Presentation of delegates UM Program services as approval of UM processes and criteria.	Reporting Submission Updates	Delegation Oversight Staff or Manager UM	Quarterly	**UMC**		
Administrative								
CM Internal Monitoring	Not met	≥ 90% total score per case	Internal Monitoring Worksheet	Manager, CM	Quarterly	UMC		
Interrater Reliability	NA	100% of staff will receive 90% on IRR	Internal IRR report for management of CCM cases	Manager, CM	Annually	UMC		
Staff Competence Documentation	Not met	Train UM staff on standards of practice and standard workflows	Training Documents	Director, Health Care Services	Annual	UMC		
CM Evidence Based Guidelines (NCQA)		100% Annual Review of CM Evidence Based Guidelines	Review of UM criteria contract(s),, QI	Director, Health Services	Annually	UMC		
Annual Review of Policies &Procedure	Completed	100% Annual Review of P&Ps	P&Ps	Director, Health Services	Annually to the UMC and as needed	UMC		

THE ALLIANCE
UTILIZATION MANAGEMENT DEPARTMENT
2018 WORK PLAN - MEDI-CAL

Performance Measures	2018 Performance	2019 Performance Goal	Document/Report	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	UM - '19 Updates	R=Did Not Meet Goal Y=At Risk G=On Target
CM/CCM Evaluation	Completed	Annual UM Evaluation	QI Program Evaluation	Director, Health Services	Annually	UMC		
CM Program Document	Completed	Annual CM Program Description	QI Program Description	Director, Health Services	Annually	UMC		
CM Work Plan/Calendar	Completed	Annual CM Work Plan	CM Work Plan	Director, Health Services	Quarterly	UMC		
CM Workplan Updates	Not met	Review and Update of CM Work Plan	CM Work Plan	Director, Health Services	Quarterly	UMC		

ALAMEDA Alliance FOR HEALTH

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

CEO Update

Scott Coffin

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

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

Date: **May 10, 2019**

Subject: **CEO Report**

- **Governor Newsom Budget – May Revise and Executive Order**
  - Pharmacy benefit is transitioning from managed care into fee-for-service by January 1, 2021. Operational readiness begins in early 2020 following DHCS guidance on the transition plan.

- **Financial Performance Updates**
  - $1.8 million net loss year-to-date (9 months), $25.2 million favorable to budget. Current fiscal year Q3 forecast will be distributed by May 31.
  - Alliance's core operating metrics and regulatory dashboard reports.
  - Membership trends continue to decline for Medi-Cal, steady in GroupCare.
  - Fiscal Year 2019/2020 Budget Process Update.
    Preliminary budget is presented to the Board for approval in June, and the final budget is presented for Board approval in September.

- **Healthcare Effectiveness Data and Information Set (HEDIS)**
  - 95.2 % of records collected, targeting approx. 70% AQFS score.
  - HEDIS finishes in June, DHCS reports results in December.

- **DHCS scheduled to initiate Medi-Cal managed care procurement in 2020.**

- **Alliance is hearing final approval from DHCS to launch the state-funded Health Home Program on July 1, 2019.**

- **Scheduled Audits**
  - DHCS Medical Survey Audit begins June 10-21, 2019.
  - Moss Adams financial audit starts June 17th, results in October.
  - DMHC Financial Audit scheduled November 4-14, 2019.

- **Pending Audits**
  - Federal Office of Inspector General (OIG) to be scheduled, examining medical loss ratios for two periods: 1/1/14–6/30/15 & 7/1/15–6/30/16.

EXECUTIVE DASHBOARD
MAY 2019

ALAMEDA Alliance FOR HEALTH

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

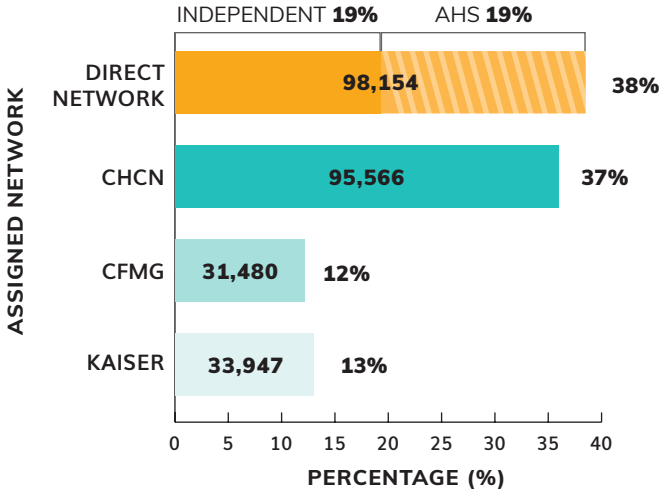
MEMBERSHIP

259,147

TOTAL MEMBERSHIP

IHSS 5,892 | MEDI-CAL 253,255

DISTRIBUTION OF ALL MEMBERSHIP BY ASSIGNED NETWORK

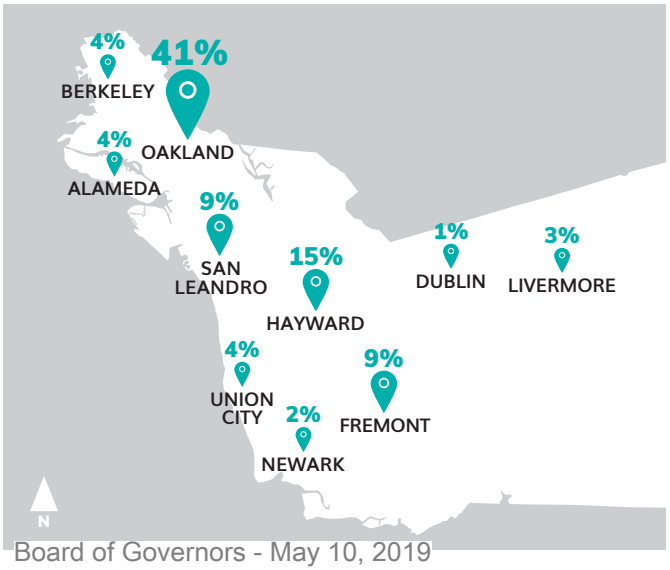


DISTRIBUTION OF MEMBERSHIP BY CITY

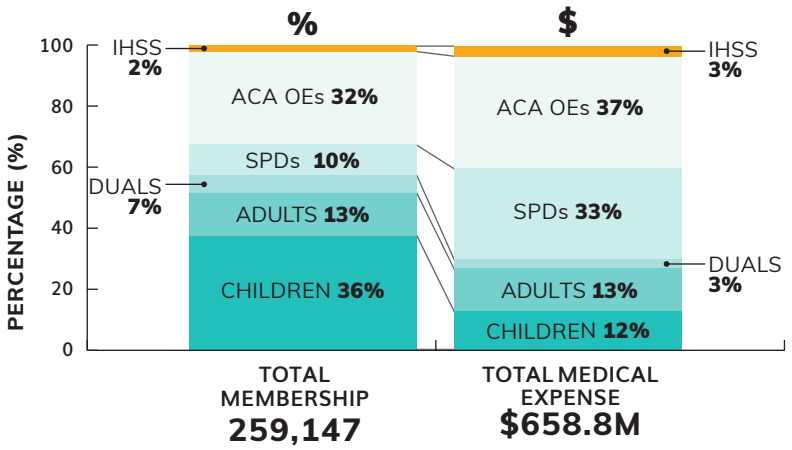
92%

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

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

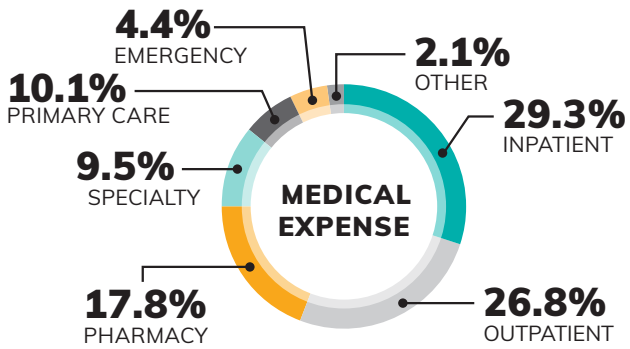


DISTRIBUTION OF MEDICAL EXPENSE BY MEMBERSHIP CATEGORY



REVENUE & EXPENSES

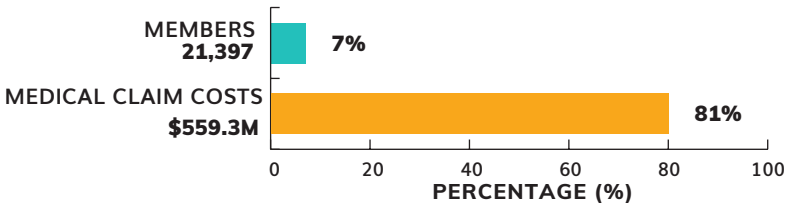
	MARCH 2019	FISCAL YTD
REVENUE	$79.6M	$690.5M
MEDICAL EXPENSE	($79.9M)	($658.8M)
ADMIN EXPENSE	($3.9M)	($37.7M)
OTHER	$518K	$4.29M
NET INCOME	**($3.7M)**	**($1.75M)**



TANGIBLE NET EQUITY*

583.3% **$188.4M**

HIGH UTILIZER DISTRIBUTION*



*REPORTING 4 MONTH LAG

UTILIZATION*

5,544
INPATIENT BED DAYS

7,949
EMERGENCY ROOM VISITS

4.2 DAYS
AVERAGE LENGTH OF STAY

*REPORTING 2 MONTH LAG

CASE AND DISEASE MANAGEMENT*

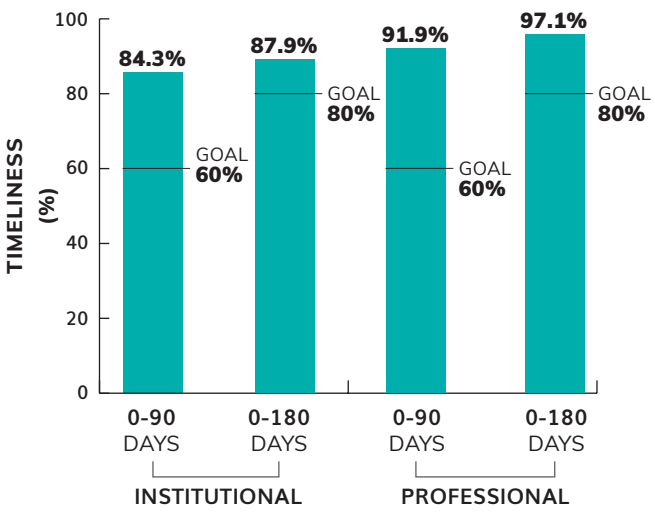
	NEW CASES	TOTAL ENROLLED
CARE COORDINATION	276	521
COMPLEX CASE MANAGEMENT	5	63
HEALTH HOMES	23	173
WHOLE PERSON CARE (AC3)	43	383
TOTAL	347	1,140

*REPORTING 2 MONTH LAG

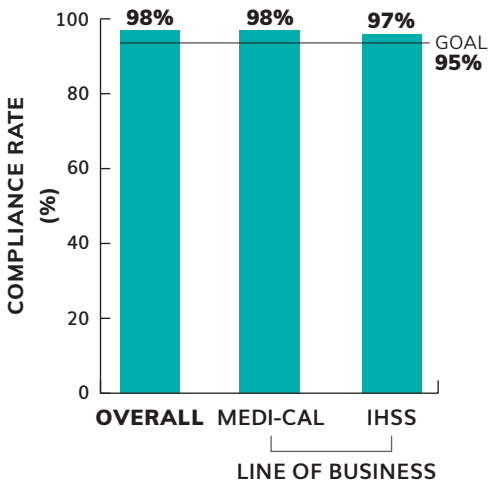
REGULATORY COMPLIANCE

ALL REGULATORY COMPLIANCE MEASURES ARE IN COMPLIANCE WITH THE EXCEPTION OF PROVIDER DISPUTES & RESOUTIONS FALLING SLIGHTLY BELOW THE TURNAROUND TIME GOAL, AND NOT MEETING THE OVERTURN GOAL.

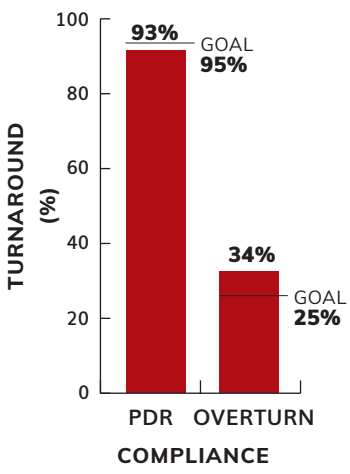
ENCOUNTER DATA



MEDICAL AUTHORIZATIONS



PROVIDER DISPUTES & RESOLUTIONS



CALL CENTER

17,655
CALLS RECEIVED

83%
ANSWERED IN 30 SECONDS

2%
CALLS ABANDONED

CLAIMS

116,839
PROCESSED CLAIMS

75.1%
AUTO-ADJUDICATED

24 DAYS
PROCESSED PAYMENTS

STAFF & RECRUITING

290
TOTAL EMPLOYEES

7
HIRED IN THE LAST 30 DAYS

12%
CURRENT VACANCY

ALAMEDA Alliance FOR HEALTH

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

Operations Dashboard

Alameda Alliance for Health
Operations Dashboard
- May-2019 -

ID	Section	Subject Area	Category	Performance Metric					ID
1	1	Financials			Mar-19 FYTD		%	Annual Budget	1
2									2
3			Income & Expenses	Revenue $	$690,584,302		76.6%	$901,768,537	3
4				Medical Expense $	$658,849,677		73.9%	$891,743,509	4
5				*Inpatient (Hospital)*	$192,869,614		*29.3%*	$264,836,870	5
6				*Outpatient/Ancillary*	$176,583,302		*26.8%*	$244,543,907	6
7				*Emergency Department*	$29,317,213		*4.4%*	$44,758,855	7
8				*Pharmacy*	$117,268,751		*17.8%*	$157,683,791	8
9				*Primary Care*	$66,367,034		*10.1%*	$67,275,537	9
10				*Specialty Care*	$62,408,319		*9.5%*	$92,495,171	10
11				*Other*	$14,035,444		*2.1%*	$20,149,379	11
12				Admin Expense $	$37,777,396		70.2%	$53,843,839	12
13				Other Income / (Exp.) $	$4,292,538		8.0%	$5,970,413	13
14				Net Income $	($1,750,233)			($37,848,398)	14
15				Gross Margin %	4.6%			1.1%	15
16			Liquid Reserves	Medical Loss Ratio (MLR) - Net %	95.4%			98.9%	16
17				Tangible Net Equity (TNE) %	583.3%			468.0%	17
18				Tangible Net Equity (TNE) $	$188,409,481			$152,311,317	18
19			Reinsurance Cases	2018-2019 Cases Submitted	13				19
20				2018-2019 New Cases Submitted	6				20
21				2017-2018 Cases Submitted	45				21
22				2017-2018 New Cases Submitted	0				22
23			Balance Sheet	Cash Equivalents	$370,524,792				23
24				Pass-Through Liabilities	$255,967,348				24
25				Uncommitted Cash	$114,557,444				25
26				Working Capital	$177,089,128				26
27				Current Ratio %	147.1%			100%	27
28									28
29	2	Membership			Jan-19	Feb-19	Mar-19	Mar-19 Budget	29
30									30
31			Medi-Cal Members	Adults	35,035	34,651	34,525	36,525	31
32				Children	94,491	93,809	93,457	97,288	32
33				Seniors & Persons with Disabilities (SPDs)	26,078	26,059	25,938	26,722	33
34				ACA Optional Expansion (ACA OE)	82,684	82,149	81,821	82,508	34
35				Dual-Eligibles	17,348	17,399	17,514	16,818	35
36									36
37				Total Medi-Cal	255,636	254,067	253,255	259,861	37
38			IHSS Members	IHSS	5,890	5,854	5,892	5,893	38
39			Total Membership	Medi-Cal and IHSS	261,526	259,921	259,147	265,754	39
40									40
41			Members Assigned By Delegate	Direct-contracted network	50,615	50,235	50,169		41
42				Alameda Health System (Direct Assigned)	48,787	48,241	47,985		42
43				Children's First Medical Group	31,962	31,722	31,480		43
44				Community Health Center Network	96,389	95,906	95,566		44
45				Kaiser Permanente	33,773	33,817	33,947		45
46									46

Alameda Alliance for Health
Operations Dashboard
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ID	Section	Subject Area	Category	Performance Metric						ID
47	3	Claims			Feb-19	Mar-19	Apr-19	%	Performance Goal	47
48										48
49			HEALTHsuite Claims Processing	Number of Claims Received	117,729	124,018	129,488			49
50				Number of Claims Paid	90,486	89,738	90,892			50
51				Number of Claims Denied	25,186	28,805	25,947			51
52				Inventory (Unfinalized Claims)	90,446	88,779	99,223			52
53				Pended Claims (Days)	13,151	11,449	7,322	7%		53
54				*0-29 Calendar Days*	11,515	11,014	7,165	7%		54
55				*30-44 Calendar Days*	633	404	128	0%		55
56				*45-59 Calendar Days*	5	14	8	0%		56
57				*60-89 Calendar Days*	1	4	8	0%		57
58				*90-119 Calendar Days*	15	1	3	0%		58
59				*120 or more Calendar Days*	982	12	10	0%		59
60				Total Claims Paid (dollars)	$40,206,582	$41,574,288	$44,721,415			60
61				Interest Paid (Total Dollar)	$24,209	$55,336	$29,425	0%		61
62				Auto Adjudication Rate (%)	72.2%	73.3%	75.1%		70%	62
63				Average Payment Turnaround (days)	23	30	24		25 days or less	63
64			Claims Auditing	# of Pre-Pay Audited Claims	2,546	2,922	3,292			64
65			Claims Compliance	% of Claims Processed Within 30 Cal Days (DHCS Goal = 90%)	99%	94%	97%		90%	65
66				% of Claims Processed Within 90 Cal Days (DHCS Goal = 99%)	100%	96%	99%		99%	66
67				% of Claims Processed Within 45 Work Days (DMHC Goal = 95%)	100%	96%	98%		95%	67
68										68
69	4	Member Services			Feb-19	Mar-19	Apr-19	%	Performance Goal	69
70										70
71			Member Call Center	Inbound Call Volume	16,861	18,732	17,655			71
72				Calls Answered in 30 Seconds %	82.0%	75.0%	83.0%		80.0%	72
73				Abandoned Call Rate %	5.0%	6.0%	2.0%		5.0% or less	73
74				Average Wait Time	00:26	01:00	00:38			74
75				Average Call Duration	08:01	07:08	07:19			75
76				Outbound Call Volume	11,073	12,312	12,527			76
77										77
78	5	Provider Services			Feb-19	Mar-19	Apr-19	%	Performance Goal	78
79										79
80			Provider Call Center	Inbound Call Volume	6,262	6,811	6,997			80
81										81
82	6	Provider Contracting			Feb-19	Mar-19	Apr-19	%	Performance Goal	82
83										83
84			Provider Network	Primary Care Physician	595	595	596			84
85				Specialist	6,520	6,597	6,628			85
86				Hospital	17	17	17			86
87				Skilled Nursing Facility	56	56	56			87
88				Durable Medical Equipment	Capitated	Capitated	Capitated			88
89				Urgent Care	14	16	16			89
90				Health Centers (FQHCs and Non-FQHCs)	73	73	72			90
91				Transportation	380	380	380			91
92			Provider Credentialing	Number of Providers in Credentialing	1,423	1,421	1,424			92
93				Number of Providers Credentialed	1,423	1,421	1,424			93
94										94

Alameda Alliance for Health
Operations Dashboard
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ID	Section	Subject Area	Category	Performance Metric						ID
95	7	Human Resources & Recruiting			Feb-19	Mar-19	Apr-19	%	Annual Budget	95
96										96
97			Employees	Total Employees	296	298	290		319	97
98				Full Time Employees	294	297	289	100%		98
99				Part Time Employees	2	1	1	0%		99
100				New Hires	5	8	7			100
101				Separations	2	6	3			101
102				Open Positions	46	46	38	12%	10% or less	102
103				Signed Offer Letters Received	9	6	5			103
104				Recruiting in Process	37	40	33	10%		104
105										105
106			Non-Employee (Temps / Seasonal)		13	10	8			106
107										107
108	8	Compliance			Feb-19	Mar-19	Apr-19	%	Performance Goal	108
109										109
110			Provider Disputes & Resolutions	Turnaround Compliance (45 business days)	98%	99%	93%		95%	110
111				% Overturned	30%	22%	34%		25% or less	111
112										112
113			Member Grievances	Overall Standard Grievance Compliance Rate % (30 calendar days)	100%	100%	100%		95%	113
114				Overall Expedited Grievance Compliance Rate % (3 calendar days)	100%	100%	100%		95%	114
115										115
116			Member Appeals	Overall Standard Appeal Compliance Rate (30 calendar days)	100%	100%	100%		95%	116
117				Overall Expedited Appeal Compliance Rate (3 calendar days)	100%	100%	100%		95%	117
118										118
119	9	Encounter Data & Technology			Feb-19	Mar-19	Apr-19		Performance Goal	119
120										120
121			Business Availability	HEALTHsuite (Claims and Membership System)	99.99%	100.00%	100.00%		99.99%	121
122				TruCare (Care Management System)	100.00%	100.00%	100.00%		99.99%	122
123				All Other Applications and Systems	100.00%	100.00%	100.00%		99.99%	123
124										124
125			Encounter Data	Inbound Trading Partners 837 (Trading Partner To AAH)						125
126				Timeliness of file submitted by Due Date	100.00%	100.00%	100.00%		100.0%	126
127										127
128				AAH Outbound 837 (AAH To DHCS)						128
129				Timeliness - % Within Lag Time - Institutional 0-90 days	91.5%	87.2%	84.3%		60.0%	129
130				Timeliness - % Within Lag Time - Institutional 0-180 days	98.6%	98.0%	87.9%		80.0%	130
131				Timeliness - % Within Lag Time - Professional 0-90 days	93.0%	89.2%	91.9%		65.0%	131
132				Timeliness - % Within Lag Time - Professional 0-180 days	98.3%	97.5%	97.1%		80.0%	132
133										133

Alameda Alliance for Health
Operations Dashboard
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ID	Section	Subject Area	Category	Performance Metric						ID
134	10	Health Care Services			Feb-19	Mar-19	Apr-19		Performance Goal	134
135										135
136			Authorization Turnaround	Overall Authorization Turnaround % Compliant	98%	97%	98%		95%	136
137				Medi-Cal %	98%	97%	98%		95%	137
138				Group Care %	98%	98%	97%		95%	138
139										139
140			Outpatient Authorization Denial Rates	Overall Denial Rate (%)	6.7%	6.2%	5.9%			140
141				Denial Rate Excluding Partial Denials (%)	6.1%	5.6%	5.8%			141
142				Partial Denial Rate (%)	0.7%	0.6%	0.1%			142
143										143
144			Pharmacy Authorizations	Approved Prior Authorizations	565	654	698	37%		144
145				Denied Prior Authorizations	584	590	562	30%		145
146				Closed Prior Authorizations	561	611	613	33%		146
147				Total Prior Authorizations	1,710	1,855	1,873			147
148										148
149					Jan-19	Feb-19	Mar-19			149
150										150
151			Inpatient Utilization	Days / 1000	331.5	290.2	294.3			151
152				Admits / 1000	68.5	63.9	70.8			152
153				Average Length of Stay	4.8	4.5	4.2			153
154										154
155			Emergency Department (ED) Utilization	# ED Visits / 1000	50.52	44.75	44.95			155
156										156
157			Case Management	New Cases						157
158				Care Coordination	148	180	276			158
159				Complex Case Management	108	66	5			159
160				Health Homes	17	18	23			160
161				Whole Person Care (AC3)	128	28	43			161
162				Total New Cases	401	292	347			162
163										163
164				Total Enrolled						164
165				Care Coordination	435	401	521			165
166				Complex Case Management	140	117	63			166
167				Health Homes	163	178	173			167
168				Whole Person Care (AC3)	307	322	383			168
169				Total Enrollment	1,045	1,018	1,140			169
170										170

ALAMEDA Alliance FOR HEALTH

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

Finance

Gil Riojas

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

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

Date: **May 10, 2019**

Subject: **Finance Report**

Executive Summary

- For the month ended March 31, 2019, the Alliance had enrollment of 259,147 members, a Net Loss of $3.7 million, and 583% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$ 79,612	$ 690,584
Medical Expense	79,945	658,850
Admin. Expense	3,912	37,777
Other Inc. / (Exp.)	518	4,293
Net Income	$ (3,727)	$ (1,750)

Net Income by Program:

	Month	YTD
Medi-Cal	$ (3,171)	$ (1,939)
Group Care	($556)	$189
	$ (3,727)	$ (1,750)

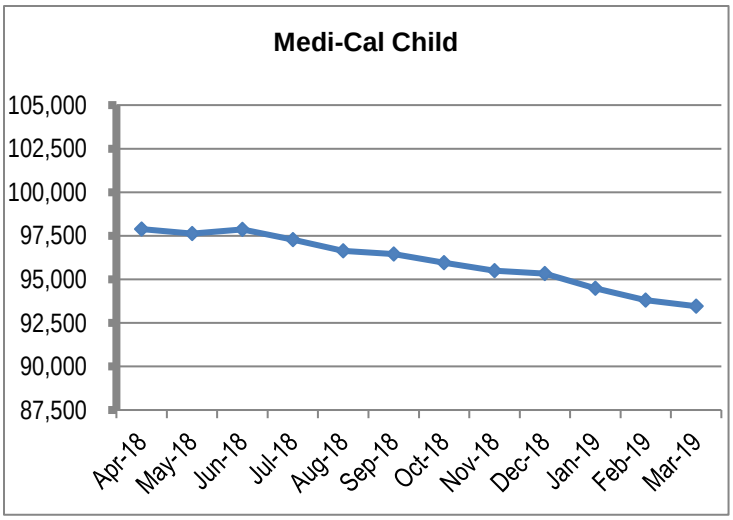
Enrollment

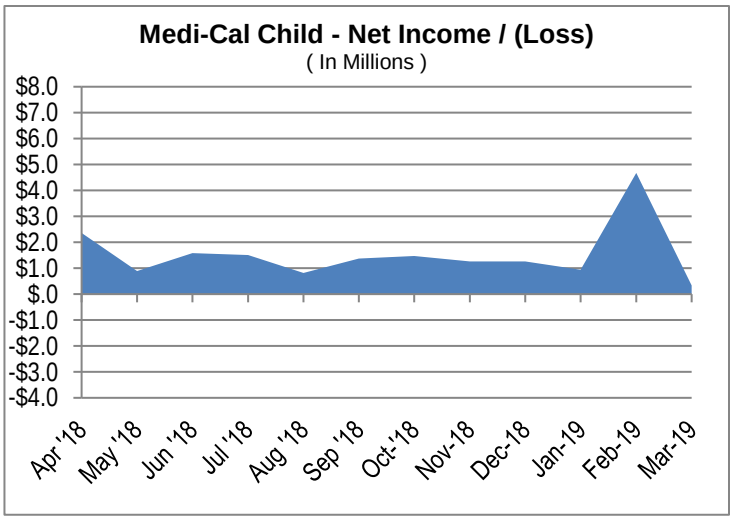
- Total enrollment decreased by 774 members since February 2019.
- Total enrollment decreased by 7,150 members since June 2018.

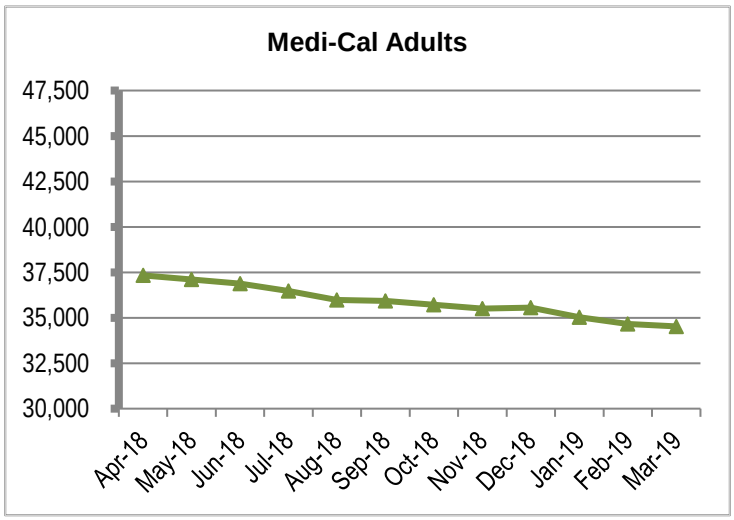
Monthly Membership and YTD Member Months Actual vs. Budget For the Month and Fiscal Year-to-Date

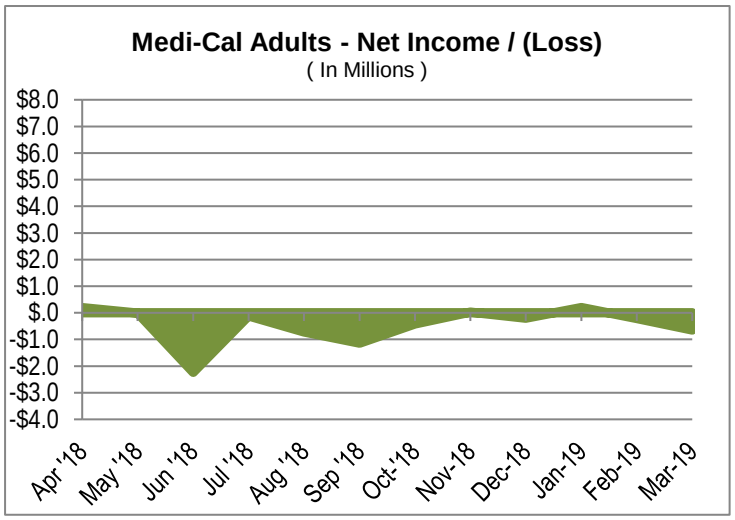
Enrollment					Member Months			
March-2019					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
34,525	36,525	(2,000)	-5.5%	Adults	319,364	327,034	(7,670)	-2.3%
93,457	97,288	(3,831)	-3.9%	Child	858,907	873,350	(14,443)	-1.7%
25,938	26,722	(784)	-2.9%	SPD	235,180	237,569	(2,389)	-1.0%
17,514	16,818	696	4.1%	Duals	155,002	152,231	2,771	1.8%
81,821	82,508	(687)	-0.8%	ACA OE	748,497	748,025	472	0.1%
253,255	259,861	(6,606)	-2.5%	Medi-Cal Total	2,316,950	2,338,209	(21,259)	-0.9%
5,892	5,893	(1)	0.0%	Group Care	52,806	52,843	(37)	-0.1%
259,147	265,754	(6,607)	-2.5%	Total	2,369,756	2,391,052	(21,296)	-0.9%

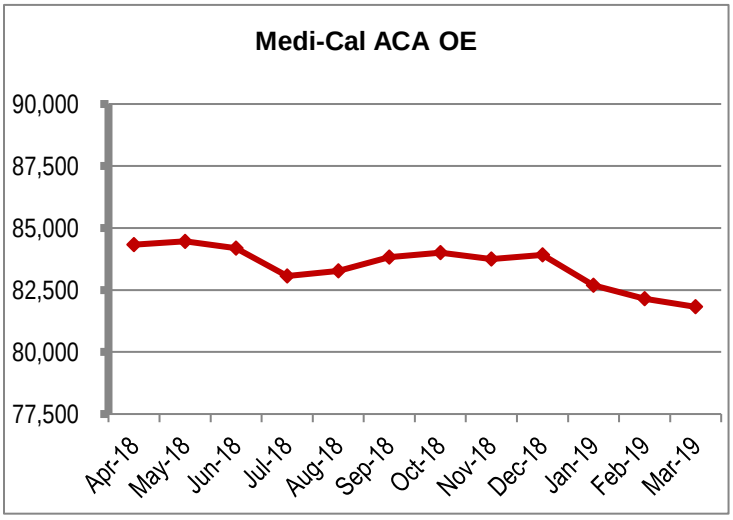
Enrollment and Profitability by Program and Category of Aid

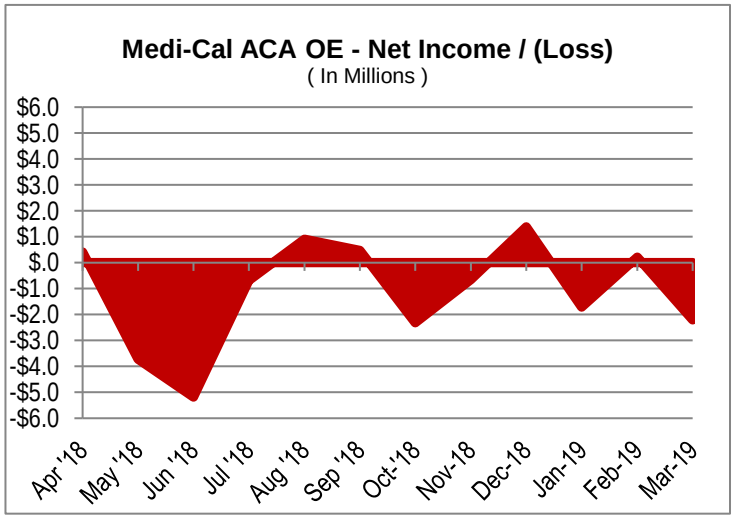




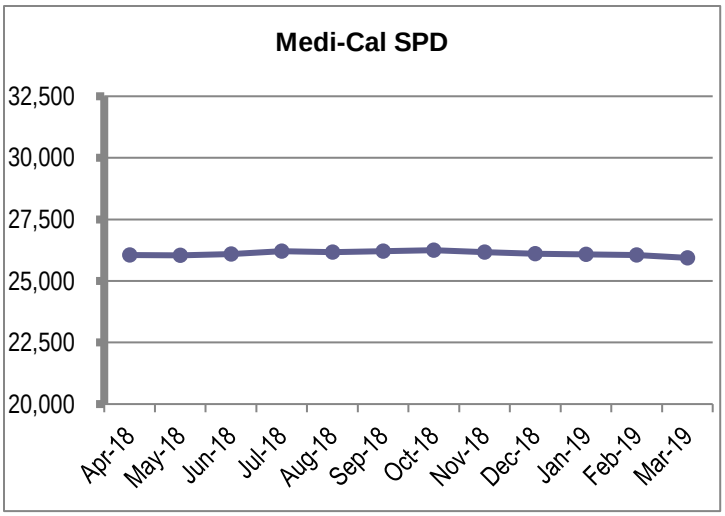


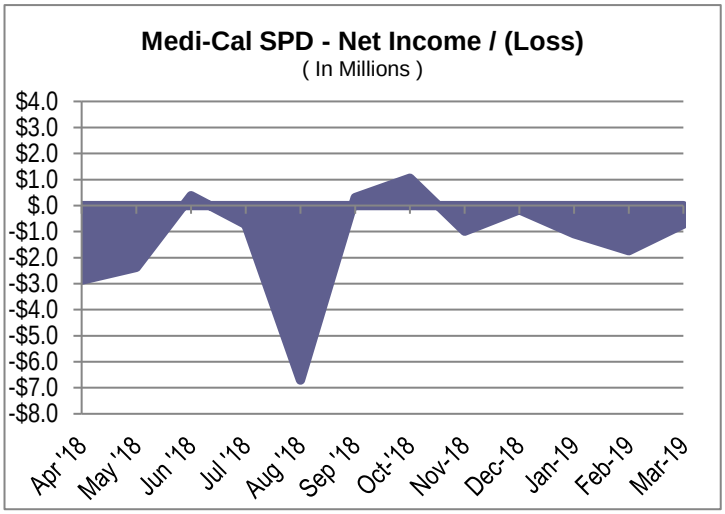


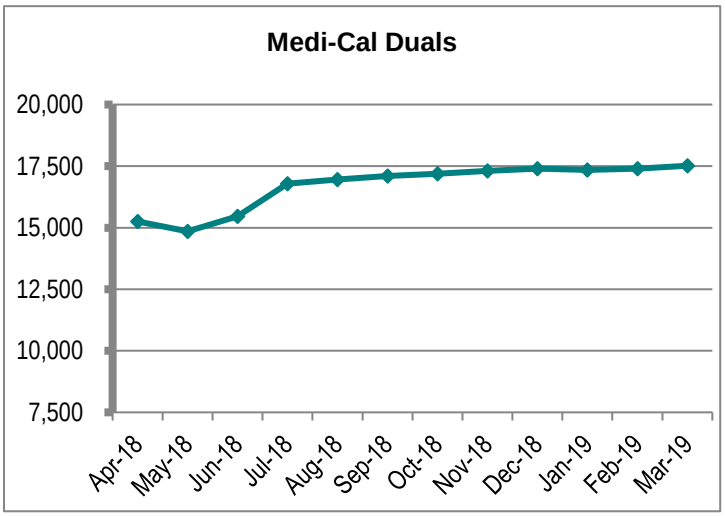


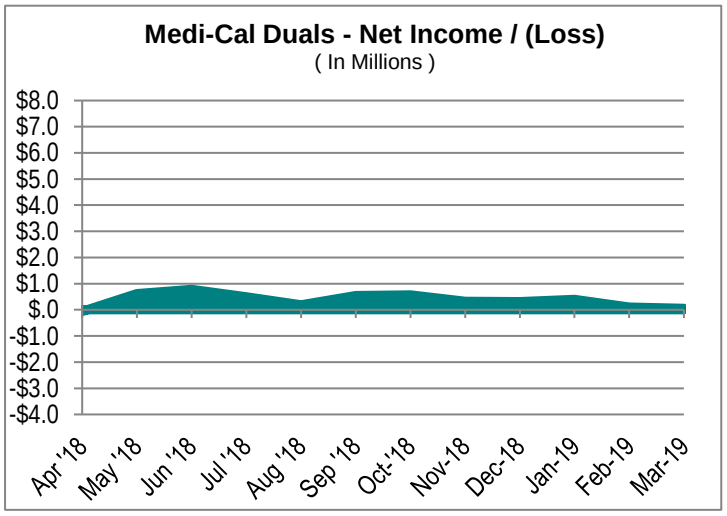


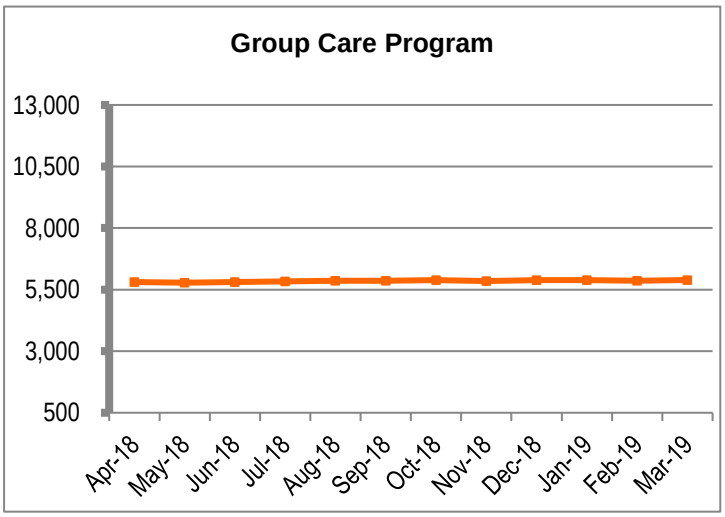
Enrollment and Profitability by Program and Category of Aid

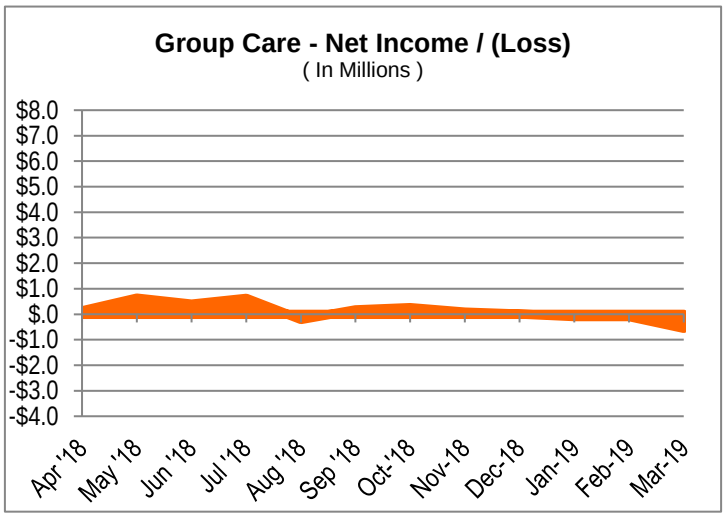








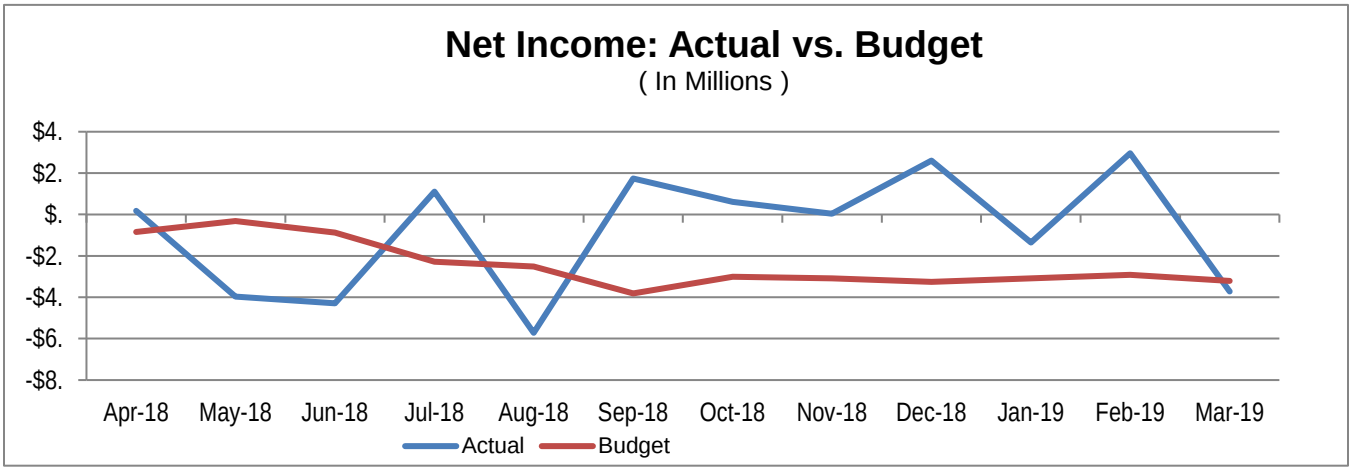




Net Income

- For the month ended March 31, 2019:
  - Actual Net Loss: $3.7 million.
  - Budgeted Net Loss: $3.2 million.

- For the year-to-date (YTD) ended March 31, 2019:
  - Actual YTD Net Loss: $1.8 million.
  - Budgeted YTD Net Loss: $27.0 million.

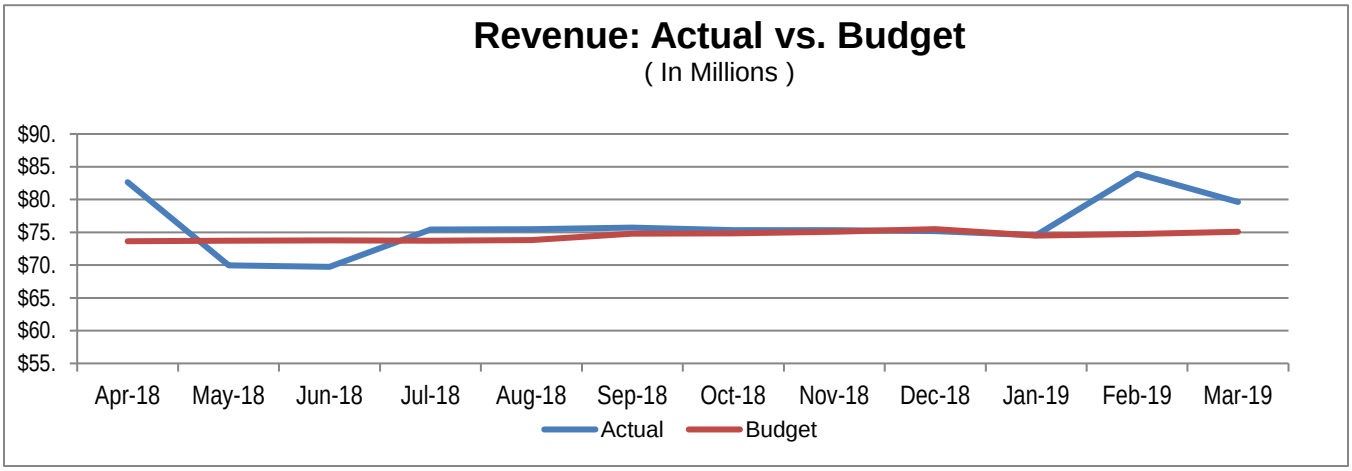


- The unfavorable variance of $517,000 in the current month is largely due to:
  - Unfavorable $5.7 million higher than anticipated Medical Expense.
  - Partially offset by favorable $4.5 million higher than anticipated Revenue.
  - Favorable $648,000 lower than anticipated Administrative Expense.
  - Favorable $38,000 higher than anticipated Other Income & Expense.

Revenue

- For the month ended March 31, 2019:
  - Actual Revenue: $79.6 million.
  - Budgeted Revenue: $75.1 million.

- For the fiscal year-to-date ended March 31, 2019:
  - Actual YTD Revenue: $690.6 million.
  - Budgeted YTD Revenue: $675.5 million.

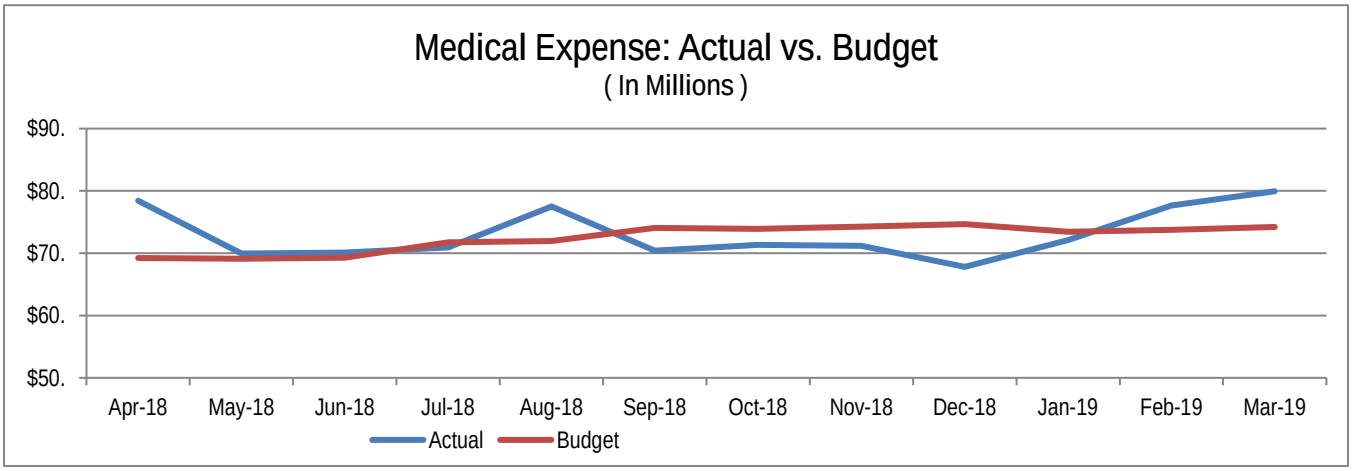


- For the month ended March 31, 2019, the favorable revenue variance of $4.5 million is mainly due to:
    - Favorable $4.7 million revenue for amounts to be paid to providers of Ground Emergency Medical Transportation (GEMT). Revenue received will have a corresponding offset in Medical Expenses. The Alliance received DHCS final FY19 capitation rates (retroactive to July 2018) which included a new additional payment for GEMT. This is a supplemental payment to GEMT providers for non-contracted trips. An APL will be finalized and released by the State on the new payment stream in April of 2019.
    - Favorable $1.1 million revenue for amounts to be paid to physicians funded by Prop 56. This revenue is offset by corresponding Medical Expense. The Alliance has received DHCS final FY19 Capitation rates (retroactive to July 2018) which reflect the higher FY19 Prop 56 rates.
    - Unfavorable $987,000 in lower than expected Base Capitation primarily due to lower enrollment than anticipated.
    - Unfavorable $290,000 in lower Behavioral Health Supplemental payments, primarily due to lower utilization than planned.

Medical Expense

- For the month ended March 31, 2019:
    - Actual Medical Expense: $79.9 million.
    - Budgeted Medical Expense: $74.2 million.

- For the fiscal year-to-date ended March 31, 2019:
    - Actual YTD Medical Expense: $658.8 million.
    - Budgeted YTD Medical Expense: $666.8 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 at Optumas.

- For March, updates to Fee-For-Service (FFS) increased the estimate for unpaid Medical Expenses for prior months by $946,000. Year-to-date, the estimate for prior years decreased by $3.5 million (per table below).

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

	Actual			Budget	Variance - Adjusted Actual vs. Budget	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$150,423,300	$0	$150,423,300	$154,722,056	$4,298,756	2.8%
Primary Care FFS	28,593,885	(572,092)	28,021,793	16,841,036	($11,752,849)	-69.8%
Specialty Care FFS	33,735,784	459,105	34,194,889	35,667,912	$1,932,128	5.4%
Outpatient FFS	64,257,010	438,689	64,695,699	71,564,984	$7,307,974	10.2%
Ancillary FFS	28,107,980	(85,000)	28,022,980	22,679,334	($5,428,646)	-23.9%
Pharmacy FFS	118,035,475	(766,724)	117,268,751	117,871,912	($163,562)	-0.1%
ER Services FFS	30,151,614	(834,401)	29,317,213	33,027,335	$2,875,720	8.7%
Inpatient Hospital & SNF FFS	195,020,157	(2,150,543)	192,869,614	199,557,882	$4,537,724	2.3%
Other Benefits & Services	12,821,172	0	12,821,172	13,747,964	$926,792	6.7%
Net Reinsurance	414,270	0	414,270	305,647	($108,623)	-35.5%
Provider Incentive	799,997	0	799,997	799,997	($0)	0.0%
	$662,360,643	($3,510,966)	$658,849,677	$666,786,059	$4,425,415	0.7%

Medical Expense - Actual vs. Budget (Per Member Per Month) Adjusted to Eliminate the Impact of Prior Year IBNP Estimates Favorable/(Unfavorable)						
	Actual			Budget	Variance - Adjusted Actual vs. Budget	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$63.48	$0.00	$63.48	$64.71	$1.23	1.9%
Primary Care FFS	12.07	(0.24)	11.82	7.04	(5.02)	-71.3%
Specialty Care FFS	14.24	0.19	14.43	14.92	0.68	4.6%
Outpatient FFS	27.12	0.19	27.30	29.93	2.81	9.4%
Ancillary FFS	11.86	(0.04)	11.83	9.49	(2.38)	-25.1%
Pharmacy FFS	49.81	(0.32)	49.49	49.30	(0.51)	-1.0%
ER Services FFS	12.72	(0.35)	12.37	13.81	1.09	7.9%
Inpatient Hospital & SNF FFS	82.30	(0.91)	81.39	83.46	1.16	1.4%
Other Benefits & Services	5.41	0.00	5.41	5.75	0.34	5.9%
Net Reinsurance	0.17	0.00	0.17	0.13	(0.05)	-36.8%
Provider Incentive	0.34	0.00	0.34	0.33	(0.00)	-0.9%
	$279.51	($1.48)	$278.02	$278.87	($0.64)	-0.2%

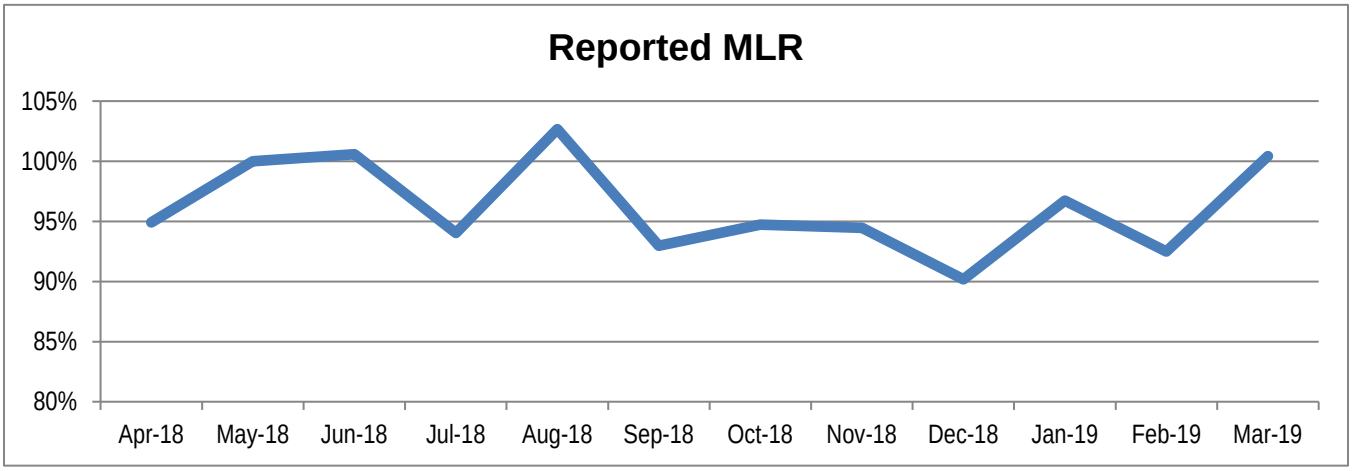
- Excluding the effect of prior year estimates for IBNP, year-to-date medical expense variance is $4.4 million favorable to budget. On a PMPM basis, medical expense is unfavorable to budget by 0.2%.
    - Primary Care Expense is over budget, due to the significant increase in Prop 56 rates. The expanded list of codes and higher rates per code were received in March and paid retroactively to July 2018.
    - Ancillary expense is over budget, due to the implementation of supplemental payments to providers for Ground Emergency Medical Transportation. Code and rate information was received in March and paid retroactively to July 2018.
    - Outpatient Expense is under budget for all populations, particularly for SPDs. Lab, Radiology, Behavioral Health Therapy, Mental Health, and Other Outpatient services showed lower than trend utilization. Also contributing, are refunds for overpayment of dialysis services.
    - Inpatient Expense is significantly under budget for SPDs. Expense for catastrophic cases has been materially less than anticipated. SPD unit cost has decreased by 11% and days per 1,000 member months have decreased by 2%. This was partially offset by higher than planned expense for the ACA OE, Group Care, Adult and Child populations.
    - Emergency Expense is favorable for all populations, primarily driven by lower cost per visit.
    - Pharmacy Expense is slightly higher than planned, driven by the ACA OE Category of Aid. This was primarily due to increased unit cost for specialty

and brand drugs, such as Anti-rheumatoid and Oncology medications. Expense for SPDs and Adults was lower than planned.

- Favorable capitation expense mainly results from a retroactive adjustment to supplemental payments for our Globally Sub-capitated Delegate. This corresponds to an equivalent revenue reduction. We have also had fewer BHT Kick payments, which are passed through to our Globally Sub-capitated Delegate.
- Favorable Net Reinsurance Expense represents higher prior year recoveries than anticipated.

Medical Loss Ratio (MLR)

- The Medical Loss Ratio (total reported medical expense divided by operating revenue) was 100.4% of net revenue for the month and 95.4% for the fiscal year-to-date.



Administrative Expense

- For the month ended March 31, 2019:
  - Actual Administrative Expense: $3.9 million.
  - Budgeted Administrative Expense: $4.6 million.

- For the fiscal year-to-date ended March 31, 2019:
  - Actual YTD Administrative Expense: $37.8 million.
  - Budgeted YTD Administrative Expense: $40.2 million.

Summary of Administrative Expense (In Dollars) For the Month and Fiscal Year-to-Date Favorable/(Unfavorable)								
Month					Year-to-Date			
Actual	Budget	Variance $	Variance %		Actual	Budget	Variance $	Variance %
$2,240,000	$2,555,679	$315,679	12.4%	Employee Expense	$20,433,496	$22,024,307	$1,590,811	7.2%
447,551	495,419	47,868	9.7%	Medical Benefits Admin Expense	4,633,773	4,747,040	113,267	2.4%
424,816	768,349	343,533	44.7%	Purchased & Professional Services	4,000,411	5,755,817	1,755,406	30.5%
799,783	741,171	(58,612)	-7.9%	Other Admin Expense	8,709,716	7,696,980	(1,012,736)	-13.2%
$3,912,150	$4,560,618	$648,468	14.2%	Total Administrative Expense	$37,777,396	$40,224,144	$2,446,748	6.1%

- The year-to-date favorable variance is primarily due to:
    - Fewer than anticipated employees – four Full-Time Equivalent (FTE) employees less than budget.
    - Less than planned Computer Support Services.
    - Partially offset by unfavorable estimated MCO tax shortfall.
- Administrative expense represented 4.9% of net revenue for the month and 5.5% of net revenue for the year-to-date.

Other Income / (Expense)

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

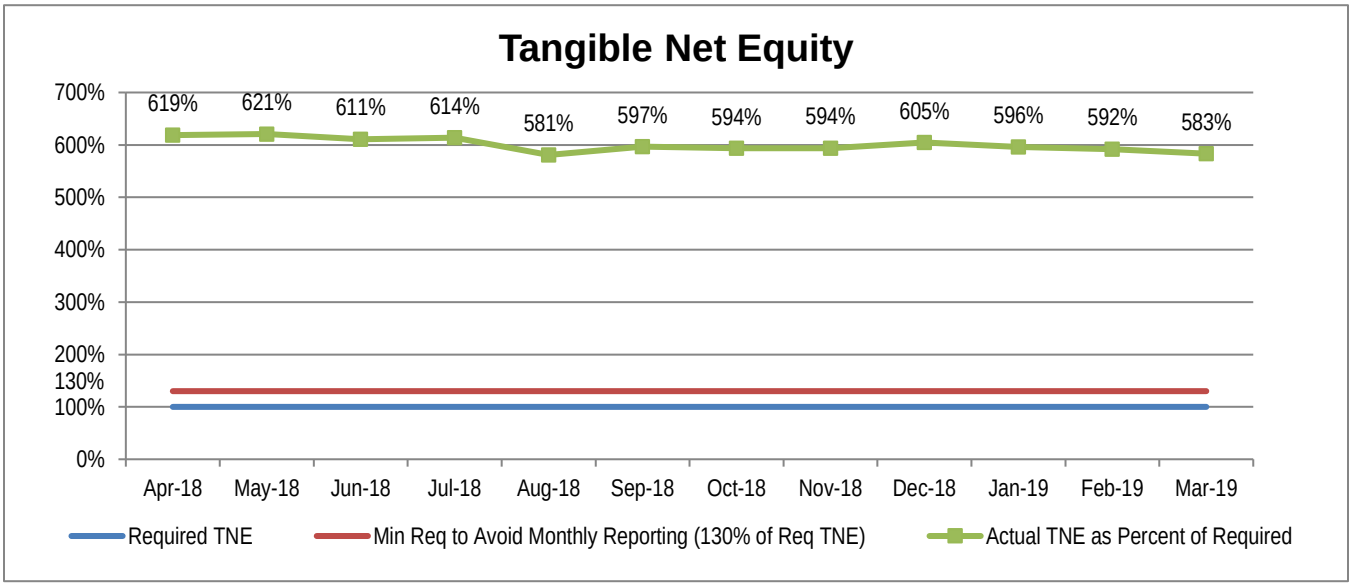
- Year-to-date interest income from investments is $4.4 million.

- Year-to-date claims interest expense, due to delayed payment of certain claims or recalculated interest on previously paid claims is $474,000.

Tangible Net Equity (TNE)

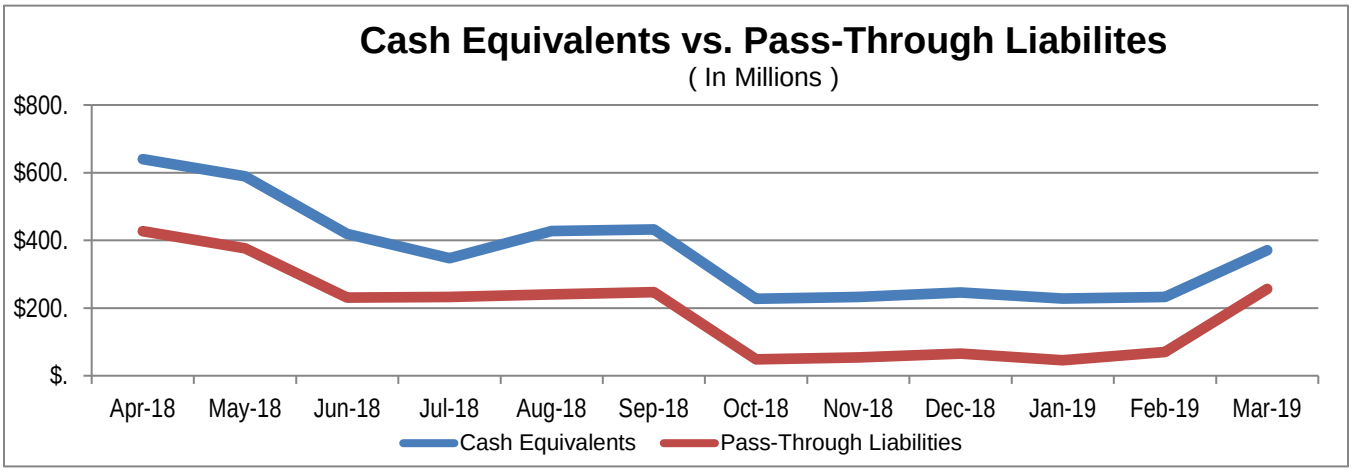
- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to consumers. TNE is a calculation of a company's total tangible assets minus the company's total liabilities. The Alliance exceeds DMHC's required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

    - Required TNE $32.3 million
    - Actual TNE $188.4 million
    - Surplus TNE $156.1 million
    - TNE as % of Required TNE 583%



- Cash and Liabilities reflect pass-through liabilities and ACA OE MLR accrual. The ACA OE MLR accrual represents funds that must be paid back to the Department of Health Care Services (DHCS) / Centers for Medicare & Medicaid Services (CMS) and are a result of ACA OE MLR being less than 85% for the 2017 fiscal year.
- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments and highly-liquid money market funds. An investment strategy was implemented in April 2018. The strategy focuses on security of funds, liquidity, and interest maximization.

- Key Metrics
  - Cash & Cash Equivalents $370.5 million
  - Pass-Through Liabilities $256.0 million
  - Uncommitted Cash $114.5 million
  - Working Capital $177.1 million
  - Current Ratio 1.47 (regulatory minimum is 1.0)



Capital Investment

- Fiscal year-to-date Capital assets acquired: $678,000.
- Annual capital budget: $1.7 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 March 31, 2019

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				MEMBERSHIP				
253,255	259,861	(6,606)	(2.5%)	1 - Medi-Cal	2,316,950	2,338,209	(21,259)	(0.9%)
5,892	5,893	(1)	0.0%	2 - Group Care	52,806	52,843	(37)	(0.1%)
259,147	**265,754**	**(6,607)**	**(2.5%)**	**3 - Total Member Months**	**2,369,756**	**2,391,052**	**(21,296)**	**(0.9%)**
				REVENUE				
$79,612,444	**$75,105,646**	**$4,506,798**	**6.0%**	**4 - TOTAL REVENUE**	**$690,584,302**	**$675,491,885**	**$15,092,417**	**2.2%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses:				
16,812,322	17,626,713	814,391	4.6%	5 - Capitated Medical Expense	150,423,300	154,722,056	4,298,756	2.8%
				Fee for Service Medical Expenses:				
23,569,140	21,557,831	(2,011,309)	(9.3%)	6 - Inpatient Hospital & SNF FFS Expense	192,869,614	199,557,882	6,688,268	3.4%
3,106,383	1,736,475	(1,369,908)	(78.9%)	7 - Primary Care Physician FFS Expense	28,021,793	16,841,036	(11,180,757)	(66.4%)
3,790,525	3,912,112	121,587	3.1%	8 - Specialty Care Physician Expense	34,194,889	35,667,912	1,473,023	4.1%
6,961,107	2,600,665	(4,360,442)	(167.7%)	9 - Ancillary Medical Expense	28,022,980	22,679,334	(5,343,646)	(23.6%)
8,183,348	8,086,760	(96,588)	(1.2%)	10 - Outpatient Medical Expense	64,695,699	71,564,984	6,869,285	9.6%
2,873,399	3,867,254	993,855	25.7%	11 - Emergency Expense	29,317,213	33,027,335	3,710,122	11.2%
12,767,617	13,141,279	373,662	2.8%	12 - Pharmacy Expense	117,268,751	117,871,912	603,161	0.5%
61,251,519	54,902,376	(6,349,143)	(11.6%)	13 - Total Fee for Service Expense	494,390,939	497,210,395	2,819,456	0.6%
1,426,303	1,578,930	152,627	9.7%	14 - Other Benefits & Services	12,821,172	13,747,964	926,792	6.7%
387,819	60,586	(327,233)	(540.1%)	15 - Reinsurance Expense	414,270	305,647	(108,623)	(35.5%)
66,667	66,667	0	0.0%	16 - Risk Pool Distribution	799,997	799,997	0	0.0%
79,944,629	**74,235,272**	**(5,709,357)**	**(7.7%)**	**17 - TOTAL MEDICAL EXPENSES**	**658,849,677**	**666,786,059**	**7,936,381**	**1.2%**
(332,185)	**870,374**	**(1,202,559)**	**(138.2%)**	**18 - GROSS MARGIN**	**31,734,625**	**8,705,826**	**23,028,799**	**264.5%**
				ADMINISTRATIVE EXPENSES				
2,240,000	2,555,679	315,679	12.4%	19 - Personnel Expense	20,433,496	22,024,307	1,590,810	7.2%
447,551	495,419	47,868	9.7%	20 - Benefits Administration Expense	4,633,773	4,747,040	113,266	2.4%
424,816	768,349	343,533	44.7%	21 - Purchased & Professional Services	4,000,411	5,755,817	1,755,406	30.5%
799,783	741,171	(58,611)	(7.9%)	22 - Other Administrative Expense	8,709,715	7,696,980	(1,012,734)	(13.2%)
3,912,150	**4,560,618**	**648,469**	**14.2%**	**23 -Total Administrative Expense**	**37,777,396**	**40,224,144**	**2,446,748**	**6.1%**
(4,244,335)	**(3,690,244)**	**(554,091)**	**(15.0%)**	**24 - NET OPERATING INCOME / (LOSS)**	**(6,042,771)**	**(31,518,317)**	**25,475,547**	**80.8%**
				OTHER INCOME / EXPENSE				
517,588	**480,000**	**37,588**	**7.8%**	**25 - Total Other Income / (Expense)**	**4,292,538**	**4,530,416**	**(237,878)**	**(5.3%)**
($3,726,747)	**($3,210,244)**	**($516,502)**	**(16.1%)**	**26 - NET INCOME / (LOSS)**	**($1,750,233)**	**($26,987,901)**	**$25,237,668**	**93.5%**
4.9%	6.1%	1.2%	19.1%	27 - Admin Exp % of Revenue	5.5%	6.0%	0.5%	8.1%

ALAMEDA ALLIANCE FOR HEALTH
SUMMARY BALANCE SHEET 2019
CURRENT MONTH VS. PRIOR MONTH
March 31, 2019

	March	February	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	$5,253,404	$9,306,704	($4,053,300)	-43.55%
Short-Term Investments	365,271,388	223,796,866	141,474,522	63.22%
Interest Receivable	183,592	140,712	42,880	30.47%
Other Receivables - Net	174,061,087	124,424,728	49,636,358	39.89%
Prepaid Expenses	3,818,429	3,798,352	20,077	0.53%
Prepaid Inventoried Items	4,488	4,488	0	0.00%
CalPERS Net Pension Asset	(630,096)	(630,096)	0	0.00%
Deferred CalPERS Outflow	5,347,248	5,347,248	0	0.00%
TOTAL CURRENT ASSETS	**553,309,540**	**366,189,003**	**187,120,537**	**51.10%**
OTHER ASSETS:				
Restricted Assets	344,400	341,716	2,685	0.79%
TOTAL OTHER ASSETS	**344,400**	**341,716**	**2,685**	**0.79%**
PROPERTY AND EQUIPMENT:				
Land, Building & Improvements	9,460,667	9,460,000	668	0.01%
Furniture And Equipment	13,358,311	13,304,025	54,286	0.41%
Leasehold Improvement	849,885	849,885	0	0.00%
Internally-Developed Software	16,824,002	16,824,002	0	0.00%
Fixed Assets at Cost	40,492,865	40,437,911	54,954	0.14%
Less: Accumulated Depreciation	(29,516,911)	(29,354,736)	(162,176)	0.55%
NET PROPERTY AND EQUIPMENT	**10,975,953**	**11,083,175**	**(107,222)**	**-0.97%**
TOTAL ASSETS	**$564,629,893**	**$377,613,894**	**$187,016,000**	**49.53%**
CURRENT LIABILITIES:				
Accounts Payable	$1,774,761	$1,358,550	$416,211	30.64%
Pass-Through Liabilities	255,967,348	70,269,936	185,697,412	264.26%
Claims Payable	12,419,722	10,582,492	1,837,230	17.36%
IBNP Reserves	94,422,260	91,758,038	2,664,222	2.90%
Payroll Liabilities	2,719,482	2,658,478	61,004	2.29%
CalPERS Deferred Inflow	3,024,492	3,024,492	0	0.00%
Risk Sharing	4,598,620	4,531,953	66,667	1.47%
Provider Grants/ New Health Program	1,293,728	1,293,728	0	0.00%
TOTAL CURRENT LIABILITIES	**376,220,412**	**185,477,666**	**190,742,747**	**102.84%**
TOTAL LIABILITIES	**376,220,412**	**185,477,666**	**190,742,747**	**102.84%**
NET WORTH:				
Contributed Capital	840,233	840,233	0	0.00%
Restricted & Unrestricted Funds	189,319,480	189,319,480	0	0.00%
Year-to Date Net Income / (Loss)	(1,750,233)	1,976,514	(3,726,747)	-188.55%
TOTAL NET WORTH	**188,409,481**	**192,136,228**	**(3,726,747)**	**-1.94%**
TOTAL LIABILITIES AND NET WORTH	**$564,629,893**	**$377,613,894**	**$187,016,000**	**49.53%**

Alameda Alliance for Health
FY19 Income Statement Run-Rate Analysis
March 2019
$000s: Favorable/(Unfavorable)

This Schedule adjusts General Ledger results as booked to determine the current period operating results.

	Month					Year-To-Date				
	As Reported	Adjustments	Normalized	Budget	Normalized vs. Budget	As Reported	Adjustments	Normalized	Budget	Normalized vs. Budget
Members	**259,147**		**259,147**	**265,754**	**(6,607)**	**2,369,756**		**2,369,756**	**2,391,052**	**(21,296)**
Profit & Loss										
Revenue	$79,612	($4,662)	**$74,950**	**$75,106**	**($156)**	$690,584	($1,138)	**$689,446**	**$675,492**	**$13,954**
Medical Expense	79,945	5,608	**74,336**	**74,235**	**(101)**	658,850	(5,610)	**664,459**	**666,786**	**2,327**
Gross Margin	**(332)**	**946**	**614**	**870**	**(257)**	**31,735**	**(6,748)**	**24,987**	**8,706**	**16,281**
Administrative Expense	3,912	0	**3,912**	**4,561**	**648**	37,777	0	**37,777**	**40,224**	**2,447**
Operating Income / (Loss)	**(4,244)**	**946**	**(3,298)**	**(3,690)**	**392**	**(6,043)**	**(6,748)**	**(12,791)**	**(31,518)**	**18,728**
Other Income / (Expense)	518	0	**518**	**480**	**38**	4,293	0	**4,293**	**4,530**	**(238)**
Net Income / (Loss)	**($3,727)**	**$946**	**($2,781)**	**($3,210)**	**$429**	**($1,750)**	**($6,748)**	**($8,498)**	**($26,988)**	**$18,490**
PMPM										
Revenue	$307.21		**$289.22**	**$282.61**	**$6.61**	$291.42		**$290.94**	**$282.51**	**$8.43**
Medical	$308.49		**$286.85**	**$279.34**	**($7.51)**	$278.02		**$280.39**	**$278.87**	**($1.52)**
Gross Margin	($1.28)		**$2.37**	**$3.28**	**($0.91)**	$13.39		**$10.54**	**$3.64**	**$6.90**
Ratios										
Medical Loss Ratio	100.4%		**99.2%**	**98.8%**	**-0.3%**	95.4%		**96.4%**	**98.7%**	**2.3%**
Administrative Expense %	4.9%		**5.2%**	**6.1%**	**0.9%**	5.5%		**5.5%**	**6.0%**	**0.5%**
Net Income / (Loss) %	-4.7%		**-3.7%**	**-4.3%**	**0.6%**	-0.3%		**-1.2%**	**-4.0%**	**2.8%**

Notes:

Adjustments generally limited to $300K.

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 3/31/2019

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$2,011,941	$6,037,452	$12,046,830	$18,080,321
Total	2,011,941	6,037,452	12,046,830	18,080,321
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	77,344,782	231,622,864	451,230,585	671,632,713
Allowance for Doubtful Accounts	0	0	0	0
Deferred Premium Revenue	0	0	0	0
Premium Receivable	(49,089,812)	(68,007,199)	(68,771,318)	(72,655,540)
Total	28,254,970	163,615,665	382,459,267	598,977,173
Investment & Other Income Cash Flows				
Other Revenue (Grants)	280,435	672,411	901,186	1,177,838
Interest Income	546,902	1,178,831	2,851,679	4,460,557
Interest Receivable	(42,880)	12,157	(86,203)	(81,798)
Total	784,457	1,863,399	3,666,662	5,556,597
Medical & Hospital Cash Flows				
Total Medical Expenses	(79,944,629)	(229,671,142)	(440,022,557)	(658,849,677)
Other Receivable	(546,546)	803,003	2,912,423	3,191,159
Claims Payable	1,837,230	842,622	(356,737)	680,530
IBNP Payable	2,664,222	1,898,187	(5,086,260)	(1,554,728)
Risk Share Payable	66,667	199,998	399,998	(2,531,713)
Health Program	0	(135,845)	(867,162)	(702,611)
Other Liabilities	1	0	(1)	0
Total	(75,923,055)	(226,063,177)	(443,020,296)	(659,767,040)
Administrative Cash Flows				
Total Administrative Expenses	(3,966,177)	(11,965,481)	(25,875,337)	(38,251,985)
Prepaid Expenses	(20,077)	380,041	(321,831)	(1,002,341)
CalPERS Pension Asset	0	0	0	0
CalPERS Deferred Outflow	0	0	0	0
Trade Accounts Payable	416,211	(653,017)	(138,440)	106,995
Other Accrued Liabilities	0	0	0	0
Payroll Liabilities	61,004	165,177	111,280	90,752
Depreciation Expense	162,176	505,435	1,105,835	1,700,045
Total	(3,346,863)	(11,567,845)	(25,118,493)	(37,356,534)
Interest Paid				
Debt Interest Expense	0	0	0	0
Total Cash Flows from Operating Activities	**(48,218,550)**	**(66,114,506)**	**(69,966,030)**	**(74,509,483)**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 3/31/2019

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Restricted Cash & Other Asset Cash Flows				
Provider Pass-Thru-Liabilities	185,697,412	190,818,215	8,820,527	26,783,198
Restricted Cash	(2,685)	347,295	3,591	1,950
	185,694,727	191,165,510	8,824,118	26,785,148
Fixed Asset Cash Flows				
Depreciation expense	162,176	505,435	1,105,835	1,700,045
Fixed Asset Acquisitions	(54,954)	(237,078)	(509,540)	(677,953)
Change in A/D	(162,176)	(505,435)	(1,105,835)	(1,700,045)
	(54,954)	(237,078)	(509,540)	(677,953)
Total Cash Flows from Investing Activities	**185,639,773**	**190,928,432**	**8,314,578**	**26,107,195**
Financing Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Total Cash Flows	**137,421,223**	**124,813,926**	**(61,651,452)**	**(48,402,288)**
Rounding	(1)	(1)	(2)	(1)
Cash @ Beginning of Period	233,103,570	245,710,867	432,176,246	418,927,081
Cash @ End of Period	**$370,524,792**	**$370,524,792**	**$370,524,792**	**$370,524,792**
Difference (rounding)	0	0	0	0

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 3/31/2019

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	($3,726,747)	($2,125,065)	$1,132,385	($1,750,233)
Add back: Depreciation	162,176	505,435	1,105,835	1,700,045
Receivables				
Premiums Receivable	(49,089,812)	(68,007,199)	(68,771,318)	(72,655,540)
First Care Receivable	0	0	0	0
Family Care Receivable	0	0	0	0
Healthy Kids Receivable	0	0	0	0
Interest Receivable	(42,880)	12,157	(86,203)	(81,798)
Other Receivable	(546,546)	803,003	2,912,423	3,191,159
FQHC Receivable	0	0	0	0
Allowance for Doubtful Accounts	0	0	0	0
Total	(49,679,238)	(67,192,039)	(65,945,098)	(69,546,179)
Prepaid Expenses	(20,077)	380,041	(321,831)	(1,002,341)
Trade Payables	416,211	(653,017)	(138,440)	106,995
Claims Payable, IBNR & Risk Share				
IBNP	2,664,222	1,898,187	(5,086,260)	(1,554,728)
Claims Payable	1,837,230	842,622	(356,737)	680,530
Risk Share Payable	66,667	199,998	399,998	(2,531,713)
Other Liabilities	1	0	(1)	0
Total	4,568,120	2,940,807	(5,043,000)	(3,405,911)
Unearned Revenue				
Deferred Premium Revenue	0	0	0	0
Deferred Grant Revenue	0	0	0	0
Deferred Revenue - Family	0	0	0	0
Deferred Revenue - First	0	0	0	0
Deferred Revenue - IHSS	0	0	0	0
Deferred Revenue - HK	0	0	0	0
Deferred Revenue - Other	0	0	0	0
Total	0	0	0	0
Other Liabilities				
Accrued Expenses	0	0	0	0
Payroll Liabilities	61,004	165,177	111,280	90,752
Health Program	0	(135,845)	(867,162)	(702,611)
Accrued Sub Debt Interest	0	0	0	0
Total Change in Other Liabilities	61,004	29,332	(755,882)	(611,859)
Cash Flows from Operating Activities	**($48,218,551)**	**($66,114,506)**	**($69,966,031)**	**($74,509,483)**
Difference (rounding)	(1)	0	(1)	0

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 3/31/2019

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received From:				
Capitation Received from State of CA	$28,254,970	$163,615,665	$382,459,267	$598,977,173
Commercial Premium Revenue	2,011,941	6,037,452	12,046,830	18,080,321
Other Income	280,435	672,411	901,186	1,177,838
Investment Income	504,022	1,190,988	2,765,476	4,378,759
Cash Paid To:				
Medical Expenses	(75,923,055)	(226,063,177)	(443,020,296)	(659,767,040)
Vendor & Employee Expenses	(3,346,863)	(11,567,845)	(25,118,493)	(37,356,534)
Interest Paid	0	0	0	0
Net Cash Provided By (Used In) Operating Activities	(48,218,550)	(66,114,506)	(69,966,030)	(74,509,483)
Cash Flows from Financing Activities:				
Purchases of Fixed Assets	(54,954)	(237,078)	(509,540)	(677,953)
Net Cash Provided By (Used In) Financing Activities	(54,954)	(237,078)	(509,540)	(677,953)
Cash Flows from Investing Activities:				
Changes in Investments	0	0	0	0
Restricted Cash	185,694,727	191,165,510	8,824,118	26,785,148
Net Cash Provided By (Used In) Investing Activities	185,694,727	191,165,510	8,824,118	26,785,148
Financial Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Net Change in Cash	**137,421,223**	**124,813,926**	**(61,651,452)**	**(48,402,288)**
Cash @ Beginning of Period	233,103,570	245,710,867	432,176,246	418,927,081
Subtotal	$370,524,793	$370,524,793	$370,524,794	$370,524,793
Rounding	(1)	(1)	(2)	(1)
Cash @ End of Period	**$370,524,792**	**$370,524,792**	**$370,524,792**	**$370,524,792**
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	($3,726,747)	($2,125,065)	$1,132,385	($1,750,233)
Depreciation	162,176	505,435	1,105,835	1,700,045
Net Change in Operating Assets & Liabilities:				
Premium & Other Receivables	(49,679,238)	(67,192,039)	(65,945,098)	(69,546,179)
Prepaid Expenses	(20,077)	380,041	(321,831)	(1,002,341)
Trade Payables	416,211	(653,017)	(138,440)	106,995
Claims payable & IBNP	4,568,120	2,940,807	(5,043,000)	(3,405,911)
Deferred Revenue	0	0	0	0
Accrued Interest	0	0	0	0
Other Liabilities	61,004	29,332	(755,882)	(611,859)
Subtotal	(48,218,551)	(66,114,506)	(69,966,031)	(74,509,483)
Rounding	1	0	1	0
Cash Flows from Operating Activities	**($48,218,550)**	**($66,114,506)**	**($69,966,030)**	**($74,509,483)**

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE CURRENT MONTH - MARCH 2019

	Child	Adults	Medi-Cal SPD	ACA OE	Duals	Medi-Cal Total	Group Care	Grand Total
Enrollment	93,457	34,525	25,938	81,821	17,514	253,255	5,892	259,147
Gross Revenue	$10,602,278	$9,721,562	$25,886,670	$28,550,906	$2,839,087	$77,600,503	$2,011,941	$79,612,444
Contra Revenue	$0	$0	$0	$0	$0	$0	$0	$0
Net Revenue	$10,602,278	$9,721,562	$25,886,670	$28,550,906	$2,839,087	$77,600,503	$2,011,941	$79,612,444
Medical Expense	$9,942,697	$9,938,110	$25,415,050	$29,553,510	$2,663,318	$77,512,685	$2,431,944	$79,944,629
Gross Margin	$659,581	($216,548)	$471,620	($1,002,604)	$175,769	$87,818	($420,003)	($332,185)
Administrative Expense	$366,419	$494,793	$1,360,898	$1,396,041	$140,316	$3,758,467	$153,683	$3,912,150
Operating Income / (Expense)	$293,162	($711,340)	($889,279)	($2,398,645)	$35,453	($3,670,649)	($573,686)	($4,244,335)
Other Income / (Expense)	$42,831	$63,422	$191,354	$189,332	$12,553	$499,492	$18,096	$517,588
Net Income / (Loss)	$335,994	($647,919)	($697,925)	($2,209,313)	$48,006	($3,171,157)	($555,590)	($3,726,747)
Revenue PMPM	$113.45	$281.58	$998.02	$348.94	$162.10	$306.41	$341.47	$307.21
Medical Expense PMPM	$106.39	$287.85	$979.84	$361.20	$152.07	$306.07	$412.75	$308.49
Gross Margin PMPM	$7.06	($6.27)	$18.18	($12.25)	$10.04	$0.35	($71.28)	($1.28)
Administrative Expense PMPM	$3.92	$14.33	$52.47	$17.06	$8.01	$14.84	$26.08	$15.10
Operating Income / (Expense) PMPM	$3.14	($20.60)	($34.28)	($29.32)	$2.02	($14.49)	($97.37)	($16.38)
Other Income / (Expense) PMPM	$0.46	$1.84	$7.38	$2.31	$0.72	$1.97	$3.07	$2.00
Net Income / (Loss) PMPM	$3.60	($18.77)	($26.91)	($27.00)	$2.74	($12.52)	($94.30)	($14.38)
Medical Loss Ratio	93.8%	102.2%	98.2%	103.5%	93.8%	99.9%	120.9%	100.4%
Gross Margin Ratio	6.2%	-2.2%	1.8%	-3.5%	6.2%	0.1%	-20.9%	-0.4%
Administrative Expense Ratio	3.5%	5.1%	5.3%	4.9%	4.9%	4.8%	7.6%	4.9%
Net Income Ratio	3.2%	-6.7%	-2.7%	-7.7%	1.7%	-4.1%	-27.6%	-4.7%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR-TO-DATE - MARCH 2019

	Medi-Cal					Medi-Cal	Group	Grand
	Child	Adults	SPD	ACA OE	Duals	Total	Care	Total
Member Months	858,907	319,364	235,180	748,497	155,002	2,316,950	52,806	2,369,756
Revenue	$94,398,717	$87,900,035	$216,686,413	$248,572,138	$24,946,662	$672,503,966	$18,080,336	$690,584,302
Contra Revenue				$0		$0		$0
Net Revenue	$94,398,717	$87,900,035	$216,686,413	$248,572,138	$24,946,662	$672,503,966	$18,080,336	$690,584,302
Medical Expense	$78,097,258	$86,750,788	$215,546,568	$240,704,115	$20,932,006	$642,030,736	$16,818,941	$658,849,677
Gross Margin	$16,301,459	$1,149,247	$1,139,845	$7,868,022	$4,014,656	$30,473,230	$1,261,395	$31,734,625
Administrative Expense	$2,956,694	$4,932,873	$13,463,682	$14,075,289	$1,160,816	$36,589,353	$1,188,042	$37,777,396
Operating Income / (Expense)	$13,344,765	($3,783,626)	($12,323,837)	($6,207,266)	$2,853,840	($6,116,123)	$73,353	($6,042,771)
Other Income / (Expense)	$301,571	$558,624	$1,585,668	$1,608,754	$122,458	$4,177,075	$115,463	$4,292,538
Net Income / (Loss)	$13,646,336	($3,225,001)	($10,738,169)	($4,598,512)	$2,976,298	($1,939,048)	$188,816	($1,750,233)
Revenue PMPM	$109.91	$275.23	$921.36	$332.10	$160.94	$290.25	$342.39	$291.42
Medical Expense PMPM	$90.93	$271.64	$916.52	$321.58	$135.04	$277.10	$318.50	$278.02
Gross Margin PMPM	$18.98	$3.60	$4.85	$10.51	$25.90	$13.15	$23.89	$13.39
Administrative Expense PMPM	$3.44	$15.45	$57.25	$18.80	$7.49	$15.79	$22.50	$15.94
Operating Income / (Expense) PMPM	$15.54	($11.85)	($52.40)	($8.29)	$18.41	($2.64)	$1.39	($2.55)
Other Income / (Expense) PMPM	$0.35	$1.75	$6.74	$2.15	$0.79	$1.80	$2.19	$1.81
Net Income / (Loss) PMPM	$15.89	($10.10)	($45.66)	($6.14)	$19.20	($0.84)	$3.58	($0.74)
Medical Loss Ratio	82.7%	98.7%	99.5%	96.8%	83.9%	95.5%	93.0%	95.4%
Gross Margin Ratio	17.3%	1.3%	0.5%	3.2%	16.1%	4.5%	7.0%	4.6%
Administrative Expense Ratio	3.1%	5.6%	6.2%	5.7%	4.7%	5.4%	6.6%	5.5%
Net Income Ratio	14.5%	-3.7%	-5.0%	-1.8%	11.9%	-0.3%	1.0%	-0.3%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED March 31, 2019

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSE SUMMARY				
$2,240,000	$2,555,679	$315,679	12.4%	Personnel Expenses	$20,433,496	$22,024,307	$1,590,810	7.2%
447,551	495,419	47,868	9.7%	Benefits Administration Expense	4,633,773	4,747,040	113,266	2.4%
424,816	768,349	343,533	44.7%	Purchased & Professional Services	4,000,411	5,755,817	1,755,406	30.5%
328,846	305,171	(23,676)	(7.8%)	Occupancy	3,234,373	3,094,210	(140,162)	(4.5%)
77,903	139,337	61,434	44.1%	Printing Postage & Promotion	1,005,422	1,289,475	284,053	22.0%
374,671	406,786	32,116	7.9%	Licenses Insurance & Fees	3,153,049	3,520,257	367,208	10.4%
18,362	(110,123)	(128,485)	116.7%	Supplies & Other Expenses	1,316,871	(206,962)	(1,523,833)	736.3%
1,672,149	2,004,939	332,790	16.6%	Total Other Administrative Expense	17,343,899	18,199,837	855,938	4.7%
$3,912,150	**$4,560,618**	**$648,469**	**14.2%**	**Total Administrative Expenses**	**$37,777,396**	**$40,224,144**	**$2,446,748**	**6.1%**

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED March 31, 2019

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
$1,484,603	$1,615,243	$130,639	8.1%	Salaries & Wages	$13,497,012	$14,027,745	$530,733	3.8%
122,398	158,164	35,766	22.6%	Paid Time Off	1,271,351	1,391,012	119,661	8.6%
600	8,700	8,100	93.1%	Incentives	8,433	64,050	55,617	86.8%
(75)	250	325	130.0%	Employee of the Month	1,325	2,250	925	41.1%
0	0	0	0.0%	Severance Pay	27,681	0	(27,681)	0.0%
10,021	26,127	16,105	61.6%	Payroll Taxes	315,673	364,761	49,089	13.5%
15,563	12,448	(3,115)	(25.0%)	Overtime	146,723	150,442	3,719	2.5%
121,236	135,506	14,270	10.5%	CalPERS ER Match	1,072,109	1,157,237	85,128	7.4%
396,526	492,782	96,256	19.5%	Employee Benefits	3,440,498	3,841,528	401,030	10.4%
0	0	0	0.0%	Personal Floating Holiday	76,610	81,277	4,667	5.7%
13,360	20,265	6,905	34.1%	Employee Relations	89,795	123,606	33,811	27.4%
1,007	2,378	1,371	57.6%	Transportation Reimbursement	11,779	17,242	5,463	31.7%
1,270	6,225	4,955	79.6%	Travel & Lodging	21,434	37,937	16,504	43.5%
32,750	0	(32,750)	0.0%	Temporary Help Services	127,243	122,940	(4,304)	(3.5%)
18,178	26,682	8,504	31.9%	Staff Development/Training	174,201	216,681	42,480	19.6%
22,561	50,909	28,348	55.7%	Staff Recruitment/Advertising	151,631	425,598	273,967	64.4%
2,240,000	**2,555,679**	**315,679**	**12.4%**	**Total Employee Expenses**	**20,433,496**	**22,024,307**	**1,590,810**	**7.2%**
				Benefit Administration Expense				
261,499	268,431	6,932	2.6%	RX Administration Expense	2,969,715	2,942,618	(27,097)	(0.9%)
186,052	226,989	40,937	18.0%	Behavioral Hlth Administration Fees	1,664,058	1,804,422	140,364	7.8%
447,551	**495,419**	**47,868**	**9.7%**	**Total Employee Expenses**	**4,633,773**	**4,747,040**	**113,266**	**2.4%**

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED March 31, 2019

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Purchased & Professional Services				
39,794	85,366	45,572	53.4%	Consulting Services	657,526	839,791	182,265	21.7%
292,029	442,128	150,099	33.9%	Computer Support Services	2,333,032	3,360,959	1,027,927	30.6%
8,750	8,750	0	0.0%	Professional Fees-Accounting	90,486	99,750	9,264	9.3%
36,799	178,756	141,957	79.4%	Other Purchased Services	555,418	1,075,623	520,206	48.4%
7,382	0	(7,382)	0.0%	Maint.& Repair-Office Equipment	58,947	13,400	(45,547)	(339.9%)
132	600	468	78.0%	MIS Software (Non-Capital)	4,663	3,011	(1,652)	(54.9%)
897	9,399	8,503	90.5%	Hardware (Non-Capital)	23,175	69,234	46,058	66.5%
5,108	8,000	2,892	36.2%	Provider Relations-Credentailing	58,794	67,741	8,947	13.2%
33,926	35,350	1,424	4.0%	Legal Fees	218,371	226,308	7,938	3.5%
424,816	**768,349**	**343,533**	**44.7%**	**Total Purchased & Professional Services**	**4,000,411**	**5,755,817**	**1,755,406**	**30.5%**
				Occupancy				
136,068	140,459	4,390	3.1%	Depreciation	1,334,658	1,367,205	32,546	2.4%
26,107	26,107	0	(0.0%)	Amortization	365,546	365,546	0	0.0%
61,246	62,096	850	1.4%	Building Lease	551,216	557,166	5,950	1.1%
3,195	3,157	(37)	(1.2%)	Leased and Rented Office Equipment	28,453	28,416	(37)	(0.1%)
14,400	15,793	1,393	8.8%	Utilities	124,745	143,102	18,356	12.8%
79,522	48,959	(30,563)	(62.4%)	Telephone	734,679	540,860	(193,819)	(35.8%)
8,307	8,600	293	3.4%	Building Maintenance	95,075	91,916	(3,159)	(3.4%)
328,846	**305,171**	**(23,676)**	**(7.8%)**	**Total Occupancy**	**3,234,373**	**3,094,210**	**(140,162)**	**(4.5%)**

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED March 31, 2019

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Printing Postage & Promotion				
21,116	45,227	24,111	53.3%	Postage	310,914	425,227	114,313	26.9%
2,678	3,800	1,123	29.5%	Design & Layout	16,363	28,980	12,618	43.5%
25,660	67,004	41,345	61.7%	Printing Services	488,865	577,463	88,598	15.3%
3,673	6,600	2,927	44.3%	Mailing Services	28,287	72,775	44,488	61.1%
3,855	2,945	(910)	(30.9%)	Courier/Delivery Service	28,083	24,902	(3,181)	(12.8%)
9	808	799	98.9%	Pre-Printed Materials and Publications	2,081	5,905	3,824	64.8%
0	0	0	0.0%	Promotional Products	23,821	21,000	(2,821)	(13.4%)
(2,324)	0	2,324	0.0%	Promotional Services	0	10,000	10,000	100.0%
10,224	7,500	(2,724)	(36.3%)	Community Relations	58,119	73,000	14,881	20.4%
111	0	(111)	0.0%	Health Education-Member	111	0	(111)	0.0%
12,902	5,452	(7,450)	(136.6%)	Translation - Non-Clinical	48,780	50,224	1,444	2.9%
77,903	**139,337**	**61,434**	**44.1%**	**Total Printing Postage & Promotion**	**1,005,422**	**1,289,475**	**284,053**	**22.0%**
				Licenses Insurance & Fees				
17,738	24,994	7,257	29.0%	Bank Fees	141,473	193,974	52,502	27.1%
0	5,700	5,700	100.0%	Payroll Fees	0	44,090	44,090	100.0%
47,528	50,194	2,666	5.3%	Insurance	427,749	446,413	18,664	4.2%
260,238	272,365	12,127	4.5%	Licenses, Permits and Fees	2,113,981	2,336,470	222,489	9.5%
49,167	53,533	4,366	8.2%	Subscriptions & Dues	469,846	499,310	29,464	5.9%
374,671	**406,786**	**32,116**	**7.9%**	**Total Licenses Insurance & Postage**	**3,153,049**	**3,520,257**	**367,208**	**10.4%**
				Supplies & Other Expenses				
6,290	9,500	3,210	33.8%	Office and Other Supplies	48,125	78,759	30,634	38.9%
4,255	2,925	(1,330)	(45.5%)	Ergonomic Supplies	15,263	24,900	9,637	38.7%
6,833	10,785	3,952	36.6%	Commissary-Food & Beverage	49,544	89,378	39,835	44.6%
0	(133,333)	(133,333)	100.0%	Miscellaneous Expense	1,200,000	(399,999)	(1,599,999)	400.0%
985	0	(985)	0.0%	Member Incentive Expense	3,940	0	(3,940)	0.0%
18,362	**(110,123)**	**(128,485)**	**116.7%**	**Total Supplies & Other Expense**	**1,316,871**	**(206,962)**	**(1,523,833)**	**736.3%**
$3,912,150	**$4,560,618**	**$648,469**	**14.2%**	**TOTAL ADMINISTRATIVE EXPENSE**	**$37,777,396**	**$40,224,144**	**$2,446,748**	**6.1%**

ALAMEDA ALLIANCE FOR HEALTH
CAPITAL SPENDING INCLUDING CONSTRUCTION-IN-PROCESS
ACTUAL VS. BUDGET
FOR THE FISCAL YEAR-TO-DATE ENDED JUNE 30, 2019

	Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Detail	$ Variance Fav/(Unf.)
1. Hardware:						
Laptops	IT-FY19-01	4,479		**$ 4,479**	$ 33,000	$ 28,521
Tablets, Surfaces, Macs	IT-FY19-02	14,595	4,082	**$ 18,677**	$ 55,000	$ 36,323
Monitors-(Dual per User)	IT-FY19-03	-		**$ -**	$ 57,000	$ 57,000
Cisco IP Phone	IT-FY19-04	-		**$ -**	$ 20,000	$ 20,000
Desk Tops	IT-FY19-05	29,432		**$ 29,432**	$ 52,500	$ 23,068
UCS Blades	IT-FY19-06	-	24,958	**$ 24,958**	$ 103,840	$ 78,882
DLP Hardware	IT-FY19-07	-		**$ -**	$ 45,000	$ 45,000
Cisco Switch	IT-FY19-08	163,259		**$ 163,259**	$ 162,660	$ (599)
Cisco Wireless Access Points	IT-FY19-09	-		**$ -**	$ 12,000	$ 12,000
Video Conferencing Upgrades	IT-FY19-10	-		**$ -**	$ 32,000	$ 32,000
Unplanned Hardware	IT-FY19-11	48,865	25,246	**$ 74,111**	$ -	$ (74,111)
Carryover from FY18	IT-FY19-12	-		**$ -**	$ -	$ -
Hardware Subtotal		**$ 260,631**	**$ 54,286**	**$ 314,917**	**$ 573,000**	**$ 258,083**
2. Software:						
Storage Upgrade	AC-FY19-01			**$ -**	$ -	$ -
MS Server 2016	AC-FY19-02			**$ -**	$ 128,700	$ 128,700
VMWare Licensisng	AC-FY19-03			**$ -**	$ 95,500	$ 95,500
Unplanned Software	AC-FY19-04			**$ -**	$ -	$ -
Carryover from FY18	AC-FY19-05			**$ -**	$ -	$ -
Software Subtotal		**$ -**	**$ -**	**$ -**	**$ 224,200**	**$ 224,200**
3. Building Improvement:						
1240 HVAC Replace AC-4 1st Floor IT area 5Ton Unit	FA-FY19-01	12,354		**$ 12,354**	$ 11,770	$ (584)
1240 HVAC Replace AC4-Livermore Piedmont 8Ton Unit	FA-FY19-02	15,934		**$ 15,934**	$ 15,350	$ (584)
1240 HVAC Emeryville East 14Ton Unit	FA-FY19-03	23,344		**$ 23,344**	$ 22,760	$ (584)
1240 HVAC AC-6 1st Floor Training 2Ton Unit	FA-FY19-04	9,544		**$ 9,544**	$ 8,960	$ (584)
1240 HVAC AC-6 1st Floor IT Area 5Ton Unit	FA-FY19-05	12,354		**$ 12,354**	$ 11,770	$ (584)
1240 HVAC Emeryville West 10Ton Unit	FA-FY19-06	16,124		**$ 16,124**	$ 15,540	$ (584)
1240 HVAC - Air Balance Trane 50 Ton & 400K Furnace unit, 42 VAV boxes, 6 AC package units, and 2 AC split systems	FA-FY19-07	-		**$ -**	$ 25,000	$ 25,000
ACME Security Readers, Cameras, Doors, HD Boxes, if needed or repairs	FA-FY19-08	-		**$ -**	$ 20,000	$ 20,000
ACME Badge printer, supplies, sofwares/extra security (est.)	FA-FY19-09	-		**$ -**	$ 10,000	$ 10,000
Red Hawk Full Fire Equipment upgrades (est.)	FA-FY19-10	27,681	668	**$ 28,348**	$ 80,000	$ 51,652

	Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Budget Detail	$ Variance Fav/(Unf.)
Appliances over 1K for 1240, 1320 all suites, if needed to be replaced	FA-FY19-11	-		**$ -**	$ 5,000	$ 5,000
Upgrade the Symmetry system	FA-FY19-12	-		**$ -**	$ 60,000	$ 60,000
1240 Lighting: sensors, energy efficient bulbs (est.)	FA-FY19-13	-		**$ -**	$ 40,000	$ 40,000
1240 (3) Water heater replacements (est.)	FA-FY19-14	-		**$ -**	$ 10,000	$ 10,000
Unplanned Building Improvements	FA-FY19-15	42,848		**$ 42,848**	$ 20,000	$ (22,848)
Carryover from FY18 / unplanned	FA-FY19-16	6,749		**$ 6,749**	$ -	$ (6,749)
Building Improvement Subtotal		**$ 166,932**	**$ 668**	**$ 167,599**	**$ 356,150**	**$ 188,551**
4. Furniture & Equipment:						
Office Desks, cabinets, box files/ shelves old/broken	FA-FY19-17	2,906		**$ 2,906**	$ 100,000	$ 97,094
Cubicles and Workstations (various areas)	FA-FY19-18	100,925		**$ 100,925**	$ 250,000	$ 149,075
Facilities/Warehouse Shelvings, for re-organization	FA-FY19-19	0		**$ -**	$ 5,000	$ 5,000
Construction (projects, ad hoc, patch/paint)	FA-FY19-20	0		**$ -**	$ 20,000	$ 20,000
Varidesks/ Ergotrons - Ergo	FA-FY19-21	11,362		**$ 11,362**	$ 30,000	$ 18,638
Tasks Chairs : Various sizes, special order or for Ergo	FA-FY19-22	24,163		**$ 24,163**	$ 20,000	$ (4,163)
Electrical work (projects, cubes, ad hoc requests)	FA-FY19-23	0		**$ -**	$ 20,000	$ 20,000
Carryover from FY18	FA-FY19-24	4,707		**$ 4,707**	$ -	$ (4,707)
Furniture & Equipment Subtotal		**$ 144,063**	**$ -**	**$ 144,063**	**$ 445,000**	**$ 300,937**
5. Leasehold Improvement:						
1320, Suite 100 build out offices/Construction (est.)	FA-FY19-25	49,906		**$ 49,906**	$ 45,000	$ (4,906)
1320, Suite 100 Carpet Replacement & Paint (est.)	FA-FY19-26	1468		**$ 1,468**	$ 80,000	$ 78,532
Carryover from FY18	FA-FY19-27	0		**$ -**	$ -	$ -
Leasehold Improvement Subtotal		**$ 51,374**	**$ -**	**$ 51,374**	**$ 125,000**	**$ 73,626**
6. Contingency:						
Contingency	FA-FY19-27			**$ -**	$ -	$ -
Emergency Kits Reorder	FA-FY19-28			**$ -**	$ -	$ -
Shelving for Cage (vendor: Uline)	FA-FY19-29			**$ -**	$ -	$ -
Contingency Subtotal		**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
GRAND TOTAL		**$ 623,000**	**$ 54,954**	**$ 677,953**	**$ 1,723,350**	**$ 1,045,397**

7. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 3/31/19	**$ 40,492,865**
Fixed Assets @ Cost - 6/30/18	**$ 39,814,912**
Fixed Assets Acquired YTD	**$ 677,953**
	$ (0)

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
SUMMARY - FISCAL YEAR 2019

TANGIBLE NET EQUITY (TNE)

	Jul-18	Aug-18	QTR. END Sep-18	Oct-18	Nov-18	QTR. END Dec-18	Jan-19	Feb-19	QTR. END Mar-19
Current Month Net Income / (Loss)	$1,100,779	($5,717,223)	$1,733,826	$607,174	$41,636	$2,608,640	($1,357,479)	$2,959,161	($3,726,747)
YTD Net Income / (Loss)	$1,100,779	($4,616,444)	($2,882,618)	($2,275,443)	($2,233,807)	$374,833	($982,647)	$1,976,514	($1,750,233)
Actual TNE									
Net Assets	$191,260,493	$185,543,269	$187,277,096	$187,884,270	$187,925,906	$190,534,546	$189,177,067	$192,136,228	$188,409,481
Subordinated Debt & Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Actual TNE	**$191,260,493**	**$185,543,269**	**$187,277,096**	**$187,884,270**	**$187,925,906**	**$190,534,546**	**$189,177,067**	**$192,136,228**	**$188,409,481**
Increase/(Decrease) in Actual TNE	$1,100,780	($5,717,224)	$1,733,827	$607,174	$41,636	$2,608,640	($1,357,479)	$2,959,161	($3,726,747)
Required TNE[(1)]	**$31,166,625**	**$31,946,145**	**$31,392,360**	**$31,655,826**	**$31,645,459**	**$31,508,335**	**$31,739,329**	**$32,455,566**	**$32,301,008**
Min. Req'd to Avoid Monthly Reporting (130% of Required TNE)	$40,516,613	$41,529,989	$40,810,068	$41,152,573	$41,139,097	$40,960,836	$41,261,128	$42,192,236	$41,991,310
TNE Excess / (Deficiency)	$160,093,868	$153,597,124	$155,884,736	$156,228,444	$156,280,447	$159,026,211	$157,437,738	$159,680,662	$156,108,473
Actual TNE as a Multiple of Required	**6.14**	**5.81**	**5.97**	**5.94**	**5.94**	**6.05**	**5.96**	**5.92**	**5.83**

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	$191,260,493	$185,543,269	$187,277,096	$187,884,270	$187,925,906	$190,534,546	$189,177,067	$192,136,228	$188,409,481
Fixed Assets at Net Book Value	(11,799,357)	(11,604,651)	(11,572,248)	(11,489,296)	(11,412,796)	(11,244,310)	(11,177,617)	(11,083,175)	(10,975,953)
CD Pledged to DMHC	(346,350)	(346,350)	(347,991)	(347,991)	(347,991)	(691,695)	(341,716)	(341,716)	(344,400)
Liquid TNE (Liquid Reserves)	**$179,114,786**	**$173,592,268**	**$175,356,857**	**$176,046,983**	**$176,165,119**	**$178,598,541**	**$177,657,734**	**$180,711,337**	**$177,089,128**
Liquid TNE as Multiple of Required	**5.75**	**5.43**	**5.59**	**5.56**	**5.57**	**5.67**	**5.60**	**5.57**	**5.48**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2019

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

	Actual Jul-18	Actual Aug-18	Actual Sep-18	Actual Oct-18	Actual Nov-18	Actual Dec-18	Actual Jan-19	Actual Feb-19	Actual Mar-19	Actual Apr-19	Actual May-19	Actual Jun-19	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	97,284	96,634	96,457	95,954	95,499	95,322	94,491	93,809	93,457	0	0	0	858,907
Adults	36,468	35,987	35,922	35,716	35,501	35,559	35,035	34,651	34,525	0	0	0	319,364
SPD	26,208	26,170	26,207	26,249	26,168	26,103	26,078	26,059	25,938	0	0	0	235,180
ACA OE	83,068	83,271	83,829	84,009	83,746	83,920	82,684	82,149	81,821	0	0	0	748,497
Duals	16,790	16,951	17,097	17,192	17,311	17,400	17,348	17,399	17,514	0	0	0	155,002
Medi-Cal Program	259,818	259,013	259,512	259,120	258,225	258,304	255,636	254,067	253,255	0	0	0	2,316,950
Group Care Program	5,839	5,858	5,856	5,889	5,842	5,886	5,890	5,854	5,892	0	0	0	52,806
Total	**265,657**	**264,871**	**265,368**	**265,009**	**264,067**	**264,190**	**261,526**	**259,921**	**259,147**	**0**	**0**	**0**	**2,369,756**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(585)	(650)	(177)	(503)	(455)	(177)	(831)	(682)	(352)	0	0	0	(4,412)
Adults	(417)	(481)	(65)	(206)	(215)	58	(524)	(384)	(126)	0	0	0	(2,360)
SPD	119	(38)	37	42	(81)	(65)	(25)	(19)	(121)	0	0	0	(151)
ACA OE	(1,113)	203	558	180	(263)	174	(1,236)	(535)	(328)	0	0	0	(2,360)
Duals	1,324	161	146	95	119	89	(52)	51	115	0	0	0	2,048
Medi-Cal Program	(672)	(805)	499	(392)	(895)	79	(2,668)	(1,569)	(812)	0	0	0	(7,235)
Group Care Program	32	19	(2)	33	(47)	44	4	(36)	38	0	0	0	85
Total	**(640)**	**(786)**	**497**	**(359)**	**(942)**	**123**	**(2,664)**	**(1,605)**	**(774)**	**0**	**0**	**0**	**(7,150)**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	37.4%	37.3%	37.2%	37.0%	37.0%	36.9%	37.0%	36.9%	36.9%	0.0%	0.0%	0.0%	37.1%
Adults % of Medi-Cal	14.0%	13.9%	13.8%	13.8%	13.7%	13.8%	13.7%	13.6%	13.6%	0.0%	0.0%	0.0%	13.8%
SPD % of Medi-Cal	10.1%	10.1%	10.1%	10.1%	10.1%	10.1%	10.2%	10.3%	10.2%	0.0%	0.0%	0.0%	10.2%
ACA OE % of Medi-Cal	32.0%	32.1%	32.3%	32.4%	32.4%	32.5%	32.3%	32.3%	32.3%	0.0%	0.0%	0.0%	32.3%
Duals % of Medi-Cal	6.5%	6.5%	6.6%	6.6%	6.7%	6.7%	6.8%	6.8%	6.9%	0.0%	0.0%	0.0%	6.7%
Medi-Cal Program % of Total	97.8%	97.8%	97.8%	97.8%	97.8%	97.8%	97.7%	97.7%	97.7%	0.0%	0.0%	0.0%	97.8%
Group Care Program % of Total	2.2%	2.2%	2.2%	2.2%	2.2%	2.2%	2.3%	2.3%	2.3%	0.0%	0.0%	0.0%	2.2%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2019

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

	Actual Jul-18	Actual Aug-18	Actual Sep-18	Actual Oct-18	Actual Nov-18	Actual Dec-18	Actual Jan-19	Actual Feb-19	Actual Mar-19	Actual Apr-19	Actual May-19	Actual Jun-19	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	52,622	52,107	52,066	51,544	51,835	52,152	50,615	50,235	50,169	0	0	0	463,345
Alameda Health System	48,458	48,710	48,959	49,159	48,771	48,873	48,787	48,241	47,984	0	0	0	437,942
	101,080	100,817	101,025	100,703	100,606	101,025	99,402	98,476	98,153	0	0	0	901,287
Delegated:													
CFMG	33,132	32,898	32,836	32,676	32,488	32,520	31,962	31,722	31,480	0	0	0	291,714
CHCN	97,049	96,859	97,120	97,107	96,559	96,414	96,389	95,906	95,567	0	0	0	868,970
Kaiser	34,396	34,297	34,387	34,523	34,414	34,231	33,773	33,817	33,947	0	0	0	307,785
Delegated Subtotal	164,577	164,054	164,343	164,306	163,461	163,165	162,124	161,445	160,994	0	0	0	1,468,469
Total	**265,657**	**264,871**	**265,368**	**265,009**	**264,067**	**264,190**	**261,526**	**259,921**	**259,147**	**0**	**0**	**0**	**2,369,756**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(454)	(263)	208	(322)	(97)	419	(1,623)	(926)	(323)	0	0	0	(3,381)
Delegated:													
CFMG	(279)	(234)	(62)	(160)	(188)	32	(558)	(240)	(242)	0	0	0	(1,931)
CHCN	241	(190)	261	(13)	(548)	(145)	(25)	(483)	(339)	0	0	0	(1,241)
Kaiser	(148)	(99)	90	136	(109)	(183)	(458)	44	130	0	0	0	(597)
Delegated Subtotal	(186)	(523)	289	(37)	(845)	(296)	(1,041)	(679)	(451)	0	0	0	(3,769)
Total	**(640)**	**(786)**	**497**	**(359)**	**(942)**	**123**	**(2,664)**	**(1,605)**	**(774)**	**0**	**0**	**0**	**(7,150)**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	38.0%	38.1%	38.1%	38.0%	38.1%	38.2%	38.0%	37.9%	37.9%	0.0%	0.0%	0.0%	38.0%
Delegated:													
CFMG	12.5%	12.4%	12.4%	12.3%	12.3%	12.3%	12.2%	12.2%	12.1%	0.0%	0.0%	0.0%	12.3%
CHCN	36.5%	36.6%	36.6%	36.6%	36.6%	36.5%	36.9%	36.9%	36.9%	0.0%	0.0%	0.0%	36.7%
Kaiser	12.9%	12.9%	13.0%	13.0%	13.0%	13.0%	12.9%	13.0%	13.1%	0.0%	0.0%	0.0%	13.0%
Delegated Subtotal	62.0%	61.9%	61.9%	62.0%	61.9%	61.8%	62.0%	62.1%	62.1%	0.0%	0.0%	0.0%	62.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED March 31, 2019

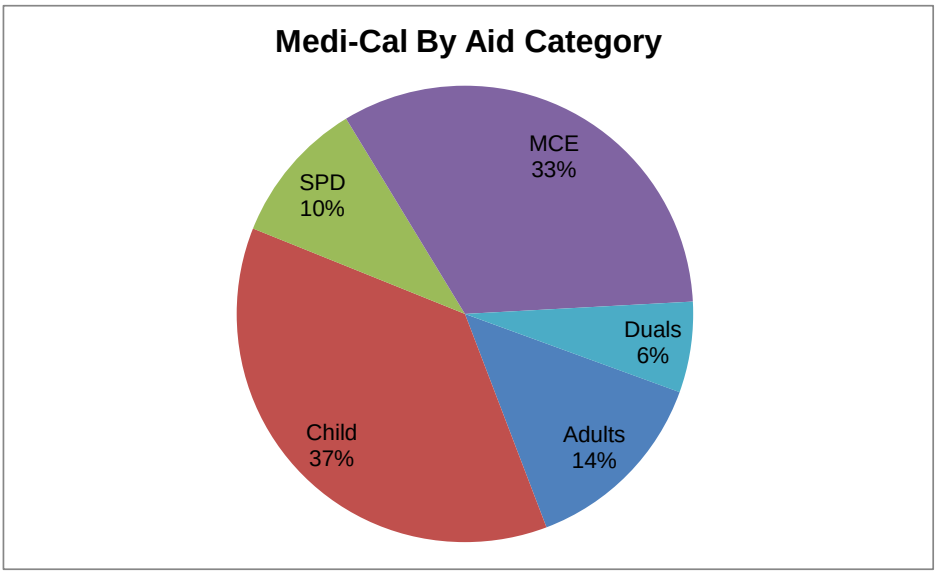
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES:				
$1,720,871	$1,155,623	($565,248)	(48.9%)	PCP-Capitation	$13,275,955	$10,756,083	($2,519,872)	(23.4%)
2,742,979	2,694,950	(48,029)	(1.8%)	PCP-Capitation - FQHC	25,069,288	22,801,016	(2,268,272)	(9.9%)
275,078	293,186	18,108	6.2%	Specialty-Capitation	2,526,712	2,621,203	94,491	3.6%
2,806,391	3,563,708	757,317	21.3%	Specialty-Capitation FQHC	25,686,715	30,682,534	4,995,819	16.3%
251,307	255,404	4,097	1.6%	Laboratory-Capitation	2,312,229	2,302,557	(9,672)	(0.4%)
413,480	345,481	(67,999)	(19.7%)	Transportation (Ambulance)-Cap	3,106,973	2,995,046	(111,927)	(3.7%)
194,600	200,473	5,873	2.9%	Vision Cap	1,795,391	1,806,191	10,800	0.6%
79,973	85,249	5,276	6.2%	CFMG Capitation	734,831	762,132	27,301	3.6%
142,479	270,149	127,670	47.3%	Anc IPA Admin Capitation FQHC	1,303,146	2,176,528	873,382	40.1%
7,684,221	8,223,282	539,061	6.6%	Kaiser Capitation	70,048,416	73,046,451	2,998,035	4.1%
500,942	539,208	38,266	7.1%	DME - Cap	4,563,645	4,772,315	208,670	4.4%
16,812,322	**17,626,713**	**814,391**	**4.6%**	**5-TOTAL CAPITATED EXPENSES**	**150,423,300**	**154,722,056**	**4,298,756**	**2.8%**
				FEE FOR SERVICE MEDICAL EXPENSES:				
1,892,681	0	(1,892,681)	0.0%	IBNP-Inpatient Services	1,481,876	0	(1,481,876)	0.0%
56,781	0	(56,781)	0.0%	IBNP-Settlement (IP)	44,460	0	(44,460)	0.0%
189,268	0	(189,268)	0.0%	IBNP-Claims Fluctuation (IP)	148,184	0	(148,184)	0.0%
18,685,851	21,557,831	2,871,980	13.3%	Inpatient Hospitalization-FFS	164,997,873	199,557,882	34,560,009	17.3%
1,294,919	0	(1,294,919)	0.0%	IP OB - Mom & NB	10,822,543	0	(10,822,543)	0.0%
88,245	0	(88,245)	0.0%	IP Behavioral Health	552,092	0	(552,092)	0.0%
0	0	0	0.0%	IP - Per Diem	(3,438)	0	3,438	0.0%
834,183	0	(834,183)	0.0%	IP - Long Term Care	8,423,011	0	(8,423,011)	0.0%
527,212	0	(527,212)	0.0%	IP - Facility Rehab FFS	6,403,012	0	(6,403,012)	0.0%
23,569,140	**21,557,831**	**(2,011,309)**	**(9.3%)**	**6-Inpatient Hospital & SNF FFS Expense**	**192,869,614**	**199,557,882**	**6,688,268**	**3.4%**
18,363	0	(18,363)	0.0%	IBNP-PCP	(706,301)	0	706,301	0.0%
551	0	(551)	0.0%	IBNP-Settlement (PCP)	(21,185)	0	21,185	0.0%
1,836	0	(1,836)	0.0%	IBNP-Claims Fluctuation (PCP)	(70,637)	0	70,637	0.0%
1,243,038	1,068,681	(174,357)	(16.3%)	Primary Care Non-Contracted FF	11,580,715	10,208,945	(1,371,770)	(13.4%)
82,604	51,611	(30,993)	(60.1%)	PCP FQHC FFS	1,083,286	1,042,906	(40,380)	(3.9%)
1,759,991	616,183	(1,143,808)	(185.6%)	Prop 56 Direct Payment Expenses	16,155,914	5,589,185	(10,566,729)	(189.1%)
3,106,383	**1,736,475**	**(1,369,908)**	**(78.9%)**	**7-Primary Care Physician FFS Expense**	**28,021,793**	**16,841,036**	**(11,180,757)**	**(66.4%)**
77,907	0	(77,907)	0.0%	IBNP-Specialist	126,142	0	(126,142)	0.0%
1,867,042	0	(1,867,042)	0.0%	Specialty Care-FFS	15,940,866	0	(15,940,866)	0.0%
131,860	0	(131,860)	0.0%	Anesthesiology - FFS	1,327,823	0	(1,327,823)	0.0%
474,081	0	(474,081)	0.0%	Spec Rad Therapy - FFS	5,446,024	0	(5,446,024)	0.0%
91,373	0	(91,373)	0.0%	Obstetrics-FFS	1,057,489	0	(1,057,489)	0.0%
254,641	0	(254,641)	0.0%	Spec IP Surgery - FFS	2,123,244	0	(2,123,244)	0.0%
436,095	0	(436,095)	0.0%	Spec OP Surgery - FFS	4,216,429	0	(4,216,429)	0.0%
341,203	3,830,895	3,489,692	91.1%	Spec IP Physician	2,978,898	34,826,463	31,847,565	91.4%
106,195	81,217	(24,978)	(30.8%)	SCP FQHC FFS	961,576	841,449	(120,127)	(14.3%)
2,337	0	(2,337)	0.0%	IBNP-Settlement (SCP)	3,779	0	(3,779)	0.0%
7,792	0	(7,792)	0.0%	IBNP-Claims Fluctuation (SCP)	12,619	0	(12,619)	0.0%
3,790,525	**3,912,112**	**121,587**	**3.1%**	**8-Specialty Care Physician Expense**	**34,194,889**	**35,667,912**	**1,473,023**	**4.1%**
(140,449)	0	140,449	0.0%	IBNP-Ancillary	106,483	0	(106,483)	0.0%
(4,212)	0	4,212	0.0%	IBNP Settlement (ANC)	3,200	0	(3,200)	0.0%
(14,045)	0	14,045	0.0%	IBNP Claims Fluctuation (ANC)	10,649	0	(10,649)	0.0%
300,068	0	(300,068)	0.0%	Acupuncture/Biofeedback	2,732,204	0	(2,732,204)	0.0%
105,910	0	(105,910)	0.0%	Hearing Devices	899,703	0	(899,703)	0.0%
15,040	0	(15,040)	0.0%	Imaging/MRI/CT Global	203,660	0	(203,660)	0.0%
35,302	0	(35,302)	0.0%	Vision FFS	325,401	0	(325,401)	0.0%
8,744	0	(8,744)	0.0%	Family Planning	63,524	0	(63,524)	0.0%
174,821	0	(174,821)	0.0%	Laboratory-FFS	1,745,520	0	(1,745,520)	0.0%
89,285	0	(89,285)	0.0%	ANC Therapist	872,703	0	(872,703)	0.0%
286,311	0	(286,311)	0.0%	Transportation (Ambulance)-FFS	2,522,578	0	(2,522,578)	0.0%
69,074	0	(69,074)	0.0%	Transportation (Other)-FFS	514,875	0	(514,875)	0.0%
372,659	0	(372,659)	0.0%	Hospice	3,378,431	0	(3,378,431)	0.0%
294,428	0	(294,428)	0.0%	Home Health Services	3,322,673	0	(3,322,673)	0.0%
0	2,600,665	2,600,665	100.0%	Other Medical-FFS	17	22,679,334	22,679,317	100.0%
0	0	0	0.0%	Denials	8,689	0	(8,689)	0.0%
0	0	0	0.0%	Refunds-Medical Payments	15,668	0	(15,668)	0.0%
194,500	0	(194,500)	0.0%	DME & Medical Supplies	1,704,360	0	(1,704,360)	0.0%

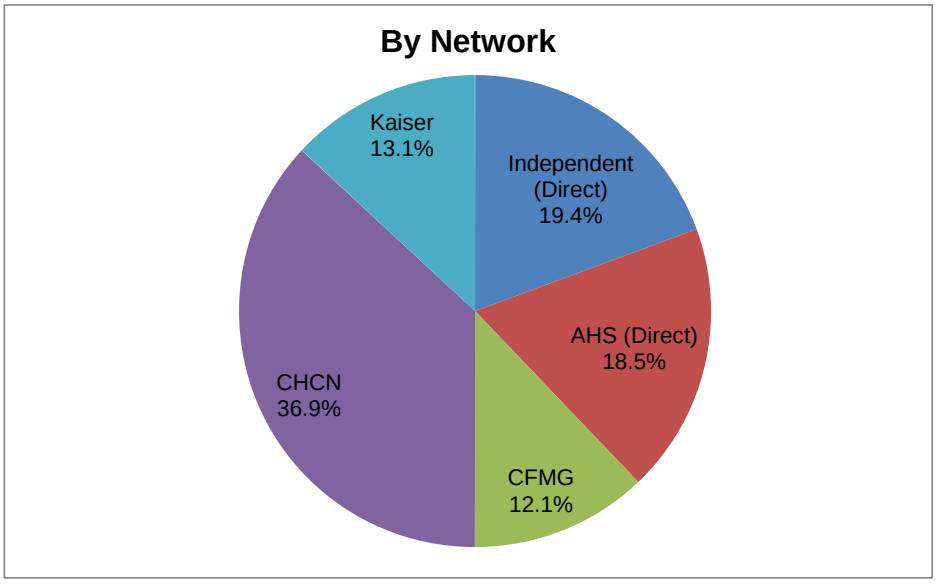
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED March 31, 2019

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
$4,679,793	$0	($4,679,793)	0.0%	GEMT Direct Payment Expense	$5,265,768	$0	($5,265,768)	0.0%
493,877	0	(493,877)	0.0%	Community Based Adult Services (CBAS)	4,326,876	0	(4,326,876)	0.0%
6,961,107	**2,600,665**	**(4,360,442)**	**(167.7%)**	**9-Ancillary Medical Expense**	**28,022,980**	**22,679,334**	**(5,343,646)**	**(23.6%)**
772,940	0	(772,940)	0.0%	IBNP-Outpatient	(42,174)	0	42,174	0.0%
23,189	0	(23,189)	0.0%	IBNP Settlement (OP)	(1,267)	0	1,267	0.0%
77,294	0	(77,294)	0.0%	IBNP Claims Fluctuation (OP)	(4,214)	0	4,214	0.0%
1,507,331	8,086,760	6,579,429	81.4%	Out-Patient FFS	13,881,041	71,564,984	57,683,943	80.6%
960,481	0	(960,481)	0.0%	OP Ambul Surgery - FFS	9,147,826	0	(9,147,826)	0.0%
1,086,494	0	(1,086,494)	0.0%	OP Fac Imaging Services-FFS	9,190,728	0	(9,190,728)	0.0%
1,641,730	0	(1,641,730)	0.0%	Behav Health - FFS	15,248,334	0	(15,248,334)	0.0%
262,144	0	(262,144)	0.0%	OP Facility - Lab FFS	2,660,961	0	(2,660,961)	0.0%
76,717	0	(76,717)	0.0%	OP Facility - Cardio FFS	705,770	0	(705,770)	0.0%
63,729	0	(63,729)	0.0%	OP Facility - PT/OT/ST FFS	515,612	0	(515,612)	0.0%
1,711,297	0	(1,711,297)	0.0%	OP Facility - Dialysis FFS	13,393,083	0	(13,393,083)	0.0%
8,183,348	**8,086,760**	**(96,588)**	**(1.2%)**	**10-Outpatient Medical Expense Medical Expense**	**64,695,699**	**71,564,984**	**6,869,285**	**9.6%**
(331,804)	0	331,804	0.0%	IBNP-Emergency	(1,674,931)	0	1,674,931	0.0%
(9,956)	0	9,956	0.0%	IBNP Settlement (ER)	(50,252)	0	50,252	0.0%
(33,184)	0	33,184	0.0%	IBNP Claims Fluctuation (ER)	(167,496)	0	167,496	0.0%
535,628	0	(535,628)	0.0%	Special ER Physician-FFS	5,277,983	0	(5,277,983)	0.0%
0	0	0	0.0%	ER-Non Emergent-FFS	6,202	0	(6,202)	0.0%
2,712,715	3,867,254	1,154,539	29.9%	ER-Facility	25,925,707	33,027,335	7,101,628	21.5%
2,873,399	**3,867,254**	**993,855**	**25.7%**	**11-Emergency Expense**	**29,317,213**	**33,027,335**	**3,710,122**	**11.2%**
68,081	0	(68,081)	0.0%	IBNP-Pharmacy	(666,959)	0	666,959	0.0%
2,042	0	(2,042)	0.0%	IBNP Settlement (RX)	(20,011)	0	20,011	0.0%
6,810	0	(6,810)	0.0%	IBNP Claims Fluctuation (RX)	(66,693)	0	66,693	0.0%
3,315,447	2,519,435	(796,012)	(31.6%)	RX - Non-PBM FFFS	29,960,614	24,646,467	(5,314,147)	(21.6%)
9,787,366	11,033,974	1,246,608	11.3%	Pharmacy-FFS	92,297,472	97,077,136	4,779,664	4.9%
(412,130)	(412,130)	0	0.0%	Pharmacy-Rebate	(4,235,672)	(3,851,691)	383,981	(10.0%)
12,767,617	**13,141,279**	**373,662**	**2.8%**	**12-Pharmacy Expense**	**117,268,751**	**117,871,912**	**603,161**	**0.5%**
61,251,519	**54,902,376**	**(6,349,143)**	**(11.6%)**	**13-TOTAL FFS MEDICAL EXPENSES**	**494,390,939**	**497,210,395**	**2,819,456**	**0.6%**
0	(138,417)	(138,417)	100.0%	Clinical Vacancy	0	(687,593)	(687,593)	100.0%
68,077	178,008	109,931	61.8%	Quality Analytics	808,445	1,177,834	369,390	31.4%
271,391	380,045	108,654	28.6%	Health Plan Services Department Total	2,420,820	3,149,419	728,599	23.1%
434,992	361,568	(73,424)	(20.3%)	Case & Disease Management Department Total	3,306,503	3,065,642	(240,860)	(7.9%)
122,300	157,687	35,388	22.4%	Medical Services Department Total	1,171,832	1,330,998	159,167	12.0%
427,915	476,485	48,570	10.2%	Quality Management Department Total	4,037,521	4,365,414	327,892	7.5%
85,225	132,976	47,750	35.9%	Pharmacy Services Department Total	992,827	1,170,226	177,399	15.2%
16,403	30,578	14,175	46.4%	Regulatory Readiness Total	83,224	176,024	92,799	52.7%
1,426,303	**1,578,930**	**152,627**	**9.7%**	**14-Other Benefits & Services**	**12,821,172**	**13,747,964**	**926,792**	**6.7%**
				Reinsurance Expense				
(7,281)	(343,328)	(336,047)	97.9%	Reinsurance Recoveries	(3,184,685)	(3,320,877)	(136,192)	4.1%
395,100	403,914	8,814	2.2%	Stop-Loss Expense	3,598,955	3,626,524	27,569	0.8%
387,819	**60,586**	**(327,233)**	**(540.1%)**	**15-Reinsurance Expense**	**414,270**	**305,647**	**(108,623)**	**(35.5%)**
				Preventive Health Services				
66,667	66,667	0	0.0%	Risk Sharing PCP	799,997	799,997	0	0.0%
66,667	**66,667**	**0**	**0.0%**	**16-Risk Pool Distribution**	**799,997**	**799,997**	**0**	**0.0%**
79,944,629	**74,235,272**	**(5,709,357)**	**(7.7%)**	**17-TOTAL MEDICAL EXPENSES**	**658,849,677**	**666,786,059**	**7,936,381**	**1.2%**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Current Membership by Network By Category of Aid							
Category of Aid	**Mar 2019**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	34,525	14%	8,631	6,764	329	13,153	5,648
Child	93,457	37%	8,783	8,366	28,860	31,518	15,930
SPD	25,855	10%	8,815	3,604	1,326	10,243	1,867
MCE	83,189	33%	14,896	26,651	957	32,034	8,651
Duals	16,229	6%	6,378	1,811	8	6,181	1,851
Medi-Cal	253,255		47,503	47,196	31,480	93,129	33,947
Group Care	5,892		2,666	789	-	2,437	-
Total	**259,147**	**100%**	**50,169**	**47,985**	**31,480**	**95,566**	**33,947**
Medi-Cal %	97.7%		94.7%	98.4%	100.0%	97.4%	100.0%
Group Care %	2.3%		5.3%	1.6%	0.0%	2.6%	0.0%
	Network Distribution		*19.4%*	*18.5%*	*12.1%*	*36.9%*	*13.1%*
			% Direct:	**38%**		**% Delegated:**	**62%**

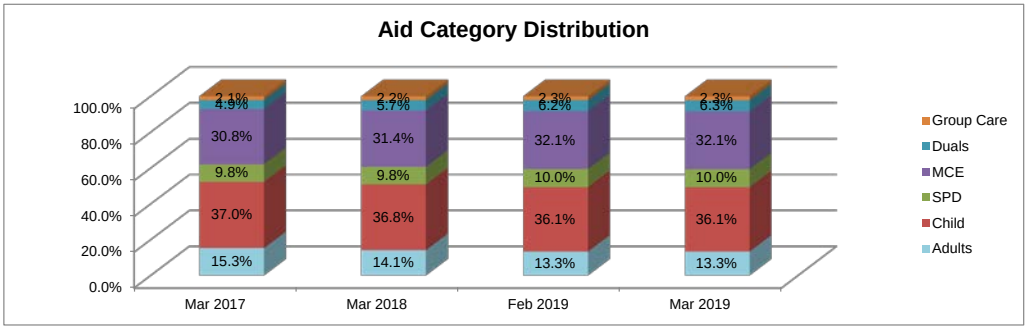




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

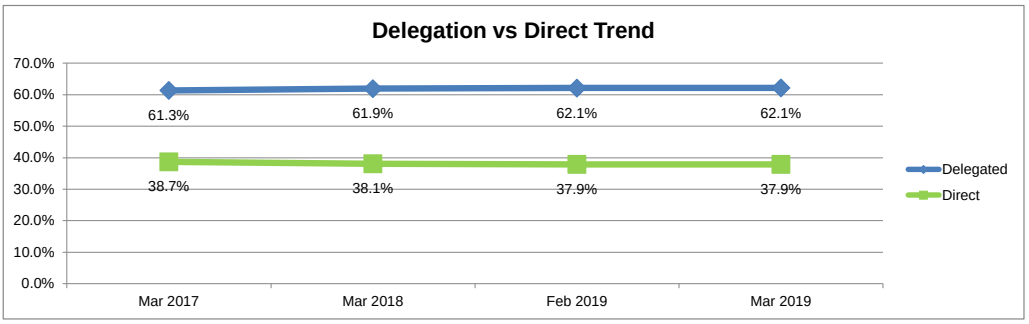
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Mar 2017	Mar 2018	Feb 2019	Mar 2019	Mar 2017	Mar 2018	Feb 2019	Mar 2019	Mar 2017 to Mar 2018	Mar 2018 to Mar 2019	Feb 2019 to Mar 2019
Adults	41,024	37,691	34,651	34,525	15.3%	14.1%	13.3%	13.3%	-8.1%	-8.4%	-0.4%
Child	99,390	98,112	93,809	93,457	37.0%	36.8%	36.1%	36.1%	-1.3%	-4.7%	-0.4%
SPD	26,407	26,221	25,979	25,855	9.8%	9.8%	10.0%	10.0%	-0.7%	-1.4%	-0.5%
MCE	82,639	83,883	83,493	83,189	30.8%	31.4%	32.1%	32.1%	1.5%	-0.8%	-0.4%
Duals	13,269	15,275	16,135	16,229	4.9%	5.7%	6.2%	6.3%	15.1%	6.2%	0.6%
Medi-Cal Total	262,729	261,182	254,067	253,255	97.9%	97.8%	97.7%	97.7%	-0.6%	-3.0%	-0.3%
Group Care	5,664	5,774	5,854	5,892	2.1%	2.2%	2.3%	2.3%	1.9%	2.0%	0.6%
Total	**268,393**	**266,956**	**259,921**	**259,147**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**-0.5%**	**-2.9%**	**-0.3%**



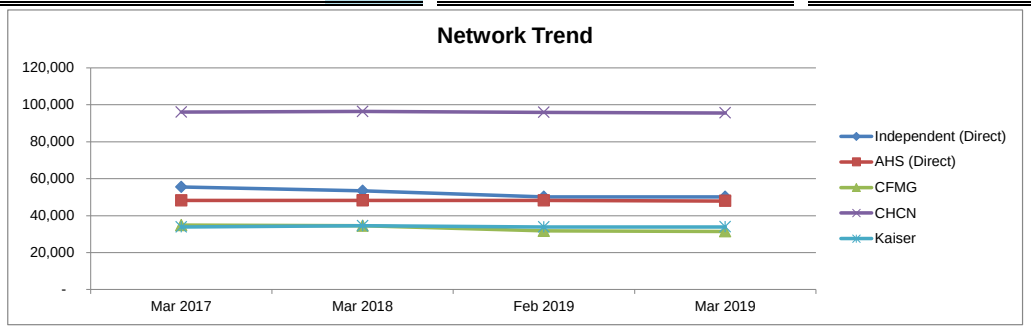
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Mar 2017	Mar 2018	Feb 2019	Mar 2019	Mar 2017	Mar 2018	Feb 2019	Mar 2019	Mar 2017 to Mar 2018	Mar 2018 to Mar 2019	Feb 2019 to Mar 2019
Delegated	164,646	165,308	161,445	160,993	61.3%	61.9%	62.1%	62.1%	0.4%	-2.6%	-0.3%
Direct	103,747	101,648	98,476	98,154	38.7%	38.1%	37.9%	37.9%	-2.0%	-3.4%	-0.3%
Total	**268,393**	**266,956**	**259,921**	**259,147**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**-0.5%**	**-2.9%**	**-0.3%**



Network Trend

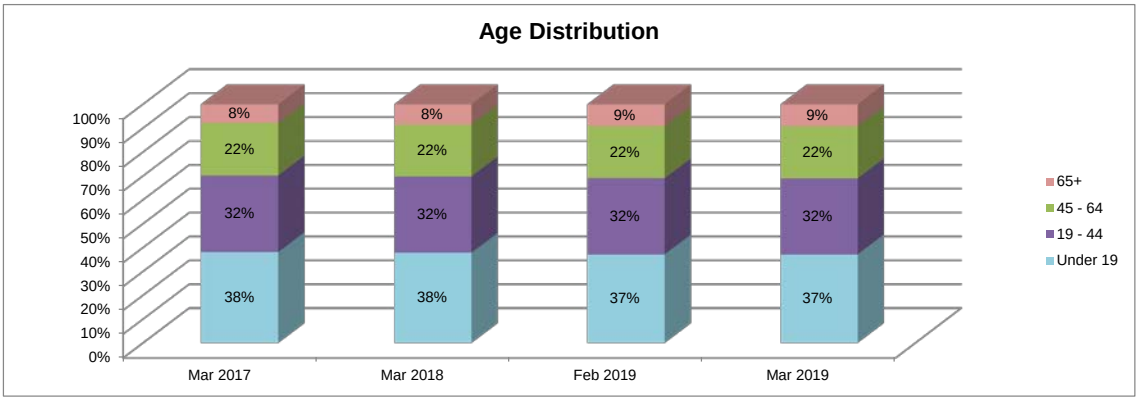
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Mar 2017	Mar 2018	Feb 2019	Mar 2019	Mar 2017	Mar 2018	Feb 2019	Mar 2019	Mar 2017 to Mar 2018	Mar 2018 to Mar 2019	Feb 2019 to Mar 2019
Independent (Direct)	55,519	53,449	50,235	50,169	20.7%	20.0%	19.3%	19.4%	-3.7%	-6.1%	-0.1%
AHS (Direct)	48,228	48,199	48,241	47,985	18.0%	18.1%	18.6%	18.5%	-0.1%	-0.4%	-0.5%
CFMG	34,821	34,480	31,722	31,480	13.0%	12.9%	12.2%	12.1%	-1.0%	-8.7%	-0.8%
CHCN	95,980	96,337	95,906	95,566	35.8%	36.1%	36.9%	36.9%	0.4%	-0.8%	-0.4%
Kaiser	33,845	34,491	33,817	33,947	12.6%	12.9%	13.0%	13.1%	1.9%	-1.6%	0.4%
Total	**268,393**	**266,956**	**259,921**	**259,147**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**-0.5%**	**-2.9%**	**-0.3%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

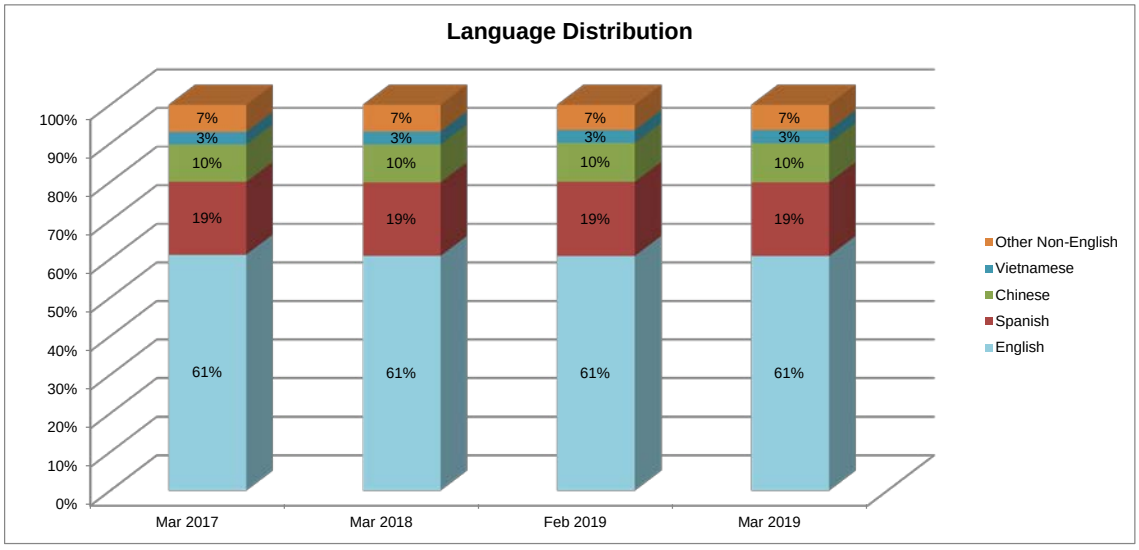
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Mar 2017	Mar 2018	Feb 2019	Mar 2019	Mar 2017	Mar 2018	Feb 2019	Mar 2019	Mar 2017 to Mar 2018	Mar 2018 to Mar 2019	Feb 2019 to Mar 2019
Under 19	102,337	101,002	96,617	96,240	38%	38%	37%	37%	-1%	-5%	0%
19 - 44	86,033	85,315	82,854	82,436	32%	32%	32%	32%	-1%	-3%	-1%
45 - 64	59,064	58,094	56,428	56,392	22%	22%	22%	22%	-2%	-3%	0%
65+	20,959	22,545	24,022	24,079	8%	8%	9%	9%	8%	7%	0%
Total	**268,393**	**266,956**	**259,921**	**259,147**	**100%**	**100%**	**100%**	**100%**	**-1%**	**-3%**	**0%**



Language Trend

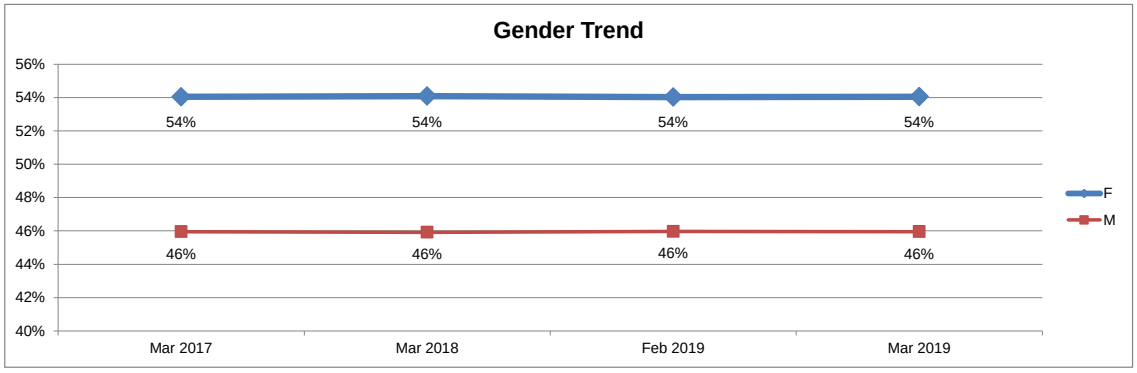
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Mar 2017	Mar 2018	Feb 2019	Mar 2019	Mar 2017	Mar 2018	Feb 2019	Mar 2019	Mar 2017 to Mar 2018	Mar 2018 to Mar 2019	Feb 2019 to Mar 2019
English	164,138	162,270	157,949	157,481	61%	61%	61%	61%	-1%	-3%	0%
Spanish	50,518	50,932	49,985	49,653	19%	19%	19%	19%	1%	-3%	-1%
Chinese	26,059	26,330	26,180	26,190	10%	10%	10%	10%	1%	-1%	0%
Vietnamese	8,764	8,841	8,686	8,736	3%	3%	3%	3%	1%	-1%	1%
Other Non-English	18,914	18,583	17,121	17,087	7%	7%	7%	7%	-2%	-8%	0%
Total	**268,393**	**266,956**	**259,921**	**259,147**	**100%**	**100%**	**100%**	**100%**	**-1%**	**-3%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

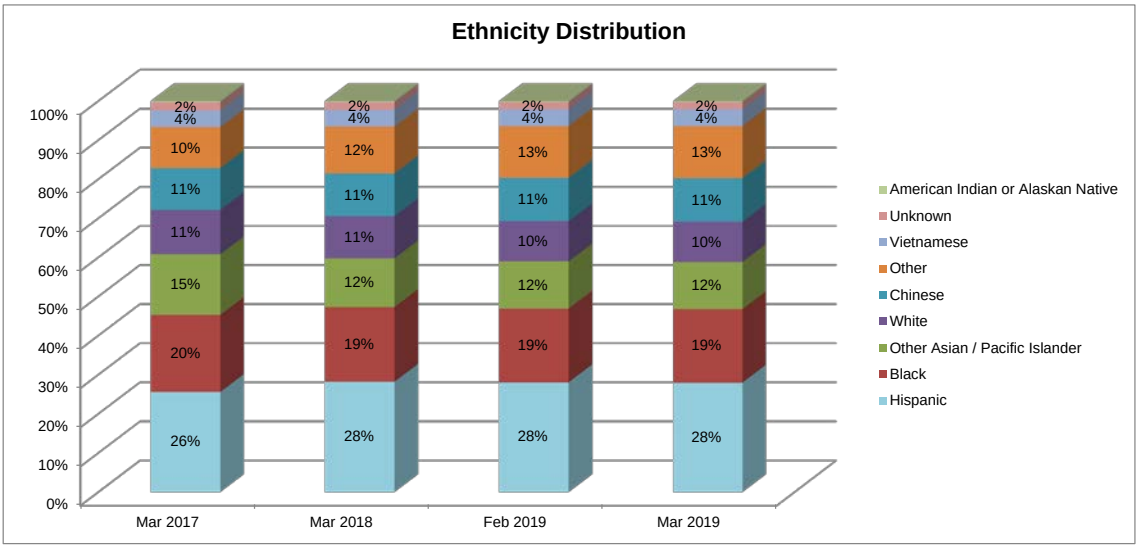
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Mar 2017	Mar 2018	Feb 2019	Mar 2019	Mar 2017	Mar 2018	Feb 2019	Mar 2019	Mar 2017 to Mar 2018	Mar 2018 to Mar 2019	Feb 2019 to Mar 2019
F	145,047	144,381	140,441	140,059	54%	54%	54%	54%	0%	-3%	0%
M	123,346	122,575	119,480	119,088	46%	46%	46%	46%	-1%	-3%	0%
Total	**268,393**	**266,956**	**259,921**	**259,147**	**100%**	**100%**	**100%**	**100%**	**-1%**	**-3%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Mar 2017	Mar 2018	Feb 2019	Mar 2019	Mar 2017	Mar 2018	Feb 2019	Mar 2019	Mar 2017 to Mar 2018	Mar 2018 to Mar 2019	Feb 2019 to Mar 2019
Hispanic	68,603	75,249	72,926	72,470	26%	28%	28%	28%	10%	-4%	-1%
Black	53,046	51,033	49,015	48,784	20%	19%	19%	19%	-4%	-4%	0%
Other Asian / Pacific Islander	41,504	33,179	31,329	31,190	15%	12%	12%	12%	-20%	-6%	0%
White	30,408	28,833	26,750	26,649	11%	11%	10%	10%	-5%	-8%	0%
Chinese	28,763	29,145	28,898	28,913	11%	11%	11%	11%	1%	-1%	0%
Other	28,137	32,033	34,418	34,595	10%	12%	13%	13%	14%	8%	1%
Vietnamese	11,413	11,478	11,167	11,211	4%	4%	4%	4%	1%	-2%	0%
Unknown	5,712	5,278	4,721	4,647	2%	2%	2%	2%	-8%	-12%	-2%
American Indian or Alaskan Native	807	728	697	688	0%	0%	0%	0%	-10%	-5%	-1%
Total	**268,393**	**266,956**	**259,921**	**259,147**	**100%**	**100%**	**100%**	**100%**	**-1%**	**-3%**	**0%**



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

Medi-Cal By City

City	Mar 2019	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	103,531	41%	11,815	23,229	14,461	44,557	9,469
Hayward	38,654	15%	8,110	7,647	4,639	11,623	6,635
Fremont	22,113	9%	9,149	2,988	530	5,987	3,459
San Leandro	22,570	9%	4,036	3,243	3,367	8,523	3,401
Union City	11,138	4%	4,334	1,471	409	2,922	2,002
Alameda	10,249	4%	2,037	1,455	1,625	3,754	1,378
Berkeley	9,173	4%	992	1,558	1,302	4,047	1,274
Livermore	7,171	3%	956	593	1,658	2,793	1,171
Newark	5,943	2%	1,762	1,856	111	1,150	1,064
Castro Valley	5,989	2%	1,222	870	1,026	1,722	1,149
San Lorenzo	5,141	2%	862	826	703	1,723	1,027
Pleasanton	3,674	1%	826	337	427	1,493	591
Dublin	3,825	2%	829	338	506	1,477	675
Emeryville	1,526	1%	247	319	236	503	221
Albany	1,488	1%	121	200	340	552	275
Piedmont	280	0%	43	65	31	71	70
Sunol	63	0%	15	13	3	11	21
Antioch	31	0%	11	5	5	8	2
Other	696	0%	136	183	101	213	63
Total	**253,255**	**100%**	**47,503**	**47,196**	**31,480**	**93,129**	**33,947**

Group Care By City

City	Mar 2019	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	2,065	35%	585	367	-	1,113	-
Hayward	656	11%	396	105	-	155	-
Fremont	622	11%	483	46	-	93	-
San Leandro	538	9%	219	76	-	243	-
Union City	344	6%	248	29	-	67	-
Alameda	257	4%	113	26	-	118	-
Berkeley	207	4%	50	20	-	137	-
Livermore	85	1%	32	-	-	53	-
Newark	139	2%	98	23	-	18	-
Castro Valley	189	3%	100	21	-	68	-
San Lorenzo	111	2%	51	19	-	41	-
Pleasanton	45	1%	23	1	-	21	-
Dublin	99	2%	46	3	-	50	-
Emeryville	27	0%	13	-	-	14	-
Albany	12	0%	3	-	-	9	-
Piedmont	15	0%	4	1	-	10	-
Sunol	-	0%	-	-	-	-	-
Antioch	21	0%	6	3	-	12	-
Other	460	8%	196	49	-	215	-
Total	**5,892**	**100%**	**2,666**	**789**	**-**	**2,437**	**-**

Total By City

City	Dec 2018	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	107,558	41%	12,400	23,596	14,461	45,670	9,469
Hayward	40,258	15%	8,506	7,752	4,639	11,778	6,635
Fremont	23,174	9%	9,632	3,034	530	6,080	3,459
San Leandro	23,456	9%	4,255	3,319	3,367	8,766	3,401
Union City	11,656	4%	4,582	1,500	409	2,989	2,002
Alameda	10,718	4%	2,150	1,481	1,625	3,872	1,378
Berkeley	9,496	4%	1,042	1,578	1,302	4,184	1,274
Livermore	7,429	3%	988	593	1,658	2,846	1,171
Newark	6,301	2%	1,860	1,879	111	1,168	1,064
Castro Valley	6,299	2%	1,322	891	1,026	1,790	1,149
San Lorenzo	5,389	2%	913	845	703	1,764	1,027
Pleasanton	3,789	1%	849	338	427	1,514	591
Dublin	3,946	1%	875	341	506	1,527	675
Emeryville	1,601	1%	260	319	236	517	221
Albany	1,540	1%	124	200	340	561	275
Piedmont	310	0%	47	66	31	81	70
Sunol	59	0%	15	13	3	11	21
Antioch	58	0%	17	8	5	20	2
Other	1,153	0%	332	232	101	428	63
Total	**264,190**	**100%**	**50,169**	**47,985**	**31,480**	**95,566**	**33,947**

ALAMEDA Alliance FOR HEALTH

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

Operations

Matt Woodruff

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

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

Date: **May 10, 2019**

Subject: **Operations Report**

Member Services

- 12-month Trend Summary:
    - The Member Services Department received an increased volume of calls, 17%; 17,655 in April 2019 compared to 14,584 in April 2018. The abandonment rate decreased by 4% in April 2019 from the 6% in April 2018.
    - The service level for the department was 16% higher in April 2019 (83%), compared to April 2018 (67%).
        - The top five call reasons (Change of PCP; Eligibility/Member; Kaiser; Benefits; ID Card Request) have remained the same in 2018 and 2019 with the exception of Benefits being the third highest call reason and Kaiser being the fourth call reason in 2018.
    - Efforts to decrease the abandonment rate to meet our internal standard of 5% or below have proven to be successful for April 2019. The overflow call vendor, who has trained 11 additional agents to manage peak call volumes during monthly Department meetings, All Staff meetings, and Member Services staff trainings, continues to have a positive impact on service level delivery.

- Main Office:
    - The Member Services department blended service level for April was 83%, which met our internal standards. The Department answered 17,239 calls in April and had a blended abandonment rate of 2%. The 2% meets our standard of 5% or less. As anticipated, contract amendments to the overflow vendor have facilitated the onboarding process of additional agents. Departmental promotions of Member Services Representatives (MSR) Tier I to MSR Tier II and MSR Tier III have allowed member calls to be routed to the correct representative, with the right skills, which improves staff efficiencies and member experience.

- A total of 460 member calls were transferred by the Provider Services Contact Center (PR) to MSD in April. The department received 31 less member calls this month compared to 491 in March. Changes are in queue for the Group Care Member ID cards to add the Member Services phone number to the front of the ID cards to ensure our Group Care (GP) members are connected to the appropriate call centers. This change will increase first call resolution and member satisfaction efforts to make the member experience our first priority.
- The Department continues to participate in bi-monthly conference calls with the overflow call center vendor to address concerns, review process workflows, identify training opportunities, and to ensure continued compliance with service level agreements.

- Staffing:

  - The Department continues to actively interview candidates for the Member Service Representative (MSR) I Spanish position that remains currently open. The MSR I Cantonese hire started on April 29, 2019, and is currently in training.

- Training:

  - The Department is working to create engaging and continuous training sessions to reinforce good practices, boost staff knowledge and performance, and get staff excited about learning. In April, the department attended multiple staff trainings. The Member Services Representatives completed the “Delighting Your Customers” training. Tier II and Tier III MSRs received additional training on processing procedures and categorization of inquiries; Exempt Grievances and/or Standard Grievance or Appeals. Supervisors and the Director are scheduled to attend training on “Legal Aspects of Supervision” on May 20, 2019.
  - The Customer Satisfaction Survey results continue to reflect that members are generally satisfied with the level of service they received when speaking to member services representatives. During April, 2,376 callers elected to participate in the survey and 2,044 callers elected to answer the survey questions completely.
  - Participants were asked to rate their call experience by answering 4 questions.
  - A response of 1 being the most satisfied and response of 3 being the least satisfied with their call experience.

- The questions and the results of the survey are as follows:

    - The Member Services Staff understood the reason for my call.
      April (2012 – satisfied, 27- neutral, 5 – dissatisfied)
    - The Member Services Staff was open to my questions and concerns.
      April (2003 – satisfied, 37 - neutral, 4 – dissatisfied)
    - The Member Services Staff gave me clear information.
      April (2019 – satisfied, 22 - neutral, 3- dissatisfied)
    - Overall, I was happy with the services I received today.
      April (2021 – satisfied, 21 - neutral, 2 - dissatisfied)

- Overall satisfaction for April shows that 99% of the callers that took the survey or 2021 out of 2044, were satisfied with the results of their call experience. Our first contact resolution (FCR), per survey question #2 above, was 98%.

- Mystery Shopper Survey:

    - During April, our contracted vendor completed 109 “Mystery Shopper” calls.
    - Mystery Shopper questions targeted the following benefits:

Topic 1: Eligibility & Enrollment
Topic 2: Cost Sharing
Topic 3: Member ID Card
Topic 4: Primary Care Provider
Topic 5: Provider Network
Topic 6: Emergency & Urgent Care
Topic 7: Benefits
Topic 8: Mental Health
Topic 9: Transportation
Topic 10: DME
Topic 11: Skilled Nursing
Topic 12: Pharmacy
Topic 13: Authorizations
Topic 14: Kaiser
Topic 15: Complaints/G&A

    - Mystery shopping survey results demonstrated that the member services representatives are compliant with the processes and standards initiated by the Alliance. Of the 109 survey calls conducted for April, scripts were followed for the closing of 107 calls. 98% of the calls were closed according

to the approved script. 2% of the calls were opened or closed off script. This is a 5% improvement from March. The survey results are reviewed with team members. The Mystery Shoppers reported the MSRs as being very nice, friendly and eager to assist the caller. Learning objectives to correct deficiencies address areas where refresher trainings are identified.

- Exempt Grievances:
    - 654 Exempt Grievances were processed in April. Exempt Grievances are reported monthly and quarterly to various committees for tracking and trending (refer to the Grievance and Appeals report for details). Staff training is on-going for the processing and categorizing of exempt grievances. Our goal is to enrich staff knowledge about plan benefits and services to improve efficiencies. Providing prompt and accurate information is key to increasing member satisfaction.

Claims

- 12-Month Trend Summary:
    - The Claims Department received an increased volume of claims of 129,482 in April 2019 compared to 121,859 in April 2018.
    - The Auto-adjudication rate increased in April 2019 to 75% as compared to 70% in April 2018.
    - Claims Compliance (30-day turn-around time) was 97% in April 2019 and remained unchanged from April 2018.

- Monthly Analysis:
    - In the month of April, we received a total of 129,482 claims in the HEALTHsuite system.
    - We received 72% of claims via EDI and 28% of claims via paper.
    - 98% of our claims were processed within 45 working days during the month of April.
    - Auto Adjudication was 75% for the month of April.

Provider Services

- 12-Month Trend Summary:

    - The Provider Services Department's call volume increased in April 2019 to 6,997 calls compared to 4,726 calls in April 2018.
    - We are anticipating our call volume to increase this year. Provider Services continuously works to achieve first call resolution and reduction of the abandonment rates. Our efforts are to promote the provider's satisfaction as our first priority.
    - The Provider Services department completed 23 visits during the month of April.
    - The Provider Services department answered over 6,065 calls for the month of April and made over 1,658 outbound calls.

Credentialing Department

- Summary:

    - At the Peer Review and Credentialing (PRCC) meeting held on April 16, 2019, there were 18 initial providers approved; 5 primary care providers, 6 specialists, 0 ancillary providers, and 7 midlevel providers. Additionally, 45 providers were re-credentialed at this meeting; 13 primary care providers, 21 specialists, 0 ancillary providers, and 11 midlevel providers.
    - For more information, please refer to the Credentialing charts and graphs located in the Operations supporting documentation.

Provider Dispute Resolution

- 12-Month Trend Summary:

    - The PDR department resolved 490 cases in April 2019 compared to 883 cases in April 2018.
    - In April 2019 the PDR department upheld 66% of cases versus 76% in April 2018.
    - The PDR department resolved 93% of cases within the compliance standard of 95% within 45 working days in April 2019 compared to 100% in April 2018.

- Monthly Analysis:

    - We received 796 PDRs in April 2019 (no stats were kept for April 2018 for comparison purposes).
    - In the month of April, 490 PDRs were resolved. Out of the 490 PDRs, 168 were overturned.
    - The overturn rate of PDRs was 34%, which did not meet our goal of no more than 25%.
    - All cases were resolved with a 93% compliance rate.
    - There are 486 PDRs that are less than 45 working days old that are currently pending resolution.

Community Relations and Outreach

- 12-Month Trend Summary:

    - The Communications & Outreach (C&O) Department increased the number of events by 279% in April 2019 and completed 53 out of 63 events (84% completion rate), compared to 14 out of 17 events (82% completion rate) in April 2018.
    - The C&O Department increased the total number of individuals reached by 131% in April 2019 to 2,051 (792 self-identified Alliance members) compared to 888 in April 2018.
    - The C&O Department increased the number of event participation cities throughout Alameda County to 12 cities or unincorporated areas in April 2019 compared to 8 cities or unincorporated areas in April 2018.

- Monthly Analysis:

    - In April 2019, the C&O Department completed 53 out of 63 events (84% completion rate).
    - In April 2019, the C&O Department reached 2,051 individuals and 792 self-identified Alliance members during outreach events and activities.
    - In April 2019, the C&O Department completed events in 12 cities or unincorporated areas throughout Alameda County.
    - Please see attached **Addendum A**

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	March
Incoming Calls (R/V)	17,655
Abandoned Rate (R/V)	2%
Answered Calls (R/V)	17,239
Average Speed to Answer (ASA)	00:38
Calls Answered in 30 Seconds (R/V)	83%

Top 5 Call Reasons (Medi-Cal and Group Care) April 2019
Change of PCP
Eligibility - Member
Kaiser
Benefits
ID Card Requests

Member Walk-Ins April 2019 Alameda Location
Eligibility
Enrollment Inquiry
Benefits
Total Walk-Ins: 60

Claims Department

March 2019 Final and April 2019 Final

METRICS

Claims Compliance	Mar-19	Apr-19
90% of clean claims processed within 30 calendar days	93.9%	96.9%
95% of all claims processed within 45 working days	95.8%	98.4%

Claims Volume (Received)	Mar-19	Apr-19
Paper claims	31,624	35,951
EDI claims	92,394	93,531
Claim Volume Total	**124,018**	**129,482**

Percentage of Claims Volume by Submission Method	Mar-19	Apr-19
% Paper	25.50%	27.77%
% EDI	74.50%	72.23%

Claims Processed	Mar-19	Apr-19
HEALTHsuite Paid (original claims)	89,738	90,892
HEALTHsuite Denied (original claims)	28,805	25,947
HEALTHsuite Original Claims Sub-Total	**118,543**	**116,839**
HEALTHsuite Adjustments	3,160	766
HEALTHsuite Total	**121,703**	**117,605**

Claims Expense	Mar-19	Apr-19
Medical Claims Paid	$41,574,288	$44,721,415
Interest Paid	$55,336	$29,425

Auto Adjudication	Mar-19	Apr-19
Claims Auto Adjudicated	86,940	87,717
% Auto Adjudicated	73.3%	75.1%

Average Days from Receipt to Payment	Mar-19	Apr-19
HEALTHsuite	30	24

Pended Claim Age	Mar-19	Apr-19
0-30 calendar days		
HEALTHsuite	11,014	7,165
30-60 calendar days		
HEALTHsuite	418	136
Over 60 calendar days		
HEALTHsuite	17	21

Overall Denial Rate	Mar-19	Apr-19
Claims denied in HEALTHsuite	28,805	25,947
% Denied	23.7%	22.1%

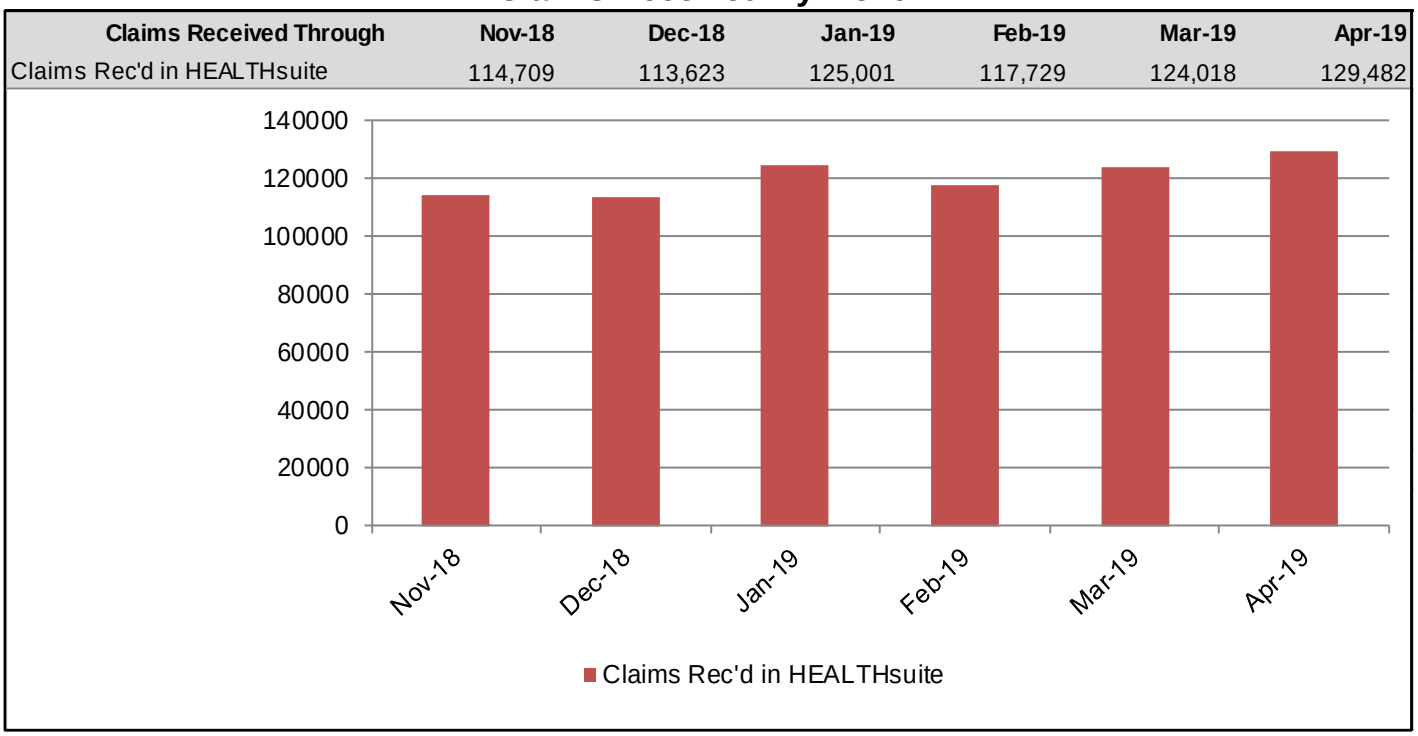
Claims Department
March 2019 Final and April 2019 Final

Apr-19

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	27%
Duplicate Claim	17%
Must Submit as a Paper Claim with Copy of Primary Payer EOB	11%
No Benefits Found for This Date of Service	7%
Non-Covered Benefit for This Plan	6%
% Total of all denials	**68%**

Claims Received By Month

Claims Received Through	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Claims Rec'd in HEALTHsuite	114,709	113,623	125,001	117,729	124,018	129,482



Provider Relations Dashboard April 2019

Alliance Provider Relations Staff	Jan-19	Feb-19	Mar-19	Apr-19
Incoming Calls (PR)	7386	6262	6811	6997
Abandoned Calls	1718	1146	829	932
Answered Calls (PR)	5664	5116	5982	6065
Recordings/Voicemails	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**
Incoming Calls (R/V)	849	644	420	428
Abandoned Calls (R/V)				
Answered Calls (R/V)	849	644	420	428
Outbound Calls	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**
Outbound Calls	1642	1602	1814	1658
N/A				
Outbound Calls	1642	1602	1814	1658
Totals	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**
Total Incoming, R/V, Outbound Calls	9873	8508	9045	9083
Abandoned Calls	1718	1146	829	932
Total Answered Incoming, R/V, Outbound Calls	8155	7362	8216	8151

Provider Relations Dashboard April 2019

Call Reasons (Medi-Cal and Group Care)

Category	Jan	Feb	Mar	Apr
Authorizations	4.5%	5.1%	4.9%	5.1%
Benefits	2.3%	2.9%	2.6%	2.9%
Claims Inquiry	35.4%	37.0%	37.3%	35.6%
Change of PCP	2.1%	3.4%	3.1%	3.7%
Complaint/Grievance (includes PDR's)	2.5%	2.5%	2.2%	2.2%
Contracts	0.4%	0.4%	0.5%	0.3%
Correspondence Question/Followup	0.1%	0.0%	0.0%	0.0%
Demographic Change	0.1%	0.1%	0.2%	0.1%
Eligibility - Call from Provider	30.5%	30.1%	29.7%	30.1%
Exempt Grievance/ G&A	0.1%	0.0%	0.2%	0.0%
General Inquiry/Non member	0.1%	0.2%	0.2%	0.1%
Health Education	0.0%	0.0%	0.0%	0.0%
Intrepreter Services Request	1.0%	1.2%	1.7%	1.8%
Kaiser	0.1%	0.2%	0.2%	0.1%
Member bill	0.1%	0.1%	0.2%	0.2%
Mystery Shopper Call	0.0%	0.0%	0.0%	0.0%
Provider Portal Assistance	3.3%	3.2%	3.0%	2.9%
Pharmacy	0.8%	1.2%	1.2%	1.5%
Provider Network Info	0.1%	0.1%	0.1%	0.2%
Transferred Call	7.3%	0.5%	0.1%	0.5%
All Other Calls	9.2%	12.1%	12.6%	12.5%
TOTAL	100.0%	100.0%	100.0%	100.0%

Field Visit Activity Details

Alliance Provider Relations Staff	Jan-19	Feb-19	Mar-19	Apr-19
Claims Issues	1	1	4	4
Contracting/Credentialing	0	1	1	0
Drop-ins	0	5	10	10
JOM's	3	2	2	3
New Provider Orientation	0	3	5	4
Quarterly Visits	52	75	44	2
UM Issues	2	0	1	0
Total Field Visits	**58**	**87**	**67**	**23**

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS

Practitioners		AHP 382	PCP 360	SPEC 663	PCP/SPEC 19
AAH/AHS/CHCN Breakdown		AAH 410	AHS 201	CHCN 396	COMBINATION OF GROUPS 417
Facilities	**227**				

VENDOR SUMMARY

Credentialing Verification Organization, Gemini Diversified Services

	Number	Average Calendar Days in Process	Goal - Business Days	Goal - 98% Accuracy	Compliant
Initial Files in Process	37	35	25	Y	N
Recred Files in Process	62	20	Y	Y	Y
Expirables updated Insurance, License, DEA, Board Certifications					Y
Files currently in process					

CAQH Applications Processed in March 2019

Standard Providers and Allied Health	**120**

April 2019 Peer Review and Credentialing Committee Approvals

Initial Credentialing	Number
PCP	5
SPEC	6
ANCILLARY	0
MIDLEVEL/AHP	7
Recredentialing	**18**
PCP	13
SPEC	21
ANCILLARY	11
MIDLEVEL/AHP	0
TOTAL	**45**

April 2019 Facility Approvals

Initial Credentialing	2
Recredentialing	3
Facility Files in Process	33

April 2019 Employee Metrics

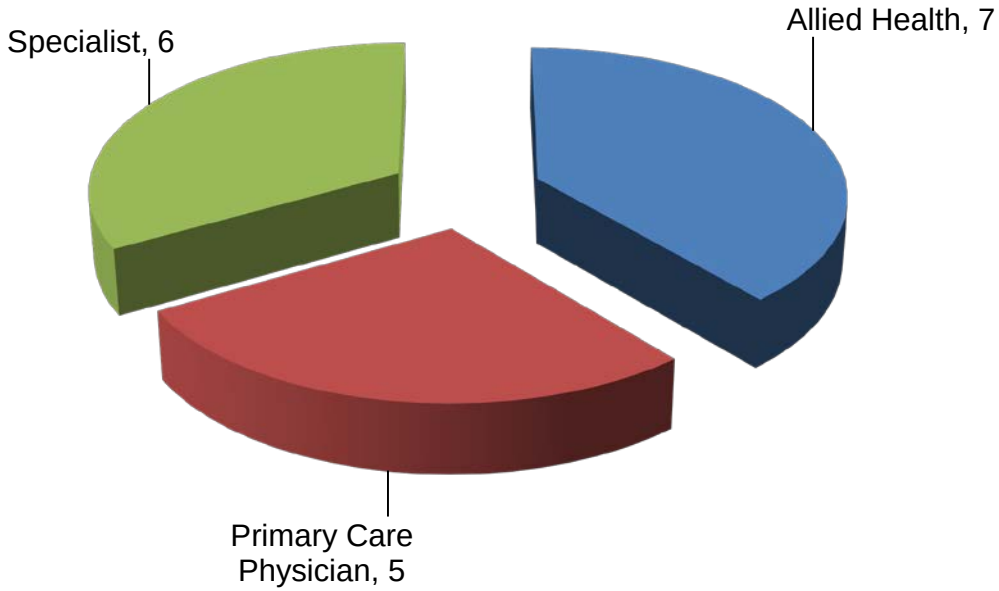
File Processing	Timely processing within 3 days of receipt	Y
Credentialing Accuracy	<3% error rate	Y
DHCS, DMHC, CMS, NCQA Compliant	98%	Y
MBC Monitoring	Timely processing within 3 days of receipt	Y

Initial/Recred				
LAST NAME	FIRST NAME	PCP/Spec/Mid/Ancillary	Initial/Recrd	CRED DATE
Allami	Nadia	Allied Health	Initial	4/16/2019
Bagshaw	Hilary	Specialist	Initial	4/16/2019
Bonnel	Galadriel	Allied Health	Initial	4/16/2019
Chichili	Sudhati	Specialist	Initial	4/16/2019
Dugoni	William	Specialist	Initial	4/16/2019
Dzubur	Valerie	Allied Health	Initial	4/16/2019
Enteen	Lauren	Allied Health	Initial	4/16/2019
Lam	Felicia	Primary Care Physician	Initial	4/16/2019
Le	Carolyn	Primary Care Physician	Initial	4/16/2019
Parma	Carolyn	Specialist	Initial	4/16/2019
Peterson	Wendy	Allied Health	Initial	4/16/2019
Phung	Stephanie	Allied Health	Initial	4/16/2019
Proddatoori	Kruthika	Primary Care Physician	Initial	4/16/2019
Rahman	Sophia	Specialist	Initial	4/16/2019
Reynolds	Matthew	Allied Health	Initial	4/16/2019
Shah	Charmi	Primary Care Physician	Initial	4/16/2019
Smith	Kevin	Specialist	Initial	4/16/2019
Tinajero-Deck	Lydia	Primary Care Physician	Initial	4/16/2019
Achanta	Kranthi	Specialist	Recred	4/16/2019
Austin	Allison	Allied Health	Recred	4/16/2019
Berke	David	Primary Care Physician and Specialist	Recred	4/16/2019
Caplin	Mark	Allied Health	Recred	4/16/2019
Caygill-Walsh	Rory	Allied Health	Recred	4/16/2019
Chan	Vanessa	Specialist	Recred	4/16/2019
Chavarkar	Milan	Allied Health	Recred	4/16/2019
Coleman	Dione	Allied Health	Recred	4/16/2019
Dang	Chuc	Specialist	Recred	4/16/2019
DeBree	Olivia	Allied Health	Recred	4/16/2019
Devane	Matthew	Specialist	Recred	4/16/2019
Enriquez	Christopher	Specialist	Recred	4/16/2019
Farahmand	Guity	Specialist	Recred	4/16/2019
Grewal-Bahl	Ranu	Specialist	Recred	4/16/2019

Initial/Recred				
LAST NAME	FIRST NAME	PCP/Spec/Mid/Ancillary	Initial/Recrd	CRED DATE
Gwalani	Tulsidas	Specialist	Recred	4/16/2019
Halio	Amy	Primary Care Physician	Recred	4/16/2019
Hopson	Christina	Specialist	Recred	4/16/2019
Khalsa	Prabhjot	Specialist	Recred	4/16/2019
Kwok-Oleksy	Christina	Specialist	Recred	4/16/2019
Lee	Diane	Specialist	Recred	4/16/2019
Lee	Min-Wei Christine	Specialist	Recred	4/16/2019
Lomeli-Loibl	Cadelba	Allied Health	Recred	4/16/2019
Magalong, Jr	Elpidio	Specialist	Recred	4/16/2019
Maramreddy	Neeraja	Primary Care Physician	Recred	4/16/2019
Marusczak	Melanie	Allied Health	Recred	4/16/2019
Moorstein	Bruce	Specialist	Recred	4/16/2019
Nye	Ann	Specialist	Recred	4/16/2019
Parekh	Hemal	Specialist	Recred	4/16/2019
Paxton	Lamont	Specialist	Recred	4/16/2019
Pierce	Lasha	Specialist	Recred	4/16/2019
Raj	Kavitha	Specialist	Recred	4/16/2019
Ramos-Scott	Chereamie	Allied Health	Recred	4/16/2019
Riley	Jenny	Primary Care Physician	Recred	4/16/2019
Shah	Shaista	Primary Care Physician	Recred	4/16/2019
Shekarloo	Afra	Specialist	Recred	4/16/2019
Sombredero-Sanchez	Alisson	Primary Care Physician	Recred	4/16/2019
Straus	Diane	Allied Health	Recred	4/16/2019
Truong	Kenneth	Primary Care Physician	Recred	4/16/2019
Tuttie	Ann	Allied Health	Recred	4/16/2019
Venzon	Merlin	Primary Care Physician	Recred	4/16/2019
Vesga	Liana	Specialist	Recred	4/16/2019
Vu	John	Specialist	Recred	4/16/2019
Wolfe	Ashby	Primary Care Physician	Recred	4/16/2019
Yeh	Ray	Specialist	Recred	4/16/2019
Zonner	Steven	Primary Care Physician	Recred	4/16/2019

APRIL PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY

Allied Health	7
Primary Care Physician	5
Specialist	6
	18



Project Management Office Portfolio Overview for April 2019

Alliance Portal Redesign Project

- The Portal redesign project will enhance our Alliance.org site, and our member and provider portals. This is a phased project with final go live in 2020.

CobbleStone Project

- Cobblestone is a vendor and contract management software tool that will enhance the way we manage vendor contracts to include but not limited to renewals and contract storage. We will use this tool to roll out all provider contracts.

Preferred Vendor Project

- The purpose of this project is to identify a select list of preferred vendors (SNF, Respite, Health Home, and Infusion) to partner with patient care. This will enable us to determine the cost-effectiveness of existing vendor relationships and the best fit for the Alliance patient portfolio. Target Go-Live date is June 2019.

COBA Project

- This is a compliance-driven project. Later this fall the Alliance will begin to receive coordination of Benefits files from CMS for our Medicare and Medi-Cal dual eligible members.

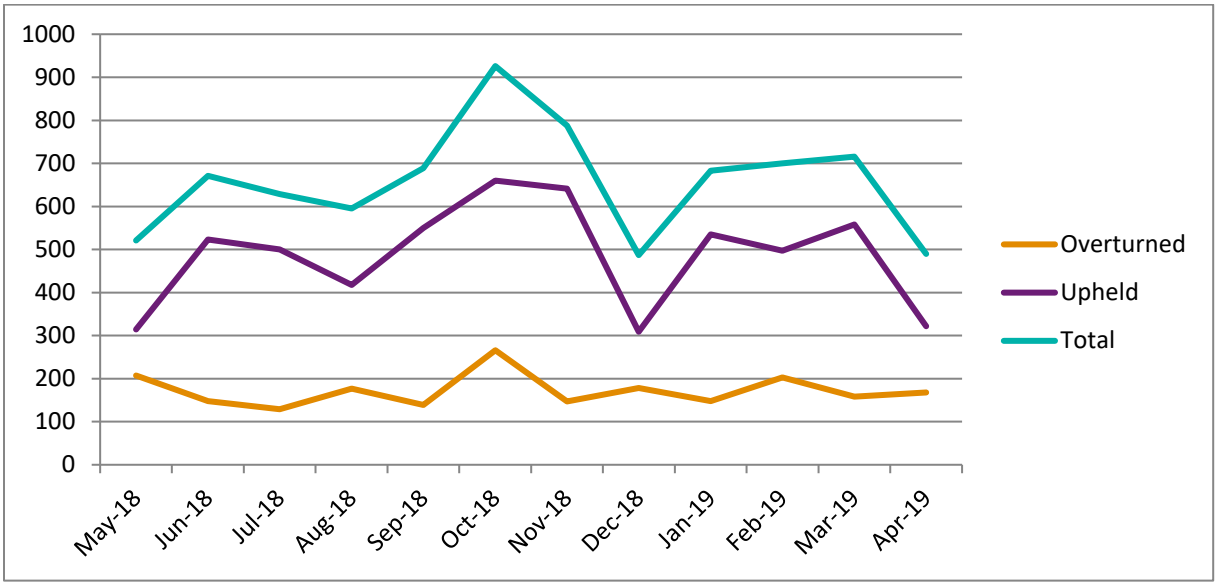
HEALTHsuite Upgrade Project

- The HEALTHsuite upgrade is scheduled to go live on May 17, 2019. The Alliance is currently testing the new functionalities via this upgrade. This includes over 200 fixes and enhancements.

Provider Dispute Resolution (PDR) Update – April 2019

- The Alliance received 796 PDRs in April 2019 compared to 716 in March 2019.
- A total of 490 PDRs were resolved during the month and 93% (456) were resolved within 45 working days so the goal of 95% resolution within 45 working days was not met.
    - One PDR Analyst was out on leave the majority of the month.
    - Two Claims Specialists continued to work on PDRs during the month, as available, to assist with the caseload but their available time was impacted by regular work activities.
    - Interviews were conducted for the two open PDR Analyst positions and offers are pending.
- The PDR overturn rate increased from 22% in March to 34% in April so the goal of an overturn rate less than 25% was not met.
- The inventory is currently at 852 acknowledged PDRs pending resolution with 366 cases out of compliance. The bulk of the cases out of compliance are for one provider, Washington Township that required a review of the provider set-up for all providers associated with the group and re-configuration, as needed. The impacted claims have been adjusted and resolution of the cases is in progress with the provider. This inventory total does not include the PDRs that have not been acknowledged which represents an additional 489 potential cases.

Rolling 12-month PDR Trend Line



Provider Dispute Resolution

March 2019 Final and April 2019 Final

METRICS

PDR Compliance	Mar-19	Apr-19
# of PDRs Resolved	716	490
# Resolved Within 45 Working Days	710	456
% of PDRs Resolved Within 45 Working Days	99%	93%

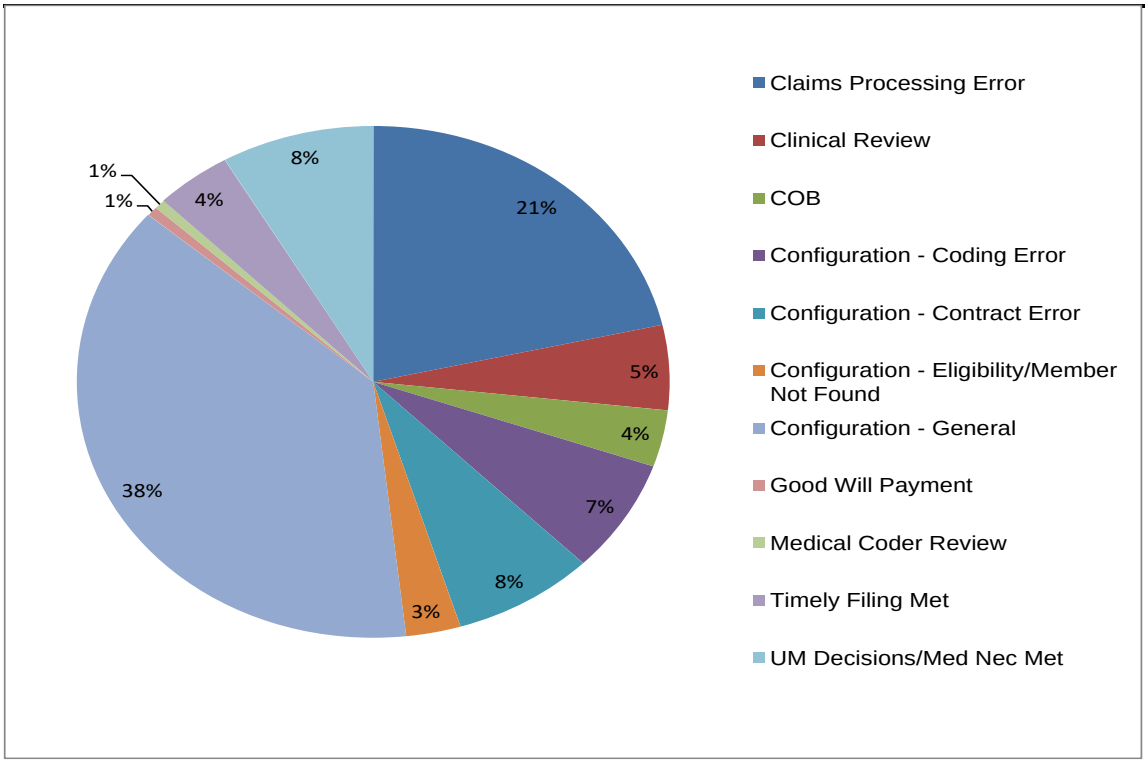
PDRs Received	Mar-19	Apr-19
# of PDRs Received	717	796
PDR Volume Total	**717**	**796**

PDRs Resolved	Mar-19	Apr-19
# of PDRs Upheld	558	322
% of PDRs Upheld	78%	66%
# of PDRs Overturned	158	168
% of PDRs Overturned	22%	34%
Total # of PDRs Resolved	**716**	**490**

Unresolved PDR Age	Mar-19	Apr-19
0-45 Working Days	537	486
Over 45 Working Days	380	366
Total # of Unresolved PDRs	**917**	**852**

Apr-19

PDR Resolved Case Overturn Reasons



Public Affairs External Communications Summary

- April 6, 2019 – May 6, 2019

- The following article was submitted by Scott Coffin, CEO, to the Alameda-Contra Costa Medical Association
(ACCMA) March – April 2019 Provider Bulletin:

- Alameda Alliance for Health (the Alliance) is honored to serve nearly 260,000 children and adults in Alameda County. In this edition you will learn about Governor Gavin Newsom's focus on improving children's health outcomes. You will also learn about the Governor's plans to increase oversight on pediatric screening, diagnosis, and treatment of children across California.
- On January 10, Governor Newsom released his 2019-2020 "California For All" state budget. While we are still likely to see many changes before the final budget is adopted in June, one focus that we expect to remain is on efforts to improve the health and education of California's children. Governor Newsom's first proposal includes $60 million for early developmental health screenings for children covered by Medi-Cal, nearly $110 million to expand home visiting programs that support pregnant women and their families, and $260 million to extend full Medi-Cal coverage to undocumented young adults ages 19 through 25 years old. Additionally, the budget focuses on reducing health disparities in early childhood by providing additional funding to improve the detection of adverse childhood experiences and significantly increasing funding for new state-subsidized preschool slots for low-income 4-years-olds. At the Alliance, we understand that access to quality health care and education is linked to stronger outcomes for our youngest residents, and we commend the Governor for his efforts that will change the landscape of services provided to children and families for years to come.

Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)

- The EPSDT benefit was enacted through a federal statute in 1967 as a part of Medicaid, and today the benefit is designed to ensure that eligible Medi-Cal members receive early detection and preventive care in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible. With the Governor's focus on supports and services for California's children, the Department of Health Care Services (DHCS) is increasing oversight on the EPSDT benefit to ensure that Medi-Cal managed care plans such as the Alliance are performing required services, and that we are strengthening our coordination efforts with entities such as the Regional

Center of the East Bay and California Children Services on all EPSDT services that they provide to our youngest members.

- The DHCS is currently developing additional resources and expanding information regarding the EPSDT benefit, including increasing the amount of EPSDT information on their website, providing a more detailed description of EPSDT services in the member handbook, and adding new EPSDT-focused material in the Medi-Cal Provider Manual. The Alliance will be working internally on our processes to ensure that we are properly overseeing EPSDT services that local health entities provide to our members.

  For more information on EPSDT and covered services, visit the DHCS website at **www.dhcs.ca.gov/services/pages/EPSDT.aspx.**

Advancing Care Quality Oversight

- In addition to expanding supports and services to children, the Governor is committed to efforts that advance and improve the state's process for monitoring and overseeing the quality of health care provided to children covered by Medi-Cal. As part of his commitment to early childhood development, the Governor directed the DHCS to review all pediatric measures and identify health measurements that require improvement. Consequently, the DHCS determined that changes were needed to strengthen quality oversight for Medi-Cal managed care plans, including adding a new set of measures in children's health, women's health, behavioral health, and acute and chronic disease management. This new set of measures is based on the Centers for Medicare & Medicaid Services' Adult and Child Core Sets that are evidence-based and assess the quality of care. Additionally, the DHCS has raised the minimum performance level by 100% on a statewide basis, and resulting in managed care plans and providers working collaboratively to target quality improvement opportunities. These quality benchmarks have been retroactively implemented to January 1, 2019, and will be reported to DHCS in May 2020.
- At the Alliance, we understand that improving the quality of our services is a continuous process that includes laying out priorities, measuring outcomes and setting interventions to improve performance. Since 2015, the Alliance has steadily improved its quality measures by 30 percentage points, in large part, due to the hard work and dedication of our community providers. We are confident that by working with our community providers, and with a strong commitment from our Alliance employees, we will be able to exceed the state's new quality standards.

2019 Legislative Tracking List

The following is a list of state legislation currently tracked by the Public Affairs Department that has been introduced during the 2019-2020 Legislative Session. This list of bills is of interest to and could have a direct impact on Alameda Alliance for Health and its membership.

Medi-Cal (Medicaid)

- **AB 4 (Bonta – D) Medi-Cal: Eligibility**
  - **Status:** 5/1/2019 - In committee: Set, first hearing. Referred to committee on appropriations. Suspense file.
  - **Summary:** Federal law prohibits payment to a state for medical assistance furnished to an individual who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States. AB 4 would extend eligibility for full-scope Medi-Cal benefits to individuals of all ages, if otherwise eligible for those benefits, but for their immigration status.

- **AB 385 (Calderon – D) Medi-Cal: Early and Periodic Screening, Diagnosis, and Treatment Mental Health Services**
  - **Status:** 4/24/19 – Re- referred to committee on appropriations.
  - **Summary:** Current law requires the State DHCS (department) to create a plan for a performance outcome system for EPSDT mental health services, as specified. This bill would require the department to develop a platform, or integrate with an existing platform, to support the performance outcome system that will improve outcomes at the individual and system levels and will inform fiscal decision making related to the purchase of services.

- **AB 741 (Arambula – D) Early and Periodic Screening, Diagnosis, and Treatment Program: Trauma Screening**
  - **Status:** 4/24/19 – From committee: Do pass and re-refer to committee on appropriations.
  - **Summary:** Current law requires the State DHCS to convene an advisory working group to update, amend, or develop, if appropriate, tools and protocols for the screening of children, within the EPSDT benefit. Current law requires that the group be disbanded on December 31, 2019, and requires, on or before May 1, 2019, the department to identify an existing advisory working group to periodically review and consider the protocols for the screening of trauma in children at least once every 5 years, or upon the request of the department. This bill would require the department to provide training for certain personnel, including among other things, instruction on how to identify and make appropriate referrals for patients who have tested positive in trauma screenings.

- **AB 1004 (McCarty – D) Developmental Screening Services**
  - **Status: 4/24/19 – Re-referred to committee on appropriations.**
  - **Summary:** Would require that screening services provided as an EPSDT benefit include developmental screening services for individuals zero to 3 years of age. This bill would require the department to ensure a Medi-Cal managed care plan's ability and readiness to perform these developmental screening services, and would require the department to adjust a Medi-Cal manage care plan's capitation rate, as specified. Until July 1, 2023, the bill would require an external quality review organization entity to annually review, survey, and report on managed care plan reporting and compliance.

- **AB 763 (Gray – D) Medi-Cal Specialty Mental Health Services**
  - **Status: 4/24/19 – From committee: Do pass and re-refer to committee on appropriations.**
  - **Summary:** Would require, on or before March 31, 2020, the State DHCS to convene a stakeholder workgroup, including representatives from the County Behavioral Health Directors Association of California, to develop standard forms to be used by Medi-Cal managed contractors, including mental health plan contractors and contractor provider networks, for performing the intake of, the assessment of, and the treatment planning for, Medi-Cal beneficiaries who are eligible for specialty mental health services under the Early and Periodic Screening, Diagnosis, and Treatment Program.

- **AB 537 (Wood – D) Medi-Cal Managed Care: Quality Improvement and Value-Based Financial Incentive**
  - **Status:** 4/24/19 – In committee: Set, first hearing. Referred to committee on appropriations. Suspense file.
  - **Summary:** Would require a Medi-Cal managed care plan to meet a minimum performance level (MPL) that improves the quality of health care and reduces health disparities for enrollees, commencing January 1, 2022. The bill would require DHCS to establish both a quality assessment and performance improvement program and a value-based financial incentive program to ensure that a Medi-Cal managed care plan achieves an MPL.

- **AB 715 (Wood – D) Medi-Cal: Program for Aged and Disabled Persons**
  - **Status:** 4/3/19 – From committee: Do pass and re-refer to committee on appropriations.
  - **Summary:** Current law requires the State DHCS to exercise its option under federal to implement a program for aged individuals and disabled persons that satisfy certain financial eligibility requirements. Upon federal approval, this bill would raise income eligibility limit for seniors and adults with disabilities to 138% of the federal poverty level (FPL) from 123% FPL. This bill would create parity between other Medi-Cal programs that serve adults and the Medi-Cal Aged & Disabled program.

- **AB 683 (Carrillo – D) Medi-Cal: Eligibility**
    - **Status:** 4/10/19 – Re-referred to committee on appropriations.
    - **Summary:** Current law prohibits the use of an asset or resources test for individuals whose financial eligibility for Medi-Cal is determined based on the application of modified adjusted gross income (MAGI). This bill would require the department to disregard specified assets and resources, such as motor vehicles and life insurance policies, in determining Medi-Cal eligibility. This bill would prohibit the department from using an asset or resource test to make a Medi-Cal eligible determination for an applicant or beneficiary who is enrolled in the Medicare Shared Savings program.

- **AB 1088 (Wood – D) Medi-Cal: Eligibility**
    - **Status:** 5/1/19 – In committee: Hearing postponed by committee.
    - **Summary:** Would provide that an aged, blind or disabled individual who would otherwise be eligible for Medi-Cal benefits, as specified, would be eligible for Medi-Cal without a share of cost if their income and resources otherwise meet eligibility requirements.

    - **AB 166 (Gabriel – D) Medi-Cal: Violence Preventive Services Status:** 5/1 Re-referred to committee on appropriations.
    - **Summary:** Would make violence preventive services provided by a qualified violence prevention professional, a covered benefit under the Medi-Cal program. This bill would make the benefit available to a Medi-Cal beneficiary who has received Medi-Cal treatment for a violent injury and for whom a licensed health care provider has determined that the beneficiary is at elevated risk of re-injury o retaliation and whom has been referred to participate in a violence prevention services program.

- **AB 318 (Chu – D) Medi-Cal Materials: Readability**
    - **Status:** 4/10/2019 – In committee: Set, first hearing. Referred to committee on appropriations. Suspense file.
    - **Summary:** Would require the State DHCS and managed care plans to require field testing of all translated materials released by the department or managed care plans, respectively, to Medi-Cal beneficiaries, commencing January 1, 2020. The bill would define “field testing” as a review of translations for accuracy, cultural appropriateness, and readability.

- **AB 577 (Eggman – D) Medi-Cal: Maternal Mental Health**
    - **Status:** 4/24/19 – In committee: Set, first hearing. Referred to committee on appropriations. Suspense file.
    - **Summary:** Would extend Medi-Cal eligibility for a pregnant individual who is receiving health care coverage under the Medi-Cal program, or another specified program, and who has been diagnosed with a maternal mental health condition, for a period of one year following the last day of the individual’s pregnancy if the individual complies with certain requirements.

- **AB 678 (Flora – R) Medi-Cal: Podiatric Services**
    - **Status:** 4/24/19 – In committee: Set, first hearing. Referred to committee on appropriations. Suspense file.
    - **Summary:** Current law excludes certain optional Medi-Cal benefits, including podiatric services and chiropractic services, from coverage under the Medi-Cal program, except for specified beneficiaries. This bill would restore podiatric services as a covered benefit of the Medi-Cal program as of January 1, 2020, of the effective date of federal approvals as specified.

- **AB 744 (Aguiar-Curry – D) Health Care Coverage: Telehealth**
    - **Status:** 4/24/19 – Re-referred to committee on appropriations.
    - **Summary:** Under current law, face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for teleophthalmology, teledermatology, or teledentistry by store and forward to be notified of the right to receive interactive communication with a distant specialist physician, optometrist, or dentist, and authorizes a patient to request that interactive communication. This bill would delete those interactive communication provisions. This bill requires a health plan's contract with providers to cover and reimburse telehealth services to the same extent as it would for the same services provided in person, and prohibits plans from placing limitations on telehealth services within certain parameters.

- **AB 781 (Maienschein – D) Medi-Cal: Family Respite Care**
    - **Status:** 4/24/19 – Referred to committee on health.
    - **Summary:** Current law provides that pediatric day health care is a covered benefit under the Medi-Cal program and that pediatric day health care is does not include inpatient long-term care or family respite care. This bill would specify that pediatric day health care services may be provided at any time of the day and on any day of the week, so long as the total number of authorized hours is not exceeded.

- **AB 848 (Gray – D) Medi-Cal: Covered Benefits: Continuous Glucose Monitors**
    - **Status:** 4/24/19 – In committee: Set, first hearing. Referred to committee on appropriations. Suspense file.
    - **Summary:** Would, to the extent that federal financial participation is available and any necessary federal approvals have been obtained, add continuous glucose monitors and related supplies required for use with those monitors to the schedule of benefits under the Medi-Cal program for the treatment of diabetes mellitus when medically necessary, subject to utilization controls. The bill would also authorize the department to require the manufacturer of a continuous glucose monitor to enter into a rebate agreement with the department.

- **AB 1175 (Wood – D) Medi-Cal Specialty Mental Health Services: Memorandum of Understanding**
  - **Status:** 4/24/19 – Re-referred to committee on appropriations.
  - **Summary:** Current law requires that an external quality review organization (EQRO) annually review mental health plans and Medi-Cal managed care plans on plan data, such as the number of Medi-Cal beneficiaries in foster care who receive mental health services each year and network adequacy standards. This bill would require the EQRO to collect additional data, including performance data for each Medi-Cal managed care health plan and county mental health plan, to inform strategies to improve access to mental health services.

- **AB 1494 (Aguiar-Curry – D) Medi-Cal: Telehealth: State of Emergency**
  - **Status:** 5/1/19 – In committee: Set, first hearing. Referred to committee on appropriations. Suspense file.
  - **Summary:** Would require, to the extent that federal financial participation is available, that neither face-to-face contact nor a patient's physical presence on the premises of an enrolled community clinic, is required for services provided by the clinic to a Medi-Cal beneficiary during or immediately following a state of emergency. This bill would require that telehealth services, telephonic services, and other specified services be reimbursable when provided by one of those entities during or immediately following a state of emergency.

- **AB 1642 (Wood – D) Medi-Cal: Managed Care Plans**
  - **Status:** 4/24/19 – Re-referred to committee on appropriations.
  - **Summary:** Would require a Medi-Cal managed care plan to provide to the State Department of Health Care Services additional information in its request for the alternative access standards, including a description of the reasons justifying the alternative access standards, and to report to the department on how the Medi-Cal managed care plan arranged for the delivery of Medi-Cal covered services to Medi-Cal enrollees, such as through the use of nonemergency medical transportation.

- **SB 29 (Durazo – D) Medi-Cal: Eligibility**
  - **Status:** 4/22/19 – April 22 hearing: Placed on committee on appropriations. Suspense file.
  - **Summary:** This bill would extend eligibility for full-scope Medi-Cal benefits to individuals of all ages who are otherwise eligible for those benefits but for their immigration status, and would delete provision delaying implementation until the director makes the determination as specified.

- **SB 207 (Hurtado – D) Medi-Cal: Asthma Preventive Services**
  - **Status:** 4/29/19 – April 29 hearing: Placed on committee on appropriations. Suspense file.

- **Summary:** This bill would require the State DHCS to approve 2 accrediting bodies with expertise in asthma to review and approve training curricula for asthma preventive services providers, and would require the curricula to be consistent with specified federal and clinically appropriate guidelines.

- **SB 361 (Mitchell – D) Medi-Cal: Health Homes Program**
  - **Status:** 4/29/19 – April 29 hearing: Placed on committee on appropriations. Suspense file.
  - **Summary:** Current law prohibits the implementation of the Health Home Program using additional General Fund moneys to fund the administration and costs of services, unless the department projects that no net increase in ongoing General Fund costs for the Medi-Cal program would result. Existing law requires the nonfederal share for the program to be provided by funds from local governments, private foundations, or any other source permitted under state and federal law. This bill would remove the prohibition on the use of General Fund moneys for the implementation of the program.

- **SB 446 (Stone – R) Medi-Cal: Hypertension Medication Management Services**
  - **Status:** 5/3/19 – Set for hearing May 13.
  - **Summary:** This bill would additionally provide that hypertension medication management services are a covered pharmacist services under the Medi-Cal program, as specified.

- **SB 503 (Pan – D) Medi-Cal: managed care plan: subcontracts**
  - **Status:** 5/3/19 – Set for hearing May 13.
  - **Summary:** Current law requires the State DHCS to either terminate a contract with or impose one or more sanctions on a prepaid health plan or Medi-Cal managed care plan if the department makes a finding of noncompliance or for other good cause. “Good cause” is defined to include 3 repeated and uncorrected finding of serious deficiencies, which potentially endanger patient care and are identified in medical audits conducted by the department. This bill would instead authorize “good cause” to be based on findings of serious deficiencies that have the potential to endanger patient care and are identified in the specified medical audits, and would conform the civil penalties to federal law.

- **AB 50 (Kalra – D) Medi-Cal: Assisted Living Waiver Program**
  - **Status:** 4/29/19 – Re-referred to committee on appropriations.
  - **Summary:** Would require the State DHCS to submit to the federal CMS a request for amendment of the Assisted Living Waiver program with specified amendments. This bill would require the department to increase the number of participants in the program from the currently authorized 5,744 participants to 18,500, to be phased in, as specified. This bill would require the department to increase its provider reimbursement tiers to compensate for mandatory minimum wage increases, as specified.

- **AB 914 (Holden – D) Medi-Cal: Inmates: Eligibility**
    - **Status:** 4/24/19 – In committee: Hearing postponed by committee.
    - **Summary:** Current law requires Medi-Cal benefits of an individual who is an inmate of a public institution to be suspended effective the date the individual becomes an inmate and requires the suspension to end on the date the individual is no longer an inmate or one year from the date they become an inmate, whichever is sooner. This bill would instead require the suspension of Medi-Cal eligibility to end either on the date the individual is no longer an inmate or is no longer otherwise eligible for benefits under the Medi-Cal program, whichever is sooner.

IHSS (Alliance Group Care)

- **AB 598 (Bloom – D) Hearing Aids: Minors**
    - **Status:** 4/24/19 From committee: Do pass and re-refer to committee on appropriations.
    - **Summary:** Would require a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2020, to include coverage for hearing aids, as defined, for an enrollee or insured under 18 years of age, as specified. Because a willful violation of these requirements by a health care service plan would be a crime, this bill would impose a state-mandated local program.

- **AB 744 (Aguiar-Curry – D) Health Care Coverage: Telehealth**
    - **Summary:** See details above in Medi-Cal section.

- **AB 1676 (Maienschein – D) Health Care: Mental Health**
    - **Status:** 4/24/19 – Re-referred to committee on appropriations.
    - **Summary:** Would require health care service plans and health insurers, by January 1, 2021, to establish a telehealth consultation program that provides providers who treat children and pregnant and postpartum persons with access to a psychiatrist, as specified, in order to more quickly diagnose and treat children and pregnant and postpartum persons suffering from mental illness. The bill would require health care service plans and insurers to communicate information relating to the telehealth program at least twice a year in writing. *Also impacts Medi-Cal line of business.

- **SB 163 (Portantino – D) Healthcare Coverage: Pervasive Developmental Disorder or Autism**
    - **Status:** 5/6/19 – May 6 hearing: Placed on committee on appropriations. Suspense file.
    - **Summary:** Would revise the definition of behavioral health treatment to require the services and treatment programs provided to be based on behavioral, developmental, behavior-based, or other evidence-based models. The bill would remove the exception for health care service plans and health insurance policies in the Medi-Cal program, consistent with the MHPAEA. *Also impacts Medi-Cal line of business.

- **SB 382 (Nielsen – R) Health Care Coverage: State of Emergency**
  - **Status:** 5/3/19 – Set for hearing May 13.
  - **Summary:** Would require a health care service plan contract or health insurance policy entered into, amended, or renewed on or after January 1, 2020, to provide reimbursement of at least the administrative day rate to enrollees and insureds who remain in acute care hospitals, but no longer meet medically necessary criteria, due to a lack of access to postacute care services during a state of emergency. The bill would specify that a plan or insurer may be required to identify enrollees or insureds being cared for in acute care hospitals and create individualized postacute care services plans during a state of emergency. *Also impacts Medi-Cal line of business.

Other

- **AB 341 (Maienschein – D) CalHEERS: Application for CalFresh**
  - **Status:** 4/24/19 – In committee: Set, first hearing. Referred to committee on appropriations. Suspense file.
  - **Summary:** Would require the Office of Systems Integration to ensure that CalHEERS transfers an individual's application for health care benefits that is processed by CalHEERS to the county of residence of the individual if that individual is determined by CalHEERS to be potentially eligible for CalFresh benefits and the individual opts into applying for CalFresh benefits, as specified. The bill would require the office to collaborate with the State Department of Social Services to ensure that the application transferred via CalHEERS to a county for purposes of treatment as a CalFresh application meets all state and federal requirements necessary to qualify as a CalFresh application.

- **AB 1759 (Salas- D) Health Care Workers: Rural and Underserved Areas**
  - **Status:** 5/1/19 – In committee: Set, first hearing. Referred to committee on appropriations. Suspense file.
  - **Summary:** Would appropriate the sum of $50,000,000 from the General Fund to the Office of Statewide Health Planning and Development for the purpose of increasing the health care workforce in rural and underserved areas. The bill would require the office to allocate those funds for the support of programs that effect that purpose, including programs to recruit and train students from areas with a large disparity in patient-to-doctor ratios to practice in community health centers in the area from which each student was recruited and to expand and strengthen programs to recruit and prepare students from underrepresented and low-income backgrounds for health careers.

- **AB 1126 (O'Donnell – D) Mental Health Services Oversight and Accountability Commission**
  - **Status:** 4/24/19 – From committee: Do pass and re-refer to committee on appropriations. Re-refer to committee on appropriations.
  - **Summary:** Would require the Mental Health Services Oversight and Accountability Commission, by January 1, 2021, to establish technical assistance centers and one or more clearinghouses to support counties in addressing mental health issues of statewide concern, with a focus on school mental health and reducing unemployment and criminal justice involvement due to untreated mental health issues.

- **AB 887 (Kalra – D) Office of Health Equity: Surgeon General**
  - **Status:** 5/1/2019-In committee: Set, first hearing. Referred to committee on appropriations. Suspense file.
  - **Summary:** Current law requires the State Department of Public Health to establish an Office of Health Equity for the purpose of aligning state resources, decision making, and programs to accomplish specified goals, including, among other things, to advise and assist other state departments in their mission to increase access to, and the quality of, culturally and linguistically competent health and mental health care and services and to improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and inequities. This bill would also require the office to advise and assist other state departments in their mission to increase the general well-being of all Californians, and would require the office to work toward eliminating adverse childhood experiences.

- **AB 1593 (Reyes) Personal Income Taxes: Earned Income Tax Credit**
  - **Status:** 4/22/19 – Do pass and re-refer to committee on appropriations.
  - **Summary:** AB 1593 would extend eligibility for the existing California Earned Income Tax Credit (CalEITC) to some of the most vulnerable working Californians, including all working Californians who files taxes and are income eligible. This bill would remove the exclusion of immigrant filers for CalEITC, allowing those with federally assigned Individual Tax Identification Numbers (ITINs) or SSNs to benefit from the credit.

- **SB 26 (Caballero – D) Restore Refundable Child Care Tax Credit**
  - **Status:** 4/22/19 – Placed on Suspense file.
  - **Summary:** Would make the state Child and Dependent Care Expenses Credit refundable, so that low-income and moderate-income working families can benefit from the credit and receive a tax refund for their child care expenses.

- **SB 321 (Mitchell – D) CalWORKS: Support Services: Childcare**
  - **Status:** 5/6/2019-May 6 hearing: Placed on committee on appropriations. Suspense file.
  - **Summary:** Would require that specified information necessary to enroll or transfer a family into childcare services be made available by a county welfare department to a contractor that provides childcare services. The bill would require, beginning no later than November 1, 2020, a county welfare department to provide a monthly report to stage-2 contractors containing specified information. The bill would authorize a county welfare department to provide training on security protocols and confidentiality of individual family data to a contractor who is given access to data pursuant to those provisions.

- **ACR 1 (Bonta – D) Immigration: Public Charges**
  - **Status:** 4/3/2019-Re-referred to committee on Human Services.
  - **Summary:** This measure would condemn regulations proposed by the Department of Homeland Security to prescribe how a determination of inadmissibility for a person who is not a citizen or national is made based on the likelihood that the person will become a public charge. This measure would also urge the federal government to reconsider and roll back the proposed regulations.

COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

APRIL 2019

During the month of April, the Alliance initiated and/or was invited to participate in a total of **63** events throughout Alameda County. The Alliance completed **53** out of the **63** events (**84**%). All events are listed in the table starting on page **3**.

All of the numbers reached at member orientations (NMO) are Alliance Members. Approximately 20% of the numbers reached at community events are Medi-Cal Members, of which, 82% are estimated to be Alliance members based on Managed Care Enrollment Reports. Additionally, the Outreach Team began tracking Alliance members at community events in late February 2018. Since July 2018, **8,787** self-identified Alliance members were reached at community events, and member education events.

10 events were not completed during the month of April:

- **Food Pantry -** Union City Family Center – Event was canceled due to no food at site.
- **Ohana Health Fair** – Event is rescheduled for Saturday, June 6, 2019.
- **Tennyson High School - College & Career Day** – Event was not assigned due to short notice.
- **Easter LOVE Reach 2019** – Event was canceled by organizer.
- **FUSD - Spanish Immersion Taskforce Meeting** – Unable to attend due to staffing capacity.
- **Food Pantry – USDA** – Event was canceled by organizer.
- **Oakland Public Library Community Kiosk** – Unable to attend due to staffing capacity.
- **Davis Street Family Resource Center - Basic Needs Information Table** – Unable to attend due to staffing capacity.
- **Food Pantry - Well Community Outreach Center** – Unable to attend due to staffing capacity.
- **Glad Tidings** – Unable to attend due to staffing capacity.

ALLIANCE IN THE COMMUNITY
APRIL 2019

APRIL 2018 TOTALS

5 COMMUNITY EVENTS
10 MEMBER ORIENTATIONS
2 MEETINGS/ PRESENTATIONS
17 TOTAL INITIATED/ INVITED EVENTS
14 **TOTAL COMPLETED EVENTS**

8 CITIES
ALAMEDA
EMERYVILLE
FREMONT
HAYWARD
NEWARK
OAKLAND
PLEASANTON
SAN LEANDRO

865 TOTAL REACHED AT COMMUNITY EVENTS
12 TOTAL REACHED AT MEMBER ORIENTATIONS
11 TOTAL REACHED AT MEETINGS/PRESENTATIONS
143 MEMBERS REACHED AT ALL EVENTS
888 **TOTAL REACHED AT ALL EVENTS**

$5,400*
TOTAL SPENT IN DONATION, FEES & SPONSORSHIPS

APRIL 2019 TOTALS

13 COMMUNITY EVENTS
23 MEMBER EDUCATION EVENTS
24 MEMBER ORIENTATIONS
3 MEETINGS/ PRESENTATIONS
63 TOTAL INITIATED/ INVITED EVENTS
53 **TOTAL COMPLETED EVENTS**

12 CITIES
ALAMEDA
BERKELEY
DUBLIN
FREMONT
HAYWARD
LIVERMORE
NEWARK
OAKLAND
PLEASANTON
SAN LEANDRO
SAN LORENZO
UNION CITY

517 TOTAL REACHED AT COMMUNITY EVENTS
1309 TOTAL REACHED AT MEMBER EDUCATION EVENTS
114 TOTAL REACHED AT MEMBER ORIENTATIONS
111 TOTAL REACHED AT MEETINGS/PRESENTATIONS
792 MEMBERS REACHED AT ALL EVENTS
2051 **TOTAL REACHED AT ALL EVENTS**

$450*
TOTAL SPENT IN DONATION, FEES & SPONSORSHIPS

** Includes refundable deposit.*

ALLIANCE IN THE COMMUNITY
APRIL 2019

	EVENT	DATE	CITY	NUMBER REACHED**	DONATION, FEES & SPONSORSHIPS***
430	Fremont Family Resource Center	Mon, Apr 1	Fremont	6	$0
431	Mujeres Unidas y Activas	Tue, Apr 2	Oakland	0	$0
432	Food Bank - HUSD	Tue, Apr 2	Hayward	41 / 12	$0
433	Food Pantry - Union City Family Center	Tue, Apr 2	Union City	N/A	N/A
434	West Oakland Health Center	Wed, Apr 3	Oakland	3	$0
435	Tobacco Control	Wed, Apr 3	Oakland	63 / 39	$0
436	Union City Family Center	Thu, Apr 4	Union City	2	$0
437	HUSD Tyrrell Elementary School Parents' Meeting and MO Table	Fri, Apr 5	Hayward	12	$0
438	Fuente Wellness Center	Fri, Apr 5	San Leandro	0	$0
439	Oakland Public Library Community Kiosk	Fri, Apr 5	Oakland	4 / 2	$0
440	Ohana Health Fair	Sat, Apr 6	Fremont	N/A	N/A
441	Food Pantry - Alameda Food Bank Warehouse	Sat, Apr 6	Alameda	89 / 16	$0
442	Spring into Health	Sat, Apr 6	Oakland	43 / 21	$0

COMMUNITY EVENT MEMBER EDUCATION EVENT MEMBER ORIENTATION MEETINGS/PRESENTATIONS

DID NOT ATTEND **OTF** = ONE TIME FEE

** **Number Reached** = Total Number of people who stopped by the Alliance table, attended a presentation, or MO / Number of self-identified Alliance members.

*** **Donation, Fees & Sponsorships** = Applicable vendor donation, fee or sponsorship / refundable deposit.

ALLIANCE IN THE COMMUNITY
APRIL 2019

	EVENT	DATE	CITY	NUMBER REACHED**	DONATION, FEES & SPONSORSHIPS***
443	Axis Community Health	Mon, Apr 8	Pleasanton	12	$0
444	Fresh Food for Families - Hayward Promise Neighborhood	Mon, Apr 8	Hayward	19 / 8	$0
445	East Oakland Health Center	Tue, Apr 9	Oakland	9	$0
446	Tiburcio Vasquez Health Center	Wed, Apr 10	Hayward	1	$0
447	Asian Health Services	Wed, Apr 10	Oakland	0	$0
448	Food Pantry - Chabot College	Wed, Apr 10	Hayward	13 / 5	$0
449	Mobile Pantry - Kidango Graham Center	Wed, Apr 10	Newark	34 / 4	$0
450	Percy Abrams Jr. Senior Homes	Wed, Apr 10	Oakland	5 / 2	$0
451	Las Positas Community College Wellness Event for Sexual Assault Awareness	Wed, Apr 10	Livermore	43 / 11	$0
452	Tri-City Health Center	Thu, Apr 11	Fremont	0	$0
453	DayBreak Adult Care Centers Spring Conference: From Surviving to Thriving Older adults and Trauma Informed Care	Thu, Apr 11	Alameda	57	$0
454	Food Pantry - Alameda Food Bank Warehouse	Thu, Apr 11	Alameda	21 / 8	$0

COMMUNITY EVENT MEMBER EDUCATION EVENT MEMBER ORIENTATION MEETINGS/PRESENTATIONS

DID NOT ATTEND **OTF** = ONE TIME FEE

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*** **Donation, Fees & Sponsorships** = Applicable vendor donation, fee or sponsorship / refundable deposit.

ALLIANCE IN THE COMMUNITY
APRIL 2019

	EVENT	DATE	CITY	NUMBER REACHED**	DONATION, FEES & SPONSORSHIPS***
455	Tennyson High School - College & Career Day	Thu, Apr 11	Hayward	N/A	N/A
456	La Clinica - Transit Village	Fri, Apr 12	Oakland	0	$0
457	Asian Health Services - Specialty Mental Health Department	Fri, Apr 12	Oakland	12	$0
458	Oakland Public Library Community Kiosk	Fri, Apr 12	Oakland	11 / 4	$0
459	D5 Disaster Preparedness Day	Sat, Apr 13	Oakland	82 / 17	$100.00
460	Easter LOVE Reach 2019	Sat, Apr 13	Oakland	N/A	$30.00
461	DeafNation Expo 2019	Sat, Apr 13	Pleasanton	182 / 28	$295.00
462	2019 Bay Area Diabetes Summit	Sun, Apr 14	Hayward	164 / 34	$0
463	FUSD - Spanish Immersion Taskforce Meeting	Mon, Apr 15	Fremont	N/A	N/A
464	Chabot College Job Fair & Networking Event	Tue, Apr 16	Hayward	132 / 47	$0
465	Food Pantry - Davis Street Clinic	Tue, Apr 16	San Leandro	10	$0
466	Newark Wellness Center	Tue, Apr 16	Newark	3	$0
467	Food Bank - HUSD	Tue, Apr 16	Hayward	22 / 11	$0

COMMUNITY EVENT MEMBER EDUCATION EVENT MEMBER ORIENTATION MEETINGS/PRESENTATIONS

DID NOT ATTEND **OTF** = ONE TIME FEE

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*** **Donation, Fees & Sponsorships** = Applicable vendor donation, fee or sponsorship / refundable deposit.

ALLIANCE IN THE COMMUNITY
APRIL 2019

	EVENT	DATE	CITY	NUMBER REACHED**	DONATION, FEES & SPONSORSHIPS***
468	Newark Adult School	Wed, Apr 17	Newark	3	$0
469	Asian Health Services	Wed, Apr 17	Oakland	0	$0
470	Eastmont Wellness Center	Thu, Apr 18	Oakland	8	$0
471	Tri-Valley Haven Food Pantry	Thu, Apr 18	Livermore	56 / 32	$0
472	San Leandro Public Library	Thu, Apr 18	San Leandro	55 / 30	$0
473	Lifelong Over 60 Health Center	Fri, Apr 19	Berkeley	2	$0
474	Oakland Public Library Community Kiosk	Fri, Apr 19	Oakland	6 / 3	$0
475	Glad Tiding Easter Egg Hunt	Sat, Apr 20	Hayward	285 / 211	$0
476	2019 Spring Eggstravaganza	Sat, Apr 20	Dublin	158 / 21	$25.00
477	East Bay Agency for Children	Mon, Apr 22	Fremont	0	$0
478	Fathers Corp Meeting	Tue, Apr 23	Alameda	54	$0
479	Native American Health Center	Tue, Apr 23	Oakland	10	$0
480	Food Pantry - Chabot College	Tue, Apr 23	Hayward	60 / 25	$0
481	Roots Community Health Center	Wed, Apr 24	Oakland	19	$0

COMMUNITY EVENT MEMBER EDUCATION EVENT MEMBER ORIENTATION MEETINGS/PRESENTATIONS

DID NOT ATTEND **OTF** = ONE TIME FEE

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*** **Donation, Fees & Sponsorships** = Applicable vendor donation, fee or sponsorship / refundable deposit.

ALLIANCE IN THE COMMUNITY
APRIL 2019

	EVENT	DATE	CITY	NUMBER REACHED**	DONATION, FEES & SPONSORSHIPS***
482	Oakland Senior High School - Health Fair	Wed, Apr 24	Oakland	60 / 30	$0
483	Food Pantry - USDA	Thu, Apr 25	Union City	N/A	N/A
484	Food Pantry - South Hayward Parish	Fri, Apr 26	Hayward	27 / 17	$0
485	Hayward Wellness Center	Fri, Apr 26	Hayward	2	$0
486	Oakland Public Library Community Kiosk	Fri, Apr 26	Oakland	N/A	N/A
487	Davis Street Family Resource Center - Basic Needs Information Table	Fri, Apr 26	San Leandro	N/A	N/A
488	Family Literacy Day	Fri, Apr 26	Oakland	105 / 15	$0
489	Food Pantry - Well Community Outreach Center	Sat, Apr 27	Livermore	N/A	N/A
490	2nd Annual REDEFINED: A Day of Healing	Sat, Apr 27	Oakland	39 / 20	$0
491	Glad Tidings	Tue, Apr 30	Hayward	N/A	N/A
492	San Lorenzo Library - Community Healthcare Information Outreach	Tue, Apr 30	San Lorenzo	7 / 5	$0

COMMUNITY EVENT MEMBER EDUCATION EVENT MEMBER ORIENTATION MEETINGS/PRESENTATIONS

DID NOT ATTEND **OTF** = ONE TIME FEE

** **Number Reached** = Total Number of people who stopped by the Alliance table, attended a presentation, or MO / Number of self-identified Alliance members.

*** **Donation, Fees & Sponsorships** = Applicable vendor donation, fee or sponsorship / refundable deposit.

ALAMEDA Alliance FOR HEALTH

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

Compliance

Gil Riojas

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

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

Date: **May 10, 2019**

Subject: **Compliance Report**

DHCS Updates

- 2019 DHCS Medical Audit:
    - The Plan has submitted the pre-audit documents request by the Department of Health Care Services on April 26 for the upcoming June audit. The Compliance team continues to work with the DHCS Audit Team lead for additional requests needed by DHCS prior to their onsite visit.
- 2018 DHCS Medical Audit:
    - The DHCS Audit team reviewing the Plan's corrective action plan responses to the 2018 survey findings has closed the following CAP items:
        - 3.5.1: ER & Family Planning Claims monitoring for Access & Availability.
        - 3.5.2: Interest Payments for Late ER Claims.
        - 3.5.3: Out-of-Network Family Planning Claims.

Regulatory Updates

- Health Homes Program Application (HHP):
    - The Plan submitted its Health Home Program application to the DHCS on March 1, 2019. The DHCS has officially approved all sections of the Plan's initial application as of April 26. The second phase of the application process required program oversight and monitoring policies & procedures, which were submitted to DHCS on May 1. These deliverables are currently under review by the DHCS.
- Annual Network Certification (ANC):
    - DHCS has issued its preliminary findings for the required Annual Network Certification submission the Plan completed on March 18. The DHCS has requested follow-up information in the following areas:

- Data validation for hospital network.
- Data validation for pharmacy network.
- Monitoring P&Ps for access to Skilled Nursing Facilities (SNFs).
- Monitoring P&Ps for access to Community-Based Adult Services providers (CBAS).

Legislative Updates

- The Plan is tracking priority bills of interest that have been submitted for Committee Hearings. General themes of focus areas include single payer/universal coverage, cost containment, and pharmacy-related benefits. Below is a summary of new proposed bills this year that are being tracked closely by the Plan and its trade associations:

    - Senate Bill 642: Pharmacy Benefit Management:

        - This bill would end the Plans' ability to enter into new contracts with, or extend current contracts with pharmacy benefits managers after July 2021. The proposed bill is in line with State's efforts to have pharmacy benefits management entirely under the scope of the DHCS.

ALAMEDA Alliance FOR HEALTH

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Health Care Services

Steve O'Brien, MD

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

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

Date: **May 10, 2019**

Subject: **Health Care Services Report**

Utilization Management – Inpatient

- Inpatient Utilization Management has made good progress this month. A permanent inpatient UM manager will start at the end of May. Work on consistent practices and procedures to support the team have allowed for appropriate and timely approvals and denials to be consistently applied to all acute settings. This has resulted in an increase in denials to 3 Sutter hospitals.

- Inpatient UM team underwent refresher training with MCG (our evidenced-based criteria vendor), including inter-rater reliability testing.

Inpatient Barometer Total All Aid Categories				
	Actuals (excludes Maternity)			
Metric	**January 2019**	**February 2019**	**March 2019**	**Target**
ALOS	4.8	4.5	4.2	3.5
Admits/1,000	68.5	63.9	70.8	84.4
Days/1,000	331.5	290.2	294.3	297.8

Utilization Management – Outpatient

- Outpatient Utilization Management team also underwent recent MCG training and will be doing inter-rater reliability testing this month. The team is fully staffed and maintaining consistent processes. The addition of UM supervisor has helped with training and consistency of work.

    - Turn-around times (98%) remain above benchmark of ≥95%.
    - Outpatient denial rates are stable.
    - Preparation and training is underway to absorb the radiology imaging approval from Evicore, starting August 1, 2019.

YTD Outpatient Denials

Total OP Denial Rates	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
2018	7.4%	7.0%	5.8%	6.2%	6.5%	7.2%	7.1%	7.2%	9.2%	7.3%	6.6%	6.3%	7.0%
2019	6.0%	6.9%	6.6%	5.9%									6.4%

YTD Outpatient Denials Excluding Partial Denials

Total OP FULL Denial Rates	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
2018	7.2%	6.7%	5.6%	6.1%	6.2%	5.9%	6.6%	6.7%	7.3%	6.5%	6.1%	5.8%	6.4%
2019	5.3%	6.2%	6.1%	5.8%									5.9%

Turn Around Time Compliance	
Line of Business	**April 2019**
Overall	98%
Medi-Cal	98%
IHSS	97%
Benchmark	*95%*

Quality and Health Care Quality Committee (HCQC)

- The Health Care Quality Committee meets next on May 16, 2019.
- HEDIS season is wrapping up for this year. Tiffany Cheang's Analytics team has led the way in data collection. The Quality team is partnering in the over-reads and quality assessment of the data. Preliminary results will be available soon.
- Two new managers have started in the Quality area: Gina Battaglia is Access to Care Manager and Jessica Pedden is the Clinical Quality manager.
- Stephanie Wakefield and Dr. Sanjay Bhatt, in partnership with AAH leadership, are developing a strategy to focus on improving care quality, particularly in areas of Early and Periodic Screening, Diagnosis and Treatment for our pediatric population. This work will be done in partnership with our large pediatric care providers.

Pharmacy

- Pharmacy initiatives focusing on contract changes with our PBM and specialty pharmacy have decreased expected expenditures on drugs for members. Additional pharmacy initiatives of coordination of benefits and physician administered/outpatient infusion drugs are underway with launch expected in the next fiscal year.

- The pharmacy team has added their 4th clinical pharmacist to allow the team to continue increased peer-to-peer conversations with providers and help guide them to formulary appropriate medical choices. Clinical training and discussion between the physicians and pharmacists is being enhanced in order to improve consistent, evidence-based care decisions.

- Outpatient denial rates remain consistent and steady. Asthma medications and diabetes medications are common reasons for denials, as equally efficacious alternatives on our formulary are preferred. There has been a trend for some medications (e.g. Restasis) being handed out freely as samples by some providers who then let the drug companies submit authorization requests and appeals on their behalf. AAH is exploring methodologies to restrict drug companies gaming the system and seeking to inform providers who allow this that this is inappropriate.

Number of Prior Authorizations Processed		
Decision	**March 2019**	**April 2019**
Approved	654	698
Denied	590	562
Closed	611	613
Total	1,855	1,873

- **April 2019 Top 10 Drugs by Number of Denials:**

Rank	Drug Name	Common Use	Common Denial Reason
1	DULERA 200 MCG/5 MCG INHALER	Asthma	Criteria for approval not met
2	DEXILANT DR 60 MG CAPSULE	Gastroesophageal reflux disease (GERD)	Criteria for approval not met
3	TRETINOIN 0.025% CREAM	Acne	Criteria for approval not met
4	SYMBICORT 160-4.5 MCG INHALER	Asthma or chronic obstructive pulmonary disease (COPD)	Criteria for approval not met
5	SEVELAMER CARBONATE 800 MG TAB	Control of serum phosphorus in patients who are on dialysis due to severe kidney disease	Criteria for approval not met
6	RESTASIS 0.05% EYE EMULSION	Dry Eyes	Criteria for approval not met
7	LYRICA 75 MG CAPSULE	Pain	Criteria for approval not met
8	ALPRAZOLAM 0.25 MG TABLET	Anxiety	Non-formulary
9	SPIRIVA 18 MCG CP-HANDIHALER	COPD/Asthma	Non-formulary
10	DICLOFENAC SODIUM 3% GEL	Pain	Criteria for approval not met

Case and Disease Management

- The Case management team, led by Amy Stevenson and Julie Anne Miller, has done an excellent job of recruiting and hiring nurses and social workers. All but 3 positions are now filled in CM. The growing internal team is connected to our external case management resources and partners (health Homes/Whole Person Care) developing an intelligent web of care management for Medi-Cal patients across Alameda County.

    - A partial work from home pilot for nurses began in April with strong results thus far.
    - Training: we have written retraining modules for Case Management that includes the writing of standard work. The Case Management staff has

received this training, and auditing will start in order to hardwire the standard work.

- External Case Management resources:

    - Health Homes & AC3:
        - For March, 2019, we have 556 members enrolled in external CM (Health Homes 173, Alameda County Care Connect 383). This surpasses our previous targets and sets us up nicely for the launch of the official, state funded Health Homes program set to launch 7/1/19.

    - Health Homes California Program:
        - All of our Policies and Procedures have been approved by the State of California so we are on track for our official launch on July 1, 2019.

- Internal Case Management Volume:

    - Case volume for the AAH employed Case Management team continues to rise slowly. Additional trained staff with RNs and MSWs will greatly increase our ability to case manage more patients.

Case Type	New Cases Opened in March 2019	Total Open Cases As of March 2019
Care Coordination	276	521
Complex Care Management	5	63

Grievance & Appeals

- Grievances are any expression of dissatisfaction by a member. Our actual grievance rate (3.83/1000 members) is higher than our goal (≤1/1000 members).

    - Elevated grievance rates in our durable medical equipment (DME) vendor resulted in specific action plan by our vendor (CHME). They have demonstrated significant improvement in the first four months of 2019 when compared to 2018. Their rate of grievances is still higher than in 2017 so work continues for improvement in this area.

- Appeals had an overturn rate of 39.6% which, although better than the 60% they were at one year ago, is above our goal of 25% overturn rate. We have made

good progress in this area and anticipate the change of internalizing our radiology adjudications will further decrease our overturn rate.

- All cases were resolved within the goal of 95% regulatory compliance timeframes.

- Recruitment of additional G&A nurses is a top priority and strategies are being actively discussed with human resources.

April 2019 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	240	30 Calendar Days	95% compliance within standard	240	100%	0.93
Expedited Grievance	0	72 Hours	95% compliance within standard	0	NA	NA
Exempt Grievance	654	Next Business Day	95% compliance within standard	651	99.5%	2.53
Standard Appeal	89	30 Calendar Days	95% compliance within standard	89	100%	0.34
Expedited Appeal	7	72 Hours	95% compliance within standard	7	100%	0.03
Total Cases:	990		95% compliance within standard	987	99.7%	3.83

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
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Information Technology

Sasikumar Karaiyan

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

From: **Sasi Karaiyan, Executive Director of Information Technology**

Date: **May 10, 2019**

Subject: **Information Technology Report**

Call Center System Availability

- AAH phone systems and call center applications remained 100% available during the month of April. No call center outages occurred during this month. Overall, we are continuing to perform the following activities to optimize the call center eco-system (applications, backend integration, configuration, and network).
    - Phase 3 – IVR Migration from Avaya to Cisco – 85% Nearing completion of project.
    - Improved alerts and notifications – 80% Work in progress.
    - Session Initiation Protocol (SIP) trunk migration from Vonage to AT&T – In process.
    - Improving call manager system and device pool configuration – Work in progress.

Encounter Data

- In the month of April, AAH submitted 98 encounter files to DHCS with a total of 293,916 encounters.

Enrollment

- The April 834 monthly file from DHCS was received and processed on time.

HEALTHsuite

- The HEALTHsuite system continued to operate normally with an uptime of 99.99%.

TruCare

- The TruCare system continued to operate normally with an uptime of 99.99%. There were 8,963 authorizations (total authorizations loaded in TruCare production) processed through the system.

- There were 11,266 manually updated authorizations in TruCare.

Web Portal

- The web portal usage for the month of April 2019 among our group providers and members remains consistent with prior months.

Information Security

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

- Email based metrics currently monitored have increased with a return to a reputation-based blocks for a total of 344.7k.

- Attempted information leaks detected and blocked at the firewall are slightly lower from 72 to 54 for the month.

- Network scans returned a value of 0 which is in line with previous months data.

- Attempted User Privilege Gain is lower at 84 from a previous six months average of 191.

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 “Summary of Medical and Group Care member enrollment in the month of April 2019”.
- Summary of Primary Care Physician (PCP) Auto-assignment in the month of April 2019.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of April 2019”.
- The following tables 1-1 and 1-2 are supporting documents from the enrollment summary section.

- Table 1-1 Summary of Medical and Group Care Member Enrollment in the Month of April.

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
April	252,650	5,555	7,466	5,911	205	180

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

- Table 1-2 Summary of Primary Care Physician (PCP) Auto-Assignment in the Month of April 2019.

Auto-Assignments	Member Count
Auto-assignments MC	1,400
Auto-assignments Expansion	1,067
Auto-assignments GC	56
PCP Changes (PCP Change Tool) Total	3,790

TruCare

- See Table 2-1 “Summary of TruCare Authorizations for the month of April 2019”.
- There were 8,963 authorizations (total authorizations loaded in TruCare production) processed through the system.
- TruCare Application Uptime – 99.99%.
- The following table 2-1 is a supporting document from the TruCare summary section.

Table 2-1 Summary of TruCare Authorizations for the Month of April 2019.

Transaction Type	Inbound EDI Auths	Failed PP-Already In TC	Failed PP-MNF	Failed PP-PNF	Failed PP-Procedure Code	Failed PP-Diagnosis Code	Misc	Total EDI failure	New Auths entered	Total Auths loaded in TruCare Production
EDI-CHCN	4,235	144	0	46	14	11	15	230	0	4,005
EDI-Care Core Radiology	1,117	0	0	0	0	0	0	0	0	1,117
Manual Entry	0	0	0	0	0	0	0	0	3,841	3,841
Total										**8,963**

Key: - PP=Pre-Processor; MNF=Member Not Found; PNF=Provider Not Found; TC=TruCare

Web Portal

- The following table 3-1 is a supporting document from the Web Portal summary section.
- Table 3-1 Web Portal Usage for the Month of March 2019.

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	2,711	2,363	157,430	260
MCAL	55,718	1,690	3,505	616
IHSS	2,243	83	162	28
AAH Staff	122	39	443	-
Total	**60,794**	**4,175**	**161,540**	**904**

- Table 3-2 Top Pages Viewed for the month of March 2019.

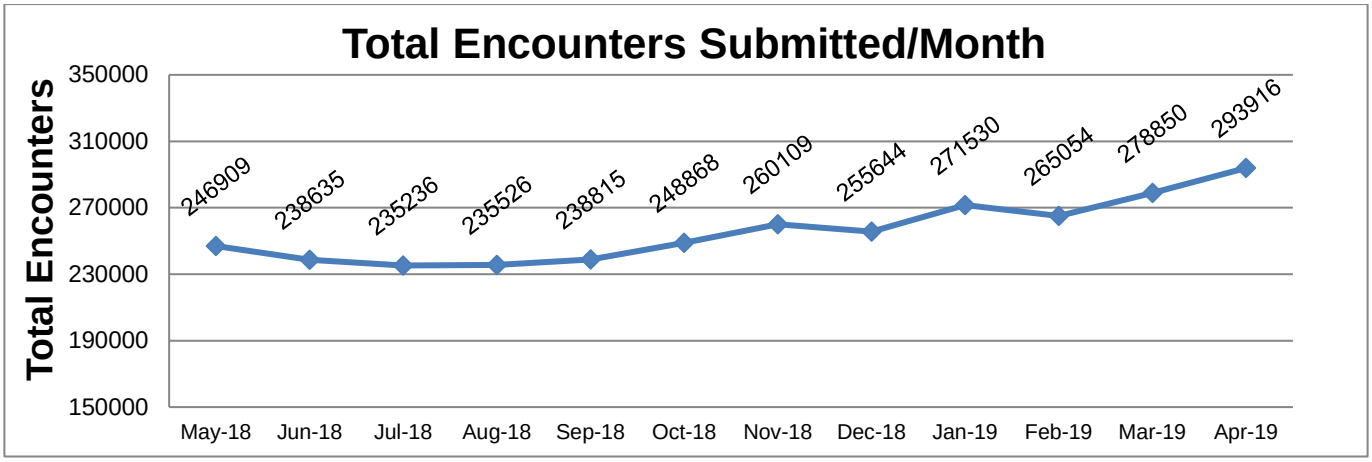
Top 25 Pages Viewed		
Category	**Page Name**	**March-19**
Provider	Member Eligibility	689,358
Provider	Claim Status	87,192
Provider	Member Roster	82,364
Provider	Authorization Status	7,340
Member - Eligibility	Member Eligibility	4,780

Member - Claims	Claims - Services	3,873
Member - Help Center	Find a Doctor or Facility	2,875
Member - Help Center	Member ID Card	2,373
Member - Help Center	Select/Change PCP	607
Provider - Provider Directory	Provider Directory PCP/Specialist	575
Member - Pharmacy	My Pharmacy Claims	396
Member - Help Center	Update My Contact Info	243
Member - Pharmacy	Find a drug	62
Member - Help Center	Contact Us	155
Member - Help Center	Authorizations & Referrals	108
Provider	Pharmacy	93
Provider - Provider Directory	Attestation	90
Member – Health/Wellness	Personal Health Record - Intro	69
Member - Pharmacy	Pharmacy	90
Member - Forms/Resources	Authorized Representative Form	80
Member – Health/Wellness	Personal Health Record - Intro	69
Member - Forms/Resources	Reimbursement Form	40
Member – Help Center	File a Grievance or Appeal	60
Provider – Provider Directory	Provider Directory - Facility	61
Member – Health/Wellness	Member Materials	46

Encounter Data from Trading Partners

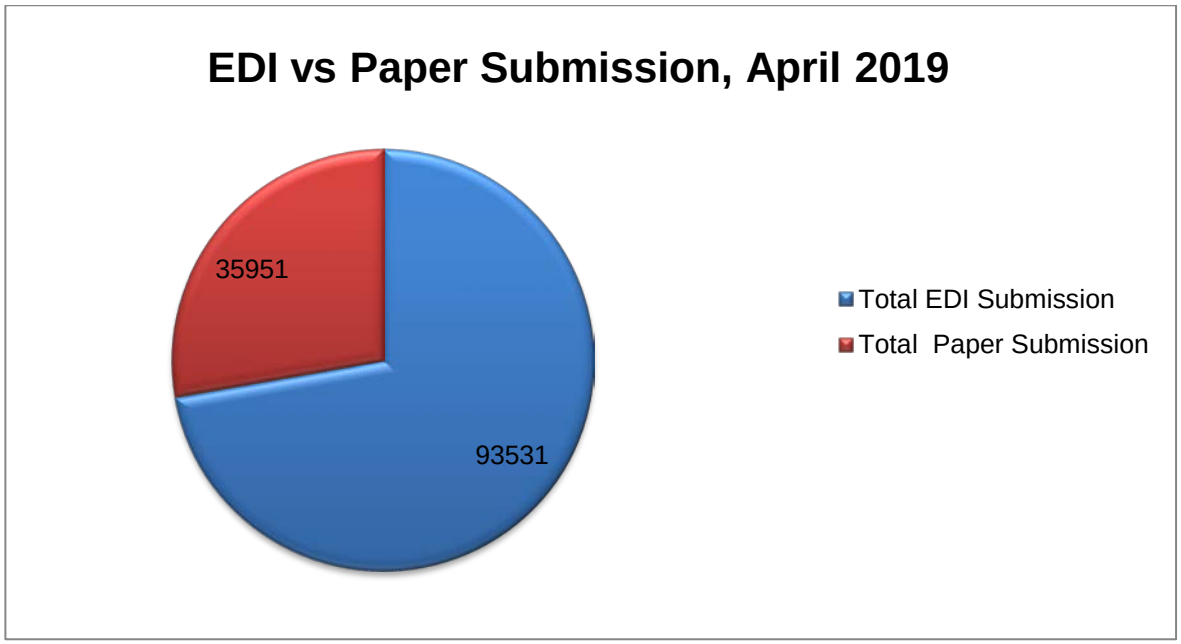
- AHS:
  - April weekly files (5,595 records) were received on time.
- Beacon:
  - April monthly files (11,797 records) were received on time.
- CHCN:
  - April weekly files (66,233 records) were received on time.
- CHME:
  - April monthly file (4,396 records) was received on time.
- CFMG:
  - April weekly files (8,965 records) were received on time.
- PerformRx:
  - April monthly files (174,462 records) were received on time.
- Kaiser:
  - April monthly files (36,876 records) were received on time.
  - April Kaiser Pharmacy – monthly files (20,316 records) were received on time.
- LogistiCare:
  - April weekly files (14,416 records) were received on time.

- March Vision:
  - April monthly file (2,651 records) was received on time.
- Quest Diagnostics:
  - April weekly files (13,505 records) were received on time.



Paper vs EDI Claims:

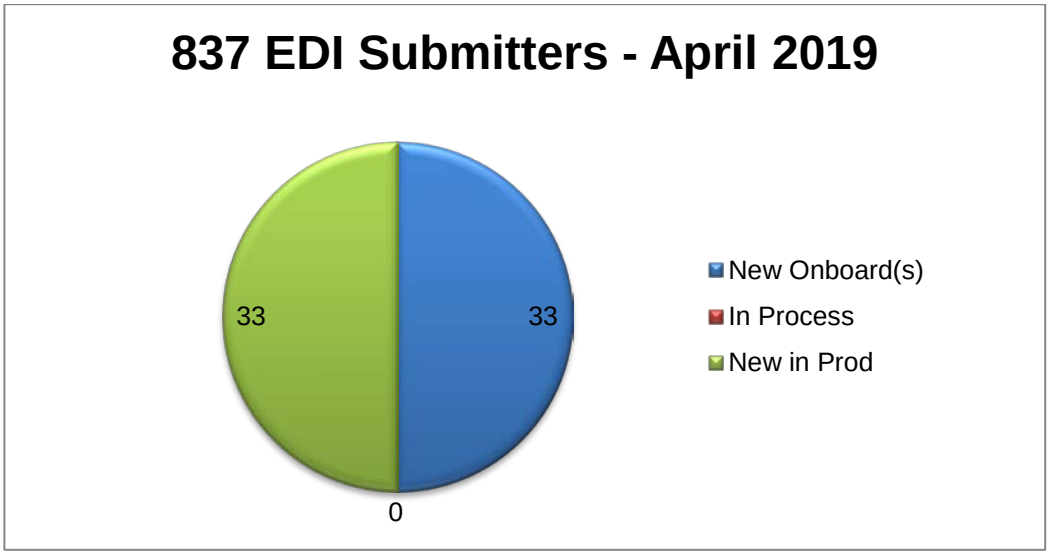
Period	Total EDI Submissions	Total Paper Submissions	Total claims
19-Apr	93,531	35,951	129,482

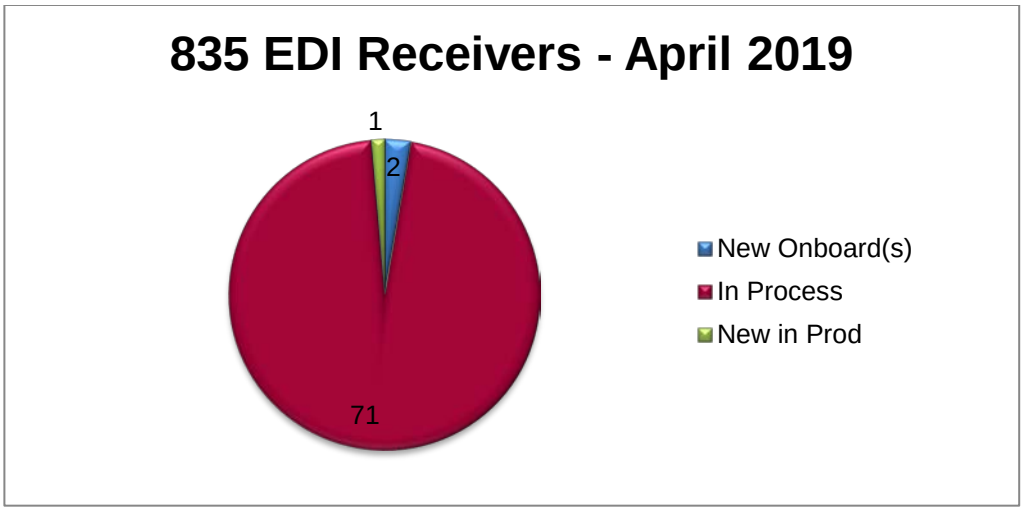


Onboarding EDI Providers - Updates:

- April 2019 EDI Claims:
  - A total of 613 new EDI submitters have been added since October 2015, with 33 added in April 2019.
  - The total number of EDI submitters is 1345 providers.
- April 2019 EDI Remittances (ERA):
  - A total of 163 new ERA receivers have been added since October 2015, with 1 added in April 2019.
  - The total number of ERA receivers is 202 providers.

	837				835			
	New on boards	In process	New In prod	Total in Prod	New on boards	In process	New In prod	Total in Prod
May - 18	22	4	18	1128	4	54	2	148
June - 18	20	0	20	1148	4	56	2	150
July - 18	15	0	15	1163	8	60	4	154
Aug - 18	19	0	19	1182	9	60	9	163
Sept - 18	11	1	10	1192	1	61	0	163
Oct - 18	37	0	37	1229	4	64	1	164
Nov - 18	12	1	11	1240	5	69	0	164
Dec - 18	8	1	7	1247	9	69	9	173
Jan - 19	23	0	23	1270	26	69	26	199
Feb - 19	23	0	23	1293	2	69	2	201
Mar - 19	22	3	19	1312	1	70	0	201
Apr - 19	33	0	33	1345	2	71	1	202





Summary of Lag Times:

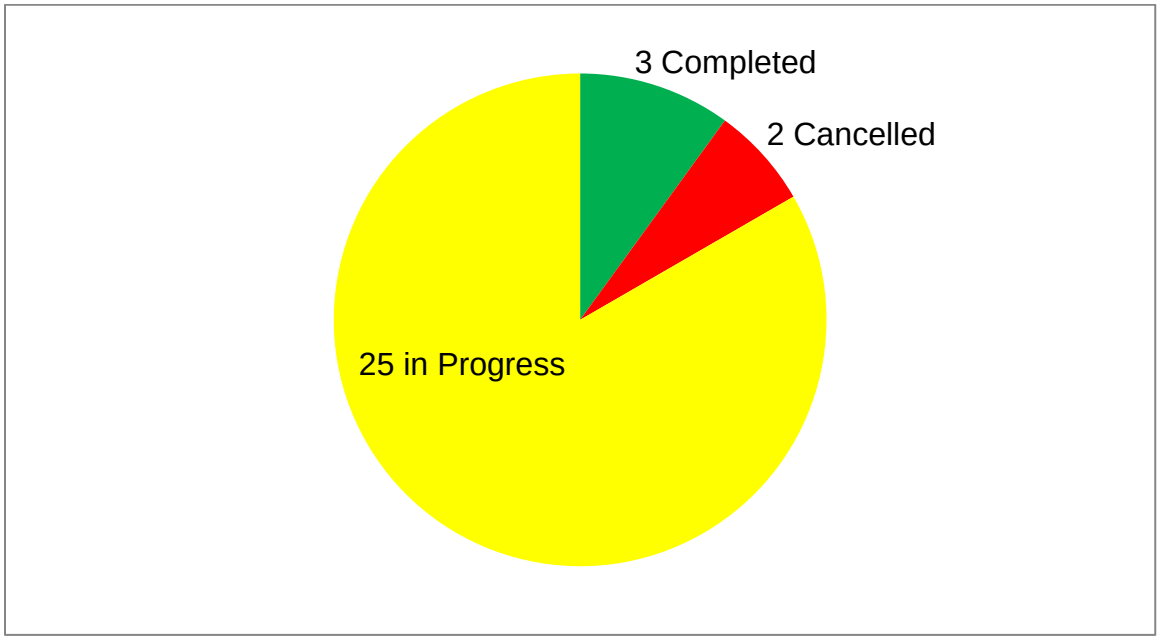
- The following is a summary of Lag Times.

AAH Encounters: Outbound 837 (AAH to DHCS)	Apr-19	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	84%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	88%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	92%	73%
Timeliness-% Within Lag Time – Professional 0-180 days	97%	80%

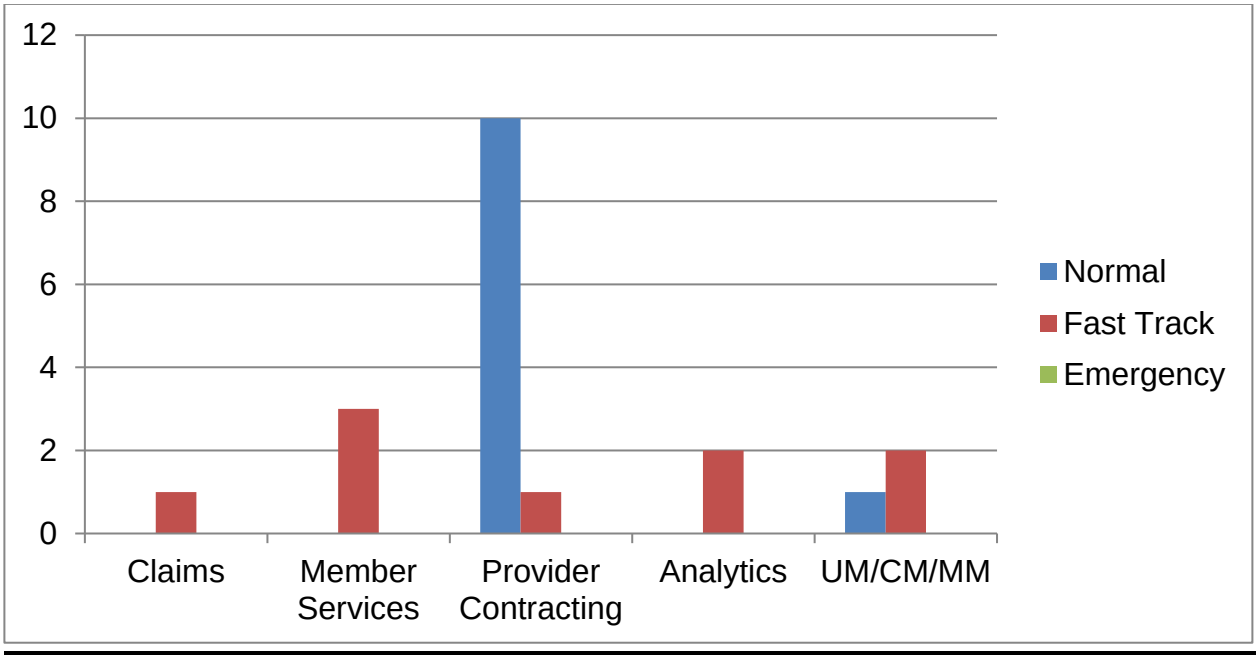
Change Management Key Performance Indicator (KPI)

- Change Request Submitted by Type in the month of April 2019.
    - 15 Normal CR.
    - 14 Fast Track CR.
    - 1 Emergency CR.

- 30 CRs Submitted/logged in the month of April 2019 resulting in:

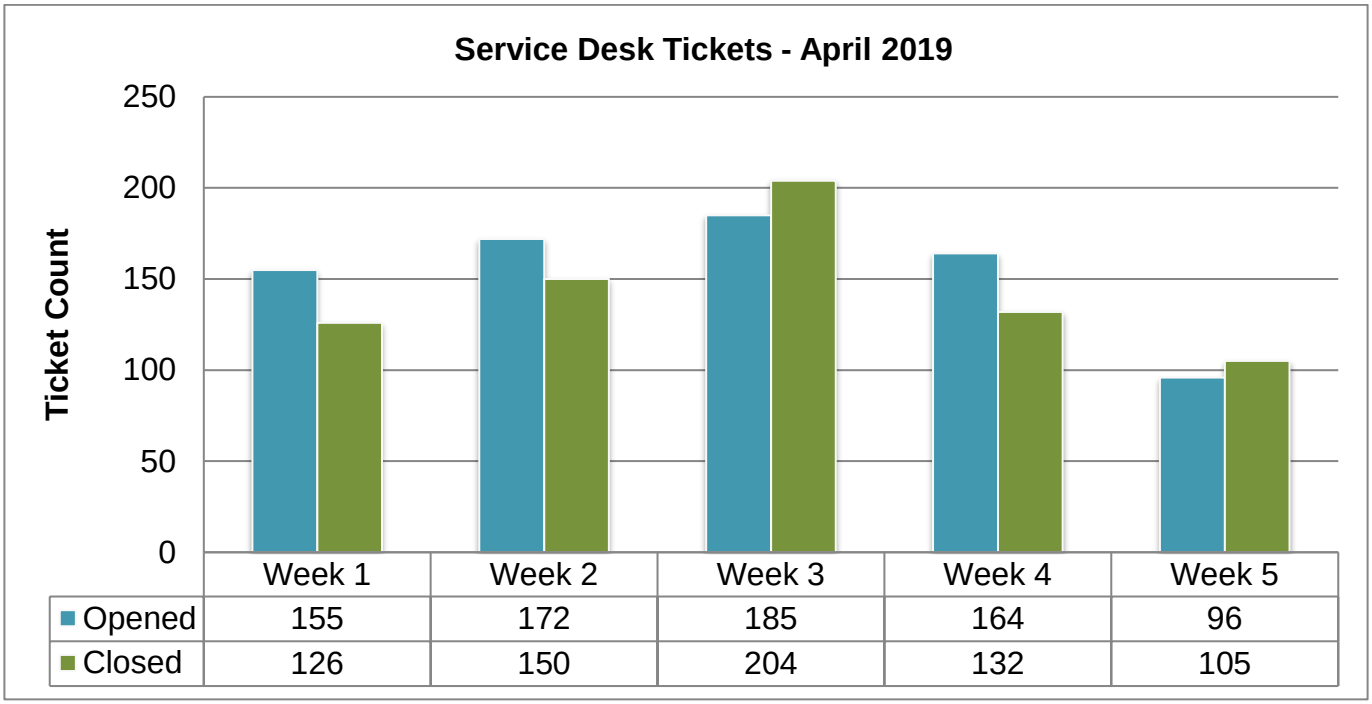


Business Units CRs Submitted



IT Stats: Infrastructure

- AAH phone systems and call center applications remained 100% available during the month of April. No call center outages occurred during this month. Overall, we are continuing to perform the following activities to optimize the call center eco-system (applications, backend integration, configuration, and network).
    - Phase 3 – IVR Migration from Avaya to Cisco – 85% nearing completion of project.
    - Improved alerts and notifications – 80% Work in progress.
    - Session Initiation Protocol (SIP) trunk migration from Vonage to AT&T – In process.



	Week 1	Week 2	Week 3	Week 4	Week 5
Opened	155	172	185	164	96
Closed	126	150	204	132	105

- 772 Service Desk tickets were opened for the month, which is 40.1% higher than the previous month.
- 717 Service Desk tickets were closed, which is 42% higher than the previous month.

Information Security

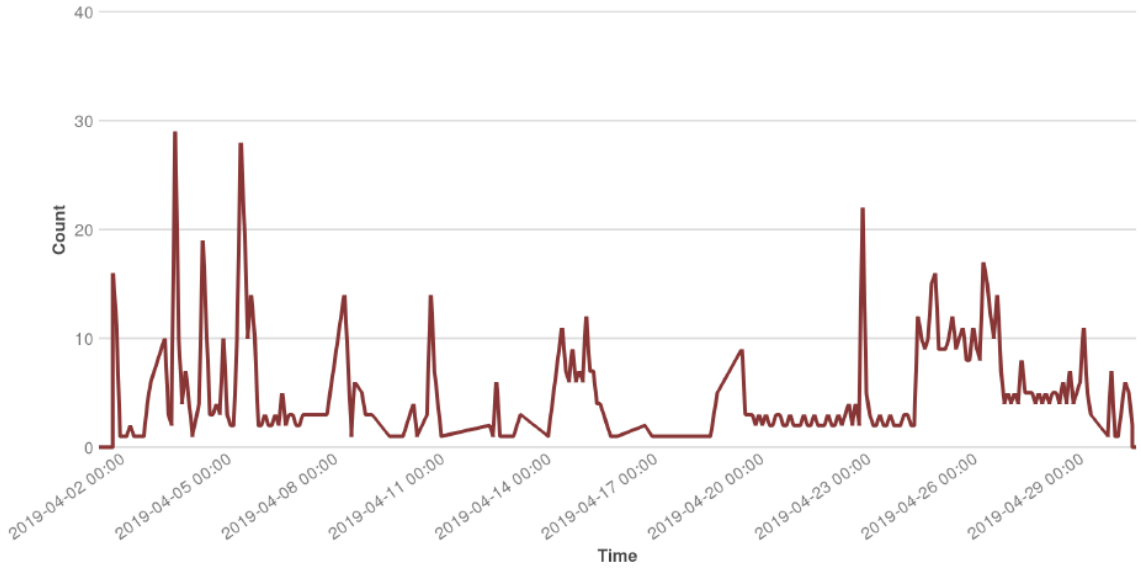
- The following is supporting security data furnishing additional information for the Information Security summary.
- All security activity data is based on the current months metrics as a percentage. This is compared to the previous three months average, except as noted.

Item / Date	18-Oct	18-Nov	18-Dec	18-Jan	19-Feb	19-Mar	19-Apr
Stopped By Reputation	338K*	1058K	511.5K	458.0K	14.2K	371.8K	374.7K
Invalid Recipients	24*	49	26	37	0	41	33
Spam Detected	27K*	58.8K	30.0K	29.8K	1,269	28.5k	26.2k
Virus Detected	1*	2	0	6	1	0	2
Advanced Malware	3*	1	9	4	0	0	2
Malicious URLs	466*	1,023	284	579	4	248	263
Content Filter	952*	2,801	7,357	1,917	1	14	23
Marketing Messages	3,063*	7,328	2,973	3,413	179	4,239	4,347
Attempted Admin Privilege Gain	328*	288	626	626	2,128	1,588	843
Attempted User Privilege Gain	257	260	258	348	78	129	84
Attempted Information Leak	65	63	64	44	47	72	54
Potential Corp Policy Violation	9	13	21	16	30	24	34
Network Scans Detected	4	8	6	5	4	1	0
Web Application Attack	11	10	9	47	42	24	22
Misc. Attack	5	3	4	78	18	5	7

* These results are not representative as they include sensor detection of PEN testing activities

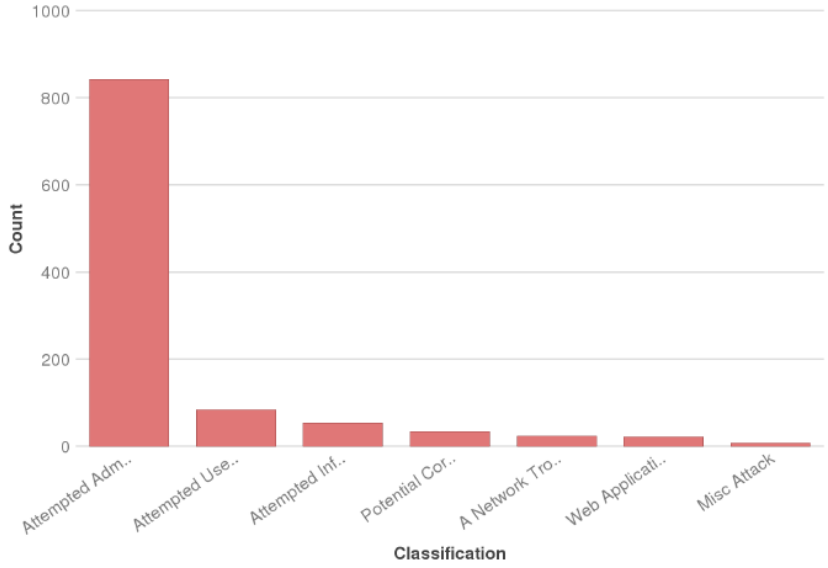
All Intrusion Events

Time Window: *2019-04-01 09:37:00 - 2019-04-30 13:45:00*



Dropped Intrusion Events

Time Window: *2019-04-01 09:28:00 - 2019-04-30 13:46:00*
Constraints: *Inline Result = dropped*



Classification	Count
Attempted Administrator Privilege Gain	843
Attempted User Privilege Gain	84
Attempted Information Leak	54
Potential Corporate Policy Violation	34
A Network Trojan was Detected	24
Web Application Attack	22
Misc Attack	7

- The above graph represents the list of intrusion events attempted by various groups:

- Email based metrics currently monitored have increased with a return to a reputation-based blocks for a total of 344.7k.

- Attempted information leaks detected and blocked at the firewall are slightly lower from 72 to 54 for the month.

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

- Attempted User Privilege Gain is lower at 84 from a previous six months average of 191.

ALAMEDA Alliance FOR HEALTH

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

Analytics

Tiffany Cheang

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

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

Date: **May 10, 2019**

Subject: **Performance & Analytics Report**

Membership Demographics

- Note: Membership demographics have been moved to the Finance section.

Member Cost Analysis

- The Member Cost Analysis below is based on the following 12 month rolling periods:
  - Current reporting period: February 2018 – January 2019 dates of service.
  - Prior reporting period: February 2017 – January 2018 dates of service.
  - (Note: Data excludes Kaiser membership data).

- For the Current reporting period, the top 7.4% of members account for 81.0% of total costs.

- In comparison, the Prior reporting period was slightly lower at 7.2% of members accounting for 79.7% 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 continue to account for almost 60% of the members, with SPDs accounting for 28.4% and ACA OE's at 30.6%.
  - The percent of members with costs >= $30K has remained consistent at 1.4%.
  - Of those members with costs >= $100K, the percentage of total members has remained consistent at 0.3%.
    - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, increasing slightly from 48% to 52%.

- 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 7.4% is more concentrated in the 45-66 year old category (43%) compared to the overall population (22%).

ALAMEDA Alliance FOR HEALTH

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Service you can trust.

Human Resources

Anastacia Swift

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

From: **Anastacia Swift, Executive Director, Human Resources**

Date: **May 10, 2019**

Subject: **Human Resources Report**

Staffing

- As of May 1, 2019 the Alliance had 289 full time employees and 1-part time employee.

- On May 1, 2019 the Alliance had 38 open positions in which 5 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 33 positions open to date. The Alliance is actively recruiting for the remaining 33 positions and several of these positions are in the interviewing or job offer stage.

- Summary of open positions by department:

Department	Open Positions May 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	16	4	12
Operations	9		9
Healthcare Analytics	2		2
Information Technology	6	1	5
Finance	4		4
Human Resources	1		1
Total	38	5	33

- Our current open positions rate is 12%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in April 2019 included:
    - 7 years:
        - Elsa Guzman (CMDM).
        - Christine Clark (Quality Improvement).
    - 9 years:
        - Latrina Brodnax (Claims).
        - Marlowe West (Claims).
    - 10 years:
        - Tyisha Pierce (Claims).
    - 11 years:
        - Ed Sanares (IT - Infrastructure).
    - 17 years:
        - Mandy Gutierrez (Community Relations).
    - 18 years:
        - Teresa Corral (Claims).