ALAMEDA Alliance FOR HEALTH

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

Board of Governors

Regular Meeting

Friday, July 10, 2020
12:00 p.m. – 2:00 p.m.

Video Conference Meeting

AGENDA

BOARD OF GOVERNORS
Regular Meeting
Friday, July 10, 2020
12:00 p.m. – 2:00 p.m.

Join Video Conference Meeting
https://zoom.us/j/94668113318

Meeting ID: 946 6811 3318

Dial in Conference numbers

(Please mute your phones)

(669) 900-6833

(408) 638-0968

(346) 248-7799

946 6811 3318

Alameda, CA 94502

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

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

YOU MAY SUBMIT COMMENTS ON ANY AGENDA ITEM OR ON ANY ITEM NOT ON THE AGENDA, IN WRITING VIA MAIL TO "ATTN: ALLIANCE BOARD," 1240 SOUTH LOOP ROAD, ALAMEDA, CA 94502; OR THROUGH E-COMMENT AT jmurray@alamedaalliance.org. YOU MAY WATCH THE MEETING LIVE BY LOGGING IN VIA COMPUTER AT THE FOLLOWING LINK https://zoom.us/j/94668113318 OR MAY LISTEN TO THE MEETING BY CALLING IN TO THE FOLLOWING TELEPHONE NUMBER: (669) 900-6833. IF YOU USE THE LINK AND PARTICIPATE VIA COMPUTER, YOU MAY, THROUGH THE USE OF THE CHAT FUNCTION, REQUEST AN OPPORTUNITY TO SPEAK ON ANY AGENDIZED ITEM, INCLUDING GENERAL PUBLIC COMMENT. YOUR REQUEST TO SPEAK MUST BE RECEIVED BEFORE THE ITEM IS CALLED ON THE AGENDA. IF YOU PARTICIPATE BY TELEPHONE, YOU MUST SUBMIT ANY COMMENTS VIA

THE E-COMMENT EMAIL ADDRESS DESCRIBED ABOVE.

PLEASE NOTE: THE ALAMEDA ALLIANCE FOR HEALTH IS MAKING EVERY EFFORT TO FOLLOW THE SPIRIT AND INTENT OF THE BROWN ACT AND OTHER APPLICABLE LAWS REGULATING THE CONDUCT OF PUBLIC MEETINGS, IN ORDER TO MAXIMIZE TRANSPARENCY AND PUBLIC ACCESS. IT WOULD BE APPRECIATED IF COMMUNICATIONS OF PUBLIC COMMENTS RELATED TO ITEMS ON THE AGENDA, OR ITEMS NOT ON THE AGENDA, ARE PROVIDED PRIOR TO THE COMMENCEMENT OF THE MEETING. IF THAT IS NOT POSSIBLE, EVERY EFFORT WILL BE MADE TO ATTEMPT TO REVIEW E-COMMENTS DURING THE COURSE OF THE MEETING. TOWARDS THIS END, THE CHAIR OF THE BOARD WILL ENDEAVOR TO TAKE A BRIEF PAUSE BEFORE ACTION IS TAKEN ON ANY AGENDA ITEM TO ALLOW THE BOARD CLERK TO REVIEW E-COMMENTS, AND SHARE ANY E-COMMENTS RECEIVED DURING THE MEETING.

1. **CALL TO ORDER**

   (A regular meeting of the Alameda Alliance for Health Board of Governors will be called to order on July 10, 2020 at 12:00 p.m. in Alameda County, California, by Dr. Evan Seevak, Presiding Officer. This meeting to take place by video conference call.)

2. **ROLL CALL**

3. **AGENDA APPROVAL OR MODIFICATIONS**

4. **INTRODUCTIONS**

5. **CONSENT CALENDAR**

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

   a) **JUNE 12, 2020 BOARD OF GOVERNORS MEETING MINUTES**

   b) **2020 PROCUREMENT POLICY VMG-04_POLICY AND PROCEDURE**

6. **BOARD MEMBER REPORTS**

   a) **COMPLIANCE ADVISORY GROUP**

   b) **FINANCE COMMITTEE**

7. **CEO UPDATE**

8. **BOARD BUSINESS**

   a) **DISCUSSION AND VOTE:**

      I. **BOARD MEMBER VOTE FOR CONSUMER MEMBER SEAT**

      II. **BOARD MEMBER VOTE FOR LABOR STAKEHOLDERS SEAT – SEIU UNITED HEALTHCARE WORKERS WEST**

   b) **SAFETY-NET SUSTAINABILITY FUND**

   c) **REVIEW AND APPROVE MAY 2020 MONTHLY FINANCIAL STATEMENTS**

d) **REVIEW AND APPROVE PUBLIC STATEMENT OPPOSING STRUCTURAL RACISM**

9. STANDING COMMITTEE UPDATES

a) **PEER REVIEW AND CREDENTIALING COMMITTEE**

b) **PHARMACY AND THERAPEUTICS COMMITTEE**

c) **CONSUMER ADVISORY COMMITTEE**

10. STAFF UPDATES

11. UNFINISHED BUSINESS

12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

13. PUBLIC COMMENTS (NON-AGENDA ITEMS)

14. ADJOURNMENT

NOTICE TO THE PUBLIC

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

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

NOTICE TO THE PUBLIC

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

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

An agenda is provided for each Board of Governors meeting, which 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. To obtain a document, please call the Clerk of the Board at 510-747-6160.

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

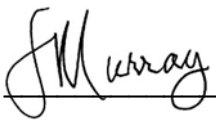
Public Input: If you are interested in addressing the Board, you may submit comments on any agenda item or on any item not on the agenda, in writing via mail to "Attn: Alliance Board," 1240 S. Loop Road, Alameda, CA 94502; or through e-comment at jmurray@alamedaalliance.org.

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

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

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

I hereby certify that the agenda for the Board of Governors meeting was posted in the posting book located at 1240 S. Loop Road, Alameda, California on July 7, 2020 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

CONSENT CALENDAR

ALAMEDA Alliance FOR HEALTH

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

Board of Governors Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
BOARD OF GOVERNORS
REGULAR MEETING

June 12, 2020
12:00 PM – 2:00 PM
(Video Conference Call)
Alameda, CA

SUMMARY OF PROCEEDINGS

Board of Governors on Conference Call: Dr. Evan Seevak (Chair), Rebecca Gebhart (Vice Chair), Dr. Noha Aboelata, Aarondeep Basrai, Dr. Rollington Ferguson, Marty Lynch, Delvecchio Finley, David B. Vliet, Wilma Chan, Dr. Michael Marchiano, Feda Almaliti, Dr. Kelley Meade
Alliance Staff Present: Scott Coffin, Dr. Steve O'Brien, Gil Riojas, Tiffany Cheang, Diana Sekhon, Sasi Karaiyan, Anastacia Swift, Jeanette Murray, Matt Woodruff
Board Members Excused: Nicholas Peraino
Guest Speakers: None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
1. CALL TO ORDER			
Dr. Seevak	The regular board meeting was called to order by Dr. Seevak at 12:00 PM.	None	None
2. ROLL CALL			
Dr. Seevak	A telephonic roll call was taken of the Board Members and a quorum was confirmed.	None	None
3. AGENDA APPROVAL OR MODIFICATIONS			
Dr. Seevak	None	None	None
4. INTRODUCTIONS			
Dr. Seevak	Introduction of Board Members, Staff, and Guests was completed.	None	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
5. CONSENT CALENDAR - MAY			
Dr. Seevak	Motion to approve the May 2020 Consent Calendar as presented. • May 8, 2020 Board Of Governors Meeting Minutes • 2019 Case Management & Care Coordination, Complex Case Management & Disease Management Program Evaluation • 2020 Case Management & Care Coordination, Complex Case Management & Disease Management Program Description • 2019 Quality Improvement Program Evaluation • 2020 Quality Improvement Program Description • 2019 Utilization Management Program Evaluation • 2020 Utilization Management Program Description • 2020 Cultural And Linguistic Services Program Description All 8 items on the consent calendar were approved. Comment: • A request was made that when there are large consent calendar items as above, that each item have a coversheet with a short explanation and to have staff available to answer questions. Answer: • Yes, this will be changed on future consent calendars with large amounts of information. Comment: • Alameda County Health Center is still listed in some of the above documents, which needs to be changed to Alameda Health System. Answer: • This will be changed on future documents.	Motion: Marty Lynch Second: David Vliet Vote: Yes No opposed or abstained.	None
6. a. BOARD MEMBER REPORT – COMPLIANCE ADVISORY COMMITTEE			
R. Gebhart	The Compliance Advisory Committee was held telephonically on June 12, 2020, at 10:30 AM.	Informational update to the Board of	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Dr. Seevak attended the meeting. Rebecca Gebhart gave the following updates: The Committee reviewed four (4) items: • Operations Dashboard • HEDIS Update • NCQA accreditation status • Provider dispute enforcement notice 2020 DMHC medical services audit (follow up from 2018 audit): • As stated in prior compliance reports the State wanted the Alliance to have our contact information at non-contracted hospitals in the State. Information was sent to 450 hospitals statewide on May 26, 2020. 2019 DMHC financial audit: • The State did not like our processing of claims in the mail room. We were date stamping mail and then using a courier service to deliver to Docustream. The new process is Docustream picks up the claims directly from the post office. 2019 Department of Health Care Services (DHCS) medical audit: • The State is requesting the Alliance to improve referral tracking. The State felt we did not have a vigorous enough medical tracking process for specialty services regarding prior authorizations. We have put into place a process to track all specialty services that require authorizations. This tracking process will help track Alliance members that are using out of network services and will help to move them to in-network services. HEDIS Update: • 2019 HEDIS score are good considering COVID-19. Tiffany to	Governors. Vote not required.	Tiffany to prepare a summary on current measures compared to last years and send to the Board of Governors.

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	prepare a summary on current measures scores compared to last years and send to the Board of Governors. At the end of April a DHCS directive came out stating hybrid measures may not be held to minimum performance level and this could change our calculations. NCQA Accreditation status: • Triannual accreditation of NCQA is not a requirement for the Alliance but in the fall of 2019 the Alliance passed on Medi-Cal line of business but was slightly short on the commercial line of business. In a review this spring we passed on both lines of business except for the notice of authorizations. We are requesting a re-review and asking for a Corrective Action Plan (CAP), and hopefully they will grant us a re-review and CAP so that we will not fail. From June 15 they have 30 days to respond to our request. Provider dispute enforcement notice: • The provider dispute was short staffed at the time and we are paying a $27,500 fine from 2017 - 2018. We have no actions in 2020 to date.		
6. b. BOARD MEMBER REPORT – FINANCE COMMITTEE			
Dr. Ferguson	The Finance Committee was held telephonically on Tuesday, June 9, 2020. Dr. Ferguson gave the following updates: Finance Issues: • The last year decline of membership has changed as the enrollment is up 2,300 and should continue for the rest of the year. • The TNE continues to be significantly higher at 625%. • MLR remains high at 94.0% for the month. • It was discussed that mortality data be recorded as part of the enrollment data in the future.	Informational update to the Board of Governors. Vote not required.	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
7. CEO UPDATE			
S. Coffin	Scott Coffin presented the following CEO updates. Shelter-In-Place/COVID-19 Operations: • Approximately 90% of staff are working remotely and 10% are at the corporate headquarters to maintain the facilities and core business functions. • The Alliance formed a Return-to-Work (RTW) Task Force, comprised of staff from each division, to develop recommendations for employee safety and compliance with public health orders. The RTW Task Force is led by Anastacia Swift, our Human Resource Executive Director. The purpose of the working committee is to assure that when we do return to the office we have a safe working environment and are in compliance to all public Health Orders. The staff has been working from home for 3 months now and there is no set date to return to the office to work but we will update the Board in July of any developments. State Budget: • Governor Newsom, as part of the May Revise, submitted in May a budget that contained a $54 Billion deficit. The impact affecting Medi-Cal could be in 3 areas - rates, eligibility or benefits. After the Senate & Assembly sub-committees complete their adjustments to the proposed budget, the Governor has until June 30 to sign or veto this bill.	Informational update to the Board of Governors. Vote not required.	
8. a. BOARD BUSINESS – SAFETY-NET SUSTAINABILITY FUND			

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
S. Coffin	Scott updated the Safety-Net Sustainability Fund to the Board of Governors. Safety-Net Sustainability Fund: • On May 8th, 2020, the Board of Governors approved $16.6 million in funding over a 6-month period, starting in May 2020 and ending in October 2020. • Total of 30 applications were received in the month of May, and 60% met eligibility requirements for this program. • Approximately $4.2 million awarded, or 84% of the allocated dollar amount for the first month. • The following dollar amounts were awarded to the 18 eligible entities: o COVID-19 Testing ▪ $1.0M o Public Hospital ▪ $2.5M o Health Center ▪ $300K o Primary Care Physician ▪ $255K o Other Safety-Net ▪ $115K Questions: • Did the Committee deny any of the applicants? Answer: • Yes, 12 applicants did not meet eligibility criteria.	Informational update to the Board of Governors. Vote not required.	None
8. b. BOARD BUSINESS – REVIEW AND APPROVE APRIL 2020 MONTHLY FINANCIAL STATEMENTS			
G. Riojas	Gil Riojas gave the following April Finance updates:		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Enrollment: • For the month ending April 30, 2020, the Alliance had enrollment of 249,251 members, a Net Income of $164,000 and the Tangible Net Equity is 625%. • Our enrollment has increased 2,344 members since March 2020. Net Income: • For the month ending April 30, 2020, the Actual Net Income was $164,000 and the Budged Net Income was $299,000. • Year-to-Date (YTD) ending April 30, 2020 the actual YTD net income was $18.8M and the budgeted YTD net income was $3.0M. The favorable variance is due to lower than anticipated medical and administrative expenses. Revenue: • For the month ending April 30, 2020, the actual revenue was $71.8M vs. the budgeted revenue of $77.3M. • For the year-to-date, the Alliance recorded Revenue of $804.0M vs. budgeted Revenue of $783.5M. Medical Expense: • For the month ending April 30, 2020, actual medical expenses were $67.5M vs. our budgeted medical expense of $72.8M. • Actual YTD medical expenses was $743.9M vs. budgeted YTD medical expense of $733.4M. Medical Loss Ratio (MLR): • For the month ending April 30, 2020, the MLR was 94.0% vs. year-to-date of 92.5%. Administrative Expense: • For the month ending April 30, 2020, actual administrative expenses were $4.5M vs. budgeted administrative expense $5.1M. • Actual administrative expense YTD is $44.8M vs. budgeted $50.4M.	Motion: Dr. R. Ferguson Second: Dr. K. Meade Motion passed by roll call. Vote: Yes No opposed or abstained.	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Other Income / (Expense): • As of April 30, 2020, our YTD interest income from investments is $4.0M, and YTD claims interest expense is $266,000. Tangible Net Equity (TNE): • Tangible net equity results continue to remain healthy, and at the end of April 30, 2020, the TNE was reported at 625% of the required amount, which is the highest in the last 12 months. Cash Position and Assets: • For the month ending April 30, 2020, $321.4M reported in cash; $146.0M is uncommitted cash. Our current ratio is above the minimum required at 1.66, as compared to the regulatory minimum of 1.0. Questions: • The $10.0M that we are accruing this month, where are you putting that in the expenses? Answer: • It is not reported as an expense, it is reported as a deduction to our revenue. Motion to approve the April 2020 financial report as presented.		
8. c. BOARD BUSINESS – REVIEW AND APPROVE FISCAL YEAR 2021 PRELIMINARY BUDGET			
G. Riojas	Gil presented the Fiscal Year 2021 Preliminary Budget to the Board of Governors. Questions: • Are the FTE's budgeted for a full 12 months? Answer: • We do not budget all the FTE's from the start, they are staggered.	Motion: Dr. R. Ferguson Second: Dr. K. Meade Motion passed by roll call. Vote: Yes No opposed or	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	The FY2021 Preliminary Budget was approved by the Board of Governors.	abstained.	
9. d. PUBLIC STATEMENT OPPOSING VIOLENCE			
S. Coffin	Scott Coffin presented the Public Statement Opposing Violence. The Board of Governors, staff and public discussed the creation of a Public Statement Opposing Violence. Comments: • It is appropriate for the Alliance to make a short statement and keep the content to what we do. • We should include a statement that Black Lives Matter. • Statement on disparity in Health care and Black Lives Matters, but that we also care for all members. • Statement to be meaningful and powerful to include staff and to create the document quickly. • Is this a resolution or statement? • It is a draft of a position statement, drafted by staff and approved by the Board. • Executive Committee to work with staff and others to draft statement around the killing of George Floyd. • Send to Board to review but not word smith, only if someone has s different opinion. It was decided that a team would be made up of Alliance staff to craft the Public Statement and it would be brought to the Board of Governors next meeting to review.	Motion: W. Chan Second: Dr. R. Ferguson Motion passed by roll call. Vote: Yes No opposed or abstained.	
9. a. STANDING COMMITTEE UPDATES – PEER REVIEW AND CREDENTIALING COMMITTEE			

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
Dr. O'Brien	The Peer Review and Credentialing Committee (PRCC) was held telephonically on May 19, 2020. Dr. O'Brien gave the following updates: • There were eleven (11) initial providers approved; two (2) Primary Care Providers, seven (7) Specialists, one (1) Ancillary provider, and one (1) Mid-level provider. • Additionally, sixteen (16) providers were re-credentialed at this meeting; two (2) Primary Care Providers, eleven (11) specialists, two (2) Ancillary provider, and one (1) Mid-level providers.	Informational update to the Board of Governors. Vote not required.	
9. b. HEALTH CARE QUALITY COMMITTEE			
Dr. O'Brien	The Health Care Quality Committee (HCQC) was held telephonically on May 21, 2020. Committee Medical Updates: • Presentation of QI Program/UM Program/CM Program Trilogy Documents for approval. • Presentation of CLS Program Description for approval.	Informational update to the Board of Governors. Vote not required.	None
10. STAFF UPDATES			
S. Coffin	None	None	None
11. UNFINISHED BUSINESS			
S. Coffin	Alliance Next steps: None	None	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS			
Dr. Seevak	• Reading and Approval of the Public Statement Opposing Racism • HEIDS results for measurement year 2019	None	None
13. PUBLIC COMMENTS (NON-AGENDA ITEMS)			
Dr. Seevak	None	None	None
14. ADJOURNMENT			
Dr. Seevak	Dr. Seevak adjourned the meeting at 2:00 PM.	None	None

Respectfully Submitted By: Jeanette Murray
Executive Assistant to the Chief Executive Officer and Clerk of the Board

POLICY AND PROCEDURE

VMG-004 Procurement Policy

POLICY AND PROCEDURE

Policy Number	VMG-004
Policy Name	Procurement Policy
Department Name	Vendor Management
Department Officer	Chief Financial Officer
Policy Owner	Director, Vendor Management
Line(s) of Business	All
Original Effective Date	1/22/2016
Approval / Revision Date	6/30/2020

POLICY STATEMENT

Although not generally subject to the state laws and regulations pertaining to competitive bidding, Alameda Alliance for Health ("the Alliance") has established its own policies and procedures relating to the purchase and procurement of products and services. It is the Alliance's policy to purchase products and services on the basis of quality, delivery, and price. The Alliance will establish purchasing procedures and processes to develop qualified and reliable sources and to obtain quality products and services at fair and reasonable prices through efficient, effective, and competitive procurement methods.

This policy excludes provider network contracts, employment agreements, grant agreements, sponsorships, legal retainer agreements, and regulatory fees.

These procurement policies are expressly authorized by the Bylaws of the Alameda Alliance for Health, which provide: "To further the mission and purposes of the Alliance, the Board shall have the power to adopt procedures, practices, and policies for purchasing and acquiring equipment and supplies, to lease real property and improvements, to hire employees in a manner that is cost effective and otherwise deemed appropriate by the Board, to manage its personnel and take other measures necessary and appropriate for the proper conduct of the activities and affairs of the Board and the Alliance."

PROCEDURE

This policy will govern sourcing and competitive purchasing requirements. Actual payments, and details on processing shall be government by FIN-302 Authorization of Administrative and Capital Expenditures ("FIN-302"). Where a conflict exists between FIN-302 and this policy, or in

any other policy relating to purchasing and this policy, this policy shall control. The following procedures will apply to new contracts and renewal contracts.

A. Purchase Limits and Procedures

a. Purchases less than $600.00

Alameda Alliance employees are able to purchase items without competitive sourcing or pre-purchase approval in accordance with FIN-302.

b. Purchases between $601.00 and $25,000.00

The Alliance may enter into a sole source contract for consultant, professional, information technology, or other services that are between $601.00 and $25,000. Such purchases shall have the written approval by the responsible department director and responsible c-level executive or executive director overseeing the department. It is recommended to that that Alliance staff obtain multiple bids to ensure purchasing from the Lowest Responsible Bidder as defined below; however, it is not required for each purchase.

c. Purchases greater than $25,000.00 but less than $100,000.00

The Alliance shall not enter into a sole source contract for any consultant, professional, information technology, or other services unless the Chief Executive Officer or his/her designee, or the Board (as the case maybe), makes a written finding that alternative Proposers, as defined below, are not best qualified to perform or offer the services or goods sought. Such findings will be documented in a Single Source Justification, as defined below. The Alliance shall endeavor to prepare scopes of work for RFPs and RFQs that avoid restricting to less than three the number of available Proposers capable of submitting a proposal.

Renewal for information technology products such as licensing and software renewals do not require additional justification, any information technology related profession services will be subject to Single Source Justification, requirement for renewal of consulting services contracts. Renewal of consulting services or other professional service contracts will require a single source justification for contract renewal. In the case of a consulting services agreement, the Alliance will take into consideration the compatibility of the consultant with the business needs.

d. Purchases equal to or greater than $100,000.00

The Alliance will endeavor to issue RFPs for purchases equal to or greater than $100,000.00. It is recommended that such RFPs be prepared in advance to allow for a competitive bidding process to ensure the Alliance selects the Lowest Responsible Bidder as defined further below.

In issuing RFPs, the Alliance shall endeavor to prepare scopes of work for RFPs that avoid restricting to less than three the number of available Proposers capable of submitting a proposal. However, the Alliance may decline to issue an RFP. In determining whether to forgo the RFP process, the Alliance may take into consideration such factors as to allow the organization to

make a fair assessment of the need to forgo the RFP. Such factors shall include:

i. How quickly the goods or services are needed;
ii. The existing relationship and integration of the vendor with Alliance systems or processes;
iii. The vendor's direct knowledge of Alliance systems; and
iv. Such other information as may be relevant to the business owner in determining whether to engage an existing vendor and as may be necessary for the c-level executive or executive director overseeing the department.

This process shall be documented in a Single Source Justification and before entering into the contract must be approved by the Alliance Chief Executive Officer or his/her designee, or the Board (as the case may be).

Subject to the Board approval requirement set forth further below, Renewal for information technology products such as licensing and software renewals do not require additional justification, any information technology related profession services will be subject to Single Source Justification requirement for renewal of consulting services contracts. Subject to the Board approval requirement set forth further below, Renewal of consulting services or other professional services contracts will require a Single Source Justification for renewal of the contract. In the case of a consulting services agreement, the Alliance will take into consideration the compatibility of the consultant with the business needs.

B. Emergency Purchases

From time to time instances may arise where in the interest of time and an urgent and unexpected need there is a need to bypass the procedures outlined in this policy. In such cases the following must be followed:

a. The business owner must provide written justification of the urgent need to enter into the contract without following the procedures outlined here. In such case, the business owner must complete a sole source justification;
b. The contract may not be for longer than a one year period.
c. If Board approval should have been obtained prior to entering into the contract; such request shall be requested from the Board retroactively and a description of the urgent need shall be presented to the Board for approval.

C. Board Approval

If the engagement (i.e., unique scope of services, project, or proposal) is for an amount equal to or less than $1,500,000.00 per year, the Contract may be awarded and entered into on behalf of the Alliance by its Chief Executive Officer or his/her designee. AAH shall award and enter into any other engagement greater than $1,500,000.00 per year by action of the Board.

D. Debarment

The Alliance will follow the procedure outlined in FIN-302 when negotiating purchases. However, if such review is not done during the negotiation process. Prior to signing of the

contract, the selected Proposer will be reviewed against sanctioned entities lists to determine whether the Proposer has been sanctioned by any state or federal program and prohibited from receiving funding from any programs that are wholly or partially funded by state or federal programs. Sanctioned entities lists are outlined in FIN-302.

E. Ethical Conduct

All Alliance staff and consultants participating in the vendor selection process shall conduct themselves in such a manner as to foster public confidence in the integrity of the Alliance's vendor selection process. The Alliance staff shall perform their duties impartially to ensure that bidders, proposers, and partners have fair and competitive access to do business with the Alliance. Employees and consultants are subject to applicable state conflict of interest's laws and regulations, as well as internal requirements, including obligations of confidentiality and the use of confidential information, as prescribed by Alameda Alliance Code of Conduct, the Vendor Code of Conduct and the consultant's Contract with Alameda Alliance.

No Alliance employee or consultant shall solicit, demand, or accept from any person anything of monetary value for, or because of, any action taken, or to be taken in the performance of his/her duties. Any employee or consultant failing to adhere to the above shall be subject to any disciplinary proceeding deemed appropriate by the Alliance, including and up to termination of employment or the consultant's Contract.

DEFINITIONS / ACRONYMS

Contract means a written document containing the terms and conditions of an agreement between two or more parties. A contract involves a transaction in which the Alliance agrees to pay for goods or services performed by a second party.

Lowest Responsible Bidder means the Proposer submitting a Bid or Quote to the Alliance that represents, relative to all other Bids or Quotes received for the Contract, the lowest overall cost to the Alliance, in compliance with all of the requirements of the contract documents and meeting the test for responsibility as set forth herein. In selecting the Lowest Responsible Bidder, consideration will be given not only to the financial standing but also the general competency of the Proposer for the performance of the work covered by the Bid or Quote, the Conflict Disclosure Form submitted by the Proposer and the extent of any actual or perceived conflict of interest that would be created by the award of the Contract to the Proposer. In this regard, the Alliance may, in determining the Lowest Responsible Bidder and its eligibility for the award, consider the Proposer's experience, conduct and performance under other contracts, financial condition, reputation in the industry, and any other factor which would affect the Proposer's performance of the work. The Alliance may also consider the qualifications and experience of subcontractors, sub-consultants, suppliers and other persons and organizations proposed for those portions of the work. Operating costs, maintenance considerations, performance data and guarantees of materials, equipment, and/or work product delivery dates and quality may also be considered by the Alliance. The Alliance may conduct such investigations as it deems necessary

to assist in the evaluation of any Bid or Quote and to establish the responsibility, qualifications and financial ability of the Proposer, proposed subcontractors and other persons and organizations to do the work in accordance with the contract documents to the Alliance's satisfaction within the time prescribed in the contract documents. Alameda Alliance reserves the right to reject the Bid or Quote of any Proposer who does not pass any such evaluation to the satisfaction of the Alliance.

Proposer means an individual or entity that submits a quote or proposal in response to an RFP or an RFQ.

Purchase Order (PO) means a binding contract issued by the buyer (the Alliance) to a seller. A complete PO should include the (1) type, (2) quantity, and (3) agreed upon prices for products and associated services the Alliance wishes to purchase. Generally, a PO is not issued for services only for goods. However, a PO may be issues for goods with a service component (e.g. purchase of conference room monitors that includes installation).

Request for Proposal (RFP) means is a written request for proposals published or circulated by the Alliance, soliciting proposals to provide consultant, professional or other services to the Alliance.

Request for Qualifications (RFQ) means a qualifications-based selection process applicable for professional services (legal, actuarial, accounting) where the Alliance does not require competitive bids.

Request for Quotations means the business process in which the Alliance requests a quote from a supplier for the purchase of specific products or services. It is also known as a "call for bids".

Sole Source / Single Source means the award of a contract without soliciting Bids, Quotes, proposals or statement of qualifications by means of a Notice Inviting Bids, RFP, RFQ or Request for Quotations.

Single Source Justification is the written certification by the business owner that includes accurate, complete, and necessary data to support the business owner's recommendation for procurement of services or goods for less than a full and open competition. Such written justification along with the recommendation will be presented to the Chief Executive Officer or his or her designee, or the Board (as the case may be), who will make a written finding that alternative Proposers are not best qualified to perform or offer the services or goods sought. In the case of purchases greater than $100,000.00 the business owner will attach the additional justifications required for the urgent need to bypass the RFP process. Single Source Justifications will follow the approval process outlined the workflow VM-WF-H "Single Source Justification."

AFFECTED DEPARTMENTS/PARTIES

All

RELATED POLICIES AND PROCEDURES

FIN-302: Authorization of Administrative and Capital Expenditures

REVISIONS

Original Effective Date: 1/22/2016

This policy was previously numbered COM-001 and was updated on 6/30/2020 to align with the numbering sequence for the Vendor Management Department.

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

VM-WF-A “Requests for Proposals”
VM-WF-B “Procuring a Service”
VM-WF-G “Request for Quotations”
VM-WF-H “Single Source Justification”
VM-WF-K “Purchase Orders”

REFERENCES

N/A

MONITORING

The Vendor Management Department will monitor and manage purchasing by the Alliance in accordance with this policy. The Vendor Management Department shall review the policy and update the policy as appropriate to align with organizational needs.

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: **July 10, 2020**

Subject: **CEO Report**

- **OPERATING PERFORMANCE: MAY 2020 & YEAR-TO-DATE**
    - Net income reported in May is $1.6 million, and year-to-date $20.4 million net income; revenue year-to-date is $883.8 million, $23.1 million favorable to budget; medical loss ratio is 92% year-to-date and administrative expenses are unfavorable $4.3 million year-to-date due to the safety-net sustainability fund.
    - Inpatient, outpatient, pharmacy, ancillary, and other services are trending higher as the elective procedures and wellness visits are increasing.

- **CALIFORNIA STATE BUDGET & ECONOMIC IMPACTS**
    - Governor Newsom signed the budget on June 30th, and potential for "August Revise" based on federal funding approvals.
    - Impacts to funding & covered services in the Medi-Cal program, exceeds $30 million in rate reductions to the Alliance (July 2019 to July 2021).
        - Trailer Bill being passed that authorizes DHCS to reduce managed care capitated rates and to implement a risk corridor.
    - Medi-Cal enrollment has increased by nearly 12,000 members (March through June), primarily driven by higher unemployment
    - DHCS Pharmacy transition on schedule for January 1, 2021.
    - New Medi-Cal benefit starts January 2021: "Long-Term Care at Home".

- **ALLIANCE WORKFORCE & REMOTE WORKING**
    - Majority of staff continue to work remotely through the end of December, and planning continues for returning to office in 2021 based on compliance with public health orders.

- Approximately 10% of staff are on-site to support the core operations (e.g. mailroom, provider payments, etc.).
- Flexible Working Model is being created to define a long-term solution to in-office and remote working, to maintain key operating metrics, to sustain regulatory compliance, and to improve customer satisfaction (member, provider, staff).

- **REGULATORY AUDITS, ACCREDITATION, AND QUALITY IMPROVEMENTS**

  - Annual DHCS medical survey is scheduled for October 2020 (virtual).
  - DMHC medical survey (every 3 years) is scheduled for April 2021 (virtual).
  - On July 1st, NCQA issued an accreditation status of "accredited" for the next 3 years (October 2019 – October 2022), and issued a corrective action plan on the Alliance's Medi-Cal and Group Care lines of business.
  - NCQA/HEDIS results 2014-2019 (see below) and forecast for MY2020; significant reduction in HEDIS scores in calendar year 2020 is forecasted due to the COVID-19 pandemic. More information is available in the Health Care Services section of this Board report.

EXECUTIVE DASHBOARD
JULY 2020

ALAMEDA Alliance FOR HEALTH

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

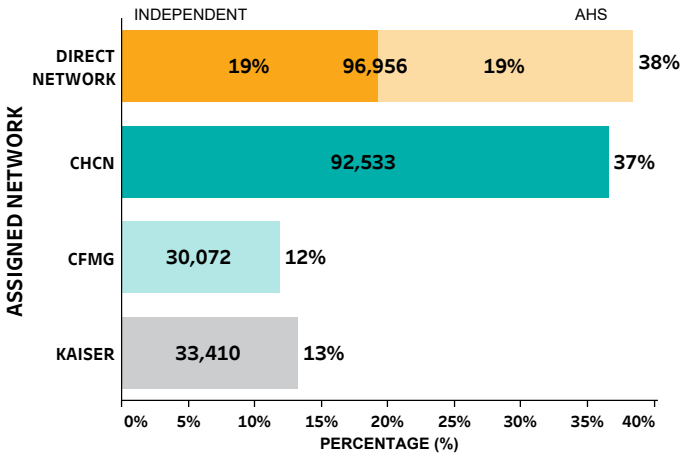
MEMBERSHIP**

252,971

TOTAL MEMBERSHIP

IHSS 6,295 **MEDI-CAL** 246,676

DISTRIBUTION OF ALL MEMBERSHIP BY ASSIGNED NETWORK**



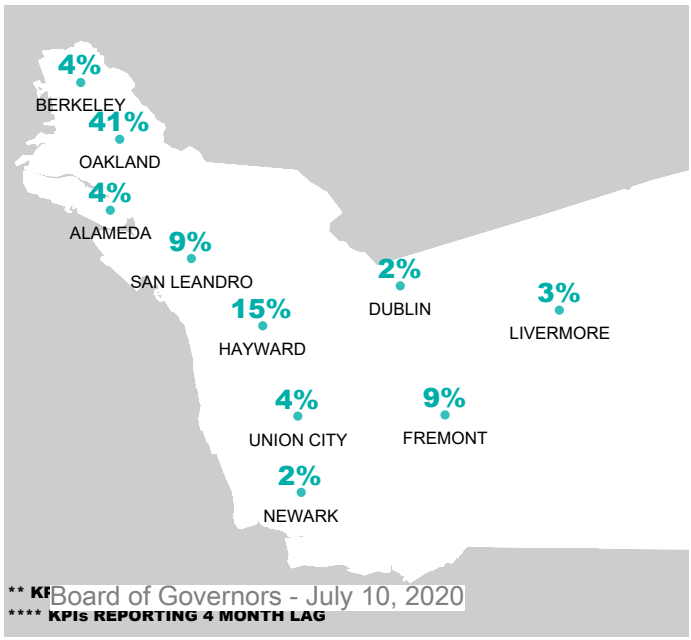
DISTRIBUTION OF MEMBERSHIP BY CITY**

92%

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

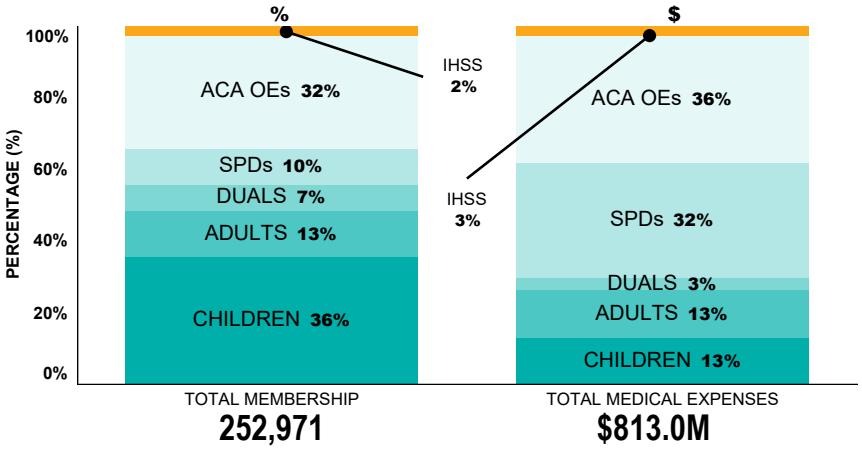
TEN CITIES

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



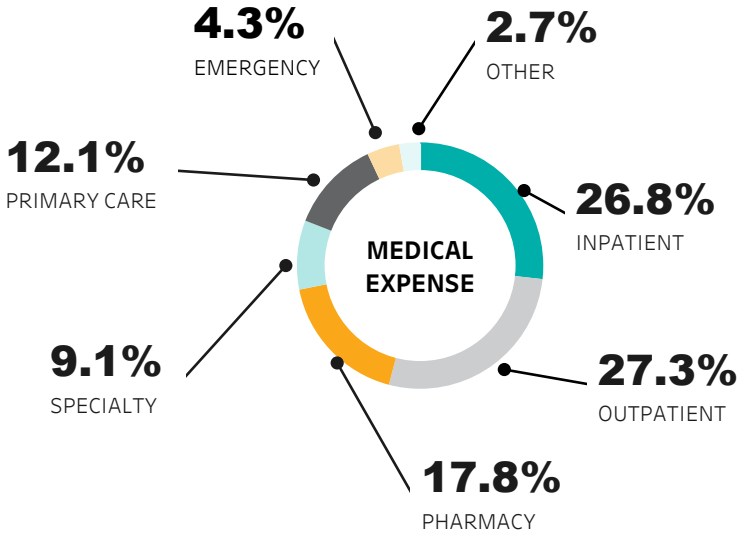
** KPIs REPORTING 4 MONTH LAG

DISTRIBUTION OF MEDICAL EXPENSE BY MEMBERSHIP CATEGORY**



REVENUE & EXPENSES**

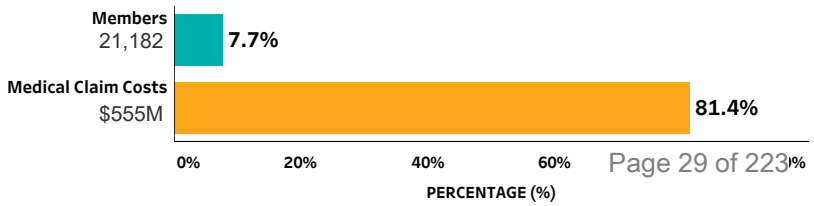
	MAY 2020	FISCAL YTD
REVENUE	$79.8M	$883.8M
MEDICAL EXPENSE	($69.1M)	($813.0M)
ADMIN EXPENSE	($9.3M)	($54.1M)
OTHER	$167K	$3.8M
NET INCOME	**$1.6M**	**$20.4M**



TANGIBLE NET EQUITY**

628% **$201M**

HIGH UTILIZER DISTRIBUTION****



**** KPIs REPORTING 4 MONTH LAG

UTILIZATION**

4,557
INPATIENT BED DAYS

4,613
EMERGENCY ROOM VISITS

4.9 DAYS
AVERAGE LENGTH OF STAY

CASE AND DISEASE MANAGEMENT**

	NEW CASES	OPEN CASES
CARE COORDINATION	252	587
COMPLEX CASE MANAGEMENT	38	91
Total	290	678

	NEW CASES	ENROLLED
HEALTH HOMES	24	764
WHOLE PERSON CARE (AC3)	3	222
Total	27	986

TOTAL CASE MANAGEMENT

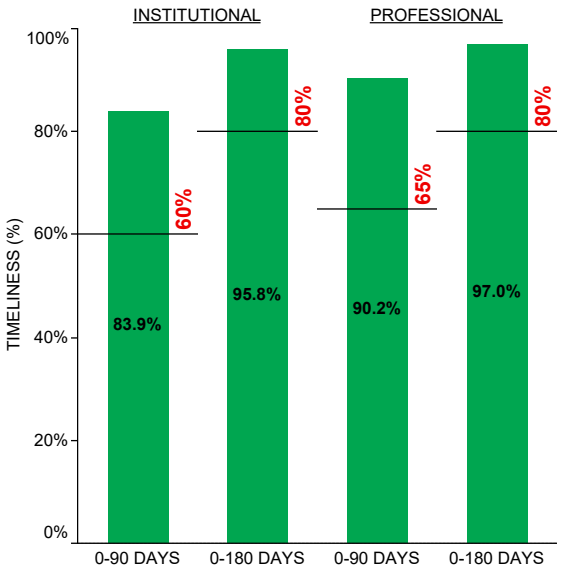
317
TOTAL NEW CASES

1,664
TOTAL OPEN CASES & ENROLLED

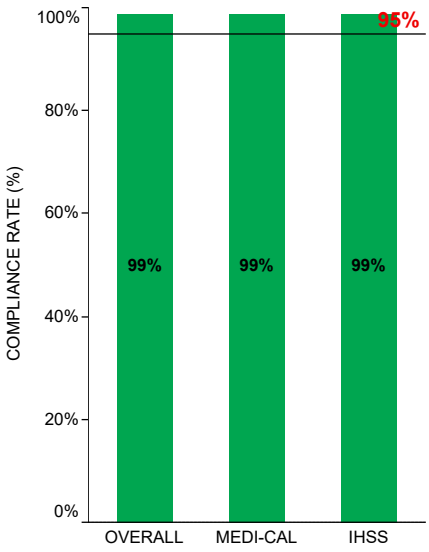
REGULATORY COMPLIANCE

ALL REGULATORY COMPLIANCE MEASURES ARE IN COMPLIANCE.

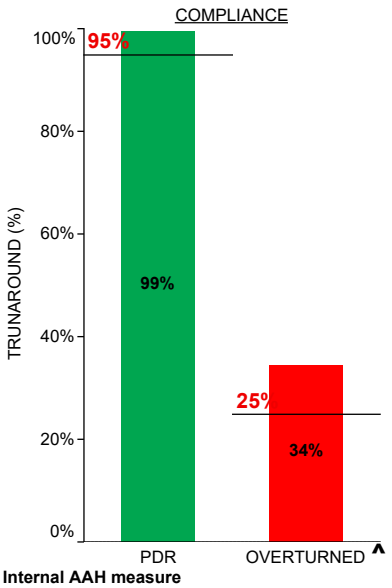
ENCOUNTER DATA



MEDICAL AUTHORIZATIONS



PROVIDER DISPUTES & RESOLUTIONS



^ For Internal AAH measure

CALL CENTER

11,469
CALLS RECEIVED

84%
ANSWERED IN 30 SECONDS

2%
CALLS ABANDONED

CLAIMS

87,032
PROCESSED CLAIMS

74.9%
AUTO ADJUDICATED

19 DAYS
PROCESSED PAYMENTS

STAFF & RECRUITING

320
TOTAL EMPLOYEES

3
HIRED IN THE LAST 30 DAYS

13%
CURRENT VACANCY

2019-2020 Legislative Tracking List

The following is a list of state legislation currently tracked by the Public Affairs Department that were 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.

This list includes bills that were introduced in 2019 and moved through the legislative process as 2-year bills as well as those that were introduced in the 2020 legislative session. This list also includes COVID-19 related bills that were introduced in the 2020 legislative session.

Medi-Cal (Medicaid)

- **AB 683 (Carillo – D) Medi-Cal Eligibility**
  - **Status:** 6/23/2020 – Referred to Committee on Health.
  - **Summary:** Current law requires Medi-Cal benefits to be provided to individuals eligible for services pursuant to prescribed standards, including a modified adjusted gross income (MAGI) eligibility standard. 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 MAGI. This bill would require the State Department of Health Care Services to disregard, commencing July 1, 2020, specified assets and resources, such as motor vehicles and life insurance policies, in determining the Medi-Cal eligibility for an applicant or beneficiary whose eligibility is not determined using MAGI, subject to federal approval and federal financial participation.

- **AB 1940 (Flora – R) Medi-Cal: Podiatric Services**
  - **Status:** 5/29/2020 – Failed Deadline pursuant to Rule 61(b)(5)
  - **Summary:** Would make conforming changes to the provisions that govern applying to be a provider in the Medi-Cal program or for a change of location by an existing provider to include a doctor of podiatric medicine licensed by the California Board of Podiatric Medicine.

- **AB 2032 (Wood – D) Medi-Cal: Medically Necessary Services**
  - **Status:** 5/29/2020 – Failed Deadline pursuant to Rule 61(b)(5)
  - **Summary:** The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under current law, for individuals 21 years of age and older, a service is “medically necessary” if it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Current law provides that for individuals under 21 years of age, “medically necessary” or “medical necessity” standards are governed by the definition in federal law. This bill would provide that the above-specified medical necessity standards do not preclude coverage for, and reimbursement of, a clinically appropriate and covered mental health or substance use disorder assessment, screening, or treatment service before a provider renders a diagnosis.

- **AB 2100 (Wood – D) Medi-Cal: Pharmacy Benefits**
  - **Status:** 7/1/2020 – Referred to Committee on Health.
  - **Summary:** By executive order, the Governor directed the State Department of Health Care Services to transition pharmacy services for Medi-Cal managed care to a fee-for-service benefit by January 1, 2021. Current law requires the department to convene an advisory group to receive feedback on the changes, modifications, and operational timeframes on the implementation of

pharmacy benefits offered in the Medi-Cal program, and to provide regular updates on the pharmacy transition, including a description of changes in the division of responsibilities between the department and managed care plans relating to the transition of the outpatient pharmacy benefit to fee-for-service. This bill would require the department to establish the Independent Medical Review System (system) for the outpatient pharmacy benefit, and to develop a framework for the system that models the above-described requirements of the Knox-Keene Health Care Service Plan Act.

- **AB 2164 (Rivas – D) Telehealth**
  - **Status:** 6/23/2020 – Referred to Committee on Health.
  - **Summary:** Current law prohibits a requirement of in-person contact between a health care provider and a Medi-Cal patient when the service may be provided by telehealth, and, for purposes of telehealth, prohibits the department from limiting the type of setting where Medi-Cal services are provided. Existing law authorizes, to the extent that federal financial participation is available, the use of health care services by store and forward under the Medi-Cal program, subject to billing and reimbursement policies developed by the department, and prohibits a requirement of in-person contact between a health care provider and a Medi-Cal patient when these services are provided by store and forward. This bill would provide that an FQHC or RHC "visit" includes an encounter between an FQHC or RHC patient and a health care provider using telehealth by synchronous real time or asynchronous store and forward.

- **AB 2276 (Reyes – D) Medi-Cal: Blood Lead Screening Tests**
  - **Status:** 6/23/2020 – Referred to Committee on Health.
  - **Summary:** Would require the State Department of Health Care Services to ensure that a Medi-Cal beneficiary who is a child receives blood lead screening tests at 12 and 24 months of age, and that a child 2 to 6 years of age, inclusive, receives a blood lead screening test if there is no record of a previous test for that child. The bill would require the department to report its progress toward blood lead screening tests for Medi-Cal beneficiaries who are children, as specified, annually on its internet website, establish a case management monitoring system, and require health care providers to test Medi-Cal beneficiaries who are children. The bill would require the department to notify a child's parent, parents, guardian, or other person charged with their support and maintenance, and the child's health care provider, with specified information, including when a child has missed a required blood lead screening test.

- **AB 2277 (Salas – D) Medi-Cal: Blood Lead Screening Tests**
  - **Status:** 6/23/2020 – Referred to Committee on Health.
  - **Summary:** Would require any Medi-Cal managed care health plan contract to impose requirements on the contractor on blood lead screening tests for children, including identifying every enrollee who does not have a record of completing those tests, and reminding the responsible health care provider of the need to perform those tests. The bill would require the State Department of Health Care Services to develop and implement procedures to ensure that a contractor performs those duties, and to notify specified individuals responsible for a Medi-Cal beneficiary who is a child, including the parent or guardian, that their child has missed a required blood lead screening test, as part of an annual notification on preventive services.

- **AB 2278 (Quirk – D) Lead Screening**
  - **Status:** 6/5/2020 – Failed Deadline pursuant to Rule 61(b)(6)
  - **Summary:** Current law requires a laboratory that performs a blood lead analysis on human blood drawn in California to report specified information, including the test results and the

name, birth date, and address of the person tested, to the department for each analysis on every person tested. Current law authorizes the department to share the information reported by a laboratory with, among other entities, the State Department of Health Care Services for the purpose of determining whether children enrolled in Medi-Cal are being screened for lead poisoning and receiving appropriate related services. This bill also would additionally require a laboratory that performs a blood lead analysis to report to the department, among other things, the Medi-Cal identification number and medical plan identification number, if available, for each analysis on every person tested.

- **AB 2348 (Wood – D) Pharmacy Benefit Manager**
  - **Status:** 5/29/2020 – Failed Deadline pursuant to Rule 61(b)(5)
  - **Summary:** Current law provides for the registration and regulation of pharmacy benefit managers, as defined, that contract with health care service plans to manage their prescription drug coverage. Under existing law, a pharmacy benefit manager is required to submit specified information to the department to apply to register with the department. This bill would require a pharmacy benefit manager to, beginning October 1, 2021, annually report specified information to the department regarding the covered drugs dispensed at a pharmacy and specified information about the pharmacy benefit manager's revenue, expenses, health care service plan contracts, the scope of services provided to the health care service plan, and the number of enrollees that the pharmacy benefit manager serves.

- **AB 2360 (Maienschein – D) Telehealth: Mental Health**
  - **Status:** 7/1/2020 – Referred to Committee on Health.
  - **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 the consultation to be done by telephone or telehealth video, and would authorize the consultation to include guidance on providing triage services and referrals to evidence based treatment options, including psychotherapy.

- **AB 2692 (Cooper – D) Medi-Cal: Lactation Support**
  - **Status:** 6/5/2020 - Failed Deadline pursuant to Rule 61(b)(5)
  - **Summary:** Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Current law requires the department to streamline and simplify Medi-Cal program procedures to improve access to lactation supports and breast pumps among Medi-Cal beneficiaries. This bill would provide that lactation supports include lactation specialists.

- **AB 2729 (Bauer-Kahan – D) Medi-Cal: Presumptive Eligibility**
  - **Status:** 5/29/2020 – Failed Deadline pursuant to Rule 61(b)(5)
  - **Summary:** Under current law, a minor may consent to pregnancy prevention or treatment services without parental consent. Under existing law, an individual under 21 years of age who qualifies for presumptive eligibility is required to go to a county welfare department office to obtain approval for presumptive eligibility. This bill would expand the presumptive eligibility for pregnant women to all pregnant people, renaming the program "Presumptive Eligibility for Pregnant People" (PE4PP).

- **AB 2830 (Wood – D) Health Care Payments Program Data**
  - **Status:** 7/1/2020 – Referred to Committee on Health.
  - **Summary:** Current law states the intent of the Legislature to establish the Health Care Cost Transparency Database to collect information on the cost of health care, and requires the Office of Statewide Health Planning and Development to convene a review committee to advise the office on the establishment and implementation of the database. Current law requires, subject to appropriation, the office to establish, implement, and administer the database by July 1, 2023. This bill would delete those provisions relative to the Health Care Cost Transparency Database and would instead require the office to establish the Health Care Payments Data Program to implement and administer the Health Care Payments Data System, which would include health care data submitted by health care service plans, health insurers, a city or county that offers self-insured or multiemployer-insured plans, and other specified mandatory and voluntary submitters.

- **AB 2871 (Fong – R) Medi-Cal: Substance Use Disorder Services: Reimbursement Rates**
  - **Status:** 5/29/2020 – Failed Deadline pursuant to Rule 61(b)(5)
  - **Summary:** Would require the State Department of Health Care Services, in establishing reimbursement rates for services under Drug Medi-Cal and capitated rates for a Medi-Cal managed care plan contract that covers substance use disorder services to ensure that those rates are equal to the reimbursement rates for similar services provided under the Medi-Cal Specialty Mental Health Services Program.

- **AB 2912 (Gray – D) Medi-Cal Specialty Mental Health Services**
  - **Status:** 5/29/2020 – Failed Deadline pursuant to Rule 61(b)(5)
  - **Summary:** Would require, on or before January 1, 2022, the State Department of Health Care Services, in consultation with specified groups, including representatives from the County Welfare Directors Association of California, to identify all forms currently used by each county mental health plan contractor for purposes of determining eligibility and reimbursement for specialty mental health services provided under the Early and Periodic Screening, Diagnostic, and Treatment Program, and to develop standard forms for the intake of, assessment of, and the treatment planning for, Medi-Cal beneficiaries who are eligible for those services to be used by all counties.

- **AB 3118 (Bonta – D) Medically Supportive Food and Nutrition Services**
  - **Status:** 6/5/2020 - Failed Deadline pursuant to Rule 61(b)(8)
  - **Summary:** Would expand the Medi-Cal schedule of benefits to include medically supportive food and nutrition services, such as medically tailored groceries and meals, and nutrition education. The bill would provide that the benefit include services that link a Medi-Cal beneficiary to community-based food services and transportation for accessing healthy food. The bill would require the department to implement these provisions by various means, including provider bulletins, without taking regulatory action, and would condition the implementation of these provisions to the extent permitted by federal law, the availability of federal financial participation, and the department securing federal approval.

- **SB 29 (Durazno – D) Medi-Cal: Eligibility**
  - **Status:** 1/3/2020 –Read second time. Ordered to third reading. (Set for hearing on 1/6/20).
  - **Summary:** This bill would, subject to an appropriation by the Legislature, extend eligibility for full-scope Medi-Cal benefits to individuals who are 65 years or older, 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 885 (Pan – D) Sexually Transmitted Diseases**
  - **Status:** 5/29/2020 – Failed Deadline pursuant to Rule 61(b)(5)
  - **Summary:** Would specify that family planning services for which a Medi-Cal managed care plan may not restrict a beneficiary's choice of a qualified provider include sexually transmitted disease (STD) testing and treatment. The bill would, subject to an appropriation by the Legislature, authorize an office visit to a Family PACT waiver provider or Medi-Cal provider for STD-related services for uninsured, income-eligible patients, or patients with health care coverage who have confidentiality concerns and who are not at risk for pregnancy, to be reimbursed at the same rate as comprehensive clinical family planning services.

- **SB 936 (Pan – D) Medi-Cal Managed Care Plans: Contract Procurement**
  - **Status:** 5/29/2020 – Failed Deadline pursuant to Rule 61(b)(5)
  - **Summary:** Would require the Director of Health Care Services to conduct a contract procurement at least once every 5 years if the director contracts with a commercial Medi-Cal managed care plan for the provision of care of Medi-Cal beneficiaries on a state-wide or limited geographic basis, and would authorize the director to extend an existing contract for one year if the director takes specified action, including providing notice to the Legislature, at least one year before exercising that extension. The bill would require the department to establish a stakeholder process in the planning and development of each Medi-Cal managed care contract procurement process, and would provide that the stakeholders include specified individuals, such as health care providers and consumer advocates.

- **SB 1073 Medi-Cal: California Special Supplemental Nutrition Program for WIC**
  - **Status:** 5/29/2020 – Failed Deadline pursuant to Rule 61(b)(5)
  - **Summary:** Would require the State Department of Health Care Services to designate the WIC Program and its local WIC agencies as Express Lane agencies, and to use WIC Program eligibility determinations to meet Medi-Cal program eligibility requirements, including financial eligibility and state residence. The bill would require the department, in collaboration with specified entities, such as program offices for the WIC Program and local WIC agencies, to complete various tasks; including receiving eligibility findings and information from WIC records on WIC recipients to process their Medi-Cal program expedited eligibility determination.

Group Care

- **AB1973 (Kamlager – D) Health Care Coverage: Abortion Services: Cost Sharing**
  - **Status:** 5/29/2020 – Failed Deadline pursuant to Rule 61(b)(5)
  - **Summary:** Would prohibit a health care service plan or an individual or group policy of disability insurance that is issued, amended, renewed, or delivered on or after January 1, 2021, from imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement on coverage for all abortion services, as specified, and additionally would prohibit cost sharing from being imposed on a Medi-Cal beneficiary for those services. The bill would apply the same benefits with respect to an enrollee's or insured's covered spouse and covered non-spouse dependents. The bill would not require an individual or group health care service plan contract or disability insurance policy to cover an experimental or investigational treatment. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program.

- **AB 2144 (Arambula – D) Health Care Coverage: Step Therapy**
  - **Status:** 5/29/2020 – Failed Deadline pursuant to Rule 61(b)(5)
  - **Summary:** Would clarify that a health care service plan may require step therapy if there is more than one drug that is appropriate for the treatment of a medical condition. The bill would require a health care service plan or health insurer to expeditiously grant a step therapy exception if specified criteria are met. The bill would authorize an enrollee or insured or their designee, guardian, primary care physician, or health care provider to file an appeal of a prior authorization or the denial of a step therapy exception request, and would require a health care service plan or health insurer to designate a clinical peer to review those appeals. The bill would require a health care service plan, health insurer, or utilization review organization to annually report specified information about their step therapy exception requests and prior authorization requests to the Department of Managed Health Care or the Department of Insurance, as appropriate.

- **SB 1033 (Pan – D) Health Care Coverage: Utilization Review Criteria**
  - **Status:** 5/29/2020 – Failed Deadline pursuant to Rule 61(b)(5)
  - **Summary:** Would authorize the Department of Managed Health Care and the Insurance Commissioner, as appropriate, to review a plan's or insurer's clinical criteria, guidelines, and utilization management policies to ensure compliance with existing law. If the criteria and guidelines are not in compliance with existing law, the bill would authorize the Director of the Department of Managed Health Care or the commissioner to issue a corrective action and send the matter to enforcement, if necessary.

COVID-19

- **AB 89 (Ting – D) Budget Act of 2019**
  - **Status:** 6/29/2020 – Approved by the Governor. Chaptered by Secretary of State – Chapter 7, Statutes of 2020.
  - **Summary:** Would amend the Budget Act of 2019 by appropriating $500,000,000 from the General Fund to be used for any purpose related to the Governor's March 4, 2020 proclamation of a state of emergency. This bill would authorize additional appropriations in increments of $50,000,000, up to a total appropriation of $1,000,000,000. The bill would amend the act to state the Legislature's intent that the administration work with stakeholders, including members of the Legislature and legislative staff, to develop strategies to be considered for inclusion in the Budget Act of 2020 to provide assistance related to the impacts of COVID-19. The bill would amend the act by adding an item of appropriation to the Department of Resources Recycling and Recovery.

- **SB 117 (Committee on Budget and Fiscal Review) Education Finance: Daily attendance and timeline waivers: protective equipment and cleaning appropriation: COVID-19**
  - **Status:** 3/17/2020 Chaptered by Secretary of State – Chapter 3, Statutes of 2020.
  - **Summary:** Current law requires the governing board of a school district to report to the Superintendent of Public Instruction during each fiscal year the average daily attendance of the school district for all full school months, and describes the period between July 1 and April 15, inclusive, as the "second period" report for the second principal apportionment. Current law requires a county superintendent of schools to report the average daily attendance for the school and classes maintained by the county superintendent and the average daily attendance for the county school tuition fund. For local educational agencies that comply with Executive Order N–

26–20, this bill would specify that for purposes of attendance claimed for apportionment purposes pursuant to the provision described above, for the 2019–20 school year average daily attendance reported to the State Department of Education for the second period and the annual period for local educational agencies only includes all full school months from July 1, 2019, to February 29, 2020, inclusive.

- **AB 2887 (Bonta – D) Statewide Emergencies: Mitigation**
  - **Status:** 5/7/2020 – Re-referred to Committee on Budget.
  - **Summary:** For purposes of state apportionments to public schools, if the average daily attendance of a school district, county office of education, or charter school during a fiscal year has been materially decreased during a fiscal year because of a specified event, including an epidemic, current law requires the Superintendent of Public Instruction to estimate the average daily attendance in a manner that credits to the school district, county office of education, or charter school the total average daily attendance that would have been credited had the emergency not occurred. This bill would revise the above-described triggering event to be an epidemic, pandemic, or outbreak of infectious disease, and would provide that the various specified triggering events apply to decreases in average daily attendance due to illness, quarantine, social isolation, and social distancing, absences taken as preemptive measures, independent study and distance learning requests, and pupils who are absent due to quarantine, but cannot provide the appropriate documentation.

- **AB 3216 (Kalra – D) Employee Leave: Authorization: Coronavirus**
  - **Status:** 7/1/2020 – Referred to Committee on L., P.E. & R.
  - **Summary:** Would make it an unlawful employment practice for an employer, as defined, to refuse to grant a request by an eligible employee to take family and medical leave due to the coronavirus (COVID-19), as specified. The bill would require a request under this provision to be made and granted in a similar manner to that provided under the California Family Rights Act (CFRA). The bill would specify that an employer is not required to pay an employee for the leave taken, but would authorize an employee taking a leave to elect, or an employer to require, a substitution of the employee's accrued vacation or other time off during this period and any other paid or unpaid time off negotiated with the employer.

- **SB 89 (Committee on Budget and Fiscal Review) Budget Act of 2019**
  - **Status:** 3/17/2020 – Chaptered by Secretary of State – Chapter 2, Statutes of 2020.
  - **Summary:** Would amend the Budget Act of 2019 by appropriating $500,000,000 from the General Fund to be used for any purpose related to the Governor's March 4, 2020 proclamation of a state of emergency. This bill would authorize additional appropriations in increments of $50,000,000, up to a total appropriation of $1,000,000,000. The bill would amend the act to state the Legislature's intent that the administration work with stakeholders, including members of the Legislature and legislative staff, to develop strategies to be considered for inclusion in the Budget Act of 2020 to provide assistance related to the impacts of COVID-19. The bill would amend the act by adding an item of appropriation to the Department of Resources Recycling and Recovery.

- **SB 943 (Chang – R) Paid Family Leave: School Closures: COVID-19**
  - **Status:** 6/18/2020 – June 18 hearing: Held in committee and under submission.
  - **Summary:** Current law establishes within the state disability insurance program a family temporary disability insurance program, also known as the Paid Family Leave program, for the provision of wage replacement benefits to workers who take time off work to care for a seriously ill family member or to bond with a minor child within one year of birth or placement, as specified.

This bill would, until January 1, 2021, also authorize wage replacement benefits to workers who take time off work to care for a minor child whose school has been closed due to the COVID-19 virus outbreak.

- **SB 939 (Wiener – D) Emergencies: COVID-19 Evictions**
  - **Status:** 6/18/2020 – June 18 hearing: Held in committee and under submission.
  - **Summary:** Would prohibit the eviction of tenants of commercial real property, including businesses and non-profit organizations, during the pendency of the state of emergency proclaimed by the Governor on March 4, 2020, related to COVID-19. The bill would make it a misdemeanor, an act of unfair competition, and an unfair business practice to violate the foregoing prohibition. The bill would render void and unenforceable evictions that occurred after the proclamation of the state of emergency but before the effective date of this bill. The bill would not prohibit the continuation of evictions that lawfully began prior to the proclamation of the state of emergency, and would not preempt local ordinances prohibiting or imposing more severe penalties for the same conduct.

- **SB 1088 (Rubio – D) Homelessness: Domestic Violence Survivors**
  - **Status:** 4/2/2020 – From committee with author's amendments. Read second time and amended. Re-referred to Committee on Rules.
  - **Summary:** Would require a city, county, or continuum of care to use at least 12% of specified homelessness prevention or support moneys for services for domestic violence survivors experiencing or at risk of homelessness. The bill would require local agencies, on or before January 1, 2022, to establish and submit to the Department of Housing and Community Development an actionable plan to address the needs of domestic violence survivors and their children experiencing homelessness. By placing new duties on cities, counties, and continuums of care, the bill would impose a state-mandated local program.

- **SB 1276 (Rubio – D) The Comprehensive Statewide Domestic Violence Program**
  - **Status:** 6/18/2020 – Referred to Committee on Public Safety.
  - **Summary:** Current law requires the Office of Emergency Services to provide financial and technical assistance to local domestic violence centers in implementing specified services. Current law authorizes domestic violence centers to seek, receive, and make use of any funds that may be available from all public and private sources to augment state funds and requires centers receiving funds to provide cash or an in-kind match of at least 10% of the funds received. This bill would remove the requirement for centers receiving funds to provide cash or an in-kind match for the funds received. The bill would make related findings and declarations.

- **SB 1322 (Rubio – D) Remote Online Notarization Act**
  - **Status:** 5/13/2020 – Set for hearing May 22. May 22 set for first hearing cancelled at the request of the author.
  - **Summary:** Current law authorizes the Secretary of State to appoint and commission notaries public in the number the Secretary of State deems necessary for the public convenience. Current law authorizes notaries public to act as notaries in any part of the state and prescribes the manner and method of notarizations. This bill, the Remote Online Notarization Act, would authorize a notary public to apply for registration with the Secretary of State to be a remote online notary public. The bill would provide that a remote online notary public is a notary public for purposes of the above-described provisions.

Other

- **AB 2055 (Wood – D) Specialty Mental Health Services and Substance Use Disorder Treatment**
  - **Status:** 5/29/2020 – Failed Deadline pursuant to Rule 61(b)(5)
  - **Summary:** Would require the State Department of Health Care Services to establish, implement, and administer the Behavioral Health Quality Improvement Program to assist county mental health plans and counties that administer the Drug Medi-Cal Treatment Program or the Drug Medi-Cal organized delivery system for purposes of preparing those entities for implementation of the behavioral health components included in the Medi-Cal Healthier California for All initiative, and would establish in the State Treasury the Behavioral Health Quality Improvement Account to fund those efforts. The bill would require the department to determine the methodology and distribution of funds appropriated to those entities.

- **AB 2279 (Garcia – D) Childhood Lead Poisoning Prevention**
  - **Status:** 6/23/2020 – Referred to Committee on Health.
  - **Summary:** The Childhood Lead Poisoning Prevention Act of 1991 establishes the Childhood Lead Poisoning Prevention Program and requires the State Department of Public Health to adopt regulations establishing a standard of care, at least as stringent as the most recent federal Centers for Disease Control and Prevention screening guidelines. Current law provides that the standard of care shall require a child who is determined to be at risk for lead poisoning to be screened. Current law requires the regulations to include the determination of specified risk factors, including a child's time spent in a home, school, or building built before 1978. This bill would add several risk factors to be considered as part of the standard of care specified in regulations, including a child's residency in or visit to a foreign country, or their residency in a high-risk ZIP Code, and would require the department to develop, by January 1, 2021, the regulations on the additional risk factors, in consultation with the specified individuals.

- **AB 2409 (Kalra – D) Medi-Cal: Assisted Living Waiver program**
  - **Status:** 5/29/2020 – Failed Deadline pursuant to Rule 61(b)(5)
  - **Summary:** Current law requires the State Department of Health Care Services to develop a federal waiver program, known as the Assisted Living Waiver program, to test the efficacy of providing an assisted living benefit to beneficiaries under the Medi-Cal program. Current law requires that the benefit include the care and supervision activities specified for residential care facilities for the elderly, and conditions the implementation of the program to the extent federal financial participation is available and funds are appropriated or otherwise available for the program. This bill would, subject to the department obtaining federal approval and on the availability of federal financial participation, require the department to submit to the federal Centers for Medicare and Medicaid Services a request for an amendment of the Assisted Living Waiver program to increase its provider reimbursement tiers to compensate for mandatory minimum wage increases.

- **AB 2413 (Ting – D) CalFresh: Eligibility and Reporting**
  - **Status:** 7/2/2020 – Re-referred to Committee on EQ.
  - **Summary:** Would require the State Department of Social Services to establish and require the use of self-attestation by CalFresh applicants and beneficiaries to verify required information to the extent permitted by federal law and to apply for any waivers necessary to simplify verification requirements. The bill would require the department to issue guidance that prohibits a county human services agency from requesting additional documents to verify dependent care expenses, except as specified. The bill would require the department to take specified actions in an effort to

expand CalFresh program outreach and retention and improve dual enrollment between the CalFresh and Medi-Cal programs.

- **AB 2464 (Aguilar-Curry – D) Project ECHO Grant Program**
  - **Status:** 6/5/2020 – Failed Deadline pursuant to Rule 61(b)(8)
  - **Summary:** Current law establishes within state government the California Health and Human Services Agency. Current law also establishes various public health programs, including grant programs, throughout the state for purposes of promoting maternal, child, and adolescent health. This bill would require the agency, upon appropriation by the Legislature, to establish, develop, implement, and administer the Project ECHO (registered trademark) Grant Program. Under the grant program, the bill would require participating children's hospitals to establish one year-long pediatric behavioral health teleECHO (trademark) clinics for specified individuals, including primary care clinicians and educators, to help them develop expertise and tools to better serve the youth that they work with by addressing their mental health needs stemming from the coronavirus pandemic.

- **AB 2535 (Mathis – R) Denti-Cal Provider Pilot Program**
  - **Status:** 5/29/2020 – Failed Deadline pursuant to Rule 61(b)(5)
  - **Summary:** Current law establishes various pilots and programs, including the Caries Risk Assessment and Disease Management Pilot, a dental integration pilot program in County of San Mateo, and a dental outreach and education program, which address dental services provided under the Medi-Cal program. This bill would require the State Department of Health Care Services to establish and administer a 5-year pilot program to educate and train Denti-Cal providers on how to effectively serve Medi-Cal beneficiaries with intellectual or developmental disabilities who are regional center consumers, to contract with an independent evaluator, and to utilize an expert to perform specified duties, including advising on the design of the pilot program.

- **AB 2581 (Reyes – D) Early childhood development: interagency workgroup**
  - **Status:** 7/1/2020 – Referred to Committee on Health.
  - **Summary:** Upon appropriation by the Legislature for the purpose of transferring early childhood development programs to a single entity, this bill would establish an administering entity or entities for early childhood development programs. The bill would require the administering entity or entities to establish an interagency workgroup comprised of specified individuals, including the Deputy Superintendent of Public Instruction and representatives from various state departments, such as the State Department of Public Health and the State Department of Health Care Services, to perform specified duties, including establishing a memorandum of understanding between the departments outlining the joint authority for the promulgation of regulations for the coordination and alignment of services relating to early childhood care and learning, and annually submitting a report on its work to the Governor, the Superintendent of Public Instruction, and the Legislature. The bill would state related findings, declarations, and intents of the Legislature.

- **AB 2817 (Wood – D) Office of Health Care Quality and Affordability**
  - **Status:** 5/29/2020 – Failed Deadline pursuant to Rule 61(b)(5)
  - **Summary:** Would create the Office of Health Care Quality and Affordability to analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs, and create a strategy to control health care costs. The bill would require the office to be governed by a board with specified membership, and would require the board to hire an executive director to organize, administer, and manage the operations of the office.

- **AB 3300 (Santiago – D) Homelessness: California Access to Housing and Services Act**
  - **Status:** 7/1/2020 – Referred to Committee on Housing.
  - **Summary:** By executive order, the Governor required the Department of Finance to establish the California Access to Housing and Services Fund, administered by the State Department of Social Services, to provide funding for additional affordable housing units, providing rental and operating subsidies, and stabilizing board and care homes. This bill, the California Access to Housing and Services Act, would establish the California Access to Housing and Services Fund in the State Treasury and continuously appropriate moneys in the fund solely for the purpose of implementing and administering the bill's provisions.

- **SB 852 (Pan – D) Health Care: Prescription Drugs**
  - **Status:** 6/29/2020 – Referred to Committee on Health.
  - **Summary:** Would establish the Office of Drug Contracting and Manufacturing within the California Health and Human Services Agency to, among other things, increase patient access to affordable drugs. The bill would require the office, on or before January 1, 2022, to contract or partner with at least one drug company or generic drug manufacturer to produce at least 10 generic prescription drugs, as determined by the office, and insulin at a price that results in savings. The bill would require the office to prepare and submit a report to the Legislature on or before January 1, 2022, that, among other things, assesses the feasibility of the office to directly manufacture generic prescription drugs and includes an estimate of the cost of building or acquiring manufacturing capacity.

- **SB 1065 (Hertzberg – D) CalWORKs: Homeless Assistance**
  - **Status:** 6/29/2020 – Referred to Committee on Human Services.
  - **Summary:** Under current law, a family is considered homeless for the purpose of establishing eligibility for homeless assistance benefits if, among other things, the family has received a notice to pay rent or quit. Current law requires the family to demonstrate that the eviction is the result of a verified financial hardship, as specified, and no other lease or rental violations, and that the family is experiencing a financial crisis that may result in homelessness if preventive assistance is not provided. This bill would eliminate the requirement for a family to demonstrate the reason for the eviction and the existence of the financial crisis.

ALAMEDA Alliance FOR HEALTH

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Board Business

Safety-Net Sustainability Fund

Progress Report

Safety-Net Sustainability Fund

Alameda Alliance Board of Governors

Presented by Scott Coffin, Chief Executive Officer

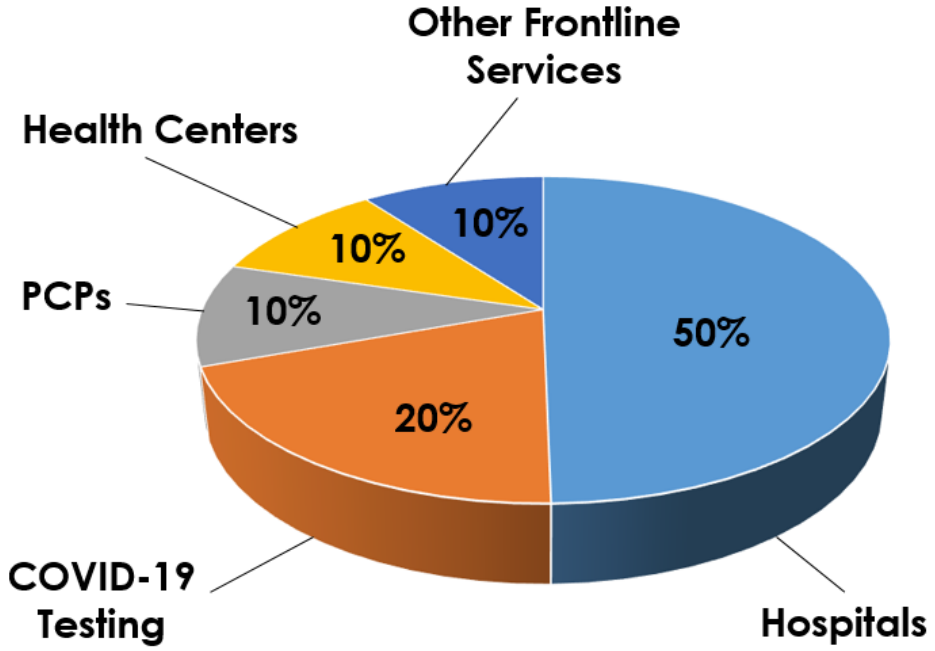
July 10th, 2020

Update – July 2020

- Board approval in May 2020 to launch a funding program to support safety-net providers, $16.6 million over a 6-month period (May-October)
- Notifications sent to contracted providers and posted publicly on the Alliance's website, and a press release was issued
- 30 applications received in the month of May 2020, and evaluated by the Selection Committee; advisory support from Alameda County [COVID-19 testing] to ensure alignment
- 17 of 30 applicants met the eligibility criteria
- Approximately 84% of available funds in May were awarded in five categories ($4.2 million)

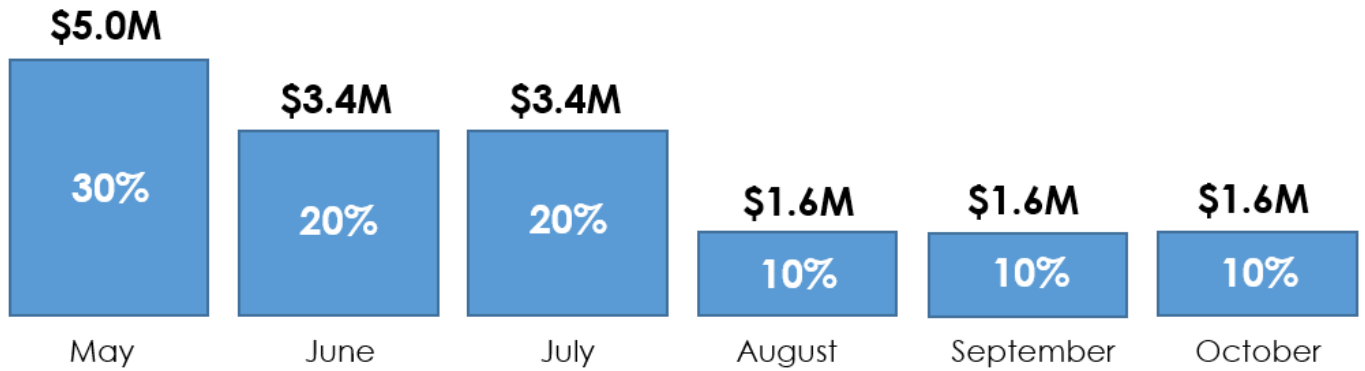
  60% to safety-net hospitals, 24% to COVID-19 testing, 7% to health centers, 6% to primary care, and 3% to other safety-net providers

- Confirmations sent to Awardees and payments are being processed in the month of July
- Applications received in the month of June are being evaluated and scored
- Payments of claims and incentive dollars accelerated to improve cash flow to our contracted hospitals, medical groups, and independent physicians



Allocation percentages of the $16.6 million to eligible safety-net providers, across five categories of service

Allocation of $16.6 million in funding by month



ALAMEDA ALLIANCE SUSTAINABILITY FUND

Funding Awarded for Applications Submitted in May 2020

Entity Name		Funding	Funding Category
Alameda Health System	$	350,000	COVID-19 Testing
Alameda Health System	$	1,500,000	Hospital
Alzheimer's Services of the East Bay	$	60,000	Other Safety-Net Services
Chabot Urology Medical Associates	$	25,000	Other Safety-Net Services
Children's Hospital & Research Center at Oakland	$	200,000	COVID-19 Testing
Children's Hospital & Research Center at Oakland	$	500,000	Hospital
Dr. Bay Dang-Vu, MD	$	25,000	Direct Contracted PCP
Dr. Clifford Melton, MD	$	5,000	Other Safety-Net Services
Ebrahim Ahmadi MD PC	$	50,000	Direct Contracted PCP
Hayward Sisters Hospital DBA St. Rose Hospital	$	500,000	Hospital
Mark Zeme, MD Ear Nose and Throat Surgery	$	25,000	Other Safety-Net Services
Merry and Bright Pediatrics	$	50,000	Direct Contracted PCP
Nabil K Abudayeh, MD	$	50,000	Direct Contracted PCP
Osita Health Clinic	$	5,000	Direct Contracted PCP
Wellness Center	$	50,000	Direct Contracted PCP
Roots Community Health Center	$	150,000	COVID-19 Testing
Roots Community Health Center	$	300,000	Health Center
Tiburcio Vasquez Health Center	$	150,000	COVID-19 Testing
West Oakland Health Council	$	150,000	COVID-19 Testing
Xiaochuan Chen MD	$	25,000	Direct Contracted PCP
Total funds awarded in May 2020	**$**	**4,170,000**	
Total dollars allocated for May 2020	**$**	**5,000,000**	
Budget: over / (under)	**$**	**(830,000)**	

The following section contains the presentation to the Board of Governors on May 8th, 2020

Overview

- Establish an emergency crisis fund for the Alameda County safety-net
- Grant funding of $16.6 million dollars allocated from excess TNE, approximately 10% of the $166.6 million
- Expand current COVID-19 testing capacity in Alameda County (city and county, health centers, hospitals)
- 6-month program, May through October
- Additional $4.8 million dollars in accelerated quality incentive payments (currently budgeted)
- Accelerated claims payments to providers for improving cash flow

Eligibility

Safety-Net providers are defined by the mission and vision of their organization, and earning a majority of their revenue through serving the underserved and uninsured residents in Alameda County

- Frontline safety-net providers treating or supporting COVID-19 patients
- Safety-net hospitals, health centers, directly-contracted primary care providers, other safety-net service entities (e.g. skilled nursing, food banks, family services, aging adult services), and public agencies
- Funding applies to providers being paid through fee-for-service
- Contracted providers that are funded through capitation continue to receive payments

Grant Methodology

- Applies to eligible fee-for-service providers, and encourages more use of Alliance's telehealth services

- External funding from county, state, and federal sources is considered, and allocations are based on highest needs of the requesting entity

- Alliance calculates a baseline from previous 12 months of paid claims (February 2019 to February 2020)

- Alliance compares to the current month claims paid amount to the 12-month historical average, pays 80% of the difference

Example: average 12-month average is $100, in May 2020 the provider is paid $50. Grant funding pays 80% of the difference, or $40.

Funding the Frontline Safety-Net

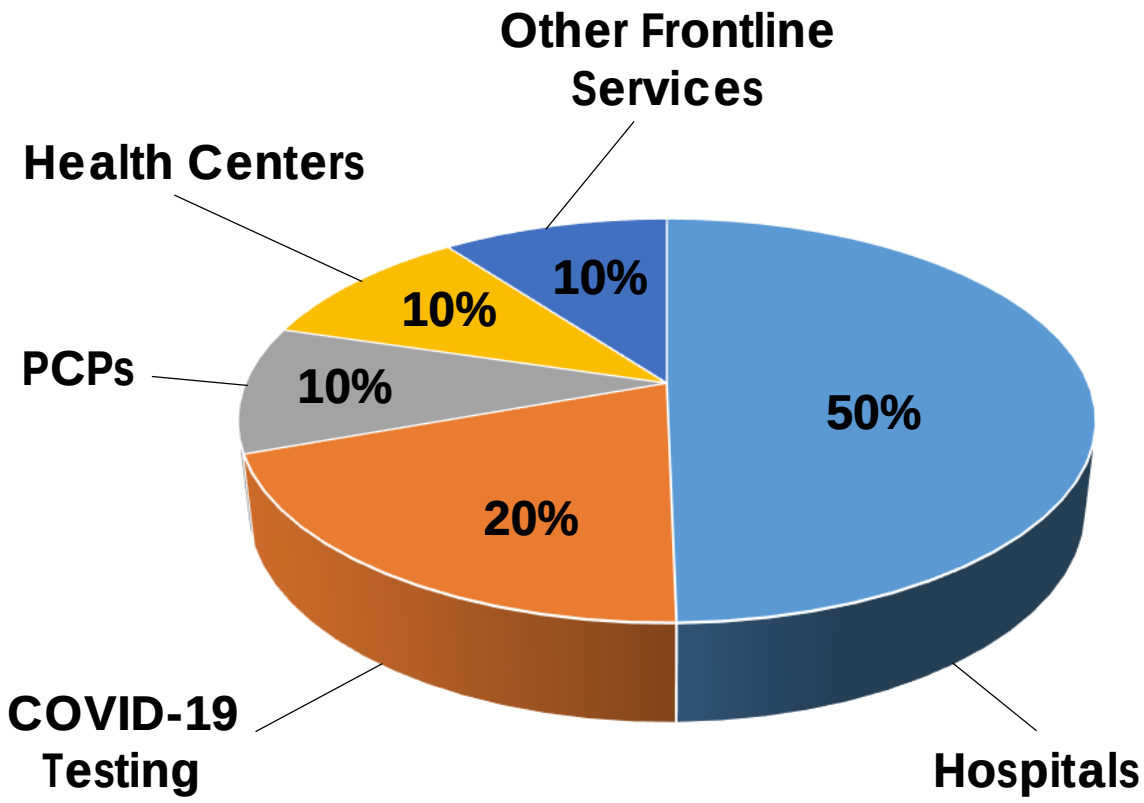
Safety-Net Hospitals
50%, or $8.3 million

COVID-19 Testing
20%, or $3.3 million

Direct-contracted Primary Care Physicians (PCPs)
10%, or $1.7 million

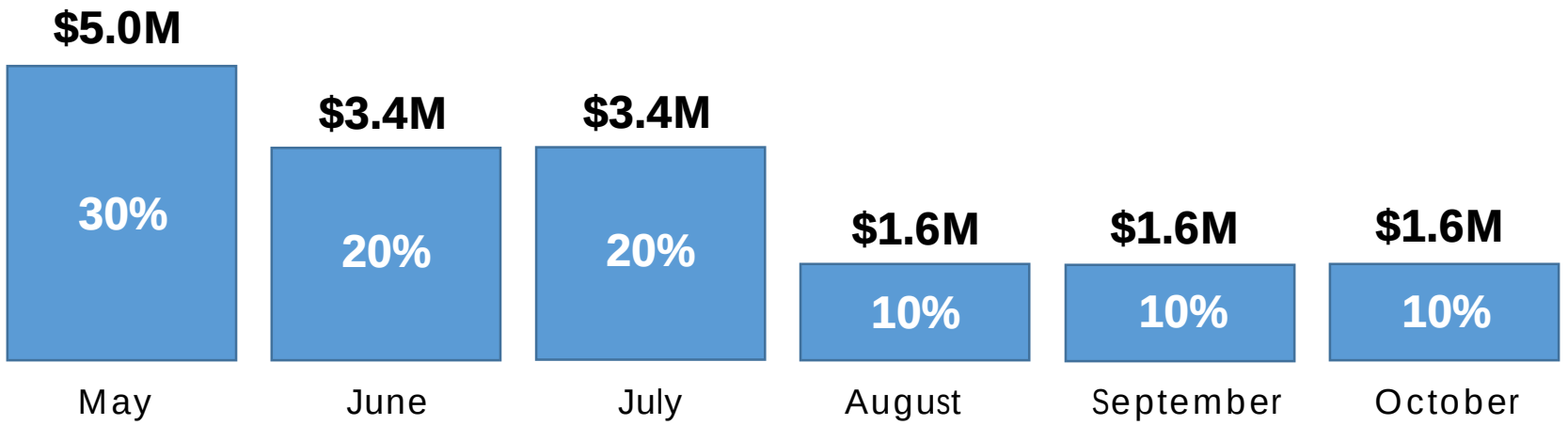
Safety-Net Health Centers
10%, or $1.7 million

Other Safety-Net Services
10%, or $1.7 million



Payment timeline: May – October 2020

- Selection committee reviews requests for funding, comprised of five members of the Alliance's Executive Team.
- Payments to eligible providers begin following Board of Governor's approval and continues through the end of October
- Grants and accelerated payments are reported to the Finance Committee and Board of Governors
- More than 70% of $16.6M is paid in the first 3 months



Accelerated Payments

- Accelerated payments are intended to assist providers with improving their cash flow
- Average payment of fee-for-service claims is 23 calendar days
- $4.8 million dollars is budgeted for the MY2019 pay-for performance quality incentive program

Proposed Actions:

- Pay claims that are ready to be paid in 12-15 business days
- Pay quality incentives to providers in July 2020, two months ahead of the normal annual payout

Considerations

- DHCS may not recognize the $16.6 million in grant funding for rates in calendar year 2023; most of the COVID-19 testing expenses are allowable expenses, and the accelerated payments would be included in rate development

- Due to the COVID-19 crisis, actual expenses in calendar year 2020 may not be used by DHCS to calculate rates for next fiscal year

Next Steps

- Approval from the Board of Governors
- Notification to the contracted providers
- Deployment of an online application, posted publicly on the Alliance website
- Document the evaluation process and criteria, and form the selection committee
- Develop reports for distribution of funding, subject to public reporting each month at Finance Committee and Board of Governors

Board Motions

- Motion to authorize CEO to create an emergency crisis fund, allocating $16.6 million dollars from the financial reserves, and distribute to eligible safety-net providers between May and October of 2020

- Motion to authorize CEO to accelerate a budgeted payment of up to $4.8 million dollars in quality incentives, paying to eligible providers in July 2020

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Reading of the Public Statement Opposing Structural Racism

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Operations Dashboard

Alameda Alliance for Health
Operations Dashboard
- July-2020 -

ID	Section	Subject Area	Category	Performance Metric					ID
1	1	Financials			May-20 FYTD		%	Annual Budget	1
2									2
3			Income & Expenses	Revenue $	$883,781,972		94.5%	$935,483,328	3
4				Medical Expense $	$813,036,631		92.5%	$879,173,524	4
5				*Inpatient (Hospital)*	$217,536,844		*26.8%*	$246,892,599	5
6				*Outpatient/Ancillary*	$222,214,264		*27.3%*	$240,198,558	6
7				*Emergency Department*	$34,758,817		*4.3%*	$38,603,091	7
8				*Pharmacy*	$144,657,921		*17.8%*	$157,323,732	8
9				*Primary Care*	$98,053,104		*12.1%*	$87,881,542	9
10				*Specialty Care*	$73,757,710		*9.1%*	$83,501,269	10
11				*Other*	$22,057,971		*2.7%*	$24,772,732	11
12				Admin Expense $	$54,100,505		89.2%	$60,618,392	12
13				Other Income / (Exp.) $	$3,756,308		6.2%	$4,013,097	13
14				Net Income $	$20,401,144			($295,490)	14
15				Gross Margin %	8.0%			6.0%	15
16			Liquid Reserves	Medical Loss Ratio (MLR) - Net %	92.0%			94.0%	16
17				Tangible Net Equity (TNE) %	627.5%			564.9%	17
18				Tangible Net Equity (TNE) $	$201,148,399			$180,451,765	18
19			Reinsurance Cases	2019-2020 Cases Submitted	13				19
20				2019-2020 New Cases Submitted	4				20
21				2018-2019 Cases Submitted	25				21
22				2018-2019 New Cases Submitted	0				22
23			Balance Sheet	Cash Equivalents	$276,257,366				23
24				Pass-Through Liabilities	$135,616,139				24
25				Uncommitted Cash	$140,641,227				25
26				Working Capital	$190,801,369				26
27				Current Ratio %	177.2%			100%	27
28									28
29	2	Membership			Mar-20	Apr-20	May-20	%	May-20 Budget	29
30										30
31			Medi-Cal Members	Adults	32,017	32,423	33,229	13%	32,591	31
32				Children	87,919	88,633	89,755	36%	89,436	32
33				Seniors & Persons with Disabilities (SPDs)	25,778	25,894	25,985	10%	24,976	33
34				ACA Optional Expansion (ACA OE)	77,199	78,295	79,736	32%	78,913	34
35				Dual-Eligibles	17,869	17,858	17,971	7%	17,061	35
36										36
37				Total Medi-Cal	240,782	243,103	246,676	98%	242,977	37
38			IHSS Members	IHSS	6,125	6,148	6,295	2%	5,976	38
39			Total Membership	Medi-Cal and IHSS	246,907	249,251	252,971	100%	248,953	39
40										40
41			Members Assigned By Delegate	Direct-contracted network	48,546	48,363	48,857	19%		41
42				Alameda Health System (Direct Assigned)	45,806	46,905	48,099	19%		42
43				Children's First Medical Group	29,278	29,619	30,072	12%		43
44				Community Health Center Network	90,726	91,469	92,533	37%		44
45				Kaiser Permanente	32,551	32,895	33,410	13%		45
46										46

Alameda Alliance for Health
Operations Dashboard
- July-2020 -

ID	Section	Subject Area	Category	Performance Metric						ID
47	3	Claims			Apr-20	May-20	Jun-20	%	Performance Goal	47
48										48
49			HEALTHsuite Claims Processing	Number of Claims Received	86,578	89,063	101,083			49
50				Number of Claims Paid	93,013	69,503	62,345			50
51				Number of Claims Denied	29,509	26,443	24,687			51
52				Inventory (Unfinalized Claims)	56,156	55,522	69,095			52
53				Pended Claims (Days)	9,059	10,597	9,639	14%		53
54				*0-29 Calendar Days*	8,970	10,533	9,616	14%		54
55				*30-44 Calendar Days*	89	63	22	0%		55
56				*45-59 Calendar Days*	0	1	1	0%		56
57				*60-89 Calendar Days*	0	0	0	0%		57
58				*90-119 Calendar Days*	0	0	0	0%		58
59				*120 or more Calendar Days*	0	0	0	0%		59
60				Total Claims Paid (dollars)	48,392,341	39,230,002	35,943,390			60
61				Interest Paid (Total Dollar)	30,207	37,539	29,670	0%		61
62				Auto Adjudication Rate (%)	74.7%	73.6%	74.9%		70%	62
63				Average Payment Turnaround (days)	24	19	19		25 days or less	63
64			Claims Auditing	# of Pre-Pay Audited Claims	297	689	2,325			64
65			Claims Compliance	% of Claims Processed Within 30 Cal Days (DHCS Goal = 90%)	97%	98%	98%		90%	65
66				% of Claims Processed Within 90 Cal Days (DHCS Goal = 99%)	100%	100%	100%		99%	66
67				% of Claims Processed Within 45 Work Days (DMHC Goal = 95%)	100%	100%	100%		95%	67
68										68
69	4	Member Services			Apr-20	May-20	Jun-20	%	Performance Goal	69
70										70
71			Member Call Center	Inbound Call Volume	9,892	9,893	11,469			71
72				Calls Answered in 30 Seconds %	89.0%	87.0%	84.0%		80.0%	72
73				Abandoned Call Rate %	3.0%	3.0%	2.0%		5.0% or less	73
74				Average Wait Time	00:21	00:25	00:27			74
75				Average Call Duration	08:24	08:31	08:42			75
76				Outbound Call Volume	8,424	10,737	10,466			76
77										77
78	5	Provider Services			Apr-20	May-20	Jun-20	%	Performance Goal	78
79										79
80			Provider Call Center	Inbound Call Volume	5,630	5,740	6,281			80
81										81
82	6	Provider Contracting			Apr-20	May-20	Jun-20	%	Performance Goal	82
83										83
84			Provider Network	Primary Care Physician	584	580	580			84
85				Specialist	7,021	7,038	7,058			85
86				Hospital	17	17	17			86
87				Skilled Nursing Facility	62	61	61			87
88				Durable Medical Equipment	Capitated	Capitated	Capitated			88
89				Urgent Care	10	10	10			89
90				Health Centers (FQHCs and Non-FQHCs)	68	67	67			90
91				Transportation	380	380	380			91
92			Provider Credentialing	Number of Providers in Credentialing	1,437	1,435	1,431			92
93				Number of Providers Credentialed	1,437	1,435	1,431			93
94										94

Alameda Alliance for Health
Operations Dashboard
- July-2020 -

ID	Section	Subject Area	Category	Performance Metric						ID
95	7	Human Resources & Recruiting			Apr-20	May-20	Jun-20	%	Annual Budget	95
96										96
97			Employees	Total Employees	319	318	320		347	97
98				Full Time Employees	317	316	318	99%		98
99				Part Time Employees	2	2	2	1%		99
100				New Hires	7	3	3			100
101				Separations	2	4	1			101
102				Open Positions	37	39	44	13%	10% or less	102
103				Signed Offer Letters Received	3	4	6			103
104				Recruiting in Process	34	35	38	11%		104
105										105
106			Non-Employee (Temps / Seasonal)		7	4	3			106
107										107
108	8	Compliance			Apr-20	May-20	Jun-20	%	Performance Goal	108
109										109
110			Provider Disputes & Resolutions	Turnaround Compliance (45 business days)	100%	100%	99%		95%	110
111				% Overturned	21%	34%	34%		25% or less	111
112										112
113			Member Grievances	Overall Standard Grievance Compliance Rate % (30 calendar days)	95%	95%	98%		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)	75%	100%	100%		95%	117
118										118
119	9	Encounter Data & Technology			Apr-20	May-20	Jun-20		Performance Goal	119
120										120
121			Business Availability	HEALTHsuite (Claims and Membership System)	100.00%	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	86.7%	88.1%	83.9%		60.0%	129
130				Timeliness - % Within Lag Time - Institutional 0-180 days	95.8%	96.3%	95.8%		80.0%	130
131				Timeliness - % Within Lag Time - Professional 0-90 days	88.6%	84.2%	90.2%		65.0%	131
132				Timeliness - % Within Lag Time - Professional 0-180 days	97.0%	94.1%	97.0%		80.0%	132
133										133

Alameda Alliance for Health
Operations Dashboard
- July-2020 -

ID	Section	Subject Area	Category	Performance Metric						ID
134	10	Health Care Services			Apr-20	May-20	Jun-20	QTR 2	Performance Goal	134
135										135
136			Authorization Turnaround	Overall Authorization Turnaround % Compliant	99%	98%	99%	99%	95%	136
137				Medi-Cal %	99%	98%	99%	99%	95%	137
138				Group Care %	100%	99%	99%	99%	95%	138
139										139
140			Outpatient Authorization Denial Rates	Overall Denial Rate (%)	3.4%	2.9%	2.5%			140
141				Denial Rate Excluding Partial Denials (%)	3.3%	2.9%	2.4%			141
142				Partial Denial Rate (%)	0.2%	0.1%	0.1%			142
143										143
144			Pharmacy Authorizations	Approved Prior Authorizations	766	641	722	41%		144
145				Denied Prior Authorizations	588	503	565	32%		145
146				Closed Prior Authorizations	630	458	466	27%		146
147				Total Prior Authorizations	1,984	1,602	1,753			147
148										148
149					Mar-20	Apr-20	May-20			149
150										150
151			Inpatient Utilization	Days / 1000	255.0	222.5	249.9			151
152				Admits / 1000	54.8	41.6	51.2			152
153				Average Length of Stay	4.7	5.3	4.9			153
154										154
155			Emergency Department (ED) Utilization	# ED Visits / 1000	44.18	24.15	25.35			155
156										156
157			Case Management	New Cases						157
158				Care Coordination	218	200	252			158
159				Complex Case Management	29	65	38			159
160				Health Homes	37	31	24			160
161				Whole Person Care (AC3)	2	5	3			161
162				Total New Cases	286	301	317			162
163										163
164				Open Cases						164
165				Care Coordination	633	550	587			165
166				Complex Case Management	70	104	91			166
167				Total Open Cases	703	654	678			167
168										168
169				Enrolled						169
170				Health Homes	723	741	764			170
171				Whole Person Care (AC3)	222	220	222			171
172				Total Enrolled	945	961	986			172
173										173
174				Total Case Management (Open Cases & Enrolled)	1,648	1,615	1,664			174
175										175

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: **July 10, 2020**

Subject: **Finance Report**

Executive Summary

- For the month ended May 31, 2020, the Alliance had enrollment of 252,971 members, a Net Income of $1.6 million and 628% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$79,808	$883,782
Medical Expense	69,127	813,037
Admin. Expense	9,289	54,101
Other Inc. / (Exp.)	167	3,756
Net Income	$1,559	$20,401

Net Income by Program:

	Month	YTD
Medi-Cal	$1,219	$20,704
Group Care	340	(303)
	$1,559	$20,401

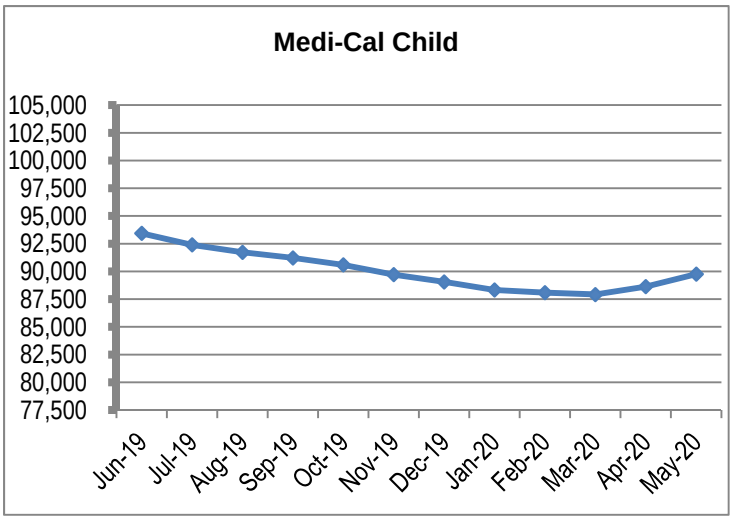
Enrollment

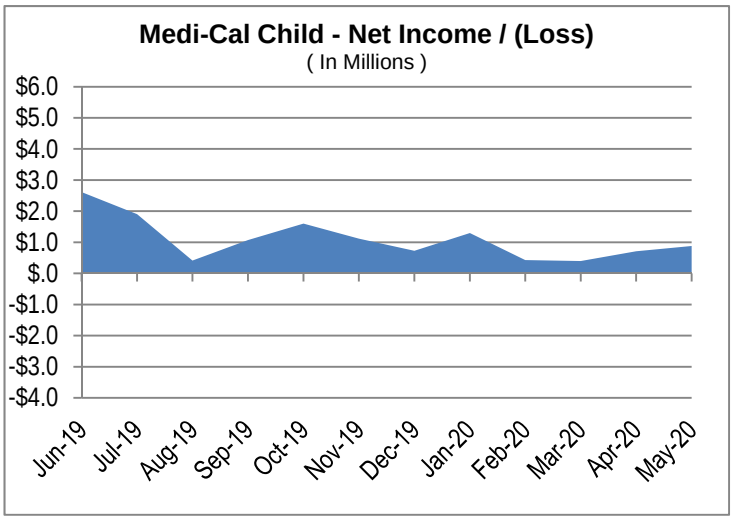
- Total enrollment increased by 3,720 members since April 2020.
- Total enrollment decreased by 5,414 members since June 2019.

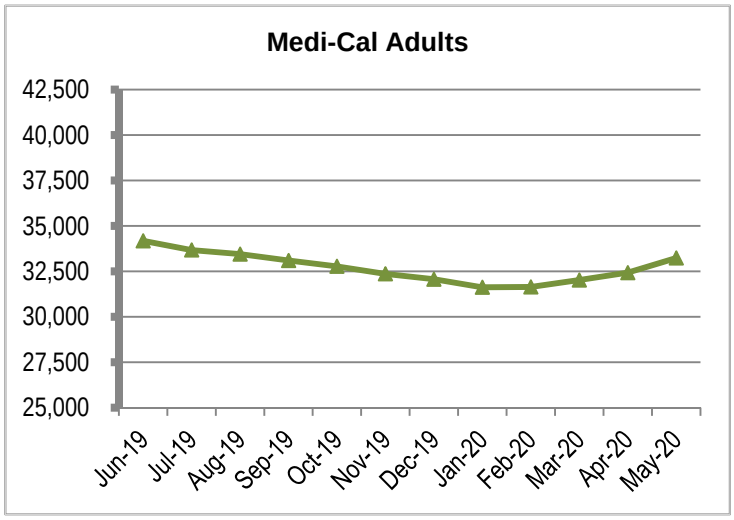
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

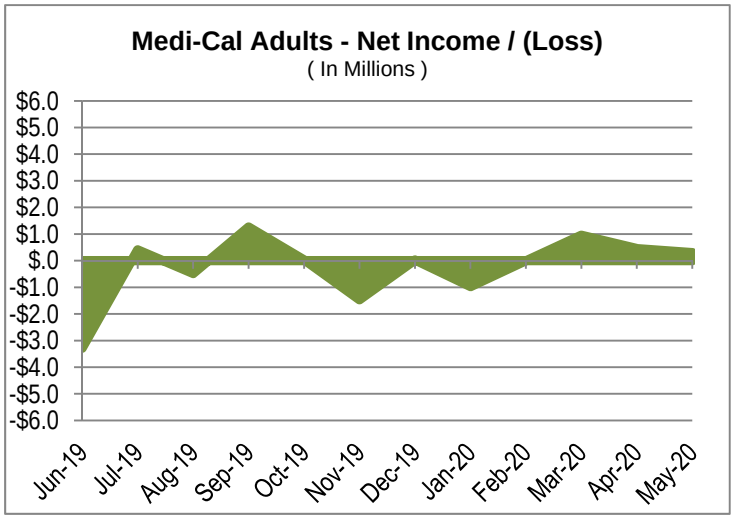
Enrollment					Member Months			
May-2020					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
33,229	32,591	638	2.0%	Adults	358,331	364,536	(6,205)	-1.7%
89,755	89,436	319	0.4%	Child	987,435	1,000,357	(12,922)	-1.3%
25,985	24,976	1,009	4.0%	SPD	283,494	279,369	4,125	1.5%
17,971	17,061	910	5.3%	Duals	195,538	190,837	4,701	2.5%
79,736	78,913	823	1.0%	ACA OE	869,191	880,678	(11,487)	-1.3%
246,676	242,977	3,699	1.5%	Medi-Cal Total	2,693,989	2,715,777	(21,788)	-0.8%
6,295	5,976	319	5.3%	Group Care	66,848	65,736	1,112	1.7%
252,971	248,953	4,018	1.6%	Total	2,760,837	2,781,513	(20,676)	-0.7%

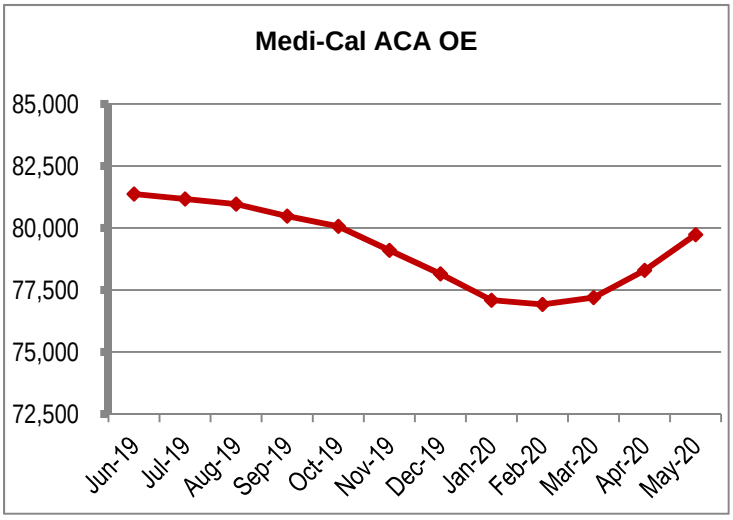
Enrollment and Profitability by Program and Category of Aid

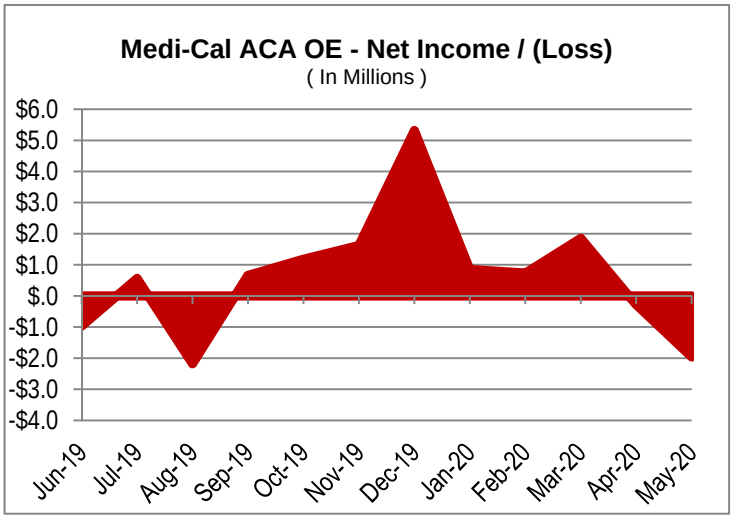




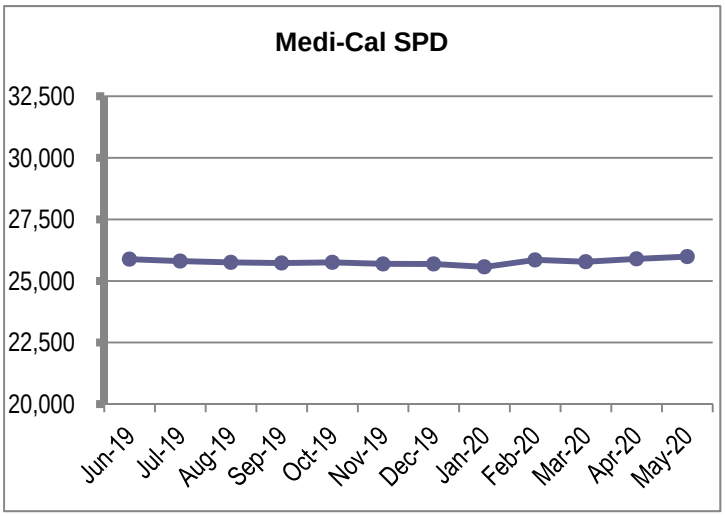


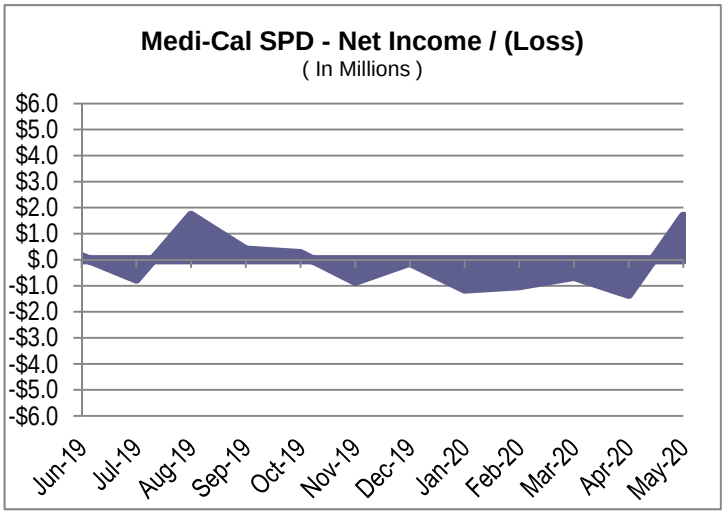


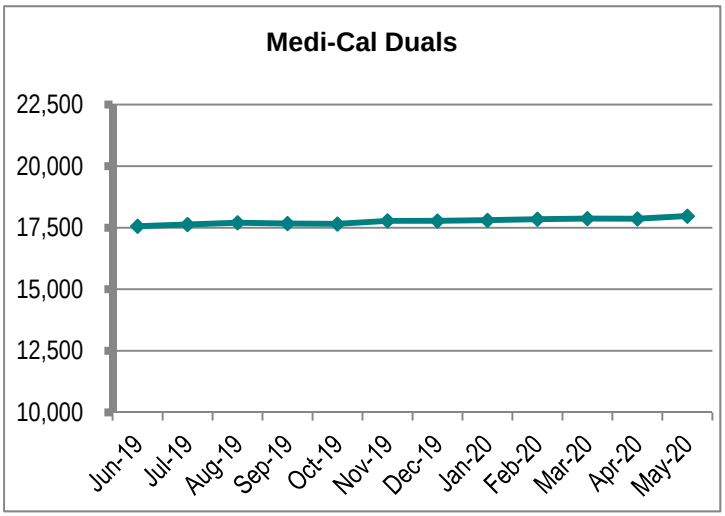


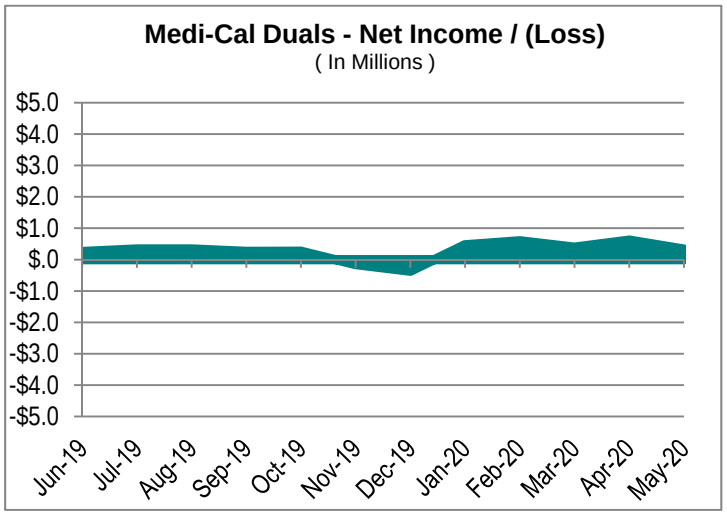


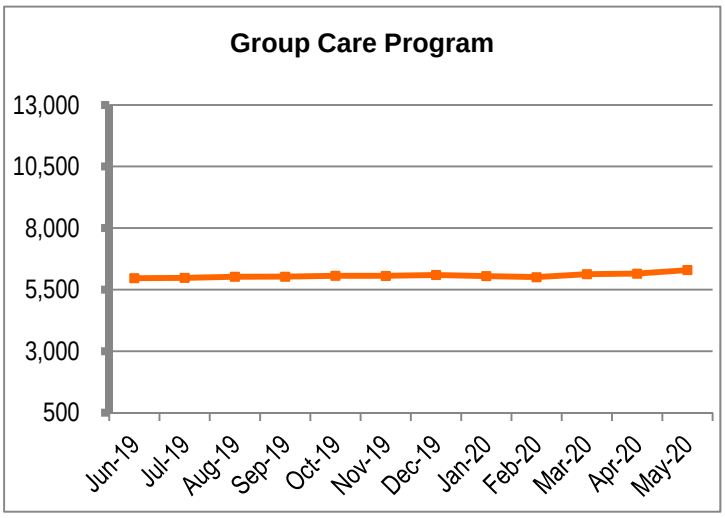
Enrollment and Profitability by Program and Category of Aid

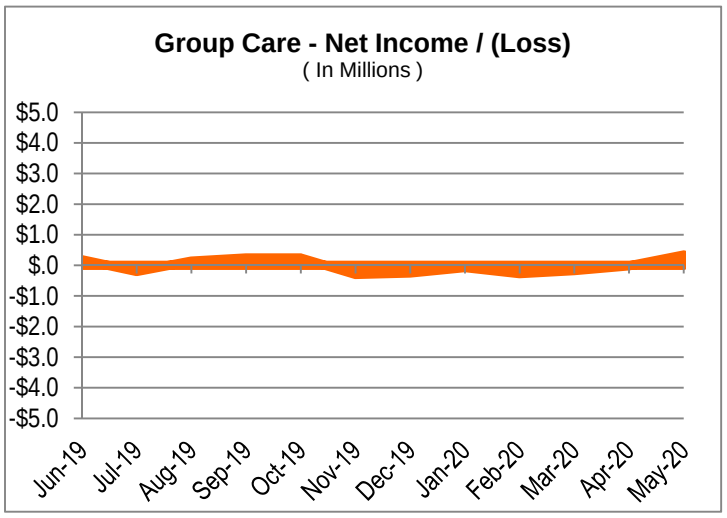








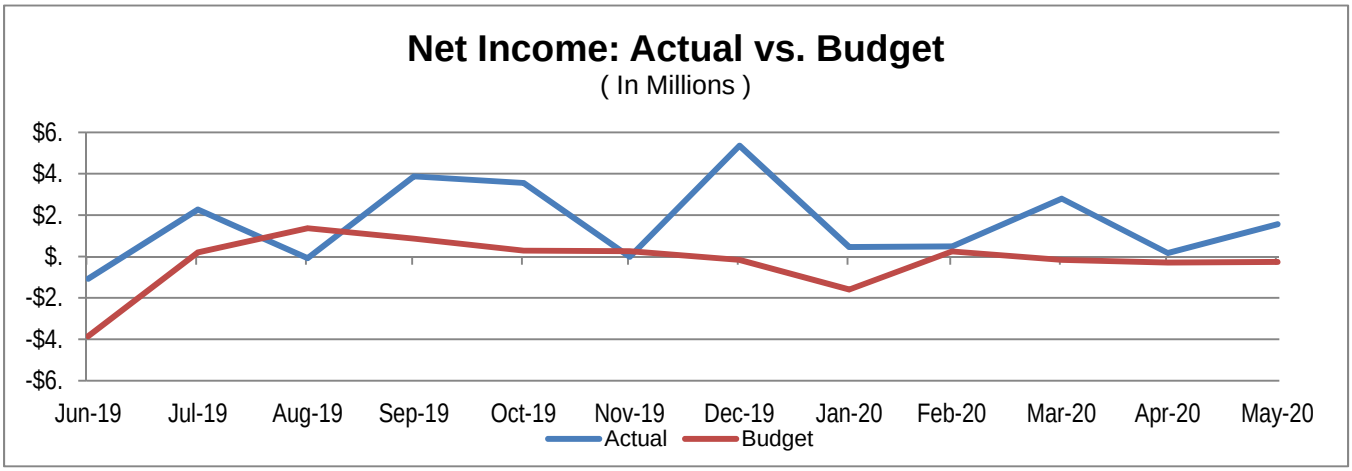




Net Income

- For the month ended May 31, 2020:
  - Actual Net Income: $1.6 million.
  - Budgeted Net Loss: $263,000

- For the year-to-date (YTD) ended May 31, 2020:
  - Actual YTD Net Income: $20.4 million.
  - Budgeted YTD Net Income: $2.8 million.

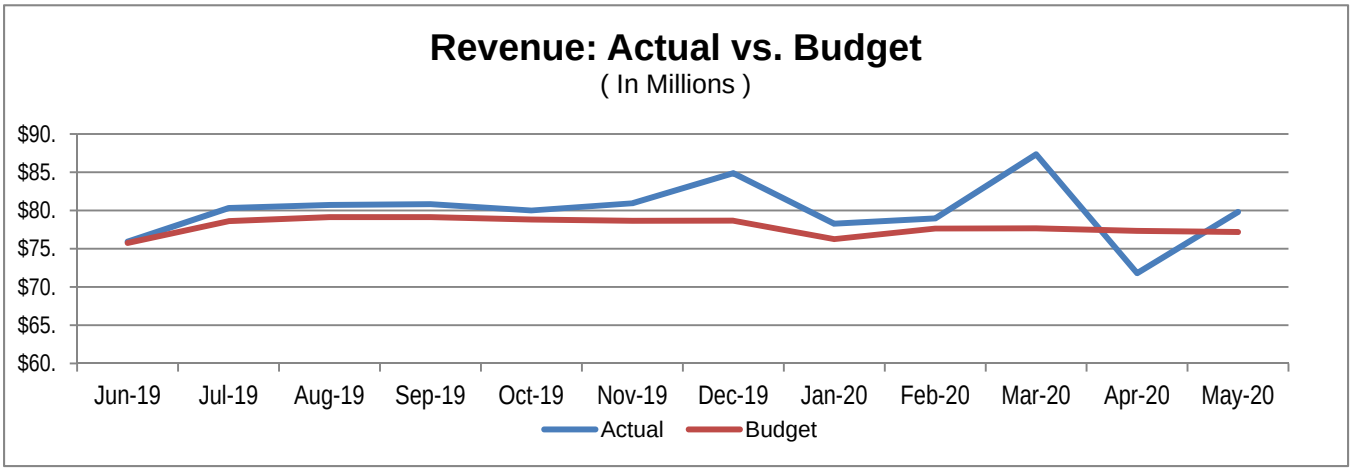


- The favorable variance of $1.8 million in the current month is due to:
  - Favorable $2.6 million higher than anticipated Revenue.
  - Favorable $3.7 million lower than anticipated Medical Expense.
  - Unfavorable $4.3 million higher than anticipated Administrative Expense.
  - Unfavorable $162,000 lower than anticipated Other Income & Expense.

Revenue

- For the month ended May 31, 2020:
  - Actual Revenue: $79.8 million.
  - Budgeted Revenue: $77.2 million.

- For the fiscal year-to-date ended May 31, 2020:
  - Actual YTD Revenue: $883.8 million.
  - Budgeted YTD Revenue: $860.7 million.

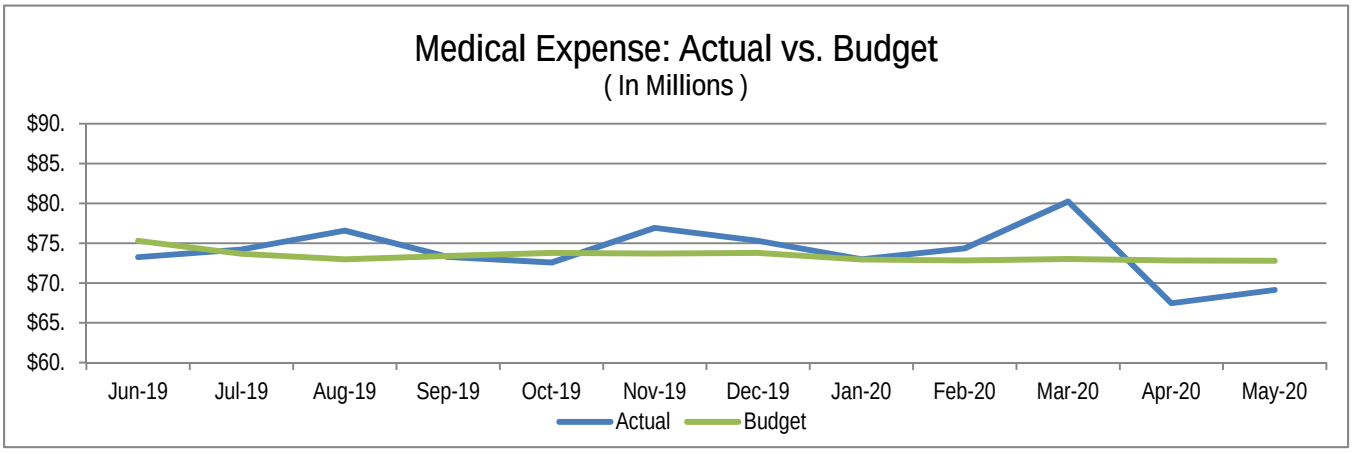


- For the month ended May 31, 2020, the favorable revenue variance of $2.6 million is mainly due to:
    - Favorable $1.4 million in higher than expected base capitation revenue due to higher paid enrollment than expected, partially offset by an accrual for a 1.5% DHCS rate reduction for Non-Dual categories of aid.
    - Favorable $1.1 million in higher than expected Prop 56 Revenue. This revenue will be largely offset by enhanced payments to qualified Providers.

Medical Expense

- For the month ended May 31, 2020:
    - Actual Medical Expense: $69.1 million.
    - Budgeted Medical Expense: $72.8 million.

- For the fiscal year-to-date ended May 31, 2020:
    - Actual YTD Medical Expense: $813.0 million.
    - Budgeted YTD Medical Expense: $806.2 million.



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

- For May, updates to Fee-For-Service (FFS) decreased the estimate for unpaid Medical Expenses for prior months by $112,000. Year-to-date, the estimate for prior years increased by $2.0 million (per table below).

Medical Expense - Actual vs. Budget (In Dollars)

Adjusted to Eliminate the Impact of Prior Period IBNP Estimates

	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Excluding IBNP Change	Change in IBNP	Reported		$	%
Capitated Medical Expense	$189,778,398	$0	$189,778,398	$188,803,810	($974,588)	-0.5%
Primary Care FFS	50,236,996	214,330	50,451,326	32,663,770	($17,573,226)	-53.8%
Specialty Care FFS	40,154,074	698,624	40,852,698	41,992,097	$1,838,022	4.4%
Outpatient FFS	77,031,964	652,954	77,684,918	79,594,419	$2,562,455	3.2%
Ancillary FFS	34,685,048	572,691	35,257,739	34,514,162	($170,886)	-0.5%
Pharmacy FFS	142,890,442	1,767,479	144,657,921	144,232,062	$1,341,620	0.9%
ER Services FFS	34,291,531	467,286	34,758,817	35,431,517	$1,139,987	3.2%
Inpatient Hospital & SNF FFS	219,957,176	(2,420,332)	217,536,844	226,631,617	$6,674,441	2.9%
Other Benefits & Services	19,715,172	0	19,715,172	20,423,075	$707,903	3.5%
Net Reinsurance	(73,995)	0	(73,995)	977,128	$1,051,123	107.6%
Provider Incentive	2,416,792	0	2,416,792	916,788	($1,500,004)	-163.6%
	$811,083,599	$1,953,032	$813,036,631	$806,180,445	($4,903,154)	-0.6%

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

Adjusted to Eliminate the Impact of Prior Year IBNP Estimates
Favorable / (Unfavorable)

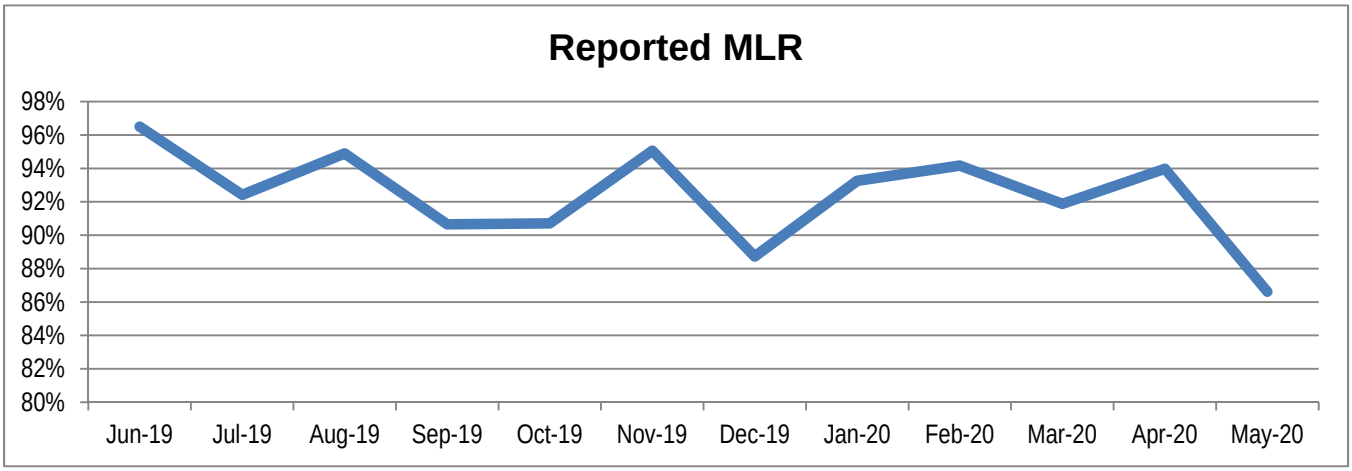
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Excluding IBNP Change	Change in IBNP	Reported		$	%
Capitated Medical Expense	$68.74	$0.00	$68.74	$67.88	($0.86)	-1.3%
Primary Care FFS	18.20	0.08	18.27	11.74	(6.45)	-55.0%
Specialty Care FFS	14.54	0.25	14.80	15.10	0.55	3.7%
Outpatient FFS	27.90	0.24	28.14	28.62	0.71	2.5%
Ancillary FFS	12.56	0.21	12.77	12.41	(0.15)	-1.2%
Pharmacy FFS	51.76	0.64	52.40	51.85	0.10	0.2%
ER Services FFS	12.42	0.17	12.59	12.74	0.32	2.5%
Inpatient Hospital & SNF FFS	79.67	(0.88)	78.79	81.48	1.81	2.2%
Other Benefits & Services	7.14	0.00	7.14	7.34	0.20	2.7%
Net Reinsurance	(0.03)	0.00	(0.03)	0.35	0.38	107.6%
Provider Incentive	0.88	0.00	0.88	0.33	(0.55)	-165.6%
	$293.78	$0.71	$294.49	$289.84	($3.95)	-1.4%

- Excluding the effect of prior year estimates for IBNP, year-to-date medical expense variance is $4.9 million unfavorable to budget. On a PMPM basis, medical expense is unfavorable to budget by 1.4%.
    - Primary Care Expense is over budget due to the implementation of four new Prop 56 Add-on programs. There is a revenue offset for these expenses.
    - Capitated Expense is over budget due to increased non-medical transportation spending.
    - Inpatient Expense is under budget. Lower than planned costs-per-day were partially offset by an increase in hospital days per thousand. Lower costs for the SPD, Adults and Group Care populations have offsets in savings in other categories of aid.
    - Outpatient Expense is under budget as utilization has slowed in the last two months:
        - Facility-Other: favorable unit cost and utilization.
        - Lab / Radiology: unfavorable increase in utilization, partially offset by lower than planned unit cost.
        - Dialysis Expense: unfavorable unit cost, slightly offset by favorable utilization.
        - Behavioral Health: unfavorable due to increases in unit cost and increases in utilization.
    - Specialty Care is lower than budget for all populations due to fewer visits. May utilization was impacted by members continuing to stay at home.
    - Ancillary Expense is higher than budget. Higher utilization in the Other Medical Supplies, Home Health, and DME and Other Medical Expense categories was partially offset by Fee-for-service Transportation, CBAS, and Hospice categories.
    - Emergency Room Expense is lower than planned due to reduced unit costs, offset by higher utilization. SPDs showed the most favorability.
    - PMPM Pharmacy spending through the PBM is favorable in the Expansion, and Adults COAs, offset by unfavorable spending in Group Care. This is primarily due to decreased cost for brand drugs and more rebates received. This is virtually offset by higher than planned expense for drugs delivered in an outpatient setting, particularly for the SPDs.
    - Net Reinsurance is favorable due to timing of recoveries from prior year.

- In May 2020 an additional $1.5 million was added to the pool for Professional Provider Incentives (Risk Pool Distribution). The payout for this pool will be determined by Measurement Year CY 2019 performance metrics.

Medical Loss Ratio (MLR)

- The Medical Loss Ratio (total reported medical expense divided by operating revenue) was 86.6% for the month and 92.0% for the fiscal year-to-date.



Administrative Expense

- For the month ended May 31, 2020:
  - Actual Administrative Expense: $9.3 million.
  - Budgeted Administrative Expense: $5.0 million.

- For the fiscal year-to-date ended May 31, 2020:
  - Actual YTD Administrative Expense: $54.1 million.
  - Budgeted YTD Administrative Expense: $55.4 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 %
$2,276,155	$2,726,302	$450,147	16.5%	Employee Expense	$25,782,469	$28,382,754	$2,600,286	9.2%
591,695	561,580	(30,115)	-5.4%	Medical Benefits Admin Expense	6,242,307	6,270,276	27,969	0.4%
556,385	717,235	160,850	22.4%	Purchased & Professional Services	6,466,305	8,783,555	2,317,250	26.4%
5,864,456	979,052	(4,885,405)	-499.0%	Other Admin Expense	15,609,424	11,977,775	(3,631,650)	-30.3%
$9,288,691	$4,984,169	($4,304,523)	-86.4%	Total Administrative Expense	$54,100,505	$55,414,360	$1,313,855	2.4%

- In May 2020 $5.0 million was allocated for the newly created and BOG approved $16.6 million in funding for Safety Net Sustainability. This fund will be used for Public Hospitals, COVID-19 Testing, Health Centers, Primary Care Physicians and other Safety-Net Providers.

- The year-to-date favorable variance is primarily due to:
    - Delay in hiring new staff.
    - Timing of new project start dates and savings in Purchased Services to date.
    - Savings in Licenses and Subscription as the result of the delay in new project starts.
    - Savings in Depreciation / Amortization due to delay in purchasing Capital Assets.
    - Savings in Printing and Postage Activities, resulting from “Go Green Initiative”.

- Administrative expense represented 11.6% of net revenue for the month and 6.1% of net revenue for the year-to-date.

Other Income / (Expense)

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

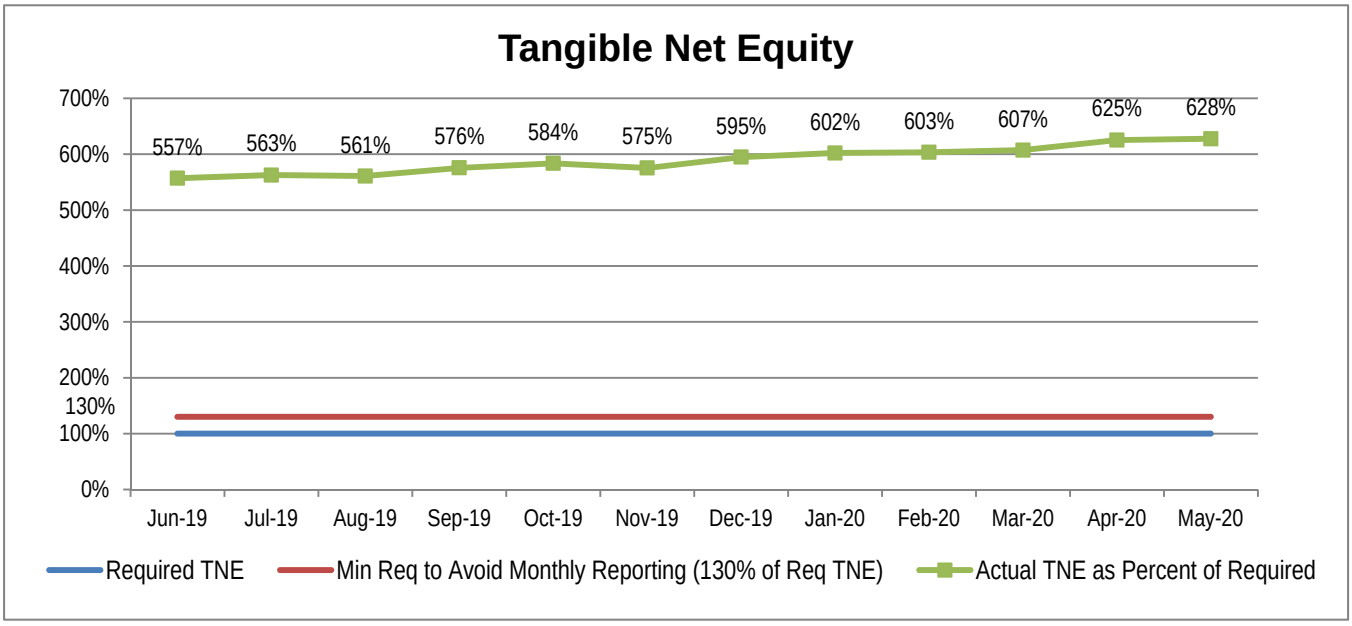
- Fiscal year-to-date interest income from investments is $4.4 million.

- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims or recalculated interest on previously paid claims is $304,000.

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.

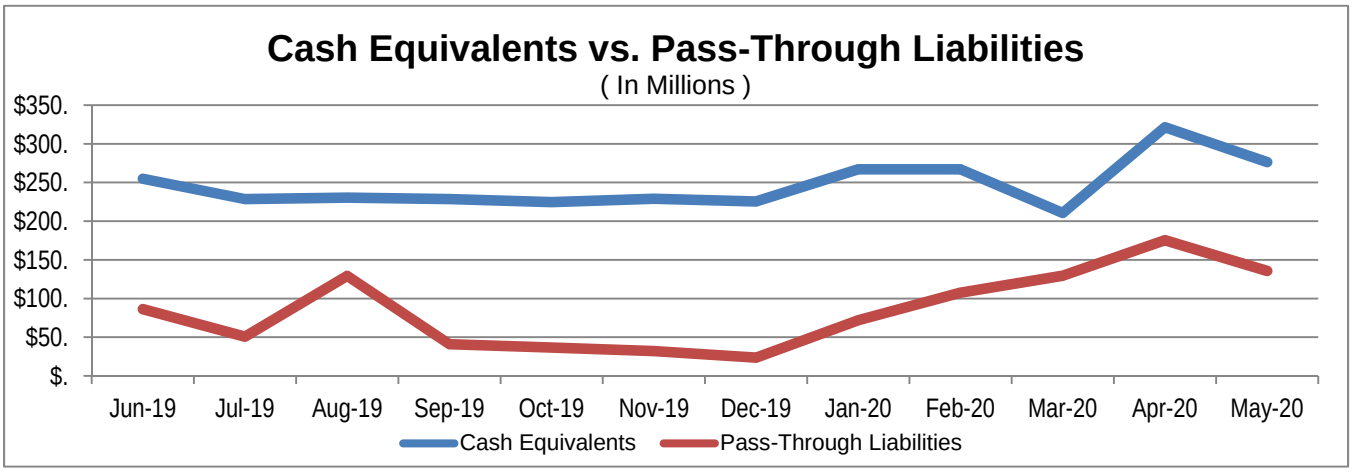
    - Required TNE $32.1 million
    - Actual TNE $201.1 million
    - Excess TNE $169.1 million
    - TNE as % of Required TNE 628%



- Cash and Liabilities reflect pass-through liabilities and an ACA OE MLR accrual. The ACA OE MLR accrual represents funds that are estimated to 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 prior fiscal years.

- 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.

- Key Metrics
    - o Cash & Cash Equivalents $276.3 million
    - o Pass-Through Liabilities $135.6 million
    - o Uncommitted Cash $140.7 million
    - o Working Capital $190.8 million
    - o Current Ratio 1.77 (regulatory minimum is 1.0)



Capital Investment

- Fiscal year-to-date Capital assets acquired: $1.3 million.
- Annual capital budget: $2.5 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 May 31, 2020

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				MEMBERSHIP				
246,676	242,977	3,699	1.5%	1 - Medi-Cal	2,693,989	2,715,777	(21,788)	(0.8%)
6,295	5,976	319	5.3%	2 - Group Care	66,848	65,736	1,112	1.7%
252,971	**248,953**	**4,018**	**1.6%**	**3 - Total Member Months**	**2,760,837**	**2,781,513**	**(20,676)**	**(0.7%)**
				REVENUE				
$79,807,929	**$77,176,651**	**$2,631,278**	**3.4%**	**4 - TOTAL REVENUE**	**$883,781,972**	**$860,688,479**	**$23,093,493**	**2.7%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses:				
16,528,202	16,993,425	465,223	2.7%	5 - Capitated Medical Expense	189,778,398	188,803,810	(974,588)	(0.5%)
				Fee for Service Medical Expenses:				
16,337,575	20,299,772	3,962,197	19.5%	6 - Inpatient Hospital & SNF FFS Expense	217,536,844	226,631,617	9,094,773	4.0%
3,812,118	2,923,354	(888,764)	(30.4%)	7 - Primary Care Physician FFS Expense	50,451,326	32,663,770	(17,787,556)	(54.5%)
3,627,576	3,785,601	158,025	4.2%	8 - Specialty Care Physician Expense	40,852,698	41,992,097	1,139,399	2.7%
4,231,472	3,057,617	(1,173,855)	(38.4%)	9 - Ancillary Medical Expense	35,257,739	34,514,162	(743,577)	(2.2%)
5,673,250	7,297,964	1,624,714	22.3%	10 - Outpatient Medical Expense	77,684,918	79,594,419	1,909,501	2.4%
2,715,503	3,181,122	465,619	14.6%	11 - Emergency Expense	34,758,817	35,431,517	672,700	1.9%
12,674,642	13,065,857	391,215	3.0%	12 - Pharmacy Expense	144,657,921	144,232,062	(425,859)	(0.3%)
49,072,137	53,611,287	4,539,150	8.5%	13 - Total Fee for Service Expense	601,200,264	595,059,644	(6,140,620)	(1.0%)
1,807,676	2,038,654	230,978	11.3%	14 - Other Benefits & Services	19,715,172	20,423,075	707,902	3.5%
135,902	58,035	(77,867)	(134.2%)	15 - Reinsurance Expense	(73,995)	977,128	1,051,123	107.6%
1,583,209	83,208	(1,500,001)	(1,802.7%)	16 - Risk Pool Distribution	2,416,792	916,788	(1,500,004)	(163.6%)
69,127,127	**72,784,609**	**3,657,482**	**5.0%**	**17 - TOTAL MEDICAL EXPENSES**	**813,036,631**	**806,180,445**	**(6,856,186)**	**(0.9%)**
10,680,803	**4,392,042**	**6,288,760**	**143.2%**	**18 - GROSS MARGIN**	**70,745,341**	**54,508,034**	**16,237,307**	**29.8%**
				ADMINISTRATIVE EXPENSES				
2,276,155	2,726,302	450,147	16.5%	19 - Personnel Expense	25,782,469	28,382,754	2,600,284	9.2%
591,695	561,580	(30,115)	(5.4%)	20 - Benefits Administration Expense	6,242,307	6,270,276	27,969	0.4%
556,385	717,235	160,850	22.4%	21 - Purchased & Professional Services	6,466,305	8,783,555	2,317,251	26.4%
5,864,456	979,052	(4,885,404)	(499.0%)	22 - Other Administrative Expense	15,609,424	11,977,775	(3,631,649)	(30.3%)
9,288,691	**4,984,169**	**(4,304,522)**	**(86.4%)**	**23 -Total Administrative Expense**	**54,100,505**	**55,414,360**	**1,313,855**	**2.4%**
1,392,112	**(592,127)**	**1,984,238**	**335.1%**	**24 - NET OPERATING INCOME / (LOSS)**	**16,644,836**	**(906,325)**	**17,551,162**	**1,936.5%**
				OTHER INCOME / EXPENSE				
167,080	**329,167**	**(162,087)**	**(49.2%)**	**25 - Total Other Income / (Expense)**	**3,756,308**	**3,683,932**	**72,376**	**2.0%**
$1,559,192	**($262,960)**	**$1,822,151**	**692.9%**	**26 - NET INCOME / (LOSS)**	**$20,401,144**	**$2,777,607**	**$17,623,538**	**634.5%**
11.6%	6.5%	-5.2%	-80.2%	27 - Admin Exp % of Revenue	6.1%	6.4%	0.3%	4.9%

ALAMEDA ALLIANCE FOR HEALTH
SUMMARY BALANCE SHEET 2020
CURRENT MONTH VS. PRIOR MONTH
May 31, 2020

	May	April	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	$27,357,511	$17,693,108	$9,664,404	54.62%
Short-Term Investments	248,899,855	303,689,274	(54,789,419)	-18.04%
Interest Receivable	11,270	28,617	(17,346)	-60.62%
Other Receivables - Net	152,235,441	144,110,406	8,125,035	5.64%
Prepaid Expenses	4,686,926	5,162,974	(476,048)	-9.22%
Prepaid Inventoried Items	4,642	4,642	0	0.00%
CalPERS Net Pension Asset	107,720	107,720	0	0.00%
Deferred CalPERS Outflow	4,500,150	4,500,150	0	0.00%
TOTAL CURRENT ASSETS	**437,803,516**	**475,296,890**	**(37,493,375)**	**-7.89%**
OTHER ASSETS:				
Restricted Assets	350,000	350,000	0	0.00%
TOTAL OTHER ASSETS	**350,000**	**350,000**	**0**	**0.00%**
PROPERTY AND EQUIPMENT:				
Land, Building & Improvements	9,647,763	9,576,631	71,133	0.74%
Furniture And Equipment	14,617,188	14,289,491	327,697	2.29%
Leasehold Improvement	924,350	924,350	0	0.00%
Internally-Developed Software	16,824,002	16,824,002	0	0.00%
Fixed Assets at Cost	42,013,303	41,614,473	398,830	0.96%
Less: Accumulated Depreciation	(32,016,272)	(31,820,428)	(195,844)	0.62%
NET PROPERTY AND EQUIPMENT	**9,997,030**	**9,794,045**	**202,985**	**2.07%**
TOTAL ASSETS	**$448,150,546**	**$485,440,935**	**($37,290,389)**	**-7.68%**
CURRENT LIABILITIES:				
Accounts Payable	$7,243,542	$3,646,431	$3,597,111	98.65%
Pass-Through Liabilities	135,616,139	175,429,137	(39,812,999)	-22.69%
Claims Payable	18,831,919	19,667,308	(835,389)	-4.25%
IBNP Reserves	74,474,306	77,972,894	(3,498,588)	-4.49%
Payroll Liabilities	3,287,493	3,170,418	117,075	3.69%
CalPERS Deferred Inflow	2,529,197	2,529,197	0	0.00%
Risk Sharing	4,426,729	2,843,520	1,583,209	55.68%
Provider Grants/ New Health Program	592,823	592,823	0	0.00%
TOTAL CURRENT LIABILITIES	**247,002,147**	**285,851,728**	**(38,849,581)**	**-13.59%**
TOTAL LIABILITIES	**247,002,147**	**285,851,728**	**(38,849,581)**	**-13.59%**
NET WORTH:				
Contributed Capital	840,233	840,233	0	0.00%
Restricted & Unrestricted Funds	179,907,022	179,907,022	0	0.00%
Year-to Date Net Income / (Loss)	20,401,144	18,841,952	1,559,192	8.28%
TOTAL NET WORTH	**201,148,399**	**199,589,207**	**1,559,192**	**0.78%**
TOTAL LIABILITIES AND NET WORTH	**$448,150,546**	**$485,440,935**	**($37,290,389)**	**-7.68%**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 5/31/2020

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received From:				
Capitation Received from State of CA	$69,643,202	$220,151,593	$411,778,073	$891,402,251
Commercial Premium Revenue	2,140,955	6,319,736	12,502,659	22,819,228
Other Income	441,220	1,566,181	3,716,743	5,216,842
Investment Income	270,017	1,006,545	2,085,848	4,691,039
Cash Paid To:				
Medical Expenses	(72,468,429)	(229,030,421)	(454,742,133)	(815,196,030)
Vendor & Employee Expenses	(4,940,152)	(18,169,104)	(31,041,707)	(52,801,219)
Interest Paid	0	0	0	0
Net Cash Provided By (Used In) Operating Activities	(4,913,187)	(18,155,470)	(55,700,517)	56,132,111
Cash Flows from Financing Activities:				
Purchases of Fixed Assets	(398,830)	(686,876)	(865,168)	(1,250,374)
Net Cash Provided By (Used In) Financing Activities	(398,830)	(686,876)	(865,168)	(1,250,374)
Cash Flows from Investing Activities:				
Changes in Investments	0	0	0	0
Restricted Cash	(39,812,999)	28,113,187	103,929,850	(33,466,663)
Net Cash Provided By (Used In) Investing Activities	(39,812,999)	28,113,187	103,929,850	(33,466,663)
Financial Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Net Change in Cash	**(45,125,016)**	**9,270,841**	**47,364,165**	**21,415,074**
Cash @ Beginning of Period	321,382,381	266,986,524	228,893,202	254,842,294
Subtotal	$276,257,365	$276,257,365	$276,257,367	$276,257,368
Rounding	1	1	(1)	(2)
Cash @ End of Period	**$276,257,366**	**$276,257,366**	**$276,257,366**	**$276,257,366**
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	$1,559,192	$4,515,474	$10,805,406	$20,401,144
Depreciation	195,844	565,075	1,109,071	1,996,552
Net Change in Operating Assets & Liabilities:				
Premium & Other Receivables	(8,107,689)	(10,099,606)	(53,384,316)	37,164,692
Prepaid Expenses	476,048	(524,905)	(866,422)	(450,994)
Trade Payables	3,597,111	53,389	890,290	(356,987)
Claims payable & IBNP	(2,750,768)	(12,767,538)	(14,427,844)	(2,528,698)
Deferred Revenue	0	0	0	0
Accrued Interest	0	0	0	0
Other Liabilities	117,075	102,642	173,298	(93,599)
Subtotal	(4,913,187)	(18,155,469)	(55,700,517)	56,132,110
Rounding	0	(1)	0	1
Cash Flows from Operating Activities	**($4,913,187)**	**($18,155,470)**	**($55,700,517)**	**$56,132,111**
Rounding Difference	0	(1)	0	1

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 5/31/2020

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$2,140,955	$6,319,736	$12,502,659	$22,819,228
Total	2,140,955	6,319,736	12,502,659	22,819,228
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	77,177,703	230,942,310	464,633,947	855,227,413
Allowance for Doubtful Accounts	0	0	0	0
Deferred Premium Revenue	0	0	0	0
Premium Receivable	(7,534,501)	(10,790,717)	(52,855,874)	36,174,838
Total	69,643,202	220,151,593	411,778,073	891,402,251
Investment & Other Income Cash Flows				
Other Revenue (Grants)	441,220	1,566,181	3,716,743	5,216,842
Interest Income	252,671	962,051	2,064,992	4,578,504
Interest Receivable	17,346	44,494	20,856	112,535
Total	711,237	2,572,726	5,802,591	9,907,881
Medical & Hospital Cash Flows				
Total Medical Expenses	(69,127,127)	(216,840,750)	(439,489,991)	(813,036,631)
Other Receivable	(590,534)	646,617	(549,298)	877,319
Claims Payable	(835,389)	4,056,180	2,554,886	9,531,612
IBNP Payable	(3,498,588)	(18,573,345)	(18,979,729)	(11,688,420)
Risk Share Payable	1,583,209	1,749,627	1,997,000	(371,890)
Health Program	0	(68,750)	(275,000)	(508,020)
Other Liabilities	0	0	(1)	0
Total	(72,468,429)	(229,030,421)	(454,742,133)	(815,196,030)
Administrative Cash Flows				
Total Administrative Expenses	(9,326,230)	(18,434,055)	(32,622,944)	(54,404,211)
Prepaid Expenses	476,048	(524,905)	(866,422)	(450,994)
CalPERS Pension Asset	0	0	0	0
CalPERS Deferred Outflow	0	0	0	0
Trade Accounts Payable	3,597,111	53,389	890,290	(356,987)
Other Accrued Liabilities	0	0	0	0
Payroll Liabilities	117,075	171,392	448,298	414,421
Depreciation Expense	195,844	565,075	1,109,071	1,996,552
Total	(4,940,152)	(18,169,104)	(31,041,707)	(52,801,219)
Interest Paid				
Debt Interest Expense	0	0	0	0
Total Cash Flows from Operating Activities	**(4,913,187)**	**(18,155,470)**	**(55,700,517)**	**56,132,111**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 5/31/2020

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Restricted Cash & Other Asset Cash Flows				
Provider Pass-Thru-Liabilities	(39,812,999)	28,112,949	103,580,977	(33,463,590)
Restricted Cash	0	238	348,873	(3,073)
	(39,812,999)	28,113,187	103,929,850	(33,466,663)
Fixed Asset Cash Flows				
Depreciation expense	195,844	565,075	1,109,071	1,996,552
Fixed Asset Acquisitions	(398,830)	(686,876)	(865,168)	(1,250,374)
Change in A/D	(195,844)	(565,075)	(1,109,071)	(1,996,552)
	(398,830)	(686,876)	(865,168)	(1,250,374)
Total Cash Flows from Investing Activities	**(40,211,829)**	**27,426,311**	**103,064,682**	**(34,717,037)**
Financing Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Total Cash Flows	**(45,125,016)**	**9,270,841**	**47,364,165**	**21,415,074**
Rounding	1	1	(1)	(2)
Cash @ Beginning of Period	321,382,381	266,986,524	228,893,202	254,842,294
Cash @ End of Period	**$276,257,366**	**$276,257,366**	**$276,257,366**	**$276,257,366**
Difference (rounding)	0	0	0	0

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 5/31/2020

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$1,559,192	$4,515,474	$10,805,406	$20,401,144
Add back: Depreciation	195,844	565,075	1,109,071	1,996,552
Receivables				
Premiums Receivable	(7,534,501)	(10,790,717)	(52,855,874)	36,174,838
First Care Receivable	0	0	0	0
Family Care Receivable	0	0	0	0
Healthy Kids Receivable	0	0	0	0
Interest Receivable	17,346	44,494	20,856	112,535
Other Receivable	(590,534)	646,617	(549,298)	877,319
FQHC Receivable	0	0	0	0
Allowance for Doubtful Accounts	0	0	0	0
Total	(8,107,689)	(10,099,606)	(53,384,316)	37,164,692
Prepaid Expenses	476,048	(524,905)	(866,422)	(450,994)
Trade Payables	3,597,111	53,389	890,290	(356,987)
Claims Payable, IBNR & Risk Share				
IBNP	(3,498,588)	(18,573,345)	(18,979,729)	(11,688,420)
Claims Payable	(835,389)	4,056,180	2,554,886	9,531,612
Risk Share Payable	1,583,209	1,749,627	1,997,000	(371,890)
Other Liabilities	0	0	(1)	0
Total	(2,750,768)	(12,767,538)	(14,427,844)	(2,528,698)
Unearned Revenue				
Total	0	0	0	0
Other Liabilities				
Accrued Expenses	0	0	0	0
Payroll Liabilities	117,075	171,392	448,298	414,421
Health Program	0	(68,750)	(275,000)	(508,020)
Accrued Sub Debt Interest	0	0	0	0
Total Change in Other Liabilities	117,075	102,642	173,298	(93,599)
Cash Flows from Operating Activities	**($4,913,187)**	**($18,155,469)**	**($55,700,517)**	**$56,132,110**
Difference (rounding)	0	1	0	(1)

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE CURRENT MONTH - MAY 2020

	Child	Adults	Medi-Cal SPD	ACA OE	Duals	Medi-Cal Total	Group Care	Grand Total
Enrollment	89,755	33,229	25,985	79,736	17,971	246,676	6,295	252,971
Net Revenue	$10,407,684	$10,459,660	$25,151,861	$28,668,755	$2,979,246	$77,667,206	$2,140,723	$79,807,929
Medical Expense	$8,827,298	$8,881,881	$20,205,633	$27,342,847	$2,339,936	$67,597,594	$1,529,532	$69,127,127
Gross Margin	$1,580,387	$1,577,779	$4,946,228	$1,325,908	$639,310	$10,069,612	$611,191	$10,680,803
Administrative Expense	$710,104	$1,298,042	$3,347,574	$3,346,798	$311,291	$9,013,810	$274,881	$9,288,691
Operating Income / (Expense)	$870,282	$279,736	$1,598,655	($2,020,890)	$328,019	$1,055,802	$336,309	$1,392,112
Other Income / (Expense)	$7,472	$24,183	$65,543	$60,000	$5,763	$162,961	$4,119	$167,080
Net Income / (Loss)	$877,755	$303,919	$1,664,198	($1,960,890)	$333,782	$1,218,763	$340,429	$1,559,192
Revenue PMPM	$115.96	$314.78	$967.94	$359.55	$165.78	$314.86	$340.07	$315.48
Medical Expense PMPM	$98.35	$267.29	$777.59	$342.92	$130.21	$274.03	$242.98	$273.26
Gross Margin PMPM	$17.61	$47.48	$190.35	$16.63	$35.57	$40.82	$97.09	$42.22
Administrative Expense PMPM	$7.91	$39.06	$128.83	$41.97	$17.32	$36.54	$43.67	$36.72
Operating Income / (Expense) PMPM	$9.70	$8.42	$61.52	($25.34)	$18.25	$4.28	$53.42	$5.50
Other Income / (Expense) PMPM	$0.08	$0.73	$2.52	$0.75	$0.32	$0.66	$0.65	$0.66
Net Income / (Loss) PMPM	$9.78	$9.15	$64.04	($24.59)	$18.57	$4.94	$54.08	$6.16
Medical Loss Ratio	84.8%	84.9%	80.3%	95.4%	78.5%	87.0%	71.4%	86.6%
Gross Margin Ratio	15.2%	15.1%	19.7%	4.6%	21.5%	13.0%	28.6%	13.4%
Administrative Expense Ratio	6.8%	12.4%	13.3%	11.7%	10.4%	11.6%	12.8%	11.6%
Net Income Ratio	8.4%	2.9%	6.6%	-6.8%	11.2%	1.6%	15.9%	2.0%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR-TO-DATE - MAY 2020

	Medi-Cal					Medi-Cal	Group	Grand
	Child	Adults	SPD	ACA OE	Duals	Total	Care	Total
Member Months	987,435	358,331	283,494	869,191	195,538	2,693,989	66,848	2,760,837
Net Revenue	$119,348,231	$116,690,216	$276,248,180	$315,815,665	$32,838,082	$860,940,374	$22,841,598	$883,781,972
Medical Expense	$104,327,646	$109,484,264	$260,414,380	$289,273,248	$28,019,437	$791,518,975	$21,517,655	$813,036,631
Gross Margin	$15,020,585	$7,205,951	$15,833,800	$26,542,417	$4,818,646	$69,421,398	$1,323,944	$70,745,341
Administrative Expense	$4,866,048	$7,388,507	$18,753,295	$19,554,915	$1,800,287	$52,363,052	$1,737,453	$54,100,505
Operating Income / (Expense)	$10,154,537	($182,556)	($2,919,495)	$6,987,502	$3,018,359	$17,058,347	($413,509)	$16,644,836
Other Income / (Expense)	$308,562	$518,169	$1,323,017	$1,383,389	$112,377	$3,645,514	$110,793	$3,756,308
Net Income / (Loss)	$10,463,099	$335,613	($1,596,478)	$8,370,891	$3,130,736	$20,703,861	($302,716)	$20,401,144
Revenue PMPM	$120.87	$325.65	$974.44	$363.34	$167.94	$319.58	$341.69	$320.11
Medical Expense PMPM	$105.66	$305.54	$918.59	$332.81	$143.29	$293.81	$321.89	$294.49
Gross Margin PMPM	$15.21	$20.11	$55.85	$30.54	$24.64	$25.77	$19.81	$25.62
Administrative Expense PMPM	$4.93	$20.62	$66.15	$22.50	$9.21	$19.44	$25.99	$19.60
Operating Income / (Expense) PMPM	$10.28	($0.51)	($10.30)	$8.04	$15.44	$6.33	($6.19)	$6.03
Other Income / (Expense) PMPM	$0.31	$1.45	$4.67	$1.59	$0.57	$1.35	$1.66	$1.36
Net Income / (Loss) PMPM	$10.60	$0.94	($5.63)	$9.63	$16.01	$7.69	($4.53)	$7.39
Medical Loss Ratio	87.4%	93.8%	94.3%	91.6%	85.3%	91.9%	94.2%	92.0%
Gross Margin Ratio	12.6%	6.2%	5.7%	8.4%	14.7%	8.1%	5.8%	8.0%
Administrative Expense Ratio	4.1%	6.3%	6.8%	6.2%	5.5%	6.1%	7.6%	6.1%
Net Income Ratio	8.8%	0.3%	-0.6%	2.7%	9.5%	2.4%	-1.3%	2.3%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED May 31, 2020

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSE SUMMARY				
$2,276,155	$2,726,302	$450,147	16.5%	Personnel Expenses	$25,782,469	$28,382,754	$2,600,284	9.2%
591,695	561,580	(30,115)	(5.4%)	Benefits Administration Expense	6,242,307	6,270,276	27,969	0.4%
556,385	717,235	160,850	22.4%	Purchased & Professional Services	6,466,305	8,783,555	2,317,251	26.4%
400,459	369,815	(30,643)	(8.3%)	Occupancy	3,986,334	4,089,946	103,612	2.5%
5,028,055	97,535	(4,930,520)	(5,055.1%)	Printing Postage & Promotion	6,688,737	1,940,494	(4,748,244)	(244.7%)
401,134	481,800	80,666	16.7%	Licenses Insurance & Fees	4,682,526	5,670,387	987,862	17.4%
34,809	29,901	(4,908)	(16.4%)	Supplies & Other Expenses	251,827	276,948	25,121	9.1%
7,012,536	2,257,867	(4,754,670)	(210.6%)	Total Other Administrative Expense	28,318,035	27,031,606	(1,286,429)	(4.8%)
$9,288,691	**$4,984,169**	**($4,304,522)**	**(86.4%)**	**Total Administrative Expenses**	**$54,100,505**	**$55,414,360**	**$1,313,855**	**2.4%**

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ADMIN YTD 2020
06/23/20
REPORT #6

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED May 31, 2020

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
$1,605,330	$1,732,987	$127,657	7.4%	Salaries & Wages	$17,072,690	$17,686,562	$613,871	3.5%
151,055	183,526	32,471	17.7%	Paid Time Off	1,554,577	1,788,249	233,671	13.1%
720	7,488	6,768	90.4%	Incentives	12,221	79,888	67,667	84.7%
0	329	329	100.0%	Employee of the Month	1,075	3,290	2,215	67.3%
0	0	0	0.0%	Severance Pay	20,147	0	(20,147)	0.0%
24,227	28,078	3,850	13.7%	Payroll Taxes	358,964	464,374	105,411	22.7%
27,838	8,365	(19,473)	(232.8%)	Overtime	184,396	110,863	(73,534)	(66.3%)
119,609	146,441	26,831	18.3%	CalPERS ER Match	1,299,330	1,481,929	182,599	12.3%
3,201	0	(3,201)	0.0%	Sick Leave Pay	3,201	0	(3,201)	0.0%
289,614	550,892	261,279	47.4%	Employee Benefits	4,269,669	5,216,540	946,872	18.2%
283	0	(283)	0.0%	Personal Floating Holiday	75,441	85,010	9,569	11.3%
0	0	0	0.0%	Premium Hour Pay	617	0	(617)	0.0%
1,487	5,274	3,787	71.8%	Employee Relations	91,574	143,584	52,010	36.2%
0	1,671	1,671	100.0%	Transportation Reimbursement	13,124	22,541	9,416	41.8%
3,285	7,720	4,435	57.4%	Travel & Lodging	45,298	118,200	72,902	61.7%
28,260	0	(28,260)	0.0%	Temporary Help Services	280,243	334,068	53,825	16.1%
12,981	43,090	30,108	69.9%	Staff Development/Training	292,694	584,711	292,017	49.9%
8,264	10,442	2,178	20.9%	Staff Recruitment/Advertising	207,208	262,946	55,738	21.2%
2,276,155	**2,726,302**	**450,147**	**16.5%**	**Total Employee Expenses**	**25,782,469**	**28,382,754**	**2,600,284**	**9.2%**
				Benefit Administration Expense				
351,611	349,769	(1,843)	(0.5%)	RX Administration Expense	3,971,795	3,902,046	(69,749)	(1.8%)
224,781	211,811	(12,970)	(6.1%)	Behavioral Hlth Administration Fees	2,255,210	2,368,230	113,020	4.8%
15,303	0	(15,303)	0.0%	Telemedicine Admin Fees	15,303	0	(15,303)	0.0%
591,695	**561,580**	**(30,115)**	**(5.4%)**	**Total Employee Expenses**	**6,242,307**	**6,270,276**	**27,969**	**0.4%**
				Purchased & Professional Services				
108,603	283,537	174,934	61.7%	Consulting Services	2,238,030	3,828,459	1,590,429	41.5%
325,997	286,457	(39,539)	(13.8%)	Computer Support Services	2,587,278	3,232,842	645,564	20.0%
8,750	9,200	450	4.9%	Professional Fees-Accounting	96,250	113,750	17,500	15.4%
0	0	0	0.0%	Professional Fees-Medical	552	0	(552)	0.0%
35,239	66,123	30,885	46.7%	Other Purchased Services	448,525	792,887	344,362	43.4%
10,293	6,369	(3,924)	(61.6%)	Maint.& Repair-Office Equipment	77,571	78,164	593	0.8%
32,410	0	(32,410)	0.0%	HMS Recovery Fees	404,753	0	(404,753)	0.0%
0	0	0	0.0%	MIS Software (Non-Capital)	295	4,140	3,845	92.9%
1,803	3,000	1,197	39.9%	Hardware (Non-Capital)	38,274	40,211	1,937	4.8%
6,473	7,548	1,075	14.2%	Provider Relations-Credentialing	70,415	82,601	12,186	14.8%
26,819	55,000	28,181	51.2%	Legal Fees	504,361	610,500	106,139	17.4%
556,385	**717,235**	**160,850**	**22.4%**	**Total Purchased & Professional Services**	**6,466,305**	**8,783,555**	**2,317,251**	**26.4%**
				Occupancy				
169,737	187,595	17,858	9.5%	Depreciation	1,709,370	1,852,844	143,474	7.7%
26,107	26,107	0	0.0%	Amortization	287,182	395,997	108,815	27.5%
64,854	72,184	7,330	10.2%	Building Lease	696,921	704,251	7,330	1.0%
2,772	3,161	389	12.3%	Leased and Rented Office Equipment	33,802	34,794	993	2.9%
10,179	16,664	6,485	38.9%	Utilities	142,332	171,443	29,111	17.0%

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ADMIN YTD 2020
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REPORT #6

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED May 31, 2020

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
$95,824	$48,870	($46,954)	(96.1%)	Telephone	$954,994	$755,091	($199,903)	(26.5%)
30,985	15,234	(15,751)	(103.4%)	Building Maintenance	161,734	175,525	13,792	7.9%
400,459	**369,815**	**(30,643)**	**(8.3%)**	**Total Occupancy**	**3,986,334**	**4,089,946**	**103,612**	**2.5%**
				Printing Postage & Promotion				
11	31,344	31,332	100.0%	Postage	290,392	453,443	163,051	36.0%
0	3,300	3,300	100.0%	Design & Layout	28,520	51,500	22,980	44.6%
2,339	31,700	29,361	92.6%	Printing Services	415,174	537,100	121,926	22.7%
0	4,500	4,500	100.0%	Mailing Services	39,663	49,500	9,837	19.9%
1,708	2,700	992	36.7%	Courier/Delivery Service	28,610	32,493	3,882	11.9%
17	175	158	90.4%	Pre-Printed Materials and Publications	1,599	8,474	6,875	81.1%
3,390	0	(3,390)	0.0%	Promotional Products	7,100	44,500	37,400	84.0%
0	100	100	100.0%	Promotional Services	0	6,100	6,100	100.0%
5,015,000	19,917	(4,995,083)	(25,079.9%)	Community Relations	5,806,976	690,783	(5,116,192)	(740.6%)
62	0	(62)	0.0%	Health Education-Member	0	0	0	0.0%
5,528	3,800	(1,728)	(45.5%)	Translation - Non-Clinical	70,702	66,600	(4,102)	(6.2%)
5,028,055	**97,535**	**(4,930,520)**	**(5,055.1%)**	**Total Printing Postage & Promotion**	**6,688,737**	**1,940,494**	**(4,748,244)**	**(244.7%)**
				Licenses Insurance & Fees				
0	0	0	0.0%	Regulatory Penalties	0	187,500	187,500	100.0%
14,662	20,700	6,038	29.2%	Bank Fees	192,535	226,932	34,397	15.2%
48,446	49,154	708	1.4%	Insurance	532,902	540,694	7,792	1.4%
306,952	347,136	40,184	11.6%	Licenses, Permits and Fees	3,290,193	3,873,582	583,389	15.1%
31,075	64,810	33,736	52.1%	Subscriptions & Dues	666,896	841,680	174,784	20.8%
401,134	**481,800**	**80,666**	**16.7%**	**Total Licenses Insurance & Postage**	**4,682,526**	**5,670,387**	**987,862**	**17.4%**
				Supplies & Other Expenses				
5,046	8,350	3,304	39.6%	Office and Other Supplies	61,212	88,750	27,538	31.0%
620	1,375	755	54.9%	Ergonomic Supplies	11,996	23,125	11,129	48.1%
1,226	19,476	18,250	93.7%	Commissary-Food & Beverage	62,789	118,873	56,084	47.2%
0	700	700	100.0%	Member Incentive Expense	14,665	46,200	31,535	68.3%
2,039	0	(2,039)	0.0%	Covid-19 IT Expenses	62,109	0	(62,109)	0.0%
25,877	0	(25,877)	0.0%	Covid-19 Non IT Expenses	39,056	0	(39,056)	0.0%
34,809	**29,901**	**(4,908)**	**(16.4%)**	**Total Supplies & Other Expense**	**251,827**	**276,948**	**25,121**	**9.1%**
$9,288,691	**$4,984,169**	**($4,304,522)**	**(86.4%)**	**TOTAL ADMINISTRATIVE EXPENSE**	**$54,100,505**	**$55,414,360**	**$1,313,855**	**2.4%**

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ADMIN YTD 2020
06/23/20
REPORT #6

ALAMEDA ALLIANCE FOR HEALTH
CAPITAL SPENDING INCLUDING CONSTRUCTION-IN-PROCESS
ACTUAL VS. BUDGET
FOR THE FISCAL YEAR-TO-DATE ENDED MAY 31, 2020

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Laptops	IT-FY20-01	$ 76,405		**$ 76,405**	$ 60,000	$ (16,405)
	Tablets, Surfaces, Macs	IT-FY20-02	$ -		**$ -**	$ 30,000	$ 30,000
	Monitors-(Dual per User)	IT-FY20-03	$ 67,652	$ (3,129)	**$ 64,523**	$ 33,971	$ (30,552)
	Cisco IP Phone	IT-FY20-04	$ -	$ 16,483	**$ 16,483**	$ 20,000	$ 3,517
	Conference Phones	IT-FY20-05	$ -	$ 10,000	**$ 10,000**	$ 10,000	$ -
	Cage Equipment (Racks, Bins, Tools)	IT-FY20-06	$ -	$ 10,000	**$ 10,000**	$ 10,000	$ -
	Data Center Equipment (Cables, Interface cards, KVM)	IT-FY20-07	$ -		**$ -**	$ 10,000	$ 10,000
	Headsets (Wired and Wireless)	IT-FY20-08	$ 4,286		**$ 4,286**	$ 20,000	$ 15,714
	Docking Stations	IT-FY20-09	$ 24,328		**$ 24,328**	$ 20,000	$ (4,328)
	Desk Tops	IT-FY20-10	$ 76,823		**$ 76,823**	$ 112,000	$ 35,177
	Cisco UCS Blade Servers	IT-FY20-11	$ 99,906		**$ 99,906**	$ 150,000	$ 50,094
	Veeam Backup (Additional Shelf)	IT-FY20-12	$ 31,015	$ 5,324	**$ 36,339**	$ 50,000	$ 13,661
	Pure Storage Upgrade (Additional Shelf)	IT-FY20-13	$ -	$ 90,000	**$ 90,000**	$ 90,000	$ -
	DLP Hardware (Security - Data Loss Prevention)	IT-FY20-14	$ -	$ 93,930	**$ 93,930**	$ 160,000	$ 66,070
	Cisco Networking Equipment Upgrades (DR)	IT-FY20-15	$ 76,128		**$ 76,128**	$ 50,000	$ (26,128)
	Cisco Wireless Access Points	IT-FY20-16	$ -	$ 5,748	**$ 5,748**	$ 20,000	$ 14,252
	Network Cabling (Moves, Construction Projects)	IT-FY20-17	$ 51,076	$ 84,890	**$ 135,967**	$ 150,000	$ 14,033
	Conference Room Upgrades (Projectors / Flat Screen)	IT-FY20-18	$ 41,660		**$ 41,660**	$ 30,000	$ (11,660)
	Keyboards, Mouse, Speakers	IT-FY20-19	$ (5,346)	$ 12,490	**$ 7,144**	$ 50,000	$ 42,856
	Unplanned Hardware	IT-FY20-20	$ -		**$ -**	$ -	$ -
	Carryover from FY19	IT-FY20-21	$ 26,887		**$ 26,887**	$ -	$ (26,887)
Hardware Subtotal			**$ 570,820**	**$ 325,736**	**$ 896,556**	**$ 1,075,971**	**$ 179,415**
2. Software:							
	Service Now (New Ticketing System)	AC-FY20-01	$ -		**$ -**	$ -	$ -
	IBM (HealthSuite) Backup Solution	AC-FY20-02	$ 118,767		**$ 118,767**	$ 130,000	$ 11,233
	Veeam Backup Licenses (for new backup shelf)	AC-FY20-03	$ -		**$ -**	$ -	$ -
	Computer Imaging Software	AC-FY20-04	$ -		**$ -**	$ 3,000	$ 3,000
	Window VDI	AC-FY20-05	$ -		**$ -**	$ 10,000	$ 10,000
	Windows Server OS (2nd payment)	AC-FY20-06	$ -		**$ -**	$ 80,000	$ 80,000
	Calabrio (Version Upgrade)	AC-FY20-07	$ -		**$ -**	$ -	$ -
	Cisco Alien Vault (Security - Anti-Virus)	AC-FY20-08	$ -		**$ -**	$ 40,000	$ 40,000
	File Access Monitoring (Security)	AC-FY20-09	$ -		**$ -**	$ 20,000	$ 20,000
	Application Monitoring Software	AC-FY20-10	$ -		**$ -**	$ -	$ -
	Microsoft Office 365	AC-FY20-11	$ -		**$ -**	$ -	$ -
	VMWare NSX Data Center (Extending Network)	AC-FY20-12	$ -		**$ -**	$ 100,000	$ 100,000
	VMWare vRealize (Monitoring)	AC-FY20-13	$ -		**$ -**	$ 50,000	$ 50,000
	VMWare Licensing (for new blades)	AC-FY20-14	$ -		**$ -**	$ -	$ -
	Carryover from FY19 / unplanned	AC-FY20-15	$ -		**$ -**	$ -	$ -
Software Subtotal			**$ 118,767**	**$ -**	**$ 118,767**	**$ 433,000**	**$ 314,233**
3. Building Improvement:							
	1240 HVAC - Air Balance Trane 50 Ton & 400K Furnace unit, 42 VAV boxes, 6 AC package units, and 2 AC split systems	FA-FY20-01	$ -		**$ -**	$ 30,000	$ 30,000
	ACME Security Readers, Cameras, Doors, HD Boxes, if needed or repairs	FA-FY20-02	$ -		**$ -**	$ 20,000	$ 20,000

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
	Appliances over 1K for 1240, 1320 all suites, if needed to be replaced	FA-FY20-03	$ -		**$ -**	$ 5,000	$ 5,000
	Red Hawk Full Fire Equipment upgrades (carryover from FY19)	FA-FY20-04	$ -		**$ -**	$ 45,000	$ 45,000
	Electrical work for projects, cube re-orgs/requirements, repairs (interior/exterior)	FA-FY20-05	$ -		**$ -**	$ 20,000	$ 20,000
	Construction (projects ad hoc, patch/paint)	FA-FY20-06	$ 6,855	$ 30,145	**$ 37,000**	$ 20,000	$ (17,000)
	Seismic Improvements (as per Seismic Evaluation reports)	FA-FY20-07	$ -		**$ -**	$ 150,000	$ 150,000
	ACME Security Readers, Cameras, Doors, HD Boxes, if needed or repairs	FA-FY20-08	$ -		**$ -**	$ -	$ -
	ACME Badge printer, supplies, sofwares/extra security (est.)	FA-FY20-09	$ -		**$ -**	$ 80,000	$ 80,000
	Red Hawk Full Fire Equipment upgrades (est.)	FA-FY20-10	$ -		**$ -**	$ -	$ -
	Appliances over 1K for 1240, 1320 all suites, if needed to be replaced	FA-FY20-11	$ -		**$ -**	$ -	$ -
	Upgrade the Symmetry system	FA-FY20-12	$ -		**$ -**	$ -	$ -
	1240 Lighting: sensors, energy efficient bulbs (est.)	FA-FY20-13	$ -		**$ -**	$ -	$ -
	1240 (3) Water heater replacements (est.)	FA-FY20-14	$ -		**$ -**	$ -	$ -
	Unplanned Building Improvements	FA-FY20-15	$ 1,316		**$ 1,316**	$ -	$ (1,316)
	Carryover from FY19	FA-FY20-16	$ 32,082	$ 1,330	**$ 33,412**	$ -	$ (33,412)
Building Improvement Subtotal			**$ 40,253**	**$ 31,475**	**$ 71,727**	**$ 370,000**	**$ 298,273**
4. Furniture & Equipment:							
	Office Desks, cabinets, box files/ shelves old/broken	FA-FY20-17	$ 14,373		**$ 14,373**	$ 100,000	$ 85,627
	Reconfigure Cubicles and Workstations (MS area)	FA-FY20-18	$ 6,700	$ 41,619	**$ 48,319**	$ 250,000	$ 201,681
	Facilities/Warehouse Shelvings, for re-organization	FA-FY20-19	$ -		**$ -**	$ 35,000	$ 35,000
	Mailroom shelvings, re-organization	FA-FY20-20	$ 2,509		**$ 2,509**	$ 5,000	$ 2,491
	Varidesks/ Ergotrons - Ergo	FA-FY20-21	$ 11,787		**$ 11,787**	$ 30,000	$ 18,213
	Tasks Chairs : Various sizes, special order or for Ergo	FA-FY20-22	$ 15,568		**$ 15,568**	$ 20,000	$ 4,432
	Electrical work (projects, cubes, ad hoc requests)	FA-FY20-23	$ 32,295		**$ 32,295**	$ -	$ (32,295)
	Carryover from FY19 / unplanned	FA-FY20-24	$ 8,773		**$ 8,773**	$ -	$ (8,773)
Furniture & Equipment Subtotal			**$ 92,006**	**$ 41,619**	**$ 133,625**	**$ 440,000**	**$ 306,375**
5. Leasehold Improvement:							
	1320, Suite 100 Carpet Replacement & Paint (est.)	FA-FY20-25	$ -		**$ -**	$ 80,000	$ 80,000
	1320, Suite 100 Construction, Kitchenette renovation	FA-FY20-26	$ 29,700		**$ 29,700**	$ 45,000	$ 15,300
	1320, Suite 100 Patch/paint, Kitchenette renovation	FA-FY20-27	$ -		**$ -**	$ 5,000	$ 5,000
	Carryover from FY19 / unplanned	FA-FY20-28	$ -		**$ -**	$ 40,000	$ 40,000
Leasehold Improvement Subtotal			**$ 29,700**	**$ -**	**$ 29,700**	**$ 170,000**	**$ 140,300**
6. Contingency:							
	Contingency	FA-FY20-29	$ -		**$ -**	$ -	$ -
	Emergency Kits Reorder	FA-FY20-30	$ -		**$ -**	$ -	$ -
	Shelving for Cage (vendor: Uline)	FA-FY20-31	$ -		**$ -**	$ -	$ -
Contingency Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
GRAND TOTAL			**$ 851,545**	**$ 398,830**	**$ 1,250,375**	**$ 2,488,971**	**$ 1,238,596**

7. Reconciliation to Balance Sheet:

Fixed Assets @ Cost -5/30/20	**$ 42,013,303**
Fixed Assets @ Cost - 6/30/19	**$ 40,762,929**
Fixed Assets Acquired YTD	**$ 1,250,375**

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
SUMMARY - FISCAL YEAR 2020

TANGIBLE NET EQUITY (TNE)	Jul-19	Aug-19	QTR. END Sep-19	Oct-19	Nov-19	QTR. END Dec-19	Jan-20	Feb-20	QTR. END Mar-20	Apr-20	May-20
Current Month Net Income / (Loss)	$2,270,904	($77,046)	$3,868,398	$3,554,356	($20,873)	$5,353,309	$449,148	$487,474	$2,791,999	$164,283	$1,559,192
YTD Net Income / (Loss)	$2,270,904	$2,193,857	$6,062,255	$9,616,612	$9,595,739	$14,949,048	$15,398,196	$15,885,670	$18,677,670	$18,841,952	$20,401,144
Actual TNE											
Net Assets	$183,018,159	$182,941,112	$186,809,510	$190,363,867	$190,342,994	$195,696,303	$196,145,451	$196,632,925	$199,424,924	$199,589,207	$201,148,399
Subordinated Debt & Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Actual TNE	**$183,018,159**	**$182,941,112**	**$186,809,510**	**$190,363,867**	**$190,342,994**	**$195,696,303**	**$196,145,451**	**$196,632,925**	**$199,424,924**	**$199,589,207**	**$201,148,399**
Increase/(Decrease) in Actual TNE	$2,270,904	($77,047)	$3,868,398	$3,554,357	($20,873)	$5,353,309	$449,148	$487,474	$2,791,999	$164,283	$1,559,192
Required TNE[(1)]	**$32,534,362**	**$32,625,189**	**$32,459,945**	**$32,622,756**	**$33,091,414**	**$32,903,837**	**$32,583,278**	**$32,592,862**	**$32,844,736**	**$31,923,063**	**$32,054,813**
Min. Req'd to Avoid Monthly Reporting (130% of Required TNE)	$42,294,671	$42,412,745	$42,197,929	$42,409,583	$43,018,838	$42,774,988	$42,358,262	$42,370,720	$42,698,157	$41,499,982	$41,671,256
TNE Excess / (Deficiency)	$150,483,797	$150,315,923	$154,349,565	$157,741,111	$157,251,580	$162,792,466	$163,562,173	$164,040,063	$166,580,188	$167,666,144	$169,093,586
Actual TNE as a Multiple of Required	**5.63**	**5.61**	**5.76**	**5.84**	**5.75**	**5.95**	**6.02**	**6.03**	**6.07**	**6.25**	**6.28**

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	$183,018,159	$182,941,112	$186,809,510	$190,363,867	$190,342,994	$195,696,303	$196,145,451	$196,632,925	$199,424,924	$199,589,207	$201,148,399
Fixed Assets at Net Book Value	(10,625,053)	(10,702,873)	(10,533,330)	(10,413,372)	(10,240,933)	(10,127,744)	(9,989,268)	(9,875,229)	(9,771,740)	(9,794,045)	(9,997,030)
CD Pledged to DMHC	(346,927)	(346,927)	(348,873)	(348,873)	(698,873)	(700,000)	(350,000)	(350,238)	(350,000)	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$172,046,179**	**$171,891,312**	**$175,927,307**	**$179,601,622**	**$179,403,188**	**$184,868,559**	**$185,806,183**	**$186,407,458**	**$189,303,184**	**$189,445,162**	**$190,801,369**
Liquid TNE as Multiple of Required	**5.29**	**5.27**	**5.42**	**5.51**	**5.42**	**5.62**	**5.70**	**5.72**	**5.76**	**5.93**	**5.95**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2020

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

	Actual Jul-19	Actual Aug-19	Actual Sep-19	Actual Oct-19	Actual Nov-19	Actual Dec-19	Actual Jan-20	Actual Feb-20	Actual Mar-20	Actual Apr-20	Actual May-20	Actual Jun-20	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	92,397	91,728	91,224	90,597	89,711	89,056	88,329	88,086	87,919	88,633	89,755		987,435
Adults	33,670	33,448	33,092	32,772	32,357	32,066	31,620	31,636	32,018	32,423	33,229		358,331
SPD	25,804	25,751	25,727	25,753	25,691	25,687	25,571	25,853	25,778	25,894	25,985		283,494
ACA OE	81,171	80,966	80,483	80,069	79,104	78,154	77,093	76,921	77,199	78,295	79,736		869,191
Duals	17,627	17,700	17,666	17,650	17,779	17,776	17,800	17,843	17,868	17,858	17,971		195,538
Medi-Cal Program	250,669	249,593	248,192	246,841	244,642	242,739	240,413	240,339	240,782	243,103	246,676		2,693,989
Group Care Program	5,976	6,020	6,023	6,060	6,056	6,092	6,048	6,005	6,125	6,148	6,295		66,848
Total	**256,645**	**255,613**	**254,215**	**252,901**	**250,698**	**248,831**	**246,461**	**246,344**	**246,907**	**249,251**	**252,971**		**2,760,837**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(1,039)	(669)	(504)	(627)	(886)	(655)	(727)	(243)	(167)	714	1,122		(3,681)
Adults	(505)	(222)	(356)	(320)	(415)	(291)	(446)	16	382	405	806		(946)
SPD	(78)	(53)	(24)	26	(62)	(4)	(116)	282	(75)	116	91		103
ACA OE	(201)	(205)	(483)	(414)	(965)	(950)	(1,061)	(172)	278	1,096	1,441		(1,636)
Duals	70	73	(34)	(16)	129	(3)	24	43	25	(10)	113		414
Medi-Cal Program	(1,753)	(1,076)	(1,401)	(1,351)	(2,199)	(1,903)	(2,326)	(74)	443	2,321	3,573		(5,746)
Group Care Program	13	44	3	37	(4)	36	(44)	(43)	120	23	147		332
Total	**(1,740)**	**(1,032)**	**(1,398)**	**(1,314)**	**(2,203)**	**(1,867)**	**(2,370)**	**(117)**	**563**	**2,344**	**3,720**		**(5,414)**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	36.9%	36.8%	36.8%	36.7%	36.7%	36.7%	36.7%	36.7%	36.5%	36.5%	36.4%		36.7%
Adults % of Medi-Cal	13.4%	13.4%	13.3%	13.3%	13.2%	13.2%	13.2%	13.2%	13.3%	13.3%	13.5%		13.3%
SPD % of Medi-Cal	10.3%	10.3%	10.4%	10.4%	10.5%	10.6%	10.6%	10.8%	10.7%	10.7%	10.5%		10.5%
ACA OE % of Medi-Cal	32.4%	32.4%	32.4%	32.4%	32.3%	32.2%	32.1%	32.0%	32.1%	32.2%	32.3%		32.3%
Duals % of Medi-Cal	7.0%	7.1%	7.1%	7.2%	7.3%	7.3%	7.4%	7.4%	7.4%	7.3%	7.3%		7.3%
Medi-Cal Program % of Total	97.7%	97.6%	97.6%	97.6%	97.6%	97.6%	97.5%	97.6%	97.5%	97.5%	97.5%		97.6%
Group Care Program % of Total	2.3%	2.4%	2.4%	2.4%	2.4%	2.4%	2.5%	2.4%	2.5%	2.5%	2.5%		2.4%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**		**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2020

Page 1	Actual Enrollment by Plan & Category of Aid
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	Actual Jul-19	Actual Aug-19	Actual Sep-19	Actual Oct-19	Actual Nov-19	Actual Dec-19	Actual Jan-20	Actual Feb-20	Actual Mar-20	Actual Apr-20	Actual May-20	Actual Jun-20	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	49,531	49,463	49,220	48,753	48,482	47,978	47,700	48,187	48,546	48,363	48,857		535,080
Alameda Health System	47,759	47,630	47,328	47,241	46,652	46,232	45,665	45,594	45,806	46,905	48,099		514,911
	97,290	97,093	96,548	95,994	95,134	94,210	93,365	93,781	94,352	95,268	96,956		1,049,991
Delegated:													
CFMG	30,752	30,542	30,214	30,114	29,790	29,654	29,460	29,338	29,278	29,619	30,072		328,833
CHCN	94,820	94,360	93,936	93,460	92,730	92,167	91,165	90,696	90,726	91,469	92,533		1,018,062
Kaiser	33,783	33,618	33,517	33,333	33,044	32,800	32,471	32,529	32,551	32,895	33,410		363,951
Delegated Subtotal	159,355	158,520	157,667	156,907	155,564	154,621	153,096	152,563	152,555	153,983	156,015		1,710,846
Total	**256,645**	**255,613**	**254,215**	**252,901**	**250,698**	**248,831**	**246,461**	**246,344**	**246,907**	**249,251**	**252,971**		**2,760,837**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(799)	(197)	(545)	(554)	(860)	(924)	(845)	416	571	916	1,688		(1,133)
Delegated:													
CFMG	(139)	(210)	(328)	(100)	(324)	(136)	(194)	(122)	(60)	341	453		(819)
CHCN	(509)	(460)	(424)	(476)	(730)	(563)	(1,002)	(469)	30	743	1,064		(2,796)
Kaiser	(293)	(165)	(101)	(184)	(289)	(244)	(329)	58	22	344	515		(666)
Delegated Subtotal	(941)	(835)	(853)	(760)	(1,343)	(943)	(1,525)	(533)	(8)	1,428	2,032		(4,281)
Total	**(1,740)**	**(1,032)**	**(1,398)**	**(1,314)**	**(2,203)**	**(1,867)**	**(2,370)**	**(117)**	**563**	**2,344**	**3,720**		**(5,414)**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	37.9%	38.0%	38.0%	38.0%	37.9%	37.9%	37.9%	38.1%	38.2%	38.2%	38.3%		38.0%
Delegated:													
CFMG	12.0%	11.9%	11.9%	11.9%	11.9%	11.9%	12.0%	11.9%	11.9%	11.9%	11.9%		11.9%
CHCN	36.9%	36.9%	37.0%	37.0%	37.0%	37.0%	37.0%	36.8%	36.7%	36.7%	36.6%		36.9%
Kaiser	13.2%	13.2%	13.2%	13.2%	13.2%	13.2%	13.2%	13.2%	13.2%	13.2%	13.2%		13.2%
Delegated Subtotal	62.1%	62.0%	62.0%	62.0%	62.1%	62.1%	62.1%	61.9%	61.8%	61.8%	61.7%		62.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**		**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED May 31, 2020

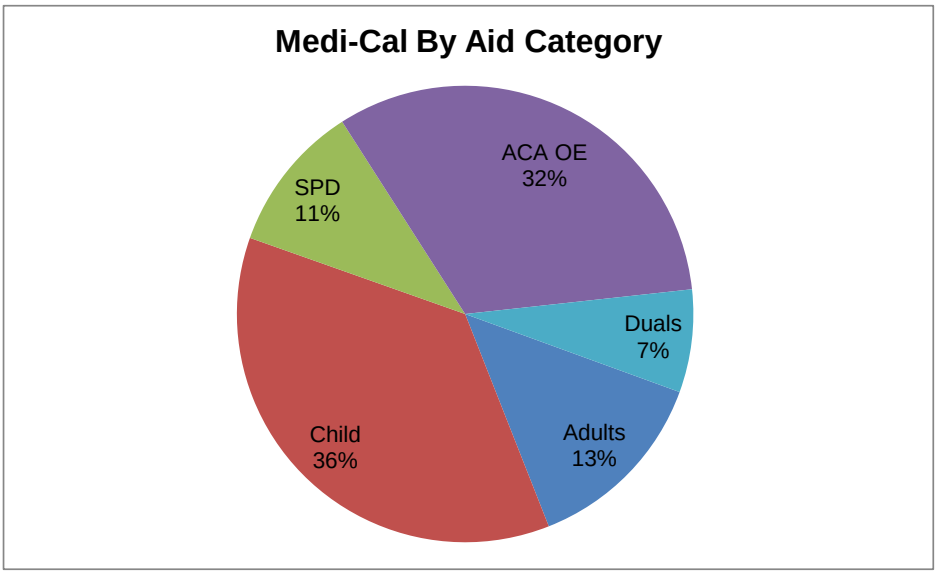
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES:				
$1,657,955	$1,604,211	($53,744)	(3.4%)	PCP-Capitation	$18,228,439	$17,969,466	($258,973)	(1.4%)
2,652,918	2,703,322	50,404	1.9%	PCP-Capitation - FQHC	29,373,351	30,032,265	658,914	2.2%
259,658	255,098	(4,560)	(1.8%)	Specialty-Capitation	2,868,982	2,857,969	(11,013)	(0.4%)
2,707,371	2,888,642	181,271	6.3%	Specialty-Capitation FQHC	30,036,027	31,723,800	1,687,773	5.3%
258,942	254,780	(4,162)	(1.6%)	Laboratory-Capitation	2,828,947	2,846,392	17,445	0.6%
460,033	622,384	162,351	26.1%	Transportation (Ambulance)-Cap	10,066,473	6,955,661	(3,110,812)	(44.7%)
190,394	186,644	(3,750)	(2.0%)	Vision Cap	2,081,206	2,087,333	6,127	0.3%
75,508	76,529	1,021	1.3%	CFMG Capitation	833,985	854,905	20,920	2.4%
137,626	143,384	5,758	4.0%	Anc IPA Admin Capitation FQHC	1,525,326	1,584,040	58,714	3.7%
6,819,523	6,915,271	95,748	1.4%	Kaiser Capitation	76,063,935	77,628,161	1,564,226	2.0%
511,519	552,594	41,075	7.4%	BHT Supplemental Expense	7,097,979	5,697,524	(1,400,455)	(24.6%)
30,756	6,228	(24,528)	(393.8%)	Hep-C Supplemental Expense	157,077	107,669	(49,408)	(45.9%)
267,707	303,216	35,509	11.7%	Maternity Supplemental Expense	3,171,403	3,076,782	(94,621)	(3.1%)
498,293	481,122	(17,171)	(3.6%)	DME - Cap	5,445,270	5,381,843	(63,427)	(1.2%)
16,528,202	**16,993,425**	**465,223**	**2.7%**	**5-TOTAL CAPITATED EXPENSES**	**189,778,398**	**188,803,810**	**(974,588)**	**(0.5%)**
				FEE FOR SERVICE MEDICAL EXPENSES:				
(2,939,412)	0	2,939,412	0.0%	IBNP-Inpatient Services	(3,920,131)	0	3,920,131	0.0%
(88,183)	0	88,183	0.0%	IBNP-Settlement (IP)	(117,606)	0	117,606	0.0%
(235,152)	0	235,152	0.0%	IBNP-Claims Fluctuation (IP)	(313,610)	0	313,610	0.0%
16,503,898	20,299,772	3,795,874	18.7%	Inpatient Hospitalization-FFS	189,608,411	226,631,617	37,023,206	16.3%
1,048,082	0	(1,048,082)	0.0%	IP OB - Mom & NB	11,809,461	0	(11,809,461)	0.0%
136,784	0	(136,784)	0.0%	IP Behavioral Health	1,264,619	0	(1,264,619)	0.0%
1,434,836	0	(1,434,836)	0.0%	IP - Long Term Care	12,527,810	0	(12,527,810)	0.0%
476,722	0	(476,722)	0.0%	IP - Facility Rehab FFS	6,677,890	0	(6,677,890)	0.0%
16,337,575	**20,299,772**	**3,962,197**	**19.5%**	**6-Inpatient Hospital & SNF FFS Expense**	**217,536,844**	**226,631,617**	**9,094,773**	**4.0%**
26,779	0	(26,779)	0.0%	IBNP-PCP	(465,312)	0	465,312	0.0%
804	0	(804)	0.0%	IBNP-Settlement (PCP)	(13,962)	0	13,962	0.0%
2,143	0	(2,143)	0.0%	IBNP-Claims Fluctuation (PCP)	(37,228)	0	37,228	0.0%
0	0	0	0.0%	Telemedicine FFS	45,600	0	(45,600)	0.0%
991,585	1,146,815	155,230	13.5%	Primary Care Non-Contracted FF	12,702,926	12,817,944	115,018	0.9%
75,248	110,503	35,255	31.9%	PCP FQHC FFS	690,018	1,200,927	510,909	42.5%
1,609,617	1,666,036	56,419	3.4%	Prop 56 Direct Payment Expenses	16,795,085	18,644,899	1,849,814	9.9%
46,138	0	(46,138)	0.0%	Prop 56-Trauma Expense	871,887	0	(871,887)	0.0%
63,092	0	(63,092)	0.0%	Prop 56-Dev. Screening Exp.	1,195,820	0	(1,195,820)	0.0%
520,264	0	(520,264)	0.0%	Prop 56-Fam. Planning Exp.	9,718,438	0	(9,718,438)	0.0%
476,448	0	(476,448)	0.0%	Prop 56-Value Based Purchasing	8,948,053	0	(8,948,053)	0.0%
3,812,118	**2,923,354**	**(888,764)**	**(30.4%)**	**7-Primary Care Physician FFS Expense**	**50,451,326**	**32,663,770**	**(17,787,556)**	**(54.5%)**
175,480	0	(175,480)	0.0%	IBNP-Specialist	(1,655,791)	0	1,655,791	0.0%
1,561,264	0	(1,561,264)	0.0%	Specialty Care-FFS	21,657,474	0	(21,657,474)	0.0%
87,535	0	(87,535)	0.0%	Anesthesiology - FFS	1,279,121	0	(1,279,121)	0.0%
715,862	0	(715,862)	0.0%	Spec Rad Therapy - FFS	6,911,456	0	(6,911,456)	0.0%
150,939	0	(150,939)	0.0%	Obstetrics-FFS	1,246,432	0	(1,246,432)	0.0%
275,128	0	(275,128)	0.0%	Spec IP Surgery - FFS	2,420,862	0	(2,420,862)	0.0%
252,661	0	(252,661)	0.0%	Spec OP Surgery - FFS	4,573,746	0	(4,573,746)	0.0%
342,867	3,671,498	3,328,631	90.7%	Spec IP Physician	3,879,194	40,736,947	36,857,753	90.5%
46,537	114,103	67,566	59.2%	SCP FQHC FFS	722,336	1,255,150	532,814	42.5%
5,264	0	(5,264)	0.0%	IBNP-Settlement (SCP)	(49,670)	0	49,670	0.0%
14,039	0	(14,039)	0.0%	IBNP-Claims Fluctuation (SCP)	(132,463)	0	132,463	0.0%
3,627,576	**3,785,601**	**158,025**	**4.2%**	**8-Specialty Care Physician Expense**	**40,852,698**	**41,992,097**	**1,139,399**	**2.7%**
(696,783)	0	696,783	0.0%	IBNP-Ancillary	(1,227,336)	0	1,227,336	0.0%
(20,903)	0	20,903	0.0%	IBNP Settlement (ANC)	(36,816)	0	36,816	0.0%
(55,743)	0	55,743	0.0%	IBNP Claims Fluctuation (ANC)	(98,187)	0	98,187	0.0%
218,540	0	(218,540)	0.0%	Acupuncture/Biofeedback	2,777,934	0	(2,777,934)	0.0%
18,075	0	(18,075)	0.0%	Hearing Devices	1,098,188	0	(1,098,188)	0.0%
22,538	0	(22,538)	0.0%	Imaging/MRI/CT Global	295,971	0	(295,971)	0.0%
(2,801)	0	2,801	0.0%	Vision FFS	380,183	0	(380,183)	0.0%
12,789	0	(12,789)	0.0%	Family Planning	133,894	0	(133,894)	0.0%
153,659	0	(153,659)	0.0%	Laboratory-FFS	2,406,931	0	(2,406,931)	0.0%
43,028	0	(43,028)	0.0%	ANC Therapist	1,106,872	0	(1,106,872)	0.0%
625,486	0	(625,486)	0.0%	Transportation (Ambulance)-FFS	3,209,293	0	(3,209,293)	0.0%
62,427	0	(62,427)	0.0%	Transportation (Other)-FFS	1,037,428	0	(1,037,428)	0.0%

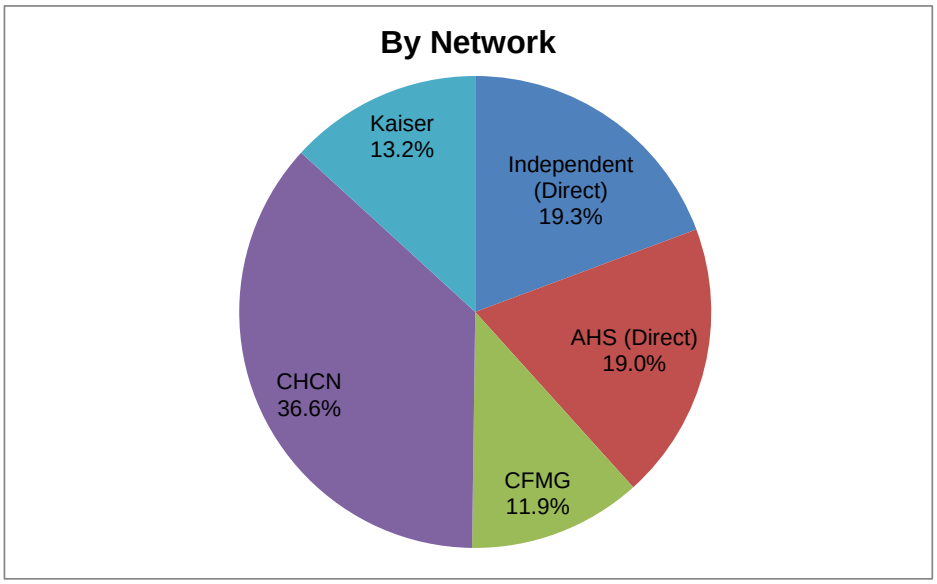
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED May 31, 2020

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
$463,936	$0	($463,936)	0.0%	Hospice	$4,257,571	$0	($4,257,571)	0.0%
837,744	0	(837,744)	0.0%	Home Health Services	5,736,436	0	(5,736,436)	0.0%
0	2,508,637	2,508,637	100.0%	Other Medical-FFS	0	28,370,886	28,370,886	100.0%
0	0	0	0.0%	Denials	320	0	(320)	0.0%
161,395	0	(161,395)	0.0%	HMS Medical Refunds	(97,327)	0	97,327	0.0%
(1,177)	0	1,177	0.0%	Refunds-Medical Payments	(5,727)	0	5,727	0.0%
300,908	0	(300,908)	0.0%	DME & Medical Supplies	3,190,189	0	(3,190,189)	0.0%
1,647,193	548,980	(1,098,213)	(200.0%)	GEMT Direct Payment Expense	6,021,144	6,143,276	122,132	2.0%
441,161	0	(441,161)	0.0%	Community Based Adult Services (CBAS)	5,070,778	0	(5,070,778)	0.0%
4,231,472	**3,057,617**	**(1,173,855)**	**(38.4%)**	**9-Ancillary Medical Expense**	**35,257,739**	**34,514,162**	**(743,577)**	**(2.2%)**
365,514	0	(365,514)	0.0%	IBNP-Outpatient	(1,638,054)	0	1,638,054	0.0%
10,965	0	(10,965)	0.0%	IBNP Settlement (OP)	(49,146)	0	49,146	0.0%
29,241	0	(29,241)	0.0%	IBNP Claims Fluctuation (OP)	(131,049)	0	131,049	0.0%
707,890	7,297,964	6,590,074	90.3%	Out-Patient FFS	13,228,875	79,594,419	66,365,544	83.4%
607,891	0	(607,891)	0.0%	OP Ambul Surgery - FFS	11,348,861	0	(11,348,861)	0.0%
863,556	0	(863,556)	0.0%	OP Fac Imaging Services-FFS	12,166,732	0	(12,166,732)	0.0%
1,139,227	0	(1,139,227)	0.0%	Behav Health - FFS	20,517,251	0	(20,517,251)	0.0%
175,587	0	(175,587)	0.0%	OP Facility - Lab FFS	3,036,688	0	(3,036,688)	0.0%
44,460	0	(44,460)	0.0%	OP Facility - Cardio FFS	959,276	0	(959,276)	0.0%
16,967	0	(16,967)	0.0%	OP Facility - PT/OT/ST FFS	188,765	0	(188,765)	0.0%
1,711,953	0	(1,711,953)	0.0%	OP Facility - Dialysis FFS	18,056,719	0	(18,056,719)	0.0%
5,673,250	**7,297,964**	**1,624,714**	**22.3%**	**10-Outpatient Medical Expense Medical Expense**	**77,684,918**	**79,594,419**	**1,909,501**	**2.4%**
245,922	0	(245,922)	0.0%	IBNP-Emergency	(471,792)	0	471,792	0.0%
7,377	0	(7,377)	0.0%	IBNP Settlement (ER)	(14,155)	0	14,155	0.0%
19,674	0	(19,674)	0.0%	IBNP Claims Fluctuation (ER)	(37,742)	0	37,742	0.0%
494,420	0	(494,420)	0.0%	Special ER Physician-FFS	6,376,605	0	(6,376,605)	0.0%
1,948,110	3,181,122	1,233,012	38.8%	ER-Facility	28,905,901	35,431,517	6,525,616	18.4%
2,715,503	**3,181,122**	**465,619**	**14.6%**	**11-Emergency Expense**	**34,758,817**	**35,431,517**	**672,700**	**1.9%**
(329,382)	0	329,382	0.0%	IBNP-Pharmacy	(1,151,684)	0	1,151,684	0.0%
(9,881)	0	9,881	0.0%	IBNP Settlement (RX)	(34,551)	0	34,551	0.0%
(26,351)	0	26,351	0.0%	IBNP Claims Fluctuation (RX)	(92,135)	0	92,135	0.0%
4,020,295	3,095,019	(925,276)	(29.9%)	RX - Non-PBM FFFS	42,135,763	34,803,120	(7,332,643)	(21.1%)
9,498,710	10,377,902	879,192	8.5%	Pharmacy-FFS	110,078,569	114,063,429	3,984,860	3.5%
(71,684)	0	71,684	0.0%	HMS RX Refunds	(677,472)	0	677,472	0.0%
(407,064)	(407,064)	0	0.0%	Pharmacy-Rebate	(5,600,569)	(4,634,487)	966,082	(20.8%)
12,674,642	**13,065,857**	**391,215**	**3.0%**	**12-Pharmacy Expense**	**144,657,921**	**144,232,062**	**(425,859)**	**(0.3%)**
49,072,137	**53,611,287**	**4,539,150**	**8.5%**	**13-TOTAL FFS MEDICAL EXPENSES**	**601,200,264**	**595,059,644**	**(6,140,620)**	**(1.0%)**
0	(75,043)	(75,043)	100.0%	Clinical Vacancy	0	(1,765,029)	(1,765,029)	100.0%
67,275	118,511	51,236	43.2%	Quality Analytics	738,397	1,218,005	479,608	39.4%
313,389	400,524	87,135	21.8%	Health Plan Services Department Total	4,007,117	4,497,554	490,438	10.9%
815,987	778,668	(37,319)	(4.8%)	Case & Disease Management Department Total	7,170,061	7,210,907	40,846	0.6%
144,097	180,766	36,669	20.3%	Medical Services Department Total	1,547,444	1,894,345	346,901	18.3%
323,906	467,030	143,123	30.6%	Quality Management Department Total	4,615,129	5,484,554	869,425	15.9%
104,249	139,461	35,212	25.2%	Pharmacy Services Department Total	1,279,528	1,548,660	269,132	17.4%
38,771	28,736	(10,036)	(34.9%)	Regulatory Readiness Total	357,496	334,078	(23,419)	(7.0%)
1,807,676	**2,038,654**	**230,978**	**11.3%**	**14-Other Benefits & Services**	**19,715,172**	**20,423,075**	**707,902**	**3.5%**
				Reinsurance Expense				
(252,390)	(328,866)	(76,476)	23.3%	Reinsurance Recoveries	(4,300,500)	(3,330,109)	970,391	(29.1%)
388,292	386,901	(1,391)	(0.4%)	Stop-Loss Expense	4,226,505	4,307,237	80,732	1.9%
135,902	**58,035**	**(77,867)**	**(134.2%)**	**15-Reinsurance Expense**	**(73,995)**	**977,128**	**1,051,123**	**107.6%**
				Preventive Health Services				
1,583,209	83,208	(1,500,001)	(1,802.7%)	Risk Sharing PCP	2,416,792	916,788	(1,500,004)	(163.6%)
1,583,209	**83,208**	**(1,500,001)**	**(1,802.7%)**	**16-Risk Pool Distribution**	**2,416,792**	**916,788**	**(1,500,004)**	**(163.6%)**
69,127,127	**72,784,609**	**3,657,482**	**5.0%**	**17-TOTAL MEDICAL EXPENSES**	**813,036,631**	**806,180,445**	**(6,856,186)**	**(0.9%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Current Membership by Network By Category of Aid							
Category of Aid	**May 2020**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	33,229	13%	8,072	7,225	249	12,409	5,274
Child	89,755	36%	8,213	8,170	27,622	30,491	15,259
SPD	25,985	11%	8,679	3,860	1,174	10,358	1,914
ACA OE	79,736	32%	13,903	26,024	1,025	29,991	8,793
Duals	17,971	7%	7,250	1,914	2	6,635	2,170
Medi-Cal	246,676		46,117	47,193	30,072	89,884	33,410
Group Care	6,295		2,740	906	-	2,649	-
Total	**252,971**	**100%**	**48,857**	**48,099**	**30,072**	**92,533**	**33,410**
Medi-Cal %	97.5%		94.4%	98.1%	100.0%	97.1%	100.0%
Group Care %	2.5%		5.6%	1.9%	0.0%	2.9%	0.0%
	Network Distribution		*19.3%*	*19.0%*	*11.9%*	*36.6%*	*13.2%*
			% Direct:	**38%**		**% Delegated:**	**62%**

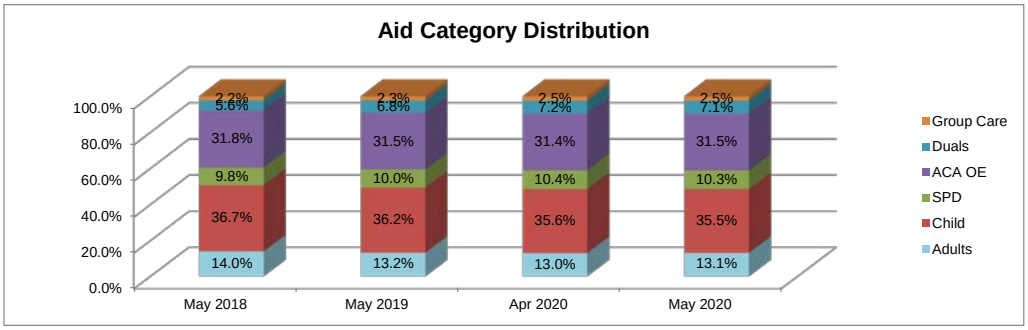




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

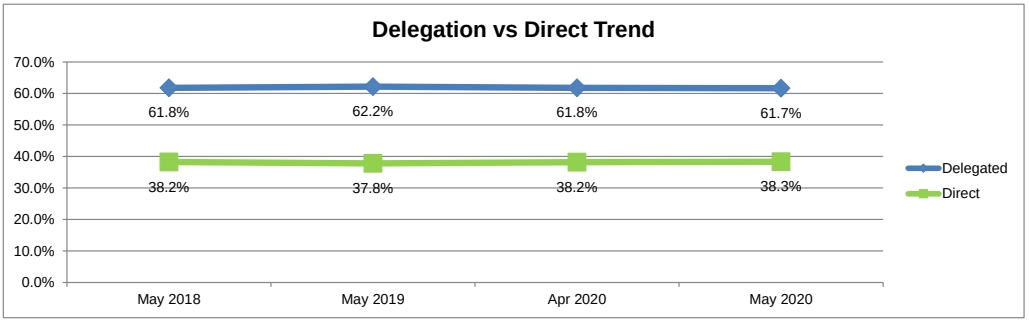
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	May 2018	May 2019	Apr 2020	May 2020	May 2018	May 2019	Apr 2020	May 2020	May 2018 to May 2019	May 2019 to May 2020	Apr 2020 to May 2020
Adults	37,109	34,120	32,423	33,229	14.0%	13.2%	13.0%	13.1%	-8.1%	-2.6%	2.5%
Child	97,621	93,274	88,633	89,755	36.7%	36.2%	35.6%	35.5%	-4.5%	-3.8%	1.3%
SPD	26,045	25,793	25,894	25,985	9.8%	10.0%	10.4%	10.3%	-1.0%	0.7%	0.4%
ACA OE	84,464	81,174	78,295	79,736	31.8%	31.5%	31.4%	31.5%	-3.9%	-1.8%	1.8%
Duals	14,851	17,487	17,858	17,971	5.6%	6.8%	7.2%	7.1%	17.7%	2.8%	0.6%
Medi-Cal Total	260,090	251,848	243,103	246,676	97.8%	97.7%	97.5%	97.5%	-3.2%	-2.1%	1.5%
Group Care	5,781	5,933	6,148	6,295	2.2%	2.3%	2.5%	2.5%	2.6%	6.1%	2.4%
Total	**265,871**	**257,781**	**249,251**	**252,971**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**-3.0%**	**-1.9%**	**1.5%**



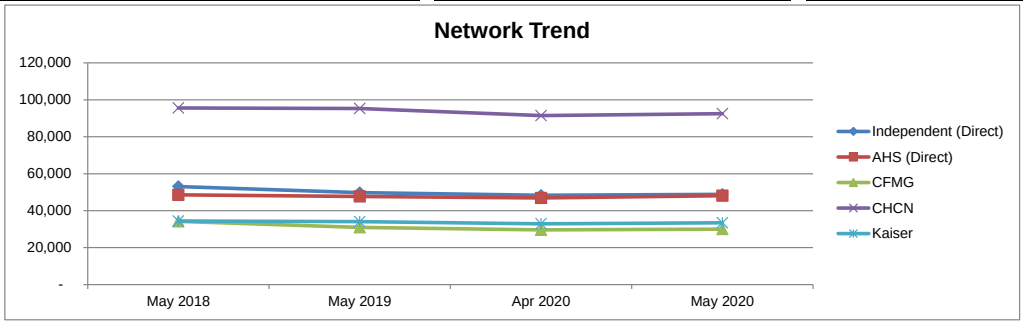
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	May 2018	May 2019	Apr 2020	May 2020	May 2018	May 2019	Apr 2020	May 2020	May 2018 to May 2019	May 2019 to May 2020	Apr 2020 to May 2020
Delegated	164,225	160,307	153,983	156,015	61.8%	62.2%	61.8%	61.7%	-2.4%	-2.7%	1.3%
Direct	101,646	97,474	95,268	96,956	38.2%	37.8%	38.2%	38.3%	-4.1%	-0.5%	1.8%
Total	**265,871**	**257,781**	**249,251**	**252,971**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**-3.0%**	**-1.9%**	**1.5%**



Network Trend

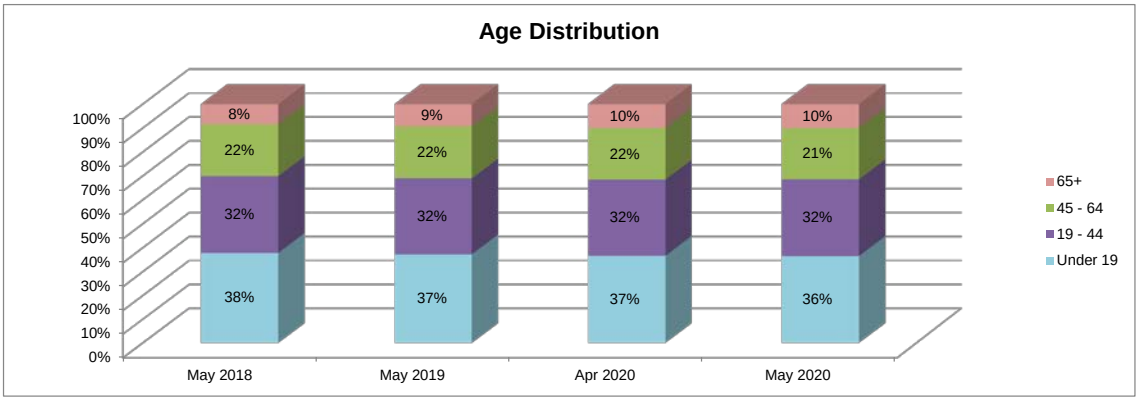
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	May 2018	May 2019	Apr 2020	May 2020	May 2018	May 2019	Apr 2020	May 2020	May 2018 to May 2019	May 2019 to May 2020	Apr 2020 to May 2020
Independent (Direct)	53,066	49,788	48,363	48,857	20.0%	19.3%	19.4%	19.3%	-6.2%	-1.9%	1.0%
AHS (Direct)	48,580	47,686	46,905	48,099	18.3%	18.5%	18.8%	19.0%	-1.8%	0.9%	2.5%
CFMG	34,225	30,944	29,619	30,072	12.9%	12.0%	11.9%	11.9%	-9.6%	-2.8%	1.5%
CHCN	95,580	95,313	91,469	92,533	35.9%	37.0%	36.7%	36.6%	-0.3%	-2.9%	1.2%
Kaiser	34,420	34,050	32,895	33,410	12.9%	13.2%	13.2%	13.2%	-1.1%	-1.9%	1.6%
Total	**265,871**	**257,781**	**249,251**	**252,971**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**-3.0%**	**-1.9%**	**1.5%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

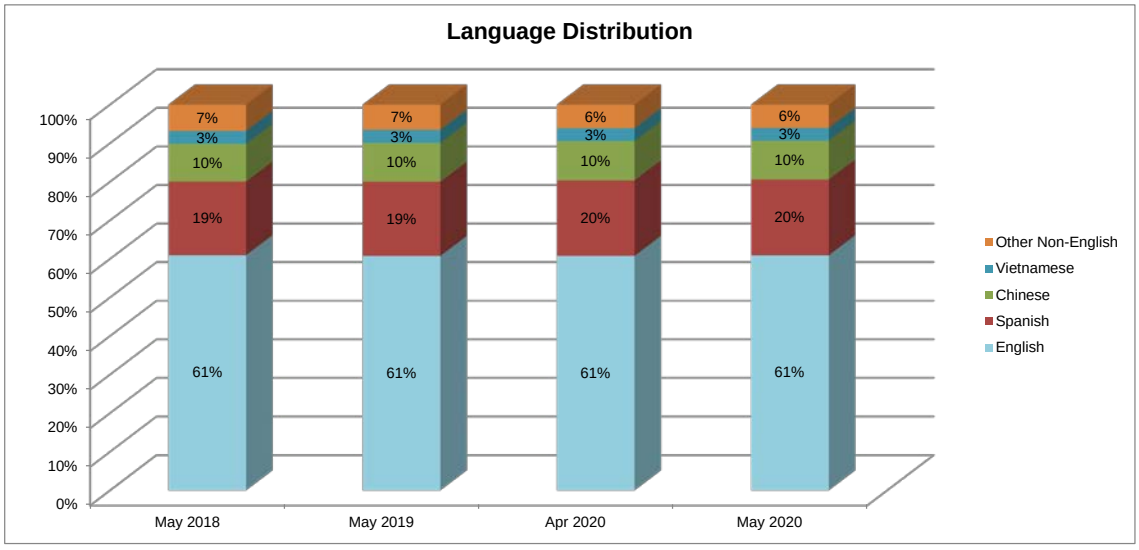
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	May 2018	May 2019	Apr 2020	May 2020	May 2018	May 2019	Apr 2020	May 2020	May 2018 to May 2019	May 2019 to May 2020	Apr 2020 to May 2020
Under 19	100,464	96,009	91,177	92,275	38%	37%	37%	36%	-4%	-4%	1%
19 - 44	85,364	81,727	79,413	81,146	32%	32%	32%	32%	-4%	-1%	2%
45 - 64	57,820	55,866	53,750	54,361	22%	22%	22%	21%	-3%	-3%	1%
65+	22,223	24,179	24,911	25,189	8%	9%	10%	10%	9%	4%	1%
Total	**265,871**	**257,781**	**249,251**	**252,971**	**100%**	**100%**	**100%**	**100%**	**-3%**	**-2%**	**1%**



Language Trend

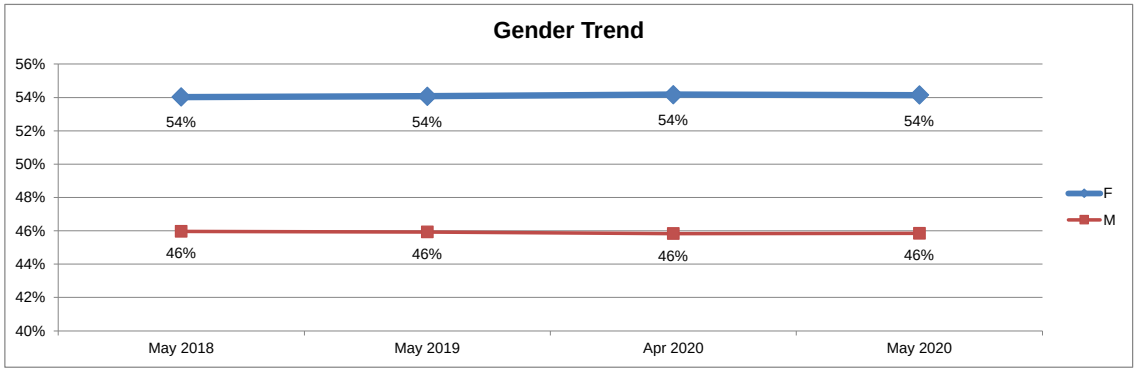
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	May 2018	May 2019	Apr 2020	May 2020	May 2018	May 2019	Apr 2020	May 2020	May 2018 to May 2019	May 2019 to May 2020	Apr 2020 to May 2020
English	162,055	156,554	151,454	154,121	61%	61%	61%	61%	-3%	-2%	2%
Spanish	50,690	49,566	48,853	49,663	19%	19%	20%	20%	-2%	0%	2%
Chinese	26,153	26,082	25,363	25,538	10%	10%	10%	10%	0%	-2%	1%
Vietnamese	8,769	8,689	8,285	8,336	3%	3%	3%	3%	-1%	-4%	1%
Other Non-English	18,204	16,890	15,296	15,313	7%	7%	6%	6%	-7%	-9%	0%
Total	**265,871**	**257,781**	**249,251**	**252,971**	**100%**	**100%**	**100%**	**100%**	**-3%**	**-2%**	**1%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

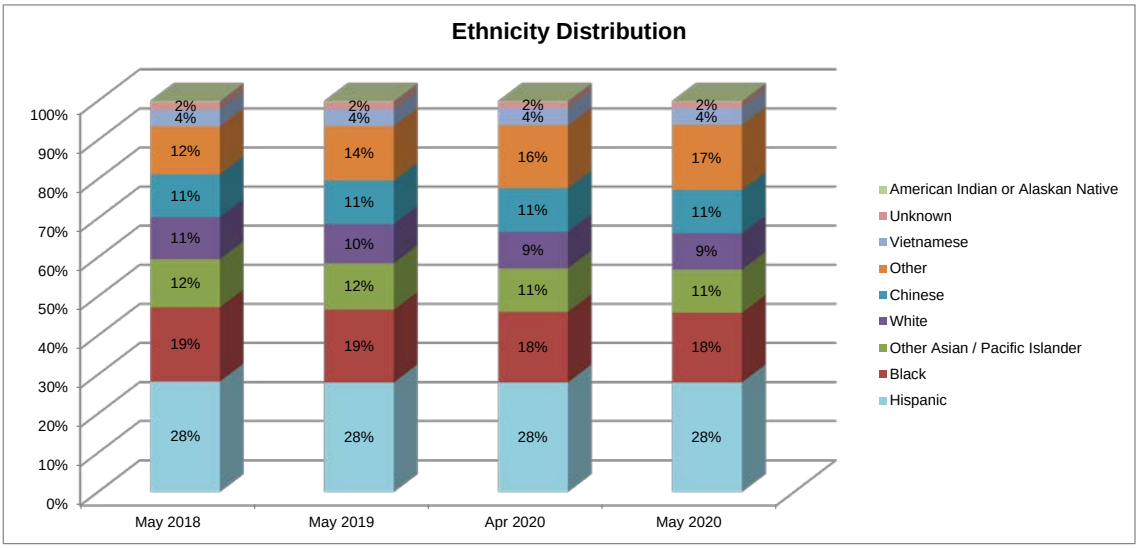
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	May 2018	May 2019	Apr 2020	May 2020	May 2018	May 2019	Apr 2020	May 2020	May 2018 to May 2019	May 2019 to May 2020	Apr 2020 to May 2020
F	143,650	139,382	135,011	136,969	54%	54%	54%	54%	-3%	-2%	1%
M	122,221	118,399	114,240	116,002	46%	46%	46%	46%	-3%	-2%	2%
Total	**265,871**	**257,781**	**249,251**	**252,971**	**100%**	**100%**	**100%**	**100%**	**-3%**	**-2%**	**1%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	May 2018	May 2019	Apr 2020	May 2020	May 2018	May 2019	Apr 2020	May 2020	May 2018 to May 2019	May 2019 to May 2020	Apr 2020 to May 2020
Hispanic	74,945	72,131	69,755	70,745	28%	28%	28%	28%	-4%	-2%	1%
Black	50,573	47,942	44,971	45,057	19%	19%	18%	18%	-5%	-6%	0%
Other Asian / Pacific Islander	32,686	30,588	27,749	27,943	12%	12%	11%	11%	-6%	-9%	1%
White	28,680	26,020	23,355	23,573	11%	10%	9%	9%	-9%	-9%	1%
Chinese	29,049	28,723	27,754	27,910	11%	11%	11%	11%	-1%	-3%	1%
Other	32,648	35,794	40,272	42,289	12%	14%	16%	17%	10%	18%	5%
Vietnamese	11,365	11,159	10,741	10,760	4%	4%	4%	4%	-2%	-4%	0%
Unknown	5,197	4,775	4,076	4,113	2%	2%	2%	2%	-8%	-14%	1%
American Indian or Alaskan Native	728	649	578	581	0%	0%	0%	0%	-11%	-10%	1%
Total	**265,871**	**257,781**	**249,251**	**252,971**	**100%**	**100%**	**100%**	**100%**	**-3%**	**-2%**	**1%**



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

Medi-Cal By City

City	May 2020	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	101,137	41%	11,500	23,082	13,497	43,599	9,459
Hayward	38,094	15%	8,065	7,902	4,547	11,129	6,451
Fremont	21,472	9%	8,661	3,047	716	5,717	3,331
San Leandro	21,956	9%	3,818	3,265	3,205	8,230	3,438
Union City	10,509	4%	4,026	1,475	356	2,710	1,942
Alameda	9,597	4%	1,849	1,389	1,506	3,518	1,335
Berkeley	8,660	4%	1,110	1,500	1,187	3,653	1,210
Livermore	7,049	3%	957	617	1,635	2,647	1,193
Newark	5,661	2%	1,626	1,762	172	1,088	1,013
Castro Valley	5,830	2%	1,179	886	949	1,715	1,101
San Lorenzo	5,084	2%	868	835	664	1,765	952
Pleasanton	3,718	2%	904	354	400	1,449	611
Dublin	3,975	2%	931	357	547	1,432	708
Emeryville	1,543	1%	255	306	246	489	247
Albany	1,425	1%	169	204	325	464	263
Piedmont	254	0%	45	60	18	75	56
Sunol	54	0%	9	8	6	12	19
Antioch	19	0%	3	2	6	5	3
Other	639	0%	142	142	90	187	78
Total	**246,676**	**100%**	**46,117**	**47,193**	**30,072**	**89,884**	**33,410**

Group Care By City

City	May 2020	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	2,205	35%	576	399	-	1,230	-
Hayward	693	11%	393	129	-	171	-
Fremont	675	11%	517	49	-	109	-
San Leandro	587	9%	229	79	-	279	-
Union City	334	5%	241	31	-	62	-
Alameda	290	5%	118	29	-	143	-
Berkeley	206	3%	59	22	-	125	-
Livermore	88	1%	38	1	-	49	-
Newark	142	2%	93	29	-	20	-
Castro Valley	192	3%	99	22	-	71	-
San Lorenzo	121	2%	48	19	-	54	-
Pleasanton	49	1%	26	3	-	20	-
Dublin	101	2%	48	6	-	47	-
Emeryville	31	0%	13	5	-	13	-
Albany	14	0%	5	1	-	8	-
Piedmont	10	0%	2	1	-	7	-
Sunol	-	0%	-	-	-	-	-
Antioch	28	0%	9	7	-	12	-
Other	529	8%	226	74	-	229	-
Total	**6,295**	**100%**	**2,740**	**906**	**-**	**2,649**	**-**

Total By City

City	May 2020	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	103,342	41%	12,076	23,481	13,497	44,829	9,459
Hayward	38,787	15%	8,458	8,031	4,547	11,300	6,451
Fremont	22,147	9%	9,178	3,096	716	5,826	3,331
San Leandro	22,543	9%	4,047	3,344	3,205	8,509	3,438
Union City	10,843	4%	4,267	1,506	356	2,772	1,942
Alameda	9,887	4%	1,967	1,418	1,506	3,661	1,335
Berkeley	8,866	4%	1,169	1,522	1,187	3,778	1,210
Livermore	7,137	3%	995	618	1,635	2,696	1,193
Newark	5,803	2%	1,719	1,791	172	1,108	1,013
Castro Valley	6,022	2%	1,278	908	949	1,786	1,101
San Lorenzo	5,205	2%	916	854	664	1,819	952
Pleasanton	3,767	1%	930	357	400	1,469	611
Dublin	4,076	2%	979	363	547	1,479	708
Emeryville	1,574	1%	268	311	246	502	247
Albany	1,439	1%	174	205	325	472	263
Piedmont	264	0%	47	61	18	82	56
Sunol	54	0%	9	8	6	12	19
Antioch	47	0%	12	9	6	17	3
Other	1,168	0%	368	216	90	416	78
Total	**252,971**	**100%**	**48,857**	**48,099**	**30,072**	**92,533**	**33,410**

Risk Corridor Overview

- Method for DHCS to measure medical expenses of the Plan compared to rates provided to the plan.
- Measures medical expenses to revenue over the State rate bridge period (July 2019 to December 2020).
- DHCS deeming this a way to protect the State, Federal Government and Plans against excessive gains/losses due to cost/utilization changes as a result of COVID-19.
- Allows a two-sided sharing of savings or losses.

	Shared Gains			Alliance at Risk	Shared Losses		
Gross Medical Expenses	GME ≤ 91%	92%-95%	96%-99%	100%-104%	105%-108%	109%-112%	113% ≤ GME
Sharing Percentage	100% DHCS	75% DHCS/25% Plan	50% DHCS/50% Plan	Plan fully at risk	50% DHCS/50% Plan	75% DHCS/25% Plan	100% DHCS

- Calculations for Risk Corridor will happen no sooner than January 2022.
- Further defining of Gross Medical Expenses is needed from DHCS.
- Potential revenue “at risk” ranges from $0 to $7M.

ALAMEDA Alliance FOR HEALTH

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

Operations

Matt Woodruff

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

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

Date: **July 10, 2020**

Subject: **Operations Report**

Member Services

- 12-month Trend Summary:

    - The Member Services Department received a twenty-eight (28%) percent decrease in calls in June 2020, totaling 11,469 compared to 15,870 in June 2019.
    - The abandonment rate for June 2020 was two percent (2%), compared to three percent (3%) in June 2019. The goal is 5% or less.
    - The service level for the Department was eighty-four percent (84%) for June 2020.
    - The Department continues to service members via multiple communication channels (telephonic, email, web-based requests) while honoring the 'shelter in place" order. The Department responded to 678 web-based requests in June 2020.
    - The top five call reasons for June 2020 were: 1) Eligibility/Enrollment **2). Kaiser,** 3). Change of PCP 4). Benefits, 5). ID Card**.** The top five call reasons for June 2019 were: 1) Eligibility/Enrollment **2). Change PCP** 3). Kaiser, 4). Benefits, 5). ID card. Kaiser assignment requests were higher in June 2020 compared to the Change of PCP requests in 2019.
    - The average talk time (ATT) was eight minutes and forty-two seconds (08:42) for June 2020 compared to seven minutes and thirty-seven seconds (07:37) for June 2019.

Claims

- 12-Month Trend Summary:

    - The Claims Department received 101,083 claims in June 2020 compared to 111,286 in June 2019.
    - The Auto Adjudication was 74.9% in June 2020 compared to 67.9% in June 2019.
    - Claims compliance for the 30-day turn-around time was 98.3% in June 2020 compared to 98.9% in June 2019. The 45-day turnaround time was 99.9% in June 2020 compared to 99.9% in June 2019.

- Training:

    - Routine and new hire training will continue to be conducted remotely by the managers/supervisors until staff returns to the office.

- Monthly Analysis:

    - In June, we received a total of 101,083 claims in the HEALTHsuite system. This represents an increase of 13.5% from May; the lower volume of received claims remains attributed to COVID-19.
    - We received 76% of claims via EDI and 24% of claims via paper.
    - During June, 99.9% of our claims were processed within 45 working days.
    - The Auto Adjudication rate was 74.9% for June.

Provider Services

- 12-Month Trend Summary:

    - The Provider Services Department's call volume in June 2020 was 6,281 compared to 6,077 calls in June 2019.
    - Provider Services continuously works to achieve first call resolution and reduction of the abandonment rates. Efforts to promote provider satisfaction is our first priority.
    - The Provider Services department completed 183 visits during June 2020.

- The Provider Services department answered over 6,281 calls for June 2020 and made over 1,035 outbound calls.

Credentialing

- 12-Month Trend Summary:
  - At the Peer Review and Credentialing (PRCC) meeting held on June 16, 2020, there were twelve (12) initial providers approved; three (3) primary care provider, four (4) specialists, two (2) ancillary provider, and three (3) midlevel provider. Additionally, nineteen (19) providers were re-credentialed at this meeting; five (5) primary care providers, twelve (12) specialists, one (1) ancillary provider, and one (1) midlevel provider.
  - For more information, please refer to the Credentialing charts and graphs located in the Operations supporting documentation.

Provider Dispute Resolution

- 12-Month Trend Summary:
  - In June 2020, the Provider Dispute Resolution (PDR) team received 849 PDRs versus 816 in June 2019.
  - The PDR team resolved 676 cases in June 2020 compared to 530 cases in June 2019.
  - In June 2020, the PDR team upheld 66% of cases versus 69% in June 2019.
  - The PDR team resolved 99% of cases within the compliance standard of 95% within 45 working days in June 2020 compared to 99% in June 2019.

- Monthly Analysis:
  - AAH received 849 PDRs in June 2020.
  - In June, 676 PDRs were resolved. Out of the 676 PDRs, 444 were upheld, and 232 were overturned.
  - The overturn rate for PDRs was 34%, which did not meet our goal of 25% or less.

        - Of the 232 overturned PDRs, 11 were attributed to one specific CES error, which has since been corrected. 18 overturned PDRs were related to surgery center claims where there was a delay in entering new ASC rates. 42 overturned PDRs were related to a system bug where the claim was manually priced correctly by the processor, but the system changed the pricing when the claim was adjudicated. Without these three issues, the overturn rate would have been 24%.
    - 31% of the overturned PDRs were attributed to "general" configuration issues; the re-design of the PDR database continues and will allow for more specificity of these configuration issues going forward.
    - 673 out of 676 cases were resolved within 45 working days resulting in a 99% compliance rate.
    - There are 713 PDRs currently pending resolution; none are older than 45 working days.

Community Relations and Outreach

- 12-Month Trend Summary:

    - The Communications & Outreach (C&O) Department completed 0 out of 88 events (0% completion rate) in Q4 2020 compared to 142 out of 184 events (77% completion rate) in Q4 2019.
    - The C&O Department reached 909 people in the community in Q4 2020 compared to 5,833 in Q4 2019.
    - The C&O Department contacted new members in 24 cites*/unincorporated areas throughout Alameda County and the Bay Area in Q4 2020 compared to 14 cities/unincorporated areas in Q4 2019.

- Quarterly Analysis:

    - In Q4 2020, the C&O Department completed 0 out of 88 events (0% completion rate).
    - In Q4 2020, the C&O Department reached 909 individuals (909 or 100% self-identified as Alliance members) through our new member orientation calling campaigns.

- Monthly Analysis:

    - In June 2020, the C&O Department completed 0 out of 25 events (0% completion rate). The Outreach team also completed 286 net new member orientation calls.
    - In June 2020, the C&O Department reached 286 individuals (286 or 100% self-identified as Alliance members) through our new member orientation calling campaigns.
    - In June 2020, the C&O Department completed events in 24 cities* /unincorporated areas throughout Alameda County and the Bay Area.
    - Please see attached Addendum A.

**Cities represent the mailing addresses for members who completed a Member Orientation by phone. The C&O Department started including these cities in the Q4 2020 Outreach Report.*

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	June 2020
Incoming Calls (R/V)	11,469
Abandoned Rate (R/V)	2%
Answered Calls (R/V)	11,206
Average Speed to Answer (ASA)	00:27
Calls Answered in 30 Seconds (R/V)	84%
Average Talk Time (ATT)	08:42
Outbound Calls	10,466

Top 5 Call Reasons (Medi-Cal and Group Care) June 2020
Eligibility/Enrollment
Kaiser
Change of PCP
Benefits
ID Card Request

Top 3 Web-Based Request Reasons (Medi-Cal and Group Care) June 2020
ID Card Request
Change of PCP
Update Contact Info

Claims Department
May 2020 Final and June 2020 Final

METRICS

Claims Compliance	May-20	Jun-20
90% of clean claims processed within 30 calendar days	98.1%	98.3%
95% of all claims processed within 45 working days	100.0%	99.9%

Claims Volume (Received)	May-20	Jun-20
Paper claims	21,632	24,075
EDI claims	67,431	77,008
Claim Volume Total	**89,063**	**101,083**

Percentage of Claims Volume by Submission Method	May-20	Jun-20
% Paper	24.29%	23.82%
% EDI	75.71%	76.18%

Claims Processed	May-20	Jun-20
HEALTHsuite Paid (original claims)	69,503	62,345
HEALTHsuite Denied (original claims)	26,443	24,687
HEALTHsuite Original Claims Sub-Total	**95,946**	**87,032**
HEALTHsuite Adjustments	3,411	2,617
HEALTHsuite Total	**99,357**	**89,649**

Claims Expense	May-20	Jun-20
Medical Claims Paid	$39,230,002	$35,943,390
Interest Paid	$37,539	$29,670

Auto Adjudication	May-20	Jun-20
Claims Auto Adjudicated	70,650	65,167
% Auto Adjudicated	73.6%	74.9%

Average Days from Receipt to Payment	May-20	Jun-20
HEALTHsuite	20	19

Pended Claim Age	May-20	Jun-20
0-29 calendar days		
HEALTHsuite	10,533	9,616
30-59 calendar days		
HEALTHsuite	64	23
Over 60 calendar days		
HEALTHsuite	0	0

Overall Denial Rate	Apr-20	Jun-20
Claims denied in HEALTHsuite	26,443	24,687
% Denied	26.6%	27.5%

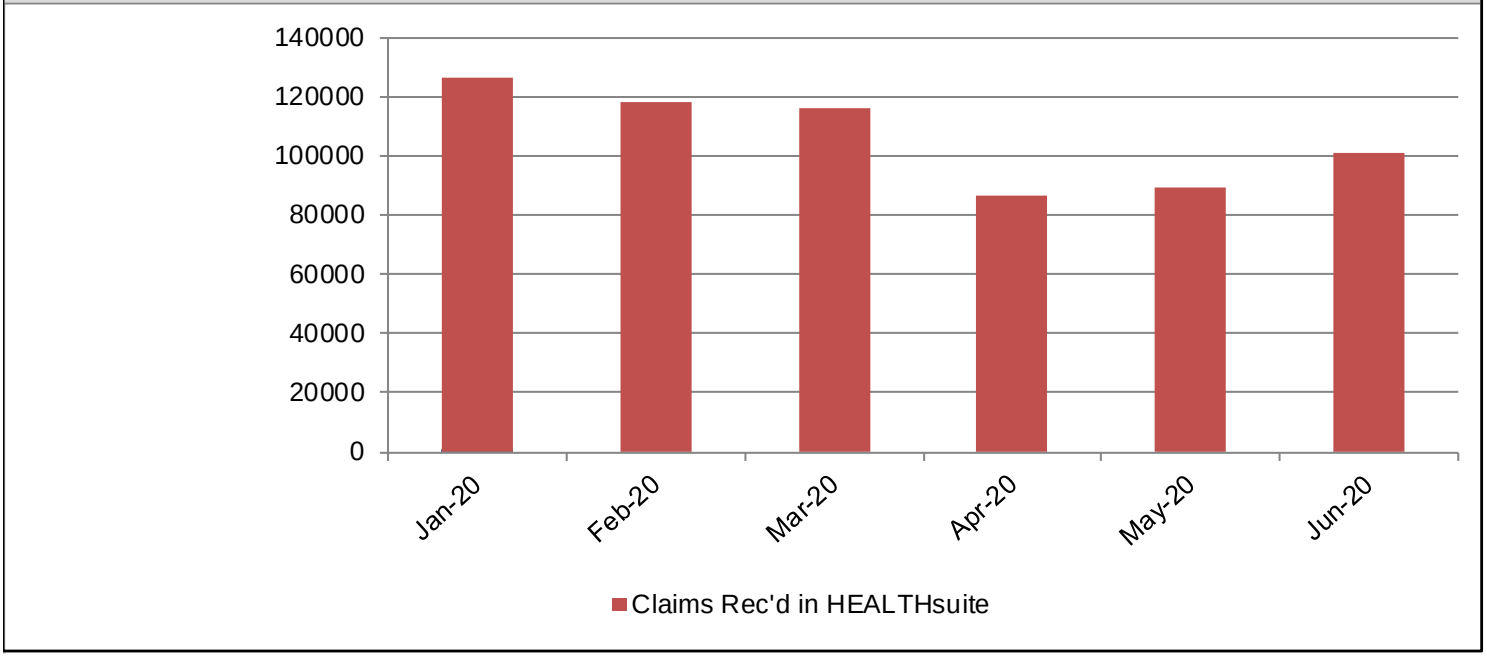
Claims Department
May 2020 Final and June 2020 Final

Jun-20

Top 5 HEALTHsuite Denial Reasons	% of all denials
Duplicate Claim	22%
Responsibility of Provider	16%
Must Submit as a Paper Claim with Copy of Primary Payer EOB	13%
Non-Covered Benefit for this Plan	7%
Per Medi-Cal Guidelines The Place of Service Code is Missing or Invalid for Procedure Code	6%
% Total of all denials	**64%**

Claims Received By Month

Claims Received Through	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Claims Rec'd in HEALTHsuite	126,044	118,309	115,716	86,578	89,063	101,083



Provider Relations Dashboard June 2020

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	6256	5179	6191	5630	5740	6281						
Abandoned Calls	1354	566	921	981	781	1158						
Answered Calls (PR)	4902	4613	5270	4649	4959	5123						
Recordings/Voicemails	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Incoming Calls (R/V)	680	309	517	563	376	588						
Abandoned Calls (R/V)												
Answered Calls (R/V)	680	309	517	563	376	588						
Outbound Calls	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Outbound Calls	1308	1187	1439	948	1032	1035						
N/A												
Outbound Calls	1308	1187	1439	948	1032	1035						
Totals	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Total Incoming, R/V, Outbound Calls	8244	6675	8147	7141	7148	7904						
Abandoned Calls	1354	566	921	981	781	1158						
Total Answered Incoming, R/V, Outbound Calls	6890	6109	7226	6160	6367	6746						

Provider Relations Dashboard June 2020

Call Reasons (Medi-Cal and Group Care)

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	3.0%	3.3%	3.6%	2.1%	2.1%	1.6%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Benefits	4.7%	6.1%	0.6%	5.2%	4.3%	4.4%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Claims Inquiry	40.7%	39.7%	41.9%	51.7%	54.8%	46.2%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Change of PCP	3.2%	3.5%	3.7%	1.7%	2.1%	2.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Complaint/Grievance (includes PDR's)	2.7%	2.9%	2.4%	2.5%	2.9%	2.3%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Contracts	0.2%	0.4%	0.3%	0.3%	0.4%	0.4%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Correspondence Question/Followup	0.0%	0.0%	0.1%	0.0%	0.1%	0.1%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Demographic Change	0.1%	0.1%	0.1%	0.0%	0.1%	0.1%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Eligibility - Call from Provider	27.7%	24.3%	25.3%	14.0%	14.8%	15.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Exempt Grievance/ G&A	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
General Inquiry/Non member	0.2%	0.1%	0.2%	0.1%	0.2%	0.2%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Health Education	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Intrepreter Services Request	2.0%	2.3%	2.8%	1.4%	1.6%	1.6%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Kaiser	0.1%	0.3%	0.0%	0.3%	0.2%	0.2%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Member bill	0.0%	0.0%	0.7%	0.8%	1.0%	0.9%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Mystery Shopper Call	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Provider Portal Assistance	2.3%	3.4%	6.3%	7.6%	6.4%	3.7%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Pharmacy	0.8%	1.0%	0.7%	0.8%	0.8%	0.7%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Provider Network Info	0.1%	0.3%	0.1%	0.1%	0.1%	0.1%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Transferred Call	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
All Other Calls	11.9%	12.1%	11.1%	11.2%	8.2%	20.7%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Field Visit Activity Details

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Claims Issues	8	3	6	31	33	11						
Contracting/Credentialing	1	2	2	22	24	9						
Drop-ins	12	6	48	6	0	0						
JOM's	2	3	4	3	1	4						
New Provider Orientation	17	3	3	22	23	11						
Quarterly Visits	64	124	23	177	145	147						
UM Issues	0	0	0	0	4	1						
Total Field Visits	104	141	86	261	230	183	0	0	0	0	0	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS					
Practitioners		AHP 390	PCP 358	SPEC 664	PCP/SPEC 19
AAH/AHS/CHCN Breakdown		AAH 438	AHS 203	CHCN 415	COMBINATION OF GROUPS 375
Facilities	**255**				

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	40	52	37	Y	Y
Recred Files in Process	78	64	46	Y	Y
Expirables updated Insurance, License, DEA, Board Certifications					Y
Files currently in process	**118**				

CAQH Applications Processed in June 2020	
Standard Providers and Allied Health	**Invoice not received**

June 2020 Peer Review and Credentialing Committee Approvals	
Initial Credentialing	**Number**
PCP	3
SPEC	4
ANCILLARY	2
MIDLEVEL/AHP	3
	12
Recredentialing	
PCP	5
SPEC	12
ANCILLARY	1
MIDLEVEL/AHP	1
	19
TOTAL	**31**

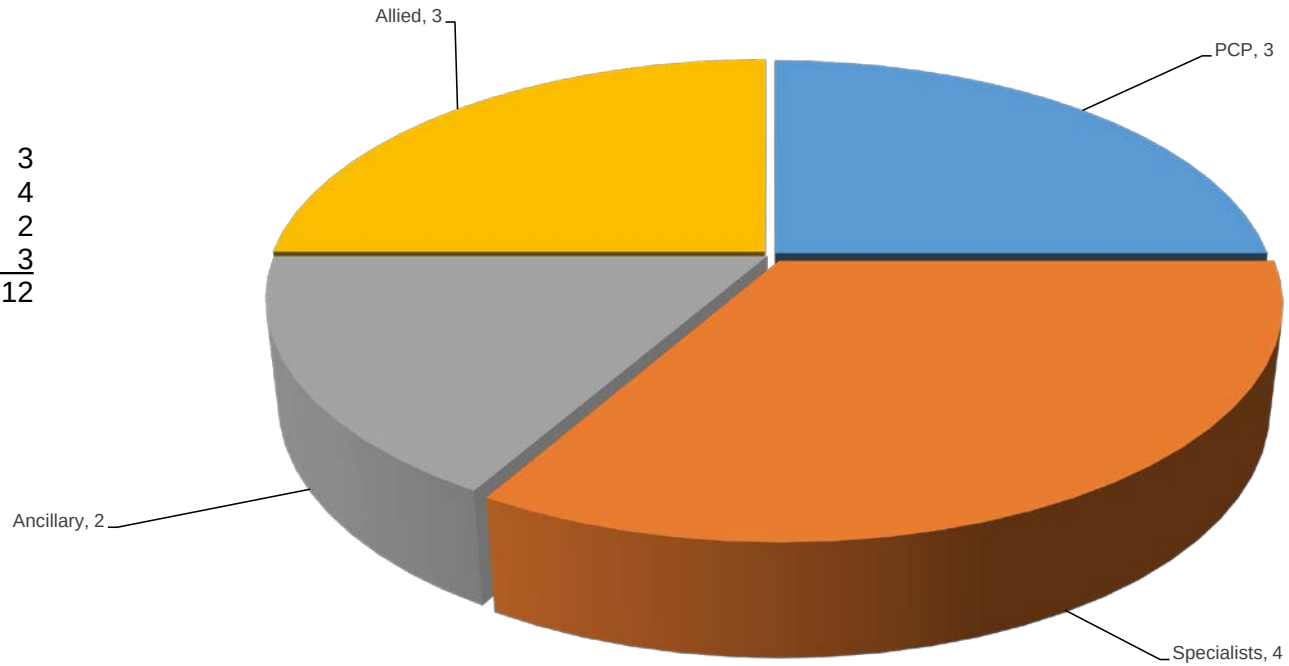
June 2020 Facility Approvals	
Initial Credentialing	3
Recredentialing	3
Facility Files in Process	34

June 2020 Employee Metrics	2.5	
File Processing	Timely processing within 3 days of receipt	Y
Credentialing Accuracy	<3% error rate	Y
DHCS, DMHC, CMS, NCQA Compliant	98%	Y
MBC Monitoring	Timely processing within 3 days of receipt	Y

Initial/Recred				
LAST NAME	**FIRST NAME**	**CATEGORY**	**INITIAL/RECRED**	**CRED DATE**
Chong	Erica	Allied Health	Initial	6/16/2020
Danishwar	Shireen	Ancillary	Initial	6/16/2020
Everett	Nancy	Specialist	Initial	6/16/2020
Gorman	Jodi	Allied Health	Initial	6/16/2020
Jagirdar	Yogesh	Primary Care Physician	Initial	6/16/2020
Kishore	Shweta	Specialist	Initial	6/16/2020
McMillan-Gordon	Brim	Specialist	Initial	6/16/2020
Mosley	Amy	Ancillary	Initial	6/16/2020
Nogue	Sophia	Allied Health	Initial	6/16/2020
Parfitt	Joshua	Specialist	Initial	6/16/2020
Seven	Nigar	Primary Care Physician	Initial	6/16/2020
Sharma	Amita	Primary Care Physician	Initial	6/16/2020
Bry	John	Specialist	Recred	6/16/2020
Cardoso	Kimberly	Allied Health	Recred	6/16/2020
Chung	Christine	Specialist	Recred	6/16/2020
Co	Christopher	Primary Care Physician	Recred	6/16/2020
Elias	Christine	Specialist	Recred	6/16/2020
Gregory	Blake	Primary Care Physician	Recred	6/16/2020
Keyashian	Brian	Specialist	Recred	6/16/2020
Khade	Ushakiran	Primary Care Physician	Recred	6/16/2020
Lai	Eric	Specialist	Recred	6/16/2020
Le	Chi	Primary Care Physician	Recred	6/16/2020
Lin	David	Specialist	Recred	6/16/2020
McDonald	Alden	Specialist	Recred	6/16/2020
Murphy	Aileen	Specialist	Recred	6/16/2020
Obnial	Gonzalo	Specialist	Recred	6/16/2020
Patel	Bijal	Specialist	Recred	6/16/2020
Rajah	R	Specialist	Recred	6/16/2020
Ramakrishnan	Sampath	Primary Care Physician	Recred	6/16/2020
Suba	Chandni	Ancillary	Recred	6/16/2020
Yu	Anne	Specialist	Recred	6/16/2020

JUNE PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY

PCP	3
Specialists	4
Ancillary	2
Allied	3
Total	12



Provider Dispute Resolution
May 2020 Final and June 2020 Final

METRICS

PDR Compliance	May-20	Jun-20
# of PDRs Resolved	603	676
# Resolved Within 45 Working Days	603	673
% of PDRs Resolved Within 45 Working Days	100%	100%

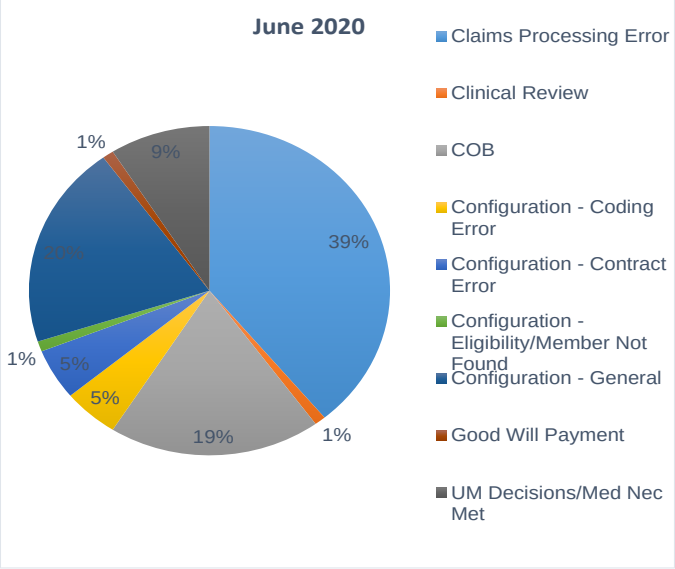
PDRs Received	May-20	Jun-20
# of PDRs Received	812	849
PDR Volume Total	**812**	**849**

PDRs Resolved	May-20	Jun-20
# of PDRs Upheld	404	444
% of PDRs Upheld	67%	66%
# of PDRs Overturned	199	232
% of PDRs Overturned	33%	34%
Total # of PDRs Resolved	**603**	**676**

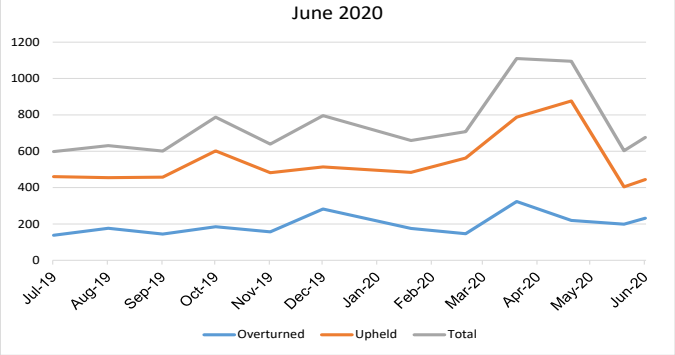
Unresolved PDR Age	May-20	Jun-20
0-45 Working Days	343	713
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**343**	**713**

Jun-20

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



Project Management Office Portfolio Overview for June 2020

Alliance Portal Redesign Project

Alliance.org- Phase 2

Objective: Phase II includes the rebuild of the entire Member Portal and also further enhance the Provider Portal. The Member Portal will be redesigned to support the new look and feel, enable new capabilities, the ability to easily access their medical information, and enable member mobile capabilities. Our goal is to redirect the customer service inquiry/response traffic to the Alliance.org channel and increase the adoption rate of the Member/Provider Portal.

Planning Phase 2: June - July

- Scope confirmed:
    - Build New Member Portal Capabilities
        - Submit and process member grievances (Automation)
        - View authorization status
        - Quarterly/Annual Member Satisfaction Data
        - Mobile compatibility (search Provider Directory, retrieve claim status, view and save ID Card as image, secure messaging, push notification for secure messaging)
        - Secure communication with Alliance representative
    - Build New Provider Portal Capabilities
        - Increase online Provider traffic by 50%
        - Redesign EOP
        - Authorization contact info (phone and fax) captured for Rendering/Servicing Provider
- Requirements gathering for in-scope capabilities complete
- Go-Live date to be confirmed
- Planning for Project kick-off meeting in progress

Preferred Vendor Project

No update

- The purpose of this project is to identify a select list of preferred vendors (SNF, Respite, Health Home, and Infusion) to collaborate with direct patient care. This will enable the Alliance to help place our most vulnerable populations and give them the services they need.
    - SNF contract signed 9/5/19
    - Oncology contract (Letter of Agreement) signed 9/3/19
    - Respite(BACS) contract signed 10/17/19, effective 11/1/19
    - Health Home internal meetings signed 10/17/19, effective 1/1/20
    - Infusion/J-Coded Drugs workgroup contract pending

COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

FY 2019-2020 | 4TH QUARTER (Q4) OUTREACH REPORT

ALLIANCE IN THE COMMUNITY

FY 2019-2020 | Q4 OUTREACH REPORT

During the 4th Quarter (Q4 – April, May, June) of Fiscal Year (FY) 2019-2020, the Alliance initiated and/or was invited to participate in a total of **88** events throughout Alameda County. The Alliance completed **0** out of the **88** events (**0%**). The Alliance reached a total of **909** people, and spent a total of **$0** in donations, fees, and/or sponsorships during Q4.

The majority of people reached at member orientations (MO) are Alliance Members. Approximately 20% of the numbers reached at community events are Medi-Cal Members, of which approximately 82% are 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, **20,306** self-identified Alliance members were also reached at community events, and member education events.

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

On **Wednesday, March 18, 2020**, the Alliance began conducting member orientations by phone. Between Wednesday, March 18, 2020 and Tuesday, June 30, 2020, the Alliance completed **1,059** net new member orientations by phone.

ALLIANCE IN THE COMMUNITY

FY 2019-2020 | Q4 OUTREACH REPORT

FY 2018-2019 Q4 TOTALS

53 COMMUNITY EVENTS

49 MEMBER EDUCATION EVENTS

72 MEMBER ORIENTATIONS

10 MEETINGS/ PRESENTATIONS

184 TOTAL INITIATED/ INVITED EVENTS

142 **TOTAL COMPLETED EVENTS**

14 CITIES

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

2509 TOTAL REACHED AT COMMUNITY EVENTS

2535 TOTAL REACHED AT MEMBER EDUCATION EVENTS

361 TOTAL REACHED AT MEMBER ORIENTATIONS

428 TOTAL REACHED AT MEETINGS/PRESENTATIONS

2008 MEMBERS REACHED AT ALL EVENTS

5833 **TOTAL REACHED AT ALL EVENTS**

$2,515 TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

FY 2019-2020 Q4 TOTALS

9 COMMUNITY EVENTS

20 MEMBER EDUCATION EVENTS

57 MEMBER ORIENTATIONS

2 MEETINGS/ PRESENTATIONS

88 TOTAL INITIATED/ INVITED EVENTS

0 **TOTAL COMPLETED EVENTS**

24 CITIES**

Alameda
Albany
Berkeley
Castro Valley
Dublin
Fremont
Hayward
Livermore
Newark
Oakland
Pleasanton
San Leandro
San Lorenzo
Union City
Burlingame
El Sobrante
Emeryville
Richmond
San Francisco
San Jose
San Pablo
San Ramon
Stockton
Tracy

0 TOTAL REACHED AT COMMUNITY EVENTS

0 TOTAL REACHED AT MEMBER EDUCATION EVENTS

909 TOTAL REACHED AT MEMBER ORIENTATIONS

0 TOTAL REACHED AT MEETINGS/PRESENTATIONS

909 MEMBERS REACHED AT ALL EVENTS

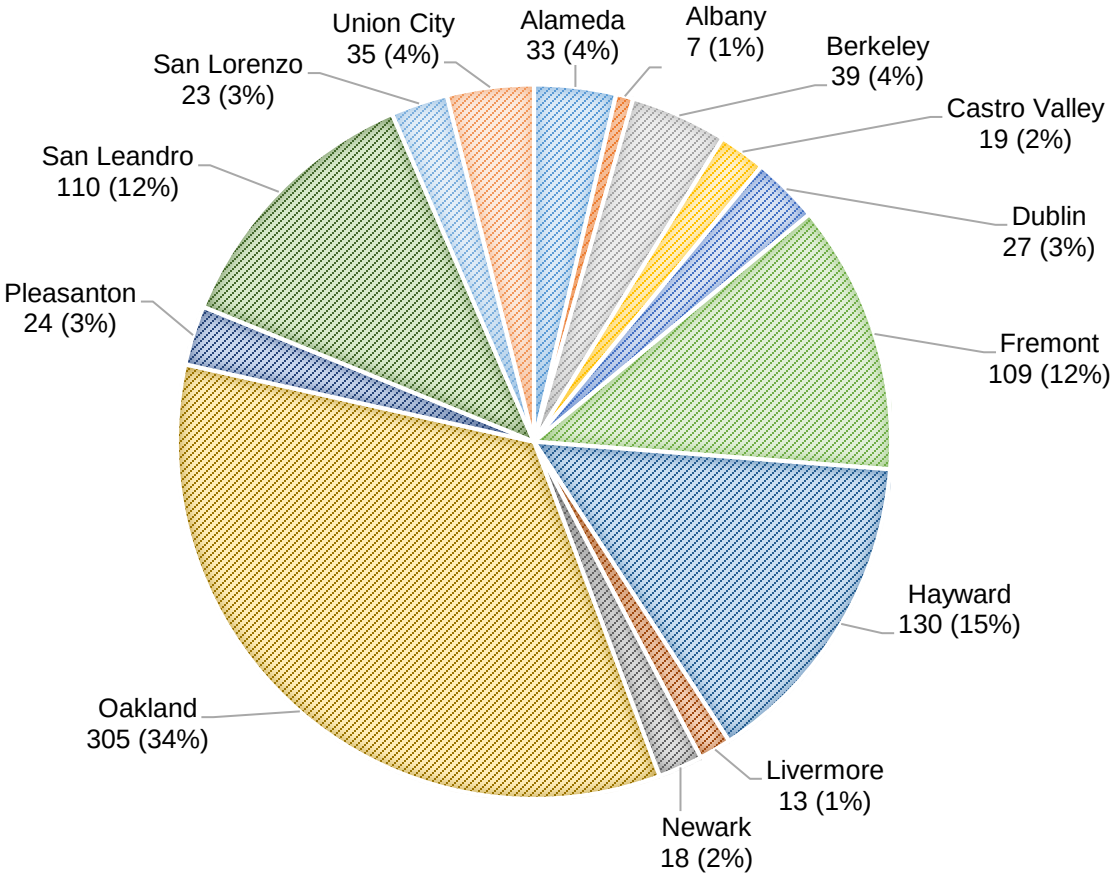
909 **TOTAL REACHED AT ALL EVENTS**

$0 TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

** Includes refundable deposit.*

***Cities represent the mailing addresses for members who completed a Member Orientation by phone. The italicized cities are outside of Alameda County. The C&O Department started including these cities in the Q4 2020 Outreach Report.*

NUMBERS REACHED BY CITY*

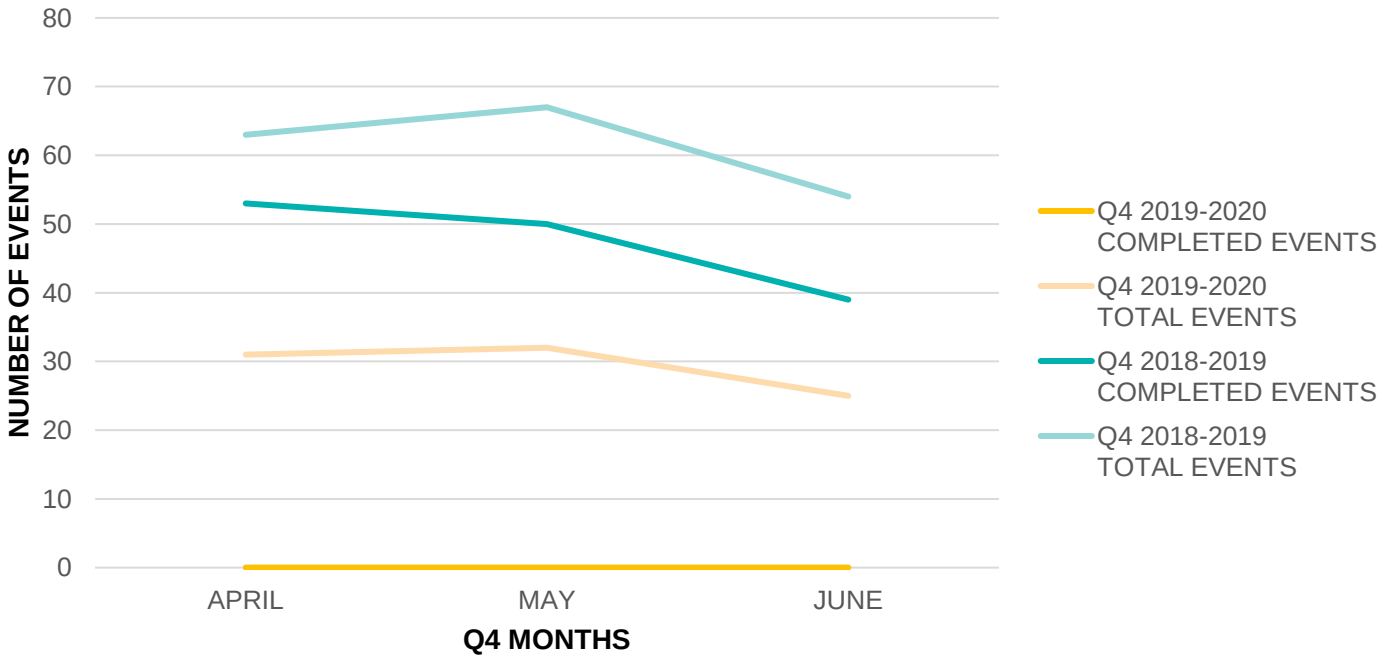


** The following cities had <1% reach during Q4 2020: Burlingame, El Sobrante, Emeryville, Richmond, San Francisco, San Jose, San Pablo, San Ramon, Stockton and Tracy.*

ALLIANCE IN THE COMMUNITY

FY 2019-2020 | Q4 OUTREACH REPORT

EVENTS
BY Q4



	APRIL	MAY	JUNE	TOTAL
Q4 2019-2020 – COMPLETED EVENTS	0	0	0	**0**
Q4 2019-2020 – TOTAL EVENTS	31	32	25	**88**
Q4 2018-2019 – COMPLETED EVENTS	53	50	39	**142**
Q4 2018-2019 – TOTAL EVENTS	63	67	54	**184**

The graph above compares completed events to total events during Q4 of FY 2018-2019 and FY 2019-2020.

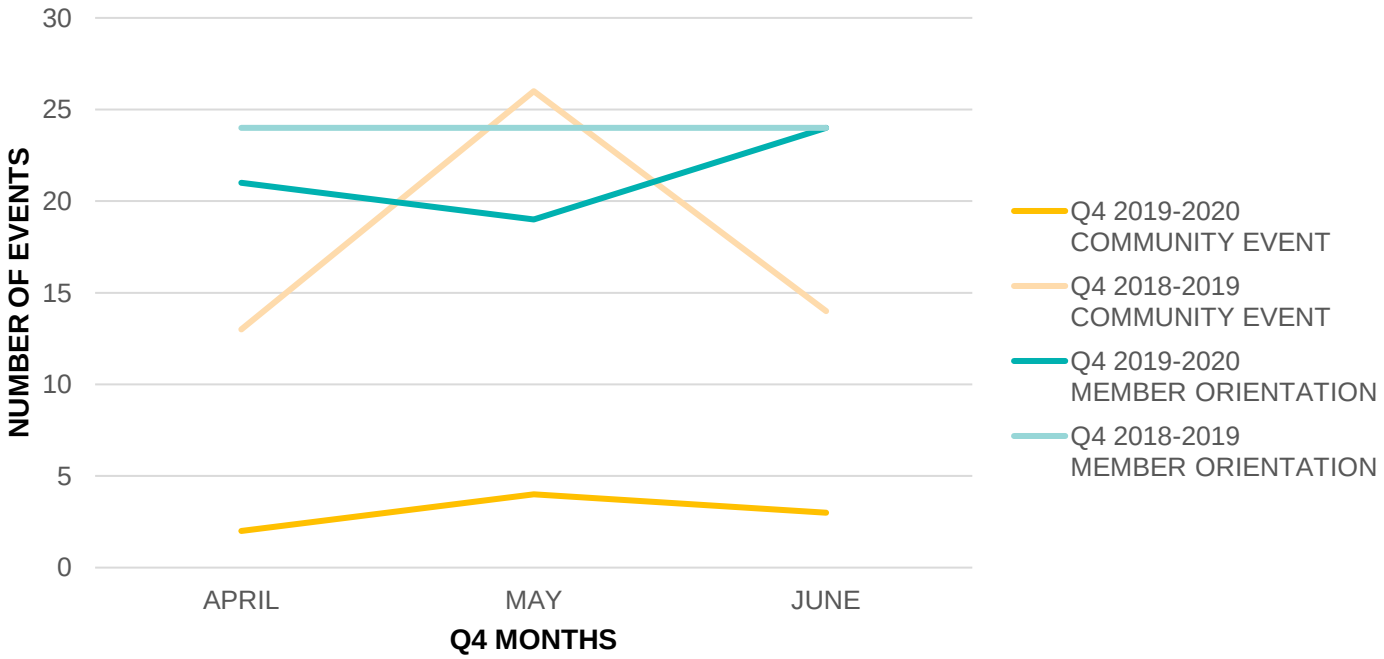
During Q4 of FY 2019-2020, the Alliance completed a total of **0** out of **88** events (0%), compared to 142 out of 184 (77%) during Q4 of FY 2018-2019.

The graph on page **7** compares community events, and member orientations (MOs) in Q4 of FY 2018-2019 and 2019-2020.

ALLIANCE IN THE COMMUNITY

FY 2019-2020 | Q4 OUTREACH REPORT

EVENT TYPE
BY Q4



	APRIL	MAY	JUNE	TOTAL
Q4 2019-2020 – COMMUNITY EVENT	2	4	3	**9**
Q4 2018-2019 – COMMUNITY EVENT	13	26	14	**53**
Q4 2019-2020 – MEMBER ORIENTATION	21	19	17	**57**
Q4 2018-2019 – MEMBER ORIENTATION	24	24	24	**72**

In Q4 of FY 2019-2020, the Alliance scheduled a total of 9 community events, compared to the scheduled 53 in Q4 of FY 2018-2019. The Alliance decreased the number of scheduled community events by **83%**.

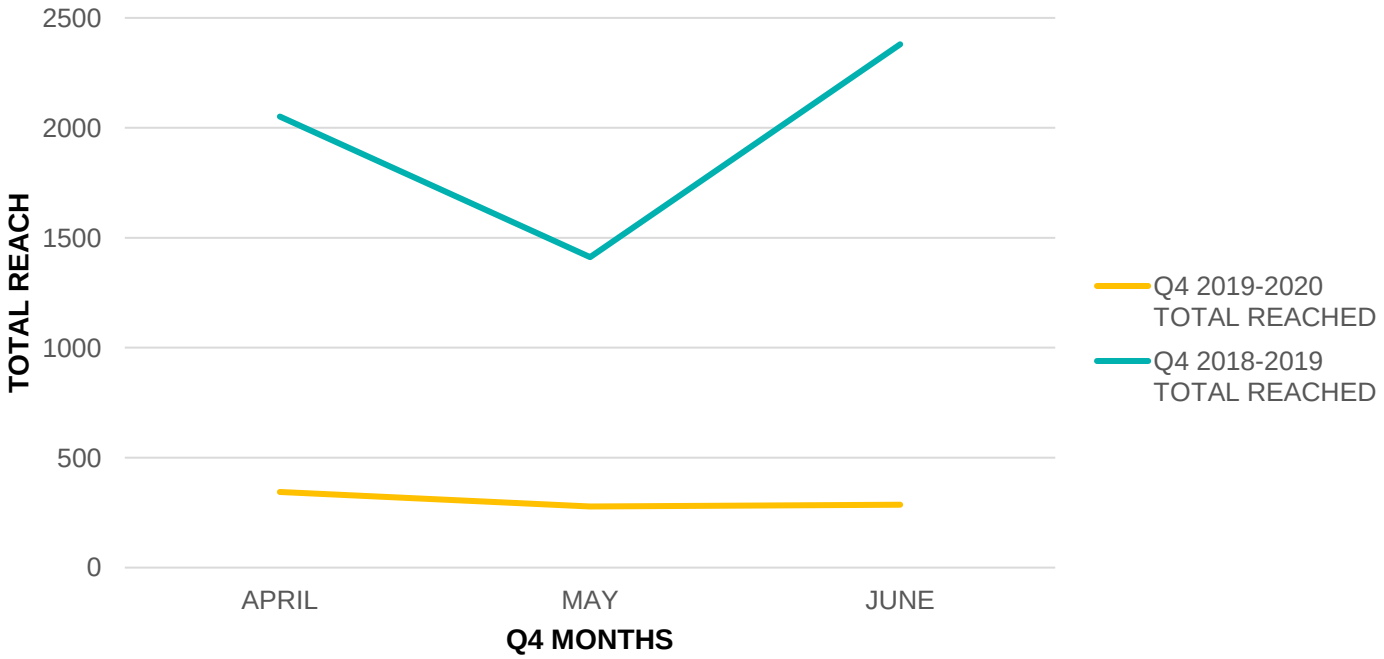
In Q4 of FY 2019-2020, the number of scheduled MOs decreased by **21%**. There was a total of 57 MOs in Q4 of FY 2019-2020, compared to the scheduled 72 in Q4 of FY 2018-2019.

Prior to 2018, the C&O Department measured two (2) event types: community events, and MOs. Since 2018, the C&O Department added three (3) additional categories: member education events, meeting/presentations, and community trainings.

ALLIANCE IN THE COMMUNITY

FY 2019-2020 | Q4 OUTREACH REPORT

TOTAL REACHED
BY Q4



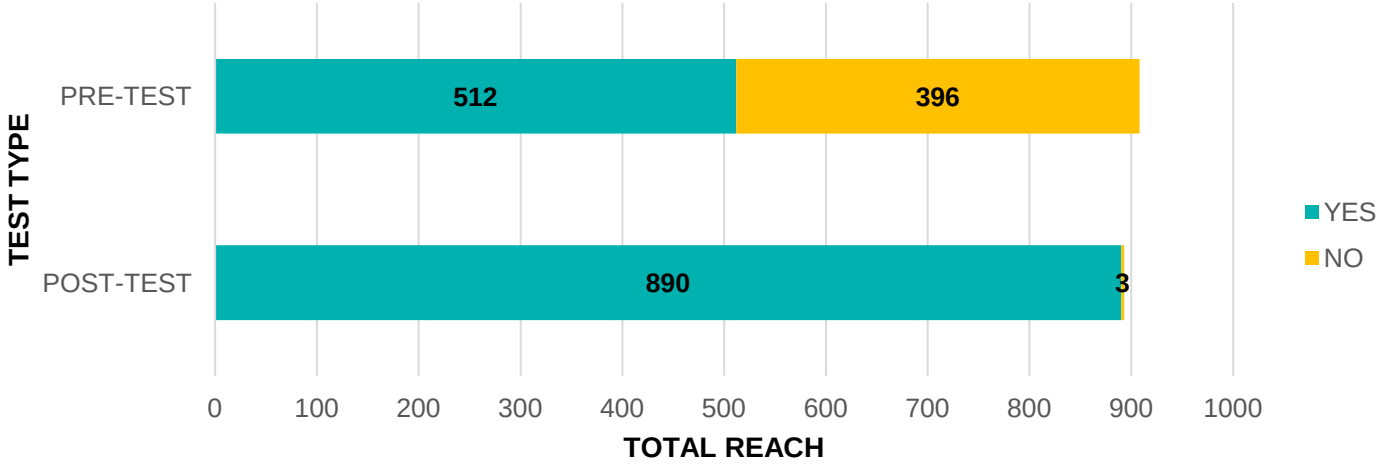
	APRIL	MAY	JUNE	TOTAL
Q4 2019-2020 – TOTAL REACHED	344	278	286	**909**
Q4 2018-2019 – TOTAL REACHED	2051	1412	2380	**5833**

The graph above compares the total reached at **all Alliance outreach events** in Q4 of FY 2018-2019 and Q4 of FY 2019-2020.

During Q4 of FY 2019-2020, the Alliance decreased the total reach by **84%** from 5,833 to 909 at all events.

During Q2 of Fiscal Year 2017-2018, the C&O Department implemented an event tracking tool to improve our tracking method, and to help prevent overstating numbers reached.

INITIAL HEALTH ASSESMENT KNOWLEDGE
DURING Q4



	YES	NO	TOTAL
Q4 2019-2020 – PRE-TEST	510	396	**908**
Q4 2019-2020 – POST-TEST	890	3	**893**

Before and after an MO, members are asked to complete a pre-test and a post-test. The graph above compares the responses of members when asked “Do you know when to get your Initial Health Assessment (IHA)?”

After completing an MO, **98%** of members who completed the post-test survey in Q4 of FY 2019-2020 reported knowing when to get their IHA, compared to only 57% of members knowing in the pre-test.

ALAMEDA Alliance FOR HEALTH

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

Compliance

Kofi Johnson

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

From: **Kofi Johnson, Compliance Manager**

Date: **July 10, 2020**

Subject: **Compliance Report**

State Audit Updates

- 2020 DMHC Follow Up Medical Audit:
  - The DMHC conducted a follow up audit onsite on 2/04/20 for the outstanding deficiencies identified in the 2018 final report of the routine medical audit. There were 12 outstanding findings that were reviewed during the onsite audit. The Plan received the final report on June 30. According to the report, five (5) of the 12 outstanding items remain "not corrected." The Plan will provide a narrative response for these items, to be published along with the final report on July 10. The Plan is likely to receive an enforcement action request from the DMHC in the next 6-12 months.

- 2020 DHCS Medical Audit:
  - The DHCS has postponed the annual medical audit previously scheduled in June due to COVID-19. The Plan's audit has been tentatively rescheduled for October 12-23, and will be conducted entirely remotely. The Plan expects the formal audit notification within the next two weeks.

- 2020 DMHC Medical Audit:
  - The DMHC has rescheduled this year's expected triannual full survey, originally set for October 12, to April 12, 2021. Determination as to whether the audit will be conducted in-person or remotely will occur in early 2021.

Regulatory Updates

- Since the declaration of the public emergency, the Plan has prioritized tracking daily State guidance for implementation to ensure members have access to medically necessary services and providers are kept up to date with the Plan's operational changes. Since mid-March, the Plan reports any new COVID-19 positive tests and hospitalization daily to DHCS. As of 7/6/20, the Plan has had 217 members test positive for COVID-19 and 314 hospital admissions associated with COVID-19.

- No new relevant all plan letters have been released by either the DMHC or DHCS in the previous month.

Compliance

Supporting Documents

APL/PL IMPLEMENTATION TRACKING LIST							
#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	Summary of Key Requirements	Status
1	DHCS	20-001	1/3/2020	2020-2021 MEDI-CAL MANAGED CARE HEALTH PLAN MEDS/834 CUTOFF AND PROCESSING SCHEDULE	Medi-Cal	1) MEDS/834 cutoff and processing schedule covers the period of Dec 2019-Jan 2021. These cutoff dates and timelines are established to ensure timely processing of eligibility files and data. 2) DHCS must receive all enrollments and disenrollments on a dialy basis. 3) MCPs must adhere to the cutoff dates and timelines to allow adequate processing time and to ensure timely payments. 4) MCPs must notify the Managed Care Operations Division (MCOD) Systems Support Unit (SSU) of any MCP/MEDS/834 changes prior to the 15th of any given month by sending an email to ssuhelpdesk@dhcs.ca.gov. 5) MCPs send the original copy of their notification to their assigned MCOD Contract Mgr.	Completed
2	DMHC	20-001	1/15/2020	Newly Enacted Statutes Impacting Health Plans	Both	14 new statutory requirements. 6 of the 14 are not applicable to AAH. The others are still under review.	Ongoing
3	DHCS	20-002	1/31/2020	Non-Contract Ground Emergency Medical Transport Payment Obligations (GEMT)	Medi-Cal	Provides Medi-Cal managed care health plans (MCPs) with pertinent information concerning enhanced reimbursement obligations for Fee-For-Service (FFS) ground emergency medical transport (GEMT) "Rogers Rates" On September 6, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 19-0020, with an effective date of July 1, 2019. SPA 19-0020 continues the GEMT QAF program and a reimbursement add-on amount for GEMT services provided by emergency medical transport providers to MCP Members beginning on July 1, 2019. DHCS intends to renew the GEMT QAF program and the reimbursement add-on for GEMT services provided by emergency medical transport providers for future program years. Beginning on July 1, 2019, in addition to the FFS fee schedule base rate for GEMT services, emergency medical transport providers will be entitled to a fixed add-on amount of $220.80 for non-contracted GEMT services provided to MCP Members. The resulting payment amounts will be equal to the sum of the FFS fee schedule base rate and the add-on amount for each CPT Code. The resulting total payment amount for CPT codes A0429, A0427, A0433, and A0434 is $339.00 and for CPT code A0225, it is $400.72.	Completed
4	DMHC	20-002	1/21/2020	Enrollment Data Reporting	Group	New template to be used annually to report MEWA and Exchange Enrollment Report as of December 31st. Must be filed by 2/15/20 as an attachment to the 4Q19 Financial Satement via the DMHC's Financial Statements web portal. Subsequent years filing due by 2/15.	Completed
5	DMHC	20-003	1/24/2020	Provider Directory Annual filings 2020	Both	Submit provider directory policies and procedures to the Department annually. Attached are the Department's Provider Directory Checklist – Annual Filing and the Model E-1 Exhibit for Section 1376.27 compliance filings.	Completed
6	DHCS	20-003	2/27/2020	Network Certification Requirements	Medi-Cal	MCP's must: Contract with the required number and mix of primary and specialty care providers; Provide medically necessary services needed for their anticipated membership and utilization; Confirm that the geographic location of network providers complies with time and distance standars; and Comply iwth service availability, physical accessibility, out-of-netowrk (OON) access, timely access, continuity of care, and 24/7 language assistance requirements.	Ongoing
7	DHCS	20-004	3/27/2020	Emergency Guidance for Medi-Cal Managed Care Health Plans in Response to COVID-19	Medi-Cal	1. Well-Child Visits: DHCS is providing guidance on pediatric well-care services via telehealth during the pandemic. The guidance suggests that well-child visits should be initiated through telehealth, however there are some services that should be done in person such as the comprehensive physical exam, office testing, immunizations, hearing, vision, and oral health screenings. These services would be a continuation of services provided via telehealth/virtual and the provider should only bill for one encounter/visit. In addition, to ensure adherence to the Bright Futures guidelines, DHCS is advising MCPs to encourage pediatric providers to discuss with members the benefits of attending well-child visits in person to receive the necessary immunizations and screenings, in addition to the provision of services via telehealth. 2. File and Use: DHCS has approved for MCPs to submit certain documents including proposed telephone outreach scripts related to COVID-19 as file and use, which means that once an MCP submits documents or scripts to DHCS, the MCP can immediately begin using those documents or scripts with its members. All information communicated to members must be information related to COVID-19 that directly came from DHCS, the California Department of Public Health, or the CDC. In addition, documents or scripts must not contain any PHI or Personal Information of a member. The following are documents and scripts approved for file and use. 3. Temporary Reinstatement of Acetaminophen and Cough/Cold Medicines: DHCS issued guidance on May 13, 2020 regarding the temporary reinstatement of non-legend acetaminophen-containing products and non-legend cough and cold products for adults as covered benefits with the Medi-Cal FFS program. MCPs are required to follow this FFS-issued guidance, including the provision of these over-the-counter drugs without prior authorization. 4. Temporary Addition of Provider Types at FQHCs and RHCs: Pursuant to SPA 20-0024, DHCS issued guidance on May 20, 2020, temporarily adding the services of Associate Clinical Social Workers (ACSWs) and Associate Marriage and Family Therapists (AMFTs) at FQHCs and RHCs as billable visits. The California Board of Behavioral Sciences (BBS) does not consider ACSWs or AMFTs to be licensed practitioners, therefore licensed behavioral health practitioners must supervise and assume the professional liability of services furnished by the unlicensed ACSW and AMFT practitioners. FQHCs or RHCs can be reimbursed in accordance with the terms of the MCPs contract with the State related to FQHCs and RHCs for a visit between an FQHC or RHC patient and an ACSW or AMFT. The visit may be conducted as a face to face encounter or meet the requirements of a visit provided via telehealth.	Ongoing

8	DMHC	20-004	2/7/2020	Federal SBC Template Filing	Group	A new federal template must be used for the Summary of Benefits and Coverage (SBC) to enrollees. The template must be used in connection with Individual and Group contract issued, amended, or renewed for plan or policy years that begin on or after Juanuary 1, 2021. **Filing is due March 2, 2020.**	Completed
9	DMHC	20-005	2/7/2020	Plan Year 2021 QHP an QDP Filing Requirements	N/A	Doesn't Apply to AAH	N/A
10	DHCS	20-005		Extension of the Adult Expansion Risk Corridor for SFY 2017-2018	N/A	Doesn't Apply to AAH	N/A
11	DMHC	20-006	3/5/2020	COVID-19 Screening and Testing	Both	1.Immediately reduce cost-sharing (including, but not limited to, co-pays,deductibles, or coinsurance) to zero for all medically necessary screening andtesting for COVID-19, including hospital (including emergency department),urgent care visits, and provider office visits where the purpose of the visit is to bescreened and/or tested for COVID-19. 2.Notify, as expeditiously as possible, the plan's contracted providers that the planis waiving cost-sharing as described above. 3.Ensure the plan's advice line/customer service representatives are adequatelyinformed that the plan is waiving cost-sharing as described above and clearlycommunicate this to enrollees who contact the plan seeking medically necessaryscreening and testing for COVID-19. 4.Prominently display on the plan's public website a statement that the plan iswaiving cost-sharing for medically necessary screening and testing for COVID-19. 5. Plans should work with their contracted providers to use telehealth services to deliver care when medically appropriate, as a means to limit enrollees' exposure to others who may be infected with COVID-19, and to increase the capacity of the plans' contracted providers. 6. In the event of a shortage of any particular prescription drug, plans should waive prior authorization and/or step therapy requirements if the enrollee's prescribing provider recommends the enrollee take a different drug to treat the enrollee's condition.	Ongoing
12	DHCS	20-006	3/4/2020	Site Reviews - Facility Site Reivew and Medical Record Review	Medi-Cal	The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (MCPs) of updates to the Department of Health Care Services' (DHCS) site review process, which includes Facility Site Review (FSR) and Medical Record Review (MRR) policies. This APL includes changes made to the criteria and scoring of DHCS' FSR and MRR tools and standards.	Ongoing
13	DMHC	20-007	3/12/2020	"Social Distancing" Measures in Response to COVID-19	Both	1. If the health plan has pre-authorization or pre-certification requirements that contracted providers must meet before the plan will cover care delivered via telehealth, as defined in Business and Professions Code section 2290.5, the plan should either expedite the plan's review process or relax those pre-authorization/pre-certification requirements to allow the plan to more quickly approve providers to offer services via telehealth. 2. Plans should waive applicable cost-sharing for care delivered via telehealth, notwithstanding that a cost-share might apply if the provider delivered the care in-person. 3. Plans should allow enrolless to receive at least a 90-day supply of maintenance drugs, as defined in California Code of Regulations section 1300.67.24(d)(3)(D), unless the enrollee's provider has indicated a shorter supply of a drug is appropriate for the enrollee. 4. Plans should suspend prescription drug refill limitations where the enrollee's provider has indicated a refill is appropriate for the enrollee. 5. Plans should waive delivery charges for home delivery of prescription medications.	Completed
14	DHCS	20-007	3/30/2020	Policy Guidance for Community-Based Adult Services in Response to COVID-19 Public Health Emergency	Medi-Cal	1. Congregate services provided inside the center are not allowed during the period of this public health emergency. Essential services to individual members may be provided in the center so long as they meet criteria defined in this APL and with proper safety precautions. 2. CBAS centers are granted time-limited flexibility to reduce day-center activities and to provide CBAS in the home, telephonically, or via live virtual video conferencing, including but not limited to: Professional nursing care-Personal care services Social Services-Behavioral Health Services-Speech therapy-Therapeutic activities-Registered dietician-nutrition counseling 3. CBAS centers are also permitted to provide or arrange for home-delivered meals, in absence of meals provided at the CBAS center, and may continue to provide transportation services, as necessary and appropriate. 4. CBAS centers are eligible to receive their existing per diem rate for the provision of CBAS as described in this APL. MCPs must continue to authorize and reimburse CBAS centers for the delivery of services provided in the member's home, telephonically or via live virtual video conferencing. Delivery of services must be based on a CBAS member's assessed needs as documented in the current Individual Plan of Care (IPC), and/or identified by subsequent assessment by the center's multidisciplinary team. 5. Per the current 1115 Waiver special terms and conditions, for initial eligibility determinations, an initial face-to-face review is not required when an MCP determines that a member is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on the information that the MCP possesses. MCPs may extend eligibility re-determinations for the ongoing receipt of CBAS to up to 12 months for members determined by the MCP to be clinically appropriate. DHCS encourages MCPs to minimize or eliminate requirements for face-to-face interactions, whenever possible. 6. Existing CBAS health record documentation standards for services provided will continue to apply. CBAS centers are responsible for updating member IPCs when a change in assessed need is identified through regularly scheduled reassessments, and reassessments conducted due to a change in participant condition. 7. MCPs may require regular reporting by the CBAS centers, at a frequency and format required by the MCP, to substantiate the provision of services provided in accordance with this APL. 8. MCPs are responsible for ensuring that their subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all subcontractors and network providers.	Completed

15	DMHC (OPL)	20-008	3/18/2020	Provision of Health Care Services During Self Isolation Orders		1. On March 16, 2020, seven Bay Area counties (Contra Costa, Santa Clara, San Mateo, San Francisco, Alameda, Santa Cruz and Marin) and the city of Berkeley issued an order (Orders) directing people to self-isolate to the maximum extent possible at their residences through April 7, 2020. 2. The County and City Orders are explicit that health plan personnel whose work is necessary to "avoid any impacts to the delivery of healthcare, broadly defined" are exempt from the Orders and may travel to and from work. Also exempt from the Orders are health plan personnel whose work is necessary to ensure the continued performance of core health plan functions and/or facilitate the remote work of other health plan employees. 3. The DMHC understands plans may choose to delay some services, such as elective surgeries or other non-urgent procedures, during this time. This is permissible provided the referring or treating provider, or the health professional providing triage or screening services, as applicable, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee. 4. If the plan does not have personnel available to mail hard-copy information, it is sufficient to communicate with enrollees and providers electronically and/or telephonically, so long as the plan maintains a log or record of the communications.	Ongoing
16	DHCS	20-008	4/7/2020	Mitigating Health Impacts of Secondary Stress Due to the COVID-19 Emergency	Medi-Cal	1. MCPs and their providers are reminded to utilize the ACEs-oriented, trauma-informed care training for providers, as well the ACEs screening services, billing codes, and minimum provider fee schedule described in APL 19-018. 2. MCPS and their providers are to stay informed as to the most current guidance and best practices relative to COVID-19. 3. MCPs and their providers should support continuity and integration of medical and behavioral services via telehealth and related adaptions in delivery during the crisis. 4. MCPs should educate their providers on disaster-responsive, trauma-informed care. 5. MCPS should ensure their providers learn the signs of and assess for stress-related morbidity, and create responsive treatment plans, including supplementing usual care with measures that help regulate the stress response system. 6. MCPs are responsible for ensuring that their subcontractors and network providers comply. Requirements must be communicated by each MCP to all subcontractor and network providers.	Closed
17	DMHC	20-009	3/18/2020	Reimbursement for Telehealth Services	Both	1. Health plans shall reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim. For example, if a health plan reimburses a mental health provider $100 for a 50-minute therapy session conducted in-person, the health plan shall reimburse the provider $100 for a 50-minute therapy session done via telehealth. 2. For services provided via telehealth, a health plan may not subject enrollees to cost-sharing greater than the same cost-sharing if the service were provided in-person. 3. Health plans shall provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the enrollee.	Closed
18	DHCS	20-009	4/15/2020	Preventing Isolation of and Supporting Older and Other At-Risk Individuals to Stay Home and Stay Healthy During COVID-19 Efforts	Medi-Cal	1. MCPs must continue to support telehealth for all services for which it is medically appropriate. 2. MCPs and their contracted providers should continually assess for and provide allowable additional services and supports during this time that may be vital for an older or at-risk adult to stay home and stay healthy. 3. MCPs and their contracted providers should support continuity and coordinate the integration of medical and behavioral health services for all ages. 4. MCPs are encouraged to continue their check-in calls (see below resources) with older and other at-risk adults, to check on basic needs, health care, mental health, and safety from abuse and neglect.	Closed
19	DHCS	20-010	4/20/2020	Cost Avoidance and Post-Payment Recovery for Other Health Coverage	Medi-Cal	1. MCPs must report new OHC information not found on the Medi-Cal eligibility record or OHC information thaty is different from what is found on the Medi-Cal eligibility record to DHCS within 10 calendar days of discovery. 2. Beginning January 1, 2021, MCPs must include OHC information in their notification to the provider when a claim is denied due to the presence of OHC. 3. MCPs must ensure providers review the Medi-Cal eligibility record for the presence of OHC. 4. Prior to delivering services to members, MCPs must ensure providers review the Medi-Cal eligibility record for the presence of OHC. 5. MCPs must ensure providers do not refuse a covered Medi-Cal service to a Medi-Cal member regardless of the presence of OHC. 6. Effective February 9, 2018, prenatal care is subject to cost avoidance. 7. MCPs must not process claims for a member whose Medi-Cal eligibility record indicates OHC, other than a code of A or N, unless the provider presents proof that sources of payment have been exhausted or the provided service meets the requirements for billing Medi-Cal directly. 8.	Ongoing
20	DMHC	20-010	3/18/2020	Special Enrollment Period; Coverage Effective Dates	N/A	Doesn't Apply to AAH	N/A

21	DMHC	20-011	3/26/2020	2020 Annual Assessment Letter	Both	1. Please file on or before **May 15, 2020**, the Report of Enrollment Plan, as required by Health and Safety Code section 1356 and the California Code of Regulations, title 28, section 1300.84.6(a). The Report of Enrollment Plan is an online form to be filed electronically, via the Department's eFiling web portal. This form is used to calculate the annual assessment for each health plan. 2. Once in the Department's eFiling portal, select Online Forms. From the drop-down menu, select Annual Enrollment Report, and then complete and submit the report. For questions or problems related to the electronic filing of the report or pertaining to the number of enrollees to be reported, please contact Vijon Morales at (916) 255-2447 or via electronic mail at Vijon.Morales@dmhc.ca.gov. 3. Please be aware that Health and Safety Code section 1356, subdivision (f) provides that no refunds or reductions of the amount assessed shall be allowed if any miscalculated assessment is based on a health plan's overestimate of enrollment. 4. Please note that the enrollment numbers reported in the Report of Enrollment Plan will be compared with the health plan's enrollment numbers included in Report #4: Enrollment and Utilization Table, filed with the March 31, 2020 quarterly financial statements. Therefore, the March 31, 2020 financial statements must be filed with the Department prior to the filing of the Report of Enrollment Plan. Please coordinate the submission of the Report of Enrollment Plan with the individual at the health plan who is responsible for submitting the March 31, 2020 financial statements. 5. Enhancements have been made to the online form to assist health plans that have to report Quality Improvement Fee (QIF), Administrative Services Only (ASO), or out-ofstate enrollment for financial reporting purposes that create a discrepancy regarding the enrollment numbers provided on the Report of Enrollment Plan. If there is a discrepancy between the enrollment numbers reported in the Report of Enrollment Plan and Report #4: Enrollment and Utilization Table, the health plan will need to provide an explanation in the designated area on the form. This will alleviate the health plan having to file an additional document that explains the reasons for the discrepancy in enrollment reported. Again, please take care to accurately report your enrollment because there can be no refunds issued, pursuant to Health and Safety Code section 1356, subdivision (f).	Closed
22	DHCS	20-011	4/27/2020	Governor's Executive Order N-55-20 In Resonse To COVID-19	Medi-Cal	1. DHCS is permitting MCPs to temporarily suspend the contractual requirement for in-person site reviews, medical audits of MCP subcontractors and network providers, and similar monitoring activities that would require in-person reviews; this does not negate MCPs responsibility to comply with all currently imposed CAP requirements. MCPs must continue to meet CAP milestones as outlined in the CAP process. If MCPs need additional flexibility on submission deadlines, DHCS will review requests on a a case-by-case basis and adjust timeframes accordingly. 2. DHCS encourages MCPs to explore alternatives to in-person site reviews, such as site reviews that are conducted virtually. However, DHCS may require MCPs to complete follow-up onsite site reviews as allowable under future guidance. 3. While the EO remains in effect, A&I staff may reach out to MCPs regarding an upcoming scheduled annual medical audit, or an audit that began prior to COVID-19 public health emergency but is still in progress. MCPs are encouraged to discuss with A&I the feasibility of proceeding with an upcoming annual medical audit, or continuing work on an audit that is already in progress. A&I understands that the impact that COVID-19 is having on MCP operations will be a deciding factor. 4. Virtual alternatives to in-person contact will be used to the extent possible to communicate with the MCP and to obtain needed documentation. Alternatively, if the MCP would prefer to postpone the scheduled audit, or delay current efforts to complete an audit in progress due to COVID-19, A&I will reschedule the audit or delay current audit activity to a later time. 5. MCPs are still required to conduct risk stratification using health care utilization data for all newly enrolled SPDs. MCPs must also continue to comply with Title 42, Code of Federal Regulations (CFR) section 438.208(b)(3)4 through the use of the Health Information Form/Member Evaluation Tool within 90 days of enrollment for all newly enrolled members, as required in APL 17-013 and the MCP contract. 6. MCPs may update their risk stratification and HRA survey process to identify members most vulnerable due to COVID-19 and its related impacts, addressing needs where it is possible and safe to do so. 7. MCPs are responsible for ensuring that their subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all subcontractors and network providers.	Ongoing
23	DHCS	20-012	5/15/20	Private Duty Nursing (PDN) Case Mangement Responsibilities for Medi-Cal Eligible Members Under the age of 21	Medi-Cal	PDN Case Management Responsibilities -- When a Medi-Cal eligible member under the age of 21 is approved for PDN services and requests that the MCP provide case management services for those PDN services. MCP's must notify members that MCP has the primary responsibilty for case management of PDN Services, what those case management services are and how to access those services. MCP must create a template or other means of communications to those members under 21 who have been authorized for PDN services.	Ongoing
24	DMHC need docs put into folder	20-012	3/27/2020	Health Plan Actions to Reach Vulnerable Populations	Both	The DMHC released guidance to health plans stating Plan should be actively engaging with members in vulnerable populations. These populations includes people age 65 and up, those with chronic conditions and disabilities that have an increased risk in developing complications or dying from COVID-19. The Plan is required to submit actions and steps the Plan is taking to actively engage with its members in these populations by 3/31.	
25	DMHC	20-013	4/7/2020	Billing for Telehealth Services; Telehealth for the Delivery of Services	Both	1. APL is a follow up to APL 20-009 to increase uniformity and efficiency with respect to provider billing during the COVID-19 State of Emergency to drecrease admnistrative burdens on providers and plans. As per APL 20-009, a) Reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim. b) For services provided via telehealth, not subject enrollees to cost-sharing greater than the same cost-sharing if the service were provided in-person. c) Provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the enrollee. 2. During the COVID-19 State of Emergency, when a provider delivers a service via telehealth that the provider would normally deliver in-person, the provider should document and bill the service(s) as follows: a) Thoroughly document the visit as if the visit had occurred in person. b) Use the CPT codes for the particular services rendered. c) Use Place of Service "02" to designate telehealth. d) Use modifier 95 for synchronous rendering of services or GQ for asynchronous. 3. During the COVID-19 State of Emergency, a health plan may not exclude coverage for certain types of services or categories of services simply because the services are rendered via telehealth, if the enrollee's provider, in his/her professional judgment, determines the services can be effectively delivered via telehealth. 4. During the COVID-19 State of Emergency a health plan may not place limits on covered services simply because the services are provided via telehealth if such limits would not apply if the services were provided in-person. 5. During the COVID-19 State of Emergency, a health plan may not require enrollees to use the plan's telehealth vendor, or a different provider from the one the enrollee typically sees, if the enrollee's provider is willing to deliver services to the enrollee via telehealth and the enrollee consents to receiving services via telehealth.	Closed

26	DHCS	20-013	5/13/2020	Proposition 56 Directed Payments for Family Planning Services	Medi-Cal	1. DHCS is requiring MCPs, either directly or through their delegated entities and Subcontractors, to pay qualified contracted and non-contracted Providers7 a uniform and fixed dollar add-on amount for the specified family planning services (listed below) provided to a Medi-Cal managed care member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D), with dates of service on or after July 1, 2019, in accordance with the CMS-approved preprint for this program, which will be made available on DHCS' Directed Payments Program website upon CMS approval. 2. MCPs are responsible for ensuring that qualifying family planning services are reported to DHCS in encounter data pursuant to APL 14-019, "Encounter Data Submission Requirements" using the procedure codes. 3. MCPs are responsible for ensuring that the encounter data reported to DHCS is appropriate for the services being provided. 4. MCPs must include oversight in their utilization management processes, as appropriate. The uniform dollar add-on amounts of the directed payments vary by procedure code. 5. The uniform dollar add-on amounts for these family planning services must be in addition to whatever other payments eligible Providers would normally receive from the MCP, or the MCP's delegated entities and Subcontractors. 6. Starting with the calendar quarter ending June 30, 2020, MCPs must report to DHCS within 45 days of the end of each calendar quarter all directed payments made pursuant to this APL, either directly by the MCP or by the MCP's delegated entities and Subcontractors. Reports must include all directed payments made for dates of service on or after July 1, 2019. MCPs must provide these reports in a format specified by DHCS, which, at a minimum, must include Health Care Plan code, procedure code, service month, payor (i.e., MCP, delegated entity, or Subcontractor), and the Provider's National Provider Identifier. All reports shall be submitted in a consumable file format (i.e., Excel or Comma Separated Values) to the MCP's Managed Care Operations Division (MCOD) Contract Manager. 7. For clean claims or accepted encounters with dates of service between July 1, 2019, and the date the MCP receives payment from DHCS, the MCP must ensure that payments required by this APL are made within 90 calendar days of the date the MCP receives payments accounting for the projected value of the directed payments from DHCS. From the date the MCP receives payment onward, the MCP must ensure the payments required by this APL are made within 90 calendar days of receiving a clean claim12 or accepted encounter for qualifying services, for which the clean claim or accepted encounter is received by the MCP no later than one year after the date of service. MCPs are not required to make the payments described in this APL for clean claims or accepted encounters for applicable family planning services received by the MCP more than one (1) year after the date of service. These timing requirements may be waived only through an agreement in writing between the MCP (or the MCP's delegated entities or Subcontractors) and the affected Provider. 8. MCPs must have a formal procedure for the acceptance, acknowledgment, and resolution of Provider grievances related to the processing or non-payment of a directed payment required by this APL. In addition, MCPs must have a process to communicate the requirements of this APL to Providers. This communication must, at a minimum, include a description of how payments will be processed, how to file a grievance, and how to determine who the payor will be.	Ongoing
27	DHCS	20-014	5/15/2020	Prop 56 Value-Based Payment Program Directed Payments	Medi-Cal	1. Subject to obtaining the necessary federal approvals and consistent with 42 CFR section 438.6(c), MCPs, either directly or through their delegated entities and Subcontractors, must make directed payments for qualifying VBP program services (as defined below) for dates of service on or after July 1, 2019, in the specified amounts for the appropriate procedure codes, in accordance with the CMS-approved preprint. The directed payments are in addition to whatever other payments eligible Network Providers would normally receive from the MCP or MCP's delegated entities and Subcontractors. 2. MCPs must make value-based directed payments to eligible Network Providers for specific qualifying services tied to performance across four domains, as set forth in the VBP program specifications and the valuation summary. 3. For qualifying events tied to Members diagnosed with a substance use disorder, a serious mental illness, or who are homeless or have inadequate housing, MCPs must make the add-on directed payments corresponding to at-risk Members. For qualifying events tied to all other Members, MCPs must make the add-on directed payments corresponding to non-at-risk Members. 4. MCPs must make VBP directed payments for qualifying services provided by eligible Network Providers with dates of service on or after July 1, 2019, in accordance with the requirements outlined within the VBP program specifications. If applicable, for purposes of VBP directed payments, the "measurement year" for a given service is the calendar year in which that service was provided. 5. Individual rendering Network Providers qualified to provide the VBP program services are eligible to receive VBP directed payments. In addition to the requirements outlined in APL 19-001, Network Providers must meet the following criteria; posses an individual (tpye 1) NPI and be practicing within their practice scope. 6. Starting with the calendar quarter ending June 30, 2020, MCPs must report to DHCS within 45 days of the end of each calendar quarter all directed payments made pursuant to this APL, either directly by the MCP or by the MCP's delegated entities and Subcontractors. Reports must include all directed payments made for dates of service on or after July 1, 2019	Ongoing
28	DMHC	20-014	4/7/2020	Mitigating Negative Health Outcomes due to COVID-19	Both	The purpose of this All Plan Letter (APL) is to offer reminders and resources to help health care service plans serve enrollees and mitigate negative health outcomes to members due to the COVID-19 emergency. 1. Health care service plans should educate their providers on disaster-responsive,trauma-informed care. This education or training should include the crucial roles of the following: Ensuring physical and emotional safety of patients; Building trust between providers and patients; Recognizing and responding to the signs and symptoms of stress on physicaland mental health; Promoting patient-centered, evidence-based care; Ensuring provider and patient collaboration in treatment planning; Sensitivity to the racial, ethnic, cultural, and gender identity of patients; Supporting provider resilience 2. Health care service plans may wish to ensure providers learn the signs of and assessfor stress-related morbidity, and create responsive treatment plans, includingsupplementing usual care with measures that help regulate the stress responsesystem, such as: Supportive relationships; Age-appropriate, healthy nutrition; Sufficient, high-quality sleep; Mindfulness and meditation; Adequate physical activity; Mental health care. 3. Health care service plans and their providers should support continuity and integrationof medical and behavioral health services. 4. Health care service plans must continue to support telehealth for all services for whichit is medically appropriate. The DMHC recently issued guidance on telehealth.	Completed

29	DMHC	20-015	4/13/2020	COVID-19 Temporary Extension of Plan Deadlines	Both	1. In light of the COVID-19 State of Emergency, the Director has determined that select deadlines and requirements may be temporarily extended to give health plans additional time to comply. 2. Quarterly Grievance Reports: extended by 60 days; reports must not be submitted no later than 90 days after the end of each quarter. 3. Arbitration Decisions: unredacted arbitration decisions must be submitted within the date of the decision and redacted arbitration decisions must be submitted within 60 days after the close of the quarter in which they should have been submitted. 4. Quarterly Claims Settlement Practices Report: due date extended to June 20, 2020 5. Standard Formulary Template Implementation: go-live date extended to July 1, 2020 6. Timely Access Compliance and Annual Network Reporting: extended to May 1, 2020	Completed
30	DMHC	20-016	4/15/2020	Prevention Isolation and Supporting 60+ and other At-Risk Individuals to Stay Home and Stay Healthy during COVID-19 efforts.	Both	1. Health plans must continue to support telehealth for all services for which it is medically appropriate. 2. Health plans and their contracted providers should continually assess for and consider the provision of allowable additional services and supports during this time, such as nutrition, that may be vital for an older or at-risk adult staying home and staying healthy. 3. Health plans and their contracted providers should support continuity and integration of medical and behavioral health services for all ages. 4. Health plans are encouraged to continue check-in calls with older and other at-risk adults, to check the basic needs, health care, mental health, and safety from abuse and neglect. RESOURCES 1. The State is partnering with 211 in all communities to be a first stop for all local food and other human service needs. 2. The State's Aging and Adults Info Line connects to local Area Agencies on Aging. Dial 1-800-510-2020 3. The Friendship Line, run by Institute on Aging, provides 24/7 connection and crisis line for older adults. Dial (888) 670-1360 4. "Feeling Good & Staying Connected" is a new activity guide and weekly planner available from CDA in English, Spanish, Traditional Chinese and Simple Chinese. 5. Additional resources on how to mitigate the stress-related health outcomes anticipated with the COVID-19 emergency can be found on www.ACEsAware.org.	Closed
31	DMHC	20-017	4/16/2020	Guidance Regarding DMHC General Licensure Regulation	Both	1. On June 14, 2019, the Department of Managed Health Care (DMHC) issued All Plan Letter 19-014. The All Plan Letter provided guidance regarding the Department's recently adopted General Licensure Regulation. The General Licensure Regulation requires an entity that accepts any amount of global risk, as defined in the General Licensure Regulation, to obtain either: (1) a health care service plan license; or (2) an exemption from the licensure requirements. 2. Due to the uncertainty caused by the COVID-19 pandemic, the DMHC is extending the phase-in period through December 31, 2020.	Ongoing
32	DMHC	20-018	4/29/2020	Modification of Timely Access Provider Appointment Availibility Surveys Timeframes	Both	Currently, Health and Safety Code section 1367.03(f)(3) and page 11 of the PAAS Methodology require health plans to complete the administration of the PAAS between April 1 and December 31. For MY 2020, health plans shall begin administration of the PAAS no earlier than August 1, 2020.	Ongoing
33	DMHC	20-019	5/5/2020	Association Health Plans: Extension of "Phase-Out" Period	N/A	Doesn't Apply to AAH	N/A
34	DMHC	20-020	5/20/2020	Ensuring Continued Network Adequacy and Removing Unnecessary Burdens on Providers	Group	Each plan must submit an informational filing to the DMHC explaining the steps the plan has taken, and/or will take, to ensure continued network adequacy. If actions have been taken, provide details (no later than COB Tuesday June 2nd) regarding: * the approximate dates the plan took or will take the actions described; * the amount of investments made to support California providers; * the geographic areas in California where the plan has targeted or will target its actions; *and, whether the actions apply to provider groups, hospitals and/or other entities. The DMHC encourages health plans to communicate with their contracted providers to determine whether the providers are experiencing financial difficulties that may threaten the adequacy of the plans' networks. If providers are experiencing financial difficulties, the DMHC, in the context of plan financial stability, encourages plans to take one or more of the following steps: 1. Expedite claims review and payment to decrease the accounts receivables owed to providers. As a reminder, the DMHC will continue to monitor timely payment of claims during our financial exams. 2. Identify and remove administrative burdens that may be delaying providers' abilities to submit and be paid for claims. For example, providers report experiencing extended telephone wait-times to talk with plan personnel and limits on the number of cases a provider may discuss with a plan in one phone call. The DMHC encourages plans to remove or reduce these burdens when possible. 3. Work with the plan's contracted providers to give the providers advance payments when feasible and desired by the provider. These payments could include advances on capitation payments or no-interest loans to assist providers with remaining solvent while they begin to provide more non-urgent and non-emergent procedures that were deferred during the previous several months. 4. Amend coordination of benefit procedures in situations where the enrollee has not yet verified he/she does not have alternative coverage, such that the default is to pay the claim. The DMHC understands that in some instances plans will delay reimbursement until the enrollee confirms in writing they do not have alternate coverage. During this time when many providers are delivering services via telehealth, obtaining information from enrollees may be very difficult, resulting in delayed payment to the provider. The DMHC encourages plans to pay the claims and then follow up with the enrollee regarding the existence of alternate coverage. If the enrollee did have alternative coverage that should have paid the claim, the plan could seek recoupment, as appropriate, from the provider.	Completed
35	DMHC	20-021	6/1/2020	Health Care Service Plan §1368.7 Filings for Governor's State of Emergency in Los Angeles County Due June 2, 2020	N/A	Doesn't Apply to AAH	N/A
36	DMHC	20-025	7/1/2020	Guidance Regarding New or Innovative Benefits	N/A	Doesn't Apply to AAH	N/A

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: **July 10, 2020**

Subject: **Health Care Services Report**

UTILIZATION MANAGEMENT: OUTPATIENT

Director: Julie Anne Miller
Manager: Hope Desrochers
Medical Director: Bev Juan

- The Outpatient UM team continues to maintain Turn-Around-Times (TAT) above benchmark.
- Trucare, the computer software used by the UM team, underwent a successful optimization process to streamline both work and report writing. The system is launching preparation for the 8.0 version in July.
- The UM team has begun to receive authorizations submitted online via the Provider Portal. About 30% of referrals are being received via the Portal, and it is working well. We are planning an outreach campaign with Provider Relations to encourage use of the online portal
- NOA (Notice of Action) Letter processes continue to be monitored by the team to ensure regulatory compliance and has resulted in a more consistent and streamlined process
- The UM team has almost completed work needed to prepare for the launch of access to Stanford oncology for AAH members, launch date scheduled in September 2020.
- OP UM launched engagement with delegate CHCN to align processes and work collaboratively on initiatives.

Outpatient Authorization Denial Rates			
Denial Rate Type	**April 2020**	**May 2020**	**June 2020**
Overall Denial Rate	3.4%	2.9%	2.5%
Denial Rate Excluding Partial Denials	3.3%	2.9%	2.4%
Partial Denial Rate	0.1%	0.1%	0.1%

Turn Around Time Compliance			
Line of Business	**April 2020**	**May 2020**	**June 2020**
Overall	99%	98%	99%
Medi-Cal	99%	98%	99%
IHSS	100%	99%	99%
Benchmark	*95%*	*95%*	*95%*

UTILIZATION MANAGEMENT: INPATIENT

Director: Julie Anne Miller
Manager: Carla Healy-London
MD Lead: Shani Muhammad

- Standard work to manage inpatient ALOS continues. It includes daily check in with the Inpatient team on the progress of our members through their hospitalizations. Other elements include staff performance monitoring, engagement with hospital partners, and community partner engagement, such as BACS for respite beds.
- The impact of the pandemic is being felt in the Inpatient hospitalization rates: The rate of hospitalization was 30% down from expected levels initially, for much of March and April, but most recently has normalized. There are a few elective admissions. There have been a small number of members hospitalized with COVID-19 for whom there is difficulty finding accepting Skilled Nursing Facilities. We continue to work with our SNF partners on the barriers.
- Inpatient UM is working to place members with Bay Area Community Services, (BACS) respite beds at the Henry Robinson center. Respite beds provide homeless members a safe place to recuperate from a hospitalization instead of going directly back to the street.
- Trucare, the software used by UM, is working on launching to the 8.0 version. Go-Live for 8.0 is anticipated to be in September.
- The inpatient team is working closely with Case Management on the implementation of the Transition of Care bundle for members transitioning out of Alameda Health System.
- IP UM re-engaged CHCN to further align processes and collaboratively work on initiatives.

Inpatient Utilization Total All Aid Categories Actuals (excludes Maternity)			
Metric	**March 2020**	**April 2020**	**May 2020**
Authorized LOS	4.7	5.3	4.9
Admits/1,000	54.8	41.6	51.2
Days/1,000	255.0	222.5	249.9

PHARMACY

Senior Director: Helen Lee

- Pharmacy continues strong turn-around-time performance including 100% turn-around time compliance for all line of business.
- Outpatient initial approval rate is 41% and denial rates are 32%. The approval rate was slightly increased while denial rates also slightly increased compared to previous reporting periods. Medications for pain, diabetes, asthma or chronic obstructive pulmonary disease (COPD), acne, gastroesophageal reflux (GERD) and travelers' diarrhea medications share formulary issues as the most common reason for denials. AAH offers clinically equal and more cost effective formulary alternatives.
- Pharmacy continues to ensure that our members have access to the medications that they need during the ongoing COVID-19 situation. Pharmacy have enhanced disaster program from 3/17/2020 to July 31, 2020. In order to reduce the need for in-person pharmacy visits, we have in place automatic overrides for 90 Day supply fills, refill too soon overrides, waiving home delivery fees (Walgreens, CVS) and waiving of Prior auth, step therapy and quantity limits in the event of a drug shortage. During the past fifteen weeks, we filled 51,740 'Refill Too Soon' prescriptions (which provide early refills) and 3,117 'Out of Network' for our Medi-Cal and Group Care members.
- Due to the civil unrest that is happening in our community, some pharmacies are closing down or open 8am-4pm at high risk areas. AAH is working with PBM for other alternatives to assist our members if our member's pharmacy is closed or has been vandalized. Meanwhile, Members can use mail order pharmacy. AAH overrides if needed to prevent any delay.
- There are no concerning trends or ways to correlate any increases or decreases to use of hydroxycholoroquine, chroloquine and Azithromycin in COVID-19, since these medications share indications for other disease states. WHO halted hydroxychloroquine trial over safety concerns due to higher risk of death and heart problems than those who were not. AAH has a PA requirement on hydroxychloroquine during most of the 2020 timeframe. Azithromycin has quantity limit and day supply limits.
- DHCS intends to proceed with pharmacy carve-out implementation effective 1/1/2021. Magellan and DHCS will send out communication to all enrolled providers.

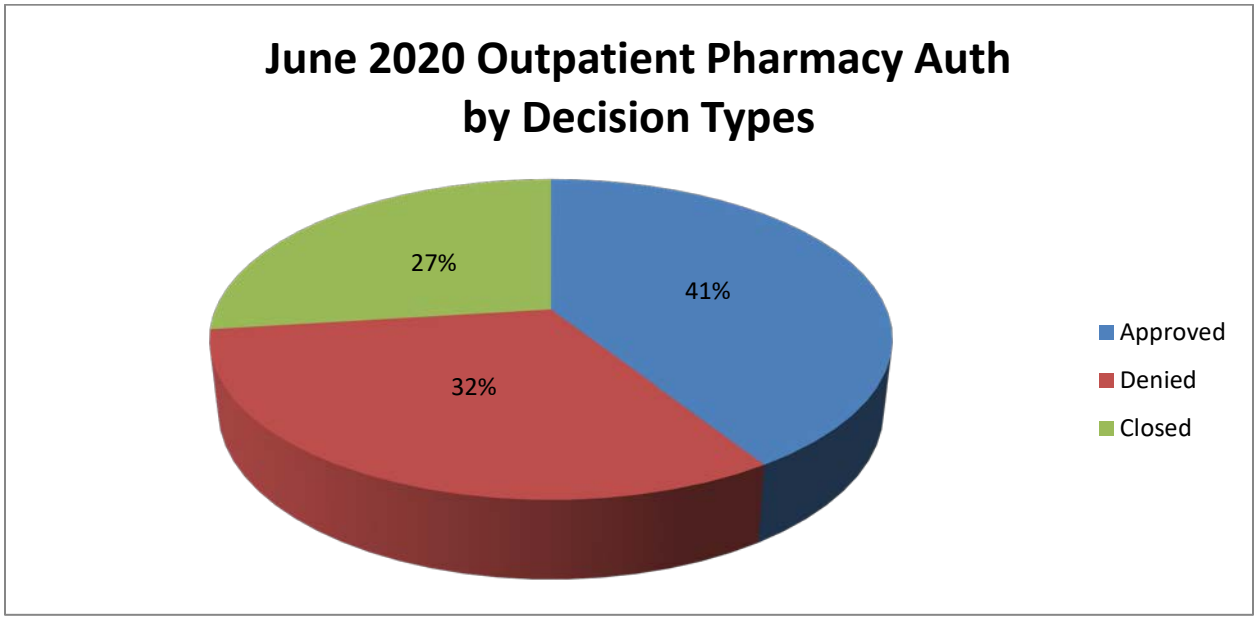
After post carve-out, the State of California will take back many pharmacy responsibilities including drug coverage, rebate, utilization management and pharmacy provider network. AAH is to maintain beneficiary care coordination, drug adherence, disease and medication management, in authorization, denial & appeals of physician administered drugs (PAD) and outpatient infusion drugs.

- Quality improvement and cost containment initiatives continue with focus on effective formulary management, coordination of benefit & joint collaboration with Quality and case management to improve drug adherence, disease medication management, and generic utilization. Senior Pharmacy Director Helen Lee is also leading initiatives on biosimilar optimization, PAD focused partnership and channel management, infusion strategy, and HCS special projects and HCS LTC readiness.

Outpatient Pharmacy Prior Authorization Request Summary, May 2020

Summary Table

Decisions	Number of PAs Processed
Approved	722
Denied	565
Closed	466
Total	**1753**



Top 10 Drug Categories by Number of Denials

Rank	Drug Name	Common Use	Common Denial Reason
1	LIDOCAINE 5% PATCH	Pain	Criteria for approval not met
2	JANUVIA 100 MG TABLET	Diabetes	Criteria for approval not met
3	TRETINOIN 0.025% CREAM	Pain	Criteria for approval not met
4	DUPIXENT 300 MG/2 ML SYRINGE	Asthma or Chronic Obstructive Pulmonary Disease (COPD)	Criteria for approval not met
5	CLINDAMYCIN PH 1% GEL	Acne	Criteria for approval not met
6	DEXILANT DR 60 MG CAPSULE	Gastroesophageal Reflux (GERD)	Criteria for approval not met
7	FREESTYLE LIBRE 14 DAY SENSOR	Diabetes	Criteria for approval not met
8	DICLOFENAC SODIUM 3% GEL	Pain	Criteria for approval not met
9	FREESTYLE LIBRE 14 DAY READER	Diabetes	Criteria for approval not met
10	XIFAXAN 550 MG TABLET	Travelers' diarrhea	Criteria for approval not met

CASE AND DISEASE MANAGEMENT

Director: Julie Anne Miller
Managers: Lily Hunter & Eva Repert
Medical Director: Shani Muhammad

- The computer software used by Case Management, TruCare, had been upgraded to version 7.0 on May 29th, with major improvements in the Case Management module, such as streamlining the member assessments and Care Plans. Preparation for the 8.0 version is launching, expected to launch in September 2020.
- AAH teams have launched the analysis of the strategic direction and opportunities in Population Health has begun, including HCS and the Ops teams. Initial work is in data analysis and inventorying the current initiatives and resources. Next steps will be to align efforts across departments and focus efforts on particular populations.

- A focus for Medical Expense Reduction will be reducing Readmissions, and the CM department will be launching focused work in this area
- One outcome expected from the Transition of Care (TOC) bundle deployed in pilot phase with Alameda Health System's three campuses is a reduction in readmission. TOC bundle includes:
    - Discharge phone call
    - Discharge appointment
    - Medication reconciliation
- CM is working to integrate the newly redesigned Health Risk Assessment, (HRA) more closely into the CM workflow, including referring directly to the Social Workers in the CM department.
- The Member Services portal is adding additional CM content to enhance Member engagement with the CM department work, including services offered and ease of communication.
- CM is working with the AAH HHP on developing an internal CB-CME staffed by the CCM staff, in order to provide HHP services to more of the AAH's most vulnerable members.
- Care bundles in Oncology and Dialysis are being developed that emphasize using transportation and other benefits as tools to help members more successfully engage in care.

HEALTH HOMES & ALAMEDA COUNTY CARE CONNECT (AC3)

Director: Julie Anne Miller
Manager: Amy Stevenson

- Evaluation of our HHP network adequacy to serve the target populations continues, both for medical CB-CMEs and those for Severe Mental Illness, (SMI).
- Bay Area Community Services, (BACS) is nearing readiness to become a SMI site, expected to go live in July.
- Exploratory conversations have started with additional potential partners to further expand the SMI network.
- Work is moving forward with CM on developing an internal CB-CME in order to serve more members in our HHP that are not associated with an existing CB-CMEs. Document submission to DHCS is being readied for July, with launch to follow after DHCS approves.
- A team from AAH HCS, Analytics and Finance has started planning our Population Health based prioritization of our target populations.

Case Type	New Cases Opened in May 2020	Total Open Cases As of May 2020
Care Coordination	252	587
Complex Case Management	38	91
Transitions of Care	166	316

GRIEVANCES & APPEALS

Director: Jennifer Karmelich

Manager: Loren Mariscal

- All cases were resolved within the goal of 95% within regulatory timeframes.
- Total grievances resolved in June went over our goal of less than 1 complaint per 1,000 members at 7.51 complaints per 1,000 members;
- The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of June 2020; we met our goal at 13.5% overturn rate;
- Grievance tracking and trending by quarter:
    - There was an increase of Quality of Care/Service grievances, a majority of the complaints were resolved as exempt grievances. The increase began in Q2 and continued throughout the year. The sub-category that presented with the steady increase was poor provider/staff attitude.
    - The Alliance will anticipate a higher number of cases not being resolved within the required timeframe due to providers limiting office hours which makes it more difficult to obtain responses to complaints for resolution.

June 2020 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	256	30 Calendar Days	95% compliance within standard	251	98.0%	0.99
Expedited Grievance	4	72 Hours	95% compliance within standard	4	100.0%	0.02
Exempt Grievance	1,630	Next Business Day	95% compliance within standard	1,628	99.9%	6.35
Standard Appeal	35	30 Calendar Days	95% compliance within standard	35	100.0%	0.14
Expedited Appeal	2	72 Hours	95% compliance within standard	2	100.0%	0.01
Total Cases:	1,927		95% compliance within standard	1,920	99.6%	7.51

*Goal is to have less than 1 complaint (Grievance and Appeals) per 1,000 members (calculation: the sum of all unique grievances for the month divided by the sum of all enrollment for the month multiplied by 1000.)

QUALITY ASSURANCE

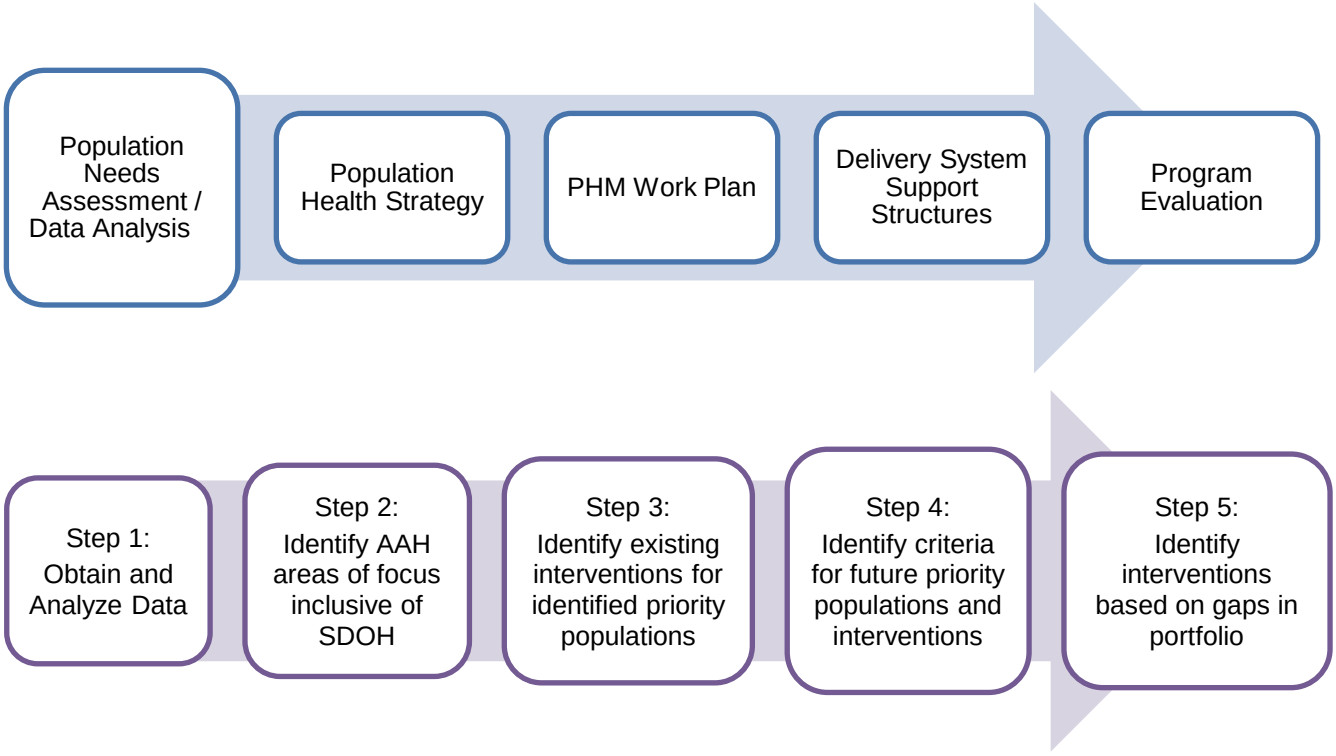
Director: Jennifer Karmelich

- The Alliance received the Final Decision Letter from NCQA in response to our resurvey that took place on June 1, 2020. We accumulated enough standard points for both our Medi-Cal and Commercial lines of business resulting in the Alliance receiving an "Accredited" status through October 15, 2022. We did receive a Corrective Action Plan (CAP) for the must-pass element UM 7B that is attached to both lines of business, this was for the review of our NOAs. We will submit a CAP response to NCQA within 30 days from July 1, 2020 and will undergo a CAP Resurvey for UM 7B. The CAP Resurvey will be scheduled for early next year.

Quality

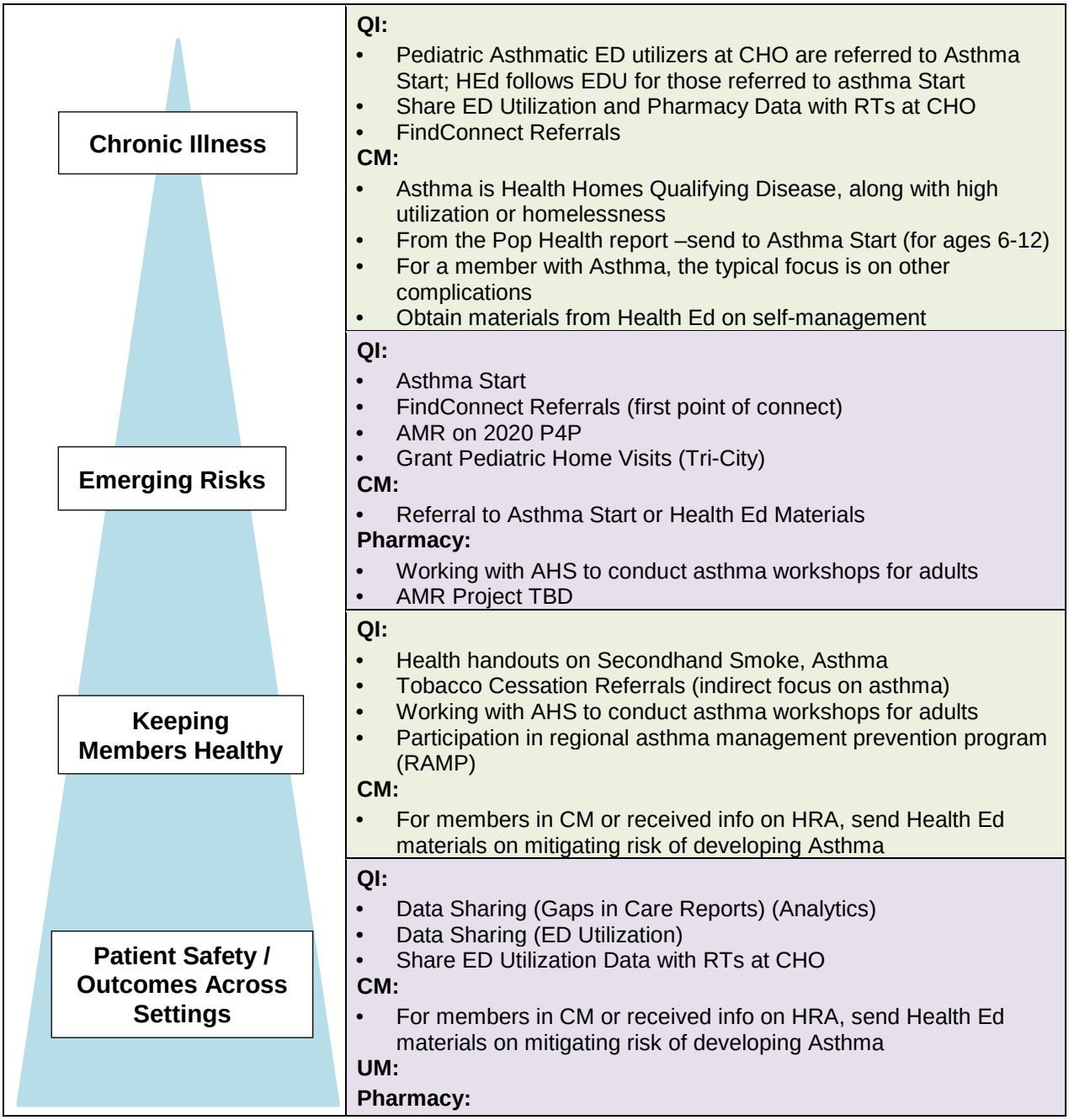
Director: Stephanie Wakefield
Managers: Jessica Pedden [Clinical Quality], Gina Battaglia [A&A], Linda Ayala [C&L/Health Ed])
Medical Director: Sanjay Bhatt

- **Population Health Management (PHM) and the Population Needs Assessment (PNA)** informs the Alliance strategies for managing the engagement, treatment, and clinical outcomes of selected populations. AAH is strengthening our PHM/PNA focus with increased organizational structure, based on NCQA/DHCS standards in addressing member needs across the continuum of care.



NCQA targeted focus goals for population health management include:

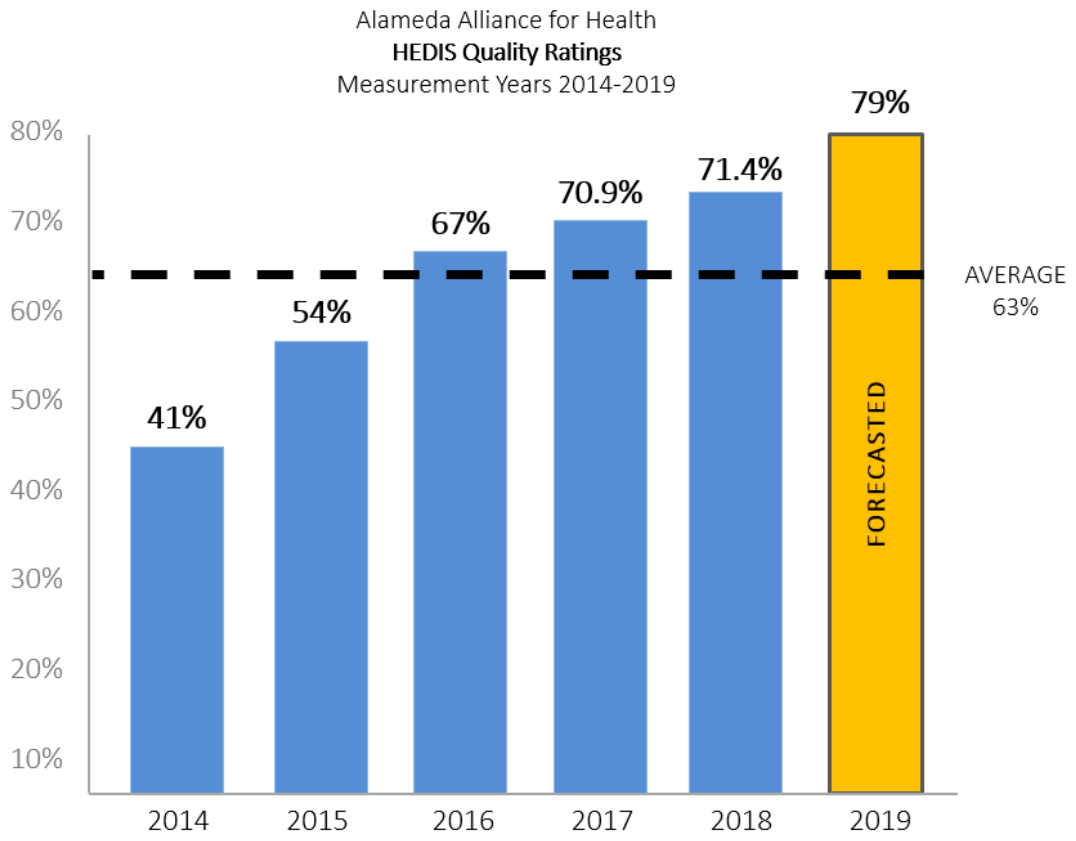
Figure 1: Example of Goals by Acuity



- **HEDIS** results continue to inform our Quality Improvement strategic planning for the second half of the fiscal year in areas including our Quality Improvement Plans (QIPs) with the state, as well as internal department integrated Performance Improvement Projects. HEDIS Gap in Care (GIC) reports served as an ‘access to care’ performance tool for our network and delegate provider office staff to engage members for scheduling clinical appointments. Preliminary HEDIS results indicate that our health plan/provider collaboration, in addition to

member gift card incentives has resulted in increased GIC closure and service utilization for timely health assessments, screenings and referrals with year over year improvement in our Aggregated Quality Factor Scores (AQFS) from MY 2014 - 2019.

Figure 2: Alliance HEDIS Quality Ratings MY2014-2019



- AAH continues its **Pediatric Care Coordination Pilot (PCCP),** an outcome of 2019 our Pediatric Strategy. Critical components of our three-prong approach to pediatric care and services include: quality improvement initiatives, clinical care initiatives and care coordination/management in addition to member incentives for target measures. Improving access to care and services and efficacy of the EPSDT benefit for member's age 0-20, through enhanced collaboration with Alameda County healthcare CBO's, as well as, direct and delegate pediatric providers, is the focus of this exciting pilot for FY21.

- **CBO Partnerships** As part of our quality improvement strategy to improve overall care and outcomes for members, as well as, improve collaboration in the community, AAH is continuing its partnership with county and community initiatives including, Food as Medicine and Asthma Start (pediatric asthma case management), and First 5 Help Me Grow for FY21.

- **DHCS** required HPs to paused implementation of a mandated Pediatric Preventive Care Outreach project due to **COVID – 19** 'shelter in place' mandates. This outbound call campaign will target Alliance beneficiaries under 21 (est. 70K members) who have under-utilized preventive care services available to them as part of their EPSDT benefit. DHCS will hold an MCP conference call late June to discuss resumption of this outreach effort.

- **Access to Care:** Multiple member and provider surveys are completed throughout the year to assess member Access to Care. Access standards come from state/federal regulations and AAH internal Policy & Procedures. Dozens of providers received correction action plans (CAPs) to address member perceived access to care deficits. Results of these CAPs are reviewed by the credentialing committee during the normal credentialing for providers. DHCS has allowed MCPs extended timeframes for providers to submit CAPs due to the impact of **COVID-19** on provider offices administrative capacity.

- **2019 CAHPS** Members Consumer Assessment of Healthcare Providers and Systems Survey
    - Survey Goals:
        - To measure how well plans meet their members' expectations and goals
        - To determine which area of service have the greatest effect on members' overall satisfaction
        - To identify the areas of opportunity for improvement

Figure 3: 2019 CAHPS Results – Highest and Lowest Measures

Highest & Lowest Measures*

Quality Compass All Plans percentile ranking

Highest Three (3) Rated Measures		
Medi-Cal Adult	**Commercial Adult**	**Child**
Health Promotion and Education (72.5%)	Shared Decision Making (84.3%)	Rating of Personal Doctor (93.6%)
Rating of Health Care (73.6%)	Coordination of Care (83.7%)	Rating of Health Care (89.8%)
Shared Decision Making (78.7%)	Rating of Health Plan (64.5%)	Rating of Health Plan (88.9%)

Lowest Three (3) Rated Measures		
Medi-Cal Adult	**Commercial Adult**	**Child**
Getting Care Quickly (74.5%)	Rating of Personal Doctor (80.4%)	Rating of Specialist (85.5%)
Getting Needed Care (76.0%)	Rating of Health Care (68.2%)	Customer Service (86.1%)
Coordination of Care (70.4%)	Getting Needed Care (72.8%)	Getting Care Quickly (85.4%)

- Red indicates that the current year score is significantly lower when compared to trend or benchmark scores
- Green indicates that the current year score is significantly higher when compared to trend or benchmark scores.

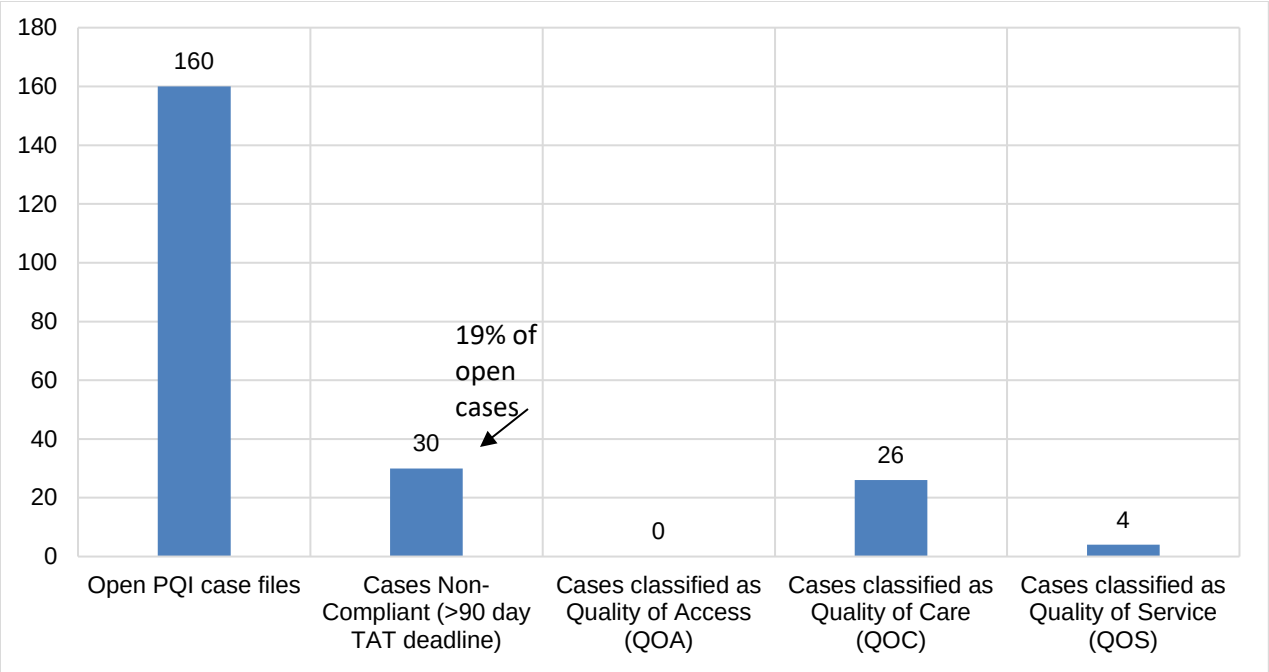
Improvement Strategies Next Steps:

- Discussion of improvement strategies with internal stakeholders, based on SPH recommendations, using the PDSA quality improvement model.

Potential Quality Issues (PQI) Aging Report

- A PQI is defined as a suspected deviation from expected provider performance, clinical care or outcome of care that requires further investigation to determine whether an actual quality issue exists. Currently P&P had a 90-day turn-around-time deadline from receipt to resolution of PQI. PQIs exceeding 90 TAT due to 1) challenges with medical record procurement during COVID public health emergency and 2) unexpected leave of absences for 2 of 4 Quality Review Nurses.

Figure 4: Potential Quality Issues (PQI) Summary 06/27/2020



- **Action** Plan: 1) Assistance from Provider Relations in attaining medical records from provider offices. 2) Recruitment of both temporary and permanent fulltime staff to backfill for Quality Review Nurse coverage 3) Implementation of DHCS approved extension of PQI TAT from 90 to 120 days effective 7/1/2020.

- On July 1, 2020, we began transition of **Interpreter Services** to primarily on-demand telephonic for Beacon Health Options and CHCN delegates. An updated guide for accessing interpreter services and Interpreter Services Request form are available for providers.

ALAMEDA Alliance FOR HEALTH

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

Health Care Quality Committee Meeting Minutes

HEALTH CARE QUALITY COMMITTEE MEETING MINUTES

Meeting Date: 03/19/2020

Attendance		
Committee Member Name and Title	**Specialty**	**Present**
Steve O'Brien, MD, Chief Medical Officer, Alameda Alliance for Health	Internal Medicine	X
Aaron Chapman, MD, Medical Director, Alameda County Behavioral Health Care Services	Psychiatry	X
Wesley Lisker, MD, Kaiser Permanente	Nephrology	X
Laura Miller, MD, Chief Medical Officer, Community Health Center Network	Internal Medicine	
Ghassan Jamaleddine, MD, Chief Medical Officer, Alameda Health Systems	Internal Medicine	
James Florey, MD, Chief Medical Officer, Children First Medical Group	Pediatrician	X
Sanjay Bhatt, MD, Medical Director of Quality, Alameda Alliance for Health	Emergency Medicine	X
Beverly Juan, MD, Medical Director of Utilization Management, Alameda Alliance for Health	Pediatrician	X
Shani Muhammad, MD, Director of Medical Services, Alameda Alliance for Health	Family Practice	X
Stephanie Wakefield, RN, Senior Director of Quality, Alameda Alliance for Health		X
Alameda Alliance for Health Staff Member Name and Title		**Present**
Scott Coffin, Chief Executive Officer		
Helen Lee, PharmD, MBA, Senior Director of Pharmacy Services		X
Julie Anne Miller, Director of Health Care Services		X
Diana Sekhon, MHPA, CHC, Director of Compliance		
Jessica Pedden, Clinical Quality Manager		X
Linda Ayala, Health Education Manager		X
Jennifer Karmelich, Director of Quality Assurance		X
Gina Battaglia, Access to Care Manager		X
Bob Hendrix, QI Project Specialist		X
Martins Umeugoji, QI Project Specialist		X
Community Members in Attendance		**Present**
None		

HEALTH CARE QUALITY COMMITTEE MEETING MINUTES

Meeting Date: 03/19/2020

Meeting Objective
To improve quality of care for Alliance members by facilitating clinical oversight and direction.

Agenda

Agenda Item	Responsible Person	Discussion	Document	Action	Follow-up by QI Staff
Call to Order/Roll Call	S. O'Brien		None	Called to order at 6:05 pm	None
1. Approved Committee Meeting Minutes: a. HCQC Meeting Minutes 1/16/20 b. C&L Meeting Minutes 10/23/19, 01/22/20 c. P&T Meeting Minutes 12/17/19	S. O'Brien		01_Meeting Min Packet 03_19_20	Meeting Minutes were sent out to the HCQC Members for e-vote and they were approved on March 18, 2020.	None
2. Chief Medical Officer Alameda Alliance Update	S. O'Brien	• Dr. O'Brien provided an update on the current ways that the Alliance is abiding by the shelter in place order which includes working from home, all meetings are now conducted by phone, and all business related travel has been canceled. • Dr. Florey, Dr. Chapman, and Dr. Lisker shared with the Committee how CFMG, County BH, and Kaiser are handling the impact of COVID-19. This includes observing social distancing, the use of telemedicine, with ongoing need for PPE and masks for frontline staff.	None	None	None
3. Follow-Up Items:	S. Wakefield	• S. Wakefield presented the updates to the Committee.	None	None	None

Agenda					
Agenda Item	**Responsible Person**	**Discussion**	**Document**	**Action**	**Follow-up by QI Staff**
a. QI will share Kaiser's methodology for their self-reported IHA results i. Update: QI is working with Lynn Parkinson at Kaiser to better understand their methodology. QI will provide an update at a future HCQC Meeting. b. QI will work with the Analytics Department to determine if IHA rates can be calculated based on auto-assignment and self-selection of PCP. i. Update: Analytics Department confirmed that we can add a member assignment field that can be utilized for data analysis. c. QI will identify who the Analytics Department is working with at AHS and report back to the committee. i. Update: AAH is working with Regalado Sabal, Sr. HIM Clinical Systems Analyst d. QI will send Dr. Miller the IHA slide so she can follow-up with CHCN staff to identify what they are doing around IHAs. Dr. Miller will report back at the next HCQC Meeting.					

Agenda					
Agenda Item	**Responsible Person**	**Discussion**	**Document**	**Action**	**Follow-up by QI Staff**
e. Update: QI sent the IHA information to Dr. Miller on 2/23/20.					
4. Policies and Procedures: a. Quality Improvement: i. QI-101, "Quality Improvement Program" – *vote to approve* b. Health Education: i. HED-001, "Health Education Program" – *vote to approve* ii. HED-002, "Health Education and Member Informing Materials" – *vote to approve* iii. HED-003, "Population Needs Assessment" – *vote to approve* iv. HED-006, "AMSC Services" – *vote to approve* v. HED-007, "Tobacco Cessation" – *vote to* approve vi. HED-008, "Staying Healthy Assessment (IHEBA)" – *vote to approve* vii. HED-009, "Diabetes Prevention Program" – *vote to approve* c. C&L: i. CLS-001, "Cultural and Linguistic Services (CLS) Program Description" – *vote to approve* ii. CLS-002, "Member Advisory Committee" – vote *to approve*	S. Wakefield L. Ayala	• The Committee was reminded that the Policies & Procedures were approved via e-vote. A majority of the Policies & Procedures updates included minor formatting updates prior to the annual renewal.	02_P&P Packet_03_19_20	Approved by e-vote on March 18, 2020	Policies & Procedures will be finalized as presented.

Agenda					
Agenda Item	**Responsible Person**	**Discussion**	**Document**	**Action**	**Follow-up by QI Staff**
iii. CLS-003, "Language Assistance Services" – *vote to approve* iv. CLS-008, "Member Assessment of Cultural and Linguistic needs" – *vote to approve* v. CLS-009, "CLS Program - Contracted Providers" – *vote to approve* vi. CLS-010, "CLS Program - Staff Training and Assessment" – *vote to approve* vii. CLS-011, "CLS Program - Compliance Monitoring" – *vote to approve* d. Access & Availability: i. QI-107, "Appointment Access and Availability Standards" – *vote to approve* ii. QI-108, "Access to Behavioral Health Services" – *vote to approve* iii. QI-114, "Monitoring of Access and Availability Standards" – *vote to approve* iv. QI-115, "Access and Availability Committee" – *vote to approve* v. QI-116, "Provider Appointment Availability Survey" – *vote to approve* vi. QI-117, "Member Satisfaction Survey (CAHPS)" – *vote to approve*	G. Battaglia				

Agenda					
Agenda Item	**Responsible Person**	**Discussion**	**Document**	**Action**	**Follow-up by QI Staff**
vii. QI-118, "Provider Satisfaction Survey" – *vote to approve*UM-036, "Continuity of Care" – *vote to approve* e. Utilization Management: i. UM-046, "Use of Board Certified Consultants," – *vote to approve* ii. UM-057, "Authorization Request," – *vote to approve* iii. UM-058, "Continuity of Care for Medical Exemption," – *vote to approve* iv. UM-062, "Behavior Health Treatment," – *vote to approve*	J. A. Miller				
5. NCQA Update	J. Karmelich	• J. Karmelich informed the Committee that the Alliance is currently preparing documentation requested by NCQA from the onsite resurvey conducted in April. The Alliance is actively preparing for the virtual file review scheduled for June 2020.	None	None	None
6. Grievance & Appeals Update	J. Karmelich	• J. Karmelich provided the following Grievance & Appeals update to the Committee: ○ The Alliance's goal is to have less than 1 per 1,000 member complaints (grievance and appeals), for the reporting period of Q4 2019, we are over our goal at 6.0 complaints per 1,000 members. ○ CHME – showed a decrease in overall complaints since Q4 2018. The trend for the last 4 months have averaged around 18 per month. As a result of the continual decrease of complaints, the Corrective Action Plan with CHME was closed in December 2019. ○ There was an increase of Quality of Care/Service grievances, a majority of the complaints were	06_Exec Sum_Grievance and Appeals_Q419_Final	None	None

Agenda					
Agenda Item	**Responsible Person**	**Discussion**	**Document**	**Action**	**Follow-up by QI Staff**
		resolved as exempt grievances. The increase began in Q2 and continued throughout the year. The sub-category that presented with the steady increase was poor provider/staff attitude. ○ There was also an increase of grievances categorized as other in Q3 and Q4, the sub-categories that presented with the largest increase were Eligibility issues, PCP Auto Assignment and AAH Systems Error, a majority of these complaints were resolved as exempt grievances. ○ The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of Q4 2019; we are over our goal at 31.8% overturn rate. However, the Alliance has continued to experience a decrease in the overturn rate throughout the quarters compared to previous years.			
7. QI Work Plan: a. Quality Initiatives Updates: i. Population Health Update ii. Pediatric Care Coordination Pilot (EPSDT) Update	S. Wakefield	S. Wakefield provided the following update to the Committee: i. **Population Health Update**: The QI Department is currently working on developing the Plan's Population Health Strategy and more information will be provided at a future HCQC meeting. ii. **Pediatric Care Coordination Pilot (EPSDT) Update:** ○ Goals: ▪ Improve access to EPSDT services ▪ Improve quality of care as reflected by increased HEDIS scores ▪ Improve connection/understanding of community EPSDT partners. ○ The Alliance is currently working with community partners that include: ▪ Alameda County Public Health Department	07_HEDIS Crunch Dashboard	None	None

Agenda					
Agenda Item	**Responsible Person**	**Discussion**	**Document**	**Action**	**Follow-up by QI Staff**
		▪ CCS ▪ Asthma Start ▪ CHCN ▪ CFMG ▪ AHS ▪ UCSF Benioff ▪ Roots ▪ Help Me Grow ▪ Regional Center of the East Bay ○ The Plan has implemented the following: ▪ Improved pediatric access to EPSDT preventive services ▪ Partnership with Tri-City FQHC providing incentives to increase access to care and behavioral and developmental screenings ▪ FINDconnect (UCSF BCHO) to deploy cloud base platform for referral and resource linkages within AAH & a CHCN FQHC ▪ Improved quality of care as reflected in preliminary increased HEDIS rates ▪ HEDIS Crunch member gift card incentives ▪ Improved connection, understanding & collaboration with community EPSDT partners. ○ HEDIS Crunch Update: ▪ The Plan worked with 21 providers to increase pediatric access to preventative care. ▪ 397 member incentives were given out during October through December which equates to an additional 397 pediatric well-child visits.			

Agenda					
Agenda Item	**Responsible Person**	**Discussion**	**Document**	**Action**	**Follow-up by QI Staff**
iii. Preventative Care Call Campaign iv. 2019 Exempt Grievance Audit Results v. PQI IRR		▪ The QI Department will continue to track that the Plan is receiving claims for the visits. As of January 10th, the Plan has received 212 claims for the 397 visits provided. iii. **Pediatric Preventative Care Member Outreach Call Campaign:** DHCS has put this initiative on hold given the current COVID 19 pandemic. The purpose of this campaign was to outreach to parents/guardians of Alliance members who have not accessed EPSDT services and encourage them to receive preventative services as a part of their covered benefits. The Alliance will resume this effort once DHCS gives the directive with a projected outreach to about 70,000 members. iv. **2019 Exempt Grievance Audit Results:** • The purpose of the Exempt Grievance Audit is to ensure clinical monitoring of exempt grievances for Potential Quality of Care Issues. In Q4, 96.67% of the 30 exempt grievances were classified appropriately. The one (1) Exempt Grievance that was identified as a Quality of Care issue, is currently being reviewed by a QI Review Nurse. Currently the QI Department is working with Compliance, Member Services, and Grievance & Appeals Departments in developing an integrated workflow that ensures Quality of Care Issues referred appropriately. v. **PQI IRR:** • During the DMHC site visit, the Plan acknowledged that there was an			

Agenda					
Agenda Item	**Responsible Person**	**Discussion**	**Document**	**Action**	**Follow-up by QI Staff**
vi. Encounter Data Validation (EDV) Record Retrieval vii. HEDIS Record Retrieval		opportunity for improvement in the initial classification and review process of PQIs. The QI Department has been working on standardizing the documentation process utilized by the RN review staff as well as ensuring that all clinical staff are appropriately triaging and classifying PQIs. In Q1, 2020 100% PQI cases randomly selected were classified appropriately. The first 8 PQI files audited using the NCQA 8/30 rule were classified correctly by all 4 of the QI Review Nurses (inclusive of Sr. QI Director). J. Pedden provided the following update to the Committee: vi. **Encounter Data Validation (EDV):** EDV is an annual study conducted by DHCS in order to validate the claims information against encounter notes. Every year DHCS randomly selects 411 members for this study. The Plan was in the process of collecting this information to submit to the State for review. vii. **HEDIS Record Retrieval:** Currently, the Alliance has stopped all in person record retrieval. Currently, the Plan is asking for providers to submit the requested medical records via fax. The Plan recognizes that COVID 19 might impact the HEDIS rates for MY2019. Currently, the plan is reviewing the guidance issued by NCQA to implement a rate rotation for the hybrid HEDIS measures. Currently QI and Analytics are reviewing this option to determine what the			

Agenda					
Agenda Item	**Responsible Person**	**Discussion**	**Document**	**Action**	**Follow-up by QI Staff**
viii. DHCS PIP Update		appropriate action will be for reporting MY2019 HEDIS rates. viii. **DHCS PIP Update:** The Alliance currently has two DHCS PIPs that include the Equity PIP focusing on W15 for the African American Population and the Priority PIP on W34. Modules 1 and 2 for both PIPs have been submitted to DHCS for review. The Plan is also in direct contact with DHCS and has shared with the State that COVID 19 may impact the implementation of both PIPs interventions which are scheduled to start in July 2020.			
8. Health Education Update a. Tobacco Cessation Update b. Translation Services	L. Ayala	L. Ayala provided the following Health Education Update to the Committee: • <u>Health Education Update:</u> ○ Health Ed Programs served 766 unique members. ○ Top three types of program participation were: ▪ 241 Asthma Start ▪ 120 School based Nutrition Education ▪ 202 Lactation Support ○ Health Ed Campaigns: ▪ Mailed out asthma resources and referral to 670 pediatric members. ▪ Mailed out pregnancy resources to 3614 members. ▪ Mailed out newborn resources to 2021 members. ▪ Mailed out tobacco cessation resources to 1,451 members. ▪ Distributed 1700 tobacco cessation postcards to 5 clinics. ○ Top 10 health topics requested in 2019: ▪ Healthy eating ▪ Healthy weight	08_HED Update 2-2020_Q4 08a_Alliance Tobacco Strategy IQIC 2-2020	None	None

Agenda					
Agenda Item	**Responsible Person**	**Discussion**	**Document**	**Action**	**Follow-up by QI Staff**
		▪ Exercise ▪ Safety ▪ Heart health ▪ Diabetes ▪ Stress and depression ▪ Independent living ▪ Back care ▪ Asthma o Activities Completed: ▪ Member communications ▪ Member Handouts ▪ Stress, anxiety and depression ▪ Baby Blues ▪ Newsletter article o Provider communications ▪ Updated referral forms to include Maternal Mental Health ▪ Quarterly provider communication a. <u>Tobacco Cessation Update:</u> o APL requirement to track tobacco users and interventions o February 2019 tobacco report to IQIC o Convened workgroup to discuss the data and what to do about it o Ran additional data o Brainstormed possible interventions o Connected with partners o Reviewed evidence o Discussed impact and feasibility of interventions o Goal is to increase percentage of tobacco users who receive cessation supports o Timeline: ▪ HED Workgroup check-ins (quarterly, starting Jan)			

Agenda					
Agenda Item	**Responsible Person**	**Discussion**	**Document**	**Action**	**Follow-up by QI Staff**
		▪ Finalize strategy at IQIC, begin to implement (Feb) ▪ Report 2020 results (February 2021) • Translation Services Update: The Plan is in the process of shifting translation services away from in-person services to telephonic services expect for ASL and end-of-life discussions.			
9. Access and Availability Update	G. Battaglia	G. Battaglia provided the follow Access & Availability to the Committee: • Survey Tool CG-CAHPS (Q27/Adult, Q37/Child) asks: Office wait time includes both the time spent in the waiting room and the exam room before you are seen by the doctor. Thinking about visits to this provider in the last 6 months, about *how many minutes did you typically wait in the waiting room and exam room until you saw the provider*? Was it... • Less than 60 minutes – 90% were compliant • More than 60 minutes – 10% noncompliant • The compliance rate was holding steady between Q3 2019 and Q4 2019 • All delegate providers scored above the 80% compliance threshold in Q4 2019 • Survey Tool CG-CAHPS (Q10/Adult, Q17/Child) asks: Thinking about visits to this provider in the last 6 months, when you called this provider's office during regular office hours, when did you get a call back? • Within 1 business day – 78% compliant • More than 1 business day or Did not hear back – 22% noncompliant • The compliance rate was holding steady between Q3 2019 and Q4 2019. • AHS and CHCN scored below the 80% compliance threshold in Q4 2019	09_Acccess and Availability Updates 3.19.20 09a_Timely Access Standards_010 92020 clean	None	None

Agenda					
Agenda Item	**Responsible Person**	**Discussion**	**Document**	**Action**	**Follow-up by QI Staff**
		• Survey Tool CG-CAHPS (Q5/Adult, Q4/Child) asks: Thinking about visits to this provider in the last 6 months, when you called this provider's office during regular office hours, how long did you wait to speak to a staff member? • 0 – 10 minutes - 77% compliance rate • Greater than 10 minutes – 23% noncompliance rate • AHS and CHCN scored below the 80% compliance threshold in Q4 2019 • Unable to perform trend analysis as this metric was captured in the Q3 2019 survey for the first time.			

10. UM Work Plan Update	J. A. Miller	J. A. Miller provided the following update to the Committee:
		• In Q4 2019, the Alliance received 1,960 Specialty Referrals. 877 of the referrals are for consults, 730 of the referrals are for invasive procedures, and 100 of the referrals are for outpatient.
		• ALOS average of 4.23
		• Admits/1000 average of 60.07
		• Days/1000 average of 254.8
		• The Alliance saw a decrease in Outpatient Denials in 2019. A large decrease was noted in July as to be expected due to the fact that the Plan reabsorbed radiology authorizations.
		• Next Steps:
		  ○ Hospitalization rates continue to hold relatively steady
		  ○ Inpatient Denials are declining in Q4.
		  ○ Launching staff audits to identify issues
		  ○ Sutter denial rates continue to be in line with all hospital rates, so will monitor periodically
		  ○ Outpatient Denials have declined and stabilized near 4% since Radiology absorption.
			10_02.2020 AAH UM	None	None

Agenda					
Agenda Item	**Responsible Person**	**Discussion**	**Document**	**Action**	**Follow-up by QI Staff**
		• Current Volume on Open cases for January 2020 ○ Complex Case Management ▪ in progress: 57 ▪ new cases: 34 ○ Care Coordination ▪ in progress: 660 ▪ new cases: 260 • Transition of Care (TOC): ○ Pilot Program with Alameda Health Systems started 11/18/19 and includes: ○ Post DC call within 1 business day (24-72 hours post-discharge) ○ Includes assessment of new or worsening symptoms, triage as needed ○ Medication reconciliation for high risk members ○ Review and teach-back of DC plan (includes review of needed DME, referrals to home health, specialty appts) ○ Disease-specific teaching for high risk members ○ Ensure understanding of and transportation to post DC follow up appt ○ As of 2/24/20 there are: ▪ 161 TOC open cases ▪ 272 TOC closed cases • Health Risk Assessment: ○ **High Risk** Stratified HRAs* (44 calendar day TAT from enrollment date) ○ *Includes new SPDs only ○ **Low Risk** Stratified HRAs (105 calendar day TAT from enrollment date) ○ December ○ Completed – 342 within TAT ○ Returned by member outside of TAT – 90 (yet to be completed)			

Agenda					
Agenda Item	**Responsible Person**	**Discussion**	**Document**	**Action**	**Follow-up by QI Staff**
		○ Returned mail (bad addresses) – 76 ○ January ○ Completed – 271 ○ Returned by member outside of TAT – 141 (yet to be completed) ○ Returned mail (bad addresses) – 69 ○ IVR calls for February are complete ○ Care Plan Mailings (to members & providers) are current • Out of Network Authorizations: ○ Two Tier process continues to show success ○ Continue to Monitor on a Periodic Basis			
11. Public Comment	S. O'Brien	None	None	None	None
12. Adjournment	S. O'Brien	Meeting was adjourned at 7:58 PM.	None	Motion to adjourn the meeting: Dr. Florey 2nd: S. Wakefield	Next meeting: May 21, 2020

DocuSigned by:
X Steve O'Brien
E16B987631B045E...
Steve O'Brien MD
Chief Medical Officer
Chair

05/21/2020
Date

Minutes prepared by: Grace Chu, QI Project Specialist

HEALTH CARE QUALITY COMMITTEE MEETING MINUTES

Meeting Date: 01/16/2020

Attendance		
Committee Member Name and Title	**Specialty**	**Present**
Steve O'Brien, MD, Chief Medical Officer, Alameda Alliance for Health	Internal Medicine	X
Aaron Chapman, MD, Medical Director, Alameda County Behavioral Health Care Services	Psychiatry	X
Wesley Lisker, MD, Kaiser Permanente	Nephrology	X
Laura Miller, MD, Chief Medical Officer, Community Health Center Network	Internal Medicine	X
Ghassan Jamaleddine, MD, Chief Medical Officer, Alameda Health Systems	Internal Medicine	X
James Florey, MD, Chief Medical Officer, Children First Medical Group	Pediatrician	X
Sanjay Bhatt, MD, Medical Director of Quality, Alameda Alliance for Health	Emergency Medicine	X
Beverly Juan, MD, Medical Director of Utilization Management, Alameda Alliance for Health	Pediatrician	X
Shani Muhammad, MD, Director of Medical Services, Alameda Alliance for Health	Family Practice	
Stephanie Wakefield, RN, Senior Director of Quality, Alameda Alliance for Health		X
Alameda Alliance for Health Staff Member Name and Title		**Present**
Scott Coffin, Chief Executive Officer		
Helen Lee, PharmD, MBA, Senior Director of Pharmacy Services		X
Julie Anne Miller, Director of Health Care Services		X
Diana Sekhon, MHPA, CHC, Director of Compliance		X
Jessica Pedden, Clinical Quality Manager		X
Linda Ayala, Health Education Manager		X
Christine Clark, RN, Quality Improvement Supervisor		X
Gina Battaglia, Access to Care Manager		X
Grace Chu, QI Project Specialist		X
Martins Umeugoji, QI Project Specialist		X
Community Members in Attendance		**Present**
None		

HEALTH CARE QUALITY COMMITTEE MEETING MINUTES

Meeting Date: 01/16/2020

Meeting Objective
To improve quality of care for Alliance members by facilitating clinical oversight and direction.

Agenda

Agenda Item	Responsible Person	Discussion	Document	Action	Follow-up by QI Staff
Call to Order/Roll Call	S. O'Brien		None	Called to order at 6:02 PM	None
1. Approved Committee Meeting Minutes: a. HCQC Meeting Minutes 11/21/19 b. IQIC Meeting Minutes 12/17/19 c. UM Meeting Minutes 11/22/19; 12/20/19 d. A&A Meeting Minutes 11/6/19	S. O'Brien		01_Meeting Min Packet	Meeting Minutes were sent out to the HCQC Members for e-vote and they were approved on January 15, 2020.	None
2. QI Alameda Alliance Update	S. Wakefield	• S. Wakefield, the Sr. Director of Quality, presented an overview of Medi-Cal Healthier California for All, formally known as CalAIM. The Governor's initiative is to improve health care quality and clinical outcomes of the Medi-Cal population. The following information was discussed: ○ Major components of the program are built on successful outcomes of the whole person/HHP/care coordination pilot that began in 2016. ○ Primary goals of CalAIM are to : ▪ Manage members' risks/needs while addressing SDOH ▪ System transformation to make Medi-Cal less complex and more flexible and seamless for member navigation.	02_Medi-Cal Healthier CA for All	None	None

Agenda					
Agenda Item	**Responsible Person**	**Discussion**	**Document**	**Action**	**Follow-up by QI Staff**
		▪ System transformation to remove barriers better administration and payment experiences while at the same time making sure there is consistency from county to county for reimbursement. • The Alliance's priorities include complete readiness for the following: ○ Administration oversight of organ transplants ○ Transition of long-term care services: ○ SNF ○ Subacute conditions ○ Managing transitions of care ○ Transition of pharmacy of pharmacy to the State for MCL LOB except for provider administered drugs • The 2020 to Do's include the following: ○ Better understanding of in lieu of services are available in Alameda County in terms of the following: ▪ Housing transition ▪ Respite care ▪ Other services ○ Enhanced Case Management coming from UM ○ Role of PBM for Medi-Cal ○ What do we need to do to be ready for the requirements by 2021 • Dr. O'Brien, the Chief Medical Officer, shared with the committee the following information that he learned at the DHCS CMO Meeting: ○ Enhanced Case Management (ECM) which will be a new benefit, which will be focused on a specific member population but it is not as specific as HHP.			

Agenda					
Agenda Item	**Responsible Person**	**Discussion**	**Document**	**Action**	**Follow-up by QI Staff**
		○ The Alliance will utilize its own population health process to select high-risk patients that fit into categories that are identified by the State. ○ Dr. Miller would like to partner with the Alliance in the development of ECM strategy.			
3. Follow-Up Items: a. HCQC 2020 Meeting Schedule Email Distribution	S. Wakefield	• J. Pedden, the Quality Improvement Manager, confirmed with the committee their receipt of invites for all of the HCQC Meetings in 2020.	None	None	None
4. Policies & Procedures: a. Quality Improvement: i. QI-124, **"**Initial Health Assessment (IHA)/Health Information Form/Member Evaluation Tool (HIF/MET)" – *vote to approve* ii. QI-134, "Medical Record Review Overview – HEDIS Audit" – *vote to approve* b. Utilization Management: i. UM-001, "Utilization Management" – *vote to approve*	J. Pedden J. A. Miller	• J. Pedden discussed the following changes to QI-124: ○ As part of the annual code validation, additional E&M codes were added to better identify IHA completion. The purpose of adding additional codes is allow for opportunities for providers to increase compliance rates for IHA within 120 days of assignment. • J. Pedden discussed the following changes to QI-134: ○ The appropriate percentage of overreads that are conducted by the Alliance will be determined in conjunction with our HEDIS Vendor. • J. A. Miller, the Director of Health Care Services, provided the following updates on the UM P&Ps: ○ One important change is with regards to the use of LVNs. Moving forward, only RNs can make authorization approval decisions. This change was made to ensure that LVNs work within their scope of practice. ○ D. Sekhon, Director of Compliance, informed the committee that the State is really pushing on plans regarding LVN scope of practice. The	**Quality Improvement:** 04a_P&P Packet_HCQC_1_16_20 **Utilization Management:** O4b_UM P&P	Policies and Procedures were approved by committee member e-vote on January 15, 2020.	Policies & Procedures will be finalized as presented.

Agenda					
Agenda Item	**Responsible Person**	**Discussion**	**Document**	**Action**	**Follow-up by QI Staff**
ii. UM-057, " Authorization Management" – *vote to approve*		Alliance needed to revise its policy on LVNs and assess the impact of some of our delegates. ○ The Alliance raises this as an issue because CFMG and CHCN utilize LVNs in various roles and functions within UM. The Plan does not know what the implications are for the delegates and their use of LVNs at this time.			
5. Compliance Update	D. Sekhon	• D. Sekhon provided the following updates to the committee: ○ January- a senate bill passed that extended Medi-Cal for young adults under age of 26 to be eligible. ○ Restoration of optical services like glasses, podiatry, and speech therapy. ○ Starting in January, providers will receive payment for developmental screening services (ACES) once they have completed the DHCS provider training. ○ The Alliance is working on wrapping-up items identified in DHCS' 2019 CAP. ○ DMHC follow-up audit from 2018 will be in February 2020.	None	None	None
6. QI Work Plan: a. Quality Initiatives Updates: i. New Member IHA Report ii. Pediatric Underutilization iii. HEDIS Crunch MY2019 Update iv. HEDIS 2020 Rollout	J. Pedden	• J. Pedden provided the following update on the Initial Health Assessment (IHA) for 2018: ○ The IHA needs to be completed within 120 days of member assignment ○ It is part of the Alliance's P4P ○ It is a component that the Alliance is audited on by DHCS ○ There are 6 elements of the IHA, the first five elements can be found within the chart notes and the sixth element is the Staying Health	**Quality Initiatives Updates:** 06a_Quality Initiatives	None	J. Pedden with share Kaiser's methodology for their self-reported IHA results. J. Pedden will send Dr. Miller the IHA slide so she can follow-up with CHCN staff to identify what they are doing around IHAs. Dr. Miller

Agenda					
Agenda Item	**Responsible Person**	**Discussion**	**Document**	**Action**	**Follow-up by QI Staff**
b. Member Non-Utilization c. Population Health Update	J.A. Miller S. Wakefield	Assessment (SHA) form that can be downloaded from DHCS' website ○ The Alliance recognizes that there is a large discrepancy between what the Plan has identified as Kaiser's IHA completion rate and what Kaiser self-reports on a quarterly basis. The Alliance is currently working with L. Parkinson from Kaiser to determine what is causing the discrepancy. ○ Across the network, currently 23% of the Plan's members are receiving an IHA within 120 days. ○ On average in 2018, 23.5% of the Plan's new members get an IHA completed. Notice AHS lowest completion rate of 17%. QI is trying to identify nuances of member assignment and see how that plays into the completion rate. CHCN has highest average IHA completion rate of 28.2%. • The Alliance intends to improve the IHA performance rate through: ○ Provider incentives as it is a component of the Alliance's 2020 P4P ○ Provider education during FSRs ○ New provider orientation ○ Quarterly provider newsletters ○ Monthly IHA GIC reports to our delegates and direct providers ○ Auditing medical records twice a year • HEDIS Crunch, Pediatric Underutilization - For the measurement year 2019, the Alliance's goal is increase HEDIS rates by 0.6% from 71.4% to 72%. J. Pedden provided the following update on pediatric underutilization which is based on claims data as of December 6th:	**Member Non-Utilization:** None **Population Health Update:** 06c_HCQC AAH Population Health Management 1.16.2020		will report back at the next HCQC Meeting. J. Pedden will work with the Analytics Department to determine if IHA rates can be calculated based on auto-assignment and self-selection of PCP. J. Pedden will identify who the Analytics Department is working with at AHS and report back to the committee.

Agenda					
Agenda Item	**Responsible Person**	**Discussion**	**Document**	**Action**	**Follow-up by QI Staff**
		○ AWC: the largest improvement is seen by CFMG of 6% from November to December. ○ W15: Largest improvement from November to December is by our direct providers. ○ W34: Kaiser surpassed the MPL for this measure. The Plan had a 4% increase from November to December and the largest increase of 7.3% is in our directly contracted providers. ○ CAP 12-19: Slight increase from November to December of 0.76%. The Plan recognizes that this is a challenging measure because this population is hard to engage and connect into care. • HEDIS Crunch initiative at Tri-City, part of the CHCN Network: ○ As of December 10, 2019, 136 gift cards were given to patients by Tri-City ○ W15: there was a decline in rate due to a decrease in eligible population. Therefore a member who was compliant was no longer assigned to Tri-City. ○ W34 and CAP 12-19: there is a positive increase in compliance rates which can be attributed to the increase in visits by offering a member incentive of $25 to Safeway or AMC. ○ Lessons learned: identify an employee at the clinic location that is available for warm transfers • J. Pedden provided the following update on HEDIS Record Retrival 2020 Rollout: ○ Provider visits for record retrieval will be starting on February 14th and will last until May 4th ○ Based on an analysis conducted by the Analytics Department, there will be a minimum of 5,400 retrievals this year			

Agenda					
Agenda Item	**Responsible Person**	**Discussion**	**Document**	**Action**	**Follow-up by QI Staff**
		○ QI is working with the Analytics Department to complete the appropriate sections of the Roadmap that needs to be submitted to NCQA ○ CHCN will provide the Alliance with access to the FQHC's EPIC and Nextgen systems for revival ○ Analytics Department is working with AHS' IT Department to gain access to EPIC Link • J. A. Miller provided the following update on non-utilizers that excludes Kaiser members: ○ From August 2018 to July 2019, 87K of our 250K have zero claims and have not accessed services. ○ 8,600 were kids ages 6-18 were assigned to CFMG, CHCN, and the Alliance ○ The Plan continues to examine this data to identify the zip code and develop a list to share with the delegates to see which members are not coming in. • S. Wakefield gave the following update on Population Health: ○ Population Health is one of the comprehensive NCQA standards ○ The Alliance adopted definition with a focus on health and well-being, preventing adverse events, and improving health outcomes for members ○ Goal is increase members' responsibility to be involved in their care with outward extension that includes our CM, PCPs direct and delegate, county agencies, CBOs, and med system entities ○ We were surveyed this past fall by NCQA for reaccreditation for our Medi-Cal LOB. One finding is that AAH really needs a more robust documented workplan and strategy around population health			

Agenda					
Agenda Item	**Responsible Person**	**Discussion**	**Document**	**Action**	**Follow-up by QI Staff**
		○ Focus to move from DHCS' Group Needs Assessment to a Population Needs Assessment to be incorporated as part of Pop Health Strategy ○ Healthcare services has number of Pop Health related initiatives and programs that are currently being implemented. There is a lot of cross functional integration with Analytics Department. The plan is keeping members healthy include DPP, HRAs, HIF MET, HEDIS outreach calls, and timely access surveys. ○ The Alliance is managing member emerging risk through Asthma Start, HbA1c for African American men, tobacco cessation, opioid program, and behavioral health coordination. Looking at this care across all settings, we have intensive UM discharge planning process, care coordination, HHP. CBCME care coordination, managing population with chronic health conditions through integrated behavioral health, and complex case management.			
7. Cultural & Linguistics Update a. RFP Vendor Selection	L. Ayala	• L. Ayala, Health Education Manager, provided the following update on Interpretive Services: ○ The Alliance has selected new interpreter vendor for telephonic/video translation. Increases our capacity ○ Benefit will be that it will be an on demand system accessible via an access code. No need to schedule ahead of time ○ For in person interpreter, we have set up criteria. i.e. sign language, sensitive services, palliative care, and end of life discussions	None		
8. UM Work Plan Update	J. A. Miller	• J. A. Miller provided the following update on the UM Program Evaluation:	08_UM Work Plan Update		

Agenda					
Agenda Item	**Responsible Person**	**Discussion**	**Document**	**Action**	**Follow-up by QI Staff**
a. UM Program Evaluation Update b. Inpatient UM Report		○ UM metrics include authorized LOS is what we authorize day-to-day, paid LOS is based on claims we receive ○ Results for rolling 3 months August to October. Drop fractionally for ALOS. Higher in July. There may be seasonality with this. ○ Meeting bi weekly with AHS leadership to go through hard cases to make sure members have good transition of care. It has been a fruitful collaboration. • J. A. Miller provided the following update on Inpatient UM Report: ○ Now fluctuating between 6-8%. There is still some work to be done with IP team which include a focus on standard work and process			
9. Pharmacy Update a. DUR Report b. P&T update	H. Lee	• H. Lee, Senior Director of Pharmacy Services provided the following update: ○ For drug utilization for opioid we are looking at Q3 July to September 2019, we have a lot of collaboration with QI for opioid stewardship. Trying to follow CDC recommendations with using effective dosing of opioid. Developing tools for prescriber use for short duration instead of longer duration. ○ From July to August, 4% decrease in overall MME from 50-400. From August to September see 12% decrease. From 819 to 721, has to do with various changes i.e. limiting quantity per phase, implement 14 day per new start, academic detailing. ○ Total consistent utilization of opioid by month: July had 3600 unique members, August was 3524, September was 3388. Look at July to	09_DUR Report Q3 2019		

Agenda					
Agenda Item	**Responsible Person**	**Discussion**	**Document**	**Action**	**Follow-up by QI Staff**
		September 2019 vs previous period from 2018, there has been decrease use of opioids more than 7 days. Some decrease in people on 90 or more MME on daily dose base. We will monitor and track what's happening with prescribing pattern here. ○ P&T meeting December 17, 2019, where a total of 29 therapeutic class were reviewed and a total of 30 prior authorization guidelines were reviewed. ○ Medi-Cal related admin functions, daily authorizations and member support will be transferred to the State. Plan level will maintain care coordination/drug adherence/disease medication management/physician administered drug and long term care. All pharm duties will continue for commercial line of business.			
10. Public Comment	S. O'Brien	None	None	None	None
11. Adjournment	S. O'Brien	Meeting was adjourned at 7:58 PM.	None	Motion to adjourn the meeting: Dr. Florey. 2nd: Dr. Jamaleddine.	None

DocuSigned by:
x Steve O'Brien
Steven O'Brien, MD
Chief Medical Officer
Chair

03/19/2020
Date

Minutes prepared by: Grace Chu, QI Project Specialist

HEALTH CARE QUALITY COMMITTEE MEETING MINUTES
11/21/2019

Attendance

Committee Member Name and Title	Specialty	Present
Steve O'Brien, MD, Chief Medical Officer, Alameda Alliance for Health	Internal Medicine	X
Aaron Chapman, MD, Medical Director, Alameda County Behavioral Health Care Services	Psychiatry	X
Wesley Lisker, MD, Kaiser Permanente	Nephrology	X
Laura Miller, MD, Chief Medical Officer, Community Health Center Network	Internal Medicine	X
Ghassan Jamaleddine, MD, Chief Medical Officer, Alameda Health Systems	Internal Medicine	
James Florey, MD, Chief Medical Officer, Children First Medical Group	Pediatrician	X
Sanjay Bhatt, MD, Medical Director of Quality, Alameda Alliance for Health	Emergency Medicine	X
Beverly Juan, MD, Medical Director of Utilization Management, Alameda Alliance for Health	Pediatrician	
Shani Muhammad, MD, Director of Medical Services, Alameda Alliance for Health	Family Practice	
Stephanie Wakefield, RN, Senior Director of Quality, Alameda Alliance for Health		X

Alameda Alliance for Health Staff Member Name and Title	Present
Scott Coffin, Chief Executive Officer	
Julie Anne Miller, Director of Health Care Services	X
Jennifer Karmelich, Director of Quality Assurance	X
Jessica Pedden, Clinical Quality Manager	X
Linda Ayala, Health Education Manager	X
Grace Chu, QI Project Specialist	X
Bob Hendrix, QI Project Specialist	X
Martins Umeugoji, QI Project Specialist	X

Community Members in Attendance	Present
None	

HEALTH CARE QUALITY COMMITTEE MEETING MINUTES
11/21/2019

Agenda

Agenda Item	Responsible Person	Discussion	Action	Follow-Up by QI Staff
1. Call to Order	S. O'Brien	The meeting was called to order at 6:03 PM	Called to order at 6:03 PM	None
2. Meeting Minutes	S. O'Brien	The following Meeting Minutes were presented for approval: • HCQC Meeting Minutes 9/19/19 • IQIC Meeting Minutes 8/28/19, 10/23/19 • Utilization Management 9/27/19 • A&A Meeting Minutes 9/4/19	Meeting Minutes were sent out to the HCQC Members for e-vote and they were approved on November 21, 2019.	None
3. Chief Medical Officer Alameda Alliance Update	S. O'Brien	➢ The Chief Medical Officer, Dr. O'Brien, discussed that the Alliance is currently ahead of its budget, but that can change at any time. ➢ Dr. O'Brien provided the following update on the Alliance: o Increased staffing in the Quality Improvement, Utilization Management, and Case Management Departments o The Plan is starting to focus on clinical initiatives with community partners that focus on acute care and length of stays in the hospital o The Quality Improvement Department and the Utilization Management Department have been going into the field to meet with community partners ➢ Dr. O'Brien discussed that there will be significant changes to the Medi-Cal benefit January 2021: o The Plan will be responsible for long-term care o The Plan will be responsible for oversight of transplants of all organs and bone marrow for members o The Pharmacy carve-in. The State has announced that it has a PBM awarded, Magellan		None
4. Follow-Up Items	S. Wakefield	➢ QI will provide an overview of Kaiser's 2018-2019 QI Program Document ➢ S. Wakefield, the Senior Director of Quality, presented that as part of the Plan's delegate oversight responsibility, we have to ensure that Kaiser's program		None

Agenda Item	Responsible Person	Discussion	Action	Follow-Up by QI Staff
		documents meet regulatory standards. S. Wakefield informed the committee of the following information: o The KFHP 2019 Program Description clearly defines its quality structure and process and assigns responsibility to appropriate individuals. The program description details the infrastructure necessary to improve member care and services. The program description details the governance, scope, goals, measurable objectives, structure, responsibilities and annual work plan. o The KFHP 2019 Workplan has similar initiatives to the Alliance which include: ▪ HRA ▪ Texting Pilot ▪ HIF/MET ▪ IHA		
	S. Bhatt	➢ Dr. Bhatt will send Dr. Lisker the Kaiser Gaps-in-Care Report - completed ➢ Dr. Bhatt will review the list of opioid prescribers to see if there are any pediatricians on the list. – completed.		
5. **Policies & Procedures**	J.A Miller	➢ The following Policies and Procedures were approved by committee member e-vote on November 21, 2019: o Utilization Management: ➢ UM-063, "Gender Confirmation Surgery and Transgender Services" – *vote to approve* ➢ UM-009, "Coordination of Care-Organ Transplant" – *vote to approve* ➢ UM-016, "Transportation Guidelines" – *vote to approve* ➢ UM-018, " TCM and EPSDT Supplemental" – *vote to approve* ➢ UM-052, "DCP to LLOC and Granting Administrative Days Pending Placement" – *vote to approve* ➢ UM-054, "Notice of Action" – *vote to approve* ➢ UM-060, "Delegation of UM" – *vote to approve* ➢ UM-064, "Treatment of Varicose Veins," – *vote to retire*		Policies & Procedures will be finalized as presented.

Agenda Item	Responsible Person	Discussion	Action	Follow-Up by QI Staff
	S. Bhatt J. Karmelich	o Quality Assurance: ➢ QA-001, "State of Emergency Procedures," – *vote to approve* o Performance & Analytics: ➢ ANA-033, "PCP Incentive Program" – *vote to approve* Policy and Procedure Presentation: o Grievance and Appeals: ➢ G&A-003, "Grievance and Appeals Receipt, Review and Resolution" – *vote to approve* ➢ G&A-008, "Adverse Benefit Determination Appeals Process" – *vote to approve*	Motion to approve Policy and Procedures G&A-003 and G&A-008 as presented: Dr. Florey. Second: Dr. Bhatt. Approved unanimously.	
6. Compliance Update	D. Sekhon		Deferred to HCQC Meeting 1/16/20	None
7. NCQA Update	J. Karmelich	➢ J. Karmelich, the Director of Quality Assurance, informed the committee that: o There are 7 standards that the Alliance was evaluated on utilizing a 3 year lookback period o The Plan is accredited for 3 years for the Medi-Cal LOB o The Plan is accredited for 1 year for the commercial LOB. NCQA will be back in June to review the standards that the Alliance has a deficit in. o The Plan needs to develop a strategy for Population Health. o The Plan needs to ensure that denial letters contain clear and concise language and the correct criteria is in the NOA. The Plan is currently reviewing the language used in NOAs to ensure that it meets the standards.		None
8. Grievance & Appeals Update	J. Karmelich	➢ J. Karmelich presented the G&A Report for Q3. The following information was presented to the committee: o The Alliance's goal is to have less than 1 per 1,000 member complaints (grievance and appeals), for the reporting period of Q3 2019, we are over our goal at 5.4 complaints per 1,000 members.	None	None

Agenda Item	Responsible Person	Discussion	Action	Follow-Up by QI Staff
		o CHME – showed a decrease in overall complaints since Q4 2018. The trend for the last 4 months have averaged around 20 per month, the Alliance will close the CAP by the end of the year with a new baseline of 20 per month. o The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of Q3 2019; we are over our goal at 31.7% overturn rate. However, the Alliance has continued to experience a decrease in the overturn rate throughout the quarters.		
9. QI Work Plan	S. Wakefield and S. Bhatt J. Pedden	➢ Dr. Bhatt presented the Alliance's 2020 P4P. Objectives are standard—promote QI initiatives, QI care, cost control, and standardization of methodology of payment. The committee was informed that the following elements are part of the 2020 P4P: o Childhood Immunizations – Combo 10 o Well-Child Visits in the First 15 Months of Life o Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life o Adolescent Well-Care Visits o Breast Cancer Screening o Cervical Cancer Screening o HbA1c Testing for Diabetics o Initial Health Assessments – there has been a change to the codes that will be utilized for this measure. The Plan has decided to include additional codes this year. All of the codes that are part of the IHA have been validated internally. o Emergency Department Visits per 1,000 Members o Pharmacy Utilization: Percentage of Generic Usage o Member Satisfaction Survey: Non-Urgent Appointment Availability o Opioid Intervention: DEA X-Waiver ➢ S. Wakefield presented on the Alliance's Pediatric Strategy, which is part of the organization's strategic planning. The Pediatric Strategy:		

Agenda Item	Responsible Person	Discussion	Action	Follow-Up by QI Staff
		○ Follows Bright Futures Guidelines to ensure that members receive the required screenings and have access to the EPSDT services. ○ The Plan is currently working with CBOs to identify how we can enhance our collaboration and identify target actions to improve EPSDT screenings and referrals based on Medi-Cal Benefit coverage ○ The Plan is currently looking at the data to identify members with no service utilization in order to develop strategies to connect them to care. ➢ J. Pedden, the Clinical Quality Manager, provided an update to the committee on the Plan's QI Initiatives. The following information was shared: ○ The QI Department is currently working with 6 direct providers, 13 CFMG provides, and 1 CHCN FQHC to help connect pediatric patients to care by focusing on 3 HEDIS measures, W15, W34, and CAP 12-19. ○ The Plan is giving provider offices $25 gift cards as member incentives to Safeway and AMC upon completion of their preventative exam. ○ The QI Department is working with CFMG and Tri-City Health Center by making outbound calls to noncompliant members to help schedule appointments through a warm transfer. ○ The Plan also supported a Wellness clinic day at Kiwi Pediatrics by providing member incentive gift cards. ➢ Dr. Bhatt presented the Q2 PQI results. The following information was shared: ○ In Q2 the Plan received 307 PQIs of which only 88 of them were Quality of Care (QOC). ○ Of the 88 QOCs, 31 of them were leveled as a C2, C3, or C4. ○ In Q1-Q2, 9 PQI CAPs were issued (7 were for PQIs leveled C2, 1 for C3, and 1 for C4).		

Agenda Item	Responsible Person	Discussion	Action	Follow-Up by QI Staff
		o 100% of the grievances were identified correctly as non-quality of care issues during the Exempt Grievance Audit. ➢ Dr. Bhatt presented an update on the PQI application. The following information was shared: o Phase 1: ▪ Identify QI Department's application needs ▪ Create a database that captures PQI information ▪ Create a direct feed from the G&A Application ▪ Status: Complete o Phase 2: ▪ Update user interface ▪ Improve reporting mechanism ▪ Improve data capture ▪ Status: Expected go live date 12/31/19 ➢ J. Pedden provided an update on the Plan's DHCS PIPs. The following information was presented: o DHCS PIPs are based on the PDSA Cycle. DHCS provides the framework for MCP to complete the PIPs which is found in the 5 reporting modules. 1. 2017 DHCS PIPs: a. Improve Adolescent Access to Care PIP i. **Target Population**: Members aged 12-19 who have not been seen by a PCP for two years or more and are assigned to Mowry 1. Mowry 2, or Liberty clinic locations. ii. **Plan:** To outreach to the target population and engage them to schedule an appointment with their PCP by offering a $25 gift card to Target upon completion of the visit. iii. **Goal:** To increase access to by 5.3% for the target population iv. **Intervention Testing Period:** 11/1/2018 – 6/30/2019		

Agenda Item	Responsible Person	Discussion	Action	Follow-Up by QI Staff
		a. The Alliance has adapted this strategy as part of its current Pediatric Care Coordination Pilot. b. Module 4 and 5 were validated and approved by DHCS on 10/31/19 b. Improve HbA1c Testing in African American Males i. **Target Population:** African American men aged 18-75 assigned to Alameda Health Systems who are diabetic. ii. **Plan:** To partner with Alameda Health Systems to offer point-of-care testing at the time of service. iii. **Goal:** To increase the rate of HbA1c testing of the target population from 73.12% to 79%. iv. **Intervention Testing Period:** 11/1/2018 – 6/30/2019 a. The Alliance adapted this strategy and continue working with Alameda Health Systems to improve HbA1c testing for the target population. b. Module 4 and 5 were validated and approved by DHCS on 10/31/19 2. 2019 DHCS PIPs: a. Improve MCAS Measure W34. Increase Well-Child Visits Among Members Ages 3-6 b. **Target Population:** patients age 3-6 c. **Goal:** To increase the performance rate of W34 from 62.20% to 66.20% of W34 by June 30, 2021. i. The topic was approved by DHCS on 8/29/19. ii. Module 1 has been submitted to DHCS for review. d. Improve MCAS Measure W-15. Well-Child Visits in the First 15 Months of Life		

Agenda Item	Responsible Person	Discussion	Action	Follow-Up by QI Staff
		i. **Target Population:** African American members under 15 months old ii. **Goal:** To increase the performance rate of W15 for the target population from 33.33% to 42.1% by June 30, 2021. a. The topic was approved by DHCS on 8/29/19. b. Module 1 has been reviewed by DHCS. DHCS provided additional feedback and recommendations.		
10. Health Education	L. Ayala	➢ L. Ayala, the Manager of Health Education, provided a Q3 update. The following information was presented: o Preventive Care: ▪ **Goal:** Improve member utilization of appropriate and timely preventive services ▪ **Activities Completed:** a. Member handouts content finalized b. Senior, Adult, and Child Screenings & immunizations: Created provider attestation sheet for office FSR training and verification on required guidelines c. Provider education through fax blast requirement to follow USPSTF and Bright Futures guidelines ▪ **Next Steps:** Create member preventive care book o Healthy Eating, Exercise and Weight Management – Adults: ▪ **Goal:** Increase adult members' awareness and use of strategies to practice healthy eating and regular physical activity, lose weight if needed and maintain a healthy weight. ▪ **Activity Completed:** Launch Diabetes Prevention Program on October 1, 2019 with Solera partnership ▪ **Next Steps:** Targeted clinic-based outreach with Native American, Tri-City, West Oakland and Axis Health Centers	None	None

Agenda Item	Responsible Person	Discussion	Action	Follow-Up by QI Staff
		▪ Outreach Providers November fax blast Members: Fall/Winter Newsletter article o Healthy Eating, Exercise and Weight Management – Child: ▪ **Goal:** Increase awareness and use of strategies for families with children to practice healthy eating and regular physical activity, lose weight if needed and maintain a healthy weight. ▪ **Activity:** Created member and provider needs assessment tools o Provider survey – 6 sites ▪ Member input activity tested at MAC ▪ Next Steps: Implement assessments o Q1-Q3 Distribution of Health Ed Information & Referrals: ▪ **Goal:** Provide health education, health promotion and patient education for all members ▪ **Activities Completed:** a. 620 Unique members participated in Health Education programs. b. Top three types of program participation were: (1) 193 Asthma Start, (2) 173 School based Nutrition Education, (3) 152 Lactation Support c. Mailed out pregnancy resources to 2,702 members d. Mailed out newborn resources to 1,505 members e. Mailed out tobacco cessation resources to 1,451 members f. Distributed 1700 tobacco cessation postcards to 5 clinics		
11. Access & Availability Update	S. Bhatt	➢ Dr. Bhatt informed the committee that regulators place a lot of emphasis on access to care for members. ➢ Dr. Bhatt presented the following information:		

Agenda Item	Responsible Person	Discussion	Action	Follow-Up by QI Staff
		○ Survey Tool (CG-CAHPS Q27 (Adult), Q37 (Child)) asks: Office wait time includes both the time spent in the waiting room and the exam room before you are seen by the doctor. Thinking about visits to this provider in the last 6 months, about *how many minutes did you typically wait in the waiting room and exam room until you saw the provider*? Was it (1) Less than 60 minutes or (2) More than 60 minutes? ▪ 4,296 Members were surveyed and 417 responded that their wait time was more than 60 minutes ○ The Plan analyzed the wait time results by network and has shared this information with the delegates and providers. ➢ In 2019, 261 CAPs have been issued to noncompliant providers. Currently there are 19 open CAPs.		
12. Cultural & Linguistics Update	L. Ayala	➢ L. Ayala provided a Q3 update. The following information was presented: ○ For language assistance services, the Plan fielded a RFP for interpretative services for both telephonic and in person. By January 2020 the Plan will have identified a vendor. ○ Completed the 14 pt font update for SPD and Spanish material on the following topics: ▪ Older adult preventive guidelines ▪ WW flyer ▪ SPD resource listing ▪ DPP Flyer ○ Completed data analysis of CG CAHPS Language Assistance questions. The next step is to outreach to the providers who have been identified. ○ The "I Speak" cards have been approved by the State. The next steps are to have the information translated, printed, and distributed in Q1 2020 Provider Packet.		

HEALTH CARE QUALITY COMMITTEE MEETING MINUTES
11/21/2019

Agenda Item	Responsible Person	Discussion	Action	Follow-Up by QI Staff
13. MAC Update	L. Ayala	➢ L. Ayala shared the following information as a MAC Update: o Implemented a post-MAC meeting survey on 9/19/19. Next step is to incorporate the feedback. o New SPD member voted into MAC on 9/19/19. o The Plan has identified a traditional provider to add to MAC. The next step is to present and get MAC approval for the identified provider.		
14. UM Work Plan Update	J. A. Miller	➢ J. A. Miller, the Director of Health Care Services, presented Inpatient Care Utilization and Prior Authorization Denials. J.A. Miller informed the committee that denials are based on standardization, evidence based guidelines, and best practices. ➢ The following information was presented: o In August 2019, the Plan had the following: ▪ The average length of stay is 3.2 days which is below the 3.5 target ▪ Admits/1000 is 60.8 which is below the 83.5 target ▪ Days/1000 is 196.3 which is below the 295.7 target o Inpatient Denials: ▪ In 2019, the Plan has focused on retraining staff on the use of evidence based guidelines during review, on when to escalate cases, and to ensure that there is a standardization for all UM staff. o Inpatient Denials slowly increased over 2019, following re-training of staff in 2018 o Next step is to compare to appeals and overturn rates o Sutter denial rates are in line with other hospital rates o Outpatient Denials are approaching the 5% target o Radiology denials continued to be high, EviCore delegation ended 8/1/19		

Agenda Item	Responsible Person	Discussion	Action	Follow-Up by QI Staff
		o CHME – showed a decrease in overall complaints since Q4 2018. The trend for the last 4 months have averaged around 20 per month, the Alliance will close the CAP by the end of the year with a new baseline of 20 per month. o The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of Q3 2019; we are over our goal at 31.7% overturn rate. However, the Alliance has continued to experience a decrease in the overturn rate throughout the quarters.		
9. QI Work Plan	S. Wakefield and S. Bhatt J. Pedden	➢ Dr. Bhatt presented the Alliance's 2020 P4P. Objectives are standard—promote QI initiatives, QI care, cost control, and standardization of methodology of payment. The committee was informed that the following elements are part of the 2020 P4P: o Childhood Immunizations – Combo 10 o Well-Child Visits in the First 15 Months of Life o Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life o Adolescent Well-Care Visits o Breast Cancer Screening o Cervical Cancer Screening o HbA1c Testing for Diabetics o Initial Health Assessments – there has been a change to the codes that will be utilized for this measure. The Plan has decided to include additional codes this year. All of the codes that are part of the IHA have been validated internally. o Emergency Department Visits per 1,000 Members o Pharmacy Utilization: Percentage of Generic Usage o Member Satisfaction Survey: Non-Urgent Appointment Availability o Opioid Intervention: DEA X-Waiver ➢ S. Wakefield presented on the Alliance's Pediatric Strategy, which is part of the organization's strategic planning. The Pediatric Strategy:		

Agenda Item	Responsible Person	Discussion	Action	Follow-Up by QI Staff
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ALAMEDA Alliance FOR HEALTH

HEALTH CARE QUALITY COMMITTEE MEETING MINUTES
11/21/2019

Agenda Item	Responsible Person	Discussion	Action	Follow-Up by QI Staff
15. HCQC 2020 Meeting Schedule	S. Wakefield	S. Wakefield presented the 2020 HCQC Meeting Schedule	None	QI staff will send out the calendar invites to HCQC Committee Members.
16. Public Comment	S. O'Brien	None	None	None
17. Meeting Adjournment	S. O'Brien	Meeting was adjourned at 7:44 pm.	Motion to adjourn the meeting: Dr. Florey.	None

X _____ 1/16/2020

Dr. O'Brien
Chief Medical Officer
Chair

Date

Minutes prepared by: Grace Chu, QI Project Specialist

ALAMEDA Alliance FOR HEALTH

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

Information Technology

Sasikumar Karaiyan

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

From: **Sasi Karaiyan, Executive Director of Information Technology**

Date: **July 10, 2020**

Subject: **Information Technology Report**

Call Center System Availability

- AAH phone systems and call center applications performed at 100% availability during the month of June despite supporting 100% of staff in which 90% are working remotely.

- Overall, we are continuing to perform the following activities to optimize the call center eco-system (applications, backend integration, configuration, and network).
    - Upgrading the call manager environment (2 Ring, Calabrio, and Finesse software) – The first phase (Calabrio Application) of the project is now in progress.

Encounter Data

- In the month of June, AAH submitted 87 medical encounter files to DHCS with a total of 390,723 encounters.

Enrollment

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

HEALTHsuite

- The HEALTHsuite system continued to operate normally with an uptime of 99.99%.

- The HEALTHsuite system is currently being upgraded to version 20.x00 from version 16.03. This upgrade will enable the Alliance use of new capabilities and will match the current market version. This is expected to complete before end of September 2020.

TruCare

- The TruCare system continued to operate normally with an uptime of 99.99%. Total 7,466 authorizations loaded and processed in the TruCare application.
- The Alliance's Health Care Services team and Information Technology team have started working on TruCare 7.0.0.7 Optimization effort. Optimization includes adding new business rules and a few other configuration changes. This is expected to be complete before the end of September 2020.

- The Information Technology team has started working on the TruCare upgrade to version 8.0. This upgrade is expected to go live by September 2020.

Web Portal

- The web portal usage for the month of May among our group providers and members remains consistent with prior months.

- The Alliance team started the Member portal redesign which is expected to complete before December 2020.

Information Security

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

- Email based metrics currently monitored have decreased with a return to a reputation-based blocks for a total of 322.6k.

- Attempted information leaks detected and blocked at the firewall are slightly higher from 48 to 64 for the month of June 2020.

- Network scans returned a value of 2, which is in line with the previous month's data.

- Attempted User Privilege Gain is higher at 94 from a previous six month's average of 23.

Data Warehouse

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

- In the month of June, Alliance added additional Claims/Encounters data to the Data Warehouse.

- As part of fiscal year 2021, the plan is to add Authorization, Cases and Disease Management, ADT (Admit, Discharge and Transfer), Credentialing and Pharmacy data to the Data Warehouse.

Data Governance

- Data masking is the process of de-identifying PHI data in development and test environments for external vendors. This reduces the risk of PHI exposure and will be in compliance with regulatory terms.
- Critical data domains were de-identified in the development server in May 2020 and non-critical data domains were de-identified in the month of June 2020.

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 “Summary of Medical and Group Care member enrollment in the month of June 2020”.
- Summary of Primary Care Physician (PCP) Auto-assignment in the month of June 2020.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of June 2020”.
- 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 June 2020”.

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
June	250,266	5,279	2,056	6,438	165	18

1. MC – Medical Member

2. GC – Group Care Member

Table 1-2 Summary of Primary Care Physician (PCP) Auto-Assignment
For the Month of June 2020

Auto-Assignments	Member Count
Auto-assignments MC	1,488
Auto-assignments Expansion	1,383
Auto-assignments GC	49
PCP Changes (PCP Change Tool) Total	2,766

TruCare

- See Table 2-1 “Summary of TruCare Authorizations for the month of June 2020”.
- There were 7,466 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 June 2020

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	4,113	130	0	10	1	0	0	141	0	3,972
Paper to EDI	2,320	0	0	0	0	0	0	0	0	2,320
Manual Entry	0	0	0	0	0	0	0	0	1,174	1,174
Total										7,466

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 May 2020

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	3,013	2,572	94,589	335
MCAL	63,224	1,264	2,536	467
IHSS	2,506	44	81	15
AAH Staff	158	49	1,015	3
Total	68,901	3,929	98,221	820

Table 3-2 Top Pages Viewed for the Month of May 2020

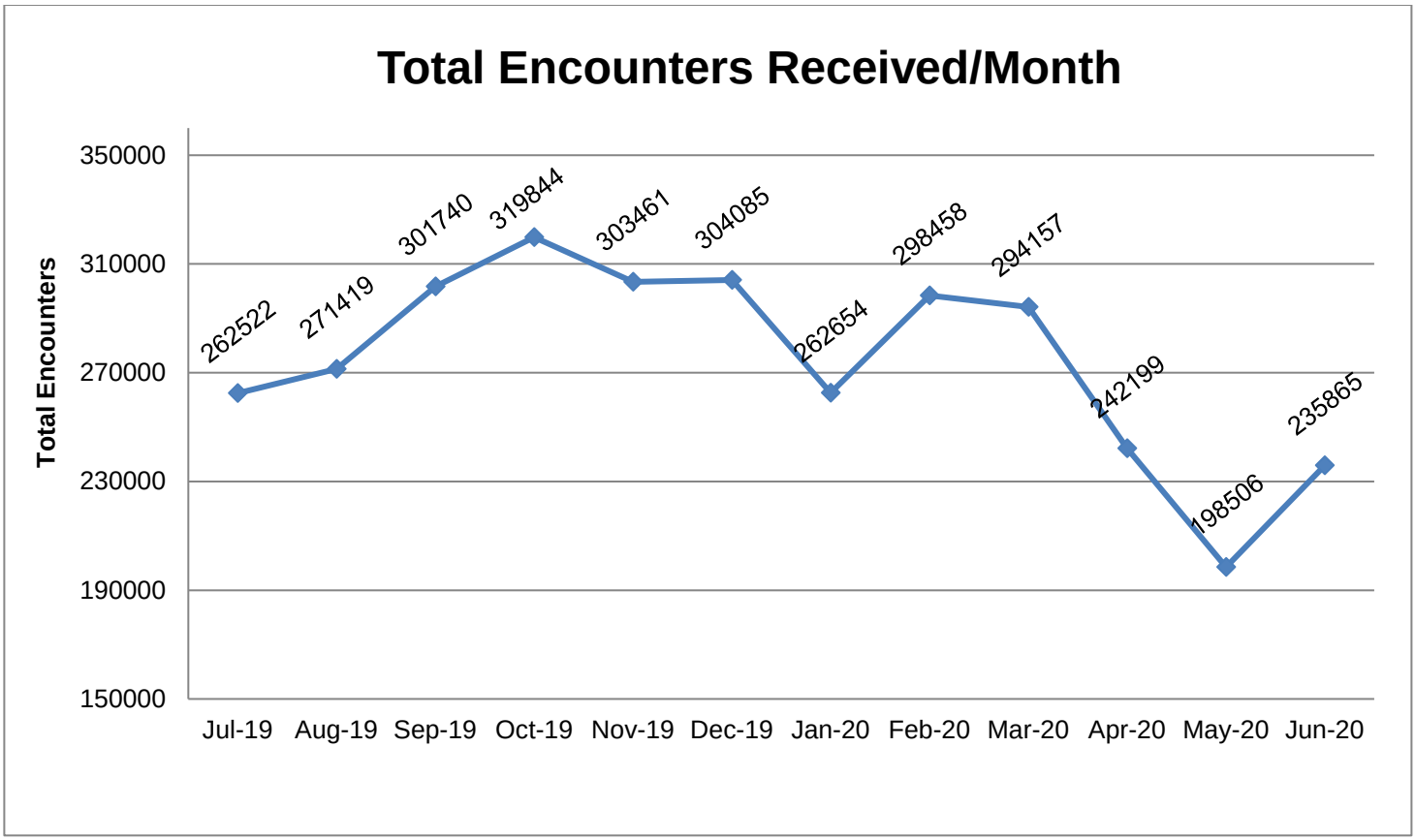
Top 25 Pages Viewed		
Category	**Page Name**	**Apr-20**
Provider	Member Eligibility	422,282
Provider	Claim Status	100,954
Member - Eligibility	Member Eligibility	3,731
Member - Claims	Claims – Services	2,858
Provider	Auth Submit	2,147
Provider	Auth Search	1,669
Member - Help Center	Member ID Card	1,561
Provider	Member Roster	1,222
Member - Help Center	Find a Doctor or Facility	690
Member - Help Center	Select/Change PCP	669
Provider	Pharmacy	573
Provider - Provider Directory	Provider Directory	479
Member - Pharmacy	My Pharmacy Claims	430
Provider - Home 2019	Forms	360
Provider - Provider Directory	Manual	324
Member - Help Center	Update My Contact Info	183
Member - Pharmacy	Pharmacy - Drugs	169
Provider - Provider Directory	Attestation	99
Member - Help Center	Authorizations & Referrals	93
Member - Help Center	Contact Us	85
Member - Health/Wellness	Personal Health Record - Intro	67
Member - Pharmacy	Pharmacy	62
Member - Forms/Resources	Authorized Representative Form	60
Member - Health/Wellness	Personal Health Record – No More Clipboard	57
Member - Pharmacy	Find a Drug	50

Encounter Data From Trading Partners 2020

- AHS:
  June daily files (7,129 records) were received on time.
- Beacon:
  June monthly files (9,612 records) were received on time
- CHCN:
  June weekly files (73,144 records) were received on time.
- CHME:
  June monthly file (4,903 records) were received on time
- CFMG:
  June weekly files (6,154 records) were received on time.
- Docustream:
  June weekly files (822 records) were received on time.
- PerformRx:
  June monthly files (149,945 records) were received on time.
- Kaiser:
  June monthly files (19,364 records) were received on time.
  June monthly Kaiser Pharmacy files (15,666 records) were received on time.
- LogistiCare:
  June weekly files (10,857 records) were received on time.
- March Vision:
  June monthly file (1,336 records) were received on time.
- Quest Diagnostics:
  June weekly files (6,809 records) were received on time.

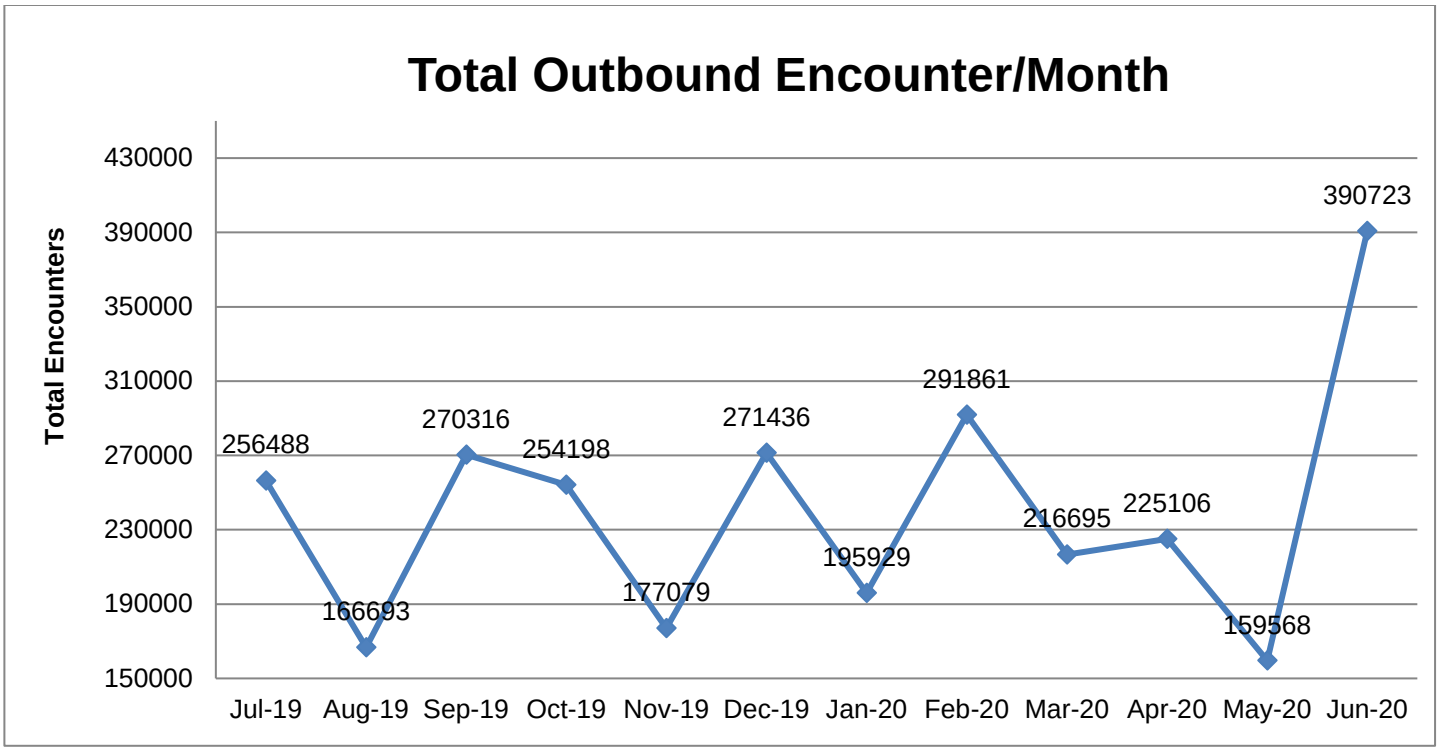
Trading Partner Encounter Inbound Submission History

Trading Partners	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Health Suite	116092	123889	111578	125442	122333	103132	104147	118309	115716	86578	89063	95735
Kaiser	27013	40478	37188	35517	44533	38079	34890	35167	36334	33670	16030	19364
LogistiCare	9831	7109	21036	18411	16867	14261	16911	19665	21375	10812	10893	10857
March Vision	2641	3598	3078	3428	3792	3183	5495	0	3127	3389	1395	1336
AHS	4886	4741	4802	3347	2531	12186	7385	4949	9907	9040	7698	7129
Beacon	9926	36	21217	12163	8328	8843	6407	14626	10010	12606	8546	9612
CHCN	66286	67396	75665	88478	72359	94805	60204	69402	76884	64623	45221	73144
CHME	4639	4807	4146	2963	3928	3090	7201	5604	3612	4346	7241	4903
CFMG	7239	6281	9255	15028	16604	13396	9027	16607	7317	12653	5484	6154
Quest	13969	13084	12987	14539	11593	12697	10509	13574	9334	3803	6072	6809
Docustream			788	528	593	413	478	555	541	679	863	822
Total	262522	271419	301740	319844	303461	304085	262654	298458	294157	242199	198506	235865



Outbound Encounter Submission

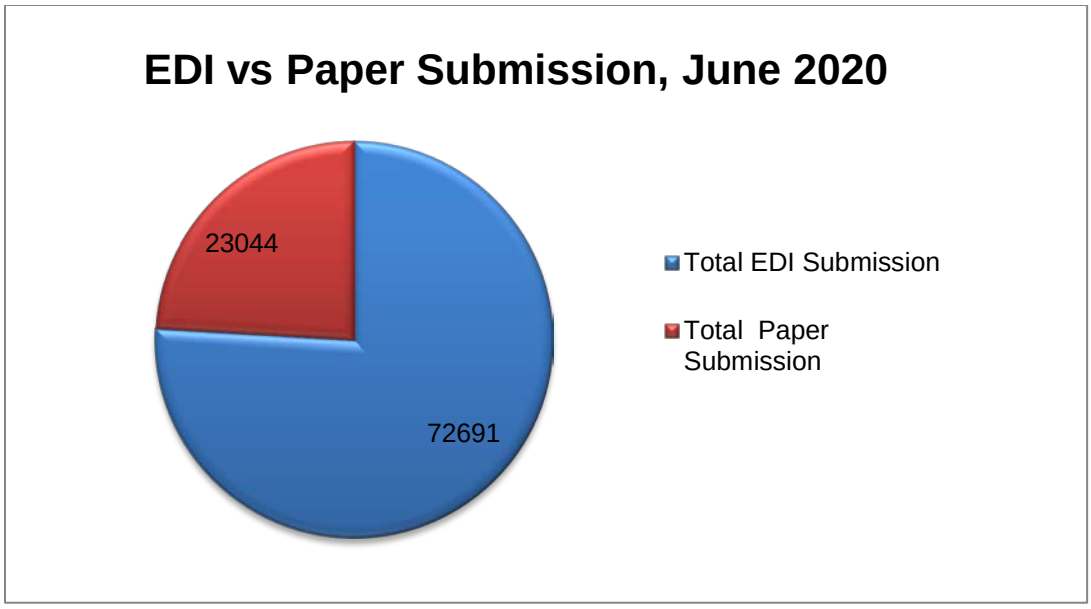
Trading Partners	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Health Suite	72977	29433	112242	87691	34874	78764	62186	141458	81483	79506	72631	60932
Kaiser	30866	38562	37153	35352	44276	37789	34583	34561	35565	32223	15191	15545
LogistiCare	14803	2972	14300	21631	12670	21692	11883	24522	22887	12988	10513	10438
March Vision	2077	2629	2277	2531	2845	2564	2150	1672	2118	2362	813	803
AHS	4304	13839	4601	5303	3762	11823	8412	4711	8545	7880	8708	6727
Beacon	2885	7083	16718	9557	7204	7369	5392	11058	6	19228	8464	7377
CHCN	98828	47619	56622	62669	43593	83370	51732	49459	43356	54436	27819	270473
CHME	9009	4080	7628	2589	3493	2692	3100	4981	3166	3847	6860	4640
Claimsnet	4228	3890	7495	10566	11508	10283	6295	8835	8788	7468	3266	5643
Quest	16511	16586	11280	15100	12337	14701	9757	10087	10331	4579	4566	7425
Docustream				1209	517	389	439	517	450	589	737	720
Total	256488	166693	270316	254198	177079	271436	195929	291861	216695	225106	159568	390723



Note: In May 2018, CHCN's & AAH contract was revised as carve out services were incorporated into the capitation payment model. This contract change required CHCN to reporting Fee for Service encounters as capitated services and removed the reimbursement information. CHCN's encounter data reporting unit was unaware of these contract changes as they continued to submit encounters incorrectly. Alameda Alliance Encounter Data Quality Workgroup identified the incorrect data submission and requested CHCN to remediate this issue immediately. Per our analysis, over 250K encounters were impacted and approximately over 12 million dollars of over spending was reported to DHCS. As a part of this clean-up effort, contract codes and reimbursement amounts were corrected in our data warehouse. This clean-up effort will ensure that rate development template information reconciles with the encounter data submission.

Health Suite Paper vs EDI Breakdown

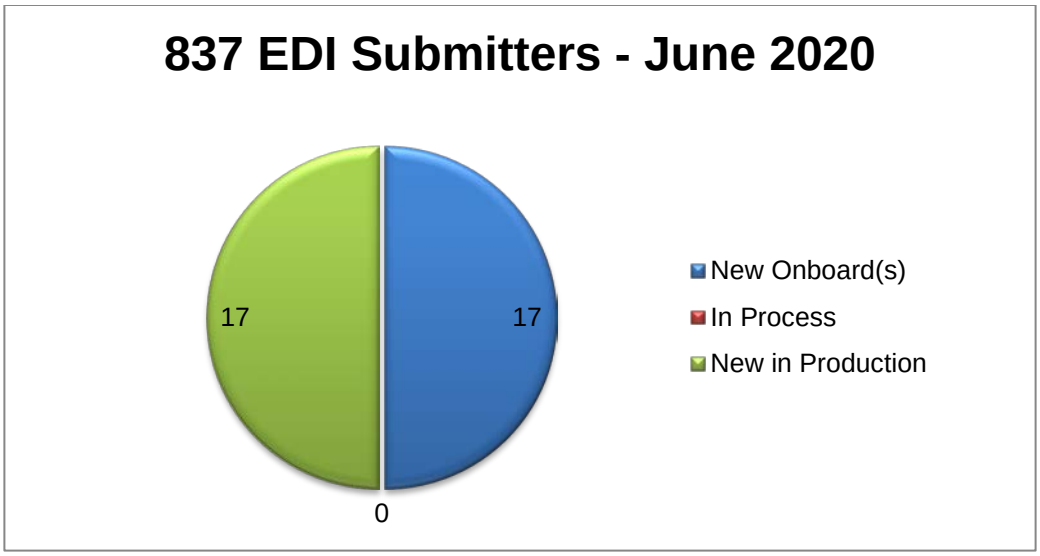
Period	Total EDI Submission	Total Paper Submission	Total Claims
20- June	7,2691	23,044	95,735

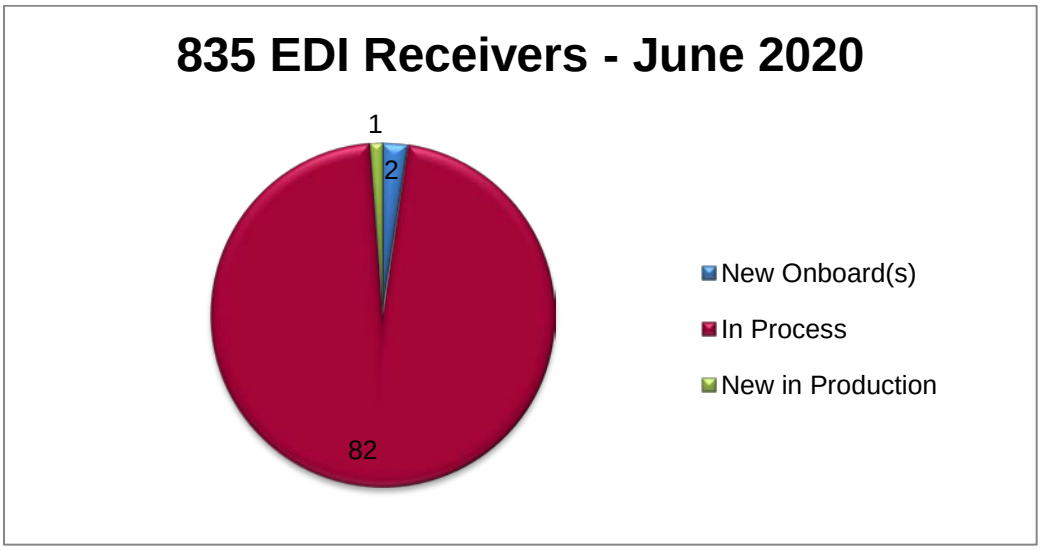


Onboarding EDI Providers - Updates

- June 2020 EDI Claims:
  - A total of 948 new EDI submitters have been added since October 2015, with 17 added in June 2020.
  - The total number of EDI submitters is 1680 providers.
- June 2020 EDI Remittances (ERA):
  - A total of 188 new ERA receivers have been added since October 2015, with 1 added in June 2020.
  - The total number of ERA receivers is 227 providers.

	837				835			
	New On Boards	In Process	New In production	Total In Prod	New On boards	In process	New In production	Total In Prod
Jul-19	21	0	21	1463	3	73	3	210
Aug-19	34	0	34	1497	2	73	2	212
Sep-19	32	1	31	1528	2	75	0	212
Oct-19	17	0	17	1545	6	76	5	217
Nov-19	18	0	18	1563	2	77	1	218
Dec-19	17	0	17	1580	2	77	2	220
Jan-20	11	2	9	1589	2	77	2	222
Feb-20	8	0	10	1599	1	77	1	223
Mar-20	9	0	9	1608	3	79	1	224
Apr-20	40	0	40	1648	2	80	1	225
May-20	15	0	15	1663	2	81	1	226
Jun-20	17	0	17	1680	2	82	1	227





EDSRF/Reconciliations

- EDSRF Submission: Below is the total number of encounter files that AAH submitted in the month of June 2020.

File Type	Jun-20
837 I Files	8
837 P Files	79
NCPDP	9
Total Files	96

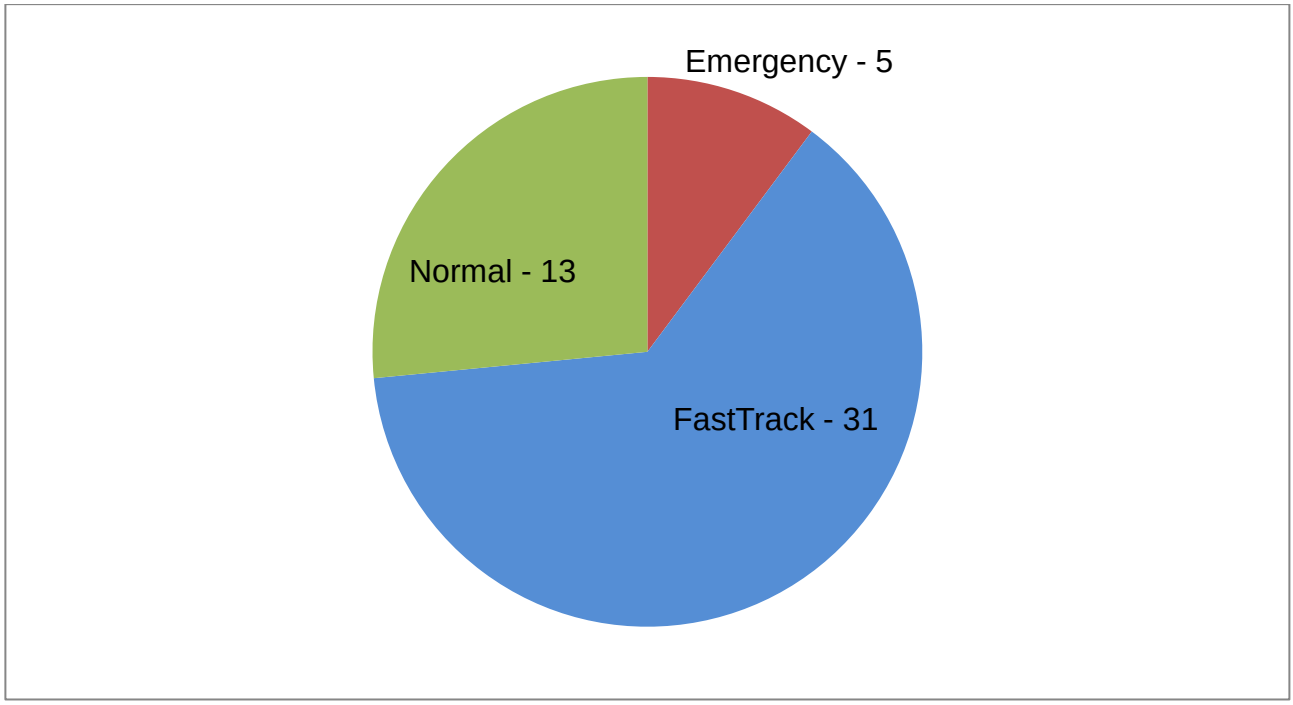
Lag-time Metrics/KPI's

AAH Encounters: Outbound 837 (AAH to DHCS)	Jun-20	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	82%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	96%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	90%	73%
Timeliness-% Within Lag Time - Professional 0-180 days	97%	80%

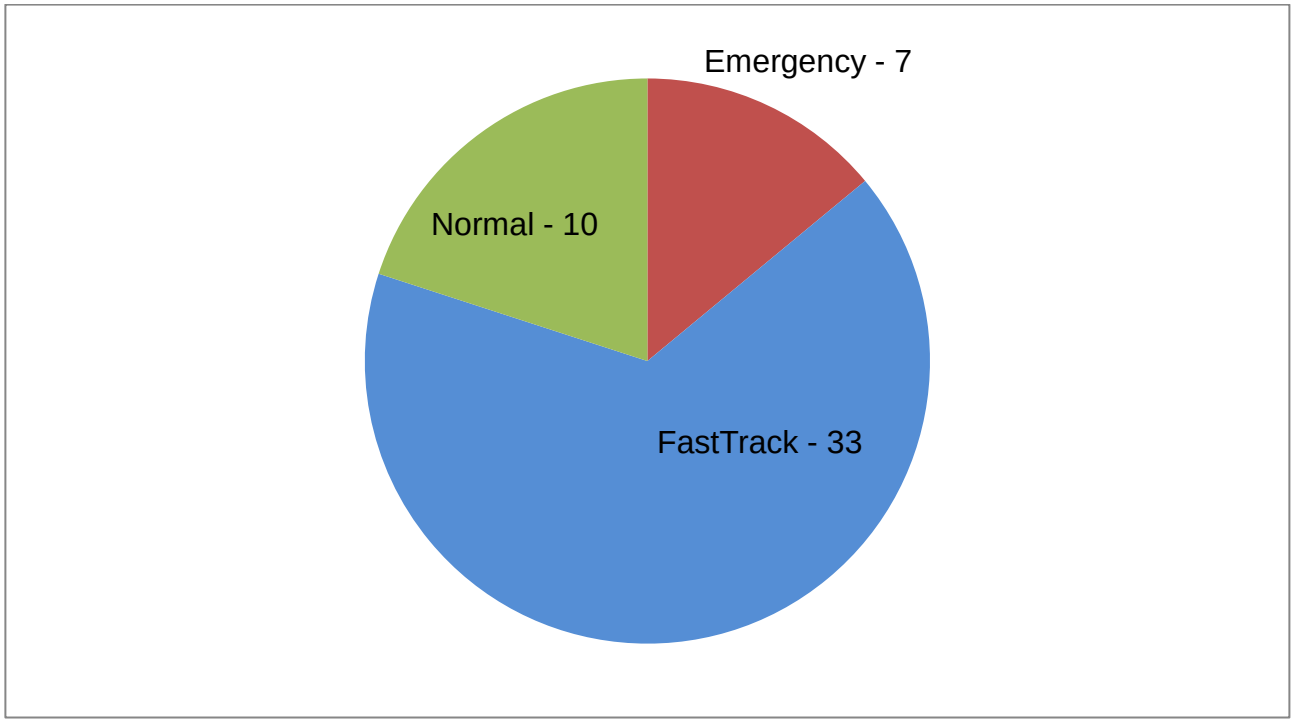
Change Management Key Performance Indicator (KPI)

- Change Request Submitted by Type in the month of June 2020 KPI – Overall Summary.
  - 1,554 Changes Submitted.
  - 1,480 Changes, Completed, and Closed.
  - 88 Active Changes.
  - 180 Changes Cancelled, and Rejected.

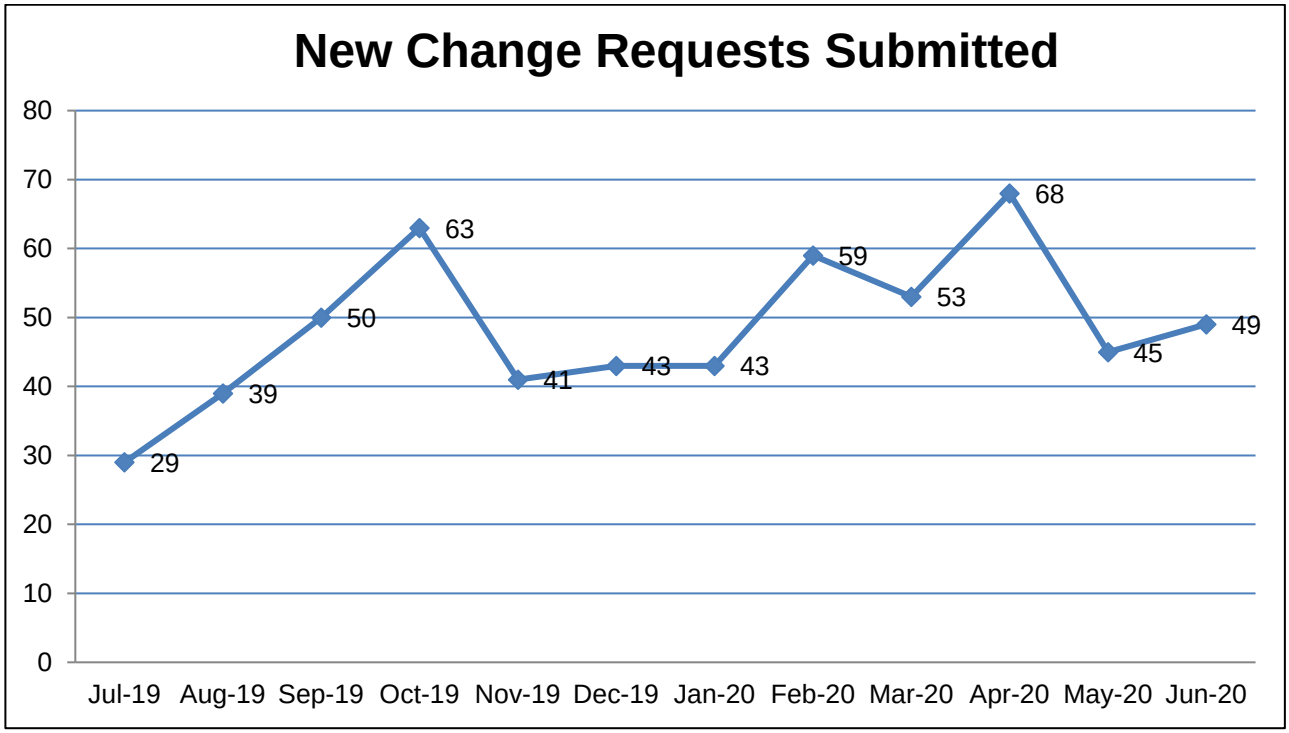
- 49 Change Requests Submitted/logged in the month of June 2020



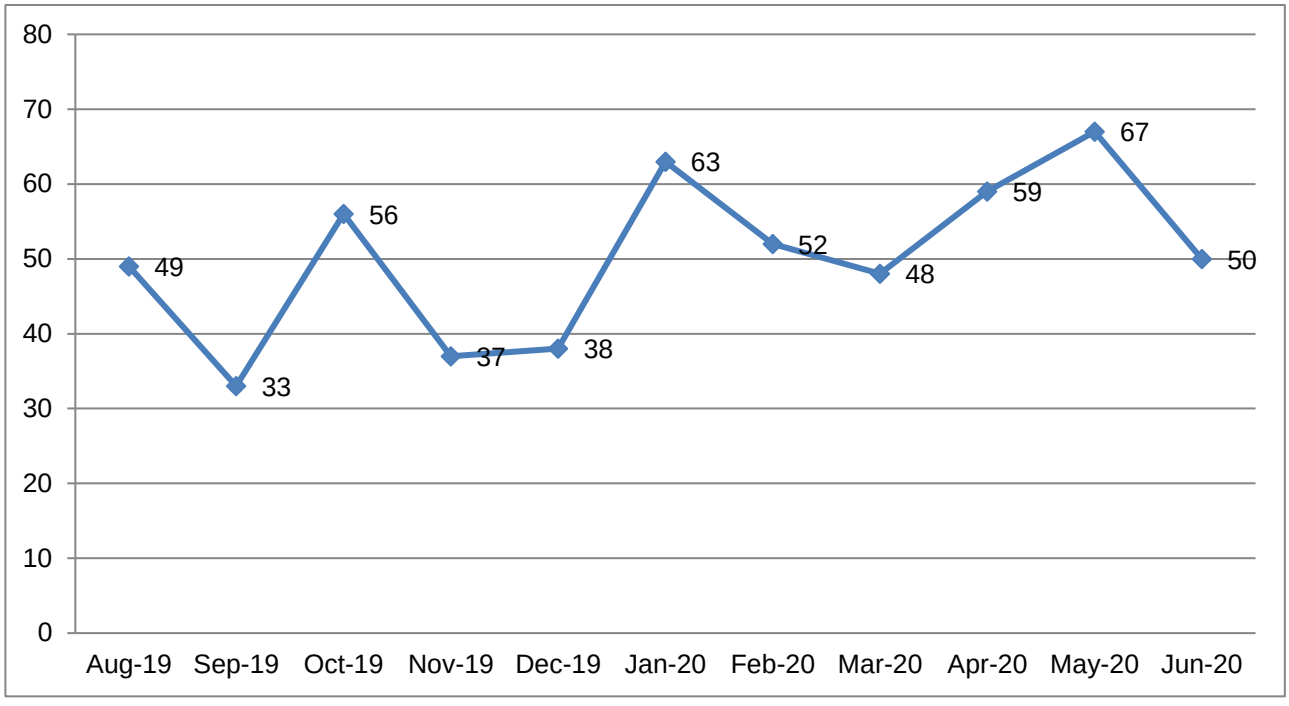
- 50 Change Requests Closed in the month of June 2020



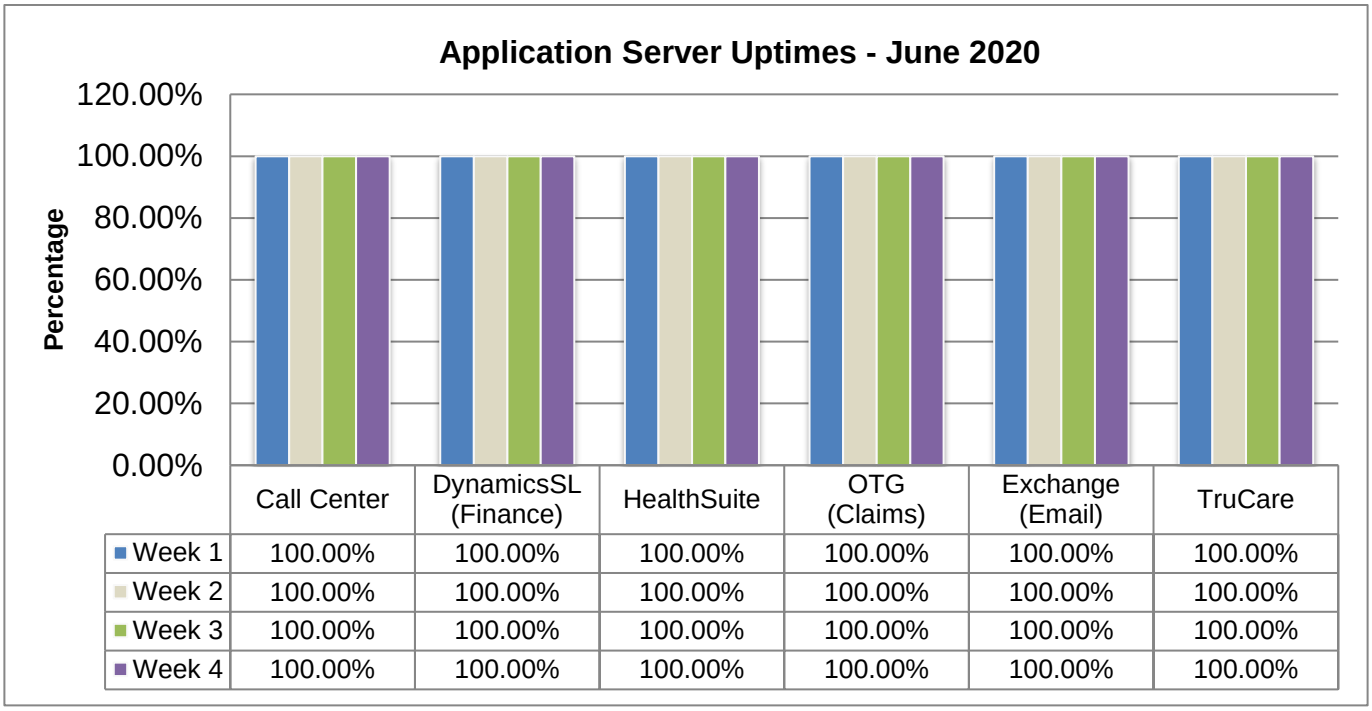
- Change Requests Submitted: Monthly Trend



- Change Requests Closed: Monthly Trend

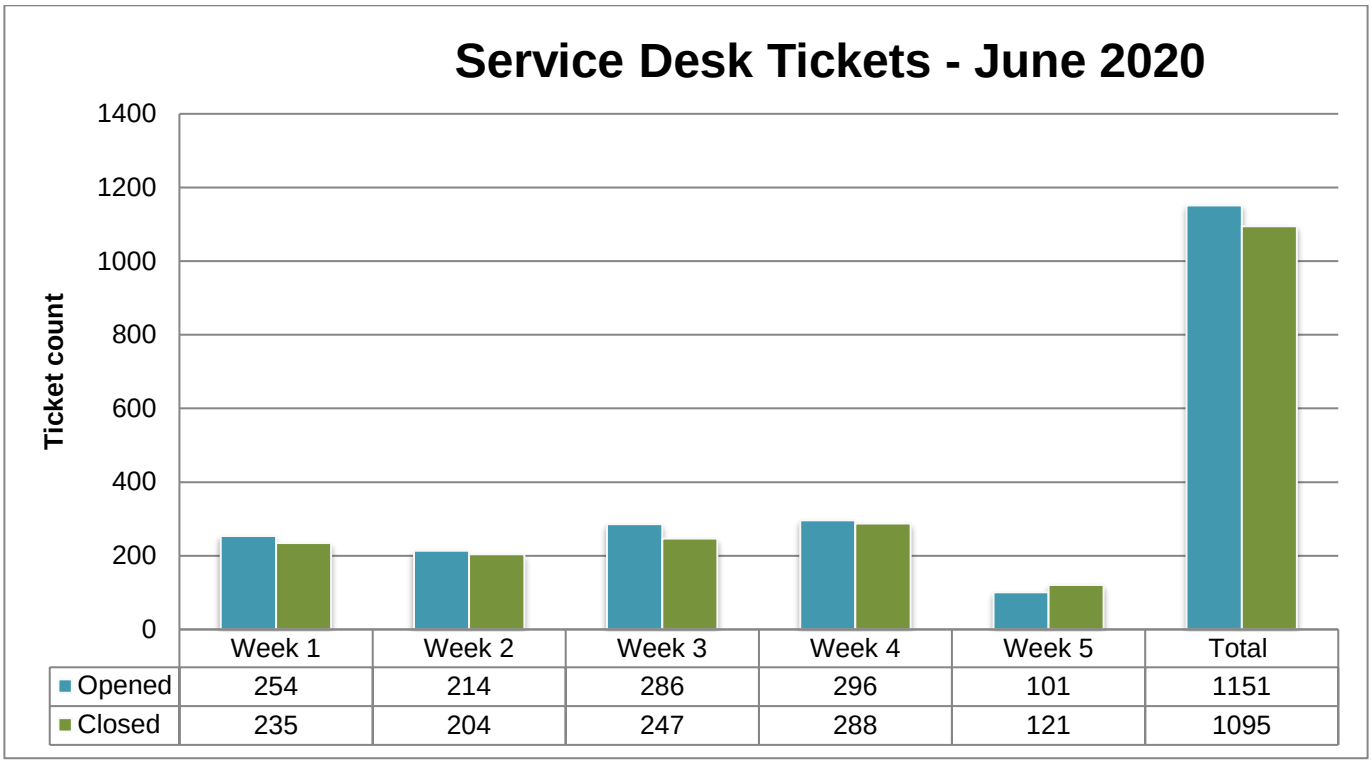


IT Stats: Infrastructure



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

- All mission critical applications are monitored and managed thoroughly.
- There were no outages experienced in the month of **June** despite supporting 100% of staff working remotely.

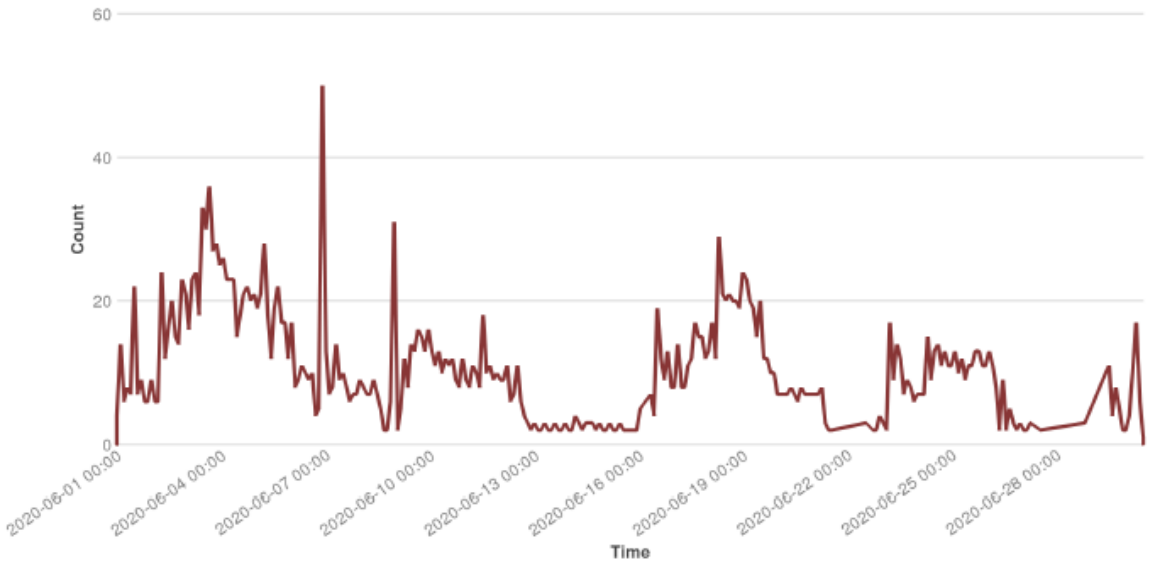


	Week 1	Week 2	Week 3	Week 4	Week 5	Total
Opened	254	214	286	296	101	1151
Closed	235	204	247	288	121	1095

- 1,151 Service Desk tickets were opened in the month of June, which is 95.5% higher than the previous month and 1,095 Service Desk tickets were closed, which is 66.5% higher than the previous month. The significant increase is triggered by a surge of a total 24 on-boarding requests for new hires and consultants for the month of June.

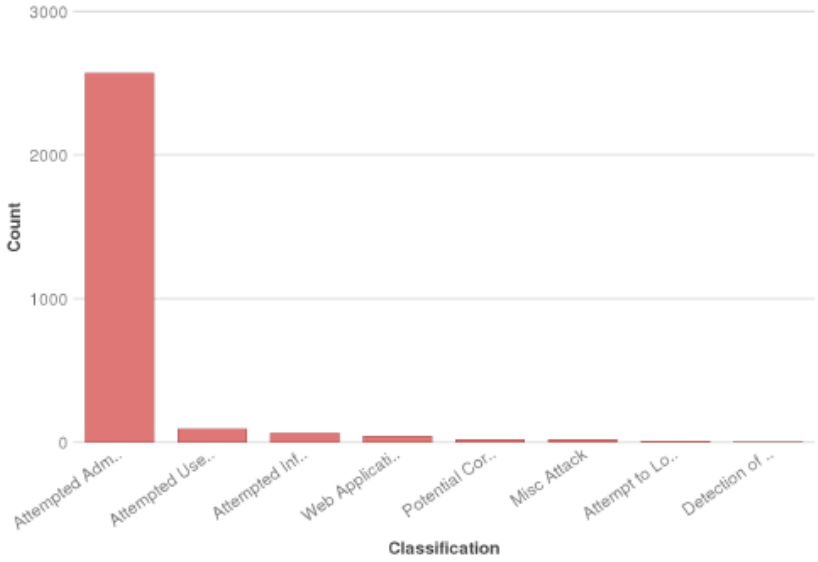
All Intrusion Events

Time Window: *2020-06-01 00:00:00 - 2020-06-30 11:33:00*

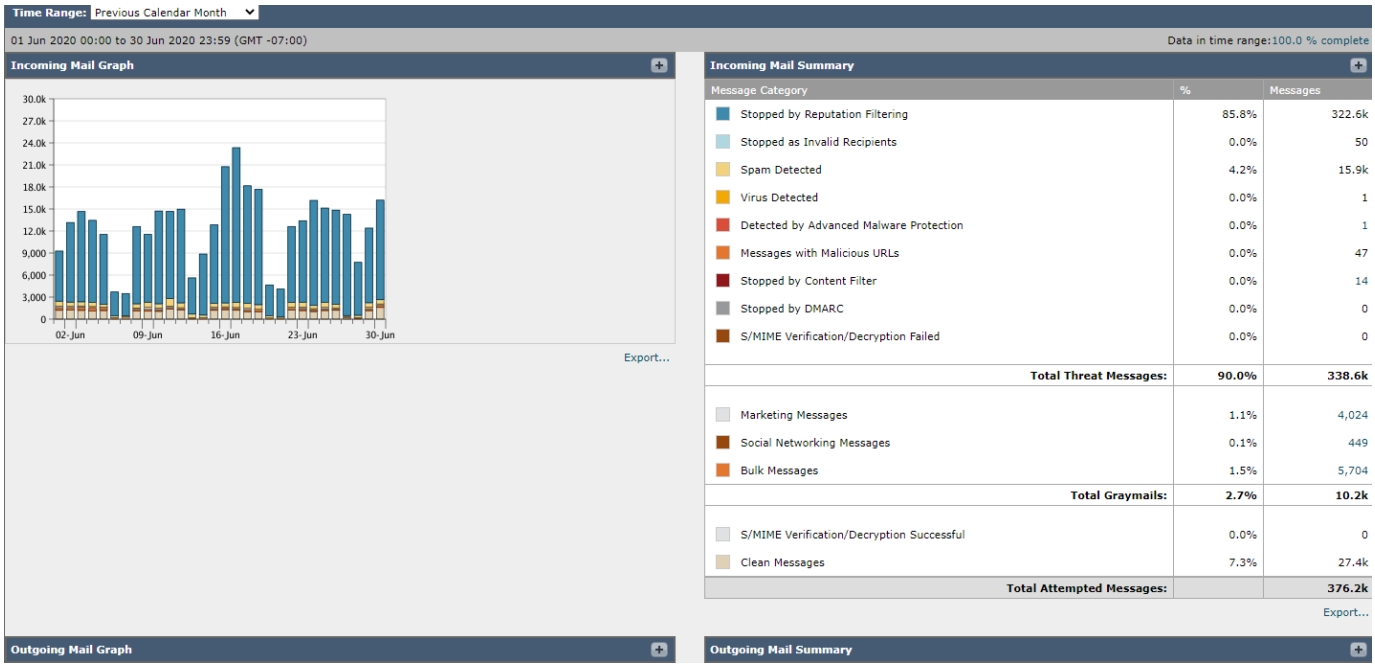


Dropped Intrusion Events

Time Window: *2020-06-01 00:00:00 - 2020-06-30 11:33:00*
Constraints: *Inline Result = dropped*



Classification	Count
Attempted Administrator Privilege Gain	2,573
Attempted User Privilege Gain	94
Attempted Information Leak	64
Web Application Attack	42
Potential Corporate Policy Violation	19
Misc Attack	18
Attempt to Login By a Default Username and Password	9
Detection of a Network Scan	2



Item / Date	Jun-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	***Jun-20***
Stopped By Reputation	299.9k	10.7k	293.7k	301.0k	264.0k	275.3k	306.6k	234.0k	280.8k	249.7k	278.0k	***322.6k***
Invalid Recipients	299	0	22	51	0	4	0	4	56	39	55	***50***
Spam Detected	23.2k	599	15.5k	17.1k	14.0k	12.0k	13.6k	12.8k	16.4k	11.4k	17.1k	***15.9k***
Virus Detected	2	0	2	3	13	0	0	0	3	4	3	***1***
Advanced Malware	1	1	3	4	1	1	0	4	6	0	0	***1***
Malicious URLs	86	21	117	140	239	81	122	91	14	36	43	***47***
Content Filter	6	0	14	10	17	7	4	9	48	9	23	***14***
Marketing Messages	3,909	145	1,748	4,606	4,677	3,854	4,211	3,804	4,296	3,730	3,834	***4,024***
Attempted Admin Privilege Gain	3,029	1,643	971	1,475	360	1,425	704	518	596	1,064	1,292	***2,573***
Attempted User Privilege Gain	20	116	1	8	0	12	7	27	17	18	23	***94***
Attempted Information Leak	67	46	30	38	46	43	31	37	59	63	48	***64***
Potential Corp Policy Violation	47	59	13	26	8	25	29	10	77	21	32	***19***
Network Scans Detected	5	6	12	18	3	4	1	4	3	15	2	***2***
Web Application Attack	83	111	19	40	45	35	72	45	121	47	124	***42***
Misc. Attack	30	29	7	18	21	1	30	21	25	18	56	***18***

- All security activity data is based on the current month's metrics as a percentage. This is compared to the previous three month's average, except as noted.
- Email based metrics currently monitored have decreased with a return to a reputation-based blocks for a total of 322.6k.
- Attempted information leaks detected and blocked at the firewall are slightly higher from 48 to 64 for the month of June.
- Network scans returned a value of 2, which is in line with previous month's data.
- Attempted User Privilege Gain is higher at 94 from a previous six month's average of 23.

Projects and Programs

Ruth Watson

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

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

Date: **July 10, 2020**

Subject: **Projects & Programs Report**

Executive Summary

- The Alliance has achieved a remarkable transformation over the past five years. The Plan has strengthened and improved daily deliverables and capabilities across the enterprise while at the same time successfully implementing several major projects and programs – the Health Homes and Whole Person Care programs, HealthSuite and TruCare upgrades, Call Center Stabilization, Data Warehouse Optimization and COB Recovery projects represent some of the Plan's successes. Throughout the process the Alliance has been learning about the value of adopting more structure and establishing enterprise standards. A key take away is the knowledge that in order to advance Plan performance to the next level, and improve operational efficiencies, the organization will need to standardize the way it operates across the entire company. The development of a robust integrated planning process will provide a view of the big picture, enable staff with tools and resources, and improve the way that projects and programs are executed.

Projects & Programs Division

- The Projects & Programs Division (PPD) has been formed to take the Alliance to the next level in project and program execution; insuring alignment of company initiatives with strategic objectives. The PPD is responsible for standardizing the way the Alliance executes on projects, and how we deploy and administer health programs into the communities we serve (e.g. Community-Based Case Management programs). This new division will work collaboratively with the other divisions and the Alliance's stakeholders to ensure that communications and actions are being coordinated with our community partners, and that we monitor our quality and cost indicators (initial and ongoing costs). Through the implementation of the PPD the governance and management system used in regards to projects and programs can be improved, data-driven decision making is focused and performing better and the maturity of the organization as it manages projects increases in a sustainable manner. This type of transformation is an iterative process and takes time.

Phase One – June through December 2020

- The first step towards the successful launch of this new division is obtaining a thorough understanding of the Alliance's short- and long-term strategic goals, how the organization is currently performing and the desired target state. A clear understanding of these factors will insure alignment to company goals and provide direction for the next steps in the evolution of this process. Tactical plans for the roll-out of the principles, policies and framework for project execution and process improvement include the development and deployment of:

    - Organization capability assessment;
    - Standardized templates and tools;
    - Project & program governance;
    - Consistent key performance metrics for all projects and programs; and
    - Reporting protocols that provide a transparent picture of the status of all projects and programs.

- Although centralized in the Projects and Programs division, successful implementation will require input and collaboration from all divisions within the organization. This enterprise-wide collaboration is essential in creating the cultural change needed to ensure that projects and programs are structured and executed in a consistent, cost-effective, and repeatable manner.

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Service you can trust.

Analytics

Tiffany Cheang

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

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

Date: **July 10, 2020**

Subject: **Performance & Analytics Report**

Member Cost Analysis

- The Member Cost Analysis below is based on the following 12 month rolling periods:
  - Current reporting period: April 2019 – March 2020 dates of service
  - Prior reporting period: April 2018 – March 2019 dates of service
    (Note: Data excludes Kaiser Membership data.)

- For the Current reporting period, the top 7.7% of members account for 81.4% of total costs.

- In comparison, the Prior reporting period was slightly lower at 7.5% of members accounting for 81.4% of total costs.

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

  - The SPD (non-duals) and ACA OE categories of aid decreased to account for 58.4% of the members, with SPDs accounting for 29.7% and ACA OE's at 28.7%.
  - The percent of members with costs >= $30K has slightly increased from 1.5% to 1.6%.
  - Of those members with costs >= $100K, the percentage of total members has slightly increased to 0.4%.
    - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 47.7%.

- 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 7.7% is more concentrated in the 45-66 year old category (41.7%) compared to the overall population (22%).

Analytics

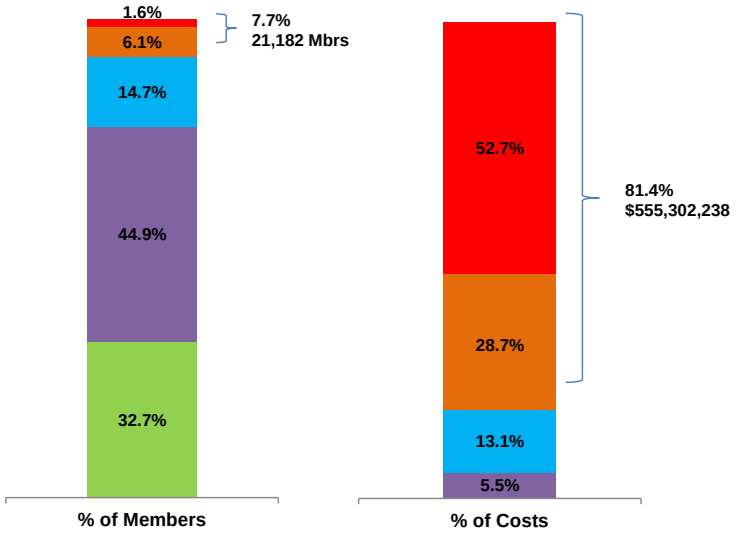
Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Apr 2019 - Mar 2020

Note: Data incomplete due to claims lag

Run Date: 06/29/2020

Member Cost Distribution



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	4,357	1.6%	$ 359,543,213	52.7%
$5K - $30K	16,825	6.1%	$ 195,759,025	28.7%
$1K - $5K	40,541	14.7%	$ 89,437,861	13.1%
< $1K	123,511	44.9%	$ 37,550,151	5.5%
$0	89,920	32.7%	$ -	0.0%
Totals	**275,154**	**100.0%**	**$ 682,290,250**	**100.0%**

Top 7.7% of Members = 81.4% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	973	0.4%	$ 180,288,230	26.4%
$75K to $100K	514	0.2%	$ 44,587,953	6.5%
$50K to $75K	1,095	0.4%	$ 66,572,192	9.8%
$40K to $50K	672	0.2%	$ 29,938,190	4.4%
$30K to $40K	1,103	0.4%	$ 38,156,648	5.6%
SubTotal	***4,357***	***1.6%***	***$ 359,543,213***	***52.7%***
$20K to $30K	2,058	0.7%	$ 50,084,393	7.3%
$10K to $20K	6,048	2.2%	$ 83,604,618	12.3%
$5K to $10K	8,719	3.2%	$ 62,070,014	9.1%
SubTotal	***16,825***	***6.1%***	***$ 195,759,025***	***28.7%***
Total	**21,182**	***7.7%***	**$ 555,302,238**	***81.4%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Mar 2020	215,256	$ 589,512,593
Dis-Enrolled During Year	59,898	$ 92,777,656
Totals	**275,154**	**$ 682,290,250**

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

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
7.7% of Members = 81.4% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Apr 2019 - Mar 2020
Note: Data incomplete due to claims lag
Run Date: 06/29/2020

7.7% of Members = 81.4% of Costs
29.7% of members are SPDs and account for 35.7% of costs.
28.7% of members are ACA OE and account for 27.7% of costs.
9.7% of members disenrolled as of Mar 2020 and account for 14.4% of costs.

Highest Cost Members: Cost Per Member >= $100K
40.1% of members are SPDs and account for 40.1% of costs.
27.0% of members are ACA OE and account for 26.3% of costs.
21.2% of members disenrolled as of Mar 2020 and account for 22.2% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	113	568	681	3.2%
MCAL	MCAL - ADULT	413	2,881	3,294	15.6%
	MCAL - BCCTP	2	2	4	0.0%
	MCAL - CHILD	164	1,457	1,621	7.7%
	MCAL - ACA OE	1,251	4,829	6,080	28.7%
	MCAL - SPD	1,695	4,590	6,285	29.7%
	MCAL - DUALS	92	1,062	1,154	5.4%
Not Eligible	Not Eligible	627	1,436	2,063	9.7%
Total		**4,357**	**16,825**	**21,182**	**100.0%**

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	19	2.0%
MCAL	MCAL - ADULT	70	7.2%
	MCAL - BCCTP	1	0.1%
	MCAL - CHILD	4	0.4%
	MCAL - ACA OE	263	27.0%
	MCAL - SPD	390	40.1%
	MCAL - DUALS	20	2.1%
Not Eligible	Not Eligible	206	21.2%
Total		**973**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 8,330,749	$ 6,188,963	$ 14,519,712	2.6%
MCAL	MCAL - ADULT	$ 30,872,815	$ 32,342,093	$ 63,214,908	11.4%
	MCAL - BCCTP	$ 279,752	$ 12,348	$ 292,100	0.1%
	MCAL - CHILD	$ 7,769,341	$ 16,735,999	$ 24,505,340	4.4%
	MCAL - ACA OE	$ 99,468,200	$ 54,504,330	$ 153,972,531	27.7%
	MCAL - SPD	$ 142,436,217	$ 56,030,843	$ 198,467,060	35.7%
	MCAL - DUALS	$ 7,287,963	$ 12,984,118	$ 20,272,081	3.7%
Not Eligible	Not Eligible	$ 63,098,176	$ 16,960,330	$ 80,058,506	14.4%
Total		**$ 359,543,213**	**$ 195,759,025**	**$ 555,302,238**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 3,470,691	1.9%
MCAL	MCAL - ADULT	$ 12,557,064	7.0%
	MCAL - BCCTP	$ 190,991	0.1%
	MCAL - CHILD	$ 677,935	0.4%
	MCAL - ACA OE	$ 47,342,316	26.3%
	MCAL - SPD	$ 72,378,429	40.1%
	MCAL - DUALS	$ 3,575,177	2.0%
Not Eligible	Not Eligible	$ 40,095,626	22.2%
Total		**$ 180,288,230**	**100.0%**

% of Total Costs By Service Type

Breakout by Service Type/Location

Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
$100K+	6%	0%	1%	12%	54%	2%	14%	6%	3%	9%
$75K to $100K	5%	0%	2%	17%	47%	2%	8%	6%	7%	12%
$50K to $75K	3%	0%	3%	20%	39%	3%	8%	8%	9%	13%
$40K to $50K	4%	1%	4%	17%	48%	3%	8%	8%	4%	12%
$30K to $40K	5%	2%	4%	18%	42%	6%	9%	7%	2%	16%
$20K to $30K	4%	5%	6%	19%	38%	7%	9%	8%	2%	17%
$10K to $20K	1%	0%	12%	19%	35%	6%	13%	11%	3%	13%
$5K to $10K	0%	0%	11%	23%	23%	9%	13%	17%	0%	14%
Total	**4%**	**1%**	**5%**	**17%**	**43%**	**4%**	**12%**	**9%**	**4%**	**12%**

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

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Human Resources

Anastacia Swift

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

From: **Anastacia Swift, Executive Director, Human Resources**

Date: **July 10, 2020**

Subject: **Human Resources Report**

Staffing

- As of June 1, 2020, the Alliance had 318 full time employees and 2-part time employees.

- On June 1, 2020, the Alliance had 44 open positions in which 6 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 38 positions open to date. The Alliance is actively recruiting for the remaining 38 positions and several of these positions are in the interviewing or job offer stage.

- Summary of open positions by department:

Department	Open Positions June 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	14	1	13
Operations	9	2	7
Healthcare Analytics	5	1	4
Information Technology	5	0	5
Finance	6	1	5
Compliance	2	1	1
Human Resources	3	0	3
Projects & Programs	0	0	0
Total	44	6	38

- Our current recruitment rate is 13%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in June 2020 included:
    - 5 years:
        - Jeanette Murray (Executive)
        - Latrice Allen (Member Services)
        - Tiana Rivas (Provider Services)
        - Yash Doshi (Information Technology-Development)
    - 7 years:
        - Alisa Thomas (Member Services)
    - 8 years:
        - Sri Phie (Claims)
        - Thuan Le (Claims)
        - Marcie Sperling-Bullock (Claims)
    - 9 years:
        - Eileen Ahn (Grievance & Appeals)
        - Elisea Toscano-Cochrane (Member Services)
    - 12 years:
        - Annie Wong (Healthcare Analytics)
    - 13 years:
        - Cindy Brazil (Quality Improvement)
    - 23 years:
        - Monina Malonzo Rayo (Claims)
    - 24 years:
        - Angie Vaziri (Member Services)