Board of Governors

Regular Meeting

Friday, June 12, 2020
12:00 p.m. – 2:00 p.m.

Video Conference Call

Alameda, CA 94502

AGENDA

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

Join Video Conference Meeting

https://zoom.us/j/98072276149

Meeting ID: 980 7227 6149

Dial in Conference numbers

(Please mute your phones)

(669) 900-6833

(408) 638-0968

(346) 248-7799

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/98072276149, 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 June 12, 2020 at 12:00 p.m. in Alameda County, California, by Dr. Evan Seevak, Presiding Officer. This meeting to take place by conference call.)

2. **ROLL CALL**

3. **AGENDA APPROVAL OR MODIFICATIONS**

4. **INTRODUCTIONS**

5. **CONSENT CALENDAR**

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

   a) **MAY 8, 2020 BOARD OF GOVERNORS MEETING MINUTES**

   b) **2019 CASE MANAGEMENT & CARE COORDINATION, COMPLEX CASE MANAGEMENT & DISEASE MANAGEMENT PROGRAM EVALUATION**

   c) **2020 CASE MANAGEMENT & CARE COORDINATION, COMPLEX CASE MANAGEMENT & DISEASE MANAGEMENT PROGRAM DESCRIPTION**

   d) **2019 QUALITY IMPROVEMENT PROGRAM EVALUATION**

   e) **2020 QUALITY IMPROVEMENT PROGRAM DESCRIPTION**

   f) **2019 UTILIZATION MANAGEMENT PROGRAM EVALUATION**

   g) **2020 UTILIZATION MANAGEMENT PROGRAM DESCRIPTION**

   h) **2020 CULTURAL AND LINGUISTIC SERVICES PROGRAM DESCRIPTION**

6. **BOARD MEMBER REPORTS**

   a) **COMPLIANCE ADVISORY GROUP**

   b) **FINANCE COMMITTEE**

7. **CEO UPDATE**

8. **BOARD BUSINESS**

   a) **SAFETY-NET SUSTAINABILITY FUND**

   b) **REVIEW AND APPROVE APRIL 2020 MONTHLY FINANCIAL STATEMENTS**

   c) **REVIEW AND APPROVE FISCAL YEAR 2021 PRELIMINARY BUDGET**

   d) **PUBLIC STATEMENT OPPOSING STRUCTURAL RACISM**

9. **STANDING COMMITTEE UPDATES**

   a) **PEER REVIEW AND CREDENTIALING COMMITTEE**

   b) **HEALTH CARE QUALITY 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.

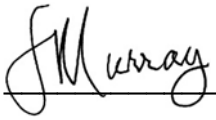
Public Input: If you are interested in addressing the Board, you may submit comments on any agenda item or on any item not on the agenda, in writing via mail to "Attn: Alliance Board," 1240 S. Loop Road, Alameda, CA 94502; or through e-comment at jmurray@alamedaalliance.org.

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 June 9, 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

ALAMEDA Alliance FOR HEALTH

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Service you can trust.

CONSENT CALENDAR

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
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Board of Governors Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
BOARD OF GOVERNORS
REGULAR MEETING

May 8, 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, Nicholas Peraino, 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
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 12:06 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 - APRIL 2020 BOARD OF GOVERNORS MEETING MINUTES			
Dr. Seevak	Motion to approve the April 2020 Board of Governors Meeting Minutes as presented.	Motion: Marty Lynch Second: Supervisor Chan 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 May 8, 2020, at 10:30 AM and discussed the compliance dashboards. Rebecca Gebhart gave the following updates: Dr. Seevak attended the meeting. Four (4) dashboards were reviewed and the Committee focused on changes since the prior April meeting. The Committee also discussed organizational compliance and shared some themes they are seeing in the managed care compliance given the COVID-19 situation. 2020 DMHC medical services audit (follow up from 2018 audit): • We still have not received DMHC audit information yet. Most self-identified issues were in documentation and the Alliance is implementing processes to correct and meet regulatory compliance. • A requirement for the plan is to ensure 100% of non-contracting hospitals in California have our contact information for timely authorizations, targeting to complete by August 2020. 2019 DMHC financial audit: • State identified 5 findings and the Alliance should receive the report about August or September. • 3 of the 5 findings have been completed. The Alliance continues to	Informational update to the Board of Governors. Vote not required.	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	work on the 2 remaining findings. 2019 Department of Health Care Services (DHCS) medical audit: • There were 25 findings and most are complete. • The State is requesting the Alliance to improve referral tracking. A report has been created to track all specialty services that require authorization. This report will help track members that are using out of network services to try to move them to in-network services. 2018 DHCS medical services audit: • 11 of 12 self-identified items are updated. • 1 outstanding self-identified item is the Memorandum of Understanding (MOU) used by Alameda County, which defines the services by the Alliance and Alameda County. • The second item is the Initial Health Assessment (IHA) required for each member and the codes used. The State wants know if we look at these health assessment codes annually so the Alliance put in procedure to do so. Question: • How has COVID-19 affected compliance? Answer: • There is more contact with the State and flexibility and postponement of audits. Operation Dashboard: • Last month there were four(4) expedited appeals, one appeal did not met the requirements so on the Alliance dashboard there will be a red mark. Future Audits: • DHCS annual medical audit – June is postponed due to COVID-19. • Department of Managed Health Care (DMHC) medical routine audit – October 12.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Today is Diana Sekhon's last day and Rebecca thanked her for all the outstanding work at the Alliance and in compliance.		
6. b. BOARD MEMBER REPORT – FINANCE COMMITTEE			
Dr. Ferguson	The Finance Committee was held telephonically on Tuesday, May 5, 2020 Dr. Ferguson gave the following updates: Finance Issues: • The TNE continues to be significantly higher than required. • Membership decline has fallen off for the month of March. • MLR remains high at 91.9% for the month of March. • Financially the Alliance is trending well. • A large portion of the meeting was spent discussing the Safety-Net Sustainability Fund Presentation and the Finance Committee supports its goals.	Informational update to the Board of Governors. Vote not required.	
7. CEO UPDATE			
S. Coffin	Scott Coffin presented the following CEO updates (pages 19 to 22): March 2020 – Financial Performance & Operating metrics: • There are two red indicators on the Operations Dashboard, one is in expedited appeals in which Rebecca reported out and the other is in HR in which our vacancies are at 11%. Given the COVID-19 circumstances, these are understandable. Potential changes to Medi-Cal program transitions: • There has been no updates at this time regarding the direction of the CalAIM program. • The State of California, Department of Health Care Services, is seeking a one-year extension of the 1115 and 1915 Waivers, as they currently expire 12/31/2020.	Informational update to the Board of Governors. Vote not required.	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	• DHCS has confirmed that pharmacy will still be transitioning back to the state for oversight except physician administered drugs and is on track to do so by 1/1/2021. The Alliance is in the planning stages now. COVID-19 Operations: • An update was given regarding the current COVID-19 situation. There are 1917 positive cases in Alameda County, 67 fatalities, 60 Alliance members positive, 93 admissions, and 26,000 COVID-19 tests have been given in Alameda County with a 7% positive rate. • Governor Newsom is revising the budget as there is an estimated $54.0M deficient due to the COVID-19 event. Medi-Cal applications have gone up in Alameda County. There will be an influx of membership and how this affects the Alliance will be shared in the pulmonary budget. In the month of April, Core operations were down except pharmacy. • 90% of the Alliance staff is working remotely and the transition occurred in 11 days. 10% of employee's remain on site for mail and core duties. • The Alliance contracted with a telehealth service provider called Tele-Doc in April 2020, and members have access to more than 2500 nationwide physicians. Question: • Is this for members that don't have primary services? Answer: • The implementation of telehealth services is to meet regulation guidelines. • During National Nurses Week, the Alliance met virtually and celebrated with the Alliance's 30 Registered Nurses. The theme this year is – compassion, expertise, and trust.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Budgeting and Forecasting – Fiscal Year 2020/2021 • Fiscal year 2021 preliminary budget is on track for presenting at the June 2020 Board of Governors meeting next month. • DHCS is delaying the release of rates for next year due to the COVID-19 until September. • Revision to the presentation of the final Alliance budget for a vote by the Board will be in October or November, depending on when the DHCS delivers the rates. Questions: • Pharmacy Question – Is the pharmacy being delayed? Answer: • No, the pharmacy is not being delayed as it was a separate initiative from CalAIM.		
8. a. BOARD BUSINESS – REVIEW AND APPROVE MARCH 2020 MONTHLY FINANCIAL STATEMENTS			
G. Riojas	Gil Riojas gave the following Finance updates: Enrollment: • For the month ending March 31, 2020, the Alliance had enrollment of 246,907 members, a Net Income of $2.8M and Tangible Net Equity is 607%. • Our enrollment has increased 563 members since February 2020. Net Income: • For the month ending March 31, 2020, the Actual Net Income was $487,000 and the Budged Net Income was $2.8M. • Year-to-Date (YTD) ending March 31, 2020 the actual YTD net income was $18.7M and the budgeted YTD net income was $3.3M. The Favorable variance is due to higher than anticipated revenue and lower administrative expenses.	Motion: Dr. R. Ferguson Second: Feda Almaliti Motion passed by roll call. Vote: Yes No opposed or abstained.	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Revenue: • For the month ending March 31, 2020, the actual revenue was $87.3M vs the budgeted revenue of $77.7M. • The favorable variance is due to higher than anticipated Proposition 56 Revenue, Behavioral Health Therapy (BHT) supplemental payments, and base capitation. Medical Expense: • For the month ending March 31, 2020, actual medical expenses were $80.2M vs. our budgeted medical expense of $73.0M. • Actual YTD medical expenses was $676.4M vs. budgeted YTD medical expense amount of $660.6M. Medical Loss Ratio (MLR): • For the month ending March 31, 2020, the MLR was 92.4% vs year-to-date of 91.9%. Due to COVID-19, the MLR is forecasted to decrease. Administrative Expense: • For the month ending March 31, 2020, Actual administrative expenses were $4.6M vs budgeted administrative expense $5.1M. • Actual administrative expense YTD is $40.3M vs. budgeted $45.3M. • With the COVID-19 Work from Home deployment, overtime expenses, and other expenses our administrative budget should increase and be closer to the actual budgeted amount. Other Income / (Expense): • As of March 31, 2020, our YTD interest income from investments is $3.9M, and YTD claims interest expense is $236,000. • With the market interest change due to COVID-19, investment income is intended to reduce. Tangible Net Equity (TNE): • Tangible net equity results continue to remain healthy, and at the end of March 31, 2020, the TNE was reported at 607% of the		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	required amount, which is the highest in the last 12 months. Cash Position and Assets: • For the month ending March 31, 2020, $210.6M reported in cash; $81.1M is uncommitted cash. Our current ratio is above the minimum required at 1.74, as compared to the regulatory minimum of 1.0. Motion to approve the March 2020 financial report as presented		
8. b. BOARD BUSINESS – SAFETY-NET SUSTAINABILITY FUND			
S. Coffin	Scott presented the Safety-Net Sustainability Fund to the Board of Governors. The Safety-Net Sustainability Fund presentation included an overview of the following information: • Eligibility • Grant Mythology • Funding the Frontline Safety-Net Providers • Payment timeline: May – October 2020 • Accelerated Payments • Considerations • Next Steps Questions: • The 20% going to the COVID-19 testing, what amount is going to hospitals in dollars Answer: • We do not have that information at the moment, as the applications have not been submitted by safety-net providers	Motion 1: David B. Vliet Second: Dr. Evan Seevak Motion passed by roll call. Vote: Yes No opposed or abstained. Motion 2: David B. Vliet Second: Dr. Evan Seevak Motion passed by roll call. Vote: Yes	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Questions: • Is giving money to facilities for the enhancement of their current testing site? Answer: • The amount could be used a number of ways, to expand the current sites or expand to a hospital or physician office. Questions: • Can some of the monies be used for other crisis management, as follow-up and tracing? Answer: • The purpose is for testing but with flexibility. Board of Governor Motions: <u>Motion 1</u>: 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. <u>Motion 2</u>: 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.	No opposed or abstained.	
9. a. STANDING COMMITTEE UPDATES – PEER REVIEW AND CREDENTIALING COMMITTEE			
Dr. O'Brien	The Peer Review and Credentialing Committee (PRCC) was held telephonically on April 21, 2020. Dr. O'Brien gave the following updates: • At the Peer Review and Credentialing (PRCC) meeting held on April 21, 2020, there were twenty-three (23) initial providers	Informational update to the Board of Governors. Vote not required.	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	approved; three (3) Primary Care Providers, six (6) Specialists, one (1) Ancillary provider, and thirteen (13) Mid-level providers. • Additionally, thirty-six (36) providers were re-credentialed at this meeting; ten (10) Primary Care Providers, sixteen (16) specialists, one (1) Ancillary provider, and nine (9) Mid-level providers.		
10. STAFF UPDATES			
S. Coffin	None	None	None
11. UNFINISHED BUSINESS			
S. Coffin	Alliance Next steps: None	None	None
12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS			
Dr. Seevak	• The decision for the Board of Governors to meet remotely in June will be communicated to the Board Members by the end of May.	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

ALAMEDA Alliance FOR HEALTH

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2019

CASE MANAGEMENT
&
CARE COORDINATION,

COMPLEX CASE MANAGEMENT
&
DISEASE MANAGEMENT PROGRAM

EVALUATION

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

2019

Case Management/Care Coordination & Disease Management
2019 Program Evaluation

Signature Page

Date _____

Julie Anne Miller, LCSW
Director, Health Care Services

Date _____

Sanjay Bhatt, M.D.
Director, Quality Improvement

Date _____

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

Date _____
Scott Coffin
Chief Executive Officer

Date _____
Evan Seevak, M.D.
Board Chair

2019
Utilization Management (UM) and Case Management (CM)
Program Evaluations
Attachment A: Case Management

Overview

Under the leadership and strategic direction established by Alameda Alliance for Health (The Alliance) Board of Directors and Quality Management Committee (QMC), senior management and the Health Care Quality Committee (HCQC), the Health Services 2019 Utilization Management and Case Management Programs were successfully implemented. This report serves as the annual evaluation of the effectiveness of the program activities. For 2019, the annual report also includes this evaluation of the Health Care Services Case Management Department which includes care coordination, care management and complex case management.

The processes and data reported covers activities conducted from January 1, 2019 through December 31, 2019.

Membership and Provider Network

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

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

Figure 1. 2019 Trended enrollment by network and age group

Current Membership by Network By Category of Aid								
Category of Aid	Dec-19	% of Medi-Cal		Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Adults	32,066	13%		7,652	6,748	241	12,283	5,142
Child	89,056	37%		8,088	8,165	27,298	30,400	15,105
SPD	25,687	11%		8,617	3,707	1,184	10,329	1,850
ACA OE	78,154	32%		13,842	24,862	930	29,947	8,573
Duals	17,776	7%		7,090	1,923	1	6,632	2,130
Medi-Cal	242,739			45,289	45,405	29,654	89,591	32,800
Group Care	6,092			2,689	827	-	2,576	-
Total	**248,831**	**100%**		**47,978**	**46,232**	**29,654**	**92,167**	**32,800**
Medi-Cal %	97.60%			94.40%	98.20%	100.00%	97.20%	100.00%
Group Care %	2.40%			5.60%	1.80%	0.00%	2.80%	0.00%
		Network Distribution		*19.30%*	*18.60%*	*11.90%*	*37.00%*	*13.20%*
				% Direct:	**38%**		**% Delegated:**	**62%**

Age Category Trend				
	Members			
Age Category	Dec 2017	Dec 2018	Nov 2019	Dec 2019
Under 19	102,258	98,122	92,318	91,641
19 - 44	86,599	84,866	79,016	78,271
45 - 64	58,713	57,340	54,703	54,210
65+	22,409	23,862	24,661	24,709
Total	**269,979**	**264,190**	**250,698**	**248,831**

For 2019, The Alliance membership remained relatively flat, as seen in Figure 1, at about 248 thousand members, which is slightly down from 264 thousand members in 2018. This trend is similar to other managed MediCal health plans in California in 2019.

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

Figure 2 Provider Network by Type and Enrollment

Provider Network	Provider Type	Members (Enrollment)	% of Enrollment in Network
Direct-Contracted Network	Independent	47,978	19%
Alameda Health System	Managed Care Organization	46,232	19%
Children First Medical Group	Medical Group	29,654	12%

Community Health Clinic Network	Medical Group	92,167	37%
Kaiser Permanente	HMO	32,800	13%
TOTAL		248,831	100%

The percentage of members within each network has been steady from 2018 to 2019.

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

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

Delegation

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

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

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

Figure 3 – 2019 the Alliance Delegated Network

2019 Alliance Delegated Network

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

Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)			
Members	Dec 2017	Dec 2018	Nov 2019	Dec 2019	Dec 2017	Dec 2018	Nov 2019	Dec 2019
Delegated	167,165	163,165	155,564	154,621	61.9%	61.8%	62.1%	62.1%
Direct	102,814	101,025	95,134	94,210	38.1%	38.2%	37.9%	37.9%
Total	**269,979**	**264,190**	**250,698**	**248,831**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Overall, the network was sufficient to meet the needs of The Alliance membership and provider network through 2019. The organization had identified issues related delegation oversight in 2018, so in 2019 there were continued improvements in the level of oversight, monitoring, reporting and training of delegates.

Program Structure

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

Responsibility, Authority and Accountability/ Governing Committee

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

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

Committee Structure

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

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

HCQC charters a sub-committee, the Utilization Management Committee (UMC) which meets at least once every 2 months (6 meetings in 2019,) serving as a forum for the Alliance to evaluate current UM and CM activities, processes, and metrics. The UMC also evaluates the impact of UM and CM programs on other key stakeholders within various departments and when needed, and assesses and plans for the implementation of any needed changes.

The 2019 CM Program Evaluation and CM Program Description were developed and presented for documentation into the March 3, 2019 HCQC minutes for Board of Directors approval. The committee was chaired by the Chief Medical Officer with support of the Director of Quality Management, external physicians and key organizational staff.

In 2019 the UM Subcommittee of HCQC has continued to support the focus on CM activities, oversight for delegated CM activities, case management/care

coordination, complex case management, transitions of care, population health, integration of behavioral health and medical as well as regulatory compliance.

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

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

During 2019 Dr. Aaron Chapman, a psychiatrist and Medical Director of Alameda County Behavioral Health Care Services, actively participated in the HCQC meetings and provided clinical input ensuring policies and reports considered behavioral health implications .

Program Scope and Structure

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

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

Case Management Resources

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

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

During 2019 several key leadership roles in Health Services were hired:

- 2 Co-Managers of Case Management
- Manager of Inpatient UM, who interfaces closely with CM department activities and services.

In 2019, based on the established staffing ratios and roles, the CM Department struggled in timely hiring for the leadership roles. As a result, staff were often called to perform in those missing roles. With the onboarding of new leadership, the Health Care Services Department teams reviewed the current organization goals and are continuing to restructure the Department as needed to achieve those goals.

Delegated Case Management

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

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

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

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

actions. All audit findings are reported into the Compliance Department and the HCQC.

In 2019, the UM and CM staff conducted annual audits on the six (6) delegates. The threshold for UM and CM audit compliance is 90%. For entities that do not meet the threshold, UM/CM may require a corrective action plan which is tracked for compliance with the resolution of the deficiency. Entity audit results for 2019 were:

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

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

Figure 5 the Alliance Network – 2019 Annual Audit Score

Delegate	Provider Type	Delegated Activity -CM	2019 Audit Results	Corrective Action Required
Kaiser	HMO	X	Failed	Multiple CAPs
(CHCN)	Medical Group	X	Failed	Multiple CAPs
Beacon/College Health IPA (CHIPA)	Vendor - BH	X	Failed	Yes: No documentation of PCP collaboration

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

Recommend Actions/Next Steps

For 2020, there is an opportunity to improve the oversight of delegated CM activities. The CM Department leadership continues to develop a robust level of delegate oversight and performance monitoring. The activities include dedicated staff, monitoring activities, performance management, delegate feedback and CM training.

Case Management Processes and Information Sources

Case Management Information Systems and Sources

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

Evidence-based clinical guidelines are available to support the Case Managers in conducting assessments, developing care plans, and managing care. The clinical practice guidelines are based on current published literature, current practice standards, and expert opinion. Whenever possible, guidelines are derived from nationally recognized sources. If a nationally recognized guideline is not available, the Alliance will involve board certified specialists in the development of the appropriate guidelines. Assessment questions were based on evidence-based guidelines from The National Guideline Clearinghouse (www.guideline.gov) until they were no longer available as of July 2018, as well as medical and behavioral healthcare specialty societies and/or Alliance Clinical Practice Guidelines, published on the AAH website .

In July 2019, the CM Department conducted a comprehensive review of the standard workflow hosted by a contractor certified in Lean Management. This included reviewing the functionality of the TruCare system. Casenet, the makers of TruCare provided onsite additional support in Q4 to assist with the re-evaluation process. Multiple areas for improvement were identified including system enhancements. Collaboration will continue into 2020.

The Alliance CM Department utilized the established evidence based clinical criteria as defined in the CM Program. Based on a review of member needs and utilization alternative criteria, the complex criteria was adjusted to better facilitate assisting the given population to incorporate additional social determinants of health.

While the standard hierarchy of evidence-based criteria met the current membership needs and CM activities, in 2019 the department continues to

prepare for the shift to population health management. For 2020, the CM Department will continue to collaborate with Senior Leadership to develop program activities, and new clinical criteria will continue to be evaluated to meet the identified needs of those programs.

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

Care Coordination and Case Management Processes

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

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

Basic Care Management

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

Care Coordination

Care coordination is provided by the Provider Group CM staff for members needing assistance in coordinating their health care services. This level of CM may include ambulatory case management, referral coordination and/or focused disease management programs. For members in need of care

coordination along the continuum of care, including arrangements for linked and carved out services, programs, and agencies, The Alliance CM team provides assistance using non-clinical staff, Health Navigators, with extensive training in facilitation and coordinating services both internally and with outside agencies. Health Navigators can manage most of the care coordination, continuity of care, and low risk transitions of care cases. They also make referrals to Beacon, Alameda County Public Health, community resources, etc.

Targeted Care Management

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

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

Complex Case Management

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

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

Specialty Programs

Transitions of Care

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

For 2020, the Transitions of Care Program plans to expand beyond the three (3) pilot hospitals and to incorporate more collaboration between additional Alliance Departments: Utilization Management (UM) and Pharmacy to further meet the member's health care needs.

Case Management Processes

Health Risk Assessments

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

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

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

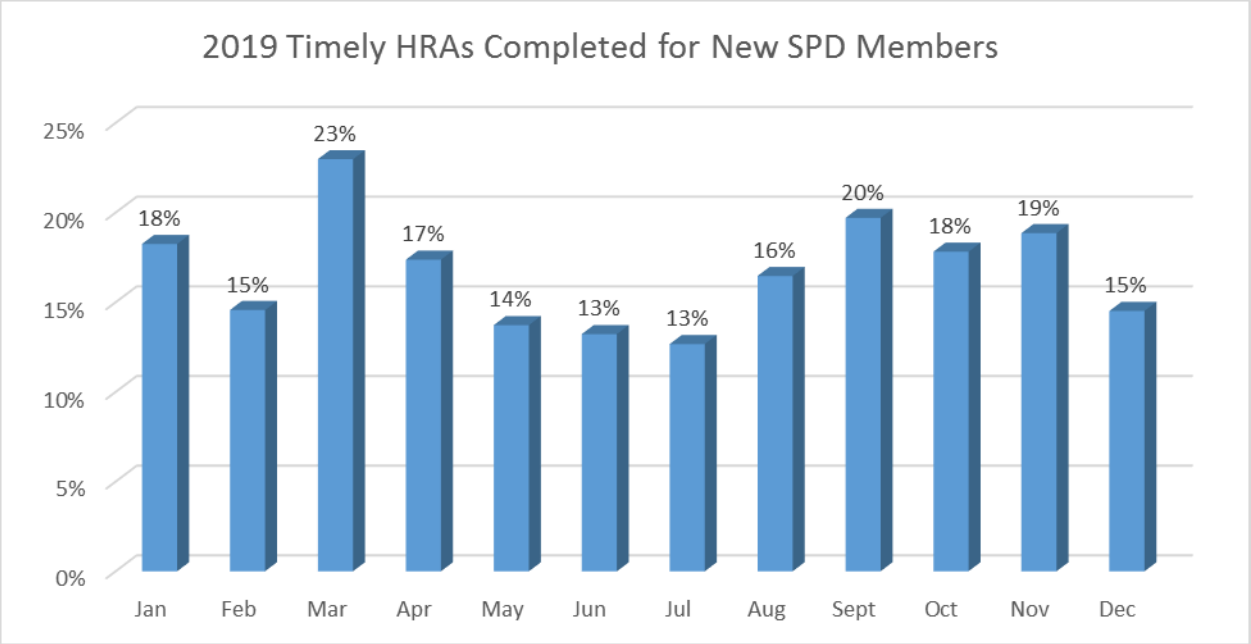
CM staff is responsible for ensuring the Member Care Plan is completed and shared as well as providing any community or health resources. For Members who completed the HRA with a final stratification of Low Risk, CM staff review

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

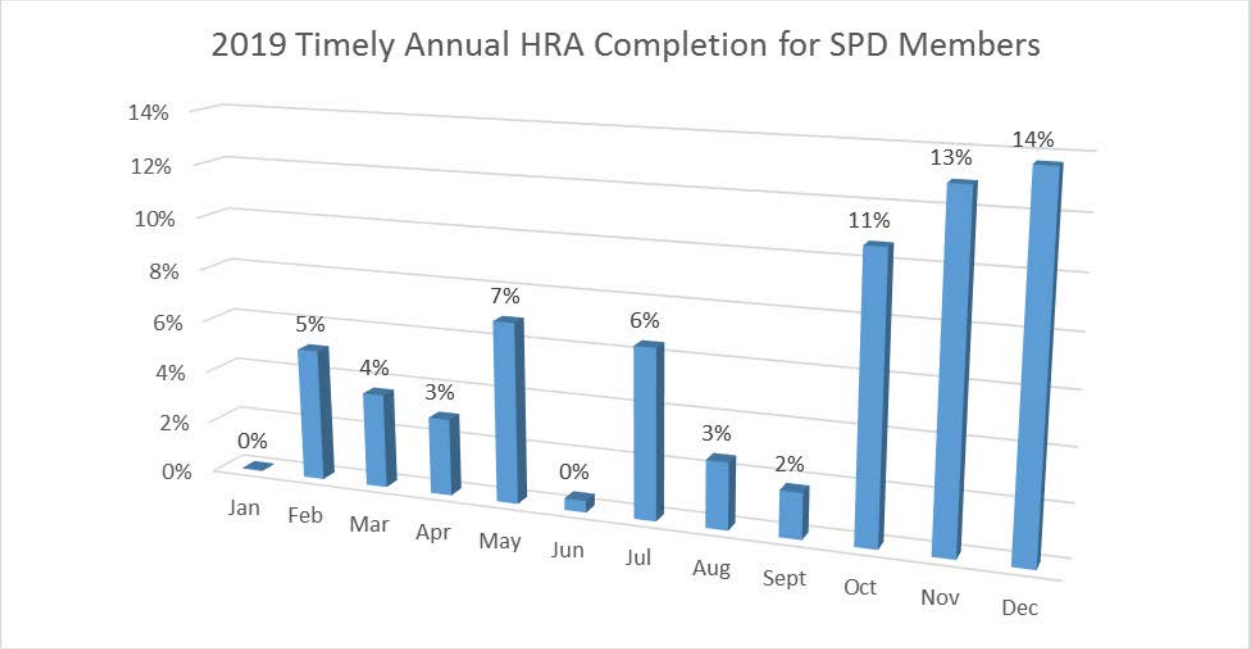
In 2019, the Alliance continues to contract with a vendor to make Interactive Voice Response (IVR) calls to members so that the Alliance can give members every opportunity to complete the HRA and have the results acted upon by the CM department.

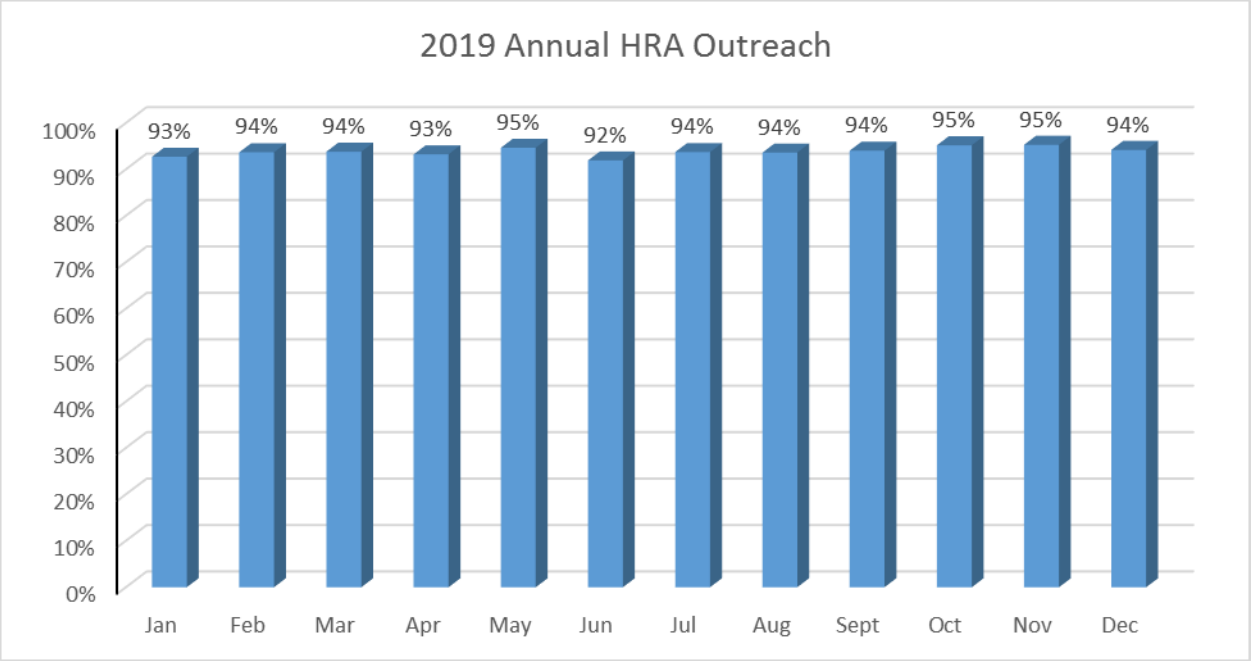
In collaboration with Healthcare Analytics, a HRA dashboard was created in 2018, to track compliance of outreach attempts and timely completion of the HRA for the SPD population, and this tracking continued in 2019.

New HRA completion for SPD Members



Annual HRA completion for SPD Members





The outreach rates for 2019 remained steady, reflecting the engagement of the vendor to assist with the HRA process, to ensure that members receive their HRAs timely, and were also responded to timely as well. The completion numbers continue to be relatively low, with the last quarter showing completion rates in the mid teens. To further evaluate this, chart review will be part of 2020 plan to futher improve and identify gaps.

CM Referral and Identification

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

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

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

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

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

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

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

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

Predictive Model Application

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

In 2017, the CM department collaborated with the Information System team to enhance the data stratification to target members for outreach. Adjusted Clinical Group, or ACGs, are the building blocks of The Johns Hopkins ACG System methodology. ACGs are a series of mutually exclusive, health status categories defined by morbidity, age, and sex. They are based on the premise that the level of resources necessary for delivering appropriate healthcare to a

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

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

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

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

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

Figure 6 - 2019 Care Analyzer data for Disease Management and Care Management Services.

Care Analyzer	2019/1	2019/2	2019/3	2019/4	2019/5	2019/6	2019/7	2019/8	2019/9	2019/10	2019/11	2019/12
Asthma	1456	1091	809	1594	743	811	695	1165	1386	244	1430	1019
Diabetes (Exculding CCM)	6110	3472	3111	5718	3146	2845	2896	5867	3642	1730	5239	7252
CCM (Diabetes + Non-Diabetes)	580	542	542	635	665	671	623	643	679	677	657	678
Care Coordination MCAL/Medicare Members	76	69	90	83	75	72	61	57	64	67	77	65
Percentage of CCM												
5%	29	27	27	32	33	34	31	32	34	34	33	34
3%	17	16	16	19	20	20	19	19	20	20	20	20
1%	6	5	5	6	7	7	6	6	7	7	7	7

Figure 6 above shows the number of members identified by CareAnalyzer algorithm for potential candidates for CCM services in 2019. The top volumes were in Diabetes, averaging about 4200 per month, followed by Asthma at around 1000 per month.

After having identified opportunities to use the RRS current and predictive changes to improve the identification of members with health conditions who are at risk for higher utilization and lower health outcomes in 2018, the CM team in 2019 was able to focus on outreach to the top 5% of members identified as high risk.

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

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

In 2019, with further evaluation of the Population Health Report the CM department was continuing to receive referrals for members not in the top 5% as identified as high risk. This led to the revival of the Transitions of Care Program and a change to the complex criteria.

Transitions of Care

In November 2019, Transitions of Care program began anew, piloting at 1 hospital system (containing 3 hospitals), with the plan for further expansion in 2020. The criteria for Transitions of Care is a discharge from an inpatient stay from one (1) of the three (3) hospitals. Continued collaboration is ongoing to prevent duplication of work by other Transitions of Care Programs.

There are two (2) reports used to create TOC referrals. The Admission, Transfer, Discharge (ADT) report is data sent from the hospital, and the TOC Discharge Report populated by Inpatient Utilization Management authorization closure. Upon discharge from the hospital, the members listed on the reports are then entered into the Clinical Information System as a referral. The referral source is listed as 'Internal Report'. Prior to CM staff assignment, the referrals are reviewed by a triage nurse to evaluate medical history and utilization history from various data sources including the hospital discharge summary. The triage nurse makes a recommendation during the assignment process as to what CM team member is appropriate to receive the referral.

The complex criteria was changed to incorporate specific diagnoses, including mental health diagnoses as well as other complex psychosocial needs. The CM workflow was changed so that every member enrolled in a case management program is evaluated for Complex Case Management (CCM). If the member meets criteria, CCM is offered to that individual.

Methodology:

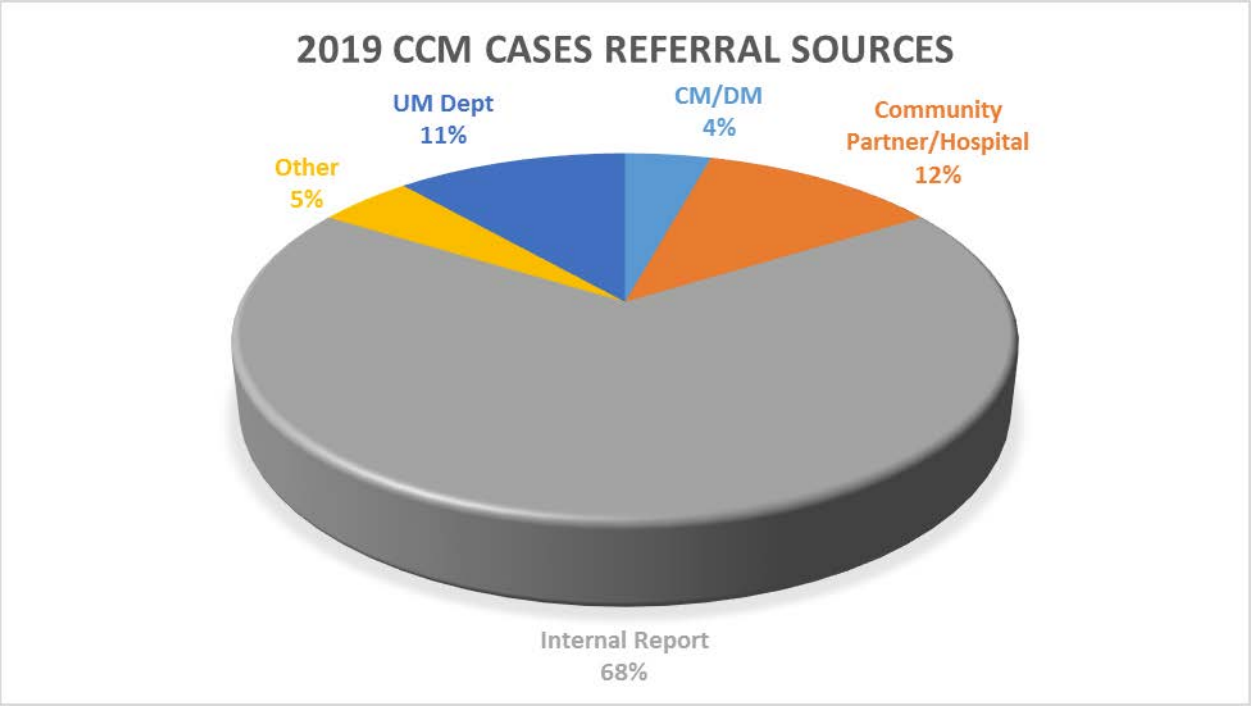
Using the Case Management Aging report, which was developed in 2018, CCM cases created in 2019 were pulled and separated based on sources. Sixty-eight percent (301 out of 445) of CCM cases came from an Internal Report. With the revival of the Transitions of Care (TOC) Program, the Internal Report category includes: ADT Feed, TOC Discharge Report and the Population Health Report.

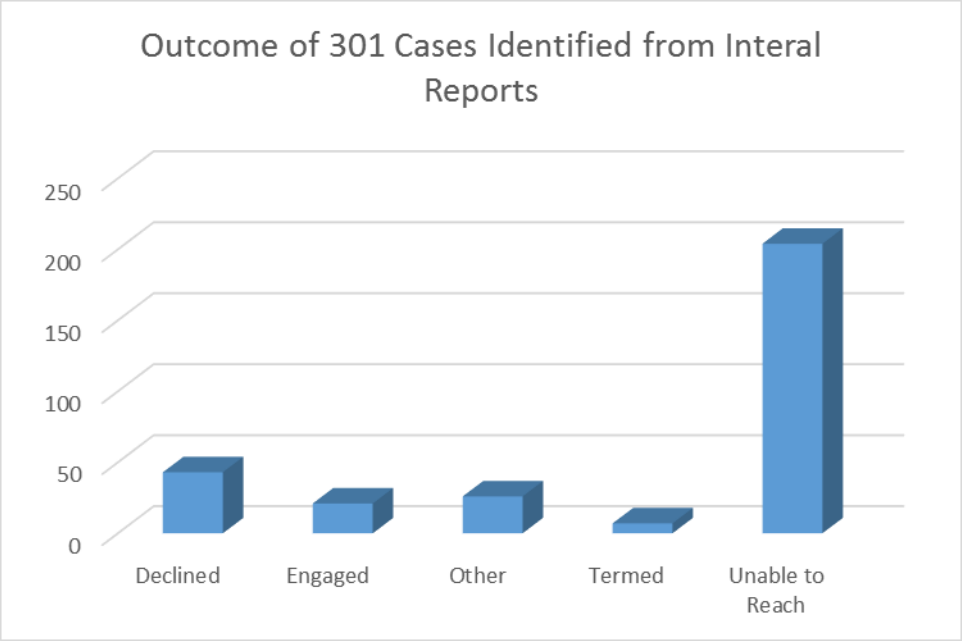
2019 Results:

Complex Case Management

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

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


2019 CCM CASES REFERRAL SOURCES
UM Dept
11%
CM/DM
4%
Community
Partner/Hospital
12%
Other
5%
Internal Report
68%


Outcome of 301 Cases Identified from Interal Reports
250
200
150
100
50
0
Declined
Engaged
Other
Termed
Unable to Reach

Outcome of 301 Cases Identified from Internal Reports	Total Cases	%
Declined	43	14%
Engaged	21	7%
Other	26	9%
Termed	7	2%
Unable to Reach	204	68%

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

- Overall for 2019, almost 70% of CCM cases were identified from the Internal Reports.
- CM had difficulty engaging members from the Internal Reports in the CCM program, with only 7 % of potential cases successfully engaged in the program.
- The majority of cases identified through the internal reports were to Unable to Reach or Declined to be in the program.

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

- There were members identified in the cost containment initiative but were not pulled from the Internal Reports.
- There were members identified in both cost containment initiative and Internal Reports but not successfully engaged.

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

- Reports pull from different sources and yield different results
- Issues with CM structure, and lack of process.
- “Cold calling” members on the Population Health Report continues to be ineffective in engaging members in the program.

2020 Plan

- Revise the Population Health report in 2020 to better reflect the changed complex criteria.
- Continue to evaluate the new/revised report until the end of the year.

- Clearly identify, implement and evaluate different avenues to attempt to improve member engagement.
- Findings will be collected and submitted as part of the 2020 CM program evaluation.

Figure 7 - 2019 CM Care Coordination Program by Referral Source

CARE COORDINATION												
REFERRALS BY REFERRAL SOURCE	201901	201902	201903	201904	201905	201906	201907	201908	201909	201910	201911	201912
Behavioral Health Program	0	1	4	0	0	3	3	1	2	3	0	0
California Children's Services	0	0	0	0	0	0	0	0	0	0	0	0
Care Advisors	0	0	0	0	0	0	0	0	0	0	0	0
CBAS/LTSS	1	0	1	1	1	0	0	0	0	0	0	0
CM/DM	1	7	3	9	14	9	8	10	14	29	1	0
Community Partner/Hospital	12	11	21	16	14	16	12	12	21	26	2	0
Grievance and Appeal	9	6	8	10	9	9	12	11	12	11	0	0
Internal Report	1	11	7	6	13	20	20	13	21	1	0	0
Member Services	9	12	33	34	38	50	99	99	74	75	1	0
NULL	0	0	0	0	0	0	0	0	0	0	0	0
Nurse Advice Line	6	0	8	7	10	7	8	10	13	4	0	0
PCP/Specialty Provider	0	1	1	1	2	1	0	0	1	0	0	0
Provider Services Dept	0	0	0	0	0	0	0	0	0	0	0	0
Self	9	5	4	1	3	5	8	1	6	10	2	0
UM Dept	93	124	175	122	112	93	104	135	97	79	0	0
TOTAL	141	178	265	207	216	213	274	292	261	238	6	0

In July 2019 when we went through the comprehensive review of the Case Management workflows a variety of improvement areas were identified. New workflows and processes were developed and implemented through the rest of 2019. Upon further review of Figure 7, some of these changes impacted Case Management's reports, showing inaccurate data starting in November 2019. Analysis of the first 10 months of 2019 show the top three referral sources are 1) UM Department at 1,134, 2) Member Services at 524, and 3) Community Partners/Hospitals at 163. Referrals from PCP/Specialty Providers are low, and may represent an opportunity to work with the Physicians/Physician Offices on the services for care coordination.

Figure 8 - 2019 CM Care Coordination Program by Active Cases

CARE COORDINATION	201901	201902	201903	201904	201905	201906	201907	201908	201909	201910	201911	201912
TOTAL	**141**	**178**	**265**	**207**	**216**	**213**	**274**	**292**	**261**	**238**	**6**	**0**
ACTIVE CASES												
New Cases	148	181	276	257	272	264	331	309	307	282	243	236
Total Cases In Progress	436	403	523	531	566	574	683	731	736	704	645	647
Total Opt Out Assessments	0	0	0	0	0	0	0	0	0	0	0	0
Total Assessments Completed w/in 30 Days of Referral	73	91	170	153	145	145	196	185	153	154	2	0
High Risk Cases In Progress	61	33	46	48	31	21	27	30	38	39	36	28
Medium Risk Cases In Progress	47	36	45	43	31	33	32	29	25	19	23	22
Low Risk Cases In Progress	11	6	5	2	2	2	5	4	4	2	2	2
Active Participation Rate % (Total Assessments Completed w/in 30 Days of Referral / Total Referrals)	**52%**	**51%**	**64%**	**74%**	**67%**	**68%**	**72%**	**63%**	**58%**	**65%**	**33%**	**n/a**

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

The Active cases were similarly impacted with the improvement of workflows and processes, also showing inaccurate reporting for the months of November and December of 2019.
The data in Figure 8 shows the number of assessments completed and the timeframe for completing the assessment. In this report the completion within the 30 days of referral was well below the 90% goal for the entire year, but improved over the year, going from 52% in January to 65% in October, with an overall average of 64%. The report also tracks the level of risk identified after the assessment. Members identified as High Risk are referred to the CCM program for further care planning.

Figure 9 - 2019 CM Care Coordination Program by Case Closure

CARE COORDINATION	201901	201902	201903	201904	201905	201906	201907	201908	201909	201910	201911	201912
CASE CLOSURE BY CLOSURE REASONS												
Already in program	0	0	0	0	0	0	0	0	0	0	0	0
Condition stable with no further Case Management needs	53	58	76	72	45	46	44	54	46	33	49	56
Condition stable with no further Disease Management needs	6	0	0	0	0	0	0	0	0	0	0	0
Deceased	0	1	4	0	4	5	0	1	1	5	4	2
Duplicate member record	0	0	0	0	3	1	5	1	0	1	0	2
Escalate services to higher level program	10	9	7	5	29	7	11	14	7	11	5	3
Inappropriately identified for program	1	1	0	1	1	0	1	2	2	3	1	1
Member declines continued Case Management services	2	2	0	1	2	0	1	4	4	2	2	3
Member declines continued Disease Management services	0	0	0	0	0	0	0	0	1	0	0	0
Member non-compliant	0	0	0	0	0	1	0	1	0	1	0	0
Member transferred to Delegate/Other	5	2	5	8	7	9	6	9	11	8	2	3
Member/Caregiver refuses services	0	3	3	1	2	2	3	8	3	2	6	0
Other	29	12	31	28	36	28	31	33	28	49	35	34
Readmission	0	0	0	1	0	0	1	0	0	0	1	0
NULL	0	0	0	0	0	0	0	0	0	0	0	0
Referred to Disease Management	0	0	0	0	0	0	0	0	1	0	1	0
Step down to lower level program	0	0	1	0	0	0	0	0	0	1	0	0
Termination of coverage	1	2	1	2	1	5	1	1	1	2	2	2
TruCare cleanup	0	0	0	0	0	0	0	0	10	1	0	2
Unable to contact member	75	50	85	87	71	51	71	67	94	84	48	55
Already in Program	3	0	5	1	1	4	0	7	5	3	7	10
Declined Program	6	1	6	4	5	8	19	23	23	8	8	6
Completed Program	5	7	15	9	21	22	32	21	35	50	23	36
Lost Contact	10	6	7	9	20	27	21	45	28	28	28	25
Member Ineligible	8	2	3	7	6	6	14	11	14	10	12	12
Case still open	0	0	0	0	2	0	0	0	0	0	0	0
Past Participant	0	0	0	1	0	0	0	0	0	0	0	1
TOTAL	**214**	**156**	**249**	**237**	**256**	**222**	**261**	**302**	**314**	**302**	**234**	**253**

Case Closure data was similarly impacted with the improvement of workflows and processes, also showing inaccurate reporting for the months of November and December of 2019.

As noted in Figure 9, the top three reasons for case closure from January to October 2019 were 1) Unable to Contact at 838 members, 2) Condition Stable with no further need for CM at 632 members and 3) Other reasons not categorized at 374 members. The high number of members for whom the program was unable to reach warrants additional strategies. In addition, given the high number of cases not categorized, further refinement of the data capture tool or additional staff training may be indicated.

Plan for 2020

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

Complex Case Management

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

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

Figure 10 – 2019 Complex Case Management – Referrals by Source

COMPLEX												
REFERRALS BY REFERRAL SOURCE	201901	201902	201903	201904	201905	201906	201907	201908	201909	201910	201911	201912
Behavioral Health Program	0	0	1	0	0	0	0	0	0	0	0	0
California Children's Services	0	0	0	0	0	0	0	0	0	0	0	0
Care Advisors	0	0	0	0	0	0	0	0	0	0	0	0
CBAS/LTSS	0	0	0	0	0	0	0	0	0	0	0	0
CM/DM	0	1	1	0	10	7	3	8	3	8	0	0
Community Partner/Hospital	9	12	17	15	15	15	6	20	21	20	1	0
Grievance and Appeal	3	2	2	3	5	5	3	4	2	0	0	0
Internal Report	101	57	0	0	1	71	40	23	16	19	1	0
Member Services	3	1	7	3	7	5	10	6	3	5	0	0
NULL	0	0	0	0	0	0	0	0	0	0	0	0
Nurse Advice Line	0	0	0	0	0	0	0	0	0	0	0	0
PCP/Specialty Provider	0	0	1	2	3	0	0	0	0	0	0	0
Provider Services Dept	0	0	0	0	0	0	0	0	0	0	0	0
Self	2	1	2	4	4	5	2	1	0	1	0	0
UM Dept	24	28	34	20	13	10	16	12	9	5	0	0
TOTAL	142	102	65	47	58	118	80	74	54	58	2	0

Similar to the Care Coordination data, November and December of 2019 are inaccuratelyely reported. Further work will be done to rectify this moving forward.

From January to October of 2019, the top three referral sources are 1) Internal Report (Care Analyzer) at 329, 2) UM Department at 171, and 3) Community Partners/Hospitals at 151. It is noted that the referrals from PCP/Specialty Providers is quite low, with only 6 referrals. This may be an area of opportunity to work with the Physicians/Physician Offices on the services for complex case management.

Figure 11 2019 CCM Active Cases and Case Assessments Rates

COMPLEX	201901	201902	201903	201904	201905	201906	201907	201908	201909	201910	201911	201912
TOTAL	142	102	65	47	58	118	80	74	54	58	2	0
ACTIVE CASES												
New Cases	108	66	5	12	46	90	63	48	24	25	19	17
Total Cases In Progress	140	117	63	41	69	143	149	114	77	71	54	39
Total Opt Out Assessments	11	7	0	0	2	6	5	7	4	3	9	1
Total Assessments Completed w/in 30 Days of Referral	53	46	39	34	40	65	56	42	20	35	0	0
High Risk Cases In Progress	8	8	7	6	7	9	10	9	8	8	3	2
Medium Risk Cases In Progress	0	0	0	0	0	0	0	0	0	0	0	0
Low Risk Cases In Progress	0	0	0	0	0	0	0	0	0	0	0	0
Active Participation Rate % (Total Assessments Completed w/in 30 Days of Referral / Total Referrals)	37%	45%	60%	72%	69%	55%	70%	57%	37%	60%	0%	n/a

Figure 11 above describes the 2019 Active case activities by the number of new cases, (523) the total open cases in program (1,077) and the number of cases in

which the members was identified and referred but opted not to engage in the program, (55).

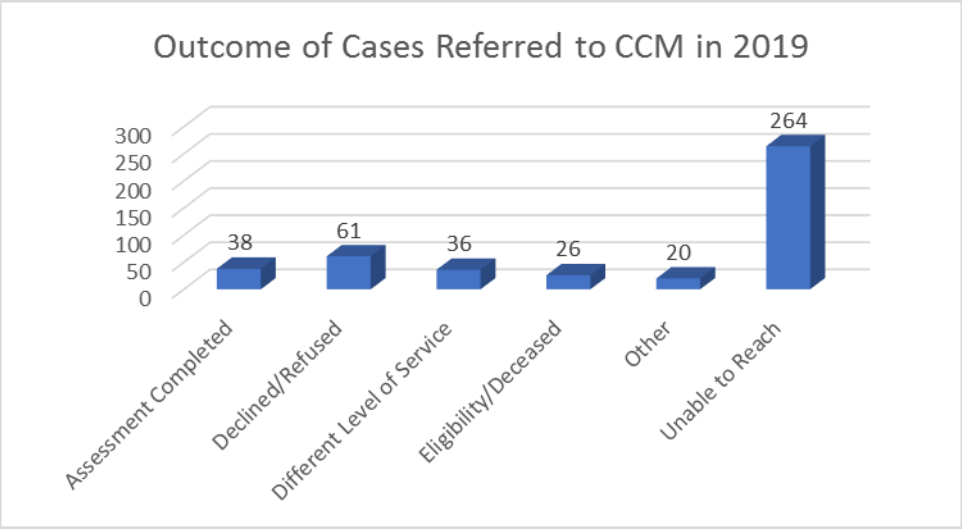
In addition, the data in Figure 11 monitors the number of assessments completed and the timeframe for completing the assessment. In this report the completion within the 30 days of referral was well below the 90% goal for the entire year at 54%, but an improvement from 2018 (49%) and there was no clear trend in the percentages.

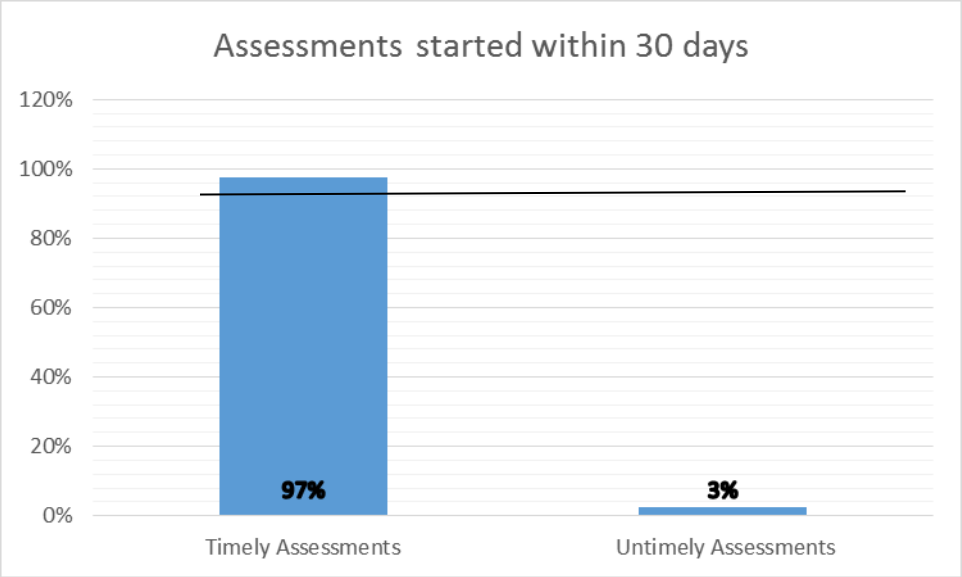
The Case Manager may begin the initial assessment in the first contact call. An initial assessment is performed as expeditiously as the Member's condition requires (and may be completed by multiple calls), but must be created within 30 calendar days and completed within 60 days from date of identification.

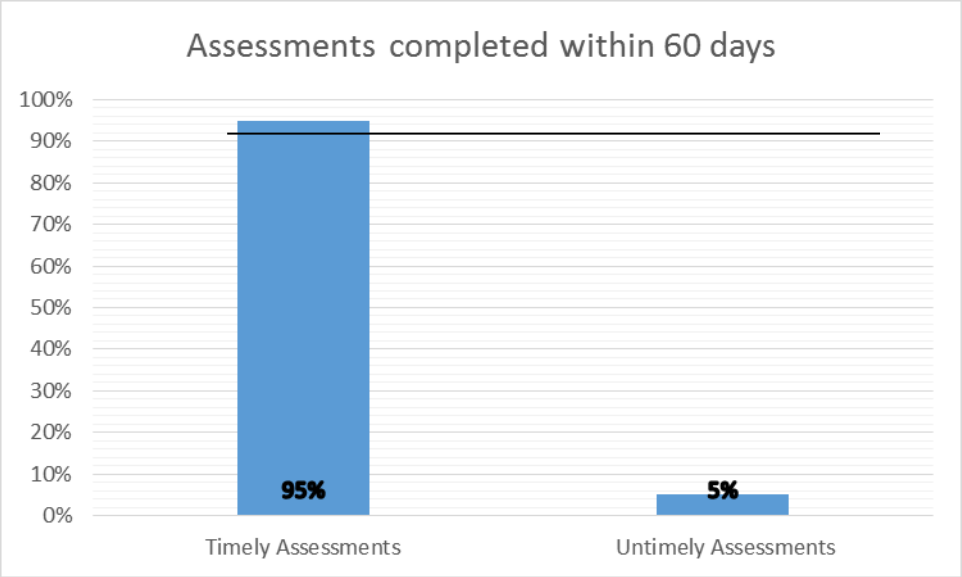
Further review of CCM case timeliness was done, using the Aging Report. The re-review revealed data integrity issues, such that cases less than 30 days were included in the report, and the report also included the members Declining CCM and Unable to Reach members.

Methodology for Data Validation:
Using the Aging report, all 445 cases referred and created in 2019 were pulled to identify the assessment status. CCM assessments completed were pulled and evaluated for timeliness.

2019 Results:







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

- Out of 38 assessments, 37 were started within 30 days and only one was started after the 30 calendar day timeframe, exceeding the goal at 97%.
- Out of 38 assessments, 36 were completed within 60 days and only two were completed after the 60 calendar day timeframe, exceeding the goal at 95%.

Qualitative analysis:

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

- The assessment that was not started within 30 days was previously reported as a Care Coordination case. Consent for CCM and the assessment were completed within 30 days of identifying the member as Complex.
- The two assessments that was not completed within 60 days were due to care coordination needs taking priority to completing the assessment and the case was previously reported as Care Coordination.

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

Plan for 2020:

- Implement appropriate case closure when changing the case to a different level of care by February 2020.
- Complete the standard of work for CCM, including workflow, screenshots and competencies by April 2020.
- Train staff on CCM standard of work by May 2020.

Interdisciplinary Care Team **(IDT)**

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

Methodology:

There were 44 cases that engaged in CCM and had completed an assessment. These cases were reviewed to identify only members who stayed in CCM for at least 90 days. CM identified 21 members from the aging report and from chart review.

2019 Results:

CCM Cases ≥ 90 days	Outcome of IDT	% of Timely IDT based on Report
14	No IDT	67%
3	Timely	14%
4	Untimely	19%

CCM Cases ≥ 90 days	Outcome of IDT	% of Timely IDT based on Chart Review
14	No IDT	67%
4	Timely	19%
3	Untimely	14%

Results show that there is an issue with completing the IDT according to the requirements (only 19% were completed timely.) There is also a data integrity issue that will affect the ability to readily track outcomes, reflected in the different outcomes of the report vs. chart review.

2020 Plan

- Create a Log to track cases for IDT appropriately by end of January 2020
- Create workflow to include: identifying case, notifying case owner, presenting at IDT Rounds and documenting accordingly in the Clinical Information System (TruCare) by February 2020
- Train staff on IDT Process by end of February 2020

Figure 12 - 2019 Complex Case Management Case Closures by Reason

COMPLEX	201901	201902	201903	201904	201905	201906	201907	201908	201909	201910	201911	201912	Total
CASE CLOSURE BY CLOSURE REASONS													
Already in program	0	0	0	0	0	0	0	0	0	0	0	0	0
Condition stable with no further Case Management needs	0	4	5	7	0	0	4	3	0	1	1	1	26
Condition stable with no further Disease Management needs	0	0	0	0	0	0	0	0	0	1	0	0	1
Deceased	2	1	0	0	0	1	3	2	1	0	0	0	10
Duplicate member record	1	1	0	0	0	0	0	1	0	1	0	0	4
Escalate services to higher level program	0	0	0	1	2	3	2	2	0	0	0	0	10
Inappropriately identified for program	1	0	0	0	0	0	1	0	2	2	0	0	6
Member declines continued Case Management services	0	0	0	0	0	1	0	0	0	2	1	0	4
Member declines continued Disease Management services	0	0	0	0	0	0	0	0	0	0	0	0	0
Member non-compliant	0	0	0	0	0	0	0	0	0	0	0	0	0
Member transferred to Delegate/Other	1	0	1	0	1	2	4	1	1	0	0	0	11
Member/Caregiver refuses services	0	0	0	0	0	1	3	4	2	0	3	0	13
Other	3	4	4	4	5	4	3	5	0	3	3	3	41
Readmission	1	0	0	0	0	0	0	2	0	0	0	0	3
NULL	0	0	0	0	0	0	0	0	0	0	0	0	0
Referred to Disease Management	0	0	0	0	0	0	0	0	0	0	0	0	0
Step down to lower level program	1	0	0	3	1	1	0	3	1	0	1	0	11
Termination of coverage	0	1	0	0	0	1	0	0	0	0	0	0	2
TruCare cleanup	0	0	0	0	0	0	0	0	0	0	0	1	1
Unable to contact member	59	38	20	3	5	27	45	25	14	14	12	7	269
Already in Program	0	0	0	0	0	2	3	0	0	0	0	0	5
Declined Program	13	7	0	0	1	8	6	4	6	3	5	2	55
Completed Program	2	1	1	0	1	0	1	0	0	2	1	0	9
Lost Contact	5	2	1	0	0	3	4	8	3	5	2	3	36
Member Ineligible	0	0	2	0	0	3	4	1	1	2	3	0	16
TOTAL	89	59	34	18	16	57	83	61	31	36	32	17	533

As noted in Figure 12, the top three reasons for case closure in 2019 1) Unable to Contact (269), 2) Member Declined the Program, (55) and 3) Other, (41) .

Recommended Interventions/Next Steps for 2020:

An opportunity to continuously improve the quality oversight of the current CM processes has been identified. This will be accomplished by internal monitoring of CM/CCM files on a routine and/or periodic basis. This also includes reviewing and revising the standardized reports focused at monitoring of CM activities referral management, outreach, case closure and PCP communications.

Performance Measures

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

Figure 13 – CM Performance Measures

	Goal	Measure	Measurement	Performance Goal	2019 Rate	Goal Met?
# 1	Achieve and maintain high level of satisfaction with CM services	Member Satisfaction Rates	High level of satisfaction with CM services	90%	95%	Yes
# 2	Improve member outcomes	All-Cause readmission Rate	readmission rates for all causes for members in CCM with admission within 6 months of enrollment in CCM	None established	19.0%	NA
# 3	Improve member outcomes	Emergency Room Visit Rate	ER rates for members enrolled in CCM	None established	Not Available	NA

#4	Achieve optimal member functioning	Health Status	% of members in CCM responding that their health status improved because of CCM	None established	Not Available	NA
#5	Use of Appropriate Health Care Services	Use of Services	Improvement in measures of office visits within Alliance Network	None established	Not Available	NA

Figure 13 captures the 2019 Performance Measures. Of the five measures, one had an established benchmark. Only one of the measures had an identified rate. The overall all cause readmission rate was reported at 19.0%, but this is not specific to the CCM population. It is noted that most measures are not specific to members enrolled in CCM. Unless the population measures can be refined to reflect outcomes for members enrolled in CCM, there will need to be consideration of different measures that can capture meaningful CCM outcomes.

Assessing Members Experience with the CM Process

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

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

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

In 2019, CM Department received a total of 3 surveys.

Figure 14 – 2019 Survey Results

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

Of the three surveys returned, the combined satisfaction was 95%.

Another way to assess member experience is through review of the filed complaints against Case Management. A review of the 2019 Grievance data shows only one case identified as a member complaint about the CM process.

Figure 15 – 2019 Complaints Filed Regarding CM Process

Grievances Filed Against	Benefits/Coverage	Quality of Care/Service		Accessibility	Grand Total
	Dispute over Covered Services	Plan Denial of Treatment	Poor Provider/Staff Attitude		
Case Management Process	1		2	3	6

There was a total of 6 complaints for 2019. Upon further investigation into the Accessibility complaints, they were related to lack of telephone accessibility. This has created an opportunity for improvement, to evaluate the current phone answer process within the department of CM. Overall, customer service communication and member engagement training (and re-training if appropriate) is provided to all staff.

Recommended Interventions/Next Steps for 2020:

In 2020, there is an opportunity to ensure the CM Department:

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

Special Programs

Transitions of Care

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

In 2018, The Alliance had a TOC program for members identified as potentially having risk for readmission. In 2019, the Alliance revamped the existing TOC program. With the collaboration of IT, a new way of identifying members was created through a report called the Admission, Discharge, Transfer Feed sent from various hospitals. This report was validated against the TOC Discharge Report, which was based off of authorization closures performed by the Inpatient UM Concurrent Review staff. To start, the TOC program was piloted with Alameda Health Systems (containing 3 local hospitals) in order to confirm the volume of cases identified were appropriately handled. Workflows were updated, staff were trained and the pilot TOC program began in November 2019, partnering with AHS on TOC initiatives related to readmission reduction and discharge planning.

Figure 16 - 2019 Transitions of Care Referrals

TRANSITION OF CARE												
REFERRALS BY REFERRAL SOURCE	201901	201902	201903	201904	201905	201906	201907	201908	201909	201910	201911	201912
Behavioral Health Program	0	0	0	0	0	0	0	0	0	0	0	0
California Children's Services	0	0	0	0	0	0	0	0	0	0	0	0
Care Advisors	0	0	0	0	0	0	0	0	0	0	0	0
CBAS/LTSS	0	0	0	0	0	0	0	0	0	0	0	0
CM/DM	0	0	0	0	0	0	0	0	0	0	0	0
Community Partner/Hospital	0	0	0	0	0	0	0	0	0	0	0	0
Grievance and Appeal	0	0	0	0	0	0	0	0	0	0	0	0
Internal Report	0	0	0	0	0	0	0	0	0	0	0	0
Member Services	0	0	0	0	0	0	0	0	0	0	0	0
NULL	0	0	0	0	0	0	0	0	0	0	0	0
Nurse Advice Line	0	0	0	0	0	0	0	0	0	0	0	0
PCP/Specialty Provider	0	0	0	0	0	0	0	0	0	0	0	0
Provider Services Dept	0	0	0	0	0	0	0	0	0	0	0	0
Self	0	0	0	0	0	0	0	0	0	0	0	0
UM Dept	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Upon further evaluation of Figure 16, there were discrepancies discovered with the reporting process of referrals to Transitions of Care. Further collaboration with the Analytics Department is warranted to rectify this error.

Figure 17 – 2019 Transitions of Care Active Cases

TRANSITION OF CARE	201901	201902	201903	201904	201905	201906	201907	201908	201909	201910	201911	201912
TOTAL	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
ACTIVE CASES												
New Cases	14	16	19	7	3	3	0	2	0	1	43	122
Total Cases In Progress	32	28	33	18	10	5	3	2	1	2	44	164
Total Opt Out Assessments	0	0	2	1	0	0	0	0	0	0	0	1
Total Assessments Completed w/in 30 Days of Referral	0	0	0	0	0	0	0	0	0	0	0	0
High Risk Cases In Progress	3	0	1	0	0	0	0	1	1	1	3	3
Medium Risk Cases In Progress	0	0	0	1	1	0	0	0	0	0	1	2
Low Risk Cases In Progress	1	1	1	1	0	0	0	0	0	0	0	0
Active Participation Rate % (Total Assessments Completed w/in 30 Days of Referral / Total Referrals)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

The data noted in Figure 17 shows the increase in cases opened and in progress. This is an expected outcome, as the program began in November of 2019. Further refinement is warranted to ensure that the Active Participation Rate percentage be properly reflected in the data.

Figure 18 – Transitions of Care Case Closures

TRANSITION OF CARE	201901	201902	201903	201904	201905	201906	201907	201908	201909	201910	201911	201912
CASE CLOSURE BY CLOSURE REASONS												
Already in program	0	0	0	0	0	0	0	0	0	0	0	0
Condition stable with no further Case Management needs	5	4	2	2	2	1	1	1	0	0	0	1
Condition stable with no further Disease Management needs	0	0	0	0	1	0	0	0	0	0	0	0
Deceased	0	0	0	0	0	0	0	0	0	0	1	0
Duplicate member record	0	1	0	0	0	0	0	0	0	0	0	0
Escalate services to higher level program	0	0	0	0	2	0	0	0	0	0	0	1
Inappropriately identified for program	0	0	1	0	0	0	0	0	0	0	1	1
Member declines continued Case Management services	0	0	2	0	0	0	0	0	0	0	0	0
Member declines continued Disease Management services	0	0	0	0	0	0	0	0	0	0	0	0
Member non-compliant	0	0	0	0	0	0	0	0	0	0	0	0
Member transferred to Delegate/Other	0	0	0	0	0	0	0	0	0	0	0	0
Member/Caregiver refuses services	0	1	1	0	0	0	0	0	0	0	0	0
Other	1	2	7	3	0	0	0	0	0	0	0	5
Readmission	0	0	0	0	0	0	0	0	0	0	0	2
NULL	0	0	0	0	0	0	0	0	0	0	0	0
Referred to Disease Management	0	0	0	0	0	0	0	0	0	0	0	0
Step down to lower level program	1	0	0	0	0	0	0	0	0	0	0	0
Termination of coverage	0	0	0	0	0	0	1	0	0	0	0	0
TruCare cleanup	0	0	0	0	0	0	0	0	0	0	0	0
Unable to contact member	11	5	6	5	3	1	1	0	0	1	0	18
Already in Program	0	0	0	0	0	0	0	0	0	0	0	0
Declined Program	1	1	1	0	0	0	0	0	0	0	0	2
Completed Program	1	0	0	0	0	0	0	0	0	0	0	3
Lost Contact	0	0	2	1	0	0	0	0	0	0	0	1
Member Ineligible	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	20	14	22	11	8	2	3	1	0	1	2	34

As noted in Figure 18, the top three (3) reasons for Case Closure in 2019: 1) Unable to Contact Member (18), 2) Other, (5) and 3) Completed Program, (3) .

Continuity of Care

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

The CM program is also responsible for assisting members who have exhausted a benefit or who are aging out of a benefit, i.e. California Children Services. The

CM Department coordinates these services through the care coordination referral process and identifies members who are aging out of CCS eligibility in order to ensure that they transition to appropriate providers. In 2020, further refinement of the Continuity of Care and CCS Transitions report process will be needed.

LONG TERM SERVICES AND SUPPORTS (LTSS)

The Alliance is responsible for ensuring Members who are eligible to receive LTSS services are identified and referred. In 2019, The CM Department worked in collaboration with the UM Department to ensure members were identified for Community Based Adult Services (CBAS), referred and assessed appropriately and timely. In 2019 the CM Department transitioned the responsibility for assessment, initial referral, re-assessments and re-authorizations of services over to the UM Department.

INTEGRATION OF MEDICAL AND BEHAVIORAL HEALTH

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

In 2019, the teams worked on efforts crossing the medical and behavioral health services which included:

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

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

HEALTH HOMES PROGRAM:

One of the Alliance's three year strategies is to 'Build internal capacity to better coordinate care for members with complex medical, behavioral, autism or

social service needs; assist navigation across systems of care; and address social determinants of health in primary care.' As part of this strategy, the Alliance opted to fund and create a Pre- Health Homes pilot program in 2017, modeled after the anticipated state Health Home Program. This decision was felt to help position the Alliance to fully realize the California HHP benefit prior to its initiation in Alameda County in July 2019.

Over the course of 2019 the Alliance created a network of community based care management entities (CB-CME's) through contracting agreements, developed and disseminated a model of care based on the projected state Health Homes program, and initiated a monthly learning collaborative in partnership with Alameda County's Whole Person Care program. By December 2019, approximately 1408 members were enrolled in the Health Homes Program across 17 multiple network CB-CME's.

The state funded Health Homes Program started in July of 2019 in Alameda County. The Alliance employed a network of community based care management entities (CB_CME's) to integrate primary, acute, and behavioral health care services (beginning in January 2020) as well as community based needs (ex. housing) for the highest risk Medi-Cal enrollees. The HHP includes six core services, delivered through the managed care system: 1) Comprehensive care management; 2) Care coordination; 3) Health promotion; 4) Comprehensive transitional care; 5) Individual and family support; 6) Referral to community and social support services.

The primary program goal is to achieve improved health outcomes for eligible members by providing them additional supportive ("wrap around") care via the plan's network of CB-CME organizations. In 2020 Alameda Alliance will simultaneously help build and oversee the capacity of CB-CME's to address the needs of the population and orchestrate reporting of encounter data and program results.

Health Homes Patient Characteristics (enrollment criteria)

Eligibility Requirement	Criteria Details

1. Chronic condition criteria (*Must meet at least one of the above to be enrolled.)	· **At least two of the following**: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic renal (kidney) disease, dementia, substance use disorders; OR · **Hypertension and one of the following:** chronic obstructive pulmonary disease, diabetes, coronary artery disease, chronic or congestive heart failure; OR · **One of the following:** major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia); OR · **Asthma**
2. Acuity/Complexity criteria (*Must meet at least one of the above to be enrolled.)	· Has at least 3 or more of the HHP eligible chronic conditions; OR · At least one inpatient hospital stay in the last year; OR · Three or more emergency department visits in the last year; OR · Chronic homelessness.

Staff were identified or hired into the program in 2019, including a Clinical Program Manager, a Physician Champion, a Health Navigator and a Housing Navigator.

Program Outcomes: As of 12/31/19, the program has served 1408 members at the 17 CB-CME sites in Alameda County:

CB-CME Site	Members Served in HHP in 2019
AHS Eastmont	34
AHS Highland	32
AHS Hayward	38
California Cardiovascular Consultants	156
CHCN Asian Health Services	110

CHCN Axis Community Center	46
CHCN La Clinica De La Raza	80
CHCN LifeLong Medical Care	232
CHCN Native America Health Center	58
CHCN Tiburcio Vasquez Health Center	122
CHCN TriCity Health Center	150
CHCN West Oakland Health Council	34
EBI	32
Family Bridges	38
Roots	72
Roots STOMP	152
Watson Wellness	22
Total Members Served	**1408**

Next Steps in 2020

Launch SMI Health Homes Program

Apply for AAH Health Homes CB-CME status

Develop, train, and maintain AAH CB-CME workflows

Identify and contract with new CB-CMEs including SMI providers to expand network capacity

Certify new CB-CMEs as appropriate members of our Health Homes network.

Coordination with Regulatory Compliance

The Alliance CM Department works closely with the Compliance Department in preparation for regulatory audits. In 2019, the department participated in two follow up regulatory audits. The final report identified the following key findings:

- The Plan did not follow the specified timeframes required for completion of the HRAs for newly enrolled SPD members. The Plan did not ensure that HRAs were completed within 45 calendar days of enrollment for those identified by the risk stratification mechanism as higher risk and within 105 calendar days of enrollment for those identified as lower risk.
    - As a result HRA tracking had been implemented in early 2019, and continues at present. HRAs are sent out within the required timeframes. IVR calls are made to low risk members to encourage them to complete and send in the HRA within the timeframe. Direct calls are made by CM staff on high risk members to encourage them to complete and send in the HRA within the timeframe. A tracking log is kept to ensure that the required timelines are met.

- The plan received a repeat find in 2019 for monitoring CCM cases and presenting the cases to an Interdisciplinary Team if the CCM case remains open ≥ 90 days.
    - As a result CM staff were provided additional training to assist with resolving this issue. As 2019 came to a close, further refinement was warranted creating and implementing a CCM Log to track cases, in order to demonstrate better outcomes in 2020.

The interventions include processes for ongoing monitoring to mitigate further regulatory deficiencies.

Recommended Interventions/Next Steps for 2020:

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

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

Conclusion

Overall, the 2019 CM Program continued to develop into an effective program maintaining compliance with regulatory and contractual requirements, monitoring of performance within the established benchmarks or goals, identifying opportunities for improvement and enhancing processes and outcomes. The CM program activities have met the established targets. The Alliance leadership has played an active role in the CM Program structure by participating in various committee meetings, providing input and assistance in resolving barriers and developing effective approaches to achieve improvements. To ensure that AAH used a comprehensive approach to the CM program structure, practicing physicians provided input through the UM Committee and subcommittees.

CM Program Recommendations for 2020

As a result of internal performance monitoring performed in 2019, opportunities for improvement were identified and will be incorporated into the 2020

department goals. Highlights of opportunities for improvement based on the regulatory findings include:

- Redesign the CM program to focus on key CM activities, monitoring through the UM Committee and HCQC.
- Revise the CM staffing model to address operational needs.
- Ensure information systems are accurately reflective of reporting needs for compliance monitoring and oversight both internal and external.
- Identify appropriate performance measures and goals for CM, and develop monitoring reports of performance toward the measures. This includes developing CM related activities to address improvement with the measures.
- Maintain the California Health Homes Program with community-based collaborations.
- Launch SMI Health Homes Program
- Apply for AAH Health Homes Internal CB-CME status
- Develop educational program for PCPs and Network Provider Groups on identification of members in need of CM/CCM, referral processes and engagement with CM team on management of ICPs and IDTs.
- Enhance reporting and analysis of CM activities focused on member experience with CM.
- Develop process for implementing activities addressing improved member experience with CM, including analysis of a member survey and member complaints.
- In collaboration with the Compliance Department, develop a department program focused on monitoring internal compliance and quality review of CM department operations.
- Collaborate with MS to obtain HRA data and information on program activities.
- Revise the continuity of care program to accurately reflect CM involvement and activities, including regulatory reporting and CCS age out program.
- Continue to enhance the Palliative Care Program
- Enhance delegation oversight activities for CM, Care Coordination, CCM, and TOC.
- Collaborate with Health Care Analytics on identifying enhancements to the predictive model algorithm to improve the identification of appropriate members for CCM.
- Continue internal auditing of cases for Care Coordination, CCM and TOC.

ALAMEDA Alliance FOR HEALTH

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

2020

CASE MANAGEMENT
&
CARE COORDINATION,

COMPLEX CASE MANAGEMENT
&
DISEASE MANAGEMENT PROGRAM

DESCRIPTION

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

2020

2020 Case Management/Care Coordination & Disease Management Program Description

Signature Page

Date _____

Julie Anne Miller, LCSW
Director, Health Care Services

Date _____

Sanjay Bhatt, M.D.
Director, Quality Improvement

Date _____

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

Date _____

Scott Coffin
Chief Executive Officer

Date _____

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

Table of Contents

Summary of Changes from 2019 Program Description

- Title changes
  - Clinical Manager of HH
- Adding in more information on integration of SW
- Optimization of TruCare
- Refined TOC process
- Formal HHP program
  - Plan to expand SMI network
  - Plan to develop internal CB-CME
- Addition of Improvement Opportunities
- Grammatical, formatting changes

I. Background

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

The Alliance provides health care coverage to over 270,000 children and adults through the Medi-Cal and Group Care programs. Alliance Members choose from a network of over 1,700 doctors, 15 hospitals, 29 community health centers, and more than 200 pharmacies throughout Alameda County. Through active partnerships with healthcare providers and community partnerships, Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan Members.

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

Comprehensive case management is one such Alliance service offering that assists Members and providers in aligning effective healthcare services and appropriate community resources. The activities of the comprehensive case management program support Alliance Members and providers to attain the highest level of functioning available to the Member in relation to their overall health condition. The Alliance oversees and maintains the following case management services in the comprehensive case management program:

- Health Risk Assessments
- Basic Case Management
- Care Coordination/Service Coordination
- Complex Care Management
- Transitions of Care
- Specialty Programs
- Continuity of Care

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

II. Purpose and Scope

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

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

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

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

III. Goals and Objectives

A. Goals

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

- To maximize the quality of life and promote a regular source of care for patients with chronic conditions
- Improve Member engagement as active participants in the care process
- Support the foundational role of the primary care physician and care team to achieve high-quality accessible, efficient health care
- Coordinate with community services to promote and provide Member access to available resources in the Alliance service area.
- Provide support, education and advocacy to Members in collaborative communications and interactions.
- Engage the provider community as collaborative partners in the delivery of effective healthcare.
- Develop and implement a program that meets all regulatory compliance and NCQA accreditation standards.

B. Objectives

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

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

IV. Program Oversight and Staff Responsibility

A. Health Care Quality Committee (HCQC)

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

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

The HCQC functional responsibilities for the CM Program include:

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

- Recommend necessary actions.

B. The Utilization Management Committee

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

UM Committee Structure

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

Authority and Responsibility

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

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

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

UM Committee Membership

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

- The Alliance Chief Analytics Officer
- The Alliance Medical Directors, UM
- The Alliance Medical Director, CM
- The Alliance Medical Director, Quality Improvement
- The Alliance Senior Director, Quality Improvement
- The Alliance Senior Director, Pharmacy & Formulary
- The Alliance Director, Health Care Services
- The Alliance Director, Compliance
- The Alliance Director, Member Services
- The Alliance Director of Provider Relations and Provider Contracting

- The Alliance Director, Quality Assurance
- The Alliance Manager, Healthcare Analytics
- The Alliance Managers, Case Management
- The Alliance Managers, Utilization Management
- The Alliance Manager, Grievance & Appeals

UMC Voting Privileges

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

UMC Quorum

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

UMC Meetings

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

UMC Minutes

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

UM Committee Functions

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

- Improve quality of care for the Alliance Members
- Evaluate and trend enrollment data for medical and behavioral health services provided to Alliance Members and benchmarks for care management program utilization.
- Provide a feedback mechanism to drive quality improvement efforts.
- Increase cross functional collaboration and provide accountability across all departments in Medical Services.
- Provide mechanism for oversight of delegated CM functions, including review and trend CM reports for delegated entities to identify improvement opportunities

UM Committee responsibilities are to:

- Maintain the annual review and approval of the CM Program & Evaluations, CM Policies/Procedures, CM Criteria, and other pertinent UM documents such as the CM

Delegation Oversight Plan.

- Participate in the utilization management/ continuing care programs aligned with the Program's quality agenda.
- Review and analysis of utilization data for the identification of trends
- Assist in monitoring performance of CM activities and recommend appropriate actions when indicated.
- Review and provide input into the annual CM effectiveness reports, i.e. Experience with the CM experience, Annual Performance Evaluations.

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

VII. Staff Resources

The Case Management and Disease Management Department in the Alliance is responsible for comprehensive case management program and activities. A department of multi-disciplinary staff administers the comprehensive case management program. (The organizational chart in Appendix A displays the reporting relationships for key staff responsible for comprehensive case management activities at the Alliance.)

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

VII. Chief Medical Officer

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

VII. Medical Director

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

VII. Director, Health Care Services

The Director of Clinical Services, a licensed clinician, provides operational leadership to the Case and Disease Management programs and staff. The Director provides guidance to the program design with a focus on analytics, operations, and regulatory adherence. The Director also ensures the collaboration of the program with other internal and external stakeholders. The Director provides leadership for case management accreditation and regulatory activities. The Director works with the Manager to carry out program goals.

4. Manager, Case Management and Disease Management

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

5. Clinical Manager of Health Homes

The Clinical Manager of Health Homes is responsible the provision of daily oversight of components of the case management program, including programs between the Alliance and contracted Community Based Care Management Entities (CB-CMEs) for the Health Home Pilot and Alameda County's Whole Person Care initiative. Under the supervision of the Director of Health Care Services, the scope of responsibilities of the Clinical Manager of Health Homes includes supervision and management of department staff; development of the operational plan; allocation and management of program resources; and accountability for the quality of care and services. The Manager reviews and evaluates the performance of the comprehensive case management program activities and presents regular reports to the UMC and HCQC.

6. Case Manager

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

7. Social Worker

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

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

Under general supervision from the Manager, Case Management, the Medical Social Worker is responsible to meet the day-to-day care coordination needs between the Alliance and contracted Community Based Care Management Entities (CB-CMEs) for the Health Home Pilot and Alameda County's Whole Person Care initiative. The Medical Social Worker is also responsible for coordinating medical, social and or behavioral health care needs with Alliance contracted providers for Members.

8. Health Navigator

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

9. Health Risk Assessment Coordinator

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

V. Population and Member Needs Assessment

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

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

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

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

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

VI. Case Management Clinical Systems

VII. Clinical Information Systems

Delivery and documentation of case management services directly provided by Alliance staff is accomplished through a clinical information system. Alliance uses a Member-centric application that automates the entire clinical, administrative, and technical components of case management into a single platform. The system supports case management with the use of algorithmic clinical intelligence and best practices to guide Case Managers through assessments, development of care plans, and ongoing management of Members. The system includes assessment templates to drive consistency in the program. Care plans are generated within the system and are individualized for each Member and include

short and long-term goals, interventions and barriers to goals. The clinical information system includes automated features that provide accurate documentation for each entry; records actions or interactions with Members, care givers and providers; and automatic date, time and user stamps. To facilitate care planning and management, the clinical information system includes features to set prompts and reminders for next steps or follow-up contact.

VII. Clinical Decision Support Tools

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

VII. Care Coordination and Case Management Services

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

- **Health Risk Assessments** clinical processes are managed by the Alliance Care Management Department including High Risk HRAs and Care Planning, as well as Low Risk care plan development, with communication to Member and Provider.
- **Basic Case Management f**or Low Risk level is provided by the Primary Care Physicians and their staff with a Network Provider Group's Care Management support. In the case of Direct Network Providers, the Alliance Case Management program provides Basic Case Management services.
- **Care Coordination/Service Coordination f**or Moderate Risk level is provided at the Provider Group level or The Alliance, supporting the PCP.
- **Specialty Programs** such as Transition of Care, Continuity of Care. Transitions of Care is provided by The Alliance Care Management staff for Members with a recent hospitalization. The level of management necessary is dependent upon the degree and complexity of illness or conditions to regain optimal health or improved functionality.
- **Complex Care Management** is provided by The Alliance Care Management staff for Members with conditions where the degree and complexity of illness or conditions is typically severe, the level of management necessary is typically intensive and the amount of resources required for Member to regain optimal health or improved functionality is typically extensive**.**

- **Health Homes/Alameda County Care Connect (AC3)** – Whole Person Care

In collaboration with Alameda County's Health Care Services Agency (the lead agency for the county's Whole Person Care Pilot – Alameda County Care Connect or AC3), the Alliance has developed and oversees a network of community-based care management teams providing in-person comprehensive multidisciplinary care coordination and care management for the Health Homes and AC3 target populations. The same network of teams also provides care for Members identified by the Alliance as high risk/high cost and/or meeting the Health Homes benefit criteria as defined by DHCS.

A. Health Risk Assessment

To ensure that the appropriate level and quality of care is delivered to newly enrolled, non-dual Seniors and Persons with Disabilities (SPD), the Alliance makes every effort to identify each Member's individual medical and resource needs. On July 11, 2017, Department of Health Care Services issued a new MMCD All Plan Letter for Requirements for Health Risk Assessments of MediCal Seniors and Persons with Disabilities. This revised MMCD APL supersedes the existing notification and clarifies the Plan's responsibilities for the early identification of Members who need early intervention and care planning to prevent adverse outcomes. The new guidance also requires development of a process for utilizing the standardized LTSS referral questions to identify and ensure the proper referral of Members who may qualify for and benefit from LTSS services. These questions are intended to assist in identifying Members who may qualify for and benefit from LTSS services. These questions are for referral purposes only and are not meant to be used in classifying high and low risk Members.

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

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

- 45 days of enrollment identified as High Risk
- 105 days of enrollment as Low Risk.

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

High Risk Members are referred to Complex Case Management team for completion of the HRA, review of the HIF/MET when available, development of a care plan and completion of care coordination. For Members initially identified as Low Risk, a vendor performs the initial outreach to complete the HRA. Vendors submit the outreach report to AAH every month including those HRAs who have scored as Low

Risk either by HRA scoring or are initially scored as Low Risk but are Unable to Contact (UTC) and complete the HRA. The responses from the HRA may result in the Members reclassification of Members as higher or lower risk. (For some Members, this re-classification based on the HRA may be different from their earlier classification based on the stratification tool. Members re-classified/scored as High Risk are routed to the CCM team for review and processing. A full description of the MS procedures for HRA is found in MS policies and procedures. The 2018 HRA and LTSS Questionnaire can be found in Appendix F and G.

CM staff is responsible for ensuring the Member Care Plan is completed and shared as well as providing any community or health resources. For Members who completed the HRA and the final stratification is Low Risk, a CM staff will review the HRA responses to identify Member needs, i.e. resources for transportation, IHSS, food banks. The CM staff will generate the Care Plan, attach the resources and prepare for mailing. If the Member remains UTC, CM staff will create a standardized care plan based on the needs identified for the initial data used to stratify the Member. The Alliance has chosen to generate the standardized high-risk care plan because this care plan includes additional health education resources as well as health education materials. All copies of the care plans are mailed to the Member and Primary Care Provider as well as to the Provider Group for potential care coordination needs. A HRA letter and resources are sent to the Member; a copy of the Care Plan is sent to the Primary Care Provider for care coordination.

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

B. Case Management

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

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

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

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

assessment with the other team Members to ensure the team is knowledgeable on care needs and understands their role in the care plan. The teams are directed by defined workflows between the team Members. Communication is key to the effectiveness of the program. The team meets daily to discuss the needs and expectations for the day.

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

Care teams also serve as sources to identify and refer Members to the CBCME programs. A full description of the program and The Alliance involvement with County Care Connect Programs is found in Section: VII.

1. Basic Case Management Services

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

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

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

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

2. Initial Health Assessment and Behavioral Risk Assessment

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

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

C. Care Navigation (Case Management/Care Coordination)

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

1. Case Management/Care Coordination

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

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

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

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

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

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

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

2. Targeted Case Management Services

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

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

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

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

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

are referred to community partners such as Regional Center of the East Bay for the provision of TCM services.

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

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

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

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

D. Special Programs

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

- Transitions of Care
- Care Coordination for Members receiving continuity of care (CoC) with non-contracted providers
- CCS Age Out Programs

1. Transitions of Care

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

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

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

- Enrollment
- Evaluation of post-discharge needs in association with TOC bundle
- All care coordination activities – including facilitating communication, referrals, treatment/service authorizations, etc.
- Maintenance of comprehensive, written records based upon evaluation.
- Clear documentation of service delivery, provider communications, Member interactions, etc.
- Periodic review of cases
- Case closure and evaluation as appropriate

2.Continuity of Care with Out-of-Network Providers

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

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

The Alliance's UM Department is responsible for the initial care determinations related to CoC situations. Once the CoC is approved, the Member is referred to Case Management for the identification of any care needs. One month prior to the termination of the CoC arrangement, CM staff contact the Member and treating Provider to ensure communication of the transition to all parties and identify any ongoing care needs. CM staff will also obtain any necessary information to share with the assigned PCP/Provider Group on the ongoing care coordination needs. Case Management staff are responsible for ensuring care is continued with out of network providers. The CM staff ensure the coordination of services with the Primary Care Providers and Specialists. A full description of the various CoC programs in found in the relevant UM Policies.

2. California Children Services/Age-Out Program

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

- Who have a chronic, disabling, or life-threatening CCS eligible medical condition
- Who need specialty medical care
- Who meet income requirements (See Eligibility, below)
- Age birth to 21

Referred children are screened for eligibility criteria and referred to a specialized contracted CCS provider. As the program is limited to providing services to children under the age of 21 years, The Alliance has developed a program to identify and provide care coordination of services for children on CCS who are nearing 21 years of age and aging out of pediatric health care services. As CCS children age out of the system, staff will assist with the transitions to appropriate adult specialists in a collaborative manner in order to protect the individual and ensure age appropriate care is provided.

In 2019, the CCS age out program transitioned to UM, andthe Case Managers assist with case management as needed.

E. Complex Case Management

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

- Case Management services
- Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team.
- Intense coordination of resources to ensure Member regains optimal health or improved functionality.

With Member and PCP input, development of care plans specific to individual needs and updating at least annually.

VIII. Case Management Program Description

A. Case Management

1. Identifying Members for Case Management

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

Data Sources

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

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

Referral Sources

Individual Members may be referred by:

- Medical Management/Internal referrals, e.g. UM, Disease Management, Health Information Line, Member Services, Appeals and Grievance, Leadership
- Direct referrals from Discharge Planners
- Self-referrals, e.g. Members, Caregivers
    - Instructions for self-referral and the phone number are provided in the Member handbook and on the Alliance website. In addition, Member Services and Health Navigators explain the process for self-referral when appropriate.

- Practitioners/provider network referrals, e.g. PCPs, Specialists, Medical Group Medical Directors
    - Instructions for referral and the phone number are documented in the provider manual and notified through Provider update communications.

- Predictive modeling, e.g. Care Analyzer

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

2. Case Management Process

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

A. Intake

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

B. Identification of Care Needs

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

C. Communication with Member

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

A. Coordination of Services

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

B. Monitoring of PCP Services

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

C. Identification of Barriers to Care

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

D. Case Closure

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

- Goals met
- Interventions not successful/All resources exhausted
- Loss of eligibility
- Unable to establish or maintain contact with Member
- Member transferred to another setting and no longer require CCM
- Client refuses necessary psychosocial services and/or medical services
- Member declines CM
- Death of the Member
- Member not compliant with plan of care
- Determination by the Case Manager that he/she is no longer able to perform or provide appropriate case management services

B. Targeted Case Management

1. Identifying Members for Targeted Case Management

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

2. Targeted Case Management Process

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

A. Referral

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

B. Documented Assessment

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

C. Development of Comprehensive Service Plan

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

plan. The Regional Center or a local government health program periodically reviews with the Member progress toward achieving goals identified in the service plan.

D. Coordination of Services

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

E. Crisis Assistance

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

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

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

G. Identification of Barriers to Care

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

H. Case Closure

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

- Goals met
- Interventions not successful/All resources exhausted
- Loss of eligibility
- Unable to establish or maintain contact with Member
- Member transferred to another setting and no longer require CCM
- Client refuses necessary psychosocial services and/or medical services
- Member declines CM
- Death of the Member
- Member not compliant with plan of care

- Determination by the Case Manager that he/she is no longer able to perform or provide appropriate case management services

IX. Complex Case Management Program Description

A. Identifying Members for Complex Case Management

1. Criteria

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

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

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

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

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

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

2. Data Sources

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

- Claim and pharmacy data (CDPS and MRx) from the data warehouse and analyzed by the Health Care Analysts. Members are identified monthly from this data source
- Hospital discharge report generated by UM staff
- Data from Admission, Transfer, Discharge (ADT) report, generated by various community hospitals
- UM data from preauthorization and concurrent review
- Data from purchasers (Medi-Cal and Commercial)
- Information provided to Alliance from Members, caregivers and community based programs that support the Member
- Data from Member Health Risk Assessment
- Data from practitioners (Referral and Medical Records)

3. Referrals to Complex Case Management

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

A. Health Information Line referral

Alliance has mechanisms in place to gather information from the phone-based health information line to identify Members who are eligible for complex case management. UM staff receive daily activity reports from the health information line vendor and they refer Members for CM services if appropriate.

b. DM program referral

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

c. Hospital discharge planner referrals

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

d. UM referral

The Utilization Management program identifies Members in need of case management at admission, discharge and concurrent review.

e. Member, caregiver and practitioner referrals

The Member Services Department receives calls from Members, caregivers and practitioners and refers them to case management based on either a request by the caller or if the nature of the call indicates that the Member would benefit from the service. At least annually, Members and Providers are informed about their ability to make referrals in the Provider and Member newsletters.

f. Community-based referrals

The CM department may receive referrals for case management from community organizations/partners such as the Nurse Advice line contractor or CCS.

g. Behavioral health referrals

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

4. Date of Eligibility for Complex Case Management

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

B. Complex Case Management Process

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

1. Referral & Screening

When a Member is identified, as described in Section IX.A ("Identifying Members for Complex Case Management") or a referral is received for case management, the CM staff enters the referral into the care management system and verifies Member health plan enrollment and eligibility. After health plan eligibility is confirmed the staff submits the referral. The Case Manager then screens and determines program eligibility in complex case management or other appropriate programs by performing the initial screening assessment with the oversight of the Associate Medical Director. If the Member does not meet criteria for complex case management, the Member may be referred to the other Alliance program for coordination of care, assistance in managing risk-factors, referral to community services or assistance in identifying a primary care practitioner. Appendix C & D contain the 2020 Case Management Criteria and Screening Checklist to assist clinical teams in consistency in assessment for CCM services.

2. Assessment of Health Status

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

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

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

3. Documentation of Clinical History Including Medications

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

4. Assessment of Activities of Daily Living

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

5. Assessment of Behavioral Health Status Including Cognitive Functions

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

6. Assessment of Social Determinants of Health

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

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

7. Assessment of Life-planning Activities

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

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

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

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

To ensure an appropriate care plan and healthcare needs are effectively met, Member visual and hearing needs, preferences or limitations are assessed by the Case Manager or Social Worker during the General Assessment. In the event Case Managers or Social Workers identify impairment, details such as use of hearing aids and eyeglasses, or any future known surgery will be provided to assist in the development of care planning.

10. Evaluation of Caregiver Resources and Involvement

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

11. Evaluation of Health Plan Benefits and Community Resources

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

12. Development of Individualized Person-Centered Case Management Plan

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

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

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

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

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

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

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

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

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

The Care Plan includes follow-up to reduce or eliminate barriers for obtaining needed health care services. The case management process facilitates linkages between Members and community organizations to enhance access to community resources and ensure Members can utilize these resources. Case Management staff coordinate access to community services, monitor service delivery, advocate for

Member needs, and evaluate service outcomes. A directory of community resources is available to Case Managers and Social Workers as they work with Members, caregivers, and providers. Case Management and Disease Management department staff regularly compile and document resources available in Alameda County and update the directory when necessary.

15. Development of Schedule for Follow-up and Communication

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

16. Development and Communication of Member Self-Management Plan

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

17. Process to Assess Progress

The Case Manager or Social Worker continuously monitors and reassesses the Member's condition, responses to case management interventions, and access to appropriate care. The case management plan includes an assessment of the Member progress toward overcoming barriers to care and meeting treatment goals. The complex case management process includes reassessing and adjusting the care plan and its goals, as needed.

18. Case Closure

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

- Goals met
- Interventions not successful/All resources exhausted
- Loss of eligibility
- Unable to establish or maintain contact with Member
- Member transferred to another setting and no longer require CCM
- Client refuses necessary psychosocial services and/or medical services
- Member declines CM
- Death of the Member
- Member not compliant with plan of care
- Determination by the Case Manager or Social Worker that he/she is no longer able to perform or provide appropriate case management services

19 Patient Safety

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

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

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

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

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

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

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

21. Initial Assessment

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

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

22. Individualized Care Plan

Following the initial assessment, the Case Manager and/or Social Worker develops an Individualized Care Plan (ICP), consisting of goals and interventions. The Case Management staff incorporate information from the initial assessment, as well as other assessments such as Health Risk Assessments, Pharmacy profile, specialized assessments, such as PHQ-9 or PH-Q2, that may be included in the Initial Assessment, HRA and Health Information Form/Member Evaluation Tool.

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

- Maintaining a prescribed diet.
- Charting daily readings (e.g., weight, blood sugar).
- Changing a wound dressing as directed.

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

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

Case Managers establish care plan goals with the following characteristics:

- Goals are relevant to the Member's condition with identified goals driving optimally coordinated care.
- Goals take into consideration the Member's or primary caregiver's goals and preferences, and desired level of involvement. These goals must be:
    - **Specific** - usually defining a maximum of four behaviors or measurable outcomes
    - **Measurable** - so that it is easily understood when the goal is achieved
    - **Achievable** - it does no good for the patient or for the manager to set unrealistic or unachievable goals. This is an invitation to frustration and disappointment for all involved parties.
    - **Relevant** - are the chosen goals the ones for which the greatest value can be achieved for the time, resources, energy expended?
    - **Time-dimensioned** - Is there a realistic timeframe in which the goal can be achieved?

- Goals are prioritized. A complex case may have many goals toward regaining optimal health or improved function, therefore each goal is prioritized against other goals for dependencies. The Alliance designates goals on a scale of 1 to 10. 1 = High, 10 = Low..
- Goals have specific time frames for re-evaluation. Members with complex health concerns require ongoing assessment and management. When establishing a goal, the Case Management staff sets a specific date for follow-up on progress toward that goal. Upon re-evaluation the goal may be on track, may require revision, or may no longer be appropriate due to changes in condition or circumstance. When a goal is retained as is or revised the Case Management staff establishes a next follow-up date in the case management system.
- Goals have identified resources to be utilized, including the appropriate level of care when applicable.
- Goals include documentation of any collaborative approaches to be used, including family participation, to achieve the goal.
- Goals have an assessment of barriers. Barriers may be assessed at the individual goal level (such as limited transportation to physical therapist) or at the case level (such as Member is in denial about prognosis).

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

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

23. Ongoing Management

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

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

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

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

24. Case Management Integration

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

25. Inter-Disciplinary Care Teams

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

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

X. Community Based Integration

The Alliance has collaborated with Alameda County Health Care Services Agency's Care Connect to implement the Health Home and Whole Person Care program. The purpose of the program is to build community infrastructure to improve integration, reduce unnecessary utilization of health services and improve health outcomes. The Whole Person Care infrastructure includes a community health record, human infrastructure and housing navigation and supports. The goal of the collaboration is to ensure targeted Members and providers can access intensive, community-based care management services by Community Based Care Management Entities (CB-CME's) from anywhere in the care continuum,

providing the “right care-right place-right time”. The program outcomes focus of providing services that will:

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

The program activities focus on transitioning from a fragmented and silo'ed approach provided by various health delivery systems, county/community programs and heath plans to an integrated county-wide program focused on accessible shared health information, effective linkages to county resources, standardized approach to allocation of limited housing resources and access to high quality community case management services. The AC3 target population for Care Management includes:

- Literally homeless (HUD definition)
- High Utilizers of multiple crisis systems

The target population for the Health Homes program is based on the DHCS definition of eligibility (a combination of complex chronic illnesses, health care utilization, and other high risk factors like homelessness and mental illness)(see Appendix I California Health Homes Service Model)

The Alliance has dedicated clinical and non-clinical staff to participate in the planning and development of The Alliance activities for Health Homes and AC3. The Alliance is also committed to piloting a plan-based CB-CME with activities aligning to the HH/WPC programs in 2020. Staff works at developing mechanisms to identify Members and provide services to meet the overall goals. The processes are defined in CM Policies and Procedures.

XI. Disease Management

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

- Pediatric Asthma – Serves Members who are 5 to 11 years old and identified with asthma based on clinical, pharmacy, and utilization data or direct referral.

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

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

XII. Case Management Monitoring and Oversight

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

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

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

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

XIII. Program Effectiveness

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

A. Complex Case Management Performance Measurement

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

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

Measure One - Member Satisfaction Rates

2. Improve Member outcomes

Measure Two - All-Cause Admission Rate

Measure Three – Emergency Room Visit Rate

3. Achieve optimal Member functioning

Measure Four – Health Status Rate

4. Use of Appropriate Health Care Services

Measure Five – Use of Services (Primary Care)

A full description of the measures, goals, methodology and sources is available in Appendix E – 2020 Performance Measures

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

1. Identifies a relevant process or outcome

2. Uses valid methods that provide quantitative results

3. Sets a performance goal

4. Clearly identifies measure specifications

5. Analyzes results

6. Identifies opportunities for improvement, if applicable

7. Develops a plan for intervention and re-measurement

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

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

B. Experience with Case Management

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

XIV. Annual Complex Case Management Program Evaluation

The Chief Medical Officer and the Director or Manager of Case and Disease Management collaboratively conduct an annual evaluation of the Alliance complex case management program. This includes an analysis of performance measures, an evaluation of Member satisfaction, a review of policies and program description, analysis of population characteristics and an evaluation of the resources to meet the needs of the population. The results of the annual program evaluation are reported to the UMC and HCQC for review and feedback. The UMC and HCQC make recommendations for corrective action interventions to improve program performance, as appropriate. The Director of Health Care Services is responsible for implementing the interventions under the oversight of the Chief Medical Officer.

XV. Delegation of Case Management Activities

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

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

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

(CFMG)	Medical Group	No	X	No	No
Beacon/College Health IPA (CHIPA)	MBHO	No	X	X	No

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

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

When a Provider Group is identified as interested in performing a delegated function, the CM team performs a pre-delegation review to ensure the entities is able to perform the functions in compliance with the regulatory and accreditation standards. When delegation occurs, the CM team works with Provider Relations to create an appropriate delegation agreement which requires the delegated entity to comply with the regulatory and accreditation requirements to evidence. The oversight of a delegated activity includes regular reporting of CM services provided to Alliance Members. (e.g., monthly, quarterly, semi-annually or annually).

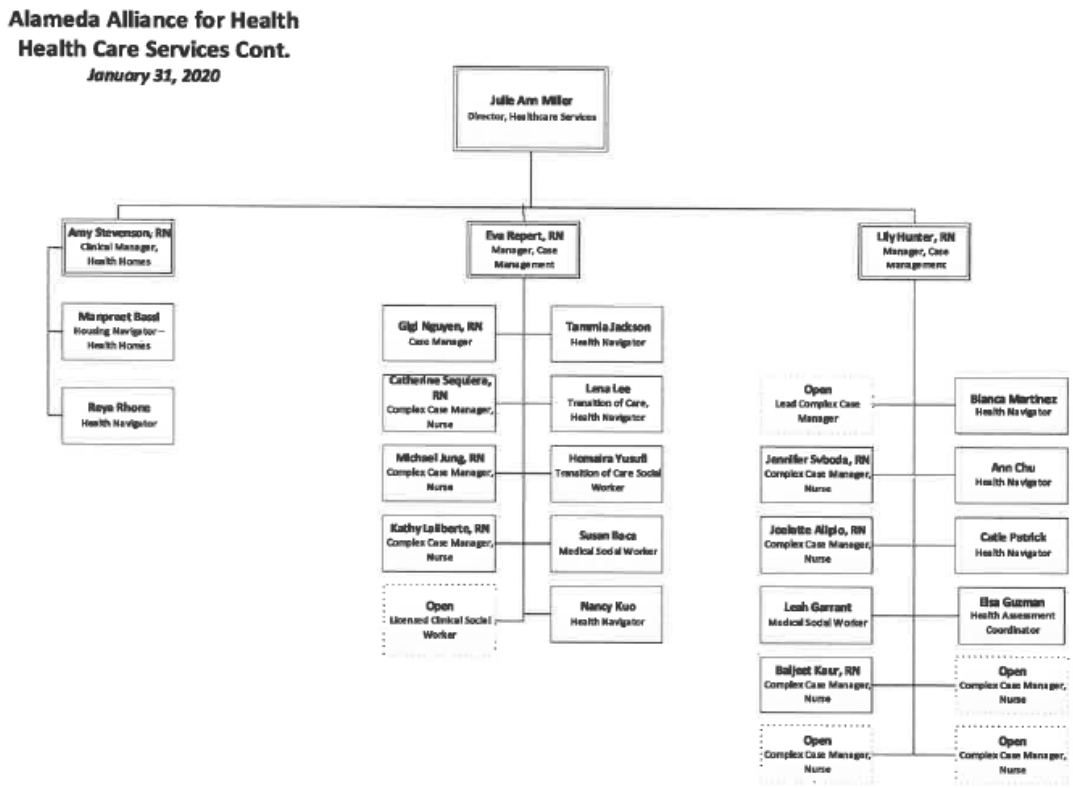
The Alliance's CM Management Team is responsible for the oversight of delegated activities and will participate in the annual performance review. Results of the annual evaluation and any audit results are reviewed by the Compliance and Delegation Oversight Committee.

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

2020 Improvement Opportunities Summary:

- Redesign the CM program to focus on key CM activities, monitoring through the UM Committee and HCQC.
- Ensure information systems reflect reporting needs for compliance monitoring and oversight, both internal and external.
- Identify appropriate performance measures and goals for CM, and develop monitoring reports for the measures.
- Maintain the Health Homes Program with community-based collaborations.
- Launch SMI Health Homes Program
- Apply for AAH Health Homes Internal CB-CME status
- Develop educational program for PCPs and Network Provider Groups

- Enhance reporting and analysis of CM activities focused on member experience with CM.
- Collaborate with MS to obtain HRA data and information on program activities.
- Continue to enhance the Palliative Care Program
- Enhance delegation oversight activities for CM, Care Coordination, CCM, and TOC.
- Collaborate with Health Care Analytics on identifying enhancements to the predictive model algorithm to improve the identification of appropriate members for CCM.



APPENDIX B: Clinical Care Guidelines

TruCare 4.7 Disease Specific Content References

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Cancer

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Preventive Health Guidelines

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

- **Asymptomatic Healthy Adults**

For Asymptomatic Healthy Adults, the Alliance follows the current edition of the Guide to Clinical Preventive Services of the U.S. Preventive Services of the U.S. Preventive Services Task Force

(USPSTF), specifically USPSTF Grade “A” and “B” recommendations for providing preventive screening, testing and counseling services.

https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

- **Members Under 21 Years of Age**

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

- **Perinatal Services**

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

- **Immunizations**

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

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

Appendix C – 2020 Criteria for Case Management

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

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

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

a. The degree and complexity of the Member's illness is typically severe
    1. Multiple specialties involved
    2. Level of specialty management (tertiary providers)
    3. Primary diagnosis with complication(s)
    4. Higher levels of disease staging
b. The level of management necessary is typically intensive.
    1. Multiple services needing coordination
    2. Frequency of care management contacts needed
    3. Large number of external care coordination services
c. The amount of resources required for the Member to regain optimal health or improved functionality is typically extensive.
    1. Multiple hospitalizations in the past 6 months
    2. Multiple ED visits in the past 6 months
    3. High cost and utilization of pharmacy

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

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

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

iii. Malnutrition, dehydration, nausea/vomiting
iv. Chronic pain

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

a. Criteria
    i. severe trauma with head injury and/or requiring prolonged facility care or complex home care
    ii. spinal cord injuries
    iii. brain injury
    iv. burns

12. Readmission:
    a. Criteria
        i. readmission to facility within 30 days of discharge due to complications or multiple admissions for same condition

13. Mental health:
    a. Criteria
        i. requests for residential treatment facilities
        ii. multiple psychiatric or chemical dependency admissions within the past 12 months
        iii. history or threat of suicide

14. Other:
    a. Criteria
        i. Any recommendation from Health Services management or direct referral from referral provider

Appendix D- REFERRAL TO COMPLEX CASE MANAGEMENT CHECK LIST

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

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

Complex Case Management Criteria

(any 3 of ANY of the following)

High Utilization:

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

At Risk Diagnoses:

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

Complex Medical/Psychosocial Needs:

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

Appendix E - 2020 CCM Performance Measures

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

Appendix F: HRA Questionnaire (Old)

ALAMEDA Alliance FOR HEALTH

Health Survey

Name:	Member ID#:
Address:	Phone: ☐ Cell ☐ Home

1. What is your preferred language:

   ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other: _____

2. Where do you live:

   ☐ Own home

   ☐ Rent

   ☐ Temporary housing

   ☐ Staying with friends/family

   ☐ Assisted living

   ☐ Homeless

   ☐ Group home

   ☐ Other _____

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

3. In general, how would you describe your health?

   ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Decline to answer

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

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

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

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

8. Are you under the care of any specialists?	☐ Yes	☐ No
9. Are you pregnant?	☐ Yes	☐ No
a. If you are pregnant, are you currently seeing a doctor for this pregnancy?	☐ Yes	☐ No
10. Do you have a condition that limits your activities or what you can do?	☐ Yes	☐ No
11. Do you need help with any of these actions?		
a. Taking a bath or shower	☐ Yes	☐ No
b. Going up stairs	☐ Yes	☐ No
c. Eating	☐ Yes	☐ No
d. Getting dressed	☐ Yes	☐ No
e. Brushing your teeth or hair, or shaving	☐ Yes	☐ No
f. Making meals or cooking	☐ Yes	☐ No
g. Getting out of a bed or a chair	☐ Yes	☐ No
h. Shopping and getting food	☐ Yes	☐ No
i. Using the toilet	☐ Yes	☐ No
j. Walking	☐ Yes	☐ No
k. Washing dishes or clothes	☐ Yes	☐ No
l. Writing checks or keeping track of money	☐ Yes	☐ No
m. Getting a ride to the doctor or to see your friends	☐ Yes	☐ No
n. Doing house or yard work	☐ Yes	☐ No
o. Going out to visit family or friends	☐ Yes	☐ No
p. Using the phone	☐ Yes	☐ No
q. Keeping track of your appointments	☐ Yes	☐ No
If yes, are you getting all the help you need with these actions?	☐ Yes	☐ No

If you get help with any of the tasks listed above, who is helper?

Name of your helper: _____

What is your relationship to the helper: _____

May we contact your helper? ☐ Yes ☐ No

Phone number of helper: _____

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

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

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

Name: _____

Relationship: _____

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

Please list _____

15. Do you need assistive devices that you do not have? ☐ Yes ☐ No

Please list _____

16. As of today, do you receive any of these services from an agency?

a. Home Health Nurse ☐ Yes ☐ No

b. Physical, Occupational, Speech Therapy at Home ☐ Yes ☐ No

c. Home Care Worker ☐ Yes ☐ No

d. Social Worker ☐ Yes ☐ No

e. Adult Day Care Center ☐ Yes ☐ No

f. Help with Transportation ☐ Yes ☐ No

g. Other (please list): _____

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

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

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

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

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

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

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

24. If no, does the place where you live have:

a. Good lighting ☐ Yes ☐ No

b. Good heating ☐ Yes ☐ No

c. Good cooling ☐ Yes ☐ No

d. Rails for any stairs or ramps ☐ Yes ☐ No

e. Hot water ☐ Yes ☐ No

f. Indoor toilet ☐ Yes ☐ No

g. A door to the outside that locks ☐ Yes ☐ No

h. Stairs to get into your home or stairs inside your home ☐ Yes ☐ No

i. Elevator ☐ Yes ☐ No

j. Space to use a wheelchair ☐ Yes ☐ No

k. Clear ways to exit your home ☐ Yes ☐ No

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

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

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

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

☐ None – I never feel lonely

☐ Less than 5 days

☐ More than half the days (more than 15 days)

☐ Most days – I always feel lonely

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

30. Over the last two (2) weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly everyday
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling asleep, staying asleep, or sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself – or that you're a failure or have let yourself or your family down?	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so slowly that other people have noticed or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

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

32. Do you feel you have a problem with:

a. Alcohol use ☐ Yes ☐ No

b. Drug Use ☐ Yes ☐ No

c. Tobacco use ☐ Yes ☐ No

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

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

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

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

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

If yes, check all that apply:

☐ Asthma ☐ Cancer ☐ Cystic Fibrosis ☐ Diabetes

☐ Heart Problems ☐ Hepatitis ☐ High Blood Pressure ☐ HIV or AIDS

☐ Kidney Disease ☐ Seizures ☐ Sickle Cell Anemia ☐ Tuberculosis

☐ Other: _____

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

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

Name of Medication	Dose (How Much)	How Often Taken

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

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

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

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

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

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

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

Only answer the next three (3) questions if you are over 64 years of age:

47. Do you get a flu shot every year? ☐ Yes ☐ No

48. Have you had a pneumonia shot in the past? ☐ Yes ☐ No

49. Have you had the Zostavax (shingles) shot in the past? ☐ Yes ☐ No

Only answer the next question if you are between 50 -74 years of age:

50. Have you had a test to screen for colon cancer with the following:
    a. FOBT (Fecal Occult Blood Test), testing the stool for presence of blood this year? ☐ Yes ☐ No
    b. Flexible sigmoidoscopy any time in the last four (4) years? ☐ Yes ☐ No
    c. Colonoscopy any time in the last 5-10 years? ☐ Yes ☐ No

This Health Survey is complete. Thank you!

Please return to:

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

If you have questions, please contact us at **1.888.433.1876**.

HRA Questionnaire (New)

(To be rolled out Spring 2020)

ALAMEDA Alliance FOR HEALTH

Health Survey

Member Name: _____ Alliance Member ID#: _____

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

1. What is your preferred language:

   ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese
   ☐ Other: _____

2. Where do you live:

   ☐ Own home ☐ Temporary housing
   ☐ Rent ☐ Homeless
   ☐ Staying with friends/family ☐ Group home
   ☐ Assisted living ☐ Other: _____

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

3. In general, how would you describe your health?

   ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Decline to answer

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

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

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

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

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

9. Are you pregnant? ☐ Yes ☐ No

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

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

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

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

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

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

15. Do you see a doctor regularly for a chronic condition? ☐ Yes ☐ No
If yes, check all that apply:

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

☐ Other: _____

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

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

Name of Medication	Dose (How Much)	How Often Taken

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

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

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

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

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

22.

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

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

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

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

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

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

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

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

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

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

Name of your helper: _____

What is your relationship to the helper: _____

May we contact your helper? ☐ Yes ☐ No

Phone number of helper: _____

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

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

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

Name: _____

Relationship: _____

31. As of today, do you receive any of these services from an agency?

a. Home Health Nurse ☐ Yes ☐ No

b. Physical, Occupational, Speech Therapy at Home ☐ Yes ☐ No

c. Home Care Worker ☐ Yes ☐ No

d. Social Worker ☐ Yes ☐ No

e. Adult Day Care Center ☐ Yes ☐ No

f. Help with Transportation ☐ Yes ☐ No

Other (please list): _____

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

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

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

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

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

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

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

39. If no, does the place where you live have:

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

40. Have you fallen in the last month?	☐ Yes	☐ No
41. Are you afraid of falling?	☐ Yes	☐ No
42. Do you need help filling out health forms?	☐ Yes	☐ No
43. Do you need help answering questions during a doctor's visit?	☐ Yes	☐ No
44. Are you afraid of anyone or is anyone hurting you?	☐ Yes	☐ No
45. Is anyone using your money without your okay?	☐ Yes	☐ No
46. Do you sometimes run out of money to pay for food, rent, bills, and medicine?	☐ Yes	☐ No

This Health Survey is complete. Thank you!

Please return to:

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

If you have questions, please call:

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

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Appendix G Long-Term Services and Supports Referral Questions

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

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

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

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

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

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

Appendix H – Disease Management Program Activities

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

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

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

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

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

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

Information needed for a DM referral includes:

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

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

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

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

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

DM Risk Stratification

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

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

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

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

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

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

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

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

Enrollment

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

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

Assessment

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

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

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

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

DM Plan Development and Management

1. The steps in developing the Care Plan involve:
    a. Development of case management goals, including prioritized goals
    b. Identification of barriers to meet the goals and complying with the plans
    c. Development of schedules for follow-up and communication with members
    d. Development and communication of member self-management plans

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

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

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

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

DM Case Evaluation and Closure

1. The DM program is structured where DM cases are closed either by meeting prescribed length in program criteria or by defined closure criteria.

2. High Risk Program enrollees will be evaluated for closure to DM services using *CM-003, Policy and Procedure, Complex Case Management Plan Evaluation and Closure Evaluation and Closure criteria.* CMs should aim to close the case within 6 months of enrollment allowing for 30 days of conducting the assessment.

3. Diabetes DM Program enrollees will also be evaluated for closure to DM services using MED-CM-0003 P&P criteria. However, the length of time in program should not exceed 6 months of participation in the program.

4. Low Risk Program enrollees will be considered disenrolled at the time a new DM Low Risk report is provided. If the member is no longer identified as having gaps in care, he/she will no longer be in the program.

5. All closure actions will be documented in the Care Plan as applicable and the Program Enrollment section of Clinical Information System except for Low Risk Program enrollees who will be considered automatically disenrolled as described above.

6. At the time of case closure, a satisfaction survey and a case closure letter if appropriate will be sent.

Appendix I – California Health Homes Services Model

http://www.dhcs.ca.gov/services/Documents/HealthHomesForPatients_Final.pdf

A. 2016 Eligibility Criteria

1. Target Population
The HHP is intended to be an intensive set of services for a small subset of Members who require coordination at the highest levels. DHCS worked with a technical expert workgroup to design eligibility criteria that identify the highest-risk three to five percent of the Medi-Cal population who present the best opportunity for improved health outcomes through HHP services. These criteria include both 1) a select group of ICD-9/ICD-10 codes for each eligible chronic condition, and 2) a required high level of acuity/complexity.

2. HHP Eligibility Criteria and the Targeted Engagement List
Using administrative data, either DHCS or Medi-Cal managed care health plans (MCPs) will develop a Targeted Engagement List of Medi-Cal MCP Members who are eligible for the HHP based on the DHCS-developed eligibility criteria noted below. The list will be refreshed on a monthly or quarterly basis, using the most recent available data. The acuity/complexity level criteria will be implemented as part of a Targeted Engagement List process. The MCP will actively attempt to engage the Members on the Targeted Engagement List. (See Section II.G, Member Assignment, for more information on MCP activity to engage eligible Members.)

To be eligible for the HHP, a Member must meet the following eligibility criteria:

a. Have chronic conditions in at least one of the following categories (DHCS will select specific ICD 9/ICD 10 codes to further define these eligible conditions):

- At least two of the following: asthma, chronic obstructive pulmonary disease (COPD), diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, dementia, substance use disorders (SUD) **OR**

- Hypertension and one of the following: COPD, diabetes, coronary artery disease, chronic or congestive heart failure **OR**

- One of the following: major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia) **OR**

- Asthma and a risk of at least one of the following: diabetes, SUD, depression, obesity

b. Meet at least one of the following acuity/complexity criteria:

- A chronic condition predictive level above three based on a method to be determined by DHCS **OR**

- At least one inpatient stay in the last year **OR**

- Three or more Emergency Department (ED) visits in the last year **OR**

- Chronic homelessness

c. Have at least two separate claims for the eligible condition.

The Targeted Engagement List may include other criteria that are intended to ensure that HHP resources are targeted to Medi-Cal Members who present the best opportunity for improved health outcomes through HHP services.

The following exclusions will be applied either through MCP data analysis for individual Members or through assessment information gathered by the Community Based Care Management Entity (CB-CME):

- Members determined through further assessment to be sufficiently well managed through self-management or through another program, or the Member is otherwise determined to not fit the high-risk eligibility criteria
- Members whose condition management cannot be improved because the Member is uncooperative
- Members whose behavior or environment is unsafe for CB-CME staff
- Members determined to be more appropriate for an alternate care management program
- Chronic Renal Disease is an HHP eligible condition, but will not be included in the Targeted Engagement List. Members who have this condition may be referred for MCP approval.

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2019

QUALITY IMPROVEMENT PROGRAM

EVALUATION

Alameda Alliance for Health

Quality Improvement Program
Program Evaluation

2019

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2019 Quality Improvement Program Evaluation Signature Page

Stephanie Wakefield, RN Director of Quality	Date
Sanjay Bhatt, M.D. Medical Director, QI Vice Chair, Health Care Quality Committee	Date
Steve O'Brien, M.D. Chief Medical Officer Chair, Health Care Quality Committee	Date
Scott Coffin Chief Executive Officer	Date
Evan Seevak, M.D. Board Chair	Date

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INTRODUCTION

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

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

The processes and data reported covers activities conducted from January 1, 2019 through December 31, 2019.

MISSION AND VISION

As its Mission, the Alliance strives to improve the quality of life of our members and people throughout our diverse community by collaborating with our provider partners in delivering high quality, accessible and affordable health care services. As participants of the safety-net system, we recognize and seek to collaboratively address social determinants of health as we proudly serve Alameda County. The Alliance Vision is be the most valued and respected managed care health plan in the state of California.

PURPOSE

The purpose of the Alliance 2019 Annual Quality Improvement Program Evaluation is to access and evaluate the overall quality and effectiveness of the QI Program in meeting the goals and objectives of the QI Program and Work Plan. The QI department leads the evaluation assessment in collaboration with cross function departments utilizing data and reports from committees, content experts, data analysts, work plans outcomes, Plan-Do-Study-Act studies, Performance Improvement and Quality Improvement Project to perform qualitative and quantitative analysis of initiatives and activities outcomes, identify barriers to established goals and objectives, best practices, next steps and other improvement opportunities. The Alliance uses the annual evaluation to identify new and ongoing goals, objectives, and activities for the QI Program in the coming year.

This evaluation assesses the following elements:

- Completed and ongoing QI activities that address quality and safety of clinical care and quality of service
- Performance measure trends to assess performance in the quality and safety of clinical care and quality of service;
- Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network wide safe clinical practices

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

MEMBERSHIP AND PROVIDER NETWORK

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

Alliance Group Care is an employer-sponsored plan offered by the Alliance. The Group Care product line provides comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County.

Table 1: 2019 Trended Enrollment by Network and Aid Category

Current Membership by Network By Category of Aid								
Category of Aid	Dec-19	% of Medi-Cal		Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Adults	32,066	13%		7,652	6,748	241	12,283	5,142
Child	89,056	37%		8,088	8,165	27,298	30,400	15,105
SPD	25,687	11%		8,617	3,707	1,184	10,329	1,850
ACA OE	78,154	32%		13,842	24,862	930	29,947	8,573
Duals	17,776	7%		7,090	1,923	1	6,632	2,130
Medi-Cal	242,739			45,289	45,405	29,654	89,591	32,800
Group Care	6,092			2,689	827	-	2,576	-
Total	**248,831**	**100%**		**47,978**	**46,232**	**29,654**	**92,167**	**32,800**
Medi-Cal %	97.60%			94.40%	98.20%	100.00%	97.20%	100.00%
Group Care %	2.40%			5.60%	1.80%	0.00%	2.80%	0.00%
		Network Distribution		*19.30%*	*18.60%*	*11.90%*	*37.00%*	*13.20%*
				% Direct:	**38%**		**% Delegated:**	**62%**

Table 2: 2019 Trend Enrollment by Age Category

Age Category Trend								
	Members				% of Total (ie.Distribution)			
Age Category	Dec-17	Dec-18	Nov-19	Dec-19	Dec-17	Dec-18	Nov-19	Dec-19
Under 19	102,258	98,122	92,318	91,641	38%	37%	37%	37%
19 - 44	86,599	84,866	79,016	78,271	32%	32%	32%	31%
45 - 64	58,713	57,340	54,703	54,210	22%	22%	22%	22%
65+	22,409	23,862	24,661	24,709	8%	9%	10%	10%
Total	**269,979**	**264,190**	**250,698**	**248,831**	**100%**	**100%**	**100%**	**100%**

In 2019, the Alliance membership decreased by 5.81% from 2018 enrollment and 7.83% from 2017 enrollment as noted in Table 2 above. Total membership numbers declined by 21,148 from Dec. 2017 to Dec. 2019. The Alliance experienced a membership decline in all age categories from 2018 to 2019. 6.6% membership decline for under 19, 7.7% decline in the 19-44 category, 5.4% decline for 45-64 age category, with the smallest increase noted for 65+ age category of 3.5%. Despite membership decline, % of total distribution by age category remained relatively unchanged from 2018 to 2019. The decline in enrollment is not unique to the Alliance but follows as state wide trend thought to be largely due to the decrease in unemployment and increase acquisition of employer sponsored insurance, as well as, the undocumented immigrant population opting out of health plan insurance. However, exact reasons for the downward trend in health plan enrollment numbers remains undetermined.

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

Table 3: 2019 Provider Network by Type, Enrollment and Percentage

Provider Network	Provider Type	Members (Enrollment)	Percent of Enrollment in Network
Direct-Contracted Network	Independent	47,978	19%
Alameda Health System	Managed Care Organization	46,232	19%
Children First Medical Group	Medical Group	29,654	12%
Community Health Clinic Network	Medical Group	92,167	37%
Kaiser Permanente	HMO	32,800	13%
	TOTAL	**248,831**	**100%**

From 2018 to 2019, the percentage of members within each provider network has remained relatively steady.

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

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

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

The Alliance provider network includes:

Table 4: Alliance Ancillary Network

Ancillary Type	Count
Hospitals	17
Skilled Nursing Facilities	54
Health Centers (FQHCs and non-FQHCs)	67
Behavioral Health Network	1
DME Vendor	1 (Capitated)
Transportation Vendor	1
Pharmacies/Pharmacy Benefit Manager (PBM)	Over 200
Radiology/Delegate (ended 7/31/19)	1 (partial year)

Alliance members may choose from a network of over 580 primary care practitioners (PCPs), and nearly 7000 specialists, 17 hospitals, 73 health centers, 70 nursing facilities and more than 200 pharmacies throughout Alameda County. Effective August 1, 2019, radiology consulting services ended as part of our ancillary network and became directly managed by the Alliance. The Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan members. Our members' optimal health is always our first priority.

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

QI STRUCTURE AND RESOURCES

A. QI STRUCTURE

The structure of the QI Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate use of the Alliance health care delivery network for medical and behavioral health care services. Additionally, the structure is designed to enhance communication and collaboration on QI program goals and objectives, activities and initiatives, that impact member care and safety both internal and external to the organization, inclusive of delegates. The QI Program is evaluated on an on-going basis for efficacy and appropriateness of content by Alliance staff and oversight committees.

B. GOVERNING COMMITTEE

The Alameda County Board of Supervisors appoints the Board of Governors (BOG) of the Alliance, a 15-member body representing provider and community partner stakeholders. The BOG is the final decision making authority for all aspects of the Alliance QI programs and is responsible for approving the annual Quality Improvement Program Description, Work Plan, and Program Evaluation. The Board of Governors delegates oversight of Quality functions to The Alliance Chief Medical Officer (CMO) and the Health Care Quality Committee (HCQC) and provides the authority, direction, guidance and resources to enable Alliance staff to carry out responsibilities, functions and activities of the QI Program. QI oversight is the responsibility of the HCQC.

The HCQC develops and implements the QI program and oversees the QI functions within the Alliance. The HCQC:

- Recommends policies or revisions to policies for effective operation of the QI program and the achievement of QI program objectives
- Oversees the analysis and evaluation of the Quality Improvement, Utilization Management (UM) and Case Management program and Work Plan activities and assesses the results.
- Ensures practitioner participation in the QI program activities through attendance and discussion in relevant QI committee or QI subcommittee meetings.
- Identifies needed actions, and ensures follow-up to improve quality, prioritizing actions based on their significance and provides guidance on which choose and pursue as appropriate. HCQC also assesses the overall effectiveness of the QI, UM, CM and Pharmacy & Therapeutics Programs. The HCQC met a total of 6 times in 2019:
    1. January 17, 2019
    2. March 21, 2019
    3. May 16, 2019
    4. July 18, 2019
    5. September 19, 2019
    6. November 21, 2019

The 2018 QI Program Evaluation, the 2019 QI Program Description and the 2019 QI Work Plan were presented to the HCQC during the March 21, 2019 meeting and unanimously approved.

C. COMMITTEE STRUCTURE

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

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

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

The major committees that support the quality and utilization of care and service include:

- Healthcare Quality Committee (HCQC)
- Peer Review and Credentialing Committee (PRC)
- Member Advisory Committee (MAC)
- Pharmacy and Therapeutics Sub-committee
- Utilization Management (UM) Sub-committee
- Access and Availability Sub-committee
- Internal Quality Improvement Sub-committee (IQIC)
- Cultural and Linguistic Sub-committee

Additionally, joint operations meetings (JOMs) support the quality improvement work of the Alliance. Each committee meets at least quarterly, some monthly, and all committees / sub-committees, except the PRC and MAC committees, report directly to the HCQC. The PRC and MAC committees report directly to the BOG. The Peer Review and Credentialing Committee supports the quality and utilization of safe care and service for the Alliance membership and reports directly to the BOG. Each committee continues to meet the goals set forth in their charters, as applicable. The HCQC membership includes practitioners representing a broad range of specialties, as well as, Alliance leadership and staff.

D. EVALUATION OF SENIOR-LEVEL PHYSICIAN AND BEHAVIORAL HEALTH PRACTITIONERS

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

During 2019 Dr. Aaron Chapman, a psychiatrist and Medical Director of Alameda County Behavioral Health Care Services (ACBHCS), actively participated in the HCQC meetings and provided clinical input ensuring policies and reports considered behavioral health implications.

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

E. PROGRAM STRUCTURE AND OPERATIONS

The Alliance QI Program encompasses quality of care across the Alliance enterprise and across the health care continuum. 2019 QI Program activities included the following but were not limited to the following:

- Evaluation of effectiveness of the QI program structure and oversight
- Implementation and completion of ongoing QI activities that addressed quality and safety or clinical care and quality of service
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service
- Analysis of QI initiatives and barriers to improvement
- Monitoring, auditing, and evaluation of delegated entities QI activities for compliance to contractual requirements with implementation of corrective action plans as appropriate
- Internal monitoring and auditing of QI activities for regulatory compliance, and assurance of quality and safety of clinical care an quality of service
- Development and revision of department policies, procedures and processes as applicable
- Development and implementation of direct and delegate network corrective action plans as a result of non-compliance and identified opportunities for improvement, as applicable.

F. QI RESOURCES

The Alliance QI Department key staff included licensed physicians and registered nurses, qualified non-clinical management staff, as well as, non-clinical specialist staff and non-clinical administrative support coordinators. The assignment and performance of work within the team, whether working on site or remotely, for both clinical and non-clinical activities, is seamless to the Alliance operations processes. Job description expectations with assigned tasks and responsibilities remain unchanged regardless of the geographical location of staff member.

During 2019 several key leadership and support staff positions in Quality Improvement were filled:

- Sr. Director of Quality
- Quality Improvement Manager
- Access to Care Manager
- Quality Improvement Specialists
- FSR Coordinator
- Director, Clinical Initiatives and Clinical Leadership Development

In 2019, with the onboarding of new senior and management level leadership, and qualified support staff the Health Care Services QI Department team was able to further mitigate gaps in both leadership

and oversight of the QI program integrity. The QI program moved forward in providing quality improvement guidance enterprise wide meeting regulatory and accreditation standards and promoting positive health outcomes for the Alliance membership. Health Care Services continues to evaluate staff turn-over and strives to provide a positive work environment while creating a stable work force.

Through 2019, vendor partnerships were a part of the QI resource strategy. The Alliance continued its contractual relationship with Health Data Decisions (HDD). HDD augmented QI resources via consulting and analytic expertise for the HEDIS program.

Additionally, the Alliance maintained its relationship with vendor: SPH Analytics. SPH provided provider and member satisfaction survey, after hours and emergency instruction survey, the Health Risk Assessment (HRA) survey and Health Information Form (HIF-MET) survey implementation, analysis and reporting.

OVERALL PROGRAM EFFECTIVENESS

The Alliance's quality improvement efforts strive to impact the safety and quality of care and service provided to our members and providers. Review of the Alliance's 2019 QI activities as described herein demonstrates the Alliance's QI department ability (in collaboration with internal and external entities) to successfully assess, design, implement, and evaluate an effective QI program by achieving, inlcuding but, not limited to, the following:

1. Improved focus on the importance of chronic condition management, and accessing appropriate care through initiatives to educate and connect with members, direct and delegated providers, communitiy based organizations, state and county entities and enhance our improvements to our internal operations
2. Maintained a targeted focus on the analysis of key drivers, barriers and best practices to improve Access to Care
3. Expanded staff knowledge of health disparities within the Alliance membership through population data colllection, analysis and segmentation
4. Promoted the awareness and concepts of inter-departmental QI initiatives and activities, including Plan-Do-Study-Act (PDSA), Inter-Rater Reliability (IRR), to create greater operational efficiencies
5. Invested in quality measurement analysis expertise
6. Identified Potential Quality Issues (PQIs) operations gaps and root cause analysis to identify and overcome barriers, as well as, best practices resulting in internal workflow improvements and staff retraining
7. Exhibited improvement in HEDIS measures' performance including CCS, CDC, and IMA, W15, AWC, W34, and CAP 12-19
8. Ensured timely Facilty Site Review/Medical Record Review audits and Physical Accessibility Review Surveys
9. Hired senior and management and non-clinical support staff in the QI Department.
10. Targeted QI initiatives to improve direct and delegate provider engagement in access to care efforts to improve rates of preventive care and services, screenings and referrals for members
11. Targeted partnerships with community based, county agencies and delegate providers to improve referral and resources triage and management through technology collaboration and supoort
12. Promoted healthcare access and safety education for members and providers through targeted pharmacy substance use program
13. Improved engagement with intereprter services vendors and Alliance network providers to ensure quality interperter services at all points of healthcare service contact.
14. Enhanced engagement with Behavioral Health delegate for improved and timely access to care
15. Collaborated with delegated providers around implementation of a revised Delegate Corrective Action Plan (CAP) Process creating increased efficiencies for compliance from both direct and delegated providers

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

SERVING MEMBERS WITH COMPLEX CONDITIONS

The Alliance continues to identify members with complex health conditions in need of supportive services based on data collection and analysis. The Alliance links members to Asthma and Diabetes Disease Management, Complex Case Management, Transition of Care, Whole Person and Health Homes Management programns and services based on healthcare needs.

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

Additionally, some of the Alliance members were identified as "high risk" for complex health conditions through claims, encounter and referral data. Identified members are forwarded to case management and health homes management for follow up. Complex Case Management and Health Homes Management staff outreach to high risk members by telephone and communicate with CB-CMEs. When outreach attempts are successful, initial assessments are performed and care plans are developed. Members who agree to care are provided assistance with provision of services and recommendations to support managing their conditions. When outreach is attempted but unsuccessful, the case is closed.

Members were also identified for "transitions of care" assistance. Transition of Care assistance is designed to ensure that the coordination and continuity of health care occurs for members who are discharged from Medical or Surgical inpatient care settings to a different level of care. Tracking and trending of outcomes through Case and Disease Management processes is a key component of the Case Management and Disease Management program activities. Serviing all members inclusive of those with complex needs and conditions for tracking and trending of more targeted improvement in health outcomes through population health and needs assessments data collection will continue to be a part of the Health Care Services fabric in 2020.

PROVIDER OUTREACH AND ENGAGEMENT

During 2019, the Provider Services department provided continued outreach to all PCP, Specialists and Ancillary provider offices via in-person visits and the use of fax blasts.

Topics covered in the visits and fax blasts included but, were not limited to: use of the provider portal, the announcement of the Member Satisfaction survey, education on current HEDIS measures, use of interpretive services and cultural sensitivity education, Health Wellness initiatives, Diabetes Self-Management Education and Support (DSMES), Gap in Care Reports, Electronic Billing, Provider, drug formulary schedule updates, Fraud Waste and Abuse reporting, Timely Access Standards, Provider Appointment Availability Survey (PASS), Provider notification regarding vaccines and Measles and Pertussis outbreaks, Podiatry Services updates, Local Breastfeeding resources, Food as Medicine Program education, Tobacco Cessation counseling, Pediatric Bright Futures Preventive Health Guidelines, and Adult United States Preventive Services Task Force Guidelines, in addition to Radiology Services and Pay for Performance updates.

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

- Plan review and summary of Alliance programs

- Review of network and contract information
- How to verify eligibility
- Referrals and how to submit prior authorizations
- Timely Access Standards
- Member benefits and services that require PCP referral
- How to submit claims
- Filing of complaints and the appeal process
- Initial Health and Staying Healthy Assessment
- Coordination of Care, CCS, Regional Center, WIC program
- Child Health and Disability Program
- Members Rights and Responsibilities
- Member Grievances
- Potential Quality Issues (PQIs)
- Health Education
- HEDIS Education

Overall, there were approximately 1,128 provider visits completed during the 2019 calendar year. The Provider Services department plans to continue our robust provider outreach and engagement strategies in 2020.

MEMBER OUTREACH AND MEMBER SERVICES

In 2019, the Alliance Member Services (MS) Department continued to have a strong focus on providing high-quality service. Quarterly call center metrics are presented below in the Member Services blended (Ansafone and AAH call center) dashboard. The dashboard represents blended (Medi-Cal and Group Care) customer service results.

Table 5: Blended Customer Service Results – Medi-Cal and Group Care

Alliance Member Services Staff	Q1	Q2	Q3	Q4
Incoming Calls (MS)	41796	39720	40255	38871
Abandoned Rate (MS)	5%	2%	3%	5%
Answered Calls (MS)	39804	39120	39216	36780
Average Speed to Answer (ASA)	00:27	00:22	00:33	00:41
Calls Answered in 30 Seconds (All)	84.0%	87%	85%	85%
Average Talk Time	8:04	8:21	8:06	8:10
Calls Answered in 10 Minutes (goal: 100%)	100.0%	100.0%	100.0%	100.0%
Ansafone Call Center	**Q1**	**Q2**	**Q3**	**Q4**
Incoming Calls (AF)	9173	6733	5970	6404
Abandoned Rate (AF)	14%	9%	12%	10%
Answered Calls (AF)	7912	6115	5241	5753
Average Speed to Answer (ASA)	3:21	1:45	2:58	1:11
Calls Answered in 30 Seconds (AF)	46%	54%	37%	61%
Average Talk Time (ATT)	5:59	6:34	7:31	5:44
Recordings/Voicemails	**Q1**	**Q2**	**Q3**	**Q4**
Incoming Calls (R/V)	4805	4268	4234	3794
Abandoned Rate (R/V)	0.00%	0.00%	0.00%	0.00%
Answered Calls (R/V)	4805	4268	4234	3794
Calls Answered in 30 Seconds (R/V)	100%	100%	100%	100%
Blended Results	**Q1**	**Q2**	**Q3**	**Q4**
Incoming Calls (R/V)	55774	50721	50459	49069
Abandoned Rate (R/V)	6%	2%	4%	6%
Answered Calls (R/V)	54774	49503	48691	46327
Average Speed to Answer (ASA)	0:51	0:30	0:46	0:42
Calls Answered in 30 Seconds (R/V)	80%	84%	81%	84%
Average Talk Time (ATT)	7:02	6:49	7:22	6:38

Figure 1: Member Services Call Volume 2019 - 2019 Member Services Call Center Report

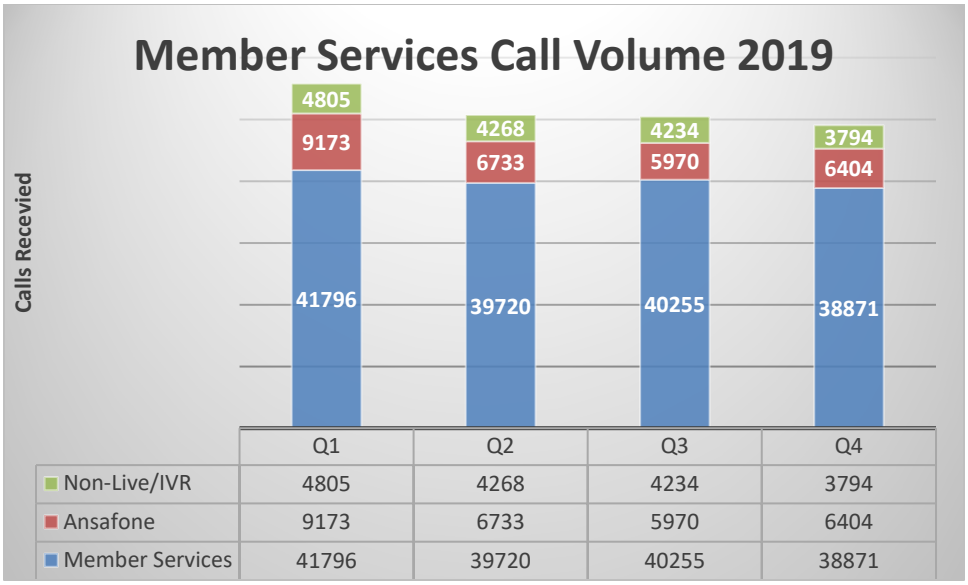
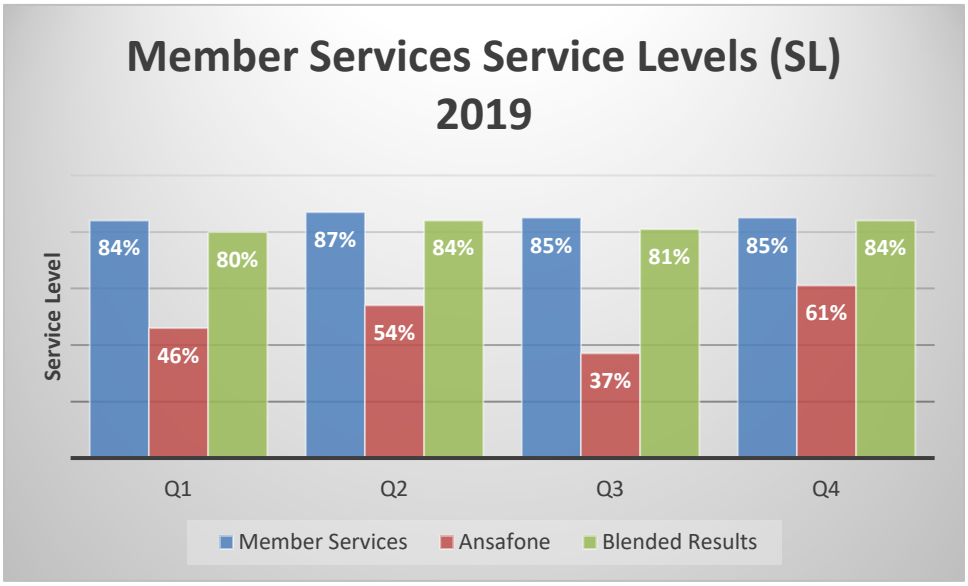


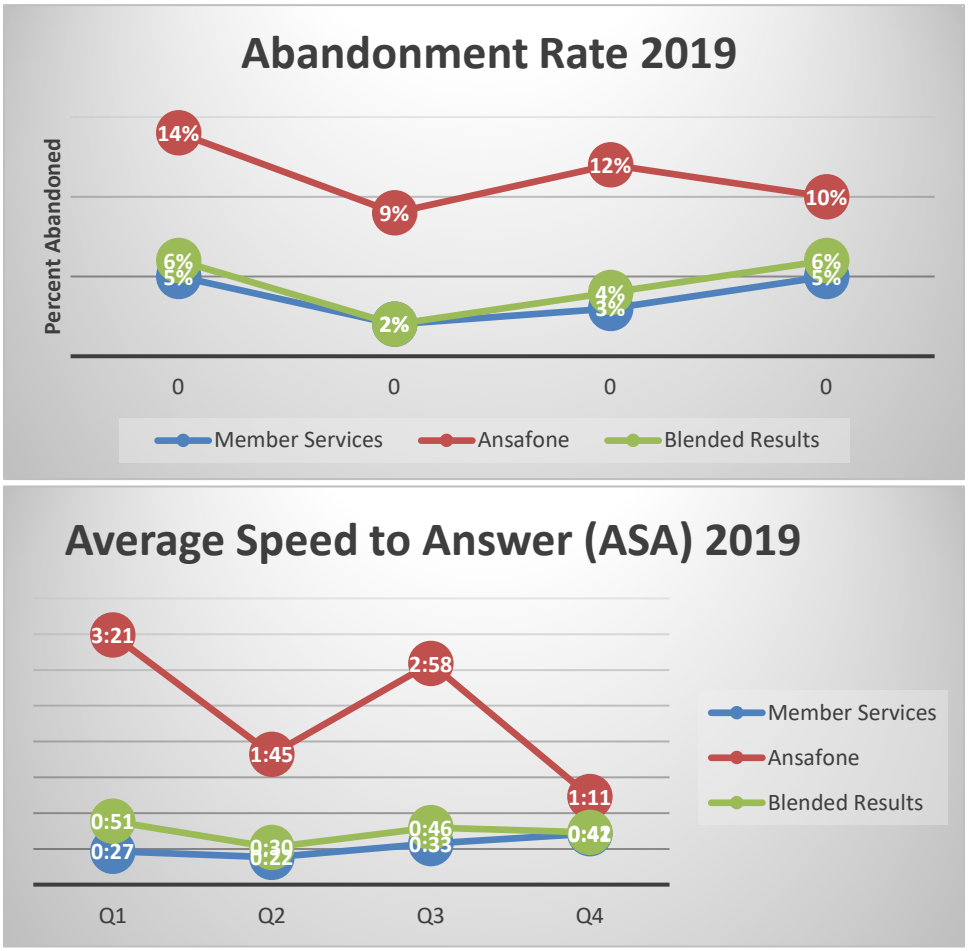
Figure 2: Member Services Levels (SL) 2019 - 2019 Member Services Call Center Report



In 2019, Member Services blended call center targeted metrics were not met for Q1 and Q4 for the abandonment rate of 5% or less. Staffing challenges due to unexpected/unplanned leave of absences (LOAs) impacted the team's ability to meet its service metrics. The MS Department reviewed and implemented various changes to improve service levels and meet metrics. The Member Services phone tree was redesigned to increase member satisfaction and decrease abandonment rates by allowing members to reach the right people, with the right skills (bilingual in particular), at the right time. Member Services Representatives are also able to transfer calls to in-house bilingual representatives (decreasing the need for interpreter service vendor) as the phone system allows for user visibility. The Department is currently reviewing the Member Services Representative – Bilingual job description and will make necessary changes to recruit and hire quality skilled customer service agents that meet quality standards. In 2020 Member Services leadership, as they did in 2019, will continue work with HR and Health Education to review the bilingual language assessment to increase the level of proficiency

required to meet the quality standards to better service our members in this important area. Member Services is currently and will continue working with Compliance to review contractual performance guarantees to ensure quality measures have been met by our call overflow vendor. Through quality assurance process when service measures are not met by the vendor, Compliance will continue to issue corrective action plans. The Department continues to monitor and track call center operations to ensure compliance and quality standards are met.

Figure 3: Abandonment Rate and Average Speed to Answer (ASA) 2019



MEMBER ADVISORY COMMITTEE (MAC)

In 2019, the Member Advisory Committee (MAC) functioned to provide information, advice, and recommendations to the Alliance on member educational and operational issues in respect to the administration of the Alliance's cultural and linguistic services. These advisory functions include but, are not limited to, providing input on the following:

- Culturally appropriate service or program design
- Priorities for the health education and outreach program
- Member satisfaction survey results
- Findings of health education and cultural and linguistic group needs assessment
- The Alliance's outreach materials and campaigns

- Communication of needs for provider network development and assessment
- Community resources and information

The Member Advisory Committee received information from the Alliance on public policy issues, including financial information, and data on the nature and volume of member grievances and the grievance disposition.

The MAC met four times in 2019:

- March 21, 2019
- June 27, 2019
- September 19, 2019
- December 19, 2019

Some of the key topics discussed in 2019 included:

- Cultural and Linguistics Work Plan and Quarterly Reports
- Grievances & Appeals
- Communications & Outreach collateral, events and activities
- Health Education Report
- Health Education Handout Review
- Durable Medical Equipment Vendor
- Health Homes Program
- Substance Use Disorder Program
- Population Needs Assessment
- CalAIM
- Alliance 2020 Organizational priorities
- Questions & Answers for member concerns

MEMBER NEWSLETTER

The Alliance 2019 Spring/Summer and Fall/Winter *Member Connect* newsletter was published and shared with more than 150,000 member households and provider offices. The newsletter contained a variety of disease self-management and preventive care topics and education on:

- Appropriate ER use
- Avoiding C-sections
- Asthma medicines
- Cervical cancer prevention
- LARC (Long-Acting Reversible Contraception)
- Perinatal mental health
- Well-child and well-care visits

- Diabetes care and prevention
- Immunizations

SAFETY OF CLINICAL CARE

In 2019, the Alliance continued its organizational focus on maintaining safety of clinical care for its membership.

PHARMACY

A. SUBSTANCE ABUSE DISORDER

The Alliance partnered with our network providers and other local leaders to develop a Substance Use Disorder Program.

Alameda Alliance has launched multiple strategies, *Communication, Community Outreach, and Pharmacy Safeguards*. However, there was a small increase in the total short acting opioid users, long acting opioid users, and members using both short and long acting opioids together. The next steps will be to identify members if grandfathered members had in increase in dose or increase in hospice/palliative/cancer member utilization or gaps in coding for non-grandfathered members. AAH will work together with analytics and PBM to monitor any increase in dose escalation month to month.

AAH is finalizing members and providers materials for distribution of academic detailing materials along with visiting provider office.

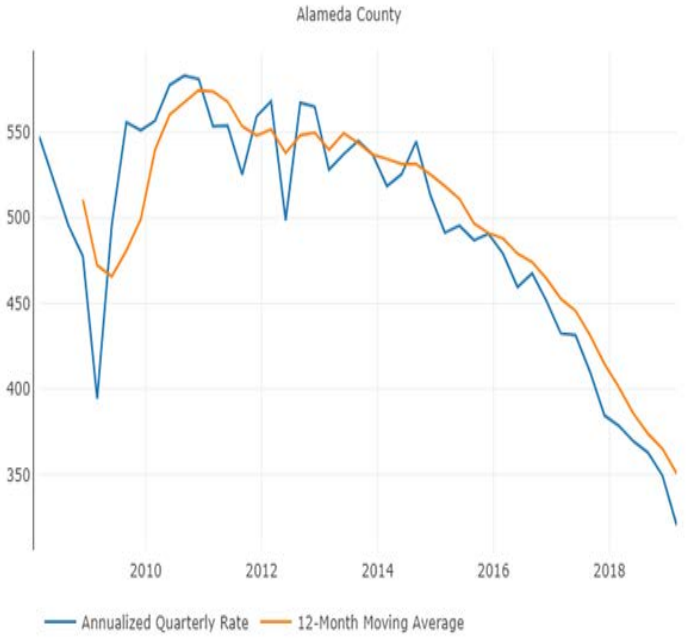
Next steps will include additional focus on prevention, intervention and treatment, and recovery support. Ongoing analysis of data regarding the use of MAT, prescribing habits, grievances, ED Data, and opioid and benzodiazepine usage will guide next steps in the program development and implementation.

Figure 4: Opioids Stewardship Report

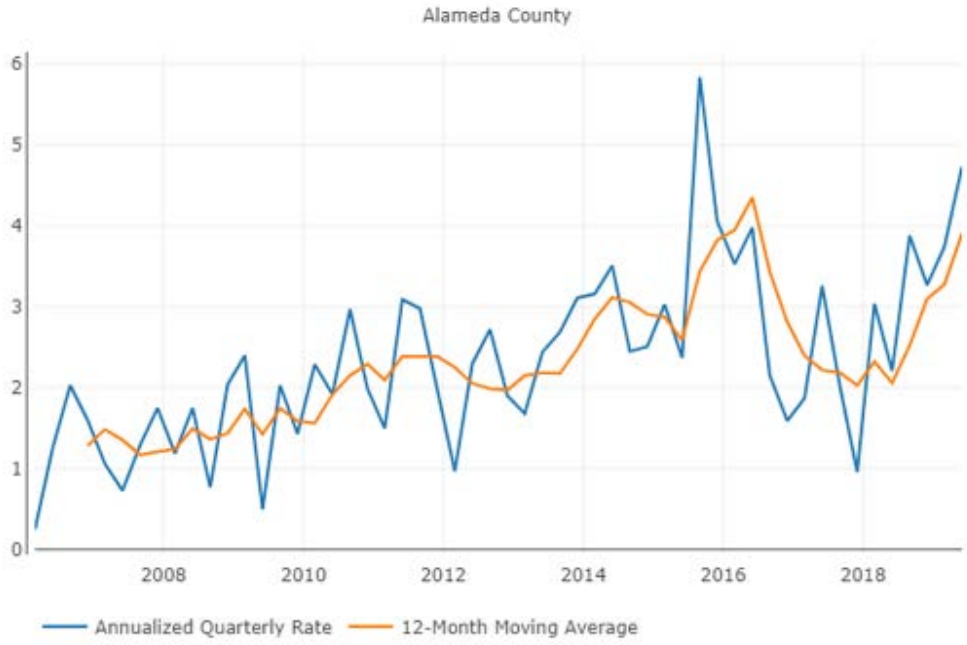
Purpose of Report: To provide periodic updates regarding steps that AAH is taking to help combat the opioid epidemic.

Current Alameda County Data

Opioid Prescriptions by Member Location



Opioid Related Overdose-Age Adjusted Rate Per 100,000 Residents

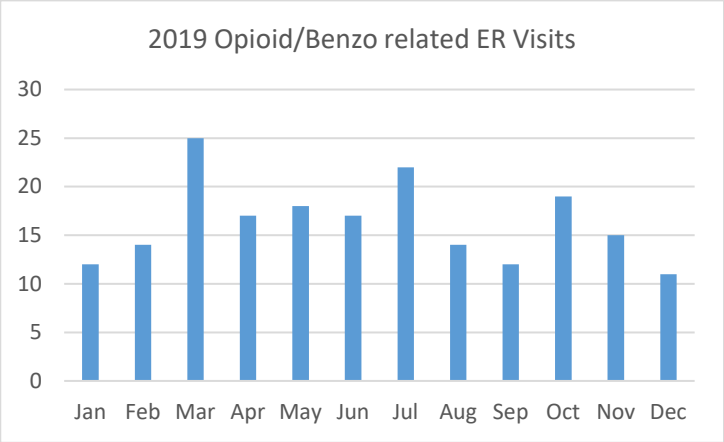


Alameda Alliance Ongoing Activities

Opioid and Benzodiazepine ER Reporting

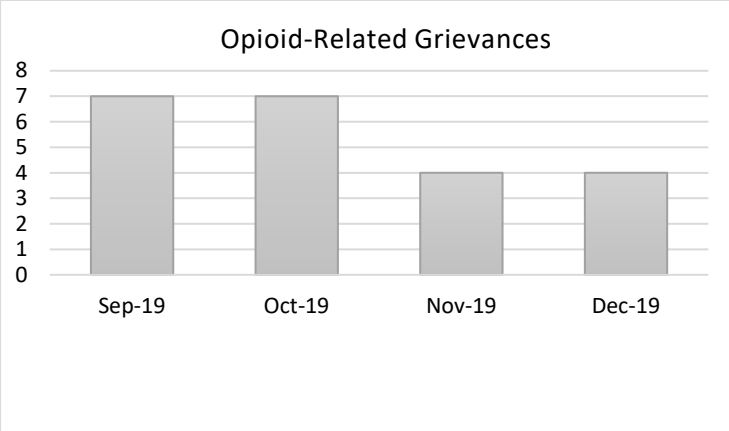
Reports based on claims data and reflects each unique claim with opioids/benzo related ICD code

Reports are shared with assigned pcps of members on these reports on a quarterly basis



Monitor Opioid-related Grievances

Methodology: QI and Pharmacy Services provided a set of keywords such as pain, opioid, and benzodiazepine to G&A. From there G&A manually searched the G&A application database for grievances with these keywords.



Academic Detailing

Overview: QI and Pharmacy Services to identify chronic users defined as greater than 3 months of use and prescribed **≥ 300 MME.** AAH will provide provider education for the providers of these chronic users which includes the following components:

Health education materials: Three documents related to safety, alternative methods, and medications for pain management have been created and designed.

Network access maps for alternative resources: Work with data analytics and C&O to create maps for providers and **members** we are focusing on for under academic detailing.

Members ≥ 300 MME data: Pharmacy services working with PBM to collect most accurate data to identify members receiving ≥ 300 MME. QI gathering CURES reports and the most recent EMR notes per member.

Alameda Alliance is continue to improve our opioid stewardship program. Below are some changes the Alliance has implemented

1. *Pharmacy Safeguards* – As of January 2020, AAH implemented additional safeguards to ensure appropriate opioid use.

Key Points include:

- SAOs have a 14-day limit on their initial start for opioid naïve patients (Table 6)
- Grandfathering chronic users 6 months prior to when program were started; chronic users defined as a cumulative day supply of greater or equal to 90 days supply.
- All SAOs formulation will be limited for to maximum of 3 times daily dosing
- All cancer diagnosis, hospice/palliative care, and sickle cell anemia diagnosis will be exempted from quantity and fill restrictions for opioids
- Monthly reporting and tracking of >120, 200, 300, 400 MME members, providers
- Quarterly reporting of chronic users

Table 6: Pharmacy Safeguard Implementations

Pharmacy Safeguards

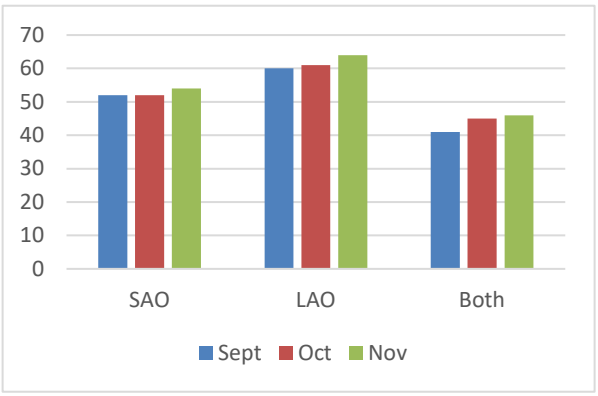
- PA: Prior Authorization
- LAO: Long Acting Opioid
- SAO: Short Acting Opioid

Action	AAH Implementation Date				
Opioid Program Start		12/2017	06/2018	10/2019	01/2020
"New Start" SAO Limit	None	None	None	None	14
SAO QL per month	180	#180/30	#180/30	#90/30	#90/30
SAO Limited by	Drug	Drug	Drug	Total	Total
PA for all LAOs	No	Yes	Yes	Yes	Yes
LAO Increase limit	No	Yes	Yes	Yes	Yes
Cover Alprazolam	Yes	Yes	No	No	No
Cover Carisoprodol	Yes	Yes	No	No	No
Diazepam Limits	3/day	3/day	3/day	3/day	3/day
Lorazepam Limits	No	4/day	4/day	4/day	4/day
Clonazepam Limits	No	3/day	3/day	3/day	3/day

Below is a table that lists the number of members on short acting opioids (SAO) only, long acting opioids (LAO) only, and both short and long acting opioids in September, October, and November. Short and long acting opioids had a slight increase but remains stable. Please note this is data is specifically for a population of >120 MME only.

Figure 5: Members on SAO, LAO, and Both SAO and LAO for Sept-Nov 2019

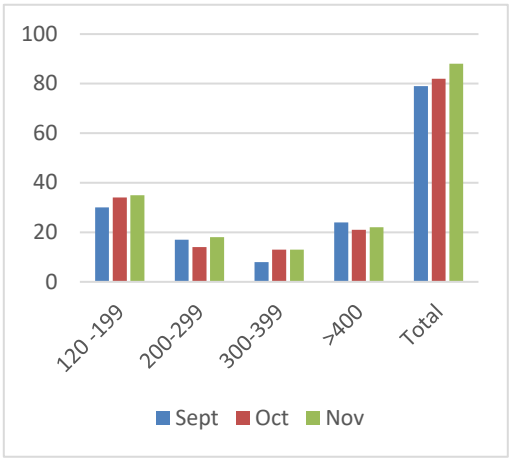
Year	SAO	LAO	Both
Sept	52	60	41
Oct	52	61	45
Nov	54	64	46



Below is a table that lists the number of members on high dose (>120 MME) opioids. From 2016 to 2018, this table shows a 20.3% decrease in members utilizing 120-199 MME, 62.5% decrease in members utilizing 200-299 MME, 20% decrease in members utilizing 300-399 MME, and a 20% increase in members utilizing more than 400 MME.

Figure 6: Members per year on >120MME

MME (Morphine Milligram Equivalents)					
Month	**120 - 199**	**200-299**	**300-399**	**≥400**	**Total**
Sept	30	17	8	24	79
Oct	34	14	13	21	82
Nov	35	18	13	22	88



B. Drug Recalls

The Pharmacy Department monitors all drug recalls. In 2019, pharmacy recall information is as below:

Table 7: 2019 Pharmacy Recalls

Total number of safety notices/recalls	**86**
Total number of withdrawals	1
The number of notifications where PBM completed a claims data review	30

In 2019, there were 86 recalls. Recalls were monitored for adversely affected members. The number of notifications where the PBM completed a claims data review were 30.

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

C. POTENIAL QUALITY ISSUES (PQI)

A Potential Quality Issues are defined as: An individual occurrence or occurrences with a potential or suspected deviation from accepted standards of care, including diagnostic or therapeutic actions or behaviors that are considered the most favorable in affecting the patient's health outcome, which cannot be affirmed without additional review and investigation to determine whether an actual quality issues exists. PQI cases classified as **Quality of Care (QOC)**, **Quality of Access (QOA)**, or **Quality of Service (QOS) Issues**

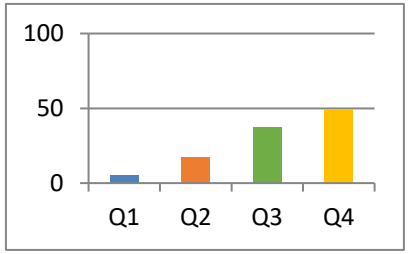
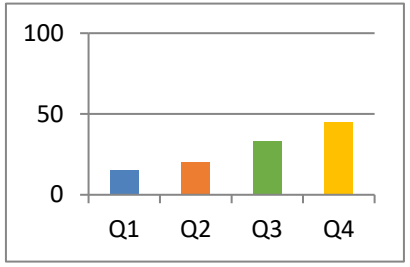
The QI Department investigates all Potential Quality Issues (PQIs). These may be submitted by members, practitioners, or internal staff. When a PQI is identified, it is forwarded to the Quality Department and logged into a database application. Quality Review Nurses investigate the PQI and summarize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

Table 8: Quality of Care (QOC) Issue Severity Level

Severity Level	Description
C0	No QOC Issue
C1	Appropriate QOC • May include medical / surgical complication in the *absence of negligence* • Examples: Medication or procedure side effect
C2	Borderline QOC • With potential for adverse effect or outcome • Examples: Delay in test with *potential* for adverse outcome
C3	Moderate QOC • Actual adverse effect or outcome (non-life or limb threatening) • Examples: Delay in / unnecessary test *resulting in* poor outcome
C4	Serious QOC • With significant adverse effect or outcome (life or limb threatening) • Examples: Life or limb threatening

Alameda Alliance for Health's Quality department received 1,109 Potential Quality Issues (PQIs), during measurement year 2019. Of the 1,109 PQIs received, a total 31.65%, or 351, of the PQIs were classified as a QOC. The quarterly frequencies are listed in the table below:

Table 9: 2019 PQI Quarterly Frequencies

Indicator	QI 2019	Q2 2019	Q3 2019	Q4 2019	
Indicator 1: QOC PQIs	Denominator: **375** Numerator: **87** Rate: **23.2%** Goal: 60% Gap to goal: **36.8%**	Denominator: **280** Numerator: **85** Rate: **30.36%** Goal: **60%** Gap to goal: **29.64**%	Denominator: **237** Numerator: **71** Rate: **29.96%** Goal: **60%** Gap to goal: **30.04%**	Denominator: **217** Numerator: **108** Rate: 49.77% Goal: **60%** Gap to goal: **10.23%**	
Indicator 2: QOC PQIs leveled at severity C2-4	Denominator: 87 Numerator: **28** Rate: 32.18% Goal: N/A	Denominator: **85** Numerator: **29** Rate: **34.12%** Goal: N/A	Denominator: **71** Numerator: **17** Rate: **23.94%** Goal: N/A	Denominator: **108** Numerator: **9** Rate: **8.33%** Goal: N/A	

In 2017, the Quality Improvement (QI) team received about **300** PQIs; in December of 2017, the QI team trained all AAH staff and changed the referral criteria. As a result, in 2018, the QI team received almost **3000** PQIs. In 2019, the QI team has continued with the adapting the PDSA (Plan-Do-Study-Act) cycles from 2018.

In PDSA cycle 1, the QI Review Nurse Supervisor continued to conduct Exempt Grievances case audits via random sampling, to ensure that PQIs are not missed. QI Department management continues to provide oversight of exempt and standard grievances, reviews and investigates *clinical* referrals internal and external to the organization, and ensures that services and access related PQIs are addressed through vendor management and compliance oversight, and other existing channels.

PDSA cycle 2, addressed the technological support and improvement of the PQI application for the QI team. In 2017 and 2018, the team heavily relied on Microsoft Excel. In Q4 2018, phase 1 of the PQI Application was introduced, and phase 1 sub-phases that permitted the QI team to transition from Excel to a home-built application. In 2019, the QI Department continued to collaborate with the IT department in developing and implementing Phase 2 of the PQI application with technology enhancements designed to improve and optimize workflow efficiencies, improve reporting, creating a central data repository that contained essential tracking components, from the initial investigation to the final resolution and leveling of a PQI. QI intends to continue to working closely with IT in 2020 to continue with Phase 3 development, which will include additional enhancements to improve the workflow efficiencies and tracking and trending of data, within the application.

The QI Review Nurse team has undergone significant transitions in 2018 and 2019, however, through 2 PDSA cycles, the team remains committed to effectively reviewing and adjudicating PQIs via root-cause-analysis to improve patient care.

D. CONSISTENCY IN APPLICATION OF CRITERIA (IRR)

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

Table 10: Inter-rater Reliability Thresholds

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

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

For 2019, IRR testing was performed with QI clinical staff to evaluate consistency in classification, investigation and leveling of PQIs. All QI Review Nurse and Medical Director Reviewers passed the IRR testing with scores of 100%.

FACILITY SITE REVIEW

Facility Site Review (FSR) and Medical Record Review (MRR) audits are mandated for each Health Plan under DHCS Plan Letter 14-004 to occur every three y. FSRs are another way the Alliance ensures member quality of care and safety within the provider office environment. Mid-cycle follow-up of FSR and MRR occurs every 18 months . Corrective Action Plans (CAPs) for non-compliance are required depending on the site FSR and MRR scores and critical element failures.

In 2019, there were 76 site reviews. The total number and types of audits are detailed in the table below:.

Table 11: 2019 Facility Site Reviews

2019	Q1	Q2	Q3	Q4	Total
FSR/MRR: Full Scope	13	6	9	4	**32**
Initial FSR	1	0	1	0	**2**
Initial MRR	7	1	0	0	**8**
Initial FSR/MRR	1	0	1	0	**2**
MRR: Follow Up	2	5	2	1	**10**
FSR/MRR: Mid-cycle	4	4	3	0	**11**
Periodic Annual	0	0	1	1	**2**
Periodic FSR	2	0	2	0	**4**
Periodic MRR	1	1	3	0	**5**
Total Reviews	**31**	**17**	**22**	**6**	**76**

DHCS regulation requires that Critical Element CAPs be received by the Alliance within 10 business days of the site review. The Alliance had 4 providers who were non-compliant in 2019.

Additionally, a critical element CAP is issued for deficiencies in any of the 9 critical elements in the FSR that identify the potential for adverse effects on patient health or safety and must be corrected within 10 business days of the site review.

Table 12: Compliant and non-compliant FSR/MRR CAPs received in 2019

2019	Q1	Q2	Q3	Q4	Total
Compliant CAPs (received within 45 calendar days)	19	10	16	4	**49**
Non-Compliant CAPs	3	0	3	1	**7**
Total CAPs Issued	**22**	**10**	**19**	**5**	**56**

Table 13: CAPs closed within 120 days of FSR in 2019

2019	Q1	Q2	Q3	Q4	Total
CAPs closed within 120 days	22	10	17	4	**53**
CAPs not closed within 120 days	0	0	2	1	**3**
Total CAPs Issued	**22**	**10**	**19**	**5**	**56**

Factors contributing to non-compliance due to Alliance follow-up with provider offices: vacant FSR Coordinator position; and lack of outreach communication to obtain needed documentation. In 2019 the Alliance hired a FSR Coordinator and initiated an Escalation Process in Q3.

In 2019 the Alliance had one (1) provider with non-passing scores below 80%.

Table 14: 2019 Audits with Non-Passing Scores

2019	Audit Date	FSR Score	MRR Score
Q1	1/9/2019	89%	76%
Q2	N/A	N/A	N/A
Q3	N/A	N/A	N/A
Q4	N/A	N/A	N/A

A. AUDIT OF INITIAL HEALTH ASSESSMENTS (IHAS) VIA FSR/MRR

IHA includes history and physical (H&P) and Individual Health Education Behavioral Assessment (IHEBA). An IHA must be completed within 120 days of member assignment.

In 2019, medical records at 65 sites were reviewed for the presence of an IHA. Table lists the results of these reviews. The compliance rate goal of 30% was exceeded in all four quarters of 2019. The 28 total non-compliant providers received re-education/training on IHA and IHEBA compliance.

Table 15: 2019 MRR Results

2019	Q1	Q2	Q3	Q4	Total
# of MRRs with Compliant IHAs	13 (48%)	10 (63%)	11 (65%)	3 (60%)	37
# of MRRs with Non-Compliant IHAs (CAPs)	14	6	6	2	28
Total IHAs Audited via FSR	27	16	17	5	65

PEER REVIEW AND CREDENTIALING COMMITTEE (PRCC)

In 2019, 38 practitioners were reviewed for lack of board certification. If there were complaints about a practitioner's office, facility site reviews were conducted and the outcome was reviewed by the PRCC. There was no site reviews conducted based on complaints in 2019. All grievances, complaints, and PQIs that required investigation were forwarded to this committee for review. In 2019, 64 practitioner grievances, complaints, or PQIs were investigated by the committee. There were no practitioners that required reporting to National Practitioner Data Bank (NPDB) by the Alliance.

In 2019, the PRCC granted one year reappointment for two practitioners for grievances filed regarding office procedures. The table below shows evidence of practitioner review by the PRCC prior to credentialing and re-credentialing decisions.

Table 16: Count of Practitioners Reviewed for Quality Issues at PRCC in 2019

Count of Practitioners Reviewed for Quality Issues At PRCC in 2019										
PRCC Date	PRC	NPDB	Attestation	Malpractice (pending/dismissed)	Facility Site Review	Grievance, Complaints, PQI	License Action	Board Certification CAP	CAP	Total
January		2		1		6		2		11
February		2		2		2		2		8
March	2	1				9		4		16
April		3		4		8		1		16
May	1		1	1		8		1		12
June	1	2		1		8		3		15
July		1		1		1		2	1	6
August		1		2		2		2	3	10
September			1	2		7		5	1	16
October		2	1	2		2	1	6		14
November	1	2	2	2		7	2	7	3	26
December				1		4		3	1	9
Total	**5**	**16**	**5**	**19**	**0**	**64**	**3**	**38**	**9**	**159**

DELEGATION OVERSIGHT

The Alliance conducts quarterly and annual delegation oversight in compliance with Department of Health Care Services (DHCS), DMHC, and the National Committee for Quality Assurance (NCQA) regulations. Annual delegation oversight reviews were conducted in 2019.

Results from the 2019 reviews were reported to the Compliance Committee. The QI delegation audit results were also reported to the HCQC.

In addition to the annual oversight audits, the Alliance held quarterly Joint Operations Meetings with delegates. Additionally, the Alliance held regular Executive Team meetings with Community Health Center Network (CHCN) and Alameda Health Systems Leadership. The Alliance, as well as, the delegate contribute to the meeting agenda. The standard Leadership meeting agenda includes but, is not limited to, the following topics with updates: claims adjudication, information technology, provider relations, member services, quality activities concerns and progress, in addition to new and/or revised legislation, or DMHC, DHCS regulations. Weekly or biweekly Alliance and delegate calls were held to improve communication and information flow, provide bi-directional updates, and resolve any immediate mutual concerns. The Alliance places a high degree of importance on problem solving and communicating with delegates.

In 2019 the Alliance conducted Joint Operations meetings with the delegated groups to review their individual Access and Timely of Care survey results, in addition to, HEDIS rate performance specific to their group to identify opportunities for improvement, strategies for improvement of scores, and HEDIS timelines for reporting year 2019.

The following delegated groups were audited in 2019:

Table 17: Alameda Alliance Delegated Entities

Delegate	Quality Improvement		Utilization Management		Credentialing		Grievances & Appeals		Claims		Call Center		Case Management		Cultural & Linguistic Services		Provider Training	
	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care
Beacon Health Strategies LLC	X	X	X	X	X	X			X	X	X	X	X		X	X	X	
Community Health Center Network (CHCN)			X	X					X	X			X	X			X	
March Vision Care Group, Inc.					X				X									
Children's First Medical Group (CFMG)			X		X				X									
PerformRx			X	X	X	X			X	X	X	X			X	X		
California Home Medical Equipment (CHME)			X	X														
Kaiser	X		X		X		X		X		X		X		X		X	
UCSF					X	X												
Physical Therapy PN					X	X												
Lucille Packard					X	X												

The Alliance will continue to conduct oversight of the delegated groups, review thresholds to ensure they are aligned with industry standards, and will issue corrective actions when warranted. After review of the QI delegates, no actions were specifically identified or taken. The QI Delegates Program Evaluation will be reviewed by the HCQC in Q1 of 2020.

QUALITY IMPROVEMENT PROJECTS

In 2019, the Alliance collaborated with the Department of Health Care Services (DHCS) and Health Services Advisory Group (HSAG) to improve the process for two quality measures. The following quality improvement projects were initiated in late 2017 and completed in June 2019. The projects were based on HEDIS 2017 reporting year data. DHCS encourages plans to adopt the Institute for Health Improvement's (IHI) model for improvement. This approach frames the improvement project to clarify and focus the project before the Plan-Do-Study-Act (PDSA) model is implemented. The project cycle was 18 months and concluded June 30, 2019. The outcomes for the quality improvement projects are stated below.

QUALITY IMPROVEMENT PROJECTS

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

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

The Alliance did not achieve the SMART Aim goal for this project. From the run chart over the course of the project, it does not appear that there was an increase in the overall rate as a result of intervention testing. The total number of patients that received HbA1c testing as a result of the intervention was only 8, or about 2.5% of the total population, over the course of three months of testing, which was not enough to make an impact on the overall rate.

Figure 7: Graph of A1c Rate in AA Men at AHS

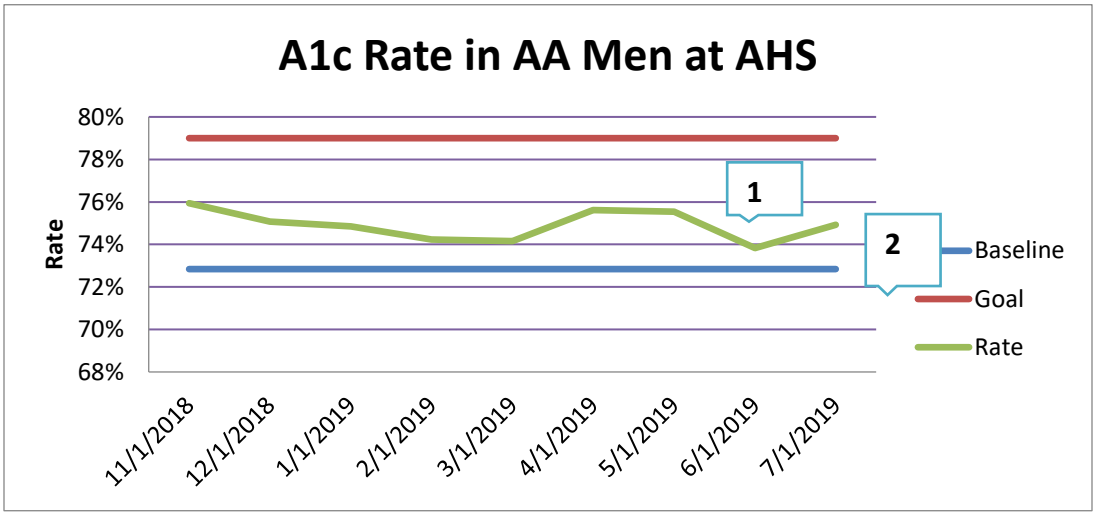


Table 18: A1c Rate of AA Men at AHS

	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
Numerator	243	238	247	242	241	248	242	235	230
Denominator	320	317	330	326	325	328	323	314	307
Rate	75.94%	75.08%	74.85%	74.23%	74.15%	75.61%	75.54%	73.83%	74.92%

Analysis: In order to perform any interventions that may improve patient care, the Alliance will need to establish key contacts at target sites. Alameda Health System is a large provider for many of the Alliance's most vulnerable patients. Performance improvement within these sites will require strong relationships with a clinic manager or another staff member who will champion and facilitate efforts. The Alliance will continue to identify opportunities for improvement within this focus. Continued telephone outreach will include the offer for transportation aimed at this population. Although the offer of transportation did not show improvements to the rate of HbA1c testing, multiple members accepted the offer of transportation, indicating that this is a need even if it is not the only need of the population. AHS is also transferring to the EPIC system and with this change they have decided to move to an open schedule system in September. The Alliance will continue its collaborative work with AHS to improve appointment availability and scheduling efforts.

Next steps: In 2020, the Alliance intends to adapt the intervention that was tested with Alameda Health System and continue its efforts in improving the HbA1c testing rates of its African American diabetic population by identifying additional partnerships with other key stakeholders within the Alliance community.

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

Physicians for ages 12-19 (CAP4). Using MY 2017 data, Alameda Alliance CAP4 rate was 85.47%, which fell under the Minimum Performance Level (MPL) of 85.73%. Additional analysis showed that Tri-City clinics, which includes Liberty, Mowry 1 and Mowry 2 offices, had a CAP4 rate of 81.12%, significantly lower than the Alameda Alliance overall rate and well below the MPL. Conversations with Tri-City clinical staff and a thorough literature revealed monetary incentives to be an effective intervention with this age group. Alameda Alliance met with providers and support staff from Tri-City seven times in 2018 to discuss intervention strategies, plan and implementation. Tri-City staff committed to calling all members who were non-compliant with this measure three times and then send them a follow up text if they were not reached by phone. Alameda Alliance committed to sending these members a mailed letter and providing a $25 gift card to all members who completed a compliant visit during the pilot. Tri-City began outreach phone calls in December 2018. The goal is to increase the rate of primary care visits for 12-19 year olds assigned to Tri-City clinics from 81.12% to 86%. This project ran until June 30, 2019.

At the time that the target clinics were chosen for intervention testing, Tri-City clinics had a SMART Aim rate of 81.12%. By the time intervention testing began in December 2018, the SMART Aim measure rate for this clinics had already increased to 88.6%. At the final run of the data report, the compliance rate for the SMART Aim target population was 90.5%, well above the goal rate. Although the intervention to perform outreach calls did appear to coincide with a slight increase in the SMART Aim after the first round of calls, there is no evidence that the second and third round of calls had any positive effect on the SMART Aim rate. Since the SMART Aim rate increased steadily in the months prior to the intervention, there is a question of whether the outreach call attempt can be attributed to the slight increase in rate that happened after. Additionally, it appears that the target sites showed a decrease in the denominator over times, which may mean that they lost non-compliant members from

their population over time rather than increasing the number of compliant members. This makes it more likely that the intervention was not be responsible for rate increase.

Figure 8: Graph of CAP Rate among Tri City Pediatric Population

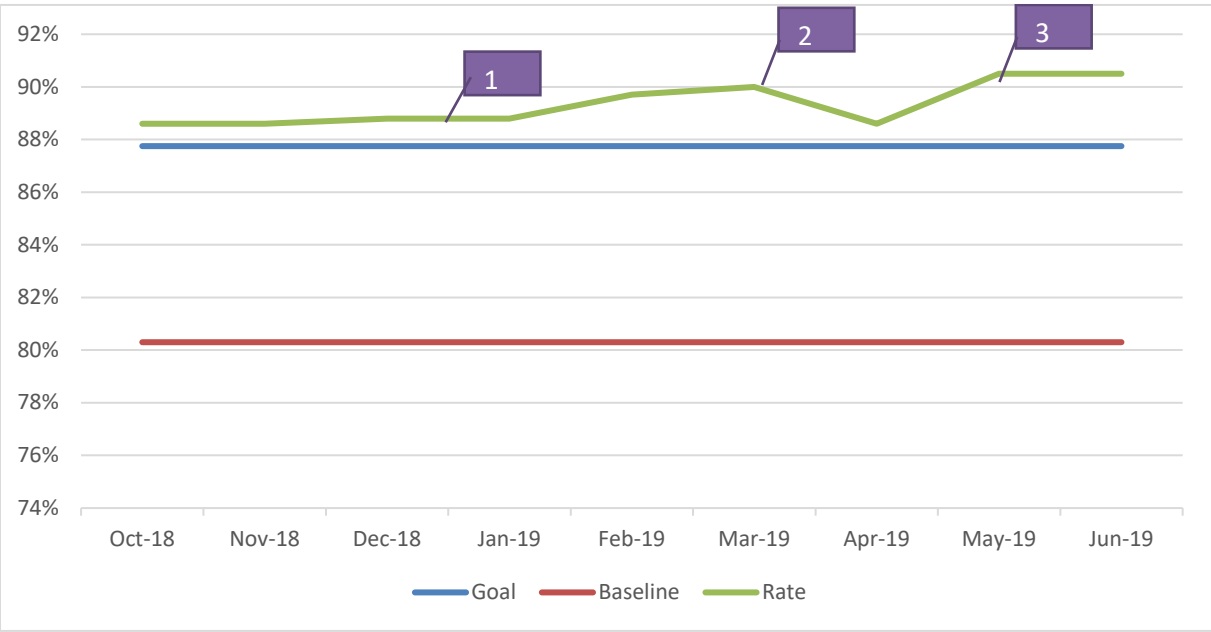


Table 19: CAP Rate among Tri City Pediatric Population

Month	Goal	Base	Rate	Num	Den
Oct 18	87.75%	81.12%	88.60%	1255	1416
Nov 18	87.75%	81.12%	88.60%	1255	1416
Dec 18	87.75%	81.12%	88.80%	1251	1408
Jan 19	87.75%	81.12%	88.80%	1253	1395
Feb 19	87.75%	81.12%	89.90%	1244	1383
Mar 19	87.75%	81.12%	90%	1244	1383
Apr 19	87.75%	81.12%	90.10%	1231	1366
May 19	87.75%	81.12%	90.50%	1244	1375
Jun 19	87.75%	81.12%	90.50%	1224	1352

In 2020, the Alliance intends to adapt this intervention and use the lessons learned to continue to engage the adolescent population to receive preventive care which include EPSDT services.

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

Screening rates for members on persistent medications were below the minimum performance level three years in a row. The rates of screening for members on the following medications: angiotensin converting enzyme (ACE) inhibiters or angiotensin receptor blockers (ARB) and diuretics (DIU) were ACE/ARB= 83.12% in RY 2015, 84.27% in RY 2016 and 86.06% in RY 2017 and DIU= 81.67% in RY 2015, 83.22% in RY 2016 and 85.14% in RY 2017. Due to consistently falling below the Minimum Performance Level for this measure, DHCS requested that Alameda Alliance participate in a pilot to rapidly improve the rates for this measure using a SWOT methodology: Strengths, Weaknesses, Opportunities and Threats. Alameda Alliance completed a data analysis of delegate performance and

reached out to clinics with low performance. Leadership at Tiburcio Vasquez clinics in the Community Health Center Network (CHCN) expressed an interested in partnering on improving this measure. Tiburcio Vasquez clinics had 556 eligible members and a compliance rate of 85.9% for ACE/ARB and 88.9% for diuretics. The interventions developed included texting members to alert them that they were due for a lab and needed to see their provider as well as a 'soft stop' put on members' pharmacy refills to encourage pharmacists to counsel members to get their labs. Alameda Alliance allocated $25 to pharmacies for each member that successfully completed their lab within the measurement period, which concluded in June 30, 2019. Text messaging was completed through Tiburcio Vasquez using their text messaging application and began in December 2018. Text messaging in December prioritized members who had not seen their provider in over a year and had multiple gaps in care in addition to missing their MPM lab. In 2019, the Plan was informed by DHCS that it had met the requirements of the State issued PDSA because it met the MPL for HEDIS reporting year 2017. As a result, the Alliance has chosen to abandon this intervention and project.

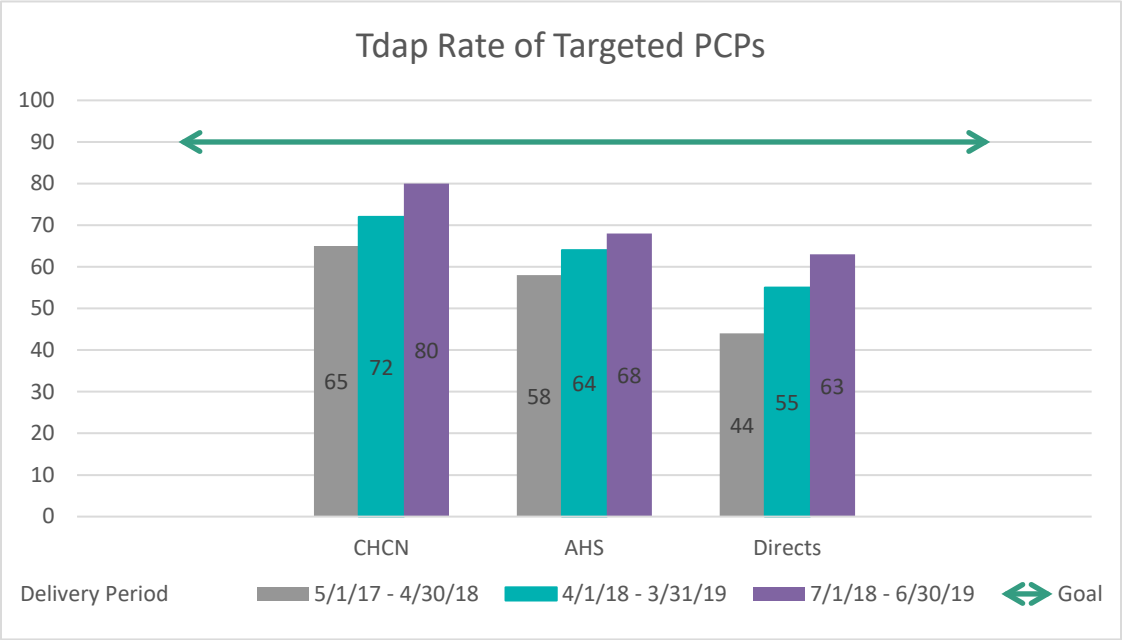
Additional QI Projects:

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

In 2018, over 300 cases of pertussis were identified in Alameda County, five of which were infants younger than 4 months old. Immunizing pregnant women with the Tdap vaccine between 27-36 weeks gestation is the most effective practice to protect infants from pertussis. The Alliance and the Immunization Division of Alameda County's Public Health Department (ACPHD) have partnered to implement a Quality Improvement Project to improve rates of prenatal Tdap vaccination. The Alliance completed a baseline data analysis of claims submitted for deliveries between 5/1/2017 to 4/30/2018 and claims data for any Tdap received within 10 months prior to delivery. As a result, 19 PCP's were identified with 30 deliveries or more and Tdap vaccination rates of 80% or lower. Among these providers thus far, Ob/Gyn leadership at Lifelong Medical Care and Alameda Health Systems have expressed interest with improving their rates.

In March and June of 2019, the Alliance and ACPHD presented best Tdap practices to Tri-City Health Center, Tiburcio Vasquez, Axis Community Health Center, as well as several direct providers. It is through the partnership with ACPHD, that 70.33% of the expectant mothers at the targeted provider locations received a Tdap vaccination during the 3rd trimester.

Figure 9: Graph of TDAP Rate of Targeted PCPs



During 2019, the targeted providers received the following interventions:

- Best practices tip sheet
- A Local Health Department (LHD) Nurse-led training on disease prevention, management, and how to promote the vaccine by effective communication
- Tdap flyers and posters in threshold languages for waiting and exams rooms
- An Alliance Nurse and Medical Director visit to discuss member level data, identify and resolve barriers, and determine opportunities to appropriately report and capture data

Analysis: During the process, several barriers were identified, which included the lack of a pharmaceutical grade refrigerator which caused the member to be referred to a pharmacy, providers misunderstanding the claims and reimbursement process, EMR changes, and lack of CAIR 2.0 interfacing with existing EMR. As a result, the Alliance intends to continue the partnership with ACPHD in 2020 in order to ensure timely Tdap administration and/or follow-up of OB care coordination for its members.

5. Improving Initial Health Assessment (IHA) Rates

The past 1 year of IHA rates is outlined below.

Table 20: 2018 IHA Rates

Q1 2018	Q2 2018	Q3 2018	Q4 2018
Denominator: 15,035 Numerator: 3,628 Rate: 24.13% Goal: 30% Gap to goal: 5.87% points	Denominator: 15,704 Numerator: 3,430 Rate: 21.84% Goal:30% Gap to goal: 8.16% points	Denominator:14,181 Numerator: 3,343 Rate: 23.57% Goal: 30% Gap to goal: 6.43% points	Denominator: 13,739 Numerator: 3,161 Rate: 23% Goal: 30% Gap to goal: 7% points

On average, an IHA is completed for 23.14% of new members (1/1/18 – 12/31/18); the table below identifies IHA completion rates by network.

Table 21: IHA Completion Rates among New Enrollees

Network	New Enrollees	With IHA Completed	IHA Compliant Rate
AHS	18,267	3,086	**16.89%**
ALLIANCE Excl. AHS	10,131	2,742	**27.06%**
CFMG	7,790	1,966	**25.24%**
CHCN	16,361	4,635	**28.33%**
KAISER	6,110	1,133	**18.54%**
ALL NETWORK	**58,659**	**13,562**	**23.12%**

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

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

Given the 6 month claims lag, data will be reviewed and analyzed in Q3 – Q4 of 2020.

PEDIATRIC CARE COORDINATION PILOT

In 2018 CA State Auditor Report cited the following:

1. "90% of children in MCL receive services through managed care plans
2. "An annual average of 2.4 million children who were enrolled in MCL over the past five (5) years have not received all of the preventive health services that the State has committed to provider them."
3. "Under-utilization of children's preventive health in CA MCL has been consistently below 50% and is ranked 40th in the country, 10% below the national average."
4. Alameda Alliance for Health Direct and Delegate Network providers are performing below 50% on several pediatric HEDIS measures

In July of 2019, to address the important issue of under-utilization and improve pediatric access to care for preventive health services, Health Care Services (HCS) QI department developed a deployed a strategy for enhanced integration of pediatric health care services for the children and adolescent population enrolled in the Alameda Alliance (AA) for Heath Medi-Cal program. The Alliance sought to constructively influence and impact care delivery for this identified population in three (3) ways:

- Quality Initiatives
- Clinical Initiatives
- Pilot Program

The HCS strategy proposed leveraging "whole child wellness" integration through:

- Improved screening and referrals as part of Medi-Cal Early and Periodic Screening, and Diagnostic and Treatment (EPSDT) supplement benefit
- Reporting via data segmentation and visualization
- Member and provider incentives
- Community based program funding
- Provider P4P
- Health Education engagement

The Alliance collaborated with external stakeholder's key to the success of this pediatric pilot

- Direct Providers
- Delegates
    - Alameda Health Services (18K Pediatric Members)
    - Beacon Health Options
    - Children's First Medical Group (32K Pediatric Members)
    - Community Health Care Network (36K Pediatric Members)
    - Kaiser (18K Pediatric Members)
- Community Based Organizations (CBOs)
    - Alameda County Public Health Asthma Start
    - Alameda County Healthy Homes Lead Poisoning Prevention

- First 5 Alameda County
- Benioff Children's Hospital Oakland
- Regional Center
- CA Children's Services

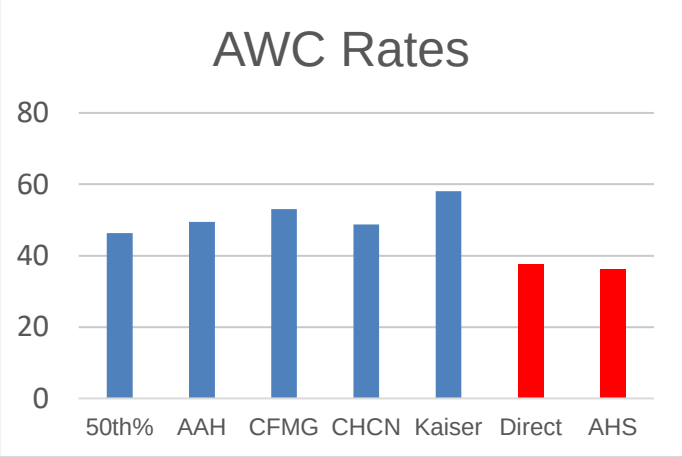
Pediatric HEDIS Performance Measures selected for improvement:

1. AWC – Adolescent Well-Care Visits

AWC - Adolescent Well-Care Visits*

Age 12-21 years of age who had at least one visit with a primary care practitioner or an OB/GYN during the year.

Figure 10: 2019 AWC Rates



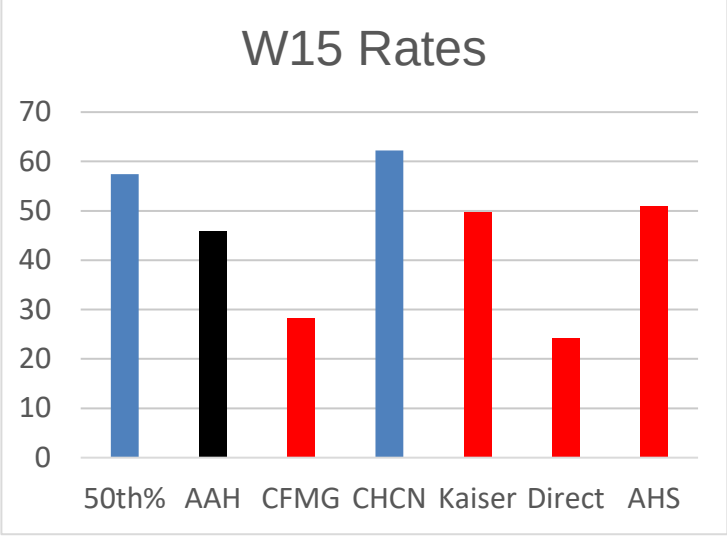
- Plan Above the 50th %: Yes
- Providers below the 50%: Directs and AHS
- Eligible Number: 41K
  - Directs: 3993
  - AHS: 3820

* Hybrid Measure, but no previous hybrid rates, thus graph is admin data only

2. W15 - Well-Child Visits in the First 15 months of Life

Figure 11: 2019 W15 Rates

15 months old and had 0–6 well-child visits with a pcp



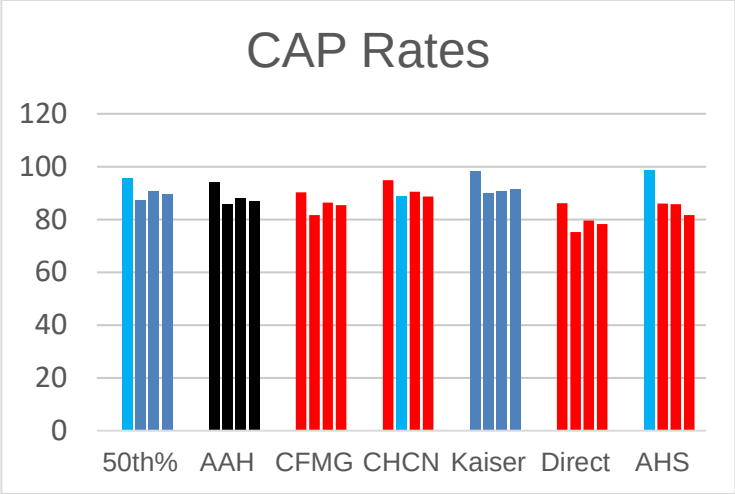
- Plan Above the 50th %: No
- Providers below the 50%: CFMG, Kaiser, Directs and AHS
- Eligible Number: 1,335
  - CFMG: 382 → PIP
  - Kaiser: 354 → Data Share
  - Directs: 70
  - AHS: 153 → Data Share

* Hybrid Measure, but no previous hybrid rates, thus graph is admin data only

3. CAP - Children & Adolescents' Access to Primary Care Practitioners

Figure 12: 2019 CAP Rates

1-19 yo who had a visit with a PCP – 1-2 (3468), 2-6 (22063), 7-11 (20826), 12-19 (30283)



- Plan Above the 50th %: No
- Providers below the 50%: CFMG (All), CHCN (3/4), Directs (All) and AHS (3/4)
- Eligible Number:
  - CHCN → Data Share
  - CFMG → Data Share
  - Directs: 3993 → PIP
  - AHS: 3820 → PIP

Goal of effective partnerships will result in value-add outcomes for the Alliance and its pediatric members that include:

- a shared vision
- improved access to care (Quality initiatives with delegates)
- increased utilization rates for preventive health services (Quality initiatives)
- improved data sharing
- improved care coordination (Clinical initiatives with delegates)
- improved health outcomes, (Clinical initiatives with delegates)
- improved HEDIS rates to MCAS 50% MPL (Quality initiatives with delegates)
- enriched member and provider experience/satisfaction (Quality initiatives)

The Pediatric Care Coordination Pilot launched October of 2019. Pilot analysis with outcomes measurements slated for July 2020.

Figure 13: HEDIS MCAS Access to Care PIP Measures with Member Incentives (CFMG, AHS, CHCN, Directs)

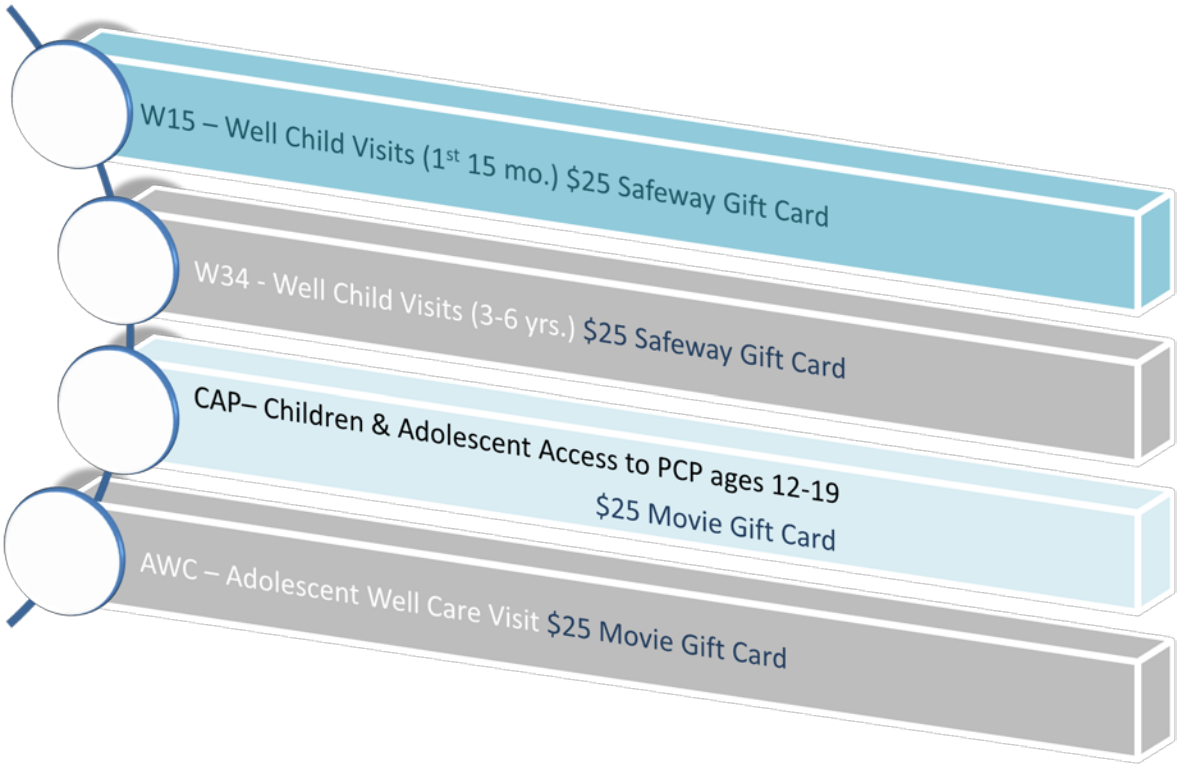


Figure 14: Pediatric Care Coordination Pilot Goals

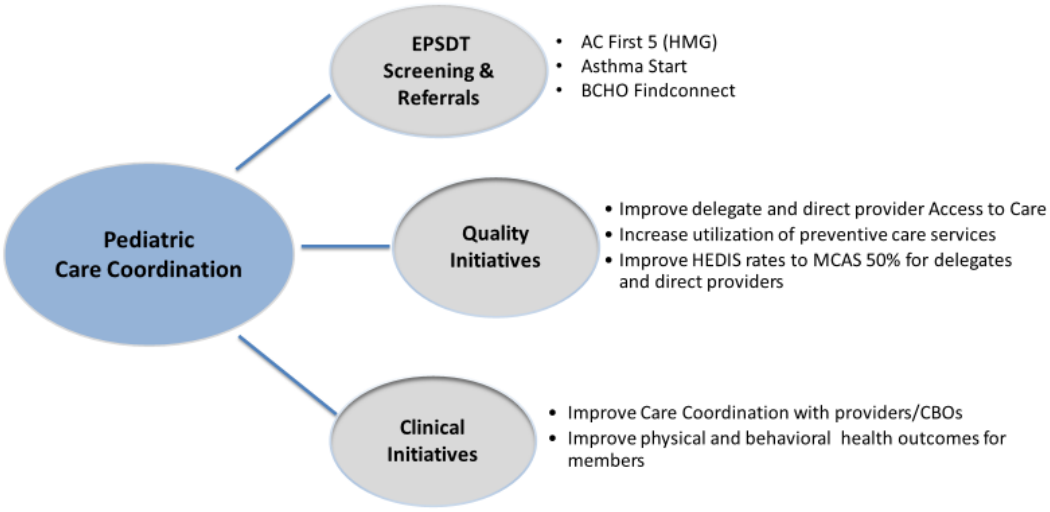


Table 22: Pediatric Care Coordination Pilot

	Potential AAH Support	Additional Value Add	Purpose of Pilot Funding
AC First 5 Help Me Grow (HMG) Ages 1-5	Multilingual call center for well visit member outreach improve HEDIS/GIC under utilization	• + Comm reputation • Culturally relevant member connections and communications • Demonstrated data sharing	• Increase outreach to AAH members • Improve screening and referrals with increased access to primary care services • Care Coordination/Navigation

Asthma Start Ages 1- 18	• Strengthen CM utilization to high risk members
	• Assist with AMR HEDIS Metric
	• Become CB-CME for scaling and sustainability
	• F/U ED visits
		• + Comm reputation
		• Intensive asthma CM for kids/families
		• Existing systems to track referrals and health outcomes
		• Integrated with county services
			• Data sharing opportunity for enhanced integration into QI and population
			• Health mgt work
			  • CM/DM coordination
			  • Increase HE funding to expand service to 19-20 year olds
			  • Fund one (1) CHW for 1yr. with outcomes tracking
			  • Become CB-CME

BCHO (ACES) Findconnect	• Strengthen provider/plan capacity to provide resource referrals via trauma informed care assessment addressing SDOH	• State funding already in place for provider trauma screenings. Resource referrals are needed to assist with BH care coordination and targeting of wrap-around service coordination- including
		  • Food is Medicine
		  • Open source Wellness
			• Pilot “Hub Model” using Health Coordinator embedded in AAH CM to promote and receive referrals via Findconnect platform
			• Data source for Pop Health reporting
			• Provide Trauma Care Training to AAH staff.

CLINICAL IMPROVEMENT TRENDS: HEDIS

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

noted and reflects prior calendar year. Minimum Performance Level and High Performance Level are determined by the Medi-Cal Managed Care Division.

Table 23: Medicaid Hybrid HEDIS Measures

NCQA Acronym	Current Rate Method	Accred - EAS - Both	Measure	Hybrid Final - June 2018	2019 Current Hybrid	2019 MPL
ABA	H	A	Adult BMI Assessment	83.09%	92.92%	*83.17%*
CCS	H	B	Cervical Cancer Screening	60.00%	63.54%	*54.26%*
CDC	H	E	CDC HbA1c	87.59%	89.05%	*84.99%*
CIS	H	E	CIS - COMBO3	73.97%	77.62%	*65.45%*
PPC	H	B	PPC - Prenatal	85.52%	84.44%	*76.89%*
W34	H	B	Well-Child Visits in the Third, Fourth, Fifth and Six	79.27%	73.84%	*67.15%*
CBP	H	B	Controlling High Blood Pressure	65.69%	64.23%	*49.15%*
CDC	H	E	CDC Poor Control	34.31%	29.68%	*47.08%*
CDC	H	B	CDC Good Control <8	53.77%	57.66%	*44.44%*
CDC	H	B	CDC Eye	58.64%	61.31%	*50.85%*
CDC	H	E	CDC Neph	89.54%	86.62%	*88.56%*
CDC	H	B	CDC BP<140/90	61.80%	67.15%	*56.33%*
IMA	H	B	IMA - Combo 2	47.69%	55.23%	*26.28%*
PPC	H	B	PPC - Postpartum	68.31%	72.78%	*59.61%*
WCC	H	A	WCC - BMI	72.27%	91.34%	*66.06%*
WCC	H	B	WCC - Counseling for Nutrition	74.45%	82.69%	*59.85%*
WCC	H	B	WCC - Counseling for Phys Activity	76.01%	80.30%	*52.31%*

Table 24: Medicaid Administrative HEDIS Rates

NCQA Acronym	Current Rate Method	Accred - EAS - Both	Measure	Admin Final - April 2018	2019 Current Admin	2019 MPL
AAB	A	B	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	41.23%	41.47%	*27.63%*
ADD	A	A	Initiation Phase	40.04%	44.02%	*47.13%*
ADD	A	A	Continuation and Maintenance (CM) Phase	54.55%	53.26%	*38.20%*
AMM	A	A	Effective Acute Phase Treatment	66.70%	70.03%	*48.90%*
AMM	A	A	Effective Continuation Phase Treatment	51.97%	53.37%	*33.45%*
AMR	A	E	Asthma Medication Ratio	62.85%	64.17%	*56.85%*
AWC	A	A	Adolescent Well-Care Visits	48.24%	49.43%	*45.74%*
BCS	A	B	Breast Cancer Screening	63.88%	63.93%	*51.82%*
CAP	A	E	12-24 Months	91.90%	93.94%	*93.64%*
CAP	A	E	25 Months - 6 Years	84.53%	85.60%	*84.39%*
CAP	A	E	7-11 Years	87.55%	88.20%	*87.73%*
CAP	A	B	12-19 Years	85.54%	86.96%	*85.91%*
CHL	A	A	Chlamydia Screening in Women - Total	59.99%	58.91%	*50.46%*
CWP	A	A	Appropriate Testing for Children With Pharyngitis	66.48%	72.17%	*72.52%*
LSC	A	A	Lead Screening in Children	64.50%	63.84%	*62.53%*
LBP	A	B	Use of Imaging Studies for Low Back Pain	81.99%	80.40%	*67.19%*
MMA	A	A	Total Medication Compliance 50%	67.73%	68.38%	*54.72%*
MMA	A	A	Total Medication Compliance 75%	46.12%	47.08%	*29.41%*
MPM	A	E	ACE Inhibitors or ARBs	86.52%	86.95%	*85.97%*
MPM	A	E	Diuretics	85.60%	85.92%	*86.00%*
NCS	A	A	Non-Recommended Cervical Cancer Screening in Adolescent Females	0.27%	0.20%	*2.06%*
SPC	A	A	SPC - Received Statin Therapy 21-75 Male	77.76%	78.34%	*74.53%*
SPC	A	A	SPC - Statin Adherence 80% 21-75 Male	82.24%	81.14%	*59.21%*
SPC	A	A	SPC - Received Statin Therapy 40-75 Female	66.04%	69.35%	*69.85%*
SPC	A	A	SPC - Statin Adherence 80% 40-75 Female	72.49%	81.40%	*56.34%*
SPD	A	A	SPD - Received Statin Therapy	69.16%	71.46%	*58.19%*
SPD	A	A	SPD - Statin Adherence 80%	76.20%	80.08%	*53.18%*
SSD	A	A	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.24%	80.70%	*77.27%*
SMD	A	A	Diabetes Monitoring for People With Diabetes and Schizophrenia	63.89%	63.28%	*65.00%*
SMC	A	A	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	68.00%	60.87%	*74.33%*
SAA	A	A	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	28.53%	32.31%	*53.91%*
PBH	A	A	Persistence of Beta-Blocker Treatment After a Heart Attack	81.30%	83.10%	*73.66%*
PCE	A	A	Systemic Corticosteroid	63.65%	63.30%	*62.92%*
PCE	A	A	Bronchodilator	85.82%	87.45%	*78.74%*
URI	A	A	Appropriate Treatment for Children With Upper Respiratory Infection	97.38%	98.09%	*86.63%*
W15	A	A	W15 - Six or More visits	21.03%	45.92%	*58.54%*

ANALYSIS OF HEDIS MEDICAID EXTERNAL ACCOUNTABILITY SET (EAS)

The above tables represent the Medicaid HEDIS measures for the DHCS Accountability measure set. Of the trended measures (including individual sub measures), 43/52 measures met the Minimum Performance Level (MPL). In 2019, 8 of the measures showed improvement while 12 showed a minimal decline, whereas 2 measures (W34 and SMC) showed more significant decline but continue to be significantly above the MPL.

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

Based on the HEDIS data presented, potential focus areas for 2020 may include the following:

- W34 – Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years
- W15 – Six or more Visits in the First 15 Months
- AWC – Adolescent Well-Care Visits
- CCS – Cervical Cancer Screening
- CDC – Comprehensive Diabetic Care – HbA1c Testing

HEALTH PLAN ACCREDITATION

In September 2019, Alameda Alliance participated in the triennial reaccreditation survey for Health Plan Accreditation (HPA) sponsored by NCQA. NCQA HPA is a voluntary recognition program consisting of a triennial desktop review of program materials, policies and procedures and on-site file review. The standards evaluate Quality Improvement, Population Health Management, Network Management, Utilization Management, Credentialing, Rights and Responsibilities, and Member Connections. Annually, the score and award are reevaluated based on the fixed survey standards score and an annual reevaluation of audited HEDIS and CAHPS scores. NCQA grants the following decisions: Excellent (90-100 points), Commendable (80-89.99 points), Accredited (65-79.99 points), Provisional (55-64.99 points), and Denied (less than 54.99 points).

Figure 15: Medicaid NCQA Accreditation Status Award

With a combined score of 86.14, Medicaid earned "Commendable" status, 48.99 Standards score, and 37.14 HEDIS + CAHPS score. However, there was a must pass element UM 7B that did not receive a passing score. The Alliance received a Corrective Action Plan for this element and will be resurveyed in June 2020. In 2020, HEDIS + CAHPS scores will be submitted for annual NCQA reevaluation and added to the Standards score of 48.99.

Figure 16: Group Care NCQA Accreditation Status Award

With a combined score of 41.66 for Standards, GroupCare earned "Accredited" status for the next year. The Alliance will have a resurvey in June 2020 to review elements that did not pass 80%, we will need a score of 42.5 for Standards to obtain our accredited status for 3 years. For GroupCare we also did not receive a passing score for the must pass element UM 7B. Resurvey of this element will also be conducted in June 2020.

QUALITY OF SERVICE

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

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

MEMBER EXPERIENCE SURVEY

The Medi-Cal and Commercial Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is administered by an NCQA-certified HEDIS survey vendor. SPH Analytics was selected by the Alliance to conduct the 2019 CAHPS 5.0 survey. The survey method includes mail and phone responses. Members in each Alliance line of business (LOB) are surveyed separately. Table 1 shows the survey response rates. As of 12/31/19, the Alliance had a total of 243,457 members. Breakdown of member enrollment by network is as follows: Community Health Center Network (CHCN) 36%; the

Alliance (directs) 18%; Alameda Health System (AHS) 18%; Kaiser 13%; and Children First Medical Group (CFMG) 12%.

Table 25: Survey Response Rates for 2019 – 2018

	Medi-Cal Adult	Medi-Cal Child	Commercial Adult
2019	21.3%	21.3%	28.3%
2018	20.9%	24.3%	27.9%

Table 26, Table 27,and

Table 28 contain trended survey results for the Medi-Cal Child, Medi-Cal Adult, and Commercial Adult populations across composites. Tables 5-7 contain trended survey results for these three populations for the delegate networks. The 2018 Quality Compass All Plans (QCAP) benchmark noted within the table is a collection of CAHPS 5.0 mean summary ratings for the Medicaid and Commercial samples that were submitted to NCQA in 2018 that provides for an aggregate or national summary. With respect to the 2018 QCAP scores, Red signifies that the current year 2019 score is significantly lower when compared to trend or benchmark score. Data values in Green indicate that the current year 2019 score is significantly higher when compared to trend or benchmark score.

Table 26: Medi-Cal Child Trended Survey Results

Summary Rate Scores: Medi-Cal Child				
Composite	**2019**	**2018 QCAP**	**2018**	**Year Over Year Trend**
Getting Needed Care	83.5%	84.7%	81.9%	↑
Getting Care Quickly	85.4%	89.5%	82.8%	↑
How Well Doctors Communicate	93.7%	93.7%	91.6%	↑
Customer Service	86.1%	88.7%	84.6%	↑
Shared Decision Making	78.4%	78.3%	75.3%	↑
Rating of Health Care (8-10)	89.8%	87.0%	85.9%	↑
Rating of Personal Doctor (8-10)	93.6%	89.5%	89.6%	↑
Rating of Specialist (8-10)	85.5%	87.0%	86.3%	↓
Rating of Health Plan (8-10)	88.9%	86.3%	88.3%	↔

Table 27: Medi-Cal Adult Trended Survey Results

Summary Rate Scores: Medi-Cal Adult				
Composite	**2019**	**2018 QCAP**	**2018**	**Year Over Year Trend**
Getting Needed Care	76.0%	82.4%	76.1%	↔
Getting Care Quickly	74.5%	82.1%	73.2%	↑
How Well Doctors Communicate	88.4%	91.6%	90.5%	↓
Customer Service	80.7%	88.3%	86.7%	↓
Shared Decision Making	78.7%	79.5%	70.8%	↑
Rating of Health Care (8-10)	73.6%	74.6%	73.5%	↔
Rating of Personal Doctor (8-10)	77.1%	81.4%	80.3%	↓
Rating of Specialist (8-10)	74.5%	82.1%	77.8%	↓
Rating of Health Plan (8-10)	73.4%	77.0%	73.0%	↔

Table 28: Commercial Adult Trended Survey Results

Summary Rate Scores: Commercial Adult				
Composite	**2019**	**2018 QCAP**	**2018**	**Year Over Year Trend**
Getting Needed Care	72.8%	86.2%	72.3%	↔
Getting Care Quickly	70.9%	84.8%	69.5%	↑
How Well Doctors Communicate	87.6%	95.0%	85.8%	↑
Customer Service	82.8%	88.4%	86.5%	↓
Shared Decision Making	84.3%	81.6%	84.3%	↔
Rating of Health Care (8-10)	68.2%	77.5%	66.8%	↑
Rating of Personal Doctor (8-10)	80.4%	84.9%	73.3%	↑
Rating of Specialist (8-10)	75.5%	84.7%	75.9%	↔
Rating of Health Plan (8-10)	64.5%	63.6%	66.5%	↓

Table 29: Medi-Cal Child Trended Survey Results – Delegates

	AHS			Alliance			CFMG			CHCN			Kaiser 2019			2018 QCAP
	2019	2018	Year Over Year Trend	2019	2018	Year Over Year Trend	2019	2018	Year Over Year Trend	2019	2018	Year Over Year Trend	2019	2018	Year Over Year Trend	
Getting Needed Care	79.2%	91.9%	↓	77.5%	65.0%	↑	82.6%	81.4%	↑	83.8%	78.9%	↑	90.1%	92.4%	↓	84.7%
Getting Care Quickly	55.7%	70.2%	↓	93.3%	84.1%	↑	89.3%	89.9%	↔	79.8%	76.8%	↑	98.6%	93.1%	↑	89.5%
How Well Doctors Communicate	94.7%	90.0%	↑	86.1%	100.0%	↓	93.8%	93.9%	↔	92.8%	86.4%	↑	98.5%	99%	↓	93.7%
Rating of Health Care (8-10)	87.5%	87.1%	↔	100.0%	93.3%	↑	91.1%	86.4%	↑	87.0%	81.4%	↑	93.9%	93.9%	↔	87.0%
Rating of Personal Doctor (8-10)	97.0%	81.3%	↑	100.0%	85.0%	↑	97.9%	93.3%	↑	88.1%	87.2%	↑	94.7%	94.7%	↔	89.5%
Rating of Specialist (8-10)	75.0%	66.7%	↑	100.0%	50.0%	↑	91.3%	93.8%	↓	77.8%	89.7%	↓	90.9%	83.3%	↑	87.0%
Rating of Health Plan (8-10)	97.2%	87.2%	↑	96.2%	81.8%	↑	88.8%	85.6%	↑	84.1%	89%	↓	95.1%	92.6%	↑	86.3%

Table 30: Medi-Cal Adult Trended Survey Results – Delegates

	AHS			Alliance			CFMG			CHCN			Kaiser			2018QCAP
	2019	2018	Year Over Year Trend	2019	2018	Year Over Year Trend	2019	2018	Year Over Year Trend	2019	2018	Year Over Year Trend	2019	2018	Year Over Year Trend	
Getting Needed Care	74.5%	69.4%	↑	81.9%	74.4%	↑	50.0%	100%	↓	70.1%	78.3%	↓	90.0%	88.3%	↑	82.4%
Getting Care Quickly	69.5%	68.9%	↑	75.0%	86.0%	↓	50.0%	83.3%	↓	75.2%	65.7%	↑	82.4%	72.3%	↑	82.1%
How Well Doctors Communicate	88.8%	87.5%	↑	82.9%	88.2%	↓	100.0%	100%	↔	91.8%	94.4%	↓	93.2%	85%	↑	91.6%
Rating of Health Care (8-10)	67.6%	60.6%	↑	71.7%	81.5%	↓	100.0%	100%	↔	75.6%	70.4%	↑	81.3%	90.9%	↓	74.6%
Rating of Personal Doctor (8-10)	70.6%	76.9%	↓	65.5%	86.8%	↓	100.0%	100%	↔	85.9%	79.2%	↑	85.7%	70.6%	↑	81.4%
Rating of Specialist (8-10)	62.5%	75.0%	↓	67.9%	71.4%	↓	0%	100%	↓	86.0%	88.9%	↓	63.6%	57.1%	↑	82.1%
Rating of Health Plan (8-10)	67.7%	62.9%	↑	71.0%	77.6%	↓	50.0%	50%	↔	74.8%	74.8%	↔	91.6%	82.6%	↑	77.0%

Table 31: Commercial Adult Trended Survey Results – Delegated Network

	Alliance			CHCN			AHS			2018 QCAP
	2019	2018	Year Over Year Trend	2019	2018	Year Over Year Trend	2019	2018	Year Over Year Trend	
Getting Needed Care	72.4%	70.6%	↑	71.8%	73.2%	↓	77.7%	75.6%	↑	86.2%
Getting Care Quickly	73.5%	69.5%	↑	71.2%	70.1%	↑	61.4%	68.3%	↓	84.8%
How Well Doctors Communicate	83.7%	81.2%	↑	90.8%	89.4%	↑	91.3%	95.0%	↓	95.0%
Rating of Health Care (8-10)	68.0%	63.7%	↑	65.6%	69.7%	↓	79.2%	69.2%	↑	77.5%
Rating of Personal Doctor (8-10)	73.2%	68.3%	↑	85.6%	78.7%	↑	88.9%	76.5%	↑	84.9%
Rating of Specialist (8-10)	70.0%	73.1%	↓	82.9%	77.3%	↑	81.8%	83.3%	↓	84.7%
Rating of Health Plan (8-10)	61.8%	64.7%	↓	67.5%	68.5%	↓	64.1%	67.7%	↓	63.6%

Table 32, Table 33, and Table 34 contain the 3-point scores across measures for the LOBs. The 3-point scores are utilized for the annual accreditation score provided by NCQA.

Table 32: Medi-Cal Child 3 Point Sorces:

Measure	Alliance 3-Point Score	2019 CAHPS 25th Percentile	Alliance Percentile Threshold
Getting Needed Care	2.40	2.40	25th
Getting Care Quickly	2.48	2.54	<25th
Customer Service	2.51	2.50	25th
Coordination of Care	NA	2.36	NA
Rating of Health Care	2.64	2.49	90th
Rating of Personal Doctor	2.76	2.58	90th
Rating of Specialist	NA	2.53	NA
Rating of Health Plan	2.69	2.51	90th

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

Table 33: Medi-Cal Adult 3-Point Scores

Measure	Alliance 3-Point Score	2019 CAHPS 25th Percentile	Alliance Percentile Threshold
Getting Needed Care	2.21	2.34	<25th
Getting Care Quickly	2.26	2.38	<25th
Customer Service	NA	2.48	NA
Coordination of Care	NA	2.36	NA
Rating of Health Care	2.32	2.35	<25th
Rating of Personal Doctor	2.45	2.43	25th
Rating of Specialist	NA	2.48	NA
Rating of Health Plan	2.40	2.39	25th

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

Table 34: Commercial Adult 3-Point Scores

Measure	Alliance 3-Point Score	2019 CAHPS 25th Percentile	Alliance Percentile Threshold
Getting Needed Care	2.15	2.36	<25th
Getting Care Quickly	2.21	2.39	<25th
Customer Service	NA	2.44	NA
Claims Processing	NA	2.36	NA
Coordination of Care	2.29	2.27	25th
Rating of Health Care	2.27	2.33	<25th
Rating of Personal Doctor	2.51	2.47	25th
Rating of Specialist	2.45	2.49	<25th
Rating of Health Plan	2.21	2.02	50th

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

Table 35 shows the measures with the highest and lowest Quality Compass All Plans percentile rankings across each LOB.

Table 35: Highest and Lowest Quality Compass All Plans Percentile Rankings

Highest Quality Compass All Plans Percentile Rankings		
Medi-Cal Adult	**Commercial Adult**	**Medi-Cal Child**
37th Health Promotion and Education	**76th** Shared Decision Making	**95th** Rating of Personal Doctor (8-10)
37th Rating of Health Care (8-10)	**54th** Coordination of Care	**79th** Rating of Health Care (8-10)
32nd Shared Decision Making	**53rd** Rating of Health Plan (8-10)	**74th** Rating of Health Plan (8-10)
Lowest Quality Compass All Plans Percentile Rankings		
Medi-Cal Adult	**Commercial Adult**	**Medi-Cal Child**
<10th Getting Care Quickly	**<10th** Rating of Personal Doctor (8-10)	**31st** Rating of Specialist (8-10)
<10th Getting Needed Care	**<10th** Rating of Health Care (8-10)	**16th** Customer Service
<10th Coordination of Care	**<10th** Getting Needed Care	**15th** Getting Care Quickly

CAHPS SURVEY ANALYSIS

The 2019 CAHPS survey results year-over-year trends show variation within the Alliance business lines. Across LOBs, the Medi-Cal Child population had the highest overall composite summary rate scores in 2019. The Commercial Adult population had the lowest overall composite summary rate scores. Additionally, from 2018 to 2019 seven of the nine composite summary rate scores increased for Medi-Cal Child, while four of the nine increased for Commercial Adult. From 2018 to 2019, four of the nine composite summary rate scores decreased for Medi-Cal Adult. Lastly, three composites - Rating of Health Plan, Rating of Health Care, and Rating of Personal Doctor – have been identified for all LOBs as key drivers of member satisfaction, as shown in Table 12, thus providing opportunities for improvement.

Table 36: Composites and Key Drivers

Composite	Key Driver
Rating of Health Plan	Customer Service
	Getting Needed Care
Rating of Health Care	How Well Doctors Communicate
	Getting Needed Care
Rating of Personal Doctor	How Well Doctors Communicate
	Coordination of Care

Table 37 shows the top priorities identified by SPH across populations, based on performance of survey composites and key measures.

Table 37: Composites and Top Priorities

Population	Top Priorities
Medi-Cal Child	Rating of Specialist
	Customer Service
Medi-Cal Adult	Rating of Personal Doctor
	Coordination of Care
	How Well Doctors Communicate
	Getting Needed Care
Commercial Adult	Rating of Specialist
	How Well Doctors Communicate
	Rating of Personal Doctor
	Claims Processing

Four of the seven composite summary rate scores increased for CFMG for their Medi-Cal Child population, while four of the seven stayed the same for their Medi-Cal Adult population. Five of the seven composite summary rate scores increased for CHCN for their Medi-Cal Child population; however, there was variation within scores for their Medi-Cal Adult population (3-increased, 3-decreased, 1-stayed the same). Four of the seven composite summary rate scores decreased for their Commercial Adult population. Six out of seven composite summary rate scores increased for Kaiser for their Medi-Cal Adult population; however, there was variation within scores for their Medi-Cal Child population (3-increased, 2-decreased, 2-flat). Four of the seven composite summary rate scores increased for AHS for their Medi-Cal Child population, while five of the seven composite summary rate scores increased for their Medi-Cal Adult population. Four of the seven composite summary rate scores decreased for their Commercial Adult population. Six out of seven composite summary rate scores increased for the Alliance network for their Medi-Cal Child population; however, six out of seven composite summary rate scores decreased for their Medi-Cal Adult population. Five of the seven composite summary rate scores increased for their Commercial Adult population.

Three-point scores are utilized for the annual accreditation score provided by NCQA. The Alliance utilized the Medi-Cal Child survey to address this portion of the annual score. Three composites are at or below the 25th percentile. The other three are at the 90th percentile.

NEXT STEPS REGARDING CAHPS RESULTS

The Alliance will continue to collaborate interdepartmentally, focusing on the areas identified as top priorities, to increase overall survey scores and percentiles. Additionally, the Alliance will continue to partner with providers on initiatives designed to improve the member experience and survey scores in 2020-2021 using the Plan-Do-Study-Act cycle to improve or maintain Member Satisfaction scores.

QUALITY OF ACCESS

A. STANDARDS AND EDUCATIONAL STANDARDS

The Alliance has continued to educate providers on, monitor, and enforce the following standards**:**

Table 38: Primary Care Phsyician (PCP) Appointment

PRIMARY CARE PHYSICIAN (PCP) APPOINTMENT	
Appointment Type:	**Appointment Within:**
Non-Urgent Appointment	10 Business Days of Request
First OB/GYN Pre-natal Appointment	2 Weeks of Request
Urgent Appointment that *requires* PA	96 Hours of Request
Urgent Appointment that *does not* require PA	48 Hours of Request

Table 39: Specialty/Other Appointment

SPECIALTY/OTHER APPOINTMENT	
Appointment Type:	**Appointment Within:**
Non-Urgent Appointment with a **Specialist** Physician	15 Business Days of Request
Non-Urgent Appointment with a **Behavioral Health** Provider	10 Business Days of Request
Non-Urgent Appointment with an **Ancillary Service** Provider	15 Business Days of Request
First OB/GYN Pre-natal Appointment	2 Weeks of Request
Urgent Appointment that *requires* PA	96 Hours of Request
Urgent Appointment that *does not* require PA	48 Hours of Request

Table 40: All Provider Wait Time/Telephone/Language Practices

ALL PROVIDER WAIT TIME/TELEPHONE/LANGUAGE PRACTICES	
Appointment Type:	**Appointment Within:**
In-Office Wait Time	60 Minutes
Call Return Time	1 Business Day
Time to Answer Call	10 Minutes
Telephone Access – Provide coverage 24 hours a day, 7 days a week.	
Telephone Triage and Screening – Wait time not to exceed 30 minutes.	
Emergency Instructions – Ensure proper emergency instructions.	
Language Services – Provide interpreter services 24 hours a day, 7 days a week.	

*** Per DMHC and DHCS Regulations, and NCQA HP Standards and Guidelines**

PA = Prior Authorization

Urgent Care refers to services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).

Non-urgent Care refers to routine appointments for non-urgent conditions.

Triage or Screening refers to the assessment of a member's health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within their scope of practice. This individual must be trained to screen or triage, and determine the urgency of the member's need for care.

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

Table 41: Primary Care Physician (PCP) Appointment

PRIMARY CARE PHYSICIAN (PCP) APPOINTMENT	
Appointment Type:	**Measured By:**
Non-Urgent Appointment	PAAS, CG-CAHPS
First OB/GYN Pre-natal Appointment	First Prenatal, Confirmatory Survey
Urgent Appointment that *requires* PA	PAAS, CG-CAHPS
Urgent Appointment that *does not* require PA	PAAS, CG-CAHPS

Table 42: Specialty/Other Appointment

SPECIALTY/OTHER APPOINTMENT	
Appointment Type:	**Measured By:**
Non-Urgent Appointment with a **Specialist** Physician	PAAS
Non-Urgent Appointment with a **Behavioral Health** Provider	PAAS
Non-Urgent Appointment with an **Ancillary Service** Provider	PAAS
First OB/GYN Pre-natal Appointment	First Prenatal, Confirmatory Survey
Urgent Appointment that *requires* PA	PAAS
Urgent Appointment that *does not* require PA	PAAS

Table 43: All Provider Wait Time/Telephone/Language Practices

ALL PROVIDER WAIT TIME/TELEPHONE/LANGUAGE PRACTICES	
Appointment Type:	**Measured By:**
In-Office Wait Time	CG-CAHPS
Call Return Time	CG-CAHPS

ALL PROVIDER WAIT TIME/TELEPHONE/LANGUAGE PRACTICES	
Appointment Type:	**Measured By:**
Time to Answer Call	CG-CAHPS
Telephone Access – Provide coverage 24 hours a day, 7 days a week	Confirmatory Survey
Telephone Triage and Screening – Wait time not to exceed 30 minutes	Confirmatory Survey
Emergency Instructions – Ensure proper emergency instructions	After Hours: Emergency Instructions Survey, Confirmatory Survey
Language Services – Provide interpreter services 24 hours a day, 7 days a week	CG-CAHPS

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

- Plan: The standards were discussed and adopted, and surveys have been aligned with our adopted standards.
- Do: The surveys are administered, per our policies and procedures (P&Ps); survey methodologies, vendors, and processes are outlined in P&Ps.
- Study: Survey results along with QI recommendations are brought forward to the A&A Committee; the Committee formalizes recommendations which are forwarded to the HCQC and Board of Governors

Act: Dependent on non-compliant providers and study / decision of the A&A Committee, actions may include, but are not limited to, provider education/re-education and outreach, focused discussions with providers and delegates, resurveying providers to assess/reassess provider compliance with timely access standard(s), issuing of corrective action plans (CAPs), and referral to the Peer Review and Credentialing Committee.

B. PROVIDER CAPACITY

The Alliance reviews network capacity reports monthly to determine whether primary care providers are reaching network capacity standards of 1:2000. In 2019, no providers exceeded the 2,000 member threshold. The Network Validation department flags the provider at 1900 and above to ensure member assignment does not reach the 2,000 capacity standard. If a provider is close to the threshold, the plan reaches out to confirm if the provider intends to recruit other providers. If not, the panel is closed to new assignment. During this time the plan and the provider are in communication of such changes.

C. GEO ACCESS

The geographic access reports are reviewed quarterly to ensure that the plan is meeting the geographic access standards for provided services in Alameda County. For PCPs, the Alliance has adopted standards of one provider within 30 minutes / 15 miles. For specialists, the Alliance has adopted standards of one provider within 30 minutes / 15 miles. During 2019, the Alliance implemented a cross functional quarterly meeting to review access issues and concerns.

In 2019, the rural areas near Livermore were the only areas in which the plan faced geographic access issues for Primary Care Provider (PCP) services. Although, there were some deficiencies in the Livermore area for PCP services for distance, the Alliance was able to demonstrate compliance in meeting "time" regulatory standards. The Alliance received DHCS approval to their request for alternative access for certain Pediatric specialist in 2019.

D. PROVIDER APPOINTMENT AVAILABILITY

The Alliance's annual Provider Appointment Availability Survey (PAAS) for MY2019 was used to review appointment wait times for the following provider types:

- Primary Care Physicians (PCPs)
- Specialist Physicians (SPCs):
    - Cardiovascular Disease
    - Endocrinology
    - Gastroenterology
- Non-Physician Mental Health (NPMH) Providers (PhD-level and Masters-level)
- Ancillary Services Providers offering Mammogram and/or Physical Therapy
- Psychiatrists

The Alliance reviewed the results of its annual PAAS for MY2019 in order to identify areas of deficiency and areas for potential improvement. The Alliance defines *deficiency* as a provider group scoring less than a seventy-five percent (75%) compliance rate on any survey question related to appointment wait times.

The Alliance analyzed results for Alameda County, as the vast majority of members live and receive care in Alameda County, the Alliance's service area. Additionally, per the MY2019 DMHC PAAS Methodology, the Alliance reported compliance rates for all counties in which its contracted providers were located, regardless of whether the providers were located outside the Alliance's service area. This included provider groups in the following counties – Contra Costa, Sacramento, San Francisco, Santa Clara, Solano, Marin, Madera, Monterey, San Mateo, Santa Cruz, and Sonoma.

Table 44:Compliance Rates by Appointment Type across All Provider Types

LOB	Urgent Appt	Routine Appt
IHSS	65%	72%
MCL	68%	75%

Across all provider types, there was greater compliance with the routine appointment standard than with the urgent appointment standard, and this was evidenced for both LOBs – MCL and IHSS (see Table 1). This was also evident in the results of the MY2018 PAAS. When engaging in provider/delegate re-education around the timely access standards, the Alliance will increase its efforts around compliance with the urgent appointment standard through the following ways:

- Dissemination of provider communications (written and posted) emphasizing the urgent appointment standards;

- Reinforcement of the urgent appointment standards by Provider Services within their interactions with providers; and
- Targeted discussions with leadership staff during Joint Operations Meetings between the Alliance and its delegate leadership.

Table 45: Overall Appointment Compliance Rates by Provider Type

LOB	Ancillary	PCPs	NPMH	Psychiatrists	Specialists
IHSS	100%	81%	78%	72%	51%
MCL	100%	82%	78%	73%	52%

Ancillary Providers had the highest level of compliance for both LOBs across both appointment types (urgent appointment standard excluded for this provider type), followed by PCPs, NPMH providers, and Psychiatrists, with Specialists having the lowest level of compliance for both LOBs (see Table 2). Results of the MY2018 PAAS also show Ancillary providers with the highest level of compliance, followed by PCPs, Psychiatrists, and NPMH providers, with Specialists again having the lowest level of compliance for both LOBs. When engaging in provider/delegate re-education around the timely access standards, the Alliance will increase its efforts on Specialists, given they had the lowest level of compliance across all provider types. This will be accomplished through targeted discussions with leadership staff during Joint Operations Meetings between the Alliance and its delegate leadership.

Table 46: Appointment Type by Provider Survey Type

Ancillary		
LOB	**Urgent Appt**	**Routine Appt**
IHSS	Not applicable	100%
MCL	Not applicable	100%
PCPs		
LOB	**Urgent Appt**	**Routine Appt**
IHSS	80%	82%
MCL	79%	86%
NPMH		
LOB	**Urgent Appt**	**Routine Appt**
IHSS	74%	83%
MCL	75%	82%

Psychiatrists		
LOB	**Urgent Appt**	**Routine Appt**
IHSS	61%	83%
MCL	63%	84%
Specialists		
LOB	**Urgent Appt**	**Routine Appt**
IHSS	50%	53%
MCL	50%	54%

All provider types had higher levels of compliance with the routine appointment standard than with the urgent appointment standard (see Table 3).

Table 47: Percentage of Ineligible Provider Types

Psychiatrists	PCPs	Specialists	Ancillary	NPMH
36%	31%	30%	29%	27%

Across all provider types, Psychiatrists had the highest percentage of ineligible providers, followed by PCPs, Specialists, and Ancillary providers, with NPMH providers having the lowest percentage of ineligible providers (see Table 4). Results of the MY2018 PAAS also show Psychiatrists as having the highest percentage of ineligible providers, followed by NPMH providers, PCPs, and Specialists, with Ancillary providers having the lowest percentage of ineligible providers. Only one provider type, Psychiatrists, showed a decrease in percentage of ineligible providers from MY2018 to MY2019; all other provider types had an increase from MY2018 to MY2019. The Alliance will ensure continued collaboration with its Analytics and Provider Services Teams, as well as with its delegate networks, to enhance accuracy of provider contact information, provider specialty, provider network status, and/or provider appointment availability, with the goal of decreasing the overall percentage of ineligible providers.

Table 48: Percentage of Non-Responsive Provider Types

Specialists	NPMH	Psychiatrists	Ancillary	PCPs
41%	37%	17%	15%	8%

Across all provider types, Specialists had the highest percentage of non-responsive providers, followed by NPMH providers, Psychiatrists, and Ancillary providers, with PCPs having the lowest percentages of non-responsive providers (see Table 5). Of those Specialists, those with a specialty in cardiology had the highest non-responding percentage (48%), followed by endocrinology (34%), and gastroenterology (18%). Only two provider types showed a decrease in their overall non-responsiveness rates year-over-year – NPMH providers (15 percentage points) and Psychiatrists (7 percentage points). Overall non-responsive rates increased year-over-year for Specialists (20 percentage points), Ancillary providers (11 percentage points), and

PCPs (1 percentage point). The Alliance will increase its level of provider/delegate education around survey completion and purpose, including a focus on the development of provider/delegate improvement plans, with the overall goal of lessening and/or removing barriers for non-responsiveness. These efforts will include a focus on Specialists, given they had the highest level of survey non-responsiveness across provider types.

E. YEAR-OVER-YEAR ANALYSIS

All provider types, with the exception of Ancillary providers, decreased in compliance rates across both appointment types and for both LOBs. Psychiatrists had the biggest drop in compliance rates for the urgent appointment standard for both LOBs, followed by Specialists. Specialists had the biggest drop in compliance rates for the routine appointment standard for both LOBs.

F. ALAMEDA HEALTH SYSTEM

For the PCP provider type, Alameda Health System decreased their rate of compliance with the routine appointment standard to 0%, as well as moved from ineligible to 0% compliance with the urgent appointment standard, both providing opportunities for improvement.

G. CFMG PROVIDERS

For the PCP provider type, CFMG providers increased their rate of compliance with the routine appointment standard. Additionally for the PCP provider type, CFMG providers decreased their rate of compliance with the urgent appointment standard, providing opportunity for improvement. For cardiology, CFMG providers demonstrated best practice by maintaining 100% compliance with both appointment standards. For endocrinology, CFMG providers made no improvement in compliance with the urgent appointment standard but doubled their rate of compliance with the routine appointment standard. For gastroenterology, CFMG providers demonstrated best practice by moving from non-responsive to 100% compliance with both appointment standards.

H. CHCN PROVIDERS

For the PCP provider type, CHCN providers demonstrated best practice with 100% compliance with both appointment standards for the MCL LOB. Alternately for the PCP provider type, CHCN providers were below the compliance threshold for both appointment standards for the IHSS LOB, providing opportunity for improvement. CHCN providers did not participate in the MY2018 survey for PCPs; as such, year-over-year analysis was not possible. For cardiology, CHCN providers increased their rate of compliance with both appointment standards. For endocrinology, CHCN providers decreased their rate of compliance with the urgent appointment standard, providing opportunity for improvement. Additionally for endocrinology, CHCN providers increased their rate of compliance with the routine appointment standard. For gastroenterology, CHCN providers demonstrated best practice by doubling their rate of compliance with the urgent appointment standard to 100%; they also increased their rate of compliance with the routine appointment standard. For the Ancillary provider type, CHCN providers demonstrated best practice by maintaining 100% compliance with the routine appointment standard.

I. ICPS

For the PCP provider type, ICPs increased their rate of compliance with the routine appointment standard. ICPs decreased their rate of compliance with the urgent appointment standard for the MCL LOB, providing opportunity for improvement. Alternately, ICPs increased their rate of compliance with the urgent appointment standard for the IHSS LOB. For cardiology, ICPs demonstrated best practice by maintaining 100% compliance with the routine appointment standard. Additionally for cardiology, ICPs decreased their rate of compliance with the urgent appointment standard, providing opportunity for improvement. For gastroenterology, ICPs demonstrated best practice by increasing their rate of compliance from 0% to 100% for both appointment standards. For the Psychiatrist provider type, ICPs increased their rate of compliance with both appointment standards from being ineligible in MY2018. For the Adult NPMH provider type, ICPs decreased their rate of compliance with both appointment standards, providing opportunities for improvement.

J. PROVIDER-FOCUSED IMPROVEMENT ACTIVITIES

As part of the Quality Improvement strategy for 2020, the Alliance will continue its ongoing re-education of providers/delegates regarding timely access standards via various methods (e.g., quarterly provider packets, fax blasts, postings on the Alliance website, targeted outreach to providers/delegates, in-office provider visits, and others as appropriate), with the goal of increasing the overall percentage of survey participation and compliance. Additionally, the Alliance will continue to conduct regularly scheduled and ad-hoc surveys/audits that assess provider compliance with timely access standards, issuing time-sensitive corrective action plans (CAPs) to all non-responsive and non-compliant providers. The Alliance will continue to discuss the importance of completion of the PAAS and other timely access surveys. Results and corrective actions needed for improvement are discussed with leadership staff during Joint Operations Meetings between the Alliance and its delegate leadership. The Alliance will also consider engaging in similar discussions with the larger provider groups in its network, especially those with low compliance rates and/or high rates of non-responsiveness. Lastly, the Alliance will continue to review other indicators of access and availability throughout the year and will engage in Plan-Do-Study-Act cycles, as appropriate.

All non-compliant PCPs, Specialists, NPMH providers, Ancillary providers, and Psychiatrists receive notification of their survey results and the timely access standards in which they were deficient, along with time-sensitive CAPs. All non-responsive PCPs, Specialists, NPMH providers, Ancillary providers, and Psychiatrists receive notification of their non-responsiveness reminding them of the requirement to respond to timely access surveys, along with the timely access standards and time-sensitive CAPs.

K. BEST PRACTICES

As part of the Quality Improvement strategy for 2020, during Joint Operations Meetings the Alliance will engage in discussions with delegate leadership whose providers have higher compliance rates, in an effort to learn about best practices that can be shared with other providers. Additionally, the Alliance will share findings from the MY2019 PAAS within its Health Care Quality Committee (HCQC), which is comprised of leadership staff from several delegated networks, offering additional opportunities for discussion of best practices.

L. AFTER HOURS SURVEY

The Alliance contracted with SPH Analytics (SPH) to conduct the annual Provider After-Hours Survey for MY2019, which measures providers' compliance with the after-hours emergency instructions standard. The MY2019 After-Hours Survey was conducted in August 2019. SPH followed a phone-only protocol to administer the survey to the eligible provider population during closed office hours. A total of 448 Alliance providers and/or their staff were surveyed, and included 115 primary care physicians (PCPs), 274 specialists, and 59 behavioral health (BH) providers. The survey assesses for the presence of instructions for a caller with an emergency situation, either via a recording or auto-attendant, or a live person.

The table below presents the compliance rates for the providers surveyed in the After-Hours Survey:

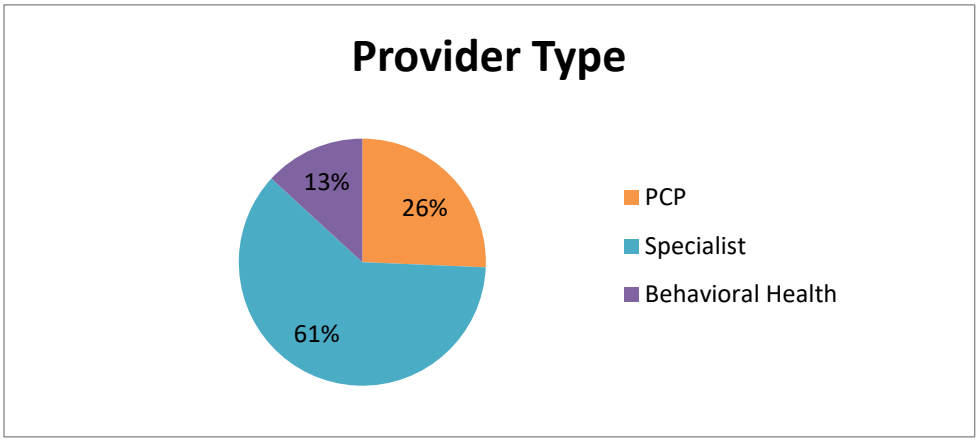
Table 49: Compliace Rates for After Hours Survey

Provider Type	Emergency Instructions		
	Total Compliant	Total Non-Compliant	Compliance Rate
PCP	109	6	94.8%
Specialist	244	29	89.1%
BH	45	14	76.3%

A total of 49 providers (6 PCPs, 29 specialists, 14 BH) were found to be non-compliant with the emergency instructions standard as a result of the After-Hours Survey. PCPs had the highest compliance rate, followed by specialists, then BH providers.

The figure below presents the response rate across provider types:

Figure 17: Response Rate by Provider Type



Specialists had the highest response rate to the survey, followed by PCPs, then BH providers.

The Alliance's Quality Improvement department staff conducted confirmatory surveys of the 49 providers identified as non-compliant as a result of the After-Hours Survey, to verify their compliance with the emergency instruction standard. This decision was made based on the Alliance's past experience and concerns relating to the integrity of SPH data from MY2017 and

MY2018 of the After-Hours Survey. The table below presents the compliance rates for the providers surveyed via the confirmatory surveys conducted by the Alliance:

Table 50: AAH Conducted Survey Compliance Rate for Providers

Provider Type	Emergency Instructions		
	Total Compliant	Total Non-Compliant	Compliance Rate
PCP	111	4	96.5%
Specialist	256	18	93.4%
BH	49	10	83.1%

Results of the confirmatory surveys show that 32 providers (4 PCPs, 18 specialists, 10 BH) were non-compliant with the emergency instructions standards, versus the 49 identified by SPH. This increased the compliance rates for all three provider types. PCPs continued to have the highest compliance rate, followed by specialists, then BH providers. The Alliance shared with SPH the results of its confirmatory surveys, after which SPH: 1) met with Alliance staff to discuss the discrepancy in the number of non-compliant providers, 2) shared with the Alliance their quality assurance process, 3) acknowledged an SPH-agent error in 9 of the 17 records that were then subsequently deemed as compliant, and 4) provided the Alliance with a survey improvement plan based on their corrected findings. The Alliance will ensure that the providers identified as non-compliant in the 2019 confirmatory surveys are included in the MY2020 After-Hours Survey, as well as those eight (8) providers for whom a discrepancy remained between SPH's MY2019 After-Hours Survey findings and the Alliance's confirmatory survey findings.

In November of 2019, the Alliance's QI department staff issued time-sensitive corrective action plans (CAPs) to the 32 providers identified as non-compliant as a result of the Alliance's confirmatory surveys. Eighty-seven percent (87%) of the CAPs were issued to directs, while the remaining 13% were issued to delegates.

In looking at year-over-year results, the PCP compliance rate in 2019 did not significantly change from 2018 (96.5% vs. 97.5%, respectively), while the specialist compliance rate showed improvement in 2019 compared to 2018 (93.4% vs. 89.9%, respectively). The compliance rates for PCPs, specialists, and BH providers all exceeded the 80% target goal in 2019, and the compliance rates for PCPs and specialists all exceeded the 80% target goal in 2018. Note: BH providers were not surveyed in the MY2018 After-Hours Survey. For those providers identified by the Alliance as repeat offenders – those found non-compliant with the timely access standard for two consecutive years – an action plan has been put in place to ensure: a) the providers' understanding of the timely access standard, and b) they have taken the necessary steps toward compliance with the standard.

Access to a physician after-hours was assessed within the MY2019 After-Hours Survey. Compliance with access to a physician after-hours was determined from the subset of providers for whom a live person was reached within the survey. Results show the average compliance rate across provider types was 89.7%. The table below presents the breakdown of compliance rates for each of the provider types.

Table 51: Compliance Rate – Access to a Physician

Provider Type	Access to a Physician		
	Total Compliant	Total Non-Compliant	Compliance Rate
PCP	42	5	89.3%
Specialist	79	9	89.8%
BH	1	0	100%

In looking at year-over-year results, the PCP compliance rate in 2019 was significantly higher than the compliance rate from confirmatory surveys conducted with PCPs in 2018 (89.3% vs. 46.7%, respectively). The compliance rates for PCPs, specialists, and BH providers all exceeded the 80% target goal in 2019.

M. FIRST PRENATAL VISIT SURVEY

The Alliance conducted the annual First Prenatal Visit Survey for MY2019, which measures providers' compliance with the first prenatal visit standard. The survey was conducted in June and July of 2019 and was administered to a random sample of eligible Alliance Obstetrics and Gynecology (OB/GYN) providers. The table below shows results of the survey.

Table 52: First Prenatal Visit Survey

Appointment Within 2 Weeks	75% Target Goal Met	Percent of Ineligibles	Precent of Non-Responsive	Total CAPs
59%	No	40%	14%	26

The 2019 compliance rate is one percentage point higher than the 2018 compliance rate. Time-sensitive corrective action plans (CAPs) will be issued to all non-responding and non-compliant providers within Q2 2020. Additionally, the Alliance's QI Department will: continue: 1) its ongoing provider education and discussions at delegate Joint Operations Meetings (JOMs) regarding timely access standards; 2) collaboration with Analytics, Provider Services, and delegate networks to improve the accuracy of provider data, thus decreasing the number of ineligible providers.

N. ONCOLOGY SURVEY

The Alliance conducted the annual Oncology Survey for MY2019, which measures providers' compliance with the urgent and non-urgent appointment standards for specialists. The survey was conducted in June and July of 2019 and was administered to a random sample of eligible Alliance oncology providers. The table below shows results of the survey.

Table 53: Oncology Survey

Urgent Appt	75% Target Goal Met	Non-Urgent Appt	75% Target Goal Met	Percent of Ineligibles	Percent of Non-Responsive	Total CAPs
92%	Yes	100%	Yes	5%	27%	1

The 2019 compliance rate for non-urgent appointments is the same as 2018, while the 2019 compliance rate for urgent appointments is 8 percentage points lower. Time-sensitive corrective action plans (CAPs) will be issued to all non-responding and non-compliant providers within Q2 2020. Additionally, the Alliance's QI Department will: continue: 1) its ongoing provider education and discussions at delegate Joint Operations Meetings (JOMs) regarding timely access standards; 2) collaboration with Analytics, Provider Services, and delegate networks to improve the accuracy of provider data, thus decreasing the number of ineligible providers.

O. CG CAHPS Surveys

The Alliance contracted with SPH Analytics (SPH) to conduct its quarterly Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey within 2019, which measures member perception of and experience with three timely access standards: in-office wait time; call return time; and time to answer call. The CG-CAHPS survey was fielded in Q1, Q3 and Q4 of 2019. The survey was not fielded in Q2 of 2019, as the Alliance was awaiting DHCS approval for a modified survey that included two changed standards and modified survey response options as a result of the changed standards. Per approval from DHCS, the in-office wait time standard changed from within 30 minutes to within 60 minutes. Also, the call return time standard changed from within 30 minutes to within one business day. The time to answer call standard remained the same (within 10 minutes). SPH followed a mixed methodology of mail and phone to administer the survey to a randomized selection of eligible members who had accessed care with their PCP within the previous six months.

The table below presents the compliance rates across the three metrics for the CG-CAHPS surveys that were conducted in 2019, as well as the number of non-compliant providers within each quarter.

Table 54: CG-CAHPS Survey Results 2019

	Compliance Rates			Non-Compliant Providers		
Metric	**Q1 2019**	**Q3 2019**	**Q4 2019**	**Q1 2019**	**Q3 2019**	**Q4 2019**
In-Office Wait Time	83.60%	90.30%	90.2%	9	6	10
Call Return Time	95.50%	78.20%	78.1%	6	23	41
Time To Answer Call	n/a	77.60%	77.2%	n/a	27	30

The target compliance goal for each of the three metrics is 80%. The time to answer call metric was captured in the Q3 2019 CG-CAHPS survey for the first time; as such, no data is available for this metric prior to that time.

The Alliance continues to follow its Escalation Process for Providers Non-Compliant with CG-CAHPS which involves: tracking and trending in the first quarter of non-compliance; sending a provider letter and discussions at Joint Operations Meetings with delegates for two consecutive quarters of non-compliance; and issuing corrective action plans (CAPs) and discussions with COOs/CFOs during three consecutive quarters of non-compliance. Given the standards changed for two of the three CG-CAHPS metrics during Q2 2019, tracking and trending started afresh with the Q3 2019 data.

In addition to the CG-CAHPS surveys noted above that were administered in 2019, the Alliance conducted three internal ad-hoc surveys during Q1 2019, each with a random selection of 50 providers, to assess compliance with each of the three standards, incorporating the two revised standards. The table below presents the compliance rates across the three metrics for the confirmatory surveys that were conducted in Q1 2019, as well as the number of non-compliant providers.

Table 55: Q1 2019 Internal Ad-Hoc Surveys

Metric	Q1 2019	Non-Compliant Providers
In-Office Wait Time	97.40%	1
Call Return Time	94.70%	2
Time To Answer Call	90.70%	4

P. Provider Satisfaction Survey Overview

The Alliance contracted with its NCQA certified vendor, SPH, to conduct a Provider Satisfaction Survey for measurement year 2019. Information obtained from these surveys allows plans to measure how well they are meeting their providers' expectations and needs. The Alliance provided SPH with a database of 5,679 Primary Care Physicians (PCPs), Specialists (SPCs) and Behavioral Health (BH) providers who were part of the Alliance network. Duplicate provider names or NPIs were removed from the databased prior to submitting to survey vendor. From the database of unique providers, a sample of 815 records was drawn. A total of 170 surveys were completed between August and November 2019 (86 mail, 23 internet, 61 phone).

Tables 1-3 contain the survey response rates, survey respondents, and role of survey respondents for 2019 compared to 2018.

Table 56: Survey Response Rates: 2019 vs. 2018

	Mail/Internet	Phone
2019	14.3%	28.6%
2018	19.9%	30.4%

Table 57: Survey Respondents 2019 vs. 2018

	PCPs	BH Providers	SPCs
2019	58.0%	29.0%	27.8%
2018	32.9%	19.3%	56.0%

Table 58: Role of Survey Respondents 2019 vs. 2018

	Physician	Office Manager	BH Clinician	Nurse/ Other Staff
2019	30.2%	24.9%	24.9%	20.1%
2018	28.9%	36.0%	14.0%	21.1%

Q. YEAR TO YEAR TREND COMPARISONS

Table 4 contains the trended survey results across composites. SPH's 2018 Commercial Book of Business[1] (BoB) benchmark is utilized, which is a collection of data from 34 plans representing 6,831 respondents in Primary Care, Specialty, and Behavioral Health areas of medicine.

Table 59: Trended Survey Results Across Composites

Summary Rate Scores				
Composite/Attribute	**2019**	**2018 SPH Commercial BoB**	**2018**	**Year Over Year Trend**
Overall Satisfaction with the Alliance	**67.8%**	71.8%	81.1%	↓
All Other Plans (Comparative Rating)	43.8%	37.3%	49.8%	↓
Finance Issues	36.2%	31.3%	41.7%	↓
Utilization and Quality Management	48.2%	32.7%	45.2%	↑
Network/Coordination of Care	36.6%	33.0%	40.9%	↓
Pharmacy	34.1%	23.8%	35.6%	↓
Health Plan Call Center Staff	44.5%	38.2%	52.8%	↓

[1] With respect to the Summary Rate scores, **blue** indicates a significant difference when compared to 2018 scores (if applicable).

Summary Rate Scores				
Composite/Attribute	**2019**	**2018 SPH Commercial BoB**	**2018**	**Year Over Year Trend**
Provider Relations	57.3%	37.4%	53.5%	↑
Recommend to Other Physicians' Practices	87.3%	85.6%	87.7%	↔

As shown in Table 4, an upward trend is noted in summary rate scores for Utilization and Quality Management and Provider Relations. A downward trend is noted in summary rate scores for Overall Satisfaction, which is significant compared to 2018. Additionally, a downward trend is noted in summary rate scores for the remaining categories of: Comparative Rating to Other Plans, Finance Issues, Network/ Coordination of Care, Pharmacy, and Health Plan Call Center Service Staff.

R. SEGMENTATION ANALYSIS

As shown in Table 5, Alliance delegate, Beacon Health Options, had the highest summary rate score for overall satisfaction with the Alliance in 2019 compared to the other networks. Of note Beacon had a higher total number of survey respondents. However, with the exception of Beacon, between 2018 and 2019 summary rate scores for overall satisfaction with the Alliance dropped across the network by 20.5% - 28.5%.

Table 60: Overall Satisfaction with the Alliance by Delegate

Summary Rate Scores for Overall Satisfaction with the Alliance				
Year	**Alliance**	**Beacon**	**CFMG**	**CHCN**
2019	60.5%	72.4%	66.7%	62.7%
2018	81.0%	71.1%	95.2%	85.7%

As shown in Table 6, PCPs had the highest summary rate scores for overall satisfaction with the Alliance in 2019 compared to the other provider types. This same pattern was seen in the 2018 scores. However, between 2018 and 2019 summary rate scores for overall satisfaction with the Alliance dropped across all provider types by 10.6% - 15.4%.

Table 61: Overall Satisfaction with the Alliance by Provider Type

Summary Rate Scores for Overall Satisfaction with the Alliance			
Year	**PCP**	**BH**	**Specialist**
2019	72.4%	60.5%	66.7%
2018	85.7%	71.1%	82.1%

S. PRIORITY MATRIX

Table 7 identifies the priority level of the various composites, along with their correlation with overall satisfaction with the Alliance, as well as their relation to the 75th percentile in comparison with the 2018 SPH Commercial BoB benchmark.

Table 62: Priority Matrix

	Composite	Correlation with Overall Satisfaction	Relation to 75th Percentile
Top Priority	Health Plan Call Center Service Staff	High	Below (73rd)
Medium Priority	Network/Coordination of Care	Slight	Below (70th & 73rd)
	Finance Issues		
Monitor and Maintain	Pharmacy	Not High	At or Above (91st and 99th)
	Provider Relations		
Strength	Utilization and Quality Management	High	At or Above (96th)

Below is an overview of the survey results for 2017-2019 broken down by composite categories, the questions that make up the composites (attributes), and rating questions.

Table 63: 2017-2019 Survey Results

170 Total Respondents	Current							
Composites and Key Questions	2019		2018		2017		2018 SPH Book of Business Benchmarks**	
	Valid n	Summary Rate*	Valid n	Summary Rate*	Valid n	Summary Rate	Commercial	Medicaid
Overall Satisfaction		67.8%		81.1%		79.1%	71.8%	66.6%
8A. Would you recommend Alameda Alliance for Health to other physicians' practices?	142	87.3%	203	87.7%	214	88.8%	85.6%	83.2%
8B. Please rate your overall satisfaction with Alameda Alliance for Health.	146	67.8%	212	81.1%	235	79.1%	71.8%	66.6%
8C. Please rate your overall satisfaction with Other managed Medi-Cal plans in your county.	105	56.2%	160	63.8%	174	60.3%	NA	NA
All Other Plans (Comparative Rating)								
1A. How would you rate Alameda Alliance for Health compared to all other health plans you contract with?	162	43.8%	239	49.8%	240	56.7%	37.3%	32.9%
Finance Issues		36.2%		41.7%		47.2%	31.3%	28.6%
2A. Consistency of reimbursement fees with your contract rates.	133	33.1%	210	39.5%	219	47.5%	30.2%	26.8%
2B. Accuracy of claims processing.	129	36.4%	204	45.1%	215	50.7%	34.0%	30.4%
2C. Timeliness of claims processing.	131	38.2%	200	43.5%	218	44.5%	32.0%	31.1%
2D. Resolution of claims payment problems or disputes.	113	37.2%	179	38.5%	193	46.1%	29.0%	26.0%
Utilization and Quality Management		48.2%		45.2%		46.6%	32.7%	30.5%
3A. Access to knowledgeable UM staff.	128	43.8%	190	40.5%	184	45.7%	31.9%	29.0%
3B. Procedures for obtaining pre-certification/referral/authorization information.	133	45.1%	199	45.7%	217	44.7%	31.6%	29.6%
3C. Timeliness of obtaining pre-certification/referral/authorization information.	131	48.1%	197	45.7%	214	43.5%	31.7%	29.9%
3D. The health plan's facilitation/support of appropriate clinical care for patients.	136	50.0%	189	46.0%	198	46.5%	32.2%	30.6%
3E. Access to Case/Care Managers from this health plan.	116	43.1%	170	40.6%	159	45.3%	31.1%	28.6%
3F. Degree to which the plan covers and encourages preventive care and wellness.	127	59.1%	170	52.4%	180	53.9%	37.7%	35.4%
Network/Coordination of Care		36.6%		40.9%		35.6%	33.0%	27.9%
4A. The number of specialists in this health plan's provider network.	134	36.6%	178	37.6%	179	30.7%	31.6%	25.8%
4B. The quality of specialists in this health plan's provider network.	130	40.0%	184	44.6%	174	39.1%	37.4%	31.5%
4C. The timeliness of feedback/reports from specialists in this health plan's provider network.	120	33.3%	171	40.4%	160	36.9%	30.2%	26.5%
Pharmacy		34.1%		35.6%		34.2%	23.8%	21.4%
5A. Consistency of the formulary over time.	99	36.4%	158	34.2%	126	34.9%	23.4%	21.8%
5B. Extent to which formulary reflects current standards of care.	101	33.7%	161	37.9%	128	34.4%	24.7%	22.6%
5C. Variety of branded drugs on the formulary.	99	30.3%	153	34.0%	126	32.5%	23.0%	20.0%
5D. Ease of prescribing your preferred medications within formulary guidelines.	101	36.6%	152	37.5%	125	36.8%	25.0%	21.8%
5E. Availability of comparable drugs to substitute those not included in the formulary.	98	33.7%	151	34.4%	123	32.5%	22.6%	20.8%
Health Plan Call Center Service Staff		44.5%		52.8%		55.4%	38.2%	35.3%
6A. Ease of reaching health plan call center staff over the phone.	137	42.3%	197	49.2%	210	51.9%	36.6%	32.9%
6B. Process of obtaining member information (eligibility, benefit coverage, co-pay amounts).	133	50.4%	199	55.8%	208	59.1%	40.4%	38.2%
6C. Helpfulness of health plan call center staff in obtaining referrals for patients in your care.	124	41.1%	190	51.6%	191	53.9%	36.2%	32.9%
6D. Overall satisfaction with health plan's call center service.	134	44.0%	201	54.7%	206	56.8%	39.5%	37.3%
Provider Relations		57.3%		53.5%		54.8%	37.4%	34.6%
7A. Do you have a Provider Relations representative from this health plan assigned to your practice?	128	48.4%	196	54.6%	212	44.3%	37.0%	47.2%
7B. Provider Relations representative's ability to answer questions and resolve problems.	53	71.7%	99	66.7%	89	70.8%	51.1%	43.2%
7C. Quality of provider orientation process.	98	46.9%	145	48.3%	158	46.8%	31.3%	30.7%
7D. Quality of written communications, policy bulletins, and manuals.	105	53.3%	167	45.5%	186	46.8%	29.9%	30.0%

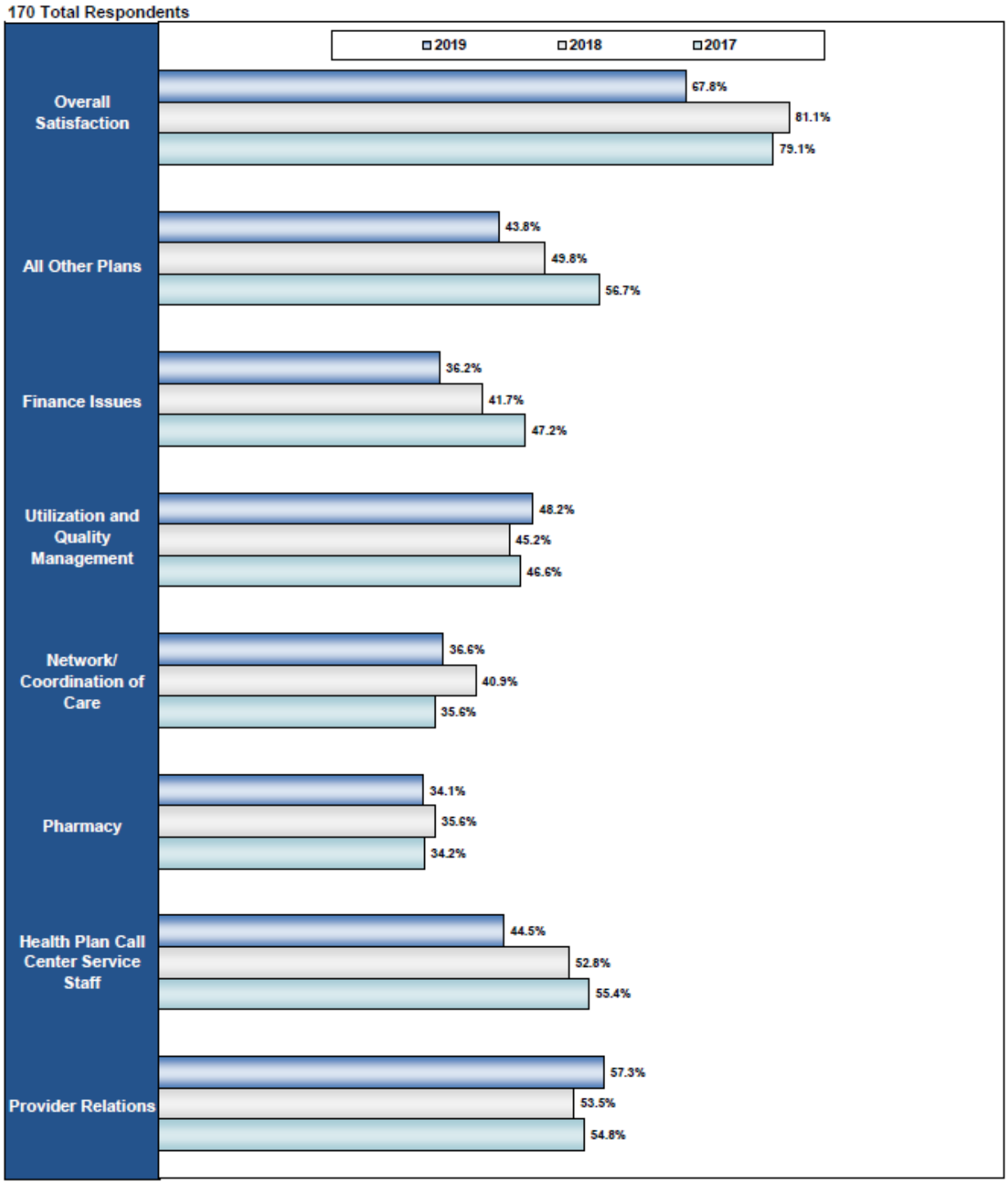
* Summary Rates represent the most favorable response percentage(s).

** SPH Analytics's 2018 Commercial Book of Business consists of data from 34 projects representing 6831 respondents, while the Medicaid Book of Business consists of data from 78 projects representing 20660 respondents in Primary Care, Specialty, and Behavioral Health areas of medicine. See Technical Notes for more information.

Note 1: Significance Testing - Cells highlighted in red denote current year plan percentage is significantly lower when compared to trend or benchmark data; Cells highlighted in green denote current year plan percentage is significantly higher when compared to trend or benchmark data; No shading denotes that there was no significant difference between the percentages, there is no benchmark, or that there was insufficient sample size to conduct the statistical test. All significance testing is performed at the 95% significance level.

Note 2: The Overall Satisfaction Summary Rate includes only 8B. It does not include 8A or 8C.

Note 3: The Provider Relations composite is the average of 7B through 7D. It does not include 7A.



Note 1: The Overall Satisfaction composite represents only Q8B, 'Please rate your overall satisfaction with: Alameda Alliance for Health'.

Note 2: The Provider Relations composite is the average of Q7B through Q7D. It does not include Q7A, 'Do you have a Provider Relations representative from this health plan assigned to your practice?'

The above information recognizes an upward trend from 2018 to 2019 in utilization and quality management and provider relations. Additionally, the above information recognizes an upward trend over time from 2017 to 2019 in utilization and quality management, network/coordination of care, and provider relations.

The above information recognizes a downward trend from 2018 to 2019 in overall satisfaction (significantly lower than 2017 and 2018 Summary Rates), comparative rating to other plans (significantly lower than 2017 Summary Rates), finance issues (significantly lower than 2017 Summary Rates), network/coordination of care, pharmacy, and health plan call center service staff (significantly lower than 2017 Summary Rates).

T. NEXT STEPS

While our goals were to have upward trends in the majority of composite categories, this data will be shared with all relevant stakeholders to improve future scores and outcomes. Specifically, next steps will involve the following:

- High level Executive Summary shared with Senior Leadership and department directors and managers
- Collaborate with department stakeholders to Identify and document quantitative and qualitative analysis
- PDSA agreed upon opportunities for improvement to improve or maintain Provider Satisfaction Scores.

GRIEVANCE AND APPEALS

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

A **Grievance** is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. A grievance may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by the Alliance to make an authorization decision. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

A **Complaint** is the same as "grievance".

An **Appeal** refers to an appeal of any adverse decisions that are not about coverage.

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

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

A. COMMERCIAL GRIEVANCES

Table 64: Commercial Compliant Volume 2018-2019

Commercial Complaint Volume				
Category	**2018 Complaint Total**	**2018 Complaints per 1,000 Members**	**2019 Complaint Total**	**2019 Complaints per 1,000 Members**
Quality of Care	161	2.31	47	0.66
Access	99	1.42	338	4.76
Attitude/Service	51	0.73	208	2.9
Billing/Financial	115	1.65	293	4.09
Quality of Practitioner Office Site	2	0.03	4	0.06
Total Number per 1,000	428	6.13	890	12.42

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

B. MEDICAID GRIEVANCES

Table 65: Medicaid Complaint Volume 2018-2019

Medicaid Complaint Volume				
Category	**2018 Complaint Total**	**2018 Complaints per 1,000 Members**	**2019 Complaint Total**	**2019 Complaints per 1,000 Members**
Quality of Care	2513	0.8	663	0.25
Access	1790	0.57	5617	2.09
Attitude/Service	1190	0.57	3539	1.31
Billing/Financial	1175	0.37	2841	1.05
Quality of Practitioner Office Site	45	0.01	73	0.03
Total Number per 1,000	6713	2.13	12733	4.73

The Alliance initiated an update to our exempt and non-exempt grievance process in 2018 which continued into 2019. We identified that in addition to not reporting exempt grievances to Committee for review we were grossly under reporting exempt grievances in general. Workflows and training was conducted with Member Services and G&A staff to ensure that all expressions of dissatisfaction were being captured. In addition, the Alliance updated the tracking system for capturing exempt grievances effective Q4 2018 to allow for accurate reporting. With this continuing training, we have a significant increase of grievances throughout the quarters, doubling the complaint numbers from 2018 to 2019.

California Home Medical Equipment (CHME) – The Alliance identified a significant trend of increased grievances against our durable medical equipment (DME) vendor, California Home Medical Equipment (CHME). In January 2018, there were 48 grievances received alone with a total of 444 (Medi-Cal and Commercial) grievances for all of 2018. The grievances involved customer service, telephone access, and delay in receiving supplies. Grievance data and trends were presented to CHME leadership during Joint Operations Meetings and on an ad-hoc basis. In Q4 2018, the Alliance Compliance Department issued a Corrective Action Plan and the Alliance has begun to meet with CHME bi-weekly starting in 2019 to resolve issues. CHME has reported that they have increased their call center staff and operational team in order to improve telephone wait times. The Alliance continued to monitor grievances against CHME in 2019, there was a decrease of grievances in 2019 at 279 (Medi-Cal and Commercial), with the only 45 filed in the last quarter of 2019. As a result of the continual decrease of complaints, the Corrective Action Plan with CHME was closed in December 2019.

We continue to see a large amount of billing and financial grievances with 1,175 grievance in 2018 with a significant increase to 2,841 grievances in 2019 related to members being balanced billed from out-of-network providers for emergency services. The Alliance covers twenty-four (24) hour care for emergencies, both in and outside of Alameda County. Although we cannot avoid these grievances, the Alliance works closely with our claims department and provider service department to resolve the complaints. There has also been an increase of complaints with regard to questions related to copays with our Commercial line of business, a majority of these complaints are resolved by reference the GroupCare Member Handbook to educate the members on their copay and financial responsibilities.

We have identified a significant increase in attitude/service, specifically under provider/staff attitude. A majority of these complaints are filed against our Delegates, PCP/Clinic, and Specialist. The Alliance provides additional education to these providers with an emphasis on the Member's Rights and Responsibilities.

C. COMMERCIAL APPEALS

Table 66: Commercial Appeal Volume 2018-2019

Commercial Appeal Volume				
Category	**2018 Appeal Total**	**2018 Appeal per 1,000 Members**	**2019 Appeal Total**	**2019 Appeal per 1,000 Members**
Quality of Care	0	0	0	0
Access	0	0	7	0.1

Commercial Appeal Volume				
Category	**2018 Appeal Total**	**2018 Appeal per 1,000 Members**	**2019 Appeal Total**	**2019 Appeal per 1,000 Members**
Attitude/Service	0	0	1	0.01
Billing/Financial	0	0	36	0.5
Quality of Practitioner Office Site	0	0	0	0
Total Number per 1,000	0	0	44	0.61

D. MEDI-CAL APPEALS

Table 67: Medi-Cal Appeal Volume 2018-2019

Medi-Cal Appeal Volume				
Category	**2018 Appeal Total**	**2018 Appeal per 1,000 Members**	**2019 Appeal Total**	**2019 Appeal per 1,000 Members**
Quality of Care	0	0	23	0.01
Access	0	0	73	0.03
Attitude/Service	0	0	34	0.01
Billing/Financial	0	0	43	0.01
Quality of Practitioner Office Site	0	0	1	0.0004
Total Number per 1,000	0	0	174	0.06

The Alliance failed to appropriately track the number of appeals for the reporting year of 2018; therefore, the table has 0 for all categories under l Appeal Volume. The Alliance conducted additional staff training in how to identify appeals in accordance with RR 2 Policies and Procedures for Complaints and Appeals, B Policies and Procedures for Appeals. There were a total of 218 appeals processed during the reporting year at 0.08 per 1,000 members. The billing/financial appeals received were with regard to dispute over covered services, the appeals were in response to grievances about members not satisfied with previous complaint resolutions with regard to copay or balance billing inquiries, member are further educated on their financial responsibility.

E. UM APPEALS

Table 68: UM Appeals

Prior Authorization Appeals	Filed Against:					Overturn %
	Beacon	CFMG	CHCN	Evictors	Plan	
Inpatient Appeal					8	50.0%
Outpatient Appeal	4		78	245	204	38.9%
Pharmacy Appeal					344	30.8%
Retro Appeal			11	3	64	19.2%
Grand Total:	**4**		**89**	**248**	**620**	**961**
Overturned %:	**50.0%**		**20.2%**	**58.5%**	**26.9%**	**34.5%**

The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of 2019; we are over our goal at 34.5% overturn rate. The Alliance also decided to end our contractual relationship with our radiology vendor and internalize the review of radiology authorizations due to the high overturn rate that had been trending throughout 2018 and into Q1 2019. This change occurred on 8/1/2019, the Alliance has identified a significant decrease in our overturn rate in the month of September, and this was the first month where we were below our internal benchmark for overturns.

Summary of UM Appeals:

- There were 831 appeals initially denied for medical necessity during the reporting period:
  - 307 overturned/approved all based on medical necessity
  - 60 partially overturned/approved
  - 464 Upheld/Denied
- There were 97 appeals initially denied for out-of-network request during the reporting period:
  - 11 overturned/approved all based on medical necessity
  - 4 overturned/approved based on network adequacy issues
    - 3 Services not available within network
    - 1 Timely Access for Specialist appointment
  - 2 overturned/approved based on Continuity of Care
  - 4 partially overturned/approved
  - 76 Upheld/Denied
- There were 33 appeals initially denied for not being a covered benefit during the reporting period:

  - 8 overturned/approved all based on medical necessity
  - 25 upheld/denied

- There was an overall decrease of the overturn rate within the reporting period.

CULTURAL AND LINGUISTIC NEEDS OF MEMBERS

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

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

The Alliance strives to ensure members have access to a PCP who can speak their language or to appropriate interpreters. For members who have not chosen a PCP upon enrollment, the Alliance will assign a member to a PCP based on characteristics, including language. In 2019, the Alliance identified the following threshold languages.

Table 69: 2019 Threshold Languages

Medi-Cal	English	146,494	60.95%
	Spanish	47,081	19.59%
	Chinese	23,803	9.90%
	Vietnamese	8,190	3.41%
Group Care	English	3,640	59.81%
	Chinese	1,405	23.09%
	Spanish	302	4.96%*

* Dec. 2019: Just under threshold criteria, but given variations in membership over the year, the Alliance chooses to treat Spanish as a threshold language for Group Care.

Table 70: Member Ethnicity – Medi-Cal

MEDI-CAL	Prior Year	YTD	Percent Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY ETHNICITY	**Jan - Dec 2018**	**Jan - Dec 2019**	**% YTD Membership in Jan - Dec 2019 (minus) Percent of Membership in Jan - Dec 2018**	**Dec 2019**	**Dec 2019 Percent**
Hispanic (Latinx)	28.69%	28.55%	-0.14%	68,144	28.35%
Black (African American)	18.60%	18.48%	-0.13%	44,513	18.52%
Other	14.57%	15.25%	0.68%	37,120	15.44%
Chinese	10.95%	11.11%	0.16%	26,869	11.18%

MEDI-CAL	Prior Year	YTD	Percent Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY ETHNICITY	Jan - Dec 2018	Jan - Dec 2019	% YTD Membership in Jan - Dec 2019 (minus) Percent of Membership in Jan - Dec 2018	Dec 2019	Dec 2019 Percent
Other Asian / Pacific Islander	11.31%	11.07%	-0.24%	26,400	10.98%
White	10.60%	10.06%	-0.54%	23,690	9.86%
Vietnamese	4.34%	4.40%	0.06%	10,704	4.45%
Unknown	0.67%	0.82%	0.16%	2,301	0.96%
American Indian Or Alaskan Native	0.27%	0.26%	-0.01%	604	0.25%
Total Members				240,345	

Medi-Cal Ethnicity Discussion: 2019 saw an overall decrease in membership, but only slight changes in ethnicities as a percent of the Medi-Cal membership. Hispanic (Latinx) members make up almost 30%, all Asian members combined make up over 25%, and Black (African American) members almost 20% of our Medi-Cal membership.

Table 71: Member Ethnicity – Group Care

GROUP CARE	Prior Year	YTD	% Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY ETHNICITY	Jan - Dec 2018	Jan - Dec 2019	% YTD Membership in Jan - Dec 2019 (minus) Percent of Membership in Jan - Dec 2018	Dec 2019	Dec 2019 Percent
Unknown	38.65%	34.99%	-3.66%	2,029	33.34%
Other Asian / Pacific Islander	24.88%	26.88%	1.99%	1,670	27.44%
Chinese	11.40%	12.19%	0.79%	787	12.93%
Black (African American)	11.63%	11.75%	0.12%	711	11.68%
Other	5.27%	5.74%	0.47%	355	5.83%
Hispanic (Latinx)	3.28%	3.43%	0.15%	217	3.57%
Vietnamese	2.79%	2.92%	0.13%	187	3.07%
White	1.97%	1.99%	0.01%	121	1.99%
American Indian Or Alaskan Native	0.12%	0.12%	-0.00%	9	0.15%
Total Members				6,086	

Group Care Ethnicity Discussion: The largest group who identified their ethnicity was the Other Asian/Pacific Islander, at almost one-fourth of the Group Care membership, of which 22% are of Asian Indian ethnicity. The percent of Group Care members with unknown ethnicity continues to decline, although still higher than desired.

Table 72: Member and Provider Languages Spoken – Medi-Cal

MEDI-CAL	Prior Year	YTD	Percent Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY LANGUAGE	Jan - Dec 2018	Jan - Dec 2019	% YTD Mbrshp in Jan - Dec 2019 (minus) Percent of Mbrshp in Jan - Dec 2018	Dec 2019	Dec 2019 Percent
English	62.14%	61.31%	-0.83%	146,495	60.95%
Spanish	19.19%	19.54%	0.35%	47,081	19.59%
Chinese	9.52%	9.76%	0.24%	23,803	9.90%
Unknown	3.58%	3.65%	0.07%	8,979	3.74%
Vietnamese	3.25%	3.35%	0.10%	8,190	3.41%
Other Non-English	1.70%	1.76%	0.06%	4,267	1.78%
Farsi	0.62%	0.63%	0.01%	1,530	0.64%
Total Members				240,345	

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

Table 73: Member and Provider Languages Spoken – Group Care

GROUP CARE	Prior Year	YTD	Percent Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY LANGUAGE	Jan - Dec 2018	Jan - Dec 2019	% YTD Mbrshp in Jan - Dec 2019 minus) Percent of Mbrshp in Jan - Dec 2018	Dec 2019	Dec 2019 Percent
English	60.86%	60.27%	-0.59%	3,640	59.81%
Chinese	21.61%	22.34%	0.72%	1,405	23.09%
Spanish	4.87%	4.95%	0.08%	302	4.96%
Unknown	4.59%	4.35%	-0.25%	257	4.22%
Vietnamese	3.39%	3.60%	0.21%	222	3.65%
Other Non-English	2.88%	2.92%	0.04%	169	2.78%
Farsi	1.79%	1.58%	-0.22%	91	1.50%
Total Members				6,086	

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

PRACTITIONER LANGUAGE CAPACITY

During 2019, the Alliance's Provider Relations staff conducted in-person surveys during provider office visits to verify languages spoken by providers. The chart below is a comparison of identified languages spoken by the plan's members to its provider network at the end of Quarter 4 2019. Please note, multi-lingual providers are counted for each language spoken by the individual.

Table 74: Provider Network vs. Members Comparison of Identified Languages

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

Source: Q4 2017 and Q4 2018 Provider Impact Reports

Table 75: MCAL PCPs & Members by Language

	2018Q4			2019Q4			Change			
Language	**PCPs**	**Members**	**Members per PCP**	**PCPs**	**Members**	**Members per PCP**	**Count PCPs**	**Percent PCPs**	**Count Members**	**Percent Members**
English	509	131,489	258	503	122,728	243	-6	-1%	-8,761	-7%
Spanish	115	45,318	394	111	42,823	385	-4	-4%	-2,495	**-2%**
Chinese	78	23,541	301	68	22,367	328	-10	-15%	-1,174	**-2%**
Vietnamese	16	8,218	513	12	7,885	657	-4	-33%	-333	**-2%**
Arabic	3	2,000	666	7	2,062	294	+4	57%	62	**-3%**
Farsi	7	1,640	234	7	1,522	217	0	0%	-118	**3%**
Total	908	224,144		**890**	**209,727**					

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

The Alliance also identified and reviewed significant changes and trends related to provider language capacity. In 2019 the Plan experienced overall decline in Medi-Cal membership for all languages as well as a decline in PCPs speaking all languages except for Arabic. The largest decline in PCPs per member is seen for Vietnamese. The plan will continue to monitor the decline to see if it persists and whether there are grievances that might require taking action.

Table 76: 2018 Q4 vs 2019 Q4 Comparison

	2018Q4	2019Q4	Change
Language	Members per PCP	Members per PCP	Difference
English	258	243	Improvement ↓11
Spanish	394	385	Improvement ↓9
Chinese	301	328	Decline ↑27
Vietnamese	513	657	Decline ↑144
Arabic	666	294	Improvement ↓ 69
Farsi	234	217	Improvement ↓ 16

Our Group Care members (data not in a table), while being a significantly smaller population, have access to most of our extensive Medi-Cal network of providers. As a result, all languages have at least 1 PCP per 25 members.

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

- Review of provider and member spoken language capacity comparison
- Review of grievances related to provider language capacity
- Monitoring of interpreter services provided

In the absence of a practitioner who speaks a member's preferred language, the Alliance ensures the provision of interpreter services at the time of appointment. The Alliance has two interpreter vendors to ensure coverage for both telephonic and in-person interpreters are available for all of our members' health care needs. In 2019, the Alliance provided over 12,500 telephonic interpreter services. In addition, we completed just approximately 21,000 requests for interpreter services at the time of appointment. This represents over 99.5% fulfillment with prescheduled interpreter requests.

ANALYSIS OF 2019 QUALITY PROGRAM EVALUATION AND EFFECTIVENESS

The Alliance has identified the challenges and barriers to improvement throughout the 2019 QI Evaluation. Recommended activities and interventions for the upcoming year consider these

challenges and barriers in working toward success and achievement of the Alliance's goals in 2020.

Challenges and barriers to achieving objectives encountered within the 2019 program year included but, are not limited to:

- Under reporting of exempt grievance due to gaps in workflows and staff training
- Reliance on mid-year annual HEDIS measurement results impedes optimal strategic rapid cycle PDSA implementation for quality improvement activities
- Limited implementation time for new Quality leadership to implement improvement strategies from 2018 CHAPS findings
- Limited implementation time for new Quality leadership to implement improvement strategies from 2018 Provider Satisfaction Survey findings
- Member Services call center "call abandonment" rate negatively impacted by staffing challenges

Program major accomplishments with objectives met for 2019 include but, are not limited to:

- Adequate QI program resources to carry out roles, functions, and responsibilities
- A consistent and stable QI committee and program structure
- Stable key positions, including Director and Managers, now filled within the Quality department
- Successful administration of all timely access surveys within the expected timeframes, allowing for timely analysis and implementation of next steps with providers and within the Alliance
- Implementation of a revised Delegate CAP Process in which corrective action plans (CAPs) were issued at the group/delegate level (rather than at the individual provider level), contributing to increased efficiencies as well as oversight management
- Increased Provider Satisfaction Survey scores in 2019 for Provider Relations and Utilization and Quality Management
- HCQC meetings held 6 times within 2019 and remains active in ensuring requirements of the QI Program were met
- Stable and consistent Senior Level Physician involvement and Appropriate External and Internal Leadership
- Improved HEDIS performance rates for most measures; above the MPL for all accountable HEDIS metrics
- Development and deployment of a Pediatric Care Coordination Pilot to promote access to care and EPSDT service utilization in partnership with direct, delegate, and CBOs.
- Improved targeted focus on direct and delegate provider education and outreach collaboration with Provider Services to improve access to care using gap in care reports
- Continued focus on health promotion and education that resulted in higher CAHPS scores
- Improved turn-around times and root cause analysis of PQIs
- Implementation of Phase I and Phase II of the PQI Application database

- Ongoing / successful performance improvement projects
- Robust Health Education and Cultural and Linguistic Programs
- Launched Diabetes Prevention Program
- Cost effective approach to quality and safety of care and services utilizing community resources such as:
    - Substance Abuse Disorder Program
    - Ongoing Performance Improvement Projects
- Improved Member Services processes and hiring new staff, resulting in improved telephone response times.
- Updated grievance tracking system for capturing exempt grievances and accurate reporting
- Comprehensive monitoring of all practitioners during credentialing / re-credentialing to ensure high quality network.
- QI Program was evaluated, discussed and approved by the HCQC Committee

The HCQC has evaluated the approved the overall effectiveness of the Alliance QI Program and determined its progress in meeting safe, clinical practice, goals, based on an assessment of performance in all aspects of the QI Program. The committee determines no need to restructure or change the QI program for the subsequent 2020 year.

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Health care you can count on.
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2020

QUALITY IMPROVEMENT PROGRAM

DESCRIPTION

ALAMEDA ALLIANCE FOR HEALTH

QUALITY IMPROVEMENT PROGRAM DESCRIPTION 2020

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
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2020 Quality Improvement Program Description Signature Page

Stephanie Wakefield, RN Director of Quality	Date
Sanjay Bhatt, M.D. Medical Director, QI Vice Chair, Health Care Quality Committee	Date
Steve O'Brien, M.D. Chief Medical Officer Chair, Health Care Quality Committee	Date
Scott Coffin Chief Executive Officer	Date
Evan Seevak, M.D. Board Chair	Date

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OVERVIEW

Alameda Alliance for Health is a public, not-for-profit managed care health plan committed to making high quality health care services accessible and affordable to lower-income people of Alameda County. Established in January 1996, the Alliance was created by and for Alameda County residents. The Alliance currently provides health care coverage to approximately 250,000 children and adults through its programs.

Alameda Alliance for Health is licensed by the State of California and product lines include Medi-Cal managed care and Group Care commercial insurance. Medi-Cal managed care beneficiaries, eligible thorough one of several Medi-Cal programs, e.g. TANF, SPD, Medi-Cal Expansion and Dually Eligible Medi-Cal members do not participate in California's Coordinated Care Initiative (CCI). For dually eligible Medi-Cal and Medicare beneficiaries, Medicare remains the primary insurance and Medi-Cal benefits are coordinated with the Medicare provider.

Alliance Group Care is an employer-sponsored plan offered by the Alliance. The Group Care product line provides comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County.

Alameda Alliance for Health's (Alliance) Quality Improvement (QI) Program strives to ensure that members have access to quality and safe health care services. The QI Program Description is a comprehensive document with a set of interconnected documents that describes quality program governance, structure and responsibilities, operations, scope goals, and measurable objectives.

The Alliance QI Program is applicable to all product lines and is designed to assess, measure, evaluate and improve the quality and safety of care that members receive. Participation of all Alliance departments and staff in quality improvement activities is essential to the organization achieving our QI goals and objectives.

The Alliance complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex. The Alliance does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Alliance QI program is committed to serving the healthcare needs of our culturally and linguistically diverse membership.

MISSION AND VISION

As its Mission, the Alliance strives to improve the quality of life of our members and people throughout our diverse community by collaborating with our provider partners in delivering high quality, accessible and affordable health care services. As participants of the safety-net system, we recognize and seek to collaboratively address social determinants of health as we proudly serve Alameda County. The Alliance Vision is be the most valued and respected managed care health plan in the state of California.

QI PROGRAM SCOPE AND GOALS

The purpose of the Alliance QI Program is to objectively monitor and evaluate the quality, safety, appropriateness, and outcome of care and services delivered to members of the Alliance. The overall goal of the QI Program is to ensure that members have access to quality medical and behavioral health care services that are safe, effective, and meet their needs. The QI program is structured to continuously pursue opportunities for improvement and problem resolution. The QI program is organized to meet overall program objectives as described below and as directed each year by the QI and UM Work Plan. Improvement priorities are selected based on volume, opportunities for improvement, risk, and evidence of disparities.

QI program goals include but, are not limited to:

1. Maintain the delivery of high quality, safe, and appropriate medical and behavioral health care that meets professionally recognized standards of practice is delivered to all enrollees.
2. Utilize objective and systematic measurement, monitoring, and evaluation through qualitative and quantitative analysis of health care services and implement QI activities based on the findings.
3. Conduct performance improvement activities that are designed implemented, evaluated, and reassessed using industry recognized quality improvement models such as Plan-Do-Study-Act (PDSA).
4. Ensure physicians and other appropriate licensed professionals, including behavioral health, are an integral and consistent part of the QI program.
5. Ensure medical and behavioral health care delivery is consistent with professionally recognized standards of practice
6. Track and trend the delivery of healthcare service to ensure care and services are not withheld or delayed for any reason, such as potential financial gain or incentive to plan providers.
7. Design and maintain an ongoing organizational culture of quality to ensure continual HEDIS improvement and accreditation readiness.

The scope of the QI program is comprehensive and encompasses the following:

1. Timely access and availability to quality and safe medical and behavioral care and services
2. Care and Disease management services
3. Cultural and linguistic services
4. Patient safety
5. Member and provider experience
6. Continuity and coordination of care
7. Tracking of service utilization trends, including over-and under-utilization
8. Clinical practice guideline development, adoption, distribution, and monitoring
9. Targeted focus on acute, chronic, and preventive care services for children and adults
10. Member and provider education
11. Perinatal, primary, specialty, emergency, inpatient, and ancillary care
12. Case review, investigation, and corrective actions of potential quality issues
13. Credentialing and re-credentialing activities
14. Delegation oversight and monitoring
15. Delegate performance improvement project collaborations
16. Targeted support of special needs populations including Seniors and Persons with Disabilities and persons with chronic conditions

ORGANIZATIONAL STRUCTURE AND SUPPORT COMMITTEES RESPONSIBILITY

A. Overview

The Alliance Board of Governors (BOG) appoints and oversees the Health Care Quality Committee (HCQC), Pharmacy & Therapeutics (P&T) Committee, Peer Review/Credentialing Committee (PRCC), Member Advisory Committee, and Compliance Committee which in turn, provide the authority, direction, guidance, and resources to enable Alliance staff to carry out the QI Program.

The organizational chart in **Appendix A** displays the reporting relationships for key staff responsible for QI activities at the Alliance. **Appendix B** displays the committee reporting relationship and organizational bodies.

B. Board of Governors

The Alliance BOG is appointed by the Alameda County Board of Supervisors and consists of up to 15 members who represent member, provider, and community partner stakeholders. The BOG is the final decision-making authority for the Alliance QI program. Its duties include:

- Reviewing annually, updating and approving the QI program description, defining the scope, objectives, activities, and structure of the program.
- Reviewing and approval of the annual QI report and evaluation of QI studies, activities, and data on utilization and quality of services.
- Assessing QI program's effectiveness and direct modification of operations as indicated.
- Defining the roles and responsibilities of HCQC.
- Designating a physician member of senior management with the authority and responsibility for the overall operation of the quality management program, who serves on HCQC.
- Appointing and approving the roles of the Chief Medical Officer (CMO) and other management staff in the QI program.
- Receiving a report from the CMO on the agenda and actions of HCQC.

C. Health Care Quality Committee (HCQC)

The HCQC is a standing committee of the BOG and meets a minimum of four times per year, and as often as needed, to follow-up on findings and required actions. The HCQC is responsible for the implementation, oversight, and monitoring of the QI Program and Utilization Management (UM) Program. As it relates to the QI Program, the HCQC recommends policy decisions, analyzes and evaluates the QI work plan activities, and assesses the overall effectiveness of the QI program. The HCQC reviews results and outcomes for all QI activities to ensure performance meets standards and makes recommendations to resolve barriers to quality improvement activities. Any quality issues related to the health plan that are identified through the CAHPS survey and health plan service reports are also discussed and addressed at HCQC meetings. The HCQC oversees and reviews all QI delegation summaries reports and evaluates delegate quality program descriptions and work plan activities. The HCQC presents to the Board the annual QI program description, work plan and prior year evaluation. Signed and dated minutes that summarize committee activities and decisions are maintained. The QI Program, Work Plan, annual Evaluation and minutes from the HCQC are submitted to the California Department of Health Care Services (DHCS).

Responsibilities include but, are not limited to:

- Approve, select, design, and schedule studies and improvement activities.
- Review results of performance measures, improvement activities and other studies.
- Review CAHPS and other survey results and related improvement initiatives.
- On-going reporting to the BOG.
- Meeting at least quarterly and maintaining approved minutes of all committee meetings.
- Approve definitions of outliers and developing corrective action plans.
- Recommend and approve of Medical Necessity Criteria, Clinical Practice Guidelines, as well as, pediatric and adult Preventive Care Guidelines and review compliance monitoring.
- Review member grievance and appeals data.
- Oversee of the Plan's process for monitoring delegated providers.
- Oversee of the Plan's UM Program.
- Review advances in health care technology and recommend incorporation of new technology into delivery of services as appropriate.
- Provide guidance to staff on quality improvement activities.
- Monitor progress in meeting QI goals.
- Evaluate annually the effectiveness of the QI program.
- Oversee the Plan's complex case management and disease management programs.
- Review and approve annual QI and UM Program Descriptions, Work Plans, and Evaluations.
- Recommends and approves resource allocation for the QI Department and Program

The HCQC is chaired by the CMO and vice-chaired by the QI Medical Director. The members are representative of the contracted provider network including, those who provide health care services to Seniors and Persons with Disabilities (SPD) and chronic conditions. The HCQC Members are appointed for two-year terms. The voting membership consists of:

- Alliance CMO (Chair)
- Medical Director of Quality (Vice-Chair)
- Chief Executive Officer (ex officio)
- Medical Director or designee from each delegated medical group (i.e., Community Health Center Network, Children First Medical Group, Kaiser)
- Physician representative of Alameda County Medical Center
- Physician representative of Alameda County Ambulatory Clinics
- Alliance contracted physicians (3 positions)
- Representative of County Public Health Department
- A Behavioral Health practitioner

- Alliance Medical Directors
- Alliance Senior QI Director

A quorum is established when the majority of the voting membership is present at the meeting. The Chief Executive Officer does not count in the determination of a quorum.

D. Pharmacy and Therapeutics Committee (P&T)

The P&T Committee assists the HCQC in oversight and assurance of ensuring the promotion of clinically appropriate, safe, and cost-effective drug therapy by managing and approving the Alliance's drug formulary, monitoring drug utilization and developing provider education programs on drug appropriateness. P&T Committee meeting minutes and pharmacy updates are shared at the HCQC meetings.

The voting membership consists of:

- Alliance Chief Medical Officer (Co-Chair) or Designee
- Alliance Pharmacist (Co-Chair/Secretary)
- Practicing physician(s) representing Family Practice and/or Internal Medicine
- Practicing physician(s) representing Pediatrics
- Practicing physician representing a medical specialty in support of agenda
- Practicing community pharmacist(s) contracted with AAH (not to exceed 3)

E. Peer Review and Credentialing Committee (PRC)

The PRC is a standing committee of the BOG that meets a minimum of ten times per year.

Responsibilities include:

- Recommending provider credentialing and re-credentialing actions.
- Performing provider-specific clinical quality peer review.
- Reviewing and approving PRCC Program Description.
- Monitoring delegated entity credentialing and re-credentialing.

The voting membership consists of:

- Alliance Chief Medical Officer (Chair) or Designee
- Medical Director/physician designee from Children First Medical Group
- Medical Director/physician designee from Community Health Center Network
- Physician representative for Alameda County Medical Center
- One specialist physician contracted with the Alliance
- Two physicians from the South County area contracted with the Alliance
- Physician representative from the Alliance BOG

F. Internal Quality Improvement Committee (IQIC)

The IQIC assists the HCQC in oversight and assurance of the quality of clinical care, patient safety, and customer service provided throughout the AAH organization. Its primary roles are to maintain and improve clinical operational quality, review organization-wide performance against the Alliance quality targets, and report results to the HCQC. All members shall complete a confidentiality and conflict-of-interest form, as required. A quorum, defined as a simple majority of voting members, must be present in order to conduct a meeting. The IQIC shall meet quarterly, at least four times per year. If urgent matters (as determined by the Alliance CMO) arise between meetings, additional meetings will be scheduled. Meetings may be conducted via conference call or webinar. All relevant matters discussed in between meetings will be presented formally at the next meeting. An agenda and supplementary materials, including minutes of the previous meeting, shall be prepared, and submitted to the IQIC members prior to the meeting to ensure proper review of the material. IQIC members may request additions, deletions, and modifications to the standard agenda. Minutes of the IQIC proceedings shall be prepared and maintained in the permanent records of the Alliance. Minutes, relevant documents, and reports will be forwarded to HCQC for review.

Responsibilities include:

- Develop, approve and monitor a dashboard of key performance and QI indicators compared to organizational goals and industry benchmarks.
- Oversee and evaluate the effectiveness of AAH's Performance Improvement and Quality Plans.
- Review reports from other sub-committees and, if acceptable, forward for review at the next scheduled HCQC.
- Reviewing plan and delegate corrective plans with regard to negative variances and serious errors.
- Oversee compliance with NCQA accreditation standards.
- Make recommendations to the HCQC on all matters related to:
    - Quality of Care, Patient Safety, and Member/Provider Experience
    - Performance Measurement
    - Preventive services including:
        - Seniors and Persons with Disability (SPD)
        - Members with chronic conditions
        - Medi-Cal Expansion (MCE) members.

The Committee shall be comprised of the following members:

- Alliance Chief Medical Officer (CMO)
- Alliance Medical Director(s)
- Director of Quality
- Quality Improvement Manager
- Access to Care Manager
- Ad Hoc members from Provider Relations, Member Services, Business Analytics and Health Education

G. Utilization Management Committee (UMC)

The UMC is a forum for facilitating clinical oversight and direction. Its responsibilities are to:

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

H. Access and Availability Subcommittee (AASC)

The AASC reviews the Alliance's access and availability data to evaluate whether the Alliance is meeting regulatory standards and provides corrective actions and recommendations for improvement to departments when needed. The committee identifies opportunities for improvement and provides recommendations to maintain compliance with access and availability regulatory requirements. Membership is comprised of Alliance staff within departments that are involved with access and availability.

The following are the monitoring activities the subcommittee reviews to ensure compliance with access and availability and network adequacy requirements including but, not limited to:

- Provider capacity levels
- Geographic accessibility
- Appointment availability
- High volume and high impact specialists
- Grievances and appeals related to access
- Potential quality issues related to access
- Triage and screening services related to access
- Member and provider satisfaction survey
- After hours care

I. Joint Operations Committee/Delegation

The contractual agreements between the Alliance and delegated groups specify:

- The responsibilities of both parties.
- The functions or activities that are delegated.
- The frequency of reporting on those functions and responsibilities to the Alliance and how performance is evaluated.
- Corrective action plan expectations, if applicable.

The Alliance may delegate QI, Credentialing, UM, Case Management, Disease Management and Claims activities to provider groups that meet delegation requirements. Prior to delegation, the Alliance conducts delegation pre-assessments to determine compliance with regulatory and accrediting requirements.

As part of delegation responsibilities, delegated providers must:

- Develop, enact, and monitor quality plans that meet contractual requirements and Alliance standards.
- Provide encounter information and access to medical records pertaining to Alliance members as required for HEDIS and regulatory agencies.
- Provide a representative to the Joint Operations Committee.
- Submit at least semi-annual reports or more frequently if required on delegated functions.
- Cooperate with state/federal regulatory audits as well as annual oversight audits.
- Complete any corrective action judged necessary by the Alliance.

The Alliance collaborates with delegates to formulate and coordinate QI activities and includes these activities in the QI work plan and program evaluation. Delegated activities are a shared function. Delegate program descriptions, work plans, reports, policies and procedures, evaluations and audit results are reviewed by the Compliance and Joint Operations Committee and findings are summarized at HCQC meetings, as appropriate.

The Alliance currently delegates the following functions:

Table 1: Alameda Alliance Delegated Entities

Delegate	Quality Improvement		Utilization Management		Credentialing		Grievances & Appeals		Claims		Call Center		Case Management		Cultural & Linguistic Services		Provider Training	
	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care
Beacon Health Strategies LLC	X	X	X	X	X	X			X	X	X	X	X		X	X	X	
Community Health Center Network (CHCN)			X	X					X	X			X	X			X	
March Vision Care Group, Inc.					X				X									
Children's First Medical Group (CFMG)			X		X				X									
PerformRx			X	X	X	X			X	X	X	X			X	X		
California Home Medical Equipment (CHME)			X	X														
Kaiser	X		X		X		X		X		X		X		X		X	
UCSF					X	X												
Physical Therapy PN					X	X												
Lucille Packard					X	X												

QUALITY IMPROVEMENT PROGRAM RESOURCES

Responsibilities for QI program activities are an integral part of all Alliance departments. Each department is responsible for setting and monitoring quality goals and activities.

The Alliance QI Department is part of the Health Care Services Department, and responsible for implementing QI activities and monitoring the QI program. The QI Department directs the accreditation process, manages the HEDIS and CAHPS data collection and improvement process, conducts facility site reviews (FSRs), and oversees the quality activities in other departments and those performed by delegated groups.

Resource allocation for the QI Department is determined by recommendations from the HCQC, CMO, and CEO. The Alliance recruits and hires trained staff, and provides resources to support activities required to meet the goals and objectives of the QI program.

The Alliance's commitment to the QI program extends throughout the organization and focuses on QI activities linked to service, access, continuity and coordination of care, and member and provider experience. The Director of Quality with direction from the Medical Director of Quality and CMO, coordinate the QI program. Titles, education and/or training for key positions within the Quality Department include:

A. Chief Medical Officer

The Alliance Chief Medical Officer (CMO) is a board-certified physician who holds a current unrestricted license to practice medicine in California. The CMO has relevant experience and current knowledge in clinical program administration, including utilization and quality improvement management. The CMO is responsible for and oversees the QI program. The CMO provides leadership to the QI program through oversight of QI study design, development, and implementation, and chairs the HCQC, PRCC, and P&T committees. The CMO makes periodic reports of committee activities, QI study and activity results, and the annual program evaluation to the BOG. The CMO reports to the Alliance CEO.

B. Medical Director of Quality Improvement

The QI Medical Director is a board-certified physician who holds a current unrestricted license to practice medicine in California. The QI Medical Director has relevant experience and current knowledge in clinical program administration, including utilization and quality improvement management and holds a Medical Doctorate, Master of Medical Management, and Master of Science in Biomedical Investigations, over 11 years of clinical experience, and 9 years of QI experience. The Medical Director is part of the medical team and is responsible for strategic direction of the Quality and Program Improvement programs. The Medical Director also forms a dyad partner with the Sr. Director of Quality and will serve as an internal expert, consultant, and resource in QI. They are responsible for clinical appropriateness, quality of care, pay for performance, access and availability, provider experience, member experience and cost-effective utilization of services delivered to Alliance members. Responsibilities include participating in the grievance and external medical review procedure process, resolving medically related and potential quality related grievances, and issuing authorizations, appeals, decisions, and denials. The QI Medical Director reports to the CMO.

C. Senior Director of Quality

The Sr. Director of Quality is responsible for the strategic direction of the Quality Improvement Program. The Sr. Director of Quality holds a Master’s degree in Public Administration in Health Care, with 21 years of QI and UM management and experience. The Sr. Director of Quality is a Registered

Nurse who holds an active license to practice in California. This position has direct responsibility for the development, implementation, and evaluation of HEDIS and CAHPS. This position is responsible for all performance improvement activities, including improving access and availability of network services; developing and managing quality programs as identified by DHCS, DMHC, and NCQA (PIPs, Improvement Programs i.e. EAS/MCAS measures, QI Standards) as well as managing, tracking, analyzing, and reporting member experience/satisfaction as requested. The Sr. Director is also responsible for the oversight of FSR and potential quality issues (PQIs) and will direct performance improvement, FSR, access and availability. The Sr. Director is also the senior nurse to the organization to augment clinical oversight. This position assists with setting the priorities of the Health Education program and ensures Health Education and Cultural and Linguistic Services are incorporated in to the Quality program. The Sr. Director of Quality reports to the CMO.

D. Quality Improvement Manager

The Clinical Quality Manager holds a Bachelor's degree in International Business and has over 17 years of QI and operational management experience in IPAs and FQHCs. The QI Manger is responsible for the day-to-day management of the QI department, including but not limited to the HEDIS measures submissions, Physician Profiling (practice profiling) activities, Performance Improvement Projects, Potential Quality of Care data tracking and quality improvement initiatives. The Manager also acts as liaison between the Alliance's physician leadership and community practitioners/providers of care across all specialties and delegates. The Manager is also responsible for creating report cards and assessing gaps in care. The QI manager works collaboratively throughout the organization to lead and establish appropriate performance management/quality improvement systems. The Quality Improvement Manager reports to the Sr. Director of Quality.

E. Access to Care Manager

The Access to Care Manager holds a Master's degree in Clinical Psychology with 16 years management experience in managed care behavioral health. The Access to Care Manager Works collaboratively throughout the organization to lead and establish appropriate access to care systems. The Access to Care Manager ensures the access program is in compliance with timely access standards as regulated by the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA). The Access to Care Manager ensures planning and oversight of access to care surveys, ensures appropriate follow up when compliance monitoring identifies deficiencies, and daily operations related to Facility Site Reviews (FSRs). The Access to Care Manager reports to the Sr. Director of Quality.

F. Quality Improvement Nurse Supervisor

The QI Nurse Supervisor is a Registered Nurse who holds an active license to practice in California and has 8 years of managed care experience.

The Quality Improvement Nurse Supervisor works collaboratively throughout the organization to ensure appropriate oversight of the performance management and clinical quality improvement assignments. The Quality Improvement Supervisor is responsible for day-to-day supervision of the work assigned to the clinical staff in the Quality Department. The Supervisor also acts as liaison between the health plan's physician leadership and community practitioners/providers of care across all specialties and delegates. The Quality Improvement Supervisor is responsible for successful and timely completion of Facility Site Review (FSR), Potential Quality Issues (PQI), Provider Preventable Conditions (PPC), quality of care corrective action plans, clinical performance of HEDIS medical record review. The QI Nurse Supervisor reports to the Sr. Director of Quality.

G. Quality Improvement Review Nurse (2)

The QI Review Nurse is a Registered Nurse who holds an active license to practice in California and has at least 3 years of managed healthcare experience. Under the direct supervision of the Quality Improvement Nurse Supervisor, the Quality Review Nurse is responsible for collecting quality related data and reviewing medical records for HEDIS abstraction and over reads, Potential Quality of Care Issues (PQIs) determination, regulatory compliance, Facility Site Review (FSR) evaluations, quality improvement (QI) activities development, data tracking and trending, and outcomes reporting. The Quality Review Nurse keeps accurate records, manages and analyzes data, as well as, responds appropriately and timely, both verbally and in writing to internal and external clinical issues of staff and regulatory agencies.

H. Senior Quality Improvement Nurse Specialist (1)

The QI Review Nurse is a Registered Nurse who holds an active license to practice in California and has at least 11 years of managed healthcare experience. Under the direct supervision of the Quality Improvement Nurse Supervisor, the Sr. Quality Improvement (QI) Nurse Specialist is responsible for the training, certification and recertification of all Alliance Network Management and Delegated Provider Oversight staff in conducting FSR audits. The Sr. QI Nurse Specialist is also responsible for the oversight and monitoring of the qualitative and quantitative content of the medical record process and maintaining compliance with state and regulatory quality of care standards. The QI Nurse Specialist develops provider training and education materials to assist providers with meeting quality standards.

The Senior QI Nurse Specialist identifies, investigates and reports on Potential Quality Issues (PQIs) and Provider Preventable Conditions (PPCs) as appropriate from FSR findings. The QI Nurse Specialist prepares cases and presents quality of care issues to the Medical and Sr. Director of Quality Improvement for review and determination.

I. Quality Improvement Project Specialist (5)

QI Project Specialist (QIPS) are Bachelor's prepared non-clinical support staff responsible for providing support for quality assessment and performance improvement activities including quality monitoring, accreditation, access and availability monitoring, evaluation and facilitation of performance improvement projects. The QI Project Specialist reports directly to either the Quality Manager or Access to Care Manager. The QIPS acts as a liaison between the Alliance and the survey vendors, assist with accreditation needs, collaborate on HEDIS interventions, and perform regular assessments of access surveys, provider surveys, CAHPS and grievances. The QIPS ensures accuracy of DHCS performance improvement projects, internal subcommittees and HCQC and subcommittee meeting facilitation. The QIPS have experience in managed care as well as other highly regulated organizations.

J. Facility Site Review QI Coordinator (1)

The Facility Site Review Coordinator (FSRC) has years of training and experience within the managed healthcare industry. The FSRC reports to the Access to Care Manager and is responsible for performing facility site review audits and quality improvement activities in conjunction with the Sr. QI Nurse Specialists. The position assists with access and availability reports, provider trainings, HEDIS data collection, disease specific outreach, and preparation for accreditation and compliance surveys by external agencies such as DHCS, DMHC and NCQA.

K. Quality Program Coordinator (1)

The Quality Program Coordinator (QPC) is a Bachelor's prepared non-clinical support staff. Under the general direction of the Quality Improvement Manager, the QPC is responsible for helping to plan, organize, and implement Alliance quality programs. Responsibilities include: coordination of quality projects including PQI case tracking, conducting reminder calls/mailings to targeted members or providers participating in quality improvement initiatives or activities, represents the Alliance at community meetings/events, create/runs periodic departmental reports, and maintains departmental worksheets.

ANCILLARY SUPPORT SERVICES FOR THE QI PROGRAM

A. Health Education

The Health Education Department consists of a Health Educator Manager and Disease Management Manager, a Health Programs Coordinator, and a Health Coordinator Specialist. The Health Education department is an inclusive component within the QI Department. The Health Education staff supports the QI team in the development and implementation of member and provider educational interventions and community collaborations to address health care quality and access to care. The Health Education Department also manages and monitors the Cultural and Linguistic programs for the Alliance. The Health Education and Cultural and Linguistic Programs are outlined in a separate document.

B. Healthcare Analytics Services

The Healthcare Analytics Department consists of seventeen staff members. This includes: one Chief Analytics Officer, two Directors, one Manager, nine analysts, two Quality Specialists, one Business Administrator, and one Executive Assistant. They perform data analyses involving clinical, financial, provider and member data. The Health Care Analysts are available to the QI department allotting at least 25% of their time to direct QI analysis. They collect and summarize QI data, and work in conjunction with the Information Technology (IT) Department and the QI department to produce analytics and reporting for various QI activities projects including HEDIS. Additionally, some quality analytics and reporting are produced by outside vendors under contract with the Alliance.

C. Quality Assurance

The Director, Quality Assurance is responsible for the operational management of the Alliance Quality Assurance Program under the direction of the Chief Medical Officer. The Director is responsible for Health Care Services internal monitoring activities as well as clinical components of delegation oversight auditing and performance monitoring. The Director is responsible for ensuring Health Care Service's overall regulatory compliance with Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) contractual responsibilities for Health Care Service Departments. The role is also responsible for overseeing ongoing audit readiness activities for DHCS, DMHC and NCQA. The Director is also responsible to coordinate processes, activities, and regulatory compliance involving grievances and appeals for all lines of business. The position identifies, analyzes, and coordinates resolution of grievances and appeals.

D. Utilization Management (UM) Services

The UM and QI Departments are part of the Alliance Health Care Services Department. These departments work collaboratively to ensure that appropriate quality and safe health care is delivered to members in a timely and organized manner. QI ensures that HCQC is able to identify improvement opportunities regarding: concurrent reviews, tracking key utilization data, and the annual evaluation of

UM activities.

The Alliance's Utilization Management (UM) activities are outlined in the UM Program Description which includes a persons with complex health conditions. The UM Program Description defines how UM decisions are made in a fair and consistent manner. There is also a Case Management (CM) and Complex Case Management Program Description. These programs address serving members with complex health needs, such as, seniors and people with physical or developmental disabilities (SPDs) and/or multiple chronic conditions. There is one staff person dedicated to working with "linked and carved out services" such as East Bay Regional Center, California Children Services (children with complex health care needs), and the Alameda County Behavioral Health Care Department. The UM Program Description is approved by the UMC and HCQC. For additional information, refer to the UM and CM/Complex CM Program Descriptions.

E. Pharmacy Services

The Pharmacy Department and QI Department work collaboratively on various QI projects. The Pharmacy Department supports patient safety initiatives including working with the Pharmacy Benefit Manager (PerformRx) to inform members, providers and network pharmacies of medication safety alerts. Responsibilities also include review and update of the formulary through P&T, oversight of the Pharmacy Benefit Manager, and collaboration with HCQC.

F. Case and Disease Management Services

The Case and Disease Management department oversees case management for high-risk members including those identified through the disease management program. Responsibilities include conducting outreach and care coordination activities for members in the programs to ensure the improvement of member outcomes and overall member satisfaction. The staff will also assist the QI department in QI activities through conducting member outreach calls and mailings.

G. Network Management/Provider Relations

The Network Management/Provider Relations Department is the primary point of contact for network providers. They assist the QI Department on various QI activities with network providers as appropriate as well as disseminating QI information to practitioners. The Department is responsible for assessing provider satisfaction with Alliance processes and monitoring availability and accessibility standards at physician offices, including after-hours coverage. Provider Services staff also assists the QI Department with practitioners who do not comply with requests from QI including scheduling HEDIS abstraction visits.

H. Credentialing Services

The Credentialing staff support the credentialing and re-credentialing processes for practitioners and network providers. The Credentialing staff conducts ongoing monitoring and evaluation of network practitioners to ensure the safety and quality of services to members. The QI Department provides the Credentialing Department with Facility Site Review and Medical Record audit scores. The Credentialing staff is responsible for coordinating the PRCC meetings.

I. Member Services

The Member Services staff fields all member inquiries regarding eligibility, benefits, claims, programs, and access to care. The staff conducts welcome calls to members to educate new members about the health plan benefits. Member Services staff also works with the QI Department on member complaints

and appeals in accordance with established policies and procedures. To assist in improving HEDIS scores, the Member Services Department may conduct reminder calls to members to get HEDIS services completed. Call abandonment data will be followed by QI in 2020 for noted improvement

GRIEVANCE AND APPEALS

Alameda Alliance for Health reviews and investigates all grievance and appeal information submitted to the plan in an effort to identify quality issues that affect member experience. The grievance and appeals intake process are broken down into two processes, complaints and appeals. In both instances, the details of the member's complaints are collected, processed, and reviewed and actions are taken to resolve the issue and Potential Quality Issues are forwarded to QI for review and investigation as needed. QI will continue to collaborate with G&A for assurance of accurate reporting exempt grievance data in 2020.

METHODS AND PROCESSES FOR QUALITY IMPROVEMENT

The QI program employs a systematic method for identifying opportunities for improvement and evaluating the results of interventions. All program activities are documented in writing and all quality studies are performed on any product line for which it seems relevant. The Alliance QI Program follows the recommended performance improvement framework used by the Department of Health Care Services (DHCS). The Alliance Quality department has adopted the DHCS framework based on a modification of the Institute for Health Care Improvement (IHI) Quality Improvement (QI) as a Model of Quality Improvement. Key concepts for DHCS performance improvement projects (PIP) utilize the following framework:

- PIP Initiation
- SMART Aim Data Collection
- Intervention Determination
- Plan-Do-Study-Act
- PIP Conclusion

IDENTIFICATION OF IMPORTANT ASPECTS OF CARE

The Alliance uses several methods to identify aspects of care that are the focus of QI activities. Some studies are initiated based on performance measured as part of contractual requirements (e.g., HEDIS). Other studies are initiated based on analyses of the demographic and epidemiologic characteristics of Alliance members and others are identified through surveys and dialogue with our member and provider communities (e.g., CAHPS, provider satisfaction and Group Needs Assessment). Particular attention is paid to those areas in which members are high risk, high volume, high cost, or problem prone.

DATA COLLECTION AND DATA SOURCES

The Alliance uses internal resources and capabilities to design sound studies of clinical and service quality that produce meaningful and actionable information.

Much of the data relevant to QI activities are maintained in a confidential and secure data warehouse named Verscend. Data integrity is validated annually through the HEDIS reporting audit process, and through adherence to the Alameda Alliance data analysis plan.

Data sources to support the QI program include, but are not limited to the following:

- Data Warehouse (HAL): Houses legacy data from previous system (Diamond).
- ODS (Operational Data Store): This is the main database and the primary source for all data including member, eligibility, encounter, provider, pharmacy data, lab data, vision, encounters, etc. and claims. This database is used for abstracting data required for quality reporting.
- Business Objects: A data mining tool used by staff to create accurate member level reporting.
- HealthSuite: a platform for integrating data from Providers, Members, Medical Records, Encounters, and claims.
- CareAnalyzer (DST): used to inform Population Health Management and Population Needs Assessment initiatives and provide QI/UM/CM access to risk-stratified, segmented data that can be effectively applied to target high-risk members for early intervention and improve the overall coordination of care.
- TruCare: in house medical record data storage software.
- HEDIS: Preventive, chronic care, and access measures run through NCQA-certified HEDIS software vendor (Verscend).
- CAHPS 5.0 and CAHPS 3.0: Member experience survey via SPH vendor support
- California Immunization Registry (CAIR): Immunization registry information.
- Laboratory supplemental data sources from: Quest, Foundation, Sorian, Epic, NextGen and Novius.
- Credentialing via Cactus, a credentialing database.
- Provider satisfaction and coordination of care surveys via SHP vendor support
- Pre-service, concurrent, post-service and utilization review data (TruCare).
- Member and provider grievance and appeal data.
- Potential Quality of Care Issue Application database used for tracking/trending data.
- Internally developed databases (e.g., asthma and diabetes).
- Provider Appointment Availability Survey (PAAS), as well as after hour access and emergency instructions.
    - Other clinical or administrative data.

EVALUATION

Health care analysts collect and summarize quality data. Quality performance staff analyzes the data to determine variances from established criteria, performance goals, and for clinical issues. Data is analyzed to determine priorities or achievement of a desired outcome. Data is also analyzed to identify disparities based on ethnicity and language. Particular subsets of our membership may also be examined when they are deemed to be particularly vulnerable or at risk.

HEDIS related analyses include investigating trends in provider and member profiling, data preparation (developing business rules for file creation, actual file creation for HEDIS vendors, mapping proprietary data to vendor and NCQA specifications, data quality review and data clean-up). These activities

involve both data sets maintained by the Alliance and supplemental files submitted by various trading partners, such as delegated provider organizations and various external health registries and programs (e.g., Kaiser Permanente, Quest Diagnostics and the California Immunization Registry).

Aggregated reports are forwarded to the HCQC. Status and final reports are submitted to regulatory agencies as contractually required. Evaluation is documented in committee minutes and attachments.

ACTIONS TAKEN AS RESULT OF QUALITY IMPROVEMENT ACTIVITIES

Action plans are developed and implemented when opportunities for improvement are identified. Each performance improvement plan specifies who or what is expected to change, the person responsible for implementing the change, the appropriate action, and when the action is to take place. Actions will be prioritized according to possible impact on the member or provider in terms of urgency and severity. Actions taken are documented in reports, minutes, attachments to minutes, and other similar documents.

An evaluation of the effectiveness of each QI activity is performed. A re-evaluation will take place after an appropriate interval between implementation of an intervention and remeasurement. The evaluation of effectiveness is described quantitatively, in most cases, compared to previous measurement, with an analysis of statistical significance when indicated.

Based on the HEDIS data presented, areas of focus for 2020 include the following:

- Childhood Immunizations: Combo 10
- Well-Child Visits in the First 15 Months of Life: Six or more Visits
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Adolescent Well-Care Visits
- Asthma Medication Ratio
- Breast Cancer Screening
- Cervical Cancer Screening
- HbA1c Testing for Diabetics

Other Non-HEDIS related measures of focus will include:

- Initial Health Assessment
- Emergency Department Visits per 1,000 Members
- Pharmacy Utilization: Percentage of Generic Usage
- Member Satisfaction Survey: Non-Urgent Appointment Availability
- Opioids Intervention: DEA X-Waiver

See Appendix C (bottom) for ongoing PIP activities that will continue into 2021.

TYPES OF QI MEASURES AND ACTIVITIES

A. Healthcare Effectiveness Data Information Set (HEDIS)

The Managed Care Accountability Set (MCAS) Performance Measures, a subset of HEDIS (Health Effectiveness Data Information Set) are calculated, audited, and reported annually as required by

DHCS. Additional measures from HEDIS are also reviewed. A root cause analysis may be performed and improvement activities initiated for measures not meeting benchmarks.

B. Consumer Assessment of Health Plan Survey (CAHPS)

The Alliance evaluates member experience periodically. The Consumer Assessment of Health Plan Survey (CAHPS) is conducted by vendors. The Alliance assists in the administration of these surveys, receives and analyzes the results, and follows up with prioritized improvement initiatives. Survey results are distributed to the HCQC and made available to members and providers upon request. The CAHPS survey is conducted annually for the entire Medi-Cal population and the results from the CAHPS are reported in the annual QI evaluation and used to identify opportunities to improve health care and service for our members.

C. State of California Measures

DHCS has developed several non-HEDIS measures that the Alliance evaluates. These measures, specified in the Alliance contract with DHCS, involve reporting rates for an Under/Over-Utilization Monitoring Measure Set.

D. State Quality Improvement Activities

DHCS requires Medi-Cal Managed Care plans to conduct at least two QI projects each year. Forms provided by DHCS are used for QI project milestones.

Annually, the Alliance submits its QI Program Description, an evaluation of the prior year's QI Work Plan and a QI Work Plan for the next year. The QI Work Plan is updated throughout the year as QI activities are designed, implemented and re-assessed.

The Alliance complies with the requirements described in regulatory All Plan Letters.

E. Monitoring Satisfaction

The QI program measures member and provider satisfaction using several sources of satisfaction, including the results of the CAHPS survey, the Group Needs Assessment (GNA), the annual DMHC Timely Access survey, plan member and provider satisfaction surveys, complaint and grievance data, disenrollment and retention data, and other data as available. These data sets are presented to the HCQC and BOG at quarterly and annual intervals. The plan may administer topic specific satisfaction surveys depending on findings of other QI studies and activities.

F. Health Education Activities

The Health Education Program at the Alliance operates as part of the Health Care Services Department. The primary goal of Health Education is to improve members' health and well-being through the lifespan through promotion of appropriate use of health care services, preventive health care guidelines: Bright Futures/American Academy of Pediatrics and U.S. Preventive Services Task Force, healthy lifestyles and disease self-care and management. The primary goal of Health Education is to provide the means and opportunities for Alameda Alliance members to maintain and support their health.

Health education programs include individual, provider, and community-focused health education activities which cluster around several topic areas. The Alliance also collaborates on a number of community projects to develop and distribute important health education messages for at risk populations.

G. Cultural and Linguistic Activities

The Alliance Cultural and Linguistic Program operates under the Health Care Services Department. It reflects the Alliance's adherence and commitment to the U.S. Department of Health & Human Services "National Standards for Culturally and Linguistically Appropriate Services". The program conducts activities designed to ensure that all members have access to quality health care services that are culturally and linguistically appropriate. These activities encompass efforts within the organization, as well as with Alliance members, providers, and our community partners.

Objectives include:

- Comply with state and federal guidelines related to assessment of enrollees in order to offer our members culturally and linguistically appropriate services.
- Identify, inform and assist Limited English Proficiency members in accessing quality interpretation services and written informing materials in threshold languages.
- Ensure that all staff, providers and subcontractors are compliant with the cultural and linguistic program through cultural competency training.
- Integrate community input into the development and implementation of Alliance cultural and linguistic accessibility standards and procedures.
- Monitor and continuously improve Alliance activities aimed at achieving cultural competence and reducing health care disparities.

The objectives for cultural and linguistic activities are addressed in the Health Education and Cultural and Linguistic work plans which are updated annually.

H. Disease Surveillance

The Alliance has executed a Memoranda of Understanding with DMHC and maintains procedures to ensure accurate, timely, and complete reporting of any disease or condition to public health authorities as required by State law. The Provider Manual describes requirements and lists Public Health Department contact phone and fax numbers.

I. Patient Safety and Quality of Care

The Alliance QI process incorporates several mechanisms to review incidents that pose potential risk or safety concerns for members. The following activities are performed to demonstrate the Alliance's commitment to improve quality of care and safety of its members:

- Reviewing complaints and grievances and determining quality of care impact.
- Monitoring iatrogenic events such as, hospital-acquired infections reported on claims and reviewing encounter submissions.
- Reviewing concurrent inpatient admissions to evaluate and monitor the medical necessity and appropriateness of ongoing care and services. Safety issues may be identified during this review.
- Investigating reported and/or identified potential quality of care issues.
- Auditing Alliance internal processes/systems and delegated providers.
- Credentialing and re-credentialing review of malpractice, license suspension registries, loss of hospital privileges.

- Performing site review of provider offices for compliance with safety, infection control, emergency, and access standards.
- Monitoring operational compliance with local regulatory practices.
- Monitoring medication usage (e.g., monitoring number of rescue medications used by asthmatics).
- Encouraging/reminding providers to use ePocrates to receive information on drug information, side effects and interactions.
- Partnering with the pharmacy benefit management company to notify members and providers of medication recalls and warnings.
- Reviewing hospital readmission reports.
- Improving continuity and coordination of care between practitioners.
- Providing educational outreach to members (e.g., member newsletter, telephonic outreach) on patient safety topics including questions asked prior to surgery and questions asked about drug-drug interaction.

Quality issues are referred to the QI Department to evaluate the issue, develop an intervention and involve the CMO when necessary.

ACCESS AND AVAILABILITY

The Alliance implements mechanisms to maintain an adequate network of primary care providers (PCP) and high volume and high impact specialty care providers. Alliance policy defines the types of practitioners who may serve as PCPs. Policies and procedures establish standards for the number and geographic distribution of PCPs and high volume specialists. The Alliance monitors and assesses the cultural, ethnic, racial, and linguistic needs and preferences of members, and adjusts availability of network providers, if necessary.

The following services are also monitored for access and availability:

- Children's preventive periodic health assessments/ EPSDT
- Adult initial health assessments
- Standing referrals to HIV/AIDS specialists
- Sexually transmitted disease services
- Minor's consent services
- Pregnant women services
- Chronic pain management specialists.

The QI program collaborates with the Provider Relations Department to monitor access and availability of care including member wait times and access to practitioners for routine, urgent, emergent, and preventive, specialty, and after-hours care. Access to medical care is ensured by monitoring compliance with timely access standards for practitioner office appointments, telephone practices, appointment availability. The HCQC also oversees appropriate access standards for appointment wait times. Alliance appointment access standards are no longer than DMHC and DHCS established standards. The Provider Manual and periodic fax blasts inform practitioners of these standards.

The HCQC reviews the following data and makes recommendations for intervention and quality

activities when network availability and access improvement is indicated:

- Member complaints about access
- CAHPS results for wait times and telephone practices
- HEDIS measures for well child and adolescent primary care visits
- Immunizations
- Emergency room utilization
- Facility site review findings
- The review of specialty care authorization denials and appeals
- Additional studies and surveys may be designed to measure and monitor access.

BEHAVIORAL HEALTH QUALITY

The Alliance maintains procedures for monitoring the coordination and quality of behavioral healthcare provided to all members including, but not limited to, all medically necessary services across the health care network. The Alliance involves a senior behavioral healthcare physician in quarterly HCQC meetings to monitor, support, and improve behavioral healthcare aspects of QI.

Behavioral Health Services are delegated to Beacon Health Strategies, an NCQA Accredited MBHO, except for Specialty Behavioral Health for Medi-Cal members, excluded from the Alliance contract with DHCS. The Specialty Behavioral Health Services are coordinated under a Memorandum of Understanding between the Alliance and Alameda County Behavioral Health Services (ACBHCS). While behavioral health is delegated, some primary care physicians may choose to treat mild mental health conditions rather than referring to Beacon.

The Alliance includes the involvement of a designated behavioral health physician in program oversight and implementation as discussed in Beacon's QI Program Description. The Alliance annually reviews Beacon's QI Program Description, Work Plan, and Annual Evaluation. The Alliance reviews Beacon behavioral health quality, utilization and member satisfaction quarterly reports in a Joint Operations Meeting (JOM) to ensure members obtain necessary and appropriate behavioral health services.

COORDINATION, CONTINUITY OF CARE AND TRANSITIONS

Member care transitions present the greatest opportunity to improve quality of care and decrease safety risks by ensuring coordination and continuity of health care as members transfer between different locations or different levels of care within the same location.

The Alliance Health Plan Health Care Services Department focuses on interventions that support planned and unplanned transitions and promote chronic disease self-management. Primary goals of the department are to reduce unplanned transitions, prevent avoidable transitions and maintain members in the least restrictive setting possible.

Comprehensive case management services are available to each member. It is the PCP's responsibility to act as the primary case manager to all assigned members. Members have access to these services regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability. All services are provided in a culturally and linguistically appropriate manner.

Members who may need or are receiving services from out-of-network providers are identified. Procedures ensure these members receive medically necessary coordinated services and joint case

management, if indicated. Written policies and procedures direct the coordination of care for the following:

- Services for Children with Special Health Care Needs (CSHCN).
- California Children's Service (CCS) eligible children are identified and referred to the local CCS program.
- Overall coordination and case management for members who obtain Child Health and Disability Prevention Program (CHDP) services through local school districts or sites.
- Early Start eligible children are identified and referred to the local program.
- Members with developmental difficulties are referred to the Regional Center of the East Bay for evaluation and access to developmental services.

All new Medi-Cal members are expected to receive an Initial Health Assessment (IHA) within 120 days of their enrollment with the plan. The IHA includes an age-appropriate health education and behavioral assessment (IHEBA). Members are informed of the importance of scheduling and receiving an IHA from their PCP. The Provider Manual informs the PCP about the IHA, the HRA, and recommended forms. All new Medi-Cal members also receive a Health Information Form\Member Information Tool (HIF\MET) in the New Member Packet upon enrollment. The Alliance ensures coordination of care with primary care for all members who return the form with a condition that requires follow up within 90 days.

The Alliance coordinates with PCPs to encourage members to schedule their IHA appointment. The medical record audit of the site review process is used to monitor whether baseline assessments and evaluations are sufficient to identify CCS eligible conditions, and if medically necessary follow-up services and referrals are documented in the member's medical record.

COMPLEX CASE MANAGEMENT PROGRAM

All Alliance members are potentially eligible for participation in the complex case management program. The purpose of the complex case management program is to provide the case management process and structure to a member who has complex health issues and medical conditions. The components of the Alliance complex case management program encompass: member identification and selection; member assessment; care plan development, implementation and management; evaluation of the member care plan; and closure of the case. Program structure is designed to promote quality case management, client satisfaction and cost efficiency through the use of collaborative communication, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

The objectives of the complex case management program are concrete measures that assess effectiveness and progress toward the overall program goal of making high quality health care services accessible and affordable to Alliance membership. The Chief Medical Officer, Director of Health Care Services, and Manager of Case and Disease Management develop and monitor the objectives. The HCQC reviews and assesses program performance against objectives during the annual program evaluation, and if appropriate, provides recommendations for improvement activities or changes to objectives. The objectives of the program include:

- Preventing and reducing hospital and facility readmissions as measured by admission and readmission rates.
- Preventing and reducing emergency room visits as measured by emergency room visit rates.

- Achieving and maintaining member's high levels of satisfaction with case management services as measured by member satisfaction rates.
- Improving functional health status of complex case management members as measured by member self-reports of health condition.

The complex case management program is a supportive and dynamic resource that the Alliance uses to achieve these objectives as well as respond to the needs and standards of consumers, the healthcare provider community, regulatory and accrediting organizations.

The Alliance annually measures the effectiveness of its complex case management program based on the following measures (detailed information can be found in the Comprehensive Case Management Program Description):

1. Satisfaction with case management services - members are mailed a survey after case closure and are asked to rate experiences and various aspects of the program's service.
2. All-cause admission rates - the Alliance measures admission rates for all causes within six months of being enrolled in complex case management.
3. Emergency room visit rate - the Alliance measures emergency room visit rates among members enrolled in complex case management.
4. Health status rate - the Alliance measures the percentage of members who received complex case management services and responded that their health status improved as a result of complex case management services.
5. Use of appropriate health care services - The Alliance measures enrolled members' office visit activity, to ensure members seek ongoing clinical care within the Alliance network.

The Chief Medical Officer and the Director of Health Care Services collaboratively conduct an annual evaluation of the Alliance complex case management program. This includes an analysis of performance measures, an evaluation of member satisfaction, a review of policies and program description, analysis of population characteristics and an evaluation of the resources to meet the needs of the population. The results of the annual program evaluation are reported to the HCQC for review and feedback. The HCQC makes recommendations for improvement and interventions to improve program performance, as appropriate. The Director of Clinical Services is responsible for implementing the interventions under the oversight of the Chief Medical Officer.

DISEASE MANAGEMENT PROGRAM

All Alliance members are eligible for participation in the disease management program. The purpose of the disease management program is to provide disease management services to children who have chronic asthma or adults with diabetes and promote healthy outcomes. This is accomplished through the provision of interventions based on member acuity level. The intervention activities range from case management to those members at high risk to making educational materials available to those members who may have gaps in care. The components of the Alliance disease management program encompass: member identification and risk stratification; provision of case management services; chronic condition monitoring; identification of gaps in care; and education and reminders. Program structure is designed to promote quality condition management, client satisfaction and cost efficiency through the use of collaborative communications, evidence-based clinical guidelines and protocols, patient - centered care plans, and targeted goals and outcomes.

The objectives of the disease management program are concrete measures that assess effectiveness and progress toward the overall program goals of meeting the health care needs of members and

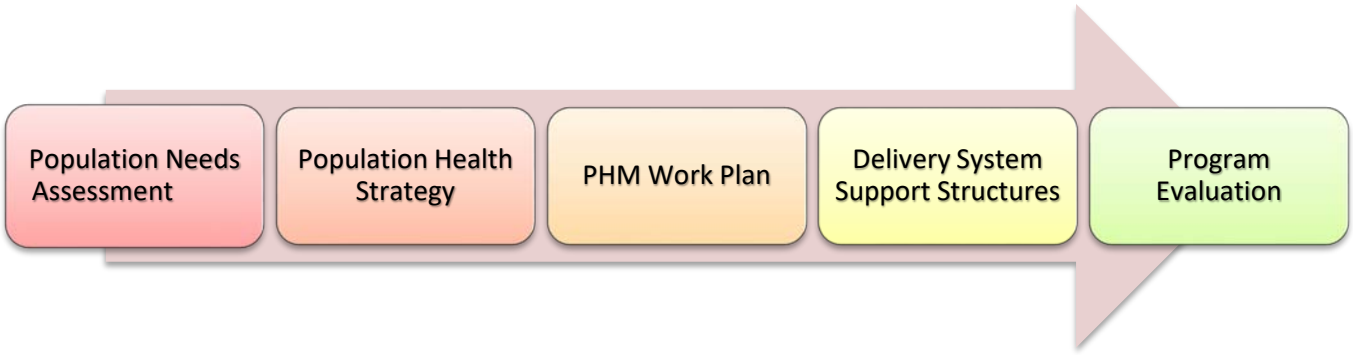
actively supporting members and practitioners to manage chronic asthma and diabetes. The Chief Medical Officer and the Director Clinical Services develop and monitor the objectives. The HCQC reviews and assesses program performance against objectives during the annual program evaluation, and if appropriate, provides recommendations for improvement activities or changes to objectives. The objectives of the disease management program include:

- Preventing and reducing hospital and facility readmissions as measured by admission and readmission rates.
- Preventing and reducing emergency room visits as measured by emergency room visit rates.
- Achieving and maintaining member's high levels of satisfaction with disease management services as measured by member satisfaction rates.
- Reducing gaps in care as measured by HEDIS clinical effectiveness measures specific to the management of asthma and diabetes.

POPULATION HEALTH MANAGEMENT (PMH) PROGRAM

Refers to strategically managing the engagement, treatment, and clinical outcomes of selected populations. PMH was developed in 2018 by the Institute for Healthcare Improvement (IHI) 100 Million Healthier Lives, with support from Robert Wood Johnson Foundation and several national partners. The Alliance follows NCQA standards for developing its strategy for meeting the care needs of its member population. PHM is ongoing.

Figure 1: Alliance PHM Timeline

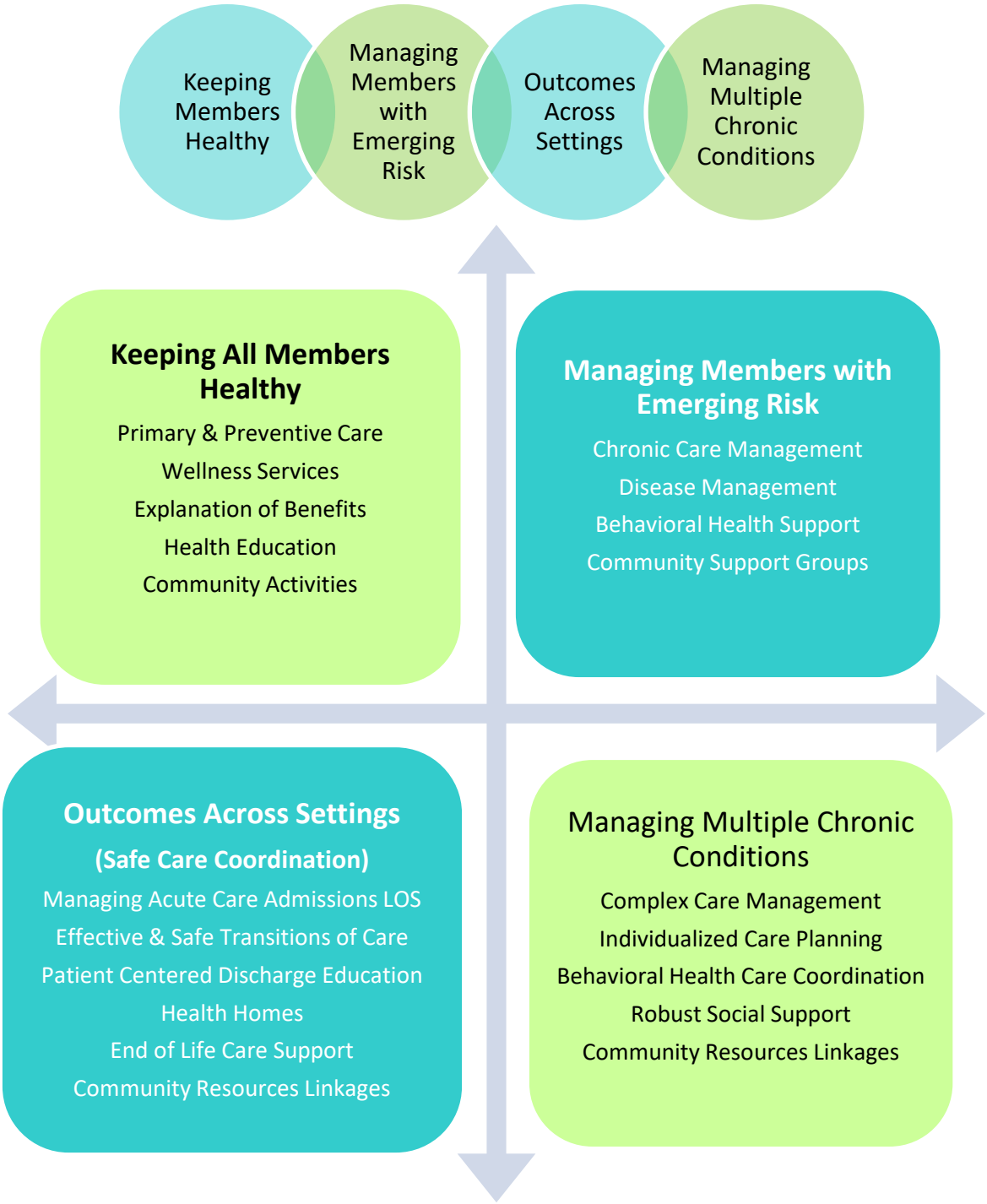


Population Needs Assessment: Data used to develop AAH population health strategy which in turn may influence:

1. Data used to develop AAH population health strategy which in turn may influence:
    - Enhanced Case Management
    - Population Needs Assessment
    - Health Education Materials and Programs
    - Quality Improvement Performance Improvement Projects
    - Understand patterns of cost and utilization
    - Pay For Performance

2. Integrated Population Health Strategy:
   - The Alliance has a comprehensive strategy for population health management that includes but, is not limited to the following four areas of focus:

Figure 2: Four Areas of Focus



3. PMH Work Plan:
    - Case Identification
    - Aligning Services with Member needs as identified
    - Delivery Systems/Provider Support Structures:
    - Sharing Data – provider measures, informing members
    - Quality Dashboards – HEDIS measure-specific data
    - Comparable Data – Peer performance, local averages, and national benchmarks
    - Value-Based Payment Programs
    - Ongoing Education/Support – Provider Newsletters & Education
    - Program Evaluation/Outcomes Data
    - HEDIS Performance Measures
    - Complex Case Management
    - Transitions of Care
    - Member Experience
    - Population Needs Re-Assessment

The Alliance Population Health Program and services are designed to improve the health and wellbeing of members and is committed to ongoing rigorous evaluation of our program that continuously looks for ways to improve our program and revise services as needed.

SENIORS AND PERSONS WITH DISABILITY (SPD)

The Alliance categories all new SPD members as high risk. High risk members are contacted for a HRA within 45 calendar days and low risk members are contacted within 105 calendar days from their date of enrollment. Existing SPD members receive an annual HRA on their anniversary date. The objectives of a HRA are to assess the health status, estimate health risk, and address members' needs relating to medical, specialty, pharmacy, and community resources. Alliance staff uses the responses to the HRAs, along with any relevant clinical information, to generate care plans with interventions to decrease health risks and improve care management.

DHCS has established performance measures to evaluate the quality of care delivered to the SPD population using HEDIS measures and a hospital readmissions measure.

PROVIDER COMMUNICATION

The Alliance contracts with its providers to foster open communication and cooperation with QI activities. Contract language specifically addresses:

- Provider cooperation with QI activities.
- Plan access to provider medical records to the extent permitted by state and federal law.
- Provider maintenance of medical record confidentiality.
- Open provider-patient communication about treatment alternatives for medically necessary and appropriate care.

Provider involvement in the QI program occurs through membership in standing and ad-hoc committees, and attendance at BOG and HCQC meetings. Providers and members may request copies of the QI program description, work plan, and annual evaluation. Provider participation is essential to the success of QI studies including HEDIS and those that focus on improving aspects of member care. Additionally, provider feedback on surveys and questionnaires is encouraged as a means of continuously improving the QI program.

Providers have an opportunity to review the findings of the QI program through a variety of mechanisms. The HCQC reports findings from QI activities to the BOG, at least quarterly. Findings include aggregate results, comparisons to benchmarks, deviation from threshold, drill-down results for provider group or type, race/ethnicity and language, and other demographic or clinical factors. Findings are distributed directly to the provider when data is provider-specific. Findings are included in an annual evaluation of the QI Program and made available to providers and members upon request. The Provider Bulletin contains a calendar of future BOG and standing committee dates and times.

EVALUATION OF QUALITY IMPROVEMENT PROGRAM

The HCQC reviews, makes recommendations, and approves a written evaluation of the overall effectiveness of the QI program on an annual basis. The evaluation includes, at a minimum:

- Changes in staffing, reorganization, structure, or scope of the program during the year.
- Allocation of resources to support the program.
- Comparison of results with goals and targets.
- Tracking and trending of key indicators.
- Description of completed and ongoing QI activities.
- Analysis of the overall effectiveness of the program, including assessment of barriers or opportunities.
- Recommendations for goals, targets, activities, or priorities in subsequent QI Work Plan.

The review and revision of the program may be conducted more frequently as deemed appropriate by the HCQC, CMO, CEO, or BOG. The HCQC's recommendations for revision are incorporated into the QI Program Description, as appropriate, which is reviewed by the BOG and submitted to DHCS on an annual basis.

ANNUAL QI WORK PLAN (SEPARATE DOCUMENT)

A QI Work Plan is received and approved annually by the HCQC. The work plan describes the QI goals and objectives, planned projects, and activities for the year, including continued follow-up on previously identified quality issues, and a mechanism for adding new activities to the plan as needed. The work plan delineates the responsible party and the time frame in which planned activities will be implemented.

The work plan is included as a separate document and addresses the following:

- Quality of clinical care
- Quality of service
- Safety of clinical care
- Members' experience

- Yearly planned activities and objectives
- Time frame within which each activity is to be achieved
- The staff member responsible for each activity
- Monitoring previously identified issues
- Evaluation of the QI program

Progress on completion of activities in the QI work plan is reported to the HCQC quarterly. A summary of this progress will be reported by the CMO to the BOG.

QI DOCUMENTS

In addition to this program description, the annual evaluation and work plan, the other additional documents important in communicating QI policies and procedures include:

- "Provider Manual" provides an overview of operational aspects of the relationship between the Alliance, providers, and members. Information about the Alliance's QI Program is included in the provider manual. It is distributed to all contracted provider sites.
- "Provider Bulletin" is a newsletter distributed to all contracted provider sites on topics of relevance to the provider community, and can include QI policies, procedures and activities.
- "Alliance Alert" is the member newsletter that also serves as a vehicle to inform members of QI policies and activities.

These documents, or summaries of the documents, are available upon request to providers, members, and community partners. In addition, the QI program information is available on the Alliance website.

CONFIDENTIALITY AND CONFLICT OF INTEREST

All employees, contracted providers, delegated medical groups and sub-contractors of the Alliance maintain the confidentiality of personally identifiable health information, medical records, peer review, internal and external, and internal electronic transmissions and quality improvement records. They will ensure that these records and information are not improperly disclosed, lost, altered, tampered with, destroyed, or misused in any manner. All information used in QI activities is maintained as confidential in compliance with applicable federal and state laws and regulations.

Access to member or provider-specific peer review and other QI information is restricted to individuals and/or committees responsible for these activities. Outside parties asking for information about QI activities must submit a written request to the CMO. Release of all information will be in accordance with state and federal laws.

All providers participating in the HCQC or any of its subcommittees, or other QI program activities involving review of member or provider records, will be required to sign and annually renew confidentiality and conflict of interest agreements. Guests or additional Alliance staff attending HCQC meetings will sign a confidentiality agreement.

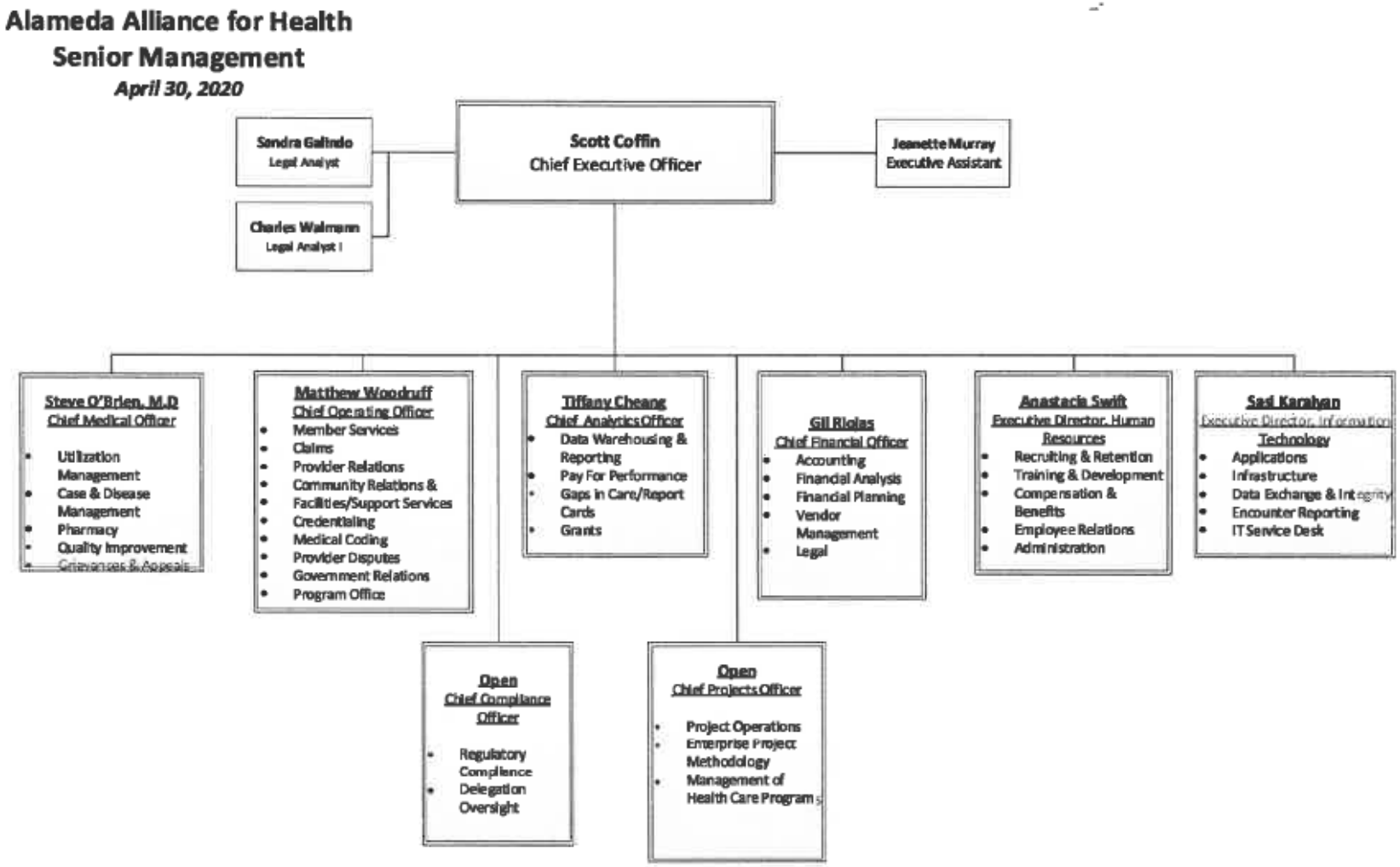
Committee members may not participate in the review of any case in which they have a direct professional, financial, or personal interest. It is each committee member's obligation to declare actual or potential conflicts of interest.

All QI meeting materials and minutes are marked with the statement "Confidential". Copies of QI meeting documents and other QI data are maintained separately and secured to ensure strict confidentiality.

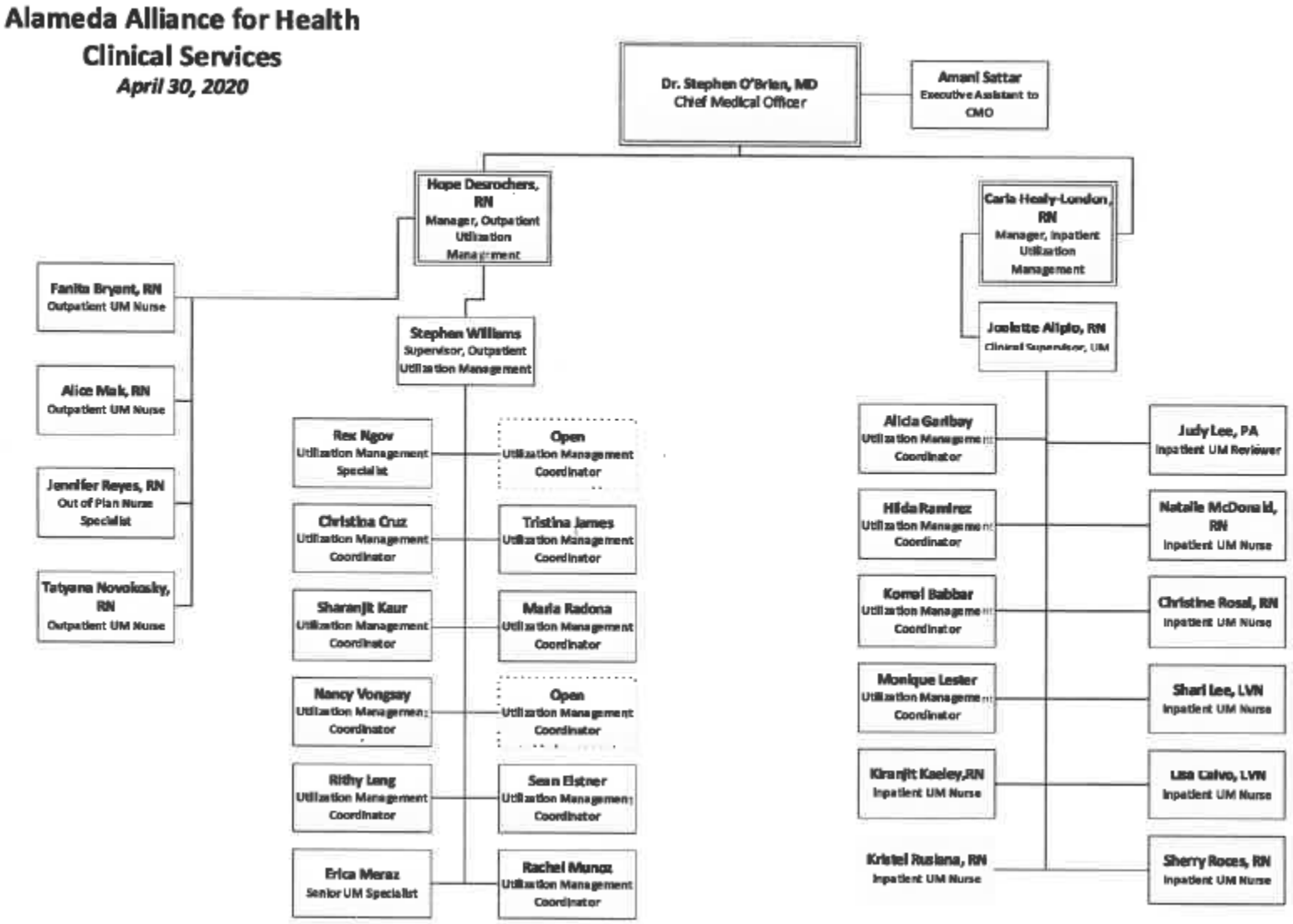
Organizational charts are as follows:

APPENDIX A

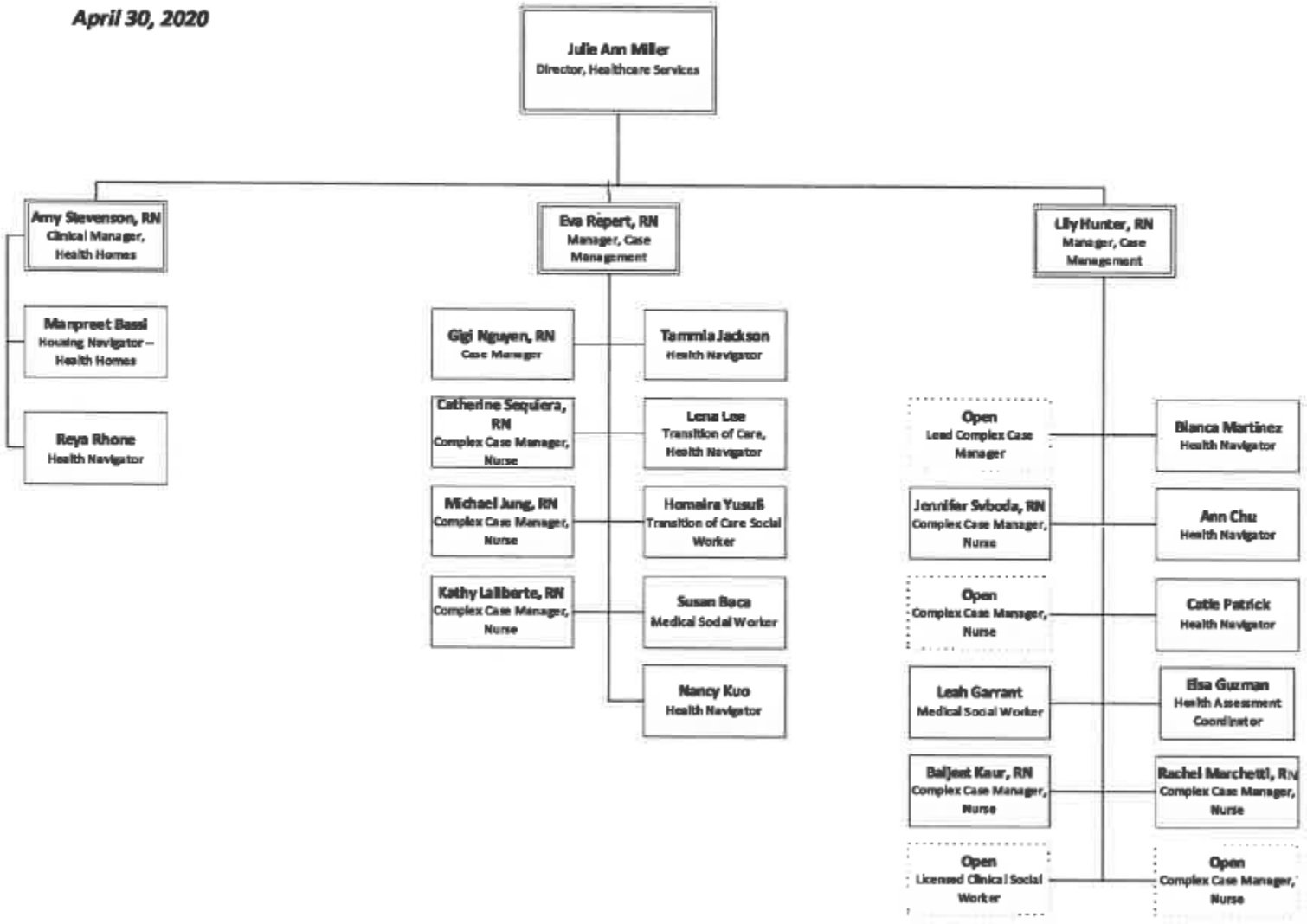
- Senior Management –

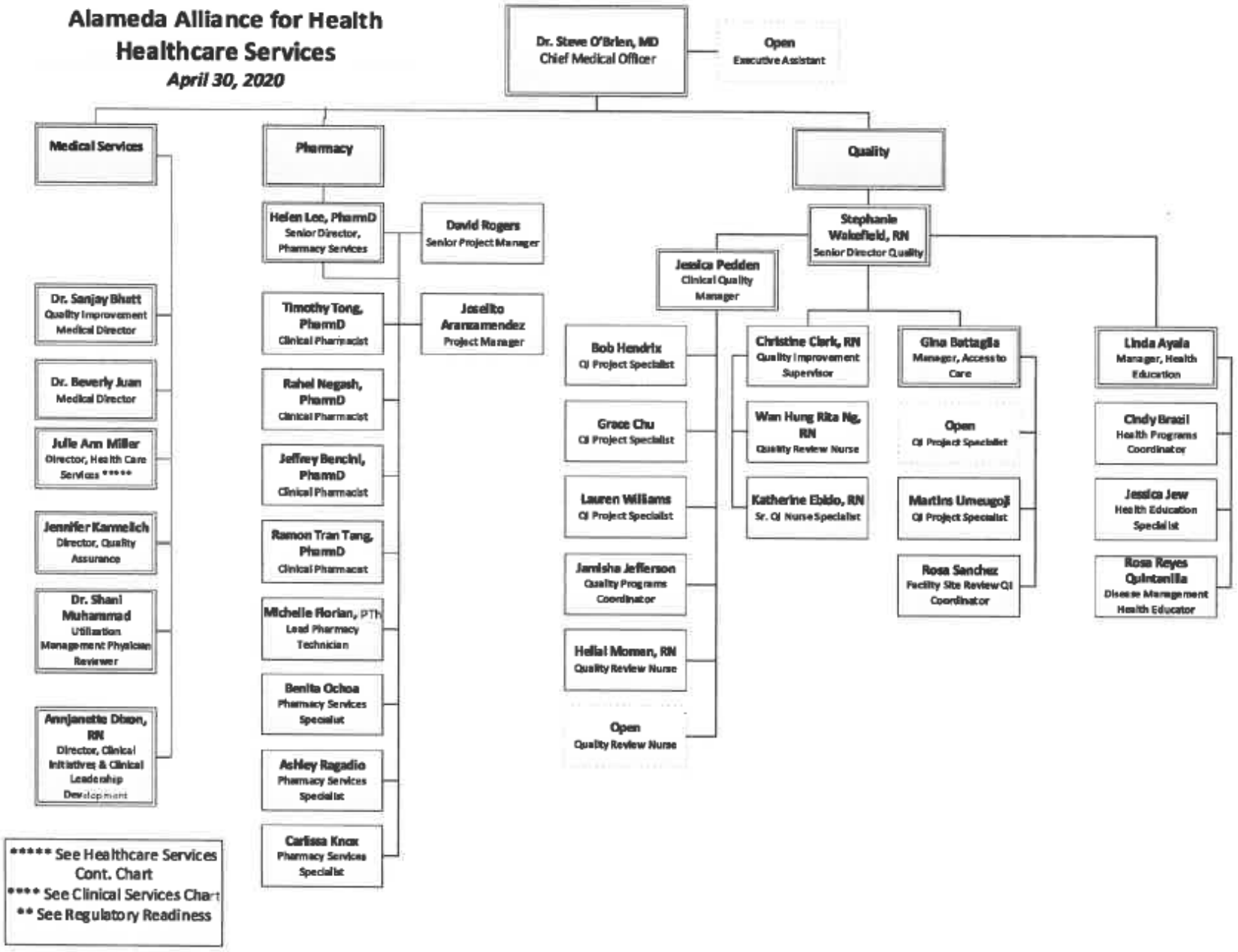


- Health Care Services –

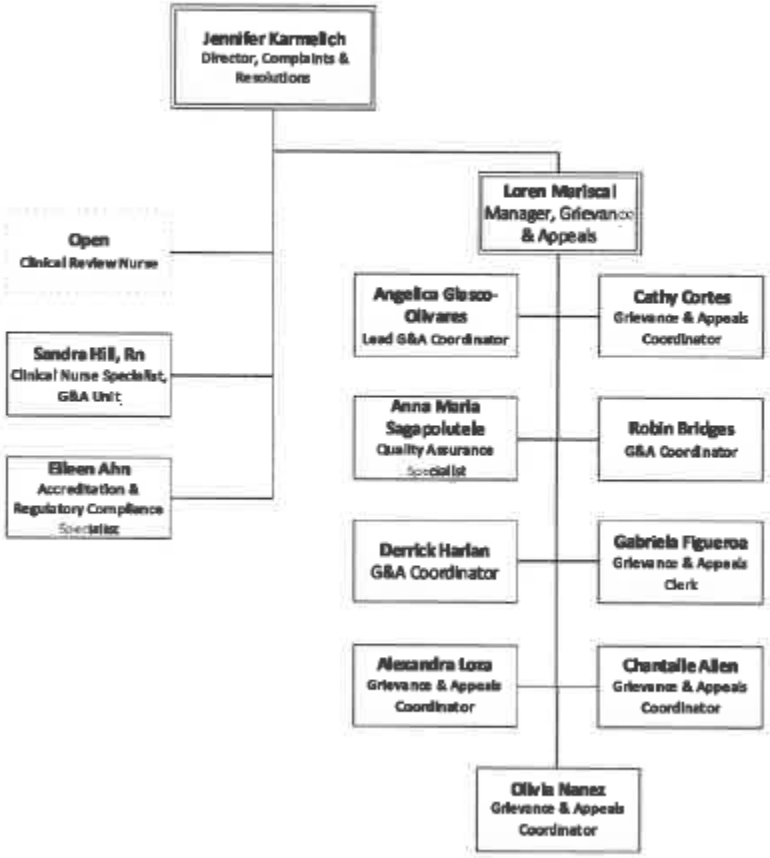


Alameda Alliance for Health
Health Care Services Cont.
April 30, 2020



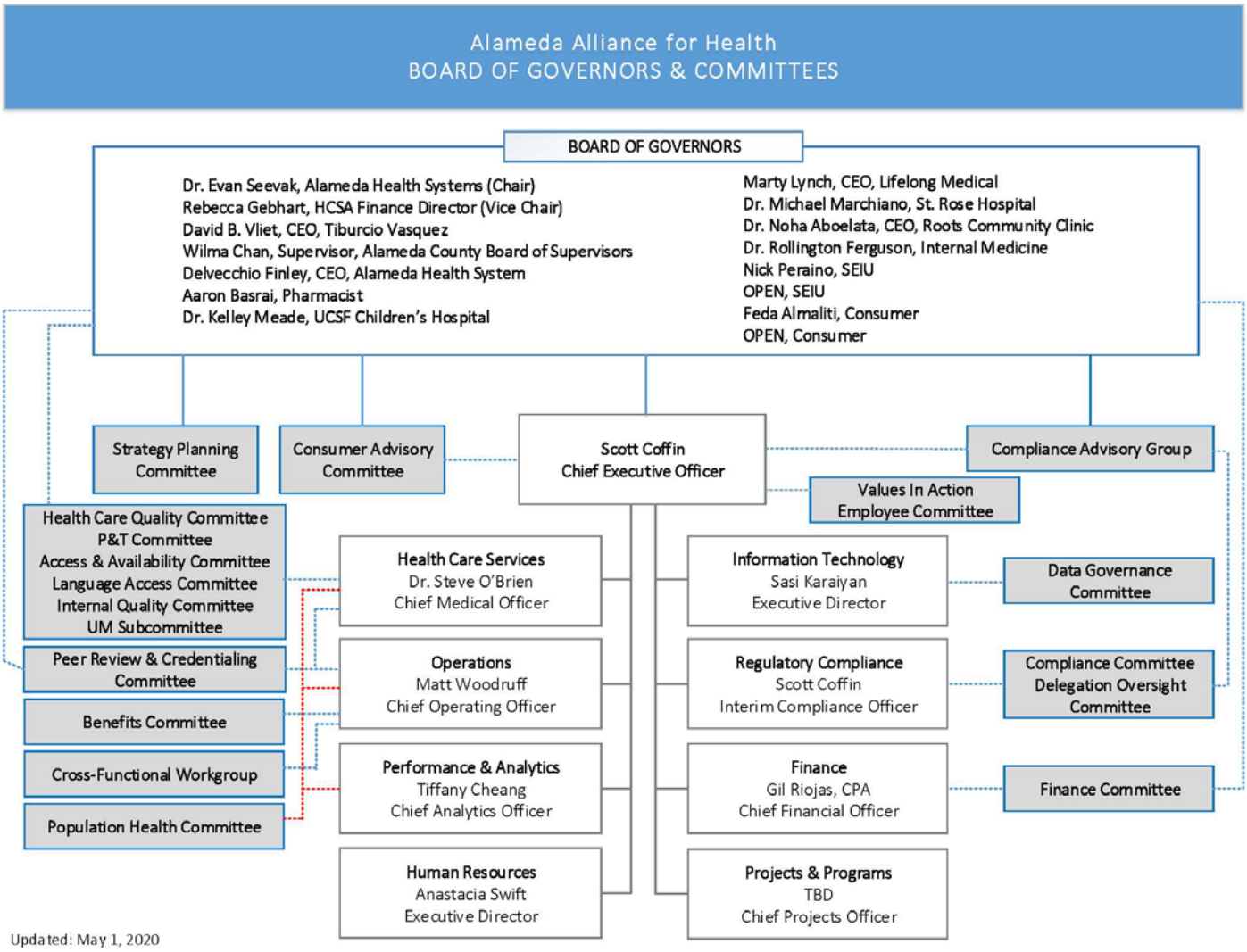

Alameda Alliance for Health
Healthcare Services
April 30, 2020
Dr. Steve O'Brien, MD
Chief Medical Officer
Open
Executive Assistant
Medical Services
Pharmacy
Quality
Helen Lee, PharmD
Senior Director, Pharmacy Services
David Rogers
Senior Project Manager
Stephanie Wakefield, RN
Senior Director Quality
Jessica Pedden
Clinical Quality Manager
Dr. Sanjay Bhatt
Quality Improvement Medical Director
Timothy Tong, PharmD
Clinical Pharmacist
Joselito Aranzamendez
Project Manager
Bob Hendrix
QI Project Specialist
Christine Clark, RN
Quality Improvement Supervisor
Gina Battaglia
Manager, Access to Care
Linda Ayala
Manager, Health Education
Dr. Beverly Juan
Medical Director
Rahel Negash, PharmD
Clinical Pharmacist
Grace Chu
QI Project Specialist
Wan Hung Rita Ng, RN
Quality Review Nurse
Open
QI Project Specialist
Cindy Brazil
Health Programs Coordinator
Julie Ann Miller
Director, Health Care Services *****
Jeffrey Bencini, PharmD
Clinical Pharmacist
Lauren Williams
QI Project Specialist
Katherine Ebido, RN
Sr. QI Nurse Specialist
Martins Umeugoji
QI Project Specialist
Jessica Jew
Health Education Specialist
Jennifer Kanmelich
Director, Quality Assurance
Ramon Tran Tang, PharmD
Clinical Pharmacist
Jamisha Jefferson
Quality Programs Coordinator
Rosa Sanchez
Facility Site Review QI Coordinator
Rosa Reyes Quintanilla
Disease Management Health Educator
Dr. Shani Muhammad
Utilization Management Physician Reviewer
Michelle Florian, PTH
Lead Pharmacy Technician
Helial Momen, RN
Quality Review Nurse
Annjanette Dixon, RN
Director, Clinical Initiatives & Clinical Leadership Development
Benita Ochoa
Pharmacy Services Specialist
Open
Quality Review Nurse
AsHley Ragadio
Pharmacy Services Specialist
Carissa Knox
Pharmacy Services Specialist
***** See Healthcare Services Cont. Chart
**** See Clinical Services Chart
** See Regulatory Readiness

Alameda Alliance for Health
Regulatory Readiness
April 30, 2020



APPENDIX B

- ALAMEDA ALLIANCE COMMITTEES



APPENDIX C

A. Quality Improvement Projects

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

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

The Alliance did not achieve the SMART Aim goal for this project. From the run chart over the course of the project, it does not appear that there was an increase in the overall rate as a result of intervention testing. The total number of patients that received HbA1c testing as a result of the intervention was only 8, or about 2.5% of the total population, over the course of three months of testing, which was not enough to make an impact on the overall rate.

Figure 3: Graph of A1c Rate in AA Men at AHS

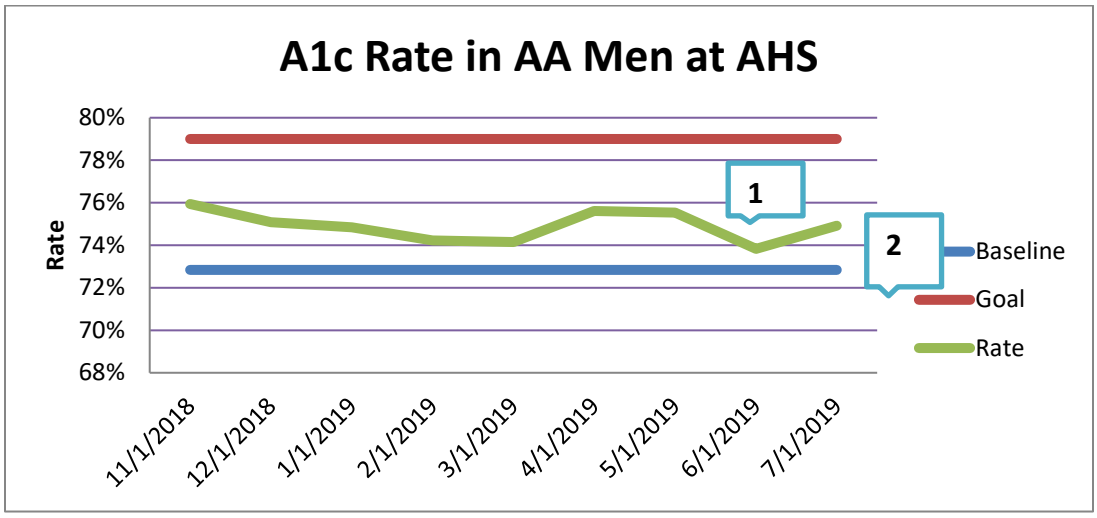


Table 2: A1c Rate of AA Men at AHS

	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
Numerator	243	238	247	242	241	248	242	235	230
Denominator	320	317	330	326	325	328	323	314	307
Rate	75.94%	75.08%	74.85%	74.23%	74.15%	75.61%	75.54%	73.83%	74.92%

Analysis: In order to perform any interventions that may improve patient care, the Alliance will need to establish key contacts at target sites. Alameda Health System is a large provider for many of the Alliance's most vulnerable patients. Performance improvement within these sites will require strong relationships with a clinic manager or another staff member who will champion and facilitate efforts. The Alliance will continue to identify opportunities for improvement within this focus. Continued telephone outreach will include the offer for transportation aimed at this population. Although the offer of transportation did not show improvements to the rate of HbA1c testing, multiple members accepted the offer of transportation, indicating that this is a need even if it is not the only need of the population. AHS is also transferring to the EPIC system and with this change they have decided to move to an open schedule system in September. The Alliance will continue its collaborative work with AHS to improve appointment availability and scheduling efforts.

Next steps: In 2020, the Alliance intends to adapt the intervention that was tested with Alameda Health System and continue its efforts in improving the HbA1c testing rates of its African American diabetic population by identifying additional partnerships with other key stakeholders within the Alliance community.

- HEDIS Measure W15: Increase the African American Pediatric Population Utilization of Primary Care Services in the First 15 Months of Life

In California, it has been identified that children are not accessing comprehensive pediatric services consistently. The California State Auditor Report identified that, "an annual average of 2.4 million children enrolled in Medi-Cal do not receive all required preventive services." Additionally, this report confirms utilization rates for children in Medi-Cal have remained below 50 percent. As a result, Alameda Alliance for Health (Alliance), has decided to focus on increasing pediatric access through its Pediatric Care Coordination Pilot. The goal of the pilot is to engage the Alliance's pediatric members to seek regular check-ups at age-appropriate intervals that follows the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule and anticipatory guidance with increased screenings and referrals to improve member health functional status and/or satisfaction. This includes Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for Medical, Dental, Vision, Hearing, and Mental Health, Substance Use Disorders, Developmental and Specialty Services.

During the development of the Pediatric Care Coordination Pilot, the Alliance identified that during 2018, only 45.92% of children who turned 15 months old received 6 or more well-child visits (W15). The Plan's performance rate for the W15 HEDIS measure is 20.31% below the 50th percentile.

During further analysis, the Alliance identified a disparity in access for Well-Child visits for the Plan's African American infant population compared to other ethnicities. For example, in 2018, 55.66% of the Plan's Chinese infant population received 6 or more Well-Child visits during the measurement year compared to 33.33% of the African American infant population. As a result, the Alliance defined the SMART Aim for this project as, "By June 30, 2021, the percentage rate of 6 Well-Child visits within the first 15 months of life among African American infants, increase from 33.33% to 42.10%." The Alliance plans to work with community stakeholders to improve the compliance rate for its African American

population that is eligible for W15 to reduce this disparity.

- HEDIS Measure W34: Increase the Alameda Alliance overall rate of Children Ages 3-6 Access to Primary Care

In California, it has been identified that children are not accessing comprehensive pediatric services consistently. The California State Auditor Report identified that, "an annual average of 2.4 million children enrolled in Medi-Cal do not receive all required preventive services." Additionally, this report confirms utilization rates for children in Medi-Cal have remained below 50 percent. As a result, Alameda Alliance for Health (the Alliance), has decided to focus on increasing pediatric access through its Pediatric Care Coordination Pilot. The goal of the pilot is to engage the Alliance's pediatric members to seek regular check-ups at age-appropriate intervals that follows the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule and anticipatory guidance with increased screenings and referrals to improve member health functional status and/or satisfaction. This includes Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for Medical, Dental, Vision, Hearing, and Mental Health, Substance Use Disorders, Developmental and Specialty Services for pediatric population less than 21 years of age.

The intervention will be focused on the HEDIS measure: W34 -- the percentage of members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year. Well-child visits provide a critical opportunity for screening, referrals, and counseling as children develop physical activity, social, nutritional, and behavioral habits that often continue into adulthood. With these visits, providers conduct comprehensive physicals, connect patients to important EPSDT services, important vaccinations and medications, as well as help answer any health-related questions patients and their families may have.

In the past two measurement years, MY2017 and MY2018, Alameda Alliance for Health (AAH)'s W34 hybrid rate was 79.27% and 73.84% respectively. In an effort to improve this rate and at the request of DHCS, AAH will conduct a W34 PIP.

W34 admin rates for direct providers within the AAH network will be the narrowed focus of this PIP. The MY2018 admin rate for AAH was 75.55% and for directs, it was 61.02%.

After looking at AAH MY2018 W34 admin data, we established a threshold to identify providers with patient panels greater than 60 and a compliance rate less than 70% to incorporate into this PIP. Based on this threshold, we identified the five providers. These five providers have the largest patient panels and the top five largest non-compliant populations in comparison to the rest of the AAH direct providers. As a result, the Alliance has defined the SMART Aim for this project as, "By June 30, 2021, increase the overall W34 admin rate from 62.20% to 66.46% for the group of five identified providers." The Plan intends to work with the identified providers to develop an intervention that will help the pediatric population access preventive healthcare services.

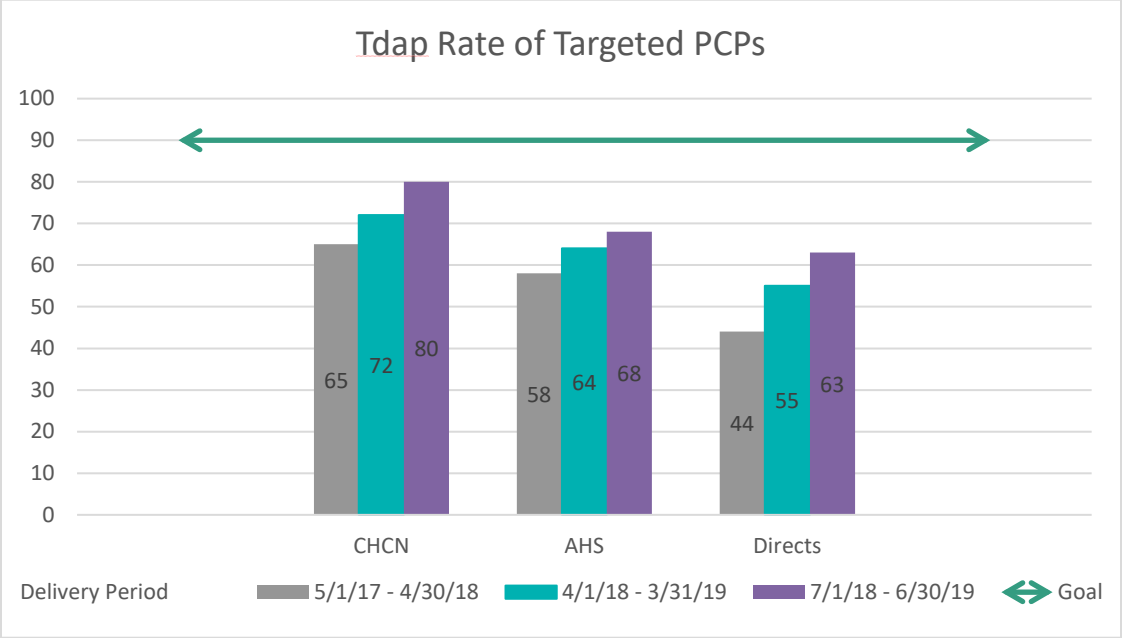
- HEDIS Measure None: Increasing rates of Tdap vaccines in pregnant women in the third trimester

In 2018, over 300 cases of pertussis were identified in Alameda County, five of which were infants younger than 4 months old. Immunizing pregnant women with the Tdap vaccine between 27-36 weeks gestation is the most effective practice to protect infants from pertussis. The Alliance and the Immunization Division of Alameda County's Public Health Department (ACPHD) have partnered to implement a Quality Improvement Project to improve rates of prenatal Tdap vaccination. The Alliance completed a baseline data analysis of claims submitted for deliveries between 5/1/2017 to 4/30/2018 and claims data for any Tdap received within 10 months prior to delivery. As a result, 19 PCP's were identified with 30 deliveries or more and Tdap vaccination rates of 80% or lower. Among these providers thus far, Ob/Gyn leadership at Lifelong Medical Care and Alameda Health Systems have

expressed interest with improving their rates.

In March and June of 2019, the Alliance and ACPHD presented best Tdap practices to Tri-City Health Center, Tiburcio Vasquez, Axis Community Health Center, as well as several direct providers. It is through the partnership with ACPHD, that 70.33% of the expectant mothers at the targeted provider locations received a Tdap vaccination during the 3rd trimester.

Figure 4: Graph of TDAP Rate of Targeted PCPs



During 2019, the targeted providers received the following interventions:

1. Best practices tip sheet
2. A Local Health Department (LHD) Nurse-led training on disease prevention, management, and how to promote the vaccine by effective communication
3. Tdap flyers and posters in threshold languages for waiting and exams rooms
4. An Alliance Nurse and Medical Director visit to discuss member level data, identify and resolve barriers, and determine opportunities to appropriately report and capture data

Analysis: During the process, several barriers were identified, which included the lack of a pharmaceutical grade refrigerator which caused the member to be referred to a pharmacy, providers misunderstanding the claims and reimbursement process, EMR changes, and lack of CAIR 2.0 interfacing with existing EMR. As a result, the Alliance intends to continue the partnership with ACPHD in 2020 in order to ensure timely Tdap administration and/or follow-up of OB care coordination for its members.

- Improving Initial Health Assessment (IHA) Rates

Table 3: 2018 IHA Rates

Q1 2018	Q2 2018	Q3 2018	Q4 2018
Denominator: 15,035 Numerator: 3,628 Rate: 24.13% Goal: 30% Gap to goal: 5.87% points	Denominator: 15,704 Numerator: 3,430 Rate: 21.84% Goal:30% Gap to goal: 8.16% points	Denominator:14,181 Numerator: 3,343 Rate: 23.57% Goal: 30% Gap to goal: 6.43% points	Denominator: 13,739 Numerator: 3,161 Rate: 23% Goal: 30% Gap to goal: 7% points

On average, an IHA is completed for 23.14% of new members (1/1/18 – 12/31/18); the table below identifies IHA completion rates by network.

Table 4: IHA Completion Rates among New Enrollees

Network	New Enrollees	With IHA Completed	IHA Compliant Rate
AHS	18,267	3,086	**16.89%**
ALLIANCE Excl. AHS	10,131	2,742	**27.06%**
CFMG	7,790	1,966	**25.24%**
CHCN	16,361	4,635	**28.33%**
KAISER	6,110	1,133	**18.54%**
ALL NETWORK	**58,659**	**13,562**	**23.12%**

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

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

Given the 6 month claims lag, data will be reviewed and analyzed in Q3 – Q4 of 2020. This intervention will continue and through 2020 at which time data analysis of results can be completed to determine the efficacy of the interventions.

- Substance Abuse Disorder

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

- Prevention – includes Provider Education, Community Outreach, Pharmacy Safeguards

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

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

Table 5: AAH Substance Abuse Program Step Approach

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

Key achievements of goals include (see above table):

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

- LAO require the concurrent prescription of naloxone.
- Monitoring of Member Grievances

Table 6: Drugs by Class

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

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

This intervention will continue and through 2019 at which time data analysis of results can be completed to determine the efficacy of the interventions.

B. Potential Quality Issues (PQI)

A Potential Quality Issues is defined as: An individual occurrence or occurrences with a potential or suspected deviation from accepted standards of care, including diagnostic or therapeutic actions or behaviors that are considered the most favorable in affecting the patient's health outcome, which cannot be affirmed without additional review and investigation to determine whether an actual quality issues exists. PQI cases classified as **Quality of Care (QOC)**, **Quality of Access (QOA)**, or **Quality of Service (QOS) Issues**

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

Table 7: Quality of Care (QOC) Issue Severity Level

Severity Level	Description
C0	No QOC Issue
C1	Appropriate QOC • May include medical / surgical complication in the *absence of negligence* • Examples: Medication or procedure side effect
C2	Borderline QOC • With potential for adverse effect or outcome • Examples: Delay in test with *potential* for adverse outcome
C3	Moderate QOC • Actual adverse effect or outcome (non-life or limb threatening) • Examples: Delay in / unnecessary test *resulting in* poor outcome
C4	Serious QOC • With significant adverse effect or outcome (life or limb threatening) • Examples: Life or limb threatening

In 2019, the QI team has continued with adapting the PDSA (Plan-Do-Study-Act) cycles from.

In PDSA cycle 1, the QI Review Nurse Supervisor continued to conduct Exempt Grievances case audits via random sampling, to ensure that PQIs are not missed. QI Department management continues to provide oversight of exempt and standard grievances, reviews and investigates *clinical* referrals internal and external to the organization, and ensures that services and access related PQIs are addressed through vendor management and compliance oversight, and other existing channels.

PDSA cycle 2, addressed the technological support and improvement of the PQI application for the QI team. In 2020, the QI Department will continued to collaborate with the IT department in developing and implementing Phase 2 of the PQI application with technology enhancements designed to improve and optimize workflow efficiencies, improve reporting, creating a central data repository that contained essential tracking components, from the initial investigation to the final resolution and leveling of a PQI will be an ongoing focus. QI intends to continue to working closely with IT in 2020 to continue with Phase 3 development, which will include additional enhancements to improve the workflow efficiencies and tracking and trending of data, within the application.

Through PDSA cycles 2 and 3, the team remains committed to effectively reviewing and adjudicating PQIs via root-cause-analysis to improve patient care. Nurse Review standards of work, management auditing and oversight of the PQI process are an ongoing focus of the PQI process in 2020.

C. Pediatric Care Coordination Pilot

In 2020 QI will continue to address the important issue of under-utilization and improve pediatric access to care for preventive health services through enhanced integration of pediatric health care services for the children and adolescent population enrolled in the Alameda Alliance (AA) for Heath Medi-Cal program. The Alliance sought to constructively influence and impact care delivery for this identified population in three (3) ways:

- Quality Initiatives
- Clinical Initiatives
- Pilot Program

The QI strategy focuses on “whole child wellness” integration through:

1. Improved screening and referrals as part of Medi-Cal Early and Periodic Screening, and Diagnostic and Treatment (EPSDT) supplement benefit
2. Reporting via data segmentation and visualization
3. Member and provider incentives
4. Community based program funding
5. Provider P4P
6. Health Education engagement

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2019

UTILIZATION MANAGEMENT PROGRAM

EVALUATION

2019
Utilization Management
Program Evaluation

2019 Utilization Management Program Evaluation

Signature Page

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2019
Utilization Management (UM) Program Evaluation

Overview

Under the leadership and strategic direction established by Alameda Alliance for Health (The Alliance) Board of Directors and Quality Management Committee (QMC), senior management and the Health Care Quality Committee (HCQC), the Health Services 2019 Utilization Management Programs were successfully implemented. This report serves as the annual evaluation of the effectiveness of the program activities.

The processes and data reported covers activities conducted from January 1, 2019 through December 31, 2019.

Membership and Provider Network

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

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

Figure 1. 2019 Trended Enrollment by Network and Age Group

Current Membership by Network By Category of Aid								
Category of Aid	Dec-19	% of Medi-Cal		Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Adults	32,066	13%		7,652	6,748	241	12,283	5,142
Child	89,056	37%		8,088	8,165	27,298	30,400	15,105
SPD	25,687	11%		8,617	3,707	1,184	10,329	1,850
ACA OE	78,154	32%		13,842	24,862	930	29,947	8,573
Duals	17,776	7%		7,090	1,923	1	6,632	2,130
Medi-Cal	242,739			45,289	45,405	29,654	89,591	32,800
Group Care	6,092			2,689	827	-	2,576	-
Total	**248,831**	**100%**		**47,978**	**46,232**	**29,654**	**92,167**	**32,800**
Medi-Cal %	97.60%			94.40%	98.20%	100.00%	97.20%	100.00%
Group Care %	2.40%			5.60%	1.80%	0.00%	2.80%	0.00%
		Network Distribution		*19.30%*	*18.60%*	*11.90%*	*37.00%*	*13.20%*
				% Direct:	**38%**		**% Delegated:**	**62%**

Age Category Trend								
	Members				% of Total (ie.Distribution)			
Age Category	Dec-17	Dec-18	Nov-19	Dec-19	Dec-17	Dec-18	Nov-19	Dec-19
Under 19	102,258	98,122	92,318	91,641	38%	37%	37%	37%
19 - 44	86,599	84,866	79,016	78,271	32%	32%	32%	31%
45 - 64	58,713	57,340	54,703	54,210	22%	22%	22%	22%
65+	22,409	23,862	24,661	24,709	8%	9%	10%	10%
Total	**269,979**	**264,190**	**250,698**	**248,831**	**100%**	**100%**	**100%**	**100%**

For 2019, The Alliance membership had continued to slowly decline over time, as seen in Figure 1. The Alliance lost a number of members in 2019 compared to 2018, (from 264,190 down to 248,831) in total members. The percentage of Child members to total membership declined from 38% in 2017 to 37% in 2019. The percentage of younger adults (19-44) declined slightly from 32% in 2017 to 31% in 2019. There has been an increase in the percentage of adults over 65 from 8% to 10%. The reduction in membership is following a state-wide trend, and it is unclear as to the reasons. It is likely multifactorial, such as more people are getting insurance through their employer, a concern on the part of undocumented immigrants to remain less visible to governmental agencies, or other reasons.

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

Figure 2 2019 Provider Network by Type, Enrollment and Percentage

Provider Network	Provider Type	Members (Enrollment)	% of Enrollment in Network
Direct-Contracted Network	Independent	47,978	19%
Alameda Health System	Managed Care Organization	46,232	19%
Children First Medical Group	Medical Group	29,654	12%
Community Health Clinic Network	Medical Group	92,167	37%
Kaiser Permanente	HMO	32,800	13%
TOTAL		248,831	100%

The percentage of members within each network has been steady from 2018 to 2019.

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

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

    - Long Term SNF Care (limited)
- Transportation
- Pharmacy
- Care coordination along the continuum of care including arrangements for linked and carved out services, programs, and agencies.

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

Figure 3 The Alliance Ancillary Network

The Alliance Ancillary Network	
Hospitals	17
Skilled Nursing Facilities	54
Health Centers (FQHCs and non-FQHCs)	67
Behavioral Health Network	1
DME Vendor	1 (Capitated)
Transportation Vendor	1
Pharmacies/Pharmacy Benefit Manager (PBM)	Over 200
Radiology/Delegate (ended 7/31/19)	1 (partial year)

The delegates or vendors are responsible for the provision of identified functions or services through contractual arrangements. Functions may be delegated to Hospitals, PBMs, and Behavioral Health Organizations. Radiology delegation to EviCore ended on 7/31/19. Vendor services include Transportation, Health Risk Appraisal, and Self-Management tools. A full description of delegated activities is provided below.

Delegation

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

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

Figure 4 – 2019 the Alliance Delegated Network

Delegate	NCQA Accreditation or Certification	Provider Type	Delegated Activity -UM	Delegated Activity – Grievance and Appeals	Exceptions
Kaiser	Yes	HMO	X	X	
(CHCN)	No	Medical Group	X		
(CFMG)	No	Medical Group	X		
California Home Medical Equipment (CHME)	No	Vendor - DME	X*		* Not delegated for denials
Beacon/College Health IPA (CHIPA)	Yes	BH	X		
eviCore Healthcare	Yes	Specialty Services	X		Ended 7/31/2019

Overall, the network was sufficient to meet the needs of The Alliance membership and provider network throughout 2019. The organization clarifies issues related to delegated activities and responsibilities as needed. The issues have led to additional clarification in contractual documents as well as additional training to delegates on roles and expectations. In 2019, Joint Operation Meetings (JOMs) facilitated communication and operational alignment. These JOMs, which are collaborative meetings between The Alliance and Delegates/Vendors to address operations and performance outcomes are also used to identify joint opportunities for improvement. For 2020, there will continue to be opportunities to continue to improve the level of oversight, monitoring, reporting and training of delegates.

UM Program Structure

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

Responsibility, Authority and Accountability/ Governing Committee

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

Committee Structure

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

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

HCQC charters a sub-committee, the Utilization Management Committee (UMC) which meets at least quarterly every year, serving as a forum for the Alliance to evaluate current UM activities, processes, and metrics. The UMC also evaluates the impact of UM programs on other key stakeholders within various departments and when needed, assesses and plans for the implementation of any needed changes. HCQC assumes responsibility for oversight of the UMC activities and monitoring its areas of accountability as needed. The structure of the committee meetings was redesigned to increase engagement from all participants.

In 2019 the HCQC approved the UM Department 2018 Evaluation, 2019 Description, and UM 2019 Workplan on March 21, 2019, for Board of Directors approval. The committee was chaired by the Chief Medical Officer with support of the Director of Quality Management, external physicians and key organizational staff. The UM Committee had ten meetings in 2019.

In 2020 the UM Subcommittee of HCQC will continue to support the focus on UM activities, oversight for delegated UM activities, case management/care coordination, population health, integration of behavioral health and medical as well as regulatory compliance.

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

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

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

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

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

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

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

Program Scope and Structure

The Alliance UM Program encompasses the management and evaluation of care across the scope of UM. This includes prior authorization, concurrent and retrospective review of institutional care, acute care, behavioral health and chemical dependency, rehabilitation, skilled nursing, pharmaceuticals, ambulatory services. The UM Program involves the medical and behavioral management of all members at the most appropriate site and level of care. (For behavioral health activities, refer to The Managed Behavioral Health Organization's [Beacon Health Strategies] UM Program for a description of delegated behavioral health UM activities.

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

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

Utilization Management Resources

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

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

During 2019 several key leadership roles in Health Services were hired:

- Manager of Inpatient UM
- Director of Clinical Initiatives and Clinical Leadership Development

In 2019, based on the established staffing ratios and roles, the UM Department hired for both department and leadership roles. With the onboarding of new leadership, the Health Care Services Department teams reviewed the current organization goals and restructured some roles in the Departments to achieve those goals, such as hiring a supervisor for the clinical staff and a supervisor for the non-clinical staff.

Delegated Utilization Management

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

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

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

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

In 2019, the UM staff conducted annual audits on the six (6) delegates. The threshold for UM audit compliance is 90%. For entities that do not meet the threshold, the UM staff may require a corrective action plan which is tracked for compliance with the resolution of the deficiency. Entity audit results for 2019 were:

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

Figure #5 the Alliance Network – 2019 Annual Audit Score

Delegate	Provider Type	Delegated Activity - UM	2019 Audit Results	Corrective Action Required
Kaiser	HMO	X	Failed (BHT)	Yes: BHT Case File timeliness
(CHCN)	Medical Group	X	Pass	None
(CFMG)	Medical Group	X	Pass	None
California Home Medical Equipment (CHME)	Vendor - DME	X* * Not delegated for denials	Pass	None
Beacon/College Health IPA (CHIPA)	BH	X	Pass	None

EviCore Healthcare	Specialty Services	X	Pass	None

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

During summer 2017, DHCS apprised The Alliance of a concern with a delegate, eviCore, who displayed a higher than expected appeal overturn rate. It was identified that this issue may be related to inappropriate UM clinical decision making or policies as well as denials to out-out-network services. The Alliance UM Department clinical team had worked with the delegate in 2018 to identify the root cause and implement corrective actions to mitigate the issue. Despite the UM Department's increased level of oversight, monitoring and clinical training of eviCore, the overturn rate continued to be unacceptably high. Therefore, delegate termination procedures were initiated to end the contract with EviCore. The contract ended July 31, 2019, at which time the Alliance UM department assumed the responsibility for Radiology Prior Authorizations.

For 2019, the rest of the current UM delegates continue to meet the program's scope of activities. The individual issues of compliance to delegation requirements are addressed with the delegate through the Compliance Department. The UM team works collaboratively with the Compliance Department on identifying potential process improvement activities and monitoring corrective action plans. In 2019, the team:

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

Recommend Actions/Next Steps

For 2020, there will be additional opportunities to improve the oversight of delegated UM activities. The UM Department leadership is continuing the development of a robust level of delegate oversight and performance monitoring. The activities includes dedicated staff monitoring activities, performance management, delegate feedback and UM training.

Utilization Management Processes and Information Sources

Utilization Management Decision Making

Decision and screening criteria are designed to assist UM staff and delegates in assessing the appropriateness of care for clinical and behavioral health situations encountered in the clinical setting. Application of the criteria is not absolute, but based upon the individual health care needs of the member and in accordance with the member's specific benefits plan and capacity of the health care delivery systems. The decision criteria are made available to the member, providers or public upon request by contacting the UM Department. A full description of the criteria utilized for UM decision making is available in the 2019 UM Program Description.

For 2019, The Alliance UM Department utilized the clinical criteria as defined in the UM Program. In 2019, The Alliance used the Milliman's CareWebQI® interactive software tools which integrate the MCG® guidelines into the core information system and the 22nd Edition MCG® criteria. Upon review of member needs and the requirement to use alternative criteria as appropriate, there were no changes to the clinical criteria. In 2019 there was one request from a

member and one from a provider for copies of the decision making clinical criteria, and they were referred to the Alliance web portal to obtain it.

In 2019 The Alliance UM staff collaborated with Senior Leadership to ensure that Transportation processes continued to match the benefits defined in APL 17-010 for Non-Emergency Medical and Non-Medical Transportation and the requirement to provide non-medical transportation for Medi-Cal services that are not covered under the MCP contract. In 2019, the Alliance operationalized all requirements of the APL to include the non-medical transportation benefits through contract with Logisticare. The Alliance monitors the performance of Logisticare's provision of this benefit by regular review of G&As and performance metrics.

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

In 2019 the Director of Quality Assurance worked to ensure smooth processing of APLs into Alliance clinical operations, policies and procedures. This includes internal and delegate training and/or regulatory reporting needs.

Consistency in Application of Criteria

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

Figure #6 Inter-rater Reliability Thresholds

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

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

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

For 2019, IRR testing was performed for UM clinical staff and non-clinical staff to establish consistency in practice and outcomes for members. For the outpatient nurses, in the initial scoring, two nurses scored below the threshold in various cases. In the final scoring, 100% (4/4) of the outpatient nurses surpassed the minimum score of 80%. Further assessment of staff overall competency shows, Nurse #3 missed 40% (2/5) of the case assessments on the first attempt. For inpatient nurses, in the initial scoring, six of the seven (86%) nurses scored below the threshold in various cases. In the final scoring, 100% (7/7) of the inpatient nurses surpassed the minimum score of 80%. Further assessment of staff overall competency shows Nurse #8 missed 60% (3/5) case assessments on the first attempt. Additionally, Nurses # 6, 7, 8, 9 and 11 have significantly lower scores on at least one case on the first attempt.

Qualitative Analysis

Overall, the final scoring shows all team members passed the study for their respective areas. As a unit, the combined inpatient score was 96.16 and the outpatient score was 99.72 indicating the UM staff are successfully able to apply clinical criteria appropriately for UM decision-making. As the staff successfully completed the study with higher than expected scores, recommendations are made to increase the IRR threshold to 90%.

Opportunities for Improvement

1. Re-educate staff on appropriate use of system for MCG IRR modules. (completed May 2019)
1. Increase the IRR threshold to 90%.
2. Given the high rate of nurses scoring below threshold in multiple cases and requiring multiple attempts of review consider moving to an IRR process of every 6 months
3. Given the high rate of nurses scoring below threshold in multiple cases and requiring multiple attempts of review further evaluation by managers with individual staff to ascertain the issues/struggles that caused multiple attempts is warranted.
4. Share collective information with clinical staff for re-education.

Of the three Medical Directors, all three passed with 100% on the 1st attempt.

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

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

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

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

- Hospital services, including acute, long-term acute and acute rehabilitation
- Skilled Nursing Facilities services
- Sub-Acute Facility services
- Durable Medical Equipment
- Prosthetics/Orthotics/Medical Supplies
- Outpatient Facility Based Services (i.e. specialized radiology or diagnostic procedures, dialysis, etc.)
- Hospice
- Out of Network, Tertiary
- Out of Area Services (Per Contract)
- Managed Long Term Services and Support/Community Based Adult Services (CBAS)
- Long Term Care, month of admission plus the following month
- Transgender Services
- Transportation
- Major Organ Transplant Services
- Acupuncture
- Home Health
- Medications covered under the pharmacy benefit - i.e., non-formulary, some self- injectable medications
- Experimental/investigational procedure/services determination
- Cancer clinical trial determinations

UM Information Systems

The Alliance maintains a core information system, TruCare, that is utilized by both UM and case management. UM and CM staff identified opportunities to enhance the functionality of the system to assist in managing UM referrals and case management functions, and in 2019 a major initiative to optimize the TruCare platform was launched. It will be completed in 2020, and will result in both optimization of the software itself and upgrade to version 7.0 in May 2020, and then to version 8.0 in Q4 of 2020. These optimization and upgrades will include staff training to ensure standard workflows are in use and staff is competent in the use of the software.

UM DETERMINATIONS

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

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

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

Referrals are tracked and reported by:

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

Denials are reported in relationship to:

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

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

Quality of NOA letters regarding all types of authorization requests are monitored to ensure clear and concise language, and that they containing all regulatorily required content. In 2019 AAH received regulatory findings of deficits in outpatient NOA content, and had multiple strategies to improve performance in this area. This included NOA template standardization, concurrent, (before sending out,) and retrospective review of the quality of the NOAs, feedback to all staff and MDs involved in the production of NOAs, training of all staff and MDs, and ongoing monitoring of the letters.

Usage of specialty referrals are monitored to ensure members have access to specialty services within or outside of the network.

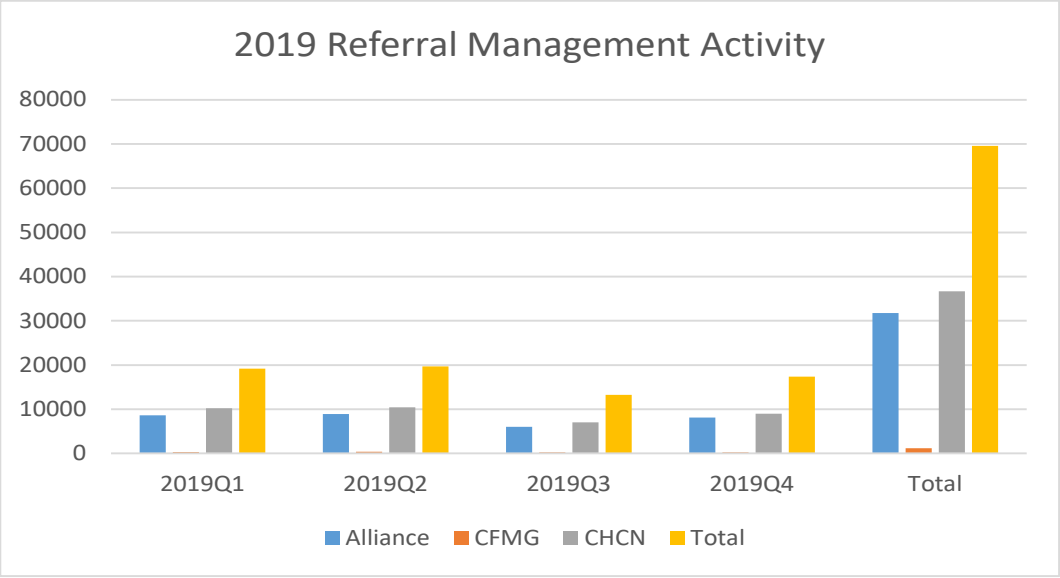
As discussed in a previous section, The Alliance manages two products, Medi-Cal and Commercial (Group Care). For the purpose of data analysis, as the commercial network, IHSS, represents only 2.2% of the total membership and 4.1% of the referral activities, the data is aggregated for reporting. In key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

Utilization Management Referral Management Data

Quantitative Analysis

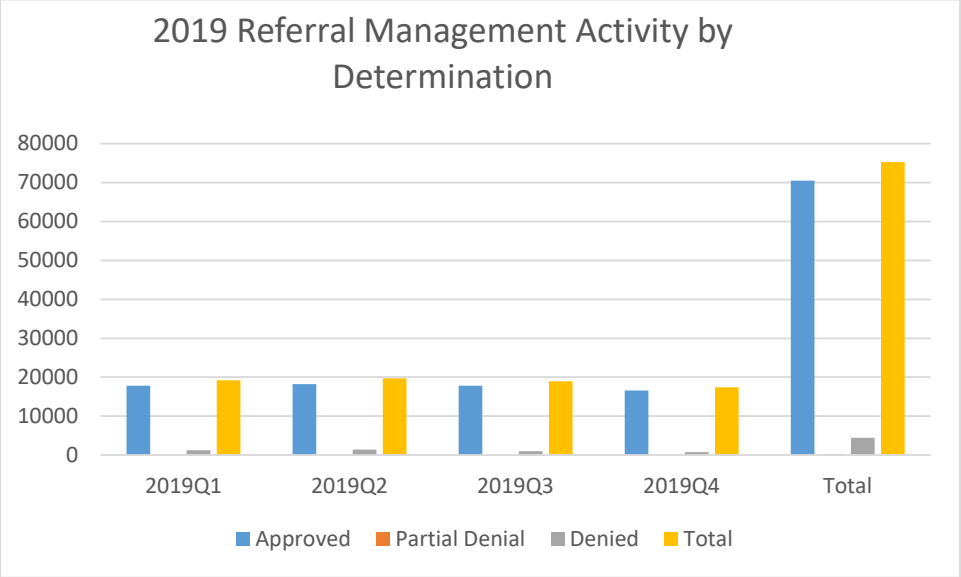
The data presented in Figures 7 – 11 represents key UM referral management functions by provider group, product and UM determination.

Figure #7 2019 Referral Management Activity



Outpatient Referral Management data by quarter based on number of authorizations managed by The Alliance by date of service; Reporting period is January 1 through December 31, 2019 for All Delegates and all products.

Figure #9 2019 Referral Management Activity by Determination



Outpatient Referral Management data using the final determination, reported by quarter based on number of authorizations managed by The Alliance by date of service; Reporting period is January 1 through December 31, 2019 for all Delegates and all products.

Figure #10 Comparisons of 2018 and 2019 Outpatient Referral Denial Rate

OP Denial Rates	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
2018	7.4%	7.0%	5.9%	6.2%	6.6%	7.3%	7.2%	7.3%	9.2%	7.6%	7.0%	6.6%	7.1%
2019	6.4%	7.6%	7.4%	7.1%	7.2%	8.4%	6.2%	6.4%	4.8%	4.4%	3.8%	3.7%	6.2%

Outpatient Referral Management Denial Rate by month based on number of authorizations by date of service through December 31, 2019 for all Delegates. The 2019 Year to Date (YTD) denial rate was 6.2%, which is a decrease of 0.9 percentage points from 2018.

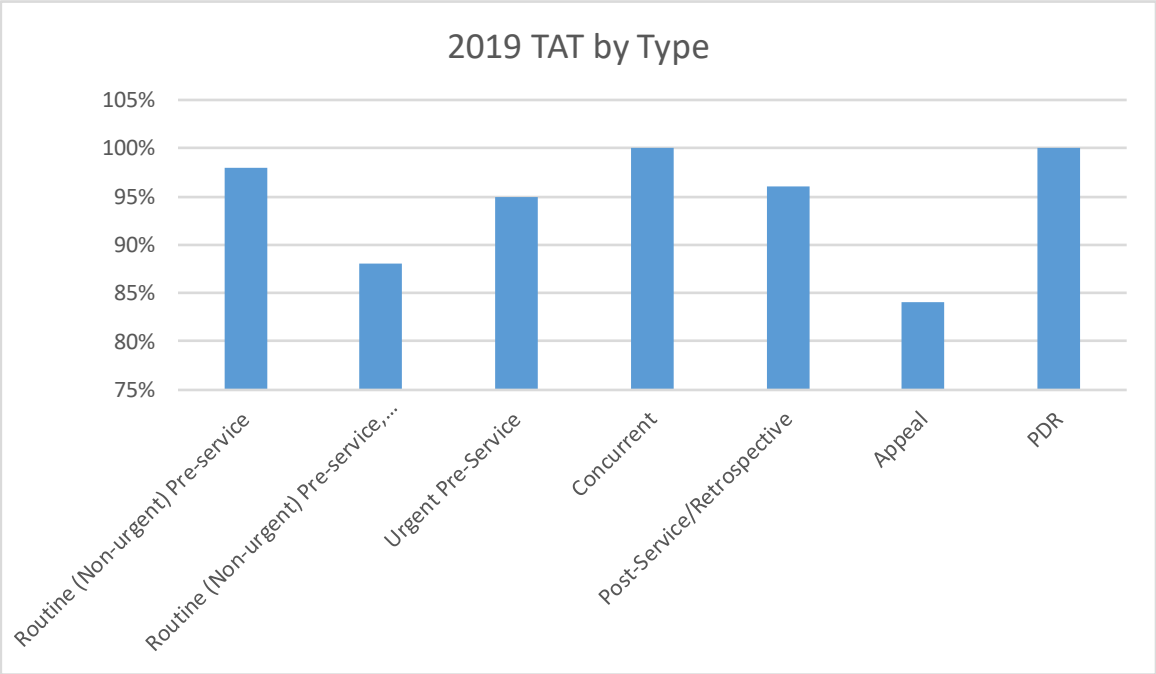
Referrals are also monitored to ensure staff process requests within the required timeframes or Turn-Around Times (TAT). The Compliance Department monitors turn-around time performance and reports it to the HCQA. The performance goal for TAT is 95%. For 2019, TAT performance was as follows:

Figure #11a 2019 Referral Management TAT Reports

2019 Performance Referral Management TAT

	Q1	Q2	Q3	Q4	YTD	Goal
Overall	**98%**	**98%**	**98%**	**98%**	**98%**	**95%**
MediCal	**98%**	**98%**	**98%**	**98%**	**98%**	**95%**
Group	**98%**	**99%**	**97%**	**97%**	**97%**	**95%**

Figure#11b 2019 Referral Management TAT Reports



Qualitative Analysis

The overall referral volume managed by network (75,298) decreased across the year in 2019, tracking the reduction in membership. The volume of referrals by network provider aligns with the volume of enrollment with CHCN having the highest volume of referrals (36,649) and the largest membership (92,167) which includes adults, MCE and SPD members; CFMG having the lowest referrals (1194) and lowest membership (29,654) which includes primarily children and adolescents.

The 2019 Year to Date (YTD) denial rate of 6.2% is above the established performance threshold of 5%. The decrease in the denial rate from 7.1% to 6.2% is attributable to the decrease in denials for radiology requests that had formerly been issued by our delegate, EviCore. EviCore was de-delegated for radiology because it had an unacceptably high denial and denial overturn rate. UM will continue to analyze opportunities to further identify denial types to further understand the appropriateness of decision making. In addition, in 2020, UM staff will be trained in standard work for utilization management as their performance indicates.

Overall authorization Turnaround Time for 2019 for both Medi-Cal (98%) and Group Care (97%) met the established goal.

Quality of NOA letters has improved and continues to remain an area of focus to ensure compliance with all regulatory requirements.

While the volume of referrals is reported in terms of product, ancillary network and determination, there is an additional opportunity to further assess the types of services by requested services and by type of authorizations, auto

approved or clinical review. In 2020, the program will analyze opportunities to increase the number of requests that may appropriately be automatically authorized, thus improving throughput for members' care. This will also assist in validating an appropriate staffing ratio for the department.

Tracking of Specialty Care Authorizations

The Alliance established a specialty referral tracking system to monitor specialty referrals requiring prior authorizations, including non-contracting providers, implemented in 2nd Qtr 2019. An unused authorization report was developed, run mid-cycle during the authorization period, along with a process to send out reminders to members to use their approved authorization. Since the unused authorizations are based on claims sent in, there is a lag in knowing whether a given authorization was actually used or not. A different report was created to capture the full picture of specialty authorizations, and will be analyzed and reported regularly at UMC:

Specialty Referral Tracking April 2019 to March 2020								
	Approved/Partial Approved/Denied				% All TAT Met			
	ALLIANCE	CFMG	CHCN	ALL	ALLIANCE	CFMG	CHCN	
NUMBER OF AUTHS					Approved	Partial	Denied	All
Acupuncture	128	6	157	**291**	99.2%	100.0%	100.0%	**99.3%**
Chiropractic	85	1	1,932	**2,018**	98.2%	100.0%	100.0%	**98.8%**
Podiatry	827	161	511	**1,499**	98.7%	100.0%	95.7%	**98.5%**
Transplant Eval	132	-	134	**268**	98.5%	100.0%	100.0%	**98.6%**
Palliative Care	52	-	-	**63**	90.3%	N/A	100.0%	**90.5%**
Professional Services*								
Out of Network	502	131	3,068	3,703	95.6%	100.0%	94.2%	**95.1%**
In Network	1,311	2	1,600	2,913	98.5%	90.0%	95.2%	**98.3%**
Total	**1,813**	**133**	**4,668**	**6,616**	97.9%	95.5%	94.4%	**97.3%**
% Out of Network	**28%**	**98%**	**66%**	**56%**				

Recommendations/Next Steps for 2020:

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

TRANSPORTATION

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

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

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

Currently, The Alliance maintains four types of transportation:

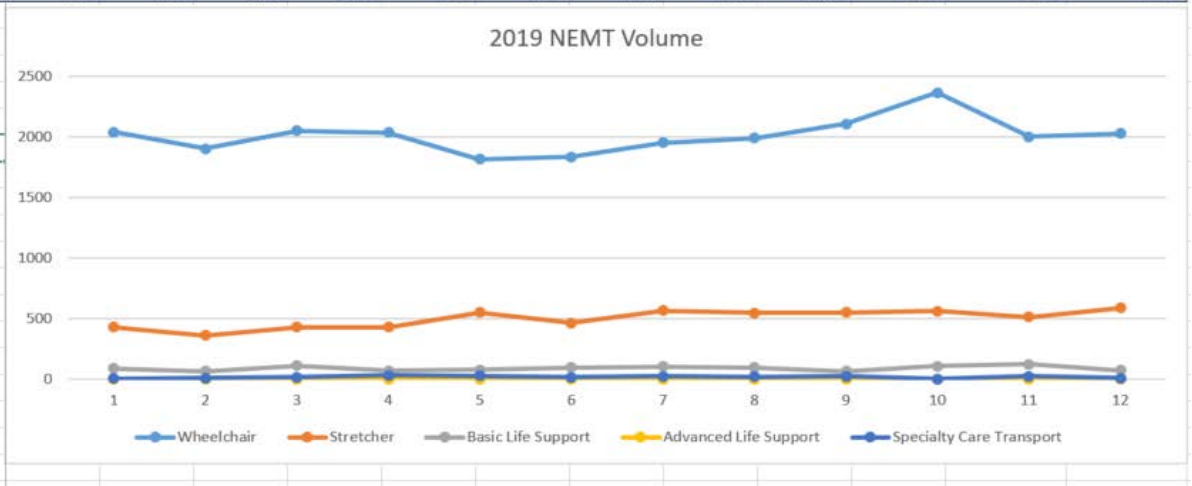
- Emergency – all products, no authorization required
- Non-emergency Medically Necessary Transportation (NEMT) - Medi-Cal, medically necessity required,
- Non-Medical Transportation (NMT) – Medi-Cal/EPSDT services

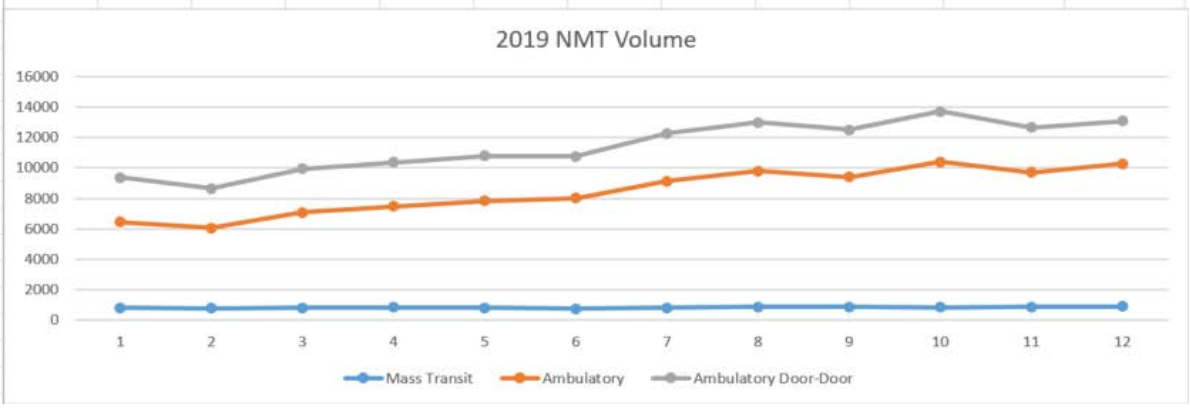
The Medi-Cal benefit includes NEMT for services deemed to be 1) to access medically necessary services and 2) member cannot be transported safely in other means of public transportation, or only NMT for access to EPSDT services.

QUANTITATIVE ANALYSIS

Figure#12 – 2019 Transportation Utilization

Month	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019
Total Membership	262,982	260,972	258,425	260,876	258,619	259,250	257,389	256,562	254,728	253,773	251,323	248,543
Total Trips	11941	10970	12546	12916	13246	13177	14890	15626	15238	16748	15323	15764
Utilization Percentage	4.3%	4.0%	4.6%	4.7%	4.9%	4.9%	5.5%	5.8%	5.7%	6.3%	5.8%	6.1%





The amount of Ambulatory transport has increased over the course of 2019, reflecting the increased use of the NMT benefit.

QUALITATIVE ANALYSIS

In 2019, the Alliance ensure the provision of the transportation benefits, using Logisticare as the provider. The Alliance UM Department developed a set of criteria to allow certain members in need of non-medical transportation to access services, policies, training materials and program monitoring reports for the new transportation benefits. This also included monitoring for the appropriateness of services with the transportation vendor.

Recommendations/Next Steps for 2020:
The Alliance UM Department will continue to monitor provision of the transportation benefit using criteria to allow appropriate members in need of non-medical transportation to access the transportation benefits. AAH will ensure that vulnerable members receive transportation services to get to needed care. Revise the transportation report to include reporting by age to allow analysis of the use of NMT transport for EPSDT and non-EPSDT services.

Monitoring of Over/Under Utilization

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

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

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

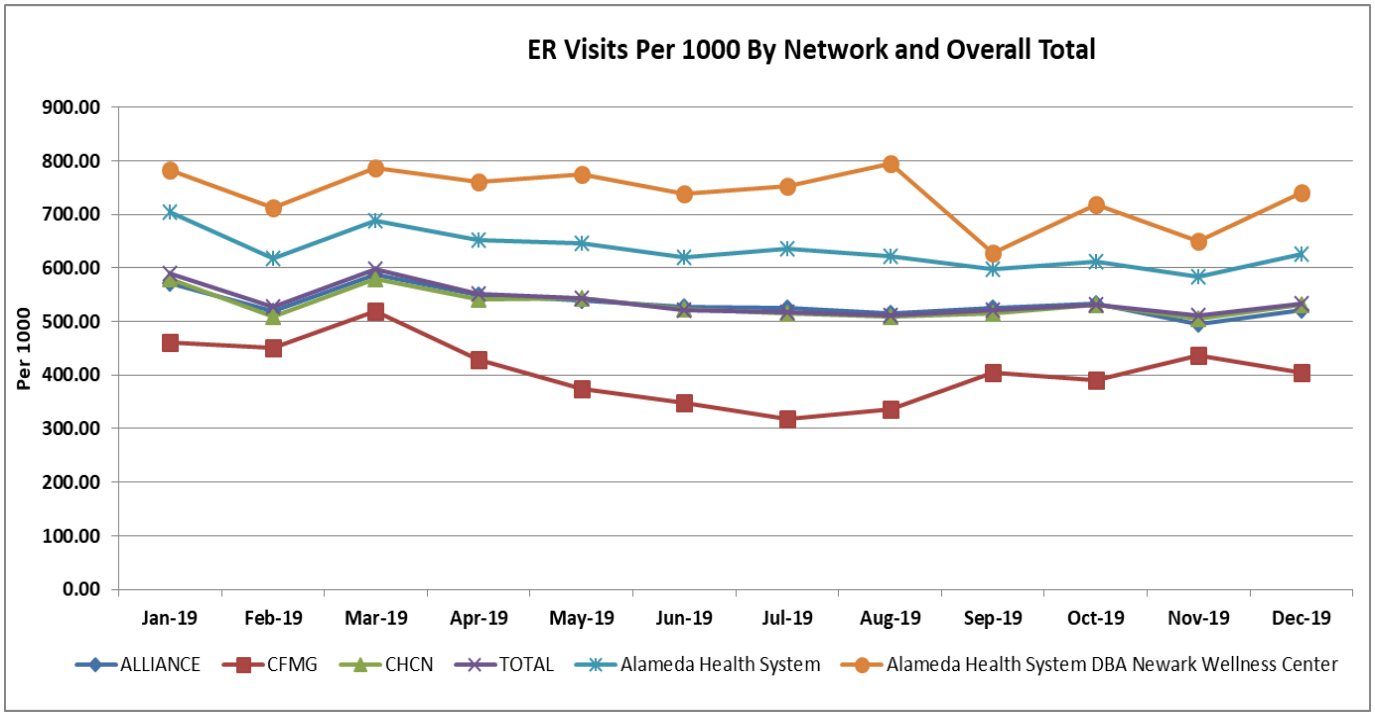
The UM Department has established monitoring activities to include:

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

Acute Hospitalization

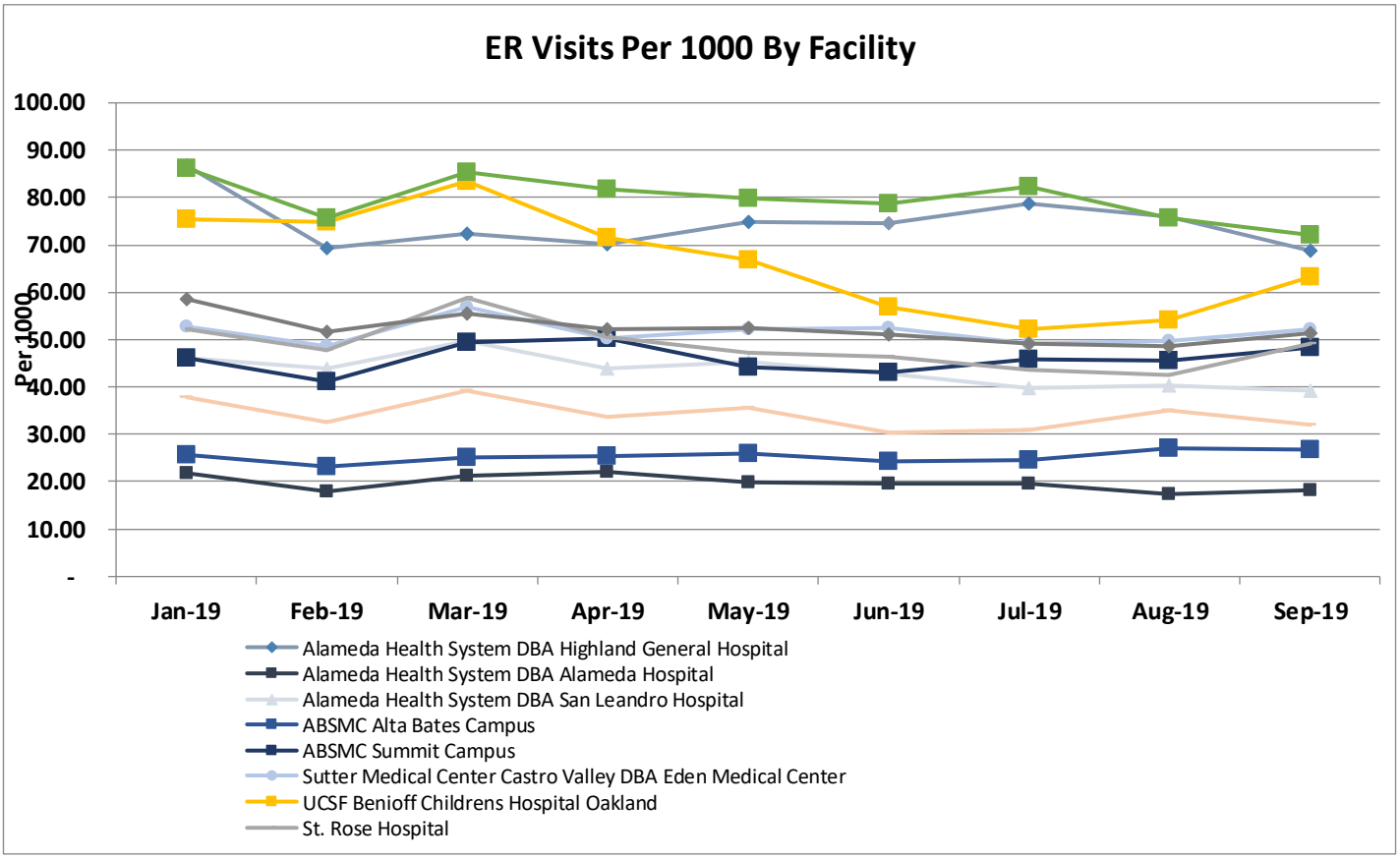
Emergency Room

Figure #13 depicts ER utilization by product from January to December 2019.



The data in Figure 13 show ER utilization across all products. The ER utilization data shows some alignment with seasonality, slightly higher in winter months and lower in late spring, summer and early autumn.

Figure 14 depicts ER Utilization by Facility for 2019



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

Qualitative Analysis

The ER visit volume remained flat relative to each network. The reporting data appears to run parallel to the seasonality of ER utilization. In reviewing the CDC Flu Portal Dashboard for the 2018-2019 Flu Season, Influenza activity in the United States began to increase in early December and remained elevated until March 2019. This aligns with activity seen across all networks. After 1st Quarter 2019, the ER utilization trended downward.

In reviewing ER visits by facilities, the top three centers for ER visits are 1) Highland General (Alameda Health Systems), 2) Other Non-network ERs, unspecified, and 3) UCSF Benioff Children's Hospital in Oakland. There may be access issues that affect ER usage, and this will be evaluated in 2020.

Hospitalization Measures

Concurrent/continued stay review for acute hospitalization focuses on:

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

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

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

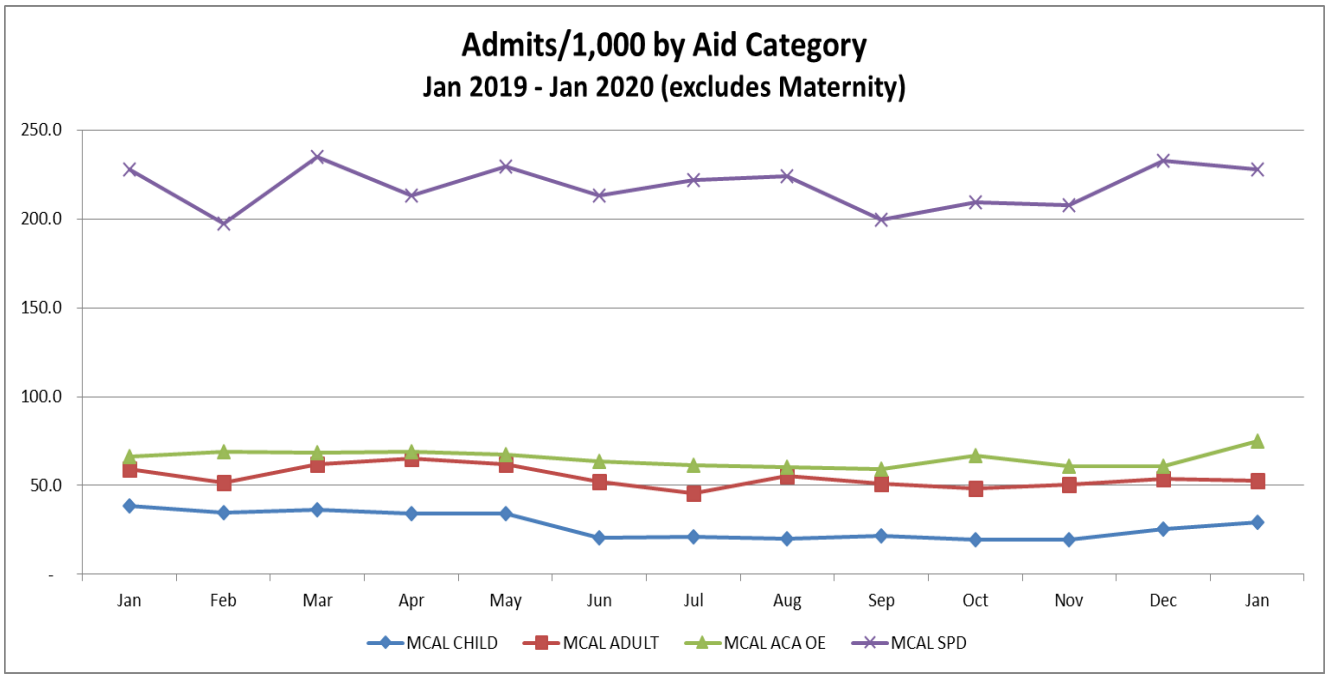
Quantitative Analysis

The Alliance has established benchmarks for inpatient admissions:

Figure #15– 2019 Hospitalization Targets

Inpatient Barometer All Products	
Metric	Target
Admits/1000	83.5
Bed Days/1000	295.7
Average Length of Stay (ALOS)	3.5

Figure #16 2019 Hospitalization admits per thousand by Aid Category.



The data above represents the 2019 performance for all lines of business in inpatient management by admits per thousand. Medi-Cal SPDs continue to have the highest admits per 1000 members while all other member aid categories remain relatively flat. This is as expected for the SPD population, who frequently have higher medical needs.

Figure #17 **2019 Hospital bed days per thousand by Aid category**

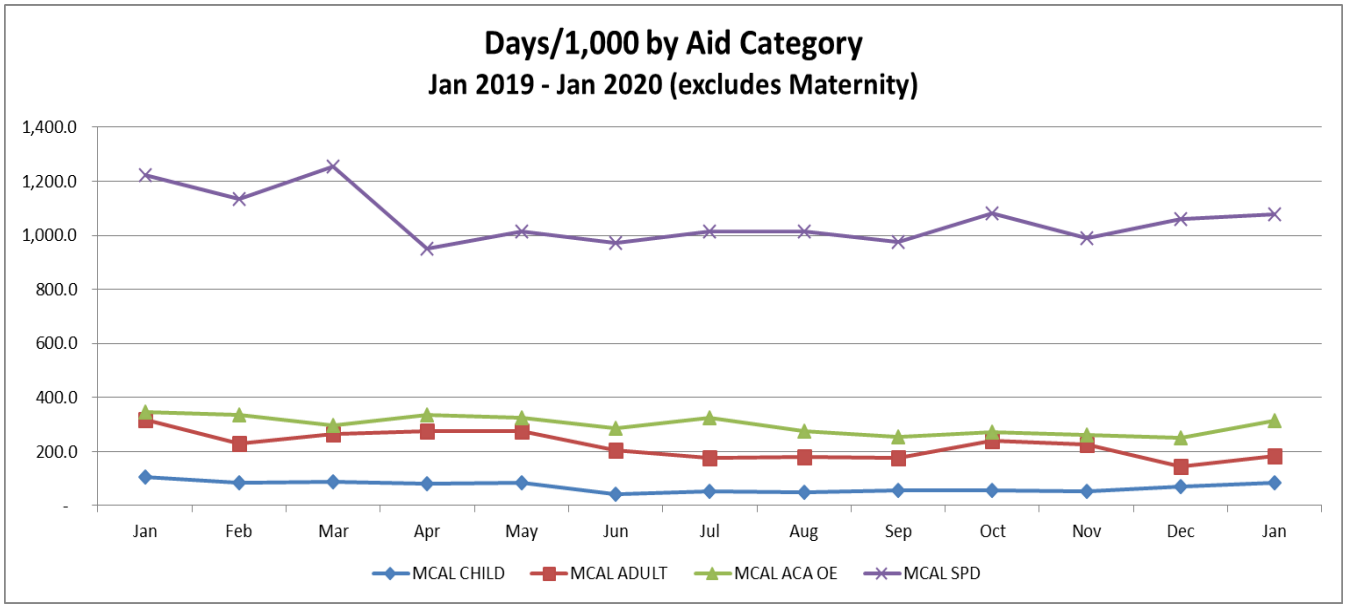
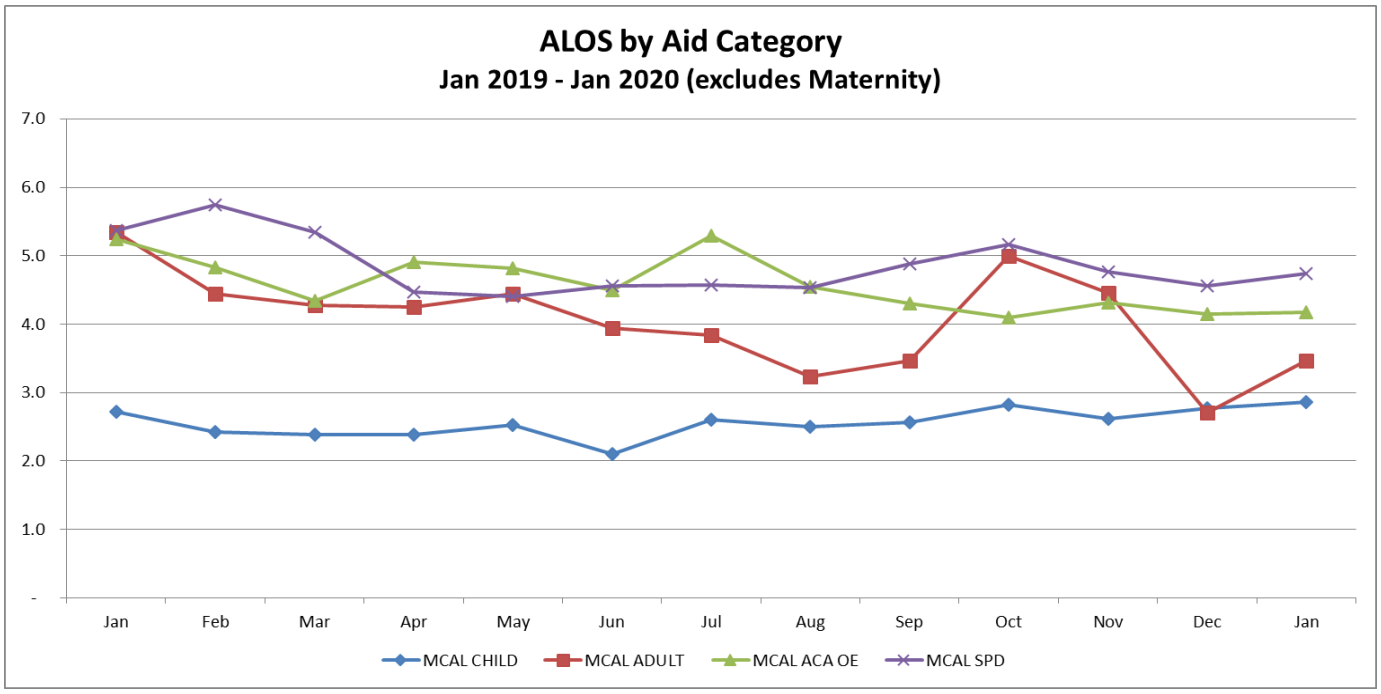


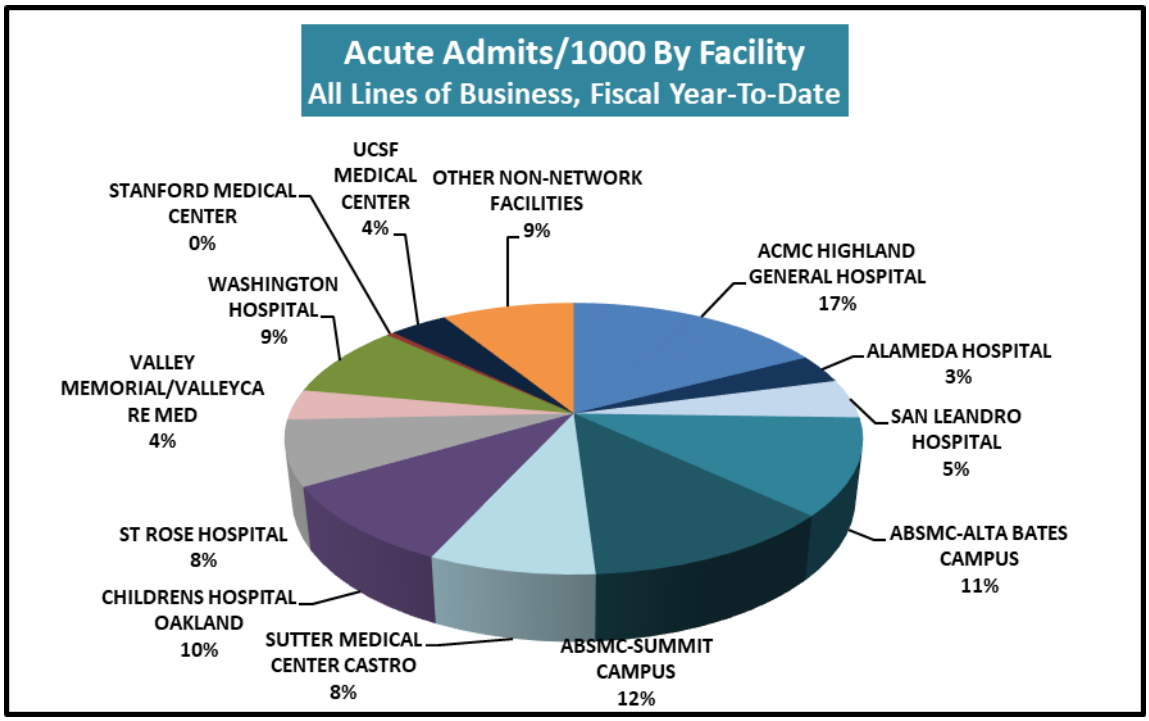
Figure #17 represents the 2019 performance for all lines of business in inpatient management by bed days per thousand. The data above again shows Medi-Cal SPDs as having the highest bed-days per 1000 members while all other member aid categories remain relatively flat.

***Figure #18* 2019 Hospital average length of stay per thousand by Aid Category.**



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

***Figure #19* 2019 Hospital admits per thousand by facility.**



Qualitative Analysis

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

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

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

<u>Readmissions</u>

All Cause Readmission rate, defined as readmission within 30 days of discharge, is trending above goal of 18%. The activities included early interventions prior to discharge and co-management with Case Management. There was an end of year trend going down, but this may represent a data lag instead of actual reduction. For 2019, the overall network readmission rate was 19%:

Quantitative Analysis

Figure #20 **- 2019 Hospital Readmission Overall**

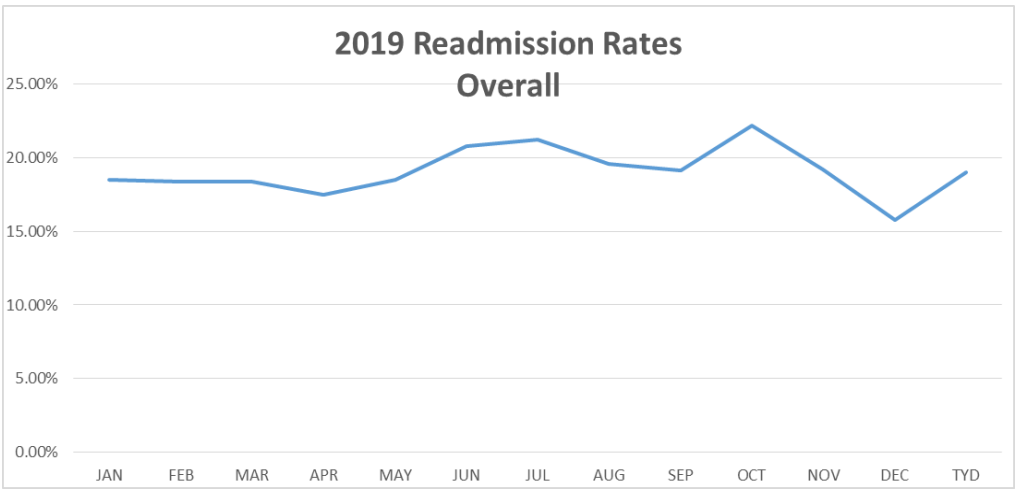
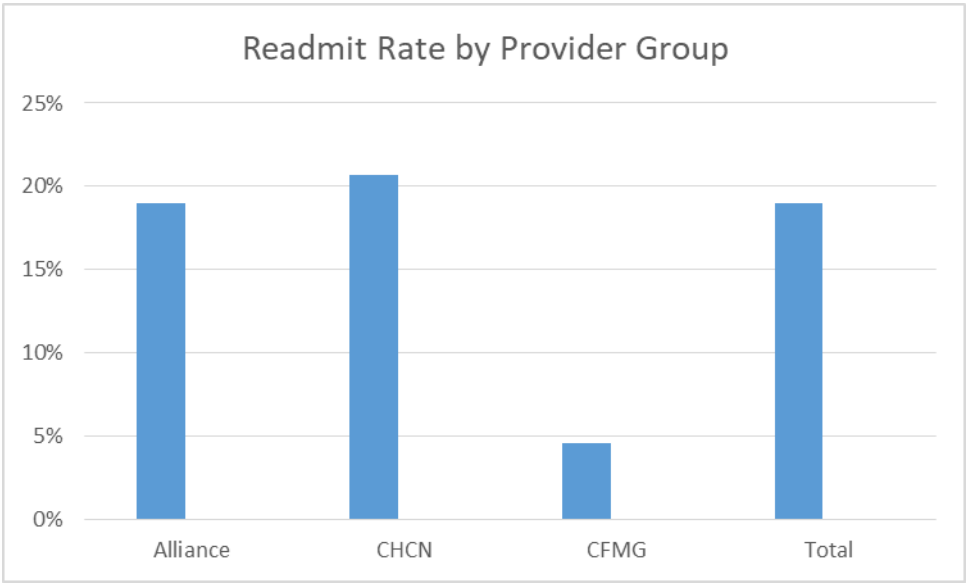


Figure 20a 2019 Readmit Rate by Provider Group



Data identifeid in Figure#20a identiifes readmission rates for the three delegated provider groups and The Alliance UM Department. The overall readmission rate represented by Health Plan total (19%) is above the threshold of 18%, Of the three entities, CHCN has a readmission rate (20.7%) that exceeds the threshold of 18%.

Figure #21 2019 **Hospital readmission by Provider Group and Aid Category/SPD**

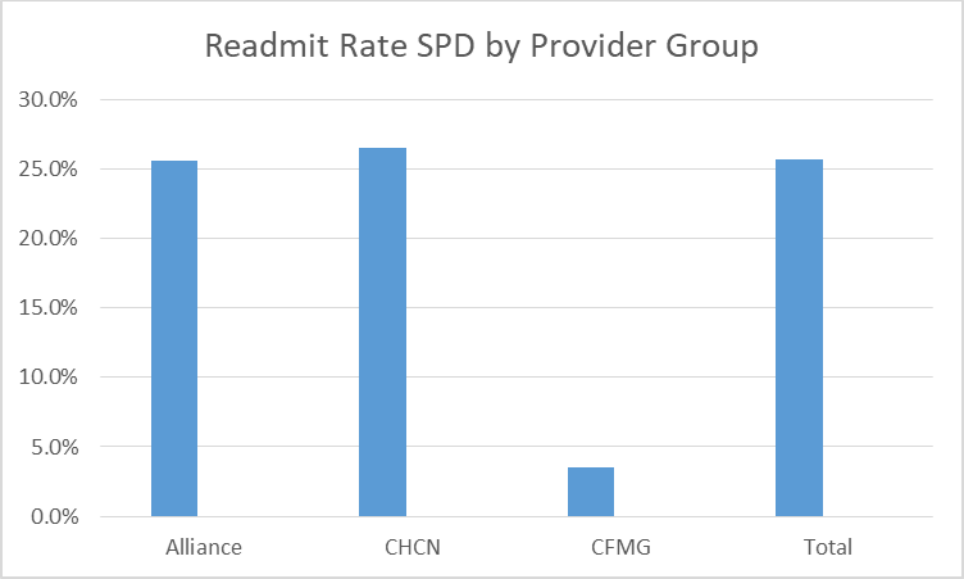
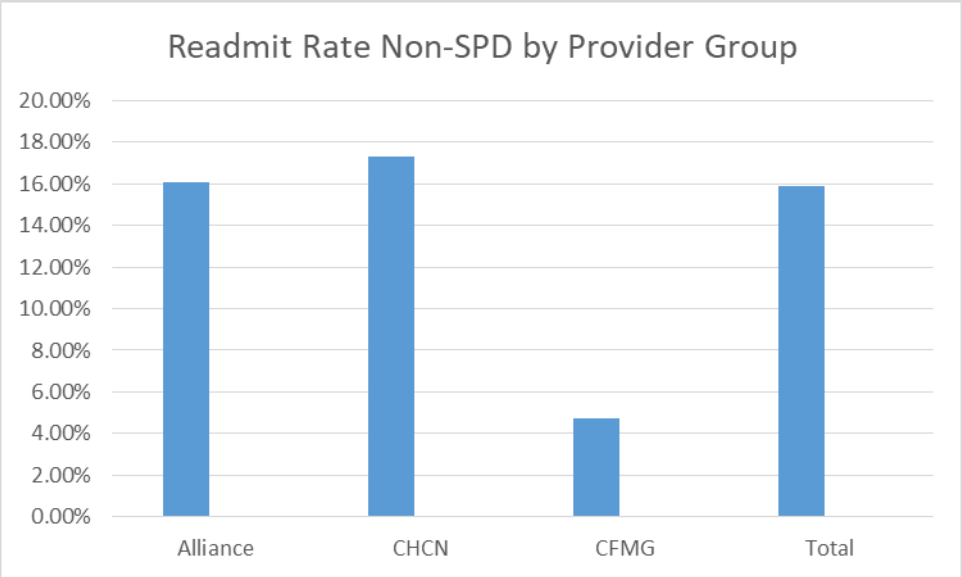


Figure #22 2019 **Hospital readmission by Provider Group and Aid Category/Non-SPD**



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

Reduction in readmissions is the focus of a Transitions of Care (TOC) program. In 2019 the Transitions of Care program was in the refinement process, collecting data to capture the disease burden of the Alliance membership, and discussion with CHCN as the Alliance's largest delegate. In 2019, the TOC program was launched as a pilot with Alameda Health Systems, reflecting both inpatient and outpatient coordination of services.

Specialty Referrals

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

Quantitative Analysis

Figure #23 2019 Specialty Referrals by Volume and Rate

2019 Q4 Specialty Referrals					
Service Type	**APPROVE**	**DENY**	**MODIFIED**	**Approval %**	**Grand Total**
Consult/Referral	740	129	8	84%	877
Invasive Procedures	606	124		83%	730
Outpatient Facility	100	47	3	67%	150
Podiatry	89	2		98%	91
Transplant Evaluation	42	1		98%	43
Rehabilitation - Outpatie	26	3	10	67%	39
Chiro	14	1		93%	15
Acupuncture	3			100%	3
Professional Services	3	3		50%	6
Hospital - Outpatient	2			100%	2
Infusion-Facility	1			100%	1
Office Procedures	1			100%	1
Radiology	1			100%	1
Physician Office Visit		1		0%	1
Grand Total	1628	311	21	83%	1960

As noted in Figure #23, the overall network specialty referrals by status shows that overall 83% are approved, and the large majority being for specialty consultation and procedures. Specialty referral tracking will be expanded and refined in 2020 in order to better assess performance, including In-Network, Out of Network, and Turn Around Time. This will be tracked through the Utilization Management Committee.

Out of Network Services

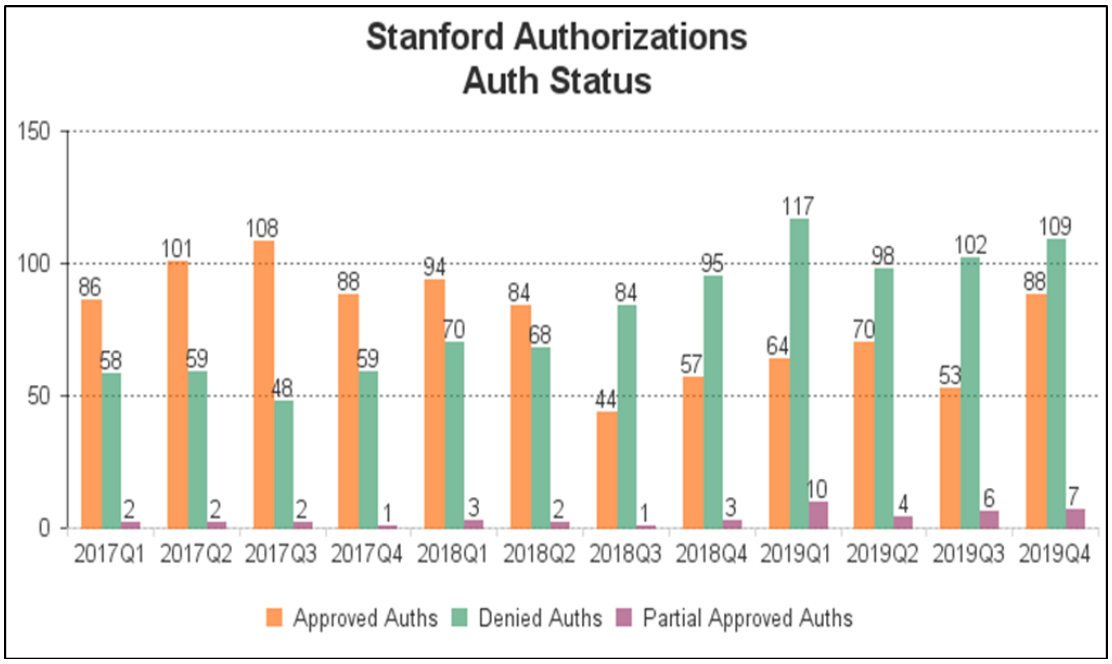
Out of the network services are defined as any service provided by non-participating practitioners or facilities. Members may access OON services either through an emergency or as a direct referral for services not available within the network. The Alliance analyzes data related to OON services to address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

Figure 24 OON Requests (10 or more requests during the year.)

Specialty Type	Total 2019 OON Requests	Total 2019 OON Approve	Percent Approved
General Acute Care Hospital	1823	1322	73%
Physical Medicine and Rehabilitation	156	147	94%
Pain Medicine	155	148	95%
Psychiatry	107	99	93%
Neurology	58	49	84%
Obstetrics and Gynecology	48	36	75%
Surgery - Orthopedic	48	44	92%
Surgery - Plastic	28	19	68%
Cardiovascular Disease	26	12	46%
Urology	26	20	77%
Rheumatology	19	16	84%
Gastroenterology	18	10	56%
Hematology	18	13	72%
Oncology	17	16	94%
Surgery - General	17	12	71%
Surgery - Cardiothoracic	16	10	63%
Surgery - Vascular	10	7	70%

In 2019, The Alliance continued to focus on monitoring OON utilization at the highest requested OON provider, Stanford Hospital Systems. The monitoring included a review of each OON service request for medical necessity and the appropriateness to re-direct to an in-network provider.

Figure#24a OON UM Determinations – Stanford



Data in Figure 24a show the Authorizations requests to Stanford for OON services from Q1 2017 to Q4 2019. The data measures the number of OON referrals to Stanford by the authorization determination, approved, modified and denied. The data over time shows demonstrates that the number of approved requests continued to decrease and the number of denials continues to increase.

Quantitative Analysis

The trend chart in Figure #24a shows continued trending of decreasing approvals and increasing denials at Stanford. In 2020 the Alliance will be working with Stanford for oncology services to be potentially provided within the network. The process for denials of OON requests is accompanied by confirmation of the requested service within the Alliance network and the availability of a timely appointment. The Case Management department also assists with the member obtaining the approved requested service within the network.

<u>Pharmacy Utilization</u>

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

Recommendations/Next Steps for 2020:

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

- Enhance UM system reporting to capture required elements for over/under utilization monitoring reports, to include access to OON specialty services.
- Emergency Room
    - Use monitoring reports identify potential frequent utilizers of ER services

- Document CM interventions for high utilizers, including ER services

- Hospital Utilization
  - Continue to assess drivers resulting in longer than expected length of hospital stays
  - Full implementation of a Transition of Care Program, with a goal of expanding to all hospital discharges
  - Implement process to support the early identification of members at risk for readmission which will include frailty scores and additional UM parameters such as medication monitoring to identify members at risk for readmission, developing targeted interventions to improve outcomes
- Ambulatory Setting - identify measures to monitor for care in the capitated setting
  - Specialty Care encounters per thousand
  - Primary/Preventive Care in the capitated setting with UM interventions–, i.e. flu vaccine, pneumococcal vaccine. Mammography, Colonoscopy, through the Quality Improvement department.
- For OON:
  - Develop process to review monthly detailed OON reports that included more specific providers and services to support prospective analysis.
  - Continue efforts to attempt contracting with tertiary and limited availability service providers, particularly Stanford
  - Continue to explore contracting options for providers who resist conventional contracting
  - Work with Provider Team to ensure that provider identification and contracting data is correctly uploaded and managed in the Alliance system

LONG TERM SERVICES AND SUPPORTS (LTSS)

The Alliance is responsible for ensuring Members who are eligible to receive LTSS services are identified and referred. In 2019, The CM Department was working in collaboration with the UM Department to ensure members identified for Community Based Adult Services (CBAS) were identified, referred and assessed appropriately and timely. In 2019 the CM Department transitioned the responsibility for assessment, initial referral, re-assessments and re-authorizations of services to the UM Department.

Figure 25 - 2019 CBAS Enrollment by Facility by Delegate

CBAS Enrollment By Facility By Delegate

Based on Active Approved Authorizations, excluding MediCal terminated members

Run Date: 12/2/2019

Number of Members					
Facility Name	**Alliance**	**IHSS**	**CHCN**	**Kaiser**	**Total**
Alzheimer Services of The East Bay	9	0	6	0	15
Family Bridges Inc.	88	0	216	0	304
Golden Castle Adult Day Health Care Center	11	0	0	0	11
Grace Adult Day Healthcare	7	0	0	0	7
Silicon Valley Adult Day Health Care	5	0	4	0	9
Total	120	0	226	0	346

As seen in the Figure 25, there were a total of 346 members receiving services through one of the six CBAS centers. The Center with the highest volume is Family Bridges, by a considerable margin. In 2019, the CM Department collaborated with UM for the transition of the CBAS program to the UM Department, and the UM department will work to develop the appropriate metrics for the program outcomes.

Behavioral Health

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

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

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

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

The Alliance contracts with Beacon to administer the applicable Medi-Cal for members with Mild/Moderate behavioral health needs and Commercial mental health benefits.

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

Figure #26– 2019 Beacon Health Strategies Agreement updated

Beacon – CHIPA Division of Responsibility Function	Beacon (Admin)	CHIPA (Clinical)
Contracting for Outpatient Professional services		X
Credentialing	X	
Member Services	X	

Utilization Management		X
Claims Adjudication/Payment	X	

The Alliance has developed multi-disciplinary team to analyze data and identify opportunities for collaboration between medical and behavioral health. A full description of the program activities is defined in the Beacon Behavioral Health Program Evaluation and UM Program Description. The BH documents were presented to The Alliance HCQC in July 2019.

Integration with Quality Improvement/Management

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

Assessing Members and Practitioners' Experience with the UM Process

Provider satisfaction survey that includes experience with the UM process results will be presented to HCQC in 2020. The Benchmark is a comparison of the Alliance outcomes to the other plans participating in in the 2019 SPH survey:

Figure #27 2019 Provider Satisfaction with Utilization Management

Provider Satisfaction with Utilization Management				
Question	**2017**	**2018**	**2019**	**Benchmark**
Access to UM Staff	46%	41%	**46%**	29%
Obtaining Pre-Auth Info	45%	46%	**45%**	30%
Timeliness of Pre-Auth Info	44%	46%	**48%**	30%
Facilitation of Care	47%	46%	**50%**	31%
Coverage of Prevention	54%	53%	**59%**	35%

As shown above in Figure #27, the overall scores from 2017 to 2019 are relatively flat for access to UM staff and auth info, but increasing satisfaction with care facilitation and coverage of preventive care. In all cases, the satisfaction rates are noted to be considerably higher than the established benchmarks. Provider satisfaction will have increased focus in 2020 with the implementation of a Provider Portal for online auth requests and feedback on auth status.

Figure #28 2019 Member Satisfaction with Utilization Management

	Member Satisfaction with Utilization Management			
CAHPS Question	**2017**	2018	**2019**	**Percentile Rank**
Getting Care Quickly	70%	73%	**75%**	<10th Percentile
Getting Needed Care	75%	76%	**76%**	<10th Percentile
Coordination of Care	79%	83%	**70.4%**	<10th Percentile

Member experience with the UM process is assessed using established survey Consumer Assessment of Healthcare Providers and Hospital Systems (CAHPS) which measure patient experience across health plans, providers and health care facilities. UM utilizes three questions to assess patient experience with UM, 1) Getting Care Quickly, 2) Getting

Needed Care and 3) Coordination of Care. The results will be presented in 2020 at HCQC, and a description of the full survey can be found in the Quality Program Description.

As identified in Figure #28, the trending shows Member satisfaction with Getting Needed Care went from 75% in 2017 to 76% in 2019. Getting Care Quickly improved from 70% in 2017 to 75% 2019, but both are below the 10th percentile. Member satisfaction with Coordination of Care decreased from 83% in 2018 to 70% in 2019, which was less than the 10th percentile, showing worsening performance in this metric. Overall, while member satisfaction shows approximately 75% of the surveyed members are satisfied with getting the care from their physicians, these are lower outcomes compared to other health plans. The continued high performance in Turn Around Time for authorizations and the high rates of approved Authorization requests suggests that the dissatisfaction with these metrics are more driven by provider services than UM processes per se. Member satisfaction will need to have increased focus in the future in collaboration with Provider Services.

Recommended Interventions/Next Steps for 2020:

In 2019, there is an opportunity to ensure the UM Department participate in the analysis of the data and development of activities associated with the member and provider experience with the UM processes. While Provider Satisfaction is above the comparative benchmark, and is nearing 50% for access to staff and auth info, and at or above 50% for care facilitation of care and preventive care coverage. However, Member experience is low compared to other health plans, and specific activities to address this will be required.

The continued lack of improvement with member satisfaction in 2019 will require a strategy with Provider Services to address this lack of improvement for Member experiences with the obtaining care.

Analysis of Clinical Appeals

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

Clinical Appeals are investigated to determine if the initial UM determination was appropriate. The final appeal is resolved with determinations of upheld, overturn or withdraw (at the request of the member or member's authorized representative). Overturn appeal determinations are considered an opportunity to assess the UM process. The Alliance established a threshold of the overturn determination of 25%.

Quantitative Analysis

Figure #28 – 2019 Clinical Appeals

	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	% Overturned
Standard Appeals	915	30 Calendar Days	95% compliance within standard	913	99.8%	33.0%
Expedited Appeals	46	72 Hours	95% compliance within standard	46	100.0%	65.2%
2019 Total Appeal Cases:	961		95% compliance within standard	959	99.8%	34.5%

In Figure #28, The Alliance processed a total of 961 clinical appeals. Of those 915 were processed as standard requests while 46 were expedited.

Figure #29a – 2019 Clinical Appeals by Resolution/ Overturn – Threshold Compliance

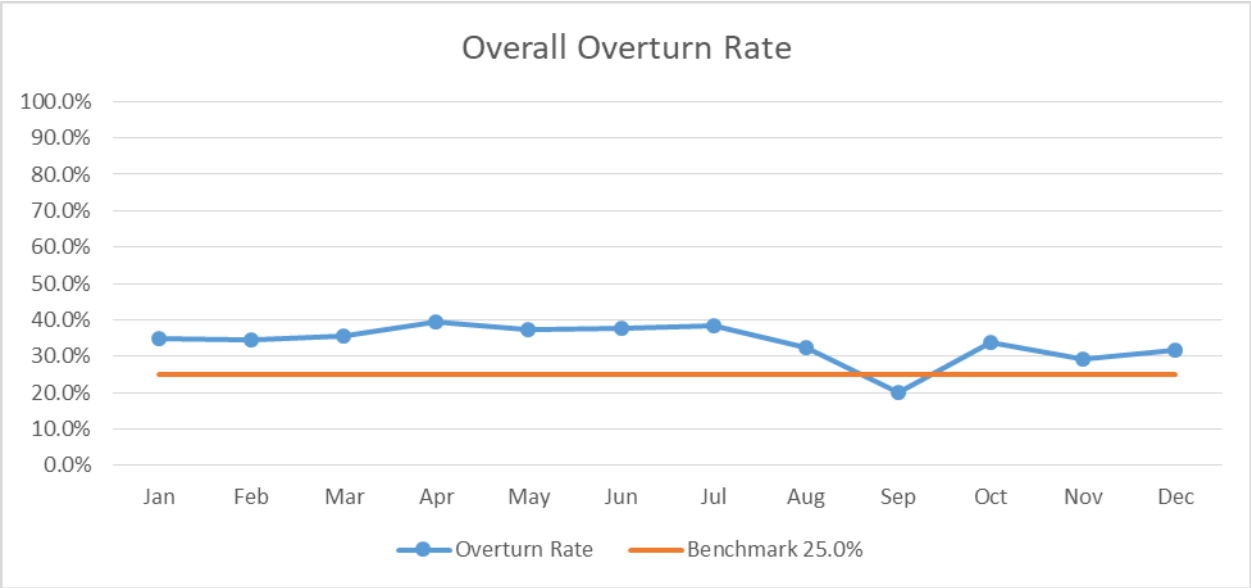
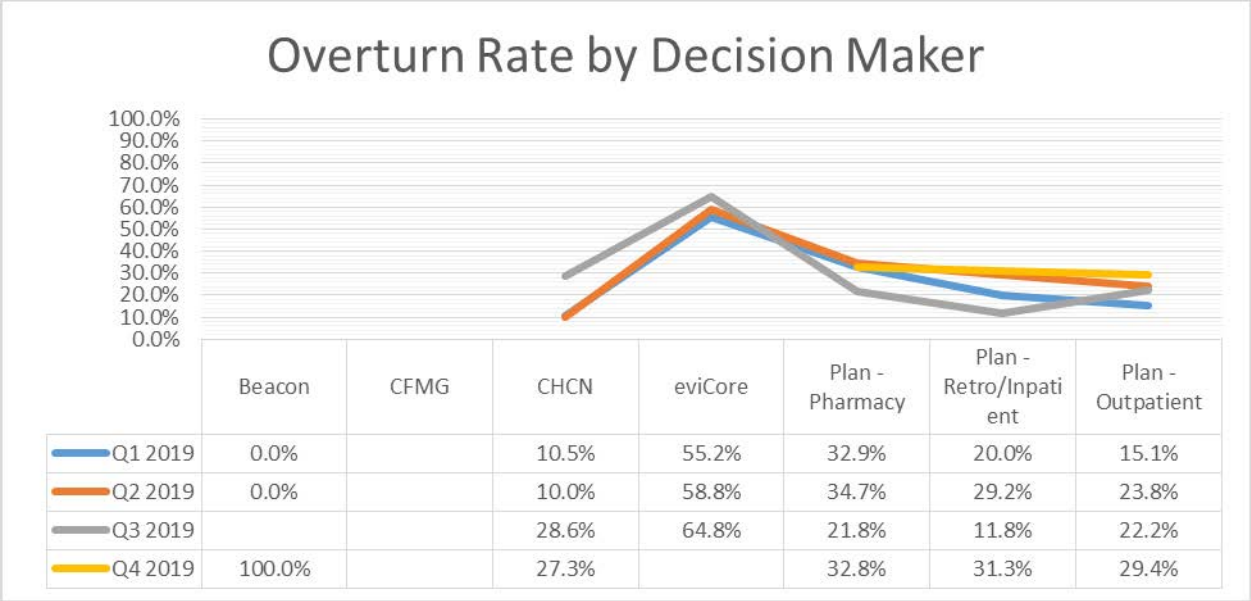


Figure #29b – 2019 Clinical Appeals by Provider Group and Resolution



	Beacon	CFMG	CHCN	eviCore	Plan - Pharmacy	Plan - Retro/Inpatient	Plan - Outpatient
Q1 2019	0.0%		10.5%	55.2%	32.9%	20.0%	15.1%
Q2 2019	0.0%		10.0%	58.8%	34.7%	29.2%	23.8%
Q3 2019			28.6%	64.8%	21.8%	11.8%	22.2%
Q4 2019	100.0%		27.3%		32.8%	31.3%	29.4%

Data represented in Figure 29a – the overall final determinations for the 961 clinical appeals. Of those, 629/961 or 65.4% were found to be appropriate thus the determination was to uphold the appeal. The remaining 332 or 34.5% were found to be inappropriate UM decisions resulting in an overturn of the initial UM decisions. This is above the overall overturn threshold of 25%

Further analysis of the clinical appeals was completed to identify the cases by the Provider Group responsible for the initial decision. Data in Figure 29b identified five provider groups were responsible for the total 961 cases. Of those, CHCN had an overturn rate of 20.2%, The Alliance was 26.9%, Beacon was 50.0%, eviCore was 58.5%, and CFMG had no appeals for the reporting period. The Alliance also decided to end our contractual relationship with our radiology vendor and internalize the review of radiology authorizations due to the high overturn rate that had been trending throughout 2018 and into Q1 2019. This change occurred on 8/1/2019, the Alliance has identified a significant decrease

in our overturn rate in the month of September, and this was the first month where we were below our internal benchmark for overturns.

A key finding for the 2019 involves UM clinical decision making. This is highlighted in the findings of the analysis of clinical appeals. There is an opportunity to look at additional elements to identify opportunities for improving the UM process, such as clinical decision making, application of criteria, understanding adequate information to make a determination. This may lead to educational opportunities for additional internal and external staff training on the UM processes.

Recommended Interventions/Next Steps for 2019:

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

Integration of medical and behavioral health

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

In 2019, the teams worked on efforts crossing the medical and behavioral health services which included:

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

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

Coordination with Regulatory Compliance

The Alliance UM Department works closely with the Compliance Department in preparation for regulatory audits. In 2019, the department participated in follow up reviews and work from regulatory audits. As a result of the reviews, several internal workgroups met to identify activities targeted at resolving the identified UM related issues. The workgroups managed these activities via ongoing work-plans. The activities identified are on target for completion within the established timeframes. The activities include mechanisms for ongoing monitoring to mitigate further regulatory deficiencies.

Recommended Interventions/Next Steps for 2020:

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

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

Conclusion

Overall, the 2019 UM Program was effective in maintaining compliance with regulatory and contractual requirements, monitoring of performance within the established benchmarks or goals, identifying opportunities for improvement and enhancing processes and outcomes. The UM program activities have met a majority of the established targets, with a reduction in regulatory findings. The Alliance leadership has played an active role in the UM Program structure by participating in various committee meetings, providing input and assistance in resolving barriers and developing effective approaches to achieve improvements.

UM Program Recommendations for 2020

As a result of internal performance monitoring performed in 2019, opportunities for improvement were identified and will be incorporated into the 2020 department goals. Highlights of opportunities for improvement based on the regulatory findings include:

- Improve monitoring of network utilization (over/under), including out of network authorization requests particularly focus on the Stanford analysis.
- Improve monitoring of Specialty Referrals.
- Collaboration with The Alliance Compliance Department on the full implementation of the UM process for internal performance monitoring of UM decisions.
- Strengthen programs around oversight of clinical decision making, both internally and for Delegates.
- Continue the care transition program in partnership with Highland Hospital.
- Develop and refine the ADT feed coming from contracted hospitals to enhance communication and coordination of care.
- Analyze the opportunity and implement the process to increase the number of authorizations that are appropriate for automatic approval.
- Improve reporting and analysis of grievance and appeals activities related to UM decision making and analysis for member and provider experience with UM.
- Continue implementation for tracking and intervening with unused Authorizations to ensure that members receive appropriate care and follow up.
- Continue to monitor the Palliative Care benefit for members.
- Continue the analysis of hospital data and develop an individual hospital strategy for management of members for appropriate length of stay.
- Hardwire the standardized work and training for the UM department staff to ensure regulatory compliance.
- Hardwire a standard process for policy review and revision that ensures UM processes maintain operational and regulatory compliance.

ALAMEDA Alliance FOR HEALTH

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

2020

UTILIZATION MANAGEMENT PROGRAM

DESCRIPTION

2020
Utilization Management
Program Description

2020 Utilization Management Program

Signature Page

Date _____

Julie Anne Miller, LCSW
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Date _____

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Chief Medical Officer, Medical Management
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Date _____

Scott Coffin
Chief Executive Officer

Date _____

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

- **<u>Changes in UM Program Description from 2019 Version</u>**
    - **Grammatical corrections**
    - **Pagination corrections**
    - **Addition/correction of relevant regulatory references**
    - **Removal of a terminated Delegate**
    - **UM Team member role clarifications**
    - **Addition of Summary of 2020 Focus areas**

Table of Contents

Introduction

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

The Alliance provides health care coverage to over 250,000 children and adults through the Medi-Cal and Alliance Group Care programs. Alliance members choose from a network of over 1,700 doctors, 17 hospitals, 29 community health centers, and more than 190 pharmacies throughout Alameda County. The Alliance cares about the health of our community and reflects the community's cultural and linguistic diversity in the health plan's structure, operations and services. In addition, many of the Alliance providers, employees, and Board of Governors (BOG) live in areas that we serve. The Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan members. Our members' optimal health is always our priority.

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

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

The annual evaluation of the effectiveness of UM processes was conducted and the recommendations were documented in the 2018 UM Program Evaluation. Based on those recommendations, the Alliance will continue its focus on the following areas for 2020:

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

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

Section I. Program Objectives & Principles

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

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

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

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

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

Section II. Program Structure

A. Program Authority and Accountability

1. Board of Governors

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

2. Committee Structure

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

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

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

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

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

The HCQC functional responsibilities for the UM Program include:

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

B. Utilization Management Committee

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

1. UM Committee Structure

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

2. Authority and Responsibility

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

recommendations and actions taken by the UM Committee.

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

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

3. UM Committee Membership

The UMC is chaired by the Chief Medical Officer.

Members of the UM Committee include:

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

4. UMC Voting Privileges

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

5. UMC Quorum

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

6. UMC Meetings

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

7. UMC Minutes

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

8. UM Committee Functions

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

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

UM Committee responsibilities are to:

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

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

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

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

C. Program Oversight and Staff Responsibility

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

Appropriately qualified and trained clinical staff use approved criteria to conduct utilization reviews and make UM determinations relevant to their positions, e.g. Non- physician staff may only approve services; qualified non-clinical staff may make non- medical necessity denial decisions (example: not eligible); potential denials are referred to physician reviewers. The CMO, Medical Director, or licensed MD staff review requests that require additional clinical interpretation or are potential denials. A qualified physician reviews all denials made, whole or in part, based on medical necessity. The CMO or a Medical Director makes medical necessity denial decisions for medical and pharmacy service requests. The Alliance Pharmacist, a licensed Pharm. D., may approve, defer, modify, or deny prior authorization requests for pharmaceutical services.

1. Chief Medical Officer

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

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

2. Medical Directors

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

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

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

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

3. Director, Health Care Services

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

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

4. Pharmacy Services Senior Director

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

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

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

5. Utilization Review Clinicians

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

6. UM Coordinators

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

Roles and responsibilities include:

- Outpatient UM Coordinators
  - Ensure appropriate UM referral entries into the information system;
  - Process UM referrals approvals for selected requests identified as Auto Authorizations or Authorization Scope of Work that do not require clinical interpretation;
  - Complete intake functions with the use of established scripted guidelines and
  - Manage and complete UM Member and Provider communications.
  - Complete administrative denials, as defined in UM Policy 057 – Authorization Requests.
- Inpatient UM Coordinators:
  - monitor and collect facility admissions census data;
  - Complete data entry of initial cases;
  - Maintain member and provider communications;
  - Assist in requesting additional information as needed and;
  - Review of hospital referral to ensure appropriate case closure.
  - Approve inpatients services as defined in UM Policy UM-057 Authorization Requests.
- Ensuring the efficient processing for the authorization process and maintain documentation in support of the on-site and telephonic UM nurse staff.

Section III. Program Scope, Processes & Information Sources

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

A. Utilization Management Activities

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

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

intensive outpatient behavioral health care, and ongoing ambulatory care.

- Post Service Review means the assessment of the appropriateness of medical services after the services have been provided. This is also called Retrospective Review.
- After Hours and Emergency Care

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

Emergency health care services are covered without prior approval:

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

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

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

B. Communication Services for UM Process with Members and Providers

The Alliance members, providers, and the public may contact the UM department to discuss any aspect of the UM program. Members contact the Member Services Department at 510-747-4567 and may be warm transferred to an UM Manager or Director. Providers contact the UM Department directly at 510.747.4540. UM staff are

available at least 8 hours per normal business day (excludes weekends and holidays). During scheduled business hours, The Alliance provides access to staff for members and practitioners seeking information about the UM process and the authorization of care. After hours calls are answered by a contracted vendor and non-emergency calls are returned the following business day. After Hour calls requiring clinical decision-making are transferred to a The Alliance on-call nurse for assistance. Staff identify themselves by name, title and as representatives of The Alliance when initiating or returning calls. HIPAA protocols are followed to ensure protection of privacy. Language assistance and TDD/TTY services are available as needed for members to communicate with The Alliance regarding the UM program.

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

C. Decision Support Tools

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

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

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

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

D. UM Review Criteria, Guidelines and Standards

The Alliance, Provider Groups and Vendors delegated for UM functions must utilize evidenced based nationally recognized criteria for UM decision making. UM criteria are

used to determine medical necessity in the Authorization Request review process.

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

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

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

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

Examples of regulations and guidelines are as follows:

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

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

1. Application of UM Criteria

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

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

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

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

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

2. Clinical Review Criteria

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

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

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

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

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

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

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

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

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

If criteria are requested, the organization makes them available:

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

E. Benefits

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

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

- IHSS benefits are developed by Public Authority of Alameda County

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

1. Benefit Exclusions

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

2. Transition to Other Care when Benefits End

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

3. New Medical Technology Evaluation Assessment

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

The following are evaluated when considering new technology:

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

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

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

4. Member Eligibility Verification

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

5. Determination Information Sources

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

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

F. UM Determinations

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

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

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

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

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

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

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

Providers are informed how to contact and speak with the Medical Director who made the decision. Notification communication includes appeal rights and procedures. Member notifications comply with appropriate contractual and regulatory guidance for each member’s line of business. Member correspondence about authorization decisions includes a statement in each Alliance threshold language instructing the member how to obtain correspondence in their preferred language. Records, including Notice of Action

letters, meet contractual retention requirements. Members are informed that they may request copies of their medical records.

G. UM Referral Management and UM Review Processes

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

1. Services Exempt from Prior Authorization

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

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

2. Auto-Authorization

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

3. Services Requiring Prior Authorization

The Alliance develops, reviews, and approves at least annually, lists of auto authorizations. Any procedure, treatment, or service not on these lists requires prior

authorization. The Alliance communicates to all contracted health care practitioners the procedures, treatments, and services that require prior authorization and the procedures and timeframes necessary to obtain such prior authorization.

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

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

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

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

4. Medical Director Responsibilities

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

care and health services.

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

5. Appropriate Professionals for UM Decision Process

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

6. Timeliness Standards

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

7. Utilization Review Processes

The UM Program includes the following utilization review processes:

Prospective Review

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

Concurrent Review

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

Retrospective Review

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

The Alliance does not accept non-emergent/urgent services that required prior authorization after the date of service. There are a few exceptions which a retrospective request will be considered by the Medical Director, if they are submitted within 30 calendar days of the date of service:

- Requests due to member eligibility issues
- Provision of inpatient services where the facility is unable to confirm enrollment with The Alliance
- Services rendered in an urgent and emergent situation.

The Alliance maintains instructions for the authorization process on the website and provider training which is available to contracted and non-contracted providers. For non-contracted facilities, The Alliance maintains a 24-hour UM contact notification process on the California DMHC website. The Alliance maintains a full list of conditions eligible for retrospective review by the Department and is reviewed annually for any changes.

8. Outpatient Referral Management

Alliance network physicians are the primary care managers for member healthcare services. Based on the member's assignment, referrals may be managed by The Alliance or a delegated Provider Group.

Network Primary Care Physicians (PCPs) may process in-network specialist and facility referrals directly to members as "direct referrals" without administrative pre-authorization from the UM Program or the Provider Group. These referrals are primarily for routine outpatient and diagnostic services and are tracked by the UM Program using claim and encounter data. For services identified as requiring prior authorization, PCPs must submit and coordinate prior authorization for several services that require prior authorization, such as DME, home health and certain radiology services. All elective inpatient surgeries and non-contracted provider referrals require prior authorization.

The UM Program clinical information system tracks all authorized, denied, deferred and modified service requests and includes timeliness records. These processes are outlined in the Provider Manual and in internal policies and procedures.

Practitioners and providers send referrals and requests for prior authorization of services to the UM Department by mail, fax and/or telephone, based on the urgency of the requested service. Request must include the following information for the requested service:

- Member demographic information (name, date of birth, etc.)
- Provider demographic information (Referring and Referred to)
- Requested service/procedure, including specific CPT/HCPCS Codes
- Member diagnosis (ICD-10 Code and description)
- Pertinent medical history and treatment
- Location where service(s) will be performed
- Clinical indications necessitating service or referral *(See Section: Minimum Clinical Information for Review of UM Requests for Authorization)*

Requests for services are reviewed in accordance with approved UM criteria and the member's benefit structure. When decisions on coverage are based on medical necessity, relevant clinical information is obtained and consultation with the treating practitioner occurs as necessary.

Requests for Authorization determinations related to Medi-Cal and IHSS Product Lines are defined differently as follows**:**

- Pre-Service Determinations for Medi-Cal and IHSS are defined in the following terms:
    - Approval - the determination to provide a service
    - Modification – the determination to either approve less than what was requested or to approve something else in place of what was requested
    - Denial - a determination to not provide the request service
    - Delay – when a determination cannot be made, and additional time is required to obtain relevant clinical information
    - Termination- to not extend an extension of a previously authorized service (e.g. PT visits, SNF days, etc.) (NOTE: must give 10 calendar days' notice of terminations)

UM staff receive requests for authorization of outpatient services and elective procedures prior to admission to ensure that admission to a healthcare facility is appropriate/medically necessary. Non-Clinical UM staff may approve services which can be auto-authorized, within their scope when the specific elements of the policy are met. Clinical UM staff will review services that require prior authorization based on medical necessity. The medical necessity clinical review is based on the severity and complexity of the individual case, unless there are questions regarding the medical necessity of services.

Should the UM staff question the medical necessity of services to be rendered, or appropriateness of the level of care for service based on review criteria and guidelines, the Medical Director will be consulted for case review. The Medical Director, or physician designee, will contact the attending physician to discuss the case, if necessary.

Should the Medical Director or physician designee determine that proposed services are not medically necessary or indicated, a denial determination may be made by the Medical Director. Denial notification and communication will be made in accordance with current regulatory timeliness standards and denial notification requirements, as

established by regulators, including the DHCS and Department of Managed Health Care (DMHC) and national accrediting organizations, such as NCQA.

9. Second Opinion

The Alliance members may request a second opinion from any qualified primary care provider or specialist within the same medical group. If a qualified specialist is not available within medical group, a referral is provided within The Alliance's network. If the qualified specialist is not available in The Alliance network, staff will assist the medical group to identify an out-of-network specialist. The second opinion from a qualified health professional will be provided at no cost to the member. The Alliance provides a second opinion from a qualified health care professional when a member or a practitioner requests it for reasons that include, but are not limited to, the following:

- The member questions the reasonableness or necessity of recommended surgical procedures.
- The member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including but not limited to, a serious chronic condition.
- The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and requests consultation, or the member requests an additional diagnosis.
- The treatment plan in progress is not improving the medical condition of the member within an appropriate period given the diagnosis and plans of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment.
- The member has attempted to follow the practitioner's advice or consulted with the initial practitioner concerning serious concerns about the diagnosis or plan of care.

The Alliance educates its members and practitioners of the availability of second opinions in annual member publications. Policies regarding second opinions are available to the public upon request. Member rights related to second opinions include:

- To be provided with the names of two physicians who are qualified to give a second opinion
- To obtain a second opinion within 30 calendar days, or if the medical need is emergent or urgent, to obtain an opinion within a timeframe that is appropriate to the member's condition and that does not exceed 72 hours
- To see the second opinion report

10. Standing Referrals

The Alliance maintains process to provide enrollees a standing referral to a specialist. The procedure shall provide for a standing referral if the PCP, in consultation with both the specialist, if any, and The Alliance Medical Director (or designee), determines that the enrollee has a condition or disease that requires continuing specialized medical care from the specialist or Specialty Care Center, (SCC).

The Alliance may require the PCP to submit a treatment plan during care or prior to the referral from the enrollee as determined by the Medical Director:

- If a treatment plan is necessary in the course of care and is approved by The Alliance, in consultation with the PCP, specialist, and enrollee, a standing referral shall be made in accordance with the treatment plan.
- A treatment plan may be deemed unnecessary if The Alliance approves a current standing referral to a specialist.
- The treatment plan may limit the number of visits to the specialist, limit the period of time during which visits are authorized, or required that the specialist provide the PCP with regular reports on the care and treatment provided to the enrollee.

The Alliance maintains guidelines for standing referral requests for enrollees that required specialized medical care over a period and who have a life-threatening, degenerative, or disabling condition, to a specialist or SCC that has expertise in treating the condition or disease for having specialist coordinate he enrollee's health care. Standing referral to a specialist or SCC are provided within The Alliance's network to participating providers, unless there is no specialist or SCC within The Alliance's network that is appropriate to provide treatment to enrollee, as determined by the PCP in consultation with the Medical Director and as documented in the treatment plan.

11. Concurrent/Continued Stay Review (Acute, Skilled, Rehabilitation)

The Alliance provides telephonic UM services and on-site UM at a sub-set of network hospitals. Appropriate inpatient medical management is ensured through consistent and coordinated Concurrent Review of members, irrespective of the presence or utilization of a contracted hospitalist. Concurrent/Continued Stay Review is a process coordinated by the UM staff during a member's course of hospitalization, which may include acute hospital, skilled nursing, and acute rehabilitation facilities, to assess the medical necessity and appropriateness of continuation at the requested level of care. Concurrent/Continued Stay review also involves the telephonic or on-site medical record review that occurs after admission if no pre-admission review has occurred.

Additional objectives of continued stay review are to:

- Ensure that services are provided in a timely and efficient manner
- Ensure that established standards of quality care are met
- Implement timely and efficient transfer to lower levels of care when clinically indicated and appropriate
- Implement effective and safe discharge planning
- Identify cases appropriate for Case Management and Transitions of Care Services

The Concurrent Review Procedure shall be followed throughout the member's hospitalization, utilizing approved criteria and guidelines. Telephonic, facsimile reviews or on-site are coordinated by the UM staff daily, or on cyclic intervals based on individual

case requirements. In the event a scheduled review date falls on a weekend or holiday, the UM staff will coordinate a Concurrent Review on the work day prior to the scheduled review date, or not later than the first work day after the holiday or weekend.

Continued hospital care and/or ancillary services, that do not meet continued stay criteria is referred to the Medical Director, or physician designee, to evaluate and consult with the attending physician, as appropriate. When the Medical Director decides that the case does not meet criteria for continued stay based on medical necessity or appropriateness, the attending physician will be contacted, and discharge planning discussed. When an acceptable discharge plan is mutually agreed upon by the attending physician and the UM Medical Director, a Notice of Action (NOA) letter may be issued immediately by fax or via overnight Certified Mail to the attending physician, hospital and the member, if the member disagrees with the discharge plan.

12. Transition of Care and Discharge Planning

Transition of Care and Discharge Planning management are components of the UM process that assess necessary services and resources available to facilitate member discharge and/or transition to the appropriate level of care. Discharge Planning refers to activities related to planning the discharge of a member out of an inpatient medical facility. Transition of Care refers to activities related to movement of a member from a clinical setting to a home or community setting.

Discharge planning begins as early as possible during an inpatient admission, and is designed to identify and initiate cost effective, quality-driven treatment intervention for post-hospital care needs. It is a cooperative effort between the attending physicians, hospital discharge planner, UM staff, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of medical/psycho-social issues with potential need for post-hospital intervention
- Development of an individual care plan involving an appropriate multi-disciplinary team and family members involved in the members care
- Communication to the attending physician and member, when appropriate, to suggest alternate health care resources
- Communication to attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization
- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge Planning staff, and UM staff
- Referral to Transitions of Care programs or Home Health Programs within or outside of AAH programs.

The UM staff obtains medical record information and identifies the need for discharge to a lower level of care based on discharge review criteria/guidelines. If the attending physician orders discharge to a lower level of care, the UM staff assists the hospital UM/Discharge Planner in coordinating post-hospital care needs. The same process is utilized for continued stay approval or denial determinations by the UM Medical Director, as previously noted in the Concurrent Review Process.

UM Review Clinicians work with facility discharge planners, attending physicians and ancillary and community service providers to assist in making necessary arrangements for member post- discharge needs.

For SPD members, UM Review Clinicians are responsible for ensuring discharge planning is in place ensuring that necessary care, services, and supports are in place in the community for the SPD beneficiary once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the patient and/or caregiver. Minimum criteria for discharge planning activities includes:

A. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, durable medical equipment (DME), and other services received.
B. Documentation of pre-discharge factors, including an understanding of the medical condition by the SPD beneficiary or a representative of the SPD beneficiary as applicable, physical and mental function, financial resources, and social supports.
C. Services needed after discharge, type of placement preferred by the SPD beneficiary/representative of the SPD beneficiary and hospital/institution, type of placement agreed to by the SPD beneficiary/representative of the SPD beneficiary, specific agency/home recommended by the hospital, specific agency/home agreed to by the SPD beneficiary/representative of the SPD beneficiary, and pre-discharge counseling recommended.
D. Summary of the nature and outcome SPD beneficiary/representative of the SPD beneficiary involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital/institution.

13. Denial Notifications

Adverse Benefit Determination letters or/and Notice of Action (NOA) letters for denials are provided to members and their practitioners in compliance with the member's regulatory appeal requirements. All potential denials and/or modifications of service are discussed with the appropriate Medical Director, who makes the final determination.

Services that are denied, modified, delayed shall contain the following elements:

- Clear, concise and easily understandable explanation of the reason for denial in the Notice of Action (NOA) or adverse determination letter
- Reference to the specific benefit, guideline, protocol or other similar criterion on which the denial decision is based

- Statement that members can obtain a copy of the actual benefit, guideline, protocol or other similar criterion on which the decision was based.
- Member Rights
- Appeal Rights and Process

In addition to the above for ongoing services that are terminated for all members, the NOA shall include:

- Agreement to an alternative treatment plan by attending practitioner for hospital concurrent decisions and by the PCP for Ambulatory Concurrent decisions
- In addition to the above for Medi-Cal members:
- Citation to the criteria used to support the decision (Medi-Cal only)
- Information about the member's State Hearing rights and process
- "Aid Paid Pending" process, as applicable for Medi-Cal, must also be included.

In addition, All UM NOA correspondences for pre-service and concurrent denials, modifications, and adverse decisions sent to the Requesting Practitioner shall include a name and phone number for contacting the Peer Reviewer to allow for the Requesting Practitioner to request a reconsider of the UM Determination

14. Peer to Peer Review (Discussing a Denial with a Peer Reviewer)

All UM Notice of Action correspondences for pre-service and concurrent denials, (including modifications, terminations, and adverse decisions) sent to the Requesting Practitioner shall include a name and phone number for contacting the Peer Reviewer to allow the Requesting Practitioner the opportunity to discuss issues or concerns regarding the decision. If a denial is being considered by the Peer Reviewer, a practitioner can discuss the decision by calling or writing to supply additional information for discussion with the Peer Reviewer. The Peer Reviewer will make himself/herself available for discussion of the denial decision within one business day of the receipt of the provider telephone call or written request. If the discussion does not result in a fully reversed denial determination, the practitioner can initiate an expedited or standard appeal, as appropriate.

15. Required Internal Reporting for UM Staff

- Potentially fraudulent or abusive practices identified to The Compliance Department
- Potential under and over utilization to the UM Manager
- Coordination of care for results or facilitation to the UM Manager
- Opportunities for improvement to the UM Manager
- Breaches of adherence to confidentiality and HIPAA policies to The Alliance's designated Compliance staff member
- Potential quality issues identified through UM activities to the Quality Improvement Department
- Barriers to accessibility and availability of UM services to their UM Manager

16. UM Documents

In addition to this program description, other documents important in communicating UM policies and procedures include:

- The Provider Manual, available on the Alliance web site and on a CD, provides an overview of operational aspects of the relationship between the Alliance, providers and members. Information about the Alliance's UM Program, referral and tracking procedures, processes, and timeframes necessary to obtain prior authorization are included in the manual. In addition, the Provider Manual describes how providers may obtain a copy of the clinical guidelines used to make medical determinations.

- The Provider Bulletin is a periodic newsletter distributed to all contracted provider sites and delegated groups on topics relevant to the provider community and may include UM policies, procedures and activities.
- The Member Alert is a periodic newsletter distributed to members in all lines of business. Each issue covers different topics of interest and importance to members about their health may include information about UM policies and procedures.

- Evidence of Coverage (EOC) documents are distributed to members based on their product line. Members have the right to submit a complaint or grievance about any plan action. The Evidence of Coverage document directs members to call the Member Service phone number to initiate complaints or grievances involving UM issues and actions. Member complaints or grievances are documented in the data system and forwarded to the UM unit for follow-up response. The Alliance Grievance and Appeal unit coordinates with the UM unit on appropriate responses to member complaints or grievances.

These documents, or summaries of the documents, are available upon request to providers, members and community partners. In addition, the UM Program information is available on the Alliance website.

H. Continuity of Care for Medical and Behavioral Health Services

Continuity of care can be defined as the lack of interruption in the care provided to members when circumstances dictate a change in the member's insurance coverage, geographic location, entity, or provider assignment.

The Alliance must provide continuity of care with an out-of-network provider when:

- The Alliance can determine that the beneficiary has an existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider);

    - An existing relationship means the beneficiary has seen an out-of-network primary care provider (PCP) or specialist at least once during the 12 months prior to the date of his or her initial enrollment in The Alliance for a non-emergency visit, unless otherwise specified by regulation.
- The provider is willing to accept the higher of The Alliance's contract rates or Medi-Cal FFS rates;
- The provider meets the applicable professional standards and has no disqualifying quality of care issues (a quality of care issue means The Alliance can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other MediCal beneficiaries);
- The provider is a California State Plan approved provider; and
- The provider supplies The Alliance with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, if it is allowable under federal and state privacy laws and regulations.

The Alliance is not required to provide continuity of care for services not covered by Medi-Cal. In addition, provider continuity of care protections does not extend to the following providers: durable medical equipment, transportation, other ancillary services, and carved-out services.

The UM staff works with the member and the member's current treating physician and/or PCP to assist the member in continuity of care. Every effort is made to maintain continuity of care for the member during the transition process. If the current treating physician is not affiliated with any of the existing Provider Groups, (PGs,) or with the member's PG selection, the UM staff works with the PGs to make arrangements with the physician to continue care of the member until the treatment is completed or the member can be safely transitioned to a physician within the PG. The UM staff notifies each PG of its membership qualifying for continuity of care assistance.

When members are identified as possibly benefiting from coordination of care, both within and outside of the network, the case is referred to Case Management for further intervention. The Case Management actively engages in activity that monitors and assesses continuity and coordination of clinical care. Individual registered nurses work closely with the Member, the physicians and any other associated healthcare delivery organization involved in the case, to provide timely, quality-based care meeting the needs of the individual member.

Continuity of care is also evaluated when members are referred from primary care physicians and specialists, including behavioral health specialists, or when a member is transferred or admitted to another level of care, such as a transfer or admittance to a skilled nursing facility (SNF), rehabilitation, chemical dependency, or mental health facility, where member follow through is a risk.

The Alliance documents all requests for assistance with continuity of care and is responsible for monitoring and oversight of the activities. A full description of the various programs is listed in the applicable policies and procedures.

1. ***New Enrollees***

The Alliance recognizes that a strong doctor-patient relationship, particularly for members with serious medical conditions, may enhance the healing process. Maintaining continuity of care as new enrollees change physicians and health plans are an important aspect of this relationship. Each newly-enrolled Medi-Cal member are placed in a transition group for up to 30 days, during which time they select their Alliance, PG, and PCP.

For a newly enrolled SPD members, The Alliance must honor any active MediCal FFS Treatment Authorization Requests (TARs) for up to 60 days or until a new assessment is completed by The Alliance. A new assessment is considered completed by The Alliance if the beneficiary has been seen by an Alliance -contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. The FFS TAR must be honored as outlined above without a request by the beneficiary or the Provider.

2. ***Terminated Practitioners (Both PCPs and Specialists)***

The Alliance's contracts with delegates establish a mechanism to continue appropriate and timely care for members whose physicians are terminating from the PG. This process includes notification from practitioners of intent to terminate, in accordance with the laws applicable to the line of business. Members under current care, and those with approved prior authorizations, not yet utilized, are identified, so that their care can be managed and coordinated with the receiving entity or with The Alliance physicians. Members, such as those undergoing cancer treatments of chemotherapy or radiation therapy, that are dialysis-dependent, awaiting transplants, in late-term pregnancies, have pending surgeries, or those awaiting transfer or admittance to a skilled nursing facility (SNF), rehabilitation, chemical dependency, or mental health facility, and any other members who might have their ongoing care negatively impacted by the termination of the group are identified.

The Alliance will notify members affected by the termination of a practitioner or practice group in general, family or internal medicine of pediatrics, at least 30 calendar days prior to the effective termination date, and help them select a new practitioner.

For members undergoing active treatment for a chronic or acute medical condition, care may be continued through the current period of active treatment or up to 90 calendar days, whichever is less.

3. ***Pregnant and Post- Partum Members***

Pregnant and post-partum Medi-Cal beneficiaries who are assigned a mandatory aid code and are transitioning from Medi-Cal FFS into The Alliance have the right to request out-of-network provider continuity of care for up to 12 months in accordance with The Alliance contracts and the general requirements listed in the regulatory guidance. This requirement is applicable to any existing Medi-Cal FFS provider relationship that is allowed under the general requirements of regulatory guidance.

For Alliance Group Care, continuation of care extends through the postpartum period for members in their second or third trimester of pregnancy.

4. *Medical Exemption Requests*

A Medical Exemption Request (MER) is a request for temporary exemption from enrollment into The Alliance only until the Medi-Cal beneficiary's medical condition has stabilized to a level that would enable the beneficiary to transfer to an Alliance provider of the same specialty without deleterious medical effects. A MER is a temporary exemption from The Alliance enrollment that only applies to beneficiaries transitioning from Medi-Cal FFS to The Alliance. A MER should only be used to preserve continuity of care with a Medi-Cal FFS provider under the circumstances described above in this paragraph. The Alliance is required to consider MERs that have been denied as an automatic continuity of care request to allow the beneficiary to complete a course of treatment with a Medi-Cal FFS provider in accordance with the most recent regulatory guidance.

5. *Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder*

The Alliance is responsible for providing Early and Periodic Screening, Diagnosis, and Treatment services for beneficiaries ages 0 to 21. Effective September 15, 2014, the services include medically necessary Behavioral Health Treatment (BHT) services such as Applied Behavioral Analysis and other evidence-based behavioral intervention services that develop or restore, to the maximum extent practicable, the functioning of beneficiaries diagnosed with Autism Spectrum Disorder (ASD). In accordance with the requirements listed in the most recent DHCS All Plan Letter, The Alliance must provide continued access to out-of-network BHT providers (continuity of care) for up to 12 months.

I. Behavioral Health Management

The provision of behavioral health and substance use services are applied to Alliance members according to their benefit. Group Care members receive a comprehensive benefit for all behavioral health services. Medi-Cal members receive services for mild to moderate behavioral health services. The provision of treatment for moderate to severe behavioral health services for Medi-Cal members is managed under a Memorandum of Understanding with Alameda County Behavioral Health Care Services, as described below.

The Alliance ensures services are provided in a culturally and linguistically appropriate manner.

1. Alameda County Behavioral Health Care Services (ACBHCS)

Specialty behavioral health services for Medi-Cal members excluded from the Alliance contract with DHCS are coordinated under a Memorandum of Understanding executed

with ACBHCS. This is a carve-out arrangement for specialty behavioral health management with the State of California directly overseeing and reimbursing the behavioral health services provided to Medi-Cal members.

The referral procedure for Alliance members includes:

- Alliance Primary Care Providers (PCPs) render outpatient behavioral health and substance abuse services within their scope of practice.
- PCPs refer the members to ACBHCS for evaluation and coordination of medically necessary specialty behavioral health services by the Access Team, including inpatient psychiatric care.
- PCPs refer members to qualified Medi-Cal providers for the provision of services not covered by ACBHCS.

2. Behavioral Health

The Alliance contracts with a Managed Behavioral Health Organization (MBHO) NCQA accredited delegate for the provision of behavioral health and substance abuse services not covered through ACBHCS, and for behavioral health and substance abuse services benefits for of all other lines of business. The Alliance delegates behavioral health utilization management activities and the maintenance of the provider network for behavioral health and substance abuse services.

All services are based on a member's benefit plan and the functions delegated to the MBHO by The Alliance. The scope of the program covers behavioral health treatment that may be beyond the customary scope of practice of a primary care physician. Care settings include home and office bases services, free-standing and hospital-based programs, residential treatment programs and facility based acute care treatment units. The MBHO uses information provided by the Alliance to determine member-specific benefit coverage, including plan-specific Evidence of Coverage documents, web-based member eligibility verification systems and direct download of member eligibility information via 834 files exchanges. Medical necessity is determined by applying level of care criteria, while the clinical appropriateness of services are evaluated using Clinical Practice Guidelines. Member specific clinical information is obtained from the member and/or family member or other legal representative, behavioral health medical providers (through verbal case review and/or submission of medical records). Program processes include; triage and referral; prospective; concurrent; post-service review and care coordination. Services include education to members and providers, coordination of care with primary care physicians, linkage and coordination with state and community agencies.

The Alliance reviews and approves the MBHO's LOC criteria through the HCQC. The Alliance reviews the criteria to ensure its clinical criteria for both medical and behavioral health services are aligned. MBHO's Level of Care criteria (LOC), as adopted by the UMC, were developed from the comparison of national, scientific and evidence-based criteria sets, including but not limited to those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA) and American Academy of Child and Adolescent Psychiatry (AACAP), Substance Abuse and Mental

Health Services Administration (SAMHSA), and the American Society of Addiction Medicine (ASAM.)

The MBHO uses the LOC criteria as guidelines, not absolute standards, and considers them in conjunction with other indications of a member's needs, strengths and treatment history in determining the best placement for a member. LOC criteria are applied to determine appropriate care for all members. In general, members will only be certified if they meet the specific medical necessity criteria for a particular LOC. However, the individual's needs and characteristics of the local service delivery system are taken into consideration prior to the making of UM decisions.

3. Alameda Alliance Triage and Referral

The Alliance arranges for triage and screening services available by telephone to members 24 hours per day, 7 days per week. The Alliance ensures that the telephone triage or screening services are provided in a timely manner appropriate for the requesting member's condition.

The Alliance is contingent on its contracted provider network to provide triage services to its members. Primary care providers and mental health care providers provide triage and screening services 24 hours a day, 7 days a week for medical and behavioral health care services.

For cases when the providers are unable to meet the time-elapsed standards, the Plan provides members the Plan's nurse advice line to call as an alternative triage and screening service arrangement. Providers who are unable to provide triage and screening services are required to inform members about the Alliance's nurse advice line information.

4. Monitoring Over and Under Utilization of Medical and Behavioral Health Services

The CMO or its physician designee monitors patterns of over and under-utilization.

Data is reviewed at the UMC and HCQC and when a pattern of under or over utilization is identified an analysis of barriers is conducted and potential interventions are identified. Data is then re-evaluated to determine the efficacy of the interventions.

When a concern over potential over or under-utilization for a specific member is identified, the clinical team including the Primary Care Physician, under the direction of the UM Medical Director, develops a plan to address the utilization issue which may include referral to Behavioral Health Case Management and/or the Alliance's Case Management or Disease Management programs, physician peer to peer with the inpatient attending physician, referral to the Alameda county mental health authority for additional services and supports.

5. Behavioral Health Integration

Members may contact their appropriate behavioral health organization directly or be referred by the PCP and/or health care professional. The Alliance maintains procedures for providers to coordinate care and services for members in need of behavioral health services including, but not limited to, all medical necessary services across the behavioral health provider network

The Alliance uses a variety of mechanisms that ensure behavioral health services and management processes are actively integrated into the UM Program and include:

- A behavioral healthcare practitioner, who is a behavioral healthcare physician or a doctoral-level behavioral health practitioner, is involved in quarterly HCQC meetings to support, advise and coordinate behavioral healthcare aspects into UM Program policies, procedures and processes.
- There are regular care coordination rounds, in which the staff attending rounds evaluates topics such as access, availability, health management systems, practice guidelines, clinical and service quality improvement activities, member satisfaction, continuity and coordination of care and member's rights and responsibilities.
- The Alliance routinely receives clinical reports from its Behavioral Health provider network which are reviewed by the Chief Medical Officer, the Director of Health Care Services, the Senior Director of Quality Improvement, and the Director, Compliance, or designees.
- The Alliance participates in quarterly operational meetings with the Behavioral Health provider network delegate to review and coordinate administrative, clinical and operational activities.

J. Pharmacy Management

The Alliance ensures the provision of pharmacy management to a pharmacy benefit manager (PBM), PerformRx. The PBM possesses service level guarantees that manages pharmacy services under the delegated arrangement and maintains clinical policies and procedures that are revised at least annually. The Alliance delegates some of its pharmacy utilization management activities to the pharmacy benefit management company. The PBM supports full prior authorization review services, including confirmation of denials for weekends/holidays/emergency. The PBM provides support to the Alliance's Pharmacy and Therapeutic Committee activities including formulary management, guideline development and trend reviews related to pharmacy services. The Pharmacy and Therapeutics Committee meets quarterly and provides oversight for evidence-based, clinically appropriate pharmacy guideline criteria. Guidelines are developed in conjunction with review of peer-reviewed literature and with consideration for such factors as safety, efficacy and cost effectiveness; with the input and evaluation of external clinical specialists appropriate to the subject matter.

The PBM receives and processes medication prior authorization requests for medications filled through network retail and specialty pharmacies. The PBM's Prior Authorization Department is comprised of certified technicians and clinical pharmacists who conduct

reviews and approve requests that meet prior authorization criteria. All requests that the PBM cannot approve per their protocol are forwarded to Alliance for the final determination. All pharmacy PA requests must be processed, and a decision rendered within the regulatory requirement. Pharmacy UM decision monitoring is reported through the UM Committee.

K. Linked and Carved Out Services

For linked and carved out services The Alliance provides linkages with community programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions, receive wrap-around services that enhance their medical benefits. These linkages are established through special programs, such as The Alliance Community Liaisons, and specific program Memoranda of Understanding (MOU) with other community agencies and programs, such as the California Children's Services, Alameda County Behavioral Health Care Services, and the Regional Center of the East Bay (RCEB). The UM staff and delegated entity practitioners are responsible for identification of such cases, and coordination of referral to appropriate State agencies and specialist care when the benefit coverage of the member dictates. The UM Department coordinates activities with the Case Management Department to assist members with the transition to other care, if necessary, when benefits end. This may include informing the member about ways to obtain continued care through other sources, such as community resources.

A full description of program the identification and referral process as well as the care coordination activities is maintained in the UM department policies and procedures.

Transportation Services

Transportation services are covered benefits. Transportation benefits include:

- Emergency
- Non-emergency medically necessary (NEMT)
- Non-medical transportation (NMT)

Benefits are administered based on the guidance of The Alliance product line. Those products include:

- MediCal
- IHSS

For the administration of the benefit:

- For Members enrolled with Kaiser, The Alliance delegates the responsibility for the provision of transportation services to the contracted Plan Partner.

- For the administration of MediCal Direct and IHSS, The Alliance is responsible for the provision of transportation services.

The Alliance contracts with a vendor, Logisticare, to provide the various modes of transportation. The vendor's UM Department is delegated for the utilization review process to determine medical necessity when required; the vendor is not delegated for potential denials. All potential denials are referred to The Alliance UM Medical Director for final determination. Utilization review is performed using the transportation guidance for the product, and as needed, a Physician Certification Statement (PCS). A full description of the process is defined the most recent policies on transportation services.

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

The Alliance is responsible for the provision of medical and non-medical transportation to eligible children under the age of 21 to access Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. The Alliance is required to provide appointment scheduling assistance and necessary transportation, including non-emergency medical transportation and non-medical transportation, to and from medical appointments for the medically necessary covered services. The Alliance is not responsible for providing non-medical transportation to and from the services that are carved-out, including dental services. DHCS All Plan Letter 19-010 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment of Services for MediCal Members Under the Age of 21, August 14, 2019.

Section IV. Special Programs

A. Long Term Services and Supports

The UM program includes oversight of the UM clinical decision-making review and authorizations for access to Long Term Service and Support benefits including Long Term Care (LTC) and Community Based Adult Services (CBAS). LTSS is responsible for the programmatic management of the LTSS programs. The Alliance administers the LTC and CBAS program elements as defined by the most recent DHCS contract, MMCD letter, or APL.

1. Long Term Care

The Long-Term Care (LTC) UM activities includes long term skilled care authorizations for the following facilities: skilled nursing, intermediate care, sub-acute care, intermediate care; developmentally disabled, intermediate care–developmentally disabled—habilitative, and intermediate care–developmentally disabled—nursing, residential care facilities, board and care, and assisted living facilities. LTC excludes Institutes for Mental Disease and special behavioral health treatment programs. Authorizations are provided based on member's meeting criteria the eligibility and nursing facility admission criteria.

For Medi-Cal members: Long Term Care (LTC) services for eligible MediCal members. The Alliance is responsible for the provision of LTC services for the month of admission plus the following month. The UM Department is responsible for providing the following activities:

- If a Member requires LTC in the facility for longer than the regulatory timeframe for admission, The Alliance shall submit a disenrollment request for the member to DHCS, for approval.
- The Alliance shall provide all Medically Necessary Covered Services to the Member until the disenrollment is effective. For these Members, an approved disenrollment request will become effective the first day of the eligible month, provided Contractor submitted the disenrollment request at least 30 calendar days prior in the appropriate timeframe. If the Alliance submitted the disenrollment request less than 30 calendar days prior to that date, disenrollment will be effective the first day of the month that begins at least 30 calendar days after submission of the disenrollment request. Prior to the disenrollment effective date, The Alliance shall ensure the Member's orderly transfer from The Alliance's Provider to the Medi-Cal Fee-For-Service program. This includes notifying the Member and his or her family or guardian of the disenrollment; assuring the appropriate transfer of medical records or copies from The Alliance's Provider to the Medi-Cal fee-for-service provider; assuring that continuity of care is not interrupted; and, completion of all administrative work necessary to assure a smooth transfer of responsibility for the health care of the Members.
- Admission to a nursing facility of a MediCal Member who has elected hospice services does not affect the Member's eligibility for Enrollment. Hospice services are Covered Services under and are not long-term care services regardless of the Member's expected or actual length of stay in a nursing facility.

2. CBAS

The Alliance administers the CBAS program elements as defined by the most recent DHCS contract, MMCD letter, or APL. The Alliance maintains procedures, processes and mechanisms for administering assessments and re-assessments for CBAS services. For providers delegated to perform the CBAS assessments, The Alliance provides the necessary delegation oversight and monitoring activities. The Alliance develops mechanisms to generate and distribute the required reports to the identified DHCS departments

D. Palliative Care

Palliative Care Services are provided to members per the requirements of the All Plan Letter (APL 18-020) Palliative care services may be delivered at the hospital, as part of the inpatient care treatment plan, or authorized and delivered in primary care, specialty care clinics, by home health teams, or by hospice entities. The Alliance offers a network of palliative care services to its members through various provider types.

The Alliance, as part of its palliative care network development, contracts with hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and /or training in palliative care. The Alliance may also contract with different types of providers depending on local provider qualifications and the need to reflect the diversity of their

membership. Community-Based Adult Services (CBAS) facilities may be considered as a palliative care partner for facilitating advance care planning or palliative care referrals. The Alliance utilizes qualified providers for palliative care based on setting and needs of the members if the provider complies with the existing Medi-Cal requirements.

The Alliance ensures that palliative care provided in a member's home complies with existing Medi-Cal requirements for in-home providers, services, and authorization, such as physician assessments and care plans.

The Alliance informs and educates its providers regarding availability of the palliative care benefit through its website and education materials.

The Alliance identifies members eligible for palliative care by the following:

- Screening for palliative care eligibility in Complex Case Management referrals
- Referrals from network providers, including through case management, concurrent review, and the general authorization process
- Analysis of member data

Palliative care services follow the general authorization process is outlined in the UM policy and procedures. Through the authorization review and decision process, the type of palliative care (including the location where palliative care services can be delivered) will be determined based on medical necessity. Referral and care coordination for palliative services will be provided to the member within the timely access standard requirements. Alliance's network providers receive instructions of the referral and authorization process for palliative care through the Alliance's provider educational materials and via the Alliance's website.

Section V. Quality Improvement Integration

The UM Program includes a wide variety of quality assurance activities to support positive member outcomes and continuous quality improvement. The CMO guides these activities in collaboration with the Director of Health Care Services, the Administrative Director of Quality and the Director of Accreditation, and oversight of the HCQC. Performance results are analyzed and reviewed with opportunities for improvement identified for intervention and performance management. The following quality activities are included in the UM Program:

- Monitoring Under and Over Utilization, including Out of Network and Provider Capacity monitoring;
- Monitoring of Member Experience with the UM process;
- Monitoring UM Appeals for UM Decision Making;
- Potential quality issue referrals;
- Provider Preventable Condition identification and referral;
- Inter-rater reliability assessments;
- Delegation oversight including Corrective Action Plan completion and process improvements if audit findings occur.

The UM data sources and information used for quality monitoring and improvement activities include the following:

- Claims and encounter data;
- Medical records;
- Medical utilization data;
- Behavioral Health utilization data;
- Pharmacy utilization data;
- Appeal, denial, and grievance information;
- Internally developed data and reports;
- Audit findings; and
- Other clinical or administrative data.

A. Monitoring Over and Under Utilization

The Alliance regularly monitors member service utilization using industry standard utilization measures. Medi-Cal contracts require that plans report rates to detect over and under-utilization. Rates for these measures vary based on the relative health of each population. For instance, usage rates for Non-SPD Medi-Cal members tend to be significantly lower than those for SPD Medi-Cal and IHSS members because the former populations are generally younger and healthier. Monitoring reports include changes in membership totals for each line of business in the last 12 months. National and regional benchmarks are not available for every line of business. In the absence of such benchmarks, the Alliance closely monitors monthly, quarterly and annual data for significant changes and trends, reports the results quarterly to the UMC and HCQC, and acts when indicated.

UM data elements are reviewed to assess over/under utilization of services for either medical and/or behavioral health include but are not limited to the following:

- Ambulatory Services – e.g. Outpatient encounters per enrollee per year primary care visits, specialist visits, preventive health care.
- Out of Network Specialty Referrals, e.g. specialists, behavioral health care;
- Acute Hospital Services
    - Emergency room visit rates;
    - Hospital admit rates;
    - Bed days rates;
    - Length of Stay;
    - Re-admission rates;
- Behavioral health utilization data;
- Pharmacy utilization rates;

- HEDIS measures for use of services
- Complaint reports (Grievance & Appeals) that reflect barriers for access to care or delivery of care.

Because of these clinical data analyses, The Alliance identifies opportunities for improvement through root cause analysis, action plans and the continuous improvement cycle ensure the actions taken are improving performance. When appropriate, feedback is provided to both entities and individual practitioners allowing their input into the improvement activities. The Alliance continues to monitor the action plans to ensure the activities improvements in the care delivery process.

B. Experience with Utilization Management

Annually Alliance members and providers are surveyed to assess their experience with the plan's utilization management processes and services. Data is collected and analyzed to identify improvement opportunities. For identified opportunities, Alliance takes actions designed to improve the experience based on the data.

1. Member

Alliance uses survey data to assess the member experience with the UM process. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is administered by mail to Alliance Medi-Cal members. Among the composite measures are member ratings for: 1) Getting Needed Care – member experience when attempting to get care, tests or treatments; 2) Getting Care Quickly – member experience when receiving care; and 3) Rating the Health Plan. The CAHPS summary rate results are compared to Medicaid benchmarks. The UM department participates on the member satisfaction team.

2. Provider

Annually, the Alliance surveys its providers for their experience with the plan's utilization management processes and services. A vendor employed by the plan contacts a sample of network providers by mail and/or internet. Among the survey questions, sx (6) questions ask providers to rate the plan on:

- Access to knowledgeable UM staff;
- Procedures for obtaining prior-authorization information;
- Timeliness for obtaining prior-authorization information;
- The Plan's facilitation/support of appropriate clinical care for patients;
- Degree to which the Plan covers and encourages preventive care and wellness. Alliance provider survey responses are benchmarked against other Medi-Cal/Medicaid plans that use the same vendor's survey.

Alliance conducts quantitative and qualitative analysis to identify areas for improvement. Outcomes of the assessments are presented to the UMC and HCQC to assist in identifying opportunities for improvement. If the analysis indicates that there are opportunities to improve experience with UM, Alliance UM Department participates

on the provider satisfaction team. Activities identified to improve the member and provider experience with UM are used to update the following years UM Program.

C. Grievances and Appeals

The Alliance maintains an effective member grievance and appeals (G&A) process that follows all regulatory, contractual and accreditation requirements. G&A is managed within Health Care Services, and complaints identified with clinical service needs are supported by UM Nurses and Physicians. Trending data for clinical appeals and fair hearings is reported to the UMC for the identification and recommendations of opportunities to improve the UM experience for members and providers. On a quarterly basis, the UM Department will review and analyze grievance data. The evaluation is reported to the UMC.

Appeal decisions are made by a practitioner who was not involved in the initial decision unless the case is overturned. A same-or similar specialist review is required for all appeals of medical necessity decisions. The details of the appeal process are outlined in The Alliance Appeals Policy and Procedure.

D. Potential Quality of Care/ Provider Preventable Reportable Conditions

At any time during an UM review, staff identify a condition or situation that appears to deviate from the professional standard of care or identified by regulatory guidance as a Potential Quality of Care or Provider Preventable Reportable Condition, are referred to the Quality Improvement Department to be evaluated per policy and procedure.

E. UM Delegation Activities

The Alliance delegates UM activities to provider groups, vendor networks and healthcare organizations that meet delegation agreement standards. The contractual agreements between the Alliance and delegated groups specify: the responsibilities of both parties; the functions or activities that are delegated; the frequency of reporting on those functions and responsibilities to the Alliance; how performance is evaluated; and corrective action plan expectations, if applicable. The Alliance conducts a pre- contractual evaluation of delegated functions to assure capacity to meet standards and requirements. The Alliance's Compliance Department is responsible for the oversight of delegated activities. The Compliance Department will work with other respective departments to conduct the annual delegation oversight audits. Delegate work plans, reports and evaluations are reviewed by the Alliance and the finding are summarized at HCQC and Compliance Committee meetings, as appropriate. The Compliance Department in conjunction with each respective department monitors the delegated functions of each delegate through reports and annual oversight audits.

As part of delegation responsibilities, delegated providers must:

- Develop, enact, and monitor a UM Program description that addresses all State, Federal, health plan and accreditation requirements;
- Provide encounter information and access to medical records pertaining to

Alliance members;

- Submit at least quarterly reports, annual evaluations, and program descriptions and work plans; and
- Cooperate with annual audits and complete any corrective actions necessary by the Alliance.
- Participate in performance improvement activities

F. Inter-Rater Reliability Testing

Inter-Rater Reliability (IRR) Testing is a method used at the Alliance to assess the degree of agreement among personnel who make utilization management decisions. It provides a score of how much homogeneity or consensus there is in responses to utilization management cases. The purpose is for The Alliance to provide consistency and accuracy of review criteria applied by all reviewers - physicians and non-physicians and to act on improvement opportunities identified through this testing. This report provides an analysis of The Alliance's testing for each year and fulfills regulatory, contractual and accreditation requirements associated with ensuring the consistency in applying UM criteria and acting on identified improvement opportunities.

IRR testing is conducted following The Alliance internal policy (QI-133 Inter-Rater Reliability—Testing for Clinical Decision Making) for UM, QM and Pharmacy staff that participates in the Health Services medical necessity decision making process. IRR test results are collated and reviewed by management.

Reports on IRR test results are reviewed and approved by the HCQC. The IRR process and reports are reviewed for delegated entities during the annual auditing process.

G. UM Department – Internal Quality Review

To ensure the oversight of the internal UM process, Alliance UM Department conducts ongoing auditing and monitoring of key operational areas to ensure compliance with all federal, state, regulatory, contractual and accreditation standards. Alliance UM Department has implemented a monitoring program for the early identification of potential compliance risks. In addition, the program includes an opportunity to provide quality oversight of the current UM processes. This is accomplished by internal monitoring of UM authorization files on a routine and/or periodic basis.

1. UM File Review

UM will complete file reviews using a defined methodology for the file selection. Files will be assessed to ensure compliance using the regulatory and accreditation requirements as well as to identify opportunities for process improvement. The process outcomes will also be utilized for staff performance. Elements of the review include, but are not limited to, ensuring the appropriate medical information is obtained, use of criteria, application of clinical decision making, and appropriate referral to physician

reviewers as needed. For cases that are denied or modified, the file will assess the NOA requirements for communication to the member and provider.

2. Audit of Authorization Processing Turn-Around-Time (TAT)

An authorization aging report is used to monitor TATs for authorizations. Any opened authorization without a final determination will appear in this report. The UM Manager or designee will work this report daily to ensure all authorization determinations are compliant with UM will complete file reviews using a defined methodology for the file selection. Files will be assessed to ensure compliance using the regulatory and accreditation requirements as well as to identify opportunities for process improvement.

H. Annual UM Workplan

Each year, The Alliance establishes objectives and priorities, and outlines a strategic UM Workplan for the coming year. The UM Workplan incorporates anticipated timeframes, responsible parties and status of activities. The UM Workplan is submitted to the UM Committee for approval annually. See Attachment B – 2020 UM Workplan.

I. Annual UM Evaluation

Members of the UM Program management team annually evaluate and update the UM Program to ensure the overall effectiveness of UM Program objectives, structure, scope and processes. The evaluation includes, at a minimum:

- Review of changes in staffing, reorganization, structure or scope of the program;
- Resources allocated to support the program;
- Review of completed and ongoing UM work plan activities;
- Assessment of performance indicators;
- Review of delegated arrangement activities; and
- Recommendations for program revisions and modifications

The UM Program management team presents a written program evaluation to the UMC and HCQC. The UMC and HCQC reviews and approves the UM Program evaluation on an annual basis. The review and revision of the UM program description may be conducted more frequently as deemed appropriate by the UMC, HCQC, CMO, CEO, or BOG.

The HCQC's recommendations for revision are incorporated into the UM Program description, as appropriate, which is reviewed and approved by the BOG and submitted to DHCS on an annual basis.

UM Program improvements for 2020

As a result of internal performance monitoring performed in 2019, opportunities for improvement were identified and will be incorporated into the 2020 department goals. Highlights of opportunities for improvement based on the regulatory findings include:

- Improve monitoring of network utilization (over/under), including out of network authorization requests particularly focus on the Stanford analysis.
- Improve monitoring of Specialty Referrals.
- Collaboration with The Alliance Compliance Department on the full implementation of the UM process for internal performance monitoring of UM decisions.
- Strengthen programs around oversight of clinical decision making, both internally and for Delegates.
- Continue the care transition program in partnership with Highland Hospital.
- Develop and refine the ADT feed coming from contracted hospitals to enhance communication and coordination of care.
- Analyze the opportunity and implement the process to increase the number of authorizations that are appropriate for automatic approval.
- Improve reporting and analysis of grievance and appeals activities related to UM decision making and analysis for member and provider experience with UM.
- Continue implementation for tracking and intervening with unused Authorizations to ensure that members receive appropriate care and follow up.
- Continue to monitor the Palliative Care benefit for members.
- Continue the analysis of hospital data and develop an individual hospital strategy for management of members for appropriate length of stay.
- Hardwire the standardized work and training for the UM department staff to ensure regulatory compliance.
- Hardwire a standard process for policy review and revision that ensures UM processes maintain operational and regulatory compliance.

Attachment A

2019 The Alliance Delegated Network or Vendor Relationships

Delegate	Provider Type		Delegated Activity - UM	Delegated Activity – Grievance and Appeals	Exceptions
Kaiser	HMO		X	X	
Alameda Health System	Delivery System		X	NA	

CHCN	Medical Group		X	NA	
CFMG	Medical Group		X	NA	
California Home Medical Equipment (CHME)	Vendor DME		X*	NA	* Not delegated for denials
Beacon/College Health IPA (CHIPA)	MBHO		X	NA	
Logisticare	Vendor - Transportation		NA	NA	* Not delegated for denials
March Vision	Vendor – Vision Services		NA	NA	

Attachment B – 2020 UM Work Plan

See attached document.

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
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2020

CULTURAL & LINGUISTIC SERVICES

PROGRAM DESCRIPTION

Cultural and Linguistic
Program Description

2020

2020 Cultural and Linguistic Services Program
Description Signature Page

Date _____

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

Date _____

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

Date _____

Scott Coffin
Chief Executive Officer

Date _____

Evan Seevak, M.D.
Board Chair

Alameda Alliance for Health
Cultural and Linguistic Services
Program Description 2020

Overview

The Alameda Alliance for Health (Alliance) is committed to delivering culturally and linguistically appropriate services (CLAS) to all eligible Medi-Cal and Group Care members. The Alliance's Cultural and Linguistic Services Program complies with Title VI of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, and 45 C.F.R. Part 80), the Patient Protection and Affordable Care Act, Section 1557 and with the Cultural and Linguistic Services requirements of the Alliance's contracts with the Department of Health Care Services (DHCS), (Exhibit A, Attachment 9. 12), and the Centers for Medicare and Medicaid Services.

The goal of the Cultural and Linguistic Services (C & L) Program is to ensure that all members receive equal access to high quality health care services that are culturally and linguistically appropriate. This includes ensuring culturally appropriate services and access for members regardless of level of English proficiency, disability, age, immigrant and refugee status, sexual orientation, gender or gender identity.

Program objectives include:

- Comply with state and federal guidelines related to assessment of enrollees in order to offer its members culturally and linguistically appropriate services.
- Provide no-cost language assistance services at all points of contact for covered benefits.
- Ensure that all staff, providers and subcontractors are compliant with the cultural and linguistic program through cultural competency training.
- Identify, inform and assist limited English proficiency (LEP) members in accessing quality interpretation services.
- Ensure that Alliance health care providers follow the Alliance C & L Services Program.
- Integrate community input into the development and implementation of Alliance cultural and linguistic accessibility standards and procedures.
- Monitor and continuously improve Alliance activities aimed at achieving cultural competence and reducing health care disparities.

The Work Plan for the C & L Program in Appendix A includes a timetable for implementation of activities related to meeting the program goal and objectives.

The Organizational Chart in Appendix B displays reporting relationships for the Alliance organization and identifies key staff with overall responsibility for the operation of the Cultural and Linguistic Services Program.

Departmental Roles

The **Quality Improvement Department** is responsible for developing, implementing and evaluating the Alliance's Cultural and Linguistic Services Program in coordination with other Alliance departments including Provider Services, Human Resources, Analytics and Performance, Member Services, Communications and Outreach, Quality Assurance, Vendor Management and Compliance. The Cultural and Linguistic Program is led by the Manager of Health Education. All participating persons/departments report ultimately to the Chief Executive Officer.

Health Education is a part of the Alliance's Quality Improvement Department. The Health Education Manager, in collaboration with aforementioned departments, develops the Cultural and Linguistic Services Program work plan and integrates information and resources on cultural competency into the Alliance's programs and services. The Health Education Manager also facilitates the Cultural and Linguistic Services Subcommittee (CLSS) of the Health Care Quality Committee which in turn reports to the Alliance Board of Governors. Health Education staff also ensure that health education materials are made available to members and providers and that these materials meet the literacy, cultural, linguistic, clinical and regulatory standards.

The Health Education Manager together with the Communications and Outreach Manager are responsible for supporting the Alliance Member Advisory Committee (see below for description) in accordance with Title 22, CCR, Section 53876 (c). There is administrative support staff as well assigned to the Member Advisory Committee.

Quality Improvement Specialists conduct member and provider surveys, and Quality Nurses conduct medical record and facility site reviews that monitor C&L requirement implementation at the provider office level and issue corrective action plans as needed.

The **Provider Services** department is responsible for ensuring that provider network composition continuously meets members' cultural and linguistic needs. Provider Services also trains providers on the Alliance Cultural and Linguistic program requirements. Language capabilities of clinicians and other provider office staff are identified during the credentialing process and providers update language capacity with the Alliance regularly.

The **Member Services** department assesses member cultural and linguistic needs at each contact by identifying and verifying language preferences, reported ethnicity and preference for use of interpreter services. Members are informed that they can access no cost oral interpretation in their preferred language and written materials translated into Alliance threshold languages or provided in alternative formats. Member Services also monitors call quality for Member Services Representatives ability to follow cultural and linguistic protocols.

The **Communications and Outreach** department is responsible for ensuring that marketing practices for eligible beneficiaries or potential enrollees do not discriminate due to race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability. In addition, they take into consideration results from member surveys and assessments, community feedback and other C&L monitoring activities when producing member materials.

Human Resources department is responsible for bilingual assessment of new staff who will use their bilingual skills with members. They maintain a listing of Alliance bilingual

staff and ensure quality monitoring of bilingual staff not monitored through the Member Services quality assurance program.

The **Quality Assurance** department supports the C&L program through monitoring and reporting of grievances grievances related to C&L services.

Compliance is responsible for conducting audits of the Alliance Cultural and Linguistic Services program, monitoring delegated C&L responsibilities and ensuring that all state and federal regulations are followed.

Vendor Management supports compliance oversight of language services vendors and implements corrective action plans as needed.

Community Advisory Committee

The **Community Advisory Committee** at the Alliance is known as the Member Advisory Committee (MAC). The MAC is supported by the Communications and Outreach Manager and Health Education Manager and their respective departments. The purpose of the Member Advisory Committee (MAC) is to provide a link between the Alliance and the community. The MAC advises the Alliance on the development and implementation of its cultural and linguistic accessibility standards and procedures. The committee's responsibilities include advising on cultural competency issues, and educational and operational issues affecting members, including seniors, people who speak a primary language other than English, and persons with disabilities. The MAC is comprised of Alliance members, community advocates, safety net providers, and at least one traditional provider.

The MAC provides input about members' cultural and linguistic needs and the Alliance cultural and linguistic access standards (CLAS) and procedures. The MAC enables the Alliance to maintain community partnerships with consumers, community advocates and traditional and safety net providers regarding CLAS. Alliance procedures ensure MAC involvement in policy decisions related to educational, operational and cultural competency decisions affecting groups that speak a primary language other than English.

Standards and Performance Requirements

The Alliance's policies and procedures comply with standards and performance requirements for the delivery of culturally and linguistically appropriate health care services. The Alliance has systems and processes to:

- Provide members access to no cost language assistance services at all points of contact, 24 hours a day, 7 days a week. Educate members and providers about the availability of language services and how to access them.

- Identify, ssess, and track linguistic capability of interpreters, bilingual employees and contracted staff in medical and non-medical settings.

- Conduct a Population Needs Assessment (PNA) according to the DHCS timeline to:
    - Identify member health needs and health disparities;

    - Evaluate health education, C&L, and quality improvement (QI) activities and available resources to address identified concerns; and
    - Implement targeted strategies for health education, C&L, and QI programs and services.9

- Provide cultural sensitivity and diversity training for staff, providers or subcontractors at key points of contact. Training will cover accessing language services, the Alliance cultural and linguistic program, importance of culturally sensitive care as well as working with identified cultural groups within the Alliance service areas including:
    - Members with limited English proficiency;
    - Diverse cultural and ethnic backgrounds;
    - Seniors and persons with disabilities;
    - Gender, sexual orientation and gender identities.

- Monitor and evaluate the Cultural and Linguistic Services Program and the performance of individuals providing linguistics services.

The program meets the standards detailed in the following Alliance Policies and Procedures:

- CLS-001 Cultural and Linguistic Services Program Description
- CLS-002 Cultural and Linguistic Services Program - Member Advisory Committee
- CLS-003 Cultural and Linguistic Services Program - Language Assistance Services
- CLS-008 Cultural and Linguistic Services Program - Enrollee Assessment
- CLS-009 Cultural and Linguistic Services Program – Contracted Providers
- CLS-010 Cultural and Linguistic Services Program - Staff Training
- CLS-011 Cultural and Linguistic Services Program – Compliance Monitoring

Alameda Alliance for Health
Cultural and Linguistic Services Program Work Plan 2020
Appendix A

Program	**Member Cultural and Linguistic Assessment**		
Goal	Assess the cultural and linguistic needs of plan enrollees.		
Rationale	**Quarterly Alliance CLSS Reports:** From 2018– 2019 there are no significant changes in demographics in the Alliance population.		
Lead Responsibility	Health Education Manager		
Performance Measure	Objective		
Complete quarterly CLSS reports	Create and review reports on Cultural and Linguistic needs of members at quarterly Cultural and Linguistic Subcommittee (CLSS).		
Major Activities		Timeline	Responsible Party
Collect member demographic information and track over time. Report on trends, discuss at the CLSS and Health Care Quality Committee (HCQC) of the Alliance Board of Governors and take action as needed.		By end of January, April, July, October 2020	Health Education Manager

Program	**Language Assistance Services**		
Goal	**Inform and assist Limited English Proficiency members in accessing quality interpretation services and translated written informing materials.**		
Rationale	**Quarterly Cultural and Linguistic Report Q4 2019:** 35% of members prefer to communicate with the plan in a non-English language. Of those, 33% speak threshold languages. **In 2019 average fill rate for in-person interpreter services** was 99.9% and **coverage** for 24/7 telephonic interpreting was 99.9%.		
Lead Responsibility	Health Education Manager		
Performance Measure	Objective		
Fulfillment rate in Quarterly Cultural and linguistic Reports.	Reach an average fulfillment rate of ninety-five percent (95%) or more of pre-appointment in-person interpreter requests during each quarter		
24/7 telephone interpreter coverage	Maintain 99.5% coverage for 24/7 telephonic interpreting throughout 2020.		
Major Activities		Timeline	Responsible Party(s)
Onboard new telephonic interpreting vendor to enhance coverage and video interpreting potential for interpreter services.		By March 31, 2020	Vendor Management Manager; Health Education Manager, Infrastructure Associate Director

Enforce 5 day advanced notice for in-person interpreter services so plan has sufficient time to schedule.	By March 31, 2020	Health Education Manager, Provider Services Manager.
Supporting Activities	Timeline	Responsible Party(s)
Inform members at all points of contact of availability of no cost Language Assistance Services (LAS) through newsletters, Evidence of Coverage (EOC), website, non-discrimination statements, significant communications/ publications, letters and flyers.	Ongoing	Health Education Manager; Directory, Provider Relations

Program	**Provider Language Capacity**
Goal	Ensure that Alliance health care providers follow the Alliance C & L Services Program and ensure interpreter access.
Rationale	**Q4 2019 Provider Language Capacity report:** All ratios were within the limit. Highest ratio was Arabic 1:666 followed by Vietnamese at 1:513. **Quarterly Cultural and Linguistic Report Q4 2019:** 35% of members prefer to communicate with the plan in a non-English language. Of those, 33% speak threshold languages. **FY2018 CAHPS Survey** adult responses to the question "Were you able to communicate with your doctor and clinic staff in your preferred language?" were 80.9% favorable for receiving a qualified interpreter through their doctor's office or health plan.
Lead Responsibility	Health Education Manager
Performance Measure	Objective
CG-CAHPS Survey	81% of adult members who need interpreter services will report receiving a non-family qualified interpreter through their doctor's office or health plan.
Provider Language Capacity Report	Maintain at minimum a 1 provider per 750 members' ratio for all languages with at least 1,000 members.

Major Activities	Timeline	Responsible Party(s)
Creation and distribution of "I Speak Cards" to providers/members to facilitate identification of interpreter needs.	By 3/31/2020	Health Education Specialist, Communications Staff
Supporting Activities	**Timeline**	**Responsible Party(s)**
Maintain language assistance program information in Provider Manual, New Provider Orientation, Member Handbook and member and provider webpages.	Ongoing	Health Education Manager; Communications and Outreach Manager
Monitor availability of providers who speak members' preferred languages at the Cultural and Linguistic Service Subcommittee.	By end of Jan, April, July, Oct 2020	Health Education Manager

Make available to providers up-to-date information on language needs of members through PCP member roster available on the Provider Portal.	Monthly update	Senior Business Analyst, IT
Maintain up-to-date information on provider language capacity in the on-line and printed provider directories.	Continual updates	Senior Business Analyst, IT

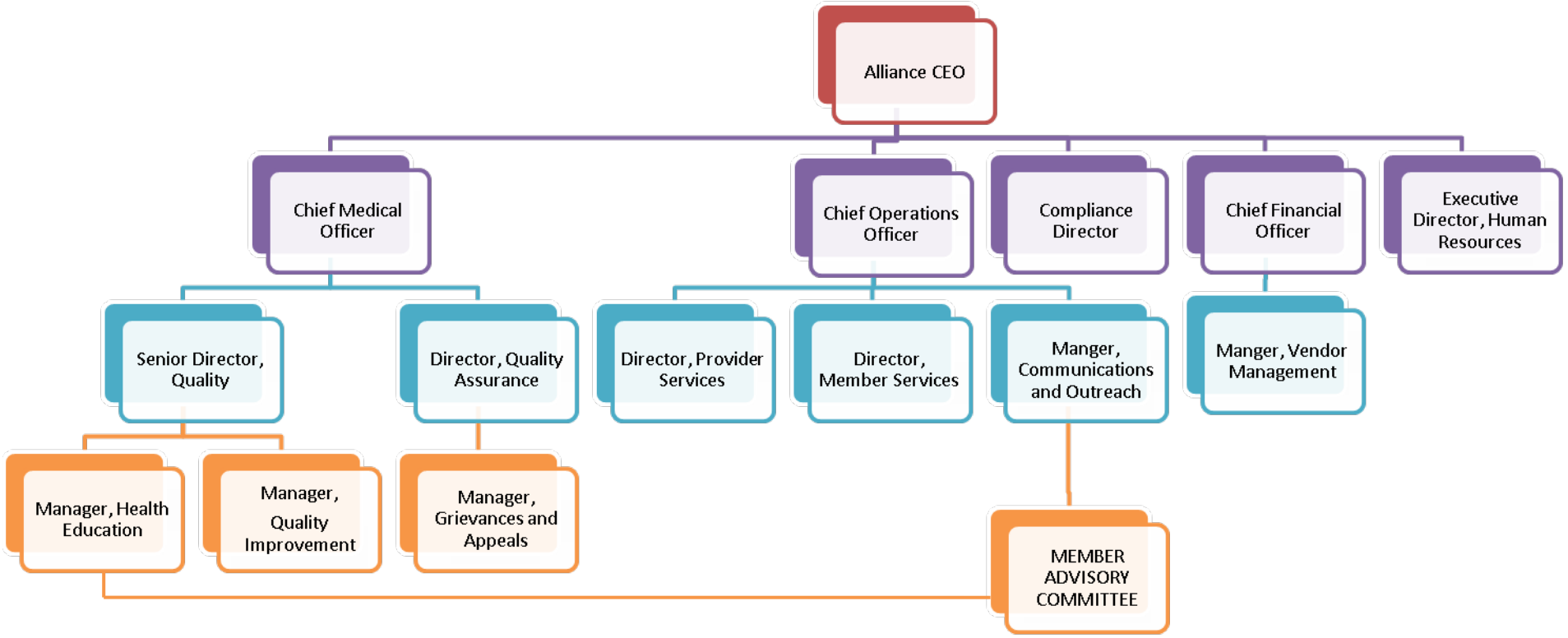
Program	**Staff and Provider Cultural Sensitivity Training**		
Goal	Ensure that all staff, providers and subcontractors are compliant with the cultural and linguistic program through cultural sensitivity training.		
Rationale	**Quarterly Cultural and Linguistic Report Q4 2019:** 35% of members prefer to communicate with the plan in a non-English language. Of those, 33% speak threshold languages. **2017 Immigration and Public Health: An Issue Brief ACPH:** 1 in 3 residents in Alameda County are immigrants, coming mostly from Asia (62%) and Latin America (26%). More than half the children in Alameda County have at least one parent born outside the U.S. **Annual Cultural Sensitivity Training AAH** Staff participation rate was 97% for 2019 and new hire participation rate was 100%.		
Lead Responsibility	Health Education Manager		
Performance Measure	Objective		
Compliance tracking of AAH staff participation in Cultural Sensitivity Training.	98% of Alliance staff (by April 30, 2020) and 100% of new staff (within 90 days of hire) will participate in the Cultural Sensitivity training.		
Provider Relations tracking of new provider orientation completion.	90% of new Providers will complete the New Provider Orientation, including the Cultural Sensitivity training and C&L processes within 90 days of becoming an Alliance provider.		
Major Activities		Timeline	Responsible Party(s)
Offer the Cultural Sensitivity training via webinar and in person to Alliance Staff within 90 days of hire and yearly thereafter.		By 4/1/2020 (yearly renewal)	Health Education Manager; Compliance Coordinator
Supporting Activities		Timeline	Responsible Party(s)
Post a provider version of the training online and promote with providers.		By 7/30/2020	Health Education Manager

Program	**Member Advisory Committee**		
Goal	Integrate community input into the development and implementation of Alliance cultural and linguistic accessibility standards and procedures.		
Rationale	**Member Advisory Meeting**– Member feedback requested more time to reflect on complex issues presented at the meeting and offer input.		
Rationale Category(s)	√ Contractual Topic ❒ GNA ❒ NCQA √ Quality Improvement		
Lead Responsibility	Health Education Manager		
Target Population	All Alliance staff		
Performance Measure	Objective		
MAC meeting minutes	Hold quarterly Member Advisory Committee meetings and provide opportunities for member input into C&L programs.		
Major Activities		Timeline	Responsible Party(s)
Recruit one Traditional Provider for the Member Advisory Committee.		By July 1, 2020.	Health Education Manager & Manager, Communications and Outreach
Supporting Activities		Timeline	Responsible Party(s)
Hold quarterly meetings of the MAC to participate in the public policy of the health plan and provide input on the Alliance cultural and linguistic services		March, June, September and December 2020.	Health Education Manager &Communications and Outreach Manager

Program	**Monitoring of Cultural and Linguistic Services**
Goal	**Monitor and continuously improve Alliance activities aimed at achieving cultural competence and reducing health care disparities.**
Rationale	**AAH Grievances Related C&L and Discrimination/Sensitivity Report Q4 19:** Lack of Language Accessibility grievances trended upward from Q1 – Q3 totaling 22, 24 and 34 respectively. This may be due to increased ability to capture member grievances.
Rationale Category(s)	√ Contractual Topic ❒ GNA ❒ NCQA √ Quality Improvement
Lead Responsibility	Health Education Manager
Performance Measure	Objective
CLSS Meeting Minutes	Meet regulatory compliance for monitoring quality of language assistance services.

Supporting Activities	Timeline	Responsible Party(s)
Monitor grievances, exempt grievances and Potential Quality Issues to identify concerns and areas of improvement in Cultural and Linguistic Services for investigation and resolution. Forward data or concern to appropriate department, provider, vendor or Joint Operations Meeting.	January, April, July and October.	Manager, Grievances and Appeals; Health Education Manager
Maintain listing of assessed bilingual employees and linguistic, their capacity as medical or non-medical interpreter and perform at minimum yearly review of bilingual capacity.	June 30, 2019 – yearly renewal.	Executive Director, Human Resources; Health Education Manager; Director, Member Services
Conduct facility site reviews re: C & L services including: 24 hour interpreter services, coverage of threshold services, documented capacity and training of bilingual medical and interpreter staff.	Complete review once every three years for Alliance PCPs.	Senior Facility Site Review Nurse
Monitor contracts with interpreter services. Establish CAPs when necessary	Quarterly JOM meetings	Manager, Vendor Management; Health Education Manager
Monitor vendors delegated for language services for quality of language services provided using the C&L Audit Tool.	Yearly review according to Compliance schedule.	Compliance Director and Health Education Manager

Alameda Alliance for Health Organizational Chart
Cultural and Linguistic Services
APPENDIX B


Alliance CEO
Chief Medical Officer
Chief Operations Officer
Compliance Director
Chief Financial Officer
Executive Director, Human Resources
Senior Director, Quality
Director, Quality Assurance
Director, Provider Services
Director, Member Services
Manger, Communications and Outreach
Manger, Vendor Management
Manager, Health Education
Manager, Quality Improvement
Manager, Grievances and Appeals
MEMBER ADVISORY COMMITTEE

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: **June 12, 2020**

Subject: **CEO Report**

- **APRIL & YEAR-TO-DATE OPERATING PERFORMANCE**
    - April net income reported is $164,000, and year-to-date $18.8 million net income; forecast to end the current fiscal year at $8.6 million.
        - Group Care year-to-date net loss is $628K.
    - Medi-Cal and Group Care enrollment exceeding 250,000 children & adults.
    - Tangible net equity is 625%, and excess reserves of nearly $168 million.
    - Core operating metrics are positive with exception to provider disputes and staffing vacancy.
    - Dissolution of the Alliance's Joint Power Authority.

- **PRELIMINARY BUDGET – FISCAL YEAR 2021**
    - Forecasted $26.8 million net loss, driven largely by rate reductions in the Medi-Cal line of business, higher enrollment and medical expenses.
    - DHCS announced the release of final Medi-Cal rates for calendar year 2020 in mid-September, and the final budget will be presented to the Alliance Board of Governors in November 2020.
    - CalAIM and long-term care initiatives excluded from the preliminary budget.
    - Operational readiness for the transition of pharmacy services on January 1, 2021; financial adjustments are included in the preliminary budget.

- **SHELTER IN PLACE & COVID-19 OPERATIONS**
    - Approximately 90% of staff are working remotely, and 10% at the corporate headquarters to maintain the facilities and core business functions.

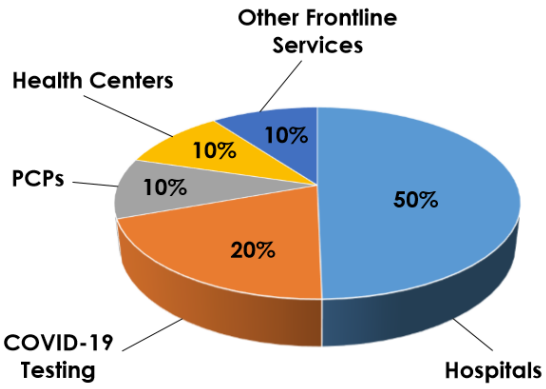
- "Return-to-Work" task force, comprised of staff from each division, to develop recommendations for employee safety and compliance with public health orders.
- Alliance's Incident Command Center coordinating efforts company-wide, and linked to community partners.

- **MEDI-CAL BENEFITS & ENROLLMENT**
  - Medi-Cal membership increased by almost 7,000 between March and May.
  - Forecast to increase Medi-Cal enrollment by additional 9,000 in FY 2021.
  - DHCS extended the delay period for processing of annual Medi-Cal redeterminations, and is delaying the discontinuances and negative actions for Medi-Cal and other state programs.
  - DHCS authorizing new long-term care at home through a State Plan Amendment (SPA) and 1915i Waiver.

- **STATE BUDGET**
  - Governor Newsom's May Revise results in a $54 billion deficit.
  - $14 billion in cuts that would take effect if Congress doesn't send more aid by July 1, referred to as the triggers (mechanisms used to limit impact to program funding).
  - Services for the older adults reinstated, adult day health and multi-purpose senior services programs, and other services (e.g. CBAS, MSSP, IHSS).
  - Cost savings attained through changes in benefits, eligibility, and rates.
  - Senate and Assembly budget subcommittees conclude their responses and scheduled to deliver to the Governor by June 15th.
  - Governor Newsom to approve or conduct line item veto by June 30th.
  - 1115 and 1915b waivers pending approval by CMS. 1115 waiver authorizes the extension of Whole Person Care "AC3" program, and the state budget funds the Health Homes Program (90/10 match).

- **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
  - Funding is paid month-to-month and this program may be terminated at any time by the Board of Governors.
  - Total of 30 applications received in the month of May, and 60% met eligibility requirements for this program.
  - 30% of the total funding ($5 million) is allocated for the month of May.
  - Approximately $4.2 million awarded, or 84% of the allocated dollar amount for the first month. The following dollar amounts were awarded to eligible entities:
    - COVID-19 Testing $1.0M
    - Public Hospital $2.5M
    - Health Center $300K
    - Primary Care Physician $255K
    - Other Safety-Net $115K

  - Allocation for the $16.6M in safety-net funding



EXECUTIVE DASHBOARD
JUNE 2020

ALAMEDA Alliance FOR HEALTH

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

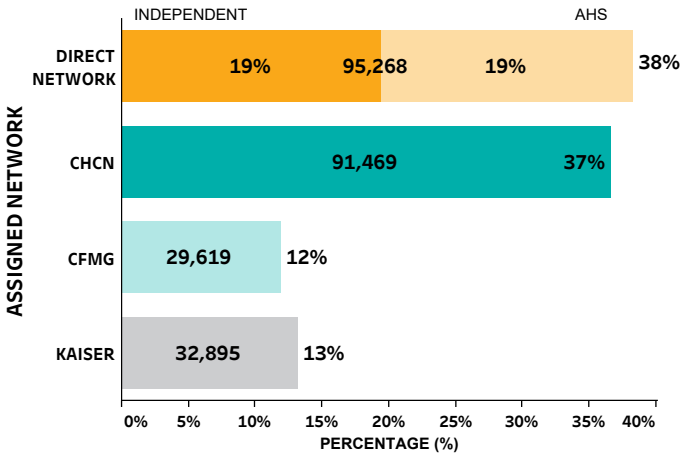
MEMBERSHIP**

249,251

TOTAL MEMBERSHIP

IHSS 6,148 **MEDI-CAL** 243,103

DISTRIBUTION OF ALL MEMBERSHIP BY ASSIGNED NETWORK**



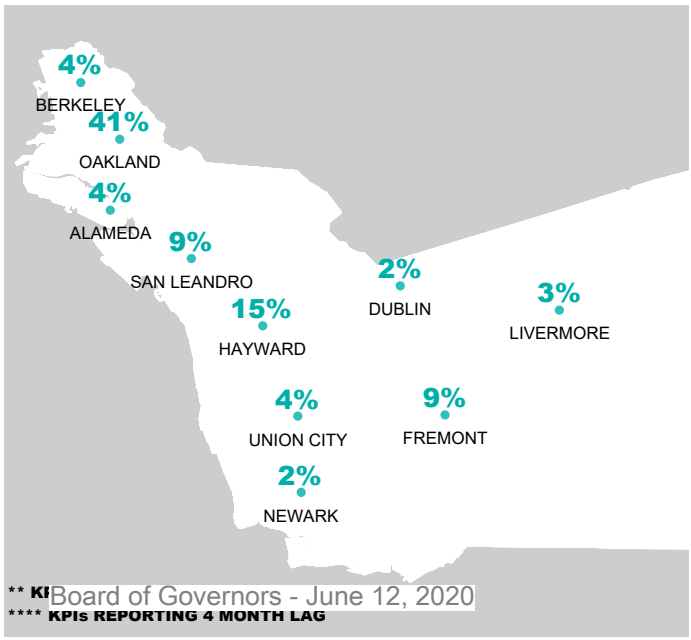
DISTRIBUTION OF MEMBERSHIP BY CITY**

92%

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

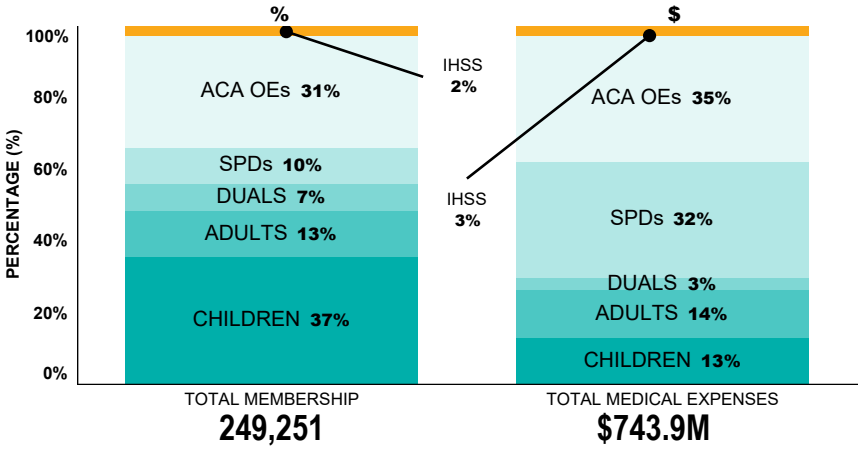
TEN CITIES

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



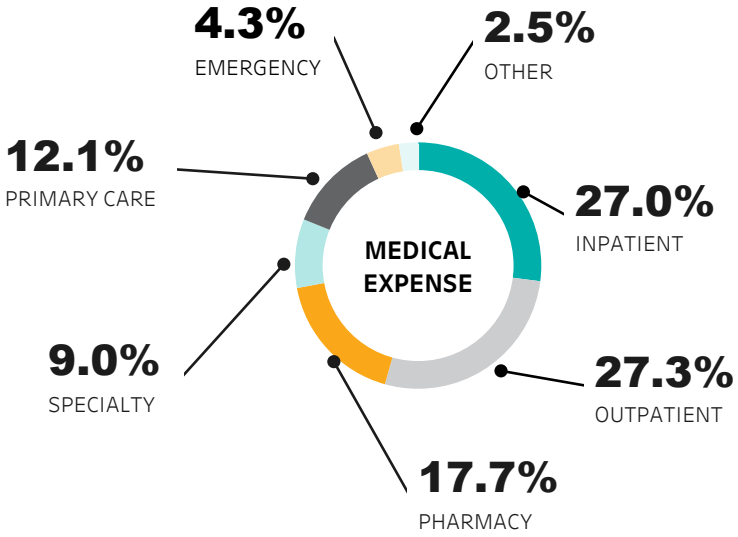
** KI
**** KPIs REPORTING 4 MONTH LAG

DISTRIBUTION OF MEDICAL EXPENSE BY MEMBERSHIP CATEGORY**



REVENUE & EXPENSES**

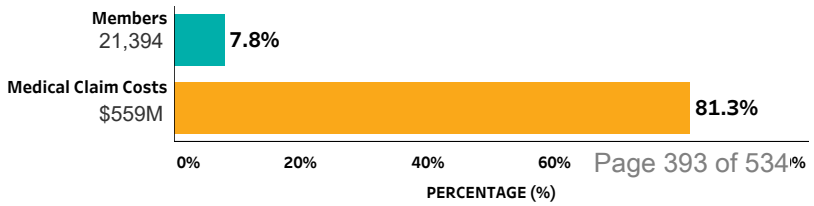
	APRIL 2020	FISCAL YTD
REVENUE	$71.8M	$804.0M
MEDICAL EXPENSE	($67.5M)	($743.9M)
ADMIN EXPENSE	($4.5M)	($44.8M)
OTHER	$342K	$3.6M
NET INCOME	**$164K**	**$18.8M**



TANGIBLE NET EQUITY**

625% $200M

HIGH UTILIZER DISTRIBUTION****



UTILIZATION**

3,743
INPATIENT BED DAYS

3,639
EMERGENCY ROOM VISITS

5.0 DAYS
AVERAGE LENGTH OF STAY

CASE AND DISEASE MANAGEMENT**

	NEW CASES	OPEN CASES
CARE COORDINATION	200	549
COMPLEX CASE MANAGEMENT	65	105
Total	265	654

	NEW CASES	ENROLLED
HEALTH HOMES	31	738
WHOLE PERSON CARE (AC3)	5	219
Total	36	957

TOTAL CASE MANAGEMENT

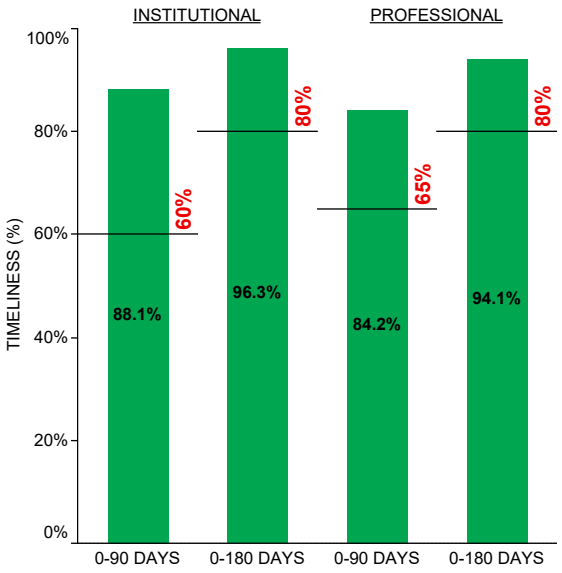
301
TOTAL NEW CASES

1,611
TOTAL OPEN CASES & ENROLLED

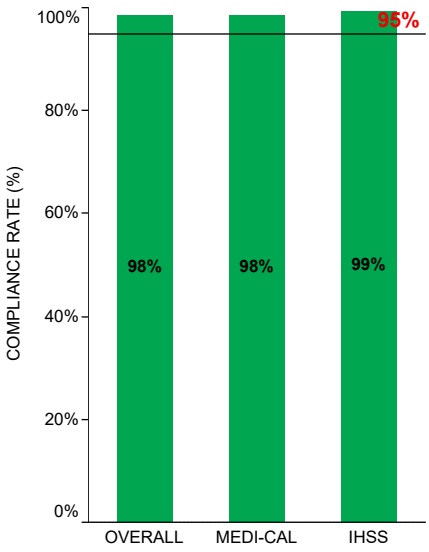
REGULATORY COMPLIANCE

ALL REGULATORY COMPLIANCE MEASURES ARE IN COMPLIANCE.

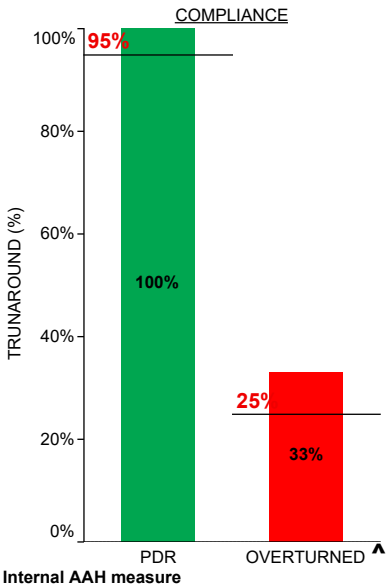
ENCOUNTER DATA



MEDICAL AUTHORIZATIONS



PROVIDER DISPUTES & RESOLUTIONS



^ For Internal AAH measure

CALL CENTER

9,893
CALLS RECEIVED

87%
ANSWERED IN 30 SECONDS

3%
CALLS ABANDONED

CLAIMS

95,946
PROCESSED CLAIMS

73.6%
AUTO ADJUDICATED

20 DAYS
PROCESSED PAYMENTS

STAFF & RECRUITING

318
TOTAL EMPLOYEES

3
HIRED IN THE LAST 30 DAYS

11%
CURRENT VACANCY

2019-2020 Legislative Tracking List

The following is a list of state legislation currently tracked by the Public Affairs Department that has been introduced during the 2019-2020 Legislative Session. This list of bills is of interest to and could have a direct impact on Alameda Alliance for Health and its membership.

This list includes bills that were introduced in 2019 and continue to move through the legislative process as 2-year bills as well as those that have been introduced thus far in the 2020 legislative session. This list also include COVID-19 related bills that were introduced in the 2020 legislative session.

Medi-Cal (Medicaid)

- **AB 683 (Carillo – D) Medi-Cal Eligibility**
  - **Status:** 1/30/2020-Read third time. Passed. Ordered to the Senate. In Senate. Read first time. To Committee on Rules for assignment.
  - **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:** 6/8/2020 – Read second time. Ordered to third reading.
  - **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:** 6/8/2020 – Read second time. Ordered to third reading.
  - **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:** 6/42020 – Coauthors revised. Read second time. Ordered to third reading.
  - **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:** 6/42020 – Coauthors revised. Read second time. Ordered to third reading.
  - **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:** 3/4/2020 – Re-referred to Committee on Health
  - **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:** 6/4/2020 – Read second time. Ordered to third reading.
  - **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:** 3/2/2020 – Referred to Committee on HEALTH
  - **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:** 6/8/2020 Read second time. Ordered to third reading.
  - **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:** 6/3/2020 In committee: Held under submission.
  - **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:** 3/16/2020 From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time and amended and re-referred to committee on Budget.
  - **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 Education Finace: 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. Pursuant to Assembly Rule 96.
  - **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:** 6/8/2020 – Read second time. Ordered to third reading.
  - **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:** 6/3/2020 – Set for hearing June 9.

- **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:** 6/3/2020 – Set for hearing June 9.
  - **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:** 6/8/2020 – From committee. Be ordered second reading pursuant to Senate Rule 28.8 and ordered to consent calendar.
  - **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:** 6/8/2020 – Read third time. Passed. Ordered to Senate.
  - **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:** 6/4/2020 – Read second time. Ordered to third reading.

- **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:** 6/3/2020 – In committee: Held under submission.
  - **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:** 6/8/2020 – Read second time. Ordered to third reading.
  - **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:** 6/8/2020 – Read second time. Ordered to third reading.
  - **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:** 6/3/2020 – Set for hearing June 9.
  - **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:** 6/3/2020 – Set for hearing June 9.
  - **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

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: **June 12, 2020**

Subject: **Finance Report**

Executive Summary

- For the month ended April 30, 2020, the Alliance had enrollment of 249,251 members, a Net Income of $164,000 and 625% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$71,791	$803,974
Medical Expense	67,464	743,910
Admin. Expense	4,504	44,812
Other Inc. / (Exp.)	342	3,589
Net Income	**$164**	**$18,842**

Net Income by Program:

	Month	YTD
Medi-Cal	$180	$19,485
Group Care	(15)	(643)
	$164	**$18,842**

Enrollment

- Total enrollment increased by 2,344 members since March 2020.
- Total enrollment decreased by 9,134 members since June 2019.

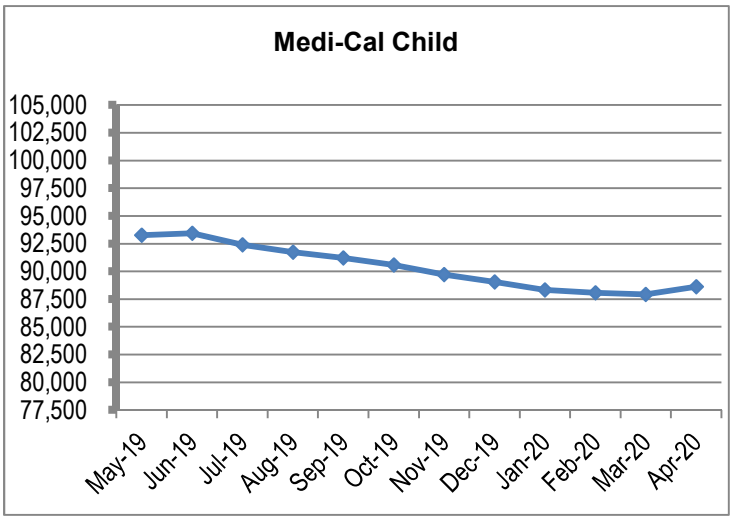
Monthly Membership and YTD Member Months

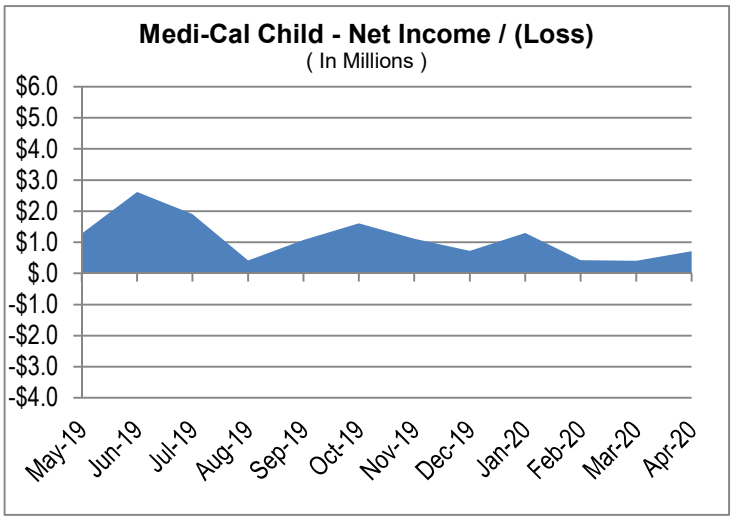
Actual vs. Budget

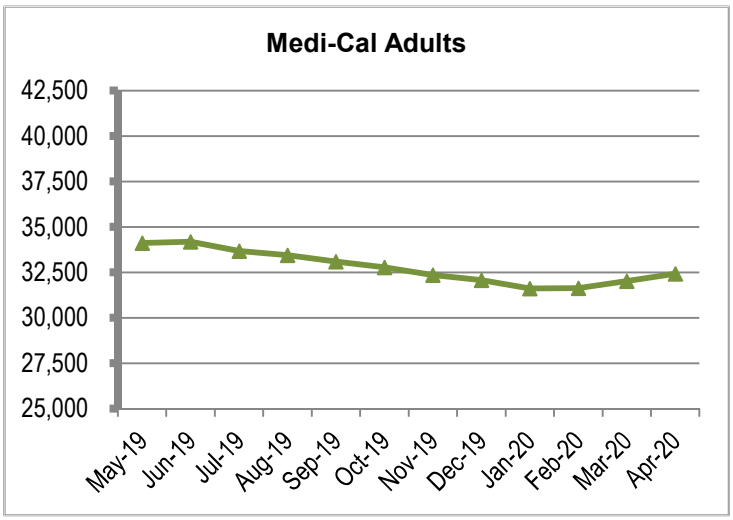
For the Month and Fiscal Year-to-Date

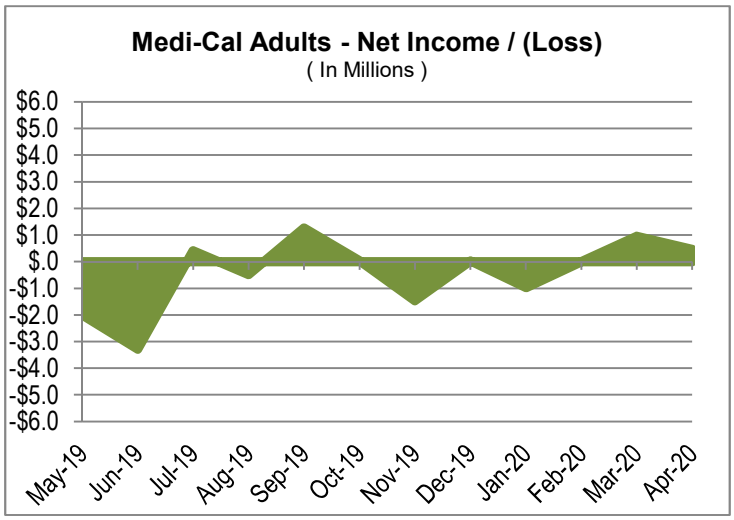
Enrollment					Member Months			
April-2020					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
32,423	32,673	(250)	-0.8%	Adults	325,102	331,945	(6,843)	-2.1%
88,633	89,660	(1,027)	-1.1%	Child	897,680	910,921	(13,241)	-1.5%
25,894	25,039	855	3.4%	SPD	257,509	254,393	3,116	1.2%
17,858	17,104	754	4.4%	Duals	177,567	173,776	3,791	2.2%
78,295	79,084	(789)	-1.0%	ACA OE	789,455	801,765	(12,310)	-1.5%
243,103	**243,560**	**(457)**	**-0.2%**	**Medi-Cal Total**	**2,447,313**	**2,472,800**	**(25,487)**	**-1.0%**
6,148	5,976	172	2.9%	Group Care	60,553	59,760	793	1.3%
249,251	**249,536**	**(285)**	**-0.1%**	**Total**	**2,507,866**	**2,532,560**	**(24,694)**	**-1.0%**

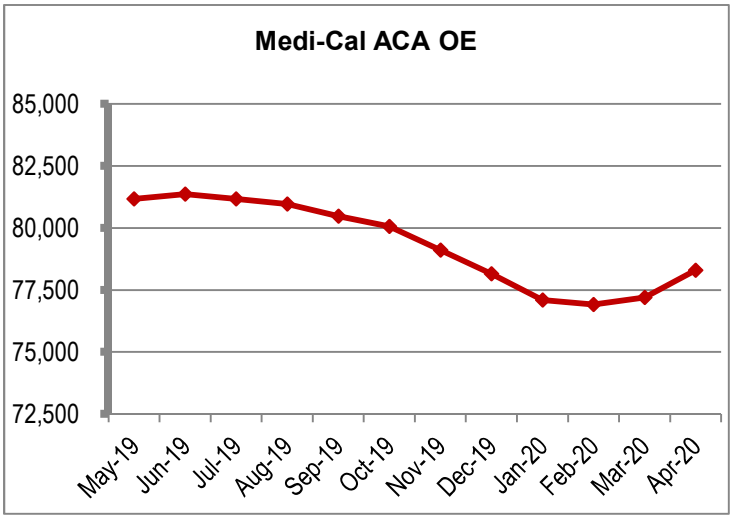
Enrollment and Profitability by Program and Category of Aid

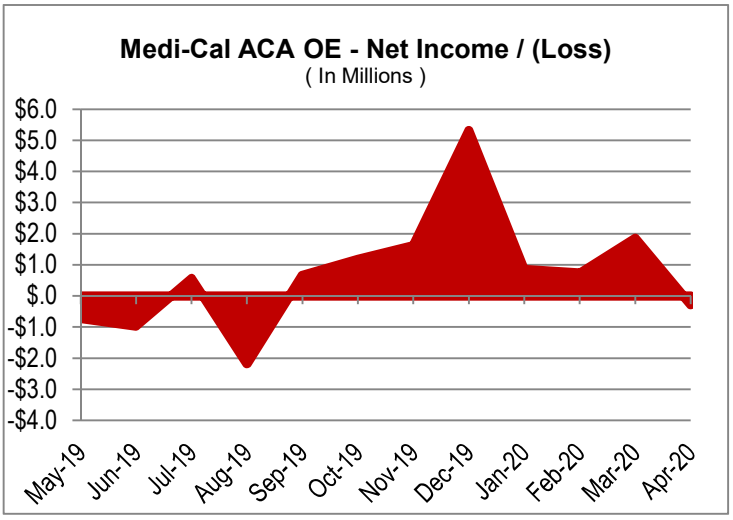




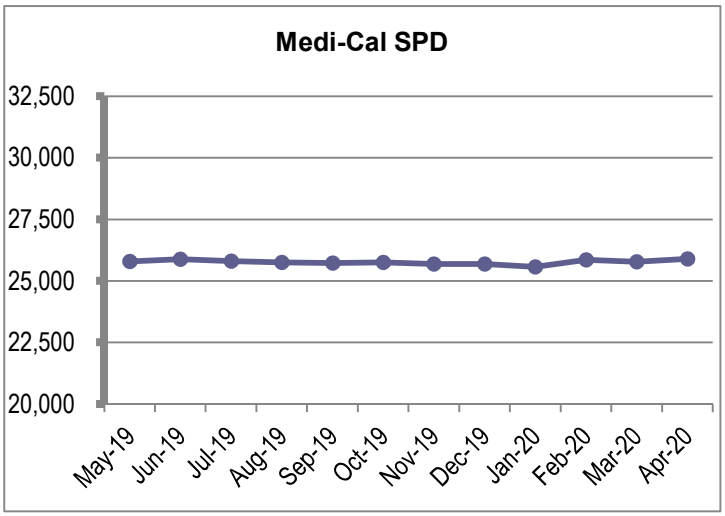


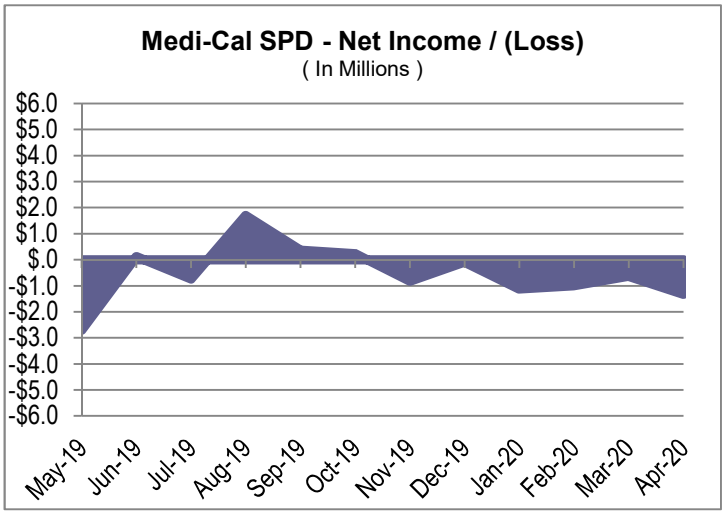


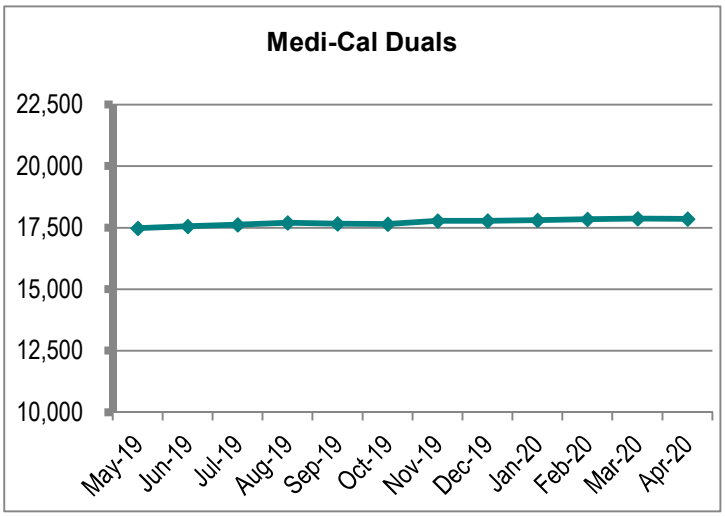


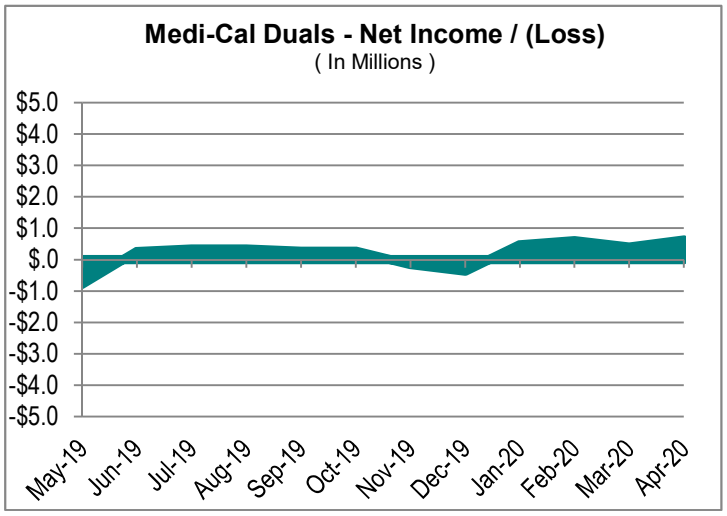


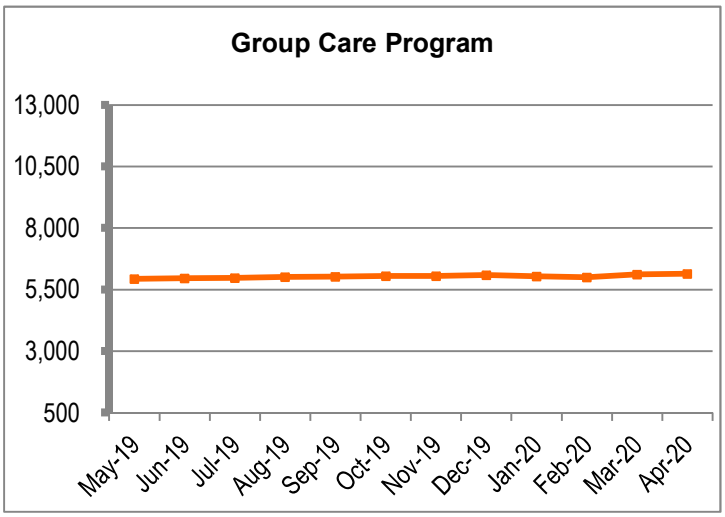
Enrollment and Profitability by Program and Category of Aid

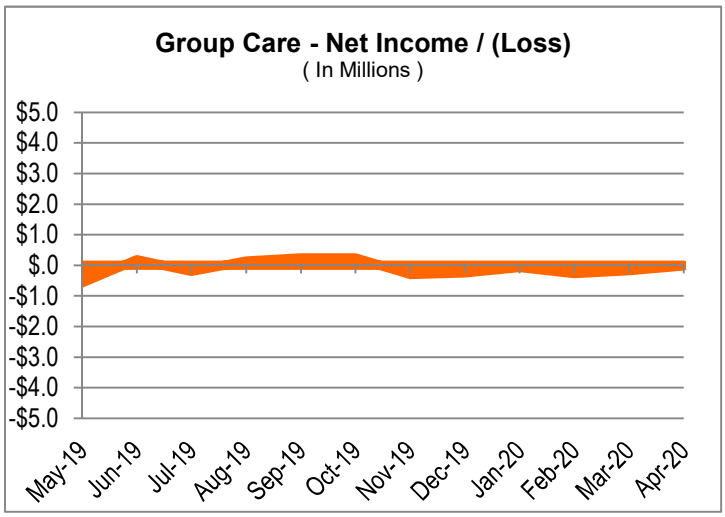








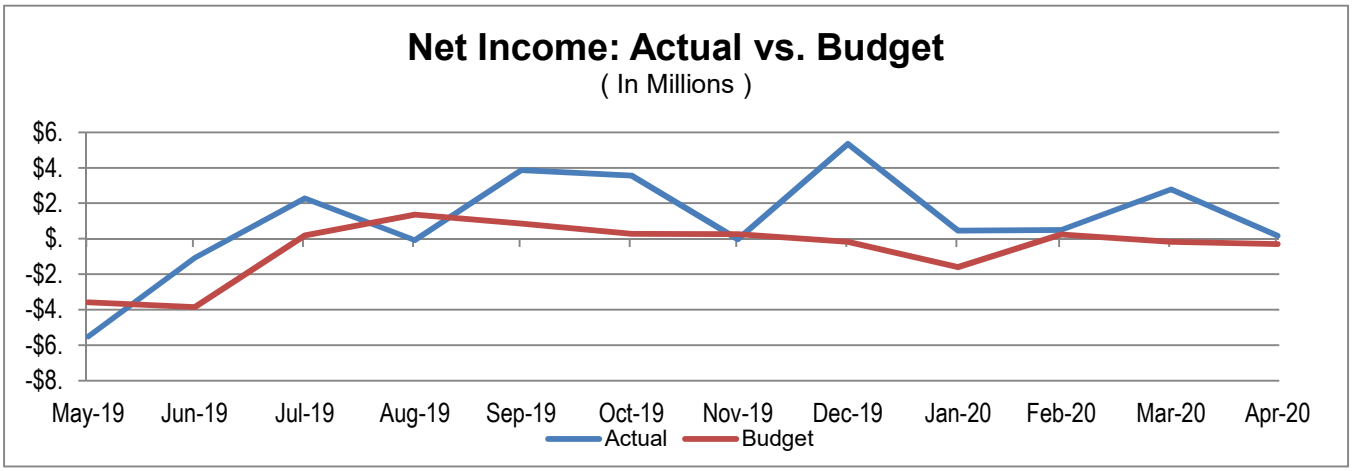




Net Income

- For the month ended April 30, 2020:
  - Actual Net Income: $164,000
  - Budgeted Net Loss: $299,000

- For the year-to-date (YTD) ended April 30, 2020:
  - Actual YTD Net Income: $18.8 million.
  - Budgeted YTD Net Income: $3.0 million.

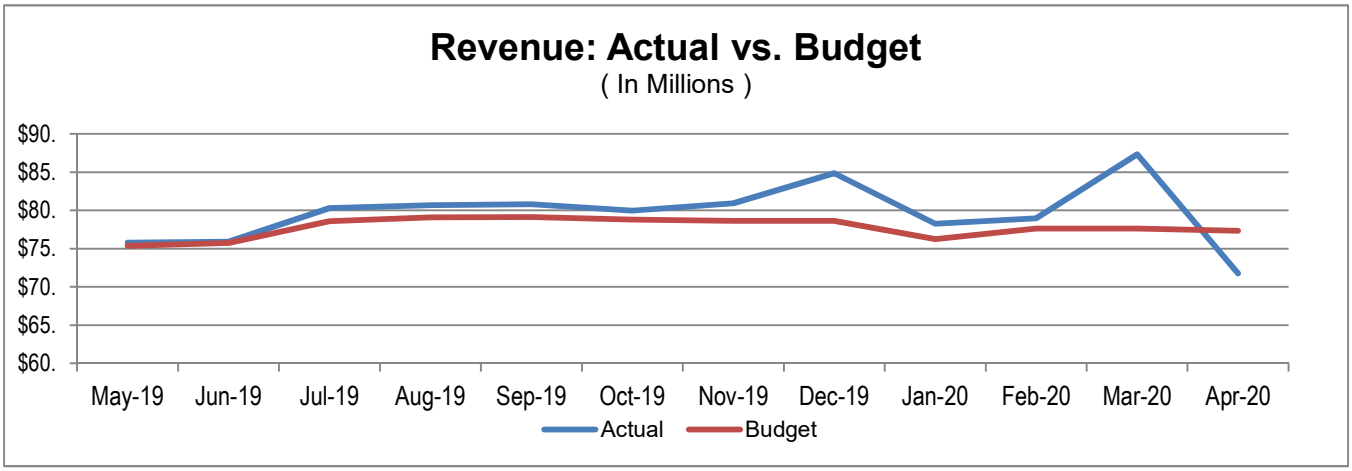


- The favorable variance of $463,000 in the current month is due to:
  - Unfavorable $5.5 million lower than anticipated Revenue.
  - Favorable $5.4 million lower than anticipated Medical Expense.
  - Favorable $626,000 lower than anticipated Administrative Expense.
  - Favorable $12,000 higher than anticipated Other Income & Expense.

Revenue

- For the month ended April 30, 2020:
  - Actual Revenue: $71.8 million.
  - Budgeted Revenue: $77.3 million.

- For the fiscal year-to-date ended April 30, 2020:
  - Actual YTD Revenue: $804.0 million.
  - Budgeted YTD Revenue: $783.5 million.

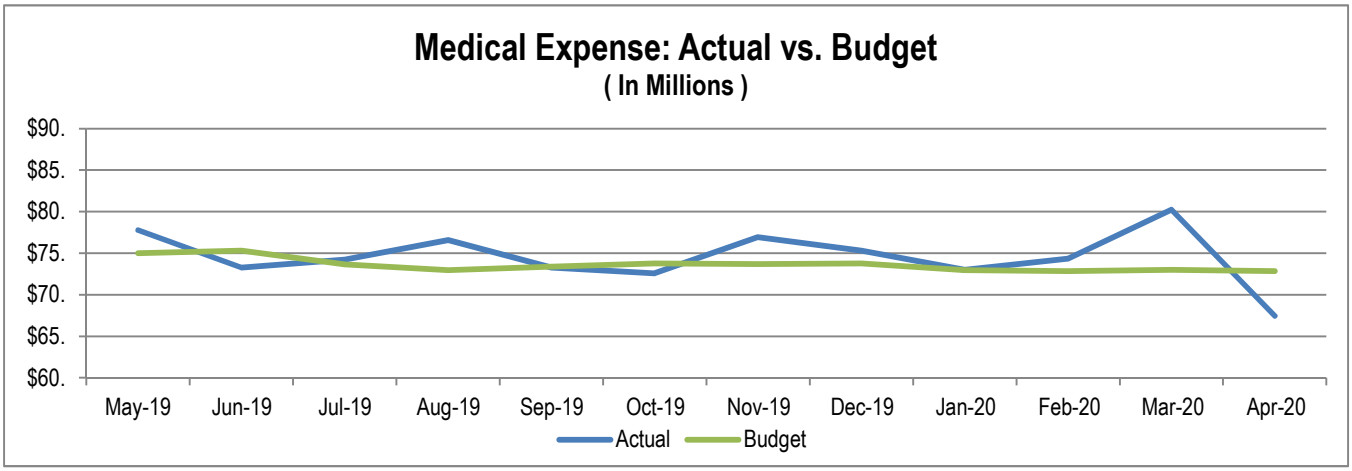


- For the month ended April 30, 2020, the unfavorable revenue variance of $5.5 million is mainly due to:
    - Unfavorable $8.4 million in lower than expected base capitation revenue due to $10 million unfavorable adjustment relating to newly announced DHCS 1.5% rate reduction effective retroactively to July 2019.
    - Favorable $1.5 million in higher than expected Prop 56 Revenue. This revenue will be largely offset by enhanced payments to qualified Providers.
    - Favorable $830,000 in higher than expected Behavioral Health Therapy Supplemental payments due to higher utilization.
    - Favorable $546,000 in higher than expected Ground Emergency Medical Transportation.

Medical Expense

- For the month ended April 30, 2020:
    - Actual Medical Expense: $67.5 million.
    - Budgeted Medical Expense: $72.8 million.

- For the fiscal year-to-date ended April 30, 2020:
    - Actual YTD Medical Expense: $743.9 million.
    - Budgeted YTD Medical Expense: $733.4 million.



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

- For April, updates to Fee-For-Service (FFS) increased the estimate for unpaid Medical Expenses for prior months by $782,000. Year-to-date, the estimate for prior years increased by $1.8 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	$173,250,195	$0	$173,250,195	$171,810,371	($1,439,824)	-0.8%
Primary Care FFS	46,440,544	198,663	46,639,207	29,740,417	($16,700,127)	-56.2%
Specialty Care FFS	36,539,798	685,323	37,225,121	38,206,498	$1,666,700	4.4%
Outpatient FFS	71,400,671	611,001	72,011,672	72,296,454	$895,783	1.2%
Ancillary FFS	30,459,731	566,535	31,026,266	31,456,544	$996,813	3.2%
Pharmacy FFS	130,232,342	1,750,936	131,983,278	131,166,206	$933,864	0.7%
ER Services FFS	31,595,029	448,286	32,043,315	32,250,395	$655,366	2.0%
Inpatient Hospital & SNF FFS	203,652,389	(2,453,118)	201,199,271	206,331,845	$2,679,455	1.3%
Other Benefits & Services	17,907,497	0	17,907,497	18,384,421	$476,924	2.6%
Net Reinsurance	(209,898)	0	(209,898)	919,092	$1,128,990	122.8%
Provider Incentive	833,583	0	833,583	833,582	($1)	0.0%
	$742,101,880	**$1,807,626**	**$743,909,506**	**$733,395,825**	**($8,706,056)**	**-1.2%**

Medical Expense - Actual vs. Budget (Per Member Per Month) Adjusted to Eliminate the Impact of Prior Year IBNP Estimates						
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Excluding IBNP Change	Change in IBNP	Reported		$	%
Capitated Medical Expense	$69.08	$0.00	$69.08	$67.84	($1.24)	-1.8%
Primary Care FFS	18.52	0.08	18.60	11.74	(6.77)	-57.7%
Specialty Care FFS	14.57	0.27	14.84	15.09	0.52	3.4%
Outpatient FFS	28.47	0.24	28.71	28.55	0.08	0.3%
Ancillary FFS	12.15	0.23	12.37	12.42	0.28	2.2%
Pharmacy FFS	51.93	0.70	52.63	51.79	(0.14)	-0.3%
ER Services FFS	12.60	0.18	12.78	12.73	0.14	1.1%
Inpatient Hospital & SNF FFS	81.21	(0.98)	80.23	81.47	0.27	0.3%
Other Benefits & Services	7.14	0.00	7.14	7.26	0.12	1.6%
Net Reinsurance	(0.08)	0.00	(0.08)	0.36	0.45	123.1%
Provider Incentive	0.33	0.00	0.33	0.33	(0.00)	-1.0%
	$295.91	**$0.72**	**$296.63**	**$289.59**	**($6.32)**	**-2.2%**

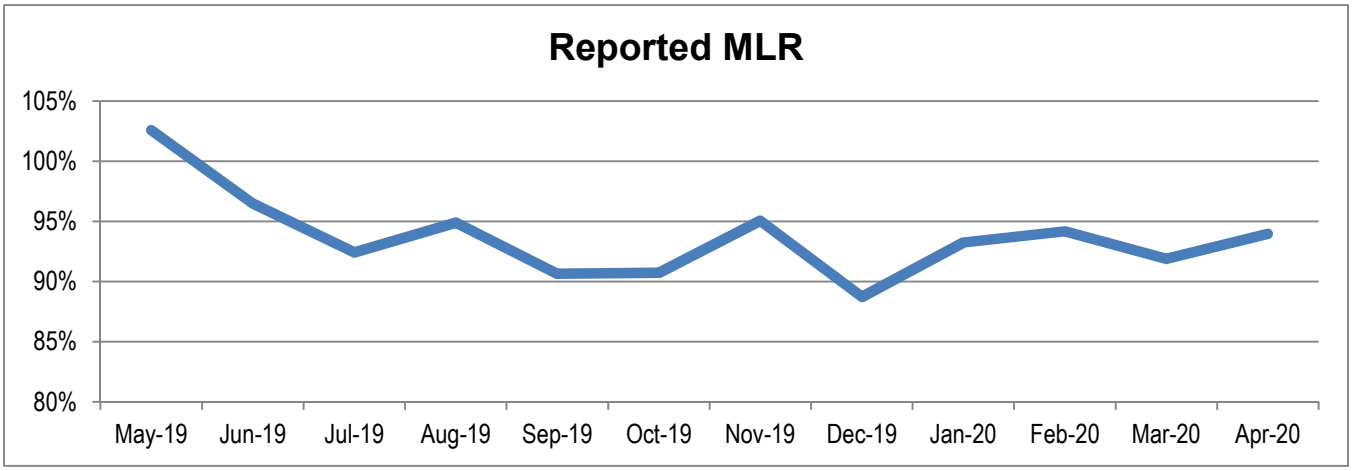
- Excluding the effect of prior year estimates for IBNP, year-to-date medical expense variance is $8.7 million unfavorable to budget. On a PMPM basis, medical expense is unfavorable to budget by 2.2%.
    - Primary Care Expense is over budget due to the implementation of four new Prop 56 Add-on programs. There is a revenue offset for these expenses.
    - Capitated Expense is over budget due to increased non-medical transportation spending.
    - Specialty Care is lower than budget for all populations due to lower utilization and unit cost.
    - Ancillary Expense is lower than budget. Favorability in the Other Medical Professional, Fee-for-service Transportation, CBAS, and Hospice categories is offset by higher utilization in the Other Medical Supplies, Home Health, and DME categories.
    - Inpatient Expense is close to budget. An increase in hospital days per thousand was offset by lower than planned cost-per-day. Higher costs for the Expansion, Adults and Duals categories of aid have offsets in savings in other populations.
    - 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 offset by higher than planned expense for drugs delivered in an outpatient setting, particularly for the SPDs.

- Outpatient Expense is over budget:
  - Behavioral Health: unfavorable due to double digit increases in unit cost, offset by slightly favorable 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.
  - Facility-Other: favorable unit cost and utilization.
- Net Reinsurance is favorable due to timing of recoveries from prior year.

Medical Loss Ratio (MLR)

- The Medical Loss Ratio (total reported medical expense divided by operating revenue) was 94.0% for the month and 92.5% for the fiscal year-to-date.



Administrative Expense

- For the month ended April 30, 2020:
  - Actual Administrative Expense: $4.5 million.
  - Budgeted Administrative Expense: $5.1 million.

- For the fiscal year-to-date ended April 30, 2020:
  - Actual YTD Administrative Expense: $44.8 million.
  - Budgeted YTD Administrative Expense: $50.4 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 %
$2,543,873	$2,710,788	$166,915	6.2%	Employee Expense	$23,506,315	$25,656,451	$2,150,137	8.4%
513,693	562,759	49,066	8.7%	Medical Benefits Admin Expense	5,650,612	5,708,696	58,084	1.0%
454,281	678,473	224,192	33.0%	Purchased & Professional Services	5,909,920	8,066,321	2,156,401	26.7%
992,336	1,178,113	185,776	15.8%	Other Admin Expense	9,744,967	10,998,723	1,253,755	11.4%
$4,504,184	$5,130,133	$625,949	12.2%	Total Administrative Expense	$44,811,814	$50,430,191	$5,618,377	11.1%

- The year-to-date favorable variance is primarily due to:
    - Delay in new staff hiring.
    - 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 6.3% of net revenue for the month and 5.6% of net revenue for the year-to-date.

Other Income / (Expense)

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

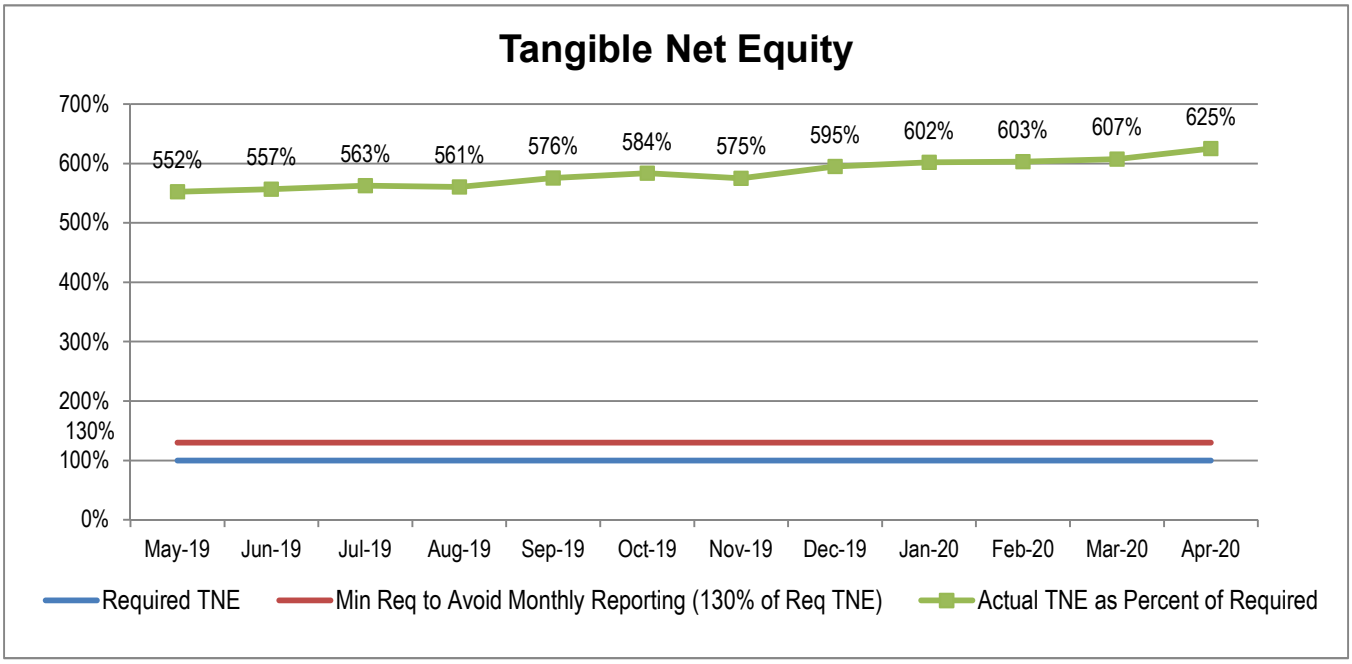
- Fiscal year-to-date interest income from investments is $4.0 million.

- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims or recalculated interest on previously paid claims is $266,000.

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.

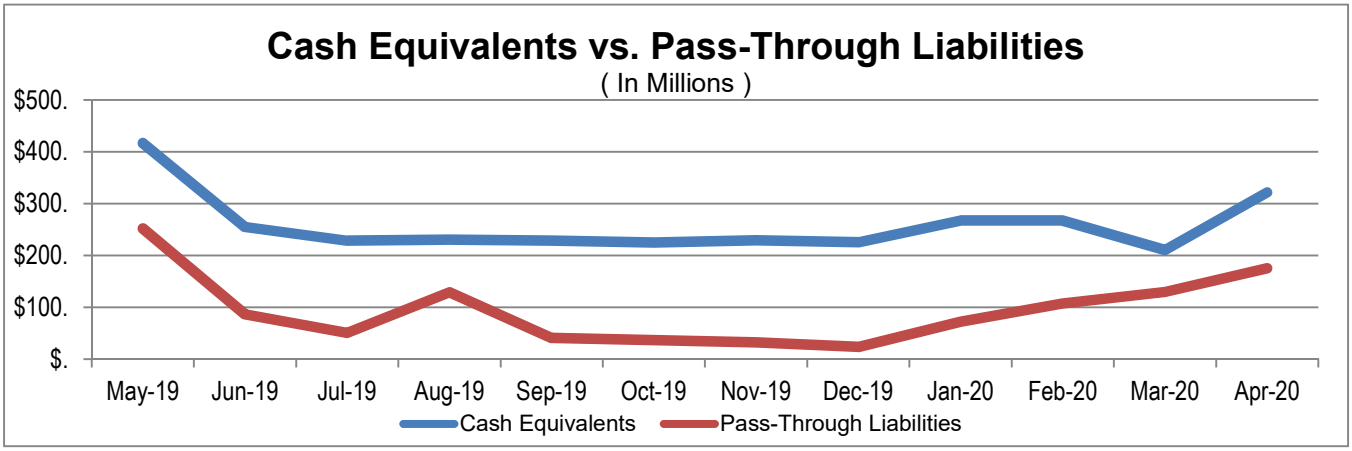
    - Required TNE $31.9 million
    - Actual TNE $199.6 million
    - Excess TNE $167.7 million
    - TNE as % of Required TNE 625%



- 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
  - Cash & Cash Equivalents $321.4 million
  - Pass-Through Liabilities $175.4 million
  - Uncommitted Cash $146.0 million
  - Working Capital $189.4 million
  - Current Ratio 1.66 (regulatory minimum is 1.0)



Capital Investment

- Fiscal year-to-date Capital assets acquired: $852,000.
- 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 April 30, 2020

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				MEMBERSHIP				
243,103	243,560	(457)	(0.2%)	1 - Medi-Cal	2,447,313	2,472,800	(25,487)	(1.0%)
6,148	5,976	172	2.9%	2 - Group Care	60,553	59,760	793	1.3%
249,251	**249,536**	**(285)**	**(0.1%)**	**3 - Total Member Months**	**2,507,866**	**2,532,560**	**(24,694)**	**(1.0%)**
				REVENUE				
$71,791,340	**$77,329,386**	**($5,538,046)**	**(7.2%)**	**4 - TOTAL REVENUE**	**$803,974,043**	**$783,511,828**	**$20,462,215**	**2.6%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses:				
17,534,171	17,033,770	(500,401)	(2.9%)	5 - Capitated Medical Expense	173,250,196	171,810,385	(1,439,811)	(0.8%)
				Fee for Service Medical Expenses:				
16,824,292	20,338,671	3,514,379	17.3%	6 - Inpatient Hospital & SNF FFS Expense	201,199,269	206,331,845	5,132,576	2.5%
4,172,837	2,928,171	(1,244,666)	(42.5%)	7 - Primary Care Physician FFS Expense	46,639,207	29,740,416	(16,898,791)	(56.8%)
2,425,663	3,780,338	1,354,675	35.8%	8 - Specialty Care Physician Expense	37,225,122	38,206,496	981,374	2.6%
3,176,693	3,060,846	(115,847)	(3.8%)	9 - Ancillary Medical Expense	31,026,267	31,456,545	430,278	1.4%
5,238,510	7,300,662	2,062,152	28.2%	10 - Outpatient Medical Expense	72,011,668	72,296,455	284,787	0.4%
3,012,808	3,190,700	177,892	5.6%	11 - Emergency Expense	32,043,314	32,250,395	207,081	0.6%
13,123,424	13,040,094	(83,330)	(0.6%)	12 - Pharmacy Expense	131,983,278	131,166,205	(817,073)	(0.6%)
47,974,226	53,639,482	5,665,256	10.6%	13 - Total Fee for Service Expense	552,128,127	541,448,357	(10,679,770)	(2.0%)
1,791,830	2,012,333	220,504	11.0%	14 - Other Benefits & Services	17,907,497	18,384,421	476,924	2.6%
81,047	58,156	(22,891)	(39.4%)	15 - Reinsurance Expense	(209,897)	919,093	1,128,990	122.8%
83,209	83,208	(1)	0.0%	16 - Risk Pool Distribution	833,583	833,580	(3)	0.0%
67,464,482	**72,826,949**	**5,362,467**	**7.4%**	**17 - TOTAL MEDICAL EXPENSES**	**743,909,504**	**733,395,836**	**(10,513,668)**	**(1.4%)**
4,326,858	**4,502,437**	**(175,579)**	**(3.9%)**	**18 - GROSS MARGIN**	**60,064,539**	**50,115,992**	**9,948,547**	**19.9%**
				ADMINISTRATIVE EXPENSES				
2,543,873	2,710,788	166,915	6.2%	19 - Personnel Expense	23,506,315	25,656,451	2,150,137	8.4%
513,693	562,759	49,066	8.7%	20 - Benefits Administration Expense	5,650,612	5,708,696	58,084	1.0%
454,281	678,473	224,192	33.0%	21 - Purchased & Professional Services	5,909,920	8,066,321	2,156,401	26.7%
992,336	1,178,113	185,776	15.8%	22 - Other Administrative Expense	9,744,967	10,998,723	1,253,755	11.4%
4,504,184	**5,130,133**	**625,949**	**12.2%**	**23 -Total Administrative Expense**	**44,811,814**	**50,430,191**	**5,618,377**	**11.1%**
(177,326)	**(627,696)**	**450,370**	**71.7%**	**24 - NET OPERATING INCOME / (LOSS)**	**15,252,725**	**(314,199)**	**15,566,924**	**4,954.5%**
				OTHER INCOME / EXPENSE				
341,609	**329,167**	**12,442**	**3.8%**	**25 - Total Other Income / (Expense)**	**3,589,228**	**3,354,765**	**234,463**	**7.0%**
$164,283	**($298,529)**	**$462,812**	**155.0%**	**26 - NET INCOME / (LOSS)**	**$18,841,952**	**$3,040,566**	**$15,801,386**	**519.7%**
6.3%	6.6%	0.4%	5.4%	27 - Admin Exp % of Revenue	5.6%	6.4%	0.9%	13.4%

ALAMEDA ALLIANCE FOR HEALTH
SUMMARY BALANCE SHEET 2020
CURRENT MONTH VS. PRIOR MONTH
April 30, 2020

	April	March	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	$17,693,108	$23,290,991	($5,597,883)	-24.03%
Short-Term Investments	303,689,274	187,330,343	116,358,931	62.11%
Interest Receivable	28,617	55,710	(27,094)	-48.63%
Other Receivables - Net	144,110,406	224,948,880	(80,838,474)	-35.94%
Prepaid Expenses	5,162,974	4,455,437	707,537	15.88%
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	**475,296,890**	**444,693,873**	**30,603,017**	**6.88%**
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	9,576,631	9,576,631	0	0.00%
Furniture And Equipment	14,289,491	14,082,570	206,920	1.47%
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	41,614,473	41,407,553	206,920	0.50%
Less: Accumulated Depreciation	(31,820,428)	(31,635,813)	(184,615)	0.58%
NET PROPERTY AND EQUIPMENT	**9,794,045**	**9,771,740**	**22,305**	**0.23%**
TOTAL ASSETS	**$485,440,935**	**$454,815,613**	**$30,625,322**	**6.73%**
CURRENT LIABILITIES:				
Accounts Payable	$3,646,431	$2,728,602	$917,828	33.64%
Pass-Through Liabilities	175,429,137	129,523,303	45,905,834	35.44%
Claims Payable	19,667,308	21,009,956	(1,342,648)	-6.39%
IBNP Reserves	77,972,894	93,067,789	(15,094,895)	-16.22%
Payroll Liabilities	3,170,418	3,178,708	(8,290)	-0.26%
CalPERS Deferred Inflow	2,529,197	2,529,197	0	0.00%
Risk Sharing	2,843,520	2,760,311	83,209	3.01%
Provider Grants/ New Health Program	592,823	592,823	0	0.00%
TOTAL CURRENT LIABILITIES	**285,851,728**	**255,390,689**	**30,461,039**	**11.93%**
TOTAL LIABILITIES	**285,851,728**	**255,390,689**	**30,461,039**	**11.93%**
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)	18,841,952	18,677,670	164,283	0.88%
TOTAL NET WORTH	**199,589,207**	**199,424,924**	**164,283**	**0.08%**
TOTAL LIABILITIES AND NET WORTH	**$485,440,935**	**$454,815,613**	**$30,625,322**	**6.73%**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 4/30/2020

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$2,085,867	$6,233,044	$12,421,387	$20,678,273
Total	2,085,867	6,233,044	12,421,387	20,678,273
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	69,323,045	230,300,871	465,963,230	778,049,710
Allowance for Doubtful Accounts	0	0	0	0
Deferred Premium Revenue	0	0	0	0
Premium Receivable	79,219,713	9,323,723	(46,303,673)	43,709,338
Total	148,542,758	239,624,594	419,659,557	821,759,048
Investment & Other Income Cash Flows				
Other Revenue (Grants)	329,154	1,488,887	3,657,054	4,775,622
Interest Income	425,091	1,067,586	2,079,606	4,325,832
Interest Receivable	27,094	22,479	8,220	95,189
Total	781,339	2,578,952	5,744,880	9,196,643
Medical & Hospital Cash Flows				
Total Medical Expenses	(67,464,482)	(222,073,481)	(447,296,104)	(743,909,504)
Other Receivable	1,618,761	1,179,856	(615,265)	1,467,853
Claims Payable	(1,342,648)	2,867,164	5,401,426	10,367,001
IBNP Payable	(15,094,895)	(12,559,652)	(5,829,439)	(8,189,832)
Risk Share Payable	83,209	249,627	496,999	(1,955,099)
Health Program	0	(202,882)	(275,000)	(508,020)
Other Liabilities	1	1	1	0
Total	(82,200,054)	(230,539,367)	(448,117,382)	(742,727,601)
Administrative Cash Flows				
Total Administrative Expenses	(4,534,391)	(13,573,150)	(27,599,833)	(45,077,981)
Prepaid Expenses	(707,537)	(496,994)	(858,798)	(927,042)
CalPERS Pension Asset	0	0	0	0
CalPERS Deferred Outflow	0	0	0	0
Trade Accounts Payable	917,828	(4,834,291)	(4,314,081)	(3,954,098)
Other Accrued Liabilities	0	0	0	0
Payroll Liabilities	(8,290)	296,693	387,098	297,346
Depreciation Expense	184,615	551,601	1,093,541	1,800,707
Total	(4,147,775)	(18,056,141)	(31,292,073)	(47,861,068)
Interest Paid				
Debt Interest Expense	0	0	0	0
Total Cash Flows from Operating Activities	**65,062,135**	**(158,918)**	**(41,583,631)**	**61,045,295**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 4/30/2020

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Restricted Cash & Other Asset Cash Flows				
Provider Pass-Thru-Liabilities	45,905,834	103,625,524	138,860,785	6,349,409
Restricted Cash	0	0	(1,127)	(3,073)
	45,905,834	103,625,524	138,859,658	6,346,336
Fixed Asset Cash Flows				
Depreciation expense	184,615	551,601	1,093,541	1,800,707
Fixed Asset Acquisitions	(206,920)	(356,377)	(474,214)	(851,544)
Change in A/D	(184,615)	(551,601)	(1,093,541)	(1,800,707)
	(206,920)	(356,377)	(474,214)	(851,544)
Total Cash Flows from Investing Activities	**45,698,914**	**103,269,147**	**138,385,444**	**5,494,792**
Financing Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Total Cash Flows	**110,761,049**	**103,110,229**	**96,801,813**	**66,540,087**
Rounding	(1)	(2)	1	1
Cash @ Beginning of Period	210,621,334	218,272,155	224,580,568	254,842,294
Cash @ End of Period	**$321,382,382**	**$321,382,382**	**$321,382,382**	**$321,382,382**
Difference (rounding)	0	0	0	0

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 4/30/2020

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$164,283	$3,443,756	$9,225,341	$18,841,952
Add back: Depreciation	184,615	551,601	1,093,541	1,800,707
Receivables				
Premiums Receivable	79,219,713	9,323,723	(46,303,673)	43,709,338
First Care Receivable	0	0	0	0
Family Care Receivable	0	0	0	0
Healthy Kids Receivable	0	0	0	0
Interest Receivable	27,094	22,479	8,220	95,189
Other Receivable	1,618,761	1,179,856	(615,265)	1,467,853
FQHC Receivable	0	0	0	0
Allowance for Doubtful Accounts	0	0	0	0
Total	80,865,568	10,526,058	(46,910,718)	45,272,380
Prepaid Expenses	(707,537)	(496,994)	(858,798)	(927,042)
Trade Payables	917,828	(4,834,291)	(4,314,081)	(3,954,098)
Claims Payable, IBNR & Risk Share				
IBNP	(15,094,895)	(12,559,652)	(5,829,439)	(8,189,832)
Claims Payable	(1,342,648)	2,867,164	5,401,426	10,367,001
Risk Share Payable	83,209	249,627	496,999	(1,955,099)
Other Liabilities	1	1	1	0
Total	(16,354,333)	(9,442,860)	68,987	222,070
Unearned Revenue				
Total	0	0	0	0
Other Liabilities				
Accrued Expenses	0	0	0	0
Payroll Liabilities	(8,290)	296,693	387,098	297,346
Health Program	0	(202,882)	(275,000)	(508,020)
Accrued Sub Debt Interest	0	0	0	0
Total Change in Other Liabilities	(8,290)	93,811	112,098	(210,674)
Cash Flows from Operating Activities	**$65,062,134**	**($158,919)**	**($41,583,630)**	**$61,045,295**
Difference (rounding)	(1)	(1)	1	0

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 4/30/2020

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received From:				
Capitation Received from State of CA	$148,542,758	$239,624,594	$419,659,557	$821,759,048
Commercial Premium Revenue	2,085,867	6,233,044	12,421,387	20,678,273
Other Income	329,154	1,488,887	3,657,054	4,775,622
Investment Income	452,185	1,090,065	2,087,826	4,421,021
Cash Paid To:				
Medical Expenses	(82,200,054)	(230,539,367)	(448,117,382)	(742,727,601)
Vendor & Employee Expenses	(4,147,775)	(18,056,141)	(31,292,073)	(47,861,068)
Interest Paid	0	0	0	0
Net Cash Provided By (Used In) Operating Activities	65,062,135	(158,918)	(41,583,631)	61,045,295
Cash Flows from Financing Activities:				
Purchases of Fixed Assets	(206,920)	(356,377)	(474,214)	(851,544)
Net Cash Provided By (Used In) Financing Activities	(206,920)	(356,377)	(474,214)	(851,544)
Cash Flows from Investing Activities:				
Changes in Investments	0	0	0	0
Restricted Cash	45,905,834	103,625,524	138,859,658	6,346,336
Net Cash Provided By (Used In) Investing Activities	45,905,834	103,625,524	138,859,658	6,346,336
Financial Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Net Change in Cash	**110,761,049**	**103,110,229**	**96,801,813**	**66,540,087**
Cash @ Beginning of Period	210,621,334	218,272,155	224,580,568	254,842,294
Subtotal	$321,382,383	$321,382,384	$321,382,381	$321,382,381
Rounding	(1)	(2)	1	1
Cash @ End of Period	**$321,382,382**	**$321,382,382**	**$321,382,382**	**$321,382,382**
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	$164,283	$3,443,756	$9,225,341	$18,841,952
Depreciation	184,615	551,601	1,093,541	1,800,707
Net Change in Operating Assets & Liabilities:				
Premium & Other Receivables	80,865,568	10,526,058	(46,910,718)	45,272,380
Prepaid Expenses	(707,537)	(496,994)	(858,798)	(927,042)
Trade Payables	917,828	(4,834,291)	(4,314,081)	(3,954,098)
Claims payable & IBNP	(16,354,333)	(9,442,860)	68,987	222,070
Deferred Revenue	0	0	0	0
Accrued Interest	0	0	0	0
Other Liabilities	(8,290)	93,811	112,098	(210,674)
Subtotal	65,062,134	(158,919)	(41,583,630)	61,045,295
Rounding	1	1	(1)	0
Cash Flows from Operating Activities	**$65,062,135**	**($158,918)**	**($41,583,631)**	**$61,045,295**
Rounding Difference	1	1	(1)	0

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE CURRENT MONTH - APRIL 2020

	Child	Adults	Medi-Cal SPD	ACA OE	Duals	Medi-Cal Total	Group Care	Grand Total
Enrollment	88,633	32,423	25,894	78,295	17,858	243,103	6,148	249,251
Net Revenue	$9,840,003	$9,520,744	$22,285,700	$25,061,078	$2,997,814	$69,705,339	$2,086,001	$71,791,340
Medical Expense	$8,856,029	$8,566,299	$22,085,804	$23,759,925	$2,236,552	$65,504,608	$1,959,874	$67,464,482
Gross Margin	$983,974	$954,445	$199,896	$1,301,153	$761,263	$4,200,731	$126,127	$4,326,858
Administrative Expense	$291,244	$542,477	$1,651,390	$1,718,072	$147,718	$4,350,902	$153,282	$4,504,184
Operating Income / (Expense)	$692,730	$411,967	($1,451,494)	($416,919)	$613,545	($150,171)	($27,155)	($177,326)
Other Income / (Expense)	$18,942	$43,035	$123,497	$134,513	$9,750	$329,738	$11,871	$341,609
Net Income / (Loss)	$711,672	$455,003	($1,327,996)	($282,406)	$623,295	$179,567	($15,284)	$164,283
Revenue PMPM	$111.02	$293.64	$860.65	$320.09	$167.87	$286.73	$339.30	$288.03
Medical Expense PMPM	$99.92	$264.20	$852.93	$303.47	$125.24	$269.45	$318.78	$270.67
Gross Margin PMPM	$11.10	$29.44	$7.72	$16.62	$42.63	$17.28	$20.52	$17.36
Administrative Expense PMPM	$3.29	$16.73	$63.78	$21.94	$8.27	$17.90	$24.93	$18.07
Operating Income / (Expense) PMPM	$7.82	$12.71	($56.06)	($5.32)	$34.36	($0.62)	($4.42)	($0.71)
Other Income / (Expense) PMPM	$0.21	$1.33	$4.77	$1.72	$0.55	$1.36	$1.93	$1.37
Net Income / (Loss) PMPM	$8.03	$14.03	($51.29)	($3.61)	$34.90	$0.74	($2.49)	$0.66
Medical Loss Ratio	90.0%	90.0%	99.1%	94.8%	74.6%	94.0%	94.0%	94.0%
Gross Margin Ratio	10.0%	10.0%	0.9%	5.2%	25.4%	6.0%	6.0%	6.0%
Administrative Expense Ratio	3.0%	5.7%	7.4%	6.9%	4.9%	6.2%	7.3%	6.3%
Net Income Ratio	7.2%	4.8%	-6.0%	-1.1%	20.8%	0.3%	-0.7%	0.2%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

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

	Medi-Cal					Medi-Cal	Group	Grand
	Child	Adults	SPD	ACA OE	Duals	Total	Care	Total
Member Months	897,680	325,102	257,509	789,455	177,567	2,447,313	60,553	2,507,866
Net Revenue	$108,940,547	$106,230,556	$251,096,319	$287,146,910	$29,858,836	$783,273,167	$20,700,875	$803,974,043
Medical Expense	$95,500,348	$100,602,383	$240,208,748	$261,930,401	$25,679,501	$723,921,381	$19,988,123	$743,909,504
Gross Margin	$13,440,198	$5,628,172	$10,887,571	$25,216,509	$4,179,335	$59,351,786	$712,753	$60,064,539
Administrative Expense	$4,155,944	$6,090,465	$15,405,721	$16,208,117	$1,488,995	$43,349,242	$1,462,572	$44,811,814
Operating Income / (Expense)	$9,284,255	($462,293)	($4,518,149)	$9,008,392	$2,690,340	$16,002,544	($749,818)	$15,252,725
Other Income / (Expense)	$301,090	$493,986	$1,257,474	$1,323,389	$106,614	$3,482,554	$106,674	$3,589,228
Net Income / (Loss)	$9,585,345	$31,694	($3,260,676)	$10,331,781	$2,796,954	$19,485,098	($643,144)	$18,841,952
Revenue PMPM	$121.36	$326.76	$975.10	$363.73	$168.16	$320.05	$341.86	$320.58
Medical Expense PMPM	$106.39	$309.45	$932.82	$331.79	$144.62	$295.80	$330.09	$296.63
Gross Margin PMPM	$14.97	$17.31	$42.28	$31.94	$23.54	$24.25	$11.77	$23.95
Administrative Expense PMPM	$4.63	$18.73	$59.83	$20.53	$8.39	$17.71	$24.15	$17.87
Operating Income / (Expense) PMPM	$10.34	($1.42)	($17.55)	$11.41	$15.15	$6.54	($12.38)	$6.08
Other Income / (Expense) PMPM	$0.34	$1.52	$4.88	$1.68	$0.60	$1.42	$1.76	$1.43
Net Income / (Loss) PMPM	$10.68	$0.10	($12.66)	$13.09	$15.75	$7.96	($10.62)	$7.51
Medical Loss Ratio	87.7%	94.7%	95.7%	91.2%	86.0%	92.4%	96.6%	92.5%
Gross Margin Ratio	12.3%	5.3%	4.3%	8.8%	14.0%	7.6%	3.4%	7.5%
Administrative Expense Ratio	3.8%	5.7%	6.1%	5.6%	5.0%	5.5%	7.1%	5.6%
Net Income Ratio	8.8%	0.0%	-1.3%	3.6%	9.4%	2.5%	-3.1%	2.3%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED April 30, 2020

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSE SUMMARY				
$2,543,873	$2,710,788	$166,915	6.2%	Personnel Expenses	$23,506,315	$25,656,451	$2,150,137	8.4%
513,693	562,759	49,066	8.7%	Benefits Administration Expense	5,650,612	5,708,696	58,084	1.0%
454,281	678,473	224,192	33.0%	Purchased & Professional Services	5,909,920	8,066,321	2,156,401	26.7%
359,115	353,358	(5,757)	(1.6%)	Occupancy	3,585,875	3,720,130	134,255	3.6%
95,473	332,425	236,952	71.3%	Printing Postage & Promotion	1,660,683	1,842,958	182,276	9.9%
452,535	476,333	23,798	5.0%	Licenses Insurance & Fees	4,281,392	5,188,587	907,195	17.5%
85,213	15,996	(69,217)	(432.7%)	Supplies & Other Expenses	217,018	247,047	30,029	12.2%
1,960,311	2,419,345	459,034	19.0%	Total Other Administrative Expense	21,305,499	24,773,739	3,468,240	14.0%
$4,504,184	**$5,130,133**	**$625,949**	**12.2%**	**Total Administrative Expenses**	**$44,811,814**	**$50,430,191**	**$5,618,377**	**11.1%**

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED April 30, 2020

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
$1,717,996	$1,726,367	$8,371	0.5%	Salaries & Wages	$15,467,361	$15,953,575	$486,214	3.0%
140,324	182,368	42,044	23.1%	Paid Time Off	1,403,522	1,604,723	201,200	12.5%
925	7,487	6,562	87.6%	Incentives	11,501	72,401	60,900	84.1%
0	329	329	100.0%	Employee of the Month	1,075	2,961	1,886	63.7%
0	0	0	0.0%	Severance Pay	20,147	0	(20,147)	0.0%
27,202	28,569	1,368	4.8%	Payroll Taxes	334,736	436,297	101,560	23.3%
32,642	8,365	(24,277)	(290.2%)	Overtime	156,558	102,498	(54,060)	(52.7%)
126,712	145,846	19,134	13.1%	CalPERS ER Match	1,179,721	1,335,489	155,768	11.7%
417,597	548,874	131,277	23.9%	Employee Benefits	3,980,055	4,665,648	685,593	14.7%
5	0	(5)	0.0%	Personal Floating Holiday	75,158	85,010	9,852	11.6%
0	0	0	0.0%	Premium Hour Pay	617	0	(617)	0.0%
5,264	10,199	4,935	48.4%	Employee Relations	90,087	138,310	48,223	34.9%
780	1,706	926	54.3%	Transportation Reimbursement	13,124	20,870	7,745	37.1%
1,553	4,715	3,162	67.1%	Travel & Lodging	42,012	110,480	68,468	62.0%
21,120	0	(21,120)	0.0%	Temporary Help Services	251,983	334,068	82,085	24.6%
45,992	34,895	(11,098)	(31.8%)	Staff Development/Training	279,712	541,621	261,909	48.4%
5,760	11,067	5,306	47.9%	Staff Recruitment/Advertising	198,945	252,504	53,560	21.2%
2,543,873	**2,710,788**	**166,915**	**6.2%**	**Total Employee Expenses**	**23,506,315**	**25,656,451**	**2,150,137**	**8.4%**
				Benefit Administration Expense				
346,715	350,464	3,749	1.1%	RX Administration Expense	3,620,183	3,552,277	(67,906)	(1.9%)
166,978	212,295	45,317	21.3%	Behavioral Hlth Administration Fees	2,030,429	2,156,419	125,990	5.8%
513,693	**562,759**	**49,066**	**8.7%**	**Total Employee Expenses**	**5,650,612**	**5,708,696**	**58,084**	**1.0%**
				Purchased & Professional Services				
115,874	241,537	125,663	52.0%	Consulting Services	2,129,428	3,544,923	1,415,495	39.9%
210,119	286,005	75,886	26.5%	Computer Support Services	2,261,282	2,946,385	685,103	23.3%
8,750	9,200	450	4.9%	Professional Fees-Accounting	87,500	104,550	17,050	16.3%
0	0	0	0.0%	Professional Fees-Medical	552	0	(552)	0.0%
15,191	69,813	54,622	78.2%	Other Purchased Services	413,287	726,764	313,477	43.1%
4,187	6,369	2,182	34.3%	Maint.& Repair-Office Equipment	67,279	71,795	4,516	6.3%
56,126	0	(56,126)	0.0%	HMS Recovery Fees	372,343	0	(372,343)	0.0%
0	0	0	0.0%	MIS Software (Non-Capital)	295	4,140	3,845	92.9%
2,608	3,000	392	13.1%	Hardware (Non-Capital)	36,471	37,211	740	2.0%
7,551	7,548	(3)	0.0%	Provider Relations-Credentialing	63,942	75,053	11,111	14.8%
33,875	55,000	21,125	38.4%	Legal Fees	477,542	555,500	77,958	14.0%
454,281	**678,473**	**224,192**	**33.0%**	**Total Purchased & Professional Services**	**5,909,920**	**8,066,321**	**2,156,401**	**26.7%**
				Occupancy				
158,508	181,866	23,358	12.8%	Depreciation	1,539,633	1,665,249	125,616	7.5%
26,107	26,107	0	0.0%	Amortization	261,075	369,890	108,816	29.4%
64,854	64,854	0	0.0%	Building Lease	632,066	632,066	0	0.0%
2,859	3,161	302	9.6%	Leased and Rented Office Equipment	31,030	31,633	603	1.9%
10,898	14,466	3,568	24.7%	Utilities	132,153	154,779	22,626	14.6%
80,307	48,870	(31,437)	(64.3%)	Telephone	859,170	706,221	(152,949)	(21.7%)
15,582	14,034	(1,548)	(11.0%)	Building Maintenance	130,749	160,291	29,542	18.4%

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ADMIN YTD 2020
05/21/20
REPORT #6

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED April 30, 2020

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
$359,115	**$353,358**	**($5,757)**	**(1.6%)**	**Total Occupancy**	**$3,585,875**	**$3,720,130**	**$134,255**	**3.6%**
				Printing Postage & Promotion				
21,327	46,644	25,317	54.3%	Postage	290,381	422,100	131,719	31.2%
4,080	3,300	(780)	(23.6%)	Design & Layout	28,520	48,200	19,680	40.8%
49,261	97,190	47,930	49.3%	Printing Services	412,835	505,400	92,565	18.3%
5,132	4,500	(632)	(14.0%)	Mailing Services	39,663	45,000	5,337	11.9%
4,915	3,100	(1,815)	(58.6%)	Courier/Delivery Service	26,902	29,793	2,891	9.7%
8	675	667	98.8%	Pre-Printed Materials and Publications	1,583	8,299	6,717	80.9%
451	0	(451)	0.0%	Promotional Products	3,710	44,500	40,790	91.7%
0	100	100	100.0%	Promotional Services	0	6,000	6,000	100.0%
5,190	169,917	164,727	96.9%	Community Relations	791,976	670,867	(121,109)	(18.1%)
0	0	0	0.0%	Health Education-Member	(62)	0	62	0.0%
5,109	7,000	1,891	27.0%	Translation - Non-Clinical	65,175	62,800	(2,375)	(3.8%)
95,473	**332,425**	**236,952**	**71.3%**	**Total Printing Postage & Promotion**	**1,660,683**	**1,842,958**	**182,276**	**9.9%**
				Licenses Insurance & Fees				
0	0	0	0.0%	Regulatory Penalties	0	187,500	187,500	100.0%
18,941	20,700	1,759	8.5%	Bank Fees	177,873	206,232	28,359	13.8%
48,446	49,154	708	1.4%	Insurance	484,457	491,540	7,083	1.4%
294,844	342,426	47,583	13.9%	Licenses, Permits and Fees	2,983,241	3,526,446	543,205	15.4%
90,305	64,053	(26,252)	(41.0%)	Subscriptions & Dues	635,821	776,869	141,048	18.2%
452,535	**476,333**	**23,798**	**5.0%**	**Total Licenses Insurance & Postage**	**4,281,392**	**5,188,587**	**907,195**	**17.5%**
				Supplies & Other Expenses				
2,078	6,050	3,972	65.7%	Office and Other Supplies	56,166	80,400	24,234	30.1%
168	1,375	1,207	87.8%	Ergonomic Supplies	11,376	21,750	10,374	47.7%
2,929	7,671	4,742	61.8%	Commissary-Food & Beverage	61,563	99,397	37,834	38.1%
6,790	900	(5,890)	(654.5%)	Member Incentive Expense	14,665	45,500	30,835	67.8%
60,070	0	(60,070)	0.0%	Covid-19 IT Expenses	60,070	0	(60,070)	0.0%
13,179	0	(13,179)	0.0%	Covid-19 Non IT Expenses	13,179	0	(13,179)	0.0%
85,213	**15,996**	**(69,217)**	**(432.7%)**	**Total Supplies & Other Expense**	**217,018**	**247,047**	**30,029**	**12.2%**
$4,504,184	**$5,130,133**	**$625,949**	**12.2%**	**TOTAL ADMINISTRATIVE EXPENSE**	**$44,811,814**	**$50,430,191**	**$5,618,377**	**11.1%**

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ADMIN YTD 2020
05/21/20
REPORT #6

ALAMEDA ALLIANCE FOR HEALTH
CAPITAL SPENDING INCLUDING CONSTRUCTION-IN-PROCESS
ACTUAL VS. BUDGET
FOR THE FISCAL YEAR-TO-DATE ENDED APRIL 30, 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	$ 7,210	$ 60,442	**$ 67,652**	$ 33,971	$ (33,681)
	Cisco IP Phone	IT-FY20-04	$ -		**$ -**	$ 20,000	$ 20,000
	Conference Phones	IT-FY20-05	$ -		**$ -**	$ 10,000	$ 10,000
	Cage Equipment (Racks, Bins, Tools)	IT-FY20-06	$ -		**$ -**	$ 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	$ 4,098	$ 20,230	**$ 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	**$ 31,015**	$ 50,000	$ 18,985
	Pure Storage Upgrade (Additional Shelf)	IT-FY20-13	$ -		**$ -**	$ 90,000	$ 90,000
	DLP Hardware (Security - Data Loss Prevention)	IT-FY20-14	$ -		**$ -**	$ 160,000	$ 160,000
	Cisco Networking Equipment Upgrades (DR)	IT-FY20-15	$ 76,128		**$ 76,128**	$ 50,000	$ (26,128)
	Cisco Wireless Access Points	IT-FY20-16	$ -		**$ -**	$ 20,000	$ 20,000
	Network Cabling (Moves, Construction Projects)	IT-FY20-17	$ 37,519	$ 13,558	**$ 51,076**	$ 150,000	$ 98,924
	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)	**$ (5,346)**	$ 50,000	$ 55,346
	Unplanned Hardware	IT-FY20-20	$ -		**$ -**	$ -	$ -
	Carryover from FY19	IT-FY20-21	$ 26,887		**$ 26,887**	$ -	$ (26,887)
Hardware Subtotal			**$ 450,922**	**$ 119,898**	**$ 570,820**	**$ 1,075,971**	**$ 505,151**
2. Software:							
	Service Now (New Ticketing System)	AC-FY20-01	$ -		**$ -**	$ -	$ -
	IBM (HealthSuite) Backup Solution	AC-FY20-02	$ 31,745	$ 87,022	**$ 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			**$ 31,745**	**$ 87,022**	**$ 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
	Appliances over 1K for 1240, 1320 all suites, if needed to be replaced	FA-FY20-03	$ -		**$ -**	$ 5,000	$ 5,000

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
	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		**$ 6,855**	$ 20,000	$ 13,145
	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		**$ 32,082**	$ -	$ (32,082)
Building Improvement Subtotal			**$ 40,253**	**$ -**	**$ 40,253**	**$ 370,000**	**$ 329,747**
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		**$ 6,700**	$ 250,000	$ 243,300
	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**	**$ -**	**$ 92,006**	**$ 440,000**	**$ 347,994**
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			**$ 644,625**	**$ 206,920**	**$ 851,545**	**$ 2,488,971**	**$ 1,637,426**

7. Reconciliation to Balance Sheet:

Fixed Assets @ Cost -4/30/20	**$ 41,614,473**
Fixed Assets @ Cost - 6/30/19	**$ 40,762,929**
Fixed Assets Acquired YTD	**$ 851,546**

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
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	$10,234,827
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	$28,912,496
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
Subordinated Debt & Interest	$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**
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
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**
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
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
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**

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
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)
CD Pledged to DMHC	(346,927)	(346,927)	(348,873)	(348,873)	(698,873)	(700,000)	(350,000)	(350,238)	(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**
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**

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			897,680
Adults	33,670	33,448	33,092	32,772	32,357	32,066	31,620	31,636	32,018	32,423			325,102
SPD	25,804	25,751	25,727	25,753	25,691	25,687	25,571	25,853	25,778	25,894			257,509
ACA OE	81,171	80,966	80,483	80,069	79,104	78,154	77,093	76,921	77,199	78,295			789,455
Duals	17,627	17,700	17,666	17,650	17,779	17,776	17,800	17,843	17,868	17,858			177,567
Medi-Cal Program	250,669	249,593	248,192	246,841	244,642	242,739	240,413	240,339	240,782	243,103			2,447,313
Group Care Program	5,976	6,020	6,023	6,060	6,056	6,092	6,048	6,005	6,125	6,148			60,553
Total	**256,645**	**255,613**	**254,215**	**252,901**	**250,698**	**248,831**	**246,461**	**246,344**	**246,907**	**249,251**			**2,507,866**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(1,039)	(669)	(504)	(627)	(886)	(655)	(727)	(243)	(167)	714			(4,803)
Adults	(505)	(222)	(356)	(320)	(415)	(291)	(446)	16	382	405			(1,752)
SPD	(78)	(53)	(24)	26	(62)	(4)	(116)	282	(75)	116			12
ACA OE	(201)	(205)	(483)	(414)	(965)	(950)	(1,061)	(172)	278	1,096			(3,077)
Duals	70	73	(34)	(16)	129	(3)	24	43	25	(10)			301
Medi-Cal Program	(1,753)	(1,076)	(1,401)	(1,351)	(2,199)	(1,903)	(2,326)	(74)	443	2,321			(9,319)
Group Care Program	13	44	3	37	(4)	36	(44)	(43)	120	23			185
Total	**(1,740)**	**(1,032)**	**(1,398)**	**(1,314)**	**(2,203)**	**(1,867)**	**(2,370)**	**(117)**	**563**	**2,344**			**(9,134)**
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%			36.7%
Adults % of Medi-Cal	13.4%	13.4%	13.3%	13.3%	13.2%	13.2%	13.2%	13.2%	13.3%	13.3%			13.3%
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%
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%
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%
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%			97.6%
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%			2.4%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**			**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 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
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			486,223
Alameda Health System	47,759	47,630	47,328	47,241	46,652	46,232	45,665	45,594	45,806	46,905			466,812
	97,290	97,093	96,548	95,994	95,134	94,210	93,365	93,781	94,352	95,268			953,035
Delegated:													
CFMG	30,752	30,542	30,214	30,114	29,790	29,654	29,460	29,338	29,278	29,619			298,761
CHCN	94,820	94,360	93,936	93,460	92,730	92,167	91,165	90,696	90,726	91,469			925,529
Kaiser	33,783	33,618	33,517	33,333	33,044	32,800	32,471	32,529	32,551	32,895			330,541
Delegated Subtotal	159,355	158,520	157,667	156,907	155,564	154,621	153,096	152,563	152,555	153,983			1,554,831
Total	**256,645**	**255,613**	**254,215**	**252,901**	**250,698**	**248,831**	**246,461**	**246,344**	**246,907**	**249,251**			**2,507,866**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(799)	(197)	(545)	(554)	(860)	(924)	(845)	416	571	916			(2,821)
Delegated:													
CFMG	(139)	(210)	(328)	(100)	(324)	(136)	(194)	(122)	(60)	341			(1,272)
CHCN	(509)	(460)	(424)	(476)	(730)	(563)	(1,002)	(469)	30	743			(3,860)
Kaiser	(293)	(165)	(101)	(184)	(289)	(244)	(329)	58	22	344			(1,181)
Delegated Subtotal	(941)	(835)	(853)	(760)	(1,343)	(943)	(1,525)	(533)	(8)	1,428			(6,313)
Total	**(1,740)**	**(1,032)**	**(1,398)**	**(1,314)**	**(2,203)**	**(1,867)**	**(2,370)**	**(117)**	**563**	**2,344**			**(9,134)**
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%			38.0%
Delegated:													
CFMG	12.0%	11.9%	11.9%	11.9%	11.9%	11.9%	12.0%	11.9%	11.9%	11.9%			11.9%
CHCN	36.9%	36.9%	37.0%	37.0%	37.0%	37.0%	37.0%	36.8%	36.7%	36.7%			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%
Delegated Subtotal	62.1%	62.0%	62.0%	62.0%	62.1%	62.1%	62.1%	61.9%	61.8%	61.8%			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%**

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

	Budget Jul-19	Budget Aug-19	Budget Sep-19	Budget Oct-19	Budget Nov-19	Budget Dec-19	Budget Jan-20	Budget Feb-20	Budget Mar-20	Budget Apr-20	Budget May-20	Budget Jun-20	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	92,397	92,166	91,936	91,706	91,477	91,248	90,336	90,110	89,885	89,660	89,436	89,212	1,089,569
Adults	33,670	33,586	33,502	33,418	33,334	33,251	32,919	32,837	32,755	32,673	32,591	32,510	397,046
SPD	25,804	25,739	25,675	25,611	25,547	25,483	25,228	25,165	25,102	25,039	24,976	24,914	304,283
ACA OE	81,171	80,995	80,820	80,645	80,470	80,296	79,600	79,428	79,256	79,084	78,913	78,742	959,420
Duals	17,627	17,583	17,539	17,495	17,451	17,407	17,233	17,190	17,147	17,104	17,061	17,018	207,855
Medi-Cal Program	250,669	250,069	249,472	248,875	248,279	247,685	245,316	244,730	244,145	243,560	242,977	242,396	2,958,173
Group Care Program	5,976	5,976	5,976	5,976	5,976	5,976	5,976	5,976	5,976	5,976	5,976	5,976	71,712
Total	**256,645**	**256,045**	**255,448**	**254,851**	**254,255**	**253,661**	**251,292**	**250,706**	**250,121**	**249,536**	**248,953**	**248,372**	**3,029,885**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(5,866)	(231)	(230)	(230)	(229)	(229)	(912)	(226)	(225)	(225)	(224)	(224)	(9,051)
Adults	(3,313)	(84)	(84)	(84)	(84)	(83)	(332)	(82)	(82)	(82)	(82)	(81)	(4,473)
SPD	(1,252)	(65)	(64)	(64)	(64)	(64)	(255)	(63)	(63)	(63)	(63)	(62)	(2,142)
ACA OE	(1,792)	(176)	(175)	(175)	(175)	(174)	(696)	(172)	(172)	(172)	(171)	(171)	(4,221)
Duals	710	(44)	(44)	(44)	(44)	(44)	(174)	(43)	(43)	(43)	(43)	(43)	101
Medi-Cal Program	(11,513)	(600)	(597)	(597)	(596)	(594)	(2,369)	(586)	(585)	(585)	(583)	(581)	(19,786)
Group Care Program	68	0	0	0	0	0	0	0	0	0	0	0	68
Total	**(11,445)**	**(600)**	**(597)**	**(597)**	**(596)**	**(594)**	**(2,369)**	**(586)**	**(585)**	**(585)**	**(583)**	**(581)**	**(19,718)**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	36.9%	36.9%	36.9%	36.8%	36.8%	36.8%	36.8%	36.8%	36.8%	36.8%	36.8%	36.8%	36.8%
Adults % of Medi-Cal	13.4%	13.4%	13.4%	13.4%	13.4%	13.4%	13.4%	13.4%	13.4%	13.4%	13.4%	13.4%	13.4%
SPD % of Medi-Cal	10.3%	10.3%	10.3%	10.3%	10.3%	10.3%	10.3%	10.3%	10.3%	10.3%	10.3%	10.3%	10.3%
ACA OE % of Medi-Cal	32.4%	32.4%	32.4%	32.4%	32.4%	32.4%	32.4%	32.5%	32.5%	32.5%	32.5%	32.5%	32.4%
Duals % of Medi-Cal	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%
Medi-Cal Program % of Total	97.7%	97.7%	97.7%	97.7%	97.6%	97.6%	97.6%	97.6%	97.6%	97.6%	97.6%	97.6%	97.6%
Group Care Program % of Total	2.3%	2.3%	2.3%	2.3%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	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%**	**100.0%**

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

	Budget Jul-19	Budget Aug-19	Budget Sep-19	Budget Oct-19	Budget Nov-19	Budget Dec-19	Budget Jan-20	Budget Feb-20	Budget Mar-20	Budget Apr-20	Budget May-20	Budget Jun-20	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted	97,290	97,070	96,850	96,630	96,410	96,190	95,318	95,102	94,887	94,672	94,457	94,243	1,149,119
Delegated:													
CFMG	30,752	30,675	30,598	30,521	30,445	30,369	30,067	29,992	29,917	29,842	29,767	29,692	362,637
CHCN	94,820	94,599	94,379	94,159	93,940	93,721	92,849	92,635	92,421	92,207	91,993	91,779	1,119,502
Kaiser	33,783	33,701	33,621	33,541	33,460	33,381	33,058	32,977	32,896	32,815	32,736	32,658	398,627
Delegated Subtotal	159,355	158,975	158,598	158,221	157,845	157,471	155,974	155,604	155,234	154,864	154,496	154,129	1,880,766
Total	**256,645**	**256,045**	**255,448**	**254,851**	**254,255**	**253,661**	**251,292**	**250,706**	**250,121**	**249,536**	**248,953**	**248,372**	**3,029,885**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(4,564)	(220)	(220)	(220)	(220)	(220)	(872)	(216)	(215)	(215)	(215)	(214)	(7,611)
Delegated:													
CFMG	(2,717)	(77)	(77)	(77)	(76)	(76)	(302)	(75)	(75)	(75)	(75)	(75)	(3,777)
CHCN	(3,197)	(221)	(220)	(220)	(219)	(219)	(872)	(214)	(214)	(214)	(214)	(214)	(6,238)
Kaiser	(967)	(82)	(80)	(80)	(81)	(79)	(323)	(81)	(81)	(81)	(79)	(78)	(2,092)
Delegated Subtotal	(6,881)	(380)	(377)	(377)	(376)	(374)	(1,497)	(370)	(370)	(370)	(368)	(367)	(12,107)
Total	**(11,445)**	**(600)**	**(597)**	**(597)**	**(596)**	**(594)**	**(2,369)**	**(586)**	**(585)**	**(585)**	**(583)**	**(581)**	**(19,718)**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	37.9%	37.9%	37.9%	37.9%	37.9%	37.9%	37.9%	37.9%	37.9%	37.9%	37.9%	37.9%	37.9%
Delegated:													
CFMG	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%
CHCN	36.9%	36.9%	36.9%	36.9%	36.9%	36.9%	36.9%	36.9%	37.0%	37.0%	37.0%	37.0%	36.9%
Kaiser	13.2%	13.2%	13.2%	13.2%	13.2%	13.2%	13.2%	13.2%	13.2%	13.2%	13.1%	13.1%	13.2%
Delegated Subtotal	62.1%	62.1%	62.1%	62.1%	62.1%	62.1%	62.1%	62.1%	62.1%	62.1%	62.1%	62.1%	62.1%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

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

	Variance Jul-19	Variance Aug-19	Variance Sep-19	Variance Oct-19	Variance Nov-19	Variance Dec-19	Variance Jan-20	Variance Feb-20	Variance Mar-20	Variance Apr-20	Variance May-20	Variance Jun-20	YTD Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	0	(438)	(712)	(1,109)	(1,766)	(2,192)	(2,007)	(2,024)	(1,966)	(1,027)			(13,241)
Adults	0	(138)	(410)	(646)	(977)	(1,185)	(1,299)	(1,201)	(737)	(250)			(6,843)
SPD	0	12	52	142	144	204	343	688	676	855			3,116
ACA OE	0	(29)	(337)	(576)	(1,366)	(2,142)	(2,507)	(2,507)	(2,057)	(789)			(12,310)
Duals	0	117	127	155	328	369	567	653	721	754			3,791
Medi-Cal Program	0	(476)	(1,280)	(2,034)	(3,637)	(4,946)	(4,903)	(4,391)	(3,363)	(457)			(25,487)
Group Care Program	0	44	47	84	80	116	72	29	149	172			793
Total	**0**	**(432)**	**(1,233)**	**(1,950)**	**(3,557)**	**(4,830)**	**(4,831)**	**(4,362)**	**(3,214)**	**(285)**			**(24,694)**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted	0	23	(302)	(636)	(1,276)	(1,980)	(1,953)	(1,321)	(535)	596			(7,384)
Delegated:													
CFMG	0	(133)	(384)	(407)	(655)	(715)	(607)	(654)	(639)	(223)			(4,417)
CHCN	0	(239)	(443)	(699)	(1,210)	(1,554)	(1,684)	(1,939)	(1,695)	(738)			(10,201)
Kaiser	0	(83)	(104)	(208)	(416)	(581)	(587)	(448)	(345)	80			(2,692)
Delegated Subtotal	0	(455)	(931)	(1,314)	(2,281)	(2,850)	(2,878)	(3,041)	(2,679)	(881)			(17,310)
Total	**0**	**(432)**	**(1,233)**	**(1,950)**	**(3,557)**	**(4,830)**	**(4,831)**	**(4,362)**	**(3,214)**	**(285)**			**(24,694)**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED April 30, 2020

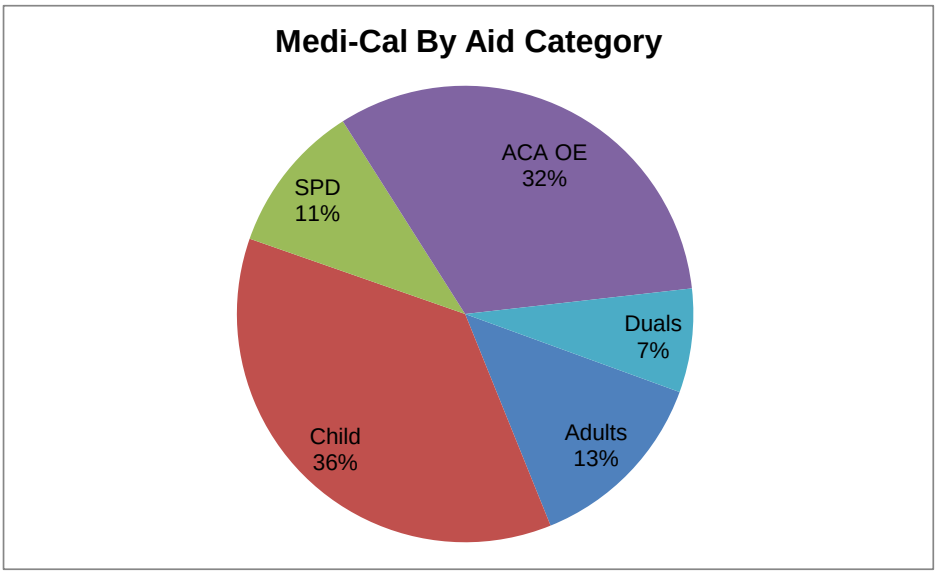
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES:				
$1,657,604	$1,608,016	($49,588)	(3.1%)	PCP-Capitation	$16,570,484	$16,365,255	($205,229)	(1.3%)
2,656,879	2,709,574	52,695	1.9%	PCP-Capitation - FQHC	26,720,433	27,328,943	608,510	2.2%
259,797	255,740	(4,057)	(1.6%)	Specialty-Capitation	2,609,324	2,602,871	(6,453)	(0.2%)
2,713,202	2,895,213	182,011	6.3%	Specialty-Capitation FQHC	27,328,656	28,835,158	1,506,502	5.2%
256,760	255,377	(1,383)	(0.5%)	Laboratory-Capitation	2,570,005	2,591,612	21,607	0.8%
985,648	623,841	(361,807)	(58.0%)	Transportation (Ambulance)-Cap	9,606,440	6,333,277	(3,273,163)	(51.7%)
189,261	187,096	(2,165)	(1.2%)	Vision Cap	1,890,812	1,900,689	9,877	0.5%
75,531	76,721	1,190	1.6%	CFMG Capitation	758,477	778,376	19,899	2.6%
137,877	143,712	5,835	4.1%	Anc IPA Admin Capitation FQHC	1,387,700	1,440,656	52,956	3.7%
7,024,515	6,931,954	(92,561)	(1.3%)	Kaiser Capitation	69,244,412	70,712,890	1,468,478	2.1%
903,367	554,043	(349,324)	(63.1%)	BHT Supplemental Expense	6,586,459	5,144,930	(1,441,529)	(28.0%)
(10,252)	6,242	16,494	264.2%	Hep-C Supplemental Expense	126,321	101,441	(24,880)	(24.5%)
186,584	303,943	117,359	38.6%	Maternity Supplemental Expense	2,903,695	2,773,566	(130,129)	(4.7%)
497,398	482,298	(15,100)	(3.1%)	DME - Cap	4,946,977	4,900,721	(46,256)	(0.9%)
17,534,171	**17,033,770**	**(500,401)**	**(2.9%)**	**5-TOTAL CAPITATED EXPENSES**	**173,250,196**	**171,810,385**	**(1,439,811)**	**(0.8%)**
				FEE FOR SERVICE MEDICAL EXPENSES:				
(7,002,506)	0	7,002,506	0.0%	IBNP-Inpatient Services	(980,719)	0	980,719	0.0%
(210,076)	0	210,076	0.0%	IBNP-Settlement (IP)	(29,423)	0	29,423	0.0%
(560,201)	0	560,201	0.0%	IBNP-Claims Fluctuation (IP)	(78,458)	0	78,458	0.0%
20,729,487	20,338,671	(390,816)	(1.9%)	Inpatient Hospitalization-FFS	173,104,513	206,331,845	33,227,332	16.1%
1,461,192	0	(1,461,192)	0.0%	IP OB - Mom & NB	10,761,379	0	(10,761,379)	0.0%
196,691	0	(196,691)	0.0%	IP Behavioral Health	1,127,835	0	(1,127,835)	0.0%
1,381,628	0	(1,381,628)	0.0%	IP - Long Term Care	11,092,974	0	(11,092,974)	0.0%
828,077	0	(828,077)	0.0%	IP - Facility Rehab FFS	6,201,168	0	(6,201,168)	0.0%
16,824,292	**20,338,671**	**3,514,379**	**17.3%**	**6-Inpatient Hospital & SNF FFS Expense**	**201,199,269**	**206,331,845**	**5,132,576**	**2.5%**
(397,303)	0	397,303	0.0%	IBNP-PCP	(492,091)	0	492,091	0.0%
(11,919)	0	11,919	0.0%	IBNP-Settlement (PCP)	(14,766)	0	14,766	0.0%
(31,784)	0	31,784	0.0%	IBNP-Claims Fluctuation (PCP)	(39,371)	0	39,371	0.0%
45,600	0	(45,600)	0.0%	Telemedicine FFS	45,600	0	(45,600)	0.0%
1,305,021	1,147,618	(157,403)	(13.7%)	Primary Care Non-Contracted FF	11,711,341	11,671,129	(40,212)	(0.3%)
68,765	110,510	41,745	37.8%	PCP FQHC FFS	614,771	1,090,424	475,653	43.6%
1,619,243	1,670,043	50,800	3.0%	Prop 56 Direct Payment Expenses	15,185,468	16,978,863	1,793,395	10.6%
67,171	0	(67,171)	0.0%	Prop 56-Trauma Expense	825,749	0	(825,749)	0.0%
92,528	0	(92,528)	0.0%	Prop 56-Dev. Screening Exp.	1,132,728	0	(1,132,728)	0.0%
737,760	0	(737,760)	0.0%	Prop 56-Fam. Planning Exp.	9,198,174	0	(9,198,174)	0.0%
677,754	0	(677,754)	0.0%	Prop 56-Value Based Purchasing	8,471,605	0	(8,471,605)	0.0%
4,172,837	**2,928,171**	**(1,244,666)**	**(42.5%)**	**7-Primary Care Physician FFS Expense**	**46,639,207**	**29,740,416**	**(16,898,791)**	**(56.8%)**
(1,390,317)	0	1,390,317	0.0%	IBNP-Specialist	(1,831,271)	0	1,831,271	0.0%
1,974,681	0	(1,974,681)	0.0%	Specialty Care-FFS	20,096,210	0	(20,096,210)	0.0%
99,349	0	(99,349)	0.0%	Anesthesiology - FFS	1,191,586	0	(1,191,586)	0.0%
635,215	0	(635,215)	0.0%	Spec Rad Therapy - FFS	6,195,594	0	(6,195,594)	0.0%
130,737	0	(130,737)	0.0%	Obstetrics-FFS	1,095,492	0	(1,095,492)	0.0%
189,652	0	(189,652)	0.0%	Spec IP Surgery - FFS	2,145,734	0	(2,145,734)	0.0%
457,320	0	(457,320)	0.0%	Spec OP Surgery - FFS	4,321,085	0	(4,321,085)	0.0%
357,510	3,666,380	3,308,870	90.2%	Spec IP Physician	3,536,327	37,065,449	33,529,122	90.5%
124,451	113,958	(10,493)	(9.2%)	SCP FQHC FFS	675,800	1,141,047	465,247	40.8%
(41,710)	0	41,710	0.0%	IBNP-Settlement (SCP)	(54,934)	0	54,934	0.0%
(111,225)	0	111,225	0.0%	IBNP-Claims Fluctuation (SCP)	(146,502)	0	146,502	0.0%
2,425,663	**3,780,338**	**1,354,675**	**35.8%**	**8-Specialty Care Physician Expense**	**37,225,122**	**38,206,496**	**981,374**	**2.6%**
(577,281)	0	577,281	0.0%	IBNP-Ancillary	(530,553)	0	530,553	0.0%
(17,318)	0	17,318	0.0%	IBNP Settlement (ANC)	(15,913)	0	15,913	0.0%
(46,183)	0	46,183	0.0%	IBNP Claims Fluctuation (ANC)	(42,444)	0	42,444	0.0%
246,939	0	(246,939)	0.0%	Acupuncture/Biofeedback	2,559,394	0	(2,559,394)	0.0%
83,512	0	(83,512)	0.0%	Hearing Devices	1,080,114	0	(1,080,114)	0.0%
24,325	0	(24,325)	0.0%	Imaging/MRI/CT Global	273,433	0	(273,433)	0.0%
31,161	0	(31,161)	0.0%	Vision FFS	382,983	0	(382,983)	0.0%
16,996	0	(16,996)	0.0%	Family Planning	121,105	0	(121,105)	0.0%
198,370	0	(198,370)	0.0%	Laboratory-FFS	2,253,272	0	(2,253,272)	0.0%
78,759	0	(78,759)	0.0%	ANC Therapist	1,063,844	0	(1,063,844)	0.0%
235,839	0	(235,839)	0.0%	Transportation (Ambulance)-FFS	2,583,807	0	(2,583,807)	0.0%
137,933	0	(137,933)	0.0%	Transportation (Other)-FFS	975,001	0	(975,001)	0.0%

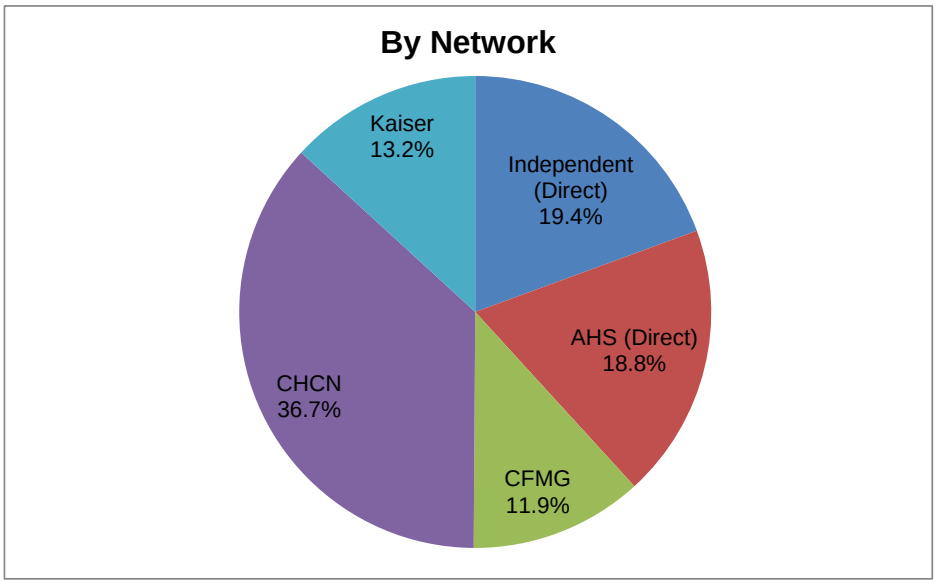
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED April 30, 2020

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
$564,273	$0	($564,273)	0.0%	Hospice	$3,793,635	$0	($3,793,635)	0.0%
542,599	0	(542,599)	0.0%	Home Health Services	4,898,692	0	(4,898,692)	0.0%
0	2,510,554	2,510,554	100.0%	Other Medical-FFS	0	25,862,249	25,862,249	100.0%
0	0	0	0.0%	Denials	320	0	(320)	0.0%
(82,965)	0	82,965	0.0%	HMS Medical Refunds	(258,722)	0	258,722	0.0%
137	0	(137)	0.0%	Refunds-Medical Payments	(4,550)	0	4,550	0.0%
314,100	0	(314,100)	0.0%	DME & Medical Supplies	2,889,282	0	(2,889,282)	0.0%
1,051,676	550,292	(501,384)	(91.1%)	GEMT Direct Payment Expense	4,373,951	5,594,296	1,220,345	21.8%
373,821	0	(373,821)	0.0%	Community Based Adult Services (CBAS)	4,629,617	0	(4,629,617)	0.0%
3,176,693	**3,060,846**	**(115,847)**	**(3.8%)**	**9-Ancillary Medical Expense**	**31,026,267**	**31,456,545**	**430,278**	**1.4%**
(1,964,548)	0	1,964,548	0.0%	IBNP-Outpatient	(2,003,568)	0	2,003,568	0.0%
(58,936)	0	58,936	0.0%	IBNP Settlement (OP)	(60,111)	0	60,111	0.0%
(157,164)	0	157,164	0.0%	IBNP Claims Fluctuation (OP)	(160,290)	0	160,290	0.0%
1,079,842	7,300,662	6,220,820	85.2%	Out-Patient FFS	12,520,985	72,296,455	59,775,470	82.7%
1,197,954	0	(1,197,954)	0.0%	OP Ambul Surgery - FFS	10,740,970	0	(10,740,970)	0.0%
1,863,444	0	(1,863,444)	0.0%	OP Fac Imaging Services-FFS	11,303,176	0	(11,303,176)	0.0%
959,027	0	(959,027)	0.0%	Behav Health - FFS	19,378,024	0	(19,378,024)	0.0%
325,651	0	(325,651)	0.0%	OP Facility - Lab FFS	2,861,101	0	(2,861,101)	0.0%
84,479	0	(84,479)	0.0%	OP Facility - Cardio FFS	914,816	0	(914,816)	0.0%
61,160	0	(61,160)	0.0%	OP Facility - PT/OT/ST FFS	171,798	0	(171,798)	0.0%
1,847,603	0	(1,847,603)	0.0%	OP Facility - Dialysis FFS	16,344,766	0	(16,344,766)	0.0%
5,238,510	**7,300,662**	**2,062,152**	**28.2%**	**10-Outpatient Medical Expense Medical Expense**	**72,011,668**	**72,296,455**	**284,787**	**0.4%**
(569,784)	0	569,784	0.0%	IBNP-Emergency	(717,714)	0	717,714	0.0%
(17,095)	0	17,095	0.0%	IBNP Settlement (ER)	(21,532)	0	21,532	0.0%
(45,584)	0	45,584	0.0%	IBNP Claims Fluctuation (ER)	(57,416)	0	57,416	0.0%
620,187	0	(620,187)	0.0%	Special ER Physician-FFS	5,882,185	0	(5,882,185)	0.0%
3,025,085	3,190,700	165,615	5.2%	ER-Facility	26,957,791	32,250,395	5,292,604	16.4%
3,012,808	**3,190,700**	**177,892**	**5.6%**	**11-Emergency Expense**	**32,043,314**	**32,250,395**	**207,081**	**0.6%**
(1,697,262)	0	1,697,262	0.0%	IBNP-Pharmacy	(822,302)	0	822,302	0.0%
(50,917)	0	50,917	0.0%	IBNP Settlement (RX)	(24,670)	0	24,670	0.0%
(135,782)	0	135,782	0.0%	IBNP Claims Fluctuation (RX)	(65,784)	0	65,784	0.0%
4,981,919	3,085,741	(1,896,178)	(61.4%)	RX - Non-PBM FFFS	38,115,468	31,708,101	(6,407,367)	(20.2%)
10,470,440	10,361,417	(109,023)	(1.1%)	Pharmacy-FFS	100,579,859	103,685,527	3,105,668	3.0%
(37,911)	0	37,911	0.0%	HMS RX Refunds	(605,787)	0	605,787	0.0%
(407,064)	(407,064)	0	0.0%	Pharmacy-Rebate	(5,193,505)	(4,227,423)	966,082	(22.9%)
13,123,424	**13,040,094**	**(83,330)**	**(0.6%)**	**12-Pharmacy Expense**	**131,983,278**	**131,166,205**	**(817,073)**	**(0.6%)**
47,974,226	**53,639,482**	**5,665,256**	**10.6%**	**13-TOTAL FFS MEDICAL EXPENSES**	**552,128,127**	**541,448,357**	**(10,679,770)**	**(2.0%)**
0	(87,482)	(87,482)	100.0%	Clinical Vacancy	0	(1,689,986)	(1,689,986)	100.0%
52,942	124,011	71,069	57.3%	Quality Analytics	671,122	1,099,494	428,371	39.0%
368,063	400,549	32,486	8.1%	Health Plan Services Department Total	3,693,728	4,097,030	403,303	9.8%
661,228	756,010	94,782	12.5%	Case & Disease Management Department Total	6,354,073	6,432,239	78,166	1.2%
148,833	180,836	32,003	17.7%	Medical Services Department Total	1,403,347	1,713,579	310,232	18.1%
382,039	464,280	82,240	17.7%	Quality Management Department Total	4,291,223	5,017,525	726,302	14.5%
116,589	145,393	28,804	19.8%	Pharmacy Services Department Total	1,175,279	1,409,199	233,921	16.6%
62,135	28,736	(33,399)	(116.2%)	Regulatory Readiness Total	318,725	305,342	(13,383)	(4.4%)
1,791,830	**2,012,333**	**220,504**	**11.0%**	**14-Other Benefits & Services**	**17,907,497**	**18,384,421**	**476,924**	**2.6%**
				Reinsurance Expense				
(302,261)	(329,550)	(27,289)	8.3%	Reinsurance Recoveries	(4,048,110)	(3,001,243)	1,046,867	(34.9%)
383,308	387,706	4,398	1.1%	Stop-Loss Expense	3,838,213	3,920,336	82,123	2.1%
81,047	**58,156**	**(22,891)**	**(39.4%)**	**15-Reinsurance Expense**	**(209,897)**	**919,093**	**1,128,990**	**122.8%**
				Preventive Health Services				
83,209	83,208	(1)	0.0%	Risk Sharing PCP	833,583	833,580	(3)	0.0%
83,209	**83,208**	**(1)**	**0.0%**	**16-Risk Pool Distribution**	**833,583**	**833,580**	**(3)**	**0.0%**
67,464,482	**72,826,949**	**5,362,467**	**7.4%**	**17-TOTAL MEDICAL EXPENSES**	**743,909,504**	**733,395,836**	**(10,513,668)**	**(1.4%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Current Membership by Network By Category of Aid							
Category of Aid	**Apr 2020**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	32,423	13%	7,918	6,953	242	12,158	5,152
Child	88,633	36%	8,046	8,127	27,204	30,160	15,096
SPD	25,894	11%	8,662	3,803	1,185	10,343	1,901
ACA OE	78,295	32%	13,799	25,281	987	29,610	8,618
Duals	17,858	7%	7,245	1,887	1	6,597	2,128
Medi-Cal	243,103		45,670	46,051	29,619	88,868	32,895
Group Care	6,148		2,693	854	-	2,601	-
Total	**249,251**	**100%**	**48,363**	**46,905**	**29,619**	**91,469**	**32,895**
Medi-Cal %	97.5%		94.4%	98.2%	100.0%	97.2%	100.0%
Group Care %	2.5%		5.6%	1.8%	0.0%	2.8%	0.0%
	Network Distribution		*19.4%*	*18.8%*	*11.9%*	*36.7%*	*13.2%*
			% Direct:	**38%**		**% Delegated:**	**62%**

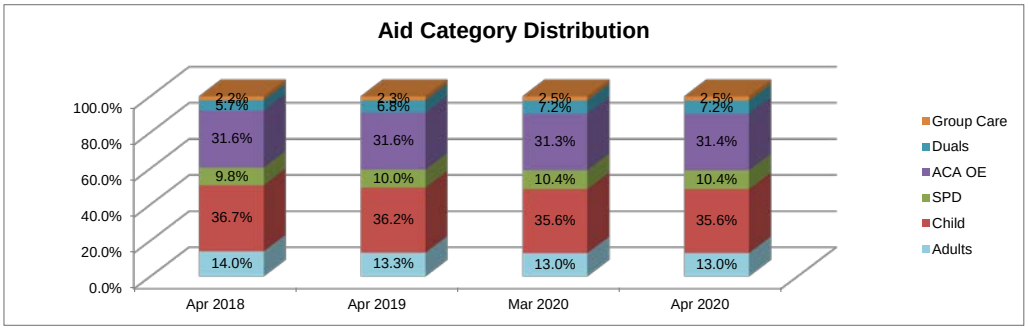




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

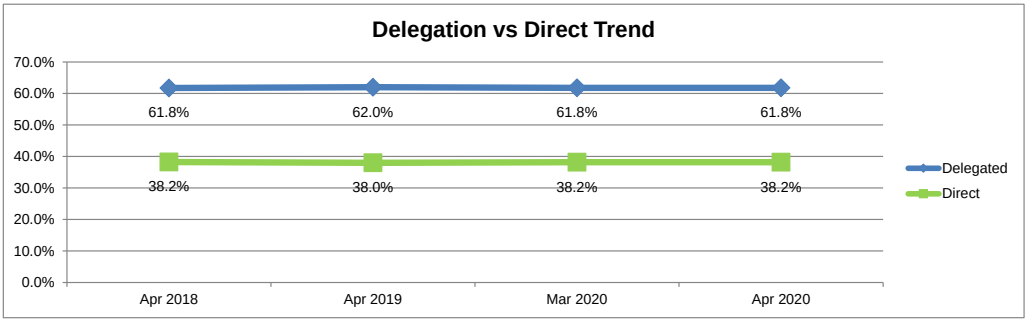
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Apr 2018	Apr 2019	Mar 2020	Apr 2020	Apr 2018	Apr 2019	Mar 2020	Apr 2020	Apr 2018 to Apr 2019	Apr 2019 to Apr 2020	Mar 2020 to Apr 2020
Adults	37,330	34,331	32,017	32,423	14.0%	13.3%	13.0%	13.0%	-8.0%	-5.6%	1.3%
Child	97,883	93,615	87,919	88,633	36.7%	36.2%	35.6%	35.6%	-4.4%	-5.3%	0.8%
SPD	26,057	25,787	25,778	25,894	9.8%	10.0%	10.4%	10.4%	-1.0%	0.4%	0.4%
ACA OE	84,333	81,813	77,199	78,295	31.6%	31.6%	31.3%	31.4%	-3.0%	-4.3%	1.4%
Duals	15,248	17,481	17,869	17,858	5.7%	6.8%	7.2%	7.2%	14.6%	2.2%	-0.1%
Medi-Cal Total	260,851	253,027	240,782	243,103	97.8%	97.7%	97.5%	97.5%	-3.0%	-3.9%	1.0%
Group Care	5,811	5,910	6,125	6,148	2.2%	2.3%	2.5%	2.5%	1.7%	4.0%	0.4%
Total	**266,662**	**258,937**	**246,907**	**249,251**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**-2.9%**	**-3.7%**	**0.9%**



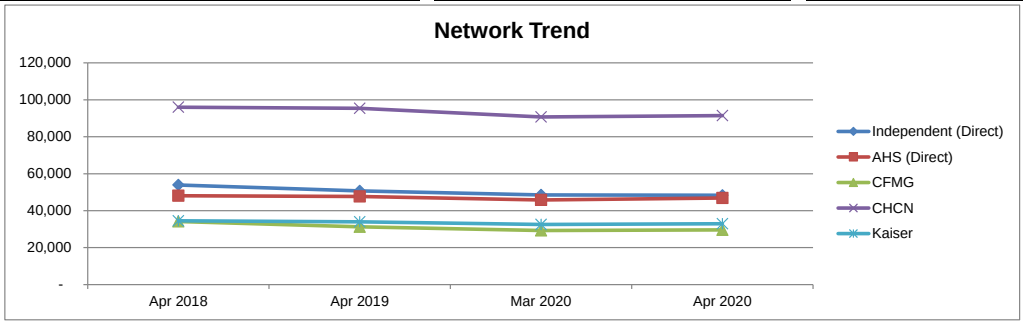
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Apr 2018	Apr 2019	Mar 2020	Apr 2020	Apr 2018	Apr 2019	Mar 2020	Apr 2020	Apr 2018 to Apr 2019	Apr 2019 to Apr 2020	Mar 2020 to Apr 2020
Delegated	164,671	160,549	152,555	153,983	61.8%	62.0%	61.8%	61.8%	-2.5%	-4.1%	0.9%
Direct	101,991	98,388	94,352	95,268	38.2%	38.0%	38.2%	38.2%	-3.5%	-3.2%	1.0%
Total	**266,662**	**258,937**	**246,907**	**249,251**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**-2.9%**	**-3.7%**	**0.9%**



Network Trend

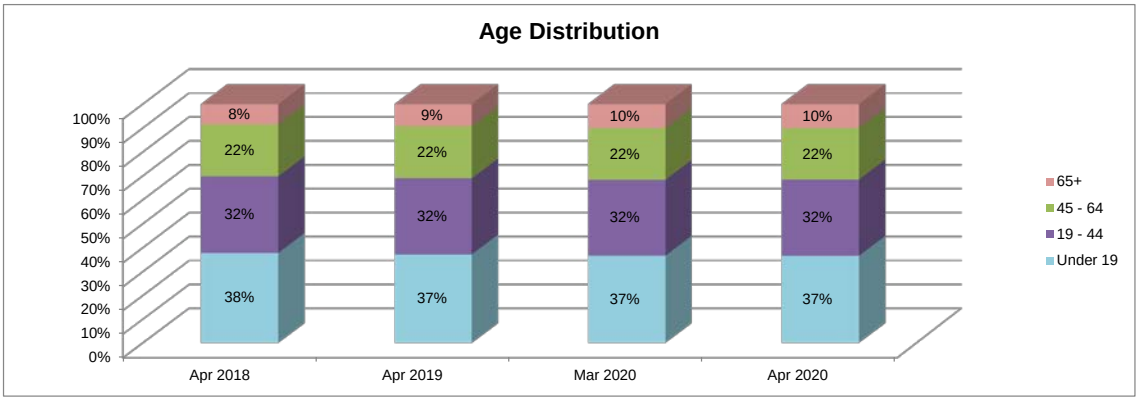
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Apr 2018	Apr 2019	Mar 2020	Apr 2020	Apr 2018	Apr 2019	Mar 2020	Apr 2020	Apr 2018 to Apr 2019	Apr 2019 to Apr 2020	Mar 2020 to Apr 2020
Independent (Direct)	53,904	50,735	48,546	48,363	20.2%	19.6%	19.7%	19.4%	-5.9%	-4.7%	-0.4%
AHS (Direct)	48,087	47,653	45,806	46,905	18.0%	18.4%	18.6%	18.8%	-0.9%	-1.6%	2.4%
CFMG	34,150	31,252	29,278	29,619	12.8%	12.1%	11.9%	11.9%	-8.5%	-5.2%	1.2%
CHCN	95,990	95,361	90,726	91,469	36.0%	36.8%	36.7%	36.7%	-0.7%	-4.1%	0.8%
Kaiser	34,531	33,936	32,551	32,895	12.9%	13.1%	13.2%	13.2%	-1.7%	-3.1%	1.1%
Total	**266,662**	**258,937**	**246,907**	**249,251**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**-2.9%**	**-3.7%**	**0.9%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

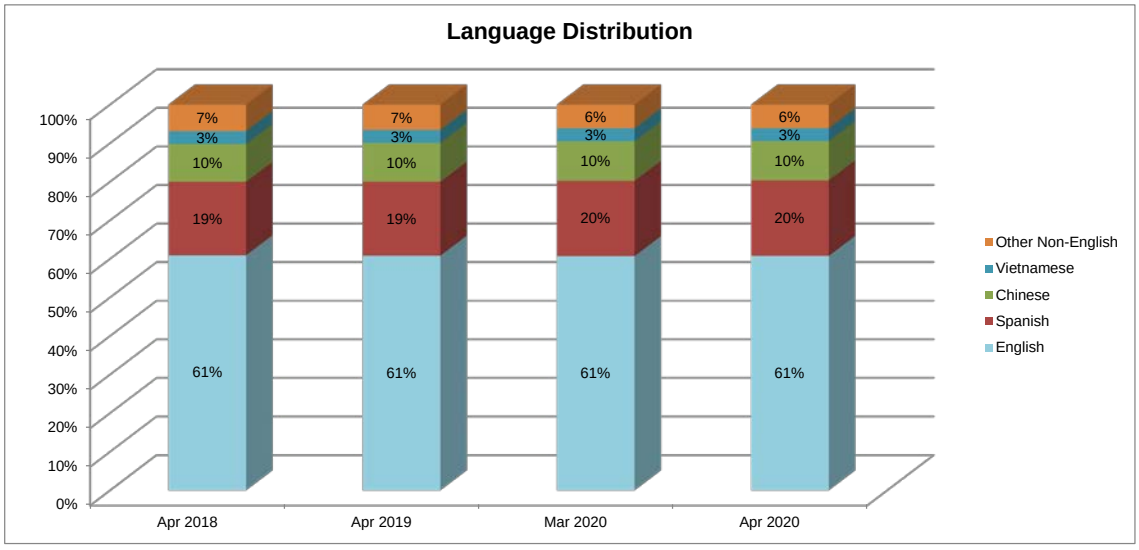
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Apr 2018	Apr 2019	Mar 2020	Apr 2020	Apr 2018	Apr 2019	Mar 2020	Apr 2020	Apr 2018 to Apr 2019	Apr 2019 to Apr 2020	Mar 2020 to Apr 2020
Under 19	100,761	96,382	90,475	91,177	38%	37%	37%	37%	-4%	-5%	1%
19 - 44	85,420	82,257	78,297	79,413	32%	32%	32%	32%	-4%	-3%	1%
45 - 64	57,979	56,248	53,374	53,750	22%	22%	22%	22%	-3%	-4%	1%
65+	22,502	24,050	24,761	24,911	8%	9%	10%	10%	7%	4%	1%
Total	**266,662**	**258,937**	**246,907**	**249,251**	**100%**	**100%**	**100%**	**100%**	**-3%**	**-4%**	**1%**



Language Trend

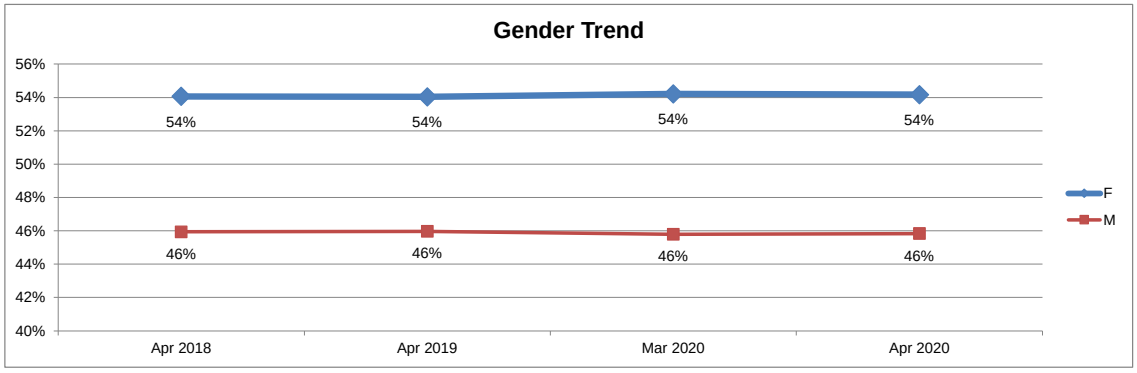
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Apr 2018	Apr 2019	Mar 2020	Apr 2020	Apr 2018	Apr 2019	Mar 2020	Apr 2020	Apr 2018 to Apr 2019	Apr 2019 to Apr 2020	Mar 2020 to Apr 2020
English	162,451	157,438	149,817	151,454	61%	61%	61%	61%	-3%	-4%	1%
Spanish	50,742	49,619	48,269	48,853	19%	19%	20%	20%	-2%	-2%	1%
Chinese	26,291	26,131	25,274	25,363	10%	10%	10%	10%	-1%	-3%	0%
Vietnamese	8,803	8,699	8,259	8,285	3%	3%	3%	3%	-1%	-5%	0%
Other Non-English	18,375	17,050	15,288	15,296	7%	7%	6%	6%	-7%	-10%	0%
Total	**266,662**	**258,937**	**246,907**	**249,251**	**100%**	**100%**	**100%**	**100%**	**-3%**	**-4%**	**1%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

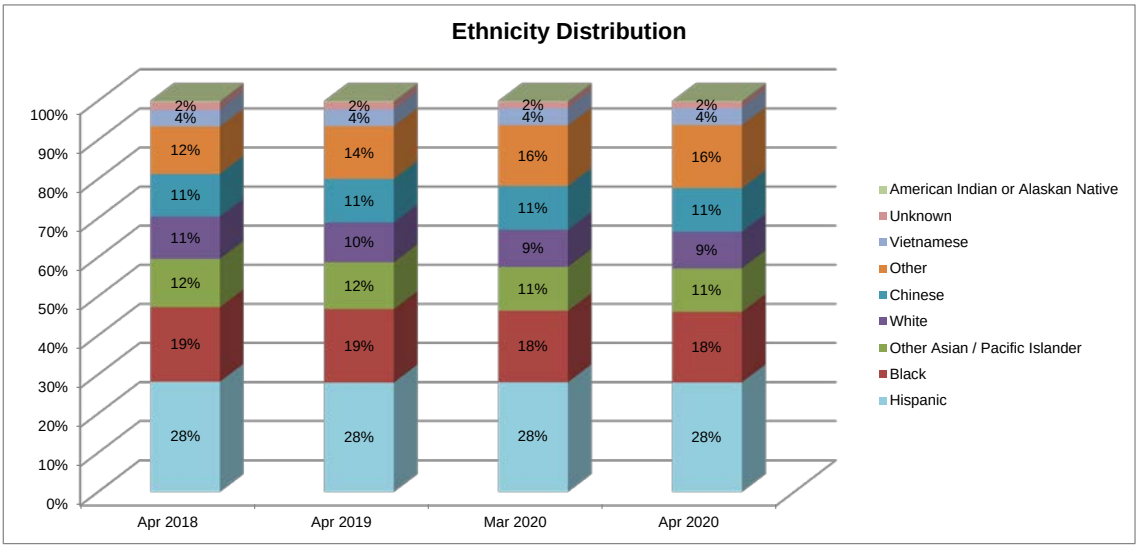
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Apr 2018	Apr 2019	Mar 2020	Apr 2020	Apr 2018	Apr 2019	Mar 2020	Apr 2020	Apr 2018 to Apr 2019	Apr 2019 to Apr 2020	Mar 2020 to Apr 2020
F	144,165	139,906	133,844	135,011	54%	54%	54%	54%	-3%	-3%	1%
M	122,497	119,031	113,063	114,240	46%	46%	46%	46%	-3%	-4%	1%
Total	**266,662**	**258,937**	**246,907**	**249,251**	**100%**	**100%**	**100%**	**100%**	**-3%**	**-4%**	**1%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Apr 2018	Apr 2019	Mar 2020	Apr 2020	Apr 2018	Apr 2019	Mar 2020	Apr 2020	Apr 2018 to Apr 2019	Apr 2019 to Apr 2020	Mar 2020 to Apr 2020
Hispanic	75,061	72,383	69,186	69,755	28%	28%	28%	28%	-4%	-4%	1%
Black	50,898	48,646	45,120	44,971	19%	19%	18%	18%	-4%	-8%	0%
Other Asian / Pacific Islander	32,939	30,981	27,695	27,749	12%	12%	11%	11%	-6%	-10%	0%
White	28,815	26,448	23,400	23,355	11%	10%	9%	9%	-8%	-12%	0%
Chinese	29,157	28,806	27,724	27,754	11%	11%	11%	11%	-1%	-4%	0%
Other	32,366	35,013	38,390	40,272	12%	14%	16%	16%	8%	15%	5%
Vietnamese	11,440	11,175	10,722	10,741	4%	4%	4%	4%	-2%	-4%	0%
Unknown	5,253	4,816	4,103	4,076	2%	2%	2%	2%	-8%	-15%	-1%
American Indian or Alaskan Native	733	669	567	578	0%	0%	0%	0%	-9%	-14%	2%
Total	**266,662**	**258,937**	**246,907**	**249,251**	**100%**	**100%**	**100%**	**100%**	**-3%**	**-4%**	**1%**



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

Medi-Cal By City

City	Apr 2020	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	99,850	41%	11,542	22,586	13,328	43,101	9,293
Hayward	37,554	15%	8,019	7,707	4,480	10,972	6,376
Fremont	21,120	9%	8,507	2,980	702	5,651	3,280
San Leandro	21,658	9%	3,759	3,162	3,181	8,150	3,406
Union City	10,345	4%	3,988	1,435	346	2,669	1,907
Alameda	9,533	4%	1,830	1,365	1,508	3,504	1,326
Berkeley	8,528	4%	1,092	1,436	1,157	3,644	1,199
Livermore	6,893	3%	940	586	1,612	2,600	1,155
Newark	5,557	2%	1,561	1,740	171	1,081	1,004
Castro Valley	5,704	2%	1,151	874	920	1,677	1,082
San Lorenzo	4,969	2%	882	794	635	1,726	932
Pleasanton	3,639	1%	881	338	394	1,428	598
Dublin	3,908	2%	929	342	521	1,423	693
Emeryville	1,512	1%	255	291	231	492	243
Albany	1,396	1%	161	196	318	466	255
Piedmont	244	0%	40	58	18	74	54
Sunol	52	0%	10	8	6	11	17
Antioch	16	0%	4	3	3	5	1
Other	625	0%	119	150	88	194	74
Total	**243,103**	**100%**	**45,670**	**46,051**	**29,619**	**88,868**	**32,895**

Group Care By City

City	Apr 2020	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	2,165	35%	571	382	-	1,212	-
Hayward	678	11%	387	122	-	169	-
Fremont	659	11%	504	47	-	108	-
San Leandro	574	9%	223	74	-	277	-
Union City	329	5%	237	30	-	62	-
Alameda	285	5%	118	27	-	140	-
Berkeley	197	3%	56	21	-	120	-
Livermore	84	1%	35	1	-	48	-
Newark	139	2%	91	28	-	20	-
Castro Valley	190	3%	101	20	-	69	-
San Lorenzo	116	2%	50	18	-	48	-
Pleasanton	48	1%	25	3	-	20	-
Dublin	101	2%	49	5	-	47	-
Emeryville	30	0%	14	3	-	13	-
Albany	14	0%	6	1	-	7	-
Piedmont	10	0%	2	1	-	7	-
Sunol	-	0%	-	-	-	-	-
Antioch	26	0%	9	6	-	11	-
Other	503	8%	215	65	-	223	-
Total	**6,148**	**100%**	**2,693**	**854**	**-**	**2,601**	**-**

Total By City

City	Apr 2020	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	102,015	41%	12,113	22,968	13,328	44,313	9,293
Hayward	38,232	15%	8,406	7,829	4,480	11,141	6,376
Fremont	21,779	9%	9,011	3,027	702	5,759	3,280
San Leandro	22,232	9%	3,982	3,236	3,181	8,427	3,406
Union City	10,674	4%	4,225	1,465	346	2,731	1,907
Alameda	9,818	4%	1,948	1,392	1,508	3,644	1,326
Berkeley	8,725	4%	1,148	1,457	1,157	3,764	1,199
Livermore	6,977	3%	975	587	1,612	2,648	1,155
Newark	5,696	2%	1,652	1,768	171	1,101	1,004
Castro Valley	5,894	2%	1,252	894	920	1,746	1,082
San Lorenzo	5,085	2%	932	812	635	1,774	932
Pleasanton	3,687	1%	906	341	394	1,448	598
Dublin	4,009	2%	978	347	521	1,470	693
Emeryville	1,542	1%	269	294	231	505	243
Albany	1,410	1%	167	197	318	473	255
Piedmont	254	0%	42	59	18	81	54
Sunol	52	0%	10	8	6	11	17
Antioch	42	0%	13	9	3	16	1
Other	1,128	0%	334	215	88	417	74
Total	**249,251**	**100%**	**48,363**	**46,905**	**29,619**	**91,469**	**32,895**

PRELIMINARY BUDGET

FISCAL YEAR 2020/2021

ALAMEDA Alliance FOR HEALTH

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

June 12, 2020

Budget Process

- Preliminary budget presented to Finance Committee on June 9th and the Board of Governors on June 12th.
- DHCS has communicated CY 2021 rates will be delivered in September.
- Final budget presented to Board of Governors in the October / November timeframe.
- Alliance coordinated with Alameda County Public Authority and Social Services for renewal of Group Care (IHSS).
- Governor's May Revise to be finalized by mid-June.

Budget Assumptions FY 2021

FY 2021 Budget compared to FY 2020 Forecast

Revenue:

- 97% of revenue for Medi-Cal, 3% for Group Care.

Staffing:

- Headcount is 354 full-time employees by June 30, 2021.
- There are 37 new positions budgeted. The new positions are in Operations (16), Health Care Services (6), Compliance (4), Executive (1), Projects and Programs (3), Human Resources (3), Information Technology (2), Finance (1), Performance and Analytics (1).
- Of the new positions,12 are related to increased administrative burden, 11 stem from membership growth, 9 are related to new and expanded mandates, and 5 are related to restructuring and new projects.

Enrollment:

- Medi-Cal enrollment typically peaks in December and gradually declines by June 2021.
- Group Care enrollment remains steady at approximately 6,000.
- Federal and State continue to fund Health Homes and Whole Person Care (AC3). Enrollment remains relatively constant at approximately 900 members.

Budget Assumptions FY 2021 (cont'd)

FY 2021 Budget compared to FY 2020 Forecast

Medical Expense:

- Medical loss ratio is 95.0%, an increase of 2.0%.
- Underlying utilization trend is 0.5%, unit cost trend is 0.4%.

Reimbursement Rates:

- Medi-Cal base rates assumed to decrease by 9.4% on a per member/per month basis, equating to a decrease of $70.2M in revenue.
- Pharmacy is carved out of Medi-Cal beginning in January 2021, resulting in reduced revenue of $64.2 million. Pharmacy revenue of $63.9M remains for July to December 2020. Analysis in process to estimate reimbursement for Physician Administered Drugs.
- Governor's May Revision to the budget proposes 1.5% rate cuts (ACA/Optional Expansion, Adult, Child and SPDs) for the rate bridge period (July 2019 to December 2020). Additional rate cut of 3% in CY 2021.
- Group Care rate increases by 9% from current rates.

Hospital & Provider Rates (Alliance to the Providers):

- Hospital contract rates increase by $6.9 million in the year.
- Professional capitation rates increase by $0.4 million in the year.

Summary of Proposed Budget to the Board of Governors

FY 2021 Budget compared to FY 2020 Forecast

- Membership is 267,000 in Medi-Cal & Group Care, approximately 9,000 members higher (primarily Medi-Cal). Increase is due to higher unemployment.
- Revenue is $917.5 million, $45.4 million lower as compared to FY 2020.
- Medical expenses are $871.2 million, $23.6 million lower. This is comprised of the carve-out of pharmacy services, offset by contract changes and increasing trends.
- $4.5 million in medical and operational expense savings are included in the net results.
- Administrative expenses are 8.1% of revenue, $11.1 million higher. Led by labor ($5.8 million) and purchased and professional services ($3.9 million).
- $8.4 million Safety-Net Sustainability Funds are budgeted in FY 2020, additional $8.2 million budgeted in FY 2021.
- Tangible Net Equity of 541% or $174.9 million projected by June 2021.
- Net loss is $26.8 million. Medi-Cal is $26.3 million net loss and Group Care is $500,000 net loss.

Summary of Proposed Budget to the Board of Governors

FY 2021 Budget compared to FY 2020 Forecast

Medical and Operational Savings Initiatives:

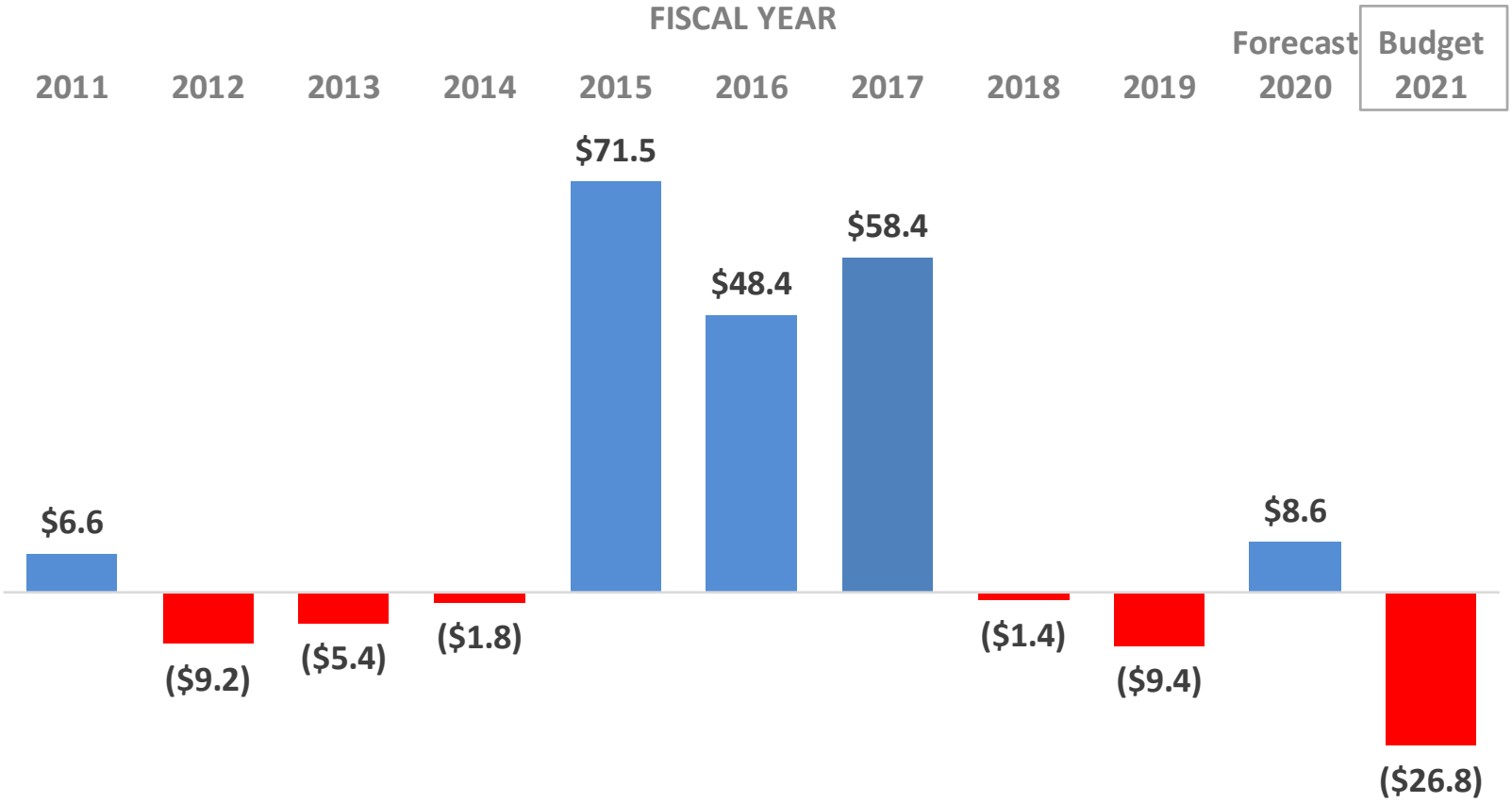
- Reduce inpatient readmissions by 1.0%: $1.6 million
- Identify eligible Medi-Cal only ESRD members, offer Medicare options: $1.0 million
- Increased use of biosimilar medications: $540,000
- Transportation policy changes: $500,000
- Alignment of Prior Authorizations in claims and care management systems: $500,000
- Third Party Liability and Coordination of Benefits recoupment: $330,000

Preliminary Budget FY 2021 comparison to FY 2020 Forecast

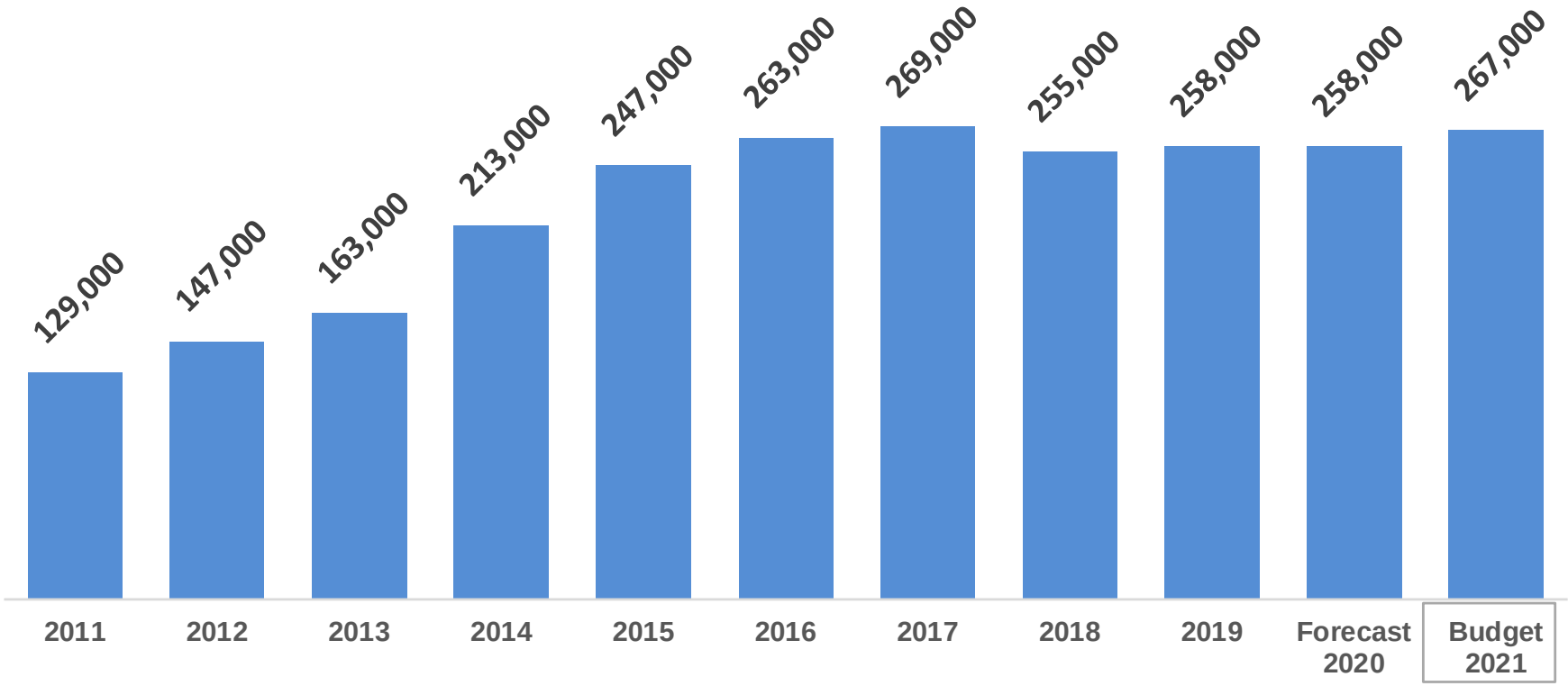
FY 2021 Budget compared to FY 2020 Forecast

$ in Thousands	FY 2021 Budget			FY 2020 Forecast			Variance F/(U)		
	Medi-Cal	Group Care	Total	Medi-Cal	Group Care	Total	Medi-Cal	Group Care	Total
Enrollment at Year-End	***260,282***	***6,600***	***266,882***	***251,489***	***6,271***	***257,760***	***8,793***	***329***	***9,122***
Member Months	***3,179,601***	***78,263***	***3,257,864***	***2,946,176***	***73,033***	***3,019,209***	***233,425***	***5,230***	***238,655***
Revenues	$888,230	$29,263	$917,492	$937,955	$24,945	$962,900	($49,725)	$4,318	($45,408)
Medical Expense	844,166	27,073	871,239	871,111	23,685	894,796	26,946	(3,388)	23,557
Gross Margin	**44,064**	**2,189**	**46,253**	**66,844**	**1,260**	**68,104**	**(22,780)**	**929**	**(21,850)**
Administrative Expense	71,878	2,749	74,627	61,464	2,019	63,483	(10,414)	(729)	(11,143)
Operating Margin	**(27,814)**	**(559)**	**(28,373)**	**5,380**	**(759)**	**4,620**	**(33,194)**	**200**	**(32,994)**
Other Income / (Expense)	1,526	54	1,580	3,822	117	3,939	(2,296)	(63)	(2,359)
Net Income / (Loss)	**($26,288)**	**($505)**	**($26,793)**	**$9,202**	**($642)**	**$8,560**	**($35,490)**	**$137**	**($35,353)**
Administrative Expense % of Revenue	**8.1%**	**9.4%**	**8.1%**	**6.6%**	**8.1%**	**6.6%**	**-1.5%**	**-1.3%**	**-1.5%**
Medical Loss Ratio	**95.0%**	**92.5%**	**95.0%**	**92.9%**	**94.9%**	**92.9%**	**-2.2%**	**2.4%**	**-2.0%**
TNE at Year-End			**$174,922**			**$198,777**			**($23,855)**
TNE Percent of Required at Year-End			**541.3%**			**611.6%**			**(70.3%)**

Operating Performance: 2011 to 2021: Net Profit (Loss)

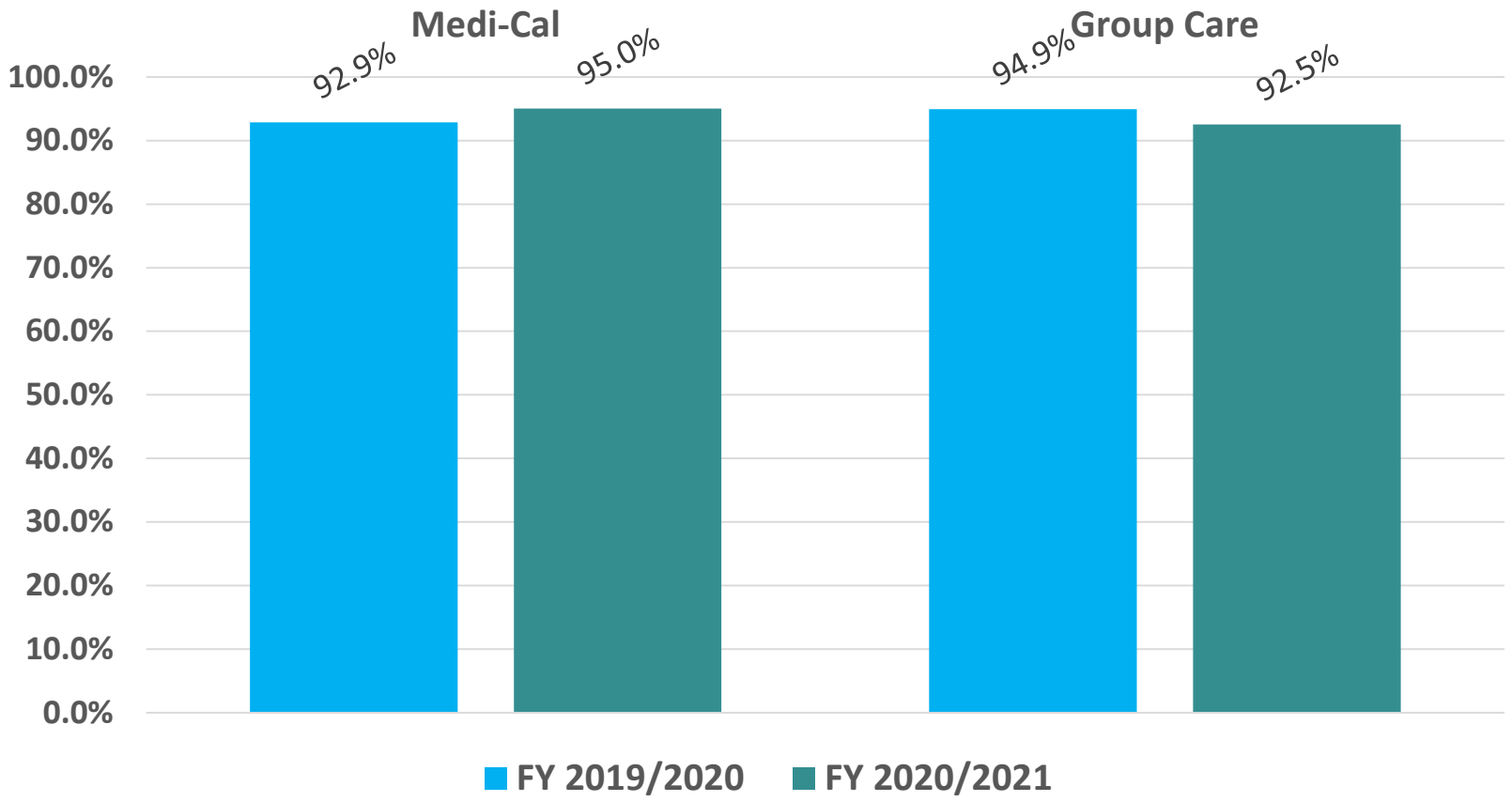


Enrollment Year End: 2011 to 2021



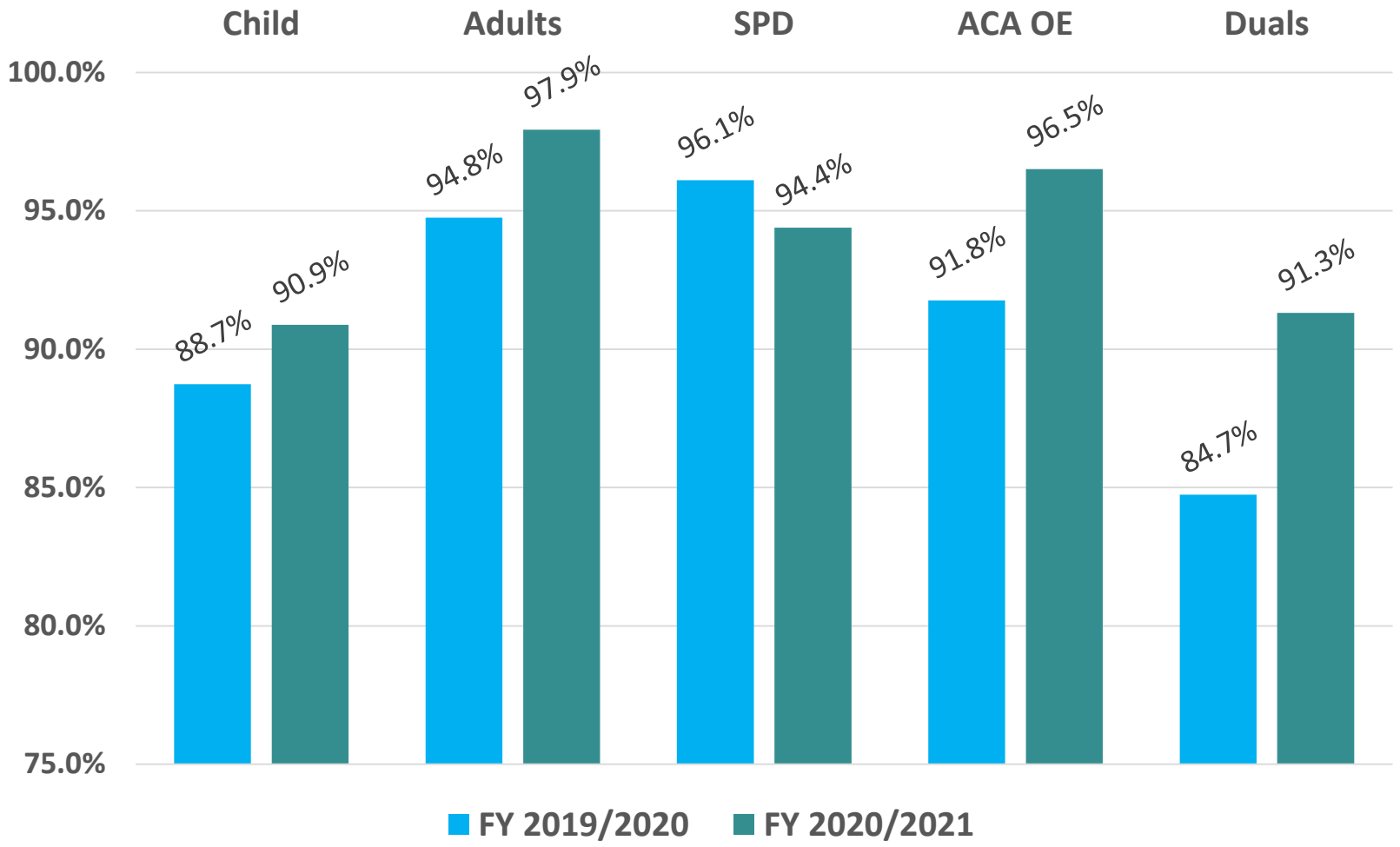
Medical Loss Ratio by Line of Business

FY 2021 Budget compared to FY 2020 Forecast

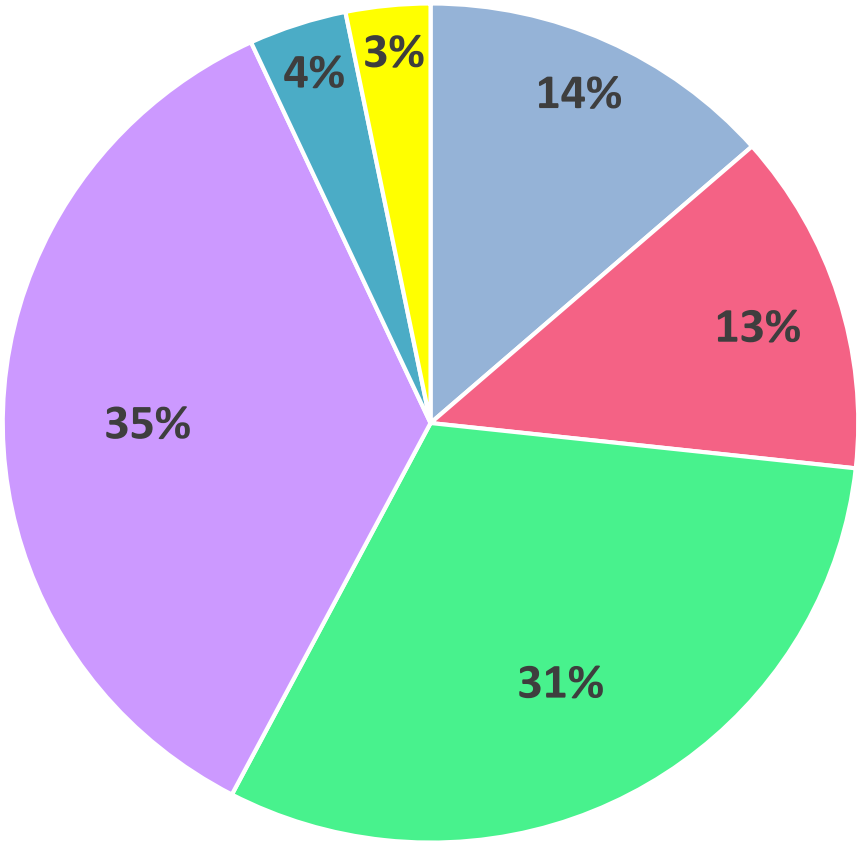


Medical Loss Ratio by Medi-Cal Aid Category

FY 2021 Budget compared to FY 2020 Forecast



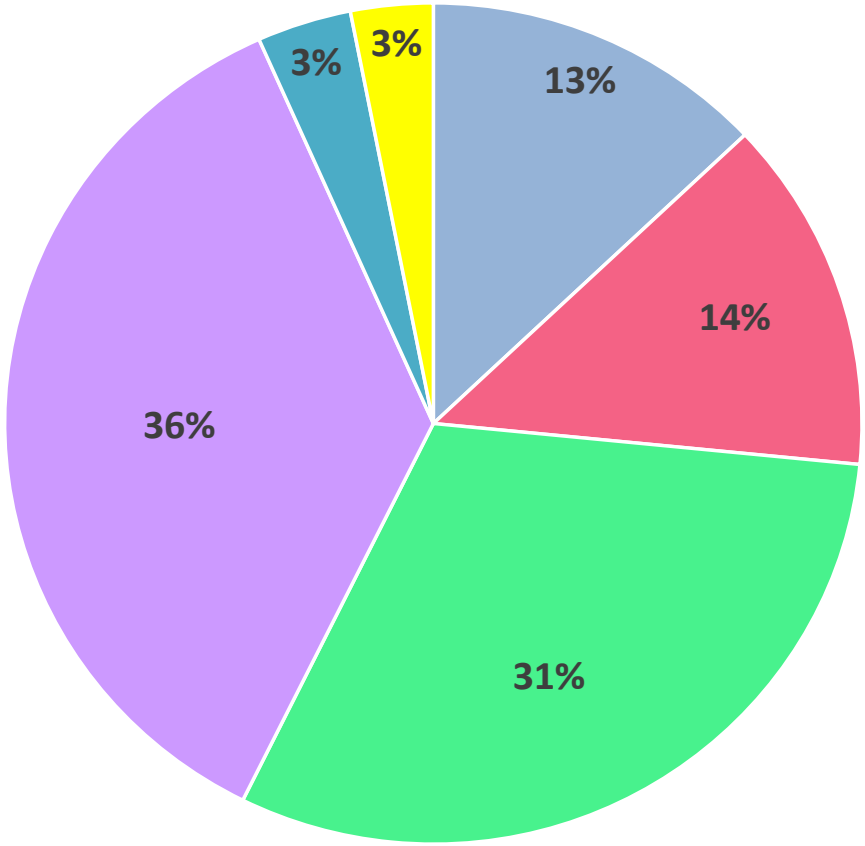
FY 2021 Revenue by Aid Category & Group Care



MEDI-CAL

Child	14%
Adults	13%
SPD	31%
ACA OE	35%
Duals	4%
Group Care	3%

FY 2021 Medical Expense by Aid Category & Group Care



MEDI-CAL

Child	13%
Adults	14%
SPD	31%
ACA OE	36%
Duals	3%
Group Care	3%

FY 2021 Administrative Expenses

Addition of $11.1 million in operating expenses:

• Employee expense increases	$5.8 million
• Member benefits administration	($1.0) million
• Projects and professional services	$3.9 million
• Technology infrastructure & licensing	$0.5 million
• Supplies, postage, and other expenses	$2.0 million
Total	**$11.1 million**

FY 2021 Capital Expenses

Approximately $2.5 million in capitalized purchases for technology and facilities enhancements ($1.3 million more than FY 2020).

- **Information Technology: $1.8 million**
  - **Hardware: $1.6 million**
    - Network, Hardware, and Cabling: $600,000
    - Voice Infrastructure, Laptops, Desktops, Monitors: $500,000
    - Application Server Room Hardware: $500,000
  - **Software: $100,000**
    - Monitoring Software, Licensing and Upgrades: $100,000
- **Facilities: $0.7 million**
  - Building Upgrades & Construction: $400,000
  - Workspace Resources: Cubicles, Workstations, Furniture: $300,000

Clinical & Administrative Expenses by Line of Business

$ In Thousands

	Administrative Departments			Clinical Departments			Total
	Medi-Cal	Group Care	Total	Medi-Cal	Group Care	Total	
Employee Related Expense	$33,159	$1,173	$34,332	$14,785	$523	$15,307	49,640
Member Benefits Administration	$5,481	$339	$5,819	$5,517	$0	$5,517	11,336
Purchased & Professional Services	$11,237	$435	$11,672	$4,786	$195	$4,981	16,653
Other	$22,001	$802	$22,803	$1,319	$46	$1,365	24,168
Total	**$71,878**	**$2,749**	**$74,627**	**$26,406**	**$764**	**$27,170**	**$101,797**

Staffing: Administrative & Clinical FTEs*

Administrative FTEs	FY20 YE Actual	Hire in FY21	FY21 YE Budget
Administrative Vacancy	(26.3)	(2.1)	(28.5)
Operations	3.0	0.0	3.0
Executive	2.0	1.0	3.0
Finance	19.0	4.0	23.0
Healthcare Analytics	12.0	1.0	13.0
Claims	37.0	3.0	40.0
Information Technology	5.0	(2.0)	3.0
IT Infrastructure	12.0	1.0	13.0
IT Applications	13.0	8.0	21.0
IT Development	27.0	(13.0)	14.0
IT Data Exchange	0.0	8.0	8.0
Member Services	42.0	10.0	52.0
Provider Relations	17.0	9.0	26.0
Network Data Validation	8.0	(8.0)	0.0
Credentialing	2.0	1.0	3.0
Health Plan Operations	1.0	0.0	1.0
Human Resources	7.0	3.0	10.0
Vendor Management	6.0	(2.0)	4.0
Legal	0.0	2.0	2.0
Facilities	7.0	2.0	9.0
Community Relations	8.0	0.0	8.0
Regulatory Compliance	10.0	3.0	13.0
Delegation Oversight and G&A	10.0	0.0	10.0
Project Office	3.0	3.0	6.0
Total Administrative FTEs	**224.6**	**31.9**	**256.5**

Clinical FTEs	FY20 YE Actual	Hire in FY21	FY21 YE Budget
Clinical Vacancy	(7.7)	(0.9)	(8.5)
Quality Analytics	6.0	0.0	6.0
Utilization Management	36.4	0.0	36.4
Disease Mgmt. / Care Mgmt.	28.0	(1.0)	27.0
Medical Services	4.5	0.5	5.0
Quality Management	17.0	3.0	20.0
Pharmacy Services	11.0	(1.0)	10.0
Regulatory Readiness	2.0	0.0	2.0
Total Clinical FTEs	**97.2**	**0.6**	**97.8**

Total FTEs	**321.8**	**32.5**	**354.3**

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

ALAMEDA Alliance FOR HEALTH

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

Operations

Matt Woodruff

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

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

Date: **June 12, 2020**

Subject: **Operations Report**

Member Services

- 12-month Trend Summary:

    - The Member Services Department received a forty-two (42%) percent decrease in calls in May 2020, totaling 9,893 compared to 17,196 in May 2019.
    - The abandonment rate for May 2020 was three percent (3%), which was one percent greater, 2%, than in May 2019.
    - The service level for the Department was the same in May 2020, eighty-seven percent (87%), as that of May 2019.
    - The Department continues to service members via multiple non-contact communication channels (telephonic, email, web-based requests) while honoring the 'shelter in place" order. The Department responded to 451 web-based requests in May 2020.
    - Member Services conducted over 2860 outreach calls to 1770 at-risk members as part of the Outbound Call Campaign to our vulnerable population. Of the 1718 members reached, fifty-two (52) member referrals were made to case management for follow-up, and sixteen (16) members were connected to 211 (housing/food)/Beacon mental health services.
    - The top five call reasons for May 2020 were: 1) Eligibility/Enrollment **2). Kaiser**, 3). Change of PCP 4). Benefits, 5). ID Card**.** The top five call reasons for May 2019 were: 1) Eligibility/Enrollment **2). Change PCP** 3). Kaiser, 4). Benefits, 5). Kaiser assignment requests were higher in May 2020 compared to the Change of PCP requests in 2019.
    - The average talk time (ATT) was eight minutes and thirty-one seconds (08:31) for May 2020 compared to seven minutes and eighteen seconds (07:18) for May 2019.

Claims

- 12-Month Trend Summary:

    - The Claims Department received 89,063 claims in May 2020 compared to 121,763 in May 2019.
    - The Auto Adjudication was 73.6% in May 2020 compared to 72.7% in May 2019.
    - Claims Compliance for the 30-day turn-around time was 98.1% in May 2020 compared to 98.8% in May 2019. The 45-day turnaround time was 100% in May 2020 compared to 99.9% in May 2019.

- Monthly Analysis:

    - In May, we received a total of 89,063 claims in the HEALTHsuite system. This represents a modest 2.9% increase from April; 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 May, 100% of our claims were processed within 45 working days!
    - The Auto Adjudication rate was 73.6% for May.

Provider Services

- 12-Month Trend Summary:

    - The Provider Services Department's call volume in May 2020 was 5,740, compared to 6,926 calls in May 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 230 visits/telephonic calls during May 2020.
    - The Provider Services department answered over 5,740 calls for May 2020 and made over 1,032 outbound calls.

Credentialing

- 12-Month Trend Summary:
    - At the Peer Review and Credentialing (PRCC) meeting held on May 19, 2020, there were eleven (11) initial providers approved; two (2) primary care provider, seven (7) specialists, one (1) ancillary provider, and one (1) midlevel provider. Additionally, sixteen (16) providers were re-credentialed at this meeting; two (2) primary care providers, eleven (11) specialists, two (2) ancillary providers, 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 May 2020, the Provider Dispute Resolution (PDR) team received 812 PDRs versus 762 in May 2019.
    - The PDR team resolved 603 cases in May 2020, compared to 505 cases in May 2019.
    - In May 2020, the PDR team upheld 67% of cases versus 75% in May 2019.
    - The PDR team resolved 100% of cases within the compliance standard of 95% within 45 working days in May 2020, compared to 96% in May 2019.

- Monthly Analysis:
    - AAH received 812 PDRs in May 2020.
    - In May, 603 PDRs were resolved. Out of the 603 PDRs, 404 were upheld, and 199 were overturned.
    - The overturn rate for PDRs was 33%, which did not meet our goal of 25% or less.
        - Of the 199 overturned PDRs, 33 were attributed to one specific CES error, which has since been corrected. 27 overturned PDRs were related to surgery center claims where there was a delay in entering new ASC rates. Without these two issues, the overturn rate would have been 24%.

- 45% 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.
- 603 out of 603 cases were resolved within 45 working days resulting in a 100% compliance rate.
- There are 343 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 32 events (0% completion rate) in May 2020, compared to 51 out of 67 events (76% completion rate) in May 2019.
  - The C&O Department reached 278 people in the community in May 2020, compared to 1,412 in May 2019.
  - The C&O Department events were held in 0 cites / unincorporated areas throughout Alameda County in May 2020, compared to 13 cities/unincorporated areas in May 2019.

- Monthly Analysis:

  - In May 2020, the C&O Department completed 0 out of 32 events (0% completion rate). The Outreach team also completed 278 net new member orientations by phone.
  - In May 2020, the C&O Department reached 278 individuals (278 or 100% self-identified as Alliance members) during outreach activities.
  - In May 2020, the C&O Department completed events in 0 cities/unincorporated areas throughout Alameda County.
  - Please see attached Addendum A.

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	May 2020
Incoming Calls (R/V)	9893
Abandoned Rate (R/V)	3%
Answered Calls (R/V)	9552
Average Speed to Answer (ASA)	00:25
Calls Answered in 30 Seconds (R/V)	87%
Average Talk Time (ATT)	08:31
Outbound Calls	10737

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

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

Claims Department
April 2020 Final and May 2020 Final

METRICS

Claims Compliance	Apr-20	May-20
90% of clean claims processed within 30 calendar days	96.7%	98.1%
95% of all claims processed within 45 working days	99.9%	100.0%

Claims Volume (Received)	Apr-20	May-20
Paper claims	26,775	21,632
EDI claims	59,803	67,431
Claim Volume Total	**86,578**	**89,063**

Percentage of Claims Volume by Submission Method	Apr-20	May-20
% Paper	30.93%	24.29%
% EDI	69.07%	75.71%

Claims Processed	Apr-20	May-20
HEALTHsuite Paid (original claims)	93,013	69,503
HEALTHsuite Denied (original claims)	29,509	26,443
HEALTHsuite Original Claims Sub-Total	**122,522**	**95,946**
HEALTHsuite Adjustments	3,725	3,411
HEALTHsuite Total	**126,247**	**99,357**

Claims Expense	Apr-20	May-20
Medical Claims Paid	$48,392,341	$39,230,002
Interest Paid	$30,207	$37,539

Auto Adjudication	Apr-20	May-20
Claims Auto Adjudicated	91,539	70,650
% Auto Adjudicated	74.7%	73.6%

Average Days from Receipt to Payment	Apr-20	May-20
HEALTHsuite	24	20

Pended Claim Age	Apr-20	May-20
0-29 calendar days		
HEALTHsuite	8,970	10,533
30-59 calendar days		
HEALTHsuite	89	64
Over 60 calendar days		
HEALTHsuite	0	0

Overall Denial Rate	Apr-20	May-20
Claims denied in HEALTHsuite	29,509	26,443
% Denied	23.4%	26.6%

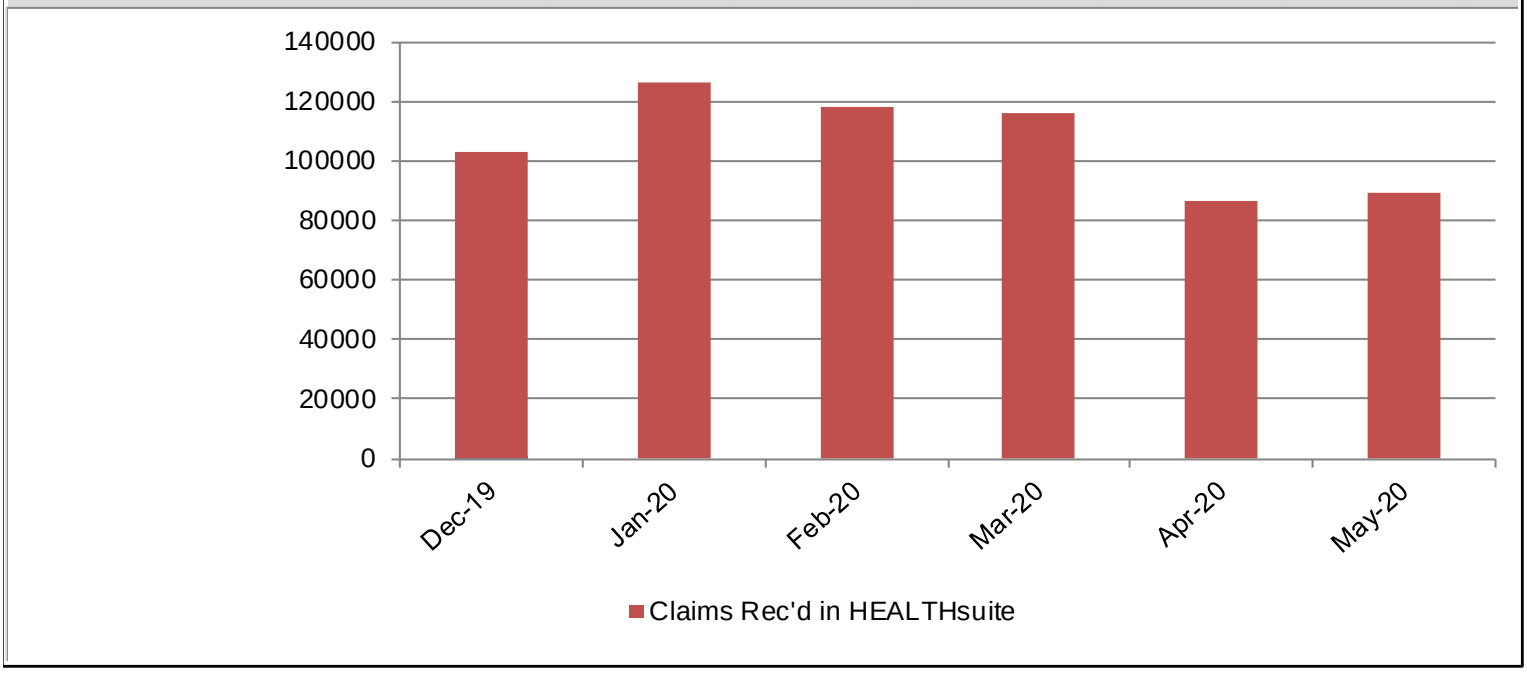
Claims Department
April 2020 Final and May 2020 Final

May-20

Top 5 HEALTHsuite Denial Reasons	% of all denials
Duplicate Claim	21%
Responsibility of Provider	17%
Must Submit as a Paper Claim with Copy of Primary Payer EOB	9%
Non-Covered Benefit for this Plan	9%
Per Medi-Cal Guidelines The Place of Service Code is Missing or Invalid for Procedure Code	7%
% Total of all denials	**63%**

Claims Received By Month

Claims Received Through	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Claims Rec'd in HEALTHsuite	103,216	126,044	118,309	115,716	86,578	89,063



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

Provider Relations Dashboard May 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%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Benefits	4.7%	6.1%	0.6%	5.2%	4.3%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Claims Inquiry	40.7%	39.7%	41.9%	51.7%	54.8%	#DIV/0!	#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%	#DIV/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%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Contracts	0.2%	0.4%	0.3%	0.3%	0.4%	#DIV/0!	#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%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Demographic Change	0.1%	0.1%	0.1%	0.0%	0.1%	#DIV/0!	#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%	#DIV/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%	#DIV/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%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Health Education	0.1%	0.0%	0.0%	0.0%	0.0%	#DIV/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%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Kaiser	0.1%	0.3%	0.0%	0.3%	0.2%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Member bill	0.0%	0.0%	0.7%	0.8%	1.0%	#DIV/0!	#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%	#DIV/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%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Pharmacy	0.8%	1.0%	0.7%	0.8%	0.8%	#DIV/0!	#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%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Transferred Call	0.1%	0.0%	0.1%	0.0%	0.0%	#DIV/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%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Field Visit Activity Details

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

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS

Credentialed Practitioners		AHP 393	PCP 360	SPEC 663	PCP/SPEC 19
AAH/AHS/CHCN Breakdown		AAH 440	AHS 204	CHCN 417	COMBINATION OF GROUPS 374
Facilities	**252**				

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	43	33	25	Y	Y
Recred Files in Process	109	45	25	Y	Y
Expirables updated Insurance, License, DEA, Board Certifications					Y
Files currently in process	**152**				

CAQH Applications Processed in May 2020

Standard Providers and Allied Health	**Invoice not received**

May 2020 Peer Review and Credentialing Committee Approvals

Initial Credentialing	**Number**
PCP	2
SPEC	7
ANCILLARY	1
MIDLEVEL/AHP	1
	11
Recredentialing	
PCP	2
SPEC	11
ANCILLARY	2
MIDLEVEL/AHP	1
	16
TOTAL	**27**

May 2020 Facility Approvals

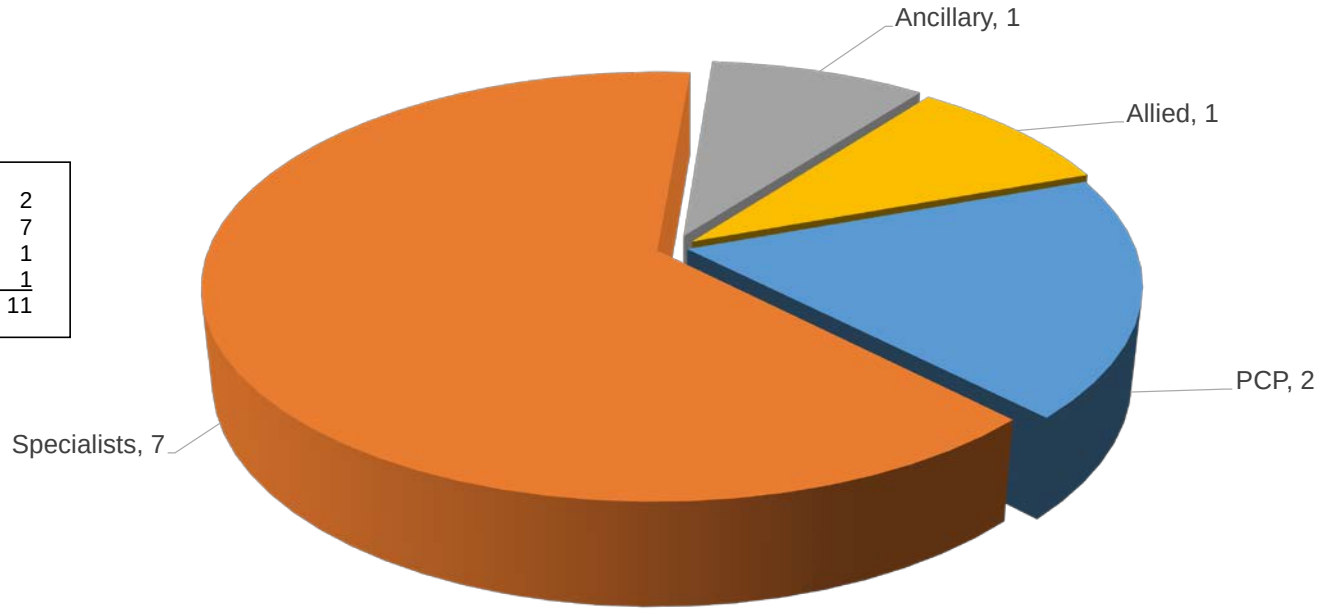
Initial Credentialing	3
Recredentialing	0
Facility Files in Process	37

May 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**
Abe	Shoko	Specialist	Initial	5/19/2020
Berger	Victoria	Specialist	Initial	5/19/2020
Browder	Timothy	Specialist	Initial	5/19/2020
Chen	Steven	Specialist	Initial	5/19/2020
Chou	Christina	Specialist	Initial	5/19/2020
Goodwin	Karen	Specialist	Initial	5/19/2020
Jenkins	Gerard	Specialist	Initial	5/19/2020
Karamloo	Sara	Specialist	Initial	5/19/2020
Kelsen	Kenneth	Specialist	Initial	5/19/2020
Low	Jennifer	Specialist	Initial	5/19/2020
Younes	Samantha	Specialist	Initial	5/19/2020
Barez	Shirin	Specialist	Recred	5/19/2020
Chan	Sue	Specialist	Recred	5/19/2020
Chen	Kevin	Specialist	Recred	5/19/2020
Cheung	Norman	Specialist	Recred	5/19/2020
Harrell	Jill	Specialist	Recred	5/19/2020
Japra	Romesh	Specialist	Recred	5/19/2020
Kunwar	Sandeep	Specialist	Recred	5/19/2020
Kurkjian	Elizabeth	Specialist	Recred	5/19/2020
Kwan	Diane	Specialist	Recred	5/19/2020
Lee	Ivan	Specialist	Recred	5/19/2020
Lilja	James	Specialist	Recred	5/19/2020
Lo	Irene	Specialist	Recred	5/19/2020
Lynch	Bonney	Specialist	Recred	5/19/2020
McNeil	Enav	Specialist	Recred	5/19/2020
Patel	Bimal	Specialist	Recred	5/19/2020
Sidhu	Pramodh	Specialist	Recred	5/19/2020

MAY PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY

PCP	2
Specialists	7
Ancillary	1
Allied	1
Total	11

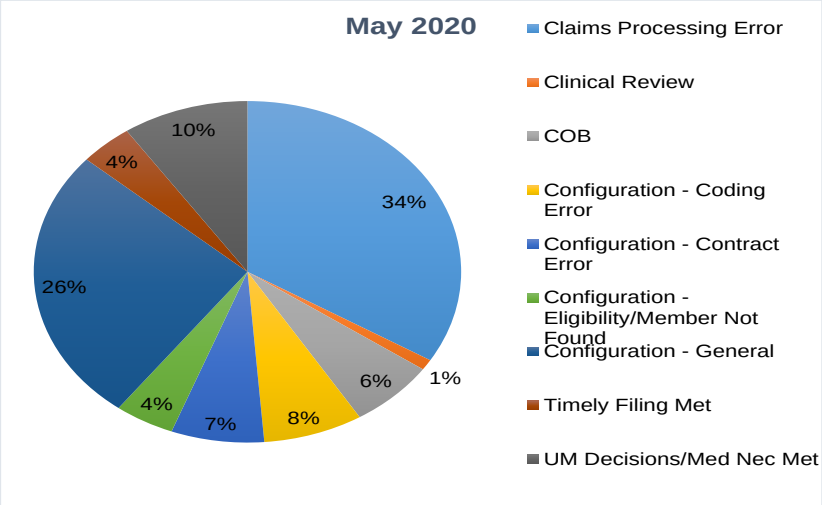


Provider Dispute Resolution
April 2020 Final and May 2020 Final

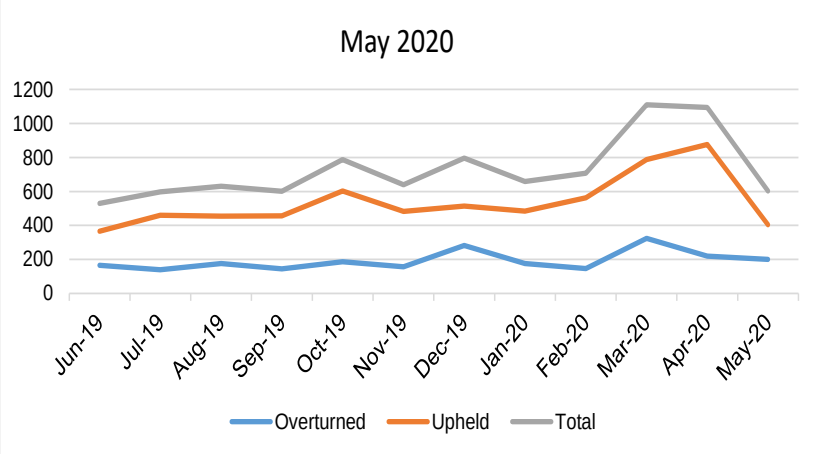
METRICS		
PDR Compliance	**Apr-20**	**May-20**
# of PDRs Resolved	1,095	603
# Resolved Within 45 Working Days	1,095	603
% of PDRs Resolved Within 45 Working Days	100%	100%
PDRs Received	**Apr-20**	**May-20**
# of PDRs Received	742	812
PDR Volume Total	**742**	**812**
PDRs Resolved	**Apr-20**	**May-20**
# of PDRs Upheld	876	404
% of PDRs Upheld	80%	67%
# of PDRs Overturned	219	199
% of PDRs Overturned	20%	33%
Total # of PDRs Resolved	**1,095**	**603**
Unresolved PDR Age	**Apr-20**	**May-20**
0-45 Working Days	411	343
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**411**	**343**

May-20

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



Project Management Office Portfolio Overview for May 2020

Alliance Portal Redesign Project

Finalizing Phase 2 and 3 scope in progress

HX pre-requisite training courses complete for Member Portal requirement gathering session

- Level 100- Member Portal (Basic Admin Training)
- Level 200 (Advanced Administrative Tools Training)
- Level 300 Content Management Training)
- Level 400 (Express Request Training)

Contract Database Project

- On hold

Preferred Vendor Project

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 | MAY 2020 OUTREACH REPORT

ALLIANCE IN THE COMMUNITY

FY 2019-2020 | MAY 2020 OUTREACH REPORT

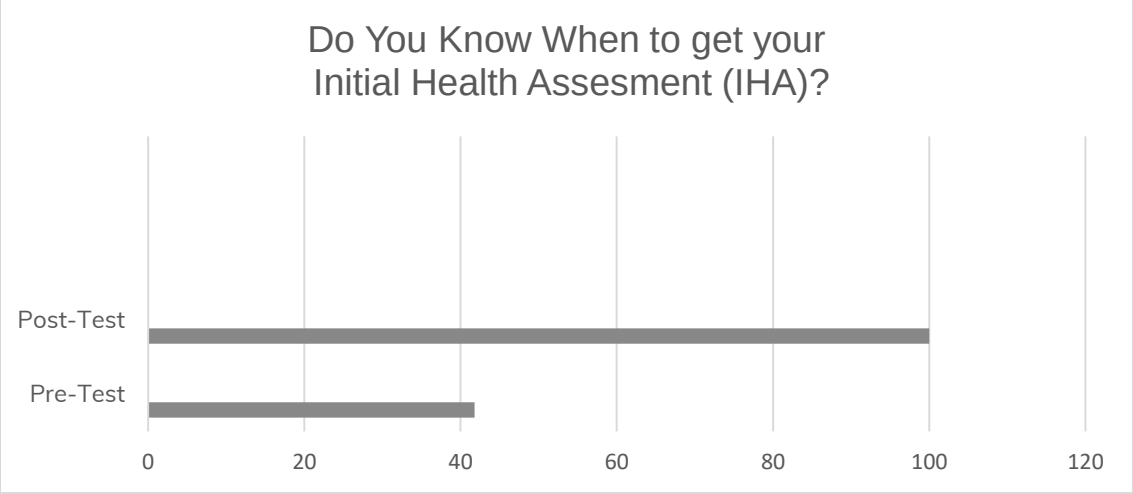
During May 2020, the Alliance initiated and/or was invited to participate in a total of **32** events throughout Alameda County. The Alliance completed **0** out of the **32** events (**0%**). The Alliance reached a total of **278** members, and spent a total of **$0** in donation, fees, and sponsorships in May 2020.

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, **20,020** self-identified Alliance members were reached during outreach activities.

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.

The Alliance Member Orientation (MO) program has been in place since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Assessment, by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our last 6 month average participation rate was **111** members per month. Between May 1, through May 31, 2020 (20 working days) – **278** net new members completed a MO by phone.

After completing a MO **100%** of members who completed the survey in May 2020 reported knowing when to get their IHA, compared to only **42%** of members knowing when to get their IHA in the pre-test.



All report details can be reviewed at: **W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Outreach Reports\FY 19-20\Q4\2. May 2020**

ALLIANCE IN THE COMMUNITY

FY 2019-2020 | MAY 2020 OUTREACH REPORT

FY 2018-2019 MAY 2019 TOTALS

26 COMMUNITY EVENTS
12 MEMBER EDUCATION EVENTS
24 MEMBER ORIENTATIONS
5 MEETINGS/ PRESENTATIONS
67 TOTAL INITIATED/ INVITED EVENTS
51 TOTAL COMPLETED **EVENTS**

13 CITIES

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

698 TOTAL REACHED AT COMMUNITY EVENTS
350 TOTAL REACHED AT MEMBER EDUCATION EVENTS
168 TOTAL REACHED AT MEMBER ORIENTATIONS
196 TOTAL REACHED AT MEETINGS/PRESENTATIONS
337 MEMBERS REACHED AT ALL EVENTS
1412 **TOTAL REACHED AT ALL EVENTS**

$700
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

FY 2019-2020 MAY 2020 TOTALS

4 COMMUNITY EVENTS
7 MEMBER EDUCATION EVENTS
19 MEMBER ORIENTATIONS
2 MEETINGS/ PRESENTATIONS
0 COMMUNITY TRAINING
32 TOTAL INITIATED/ INVITED EVENTS
0 TOTAL COMPLETED **EVENTS**

0 CITIES

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

$0
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

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: **June 12, 2020**

Subject: **Compliance Report**

State Audit Updates

- 2019 DMHC Financial Audit:
  - The DMHC conducted a routine financial audit starting in December that reviewed the Plan's financial performance, claims processing, and provider dispute resolutions (PDR). The preliminary audit report was issued by DMHC on 2/13/20 that included five (5) findings. The Plan submitted its CAP responses to the DMHC on 4/3/20 to address the deficiencies. The Plan had a follow up call with the DMHC and has submitted additional documentation and reports to support the CAP responses. The DMHC issues its final report on May 22. Four of the five items are now considered completed and closed. The final open item requires an updated response by June 21. The DMHC plans to publish the final report to its public site after June 11.

- 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 will receive the preliminary audit report within the next 3-6 months identifying if the findings have been corrected. The DMHC has requested additional detailed information regarding Potential Quality Issue (PQI) case files. The Plan has provided all requested information to the Department, and is currently awaiting any follow-up requests.

- 2020 DMHC Medical Audit:
  - DMHC has not indicated any changes to the scheduled 2020 full survey. The audit is still currently scheduled for October 12. The audit is likely to be conducted remotely.

- 2020 DHCS Medical Audit*:*
  - DHCS has postponed the annual medical audit previously scheduled in June due to COVID-19. The Plan's audit will be rescheduled for a later date.

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 hospitalizations daily to DHCS. As of 6/9/20, the Plan has had 133 members test positive for COVID-19 and 202 hospital admissions associated with COVID-19.

- Below are key requirements provided by the DMHC and DHCS related to COVID-19 guidance.

- Ensuring Continued Network Adequacy & Removing Unnecessary Burdens on Providers (DMHC All Plan Letter 20-020).

- The DMHC has requested that plans share with them any provisions undertaken to assist providers in mitigating hardships related to the current public health emergency. The DMHC's suggestions included accelerated claims payments, providing advanced capitation payments to providers, and suspending any administrative rules that providers deem burdensome (including allowing providers to contact plan call centers concerning unlimited numbers of claims per call). The DMHC limited this request to the commercial lines of business only, and requested plans with both Medi-Cal and commercial members to indicate if their affected providers serve both lines of business. The Plan provided our response on June 5. Our response included:

    - The establishment of the Plan's $16.6 million Sustainability Fund for providers

    - An average claims payment response time of eight days less than our customary 20 - 23 days

    - Waved co-pays for Group Care members receiving services related to emergency room visits, hospital stays, urgent care & outpatient services, and office visits

- Private Duty Nursing (PDN) Case Management Responsibilities for Members Under Age 21 (DHCS All Plan Letter 20-012):

    - On 5/15/2020, the DHCS released APL 20-012 which requires Medi-Cal plans to provide case management services to all members under age 21 who are approved for private duty nursing services. This includes any members whose care is managed by outside agencies (i.e. CCS). Plans must notify these members in writing by July 31.

Compliance

Supporting Documents

2019-2020 ALL PLAN LETTER (APL) IMPLEMENTATION TRACKING LIST						
#	Regulatory Agency	APL #	Date Released	APL Title	Summary of Key Requirements	Status
2019 APLS						
1	DMHC	19-001	1/11/2019 Revised - 1/25/2019	Health Plan Profile Webinars	1) Webinars pertaining to the collection of health plan data to occur between January 28th- March 8th 2) Sign up for webinars no later than January 24th 3) DMHC is targeting 05/01/2019 as the date for submission of all completed documents pertaining to the Health Plan Profile	Completed
2	DHCS	19-001	1/17/2019	Medi-Cal Managed Care Health Plan Guidance on Network Provider Status	1) Plans must ensure that providers meet the required characteristics of Network providers effective 07/01/2019 2) Ensure that all Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements 3) Must submit within 60 days (March 17th) any Network Provider Agreement boilerplates for hospital providers and 120 days (May 17th) for non-hospital that have been updated in accordance with requirements in this APL for review and approval prior to use 4) Ensure that all Network provider Agreements meet the Network Provider criteria in APL to guarantee eligibility for directed payments for rating periods starting 07/01/2019 5) Communicate to all delegates and subcontractors requirements	Completed
3	DMHC	19-002	1/11/2019	Newly Enacted Statutes Impacting Health Plans	1) Update EOC, disclosure form, provider contracts and/or other plan documents 2) Review relevant plan documents to ensure they comply with newly passed legislation 3) Compliance with 2018 legislation document to be submitted by 03/01/2019	Completed
4	DHCS	19-002	1/30/2019	Network Certification Requirements	1) Submit a complete and accurate Annual Network Certification report/template (Attach B) no later than 105 days before the fiscal year begins 2) Submit geographic access maps or accessibility analysis that cover the entire service area 3) Submit alternative access request for each provider type and zip code combination in which neither time nor distance standard were met 4) P&Ps must reflect current access standards, which redefine Alameda County as a dense county subject to the strictest standards	Completed
5	DMHC	19-003	1/14/2019	SB- 137 Guidance Regarding Provider Directory Annual Findings	1) Submit through the eFiling web portal the compliance information requested in the 2019 Annual Filing Checklist for the annual provider directory filing no later than 03/31/2019	Completed
6	DHCS	19-003	5/2/2019	Providing Informing Materials to Medi-Cal Beneficiaries in an Electronic Format	1) Plan has the option to send member DHCS approved notice informing of how to obtain the Provider Directory, Formulary, and Member Handbook electronically 2) Plan to provide SPDs individuals a notice in place of paper formulary and member handbook. SPDs must receive paper form of Provider Directory-PPD 3) All populations may receive a notice in place of paper Provider Directory, Formulary, and Member Handbook 4) Plan must meet informing materials notice approval process	Completed

7	DMHC	19-004	1/23/2019	(OPL) Telehealth/Teledentistry Sample Questions	1) EOC and Disclosure Form should reflect the telehealth services and policies in a clear manner that allows enrollees to know when and how these services are available 2) All contracts with either vendors or providers should be filed as ASA (Exhibit N-1) or provider contracts (Exhibit K-1) 3) Incorporate sample questions into process when working on a filing that mentions telehealth to ensure the services meet the requirements of the Knox-Keene Health Care Service Plan	Completed
8	DHCS	19-004	6/5/2019	Provider Credentialing/Recredentialing And Screening/Enrollment	Plans must screen and enroll providers in a manner consistent with the DHCS FFS enrollment process but may use screening results from other Plans, Medicare, or Medicaid programs to satisfy these requirements. In order to be reimbursed by Medi-Cal FFS, providers must be enrolled with DHCS as Medi-Cal FFS providers. Plans must verify every 3 years that each provider continues to possess valid credentials and must review a new application and re-verify above-mentioned information.	Ongoing
9	DMHC	19-005	1/25/2019	Plan Year 2020 QHO and QDP Filing Requirements	Not applicable to AAH	N/A
10	DHCS	19-005	6/12/2019	Financial Incentives	1) FQHCs and RHCs are to be reimbursed for their costs in providing covered health care services to Medi-Cal beneficiaries through the Prospective Payment System (PPS) methodology 2) Plans may not utilize financial incentives or P4P payments to pay a FQHC or RHC an additional rate per service or visit based exclusively on utilization 3) P4P payments provided to FQHCs or RHCs cannot be included in the calculation of wrap-around or supplemental payments 4) Communicate requirements to all delegated entities and subcontractors.	Completed
11	DMHC	19-006	2/15/2019	Clinical Quality Improvement	1) Identify how the plan assesses delegates/medical groups' clinical performance 2) identify is the plan has a focused QIP or stewardship program in place 3) identify the clinical measures the plan collects and tracks for each department-regulated line of business 4) identify any additional methods the plans utilizes for data collection and tracking pertaining to the quality measures discussed in APL 5) Complete and submit questionnaire no later than Friday, March 8th	Completed
12	DHCS	19-006	6/13/2019	Prop 56 Physicians Directed Payments for Specified Services for State FY 17-18 & 18-19	Plans must make directed payments to contracted providers when they bill for one of 13 specified CPT codes with dates of service between 7/1/17-6/30/18; payment amounts for each CPT code vary from $5 to $50. And 23 specified CPT codes with dates of service between 7/1/18-6/30/19; payment amounts for each CPT code vary from $5 to $107. Directed payments to providers must be made no later than 90 calendar days from the date of DHCS's payment to the Plan. From the date the Plan receives DHCS's payment onward, Plans must make directed payment to providers within 90 calendar days of receiving a clean claim or accepted encounter. Providers eligible to receive directed payments do not include those at FQHCs, Rural Health Centers, American Indian Health Programs, or Cost-Based Reimbursement Clinics. Qualifying services are those billed using one of the 13 specified CPT codes performed by an eligible provider for a member between 7/1/17 and the date the Plan receives payment from DHCS	Ongoing

13	DMHC	19-007	2/28/2019	Governor's Declarations of Emergency	1) State of emergency due to severe thunderstorms for other counties- does not apply to AAH 2) informed Member Services in the event that members from other counties are displaced to Alameda County for services	Completed
14	DHCS	19-007	6/14/2019	Non-Contracted Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19	1) Plan must provide increased reimbursement rates for specified GEMT services to non-contracted GEMT providers when they bill for one of the three specified CPT codes with dates of service between 7/1/18-6/30/19; increased reimbursement of $339.00 2) Plans have 90 calendar days from the date DHCS issues the capitation payments for GEMT to pay for all qualifying clean claims or accepted encounters 3) Plans are responsible for identifying and satisfying any Medicare crossover payment obligations that result from the increase in GEMT reimbursement obligations 4) Plans are responsible for ensuring that their delegated entities and subcontractors comply with requirements	Completed
15	DMHC	19-008	3/8/2019	Timely Access Compliance Reports Measurement Year 2019 (MY 2019)	1) Annual Timely Access Compliance filing for Measurement Year 2019 due by 04/01/2020 2) Plans must engage an external validation vendor to validate the results of the MY 2018 Provider Appointment Availability Survey to validate that a) the required templates were used; b) all required provider types were reported; c) the templates accurately report the Plan's network; d) the rates of compliance were accurately calculated; and e) the survey was administered in accordance with DMHC methodology. 3) Plans must file a Quality Assurance Report written by the external validation vendor, which details findings, issues Plans were unable to correct, deviation from the methodology, and steps taken to remedy issues for future years. 4) Plans may not collaborate through ICE for the MY 2019 Provider Satisfaction Survey and must instead either self-administer the survey or use a vendor not associated with ICE.	Ongoing
16	DHCS	19-008	6/18/2019	Rate Changes for Emergency and Post-Stabilization Services Provided by Out-Of-Network Border Hospitals Under the DRG Payment Methodology	1) DRG payment rates are to remain effective as approved under SPA 15-020 for those admissions on or after July 1, 2015 however, APL 13-005 allows Plans to pay a lower negotiated rate agreed by the hospital 2) Plans are responsible for ensuring that delegated entities and subcontractors comply with requirements	Completed
17	DMHC	19-009	3/29/2019	2019 Annual Assessment Letter	1) Implementation by 05/15/2019 2) Plans must file the Report of Enrollment Plan in the DMHC portal by 05/15/2019 after filing their 03/31/2019 quarterly financial statements	Completed
18	DHCS	19-009	8/5/2019 Revised-10/16/2019	Telehealth Services Policy	1) Each telehealth provider must be licensed in the State of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP). Each telehealth provider providing Medi-Cal covered services to an MCP member via a telehealth modality must meet the requirements of BPC Section 2290.5(a)(3), or equivalent requirements under California law in which the provider is considered to be licensed. Certain types of services cannot be delivered via telehealth- services that would require the in-person presence of the patient for any reason	Ongoing

19	DMHC	19-010	4/3/2019	Introduction of a New Independent Review Organization	1) Implementation by 04/15/2019 2) DMHC contracted Island Peer Review Organization, Inc (IPRO) to conduct Independent Medical Reviews (IMRs). MAXIMUS and IPRO will work together. 3) Process will remain the same, however, IPRO's rate review schedule is different from DMHC's.	Completed
20	DHCS	19-010	8/14/2019	Requirements for Coverage of EPSDT for Medi-Cal Members Under the Age of 21	1) Plan is required to provide and cover all medically necessary services for members under the age of 21 2) Provide case management and care coordination 3) All members under 21 must receive screenings designed to identify health and developmental issues, including medically necessary diagnostics and treatment services for members with developmental issues 4) Plan must provide appointment scheduling assistance and necessary transportation (emergency and non-emergency) 5) Responsible for providing BHT Services for eligible members under the age of 21 6) Ensure members who eligible for EPSDT services are aware of services (health education)	Ongoing
21	DMHC	19-011	5/9/2019	QIF Plan Regulatory Requirements	1) Notify DMHC and DHCS by July 1st if the Plan intends to maintain or transfer plan products from the QIF to the affiliated plan 2) Attend a pre-filing conference by August 1st if the Plan intends to maintain license or merge with an affiliate 3) File a Notice of Material Modification or an Application of Surrender by September 1st 4)QIF plans will be treated as distinct from affiliate plans and will be subject to the requirements of the Act by January 1, 2020	Ongoing
22	DHCS	19-011	9/30/2019	Health Education and Cultural and Linguistic Population Needs Assessment	MCPs are required to conduct a PNA. MCPs must address the special needs of seniors and persons with disabilities (SPDs), children with special health care needs (CSHCN), members with limited English proficiency (LEP), and other member subgroups from diverse cultural and ethnic backgrounds in the PNA findings. MCPs must use multiple data sources, and must include the most recently available CAHPS survey results and DHCS MCP-specific health disparities data. MCPs must complete a PNA report, which includes a PNA action plan annually and get DHCS approval. .	Completed
23	DMHC	19-012	6/4/2019	AB 72 Policy and Procedures	1) By August 15, 2019, if the plan is responsible for payment of claims must submit a policy and procedure which determines the average contracted rate 2) Plan must provide delegates that have a the responsibility for payment of claims with a copy of this APL. 3) Delegate's P&P must be submitted to AB72@dmhc.ca.gov 3) If the plan does not have the responsibility for payment of claims an E-1 indicating as such needs to be filed	Completed
24	DHCS	19-012	9/30/2019	Federal Drug Utilization Review Requirements Designed to Reduce Opioid Related Fraud, Misuse and Abuse	1) By October 1, 2019 Plans must operate a DUR program. 2) Plans must submit updated policies and procedures that address each of the requirements detailed in the APL no later than December 31, 2019 3) Requirements to address in policies: a) claims review; b) program to monitor antipsychotic medications by children; and c) fraud and abuse identification	Completed

25	DMHC	19-013	6/13/2019	Block Transfer Enrollee Transfer Notices	1) Plans must submit their Block Transfer Filings and Continuity of Care policies (and any material changes) to DMHC for review no later than 08/16/2019. Plans must complete ETNs to include detailed information when there is a contract termination with a general acute care hospital. ETN letters concerning provider group terminations shall include, in addition to the name of the terminating general acute care hospital, brief explanation as to why the redirection to alternate hospitals for future hospital-based services is necessary due to termination, and the date of the contract termination and redirection to alternate hospitals, Sections B.1 through B.6 of the APL. Plans must include in their continuity of care policy a description of the health plan's process for the block transfer of enrollees and the template(s) of the plan's ETNs	Completed
26	DHCS	19-013	10/21/2019	Proposition 56 Hyde Reimbursement Requirements for Specified Services	1) Plans must, directly or through their delegates entities/subcontractors, pay the individual rendering providers that are qualified to provide and bill for medical pregnancy termination services with dates of services between July 1, 2017- June, 30, 2020, using Prop 56 funds. 2) Plans or their delegated entities/subcontractors must pay the rate for CPT-4 code 59840 in the amount of $400 and 59841 in the amount of $700. 3) Plans must distribute payments within 90 calendar days from the date the Plan begins receiving capitation payments from DHCS. 4) Plans are responsible for ensuring that the specified CPT-4 codes are appropriate for the services being provided and that the information is submitted to DHCS in encounter data that is complete, accurate, reasonable, and timely. 5) Plans must have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment of a Prop 56 directed payment. 6) Plans must communicate the payment process with providers on how to process payments, file a provider grievance, and determine the payer. 7) Plans are responsible for ensuring delegates/subcontractors comply.	Ongoing
27	DMHC	19-014	6/14/2019	Guidance Regarding General Licensure Regulation	1) The regulation applies to any contract entered into, amended, or renewed on or after July 1, 2019 2) Entities that assume global risk must either obtain a license under Knox-Keene or receive an exemption from DMHC 3) During phase-in period, entities that assume global risk must file with DMHC their global risk contracts within 30 days of execution 4) Entity or someone acting on behalf of entity must submit Request for Expedited Exemption to the DMHC 30 days after parties have executed the contract or renewal or 30 days after the effective date of the contract or renewal	Ongoing
28	DMHC	19-015	7/8/2019	Governor's Declarations of Emergency in Kern and San Bernardino Counties- Ridgecrest Earthquakes	1) State of emergency due to severe thunderstorms for other counties- does not apply to AAH 2) Inform Member Services in the event that members from other counties are displaced to Alameda County for services	Completed

29	DHCS	19-014	11/12/2019	Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21	1) Inform members that EPSDT services are available for members under 21 years of age. 2) Provide access to comprehensive screening and prevention services but not limited to: health and development history; comprehensive unclothed physical examination; appropriate immunizations; lab tests and lead toxicity screening; screening services to identify developmental issues as early as possible. 3) Provide access to diagnostic and treatment services, including but not limited to, BHT services, when medically necessary based upon the recommendation of a licensed physician or psychologist.	Ongoing
30	DHCS	19-015	12/24/2019	Proposition 56 Directed Payments for Physician Services	1) DHCS is requiring MCPs and their delegated entities and subcontractors to make directed payments for qualifying services in the amounts and for CPT codes specified in Appendices A,B, and C. 2) Beginning w/calendar quarter ending June 30, 2018, MCPs must report to DHCS within 45 days of the end of each calendar quarter all directed payments either by the MCP or the MCPs delegated entities and subcontractors. Reports must include payments made for dates of service on or after July 1, 2017. 3) MCPs must have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a directed payment.	Ongoing
31	DMHC	19-016	9/6/2019	Amendment to the Risk Bearing Organization Regulations	1) Effective date for the phase-in period for the new requirements is 10/01/2020 2) Plans must review the amended sections 1300.75.4, 1300.75.4.2, 1300.75.4.5, 1300.75.4.5, 1300.75.4.7, 1300.75.4.8, and 1300.76 of Title 28, California Code of Regulations 3) Amended regulations include: a) clarifying definition of an organization; b) update quarterly and annual financial survey report forms and corrective action form; c) submit quarterly and annual financials; d) clarify when an organization and affiliates are to provide financial survey reports on a combined basis; e)define cash-to-claims ration, sponsoring organization, sub-delegating organization, working capital, and TNE; f) restricts organizations use of a "sponsoring organization" for purposes of calculating TNE, working capital, and cash-to-claims ratio	Completed
32	DHCS	19-016	12/26/2019	Prop 56 Directed Payments for Developmental Screening Services	1)MCPs are required to ensure that developmental screening services provided for Members as part of the Early and Periodic Screening, Diagnostic, and Treatment benefit, comply with the AAP/Bright Futures periodicity schedule and guidelines. 2)MCPs either directly or through their delegated entities and Subcontractors to make directed payments to eligible Network Providers of $59.90 (was previously $59.50) for each qualifying developmental screening service on or after January 1, 2020, in accordance with the CMS approved preprint which will be made available on the DHCS Directed Payments Program website upon CMS approval.	Ongoing
33	DMHC	19-017	10/11/2019	Requirements Pursuant to AB 315 Pharmacy Benefit Management	1) PBMs to notify a purchaser in writing of any of its activities, policies, or practices that present a conflict of interest. 2) PBMs are also required to disclose, on a quarterly basis, certain information with respect to prescription product benefits specific to the purchaser, including the aggregate wholesale acquisition costs from a pharmaceutical manufacturer or labeler for certain therapeutic drugs and any administrative fees received from a pharmaceutical manufacturer or labeler. 3) Plans are prohibited from including in a contract with a pharmacy provider, or its contracting agent, a provision that prohibits the provider from informing a patient of a less costly alternative to a prescribed medication. 4) A Plan that contacts with PBM(s) for management of prescription drug coverage must require its contracted PBMs to register with the DMHC.	Completed

34	DHCS	19-017	12/26/2019	Quality and Performance Improvement Requirements	1)MCPs must designate a performance measurement lead and at least one designated backup contact to report performance measurements to DHCS. 2) MCPs must designate an appropriate lead and a backup to participate in technical assistance conference calls. 3) MCPs must annually collect and report rates for MCAS measures. 4) MCPs must participate in an annual onsite performance measure validation audit. The audit will consist of an assessment of an MCP's (or its vendor's) information system capabilities, followed by an evaluation of an MCP's ability to comply with specifications outlined by DHCS for HEDIS® and non-HEDIS® measures. 5) MCPs must use DHCS' EQRO for conducting the performance measure validation. The EQRO contractor will perform the performance measurement audits at DHCS' expense. 6) Each MCP calculates its rates for the required performance measures, and these rates will be audited by the EQRO or its subcontractor and reported to DHCS. Each MCP must report to the EQRO the results for each of the performance measures required of that MCP while adhering to the requirements set forth by HEDIS®, CMS, or other applicable technical specifications for the RY.	Ongoing
35	DMHC	19-018	10/14/2019	Governor's Proclamation of a State of Emergency Due to Fires in Los Angeles and Riverside Counties	1) State of emergency due to effects of fires in the Los Angeles and Riverside counties- does not apply to AAH 2) Inform Member Services in the event that members from other counties are displaced to Alameda County for services	Completed
36	DHCS	19-018	12/26/2019	Prop 56 Directed Payments for Adverse Childhood Experiences Screening Services	1)Both the ACEs questionnaire and the PEARLS tool are acceptable for use for Members aged 18 or 19 years. The ACEs screening portion (Part 1) of the PEARLS tool is also valid for use to conduct ACEs screenings among adults ages 20 years and older. 2)DHCS will provide and/or authorize ACEs-oriented trauma-informed care training for Providers and their ancillary office staff. DHCS must approve or authorize any other trauma-informed care training that is not provided by DHCS. The training will be available in person, including regional convening's, and online. The training will include both general training about trauma-informed care, as well as specific training on use of the ACEs questionnaire and PEARLS tool. It will also include training on ACEs Screening Clinical Algorithms to help Providers assess patient risk of toxic stress physiology and how to incorporate ACEs screening results into clinical care and follow-up plans. More information about training is available on https://www.acesaware.org/. 3)DHCS will maintain a list of Providers who have self-attested to their completion of the training. MCPs will have access to the list. Beginning July 1, 2020, Network Providers must attest to completing certified ACEs training on the DHCS website to continue receiving directed payments.	Ongoing
37	DMHC	19-019	10/14/2019	Requirements Pursuant to SB 546: Large Group Renewal Notice Requirements	1) All commercial full-service health plans are required to deliver written notice indicating changes in premium rates or coverage at least 60 days prior to the contract renewal effective date. 2) Renewal notices shall include a statement comparing the proposed rate change stated in a group health plan service contract to the average rate increases negotiated by CalPERS and by Covered Ca.	Completed

38	DMHC	19-020	10/21/2019	Guidance for Sec. 1365 Cancellation Regulations	1) Plans are required to provide an individual who receives the State advance premium assistance subsidy with a "federal grace period," which includes complying with all notice and timing requirements 2) Plans have the authority to implement a premium threshold policy. Plan must indicate so, and affirm in its 2019 Cancellation Regulations Compliance Filing that the Plan's premium payment threshold policy complies with the requirements of Rule 1300.65(a)(21). 3) Plans have the authority to nonrenewal or rescind an enrollment or subscription of an enrollee who received advanced premium assistance or subsidy or advance payments of the federal premium tax credit for nonpayment of premiums after a three-month grace is exhausted and all other requirements are met. Plans are to issue any notices developed by Covered California for this purpose or Federal grace period notices edited to reflect the enrollee is a recipient of only the State subsidy. 4) Templates notices for cancellation, rescissions, or nonrenewal based on nonpayment of premiums for enrollees who receive State APTC must be submitted as Exhibit I-9. 5) Plans are required to submit an Amendment filing demonstrating, at a minimum, certain plan documents meet requirements set forth in the Cancellation Regulations no later than December 2, 2019. 6) Any new or revised Enrollee Subscriber, Group Contract Holder Notices, Grievance Policies, Grievance Policies and Procedures, and Forms and Templates must be submitted by the Plan for the Department to review. 7) Plans must fully implement newly-approved notices no later than April 1, 2020 for any enrollee entitled to a grace period starting on or after April 1, 2020.	Completed
39	DMHC	19-021	10/25/2019	Governor's Proclamation of a State of Emergency	1) State of emergency due to effects of fires in Sonoma and Los Angeles counties- does not apply to AAH 2) Inform Member Services in the event that members from other counties are displaced to Alameda County for services	Completed
40	DMHC	19-022	10/28/2019	Governor's Proclamation of a Statewide State of Emergency	1) State of emergency statewide due to effects of fires and power outages 2) Inform Member Services in the event that members from other counties are displaced to Alameda County for services 3) Plans are to complete an Exhibit J-17 addressing the action plans in place for impacted members.	Completed
41	DMHC	19-023	12/4/2019	Standard Prescription Drug Formulary Template	1) Effective October 1, 2019, standard prescription drug formulary template was implemented for Plans to adhere to promote accessibility and transparency in prescription drug coverage. 2) Plans are required to submit via eFiling an Exhibit E-1 acknowledging affirming the plan's intent to comply with the Formulary Regulation requirements. 3) Plan is to review disclosure and coverage documents, including but not limited to its EOC, Disclosure Form, and Schedule of Benefits and other documents, to ensure no inconsistencies exist between these documents and the requirements of the Formulary Regulation.	Completed
42	DMHC	19-024	12/9/2019	Association Health Plans	Not applicable to AAH	Completed
2020 APLS						
1	DHCS	20-001	1/3/2020	2020-2021 Medi-Cal Managed Care Health Plan MEDS/834 Cutoff and Processing Schedule	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. DHCS must receive all enrollments and disenrollments on a daily basis. MCPs must adhere to the cutoff dates and timelines to allow adequate processing time and to ensure timely payments. 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	Completed
2	DMHC	20-001	1/15/2020	Newly Enacted Statutes Impacting Health Plans	Includes 14 new statutory requirements. 6 of the 14 are not applicable to AAH.	Ongoing

3	DHCS	20-002	1/31/2020	Non-Contract Ground Emergency Medical Transport Payment Obligations (GEMT)	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" 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	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 Statement 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	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.	Ongoing
6	DHCS	20-003	2/27/2020	Network Certification Requirements	Updated requirements for the annual network certification reporting that demonstrates compliance with network adequacy requirements. The reporting requirements include data for assessing the plan's network capacity, provider to member ratios, mandatory provider types, and time and distance standards. Time and distance standards include primary care, hospitals, adult and pediatric core specialists, mental health providers, and pharmacies that must meet time and distance standards. If any time and distance standards cannot be met at 100% compliance and all reasonable contracting efforts have been exhausted, the plan must file alternative access standards to DHCS for review and approval with the reporting. The annual report is due to DHCS by 3/18/20. Due date extended to 4/20/20.	Ongoing
7	DMHC	20-004	2/7/2020	Federal SBC Template Filing	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 January 1, 2021. Filing is due March 2, 2020.	Completed

8	DHCS	20-004	3/27/2020	Emergency Guidance for Medi-Cal Managed Care Health Plans in Response to COVID-19	CMS granted numerous blanket waivers to help health providers combat and contain the spread of COVID-19. While not all of these waivers apply to Medicaid, these include guidance for blanket waivers on these topics: • Skilled Nursing Facilities • Critical Access Hospitals • Housing Acute Care Patients in Excluded Distinct Part Units • Durable Medical Equipment • Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital • Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital • Supporting Care for Patients in Long-term Care Acute Hospitals • Home Health Agencies • Provider Locations • Provider Enrollment • Medicare appeals in Fee for Service, MA and Part D. DHCS has received CMS approval to extend the timeframe for members to request a state fair hearing. For details, refer to the March 23rd CMS approval letter and the Supplement to APL 17-006, titled "Emergency State Fair Hearing Timeframe Change – Managed Care. CMS approved certain temporary flexibilities for provider screening and enrollment. DHCS has issued guidance regarding these flexibilities for provider enrollment that applies to both Medi-Cal Fee-for Service (FFS) and managed care provider screening and enrollment. This guidance is listed as "Guidance for Emergency Medi-Cal Provider Enrollment" under the 1135 Waiver Guidance heading on the DHCS COVID-19 Response webpage4 and allows for an emergency provider enrollment process. MCPs that conduct provider enrollment through their own process must implement a similar process to that contained in this guidance. MCPs that rely on DHCS' Provider Enrollment Division (PED) must direct potential new providers to the process outlined in the DHCS guidance referenced above. Immediately upon successful completion of the emergency enrollment application process through PED, providers will receive an approval email message, and an approval letter in DHCS' Provider Application and Validation for Enrollment (PAVE) portal, stating that they have been granted enrollment for 60 days, with the possibility of extension in 60-day increments. MCPs must require these providers to submit a copy of their approval letter as proof of the approved temporary enrollment. While the March 23rd Section 1135 Waiver approvals relating to prior authorization focus on Medi-Cal FFS, CMS, in its Frequently Asked Questions published March 12, 2020, acknowledged that States may modify prior authorization requirements for MCPs. DHCS reimburses FFS providers of COVID-19 testing at $35.91 for Healthcare Common Procedure Coding System (HCPCS) code U0001 (the CDC test) and $51.31 for U0002 (the non-CDC test), which is the same as the Medicare fee schedule. MCPs are encouraged to reimburse providers of COVID-19 testing at these FFS rates unless otherwise agreed to between the MCP and the provider. Based on the March 23, 2020 approval and CMS blanket waiver guidance, DHCS has issued guidance relative to the provision of care in alternative settings, hospital capacity, and blanket waiver flexibility, which will remain in effect through the end of the COVID-19 public health emergency. This guidance is applicable to MCPs, and is available on the DHCS COVID-19 Response webpage at https://www.dhcs.ca.gov/Documents/COVID-19/Section1135-Waiver-Flexibilities-Alternative-Settings-Hospital-Blanket.pdf. 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. MCPs must promptly communicate the substance of this APL to their subcontractors and network providers.	Ongoing
9	DHCS	20-005	2/7/2020	Plan Year 2021 QHP an QDP Filing Requirements	Not applicable to AAH	N/A
10	DMHC	20-006	3/5/2020	COVID-19 Screening and Testing	DMHC is taking action to ensure members have access to medically necessary screening and testing services for COVID-19. The DMHC requires plans to immediately waive cost sharing for all medically necessary screening and testing services including hospitals, urgent care visits, and provider office visits. The Plans are required to post this information on their public website and notify their provider network of the changes. DMHC also reminded plans of existing requirements for emergency care that do not require prior authorizations in or out of network	Ongoing
11	DMHC	20-007	3/12/2020	"Social Distancing" Measures in Response to COVID-19	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. 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. 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. Plans should suspend prescription drug refill limitations where the enrollee's provider has indicated a refill is appropriate for the enrollee. Plans should waive delivery charges for home delivery of prescription medications.	Completed

12	DHCS	20-007	3/30/2020	Policy Guidance for Community-Based Adult Services in Response to COVID-19 Public Health Emergency	Guidance for CBAS providers to provide services via telephonic and telehealth services to members at home. Plans to pay CBAS providers for applicable services at a per diem rate.	Completed
13	DMHC	20-008	3/18/2020	Provision of Health Care Services During Self Isolation Orders	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. 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.	Ongoing
14	DHCS	20-008	4/7/2020	Mitigating Health Impacts of Secondary Stress Due to the COVID-19 Emergency	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.	Completed
15	DMHC	20-009	3/18/2020	Reimbursement for Telehealth Services	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.	Ongoing
16	DHCS	20-009	3/4/2020	Site Reviews - Facility Site Reivew and Medical Record Review	SUPERSEDES POLICY LETTERS 14-004 AND 03-002 AND ALL PLAN LETTER 03-007 This APL includes changes made to the criteria and scoring of DHCS' FSR and MRR tools and standards. This APL supersedes Policy Letters (PL) 14-004, PL 03-002, and APL 03-007. MCPs are required to meet all requirements included in this APL by July 1, 2020.	Ongoing

17	DMHC	20-010	3/18/2020	Special Enrollment Period; Coverage Effective Dates	Not applicable to AAH	N/A
18	DHCS	20-010	4/20/2020	Cost Avoidance and Post-Payment Recovery for Other Health Coverage	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
19	DMHC	20-011	3/26/2020	2020 Annual Assessment Letter	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.	Ongoing
20	DHCS	20-011	4/27/2020	Governor's Executive Order N-55-20 In Resonse To COVID-19	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. 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. MCPs are also encouraged to explore virtual alternatives to onsite verifications for provider Corrective Action Plans (CAPs). If alternatives to onsite verification are not feasible, MCPs may consider extensions on outstanding CAPs. 4. DHCS' Audits and Investigations' annual medical audit is being suspended due to COVID-19; however, this does not preclude MCPs from complying 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 case-by-case basis and adjust timeframes accordingly. 5. DHCS is extending the timeframes specified in Welfare and Institutions Code (WIC) section 14182(c)(12)(A) and APL 17-013 for completing Health Risk Assessment (HRA) surveys for newly enrolled Seniors and Persons with Disabilities (SPDs) in an effort to ensure staff time and resources are directed to urgent care needs. 6. For the duration of the public health emergency, MCPs must conduct an HRA survey to comprehensively assess each newly enrolled SPD member's current health risk: Within 135 days of enrollment, for those identified as higher risk through the MCP's risk stratification process; or Within 195 days of enrollment, for those identified as lower risk. 7. 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. 8. 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. 9. 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

21	DMHC	20-012	3/27/2020	Health Plan Actions to Reach Vulnerable Populations	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.	Ongoing
22	DHCS	20-012	5/15/2020	Private Duty Nursing (PDN) Case Mangement Responsibilities for Medi-Cal Eligible Members Under the age of 21	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
23	DMHC	20-013	4/7/2020	Billing for Telehealth Services; Telehealth for the Delivery of Services	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. 1. Provider is to document and bill thoroughly as if the visit had occured in person, use the CPT codes for the particular services rendered, place of service '02' to designated telehealth, and use modifier 95 for synchronous rendering of services or GQ for asynchronous. 2. Health plan may not exclude coverage for certain types of services or categories of services because they are rendered via telehealth. 3.	Ongoing APL on hold
24	DHCS	20-013	5/13/2020	Proposition 56 Directed Payments for Family Planning Services	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. 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. MCPs are responsible for ensuring that the encounter data reported to DHCS is appropriate for the services being provided. 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. 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. 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. 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. 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
25	DMHC	20-014	4/7/2020	Mitigating Negative Health Outcomes due to COVID-19	Guidance from DMHC to Plan with reminders and resources to mitigate secondary health outcomes.	Completed
26	DMHC	20-015	4/13/2020	COVID-19 Temporary Extenstion of Plan Deadlines	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

27	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.	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.	Completed
28	DMHC	20-017	4/16/2020	Guidance Regarding DMHC General Licensure Regulation	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
29	DMHC	20-018	4/29/2020	Modification of Timely Access Provider Appointment Availibility Surveys Timeframes	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
30	DMHC	20-019	5/5/2020	Association Health Plans: Extension of "Phase-Out" Period	Doesn't' apply to AAH	Completed

ALAMEDA Alliance FOR HEALTH

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Service you can trust.

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: **June 12, 2020**

Subject: **Health Care Services Report**

UTILIZATION MANAGEMENT: OUTPATIENT

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

- The Outpatient UM team is now working entirely remotely in compliance with the Shelter in Place orders for the pandemic and 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 successful launch of the next version of the software (7.0) was completed on May 29th and the system is being stabilized before launching the 8.0 version in July.
- The UM team has begun to receive authorizations submitted online via the Provider Portal. About 20% of referrals are being received via the Portal, and it is working well. Once optimized, we will begin an outreach campaign with providers to encourage use of the online portal.
- A 6th month pilot linked to the HEDIS Blood Pressure measure with OP UM/Quality and Asian Health Services began 6/1/20. A total of 100 BP cuffs will be given to AHS members who do not have well controlled blood pressure. The aim of the pilot is have better BP management through closer monitoring and early intervention, and can serve as a model for future endeavors to improve member health.
- 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 but the launch date is delayed due to the pandemic focus.

Outpatient Authorization Denial Rates			
Denial Rate Type	**March 2020**	**April 2020**	**May 2020**
Overall Denial Rate	3.4%	3.2%	2.6%
Denial Rate Excluding Partial Denials	3.2%	3.0%	2.5%
Partial Denial Rate	0.2%	0.2%	0.1%

Turn Around Time Compliance			
Line of Business	**March 2020**	**April 2020**	**May 2020**
Overall	98%	99%	98%
Medi-Cal	99%	99%	98%
IHSS	97%	100%	99%
Benchmark	*95%*	*95%*	*95%*

UTILIZATION MANAGEMENT: INPATIENT

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

- The Inpatient UM Team is now working entirely remote due to the Shelter in Place order.
- Standard work to manage inpatient ALOS has been launched. 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.
- Management is performing staff audits on standard work to ensure a high level of fidelity to the standard work of both the UM process and the discharge planning process. Audits are continuing to show that staff performance is meeting the goal of 90%.
- 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. The rate is still low, about 15% down in later May, and some elective admissions are slowly starting to be scheduled. There has been a small number of members hospitalized with COVID 19 for whom there is difficulty placing them in Skilled Nursing Facilities, and we continue to work with our SNF partners on the barriers.

- Trucare, the software used by UM, was successfully upgraded to version 7.0 on May 29th. The system is being stabilized before the work of launching to the 8.0 version starts in July.
- 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. Components of the TOC bundle include discharge phone calls, discharge appointments, medication reconciliation and home care/DME/transportation needs.

Inpatient Utilization Total All Aid Categories **Actuals (excludes Maternity)**			
Metric	**February 2020**	**March 2020**	**April 2020**
Authorized LOS	4.1	4.6	5.0
Admits/1,000	64.1	54.8	42.0
Days/1,000	262.2	251.5	207.9

PHARMACY

Senior Director: Helen Lee

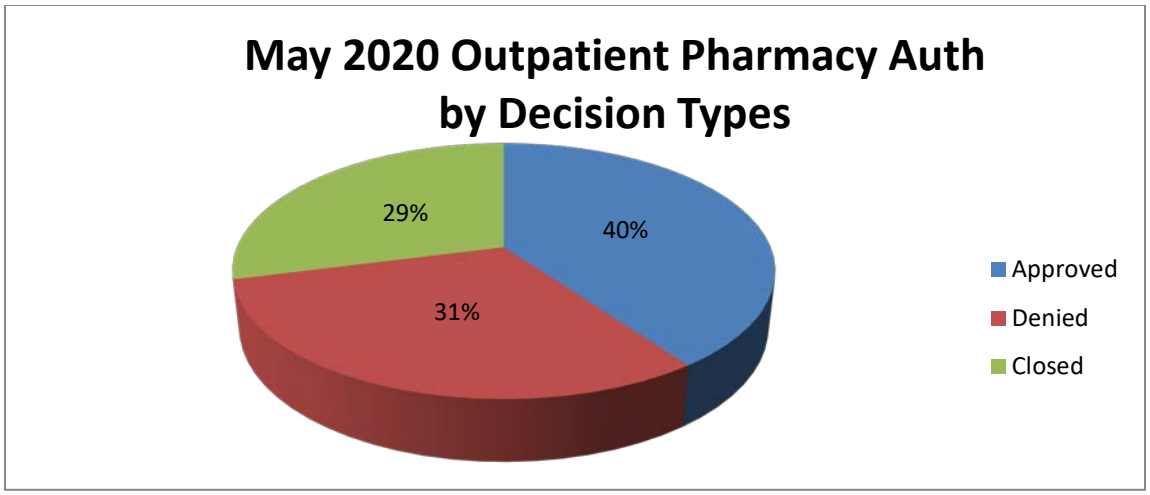
- Pharmacy has 100% turn-around time for prior authorization review for all line of business.
    - Outpatient initial approval rate is 40% and denial rates are 31%. The approval rate was slightly increased while denial rates also slightly increased compared to previous reporting periods. Medications for pain, diabetes, Malaria, rheumatoid arthritis, lupus, depression, and High triglycerides 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 June 30, 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 authorization step therapy and quantity limits in the event of a drug shortage. In May, we filled 13,878 ‘Refill Too Soon’ prescriptions (which provide early refills) and 885 ‘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.
- WHO halted hydroxychloroquine trial over safety concerns due to higher risk of death and heart problems than those who were not given the drug. There are numerous trials under way of the two drugs against coronavirus but neither is a proven treatment. AAH has a PA requirement on hydroxychloroquine during most of the 2020 timeframe.
- 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 (PADS) 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	641
Denied	503
Closed	458
Total	**1602**



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	DICLOFENAC SODIUM 3% GEL	Pain	Criteria for approval not met
3	JANUVIA 100 MG TABLET	Diabetes	Criteria for approval not met
4	TRETINOIN 0.025% CREAM	Pain	Criteria for approval not met
5	TRETINOIN 0.05% CREAM	Pain	Criteria for approval not met
6	FREESTYLE LIBRE 14 DAY SENSOR	Diabetes	Criteria for approval not met
7	HYDROXYCHLOROQUINE 200 MG TAB	Malaria, rheumatoid arthritis, lupus	Criteria for approval not met
8	TRINTELLIX 10 MG TABLET	Depression	Criteria for approval not met
9	VASCEPA 1 GM CAPSULE	High triglycerides (fats)	Criteria for approval not met
10	FREESTYLE LIBRE 14 DAY READER	Diabetes	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, has 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.
- 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.

- The AAH Member Portal is adding CM content to enhance member engagement with the CM department, including resources and care plans.
- The Transition of Care (TOC) bundle has been deployed in pilot phase with Alameda Health System's three campuses, and includes integration with the AHS Ambulatory Care team for the most vulnerable members in Health Homes or the AHS TOC programs. The TOC bundle includes:
    - Discharge phone call.
    - Discharge appointment.
    - Medication reconciliation.
- The Provider Services portal is adding additional CM content to enhance Provider engagement with the CM department work, including services offered, collaboration on member Care Plans, 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. Members on dialysis are being assessed to see if they may qualify for additional benefits

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.) Expansion of sites for both sets of members is needed to ensure appropriate care is delivered to our most vulnerable members. Exploratory conversations have started with additional potential partners.
- 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.
- A team from AAH HCS, Analytics and Finance has started planning our Population Health based prioritization of our target populations.
- Evaluation of our network adequacy to serve the target populations has begun.

Case Type	New Cases Opened in April 2020	Total Open Cases As of April 2020
Care Coordination	200	549
Complex Case Management	65	105
Transitions of Care	149	331

GRIEVANCES & APPEALS

Director: Jennifer Karmelich
Manager: Loren Mariscal

- All cases were resolved within the goal of 95% within regulatory timeframes, for standard grievances we were below our goal of 95% at 94.8%, this was due to delayed responses from provider offices.
- Total grievances resolved in March went over our goal of less than 1 complaint per 1,000 members at 5.93 complaints per 1,000 members;
- The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of May 2020; we met our goal at 24.0% 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.

May 2020 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	306	30 Calendar Days	95% compliance within standard	290	94.8%	1.21
Expedited Grievance	6	72 Hours	95% compliance within standard	6	100.0%	0.02
Exempt Grievance	1,139	Next Business Day	95% compliance within standard	1,137	99.8%	4.50
Standard Appeal	48	30 Calendar Days	95% compliance within standard	48	100.0%	0.19
Expedited Appeal	2	72 Hours	95% compliance within standard	2	100.0%	0.01
Total Cases:	1,501		95% compliance within standard	1,483	98.8%	5.93

*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

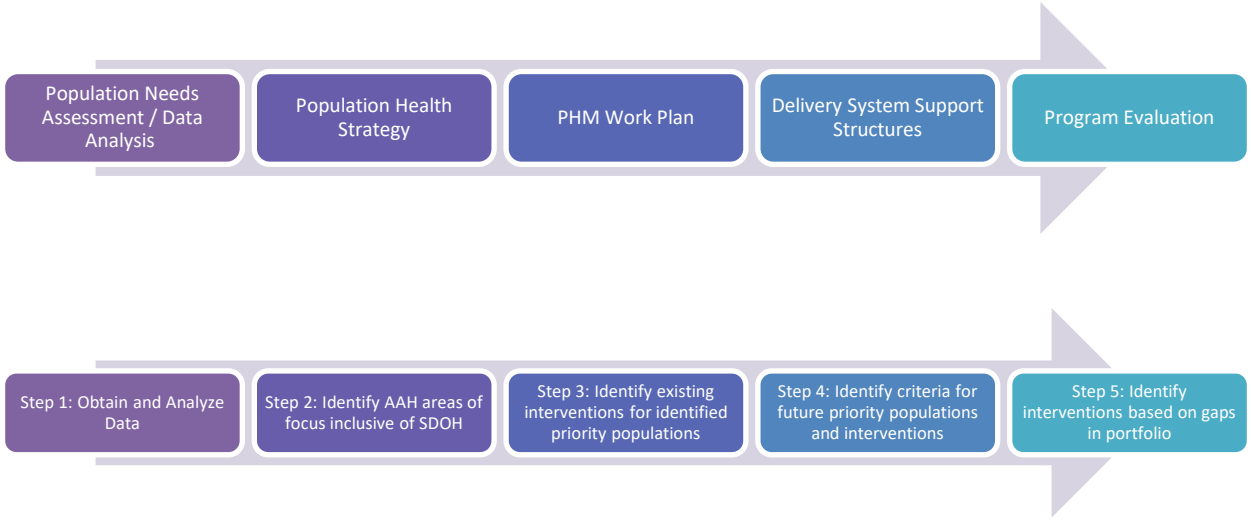
- The NCQA resurvey occurred on June 1, 2020, and included re-evaluation of elements with the commercial line (Group Care/IHSS) and Notice of Action (NOA) letters for both lines of business (Medi-Cal, Group Care). This resurvey was related to an existing Corrective Action Plan (CAP) issued by NCQA. The goal is to

accumulate enough element points for both lines of business to meet NCQA standards and to pass the "must pass" NOA element. The Alliance surpassed the needed points for the Medi-Cal line of business during the NCQA survey in 2019 and achieved more than the needed points for the commercial line of business on the June 1, 2020 survey. The survey identified one chart that did not meet full compliance with the NOAs. NCQA completed the closing conference and the Alliance has the opportunity to respond to initial findings by June 15, 2020; the Alliance team is drafting a statement to request a secondary review for the failed accreditation elements, and extension of the corrective action plan for an additional six months. The NCQA preliminary report is anticipated by mid-July.

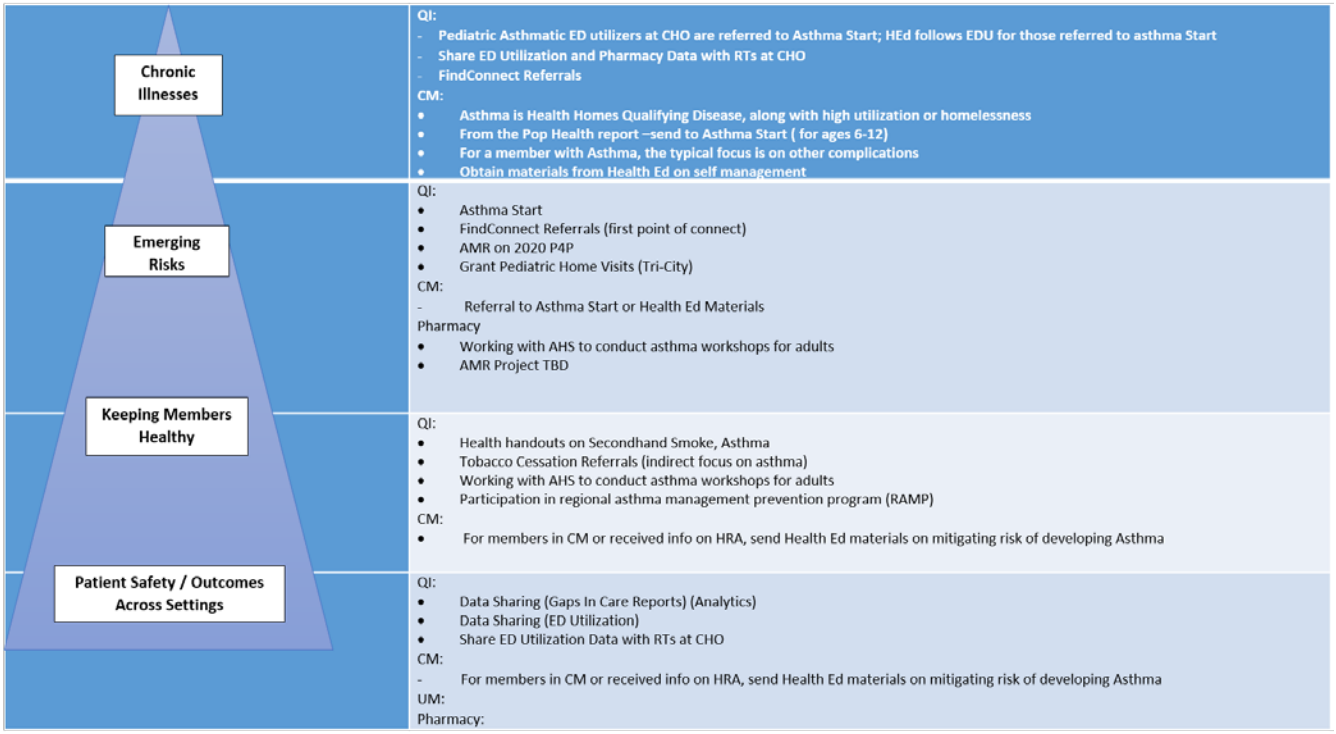
Quality

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:



- **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 and improvement in our 2019 MY rates.
- AAH continues its **Pediatric Care Coordination Pilot (PCCP),** an outcome of 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.
- Quality staff began the annual DHCS mandated **Encounter Data Validation (EDV)** Study medical record retrievals within direct and delegate provider offices. Accurate and complete encounter data are critical to AAH's assessment of quality, monitoring of program integrity, and financial decision making. The goal of the EDV study is to examine, through a review of medical records, the completeness and accuracy of the professional encounter data submitted to DHCS by MCPs. This project is currently on hold by the state due to the **COVID – 19** 'shelter in place' edict.
- **Access to Care CAPs** 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.

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.

- 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.

- Improvement Strategies Next Steps:

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

ALAMEDA Alliance FOR HEALTH

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Information Technology

Sasikumar Karaiyan

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

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

Date: **June 12, 2020**

Subject: **Information Technology Report**

Call Center System Availability

- AAH phone systems and call center applications performed at 100% availability during the month of May despite supporting 100% of staff 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 of the project is now in progress.

Encounter Data

- In the month of May, AAH submitted 92 encounter files to DHCS with a total of 159,568 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%.

TruCare

- The TruCare system continued to operate normally with an uptime of 99.99%. Total 6,127 authorizations loaded and processed in TruCare application.

- The TruCare upgrade to version 7.0.0.7 went live on June 1, 2020. This upgrade allows Alliance to retrofit defect fixes and have new features for our system users.

- The Alliance's Health Care Services team & Information Technology team have started working on TruCare 7.0.0.7 Optimization effort. Optimization includes adding new business rules and few other configuration changes. This is expected to go live before September 2020.

- IT has started the process of looking into release documents for upgrade to TruCare to 8.0.0.0 version. This upgrade is expected to go live by October 2020.

Web Portal

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

- The Alliance team started the Member portal redesign which is expected completed in 2Q- FY21.

Information Security

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

- Email based metrics currently monitored have decreased with a return to a reputation-based blocks for a total of 278.0k.

- Attempted information leaks detected and blocked at the firewall are slightly lower from 63 to 48 for the month of May.

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

- Attempted User Privilege Gain is slightly higher at 23 from a previous six month's average of 21.

Data Warehouse

- The data warehouse project initiative is aimed at bringing all critical data domains to data warehouse and make Data warehouse single source of truth for all reporting needs. So far, we have integrated 80% of the data in the data warehouse.

- Claims/Encounters domain enhancements will be added by June 2020.

- Planning in progress to add Authorization, Cases, ADT (Admission, Discharge and Transfer) and Credentialing data to data warehouse before end of fiscal year 2021.

Information Technology

Supporting Documents

Enrollment

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

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
May	252,813	4,759	1,941	6,296	150	2

1. MC – Medical Member
2. GC – Group Care Member

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

Auto-Assignments	Member Count
Auto-assignments MC	1,740
Auto-assignments Expansion	1,271
Auto-assignments GC	71
PCP Changes (PCP Change Tool) Total	2,101

TruCare

- See Table 2-1 “Summary of TruCare Authorizations for the month of May 2020”.
- There were 6,127 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 May 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	3,387	88	1	13	1	1	32	136	0	3,251
Paper to EDI	1,797	0	0	0	0	0	0	0	0	1,797
Manual Entry	0	0	0	0	0	0	0	0	1,079	1,079
Total										6,127

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 April 2020

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	3,158	2,605	88,151	419
MCAL	62,762	1,107	2,251	436
IHSS	2,491	54	92	20
AAH Staff	155	41	1,346	20
Total	**68,566**	**3,807**	**91,840**	**895**

Table 3-2 Top Pages Viewed for the month of April 2020

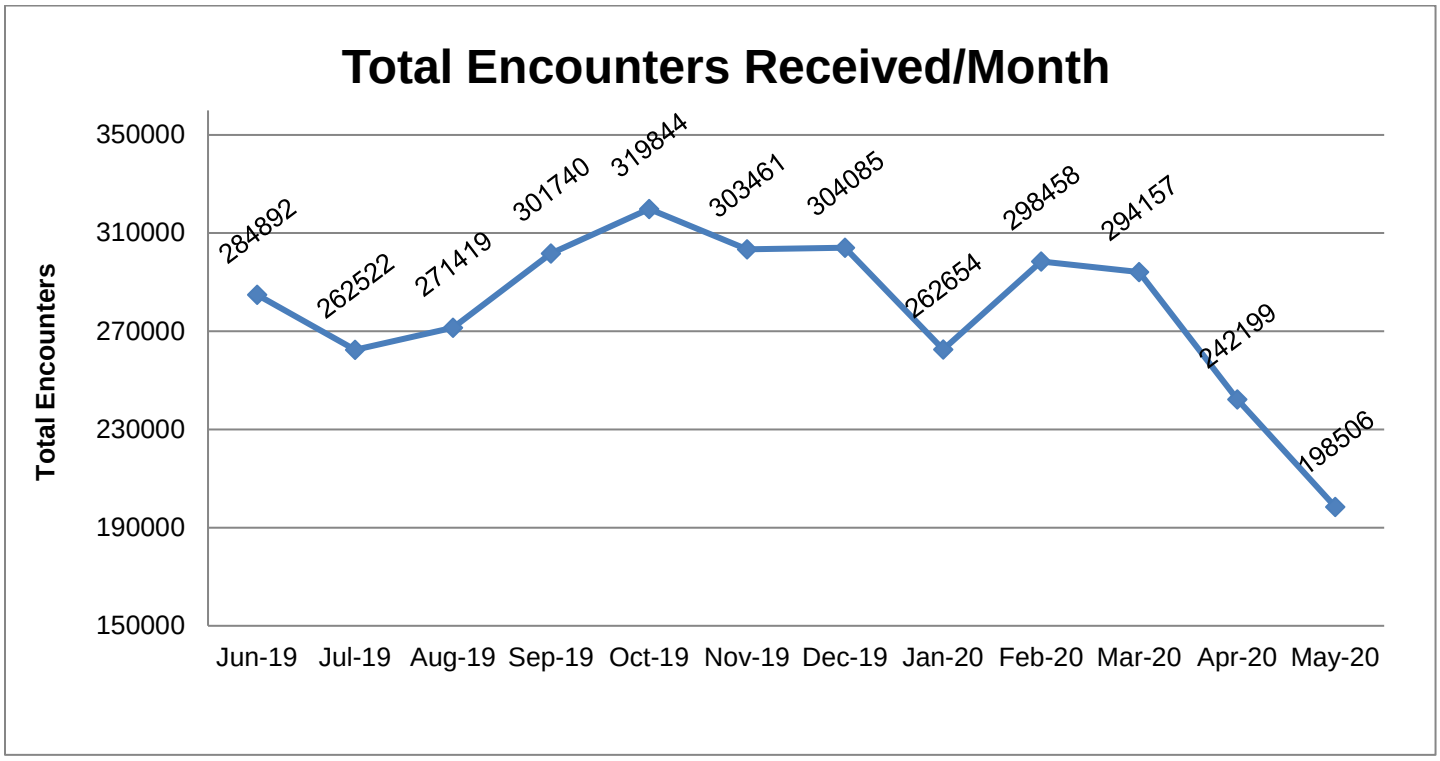
Top 25 Pages Viewed		
Category	**Page Name**	**Apr-20**
Provider	Member Eligibility	399,060
Provider	Claim Status	121,024
Member - Eligibility	Member Eligibility	3,529
Member - Claims	Claims - Services	2,847
Provider	Auth Submit	2,252
Provider	Member Roster	1,779
Provider	Auth Search	1,583
Member - Help Center	Member ID Card	1,262
Member - Help Center	Select/Change PCP	632
Provider	Pharmacy	624
Provider - Provider Directory	Provider Directory	601
Member - Help Center	Find a Doctor or Facility	525
Provider	Forms	435
Member - Pharmacy	My Pharmacy Claims	432
Provider - Provider Directory	Manual	355
Member - Pharmacy	Pharmacy - Drugs	191
Member - Help Center	Update My Contact Info	171
Provider - Provider Directory	Attestation	136
Member - Help Center	Contact Us	127
Member - Help Center	Authorizations & Referrals	93
Member - Forms/Resources	Authorized Representative Form	77
Member - Pharmacy	Pharmacy	64
Member - Health/Wellness	Personal Health Record – No More Clipboard	57
Member - Pharmacy	Find a Drug	55
Provider	New Prior Auth Forms	53

Encounter Data From Trading Partners 2020

- AHS:
  May daily files (7,698 records) were received on time.
- Beacon:
  May monthly files (8,546 records) were received on time
- CHCN:
  May weekly files (45,221 records) were received on time.
- CHME:
  May monthly file (7,241 records) were received on time
- CFMG:
  May weekly files (5,484 records) were received on time.
- Docustream:
  May weekly files (863 records) were received on time.
- PerformRx:
  May monthly files (157,846 records) were received on time.
- Kaiser:
  - May monthly files (16,030 records) were received on time.
  - May monthly Kaiser Pharmacy files (15,652 records) were received on time.
- LogistiCare:
  May weekly files (10,893 records) were received on time.
- March Vision:
  May monthly file (1,395 records) were received on time.
- Quest Diagnostics:
  May weekly files (6,072 records) were received on time.

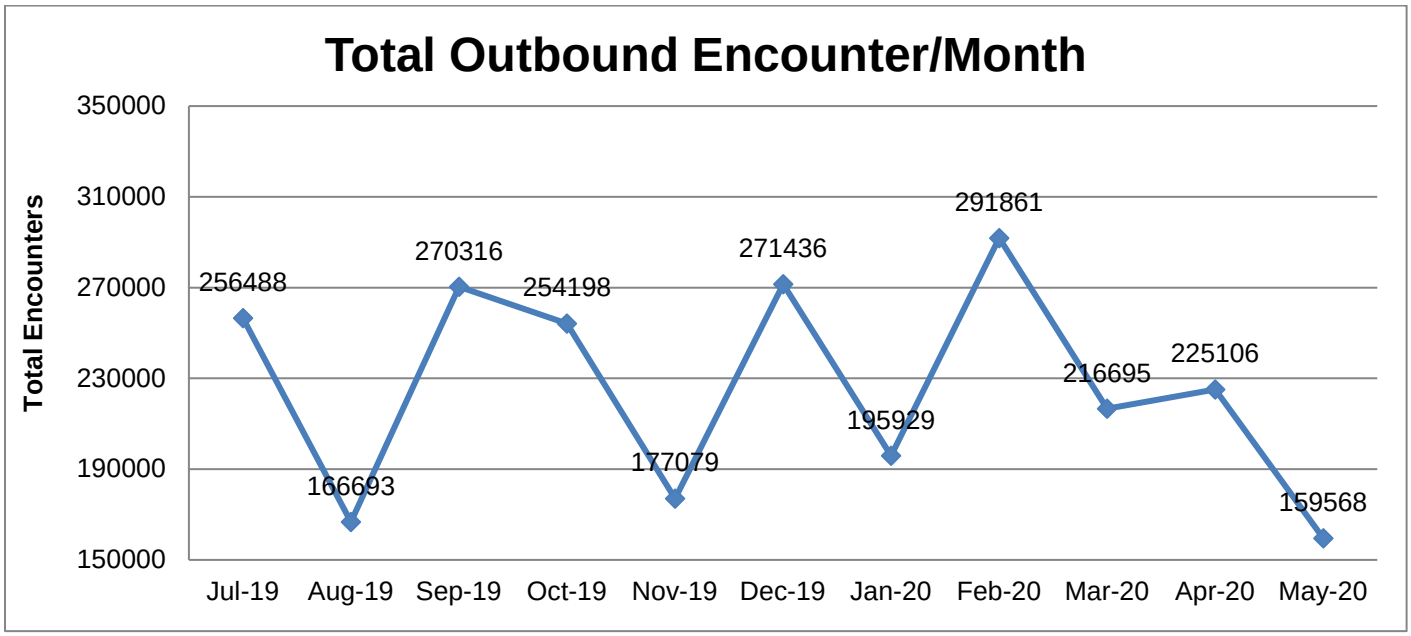
Trading Partner Encounter Inbound Submission History

Trading Partners	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
HEALTHsuite	111286	116092	123889	111578	125442	122333	103132	104147	118309	115716	86578	89063
Kaiser	37506	27013	40478	37188	35517	44533	38079	34890	35167	36334	33670	16030
LogistiCare	13945	9831	7109	21036	18411	16867	14261	16911	19665	21375	10812	10893
March Vision	2369	2641	3598	3078	3428	3792	3183	5495	0	3127	3389	1395
AHS	4857	4886	4741	4802	3347	2531	12186	7385	4949	9907	9040	7698
Beacon	21619	9926	36	21217	12163	8328	8843	6407	14626	10010	12606	8546
CHCN	70192	66286	67396	75665	88478	72359	94805	60204	69402	76884	64623	45221
CHME	4258	4639	4807	4146	2963	3928	3090	7201	5604	3612	4346	7241
Claimsnet	7475	7239	6281	9255	15028	16604	13396	9027	16607	7317	12653	5484
Quest	11385	13969	13084	12987	14539	11593	12697	10509	13574	9334	3803	6072
Docustream				788	528	593	413	478	555	541	679	863
Total	284892	262522	271419	301740	319844	303461	304085	262654	298458	294157	242199	198506



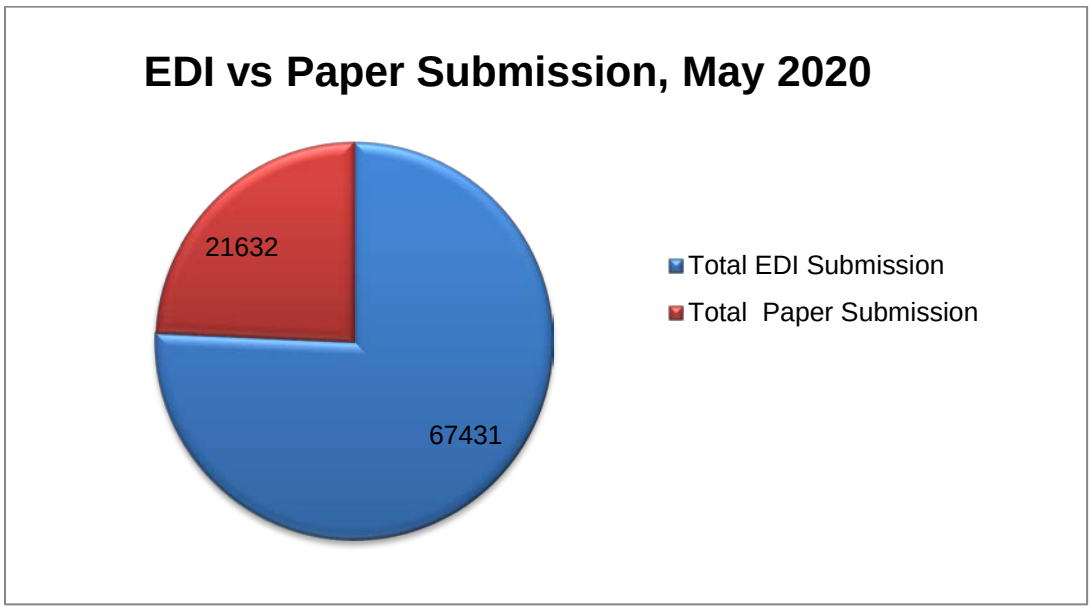
Outbound Encounter Submission

Trading Partners	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
HEALTHsuite	95843	72977	29433	112242	87691	34874	78764	62186	141458	81483	79506	72631
Kaiser	67614	30866	38562	37153	35352	44276	37789	34583	34561	35565	32223	15191
LogistiCare	13330	14803	2972	14300	21631	12670	21692	11883	24522	22887	12988	10513
March Vision	2185	2077	2629	2277	2531	2845	2564	2150	1672	2118	2362	813
AHS	5519	4304	13839	4601	5303	3762	11823	8412	4711	8545	7880	8708
Beacon	21303	2885	7083	16718	9557	7204	7369	5392	11058	6	19228	8464
CHCN	20074	98828	47619	56622	62669	43593	83370	51732	49459	43356	54436	27819
CHME	3785	9009	4080	7628	2589	3493	2692	3100	4981	3166	3847	6860
Claimsnet	8384	4228	3890	7495	10566	11508	10283	6295	8835	8788	7468	3266
Quest	9091	16511	16586	11280	15100	12337	14701	9757	10087	10331	4579	4566
Docustream					1209	517	389	439	517	450	589	737
Total	247128	256488	166693	270316	254198	177079	271436	195929	291861	216695	225106	159568



HEALTHsuite Paper vs EDI Breakdown

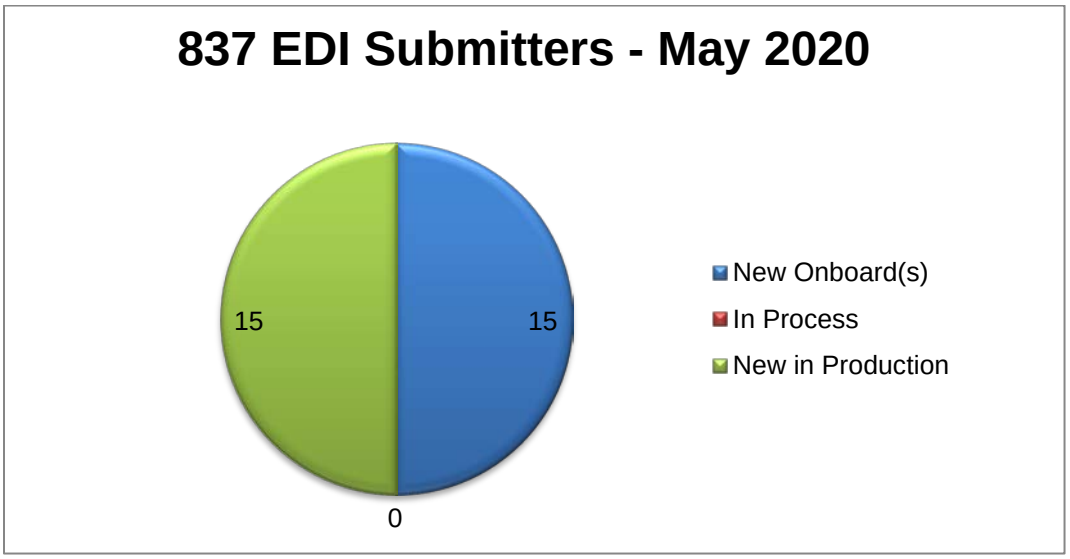
Period	Total EDI Submission	Total Paper Submission	Total Claims
20-May	67431	21632	89063

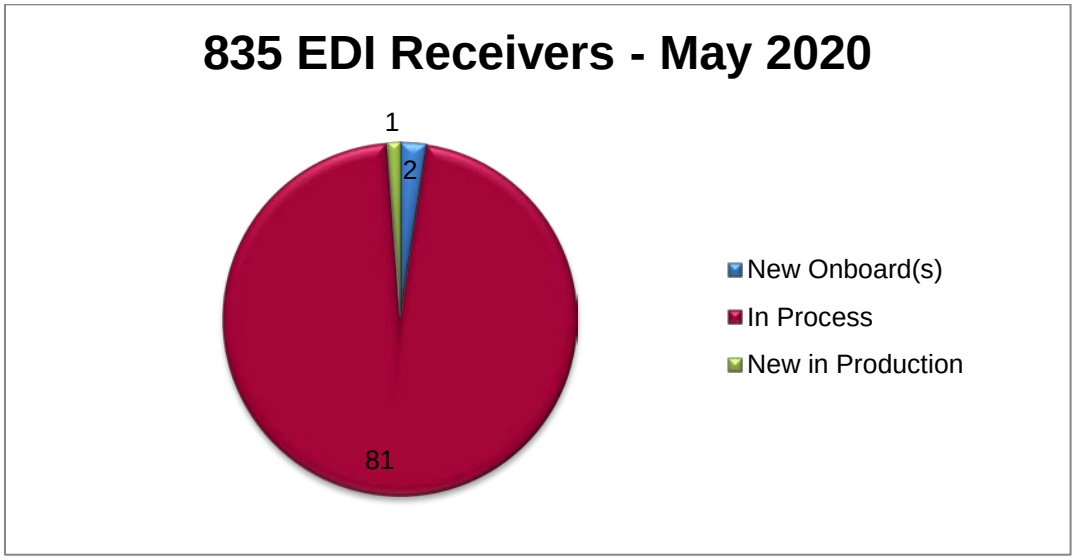


Onboarding EDI Providers - Updates

- May 2020 EDI Claims:
    - A total of 931 new EDI submitters have been added since October 2015, with 15 added in May 2020.
    - The total number of EDI submitters is 1663 providers.
- May 2020 EDI Remittances Advice(ERA):
    - A total of 187 new ERA receivers have been added since October 2015, with 1 added in May 2020.
    - The total number of ERA receivers is 226 providers.

	837				835			
	New On Boards	In Process	New In Production	Total In Production	New On Boards	In Process	New In Production	Total In Production
Apr-19	33	0	33	1345	2	71	1	202
May-19	13	5	8	1353	5	73	3	205
June-19	92	3	89	1442	2	73	2	207
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





EDSRF/Reconciliations

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

File Type	May-20
837 I Files	17
837 P Files	75
NCPDP	9
Total Files	101

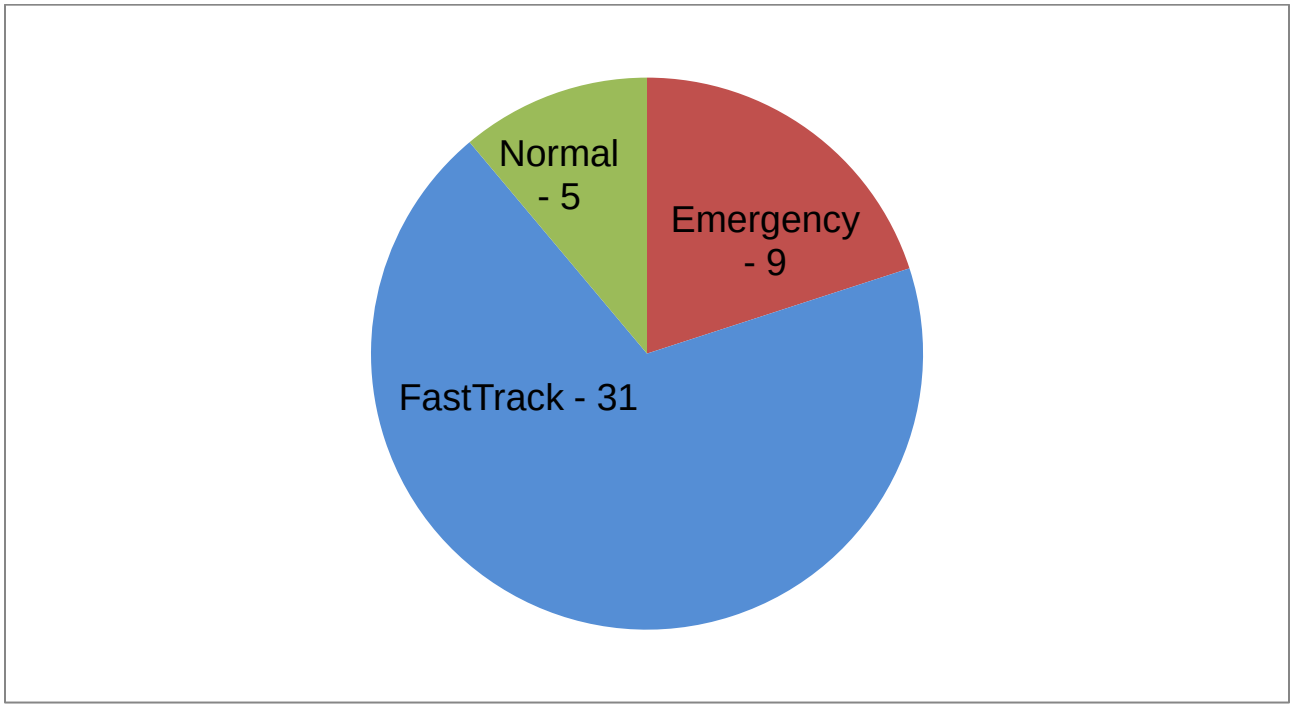
Lag-time Metrics/KPI's

AAH Encounters: Outbound 837 (AAH to DHCS)	May-20	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	88%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	96%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	84%	73%
Timeliness-% Within Lag Time – Professional 0-180 days	94%	80%

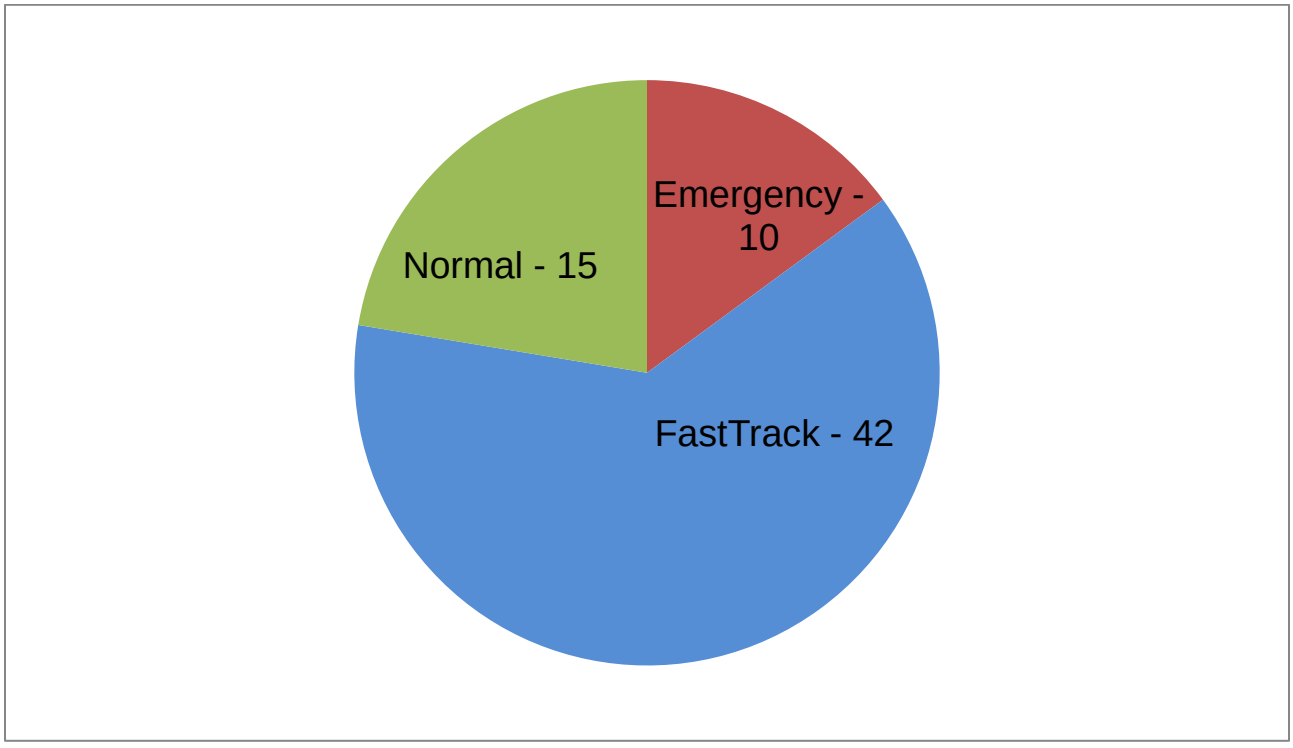
Change Management Key Performance Indicator (KPI)

- Change Request Submitted by Type in the month of May 2020 KPI – Overall Summary.
    - 1,505 Changes Submitted.
    - 1,435 Changes, Completed, and Closed.
    - 84 Active Changes.
    - 175 Changes Cancelled, and Rejected.

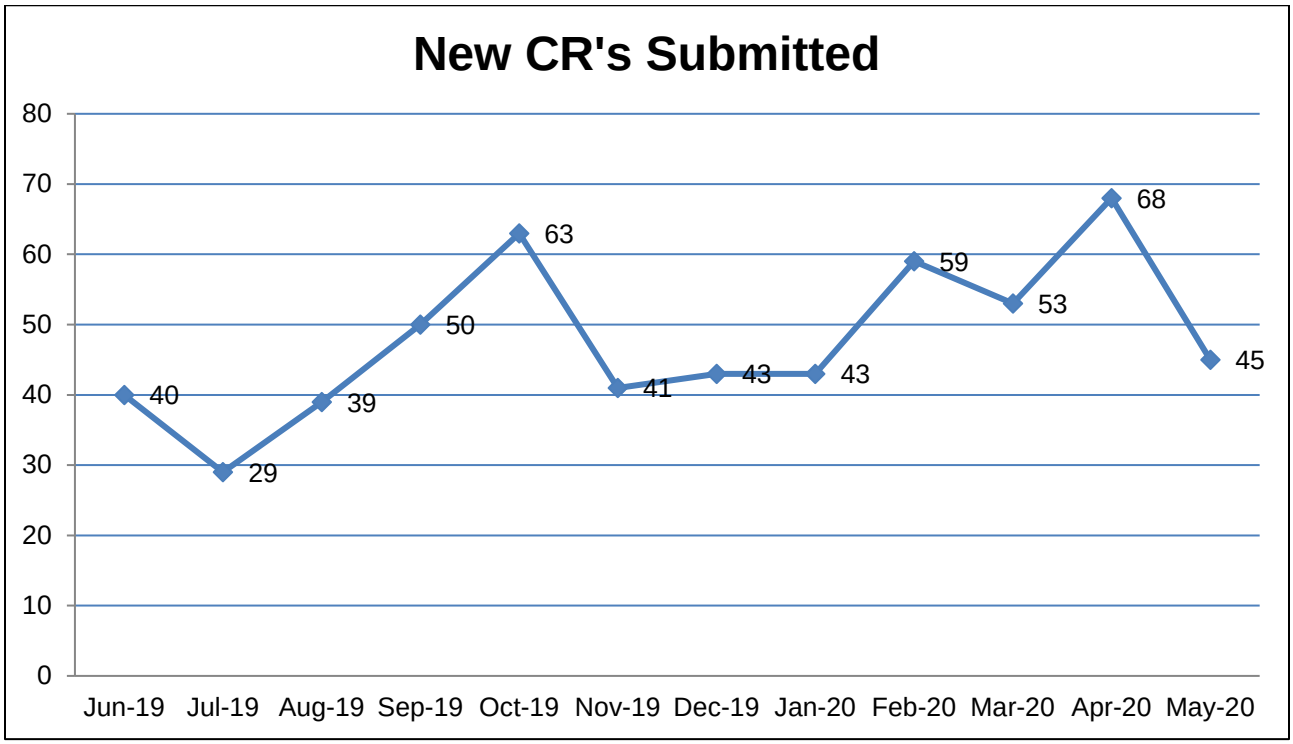
- 45 Change Requests Submitted/logged in the month of May 2020



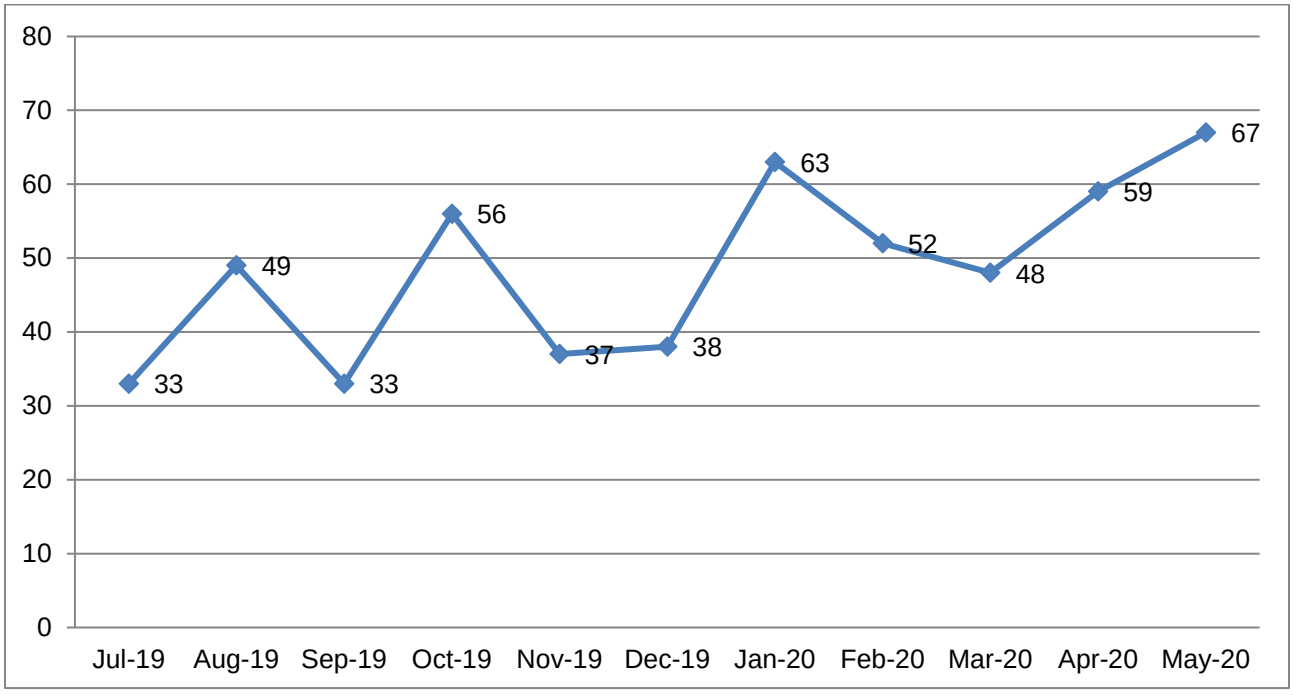
- 67 CRs Closed in the month of May 2020



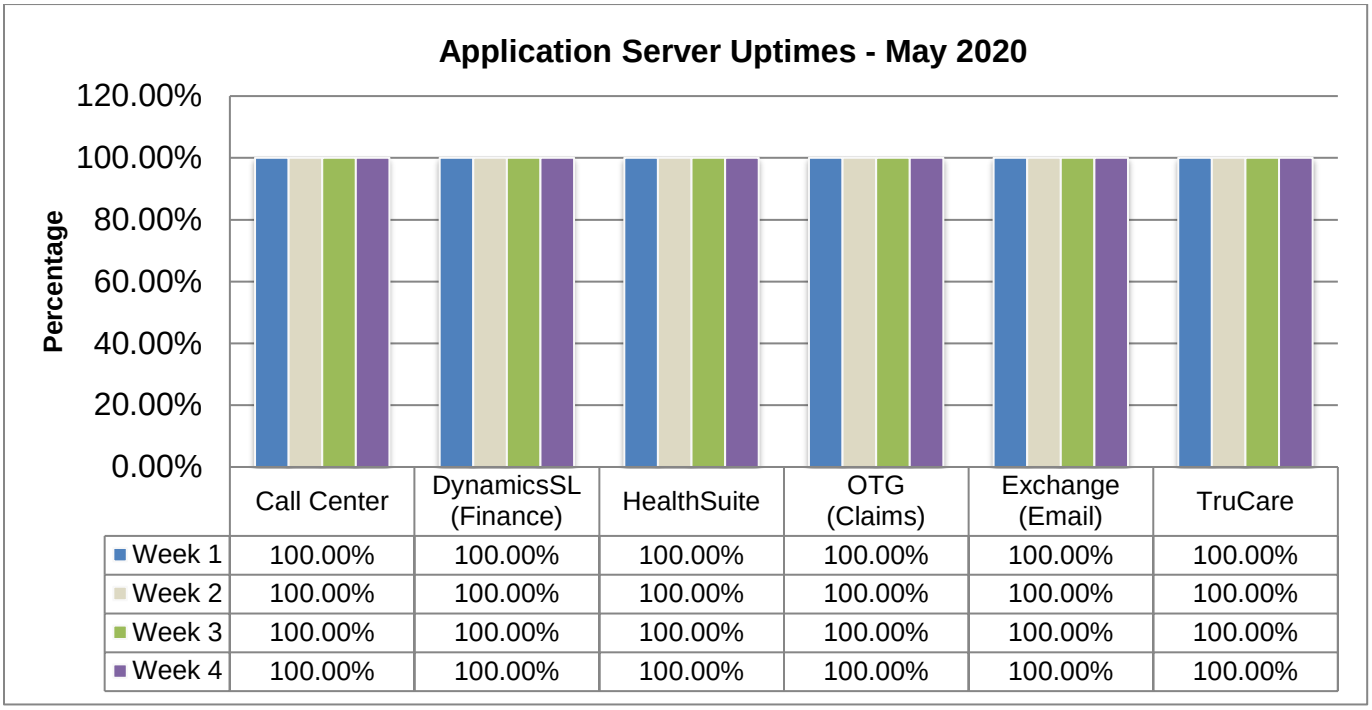
- CRs Submitted: Monthly Trend



- CRs Closed: Monthly Trend



IT Stats: Infrastructure

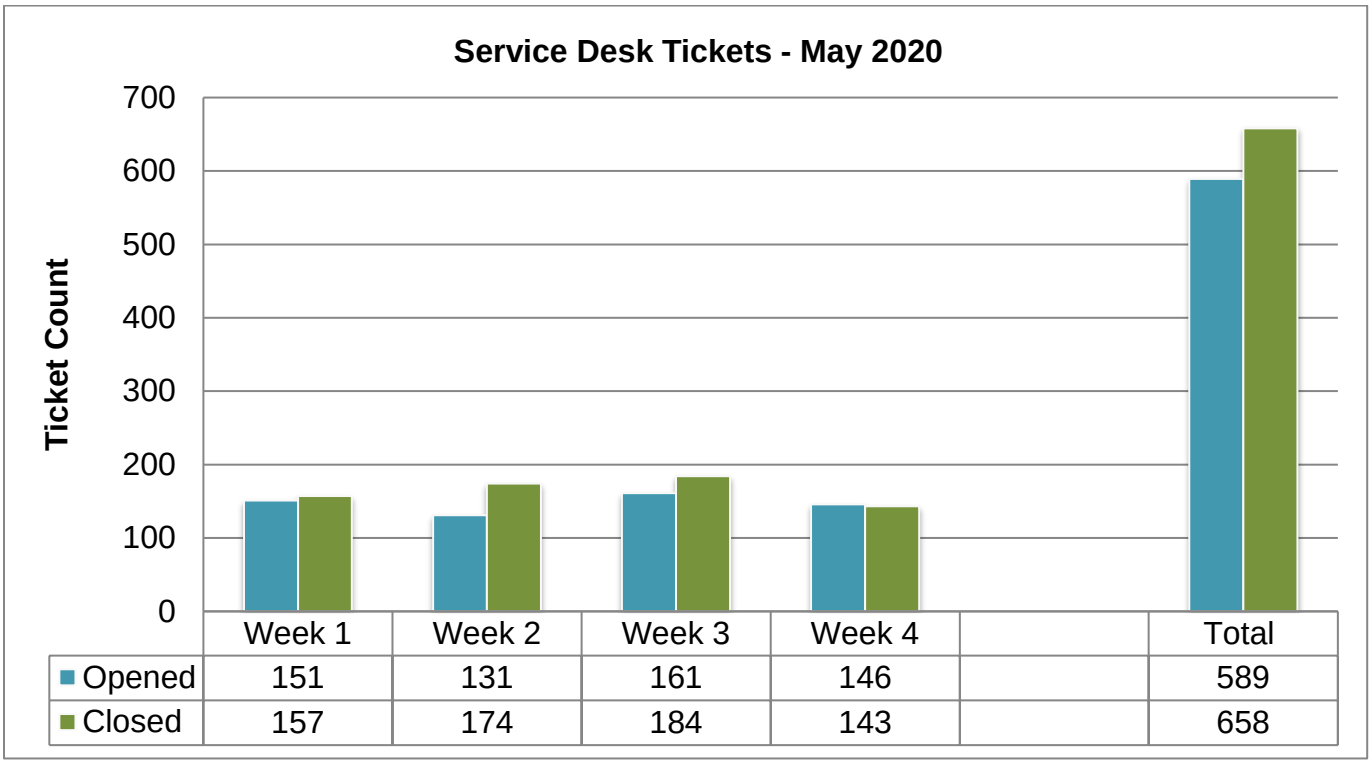


	Call Center	DynamicsSL (Finance)	HealthSuite	OTG (Claims)	Exchange (Email)	TruCare
Week 1	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 2	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 3	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 4	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

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

Office 365 Project

- Migration of email services to the cloud (Migration of Microsoft Office application to the cloud model) – In progress.
    - Completed MDM Core and Cloud setup, and testing user registration.
    - Completed Azure - AD connectivity syncing.
    - Completed Pilot Testing.
    - Weekly user migrations are in progress.
        - 38% completed.



	Week 1	Week 2	Week 3	Week 4		Total
Opened	151	131	161	146		589
Closed	157	174	184	143		658

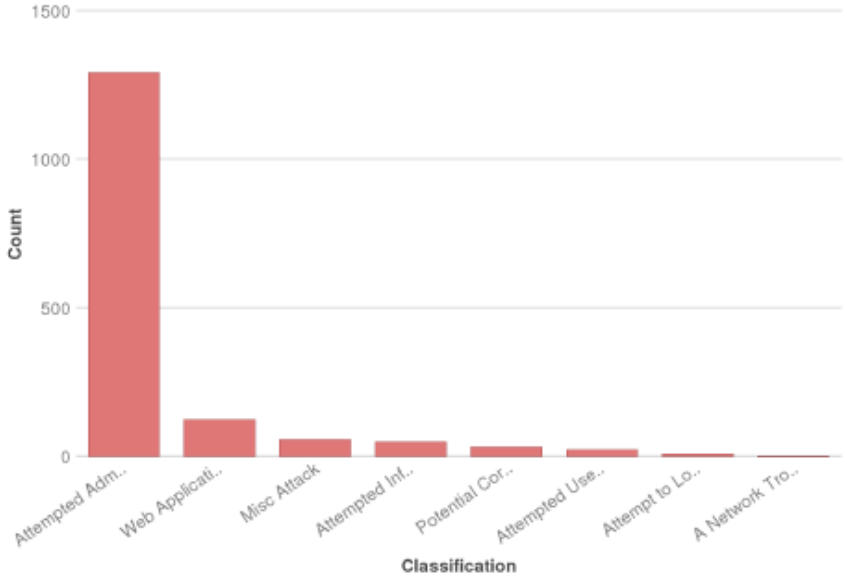
- 589 Service Desk tickets were opened in the month of May, which is 6.9% lower than the previous month and 658 Service Desk tickets were closed, which is 2.4% higher than the previous month.

All Intrusion Events

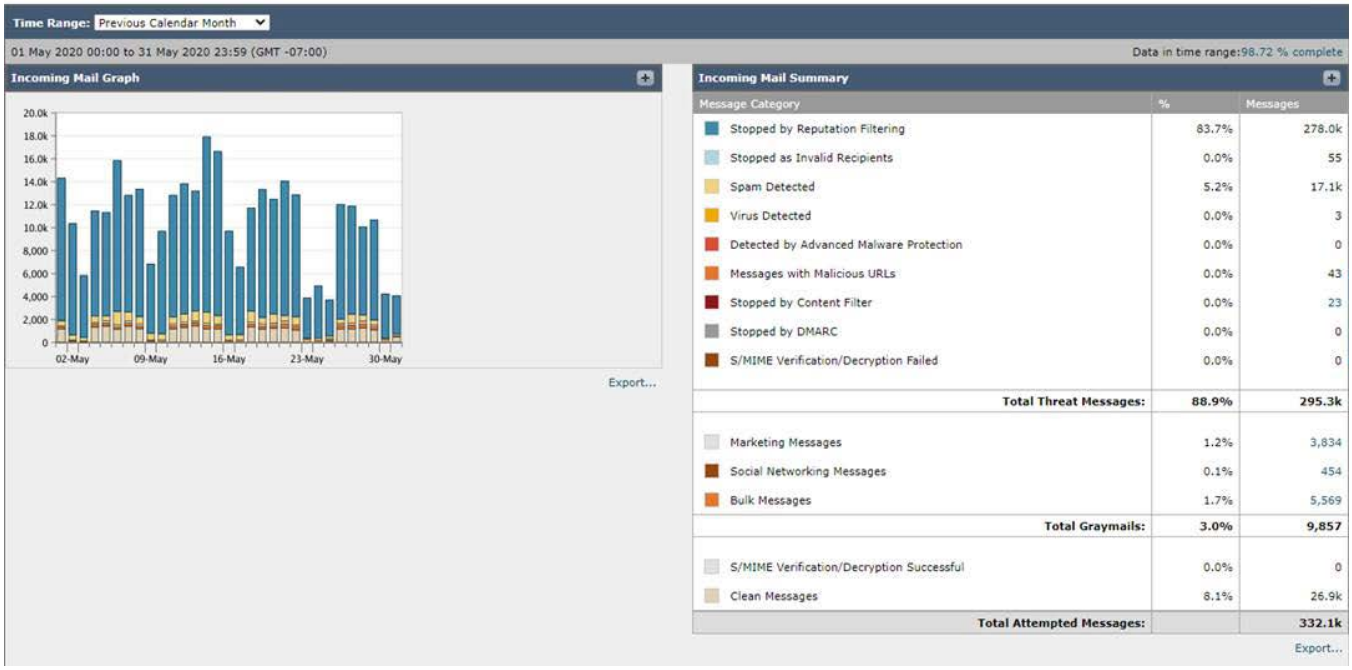
Time Window: *2020-05-01 00:00:00 - 2020-05-31 11:33:00*

Dropped Intrusion Events

Time Window: *2020-05-01 00:00:00 - 2020-05-31 11:33:00*
Constraints: *Inline Result = dropped*



Classification	Count
Attempted Administrator Privilege Gain	1,292
Web Application Attack	124
Misc Attack	56
Attempted Information Leak	48
Potential Corporate Policy Violation	32
Attempted User Privilege Gain	23
Attempt to Login By a Default Username and Password	8
A Network Trojan was Detected	2



Item / Date	May-19	Jun-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	***May-20***
Stopped By Reputation	339.1K	299.9k	10.7k	293.7k	301.0k	264.0k	275.3k	306.6k	234.0k	280.8k	249.7k	***278.0k***
Invalid Recipients	31	299	0	22	51	0	4	0	4	56	39	***55***
Spam Detected	24.0K	23.2k	599	15.5k	17.1k	14.0k	12.0k	13.6k	12.8k	16.4k	11.4k	***17.1k***
Virus Detected	0	2	0	2	3	13	0	0	0	3	4	***3***
Advanced Malware	5	1	1	3	4	1	1	0	4	6	0	***0***
Malicious URLs	174	86	21	117	140	239	81	122	91	14	36	***43***
Content Filter	13	6	0	14	10	17	7	4	9	48	9	***23***
Marketing Messages	4,475	3,909	145	1,748	4,606	4,677	3,854	4,211	3,804	4,296	3,730	***3,834***
Attempted Admin Privilege Gain	1,786	3,029	1,643	971	1,475	360	1,425	704	518	596	1,064	***1,292***
Attempted User Privilege Gain	3	20	116	1	8	0	12	7	27	17	18	***23***
Attempted Information Leak	36	67	46	30	38	46	43	31	37	59	63	***48***
Potential Corp Policy Violation	26	47	59	13	26	8	25	29	10	77	21	***32***
Network Scans Detected	2	5	6	12	18	3	4	1	4	3	15	***2***
Web Application Attack	46	83	111	19	40	45	35	72	45	121	47	***124***
Misc. Attack	1	30	29	7	18	21	1	30	21	25	18	***56***

- 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 278.0k.
- Attempted information leaks detected and blocked at the firewall are slightly lower from 63 to 48 for the month of May.
- Network scans returned a value of 2, which is in line with previous month's data.
- Attempted User Privilege Gain is slightly higher at 23 from a previous six months' average of 21.

ALAMEDA Alliance FOR HEALTH

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

Analytics

Tiffany Cheang

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

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

Date: **June 12, 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: March 2019 – February 2020 dates of service
    - Prior reporting period: March 2018 – February 2019 dates of service
      (Note: Data excludes Kaiser Membership data.)

- For the Current reporting period, the top 7.8% of members account for 81.3% 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 30.0% and ACA OE's at 28.4%.
    - 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 48.3%.

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

- However, the age distribution of the top 7.8% is more concentrated in the 45-66 year old category (41.8%) compared to the overall population (21.7%).

ALAMEDA Alliance FOR HEALTH

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Service you can trust.

Human Resources

Anastacia Swift

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

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

Date: **June 12, 2020**

Subject: **Human Resources Report**

Staffing

- As of June 1, 2020, the Alliance had 316 full time employees and 2-part time employees.

- On June 1, 2020, the Alliance had 39 open positions in which 4 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 35 positions open to date. The Alliance is actively recruiting for the remaining 35 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	10	0	10
Operations	10	1	9
Healthcare Analytics	4	0	4
Information Technology	7	2	5
Finance	4	0	4
Compliance	2	0	2
Human Resources	1	0	1
Projects & Programs	1	1	0
Total	39	4	35

- Our current recruitment rate is 11%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in May 2020 included:
    - 5 years:
        - Jeremy Alonzo (IT-Applications)
        - Scott Coffin (Administrative)
        - Thomas Garrahan (Provider Services)
    - 7 years:
        - Michelle Lewis (Community Relations)
        - Alicia Garibay (Utilization Management)
        - Josephine Camarena (Member Services)
    - 8 years:
        - Linda Ayala (Quality Improvement)
        - Brian Butcher (IT-Infrastructure)
    - 12 years:
        - Cecilia Gomez (Provider Services)
        - Saudia Lacy (Member Services)
    - 17 years:
        - Nancy Kuo (Case Management & Disease Management)