Board of Governors

Regular Meeting

Friday, October 9, 2020
12:00 p.m. – 2:00 p.m.

Alameda, CA

AGENDA

BOARD OF GOVERNORS
Regular Meeting
Friday, October 9, 2020
12:00 p.m. – 2:00 p.m.

Video Conference Call

Join meeting

Meeting number (access code): 146 980 7782

Meeting password: 53035

1-408-418-9388

1-213-306-3065

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://alamedaalliance.webex.com/alamedaalliance/j.php?MTID=m28c6194997a289ffab022bdb1250e27a OR MAY LISTEN TO THE MEETING BY CALLING IN TO THE FOLLOWING TELEPHONE NUMBER: 1-408-418-9388. 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 October 9, 2020 at 12:00 p.m. in Alameda County, California, by Dr. Evan Seevak, Presiding Officer. This meeting to take place by video conference call.)

2. **ROLL CALL**

3. **AGENDA APPROVAL OR MODIFICATIONS**

4. **INTRODUCTIONS**

5. **CONSENT CALENDAR**

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

   a) **SEPTEMBER 11, 2020 BOARD OF GOVERNORS MEETING MINUTES**

6. **BOARD MEMBER REPORTS**

   a) **COMPLIANCE ADVISORY GROUP**

   b) **FINANCE COMMITTEE**

7. **CEO UPDATE**

8. **BOARD BUSINESS**

   a) **REVIEW AND APPROVE MOSS ADAMS FISCAL YEAR 2020 AUDIT RESULTS**

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

   c) **REVIEW AND APPROVE FISCAL YEAR 2021 REVISED BUDGET PROCESS**

9. **STANDING COMMITTEE UPDATES**

   a) **PEER REVIEW AND CREDENTIALING COMMITTEE**

   b) **HEALTH CARE QUALITY COMMITTEE**

c) **PHARMACY & THERAPEUTICS COMMITTEE**

d) **CONSUMER ADVISORY COMMITTEE**

10. STAFF UPDATES

11. UNFINISHED BUSINESS

12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

13. PUBLIC COMMENT (NON-AGENDA ITEMS)

14. CLOSED SESSION:

a) **DISCUSSION AND DELIBERATION REGARDING TRADE SECRETS (HEALTH & SAFETY CODE SECTION 32106). DISCUSSION WILL CONCERN A NEW LINE OF BUSINESS; PROTECTION OF ECONOMIC BENEFIT TO THE DISTRICT. ESTIMATED PUBLIC DISCLOSURE WILL OCCUR IN THE MONTH OF JUNE, 2021.**

15. 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.

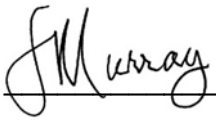
Public Input: If you are interested in addressing the Board, you may submit comments on any agenda item or on any item not on the agenda, in writing via mail to "Attn: Alliance Board," 1240 S. Loop Road, Alameda, CA 94502; or through e-comment at jmurray@alamedaalliance.org.

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 October 6, 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

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

CONSENT CALENDAR

ALAMEDA ALLIANCE FOR HEALTH
BOARD OF GOVERNORS
REGULAR MEETING

September 11, 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, Nicholas Peraino, Wilma Chan, Dr. Michael Marchiano, Dr. Kelley Meade, David B. Vliet, Byron Lopez, Natalie Williams
Alliance Staff Present: Scott Coffin, Dr. Steve O'Brien, Gil Riojas, Tiffany Cheang, Sasi Karaiyan, Anastacia Swift, Jeanette Murray, Ruth Watson, Richard Golfin
Board Members Excused: Feda Almaliti

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

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
5. CONSENT CALENDAR			
Dr. Seevak	Dr. Seevak presented the Consent Calendar and Scott Coffin gave an explanation of each of the below items. a) July 10, 2020 Board of Governors Meeting Minutes b) July 28, 2020 Special Board of Governors Meeting Minutes c) Resolution No. 2020-04 Revised Employee Salary Structure Fiscal Years Ending 2015 Through 2020. d) Resolution No. 2020-05 Conflict of Interest Motion to Approve September 11, 2020 Board of Governors Consent Calendar. A vote by roll call was taken and the motion passed.	Motion to Approve September 11, 2020 Board of Governors Consent Calendar. Motion: N. Peraino Second: R. Gebhart 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 September 11, 2020, at 10:30 AM. Scott introduced Richard Golfin, III; the Alliance's new Chief Compliance Officer. Rebecca Gebhart gave the following updates: Compliance Dashboard: • The Compliance dashboard has 5 to 6 audits with 91 findings and 90 of these corrective action plans have been completed and 68	Informational update to the Board of Governors. Vote not required.	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	have been validated (9 within the last couple of months). NCQA Plan Audit: • NCQA Accreditation Audit is voluntary for the Alliance. • In a review this spring we passed on both lines of business except for a Notice of Authorization (NOA) in Utilization Management. • The Alliance requested a re-review and asked for a Corrective Action Plan (CAP) on the NOA. • We were granted a CAP on July 1, and we are now accredited on both lines of business for the next 3 years. • The team is working hard on CAP solutions and to be prepared for future audits they are performing mock audits. • The Committee will deep-dive into the NCQA Audit at the next Compliance Advisory Committee meeting. New Delegation Oversight Committee: • Richard Golfin is in charge to lead this Committee and is working on building the membership. • The Delegation Oversight Committee is our internal control and will review our delegated entities. • The State looks close at how the plans manage delegated entitles. • Historically, plans might give a non-compliant delegated entity a CAP, and this might go on a few years with no consequences. • The Committee will be reviewing how the plan responds to non-compliance and recommending action for non-compliance, which could be, a CAP, sanction's, and termination of delegated entity. • The Committee will deep dive into solutions for non-compliance at the next Compliance Advisory Committee meeting and Board members are welcome to attend. Informational update to the Board of Governors. Vote not required.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
6. b. BOARD MEMBER REPORT – FINANCE COMMITTEE			
Dr. Ferguson	The Finance Committee was held telephonically on Tuesday, September 8, 2020. Dr. Ferguson gave the following updates: Finance Issues: • Enrollment has had a significant turnaround since March due to COVID-19. • MLR should be above 85% and in June it was 83.6 but currently is 92.3. • The administrative expense has increased and the TNE is at 647%. Informational update to the Board of Governors. Vote not required.	Informational update to the Board of Governors. Vote not required.	
7. CEO UPDATE			
S. Coffin	Scott Coffin presented the following CEO updates. Operating performance – fiscal year end 2020 & July 2021: • Over 30,000 new Medi-Cal applications were processed between March and August by Alameda County Social Services. • We are tracking 3 operational dashboard metrics that are over the Alliances, internal controls which are; provider disputes, call center wait time and abandonment, and human resources. • Claims that are disputed are over payment or underpayment. The Claims department works hard to process these claims accurately	Informational update to the Board of Governors. Vote not required.	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	and to minimize the number of disputes. • Call center volume was 16,000 – 17,000 calls per month before the pandemic, then the calls decreased after the start of the pandemic, but now the calls are starting to increase and currently there are about 13,000 calls per month. Due to adjusting to the work from home environment, technology issues, and staffing shortages, the call volume has been down. • Human Resources open positions: o Staffing shortage fluctuates in all departments. The change occurring with new applicants is the type of work they are looking for, which mostly is remote work. o Human Resources added to their staff in the recruiting area to help facilitate the recruiting process. o The Alliance has hired a company to identify what returning to the office in the future would look like and to identify remote working roles. Questions: • Since we are understaffed, adjusting salaries in real-time at this point might be good. Answer: • The Alliance has low, mid-range, and higher range in salaries and is also looking into a new salary survey for positions. Questions: • Are we having trouble attracting applicants or keeping the applicants? Answer: • Yes, both of these reasons are happening with applicants. Recently, applicants also want to know how long we will be working remote. We cannot give them this information as we do not know.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Question: • Working remotely, we could obtain individuals from across the country to fill the open positions which do not seem to be fillable here in the Bay area which could be an answer to our staffing shortage. Answer: • There would need to be a long term plan with training for managers/supervisors to be able manage in remote settings. Providing consistent training to managers is important. We are looking into a couple of companies that provide this training. Board of Governors: • New Board Members approved by Alameda County Board of Supervisors. o Bryon Lopez – SEIU / United Healthcare Workers West o Natalie Williams – Consumer Member o New Board members were thanked for their services to the Alliance • Dr. Bertram Lubin, Quality Award. o In appreciation to Dr. Bert Lubin, the Alliance created the Dr. Bert Lubin Quality Award and once a year an award will be presented to a pediatrician. o The Alliance will have more information regarding this award to present to the Board later in the year. Privacy Officer & Security Officer Appointments: • Sasi Karaiyan, Chief Information Officer, was appointed as the Chief Security Officer in August 2020. • Richard Golfin, Chief Compliance Officer, was appointed as the		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Chief Privacy Officer in August 2020. • Both of these positions will work closely with one another. Promotions: • Sasi Karaiyan has been promoted to Chief Information Officer. • Anastacia Swift has been promoted to Chief Human Resource Officer. COVID-19 Response & Public Health Policies: • Public health emergency status continues, (9 months, March – September) progressing through the pandemic. • Activities that are still occurring. o 1115 Waiver that authorizes the Whole person initiative is pending approval by CMS. A 12-month extension is planned to be completed by end of year. Health Home Program is also tied to this wavier. The Alliance will continue to update the Board on these programs. Question: • What is the internal strategy if we lose one or both of these programs? Answer: • The strategy depends on details we receive from the State. If Whole Person Care is not funded then this would have an impact on the homeless. The Alliance is working on transition plans if these programs are discontinued. The Alliance is still in active conversations with the County regarding Whole Person Care. • Long Term at Home Care benefit has been cancelled by DHCS. • The Pharmacy transition from the Alliance to DHCS is to be completed by January 1st, 2021. • In September, DHCS initiated the procurement process for		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	managed care health plans statewide. o The process is to be tentatively completed in the next 2 years. o The Alliance is not included in the process. Dissolution Of Joint Powers Authority: • Alliance Board Resolution 2020-01 authorizing CEO to issue notice of Termination to the County was approved by the Alliance Board March 2020. • The Alameda County Board of Supervisors are scheduled to vote on the contract amendment between Alameda Alliance and Alameda County Public Authority. • The Alliance Bylaws are being updated to remove the Joint Powers Authority. • The JPA dissolution is targeted to be completed by November 30, 2020. Informational update to the Board of Governors. Vote not required.		
8. a. BOARD BUSINESS – REVIEW AND APPROVE JUNE 2020 MONTHLY FINANCIAL STATEMENTS			
Gil Riojas	Gil Riojas gave the following June Finance updates: Enrollment: • For the month ending June 30, 2020, the Alliance had enrollment of 256,745 members, a net income of $5.0M and the tangible net equity is 645%. Net Income: • For the month ending June 30, 2020, the actual net income was $5.0M and the budgeted net loss was $3.1M.	Motion to approve the June 2020 financial report as presented. Motion: R. Gebhart Second: D. Vliet Motion passed by roll call. Vote: Yes	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	• The favorable variance is due to higher than anticipated revenue and lower than anticipated medical expenses. Revenue: • For the month ending June 30, 2020, the actual revenue was $81.6M vs. the budgeted revenue of $74.8M. • For the year-to-date, the Alliance recorded revenue of $965.3M vs. budgeted YTD revenue of $935.5M. Medical Expense: • For the month ending June 30, 2020, actual medical expenses were $68.2M vs. our budgeted medical expense of $91.3M. Medical Loss Ratio (MLR): • For the month ending June 30, 2020, the MLR was 83.6% and also fiscal year-to-date of 92.3%. Administrative Expense: • For the month ending June 30, 2020, actual administrative expenses were $8.4M vs. budgeted administrative expense $5.2M. Other Income / (Expense): • As of June 30, 2020, our YTD interest income from investments is $4.5M, and YTD claims interest expense is $333,000. Tangible Net Equity (TNE): • Tangible net equity results continue to remain healthy, and at the end of June 30, 2020, the TNE was reported at 645% of the required amount. Cash Position and Assets: • For the month ending June 30, 2020, $279.7M reported in cash; $138.2M is uncommitted cash. Our current ratio is above the minimum required at 1.77, as compared to the regulatory minimum of 1.0.	No opposed or abstained.	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Question: • Did we reserve funds in the event the State takes back money because of the COVID-19? Answer: • We know that there will be a reduction in rates of 1.4% and we have accounted for this. The other is the risk corridor going forward, we will know in the next few months if we need to also adjust for more. Question: • Does every plan in the State of California have this rate reduction and risk corridor? Answer: • Yes, all plans are in the same scenario. Motion to approve the June 2020 financial report as presented. A vote by roll call was taken and the motion passed.		
8. b. BOARD BUSINESS – REVIEW AND APPROVE JULY 2020 MONTHLY FINANCIAL STATEMENTS			
G. Riojas	Gil Riojas gave the following July Finance updates: Enrollment: • For the month ending July 31, 2020, the Alliance had enrollment of 259,918 members, a net income of $1.9M and the tangible net equity is 647%. • Our enrollment has increased 3,173 members since June 2020. Net Income: • For the month ending July 31, 2020, the actual net income was $1.9M and the budgeted net loss was $5.1M. • The favorable variance is due to higher than anticipated revenue and lower than anticipated medical and administrative expenses.	Motion to approve the July 2020 financial report as presented. Motion: R. Gebhart Second: D. Vliet Motion passed by roll call. Vote: Yes No opposed or abstained.	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Revenue: • For the month ending July 31, 2020, the actual revenue was $81.9M vs. the budgeted revenue of $79.2M. Medical Expense: • For the month ending July 31, 2020, actual medical expenses were $75.5M vs. our budgeted medical expense of $75.6M. Medical Loss Ratio (MLR): • For the month ending July 31, 2020, the MLR was 92.3% and also fiscal year-to-date of 92.3%. Administrative Expense: • For the month ending July 31, 2020, actual administrative expenses were $4.6M vs. budgeted administrative expense $8.8M. Other Income / (Expense): • As of July 31, 2020, our YTD interest income from investments is $96,000, and YTD claims interest expense is $39,000. Tangible Net Equity (TNE): • Tangible net equity results continue to remain healthy, and at the end of July 31, 2020, the TNE was reported at 647% of the required amount. Cash Position and Assets: • For the month ending July 31, 2020, $260.1M reported in cash; $132.4M is uncommitted cash. Our current ratio is above the minimum required at 1.82, as compared to the regulatory minimum of 1.0. Capital Investment: • Fiscal year-to-date Capital assets acquired: $160,000. • Annual capital budget: $2.5 million.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	• A summary of year-to-date capital asset acquisitions is included in this monthly financial statement package. Question: • Prop 56 revenue gap, will the State make adjustments this year and is this a straight pass through. Answer: • Not necessarily a direct pass through and we do not have the information yet regarding adjustments. Motion to approve the July 2020 financial report as presented. A vote by roll call was taken and the motion passed.		
9. a. STANDING COMMITTEE UPDATES – PEER REVIEW AND CREDENTIALING COMMITTEE			
Dr. O'Brien	The Peer Review and Credentialing Committee (PRCC) was held telephonically on July 21, 2020. Dr. O'Brien gave the following updates: • There were nine (9) initial providers approved; including two (2) Primary Care Providers, two (2) specialists, zero (0) ancillary providers, and five (5) mid-level providers • Additionally, thirty-three (33) providers were re-credentialed at this meeting; six (6) primary care providers, twenty (20) specialists, two (2) ancillary providers, and five (5) mid-level providers. Informational update to the Board of Governors. Vote not required.	Informational update to the Board of Governors. Vote not required.	
9. b. STANDING COMMITTEE UPDATES – HEALTH CARE QUALITY COMMITTEE			

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
Dr. O'Brien	The Health Care Quality Committee (HCQC) was held telephonically on July 16, 2020. Committee Medical Updates: P&P Overview and Approvals: • 66 Total P&Ps submitted for committee review and approval for HCS (QA CM, MBR, IT, HE, QI). Committee Member Presentation: • Dr. Laura Miler, CHCN presented on COVID-19 Impact: o CHCN – Rapid Adaption to Shelter in Place presentation. G&A: • Q1-2021 data presented: o Increase in total grievances – QOC and QOS grievances. NCQA Update: • NCQA accredited both the Medi-Cal and Commercial lines of business on July 1, 2020. Health Education Program Evaluation: • Top 3 Health Education Classes utilized by members include: o Asthma, Lactation services, and Nutrition services Interpreter Services – • The new telephonic vendor as of June 1, 2020 is CyraCom. • The Alliance is implementing this vendor to providers. Informational update to the Board of Governors. Vote not required.	Informational update to the Board of Governors. Vote not required.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
10. STAFF UPDATES			
S. Coffin	None	None	None
11. UNFINISHED BUSINESS			
S. Coffin	None	None	None
12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS			
Dr. Seevak	None	None	None
13. PUBLIC COMMENTS (NON-AGENDA ITEMS)			
Dr. Seevak	None	None	None
14. CLOSED SESSION			
Dr. Seevak	Dr. Seevak announced a Closed Session. All Guests and Staff left the meeting. The Board of Governors and Scott Coffin stayed for the closed session. • Public Employee Performance Evaluation (Pursuant To Government Code Section 54957). Title: Chief Executive Officer. • Conference with Labor Negotiators (Pursuant To Government Code Section 54957.6). Agency Negotiators: [Dr. Evan Seevak, Chair; Rebecca Gebhart, Vice Chair; Dr. Rollington Ferguson, Finance Committee Chair; David B. Vliet, Board Member; Marty Lynch, Board Member]; Unrepresented Employee: Chief Executive Officer.	None	None
14. ADJOURNMENT			
Dr. Seevak	Dr. Seevak adjourned the meeting at 2:17 PM.	None	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP

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

CEO Update

Scott Coffin

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

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

Date: **October 9, 2020**

Subject: **CEO Report**

- **Operating Performance & Metrics**
  - $4.8 million net loss year-to-date (July, August).
  - Medi-Cal enrollment continues to increase, nearly 18,000 higher (March to October).
  - Medical loss ratio in August 97.2%;inpatient & outpatient utilization trending upward.
  - Member call center answering 64% of calls within 30 seconds, 16% below target; abandonment rate meeting performance goal.
  - Overturn rate for provider disputes at 27%, 2% above target.
  - Vacancy factor of 14%, 4% above target.
  - Customer Service Week, October 5-9.

- **Public health emergency extended through January 31, 2021**
  - Federal authorities at Health & Human Services approved the renewal of a determination that a public health crisis exists.
  - Additional guidelines and authorizations are expected by County Officials regarding the continued suspension of the Medi-Cal redetermination process.

- **Medi-Cal Rate Development Update**
  - DHCS delivered the preliminary rates for Medi-Cal aid categories, first week in October.
  - Rates are being analyzed and compared to the rate assumptions included in the preliminary budget approved by the Board of Governors in June 2020.
  - DHCS rate adjustment process is forecasted to complete by January 2021.
  - Q1-2021 budget forecast in November, and the Finance Committee approved to accept the Q1 forecast as the final budget for Fiscal Year 2021.

- **1115 Waiver Extension & Whole Person Care:**
  - Centers for Medicare & Medicaid (CMS) has approved a 12-month extension, extending the 1115 Waiver funding through December 31, 2020.
  - Federal comment period ends November 1, 2020.
  - Whole Person Care pilot is included in the one-year extension, and the Alameda County program (AC3) will continue to operate through calendar year 2020 based on the defined funding allocations.

- **Pharmacy transition to DHCS on January 1, 2021:**
  - Alliance's project team is on schedule with DHCS 1/1/2021 go-live.
  - Key milestones include data exchange between the DHCS and contracted pharmacy vendor (Magellan), member communications, and provider communications.
  - Operational readiness phase completes by end of November, 30 days prior to go-live.

- **Alameda Health System (AHS)**
  - 5-day union strike by SEIU and CNA, starts on October 7th
  - Impacts staffing at AHS' acute care hospitals (Highland, San Leandro, Alameda), health clinics, and the psychiatric hospital (John George).
  - The labor strike results in a public health and safety concern, and maintaining access to health care for our Group Care and Medi-Cal members is a high priority.

- **Behavioral Health Integration (BHI) Pilot**
  - Funded by the California State General Funds, administered by DHCS to establish new linkages between primary care and mental health & substance use services.
  - Four projects approved in Alameda County: Lifelong (1), Tri-City Health Center (2), and Community Health Center Network (1).
  - BHI pilot starts on January 1, 2021, and continues for 2 years.
  - DHCS to release guidance to awarded entities, and to define the role of the managed care health plan.
  - https://www.dhcs.ca.gov/provgovpart/Pages/VBP_BHI_IncProApp.aspx

EXECUTIVE DASHBOARD
OCTOBER 2020

ALAMEDA Alliance FOR HEALTH

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

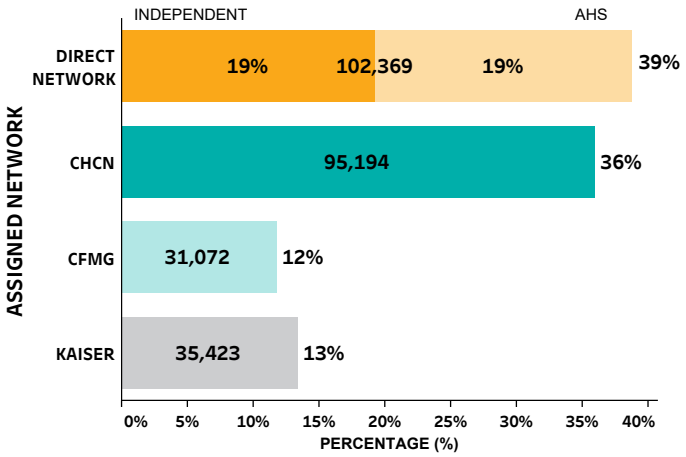
MEMBERSHIP**

264,058

TOTAL MEMBERSHIP

IHSS 6,007 **MEDI-CAL** 258,051

DISTRIBUTION OF ALL MEMBERSHIP BY ASSIGNED NETWORK**



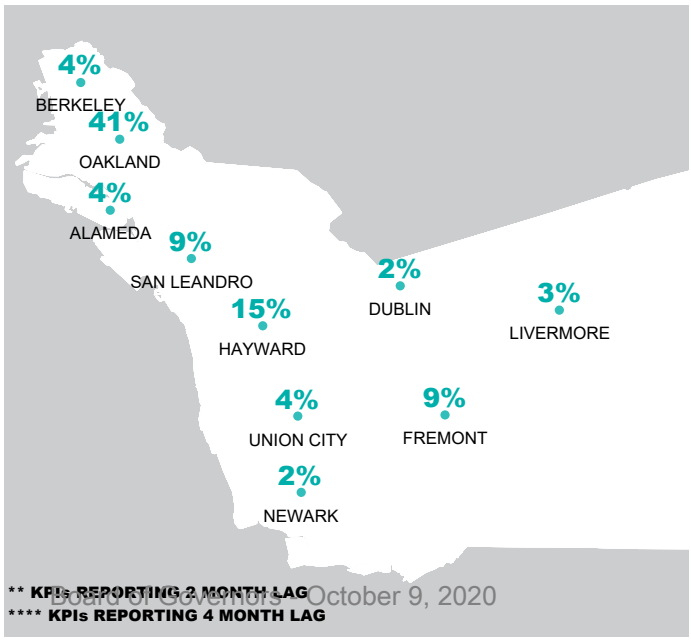
DISTRIBUTION OF MEMBERSHIP BY CITY**

92%

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

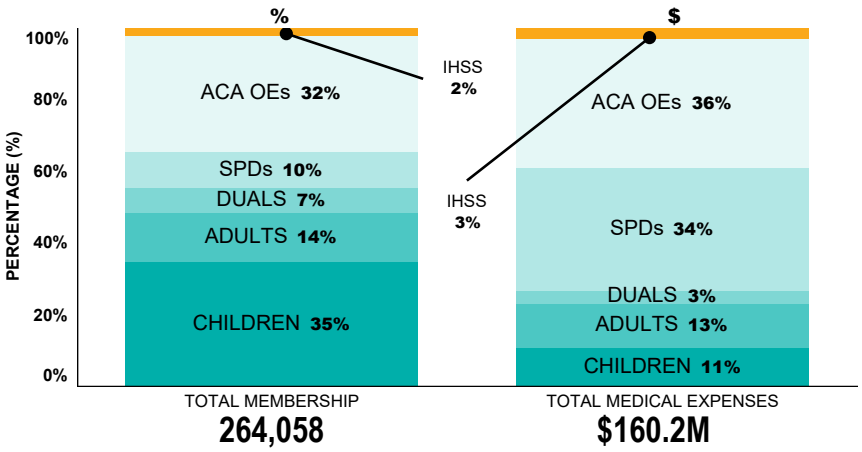
TEN CITIES

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



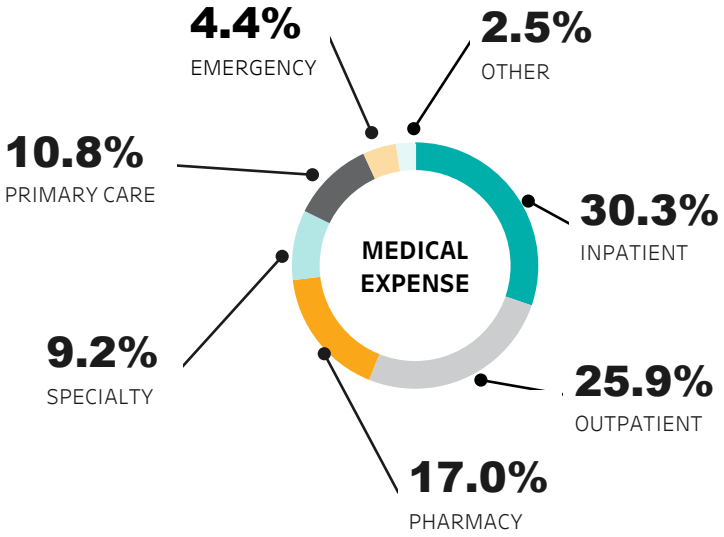
** KPIs REPORTING 2 MONTH LAG
**** KPIs REPORTING 4 MONTH LAG

DISTRIBUTION OF MEDICAL EXPENSE BY MEMBERSHIP CATEGORY**



REVENUE & EXPENSES**

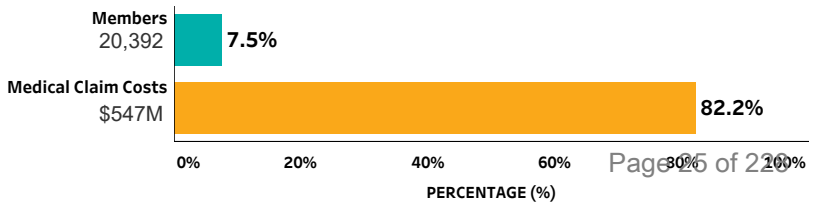
	AUGUST 2020	FISCAL YTD
REVENUE	$82.9M	$164.7M
MEDICAL EXPENSE	($84.6M)	($160.2M)
ADMIN EXPENSE	($4.9M)	($9.5M)
OTHER	$26K	$116K
NET INCOME	**($6.6M)**	**($4.8M)**



TANGIBLE NET EQUITY**

606% **$201M**

HIGH UTILIZER DISTRIBUTION****



UTILIZATION**

5,344
INPATIENT BED DAYS

6,414
EMERGENCY ROOM VISITS

4.9 DAYS
AVERAGE LENGTH OF STAY

CASE AND DISEASE MANAGEMENT**

	NEW CASES	OPEN CASES
CARE COORDINATION	193	575
COMPLEX CASE MANAGEMENT	37	62
Total	230	637

	NEW CASES	ENROLLED
HEALTH HOMES	9	697
WHOLE PERSON CARE (AC3)	5	234
Total	14	931

TOTAL CASE MANAGEMENT

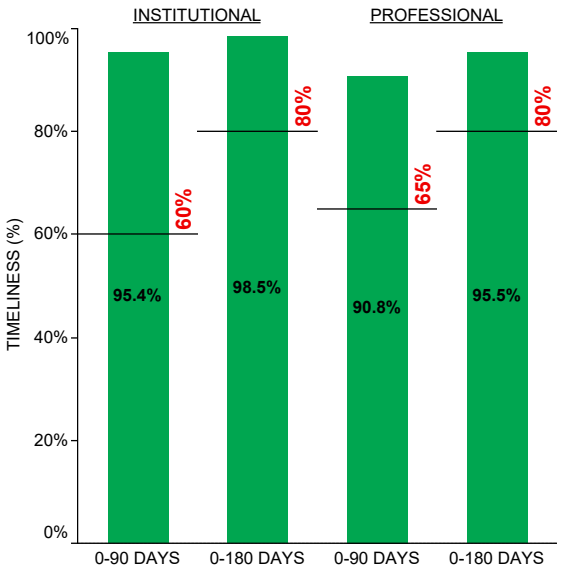
244
TOTAL NEW CASES

1,568
TOTAL OPEN CASES & ENROLLED

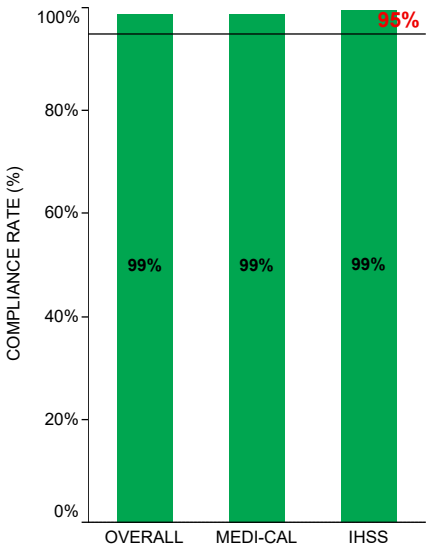
REGULATORY COMPLIANCE

ALL REGULATORY COMPLIANCE MEASURES ARE IN COMPLIANCE.

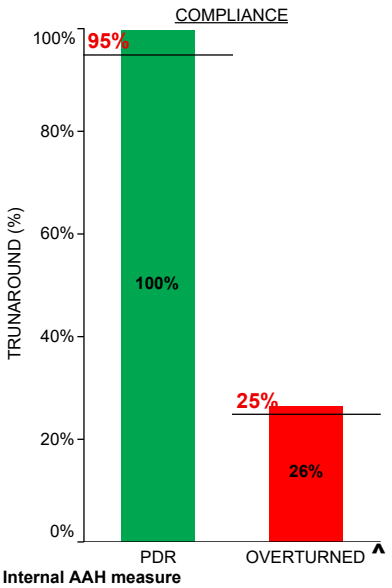
ENCOUNTER DATA



MEDICAL AUTHORIZATIONS



PROVIDER DISPUTES & RESOLUTIONS



^ For Internal AAH measure

CALL CENTER

13,274
CALLS RECEIVED

64%
ANSWERED IN 30 SECONDS

5%
CALLS ABANDONED

CLAIMS

125,757
PROCESSED CLAIMS

74.9%
AUTO ADJUDICATED

18 DAYS
PROCESSED PAYMENTS

STAFF & RECRUITING

332
TOTAL EMPLOYEES

8
HIRED IN THE LAST 30 DAYS

14%
CURRENT VACANCY

2019-2020 Legislative Tracking List

The following is a list of state bills currently tracked by the Public Affairs Department that were introduced during the 2019-2020 Legislative Session. This list of bills is of interest to and could have a direct impact on Alameda Alliance for Health and its membership.

This list includes bills that were introduced in 2019 and moved through the legislative process as 2-year bills as well as those that were introduced in the 2020 legislative session. This list also includes COVID-19 related bills that were introduced in the 2020 legislative session. This legislative tracking list was last updated on 10/05/2020.

Medi-Cal (Medicaid)

- **AB 890 (Wood – D) Nurse Practitioners: Score of practice: Practice without Standardized Procedures**
  - **Introduced:** 2/20/2019
  - **Status:** 9/29/2020 – Approved by the Governor. Chaptered by Secretary of State.
  - **Summary:** Would establish the Nurse Practitioner Advisory Committee to advise and give recommendations to the Board of Registered Nursing on matters relating to nurse practitioners. The bill would require the committee to provide recommendations or guidance to the board when the board is considering disciplinary action against a nurse practitioner. The bill would require the board, by regulation, to define minimum standards for a nurse practitioner to transition to practice independently. The bill would authorize a nurse practitioner who meets certain education, experience, and certification requirements to perform, in certain settings or organizations, specified functions without standardized procedures, including ordering, performing, and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and furnishing controlled substances.

- **AB 1327 (Petrie-Norris – D) Medi-Cal: Reimbursement Rates**
  - **Introduced:** 2/22/2019
  - **Status:** 9/29/2020 – Vetoed by Governor.
  - **Summary:** Current law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including clinical laboratory or laboratory services. The Medi-Cal program is, in part, governed by, and funded pursuant to, federal Medicaid program provisions. Current aw requires the department to develop, subject to federal approval, reimbursement rates for clinical or laboratory services according to specified standards, such as requiring that reimbursement to providers for those services not exceed the lowest of enumerated criteria, including 80% of the lowest maximum allowance established by the federal Medicare Program for the same or similar services. This bill would delete provisions relating to the above-specified 80% standard and would make conforming changes.

- **AB 2100 (Wood – D) Medi-Cal: Pharmacy Benefits**
  - **Introduced:** 2/5/2020
  - **Status:** 9/29/2020 – Vetoed by Governor.
  - **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 2157 (Wood – D) Health Care Coverage: Independent Dispute Resolution Process**
  - **Introduced:** 2/10/2020
  - **Status:** 9/29/2020 – Approved by the Governor. Chaptered by Secretary of State
  - **Summary:** Current law requires the Department of Managed Health Care and the Department of Insurance to establish an independent dispute resolution process to resolve a claim dispute between a health care service plan or health insurer, as appropriate, and a noncontracting individual health professional, and sets forth requirements and guidelines for that process, including contracting with an independent organization for the purpose of conducting the review process. Current law requires each department to establish uniform written procedures for the submission, receipt, processing, and resolution of these disputes, as specified. Current law requires the independent organization, in deciding the dispute, to base its decision regarding the appropriate reimbursement on all relevant information. This bill would require the procedures established by each department to include a process for each party to submit into evidence information that will be kept confidential from the other party, in order to preserve the confidentiality of the source contract.

- **AB 2164 (Rivas – D) Telehealth**
  - **Introduced:** 2/11/2020
  - **Status:** 9/26/2020 – Vetoed by Governor.
  - **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) Childhood Lead Poisoning: Screening and Prevention**
  - **Introduced:** 2/14/2020
  - **Status:** 9/29/2020 – Approved by the Governor. Chaptered by Secretary of State
  - **Summary:** Current law establishes the Childhood Lead Poisoning Prevention Program, which is administered by the State Department of Public Health. Current law requires the department to adopt regulations establishing a standard of care that include the determination of specified risk factors for lead exposure, including a child's time spent in a home, school, or building built before 1978. Current law requires the department to ensure appropriate case management for children who have been identified with lead poisoning, and authorizes the department to contract with any public or private entity, including any local agency, to perform that duty. 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 country. The bill would require the department to update its formula for allocating funds to a local agency that contracts with the department to administer the Childhood Lead Poisoning Prevention Program, and to revise funding allocations before each contract cycle.

- **AB 2277 (Salas – D) Medi-Cal: Blood Lead Screening Tests**
  - **Introduced:** 2/14/2020
  - **Status:** 8/18/2020 – Dead/Failed Deadline pursuant to Rule 6(b)(13).
  - **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**
  - **Introduced:** 3/4/2020
  - **Status:** 6/5/2020 – Dead/Failed Deadline pursuant to Rule 61(b)(6).
  - **Summary:** Current law requires a laboratory that performs a blood lead analysis on human blood drawn in California to report specified information, including the test results and the name, birth date, and address of the person tested, to the department for each analysis on every person tested. Current law authorizes the department to share the information reported by a laboratory with, among other entities, the State Department of Health Care Services for the purpose of determining whether children enrolled in Medi-Cal are being screened for lead poisoning and receiving appropriate related services. This bill also would additionally require a laboratory that performs a blood lead analysis to report to the department, among other things, the Medi-Cal identification number and medical plan identification number, if available, for each analysis on every person tested.

- **AB 2360 (Maienschein – D) Telehealth: Mental Health**
  - **Introduced:** 2/28/2020
  - **Status:** 9/26/2020 – Vetoed by Governor.
  - **Summary:** Would require health care service plans and health insurers, by July 1, 2021, to provide access to a telehealth consultation program that meets specified criteria and provides providers who treat children and pregnant and certain postpartum persons with access to a mental health consultation program, as specified. The bill would require the consultation by a mental health clinician with expertise appropriate for pregnant, postpartum, and pediatric patients to be conducted by telephone or telehealth video, and to include guidance on the range of evidence-based treatment options, screening tools, and referrals. The bill would require health care service plans and insurers to communicate information relating to the telehealth program at least twice a year in writing.

- **AB 2450 (Grayson – D) Air Ambulance Services**
  - **Introduced:** 2/19/2020
  - **Status:** 9/9/2020 – Approved by the Governor. Chaptered by Secretary of State.

- **Summary:** Current law imposes a penalty of $4 until July 1, 2020, upon every conviction for a violation of the Vehicle Code or a local ordinance adopted pursuant to the Vehicle Code, other than a parking offense. The act requires the county or court that imposed the fine to transfer the revenues collected to the Treasurer for deposit into the Emergency Medical Air Transportation and Children's Coverage Fund. Current law requires the assessed penalty to continue to be collected, administered, and distributed until exhausted or until December 31, 2021, whichever occurs first. Current law repeals these provisions July 1, 2022.This bill would extend the imposition of the above-described penalty by 1 year and would instead make those provisions inoperative on July 1, 2024, and repeal them on January 1, 2025.

- **AB 3118 (Bonta – D) Medically Supportive Food and Nutrition Services**
  - **Introduced:** 2/21/2020
  - **Status:** 6/5/2020 – Dead/Failed Deadline pursuant to Rule 61(b)(8).
  - **Summary:** Would expand the Medi-Cal schedule of benefits to include medically supportive food and nutrition services, such as medically tailored groceries and meals, and nutrition education. The bill would provide that the benefit include services that link a Medi-Cal beneficiary to community-based food services and transportation for accessing healthy food. The bill would require the department to implement these provisions by various means, including provider bulletins, without taking regulatory action, and would condition the implementation of these provisions to the extent permitted by federal law, the availability of federal financial participation, and the department securing federal approval.

- **SB 29 (Durazno – D) Medi-Cal: Eligibility**
  - **Introduced:** 12/03/2018
  - **Status:** 8/31/2020 – Dead/Failed Deadline pursuant to Rule 61(b)(5).
  - **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 bene89fits but for their immigration status, and would delete provision delaying implementation until the director makes the determination as specified.

- **SB 803 (Beall – D) Mental Health Services: Peer Support Specialist Certification**
  - **Introduced:** 1/8/2020
  - **Status:** 9/9/2020 – Approved by the Governor. Chaptered by Secretary of State.
  - **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 persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a schedule of benefits under the Medi-Cal program and provides for various services, including behavioral and mental health services that are rendered by Medi-Cal enrolled providers. This bill would require the department, by July 1, 2022, to establish statewide requirements for counties to use in developing certification programs for the certification of peer support specialists, who are individuals who self-identify as having lived experience with the process of recovery from mental illness, substance use disorder, or both.

Group Care

- **AB 2118 (Kalra – D)**
  - **Introduced:** 2/6/2020
  - **Status:** 9/29/2020 – Approved by the Governor. Chaptered by Secretary of State.
  - **Summary:** Would require a health care service plan and health insurer, excluding for a specialized health care service plan or specialized health care policy, to report to the Department of Managed Health Care and the Department of Insurance, respectively, by October 1, 2021, and annually thereafter, for products in the individual and small group markets, and for rates effective during the 12-month period ending January 1 of the following year, on specified information, including premiums, cost sharing, benefits, enrollment, and trend factors, and would exclude prescribed information from the reporting requirements until January 1, 2023.

- **AB 2265 (Quirk-Silva – D) Mental Health Services Act – use of funds for substance use disorder treatment**
  - **Introduced:** 2/14/2020
  - **Status:** 9/29/2020 – Approved by the Governor. Chaptered by Secretary of State.
  - **Summary:** The Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, funds a system of county mental health plans for the provision of mental health services, as specified. The act establishes the Mental Health Services Fund, which is continuously appropriated to, and administered by, the State Department of Health Care Services to fund specified county mental health programs. This bill would authorize the services for adults, older adults, and children, as well as innovative programs and prevention and early intervention programs that are provided by counties as part of the MHSA to include substance use disorder treatment for children, adults, and older adults with co-occurring mental health and substance use disorders who are eligible to receive mental health services pursuant to those programs.

COVID-19

- **SB 275 (Pan – D) Health Care and Essential Workers: Personal Protective Equipment**
  - **Introduced:** 2/13/2020
  - **Status:** 9/29/2020 – Approved by the Governor. Chaptered by Secretary of State.
  - **Summary:** Current law establishes the State Department of Public Health to implement various programs throughout the state relating to public health, including licensing and regulating health facilities and control of infectious diseases. This bill would require the State Department of Public Health and the Office of Emergency Services, in coordination with other state agencies, to, upon appropriation and as necessary, establish a personal protective equipment (PPE) stockpile. The bill would require the department to establish guidelines for the procurement, management, and distribution of PPE, taking into account, among other things, the amount of each type of PPE that would be required for all health care workers and essential workers in the state during a 90-day pandemic or other health emergency.

- **AB 2887 (Bonta – D) Statewide Emergencies: Mitigation**
  - **Introduced:** 2/21/2020
  - **Status:** 8/31/2020 – Dead/Failed Deadline pursuant to Rule 61(b)(5).

- **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**
  - **Introduced:** 2/21/2020
  - **Status:** 9/30/2020 – Vetoed by Governor.
  - **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 943 (Chang – R) Paid Family Leave: School Closures: COVID-19**
  - **Introduced:** 2/10/2020
  - **Status:** 8/31/2020 – Dead/Failed Deadline pursuant to Rule 61(b)(5).
  - **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**
  - **Introduced:** 2/6/2020
  - **Status:** 8/31/2020 – Dead/Failed Deadline pursuant to Rule 61(b)(5).
  - **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**
  - **Introduced:** 2/19/2020
  - **Status:** 8/31/2020 – Dead/Failed Deadline pursuant to Rule 61(b)(5).
  - **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**
  - **Introduced:** 2/21/2020
  - **Status:** 9/29/2020 – Approved by the Governor. Chaptered by Secretary of State.
  - **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.

Other

- **AB 1976 (Eggman – D) Mental Health Services: Assisted Outpatient Treatment**
  - **Introduced:** 1/22/2020
  - **Status:** 9/25/2020 – Approved by the Governor. Chaptered by Secretary of State.
  - **Summary:** The Assisted Outpatient Treatment Demonstration Project Act of 2002, known as Laura's Law, until January 1, 2022, authorizes each county to elect to offer specified mental health programs either through a resolution adopted by the county board of supervisors or through the county budget process, if the county board of supervisors makes a finding that specified mental health programs will not be reduced as a result of participating. Current law authorizes participating counties to pay for the services provided from moneys distributed to the counties from various continuously appropriated funds, including the Mental Health Services Fund, when included in a county plan, as specified. This bill, commencing July 1, 2021, would instead require a county or group of counties to offer those mental health programs, unless a county or group of counties opts out by a resolution passed by the governing body stating the reasons for opting out and any facts or circumstances relied on in making that decision.

- **AB 2279 (Garcia – D) Childhood Lead Poisoning Prevention**
  - **Introduced:** 2/14/2020
  - **Status:** 8/18/2020 – Failed Deadline pursuant to Rule 61(b)(5).
  - **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.

- **SB 1237 (Dodd – D) Nurse-midwives: Scope of practice**
  - **Introduced:** 2/20/2020
  - **Status:** 9/25/2020 – Approved by the Governor. Chaptered by Secretary of State.
  - **Summary:** Would delete the specified provisions defining the practice of nurse-midwifery, would delete the condition that a certified nurse-midwife practice under the supervision of a physician and surgeon, and would instead authorize a certified nurse-midwife to attend cases of low-risk pregnancy, as defined, and childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning services, interconception care, and immediate care of the newborn, consistent with standards adopted by a specified professional organization, or its successor, as approved by the Board of Registered Nursing.

- **SB 852 (Pan – D) Health Care: Prescription Drugs**
  - **Introduced:** 1/13/2020
  - **Status:** 9/28/2020 – Approved by the Governor. Chaptered by Secretary of State.
  - **Summary:** Would require the California Health and Human Services Agency (CHHSA) to enter into partnerships, in consultation with other state departments as necessary to, among other things, increase patient access to affordable drugs. The bill would require CHHSA to enter into partnerships to produce or distribute generic prescription drugs and at least one form of insulin, provided that a viable pathway for manufacturing a more affordable form of insulin exists at a price that results in savings. The bill would, subject to appropriation by the Legislature, require CHHSA to submit a report to the Legislature on or before July 1, 2023, that, among other things, assesses the feasibility and advantages of directly manufacturing generic prescription drugs and selling generic prescription drugs at a fair price.

- **SB 1065 (Hertzberg – D) CalWORKs: Homeless Assistance**
  - **Introduced:** 2/18/2020
  - **Status:** 9/25/2020 – Approved by the Governor. Chaptered by Secretary of State.
  - **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.

Operations Dashboard

Alameda Alliance for Health
Operations Dashboard
- October-2020 -

ID	Section	Subject Area	Category	Performance Metric					ID
1	1	Financials			Aug-20 FYTD			%	Prelim. Annual Budget	1
2										2
3			Income & Expenses	Revenue $	$164,728,168			18.0%	$917,492,169	3
4				Medical Expense $	$160,158,608			18.4%	$871,238,681	4
5				*Inpatient (Hospital)*	$48,450,565			*30.3%*	$276,088,226	5
6				*Outpatient/Ancillary*	$41,403,047			*25.9%*	$256,550,771	6
7				*Emergency Department*	$7,044,021			*4.4%*	$39,849,225	7
8				*Pharmacy*	$27,264,339			*17.0%*	$107,885,846	8
9				*Primary Care*	$17,311,137			*10.8%*	$71,677,546	9
10				*Specialty Care*	$14,708,081			*9.2%*	$89,550,627	10
11				*Other*	$3,977,418			*2.5%*	$29,636,441	11
12				Admin Expense $	$9,470,407			12.7%	$74,626,652	12
13				Other Income / (Exp.) $	$116,177			0.2%	$1,580,000	13
14				Net Income $	($4,784,670)				($26,793,164)	14
15				Gross Margin %	2.8%				5.0%	15
16			Liquid Reserves	Medical Loss Ratio (MLR) - Net %	97.2%				95.0%	16
17				Tangible Net Equity (TNE) %	606.1%				546.0%	17
18				Tangible Net Equity (TNE) $	$201,390,145				$174,500,908	18
19			Reinsurance Cases	2020-2021 Cases Submitted	1					19
20				2020-2021 New Cases Submitted	0					20
21				2019-2020 Cases Submitted	20					21
22				2019-2020 New Cases Submitted	18					22
23			Balance Sheet	Cash Equivalents	$262,252,036					23
24				Pass-Through Liabilities	$207,188,900					24
25				Uncommitted Cash	$55,063,136					25
26				Working Capital	$191,090,432					26
27				Current Ratio %	158.6%				100%	27
28										28
29	2	Membership			Jun-20	Jul-20	Aug-20	%	Aug-20 Budget	29
30										30
31			Medi-Cal Members	Adults	34,087	34,909	35,689	14%	35,350	31
32				Children	90,745	91,570	92,692	35%	95,939	32
33				Seniors & Persons with Disabilities (SPDs)	26,111	26,044	26,094	10%	25,998	33
34				ACA Optional Expansion (ACA OE)	81,296	82,989	85,081	32%	84,749	34
35				Dual-Eligibles	18,069	18,297	18,495	7%	17,930	35
36										36
37				Total Medi-Cal	250,308	253,809	258,051	98%	259,966	37
38			IHSS Members	IHSS	6,437	6,109	6,007	2%	6,397	38
39			Total Membership	Medi-Cal and IHSS	256,745	259,918	264,058	100%	266,363	39
40										40
41			Members Assigned By Delegate	Direct-contracted network	49,813	50,199	51,057	19%		41
42				Alameda Health System (Direct Assigned)	49,177	50,193	51,312	19%		42
43				Children's First Medical Group	30,425	30,742	31,072	12%		43
44				Community Health Center Network	93,392	94,144	95,194	36%		44
45				Kaiser Permanente	33,938	34,640	35,423	13%		45
46										46

Alameda Alliance for Health
Operations Dashboard
- October-2020 -

ID	Section	Subject Area	Category	Performance Metric						ID
47	3	Claims			Jul-20	Aug-20	Sep-20	%	Performance Goal	47
48										48
49			HEALTHsuite Claims Processing	Number of Claims Received	110,462	104,293	111,255			49
50				Number of Claims Paid	91,006	73,816	97,777			50
51				Number of Claims Denied	28,070	23,393	27,980			51
52				Inventory (Unfinalized Claims)	59,706	66,159	47,720			52
53				Pended Claims (Days)	11,563	13,112	8,204	17%		53
54				*0-29 Calendar Days*	11,512	12,969	8,131	17%		54
55				*30-44 Calendar Days*	51	141	73	0%		55
56				*45-59 Calendar Days*	0	2	0	0%		56
57				*60-89 Calendar Days*	0	0	0	0%		57
58				*90-119 Calendar Days*	0	0	0	0%		58
59				*120 or more Calendar Days*	0	0	0	0%		59
60				Total Claims Paid (dollars)	46,860,152	40,276,246	48,869,310			60
61				Interest Paid (Total Dollar)	39,150	22,530	28,629	0%		61
62				Auto Adjudication Rate (%)	72.7%	76.2%	74.9%		70%	62
63				Average Payment Turnaround (days)	18	18	18		25 days or less	63
64			Claims Auditing	# of Pre-Pay Audited Claims	2,253	2,191	1,973			64
65			Claims Compliance	% of Claims Processed Within 30 Cal Days (DHCS Goal = 90%)	99%	99%	99%		90%	65
66				% of Claims Processed Within 90 Cal Days (DHCS Goal = 99%)	100%	100%	100%		99%	66
67				% of Claims Processed Within 45 Work Days (DMHC Goal = 95%)	100%	100%	100%		95%	67
68										68
69	4	Member Services			Jul-20	Aug-20	Sep-20	%	Performance Goal	69
70										70
71			Member Call Center	Inbound Call Volume	12,696	13,024	13,274			71
72				Calls Answered in 30 Seconds %	76.0%	66.0%	64.0%		80.0%	72
73				Abandoned Call Rate %	4.0%	6.0%	5.0%		5.0% or less	73
74				Average Wait Time	00:44	01:18	01:49			74
75				Average Call Duration	08:46	06:54	06:48			75
76				Outbound Call Volume	9,965	8,744	9,342			76
77										77
78	5	Provider Services			Jul-20	Aug-20	Sep-20	%	Performance Goal	78
79										79
80			Provider Call Center	Inbound Call Volume	6,467	5,547	5,584			80
81										81
82	6	Provider Contracting			Jul-20	Aug-20	Sep-20	%	Performance Goal	82
83										83
84			Provider Network	Primary Care Physician	583	582	570			84
85				Specialist	6,655	6,851	6,911			85
86				Hospital	17	17	17			86
87				Skilled Nursing Facility	62	62	62			87
88				Durable Medical Equipment	Capitated	Capitated	Capitated			88
89				Urgent Care	10	10	10			89
90				Health Centers (FQHCs and Non-FQHCs)	67	67	67			90
91				Transportation	380	380	380			91
92			Provider Credentialing	Number of Providers in Credentialing	1,428	0	1,434			92
93				Number of Providers Credentialed	1,428	0	1,434			93
94										94

Alameda Alliance for Health
Operations Dashboard
- October-2020 -

ID	Section	Subject Area	Category	Performance Metric						ID
95	7	Human Resources & Recruiting			Jul-20	Aug-20	Sep-20	%	Annual Budget	95
96										96
97			Employees	Total Employees	323	331	332		354	97
98				Full Time Employees	321	329	330	99%		98
99				Part Time Employees	2	2	2	1%		99
100				New Hires	5	8	8			100
101				Separations	2	2	5			101
102				Open Positions	50	48	51	14%	10% or less	102
103				Signed Offer Letters Received	6	6	4			103
104				Recruiting in Process	44	42	47	12%		104
105										105
106			Non-Employee (Temps / Seasonal)		3	2	3			106
107										107
108	8	Compliance			Jul-20	Aug-20	Sep-20	%	Performance Goal	108
109										109
110			Provider Disputes & Resolutions	Turnaround Compliance (45 business days)	100%	100%	100%		95%	110
111				% Overturned	29%	31%	27%		25% or less	111
112										112
113			Member Grievances	Overall Standard Grievance Compliance Rate % (30 calendar days)	97%	97%	97%		95%	113
114				Overall Expedited Grievance Compliance Rate % (3 calendar days)	100%	100%	100%		95%	114
115										115
116			Member Appeals	Overall Standard Appeal Compliance Rate (30 calendar days)	100%	100%	100%		95%	116
117				Overall Expedited Appeal Compliance Rate (3 calendar days)	100%	100%	100%		95%	117
118										118
119	9	Encounter Data & Technology			Jul-20	Aug-20	Sep-20		Performance Goal	119
120										120
121			Business Availability	HEALTHsuite (Claims and Membership System)	100.00%	100.00%	100.00%		99.99%	121
122				TruCare (Care Management System)	100.00%	100.00%	100.00%		99.99%	122
123				All Other Applications and Systems	100.00%	100.00%	100.00%		99.99%	123
124										124
125			Encounter Data	Inbound Trading Partners 837 (Trading Partner To AAH)						125
126				Timeliness of file submitted by Due Date	100.00%	100.00%	100.00%		100.0%	126
127										127
128				AAH Outbound 837 (AAH To DHCS)						128
129				Timeliness - % Within Lag Time - Institutional 0-90 days	87.0%	93.9%	95.4%		60.0%	129
130				Timeliness - % Within Lag Time - Institutional 0-180 days	97.4%	97.8%	98.5%		80.0%	130
131				Timeliness - % Within Lag Time - Professional 0-90 days	92.6%	94.7%	90.8%		65.0%	131
132				Timeliness - % Within Lag Time - Professional 0-180 days	97.8%	98.3%	95.5%		80.0%	132
133										133

Alameda Alliance for Health
Operations Dashboard
- October-2020 -

ID	Section	Subject Area	Category	Performance Metric						ID
134	10	Health Care Services			Jul-20	Aug-20	Sep-20	Q3	Performance Goal	134
135										135
136			Authorization Turnaround	Overall Authorization Turnaround % Compliant	99%	99%	99%	99%	95%	136
137				Medi-Cal %	99%	99%	99%	99%	95%	137
138				Group Care %	98%	97%	99%	98%	95%	138
139										139
140			Outpatient Authorization Denial Rates	Overall Denial Rate (%)	4.0%	4.0%	3.5%			140
141				Denial Rate Excluding Partial Denials (%)	3.9%	3.8%	3.2%			141
142				Partial Denial Rate (%)	0.0%	0.2%	0.2%			142
143										143
144			Pharmacy Authorizations	Approved Prior Authorizations	745	718	743	40%		144
145				Denied Prior Authorizations	661	649	596	32%		145
146				Closed Prior Authorizations	478	523	501	27%		146
147				Total Prior Authorizations	1,884	1,890	1,840			147
148										148
149					Jun-20	Jul-20	Aug-20			149
150										150
151			Inpatient Utilization	Days / 1000	286.7	309.4	281.4			151
152				Admits / 1000	52.6	52.1	58.0			152
153				Average Length of Stay	5.5	5.9	4.9			153
154										154
155			Emergency Department (ED) Utilization	# ED Visits / 1000	33.06	35.57	33.84			155
156										156
157			Case Management	New Cases						157
158				Care Coordination	253	265	193			158
159				Complex Case Management	37	6	37			159
160				Health Homes	22	25	9			160
161				Whole Person Care (AC3)	3	10	5			161
162				Total New Cases	315	306	244			162
163										163
164				Open Cases						164
165				Care Coordination	647	650	575			165
166				Complex Case Management	101	60	62			166
167				Total Open Cases	748	710	637			167
168										168
169				Enrolled						169
170				Health Homes	777	788	697			170
171				Whole Person Care (AC3)	225	235	234			171
172				Total Enrolled	1,002	1,023	931			172
173										173
174				Total Case Management (Open Cases & Enrolled)	1,750	1,733	1,568			174
175										175

ALAMEDA Alliance FOR HEALTH

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

Moss Adams 2020 Audit Results:

Alameda Alliance for Health and

Alameda Alliance Joint Powers Authority

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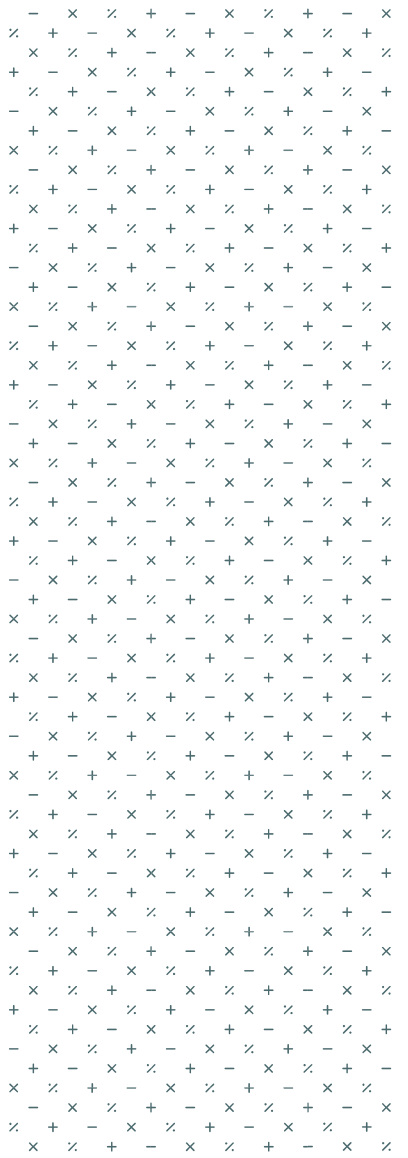
2020 Audit Results: Alameda Alliance for Health and Alameda Alliance Joint Powers Authority



Report of Independent Auditors

Unmodified Opinion

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

1

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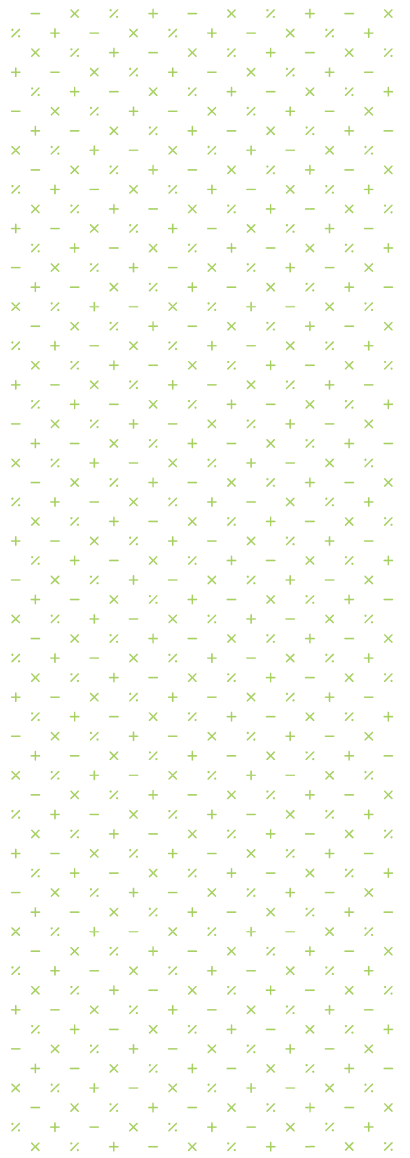
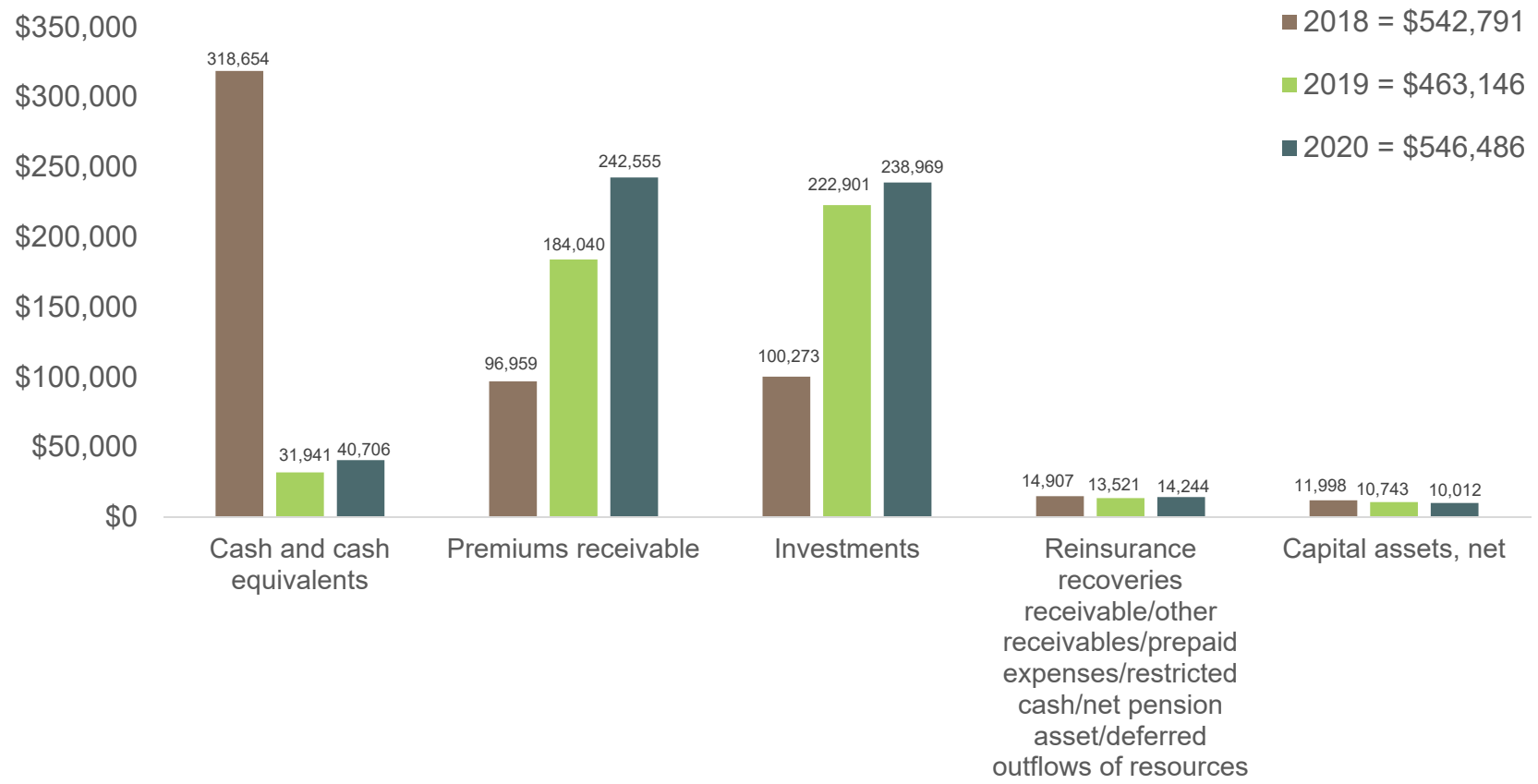
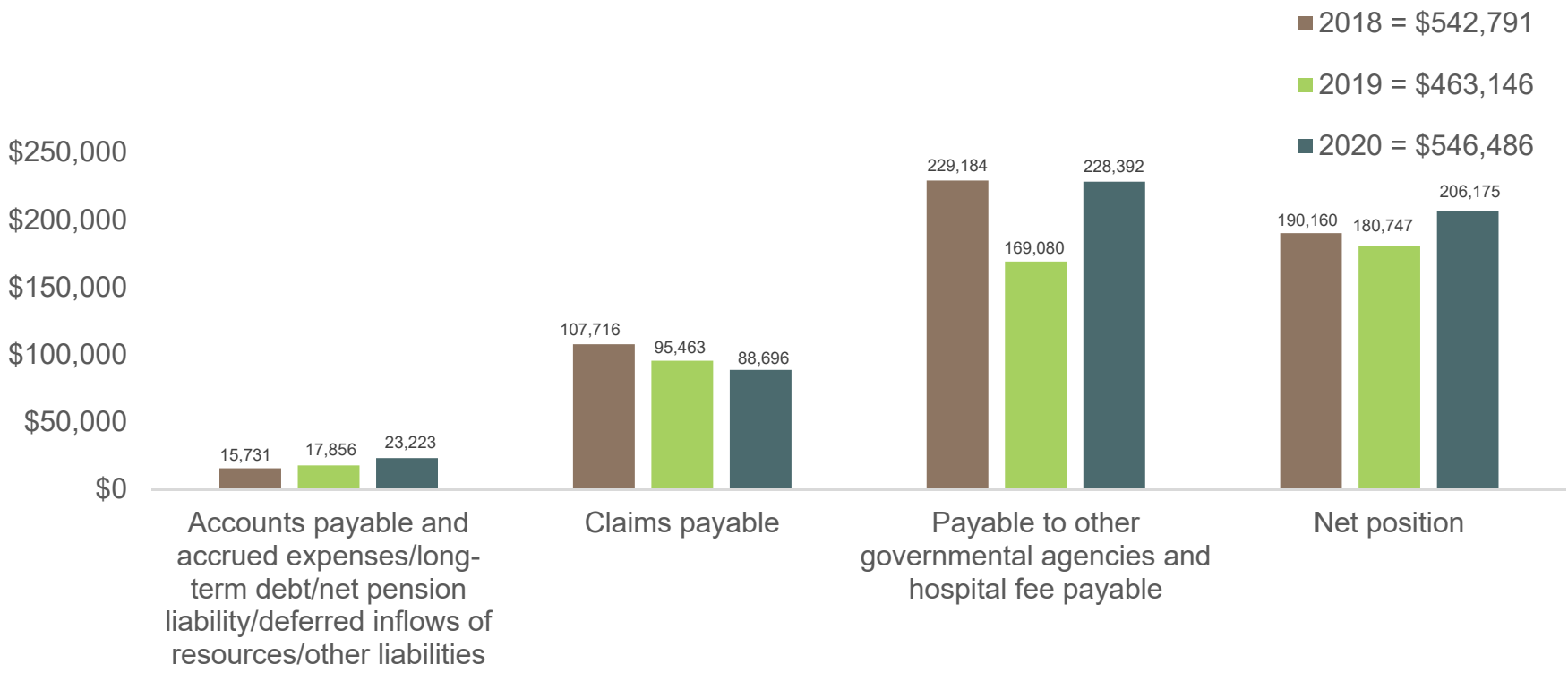
Combined Statements of Net Positions



Asset Composition (in thousands)



Liabilities and Net Position Balance (in thousands)



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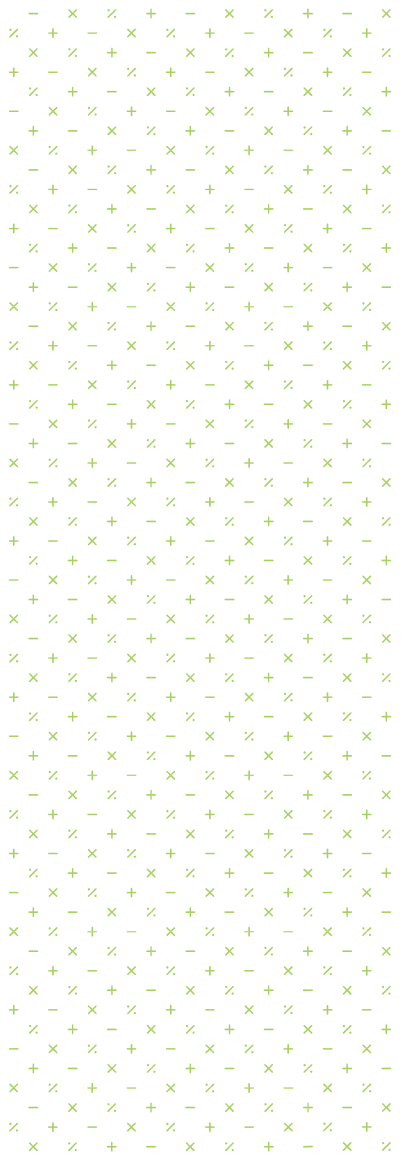
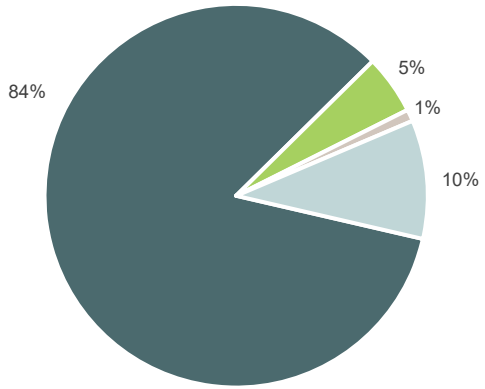
Operations



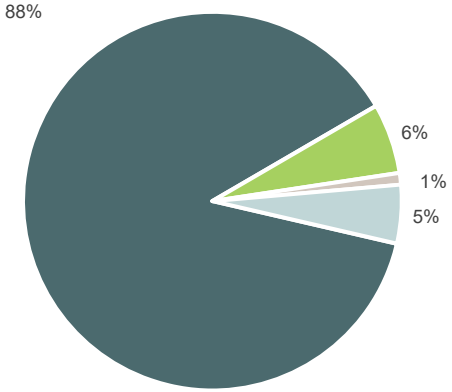
Operating Expenses (in thousands)

June 30, 2019
$1,043,877

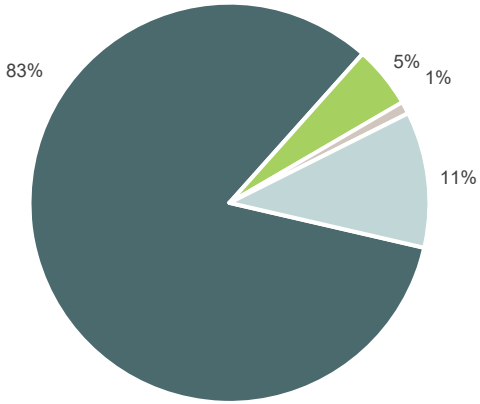


- Medical services
- Marketing, general, and administrative expenses
- Depreciation and amortization expense
- Premium tax

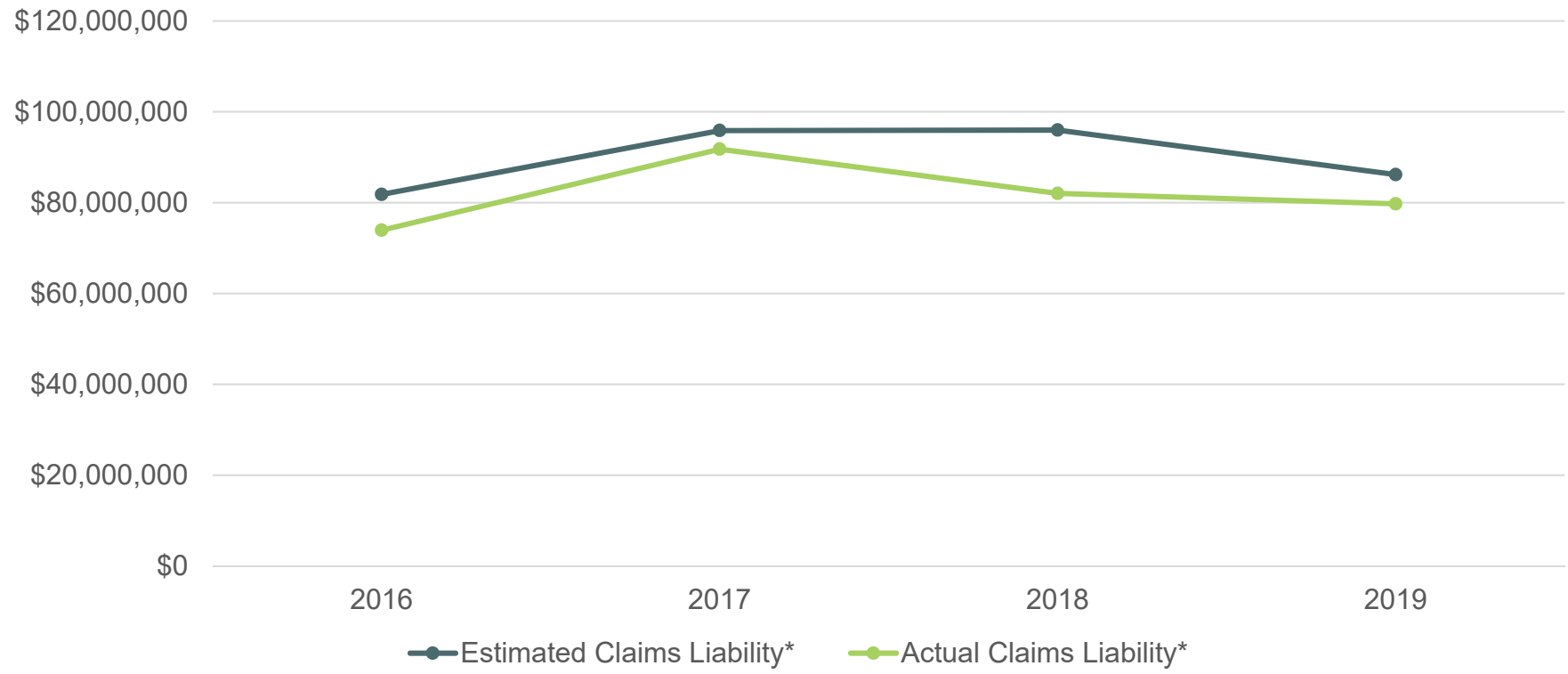
June 30, 2020
$994,634



June 30, 2018
$1,011,122



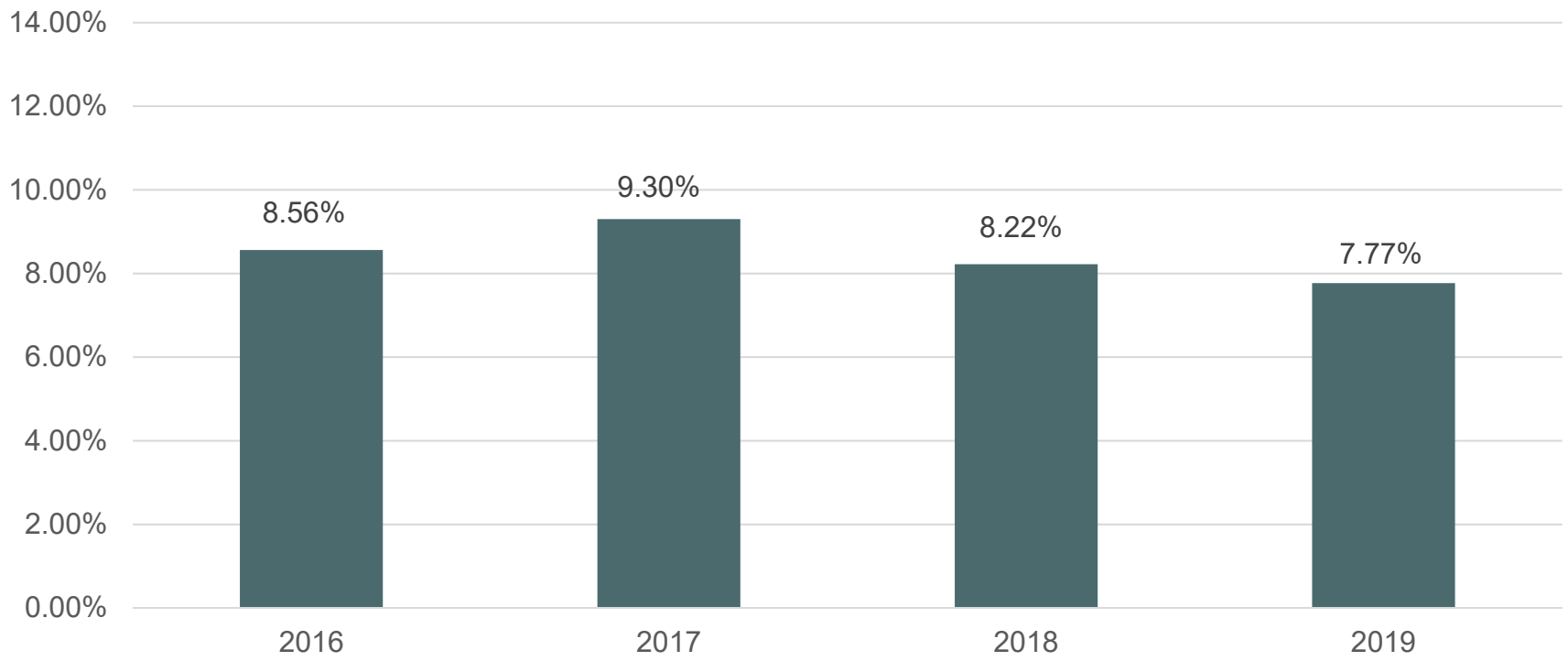
Historic Estimated Claims Liability and Historic Actual Claims Liability



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

Source: Alliance's internal reports

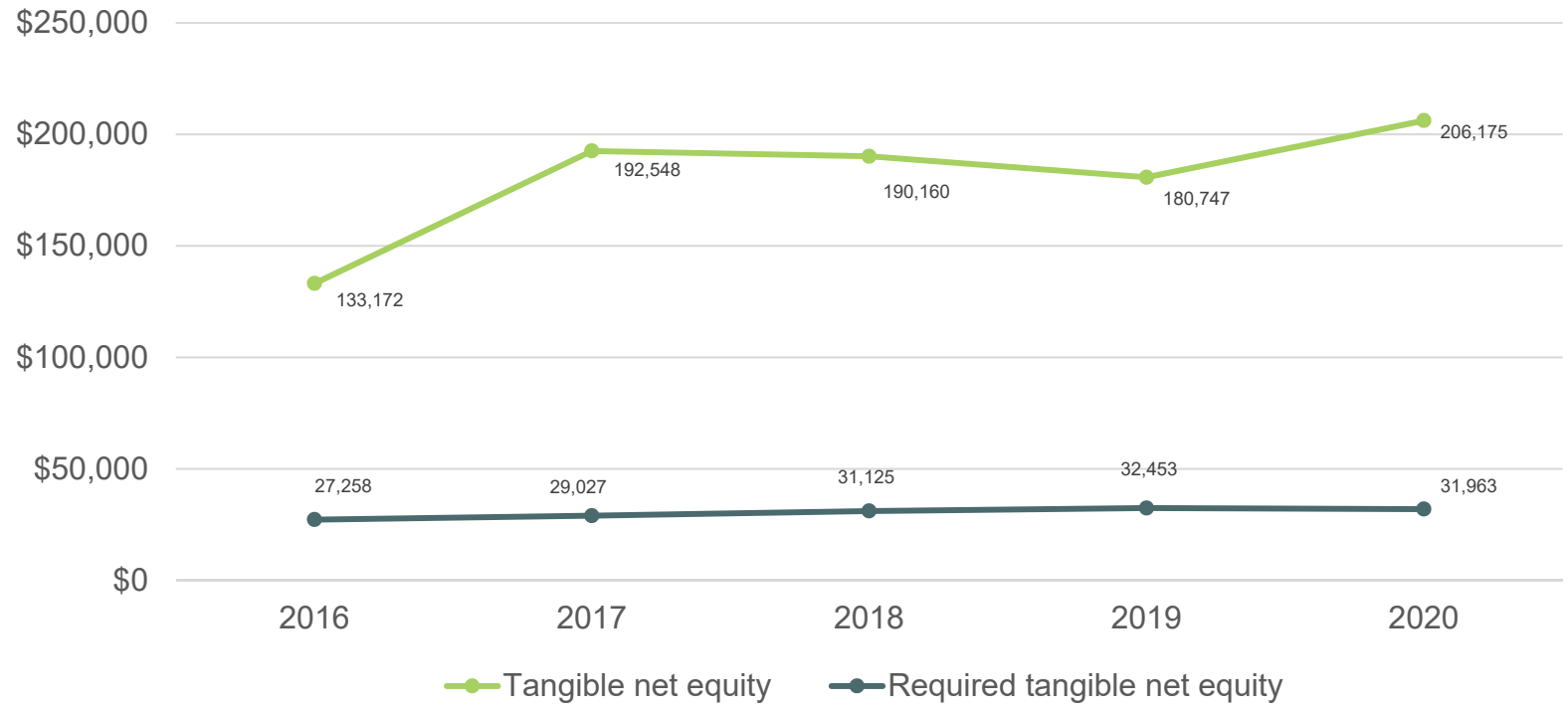
Historic Actual Claims Liability* as a % of Capitation and Premium Revenues



* Actual claims liability excludes non-hospital claims.

Source: Alliance's internal reports

Tangible Net Equity (in thousands)



Source: Annual Department of Managed Health Care Filing

Important Board Communications

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

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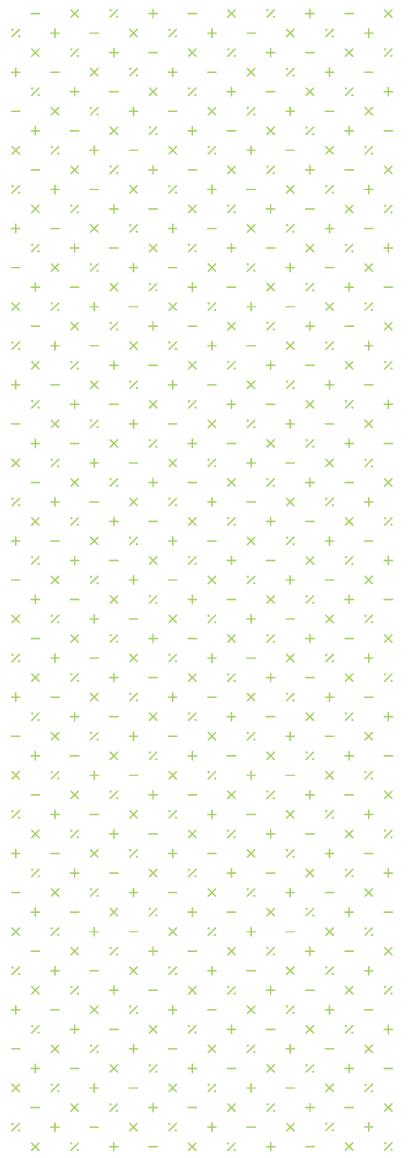
Questions?



Moss Adams

Report of Independent Auditors and Combined Financial Statements

Alameda Alliance for Health and Alameda Alliance Joint Powers Authority

June 30, 2020 and 2019

Report of Independent Auditors and
Combined Financial Statements

Alameda Alliance for Health and Alameda Alliance Joint Powers Authority

June 30, 2020 and 2019

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Management's Discussion and Analysis

Alameda Alliance for Health and
Alameda Alliance Joint Powers Authority
Management's Discussion and Analysis
As of and for the Years Ended June 30, 2020, 2019, and 2018

INTRODUCTION

In accordance with the Governmental Accounting Standards Board ("GASB") Codification Section 2200, *Comprehensive Annual Financial Report*, Alameda Alliance for Health and Alameda Alliance Joint Powers Authority (collectively the "Alliance") presents comparative financial highlights as of and for the fiscal years ended June 30, 2020, 2019, and 2018. This discussion and analysis should be read in conjunction with the combined financial statements in this report.

Alameda Alliance for Health is a licensed health maintenance organization that operates in Alameda County (the "County"). The County's Board of Supervisors established Alameda Alliance for Health in March 1994 in accordance with the State of California Welfare and Institutions Code (the "Code") Section 14087.54. This legislation provides that the Alliance is a public entity, separate and apart from the County and is not considered an agency, division, or department of the County. Alameda Alliance for Health is not governed by, nor is it subject to, the Charter of the County and is not subject to the County's policies or operational rules. Alameda Alliance for Health received its Knox-Keene license in September 1995 and commenced operations in January 1996.

Alameda Alliance for Health operates the Alameda Alliance Joint Powers Authority (the "JPA"), a licensed health maintenance organization that operates in the County. The County's Board of Supervisors established the JPA in October 2005 in accordance with Section 14087.54. This legislation provides that the JPA is also a public entity, separate and apart from the County, and is not an agency, division, or department of the County. The JPA is not governed by, nor is it subject to, the Charter of the County and is not subject to the County's policies or operational rules. The JPA received its Knox-Keene license and commenced operations in December 2005. Alameda Alliance for Health and the JPA have a mutual guarantee agreement, ensuring mutual solvency for the two organizations.

The mission and purpose of the Alliance is 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. No individual or entity has any ownership interest in the Alliance and all accumulated net position is available to invest in programs consistent with its mission.

Alameda Alliance for Health contracts with the California Department of Health Care Services ("CDHCS") to receive funding to provide health care services to the Medi-Cal eligible County residents who are enrolled as members of the Alliance ("CDHCS Contract"). The CDHCS Contract specifies capitation rates which may be adjusted annually. CDHCS revenue is paid monthly and is based upon contracted rates and actual Medi-Cal enrollment. Alameda Alliance for Health, in turn, has contracted with hospitals and physicians whereby capitation payments (agreed-upon monthly payments per member) and fee-for-service payments are made in return for contracted health care services for its members. Provider contracts are typically evergreen and contain annual rate change provisions, termination clauses, and risk-sharing provisions.

The JPA contracts with the Public Authority of Alameda County to provide health coverage to In-Home Supportive Service home care workers in the County via the Group Care program. The current contract is automatically renewed on an annual basis, absent adequate written notice to terminate by either party. No written notice of termination was provided by either party during the years ended June 30, 2020, 2019, and 2018.

In September 2009, CDHCS implemented Assembly Bill No. 1422 ("AB 1422") or Managed Care Organization ("MCO") premium tax. This program imposes an assessment on Alameda Alliance for Health's capitation and premium revenue. The proceeds from the tax are appropriated from the Children's Health and Human Services Special Fund to the State Department of Health Care Services for specified purposes. This provision was effective retroactively to January 1, 2009, and continued through June 30, 2013. The provisions of AB 1422 were continued, a higher tax rate implemented, and a sales tax replaced the premium tax, via Senate Bill ("SB") 78, beginning July 1, 2013 through June 30, 2016. On March 1, 2016, SB X2-2 established a new MCO provider tax, to be administered by CDHCS, effective July 1, 2016 through July 1, 2019. The tax would be assessed by CDHCS on licensed health care service plans, managed care plans contracted with CDHCS to provide Medi-Cal services, and alternate health care service plans ("AHCSP"), as defined, except as excluded by the bill. This bill would establish applicable taxing tiers and per enrollee amounts for the 2016–2017, 2017–2018, and 2018–2019 fiscal years for Medi-Cal enrollees, AHCSP enrollees, and all other enrollees, as defined. On September 27, 2019, Assembly Bill 115 (Chapter 348, Statutes 2019) authorized DHCS to implement a modified MCO tax model on specified health plans, which was approved by the federal Centers for Medicare & Medicaid Services on April 3, 2020. The effective date range for this approval is January 1, 2020 through December 31, 2022.

Commencing in June 2010, CDHCS implemented a supplemental revenue or intra-governmental transfer program. This program assesses fees on the revenue of participating providers. CDHCS uses these assessments to obtain matching federal funds, which are returned to participating Alliance providers through the Alliance's administration. Alameda Alliance for Health received supplemental medical revenue of $63,124,258, $61,511,930, and $235,098,432 for the years ended June 30, 2020, 2019, and 2018, respectively, representing the assessment and matching funds, net of MCO premium tax of $0, $0, and $4,264,462 for the years ended June 30, 2020, 2019, and 2018, respectively. Related liabilities are recorded under payable to other governmental agencies, hospital fee, and directed payments payables in the combined statements of net position as of June 30, 2020, 2019, and 2018.

On September 8, 2010, the California State Legislature ratified Assembly Bill No. 1653, which established a Hospital Quality Assurance Fee ("HQAF") program allowing additional draw down of federal funding to be used for increased payments to general acute care hospitals for inpatient services rendered to Medi-Cal beneficiaries. Pursuant to Section 14167.6 (a), CDHCS increased capitation payments to Medi-Cal managed health care plans retroactive for the months of April 2009 through December 2010. Additionally, Medi-Cal managed care plans are required to adhere to the following regarding the distribution of the increased capitation rates with HQAF funding: Section 14167.6 (h)(1), "Each managed health care plan shall expend 100 percent of any increased capitation payments it receives under this section, on hospital services;" and, Section 14167.10 (a), "Each managed health care plan receiving increased capitation payments under Section 14167.6 shall expend increased capitation payments on hospital services within 30 days of receiving the increased capitation payments." These payments were received and distributed in the manner as prescribed as a pass through to revenue. The payments did have an effect on the overall AB 1422 gross premium tax paid. In April of 2011, California approved SB 90, which extended the HQAF through June 30, 2012. SB 335, signed into law in September of 2011, extended the HQAF portion of SB 90 for an additional 30 months through December 31, 2013. SB 239, signed into law in October of 2013, extended the HQAF portion of SB 90 for an additional 36 months through December 31, 2016. In November of 2016, California approved Proposition 52, which made SB 239 permanent and also created HQAF V. The program period for HQAF V is from January 1, 2017 through June 30, 2019. Alameda Alliance for Health received HQAF payments of $52,269,646, $107,069,449, and $152,321,491 for the years ended June 30, 2020, 2019, and 2018, respectively, net of MCO premium tax of $0, $0, and $4,266,952 for the years ended June 30, 2020, 2019, and 2018, respectively.

Beginning with the July 1, 2017, rating period, the CDHCS implemented managed care Directed Payments: 1) Private Hospital Directed Payment ("PHDP"), 2) Designated Public Hospital Enhanced Payment Program ("EPP-FFS" and "EPP-CAP"), and 3) Designated Public Hospital Quality Incentive Pool ("QIP"). (1) For PHDP, the Department will direct Managed Care Plans ("MCP") to reimburse private hospitals as defined in the Welfare and Institutions Code 14169.51, based on actual utilization of contracted services. The enhanced payment is contingent upon hospitals providing adequate access to service, including primary, specialty, and inpatient (both tertiary and quaternary) care. The total funding available for the enhanced contracted payments are limited to a predetermined amount (pool). (2) For EPP-FFS and EPP–CAP Pools, the Department has directed MCPs to reimburse California's 21 Designated Public Hospitals for network contracted services delivered by Department of Public Health ("DPH") systems, enhanced by either a uniform percentage or dollar increment based on actual utilization of network contracted services. (3) For QIP, the Department has directed the MCPs to make QIP payments tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The payments are linked to the delivery of services under the MCP contracts and increase the amount of funding tied to quality outcomes. To receive QIP payments, the DPH and University of California systems must achieve specified improvement targets, which grow more difficult through year-over-year improvement or sustained high performance requirements. The total funding available for the QIP payments will be limited to a predetermined amount (pool).

Using This Annual Report – The Alliance's combined financial statements consist of three statements – statements of net position; statements of revenues, expenses, and changes in net position; and statements of cash flows. These combined financial statements and related notes provide information about the activities of the Alliance, including resources held by the Alliance but restricted or designated for specific purposes. The combined financial statements include Alameda Alliance for Health and the JPA as they are under common management and control.

The Statements of Net Position and Statements of Revenues, Expenses, and Changes in Net Position – The statements of net position and statements of revenues, expenses, and changes in net position report information about the Alliance's resources and activities during the period. These statements include all restricted and unrestricted assets and all liabilities using the accrual basis of accounting. All revenue and expenses are included, regardless of when cash is received or paid.

These two combined financial statements report the Alliance's net position and changes in net position. Over time, increases and decreases in the Alliance's net position are indicators of whether its financial health is improving or deteriorating. Other nonfinancial factors should also be considered, such as changes in the Alliance's membership, measurements for the quality of service provided to members, and local economic factors, to assess the overall health of the Alliance.

The Statements of Cash Flows – The final required statements are the statements of cash flows. These statements present cash receipts, cash payments, and net changes in cash resulting from operations, investing, noncapital financing, and capital and related financing activities.

Overview of the Combined Financial Statements and Financial Analysis

On June 30, 2020, the Alliance had assets and deferred outflows of resources of $459,568,726 and liabilities and deferred inflows of resources of $253,393,911. The resulting net position, which represents the Alliance's assets after the liabilities are deducted, increased by $25,427,563 to $206,174,815 at June 30, 2020, compared to $180,747,252 at June 30, 2019. The change in net position is due to total net operating income and nonoperating income recorded during the 2020 fiscal year.

On June 30, 2019, the Alliance had assets and deferred outflows of resources of $463,145,644 and liabilities and deferred inflows of resources of $282,398,392. The resulting net position, which represents the Alliance's assets after the liabilities are deducted, decreased by $9,412,455 to $180,747,252 at June 30, 2019, compared to $190,159,707 at June 30, 2018. The change in net position is due to total net operating loss and nonoperating income recorded during the 2019 fiscal year.

ASSETS

Cash and Cash Equivalents

Cash and cash equivalents increased by $8,765,113 from $31,940,900 at June 30, 2019 to $40,706,013 at June 30, 2020. The increase is due to cash provided by operating activities of $22,005,121, cash used in capital and related financing activities of $1,461,026, and cash used in investing activities of $11,778,982. Much of the increase in cash reflects enhanced investing activities.

Cash and cash equivalents decreased by $286,712,783 from $318,653,683 at June 30, 2018 to $31,940,900 at June 30, 2019. The decrease is due to cash used in operating activities of $170,660,576, cash used in capital and related financing activities of $950,412, and cash used in investing activities of $115,101,795. Much of the decrease in cash reflects repayment to CDHCS of MCE MLR, increased medical expenses, and enhanced investing activities.

Changes in cash balances are due largely to the timing of collection of year end receivables. All financial assets are invested in highly-liquid, short-term instruments held in two large money market funds and a managed investment account. Alliance management believes it has adequate liquidity to meet its operating and cash flow needs for the foreseeable future.

Investments

Investments consist of money market funds, commercial paper, U.S. government agency bonds, corporate bonds, and certificate of deposits. Investments increased by $16,067,679 from $222,901,394 at June 30, 2019 to $238,969,073 at June 30, 2020. The increase reflects purchases of investments and unrealized gains. Investments increased by $122,627,996 from $100,273,398 at June 30, 2018 to $222,901,394 at June 30, 2019. The increase reflects purchases of investments and unrealized gains.

Premiums Receivable

Premiums receivable represent amounts owed to the Alliance for capitation and premium revenue. Premiums receivable increased by $58,525,672 from $184,039,790 at June 30, 2019 to $242,555,462 at June 30, 2020, largely reflecting the timing of receipts of certain premium revenues due from the State of California and the Directed Payment pools, which will be passed through to Private and Designated Public hospitals. Premiums receivable increased by $87,081,064 from $96,958,726 at June 30, 2018 to $184,039,790 at June 30, 2019, largely reflecting the timing of receipts of certain premium revenues due from the State of California and the new Directed Payment pools, which will be passed through to Private and Designated Public hospitals.

Reinsurance Recoveries Receivable

Reinsurance recoveries receivable represent anticipated, but not yet received collections under the reinsurance policy. Reinsurance recoveries receivable increased by $1,464,156 from $144,077 at June 30, 2019 to $1,608,233 at June 30, 2020. The increase reflects a timing difference in processing of high dollar claims by the reinsurance company. Reinsurance recoveries receivable increased by $118,947 from $25,130 at June 30, 2018 to $144,077 at June 30, 2019. The increase reflects a timing difference in processing of high dollar claims by the reinsurance company.

Other Receivables

Other receivables represent miscellaneous non-premium amounts due to the Alliance. Other receivables decreased by $1,593,227 from $5,227,536 at June 30, 2019 to $3,634,309 at June 30, 2020. The decrease reflects the timing of cash receipts of certain payments owed at year end. Other receivables decreased by $2,487,107 from $7,714,643 at June 30, 2018 to $5,227,536 at June 30, 2019. The decrease reflects the timing of cash receipts of certain payments owed at year end.

Prepaid Expenses

Prepaid expenses consist of payments made in the current period for goods or services to be received in one or more future periods. Prepaid expenses increased by $712,734 from $4,240,574 at June 30, 2019 to $4,953,308 at June 30, 2020. The component increases and decreases are attributable to the timing of payments for various costs that are to be charged to expense after year end. Prepaid expenses increased by $1,419,998 from $2,820,576 at June 30, 2018 to $4,240,574 at June 30, 2019. The component increases and decreases are attributable to the timing of payments for various costs that are to be charged to expense after year end.

Restricted Cash

The California Department of Managed Health Care requires restricted cash of at least $300,000 be held in trust. Restricted cash increased by $3,073 from $346,927 at June 30, 2019 to $350,000 at June 30, 2020, due to an increase in market value of the investment. Restricted cash increased by $577 from $346,350 at June 30, 2018 to $346,927 at June 30, 2019, due to an increase in market value of the investment.

Capital Assets

Net capital assets decreased by $731,268 from $10,743,207 at June 30, 2019 to $10,011,939 at June 30, 2020. The overall decrease reflects current year capital asset acquisitions of $1,461,026 less annual depreciation and amortization expenses of $2,192,294.

Net capital assets decreased by $1,254,836 from $11,998,043 at June 30, 2018 to $10,743,207 at June 30, 2019. The overall decrease reflects current year capital asset acquisitions of $950,412 less annual depreciation and amortization expenses of $2,203,013 and loss on disposal of capital assets of $2,235.

Net Pension Asset

Net pension asset represents the excess value of the California Public Employees' Retirement System ("CalPERS") pension assets above the CalPERS pension liability under GASB Statement No. 68, *Accounting and Financial Reporting for Pensions* ("GASB 68"). Net pension asset decreased by $107,720 from $107,720 at June 30, 2019 to $0 at June 30, 2020. The decrease reflects that costs for the operation of the plan exceeded contributions for the year. Net pension asset increased by $107,720 from $0 at June 30, 2018 to $107,720 at June 30, 2019. The increase reflects that contributions exceeded costs for the operation of the plan for the year.

Deferred Outflows of Resources

Deferred outflows of resources represent the unamortized changes in assumptions, unamortized net difference between projected and actual earnings on pension plan investments, unamortized difference between expected and actual experience, and employee contributions made during 2018, 2019, and 2020 that are deferred under GASB 68. Deferred outflows of resources increased by $244,027 from $3,453,519 at June 30, 2019 to $3,697,546 at June 30, 2020, due to changes in assumptions, changes in the difference between projected and actual earnings on pension plan investments, and employee contributions made during fiscal year 2020.

Deferred outflows of resources decreased by $546,960 from $4,000,479 at June 30, 2018 to $3,453,519 at June 30, 2019, due to changes in assumptions, changes in the difference between projected and actual earnings on pension plan investments, and employee contributions made during fiscal year 2019.

LIABILITIES

Accounts Payable and Accrued Expenses

Accounts payable and accrued expenses represent the cost of services received in the current period for which payment has yet to be made. Accounts payable and accrued expenses decreased by $4,725,548 from $7,600,529 at June 30, 2019 to $2,874,981 at June 30, 2020, due to a decrease in accrued invoices at year end. Accounts payable and accrued expenses increased by $5,932,762 from $1,667,767 at June 30, 2018 to $7,600,529 at June 30, 2019, due to an increase in accrued invoices at year end.

Claims Payable

Claims payable represents the Alliance's estimated liability for health care and pharmacy expenses for which services have been performed but have not yet been paid for by the Alliance. Claims payable includes the estimated value of claims that have been incurred but not yet reported to the Alliance as well as the estimated value of claims which have been received by the Alliance but not yet paid.

Total claims payable decreased by $6,767,058 from $95,463,034 at June 30, 2019 to $88,695,976 at June 30, 2020. Included in this change is a decrease of $12,071,351 in the liability for incurred but not paid claims, and a decrease of $1,858,387 in the liability for other medical payments. The change in the liability for incurred but not paid claims reflects decreased estimates of 2019 and 2020 claims. The change in the liability for other medical payments is mainly due to a net decrease in payables to certain providers.

Total claims payable decreased by $12,253,146 from $107,716,180 at June 30,2018 to $95,463,034 at June 30, 2019. Included in this change is a decrease of $9,814,262 in the liability for incurred but not paid claims, and a decrease of $2,438,884 in the liability for other medical payments. The change in the liability for incurred but not paid claims reflects decreased estimates of 2018 and 2019 claims. The change in the liability for other medical payments is mainly due to a net decrease in payables to certain providers.

Payable to Other Governmental Agencies, Hospital Fee, and Directed Payments Payables

Payable to other governmental agencies, hospital fee, and directed payments payables includes the amounts due for MCO tax assessments, liabilities related to IGT due to Alameda Health System, HQAF, Directed Payments due to Private and Designed Public hospitals, and medical loss ratio requirements. Payable to other governmental agencies and hospital fee payables increased by $59,312,571 from $169,079,729 at June 30, 2019 to $228,392,300 at June 30, 2020, mainly due to the payout of the new Directed Payment program. Payable to other governmental agencies and hospital fee payables decreased by $60,104,422 from $229,184,151 at June 30, 2018 to $169,079,729 at June 30, 2019, mainly due to the phasing out of IGT programs for periods after June 30, 2017 and only partial payout for the new Directed Payment program through June 30, 2018.

Other Liabilities

Other liabilities are comprised of a liability for payroll earned but not paid, a liability for provider pay-for-performance earned but not paid, and a liability for provider grants and new health management programs. Payroll liabilities increased by $617,485 from $2,873,072 as of June 30, 2019 to $3,490,557 as of June 30, 2020. Most of the increase reflected higher accrued paid time off. The pay-for-performance liability increased by $1,352,998 from $4,798,619 at June 30, 2019 to $6,151,617 at June 30, 2020, due to increase in funding for calendar year 2021 incentive programs. The provider grants and new health management liability increased by $7,750,300 from $1,100,843 at June 30, 2019 to $8,851,143 at June 30, 2020, due to increase in funding for new Provider Sustainability Fund payout.

Payroll liabilities increased by $244,341 from $2,628,731 as of June 30, 2018 to $2,873,072 as of June 30, 2019. Most of the increase reflected higher accrued paid time off. The pay-for-performance liability decreased by $2,331,715 from $7,130,334 at June 30, 2018 to $4,798,619 at June 30, 2019, due to decrease in funding for calendar year 2019 incentive programs. The provider grants and new health management liability decreased by $895,496 from $1,996,339 at June 30, 2018 to $1,100,843 at June 30, 2019, due to a decrease in funding for new grants and case management programs.

Net Pension Liability

Net pension liability represents the deficit between the CalPERS pension assets and the CalPERS pension liability under GASB 68. Net pension liability increased by $832,801 from $0 at June 30, 2019 to $832,801 at June 30, 2020. The increase reflects that costs for the operation of the plan exceeded contributions for the year. Net pension liability decreased by $630,096 from $630,096 at June 30, 2018 to $0 at June 30, 2019. The decrease reflects that contributions exceeded costs for the operation of the plan for the year.

Deferred Inflows of Resources

Deferred inflows of resources represent the unamortized difference between projected and actual earnings on pension plan investments, unamortized changes in assumptions, and unamortized differences between expected and actual experiences under GASB 68. Deferred inflows of resources decreased by $460,873 from $1,482,566 at June 30, 2019 to $1,021,693 at June 30, 2020, due to the difference between projected and actual earnings on pension plan investments, changes in assumptions, and differences between expected and actual experiences.

Deferred inflows of resources decreased by $195,157 from $1,677,723 at June 30, 2018 to $1,482,566 at June 30, 2019, due to the difference between projected and actual earnings on pension plan investments, changes in assumptions, and differences between expected and actual experiences.

Net Position

Total net position increased by $25,427,563 from $180,747,252 at June 30, 2019 to $206,174,815 at June 30, 2020. The increase is due to the following:

Net operating income	$ 20,776,333
Investment income	4,651,230
Increase in net position	$ 25,427,563

Total net position decreased by $9,412,455 from $190,159,707 at June 30, 2018 to $180,747,252 at June 30, 2019. The decrease is due to the following:

Net operating loss	$ (16,591,754)
Investment income	7,179,299
Decrease in net position	$ (9,412,455)

STATEMENTS OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION

Capitation and Premium Revenue and Membership

Member Months

For the fiscal years ended June 30, 2020 and 2019, member months were as follows:

	2020	2019	Decrease/ Increase	% Decrease/ Increase
Medi-Cal	2,944,297	3,074,247	(129,950)	-4%
Group Care	73,285	70,612	2,673	4%
Total	3,017,582	3,144,859	(127,277)	-4%

There were decreases in all categories of aid, but the greatest decreases were experience in the Child and Audit category of aid.

For the fiscal years ended June 30, 2019 and 2018, member months were as follows:

	2019	2018	Decrease/ Increase	% Decrease/ Increase
Medi-Cal	3,074,247	3,150,710	(76,463)	-2%
Group Care	70,612	69,190	1,422	2%
Total	3,144,859	3,219,900	(75,041)	-2%

There were decreases in all categories of aid, but the greatest decreases were experience in the Child and Audit category of aid.

Revenues

For fiscal year 2020, capitation and premium revenue decreased by $16,613,528 from $1,026,115,712 in 2019 to $1,009,502,184 in 2020. Medi-Cal revenue, net of premium taxes, decreased by $17,458,933 or 2% due to higher supplemental payments, changes in capitation rates, and changes to the mix of members. Group Care revenue increased by $845,405 or 3.5% due to an increase in member months and offset by a 59.7% decreased in Hepatitis C Drug revenues.

For fiscal year 2019, capitation and premium revenue increased by $28,028,407 from $998,087,305 in 2018 to $1,026,115,712 in 2019. Medi-Cal revenue, net of premium taxes, increased by $27,611,490 or 2.9% due to higher supplemental payments, changes in capitation rates, and changes to the mix of members. Group Care revenue increased by $416,917 or 2% due to increase in member months and offset by a 29% decreas in Hepatitis C Drug revenues.

Medical Reinsurance

Medical reinsurance, included in other revenue, includes reinsurance premium payments less refunds received or accrued. Net reinsurance income increased by $1,126,142 from ($1,130,869) in 2019 to ($4,727) in 2020, due to higher recoveries offset by fewer deductibles. Net reinsurance income decreased by $5,729,485 from $4,598,616 in 2018 to ($1,130,869) in 2019, due to higher plan deductibles and fewer recoveries.

Health Care Expense

Health care expense represents the Alliance's cost of providing physician, hospital, pharmacy, laboratory, and other medical services to members. The Alliance has contracted with various health care providers whereby capitation payments (agreed-upon payments per member) and fee-for-service payments are made in return for contracted health care services for its members.

Health care expense decreased by $1,286,516 or 0.15%, from $883,021,602 in 2019 to $881,735,086 in 2020; decrease by 4% due to COVID-19.

The chart below shows the per-member-per-month ("PMPM") effect of these costs:

Health Care Expenses	2020	2019	2020 PMPM	2019 PMPM
Medical services	$ 881,735,086	$ 883,021,602	$ 292.20	$ 280.78
Total health care expenses	$ 881,735,086	$ 883,021,602	$ 292.20	$ 280.78
Total member months	3,017,582	3,144,859		

Health care expenses increased by $38,992,889 or 5%, from $844,028,713 in 2018 to $883,021,602 in 2019. This change is due to a 2% decrease in enrollment in all programs, and a general increase in the cost of all services.

The chart below shows the PMPM effect of these costs:

Health Care Expenses	2019	2018	2019 PMPM	2018 PMPM
Medical services	$ 883,021,602	$ 844,028,713	$ 280.78	$ 262.13
Total health care expenses	$ 883,021,602	$ 844,028,713	$ 280.78	$ 262.13
Total member months	3,144,859	3,219,900		

Marketing, General, and Administrative Expenses

Marketing, general, and administrative expenses increased by $10,955,588 from $49,650,859 in 2019 to $60,606,447 in 2020, due largely to the unplanned Provider Sustainability Fund payout of $8,400,000.

Marketing, general, and administrative expenses decreased by $1,784,035 from $51,434,894 in 2018 to $49,650,859 in 2019, due largely to delayed hiring of personnel, lower IT consulting services, and decreased printing and postage costs driven by decrease in membership.

Nonoperating Income/Expense

Nonoperating income/expense represents interest income, unrealized gains and losses resulting from cash held in financial institutions, changes in the market value of investments and investments held for restricted cash balances, contributions received for purposes other than capital asset acquisition, and interest expense.

Nonoperating income decreased by $2,528,069 from $7,179,299 in 2019 to $4,651,230 in 2020, largely due to decreased investment income, net of unrealized losses.

Nonoperating income increased by $1,222,054 from $5,957,245 in 2018 to $7,179,299 in 2019, largely due to increased investment income, net of unrealized losses.

Three Year Trend in Net Position

	2020	2019	2018
ASSETS			
Current assets	$ 532,426,398	$ 448,494,271	$ 526,446,156
Noncurrent assets	10,361,939	11,090,134	12,344,393
Net pension asset	-	107,720	-
Deferred outflow of resources	3,697,546	3,453,519	4,000,479
Total assets	$ 546,485,883	$ 463,145,644	$ 542,791,028
LIABILITIES			
Current liabilities	$ 338,456,574	$ 280,915,826	$ 350,323,502
Net pension liability	832,801	-	630,096
Deferred inflows of resources	1,021,693	1,482,566	1,677,723
Total liabilities	$ 340,311,068	$ 282,398,392	$ 352,631,321
NET POSITION			
Invested in capital assets	$ 10,011,939	$ 10,743,207	$ 11,998,043
Restricted assets	350,000	346,927	346,350
Unrestricted assets	195,812,876	169,657,118	177,815,314
Total net position	$ 206,174,815	$ 180,747,252	$ 190,159,707
Total liabilities and net position	$ 546,485,883	$ 463,145,644	$ 542,791,028

Changes in Net Assets

	2020	2019	2018
Total member months	$ 3,017,582	$ 3,144,859	$ 3,219,900
Operating revenues	$ 1,015,409,930	$ 1,027,285,388	$ 1,003,777,172
Health care expenses	881,735,086	883,021,602	844,028,713
Marketing, general, and administrative expenses	60,606,447	49,650,859	51,434,894
Depreciation and amortization expense	2,192,294	2,203,013	2,440,994
Premium tax	50,099,770	109,001,668	113,217,756
Total operating expenses	994,633,597	1,043,877,142	1,011,122,357
Net income (loss) from operations	20,776,333	(16,591,754)	(7,345,185)
Nonoperating income, net	4,651,230	7,179,299	5,957,245
Change in net position	$ 25,427,563	$ (9,412,455)	$ (1,387,940)

During the three-year period ended June 30, 2020, overall member months decreased 6%, primarily due to year over year decreased in Med-Cal member months. During the three-year period ended June 30, 2020, revenue increased 1% due to higher supplemental payments, changes to capitation rates, and changes to the mix of members. During the three-year period ended June 30, 2020, healthcare expenses increased 4%, as a result of changes in enrollment in all programs. During the three-year period ended June 30, 2020, marketing, general, and administrative expenses increased 18%, primarily due to the unbudgeted fiscal year 2020 Provider Sustainability Funding payout. The above factors combined to yield the overall favorable change in net position.

During the three-year period ended June 30, 2019, overall member months decreased 1% due to a 2% decrease in Medi-Cal member months (largely Optional Expansion ("ACA OE") members) and a 5% increase in Group Care member months. During the three-year period ended June 30, 2019, revenue increased 4% due to higher supplemental payments, changes to capitation rates, and changes to the mix of members. During the three-year period ended June 30, 2019, healthcare expenses increased 13%, as a result of decreased enrollment in all programs, and a general increase in the cost of all services. During the three-year period ended June 30, 2019, marketing, general, and administrative expenses decreased 5% due to delayed hiring of personnel and lower consulting services. The above factors combined to yield the overall unfavorable change in net position.

As a limited license plan under Knox-Keene Health Care Services Plan Action of 1975, the Alliance is required to maintain a minimum level of tangible net equity and working capital. The required tangible net equity is $31,962,073, $32,453,431, and $31,125,447 at June 30, 2020, 2019, and 2018, respectively. The tangible net equity of the Alliance is $206,174,815, $180,747,252, and $190,159,707 at June 30, 2020, 2019, and 2018, respectively.

The Alliance was in compliance with regulatory tangible net equity and working capital requirements at June 30, 2020, 2019, and 2018.

Report of Independent Auditors

To the Board of Governors
Alameda Alliance for Health and
Alameda Alliance Joint Powers Authority

Report on the Financial Statements

We have audited the accompanying combined statements of net position of the Alameda Alliance for Health and Alameda Alliance Joint Powers Authority (collectively the "Alliance"), as of June 30, 2020 and 2019, and the related combined statements of revenues, expenses, and changes in net position, and cash flows for the years then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these combined financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America, the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the combined financial statements are free from material misstatements.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the combined net position of Alameda Alliance for Health and Alameda Alliance Joint Powers Authority, as of June 30, 2020 and 2019, and the combined results of their operations and their cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Other Matter

Required Supplementary Information

The accompanying Management's Discussion and Analysis on pages 1 through 12, supplementary schedule of changes in net pension (asset) liability and related ratios and supplementary schedule of contributions on pages 39 through 40 are not a required part of the combined financial statements but are supplementary information required by the Governmental Accounting Standards Board who considers them to be an essential part of financial reporting for placing the combined financial statements in an appropriate operational, economic, or historical context.

The accompanying supplementary statement of revenues and expenses – AC Care Connect on page 41 is not a required part of the combined financial statements but is supplementary information required by the AC Care Connect contract.

This supplementary information is the responsibility of the Alliance's management. We have applied certain limited procedures in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's response to our inquiries, the combined financial statements, and other knowledge we obtained during our audit of the combined financial statements. We do not express an opinion or provide any assurance on the supplementary information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards,* we have also issued our report dated _____, 2020, on our consideration of the Alliance's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Alliance's internal control over financial reporting and compliance.

San Francisco, California
_____, 2020

Combined Financial Statements

Alameda Alliance for Health and
Alameda Alliance Joint Powers Authority
Combined Statements of Net Position
As of June 30, 2020 and 2019

	2020	2019
ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		
Current assets		
Cash and cash equivalents	$ 40,706,013	$ 31,940,900
Investments	238,969,073	222,901,394
Premiums receivable	242,555,462	184,039,790
Reinsurance recoveries receivable	1,608,233	144,077
Other receivables	3,634,309	5,227,536
Prepaid expenses	4,953,308	4,240,574
Total current assets	532,426,398	448,494,271
Noncurrent asset		
Restricted cash	350,000	346,927
Capital assets		
Nondepreciable	1,557,283	1,557,283
Depreciable, net of accumulated depreciation and amortization	8,454,656	9,185,924
Total capital assets	10,011,939	10,743,207
Net pension asset	-	107,720
Total assets	542,788,337	459,692,125
Deferred outflows of resources	3,697,546	3,453,519
Total assets and deferred outflows of resources	$ 546,485,883	$ 463,145,644
LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION		
Current liabilities		
Accounts payable and accrued expenses	$ 2,874,981	$ 7,600,529
Claims payable	88,695,976	95,463,034
Payable to other governmental agencies, hospital fee, and directed payments payables	228,392,300	169,079,729
Other liabilities	18,493,317	8,772,534
Total current liabilities	338,456,574	280,915,826
Net pension liability	832,801	-
Total liabilities	339,289,375	280,915,826
Deferred inflows of resources	1,021,693	1,482,566
Net position		
Invested in capital assets	10,011,939	10,743,207
Restricted		
Required by legislative authority	350,000	346,927
Unrestricted	195,812,876	169,657,118
Total net position	206,174,815	180,747,252
Total liabilities, deferred inflows of resources, and net position	$ 546,485,883	$ 463,145,644

See accompanying notes.

Alameda Alliance for Health and
Alameda Alliance Joint Powers Authority
Combined Statements of Revenues, Expenses, and Changes in Net Position
For the Years Ended June 30, 2020 and 2019

	2020	2019
Operating revenues		
Capitation and premium revenue	$ 1,009,502,184	$ 1,026,115,712
Other revenue	5,907,746	1,169,676
Total operating revenues	1,015,409,930	1,027,285,388
Health care expenses		
Medical services	881,735,086	883,021,602
Total health care expenses	881,735,086	883,021,602
Marketing, general, and administrative expenses	60,606,447	49,650,859
Depreciation and amortization expense	2,192,294	2,203,013
Premium tax	50,099,770	109,001,668
Total operating expenses	994,633,597	1,043,877,142
Operating income (loss)	20,776,333	(16,591,754)
Nonoperating income		
Investment income	4,651,230	7,179,299
Total nonoperating income, net	4,651,230	7,179,299
Change in net position	25,427,563	(9,412,455)
Net position, beginning of year	180,747,252	190,159,707
Net position, end of year	$ 206,174,815	$ 180,747,252

See accompanying notes.

Alameda Alliance for Health and
Alameda Alliance Joint Powers Authority
Combined Statements of Cash Flows
For the Years Ended June 30, 2020 and 2019

	2020	2019
Cash flows provided by (used in) operating activities		
Cash received from		
Capitation and premium revenue	$ 950,986,512	$ 939,034,648
Other revenue	6,267,206	822,197
Cash paid to providers for		
Medical and hospital expenses	(879,289,343)	(1,064,380,838)
Vendors and employees	(55,959,254)	(46,136,583)
Net cash provided by (used in) operating activities	22,005,121	(170,660,576)
Cash flows used in capital and related financing activities		
Purchases of furniture and equipment	(1,461,026)	(950,412)
Net cash used in capital and related financing activities	(1,461,026)	(950,412)
Cash flows used in investing activities		
Purchase of investments	(809,592,186)	(664,774,705)
Proceeds from sale of investments	793,165,047	542,494,188
Investment income	4,648,157	7,178,722
Net cash used in investing activities	(11,778,982)	(115,101,795)
Net increase (decrease) in cash and cash equivalents	8,765,113	(286,712,783)
Cash and cash equivalents, beginning of year	31,940,900	318,653,683
Cash and cash equivalents, end of year	$ 40,706,013	$ 31,940,900
Reconciliation of operating income (loss) to net cash provided by (used in) operating activities		
Operating income (loss)	$ 20,776,333	$ (16,591,754)
Adjustments to reconcile operating income (loss) to net cash provided by (used in) operating activities		
Depreciation and amortization	2,192,294	2,203,013
Net unrealized losses (gains) on investments	359,460	(347,479)
Loss on disposal of capital assets	-	2,235
Net change in operating assets and liabilities		
Premiums receivable	(58,515,672)	(87,081,064)
Reinsurance recoveries receivable	(1,464,156)	(118,947)
Other receivables	1,593,227	2,487,107
Prepaid expenses	(712,734)	(1,419,998)
Accounts payable and accrued expenses	(4,725,548)	5,932,762
Claims payable	(6,767,058)	(12,253,146)
Payable to other governmental agencies, hospital fee, and directed payments payables	59,312,571	(60,104,422)
Other liabilities	9,720,783	(2,982,870)
Net pension liability	235,621	(386,013)
Net cash provided by (used in) operating activities	$ 22,005,121	$ (170,660,576)
Supplemental cash flow disclosure		
Cash paid during the year for		
premium tax	$ -	$ 108,011,228

See accompanying notes.

NOTE 1 – ORGANIZATION

Alameda Alliance for Health is a licensed health maintenance organization that operates in Alameda County (the "County"). The County's Board of Supervisors established Alameda Alliance for Health in March 1994 in accordance with the State of California Welfare and Institutions Code (the "Code") Section 14087.54. This legislation provides that the Alliance is a public entity, separate and apart from the County and is not considered an agency, division, or department of the County. Alameda Alliance for Health is not governed by, nor is it subject to, the Charter of the County and is not subject to the County's policies or operational rules. Alameda Alliance for Health received its Knox-Keene license in September 1995 and commenced operations in January 1996.

Alameda Alliance for Health operates the Alameda Alliance Joint Powers Authority (the "JPA"), a licensed health maintenance organization that operates in the County (collectively the "Alliance"). The County's Board of Supervisors established the JPA in October 2005 in accordance with Section 14087.54. This legislation provides that the JPA is also a public entity, separate and apart from the County, and is not an agency, division, or department of the County. The JPA is not governed by, nor is it subject to, the Charter of the County and is not subject to the County's policies or operational rules. The JPA received its Knox-Keene license and commenced operations in December 2005. Alameda Alliance for Health and the JPA have a mutual guarantee agreement, ensuring mutual solvency for the two organizations. The Alliance has advised the Department of Managed Health Care of its intent to surrender the JPA's license of November 2020.

The mission and purpose of the Alliance is 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. No individual or entity has any ownership interest in the Alliance and all accumulated net position is available to invest in programs consistent with its mission.

Alameda Alliance for Health contracts with the California Department of Health Care Services ("CDHCS") to receive funding to provide health care services to the Medi-Cal eligible County residents who are enrolled as members of the Alliance ("CDHCS Contract"). The CDHCS Contract specifies capitation rates which may be adjusted annually. CDHCS revenue is paid monthly and is based upon contracted rates and actual Medi-Cal enrollment. Alameda Alliance for Health, in turn, has contracted with hospitals and physicians whereby capitation payments (agreed-upon monthly payments per member) and fee-for-service payments are made in return for contracted health care services for its members. Provider contracts are typically evergreen and contain annual rate change provisions, termination clauses, and risk-sharing provisions.

The JPA contracts with the Public Authority of Alameda County to provide health coverage to In-Home Supportive Service ("IHSS") home care workers in the County via the Group Care program. The current contract is automatically renewed on an annual basis, absent adequate written notice to terminate by either party. No written notice of termination was provided by either party during the years ended June 30, 2020 and 2019.

In September 2009, CDHCS implemented Assembly Bill No. 1422 ("AB 1422") or Managed Care Organization ("MCO") premium tax. This program imposes an assessment on Alameda Alliance for Health's capitation and premium revenue. The proceeds from the tax are appropriated from the Children's Health and Human Services Special Fund to the State Department of Health Care Services for specified purposes. This provision was effective retroactively to January 1, 2009, and continued through June 30, 2013. The provisions of AB 1422 were continued, a higher tax rate implemented, and a sales tax replaced the premium tax, via Senate Bill ("SB") 78, beginning July 1, 2013 through June 30, 2016. On March 1, 2016, SB X2-2 established a new MCO provider tax, to be administered by CDHCS, effective July 1, 2016 through July 1, 2019. The tax would be assessed by CDHCS on licensed health care service plans, managed care plans contracted with CDHCS to provide Medi-Cal services, and alternate health care service plans ("AHCSP"), as defined, except as excluded by the bill. This bill would establish applicable taxing tiers and per enrollee amounts for the 2016–2017, 2017–2018, and 2018–2019 fiscal years for Medi-Cal enrollees, AHCSP enrollees, and all other enrollees, as defined. On September 27, 2019, Assembly Bill 115 (Chapter 348, Statutes 2019) authorized DHCS to implement a modified MCO tax model on specified health plans, which was approved by the federal Centers for Medicare & Medicaid Services on April 3, 2020. The effective date range for this approval is January 1, 2020 through December 31, 2022.

Commencing in June 2010, CDHCS implemented a supplemental revenue or intra-governmental transfer program. This program assesses fees on the revenue of participating providers. CDHCS uses these assessments to obtain matching federal funds, which are returned to participating Alliance providers through the Alliance's administration. Alameda Alliance for Health received supplemental medical revenue of $63,124,258 and $61,511,930 for the years ended June 30, 2020 and 2019, respectively, representing the assessment and matching funds, net of MCO premium tax of $0 for the years ended June 30, 2020 and 2019. Related liabilities are recorded under payable to other governmental agencies, hospital fee, and directed payments payables in the combined statements of net position as of June 30, 2020 and 2019.

On September 8, 2010, the California State Legislature ratified Assembly Bill No. 1653, which established a Hospital Quality Assurance Fee ("HQAF") program allowing additional draw down of federal funding to be used for increased payments to general acute care hospitals for inpatient services rendered to Medi-Cal beneficiaries. Pursuant to Section 14167.6 (a), CDHCS increased capitation payments to Medi-Cal managed health care plans retroactive for the months of April 2009 through December 2010. Additionally, Medi-Cal managed care plans are required to adhere to the following regarding the distribution of the increased capitation rates with HQAF funding: Section 14167.6 (h)(1), "Each managed health care plan shall expend 100 percent of any increased capitation payments it receives under this section, on hospital services"; and, Section 14167.10 (a), "Each managed health care plan receiving increased capitation payments under Section 14167.6 shall expend increased capitation payments on hospital services within 30 days of receiving the increased capitation payments." These payments were received and distributed in the manner as prescribed as a pass through to revenue. The payments did have an effect on the overall AB 1422 gross premium tax paid. In April of 2011, California approved SB 90, which extended the HQAF through June 30, 2012. SB 335, signed into law in September of 2011, extended the HQAF portion of SB 90 for an additional 30 months through December 31, 2013. SB 239, signed into law in October of 2013, extended the HQAF portion of SB 90 for an additional 36 months through December 31, 2016. In November of 2016, California approved Proposition 52, which made SB 239 permanent and also created HQAF V. The program period for HQAF V is from January 1, 2017 through June 30, 2019. Alameda Alliance for Health received HQAF payments of $52,269,646 and $107,069,449 for the years ended June 30, 2020 and 2019, respectively, net of MCO premium tax of $0 for the years ended June 30, 2020 and 2019.

Beginning with the July 1, 2017, rating period, CDHCS implemented managed care Directed Payments: 1) Private Hospital Directed Payment ("PHDP"), 2) Designated Public Hospital Enhanced Payment Program ("EPP-FFS" and "EPP-CAP"), and 3) Designated Public Hospital Quality Incentive Pool ("QIP"). (1) For PHDP, the Department will direct Managed Care Plans ("MCP") to reimburse private hospitals as defined in the Welfare and Institutions Code 14169.51, based on actual utilization of contracted services. The enhanced payment is contingent upon hospitals providing adequate access to service, including primary, specialty, and inpatient (both tertiary and quaternary) care. The total funding available for the enhanced contracted payments are limited to a predetermined amount (pool). (2) For EPP-FFS and EPP–CAP pools, the Department has directed MCPs to reimburse California's 21 Designated Public Hospitals for network contracted services delivered by Department of Public Health ("DPH") systems, enhanced by either a uniform percentage or dollar increment based on actual utilization of network contracted services. (3) For QIP, the Department has directed the MCPs to make QIP payments tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The payments are linked to the delivery of services under the MCP contracts and increase the amount of funding tied to quality outcomes. To receive QIP payments, the DPH and University of California systems must achieve specified improvement targets, which grow more difficult through year-over-year improvement or sustained high performance requirements. The total funding available for the QIP payments will be limited to a predetermined amount (pool).

NOTE 2 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of accounting – Pursuant to Governmental Accounting Standards Board ("GASB") Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*, the Alliance's proprietary fund accounting and financial reporting practices are based on all applicable GASB pronouncements as well as codified pronouncements issued on or before November 30, 1989, and the California Code of Regulations, Title 2, Section 1131, State Controller's *Minimum Audit Requirements* for California Special Districts and the State Controller's Office prescribed reporting guidelines.

Proprietary fund accounting – The Alliance utilizes the proprietary fund method of accounting whereby revenues and expenses are recognized on the accrual basis and the combined financial statements are prepared using the economic resources measurement focus.

Basis of combination – The accompanying combined financial statements include the Alameda Alliance for Health and JPA as both entities are under common management and control. The operations of JPA are included from the date of its inception on December 1, 2005.

Use of estimates – The preparation of combined financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the combined financial statements and the reported amounts of revenues and expenses during the reporting period. Claims payable, useful lives of fixed assets, premiums receivable, and net pension (asset) liability represent significant estimates. Actual results could differ from those estimates.

Cash and cash equivalents – The Alliance considers all highly-liquid instruments with a maturity of three months or less at the time of purchase to be cash and cash equivalents. Cash and cash equivalents are carried at cost which approximates fair value. At June 30, 2020 and 2019, the Alliance's cash deposits had carrying amounts of $40,706,013 and $31,940,900, respectively, and bank balances of $45,111,217 and $38,293,202, respectively. Of the bank balances at June 30, 2020 and 2019, $44,861,217 and $38,043,202, respectively, were not covered by federal depository insurance.

Investments – The Alliance adopted GASB Statement No. 72, *Fair Value Measurement and Application* ("GASB 72"), effective July 1, 2016. GASB 72 requires the Alliance to use valuation techniques which are appropriate under the circumstances and are consistent with the market approach, the cost approach, or the income approach. GASB 72 establishes a hierarchy of inputs used to measure fair value consisting of three levels. Level 1 inputs are quoted prices in active markets for identical assets or liabilities. Level 2 inputs are inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly. Level 3 inputs are unobservable inputs.

Concentration of credit risk – The Alliance is highly dependent upon the State of California for its revenues. A significant portion of accounts receivable and revenue are from the State of California. Loss of the contracts with the State of California due to nonrenewal or legislative decisions that impact program funding or result in discontinuation could materially affect the combined financial position of the Alliance.

As of June 30, 2020 and 2019, the Alliance had premiums receivable of $155,638,305 and $184,039,790 due from the State of California, respectively. For the years ended June 30, 2020 and 2019, the Alliance recognized capitation and premium revenues of $984,483,191 and $1,001,942,124 from the State of California, respectively.

Restricted cash – The Alliance is required by the California Department of Managed Health Care to restrict cash having a fair value of at least $300,000 for the payment of member claims in the event of its insolvency. The amounts recorded were $350,000 and $346,927 at June 30, 2020 and 2019, respectively. Restricted cash is comprised of U.S. treasury securities and is stated at fair value.

Capital assets – Capital assets include land, building and improvements, furniture and equipment, and computer hardware and software. Capital assets are recorded at cost. Depreciation and amortization of building and improvements, furniture and equipment, computer hardware, and computer software is calculated using the straight-line method over 3 to 40 years which approximates the estimated useful lives of the assets. The Alliance capitalizes capital expenditures over $1,000, which will have a useful life of three or more years.

The Alliance evaluates prominent events or changes in circumstances affecting capital assets to determine whether impairment of a capital asset has occurred. Impairment losses on capital assets are measured using the method that best reflects the diminished service utility of the capital asset.

Net position – Net position is classified as invested in capital assets, restricted or unrestricted. Invested in capital assets represents investments in land, building and improvements, furniture and equipment, computer hardware, and computer software, net of depreciation and amortization. Restricted net position is for specific operating activities and represents the total cash balances that are restricted in their use as they represent monies received that must only be utilized for a specified purpose. It also pertains to external constraints placed on net position by law. Unrestricted net position consists of net position that does not meet the definition of restricted or invested in capital assets.

Capitation and premium revenue – Capitation and premium revenue includes amounts received from the CDHCS for Medi-Cal members and from Alameda County for IHSS home care workers.

Capitation and premium revenue is recorded as revenue in the month for which enrollees are entitled to health care services. Medi-Cal eligibility of enrollees is determined by Alameda County Social Services Agency and validated by the State of California. The State of California provides the Alliance the validated monthly eligibility file of program enrollees who are continuing, newly added, or terminated from the program in support of capitation revenue for the respective month. A portion of revenues received from the CDHCS is subject to possible retroactive adjustments. Management has made provisions for estimated retroactive adjustments. IHSS eligibility of enrollees is determined by Alameda County Social Services Agency. The County of Alameda provides the Alliance the validated monthly eligibility file of program enrollees who are continuing, newly added, or terminated from the IHSS program. Once Alameda Alliance receives current month enrollment data, AAH issues invoice to Alameda County Social Services for monthly premium revenue.

Effective with the enrollment of the Adult Expansion population per the Affordable Care Act on January 1, 2014, the Alliance is subject to CDHCS requirements to meet a minimum 85% medical loss ratio ("MLR") for this population. Specifically, the Alliance will be required to expend at least 85% of the Medi-Cal capitation revenue received for this population on allowable medical expenses as defined by CDHCS. In the event the Alliance expends less than the 85% requirement, the Alliance will be required to return to CDHCS the difference between the minimum threshold and the actual allowed medical expenses. In 2019, the Alliance made a payment to the CDHCS of $179,309,877 related to the original MLR reporting period of January 2014 – June 2016. At June 30, 2020 and 2019, the accrued payable back to CDHCS, which is included in payable to other governmental agencies, hospital fee, and directed payments payables in the accompanying statements of net position, was $11,476,054.

Premium deficiencies – The Alliance performs periodic analyses of its expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve is recorded. Management determined that no premium deficiency reserves were needed at June 30, 2020 or 2019.

Health care expense recognition and claims payable – The cost of health care services is recognized in the period provided and includes an estimate of the cost of services that have been incurred but not yet reported. The estimate for reserves for claims is based on actuarial projections of hospital and other costs using historical analysis of claims paid and authorization and admission data. Estimates are monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions.

Operating revenues and expenses – The Alliance's statements of revenues, expenses, and changes in net position distinguishes between operating and nonoperating revenues and expenses. The primary operating revenue is derived from capitation and other sources in support of providing health care services to its members. Operating expenses are all expenses incurred to provide such health care services. Nonoperating revenues and expenses consist of those revenues and expenses that are related to financing and investing activities, net interest income, and from contributions received for purposes other than capital asset acquisition.

Insurance coverage – The Alliance maintains its general liability insurance coverage through outside insurers in the form of "claims-made" policies. Should the "claims-made" policies not be renewed or replaced with equivalent insurance, claims related to the occurrences during the terms of the "claims-made" policies but reported subsequent to the termination of the insurance contract may be uninsured. These policies were renewed subsequent to year end. Physicians and hospitals that the Alliance contracts with are required to maintain their own malpractice insurance coverage.

Income taxes – The Alliance is a public entity established pursuant to Section 14087.54 of the Code and is further subject to the provisions of Ordinance No. 0-94-13 and related resolutions of the Board of Supervisors of the County. As a public entity defined by Internal Revenue Code Section 115, the Alliance is exempt from federal and state income taxes.

New accounting pronouncements – In January 2017, the GASB issued Statement No. 84, *Fiduciary Activities* ("GASB 84"). GASB 84 provides improved guidance regarding the identification of fiduciary activities for accounting and financial reporting purposes and how those activities should be reported. The statement also provides for recognition of a liability to the beneficiaries in a fiduciary fund when an event has occurred that compels the government to disburse fiduciary resources. In May 2020, the GASB issued Statement No. 95, *Postponement of the Effective Dates of Certain Authoritative Guidance*, which deferred the effective date of GASB 84 to reporting periods beginning after December 15, 2019. The Alliance is reviewing the impact of the adoption of GASB 84 for the fiscal year ending 2021.

In June 2017, the GASB issued GASB Statement No. 87, *Leases* ("GASB 87"). GASB 87 increases the usefulness of financial statements by requiring recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. GASB 87 also establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. In May 2020, the GASB issued Statement No. 95, *Postponement of the Effective Dates of Certain Authoritative Guidance*, which deferred the effective date of GASB 87 to fiscal years beginning after June 15, 2021. The Alliance is reviewing the impact of the adoption of GASB 87 for the fiscal year ending 2022.

NOTE 3 – INVESTMENTS

At June 30, 2020 and 2019, the Alliance's investments consisted of money market funds, commercial paper, U.S. government agency bonds, corporate bonds, and certificate of deposits.

Interest rate risk – Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. The Alliance manages risk of market value fluctuations due to overall changes in the general level of interest rates by complying with California Government Code Section 53600.5. As of June 30, 2020 and 2019, the Alliance's investments all have maturities of less than one year.

Credit risk – Generally, credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of rating by a nationally recognized statistical rating organization. The following are the credit ratings for each investment type at June 30, 2020:

Description	Fair value	Unrated	Aaa
Investments in:			
Commercial paper	$ 162,860,325	$ 71,635,325	$ 91,225,000
Certificate of deposits	75,925,802	75,925,802	-
Money market funds	182,946	182,946	-
Total investments	$ 238,969,073	$ 147,744,073	$ 91,225,000

The following are the credit ratings for each investment type at June 30, 2019:

Description	Fair value	Unrated	Aaa
Investments in:			
Commercial paper	$ 132,556,475	$ 65,806,475	$ 66,750,000
Certificate of deposits	59,619,589	59,619,589	-
U.S. government agency bonds	29,943,098	29,943,098	-
Money market funds	782,232	782,232	-
Total investments	$ 222,901,394	$ 156,151,394	$ 66,750,000

Concentration of credit risk – Concentration of credit risk is the risk of loss attributed to the magnitude of a government's investment in a single issuer. The Alliance's investments as a percentage of its portfolio at June 30, 2020 were as follows:

Investment	Issuer	Percentage of portfolio
Commercial paper	Various	68.0 %
Certificate of deposits	Various	31.0
Money market funds		1.0
		100 %

The Alliance's investments as a percentage of its portfolio at June 30, 2019 were as follows:

Investment	Issuer	Percentage of portfolio
Commercial paper	Various	59.0 %
Certificate of deposits	Various	27.0
U.S. government agency bonds	Federal home loan bank bonds	13.0
Money market funds		1.0
		100 %

NOTE 4 – FAIR VALUE

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. A fair value hierarchy is also established which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The standard describes three levels of inputs that may be used to measure fair value:

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in active markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

The following tables present fair value measurements of assets recognized in the accompanying financial statements measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall at June 30:

Description	Level 1	Level 2	Level 3	2020
Investments in:				
U.S. government agency bonds	$ -	$ -	$ -	$ -
Total investments subject to fair value hierarchy	$ -	$ -	$ -	-
Investments and restricted cash not subject to fair value hierarchy				
Commercial paper				162,860,325
Certificate of deposits				75,925,802
U.S. treasury securities				350,000
Money market funds				182,946
Total investments and restricted cash				$ 239,319,073

Description	Level 1	Level 2	Level 3	2019
Investments in:				
U.S. government agency bonds	$ -	$ 29,943,098	$ -	$ 29,943,098
Total investments subject to fair value hierarchy	$ -	$ 29,943,098	$ -	29,943,098
Investments and restricted cash not subject to fair value hierarchy				
Commercial paper				132,556,475
Certificate of deposits				59,619,589
Money market funds				782,232
U.S. treasury securities				346,927
Total investments and restricted cash				$ 223,248,321

NOTE 5 – CAPITAL ASSETS

Capital asset additions, retirements, and balances for the years ended June 30, 2020 and 2019, were as follows:

	Balance July 1, 2019	Increases	Decreases	Transfers	Balance June 30, 2020
Capital assets					
Land	$ 1,557,283	$ -	$ -	$ -	$ 1,557,283
Building and improvements	8,834,750	237,527	-	-	9,072,277
Furniture and equipment	2,410,114	54,970	-	-	2,465,084
Computer hardware	7,206,916	1,081,845	-	-	8,288,761
Computer software	20,753,869	86,684	-	-	20,840,553
Total capital assets	40,762,932	1,461,026	-	-	42,223,958
Less accumulated depreciation for					
Building and improvements	(4,328,293)	(804,512)	-	-	(5,132,805)
Furniture and equipment	(2,183,841)	(75,377)	-	-	(2,259,218)
Computer hardware	(4,829,908)	(980,198)	-	-	(5,810,106)
Computer software	(18,677,683)	(332,207)	-	-	(19,009,890)
Total accumulated depreciation	(30,019,725)	(2,192,294)	-	-	(32,212,019)
Net capital assets	$ 10,743,207	$ (731,268)	$ -	$ -	$ 10,011,939

	Balance July 1, 2018	Increases	Decreases	Transfers	Balance June 30, 2019
Capital assets					
Land	$ 1,557,283	$ -	$ -	$ -	$ 1,557,283
Building and improvements	8,422,992	411,758	-	-	8,834,750
Furniture and equipment	2,323,233	86,881	-	-	2,410,114
Computer hardware	6,757,538	451,773	(2,395)	-	7,206,916
Computer software	20,753,869	-	-	-	20,753,869
Total capital assets	39,814,915	950,412	(2,395)	-	40,762,932
Less accumulated depreciation for					
Building and improvements	(3,667,520)	(660,773)	-	-	(4,328,293)
Furniture and equipment	(2,123,655)	(60,186)	-	-	(2,183,841)
Computer hardware	(4,007,076)	(822,992)	160	-	(4,829,908)
Computer software	(18,018,621)	(659,062)	-	-	(18,677,683)
Total accumulated depreciation	(27,816,872)	(2,203,013)	160	-	(30,019,725)
Net capital assets	$ 11,998,043	$ (1,252,601)	$ (2,235)	$ -	$ 10,743,207

NOTE 6 – CLAIMS PAYABLE

The Alliance estimates claims payable based on historical claims payment and other relevant information. Estimates are monitored and reviewed, and as settlements are made or estimates are adjusted, differences are reflected in current operation. Such estimates are subject to impact of changes in the regulatory environment. The following is a reconciliation of the claims payable liability for the years ended June 30, 2020 and 2019:

	2020	2019
Balance, July 1	$ 95,463,034	$ 107,716,180
Incurred - current	710,469,774	714,910,629
Paid		
Current	(631,269,347)	(634,695,326)
Prior	(85,967,485)	(92,468,449)
Balance, June 30	$ 88,695,976	$ 95,463,034

As noted in the table above, $710,469,774 and $714,910,629 in medical claims were incurred at June 30, 2020 and 2019, respectively, which are reflected in medical services in the combined statements of revenues, expenses, and changes in net position.

Claims payable liability decreased by $6,767,058 in comparison to the previous year as a result of changes between actual payments for medical services and estimated amounts in previous years. Management believes the decrease in estimated prior year's claims experience is largely a result of lower-than-anticipated adverse health care claims experience.

NOTE 7 – OPERATING LEASES

The Alliance has entered into various operating lease agreements for office space which provides for minimum annual rental payments expiring in May of 2025. The total future minimum lease commitments under noncancelable leases at June 30, 2020, are as follows:

Year Ending June 30,	
2021	$ 866,348
2022	893,830
2023	919,053
2024	945,033
2025	891,130
	$ 4,515,394

Rent expense was $801,357 and $779,305 for the years ended June 30, 2020 and 2019, respectively, and is included in marketing, general, and administrative expenses in the combined statements of revenues, expenses, and changes in net position.

NOTE 8 – MEDICAL REINSURANCE ("STOP-LOSS INSURANCE")

The Alliance has entered into certain reinsurance ("stop-loss") agreements with third parties in order to limit its losses on individual claims. Under the terms of these agreements, the third parties will reimburse the Alliance certain proportions of the cost of each member's hospital, professional, and out-of-area services, excluding those that are capitated, in excess of specified deductibles ranging from $200,000 per contract, up to a maximum of $2,000,000 per member per contract year. Reinsurance premiums are recorded as other health care expenses and recoveries are recorded as a reduction of these expenses. Premiums exceeded stop-loss recoveries by $4,727 in 2020 and by $1,130,869 in 2019.

NOTE 9 – EMPLOYEE BENEFIT PLANS

Pension Plan

The Alliance has a defined contribution employee benefit plan (the "Plan"). The Plan is named the Alameda Alliance for Health Money Purchase Pension Plan and is administered by the Alliance. The Board of Governors has the authority to establish and amend benefit provisions and contribution requirements. All employees who have met certain service requirements are eligible to participate. During the years ended June 30, 2020 and 2019, the Alliance contributed 5% of each eligible employee's gross compensation to certain investment vehicles chosen by the employee. Contributions are subject to limitations on annual compensation and annual contributions. The annual compensation limit was $250,000 for both the years ended June 30, 2020 and 2019. The maximum annual contribution limit was $12,500 for both the years ended June 30, 2020 and 2019. Contributions to the Plan are made by the Alliance at the discretion of the Board of Governors. Employees do not contribute to this Plan. Employees become vested with respect to the Alliance's contributions ratably over five years.

CalPERS Plan

Plan description – Effective January 1, 1999, the Alliance joined the California Public Employees Retirement System ("CalPERS"), an agent multiple-employer defined benefit pension plan. CalPERS acts as a common investment and administrative agent for participating public entities within the State of California. Benefit provisions and all other requirements are established by state statute. Copies of the CalPERS annual financial report may be obtained from their Executive Office: 400 P Street, Sacramento, California 95814.

Benefits provided – CalPERS provides service retirement and disability benefits, annual cost of living adjustments, and death benefits to plan members, who must be public employees and beneficiaries. Benefits are based on years of credited service, equal to one full year of full-time employment. Members with five years of total service are eligible to retire at age 50 with statutorily reduced benefits. All members are eligible for nonduty disability benefits after five years of service. The death benefit is one of the following: The Basic Death Benefit, the 1957 Survivor Benefit, or the Optional Settlement 2W Death Benefit. The cost of living adjustments for the plan are applied as specified by the Public Employees' Retirement Law.

The CalPERS plan provisions and benefits in effect at June 30, 2020 and 2019, are summarized as follows:

	Hire date prior to January 1, 2013	Hire date on or after January 1, 2013
Benefit formula	2% at 60	2% at 62
Benefit vesting schedule	5 years of service	5 years of service
Benefit payments	monthly for life	monthly for life
Retirement age	50-67	52-67
Monthly benefits as a % of eligible compensation	1.1% to 3.1%	1.0% to 2.6%
Required employee contribution rates	7.0%	6.25%
Required employer contribution rates	7.2%	7.2%

Employees covered – At June 30, 2020 and 2019, the following employees were covered by the CalPERS plan:

	2020	2019
Active	304	291
Terminated	340	307
Transferred	39	34
Retired and beneficiaries	31	31
Total participants	714	663

Contributions – Section 20814(c) of the California Public Employees' Retirement Law requires that the employer contribution rates for all public employers be determined on an annual basis by the actuary and shall be effective on the July 1 following notice of a change in the rate. The total plan contributions are determined through CalPERS' annual actuarial valuation process. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability. The employer is required to contribute the difference between the actuarially determined rate and the contribution rate of employees. Employer contribution rates may change if plan contracts are amended. Payments made by the employer to satisfy contribution requirements that are identified by the pension plan terms as plan member contribution requirements are classified as plan member contributions.

Net pension asset/liability – The Alliance's net pension asset/liability for the CalPERS plan is measured as the total pension liability, less the pension's fiduciary net position. The net pension liability at June 30, 2020 is measured as of June 30, 2019, using an annual actuarial valuation as of June 30, 2018, rolled forward to June 30, 2019, using standard update procedures. The net pension asset at June 30, 2019 is measured as of June 30, 2018, using an annual actuarial valuation as of June 30, 2017, rolled forward to June 30, 2018, using standard update procedures. A summary of principal assumptions and methods used to determine the net pension asset/liability is shown below.

The total pension liability in the June 30, 2020, actuarial valuations were determined using the following actuarial assumptions:

Valuation date	June 30, 2018
Measurement date	June 30, 2019
Actuarial cost method	Entry age normal
Actuarial assumptions	
Discount rate	7.15%
Inflation	2.75%
Salary increases	Varies by entry age and service
Payroll growth	3.00%
Investment rate of return	7.375% net of pension plan investment and administrative expenses; includes inflation
Mortality rate table	Derived using CalPERS' membership data for all funds
Post retirement benefit increase	The lesser of contract COLA or 2.50% until purchasing power protection allowance floor on purchasing power applies; 2.50% thereafter

The total pension asset in the June 30, 2019, actuarial valuations were determined using the following actuarial assumptions:

Valuation date	June 30, 2017
Measurement date	June 30, 2018
Actuarial cost method	Entry age normal
Actuarial assumptions	
Discount rate	7.15%
Inflation	2.50%
Salary increases	Varies by entry age and service
Payroll growth	3.00%
Investment rate of return	7.50% net of pension plan investment and administrative expenses; includes inflation
Mortality rate table	Derived using CalPERS' membership data for all funds
Post retirement benefit increase	Contract COLA up to 2.0% until purchasing power protection allowance floor on purchasing power applies; 2.50% thereafter

The mortality table used was developed based on CalPERS' specific data. The table includes 20 years of mortality improvements using Society of Actuaries Scale BB. All other actuarial assumptions used in the 2016 and 2015 valuation were based on the results of an actuarial experience study for the period from 1997 to 2011, including updates to salary increase, mortality, and retirement rates. The Experience Study can be obtained at the CalPERS website.

Change of assumptions – GASB Statement No. 68, *Accounting and Financial Reporting for Pensions* ("GASB 68"), paragraph 68 states that the long-term rate of return should be determined net of pension plan investment expense but without reduction for pension plan administrative expense. For the June 30, 2019 and 2018 measurement date, there were changes in demographic assumptions and inflation rate and there were no changes in discount rate.

Discount rate – The discount rate used to measure the total pension asset/liability at June 30, 2020 and 2019, was 7.15%, for the CalPERS plan. To determine whether the municipal bond rate should be used in the calculation of a discount rate for each plan, CalPERS stress tested plans that would most likely result in a discount rate that would be different from the actuarially assumed discount rate. Based on the testing, none of the tested plans would run out of assets. Therefore, the current 7.15% discount rate is adequate and the use of the municipal bond rate calculation is not necessary. The long-term expected discount rate of 7.15% will be applied to all plans in the Public Employees Retirement Fund. The cash flows used in the testing were developed assuming that both members and employers will make their required contributions on time and as scheduled in all future years. The stress test results are presented in a detailed report called "GASB Crossover Testing Report" that can be obtained from the CalPERS website.

The long-term expected rate of return on pension plan investments was determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class.

In determining the long-term expected rate of return, CalPERS took into account both short-term and long-term market return expectations as well as the expected pension fund cash flows. Such cash flows were developed assuming that both members and employers will make the required contributions as scheduled in all future years. Using historical returns of all the funds' asset classes, expected compound returns were calculated over the short-term (first 10 years) and the long-term (11-60 years) using a building-block approach. Using the expected nominal returns for both short-term and long-term, the present value of benefits was calculated for each fund. The expected rate of return was set by calculating the single equivalent expected return that arrived at the same present value of benefits for cash flows as the one calculated using both short-term and long-term returns. The expected rate of return was then set equivalent to the single equivalent rate calculated above and rounded down to the nearest one quarter of one percent.

The table below reflects long-term expected real rate of return by asset class. The rate of return was calculated using the capital market assumptions applied to determine the discount rate and asset allocation.

Asset Class	Current Target Allocation	Real Return Years 1-10 [a]	Real Return Years 11+ [b]
Global equity	50.0%	4.80%	5.98%
Fixed income	28.0%	1.00%	2.62%
Inflation assets	0.0%	0.77%	1.81%
Private equity	8.0%	6.30%	7.23%
Real estate	13.0%	3.75%	4.93%
Liquidity	1.0%	0.00%	-0.92%

[a] An expected inflation rate of 2.00% was used for this period
[b] An expected inflation rate of 2.92% was used for this period

The changes in the net pension liability (asset) for the years ended June 30, 2020 and 2019, were as follows:

	Total Pension Liability	Plan Fiduciary Net Position	Net Pension (Asset) Liability
Balance at June 30, 2019	$ 39,934,477	$ 40,042,197	$ (107,720)
Changes during the year			
Service cost	3,625,677	-	3,625,677
Interest on the total pension liability	2,999,802	-	2,999,802
Differences between expected and actual experience	713,029	-	713,029
Contributions - employer	-	1,984,998	(1,984,998)
Contributions - employees	-	1,741,232	(1,741,232)
Net investment income	-	2,700,240	(2,700,240)
Benefit payments, including refunds of employee contributions	(1,010,155)	(1,010,155)	-
Administrative expense	-	(28,575)	28,575
Other miscellaneous income	-	92	(92)
Net change in total pension (asset) liability	6,328,353	5,387,832	940,521
Balance at June 30, 2020	$ 46,262,830	$ 45,430,029	$ 832,801

	Pension Liability	Fiduciary Net Position	Pension Liability (Asset)
Balance at June 30, 2018	$ 35,160,450	$ 34,530,354	$ 630,096
Changes during the year			
Service cost	3,233,750	-	3,233,750
Interest on the total pension liability	2,582,178	-	2,582,178
Differences between expected and actual experience	102,040	-	102,040
Changes of assumptions	(386,048)	-	(386,048)
Net plan to plan resource movement	-	(92)	92
Contributions - employer	-	1,854,342	(1,854,342)
Contributions - employees	-	1,583,972	(1,583,972)
Net investment income	-	2,987,504	(2,987,504)
Benefit payments, including refunds of employee contributions	(757,893)	(757,893)	-
Administrative expense	-	(53,808)	53,808
Other miscellaneous expense	-	(102,182)	102,182
Net change in total pension liability (asset)	4,774,027	5,511,843	(737,816)
Balance at June 30, 2019	$ 39,934,477	$ 40,042,197	$ (107,720)

Sensitivity of the proportionate share of the net pension liability to changes in the discount rate – The following presents the net pension liability for the CalPERS plan, calculated using the discount rate, as well as what the net pension liability (asset) would be if it were calculated using a discount rate that is 1 percentage point lower or 1 percentage point higher than the current rate.

	June 30, 2020		
	1% Decrease (6.15%)	Current Discount Rate (7.15%)	1% Increase (8.15%)
Net pension liability (asset)	$ 8,284,994	$ 832,801	$ (5,160,875)

	June 30, 2019		
	1% Decrease (6.15%)	Current Discount Rate (7.15%)	1% Increase (8.15%)
Net pension liability (asset)	$ 6,329,377	$ (107,720)	$ (5,282,975)

Pension plan fiduciary net position – Detailed information about each pension plan's fiduciary net position is available in the separately issued CalPERS financial reports.

Pension expense and deferred outflows/inflows of resources related to pensions – For the year ended June 30, 2020, the Alliance recognized pension expense of $1,752,612, included in marketing, general, and administrative expenses. At June 30, 2020, the Alliance reported deferred outflows of resources and deferred inflows of resources related to the CalPERS plan from the following sources:

Deferred outflows of resources as of June 30, 2020		
Changes of assumptions	$	910,846
Differences between expected and actual experience		632,447
Total	$	1,543,293
Deferred inflows of resources as of June 30, 2020		
Differences between expected and actual experience	$	(293,129)
Changes of assumptions		(608,232)
Net difference between projected and actual earnings on pension plan investments		(120,332)
Total	$	(1,021,693)
Contributions between the measurement date and fiscal year end recognized as deferred outflows of resources	$	2,154,253

For the year ended June 30, 2019, the Alliance recognized pension expense of $1,115,661, included in marketing, general, and administrative expenses. At June 30, 2019, the Alliance reported deferred outflows of resources and deferred inflows of resources related to the CalPERS plan from the following sources:

Deferred outflows of resources as of June 30, 2019		
Changes of assumptions	$	1,344,583
Differences between expected and actual experience		82,032
Net difference between projected and actual earnings on pension plan investments		32,333
Total	$	1,458,948
Deferred inflows of resources as of June 30, 2019		
Differences between expected and actual experience	$	(1,016,284)
Changes of assumptions		(466,282)
Total	$	(1,482,566)
Contributions between the measurement date and fiscal year end recognized as deferred outflows of resources	$	1,994,571

The Alliance reported $2,154,253 and $1,994,571 as deferred outflows of resources related to contributions made subsequent to the measurement date for the years ended June 30, 2020 and 2019, respectively. This amount will be recognized as a reduction/increase of net pension liability/asset for the measurement period ended June 30, 2019 and 2018, respectively. Other amounts reported as deferred outflows and deferred inflows of resources related to the CalPERS plan will be recognized in future pension expense as follows:

Year Ending June 30,	
2021	$ 191,446
2022	$ 59,288
2023	$ 82,059
2024	$ 188,807

At June 30, 2020 and 2019, the Alliance had no outstanding amount of contributions to the pension plan required for the years ended June 30, 2020 and 2019.

Deferred Compensation Plan

The Alliance offers its employees a deferred compensation plan with Voya Financial created in accordance with Internal Revenue Code Section 457. The deferred compensation plan is available to all employees and permits them to defer a portion of their salary. No employer contribution to the plan is required. Deferred compensation is not available to employees until termination, retirement, death, or an unforeseeable emergency.

NOTE 10 – TANGIBLE NET EQUITY

As a limited license plan under Knox-Keene Health Care Services Plan Act of 1975, the Alliance is required to maintain a minimum level of tangible net equity and working capital. The required tangible net equity is $31,962,073 and $32,453,431 at June 30, 2020 and 2019, respectively. The tangible net equity of the Alliance is $206,174,815 and $180,747,252 at June 30, 2020 and 2019, respectively. At June 30, 2020 and 2019, management believes the Alliance was in compliance with their tangible net equity regulatory requirement.

NOTE 11 – RISK MANAGEMENT

The Alliance is exposed to various risks of loss related to torts; theft of, damage to, and destruction of assets; business interruptions; errors and omissions; employee injuries and illness; natural disasters; and employee health, dental, and accident benefits. The Alliance carries commercial insurance for claims arising from such matters, and no settled claims have ever exceeded the Alliances' commercial coverage.

NOTE 12 – COMMITMENTS AND CONTINGENCIES

The Alliance is aware of certain asserted and unasserted legal claims. While the outcome cannot be determined at this time after consultation with legal counsel, it is management's opinion that the liability, if any, from these actions will not have a material adverse effect on the Alliance's combined financial position or results of operations.

NOTE 13 – HEALTH CARE REFORM

The Patient Protection and Affordable Care Act ("PPACA") allowed for the expansion of Medical members in the State of California. Any further changes in federal or state funding could have an impact on the Alliance. The future of the PPACA and the impact of future changes in Medicaid to the Alliance is uncertain at this time.

Supplementary Information

Alameda Alliance for Health and
Alameda Alliance Joint Powers Authority
Schedule of Changes in Net Pension Liability (Asset) and Related Ratios

	2020	2019	2018	2017	2016	2015
Measurement period	2018-2019	2017-2018	2016-2017	2015-2016	2014-2015	2013-2014
Total pension liability						
Service cost	$ 3,625,677	$ 3,233,750	$ 2,936,812	$ 2,378,725	$ 2,192,498	$ 2,309,399
Interest on total pension liability	2,999,802	2,582,178	2,275,291	2,016,770	1,844,544	1,602,650
Changes of assumptions	-	(386,048)	2,212,057	-	(545,758)	-
Difference between expected and actual experience	713,029	102,040	(731,181)	(1,285,655)	(97,677)	-
Benefit payments, including refunds of employee contributions	(1,010,155)	(757,893)	(811,011)	(581,326)	(604,984)	(329,311)
Net change in total pension liability	6,328,353	4,774,027	5,881,968	2,528,514	2,788,623	3,582,738
Total pension liability beginning of fiscal year	39,934,477	35,160,450	29,278,482	26,749,968	23,961,345	20,378,607
Total pension liability end of fiscal year	$ 46,262,830	$ 39,934,477	$ 35,160,450	$ 29,278,482	$ 26,749,968	$ 23,961,345
Plan fiduciary net position						
Contributions - employer	$ 1,984,998	$ 1,854,342	$ 1,541,099	$ 1,252,041	$ 1,099,813	$ 1,179,808
Contributions - employee	1,741,232	1,583,972	1,373,631	1,157,507	1,054,870	1,134,768
Net investment income	2,700,240	2,987,504	3,330,394	153,646	571,106	3,579,174
Benefit payments, including refunds of employee contributions	(1,010,155)	(757,893)	(811,011)	(581,326)	(604,984)	(329,311)
Net plan to plan resource movement	-	(92)	-	-	-	-
Administrative expense	(28,575)	(53,808)	(43,022)	(16,561)	(30,578)	-
Other miscellaneous income (expense)	92	(102,182)	-	-	-	-
Net change in fiduciary net position	5,387,832	5,511,843	5,391,091	1,965,307	2,090,227	5,564,439
Plan fiduciary net position beginning of fiscal year	40,042,197	34,530,354	29,139,263	27,173,956	25,083,729	19,519,290
Plan fiduciary net position end of fiscal year	$ 45,430,029	$ 40,042,197	$ 34,530,354	$ 29,139,263	$ 27,173,956	$ 25,083,729
Plan net pension liability (asset)	$ 832,801	$ (107,720)	$ 630,096	$ 139,219	$ (423,988)	$ (1,122,384)
Plan fiduciary net position as a percentage of the total pension liability	98.20%	100.27%	98.21%	99.52%	101.59%	104.68%
Covered employee payroll	$ 24,934,165	$ 22,106,576	$ 19,552,678	$ 17,110,667	$ 15,964,019	$ 15,942,279
Plan net pension liability (asset) as a percentage of covered payroll	3.34%	-0.49%	3.22%	0.81%	-2.66%	7.04%

Alameda Alliance for Health and
Alameda Alliance Joint Powers Authority
Schedule of Pension Contributions

	2020	2019	2018	2017	2016	2015
Measurement period	2018-2019	2017-2018	2016-2017	2015-2016	2014-2015	2013-2014
Actuarially determined contribution	$ 1,984,998	$ 1,854,342	$ 1,541,099	$ 1,252,041	$ 1,099,813	$ 1,179,808
Contributions in relation to the actuarially determined contribution	(1,984,998)	(1,854,342)	(1,541,099)	(1,252,041)	(1,099,813)	(1,179,808)
Contribution deficiency (excess)	$ -	$ -	$ -	$ -	$ -	$ -
Covered employee payroll	$ 24,934,165	$ 22,106,576	$ 19,552,678	$ 17,110,667	$ 19,552,678	$ 17,110,667
Contributions as a percentage of covered employee payroll	7.96%	8.39%	7.88%	7.32%	6.89%	7.40%

Alameda Alliance for Health and
Alameda Alliance Joint Powers Authority
Statement of Revenues and Expenses – AC Care Connect
For the Years Ended June 30, 2020 and 2019

Contract Number: 15764
Contract Amount: $3,655,693
Contract Period: July 1, 2019 - June 30, 2020

	2020
Revenues	
Care Connect revenue (95%)	$ 692,417
Care Connect administrative revenue (5%)	712,526
Total revenues	1,404,943
Expenses	
Care Connect CB-CME payments	692,417
Total expenses	692,417
Net income	$ 712,526

Contract Number: 15764
Contract Amount: $4,055,871
Contract Period: July 1, 2018 - June 30, 2019

	2019
Revenues	
Care Connect revenue (95%)	$ 1,214,634
Care Connect administrative revenue (5%)	765,346
Total revenues	1,979,980
Expenses	
Care Connect CB-CME payments	1,236,303
Total expenses	1,236,303
Net income	$ 743,677

Report of Independent Auditors on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

To the Board of Governors
Alameda Alliance for Health and
Alameda Alliance Joint Powers Authority

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the combined financial statements of Alameda Alliance for Health and Alameda Alliance Joint Powers Authority (collectively the "Alliance"), which comprise the combined statement of net position as of June 30, 2020, and the related combined statement of revenues, expenses, and changes in net position, and cash flows for the year then ended, and the related notes to the combined financial statements and have issued our report thereon dated _____, 2020.

Internal Control Over Financial Reporting

In planning and performing our audit of the combined financial statements, we considered the Alliance's internal control over financial reporting ("internal control") to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinions on the combined financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Alliance's internal control. Accordingly, we do not express an opinion on the effectiveness of the Alliance's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Alliance's combined financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audits and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

San Francisco, California
_____, 2020

Communication with
Those Charged with Governance

Alameda Alliance for Health and
Alameda Alliance Joint Powers Authority

June 30, 2020

Communication with Those Charged with Governance

To the Board of Governors
Alameda Alliance for Health and
Alameda Alliance Joint Powers Authority

We have audited the combined financial statements of Alameda Alliance for Health and Alameda Alliance Joint Powers Authority (collectively the "Alliance") as of and for the year ended June 30, 2020, and have issued our report thereon dated _____, 2020. Professional standards require that we provide you with the following information related to our audit.

Our Responsibility under Auditing Standards Generally Accepted in the United States of America and *Government Auditing Standards*

As stated in our engagement letter dated June 4, 2020, our responsibility, as described by professional standards, is to form and express an opinion about whether the combined financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America, the standards applicable to the financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States of America, and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts. Our audit of the combined financial statements does not relieve you or management of your responsibilities.

Our responsibility is to plan and perform the audit in accordance with auditing standards generally accepted in the United States of America, the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States of America, the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts, and to design the audit to obtain reasonable, rather than absolute, assurance about whether the combined financial statements are free from material misstatement. An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Alliance's internal control over financial reporting. Accordingly, we considered the Alliance's internal control solely for the purposes of determining our audit procedures and not to provide assurance concerning such internal control.

We are also responsible for communicating significant matters related to the combined financial statement audit that, in our professional judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to management, who has been charged by the Board of Governors to oversee the audit, during our pre-audit planning meeting on August 13, 2020.

Significant Audit Findings and Issues

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the Alliance are described in Note 2 to the combined financial statements. No new accounting policies were adopted and there were no changes in the application of existing policies during 2020. We noted no transactions entered into by the Alliance during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the combined financial statements in a different period than when the transaction occurred.

Significant Accounting Estimates

Accounting estimates are an integral part of the combined financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the combined financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the combined financial statements were:

- Management recorded an estimated liability for incurred but unpaid claims expense. The estimated liability for unpaid claims is based on management's estimate of historical claims experience and known activity subsequent to year end. We have gained an understanding of management's estimate methodology, and have examined the documentation supporting these methodologies and formulas. We found management's process to be reasonable.

- Management recorded an estimated liability for the medical loss ratio requirement for Medi-Cal Expansion. The estimated liability is based on management's estimate of revenues and allowable medical expenses related to Medi-Cal Expansion. We have gained an understanding of management's estimate methodology, and have examined the documentation supporting these methodologies and formulas. We found management's process to be reasonable.

- Management recorded an estimated capitation receivable. The estimated capitation receivable for eligible Medi-Cal program beneficiaries is based upon a historical experience methodology. We have an understanding of management's estimate methodology, and have examined the documentation supporting these methodologies and formulas. We found management's process to be reasonable.

- Management's estimate of the net pension asset is actuarially determined using assumptions on the long-term rate of return on pension plan assets, the discount rate used to determine the present value of benefit obligations, and the rate of compensation increases. These assumptions are provided by management. We have evaluated the key factors and assumptions used to develop the estimate. We found management's basis to be reasonable in relation to the combined financial statements taken as a whole.

- The useful lives of fixed assets have been estimated based on the intended use and are within accounting principles generally accepted in the United States of America.

Combined Financial Statement Disclosures

The disclosures in the combined financial statements are consistent, clear, and understandable. Certain combined financial statement disclosures are particularly sensitive because of their significance to combined financial statement users. The most sensitive disclosures affecting the Alliance's combined financial statements relate to medical claims payable, net pension liability, medical loss ratio, and capitation and premium revenues.

Significant Difficulties Encountered in Performing the Audit

We encountered no significant difficulties in dealing with management in performing and completing our audit.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all factual and judgmental misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. There were no corrected and uncorrected misstatements whose effects, as determined by management, are material, both individually and in the aggregate, to the combined financial statements as a whole.

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the combined financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations

We have requested certain representations from management that are included in the attached management representation letter date _____, 2020.

Management Consultation with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the Alliance's combined financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Independence

We are required to disclose to those charged with governance, in writing, all relationships between the auditors and the Alliance that in the auditor's professional judgment, may reasonably be thought to bear on our independence. We know of no such relationships and confirm that, in our professional judgment, we are independent of the Alliance within the meaning of professional standards.

Other Significant Audit Findings or Issues

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the Alliance's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

This information is intended solely for the use of the Board of Governors of Alameda Alliance for Health and the Alameda Alliance Joint Powers Authority and its management, and is not intended to be, and should not be, used by anyone other than these specified parties.

San Francisco, California
_____, 2020

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: **October 9, 2020**

Subject: **Finance Report – August 2020**

Executive Summary

- For the month ended August 31, 2020, the Alliance had enrollment of 264,058 members, a Net Loss of $6.6 million and 606% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$82,870	$164,728
Medical Expense	84,638	160,159
Admin. Expense	4,906	9,470
Other Inc. / (Exp.)	26	116
Net Income	($6,647)	($4,7,85)

Net Income by Program:

	Month	YTD
Medi-Cal	($6,246)	($3,717)
Group Care	(401)	(1,068)
	($6,647)	($4,785)

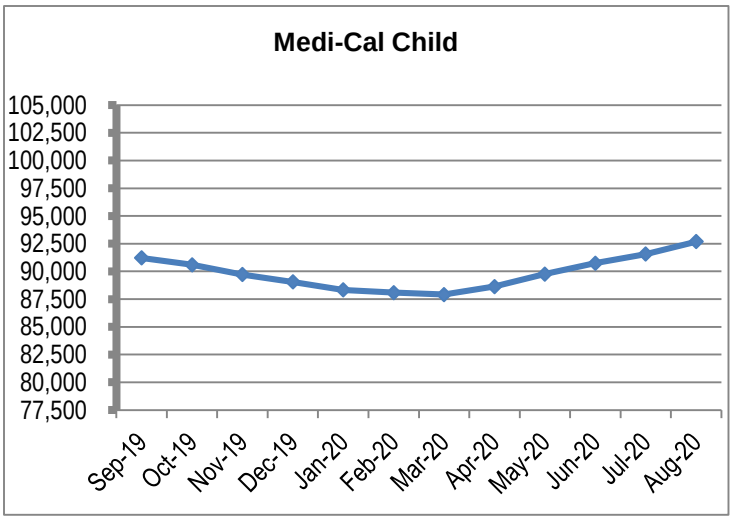
Enrollment

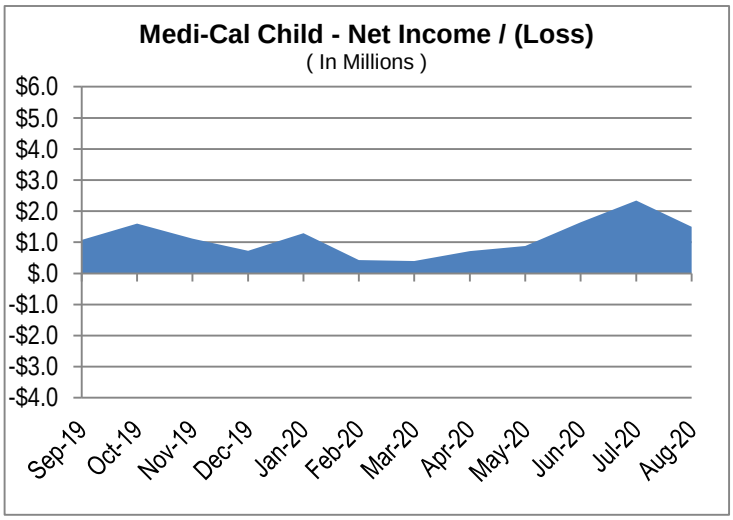
- Total enrollment increased by 4,140 members since July 2020.
- Total enrollment increased by 7,313 members since June 2020.

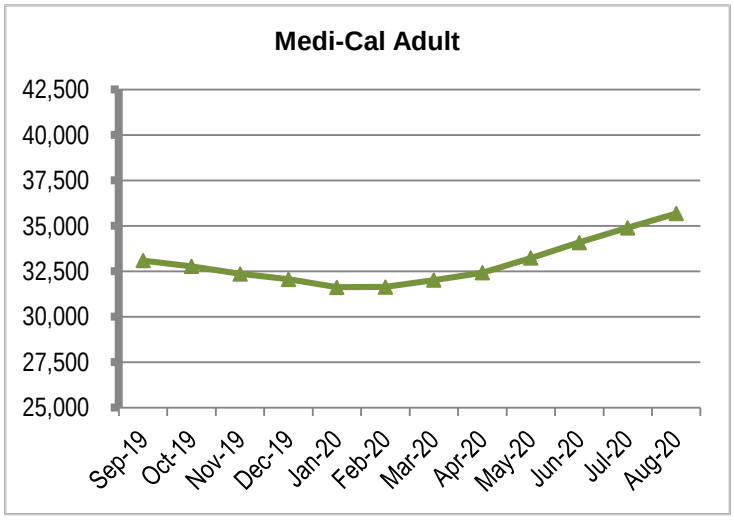
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

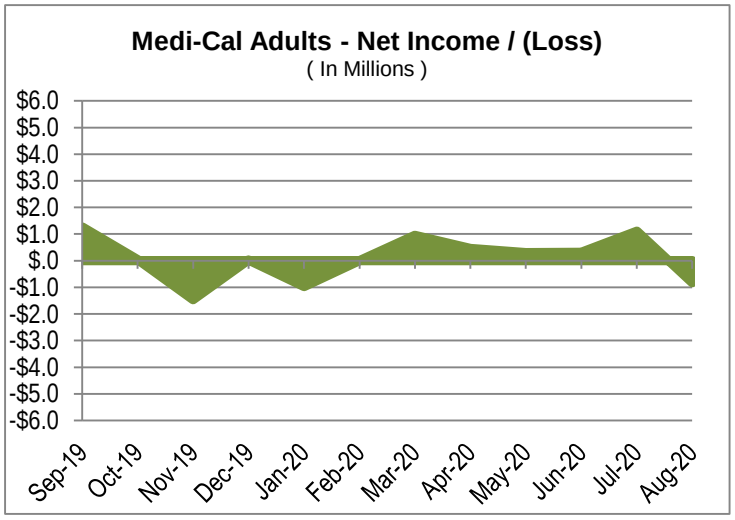
Enrollment					Member Months			
August-2020					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
35,676	35,350	326	0.9%	Adult	70,572	70,007	565	0.8%
92,692	95,939	(3,247)	-3.4%	Child	184,262	189,997	(5,735)	-3.0%
26,107	25,998	109	0.4%	SPD	52,164	51,970	194	0.4%
18,495	17,930	565	3.2%	Duals	36,792	35,842	950	2.7%
85,081	84,749	332	0.4%	ACA OE	168,070	167,836	234	0.1%
258,051	259,966	(1,915)	-0.7%	Medi-Cal Total	511,860	515,652	(3,792)	-0.7%
6,007	6,397	(390)	-6.1%	Group Care	12,116	6,397	5,719	89.4%
264,058	266,363	(2,305)	-0.9%	Total	523,976	522,049	1,927	0.4%

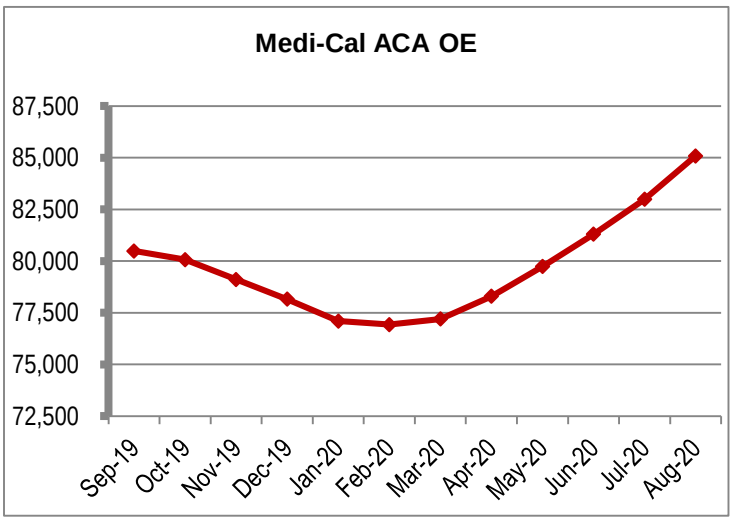
Enrollment and Profitability by Program and Category of Aid

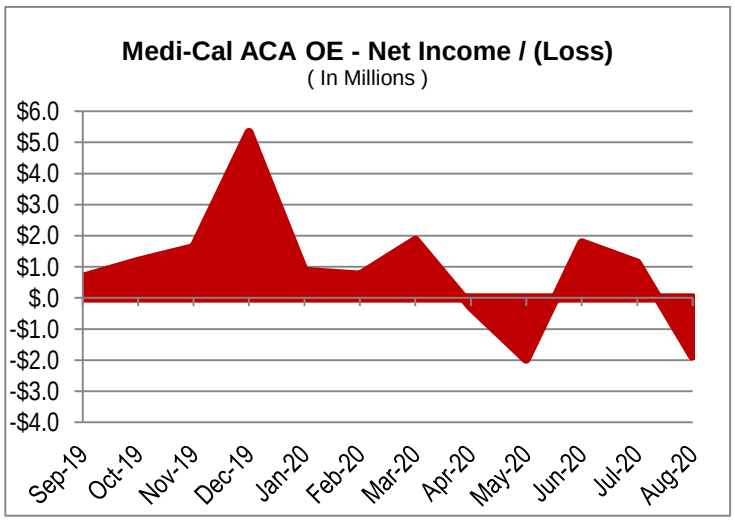




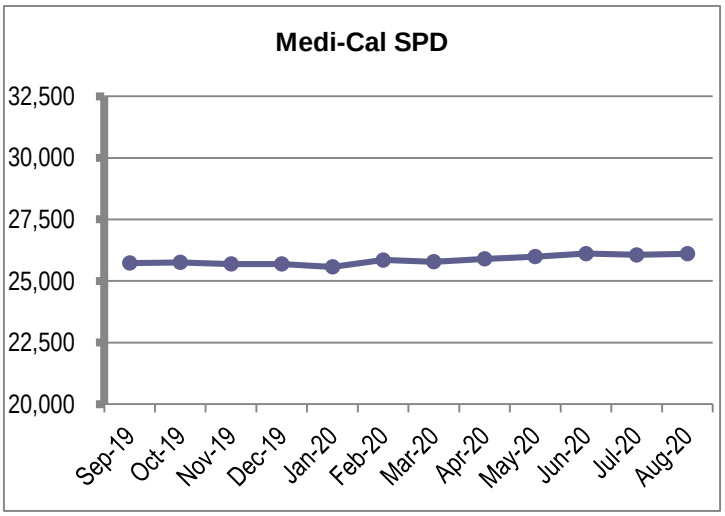


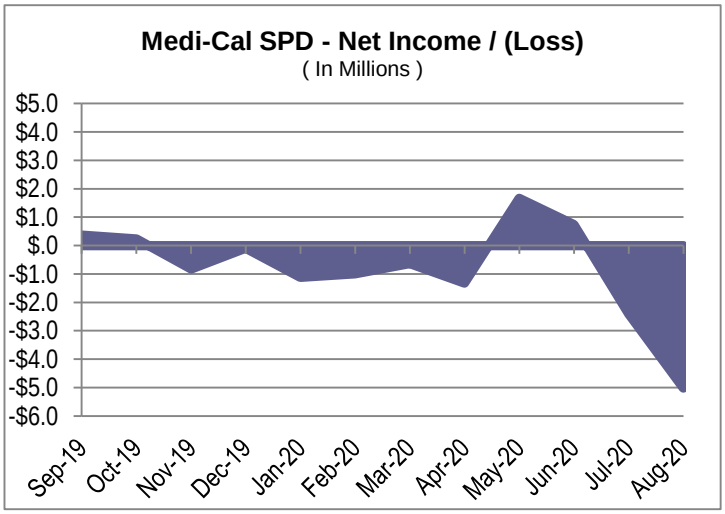


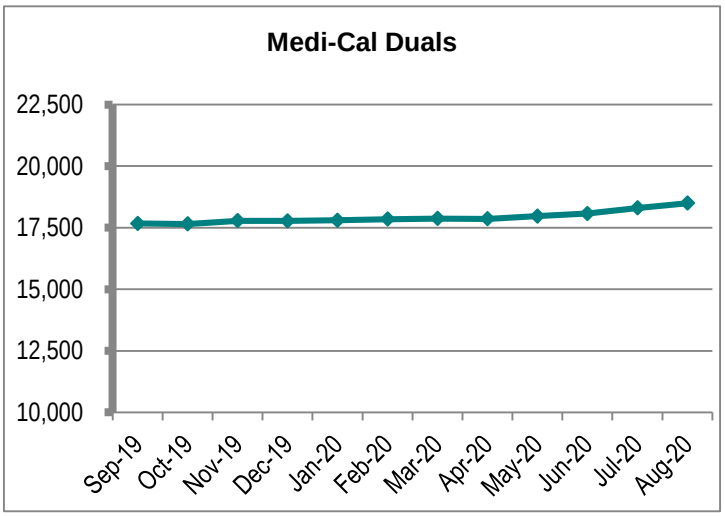


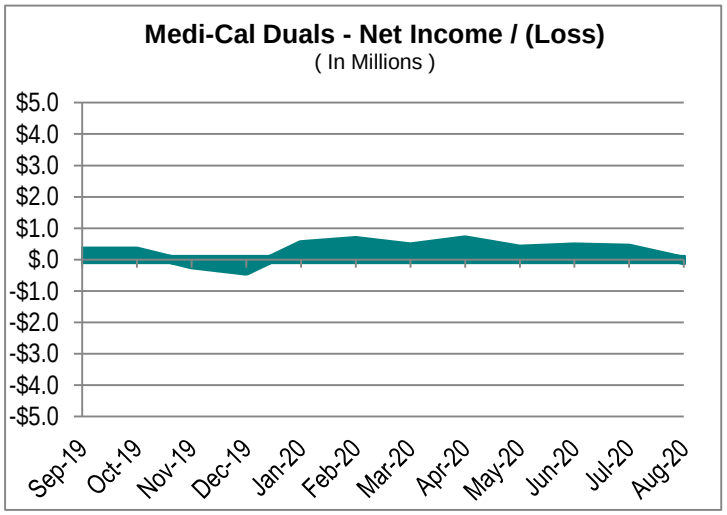


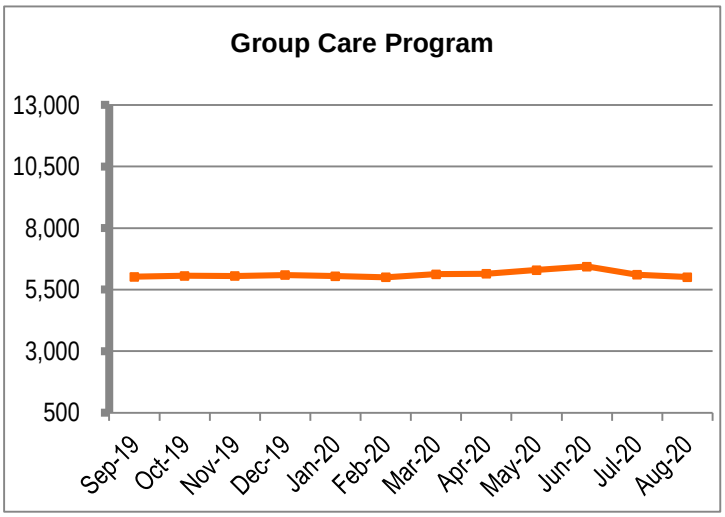
Enrollment and Profitability by Program and Category of Aid

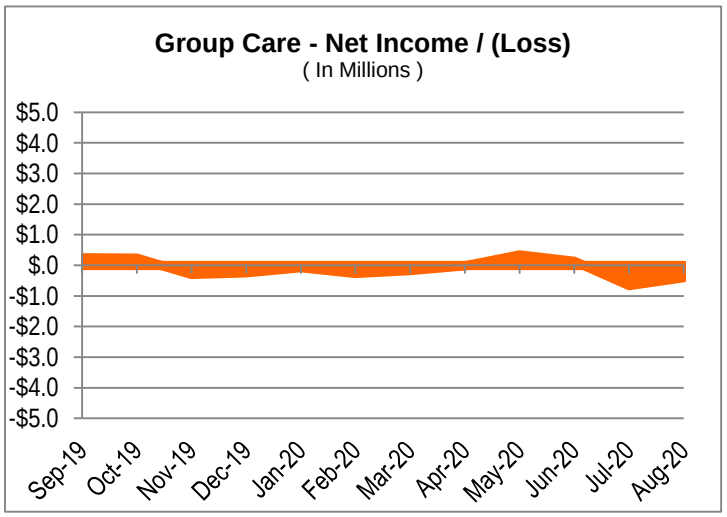




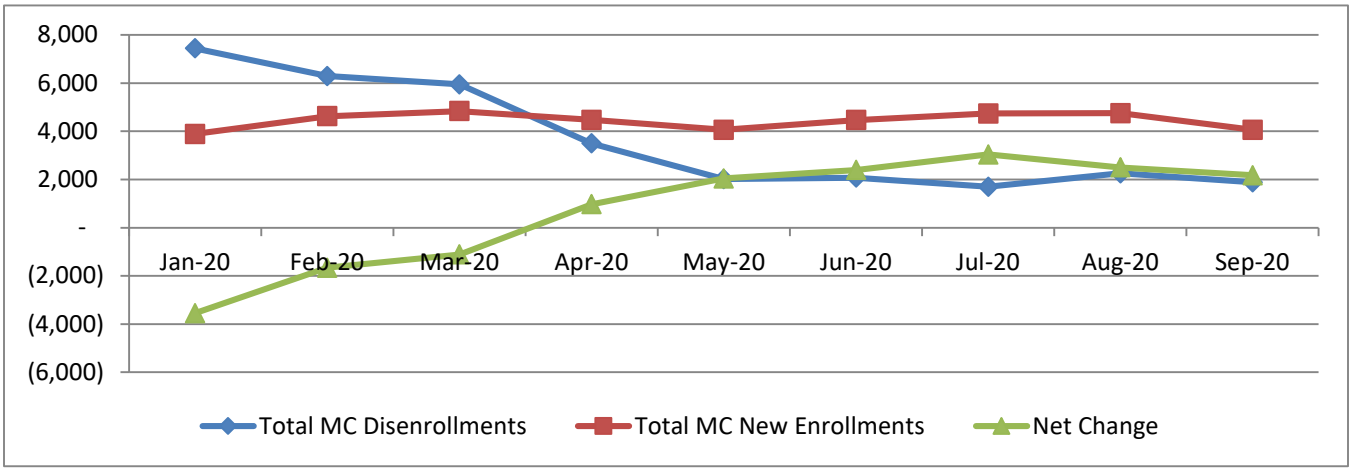








Disenrollment and New Enrollment

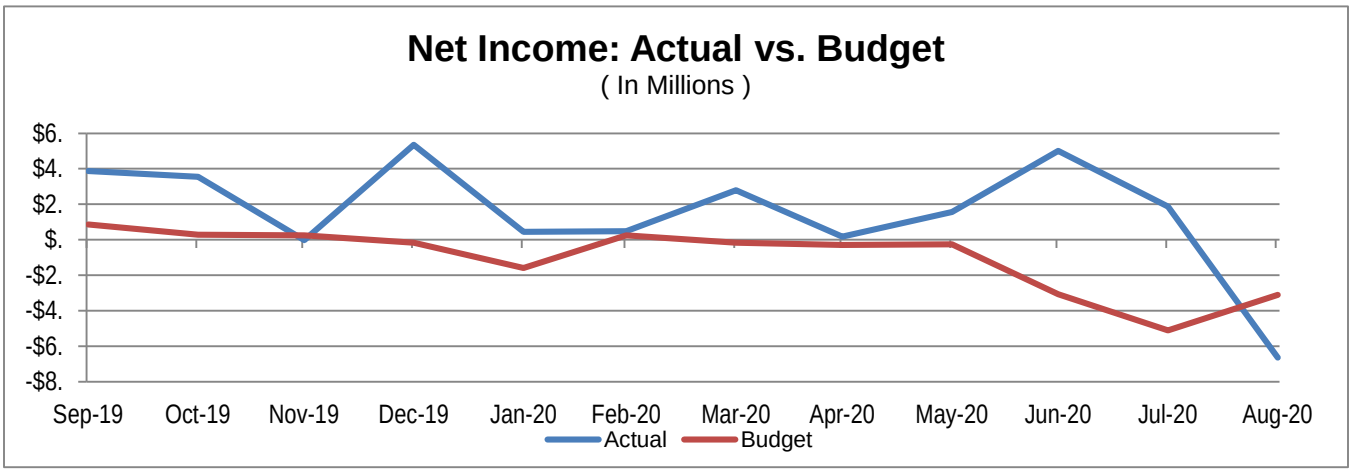


- Governor Newsom signed an executive order (EO N-29-20) in March 2020 to suspend redeterminations in the Medi-Cal program during the public health crisis. Guidelines have been issued by DHCS to the County Public Health Directors on two occasions (MEDIL I-20-07, MEDIL I-20-08).
- Disenrollment and new enrollment trends remain consistent with months starting in May.

Net Income

- For the month ended August 31, 2020:
  - Actual Net Loss: $6.6 million.
  - Budgeted Net Loss: $3.1 million.

- For the fiscal YTD ended August 31, 2020:
  - Actual Net Loss: $4.8 million.
  - Budgeted Net Loss: $8.2 million.

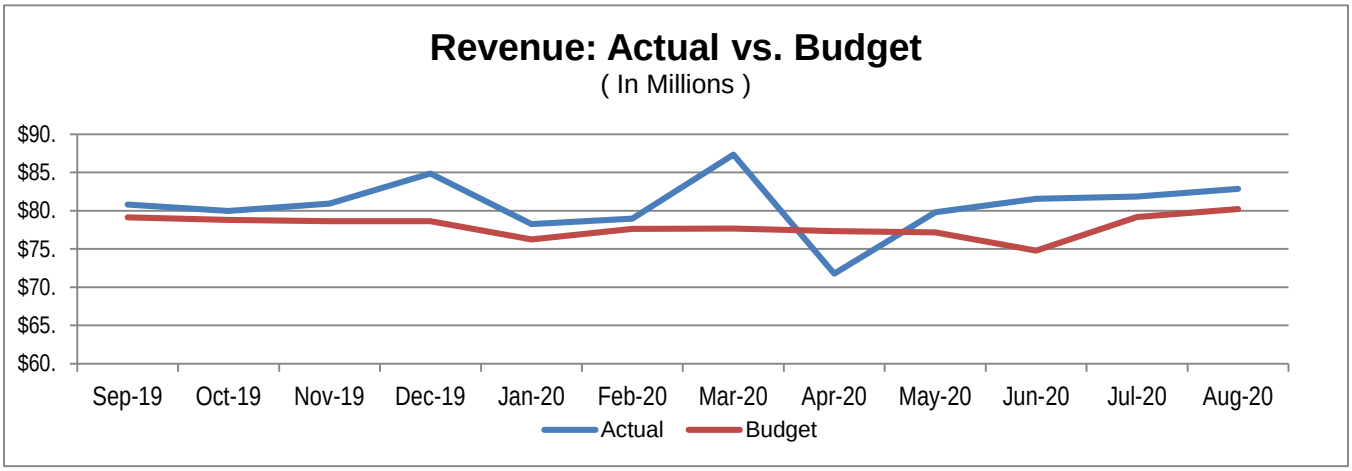


- The unfavorable variance of $6.8 million in the current month is due to:
  - Favorable $2.6 million higher than anticipated Revenue.
  - Unfavorable $8.2 million higher than anticipated Medical Expense.
  - Favorable $2.1 million lower than anticipated Administrative Expense.
  - Unfavorable $105,000 lower than anticipated Other Income & Expense.

Revenue

- For the month ended August 31, 2020:
  - Actual Revenue: $82.9 million.
  - Budgeted Revenue: $80.2 million.

- For the fiscal YTD ended August 31, 2020:
  - Actual Revenue: $164.7 million.
  - Budgeted Revenue: $159.4 million.

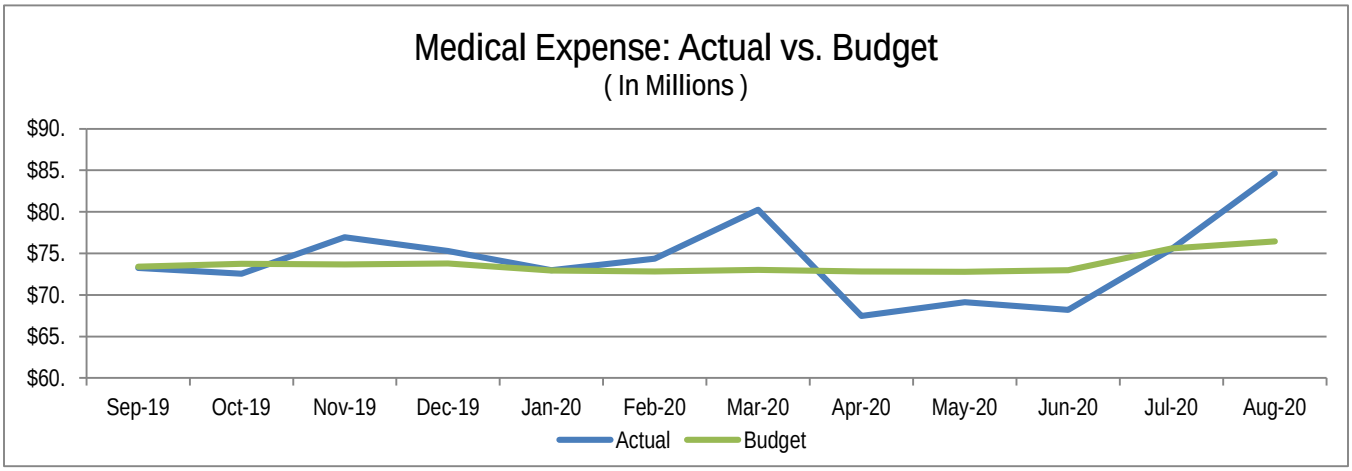


- For the month ended August 31, 2020, the favorable revenue variance of $2.6 million is mainly due to:
  - Favorable $2.8 million in Prop 56 Revenue. This revenue will be largely offset by enhanced payments to qualified Providers. The Preliminary Budget did not include Prop 56, as the State had informed that Prop 56 would be discontinued.

Medical Expense

- For the month ended August 31, 2020:
  - Actual Medical Expense: $84.6 million.
  - Budgeted Medical Expense: $76.5 million.

- For the fiscal YTD ended August 31, 2020:
  - Actual Medical Expense: $160.2 million.
  - Budgeted Medical Expense: $152.0 million.



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

- For August, updates to Fee-For-Service (FFS) expenses increased the estimate for unpaid Medical Expenses for prior months by $3.2 million. Year-to-date, the estimate for prior years increased by $3.0 million (per table below).

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

	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Excluding IBNP Change	Change in IBNP	Reported		$	%
Capitated Medical Expense	$34,339,891	$0	$34,339,891	$36,397,291	$2,057,400	5.7%
Primary Care FFS	8,227,216	188,916	8,416,132	2,540,657	($5,686,559)	-223.8%
Specialty Care FFS	8,097,235	530,374	8,627,609	7,985,318	($111,917)	-1.4%
Outpatient FFS	15,465,351	(1,002,025)	14,463,326	15,051,875	($413,476)	-2.7%
Ancillary FFS	6,669,559	905,731	7,575,290	6,443,086	($226,473)	-3.5%
Pharmacy FFS	27,186,470	77,869	27,264,339	26,814,942	($371,528)	-1.4%
ER Services FFS	7,023,179	20,842	7,044,021	6,486,364	($536,815)	-8.3%
Inpatient Hospital & SNF FFS	46,142,272	2,308,292	48,450,564	45,492,777	($649,495)	-1.4%
Other Benefits & Services	3,732,377	0	3,732,377	4,354,796	$622,419	14.3%
Net Reinsurance	78,374	0	78,374	307,027	$228,653	74.5%
Provider Incentive	166,667	0	166,667	166,664	($3)	0.0%
	$157,128,592	$3,029,999	$160,158,591	$152,040,798	($5,087,794)	-3.3%

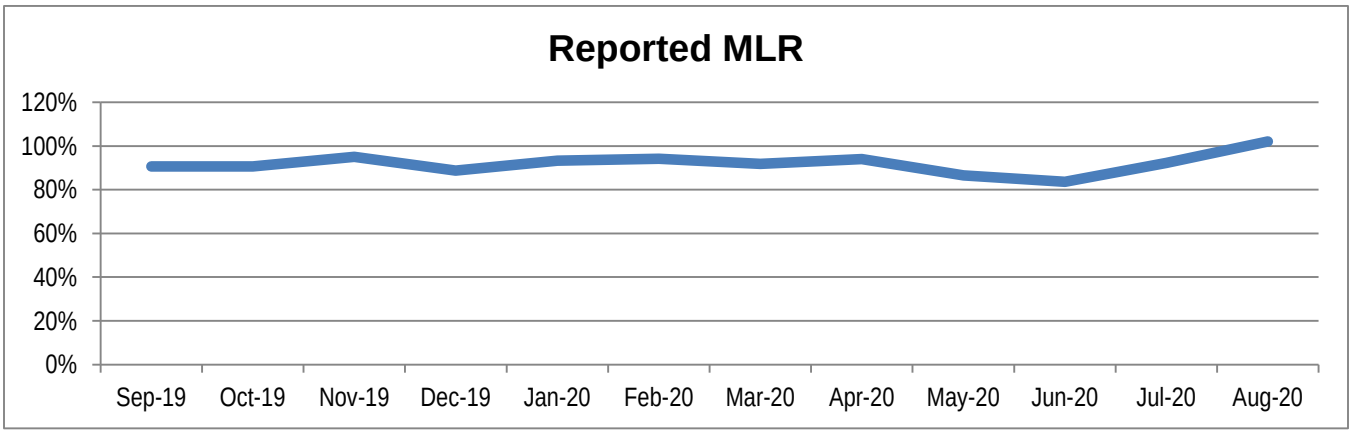
Medical Expense - Actual vs. Budget (Per Member Per Month) Adjusted to Eliminate the Impact of Prior Year IBNP Estimates						
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Excluding IBNP Change	Change in IBNP	Reported		$	%
Capitated Medical Expense	$65.54	$0.00	$65.54	$68.88	$3.35	4.9%
Primary Care FFS	15.70	0.36	16.06	4.81	(10.89)	-226.5%
Specialty Care FFS	15.45	1.01	16.47	15.11	(0.34)	-2.3%
Outpatient FFS	29.52	(1.91)	27.60	28.49	(1.03)	-3.6%
Ancillary FFS	12.73	1.73	14.46	12.19	(0.53)	-4.4%
Pharmacy FFS	51.88	0.15	52.03	50.75	(1.14)	-2.2%
ER Services FFS	13.40	0.04	13.44	12.28	(1.13)	-9.2%
Inpatient Hospital & SNF FFS	88.06	4.41	92.47	86.10	(1.96)	-2.3%
Other Benefits & Services	7.12	0.00	7.12	8.24	1.12	13.6%
Net Reinsurance	0.15	0.00	0.15	0.58	0.43	74.3%
Provider Incentive	0.32	0.00	0.32	0.32	(0.00)	-0.8%
	$299.88	$5.78	$305.66	$287.75	($12.13)	-4.2%

- Excluding the effect of prior year estimates for IBNP, year-to-date medical expense variance is $5.1 million unfavorable to budget. On a PMPM basis, medical expense is unfavorable to budget by 4.2%.
    - Primary Care Expense is over budget due to State's decision to continue Prop 56 Add-on programs which was announced after the budget was completed. There is a revenue offset for these expenses.
    - Capitated Expense is under budget primarily due to lower Transportation utilization.
    - Inpatient Expense is over budget, driven by unfavorable utilization, partially offset by favorable unit cost. SPD is substantially unfavorable driven by acute care expenses; Child is unfavorable due to unfavorable unit cost, while utilization is flat. Other COAs are favorable.
    - Other Benefits & Services is under budget, primarily due to vacancies and Leave of Absences in the Clinical Organization, lower use of temps, delay in hiring consultants, lower Care Connect utilization, lower interpreter services utilization, decrease in advanced medical reviews, and timing of member health education; partially offset by higher payouts for Health Homes driven by a higher percentage of enrollees in the Peak Tier.
    - Emergency Room Expense is higher than planned, due to higher unit costs, slightly offset by favorable utilization. SPD and Child utilization are favorable while unit costs are unfavorable; ACA OE and Adult utilization and unit cost are unfavorable.
    - Outpatient Expense is over budget:
        - Behavioral Health: unfavorable due to increases in unit cost and higher utilization.
        - Lab / Radiology: unfavorable increase in utilization, partially offset by lower than planned unit cost.

        - Dialysis Expense: unfavorable unit cost, partially offset by favorable utilization.
        - Facility-Other: favorable unit cost and utilization.
    - Pharmacy Expense is higher than budget driven by unfavorable PBM and Non-PBM expense. PBM unfavorable expense is driven by unfavorable unit cost across all COAs except for DUALs. Non-PBM unfavorable expense is driven by unfavorable utilization across all COAs, partially offset by favorable unit cost.
    - Ancillary Expense is higher than budget, primarily due to Ambulance and HHA, DME, and Other Medical Supplies, partially offset by favorable Other Medical Professional Services, Non-Emergency Transportation and CBAS Services.
    - Specialty Care is higher than budget due to unfavorable utilization, partially offset by favorable unit cost. Expense across all COAs are unfavorable except for Duals and IHSS.

Medical Loss Ratio (MLR)

- The Medical Loss Ratio (total reported medical expense divided by operating revenue) was 102.1% for the month and 97.2% for the fiscal year-to-date.



Administrative Expense

- For the month ended August 31, 2020:
    - Actual Administrative Expense: $4.9 million.
    - Budgeted Administrative Expense: $7.0 million.

- For the fiscal YTD ended August 31, 2020:
    - Actual Administrative Expense: $9.5 million.
    - Budgeted Administrative Expense: $15.9 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 %
$2,646,541	$2,614,544	($31,997)	-1.2%	Employee Expense	$5,157,816	$5,149,716	($8,099)	-0.2%
613,427	616,716	3,289	0.5%	Medical Benefits Admin Expense	1,251,930	1,234,376	(17,554)	-1.4%
715,560	1,071,000	355,440	33.2%	Purchased & Professional Services	1,276,822	2,172,151	895,329	41.2%
930,050	2,723,659	1,793,608	65.9%	Other Admin Expense	1,783,838	7,316,033	5,532,194	75.6%
$4,905,578	$7,025,919	$2,120,340	30.2%	Total Administrative Expense	$9,470,406	$15,872,276	$6,401,870	40.3%

- The year-to-date favorable variance of $6.4 million is primarily due to pausing the planned Provider Sustainability Fund payout of $5.0 million.

- The remaining favorable variance is due to:
  - Delayed timing of new project start dates in Consultants, Computer Support Services and Purchased Services.
  - Savings in Licenses and Subscription as the result of the delay in new project starts.
  - Savings in Printing / Postage Activities.

- Administrative expense represented 5.9% of net revenue for the month and 5.7% of net revenue year-to-date.

Other Income / (Expense)

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

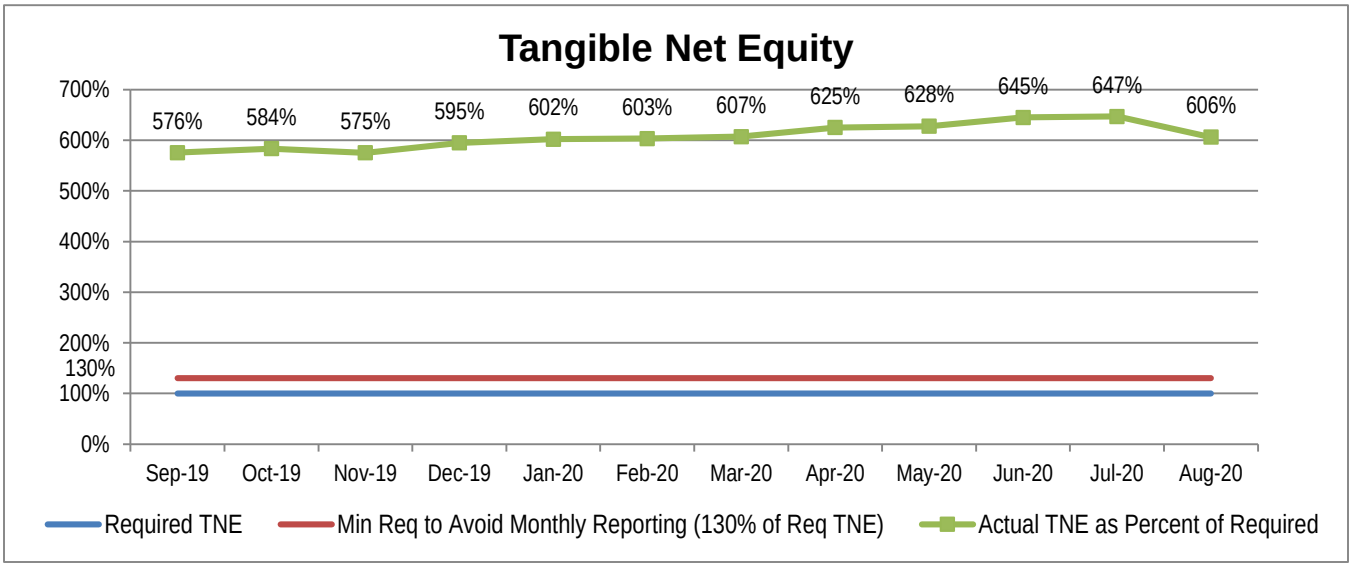
- Fiscal year-to-date interest income from investments is $145,000.

- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims or recalculated interest on previously paid claims is $62,000.

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.

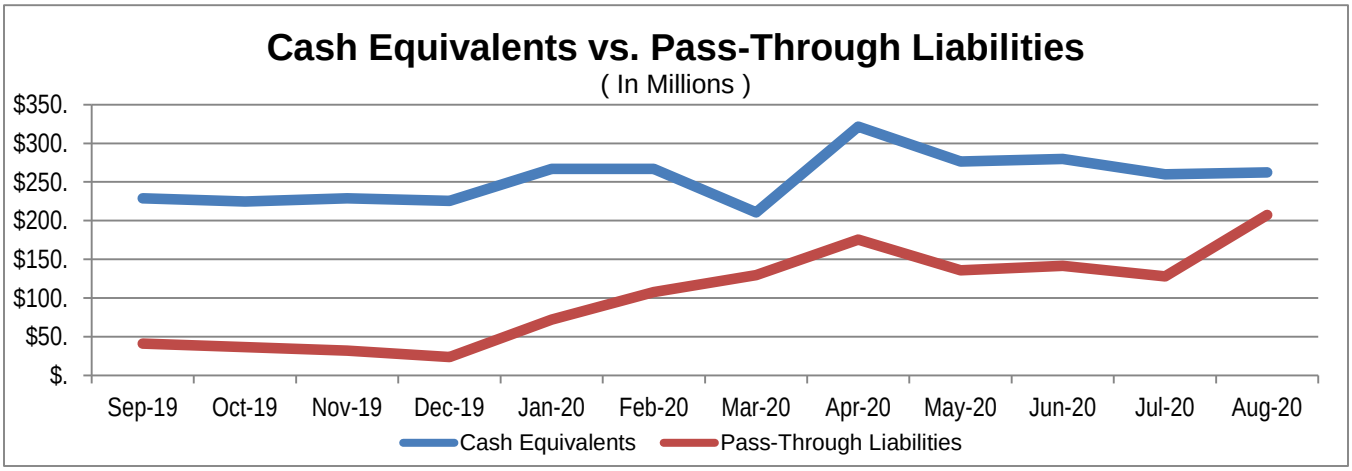
  - Required TNE $33.2 million
  - Actual TNE $201.4 million
  - Excess TNE $168.2 million
  - TNE as % of Required TNE 606%



- 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 result from the ACA OE MLR being less than 85% for the prior fiscal years.

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

- Key Metrics
    - o Cash & Cash Equivalents $262.3 million
    - o Pass-Through Liabilities $207.2 million
    - o Uncommitted Cash $55.1 million
    - o Working Capital $191.1 million
    - o Current Ratio 1.59 (regulatory minimum is 1.0)



Capital Investment

- Fiscal year-to-date Capital assets acquired: $324,000.

- 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 August 31, 2020

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				MEMBERSHIP				
258,051	259,966	(1,915)	(0.7%)	1 - Medi-Cal	511,860	515,652	(3,792)	(0.7%)
6,007	6,397	(390)	(6.1%)	2 - Group Care	12,116	12,731	(615)	(4.8%)
264,058	**266,363**	**(2,305)**	**(0.9%)**	**3 - Total Member Months**	**523,976**	**528,383**	**(4,407)**	**(0.8%)**
				REVENUE				
$82,870,019	**$80,228,092**	**$2,641,927**	**3.3%**	**4 - TOTAL REVENUE**	**$164,728,168**	**$159,424,354**	**$5,303,814**	**3.3%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses:				
17,292,413	18,338,207	1,045,794	5.7%	5 - Capitated Medical Expense	34,339,901	36,397,246	2,057,345	5.7%
				Fee for Service Medical Expenses:				
26,308,225	22,868,538	(3,439,687)	(15.0%)	6 - Inpatient Hospital & SNF FFS Expense	48,450,566	45,492,775	(2,957,791)	(6.5%)
4,376,504	1,278,413	(3,098,091)	(242.3%)	7 - Primary Care Physician FFS Expense	8,416,130	2,540,662	(5,875,468)	(231.3%)
4,715,635	4,017,253	(698,382)	(17.4%)	8 - Specialty Care Physician Expense	8,627,609	7,985,320	(642,289)	(8.0%)
4,427,080	3,233,902	(1,193,178)	(36.9%)	9 - Ancillary Medical Expense	7,575,290	6,443,086	(1,132,204)	(17.6%)
8,356,831	7,560,183	(796,648)	(10.5%)	10 - Outpatient Medical Expense	14,463,333	15,051,875	588,542	3.9%
3,832,026	3,261,232	(570,794)	(17.5%)	11 - Emergency Expense	7,044,021	6,486,361	(557,660)	(8.6%)
13,378,532	13,491,580	113,048	0.8%	12 - Pharmacy Expense	27,264,339	26,814,937	(449,402)	(1.7%)
65,394,834	55,711,101	(9,683,733)	(17.4%)	13 - Total Fee for Service Expense	121,841,288	110,815,016	(11,026,272)	(10.0%)
1,894,100	2,164,003	269,903	12.5%	14 - Other Benefits & Services	3,732,377	4,354,796	622,419	14.3%
(26,914)	154,366	181,280	117.4%	15 - Reinsurance Expense	78,376	307,027	228,651	74.5%
83,333	83,333	0	0.0%	16 - Risk Pool Distribution	166,666	166,665	(1)	0.0%
84,637,766	**76,451,010**	**(8,186,757)**	**(10.7%)**	**17 - TOTAL MEDICAL EXPENSES**	**160,158,608**	**152,040,750**	**(8,117,858)**	**(5.3%)**
(1,767,747)	**3,777,082**	**(5,544,830)**	**(146.8%)**	**18 - GROSS MARGIN**	**4,569,560**	**7,383,604**	**(2,814,044)**	**(38.1%)**
				ADMINISTRATIVE EXPENSES				
2,646,539	2,614,545	(31,995)	(1.2%)	19 - Personnel Expense	5,157,818	5,149,715	(8,103)	(0.2%)
613,426	616,716	3,289	0.5%	20 - Benefits Administration Expense	1,251,930	1,234,376	(17,554)	(1.4%)
715,560	1,070,999	355,440	33.2%	21 - Purchased & Professional Services	1,276,822	2,172,151	895,329	41.2%
930,049	2,723,658	1,793,609	65.9%	22 - Other Administrative Expense	1,783,837	7,316,034	5,532,197	75.6%
4,905,575	**7,025,918**	**2,120,343**	**30.2%**	**23 -Total Administrative Expense**	**9,470,407**	**15,872,276**	**6,401,870**	**40.3%**
(6,673,322)	**(3,248,835)**	**(3,424,487)**	**(105.4%)**	**24 - NET OPERATING INCOME / (LOSS)**	**(4,900,846)**	**(8,488,672)**	**3,587,826**	**42.3%**
				OTHER INCOME / EXPENSE				
26,227	**131,667**	**(105,440)**	**(80.1%)**	**25 - Total Other Income / (Expense)**	**116,176**	**263,335**	**(147,159)**	**(55.9%)**
($6,647,096)	**($3,117,168)**	**($3,529,927)**	**(113.2%)**	**26 - NET INCOME / (LOSS)**	**($4,784,670)**	**($8,225,337)**	**$3,440,667**	**41.8%**
5.9%	8.8%	2.8%	32.4%	27 - Admin Exp % of Revenue	5.7%	10.0%	4.2%	42.3%

ALAMEDA ALLIANCE FOR HEALTH
SUMMARY BALANCE SHEET 2021
CURRENT MONTH VS. PRIOR MONTH
August 31, 2020

	August	July	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	$23,136,277	$10,996,576	$12,139,702	110.40%
Short-Term Investments	239,115,759	249,081,762	(9,966,003)	-4.00%
Interest Receivable	1,963	1,875	89	4.73%
Other Receivables - Net	247,074,068	169,605,024	77,469,043	45.68%
Prepaid Expenses	4,544,197	5,356,134	(811,937)	-15.16%
Prepaid Inventoried Items	4,484	4,767	(283)	-5.94%
CalPERS Net Pension Asset	(832,801)	(832,801)	0	0.00%
Deferred CalPERS Outflow	4,303,523	4,303,523	0	0.00%
TOTAL CURRENT ASSETS	**517,347,471**	**438,516,859**	**78,830,611**	**17.98%**
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	9,713,866	9,713,866	0	0.00%
Furniture And Equipment	15,086,033	14,921,631	164,402	1.10%
Leasehold Improvement	924,350	924,350	0	0.00%
Internally-Developed Software	16,824,002	16,824,002	0	0.00%
Fixed Assets at Cost	42,548,250	42,383,849	164,402	0.39%
Less: Accumulated Depreciation	(32,598,537)	(32,405,690)	(192,847)	0.60%
NET PROPERTY AND EQUIPMENT	**9,949,713**	**9,978,158**	**(28,445)**	**-0.29%**
TOTAL ASSETS	**$527,647,184**	**$448,845,018**	**$78,802,166**	**17.56%**
CURRENT LIABILITIES:				
Accounts Payable	$2,510,064	$2,359,554	$150,510	6.38%
Pass-Through Liabilities	207,188,900	127,690,217	79,498,683	62.26%
Claims Payable	15,720,315	15,655,154	65,162	0.42%
IBNP Reserves	80,023,728	69,319,283	10,704,445	15.44%
Payroll Liabilities	3,713,702	3,500,236	213,465	6.10%
CalPERS Deferred Inflow	1,627,670	1,627,670	0	0.00%
Risk Sharing	3,816,518	3,604,521	211,996	5.88%
Provider Grants/ New Health Program	11,656,143	17,051,143	(5,395,000)	-31.64%
TOTAL CURRENT LIABILITIES	**326,257,039**	**240,807,777**	**85,449,262**	**35.48%**
TOTAL LIABILITIES	**326,257,039**	**240,807,777**	**85,449,262**	**35.48%**
NET WORTH:				
Contributed Capital	840,233	840,233	0	0.00%
Restricted & Unrestricted Funds	205,334,582	205,334,582	0	0.00%
Year-to Date Net Income / (Loss)	(4,784,670)	1,862,425	(6,647,096)	-356.91%
TOTAL NET WORTH	**201,390,145**	**208,037,240**	**(6,647,096)**	**-3.20%**
TOTAL LIABILITIES AND NET WORTH	**$527,647,184**	**$448,845,018**	**$78,802,166**	**17.56%**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 8/31/2020

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$2,038,727	$6,316,877	$12,636,614	$4,117,112
Total	2,038,727	6,316,877	12,636,614	4,117,112
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	80,363,927	238,889,175	469,831,486	159,733,168
Allowance for Doubtful Accounts	0	0	0	0
Deferred Premium Revenue	0	0	0	0
Premium Receivable	(77,047,414)	(94,118,037)	(104,908,753)	(85,667,880)
Total	3,316,513	144,771,138	364,922,733	74,065,288
Investment & Other Income Cash Flows				
Other Revenue (Grants)	466,917	1,572,338	3,138,519	876,708
Interest Income	49,205	251,763	1,213,814	179,037
Interest Receivable	(89)	9,307	53,801	(681)
Total	516,033	1,833,408	4,406,134	1,055,064
Medical & Hospital Cash Flows				
Total Medical Expenses	(84,637,766)	(228,861,792)	(445,702,542)	(160,158,608)
Other Receivable	(421,630)	(720,590)	(73,973)	(526,624)
Claims Payable	65,162	(3,111,604)	944,576	1,115,715
IBNP Payable	10,704,445	5,549,422	(13,023,923)	5,932,353
Risk Share Payable	211,996	(610,211)	1,139,416	(2,335,099)
Health Program	(5,395,000)	11,063,320	10,994,570	2,805,000
Other Liabilities	1	1	0	0
Total	(79,472,792)	(216,691,454)	(445,721,876)	(153,167,263)
Administrative Cash Flows				
Total Administrative Expenses	(4,928,105)	(17,926,616)	(36,360,671)	(9,532,087)
Prepaid Expenses	812,220	142,887	(382,018)	404,627
CalPERS Pension Asset	0	940,521	940,521	0
CalPERS Deferred Outflow	0	196,627	196,627	0
Trade Accounts Payable	150,510	(4,733,478)	(4,680,089)	(364,917)
Other Accrued Liabilities	0	0	0	0
Payroll Liabilities	213,465	(475,319)	(303,926)	223,145
Depreciation Expense	192,847	582,265	1,147,340	386,519
Total	(3,559,063)	(21,273,113)	(39,442,216)	(8,882,713)
Interest Paid				
Debt Interest Expense	0	0	0	0
Total Cash Flows from Operating Activities	**(77,160,582)**	**(85,043,144)**	**(103,198,611)**	**(82,812,512)**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 8/31/2020

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Restricted Cash & Other Asset Cash Flows				
Provider Pass-Thru-Liabilities	79,498,683	71,572,761	99,685,710	65,713,756
Restricted Cash	0	0	238	0
	79,498,683	71,572,761	99,685,948	65,713,756
Fixed Asset Cash Flows				
Depreciation expense	192,847	582,265	1,147,340	386,519
Fixed Asset Acquisitions	(164,402)	(534,948)	(1,221,823)	(324,294)
Change in A/D	(192,847)	(582,265)	(1,147,340)	(386,519)
	(164,402)	(534,948)	(1,221,823)	(324,294)
Total Cash Flows from Investing Activities	**79,334,281**	**71,037,813**	**98,464,125**	**65,389,462**
Financing Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Total Cash Flows	**2,173,699**	**(14,005,331)**	**(4,734,486)**	**(17,423,050)**
Rounding	0	1	(2)	1
Cash @ Beginning of Period	260,078,337	276,257,366	266,986,524	279,675,085
Cash @ End of Period	**$262,252,036**	**$262,252,036**	**$262,252,036**	**$262,252,036**
Difference (rounding)	0	0	0	0

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 8/31/2020

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	($6,647,096)	$241,745	$4,757,219	($4,784,671)
Add back: Depreciation	192,847	582,265	1,147,340	386,519
Receivables				
Premiums Receivable	(77,047,414)	(94,118,037)	(104,908,753)	(85,667,880)
First Care Receivable	0	0	0	0
Family Care Receivable	0	0	0	0
Healthy Kids Receivable	0	0	0	0
Interest Receivable	(89)	9,307	53,801	(681)
Other Receivable	(421,630)	(720,590)	(73,973)	(526,624)
FQHC Receivable	0	0	0	0
Allowance for Doubtful Accounts	0	0	0	0
Total	(77,469,133)	(94,829,320)	(104,928,925)	(86,195,185)
Prepaid Expenses	812,220	1,280,035	755,130	404,627
Trade Payables	150,510	(4,733,478)	(4,680,089)	(364,917)
Claims Payable, IBNR & Risk Share				
IBNP	10,704,445	5,549,422	(13,023,923)	5,932,353
Claims Payable	65,162	(3,111,604)	944,576	1,115,715
Risk Share Payable	211,996	(610,211)	1,139,416	(2,335,099)
Other Liabilities	1	1	0	0
Total	10,981,604	1,827,608	(10,939,931)	4,712,969
Unearned Revenue				
Total	0	0	0	0
Other Liabilities				
Accrued Expenses	0	0	0	0
Payroll Liabilities	213,465	(475,319)	(303,926)	223,145
Health Program	(5,395,000)	11,063,320	10,994,570	2,805,000
Accrued Sub Debt Interest	0	0	0	0
Total Change in Other Liabilities	(5,181,535)	10,588,001	10,690,644	3,028,145
Cash Flows from Operating Activities	**($77,160,583)**	**($85,043,144)**	**($103,198,612)**	**($82,812,513)**
Difference (rounding)	(1)	0	(1)	(1)

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 8/31/2020

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received From:				
Capitation Received from State of CA	$3,316,513	$144,771,138	$364,922,733	$74,065,288
Commercial Premium Revenue	2,038,727	6,316,877	12,636,614	4,117,112
Other Income	466,917	1,572,338	3,138,519	876,708
Investment Income	49,116	261,070	1,267,615	178,356
Cash Paid To:				
Medical Expenses	(79,472,792)	(216,691,454)	(445,721,876)	(153,167,263)
Vendor & Employee Expenses	(3,559,063)	(21,273,113)	(39,442,216)	(8,882,713)
Interest Paid	0	0	0	0
Net Cash Provided By (Used In) Operating Activities	(77,160,582)	(85,043,144)	(103,198,611)	(82,812,512)
Cash Flows from Financing Activities:				
Purchases of Fixed Assets	(164,402)	(534,948)	(1,221,823)	(324,294)
Net Cash Provided By (Used In) Financing Activities	(164,402)	(534,948)	(1,221,823)	(324,294)
Cash Flows from Investing Activities:				
Changes in Investments	0	0	0	0
Restricted Cash	79,498,683	71,572,761	99,685,948	65,713,756
Net Cash Provided By (Used In) Investing Activities	79,498,683	71,572,761	99,685,948	65,713,756
Financial Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Net Change in Cash	**2,173,699**	**(14,005,331)**	**(4,734,486)**	**(17,423,050)**
Cash @ Beginning of Period	260,078,337	276,257,366	266,986,524	279,675,085
Subtotal	$262,252,036	$262,252,035	$262,252,038	$262,252,035
Rounding	0	1	(2)	1
Cash @ End of Period	**$262,252,036**	**$262,252,036**	**$262,252,036**	**$262,252,036**
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	($6,647,096)	$241,745	$4,757,219	($4,784,671)
Depreciation	192,847	582,265	1,147,340	386,519
Net Change in Operating Assets & Liabilities:				
Premium & Other Receivables	(77,469,133)	(94,829,320)	(104,928,925)	(86,195,185)
Prepaid Expenses	812,220	1,280,035	755,130	404,627
Trade Payables	150,510	(4,733,478)	(4,680,089)	(364,917)
Claims payable & IBNP	10,981,604	1,827,608	(10,939,931)	4,712,969
Deferred Revenue	0	0	0	0
Accrued Interest	0	0	0	0
Other Liabilities	(5,181,535)	10,588,001	10,690,644	3,028,145
Subtotal	(77,160,583)	(85,043,144)	(103,198,612)	(82,812,513)
Rounding	1	0	1	1
Cash Flows from Operating Activities	**($77,160,582)**	**($85,043,144)**	**($103,198,611)**	**($82,812,512)**
Rounding Difference	1	0	1	1

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF AUGUST 2020

	Medi-Cal							
	Child	Adult*	SPD*	ACA OE	Duals	Medi-Cal Total	Group Care	Grand Total
Enrollment	92,692	35,676	26,107	85,081	18,495	258,051	6,007	264,058
Net Revenue	$10,919,208	$10,997,059	$25,256,589	$30,587,776	$3,070,661	$80,831,292	$2,038,727	$82,870,019
Medical Expense	$9,033,066	$11,180,649	$28,608,052	$30,608,158	$2,936,049	$82,365,924	$2,271,843	$84,637,766
Gross Margin	$1,886,141	($183,590)	($3,351,463)	($20,382)	$134,612	($1,534,631)	($233,116)	($1,767,748)
Administrative Expense	$393,610	$650,190	$1,677,279	$1,855,920	$159,979	$4,736,978	$168,597	$4,905,575
Operating Income / (Expense)	$1,492,531	($833,779)	($5,028,742)	($1,876,303)	($25,368)	($6,271,610)	($401,713)	($6,673,323)
Other Income / (Expense)	$3,162	$1,519	$12,297	$8,728	($119)	$25,587	$640	$26,227
Net Income / (Loss)	$1,495,694	($832,261)	($5,016,445)	($1,867,575)	($25,486)	($6,246,023)	($401,073)	($6,647,095)
Revenue PMPM	$117.80	$308.25	$967.43	$359.51	$166.03	$313.24	$339.39	$313.83
Medical Expense PMPM	$97.45	$313.39	$1,095.80	$359.75	$158.75	$319.18	$378.20	$320.53
Gross Margin PMPM	$20.35	($5.15)	($128.37)	($0.24)	$7.28	($5.95)	($38.81)	($6.69)
Administrative Expense PMPM	$4.25	$18.22	$64.25	$21.81	$8.65	$18.36	$28.07	$18.58
Operating Income / (Expense) PMPM	$16.10	($23.37)	($192.62)	($22.05)	($1.37)	($24.30)	($66.87)	($25.27)
Other Income / (Expense) PMPM	$0.03	$0.04	$0.47	$0.10	($0.01)	$0.10	$0.11	$0.10
Net Income / (Loss) PMPM	$16.14	($23.33)	($192.15)	($21.95)	($1.38)	($24.20)	($66.77)	($25.17)
Medical Loss Ratio	82.7%	101.7%	113.3%	100.1%	95.6%	101.9%	111.4%	102.1%
Gross Margin Ratio	17.3%	-1.7%	-13.3%	-0.1%	4.4%	-1.9%	-11.4%	-2.1%
Administrative Expense Ratio	3.6%	5.9%	6.6%	6.1%	5.2%	5.9%	8.3%	5.9%
Net Income Ratio	13.7%	-7.6%	-19.9%	-6.1%	-0.8%	-7.7%	-19.7%	-8.0%

*NOTE: Effective July 2020 BCCTP moved from ADULTS to SPD COA

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

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

	Medi-Cal					Medi-Cal	Group	Grand
	Child	Adult*	SPD*	ACA OE	Duals	Total	Care	Total
Member Months	184,262	70,572	52,164	168,070	36,792	511,860	12,116	523,976
Net Revenue	$21,781,979	$21,635,338	$50,567,131	$60,537,197	$6,089,411	$160,611,056	$4,117,112	$164,728,168
Medical Expense	$17,204,934	$20,124,502	$54,770,864	$57,772,071	$5,450,289	$155,322,609	$4,835,999	$160,158,608
Gross Margin	$4,577,045	$1,510,836	($4,203,733)	$2,765,126	$639,122	$5,288,447	($718,886)	$4,569,561
Administrative Expense	$746,882	$1,255,341	$3,261,360	$3,560,545	$295,535	$9,119,663	$350,744	$9,470,407
Operating Income / (Expense)	$3,830,163	$255,495	($7,465,093)	($795,419)	$343,587	($3,831,216)	($1,069,630)	($4,900,847)
Other Income / (Expense)	$10,824	$16,209	$48,680	$44,249	($5,809)	$114,154	$2,022	$116,176
Net Income / (Loss)	$3,840,987	$271,704	($7,416,412)	($751,170)	$337,778	($3,717,062)	($1,067,608)	($4,784,670)
Revenue PMPM	$118.21	$306.57	$969.39	$360.19	$165.51	$313.78	$339.81	$314.38
Medical Expense PMPM	$93.37	$285.16	$1,049.97	$343.74	$148.14	$303.45	$399.14	$305.66
Gross Margin PMPM	$24.84	$21.41	($80.59)	$16.45	$17.37	$10.33	($59.33)	$8.72
Administrative Expense PMPM	$4.05	$17.79	$62.52	$21.18	$8.03	$17.82	$28.95	$18.07
Operating Income / (Expense) PMPM	$20.79	$3.62	($143.11)	($4.73)	$9.34	($7.48)	($88.28)	($9.35)
Other Income / (Expense) PMPM	$0.06	$0.23	$0.93	$0.26	($0.16)	$0.22	$0.17	$0.22
Net Income / (Loss) PMPM	$20.85	$3.85	($142.17)	($4.47)	$9.18	($7.26)	($88.12)	($9.13)
Medical Loss Ratio	79.0%	93.0%	108.3%	95.4%	89.5%	96.7%	117.5%	97.2%
Gross Margin Ratio	21.0%	7.0%	-8.3%	4.6%	10.5%	3.3%	-17.5%	2.8%
Administrative Expense Ratio	3.4%	5.8%	6.4%	5.9%	4.9%	5.7%	8.5%	5.7%
Net Income Ratio	17.6%	1.3%	-14.7%	-1.2%	5.5%	-2.3%	-25.9%	-2.9%

***NOTE: Effective July 2020 BCCTP moved from ADULTS to SPD COA**

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSE SUMMARY				
$2,646,539	$2,614,545	($31,995)	(1.2%)	Personnel Expenses	$5,157,818	$5,149,715	($8,103)	(0.2%)
613,426	616,716	3,289	0.5%	Benefits Administration Expense	1,251,930	1,234,376	(17,554)	(1.4%)
715,560	1,070,999	355,440	33.2%	Purchased & Professional Services	1,276,822	2,172,151	895,329	41.2%
381,962	385,214	3,251	0.8%	Occupancy	760,140	855,023	94,883	11.1%
115,543	1,791,988	1,676,445	93.6%	Printing Postage & Promotion	160,384	5,355,958	5,195,574	97.0%
425,435	527,409	101,973	19.3%	Licenses Insurance & Fees	848,188	1,063,472	215,284	20.2%
7,108	19,048	11,939	62.7%	Supplies & Other Expenses	15,125	41,581	26,457	63.6%
2,259,036	4,411,373	2,152,337	48.8%	Total Other Administrative Expense	4,312,589	10,722,561	6,409,972	59.8%
$4,905,575	**$7,025,918**	**$2,120,343**	**30.2%**	**Total Administrative Expenses**	**$9,470,407**	**$15,872,276**	**$6,401,870**	**40.3%**

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
$1,756,145	$1,642,639	($113,506)	(6.9%)	Salaries & Wages	$3,421,540	$3,222,008	($199,532)	(6.2%)
215,156	171,697	(43,459)	(25.3%)	Paid Time Off	371,390	334,628	(36,761)	(11.0%)
0	0	0	0.0%	Incentives	466	0	(466)	0.0%
7,605	0	(7,605)	0.0%	Severance Pay	7,605	0	(7,605)	0.0%
27,518	51,101	23,583	46.2%	Payroll Taxes	54,550	126,263	71,712	56.8%
11,907	8,300	(3,607)	(43.5%)	Overtime	36,160	16,602	(19,558)	(117.8%)
137,692	138,633	942	0.7%	CalPERS ER Match	272,372	271,763	(609)	(0.2%)
2,290	0	(2,290)	0.0%	Sick Leave Pay	4,633	0	(4,633)	0.0%
422,537	497,016	74,479	15.0%	Employee Benefits	838,814	955,793	116,978	12.2%
125	0	(125)	0.0%	Personal Floating Holiday	99	0	(99)	0.0%
1,312	9,943	8,631	86.8%	Employee Relations	1,431	23,335	21,904	93.9%
25	3,903	3,878	99.4%	Transportation Reimbursement	54	7,607	7,553	99.3%
(615)	8,212	8,827	107.5%	Travel & Lodging	(615)	19,370	19,984	103.2%
25,563	28,200	2,637	9.4%	Temporary Help Services	61,083	62,640	1,557	2.5%
4,040	42,602	38,563	90.5%	Staff Development/Training	12,616	85,111	72,495	85.2%
35,241	12,298	(22,943)	(186.6%)	Staff Recruitment/Advertising	75,618	24,596	(51,022)	(207.4%)
2,646,539	**2,614,545**	**(31,995)**	**(1.2%)**	**Total Employee Expenses**	**5,157,818**	**5,149,715**	**(8,103)**	**(0.2%)**
				Benefit Administration Expense				
365,502	372,121	6,619	1.8%	RX Administration Expense	757,945	746,520	(11,425)	(1.5%)
231,997	227,688	(4,309)	(1.9%)	Behavioral Hlth Administration Fees	462,301	454,446	(7,855)	(1.7%)
15,928	16,907	979	5.8%	Telemedicine Admin Fees	31,684	33,410	1,727	5.2%
613,426	**616,716**	**3,289**	**0.5%**	**Total Employee Expenses**	**1,251,930**	**1,234,376**	**(17,554)**	**(1.4%)**
				Purchased & Professional Services				
144,037	188,883	44,847	23.7%	Consulting Services	263,695	544,767	281,071	51.6%
551,232	524,962	(26,271)	(5.0%)	Computer Support Services	762,734	1,033,275	270,541	26.2%
8,750	8,750	0	0.0%	Professional Fees-Accounting	17,500	17,500	0	0.0%
0	100	100	100.0%	Professional Fees-Medical	0	200	200	100.0%
23,309	84,118	60,809	72.3%	Other Purchased Services	44,333	198,036	153,703	77.6%
25,871	9,200	(16,671)	(181.2%)	Maint.& Repair-Office Equipment	29,655	18,400	(11,255)	(61.2%)
27,700	8,050	(19,650)	(244.1%)	HMS Recovery Fees	75,288	16,100	(59,188)	(367.6%)
0	150,242	150,242	100.0%	MIS Software (Non-Capital)	0	150,483	150,483	100.0%
4,080	4,000	(80)	(2.0%)	Hardware (Non-Capital)	(3,948)	8,000	11,948	149.3%
2,264	7,695	5,431	70.6%	Provider Relations-Credentialing	9,140	15,390	6,251	40.6%
(71,683)	85,000	156,683	184.3%	Legal Fees	78,425	170,000	91,575	53.9%
715,560	**1,070,999**	**355,440**	**33.2%**	**Total Purchased & Professional Services**	**1,276,822**	**2,172,151**	**895,329**	**41.2%**
				Occupancy				
166,740	158,829	(7,911)	(5.0%)	Depreciation	334,304	315,329	(18,975)	(6.0%)
26,107	47,871	21,764	45.5%	Amortization	52,215	73,978	21,764	29.4%
67,855	69,568	1,713	2.5%	Building Lease	135,710	139,136	3,426	2.5%
2,780	2,513	(267)	(10.6%)	Leased and Rented Office Equipment	5,559	5,025	(534)	(10.6%)
11,357	13,517	2,160	16.0%	Utilities	23,959	29,232	5,273	18.0%
91,240	76,900	(14,340)	(18.6%)	Telephone	181,701	153,800	(27,901)	(18.1%)
15,883	16,016	133	0.8%	Building Maintenance	26,692	138,522	111,830	80.7%

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ADMIN YTD 2021
09/30/20
REPORT #6

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
$381,962	**$385,214**	**$3,251**	**0.8%**	**Total Occupancy**	**$760,140**	**$855,023**	**$94,883**	**11.1%**
				Printing Postage & Promotion				
20,957	57,000	36,044	63.2%	Postage	28,624	94,326	65,702	69.7%
3,740	5,750	2,010	35.0%	Design & Layout	4,080	18,500	14,420	77.9%
48,767	56,250	7,483	13.3%	Printing Services	61,551	96,650	35,099	36.3%
4,419	4,530	111	2.5%	Mailing Services	4,967	9,150	4,183	45.7%
2,272	2,383	111	4.6%	Courier/Delivery Service	4,742	4,765	23	0.5%
23	392	368	94.1%	Pre-Printed Materials and Publications	17	1,200	1,183	98.6%
18,221	0	(18,221)	0.0%	Promotional Products	18,221	0	(18,221)	0.0%
0	50	50	100.0%	Promotional Services	0	100	100	100.0%
9,455	1,659,333	1,649,878	99.4%	Community Relations	25,356	5,118,667	5,093,311	99.5%
7,690	6,300	(1,390)	(22.1%)	Translation - Non-Clinical	12,826	12,600	(226)	(1.8%)
115,543	**1,791,988**	**1,676,445**	**93.6%**	**Total Printing Postage & Promotion**	**160,384**	**5,355,958**	**5,195,574**	**97.0%**
				Licenses Insurance & Fees				
18,468	19,100	632	3.3%	Bank Fees	37,503	38,200	697	1.8%
53,007	48,446	(4,561)	(9.4%)	Insurance	106,014	100,546	(5,468)	(5.4%)
293,241	389,916	96,675	24.8%	Licenses, Permits and Fees	589,847	779,261	189,413	24.3%
60,719	69,947	9,228	13.2%	Subscriptions & Dues	114,825	145,465	30,640	21.1%
425,435	**527,409**	**101,973**	**19.3%**	**Total Licenses Insurance & Postage**	**848,188**	**1,063,472**	**215,284**	**20.2%**
				Supplies & Other Expenses				
3,188	5,187	1,998	38.5%	Office and Other Supplies	3,938	13,440	9,502	70.7%
1,495	2,695	1,200	44.5%	Ergonomic Supplies	1,648	5,390	3,742	69.4%
354	7,666	7,312	95.4%	Commissary-Food & Beverage	1,433	15,751	14,318	90.9%
0	3,500	3,500	100.0%	Member Incentive Expense	4,850	7,000	2,150	30.7%
0	0	0	0.0%	Covid-19 IT Expenses	888	0	(888)	0.0%
2,072	0	(2,072)	0.0%	Covid-19 Non IT Expenses	2,368	0	(2,368)	0.0%
7,108	**19,048**	**11,939**	**62.7%**	**Total Supplies & Other Expense**	**15,125**	**41,581**	**26,457**	**63.6%**
$4,905,575	**$7,025,918**	**$2,120,343**	**30.2%**	**TOTAL ADMINISTRATIVE EXPENSE**	**$9,470,407**	**$15,872,276**	**$6,401,870**	**40.3%**

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ADMIN YTD 2021
09/30/20
REPORT #6

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

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Computer Equipment (Laptop, Desktop, Tablets)	IT-FY21-01	$ -	$ 163,787	**$ 163,787**	$ 300,000	$ 136,213
	Display Monitors	IT-FY21-02	$ 30,302		**$ 30,302**	$ 40,000	$ 9,698
	Cisco Phones (Desk phone, Conference phone)	IT-FY21-03	$ -		**$ -**	$ 30,000	$ 30,000
	Audio / Video Equipment	IT-FY21-04	$ -		**$ -**	$ 60,000	$ 60,000
	APC UPS Batteries	IT-FY21-05	$ -		**$ -**	$ 20,000	$ 20,000
	IT Cage Supplies and Tools	IT-FY21-06	$ -		**$ -**	$ 10,000	$ 10,000
	Cisco Network Hardware (Switches, Routers, Firewalls, Wireless)	IT-FY21-07	$ -		**$ -**	$ 350,000	$ 350,000
	Cisco UCS Blade RAM	IT-FY21-08	$ -		**$ -**	$ 140,000	$ 140,000
	Pure Storage Shelf	IT-FY21-09	$ -		**$ -**	$ 250,000	$ 250,000
	Security Hardware	IT-FY21-10	$ -		**$ -**	$ 80,000	$ 80,000
	Call Center Hardware	IT-FY21-11	$ -		**$ -**	$ 40,000	$ 40,000
	Computer Components (Memory, Hard drives)	IT-FY21-16	$ -		**$ -**	$ 15,000	$ 15,000
	Computer Periferals (Keyboards, Mouse, Speakers, Docks ,Headsets)	IT-FY21-17	$ -		**$ -**	$ 30,000	$ 30,000
	Network / AV Cabling	IT-FY21-18	$ -		**$ -**	$ 250,000	$ 250,000
	Carryover from FY20 / unplanned	IT-FY21-19	$ 112,974	$ (1,106)	**$ 111,868**	$ -	$ (111,868)
Hardware Subtotal			**$ 143,276**	**$ 162,681**	**$ 305,957**	**$ 1,615,000**	**$ 1,309,043**
2. Software:							
	Security Software (SIEM Tool)	AC-FY21-01	$ -		**$ -**	$ -	$ -
	Monitoring Software	AC-FY21-02	$ -		**$ -**	$ 60,000	$ 60,000
	Windows Server OS (3rd payment)	AC-FY21-03	$ -		**$ -**	$ 80,000	$ 80,000
	Carryover from FY20 / unplanned	AC-FY21-05	$ 16,616		**$ 16,616**	$ -	$ (16,616)
Software Subtotal			**$ 16,616**	**$ -**	**$ 16,616**	**$ 140,000**	**$ 123,384**
3. Building Improvement:							
	Appliances over 1k new/replacement (all buildings/suites)	FA-FY21-01	$ -		**$ -**	$ 5,000	$ 5,000
	ACME Security: Readers, HID boxes, Cameras, Doors (planned/unplanned Maintenance repairs)	FA-FY21-02	$ -		**$ -**	$ 50,000	$ 50,000
	Seismic Improvements (Carryover from FY20)	FA-FY21-03	$ -		**$ -**	$ 150,000	$ 150,000
	HVAC: Replace VAV boxes, duct work, replace old equipment	FA-FY21-04	$ -		**$ -**	$ 65,000	$ 65,000
	Electrical work for projects, workstations requirement	FA-FY21-05	$ -		**$ -**	$ 20,000	$ 20,000
	Construction work for various projects	FA-FY21-06	$ -		**$ -**	$ 20,000	$ 20,000
Building Improvement Subtotal			**$ -**	**$ -**	**$ -**	**$ 310,000**	**$ 310,000**

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
4. Furniture & Equipment:							
	Office desks, cabinets, shelvings (all building/suites: new or replacement)	FA-FY21-19	$ -	$ 1,721	**$ 1,721**	$ 100,000	$ 98,279
	Ergonomic Equipment - Sit/Stand desks	FA-FY21-20	$ -		**$ -**	$ 40,000	$ 40,000
	Task Chairs: Various sizes, special order for Ergo/WC	FA-FY21-21	$ -		**$ -**	$ 50,000	$ 50,000
	Replace, reconfigure, re-design workstations	FA-FY21-22	$ -		**$ -**	$ 150,000	$ 150,000
Furniture & Equipment Subtotal			**$ -**	**$ 1,721**	**$ 1,721**	**$ 340,000**	**$ 338,279**
5. Leasehold Improvement:							
	Electrical work for projects, workstations requirement	FA-FY21-26	$ -		**$ -**	$ 50,000	$ 50,000
Leasehold Improvement Subtotal			**$ -**	**$ -**	**$ -**	**$ 50,000**	**$ 50,000**
6. Contingency:							
	Carryover from FY20 / Unplanned/ Contingency	FA-FY21-28	$ -		**$ -**	$ -	$ -
Contingency Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
GRAND TOTAL			**$ 159,892**	**$ 164,402**	**$ 324,294**	**$ 2,455,000**	**$ 2,130,706**

7. Reconciliation to Balance Sheet:

Fixed Assets @ Cost -8/31/20	**$ 42,548,250**
Fixed Assets @ Cost - 6/30/20	**$ 42,223,957**
Fixed Assets Acquired YTD	**$ 324,294**

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
SUMMARY - FISCAL YEAR 2021

TANGIBLE NET EQUITY (TNE)

	Jul-20	Aug-20
Current Month Net Income / (Loss)	$1,862,425	($6,647,096)
YTD Net Income / (Loss)	$1,862,425	($4,784,670)
Actual TNE		
Net Assets	$208,037,240	$201,390,145
Subordinated Debt & Interest	$0	$0
Total Actual TNE	**$208,037,240**	**$201,390,145**
Increase/(Decrease) in Actual TNE	$1,862,425	($6,647,095)
Required TNE[(1)]	**$32,152,830**	**$33,226,635**
Min. Req'd to Avoid Monthly Reporting (130% of Required TNE)	$41,798,679	$43,194,626
TNE Excess / (Deficiency)	$175,884,410	$168,163,510
Actual TNE as a Multiple of Required	**6.47**	**6.06**

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	$208,037,240	$201,390,145
Fixed Assets at Net Book Value	9,978,158	9,949,713
CD Pledged to DMHC	350,000	350,000
Liquid TNE (Liquid Reserves)	**$218,365,398**	**$211,689,858**
Liquid TNE as Multiple of Required	**6.79**	**6.37**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2021

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

	Actual Jul-20	Actual Aug-20	Actual Sep-20	Actual Oct-20	Actual Nov-20	Actual Dec-20	Actual Jan-21	Actual Feb-21	Actual Mar-21	Actual Apr-21	Actual May-21	Actual Jun-21	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	91,570	92,692											184,262
Adult	34,896	35,676											70,572
SPD	26,057	26,107											52,164
ACA OE	82,989	85,081											168,070
Duals	18,297	18,495											36,792
Medi-Cal Program	253,809	258,051											511,860
Group Care Program	6,109	6,007											12,116
Total	**259,918**	**264,058**											**523,976**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	825	1,122											1,947
Adult	809	780											1,589
SPD	(54)	50											(4)
ACA OE	1,693	2,092											3,785
Duals	228	198											426
Medi-Cal Program	3,501	4,242											7,743
Group Care Program	(328)	(102)											(430)
Total	**3,173**	**4,140**											**7,313**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	36.1%	35.9%											36.0%
Adult % of Medi-Cal	13.7%	13.8%											13.8%
SPD % of Medi-Cal	10.3%	10.1%											10.2%
ACA OE % of Medi-Cal	32.7%	33.0%											32.8%
Duals % of Medi-Cal	7.2%	7.2%											7.2%
Medi-Cal Program % of Total	97.6%	97.7%											97.7%
Group Care Program % of Total	2.4%	2.3%											2.3%
Total	**100.0%**	**100.0%**											**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2021

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

	Actual Jul-20	Actual Aug-20	Actual Sep-20	Actual Oct-20	Actual Nov-20	Actual Dec-20	Actual Jan-21	Actual Feb-21	Actual Mar-21	Actual Apr-21	Actual May-21	Actual Jun-21	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	50,199	51,057											101,256
Alameda Health System	50,193	51,312											101,505
	100,392	102,369											202,761
Delegated:													
CFMG	30,742	31,072											61,814
CHCN	94,144	95,194											189,338
Kaiser	34,640	35,423											70,063
Delegated Subtotal	159,526	161,689											321,215
Total	**259,918**	**264,058**											**523,976**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	1,402	1,977											3,379
Delegated:													
CFMG	317	330											647
CHCN	752	1,050											1,802
Kaiser	702	783											1,485
Delegated Subtotal	1,771	2,163											3,934
Total	**3,173**	**4,140**											**7,313**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	38.6%	38.8%											38.7%
Delegated:													
CFMG	11.8%	11.8%											11.8%
CHCN	36.2%	36.1%											36.1%
Kaiser	13.3%	13.4%											13.4%
Delegated Subtotal	61.4%	61.2%											61.3%
Total	**100.0%**	**100.0%**											**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2021

	Budget Jul-20	Budget Aug-20	Budget Sep-20	Budget Oct-20	Budget Nov-20	Budget Dec-20	Budget Jan-21	Budget Feb-21	Budget Mar-21	Budget Apr-21	Budget May-21	Budget Jun-21	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	94,058	95,939	97,858	98,837	99,825	100,823	100,319	99,817	98,819	97,831	96,853	95,884	1,176,863
Adult	34,657	35,350	36,057	36,418	36,782	37,150	36,964	36,779	36,411	36,047	35,687	35,330	433,632
SPD	25,972	25,998	26,024	26,050	26,076	26,102	26,128	26,154	26,180	26,206	26,232	26,258	313,380
ACA OE	83,087	84,749	86,444	87,308	88,181	89,063	88,618	88,175	87,293	86,420	85,556	84,700	1,039,594
Duals	17,912	17,930	17,948	17,966	17,984	18,002	18,020	18,038	18,056	18,074	18,092	18,110	216,132
Medi-Cal Program	255,686	259,966	264,331	266,579	268,848	271,140	270,049	268,963	266,759	264,578	262,420	260,282	3,179,601
Group Care Program	6,334	6,397	6,461	6,493	6,525	6,558	6,565	6,572	6,579	6,586	6,593	6,600	78,263
Total	**262,020**	**266,363**	**270,792**	**273,072**	**275,373**	**277,698**	**276,614**	**275,535**	**273,338**	**271,164**	**269,013**	**266,882**	**3,257,864**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(1,826)	1,881	1,919	979	988	998	(504)	(502)	(998)	(988)	(978)	(969)	0
Adult	(26,931)	693	707	361	364	368	(186)	(185)	(368)	(364)	(360)	(357)	(26,258)
SPD	25,972	26	26	26	26	26	26	26	26	26	26	26	26,258
ACA OE	83,087	1,662	1,695	864	873	882	(445)	(443)	(882)	(873)	(864)	(856)	84,700
Duals	(198)	18	18	18	18	18	18	18	18	18	18	18	0
Medi-Cal Program	80,104	4,280	4,365	2,248	2,269	2,292	(1,091)	(1,086)	(2,204)	(2,181)	(2,158)	(2,138)	84,700
Group Care Program	(29,021)	63	64	32	32	33	7	7	7	7	7	7	(28,755)
Total	**51,083**	**4,343**	**4,429**	**2,280**	**2,301**	**2,325**	**(1,084)**	**(1,079)**	**(2,197)**	**(2,174)**	**(2,151)**	**(2,131)**	**55,945**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	36.8%	36.9%	37.0%	37.1%	37.1%	37.2%	37.1%	37.1%	37.0%	37.0%	36.9%	36.8%	37.0%
Adult % of Medi-Cal	13.6%	13.6%	13.6%	13.7%	13.7%	13.7%	13.7%	13.7%	13.6%	13.6%	13.6%	13.6%	13.6%
SPD % of Medi-Cal	10.2%	10.0%	9.8%	9.8%	9.7%	9.6%	9.7%	9.7%	9.8%	9.9%	10.0%	10.1%	9.9%
ACA OE % of Medi-Cal	32.5%	32.6%	32.7%	32.8%	32.8%	32.8%	32.8%	32.8%	32.7%	32.7%	32.6%	32.5%	32.7%
Duals % of Medi-Cal	7.0%	6.9%	6.8%	6.7%	6.7%	6.6%	6.7%	6.7%	6.8%	6.8%	6.9%	7.0%	6.8%
Medi-Cal Program % of Total	97.6%	97.6%	97.6%	97.6%	97.6%	97.6%	97.6%	97.6%	97.6%	97.6%	97.5%	97.5%	97.6%
Group Care Program % of Total	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	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%**	**100.0%**	**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2021

	Budget Jul-20	Budget Aug-20	Budget Sep-20	Budget Oct-20	Budget Nov-20	Budget Dec-20	Budget Jan-21	Budget Feb-21	Budget Mar-21	Budget Apr-21	Budget May-21	Budget Jun-21	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted	99,847	101,395	102,975	103,790	104,613	105,445	105,072	104,700	103,934	103,177	102,428	101,686	1,239,062
Delegated:													
CFMG	31,364	31,969	32,586	32,901	33,219	33,541	33,380	33,220	32,901	32,585	32,273	31,963	391,902
CHCN	96,094	97,666	99,270	100,095	100,929	101,771	101,381	100,994	100,202	99,420	98,645	97,878	1,194,345
Kaiser	34,715	35,332	35,962	36,286	36,612	36,941	36,781	36,621	36,300	35,982	35,667	35,355	432,554
Delegated Subtotal	162,173	164,968	167,817	169,282	170,760	172,253	171,542	170,835	169,404	167,987	166,585	165,196	2,018,802
Total	**262,020**	**266,363**	**270,792**	**273,072**	**275,373**	**277,698**	**276,614**	**275,535**	**273,338**	**271,164**	**269,013**	**266,882**	**3,257,864**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(167,035)	1,549	1,579	816	823	832	(374)	(372)	(765)	(757)	(749)	(742)	(165,196)
Delegated:													
CFMG	31,364	605	617	315	318	321	(161)	(160)	(319)	(316)	(313)	(310)	31,963
CHCN	96,094	1,572	1,603	826	833	842	(390)	(388)	(791)	(783)	(775)	(767)	97,878
Kaiser	34,715	618	630	323	326	330	(160)	(160)	(322)	(318)	(315)	(312)	35,355
Delegated Subtotal	162,173	2,794	2,850	1,464	1,478	1,493	(710)	(707)	(1,432)	(1,417)	(1,402)	(1,389)	165,196
Total	**(4,862)**	**4,343**	**4,429**	**2,280**	**2,301**	**2,325**	**(1,084)**	**(1,079)**	**(2,197)**	**(2,174)**	**(2,151)**	**(2,131)**	**(0)**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	38.1%	38.1%	38.0%	38.0%	38.0%	38.0%	38.0%	38.0%	38.0%	38.0%	38.1%	38.1%	38.0%
Delegated:													
CFMG	12.0%	12.0%	12.0%	12.0%	12.1%	12.1%	12.1%	12.1%	12.0%	12.0%	12.0%	12.0%	12.0%
CHCN	36.7%	36.7%	36.7%	36.7%	36.7%	36.6%	36.7%	36.7%	36.7%	36.7%	36.7%	36.7%	36.7%
Kaiser	13.2%	13.3%	13.3%	13.3%	13.3%	13.3%	13.3%	13.3%	13.3%	13.3%	13.3%	13.2%	13.3%
Delegated Subtotal	61.9%	61.9%	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%	61.9%	61.9%	62.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2021

	Variance Jul-20	Variance Aug-20	Variance Sep-20	Variance Oct-20	Variance Nov-20	Variance Dec-20	Variance Jan-21	Variance Feb-21	Variance Mar-21	Variance Apr-21	Variance May-21	Variance Jun-21	YTD Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	(2,488)	(3,247)	0	0	0	0	0	0	0	0	0	0	(5,735)
Adult	239	326	0	0	0	0	0	0	0	0	0	0	565
SPD	85	109	0	0	0	0	0	0	0	0	0	0	194
ACA OE	(98)	332	0	0	0	0	0	0	0	0	0	0	234
Duals	385	565	0	0	0	0	0	0	0	0	0	0	950
Medi-Cal Program	(1,877)	(1,915)	0	0	0	0	0	0	0	0	0	0	(3,792)
Group Care Program	(225)	(390)	0	0	0	0	0	0	0	0	0	0	(615)
Total	**(2,102)**	**(2,305)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(4,407)**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted	545	974	0	0	0	0	0	0	0	0	0	0	1,519
Delegated:													
CFMG	(622)	(897)	0	0	0	0	0	0	0	0	0	0	(1,519)
CHCN	(1,950)	(2,472)	0	0	0	0	0	0	0	0	0	0	(4,422)
Kaiser	(75)	91	0	0	0	0	0	0	0	0	0	0	16
Delegated Subtotal	(2,647)	(3,279)	0	0	0	0	0	0	0	0	0	0	(5,926)
Total	**(2,102)**	**(2,305)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(4,407)**

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

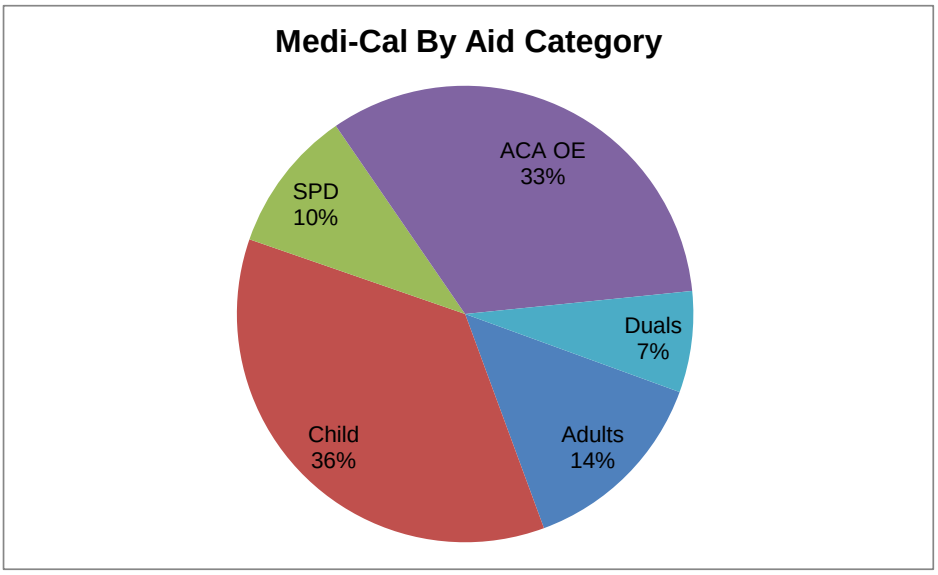
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES:				
$1,738,172	$1,773,169	$34,997	2.0%	PCP-Capitation	$3,463,681	$3,514,234	$50,554	1.4%
2,714,626	2,811,135	96,509	3.4%	PCP-Capitation - FQHC	5,431,326	5,577,538	146,212	2.6%
269,078	280,689	11,611	4.1%	Specialty-Capitation	537,124	556,065	18,941	3.4%
2,775,219	2,854,517	79,298	2.8%	Specialty-Capitation FQHC	5,543,347	5,666,964	123,617	2.2%
345,181	270,093	(75,088)	(27.8%)	Laboratory-Capitation	608,116	535,911	(72,205)	(13.5%)
371,074	1,024,572	653,498	63.8%	Transportation (Ambulance)-Cap	738,871	2,032,438	1,293,567	63.6%
196,850	253,951	57,101	22.5%	Vision Cap	392,211	503,747	111,536	22.1%
78,285	81,587	3,302	4.0%	CFMG Capitation	156,251	161,630	5,379	3.3%
140,952	145,470	4,518	3.1%	Anc IPA Admin Capitation FQHC	281,777	288,711	6,934	2.4%
7,473,794	7,307,945	(165,849)	(2.3%)	Kaiser Capitation	14,819,129	14,507,741	(311,388)	(2.1%)
654,204	616,002	(38,202)	(6.2%)	BHT Supplemental Expense	1,309,421	1,224,275	(85,146)	(7.0%)
30,756	11,130	(19,626)	(176.3%)	Hep-C Supplemental Expense	51,260	22,083	(29,177)	(132.1%)
0	355,682	355,682	100.0%	Maternity Supplemental Expense	0	704,390	704,390	100.0%
504,221	552,265	48,044	8.7%	DME - Cap	1,007,387	1,101,519	94,132	8.5%
17,292,413	**18,338,207**	**1,045,794**	**5.7%**	**5-TOTAL CAPITATED EXPENSES**	**34,339,901**	**36,397,246**	**2,057,345**	**5.7%**
				FEE FOR SERVICE MEDICAL EXPENSES:				
4,346,416	0	(4,346,416)	0.0%	IBNP-Inpatient Services	2,962,959	0	(2,962,959)	0.0%
130,393	0	(130,393)	0.0%	IBNP-Settlement (IP)	88,890	0	(88,890)	0.0%
347,713	0	(347,713)	0.0%	IBNP-Claims Fluctuation (IP)	237,037	0	(237,037)	0.0%
18,635,423	21,760,533	3,125,110	14.4%	Inpatient Hospitalization-FFS	38,833,570	43,286,752	4,453,182	10.3%
1,043,849	0	(1,043,849)	0.0%	IP OB - Mom & NB	2,297,284	0	(2,297,284)	0.0%
204,380	0	(204,380)	0.0%	IP Behavioral Health	345,190	0	(345,190)	0.0%
838,914	1,108,005	269,091	24.3%	IP - Long Term Care	1,877,304	2,206,023	328,719	14.9%
761,137	0	(761,137)	0.0%	IP - Facility Rehab FFS	1,808,332	0	(1,808,332)	0.0%
26,308,225	**22,868,538**	**(3,439,687)**	**(15.0%)**	**6-Inpatient Hospital & SNF FFS Expense**	**48,450,566**	**45,492,775**	**(2,957,791)**	**(6.5%)**
302,238	0	(302,238)	0.0%	IBNP-PCP	207,686	0	(207,686)	0.0%
9,067	0	(9,067)	0.0%	IBNP-Settlement (PCP)	6,230	0	(6,230)	0.0%
24,178	0	(24,178)	0.0%	IBNP-Claims Fluctuation (PCP)	16,615	0	(16,615)	0.0%
1,344	0	(1,344)	0.0%	Telemedicine FFS	2,394	0	(2,394)	0.0%
1,116,287	1,156,600	40,313	3.5%	Primary Care Non-Contracted FF	2,350,293	2,299,036	(51,257)	(2.2%)
41,161	73,001	31,840	43.6%	PCP FQHC FFS	89,725	144,905	55,180	38.1%
1,666,457	48,812	(1,617,645)	(3,314.0%)	Prop 56 Direct Payment Expenses	3,322,992	96,721	(3,226,271)	(3,335.6%)
72,209	0	(72,209)	0.0%	Prop 56-Trauma Expense	143,669	0	(143,669)	0.0%
97,226	0	(97,226)	0.0%	Prop 56-Dev. Screening Exp.	193,585	0	(193,585)	0.0%
551,026	0	(551,026)	0.0%	Prop 56-Fam. Planning Exp.	1,096,118	0	(1,096,118)	0.0%
495,311	0	(495,311)	0.0%	Prop 56-Value Based Purchasing	986,824	0	(986,824)	0.0%
4,376,504	**1,278,413**	**(3,098,091)**	**(242.3%)**	**7-Primary Care Physician FFS Expense**	**8,416,130**	**2,540,662**	**(5,875,468)**	**(231.3%)**
1,114,312	0	(1,114,312)	0.0%	IBNP-Specialist	752,321	0	(752,321)	0.0%
1,730,462	0	(1,730,462)	0.0%	Specialty Care-FFS	3,779,064	0	(3,779,064)	0.0%
92,232	0	(92,232)	0.0%	Anesthesiology - FFS	290,339	0	(290,339)	0.0%
656,160	0	(656,160)	0.0%	Spec Rad Therapy - FFS	1,364,827	0	(1,364,827)	0.0%
93,759	0	(93,759)	0.0%	Obstetrics-FFS	236,940	0	(236,940)	0.0%
221,497	0	(221,497)	0.0%	Spec IP Surgery - FFS	497,239	0	(497,239)	0.0%
325,879	0	(325,879)	0.0%	Spec OP Surgery - FFS	774,814	0	(774,814)	0.0%
330,191	3,918,448	3,588,258	91.6%	Spec IP Physician	783,538	7,788,924	7,005,386	89.9%
28,570	98,805	70,235	71.1%	SCP FQHC FFS	65,772	196,396	130,624	66.5%
33,429	0	(33,429)	0.0%	IBNP-Settlement (SCP)	22,569	0	(22,569)	0.0%
89,145	0	(89,145)	0.0%	IBNP-Claims Fluctuation (SCP)	60,185	0	(60,185)	0.0%
4,715,635	**4,017,253**	**(698,382)**	**(17.4%)**	**8-Specialty Care Physician Expense**	**8,627,609**	**7,985,320**	**(642,289)**	**(8.0%)**
838,170	0	(838,170)	0.0%	IBNP-Ancillary	572,681	0	(572,681)	0.0%
25,144	0	(25,144)	0.0%	IBNP Settlement (ANC)	17,180	0	(17,180)	0.0%
67,055	0	(67,055)	0.0%	IBNP Claims Fluctuation (ANC)	45,818	0	(45,818)	0.0%
193,007	0	(193,007)	0.0%	Acupuncture/Biofeedback	387,320	0	(387,320)	0.0%
43,790	0	(43,790)	0.0%	Hearing Devices	95,504	0	(95,504)	0.0%
48,767	0	(48,767)	0.0%	Imaging/MRI/CT Global	82,472	0	(82,472)	0.0%
31,118	0	(31,118)	0.0%	Vision FFS	63,049	0	(63,049)	0.0%
20,894	0	(20,894)	0.0%	Family Planning	38,799	0	(38,799)	0.0%
191,810	0	(191,810)	0.0%	Laboratory-FFS	453,036	0	(453,036)	0.0%
73,668	0	(73,668)	0.0%	ANC Therapist	162,818	0	(162,818)	0.0%
534,866	0	(534,866)	0.0%	Transportation (Ambulance)-FFS	897,722	0	(897,722)	0.0%
102,332	0	(102,332)	0.0%	Transportation (Other)-FFS	173,503	0	(173,503)	0.0%

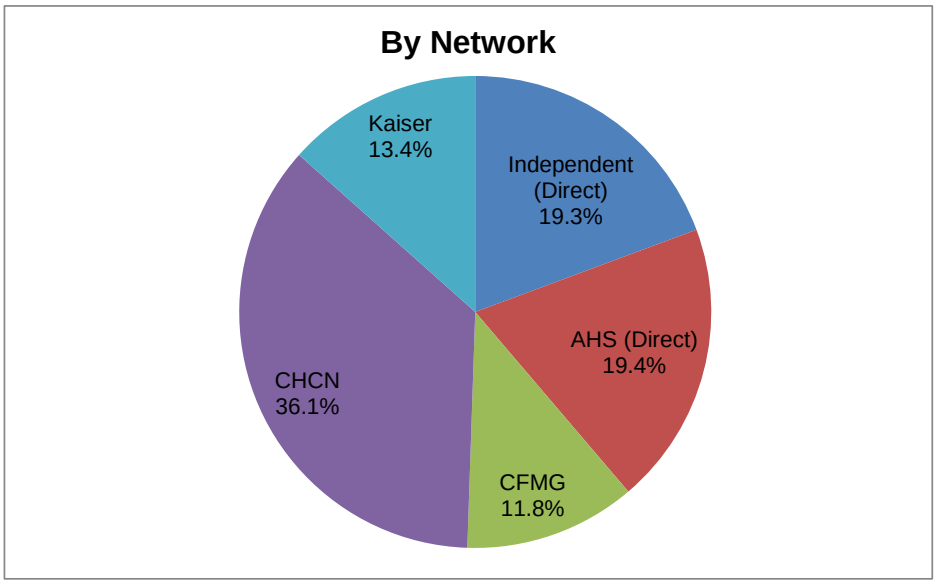
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED August 31, 2020

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
$303,017	$0	($303,017)	0.0%	Hospice	$913,346	$0	($913,346)	0.0%
364,238	0	(364,238)	0.0%	Home Health Services	1,111,810	0	(1,111,810)	0.0%
0	2,707,909	2,707,909	100.0%	Other Medical-FFS	0	5,397,215	5,397,215	100.0%
3,885	0	(3,885)	0.0%	Denials	3,885	0	(3,885)	0.0%
35,812	0	(35,812)	0.0%	HMS Medical Refunds	(75,911)	0	75,911	0.0%
267,170	0	(267,170)	0.0%	DME & Medical Supplies	573,585	0	(573,585)	0.0%
540,468	525,993	(14,475)	(2.8%)	GEMT Direct Payment Expense	1,077,815	1,045,871	(31,944)	(3.1%)
741,870	0	(741,870)	0.0%	Community Based Adult Services (CBAS)	980,857	0	(980,857)	0.0%
4,427,080	**3,233,902**	**(1,193,178)**	**(36.9%)**	**9-Ancillary Medical Expense**	**7,575,290**	**6,443,086**	**(1,132,204)**	**(17.6%)**
1,146,592	0	(1,146,592)	0.0%	IBNP-Outpatient	14,118	0	(14,118)	0.0%
34,398	0	(34,398)	0.0%	IBNP Settlement (OP)	422	0	(422)	0.0%
91,727	0	(91,727)	0.0%	IBNP Claims Fluctuation (OP)	1,129	0	(1,129)	0.0%
783,364	7,560,183	6,776,819	89.6%	Out-Patient FFS	1,819,914	15,051,875	13,231,961	87.9%
734,508	0	(734,508)	0.0%	OP Ambul Surgery - FFS	1,883,170	0	(1,883,170)	0.0%
1,084,839	0	(1,084,839)	0.0%	OP Fac Imaging Services-FFS	2,009,993	0	(2,009,993)	0.0%
2,648,462	0	(2,648,462)	0.0%	Behav Health - FFS	4,723,758	0	(4,723,758)	0.0%
369,688	0	(369,688)	0.0%	OP Facility - Lab FFS	717,305	0	(717,305)	0.0%
79,736	0	(79,736)	0.0%	OP Facility - Cardio FFS	156,787	0	(156,787)	0.0%
28,197	0	(28,197)	0.0%	OP Facility - PT/OT/ST FFS	50,337	0	(50,337)	0.0%
1,355,320	0	(1,355,320)	0.0%	OP Facility - Dialysis FFS	3,086,401	0	(3,086,401)	0.0%
8,356,831	**7,560,183**	**(796,648)**	**(10.5%)**	**10-Outpatient Medical Expense Medical Expense**	**14,463,333**	**15,051,875**	**588,542**	**3.9%**
1,077,515	0	(1,077,515)	0.0%	IBNP-Emergency	617,426	0	(617,426)	0.0%
32,325	0	(32,325)	0.0%	IBNP Settlement (ER)	18,525	0	(18,525)	0.0%
86,201	0	(86,201)	0.0%	IBNP Claims Fluctuation (ER)	49,393	0	(49,393)	0.0%
453,482	0	(453,482)	0.0%	Special ER Physician-FFS	1,028,720	0	(1,028,720)	0.0%
2,182,503	3,261,232	1,078,729	33.1%	ER-Facility	5,329,957	6,486,361	1,156,404	17.8%
3,832,026	**3,261,232**	**(570,794)**	**(17.5%)**	**11-Emergency Expense**	**7,044,021**	**6,486,361**	**(557,660)**	**(8.6%)**
818,403	0	(818,403)	0.0%	IBNP-Pharmacy	217,269	0	(217,269)	0.0%
24,551	0	(24,551)	0.0%	IBNP Settlement (RX)	6,517	0	(6,517)	0.0%
65,473	0	(65,473)	0.0%	IBNP Claims Fluctuation (RX)	17,383	0	(17,383)	0.0%
3,281,254	3,806,409	525,155	13.8%	RX - Non-PBM FFFS	7,737,951	7,568,424	(169,527)	(2.2%)
9,689,323	10,185,173	495,850	4.9%	Pharmacy-FFS	20,295,197	20,240,124	(55,073)	(0.3%)
(472)	0	472	0.0%	HMS RX Refunds	(16,369)	0	16,369	0.0%
(500,001)	(500,002)	(1)	0.0%	Pharmacy-Rebate	(993,609)	(993,611)	(2)	0.0%
13,378,532	**13,491,580**	**113,048**	**0.8%**	**12-Pharmacy Expense**	**27,264,339**	**26,814,937**	**(449,402)**	**(1.7%)**
65,394,834	**55,711,101**	**(9,683,733)**	**(17.4%)**	**13-TOTAL FFS MEDICAL EXPENSES**	**121,841,288**	**110,815,016**	**(11,026,272)**	**(10.0%)**
0	(90,228)	(90,228)	100.0%	Clinical Vacancy	0	(157,037)	(157,037)	100.0%
62,658	98,195	35,537	36.2%	Quality Analytics	125,269	198,734	73,464	37.0%
349,341	499,032	149,691	30.0%	Health Plan Services Department Total	681,772	987,062	305,291	30.9%
766,822	731,795	(35,026)	(4.8%)	Case & Disease Management Department Total	1,469,962	1,452,950	(17,011)	(1.2%)
177,865	189,441	11,576	6.1%	Medical Services Department Total	343,214	378,883	35,668	9.4%
370,266	549,633	179,367	32.6%	Quality Management Department Total	784,106	1,135,786	351,680	31.0%
139,024	147,652	8,628	5.8%	Pharmacy Services Department Total	273,160	280,896	7,737	2.8%
28,125	38,482	10,357	26.9%	Regulatory Readiness Total	54,895	77,521	22,626	29.2%
1,894,100	**2,164,003**	**269,903**	**12.5%**	**14-Other Benefits & Services**	**3,732,377**	**4,354,796**	**622,419**	**14.3%**
				Reinsurance Expense				
(461,216)	(328,550)	132,666	(40.4%)	Reinsurance Recoveries	(785,638)	(652,972)	132,666	(20.3%)
434,302	482,916	48,614	10.1%	Stop-Loss Expense	864,014	959,999	95,985	10.0%
(26,914)	**154,366**	**181,280**	**117.4%**	**15-Reinsurance Expense**	**78,376**	**307,027**	**228,651**	**74.5%**
				Preventive Health Services				
83,333	83,333	0	0.0%	Risk Sharing PCP	166,666	166,665	(1)	0.0%
83,333	**83,333**	**0**	**0.0%**	**16-Risk Pool Distribution**	**166,666**	**166,665**	**(1)**	**0.0%**
84,637,766	**76,451,010**	**(8,186,757)**	**(10.7%)**	**17-TOTAL MEDICAL EXPENSES**	**160,158,608**	**152,040,750**	**(8,117,858)**	**(5.3%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Current Membership by Network By Category of Aid							
Category of Aid	**Aug 2020**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	35,689	14%	8,557	7,857	310	13,190	5,775
Child	92,692	36%	8,873	8,448	28,503	31,102	15,766
SPD	26,094	10%	8,662	3,903	1,155	10,437	1,937
ACA OE	85,081	33%	14,912	28,257	1,101	31,163	9,648
Duals	18,495	7%	7,421	1,969	3	6,805	2,297
Medi-Cal	258,051		48,425	50,434	31,072	92,697	35,423
Group Care	6,007		2,632	878	-	2,497	-
Total	**264,058**	**100%**	**51,057**	**51,312**	**31,072**	**95,194**	**35,423**
Medi-Cal %	97.7%		94.8%	98.3%	100.0%	97.4%	100.0%
Group Care %	2.3%		5.2%	1.7%	0.0%	2.6%	0.0%
	Network Distribution		*19.3%*	*19.4%*	*11.8%*	*36.1%*	*13.4%*
			% Direct:	**39%**		**% Delegated:**	**61%**

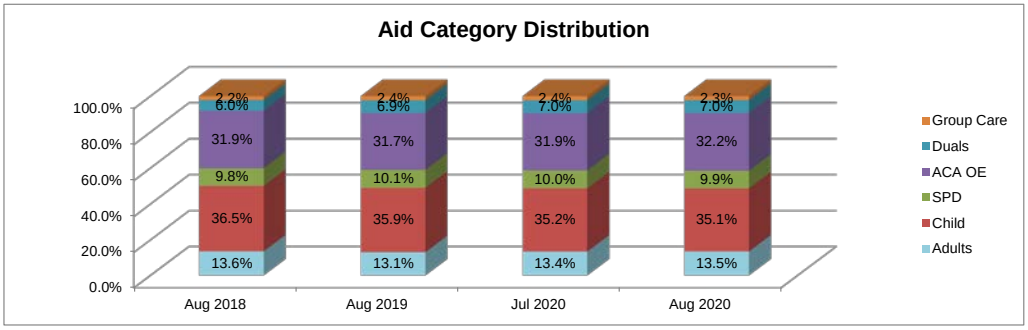




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

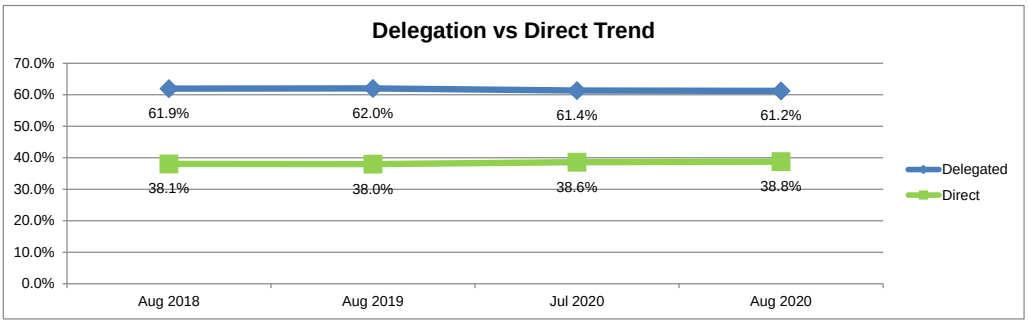
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Aug 2018	Aug 2019	Jul 2020	Aug 2020	Aug 2018	Aug 2019	Jul 2020	Aug 2020	Aug 2018 to Aug 2019	Aug 2019 to Aug 2020	Jul 2020 to Aug 2020
Adults	35,987	33,448	34,909	35,689	13.6%	13.1%	13.4%	13.5%	-7.1%	6.7%	2.2%
Child	96,634	91,728	91,570	92,692	36.5%	35.9%	35.2%	35.1%	-5.1%	1.1%	1.2%
SPD	26,075	25,751	26,044	26,094	9.8%	10.1%	10.0%	9.9%	-1.2%	1.3%	0.2%
ACA OE	84,557	80,966	82,989	85,081	31.9%	31.7%	31.9%	32.2%	-4.2%	5.1%	2.5%
Duals	15,760	17,700	18,297	18,495	6.0%	6.9%	7.0%	7.0%	12.3%	4.5%	1.1%
Medi-Cal Total	259,013	249,593	253,809	258,051	97.8%	97.6%	97.6%	97.7%	-3.6%	3.4%	1.7%
Group Care	5,858	6,020	6,109	6,007	2.2%	2.4%	2.4%	2.3%	2.8%	-0.2%	-1.7%
Total	**264,871**	**255,613**	**259,918**	**264,058**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**-3.5%**	**3.3%**	**1.6%**



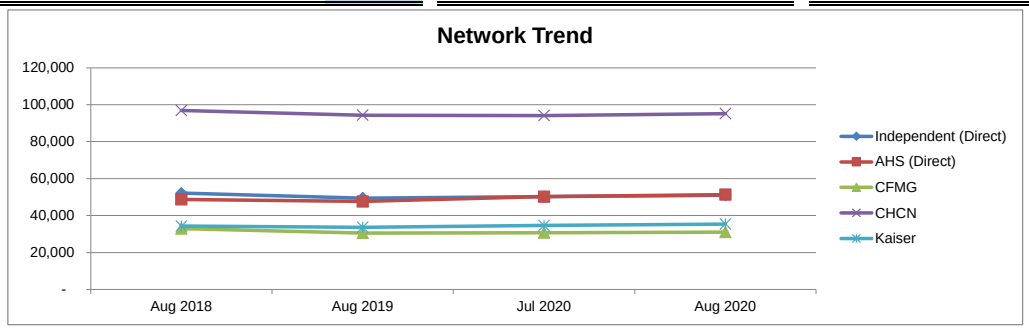
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Aug 2018	Aug 2019	Jul 2020	Aug 2020	Aug 2018	Aug 2019	Jul 2020	Aug 2020	Aug 2018 to Aug 2019	Aug 2019 to Aug 2020	Jul 2020 to Aug 2020
Delegated	164,054	158,520	159,526	161,689	61.9%	62.0%	61.4%	61.2%	-3.4%	2.0%	1.4%
Direct	100,817	97,093	100,392	102,369	38.1%	38.0%	38.6%	38.8%	-3.7%	5.4%	2.0%
Total	**264,871**	**255,613**	**259,918**	**264,058**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**-3.5%**	**3.3%**	**1.6%**



Network Trend

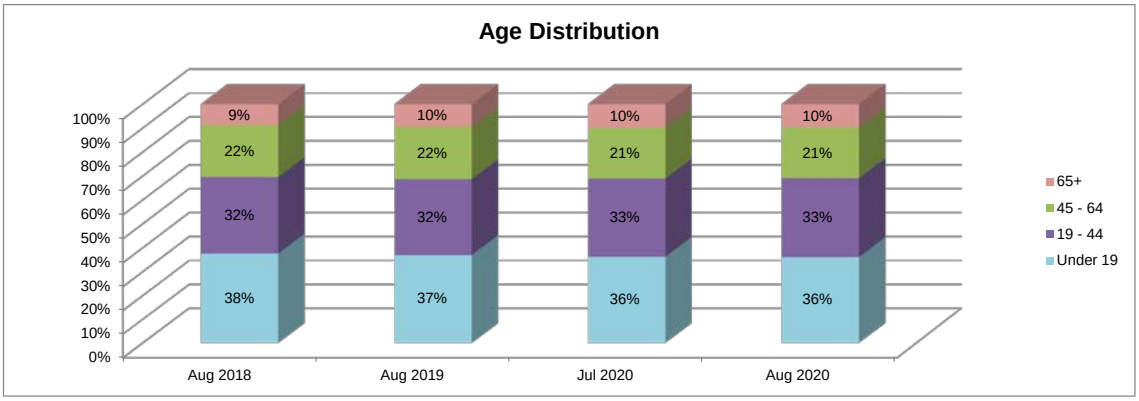
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Aug 2018	Aug 2019	Jul 2020	Aug 2020	Aug 2018	Aug 2019	Jul 2020	Aug 2020	Aug 2018 to Aug 2019	Aug 2019 to Aug 2020	Jul 2020 to Aug 2020
Independent (Direct)	52,107	49,463	50,199	51,057	19.7%	19.4%	19.3%	19.3%	-5.1%	3.2%	1.7%
AHS (Direct)	48,710	47,630	50,193	51,312	18.4%	18.6%	19.3%	19.4%	-2.2%	7.7%	2.2%
CFMG	32,898	30,542	30,742	31,072	12.4%	11.9%	11.8%	11.8%	-7.2%	1.7%	1.1%
CHCN	96,859	94,360	94,144	95,194	36.6%	36.9%	36.2%	36.1%	-2.6%	0.9%	1.1%
Kaiser	34,297	33,618	34,640	35,423	12.9%	13.2%	13.3%	13.4%	-2.0%	5.4%	2.3%
Total	**264,871**	**255,613**	**259,918**	**264,058**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**-3.5%**	**3.3%**	**1.6%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

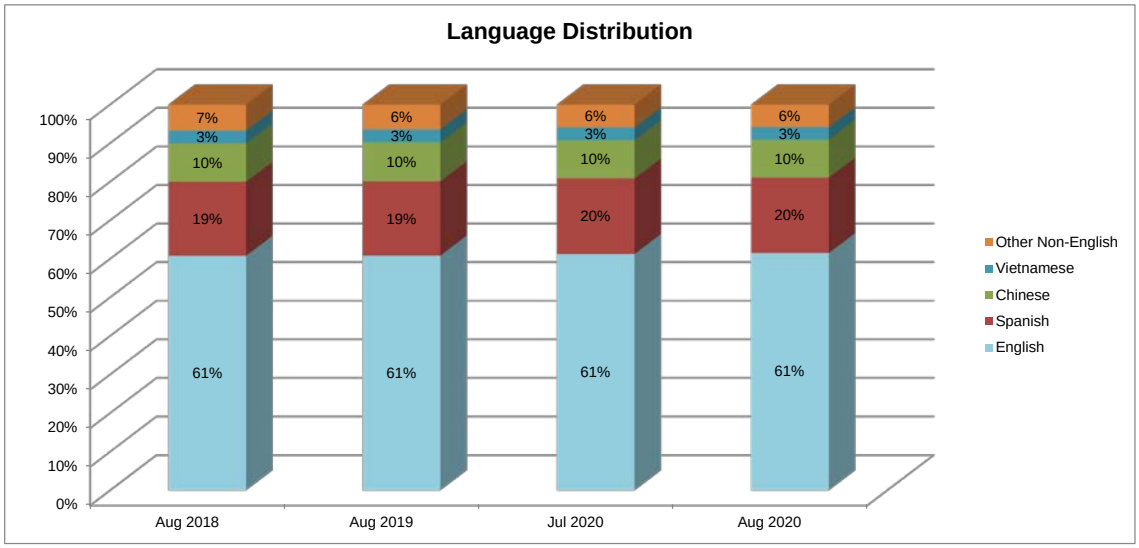
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Aug 2018	Aug 2019	Jul 2020	Aug 2020	Aug 2018	Aug 2019	Jul 2020	Aug 2020	Aug 2018 to Aug 2019	Aug 2019 to Aug 2020	Jul 2020 to Aug 2020
Under 19	99,495	94,368	94,074	95,188	38%	37%	36%	36%	-5%	1%	1%
19 - 44	84,652	81,099	84,828	87,011	32%	32%	33%	33%	-4%	7%	3%
45 - 64	57,497	55,662	55,293	55,910	22%	22%	21%	21%	-3%	0%	1%
65+	23,227	24,484	25,723	25,949	9%	10%	10%	10%	5%	6%	1%
Total	**264,871**	**255,613**	**259,918**	**264,058**	**100%**	**100%**	**100%**	**100%**	**-3%**	**3%**	**2%**



Language Trend

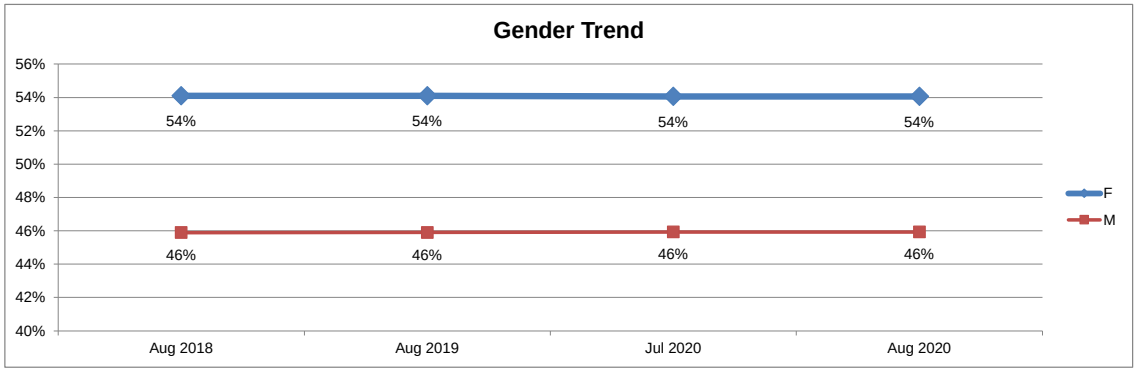
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Aug 2018	Aug 2019	Jul 2020	Aug 2020	Aug 2018	Aug 2019	Jul 2020	Aug 2020	Aug 2018 to Aug 2019	Aug 2019 to Aug 2020	Jul 2020 to Aug 2020
English	160,991	155,483	159,176	162,321	61%	61%	61%	61%	-3%	4%	2%
Spanish	50,787	49,190	50,932	51,725	19%	19%	20%	20%	-3%	5%	2%
Chinese	26,436	25,891	25,833	25,941	10%	10%	10%	10%	-2%	0%	0%
Vietnamese	8,731	8,626	8,463	8,470	3%	3%	3%	3%	-1%	-2%	0%
Other Non-English	17,926	16,423	15,514	15,601	7%	6%	6%	6%	-8%	-5%	1%
Total	**264,871**	**255,613**	**259,918**	**264,058**	**100%**	**100%**	**100%**	**100%**	**-3%**	**3%**	**2%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

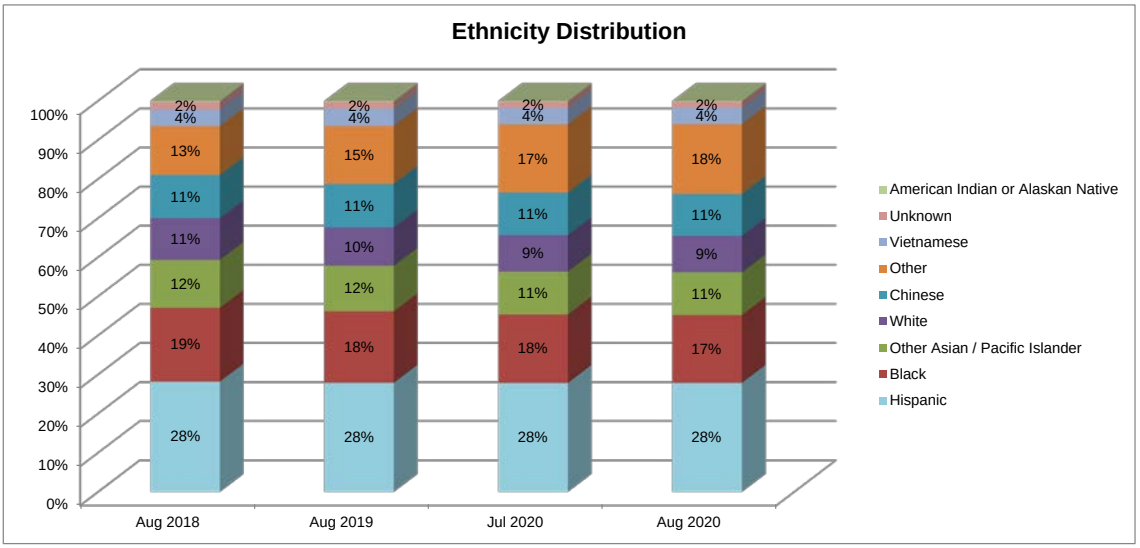
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Aug 2018	Aug 2019	Jul 2020	Aug 2020	Aug 2018	Aug 2019	Jul 2020	Aug 2020	Aug 2018 to Aug 2019	Aug 2019 to Aug 2020	Jul 2020 to Aug 2020
F	143,304	138,278	140,532	142,759	54%	54%	54%	54%	-4%	3%	2%
M	121,567	117,335	119,386	121,299	46%	46%	46%	46%	-3%	3%	2%
Total	**264,871**	**255,613**	**259,918**	**264,058**	**100%**	**100%**	**100%**	**100%**	**-3%**	**3%**	**2%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Aug 2018	Aug 2019	Jul 2020	Aug 2020	Aug 2018	Aug 2019	Jul 2020	Aug 2020	Aug 2018 to Aug 2019	Aug 2019 to Aug 2020	Jul 2020 to Aug 2020
Hispanic	74,585	71,300	72,376	73,556	28%	28%	28%	28%	-4%	3%	2%
Black	50,082	46,805	45,622	45,864	19%	18%	18%	17%	-7%	-2%	1%
Other Asian / Pacific Islander	32,516	29,677	28,453	28,805	12%	12%	11%	11%	-9%	-3%	1%
White	28,192	25,084	24,309	24,655	11%	10%	9%	9%	-11%	-2%	1%
Chinese	29,237	28,526	28,189	28,346	11%	11%	11%	11%	-2%	-1%	1%
Other	33,217	37,897	45,429	47,252	13%	15%	17%	18%	14%	25%	4%
Vietnamese	11,286	11,218	10,933	10,987	4%	4%	4%	4%	-1%	-2%	0%
Unknown	5,068	4,478	4,020	3,991	2%	2%	2%	2%	-12%	-11%	-1%
American Indian or Alaskan Native	688	628	587	602	0%	0%	0%	0%	-9%	-4%	3%
Total	**264,871**	**255,613**	**259,918**	**264,058**	**100%**	**100%**	**100%**	**100%**	**-3%**	**3%**	**2%**



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

Medi-Cal By City

City	Aug 2020	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	105,007	41%	11,974	24,425	13,851	44,640	10,117
Hayward	39,822	15%	8,465	8,353	4,699	11,592	6,713
Fremont	22,510	9%	9,086	3,278	730	5,965	3,451
San Leandro	22,923	9%	3,989	3,516	3,296	8,457	3,665
Union City	11,086	4%	4,192	1,618	361	2,859	2,056
Alameda	10,002	4%	1,944	1,502	1,585	3,554	1,417
Berkeley	9,097	4%	1,258	1,619	1,202	3,722	1,296
Livermore	7,526	3%	1,008	724	1,722	2,765	1,307
Newark	5,978	2%	1,693	1,885	176	1,159	1,065
Castro Valley	6,176	2%	1,256	960	1,019	1,772	1,169
San Lorenzo	5,350	2%	908	887	678	1,864	1,013
Pleasanton	3,970	2%	920	414	428	1,523	685
Dublin	4,291	2%	1,007	420	580	1,532	752
Emeryville	1,637	1%	277	324	256	515	265
Albany	1,502	1%	197	214	355	464	272
Piedmont	295	0%	61	66	24	76	68
Sunol	50	0%	10	8	6	12	14
Antioch	18	0%	6	3	3	4	2
Other	811	0%	174	218	101	222	96
Total	**258,051**	**100%**	**48,425**	**50,434**	**31,072**	**92,697**	**35,423**

Group Care By City

City	Aug 2020	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	2,074	35%	548	365	-	1,161	-
Hayward	665	11%	375	128	-	162	-
Fremont	653	11%	499	52	-	102	-
San Leandro	563	9%	222	79	-	262	-
Union City	319	5%	226	33	-	60	-
Alameda	274	5%	109	29	-	136	-
Berkeley	190	3%	57	21	-	112	-
Livermore	83	1%	33	-	-	50	-
Newark	141	2%	93	31	-	17	-
Castro Valley	194	3%	103	24	-	67	-
San Lorenzo	122	2%	50	19	-	53	-
Pleasanton	50	1%	27	4	-	19	-
Dublin	100	2%	47	5	-	48	-
Emeryville	30	0%	12	4	-	14	-
Albany	12	0%	3	1	-	8	-
Piedmont	10	0%	2	1	-	7	-
Sunol	-	0%	-	-	-	-	-
Antioch	25	0%	8	5	-	12	-
Other	502	8%	218	77	-	207	-
Total	**6,007**	**100%**	**2,632**	**878**	**-**	**2,497**	**-**

Total By City

City	Aug 2020	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	107,081	41%	12,522	24,790	13,851	45,801	10,117
Hayward	40,487	15%	8,840	8,481	4,699	11,754	6,713
Fremont	23,163	9%	9,585	3,330	730	6,067	3,451
San Leandro	23,486	9%	4,211	3,595	3,296	8,719	3,665
Union City	11,405	4%	4,418	1,651	361	2,919	2,056
Alameda	10,276	4%	2,053	1,531	1,585	3,690	1,417
Berkeley	9,287	4%	1,315	1,640	1,202	3,834	1,296
Livermore	7,609	3%	1,041	724	1,722	2,815	1,307
Newark	6,119	2%	1,786	1,916	176	1,176	1,065
Castro Valley	6,370	2%	1,359	984	1,019	1,839	1,169
San Lorenzo	5,472	2%	958	906	678	1,917	1,013
Pleasanton	4,020	2%	947	418	428	1,542	685
Dublin	4,391	2%	1,054	425	580	1,580	752
Emeryville	1,667	1%	289	328	256	529	265
Albany	1,514	1%	200	215	355	472	272
Piedmont	305	0%	63	67	24	83	68
Sunol	50	0%	10	8	6	12	14
Antioch	43	0%	14	8	3	16	2
Other	1,313	0%	392	295	101	429	96
Total	**264,058**	**100%**	**51,057**	**51,312**	**31,072**	**95,194**	**35,423**

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: **October 9, 2020**

Subject: **Operations Report**

Member Services

- 12-month Trend Summary:

    - The Member Services Department received a three percent (3%) decrease in calls in September 2020, totaling 13,274 compared to 13,661 in September 2019.
    - The abandonment rate for September 2020 was five percent (5%), which was the same five percent (5%) in September 2019.
    - The service level for the Department was sixty-four percent (64%) September 2020, compared to eighty-four percent (85%) in September 2019. Service levels are impacted by staffing challenges. The Department is actively recruiting to fill open positions.
    - 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 620 web-based requests in September 2020. The top three web requests were: 1). ID Card Requests, 2). Change of PCP 3). Update contact information.
    - The top five call reasons for September 2020 were: 1. Change of PCP, 2). Eligibility/Enrollment, 3). Kaiser, 4). Benefits 5). ID Card Request. The top five call reasons for September 2019 were: 1) Eligibility/Enrollment 2). Change of PCP 3). Kaiser, 4). Benefits, 5). Change of PCP was higher in September 2020 compared to the Change of PCP requests in 2019.
    - The average talk time (ATT) was six minutes and forty-eight seconds (06:48) for September 2020 compared to seven minutes and seventeen seconds (07:17) for the month of September 2019.

Claims

- 12-Month Trend Summary:

    - The Claims Department received 111,255 claims in September 2020 compared to 111,578 in September 2019.
    - The Auto Adjudication was 74.9% in September 2020 compared to 72.9% in September 2019.
    - Claims compliance for the 30-day turn-around time was 98.6% in September 2020 compared to 98.9% in September 2019. The 45-day turn-around time was 99.9% in September 2020 compared to 99.9% in September 2019.

- Training:

    - Routine and new hire training is still being conducted remotely by the managers/supervisors until staff returns to the office.

- Monthly Analysis:

    - In September, we received a total of 111,255 claims in the HEALTHsuite system. This represents an increase of 6.7% from August and still remains lower, albeit only by 323 claims, than the number of claims received in September 2019; the lower volume of received claims remains attributed to COVID-19.
    - We received 75% of claims via EDI and 25% of claims via paper.
    - During September, 99.9% of our claims were processed within 45 working days.
    - The Auto Adjudication rate was 74.9% for September.

Provider Services

- 12-Month Trend Summary:

    - The Provider Services Department's call volume in September 2020 was 5,584 calls compared to 6,001 calls in September 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 185 visits during September 2020.
- The Provider Services department answered over 4,396 calls for September 2020 and made over 840 outbound calls.

Credentialing

- 12-Month Trend Summary:

  - At the Peer Review and Credentialing (PRCC) meeting held on September 15, 2020, there were twenty-seven (27) initial providers approved; three (3) primary care providers, ten (10) specialists, four (4) ancillary providers, and ten (10) midlevel providers. Additionally, thirty-five (35) providers were re-credentialed at this meeting; thirteen (13) primary care providers, fifteen (15) specialists, two (2) ancillary providers, and five (5) midlevel providers.
  - For more information, please refer to the Credentialing charts and graphs located in the Operations supporting documentation.

Provider Dispute Resolution

- 12-Month Trend Summary:

  - In September 2020, the Provider Dispute Resolution (PDR) team received 780 PDRs versus 812 in September 2019.
  - The PDR team resolved 564 cases in September 2020 compared to 601 cases in September 2019.
  - In September 2020, the PDR team upheld 73% of cases versus 76% in September 2019.
  - The PDR team resolved 99.6% of cases within the compliance standard of 95% within 45 working days in September 2020 compared to 96% in September 2019.

- Monthly Analysis:

  - AAH received 780 PDRs in September 2020.
  - In September, 564 PDRs were resolved. Out of the 564 PDRs, 414 were upheld and 150 were overturned.
  - The overturn rate for PDRs was 27%, which did not meet our goal of 25% or less.

        - Of the 150 overturned PDRs, 24 were overturned due to the CHME change to allow secondary claims. 17 overturned PDRs were related to Timely Filing with 10 cases received with proof of timely documentation.
    - 29% of the overturned PDRs were attributed to configuration issues (coding/configuration/eligibility/general); the re-design of the PDR database continues and will allow for more specificity of these configuration issues going forward.
    - 562 out of 564 cases were resolved within 45 working days resulting in a 99.6% compliance rate.
    - The average turnaround time for resolving PDRs in September was 38 days.
    - There were 1,642 PDRs pending resolution as of 9/30/2020; with no cases older than 45 working days.

Community Relations and Outreach

- 12-Month Trend Summary:

    - The C&O Department reached 1,116 members through our member orientation outreach call campaign in Q1 of FY21 compared to 4,724 people in Q1 of FY20.
    - The C&O Department reached members in 26 cities*/unincorporated areas throughout Alameda County and the Bay Area in Q1 of FY21 compared to 13 cities/unincorporated areas in Q1 of FY20.

- Quarterly Analysis:

    - In Q1 of FY21 the C&O Department reached 1,116 members through our member orientation outreach call campaign.
    - In Q1 of FY21, the C&O Department reached 1,116 individuals (1,116 or 100% self-identified as Alliance members) during outreach events and activities.
    - In Q1 of FY21, the C&O Department completed events in 22 cities* /unincorporated areas throughout Alameda County and the Bay Area.

- Monthly Analysis:
  - The Outreach team completed 318 member orientations.
  - In September 2020, the C&O Department reached 318 individuals (318 or 100% self-identified as Alliance members) during outreach events and activities.
  - In September 2020, the C&O Department reached members in 22 cities* /unincorporated areas throughout Alameda County and the Bay Area.
  - Please see the attached **Addendum A.**

**Cities represent the mailing addresses for members who completed a Member Orientation by phone. The C&O Department started including these cities in the Q4 of FY20 Outreach Report.*

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	September 2020
Incoming Calls (R/V)	13274
Abandoned Rate (R/V)	5%
Answered Calls (R/V)	12545
Average Speed to Answer (ASA)	01:09
Calls Answered in 30 Seconds (R/V)	64%
Average Talk Time (ATT)	06:48
Outbound Calls	9342

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

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

Claims Department
August 2020 Final and September 2020 Final

METRICS

Claims Compliance	Aug-20	Sep-20
90% of clean claims processed within 30 calendar days	99.4%	98.6%
95% of all claims processed within 45 working days	99.9%	99.9%

Claims Volume (Received)	Aug-20	Sep-20
Paper claims	25,624	28,325
EDI claims	78,669	82,930
Claim Volume Total	**104,293**	**111,255**

Percentage of Claims Volume by Submission Method	Aug-20	Sep-20
% Paper	24.57%	25.46%
% EDI	75.43%	74.54%

Claims Processed	Aug-20	Sep-20
HEALTHsuite Paid (original claims)	73,816	97,777
HEALTHsuite Denied (original claims)	23,393	27,980
HEALTHsuite Original Claims Sub-Total	**97,209**	**125,757**
HEALTHsuite Adjustments	1,300	804
HEALTHsuite Total	**98,509**	**126,561**

Claims Expense	Aug-20	Sep-20
Medical Claims Paid	$40,276,246	$48,869,310
Interest Paid	$22,530	$28,629

Auto Adjudication	Aug-20	Sep-20
Claims Auto Adjudicated	74,060	94,167
% Auto Adjudicated	76.2%	74.9%

Average Days from Receipt to Payment	Aug-20	Sep-20
HEALTHsuite	18	18

Pended Claim Age	Aug-20	Sep-20
0-29 calendar days		
HEALTHsuite	12,969	8,131
30-59 calendar days		
HEALTHsuite	143	73
Over 60 calendar days		
HEALTHsuite	0	0

Overall Denial Rate	Aug-20	Sep-20
Claims denied in HEALTHsuite	23,393	27,980
% Denied	23.7%	22.1%

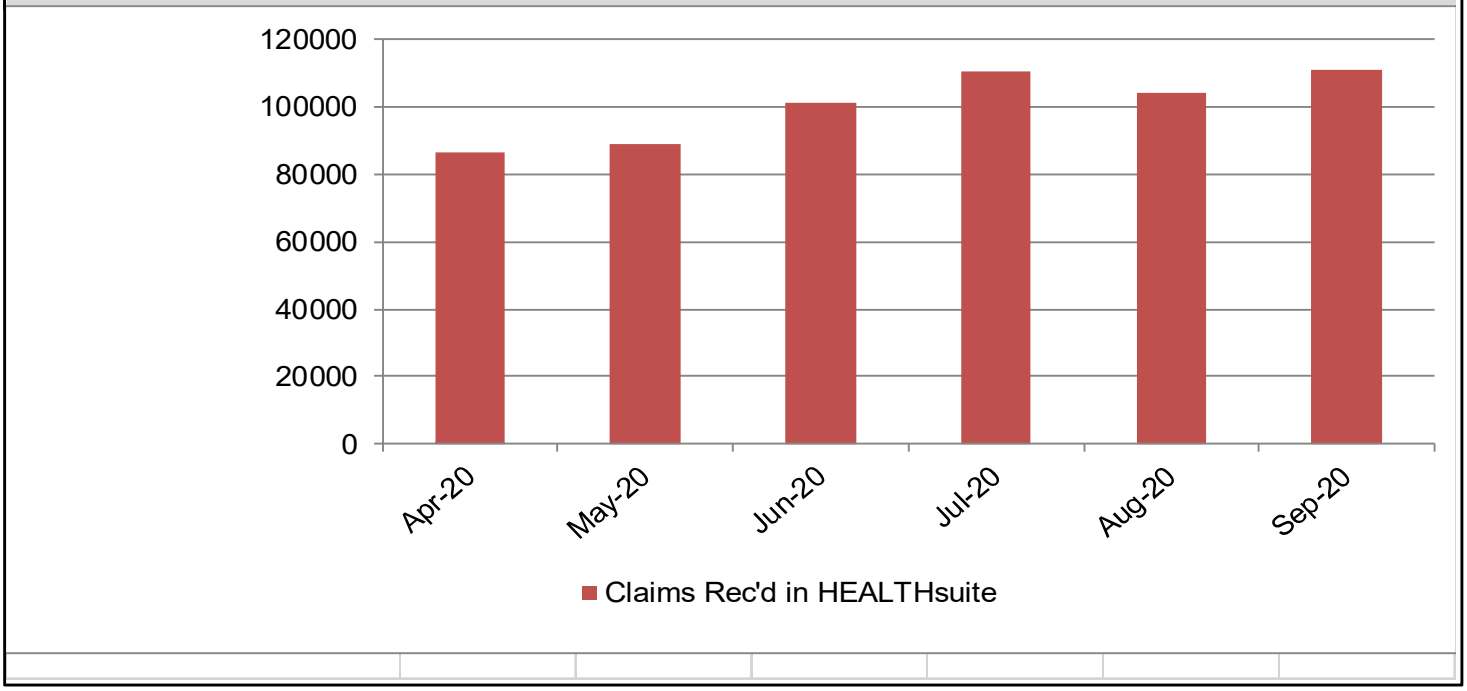
Claims Department
August 2020 Final and September 2020 Final

Sep-20

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	22%
Must Submit as a Paper Claim with Copy of Primary Payer EOB	15%
Duplicate Claim	13%
Non-Covered Benefit for this Plan	9%
No Benefits Found For Dates of Service	6%
% Total of all denials	**65%**

Claims Received By Month

Claims Received Through	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Claims Rec'd in HEALTHsuite	86,578	89,063	101,083	110,462	104,293	111,255



Provider Relations Dashboard September 2020

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	6256	5179	6191	5630	5740	6281	6467	5547	5584			
Abandoned Calls	1354	566	921	981	781	1158	1612	889	1188			
Answered Calls (PR)	4902	4613	5270	4649	4959	5123	4855	4658	4396			
Recordings/Voicemails	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Incoming Calls (R/V)	680	309	517	563	376	588	747	405	632			
Abandoned Calls (R/V)												
Answered Calls (R/V)	680	309	517	563	376	588	747	405	632			
Outbound Calls	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Outbound Calls	1308	1187	1439	948	1032	1035	996	923	840			
N/A												
Outbound Calls	1308	1187	1439	948	1032	1035	996	923	840			
Totals	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Total Incoming, R/V, Outbound Calls	8244	6675	8147	7141	7148	7904	8210	6875	7056			
Abandoned Calls	1354	566	921	981	781	1158	1612	889	1188			
Total Answered Incoming, R/V, Outbound Calls	6890	6109	7226	6160	6367	6746	6598	5986	5868			

Provider Relations Dashboard September 2020

Call Reasons (Medi-Cal and Group Care)

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	3.0%	3.3%	3.6%	2.1%	2.1%	1.6%	2.6%	1.9%	2.0%	#DIV/0!	#DIV/0!	#DIV/0!
Benefits	4.7%	6.1%	0.6%	5.2%	4.3%	4.4%	7.2%	5.1%	2.5%	#DIV/0!	#DIV/0!	#DIV/0!
Claims Inquiry	40.7%	39.7%	41.9%	51.7%	54.8%	46.2%	49.7%	46.6%	47.8%	#DIV/0!	#DIV/0!	#DIV/0!
Change of PCP	3.2%	3.5%	3.7%	1.7%	2.1%	2.0%	2.5%	3.3%	2.3%	#DIV/0!	#DIV/0!	#DIV/0!
Complaint/Grievance (includes PDR's)	2.7%	2.9%	2.4%	2.5%	2.9%	2.3%	0.0%	2.5%	2.6%	#DIV/0!	#DIV/0!	#DIV/0!
Contracts	0.2%	0.4%	0.3%	0.3%	0.4%	0.4%	0.5%	0.5%	0.4%	#DIV/0!	#DIV/0!	#DIV/0!
Correspondence Question/Followup	0.0%	0.0%	0.1%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%	#DIV/0!	#DIV/0!	#DIV/0!
Demographic Change	0.1%	0.1%	0.1%	0.0%	0.1%	0.1%	0.1%	0.0%	0.1%	#DIV/0!	#DIV/0!	#DIV/0!
Eligibility - Call from Provider	27.7%	24.3%	25.3%	14.0%	14.8%	15.0%	18.7%	20.2%	24.1%	#DIV/0!	#DIV/0!	#DIV/0!
Exempt Grievance/ G&A	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	#DIV/0!	#DIV/0!	#DIV/0!
General Inquiry/Non member	0.2%	0.1%	0.2%	0.1%	0.2%	0.2%	0.0%	0.0%	0.0%	#DIV/0!	#DIV/0!	#DIV/0!
Health Education	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	#DIV/0!	#DIV/0!	#DIV/0!
Intrepreter Services Request	2.0%	2.3%	2.8%	1.4%	1.6%	1.6%	2.3%	1.2%	1.7%	#DIV/0!	#DIV/0!	#DIV/0!
Kaiser	0.1%	0.3%	0.0%	0.3%	0.2%	0.2%	0.1%	0.0%	0.2%	#DIV/0!	#DIV/0!	#DIV/0!
Member bill	0.0%	0.0%	0.7%	0.8%	1.0%	0.9%	0.8%	0.7%	0.7%	#DIV/0!	#DIV/0!	#DIV/0!
Mystery Shopper Call	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	#DIV/0!	#DIV/0!	#DIV/0!
Provider Portal Assistance	2.3%	3.4%	6.3%	7.6%	6.4%	3.7%	4.2%	3.9%	4.5%	#DIV/0!	#DIV/0!	#DIV/0!
Pharmacy	0.8%	1.0%	0.7%	0.8%	0.8%	0.7%	0.5%	0.9%	0.8%	#DIV/0!	#DIV/0!	#DIV/0!
Provider Network Info	0.1%	0.3%	0.1%	0.1%	0.1%	0.1%	0.1%	0.2%	0.2%	#DIV/0!	#DIV/0!	#DIV/0!
Transferred Call	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	#DIV/0!	#DIV/0!	#DIV/0!
All Other Calls	11.9%	12.1%	11.1%	11.2%	8.2%	20.7%	10.5%	12.7%	10.2%	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	#DIV/0!	#DIV/0!	#DIV/0!

Field Visit Activity Details

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Claims Issues	8	3	6	31	33	11	4	4	12			
Contracting/Credentialing	1	2	2	22	24	9	1	3	7			
Drop-ins	12	6	48	6	0	0	0	0	0			
JOM's	2	3	4	3	1	4	2	4	2			
New Provider Orientation	17	3	3	22	23	11	4	7	1			
Quarterly Visits	64	124	23	177	145	147	204	281	162			
UM Issues	0	0	0	0	4	1	0	0	1			
Total Field Visits	104	141	86	261	230	183	215	299	185	0	0	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS					
Practitioners		AHP 398	PCP 356	SPEC 662	PCP/SPEC 18
AAH/AHS/CHCN Breakdown		AAH 444	AHS 202	CHCN 419	COMBINATION OF GROUPS 369
Facilities	**264**				

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	66	15	25	Y	Y
Recred Files in Process	25	15	25	Y	Y
Expirables updated Insurance, License, DEA, Board Certifications					Y
Files currently in process	**91**				

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

September 2020 Peer Review and Credentialing Committee Approvals	
Initial Credentialing	**Number**
PCP	3
SPEC	10
ANCILLARY	4
MIDLEVEL/AHP	10
	27
Recredentialing	
PCP	13
SPEC	16
ANCILLARY	4
MIDLEVEL/AHP	2
	35
TOTAL	**62**

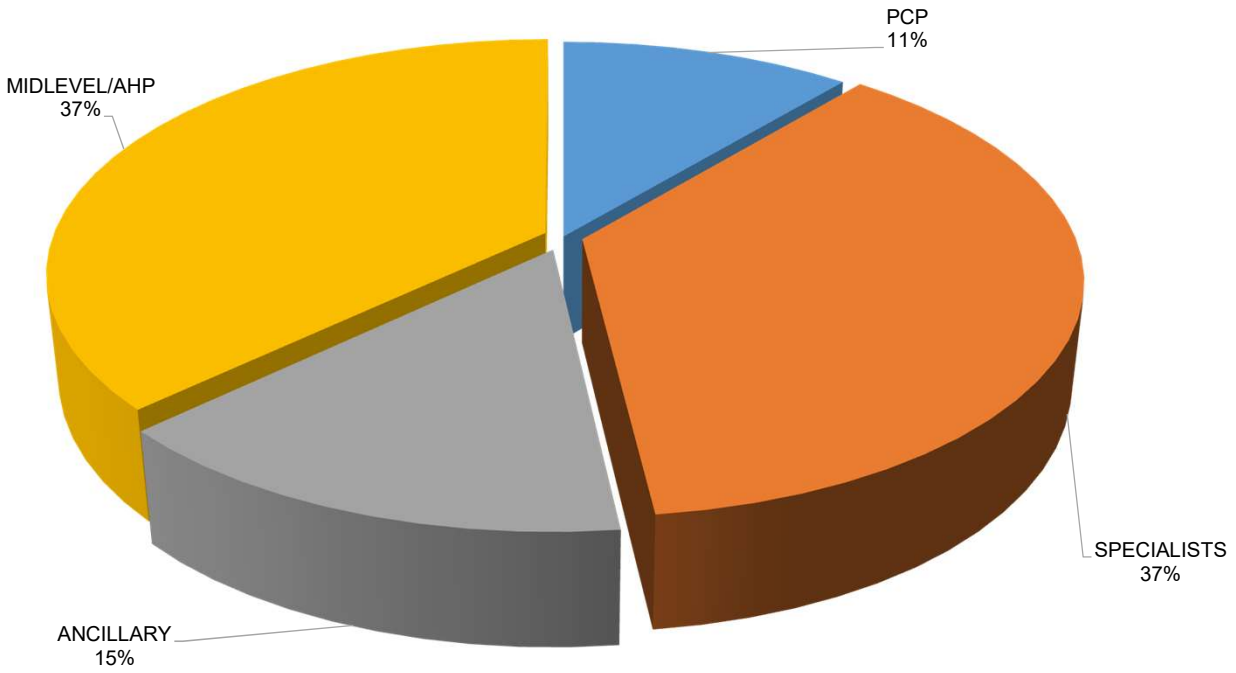
September 2020 Facility Approvals	
Initial Credentialing	6
Recredentialing	2
Facility Files in Process	264

September 2020 Employee Metrics	3	
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**
Chitnis	Amit	Specialist	Initial	9/15/2020
Drury	Jessica	Allied Health	Initial	9/15/2020
Dufour	David	Ancillary	Initial	9/15/2020
Edmunds	Magdalen	Primary Care Physician	Initial	9/15/2020
Eldridge	Cheryl	Allied Health	Initial	9/15/2020
Espinosa	Adrian	Allied Health	Initial	9/15/2020
Ford	Emma	Specialist	Initial	9/15/2020
Giovanelli	Andrea	Allied Health	Initial	9/15/2020
Hazari	Nisha	Allied Health	Initial	9/15/2020
Jamall	Akbar	Specialist	Initial	9/15/2020
Kochito	Yaroon	Allied Health	Initial	9/15/2020
Maharaj	Jaisri	Specialist	Initial	9/15/2020
Min	Byoung Wook	Ancillary	Initial	9/15/2020
Mogannam	Abid	Specialist	Initial	9/15/2020
Nanavati	Dhiren	Specialist	Initial	9/15/2020
Odera	Sampeter	Specialist	Initial	9/15/2020
Ponnuraju	Girija	Allied Health	Initial	9/15/2020
Sheinbein	Miriam	Primary Care Physician	Initial	9/15/2020
Tamoria	Shirley	Primary Care Physician	Initial	9/15/2020
Tedla	Tilksew	Allied Health	Initial	9/15/2020
Thompson	Benjamin	Ancillary	Initial	9/15/2020
Tiano	Kathryn	Allied Health	Initial	9/15/2020
Truong	Amy	Ancillary	Initial	9/15/2020
Upadhyay	Rani	Specialist	Initial	9/15/2020
Vanjani	Racha	Specialist	Initial	9/15/2020
Walsh	Jason	Allied Health	Initial	9/15/2020
Zarifa	Rafik	Specialist	Initial	9/15/2020
Adey	Jennifer	Specialist	Recred	9/15/2020
Ali	Zulfiqar	rimary Care Physician and Speciali	Recred	9/15/2020
Bhamra	Inderjeet	Specialist	Recred	9/15/2020
Bhateja	Meera	Primary Care Physician	Recred	9/15/2020
Blaschko	Sarah	Specialist	Recred	9/15/2020
Delaplane	Kathryn	Allied Health	Recred	9/15/2020
Diep	Claire	Primary Care Physician	Recred	9/15/2020
Dumouchel	Justin	Specialist	Recred	9/15/2020
Durant	Benjamin	Primary Care Physician	Recred	9/15/2020
Engel	Marvin	Specialist	Recred	9/15/2020
Falik	Rebecca	Specialist	Recred	9/15/2020
Fogel	Rachel	Primary Care Physician	Recred	9/15/2020
Greene	Robert	Specialist	Recred	9/15/2020
Herman	Erin	Allied Health	Recred	9/15/2020
Horowitz	Jenny	Primary Care Physician	Recred	9/15/2020
Huang	Susan	Primary Care Physician	Recred	9/15/2020
Hung	Sammy	Specialist	Recred	9/15/2020
Kasberger	Kate	Primary Care Physician	Recred	9/15/2020
Kim	Jamie	Specialist	Recred	9/15/2020
Lee	Justin	Specialist	Recred	9/15/2020
Lee	Lan	Specialist	Recred	9/15/2020
Leiphart	Victoria	Specialist	Recred	9/15/2020
Litwin	Joshua	Specialist	Recred	9/15/2020
Ma	Daveena	Primary Care Physician	Recred	9/15/2020
Markowski	Meghan	Allied Health	Recred	9/15/2020
Pearson	Catherine	Primary Care Physician	Recred	9/15/2020
Roberts	Alison	Allied Health	Recred	9/15/2020
Ruiz	Laura	Allied Health	Recred	9/15/2020
Sackrin	Steven	Primary Care Physician	Recred	9/15/2020
Sharma	Alka	rimary Care Physician and Speciali	Recred	9/15/2020
Suri	Vikram	Specialist	Recred	9/15/2020
Van Gompel	Gabriel	Specialist	Recred	9/15/2020
Watson	Henry	Primary Care Physician	Recred	9/15/2020
Zhang	Zhonghua	Ancillary	Recred	9/15/2020
Zhi	Qi	Ancillary	Recred	9/15/2020

SEPTEMBER PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALISTS

PCP	3
Specialists	10
Ancillary	4
MIDLEVEL/AHP	10
Total	27



Provider Dispute Resolution
August 2020 Final and September 2020 Final

METRICS

PDR Compliance	Aug-20	Sep-20
# of PDRs Resolved	593	564
# Resolved Within 45 Working Days	591	562
% of PDRs Resolved Within 45 Working Days	99.7%	99.6%

PDRs Received	Aug-20	Sep-20
# of PDRs Received	1,051	780
PDR Volume Total	**1,051**	**780**

PDRs Resolved	Aug-20	Sep-20
# of PDRs Upheld	407	414
% of PDRs Upheld	69%	73%
# of PDRs Overturned	186	150
% of PDRs Overturned	31%	27%
Total # of PDRs Resolved	**593**	**564**

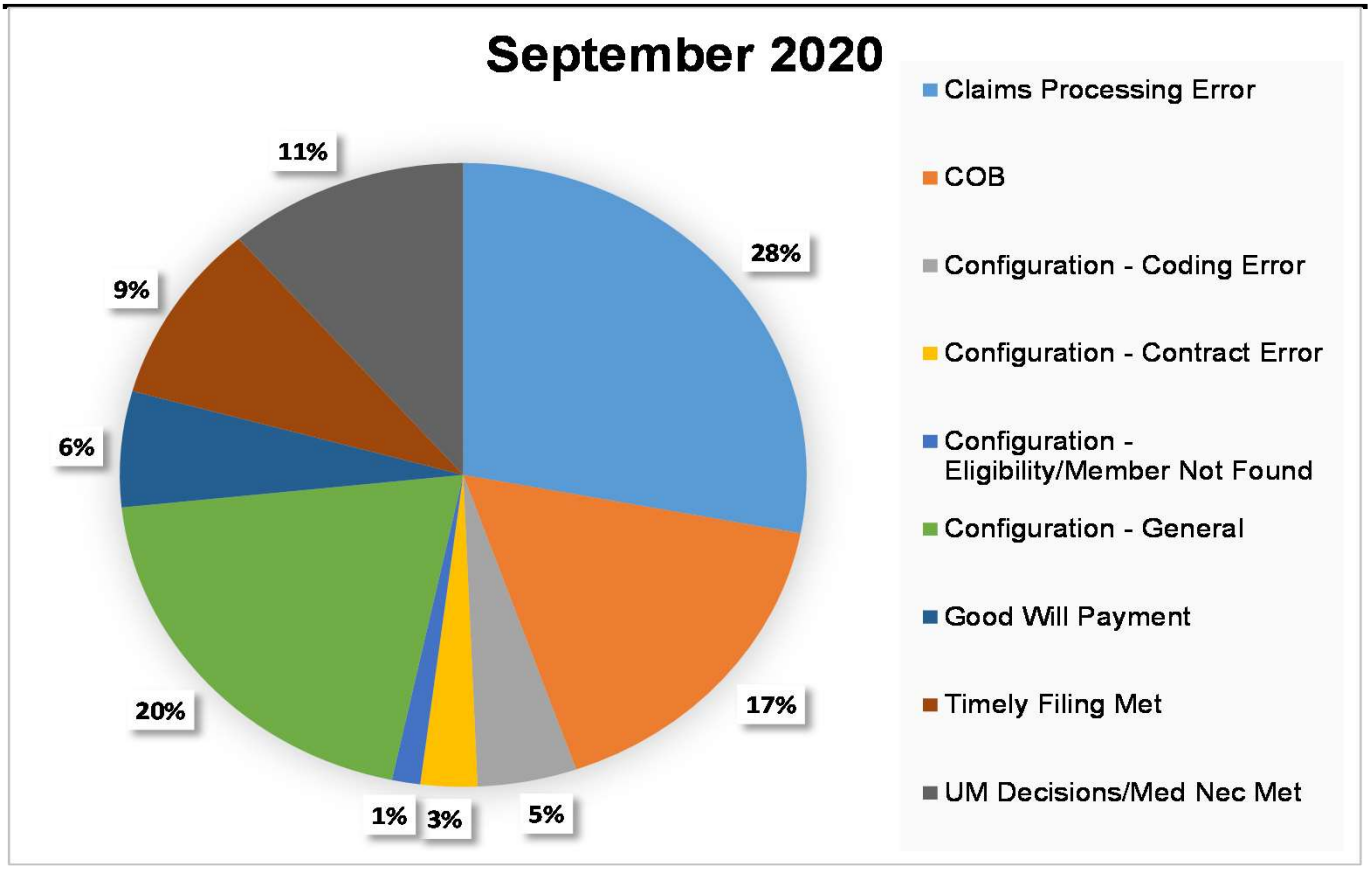
Average Turnaround Time	Aug-20	Sep-20
Average # of Days to Resolve PDRs	30	38
Oldest Unresolved PDR in Days	45	44

Unresolved PDR Age	Aug-20	Sep-20
0-45 Working Days	1,452	1,642
Over 45 Working Days	1	0
Total # of Unresolved PDRs	**1,453**	**1,642**

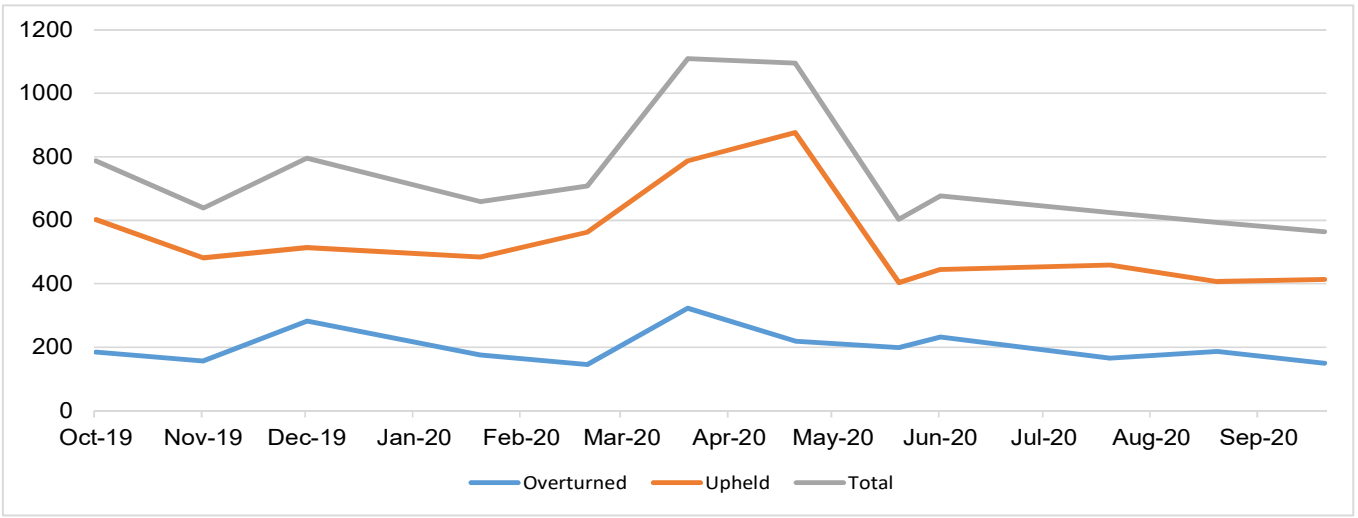
Provider Dispute Resolution
August 2020 Final and September 2020 Final

Sep-20

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

FY 2020-2021 | 1ST QUARTER (Q1) OUTREACH REPORT

ALLIANCE IN THE COMMUNITY

FY 2020-2021 | Q1 OUTREACH REPORT

During the 1st Quarter (Q1 – July, August, September) of Fiscal Year (FY) 2020-2021, the Alliance reached **1,116** members through our member orientation outreach call campaign.

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 reached in late February 2018. Since July 2018, **21,422** self-identified Alliance members were reached during community events, and member education events and 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.

All events details can be reviewed at **W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Outreach Reports\FY 20-21\Q1\3. September 2020**

ALLIANCE IN THE COMMUNITY

FY 2020-2021 | Q1 OUTREACH REPORT

FY 2019-2020 Q1 TOTALS

47 COMMUNITY EVENTS

27 MEMBER EDUCATION EVENTS

68 MEMBER ORIENTATIONS

3 MEETINGS/ PRESENTATIONS

146 TOTAL INITIATED/ INVITED EVENTS

97 **TOTAL COMPLETED EVENTS**

13 CITIES

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

2538 TOTAL REACHED AT COMMUNITY EVENTS

1806 TOTAL REACHED AT MEMBER EDUCATION EVENTS

305 TOTAL REACHED AT MEMBER ORIENTATIONS

76 TOTAL REACHED AT MEETINGS/PRESENTATIONS

1938 MEMBERS REACHED AT ALL EVENTS

4724 **TOTAL REACHED AT ALL EVENTS**

$3,520.85 TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

FY 2020-2021 Q1 TOTALS

8 COMMUNITY EVENTS

8 MEMBER EDUCATION EVENTS

48 MEMBER ORIENTATIONS

0 MEETINGS/ PRESENTATIONS

64 TOTAL INITIATED/ INVITED EVENTS

0 **TOTAL COMPLETED EVENTS**

26 CITIES

Alameda
Albany
Belton
Berkeley
Castro Valley
Dublin
Fremont
Hayward
Livermore
Newark
Oakland
Pleasanton
San Leandro
San Lorenzo
Union City
Argillite
Huntington Beach
El Sobrante
Emeryville
Hemet
Richmond
San Francisco
Rohnert Park
Los Angeles
Grand Rapids
Piedmont

0 TOTAL REACHED AT COMMUNITY EVENTS

0 TOTAL REACHED AT MEMBER EDUCATION EVENTS

1116 TOTAL REACHED AT MEMBER ORIENTATIONS

0 TOTAL REACHED AT MEETINGS/PRESENTATIONS

1116 MEMBERS REACHED AT ALL EVENTS

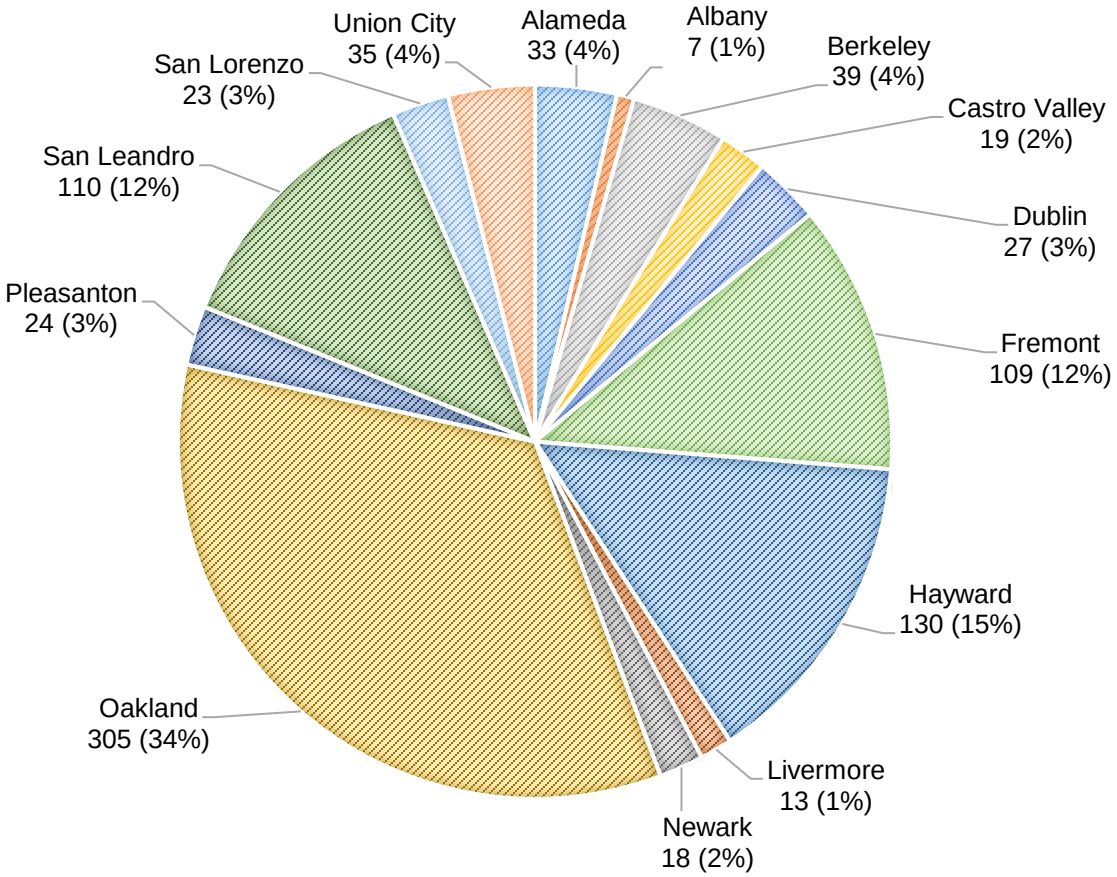
1116 **TOTAL REACHED AT ALL EVENTS**

$0 TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

** Includes refundable deposit.*

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

NUMBERS REACHED BY CITY*

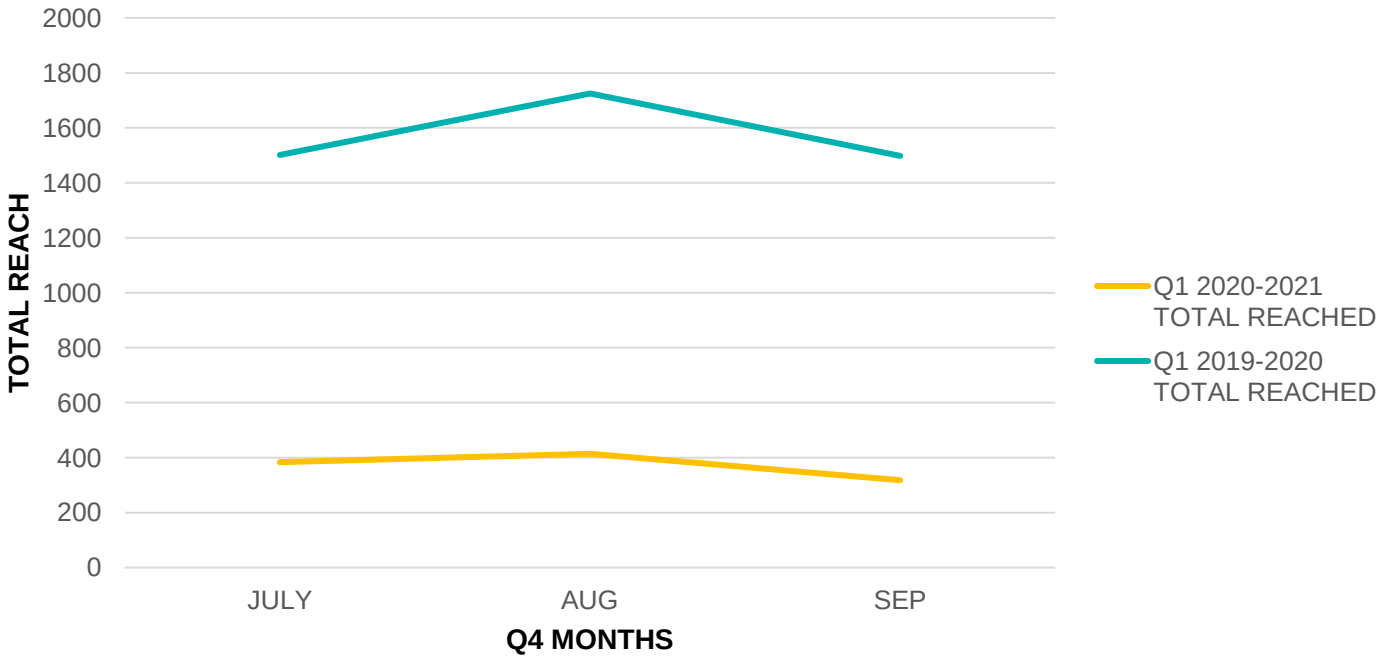


** The following cities had <1% reach during Q1 of FY21: Burlingame, El Sobrante, Emeryville, Richmond, San Francisco, San Jose, San Pablo, San Ramon, Stockton and Tracy.*

ALLIANCE IN THE COMMUNITY

FY 2020-2021 | Q1 OUTREACH REPORT

TOTAL REACHED
BY Q1



	JULY	AUG	SEP	TOTAL
Q1 2020-2021 – TOTAL REACHED	384	414	318	**1116**
Q1 2019-2020 – TOTAL REACHED	1501	1725	1498	**4724**

The graph above compares the total reached at **all Alliance outreach events** in Q1 of FY 2020-2021 and Q1 of FY 2019-2020.

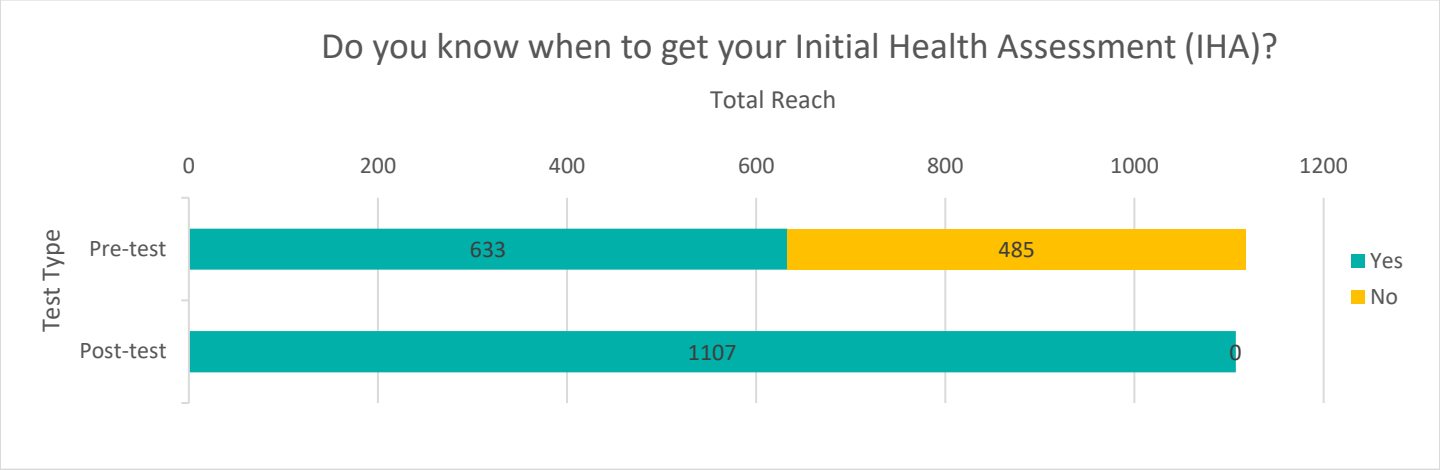
During Q1 of FY 2021-2020, the Alliance reached 1,116 members compared to 4,724 people in Q1 of FY 2019-2020 at all events.

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

ALLIANCE IN THE COMMUNITY

FY 2020-2021 | Q1 OUTREACH REPORT

INITIAL HEALTH ASSESMENT KNOWLEDGE
DURING Q1



	YES	NO	TOTAL
Q1 2020-2021 – PRE-TEST	633	485	**1118**
Q1 2020-2021 – POST-TEST	1107	0	**1107**

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

After completing an MO, **100%** of members who completed the post-test survey in Q1 of FY 2020-2021 reported knowing when to get their IHA, compared to only 57% of members knowing in the pre-test.

ALAMEDA Alliance FOR HEALTH

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

Compliance

Richard Golfin, III

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

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

Date: **October 9, 2020**

Subject: **Compliance Report**

State Audit Updates

- 2020 DMHC Follow-Up Medical Audit:
  - On February 4, 2020, the DMHC conducted an onsite follow-up audit for outstanding deficiencies identified in the 2018 Routine Medical Audit. On June 30, 2020, the Plan received the Final Audit Report from the DMHC. According to the report, five (5) of the twelve (12) findings from the 2018 Survey remain in a "not corrected" status. On July 10, 2020, the Plan provided a narrative response to the findings which were published as an addendum to the Final Audit Report. The Plan is on standby and ready to address additional questions sent by the DMHC on the Plan's narrative responses. The Plan anticipates an enforcement action to be applied based on the five (5) findings which remain in a "not corrected" status.

- 2020 DHCS Annual Medical Audit:
  - The DHCS has rescheduled the previously delayed June 2020 Annual Medical Audit to summer 2021. In addition to delaying the 2020 audit for another year, the DHCS will expand the audit lookback period to include two years of Plan activity; potentially going back as far as summer 2019. Whether the 2021 Annual Medical Audit will be held remotely or onsite remains under review at the DHCS.

- 2020 DMHC Medical Audit:
  - The DMHC has rescheduled this year's expected triannual full-survey, originally set for October 12, 2020. The new date is April 12, 2021. Whether the 2021 survey will be held remotely or onsite remains under review at the DMHC.

Regulatory Updates

- COVID-19 Network Metrics and Reporting to State Regulators:
  - Since mid-March, the Plan has reported metrics of new COVID-19 positive tests and COVID-19 related hospitalizations. These reports are made daily to the DHCS by the Compliance Department. As of 10/6/2020, the Plan has had 742 members test positive for COVID-19 and 846 hospital admissions associated with COVID-19.

Compliance

Supporting Documents

APL/PL IMPLEMENTATION TRACKING LIST							
#	Regulatory	APL/PL #	Date Released	APL/PL Title	LOB	Summary of Key Requirements	Status
1	DHCS	20-001	1/3/2020	2020-2021 MEDI-CAL MANAGED CARE HEALTH PLAN MEDS/834 CUTOFF AND PROCESSING SCHEDULE	Medi-Cal	1) MEDS/834 cutoff and processing schedule covers the period of Dec 2019-Jan 2021. These cutoff dates and timelines are established to ensure timely processing of eligibility files and data. 2) DHCS must receive all enrollments and disenrollments on a dialy basis. 3) MCPs must adhere to the cutoff dates and timelines to allow adequate processing time and to ensure timely payments. 4) MCPs must notify the Managed Care Operations Division (MCOD) Systems Support Unit (SSU) of any MCP/MEDS/834 changes prior to the 15th of any given month by sending an email to ssuhelpdesk@dhcs.ca.gov. 5) MCPs send the original copy of their notification to their assigned MCOD Contract Mgr.	Closed
2	DMHC	20-001	1/15/2020	Newly Enacted Statutes Impacting Health Plans	Both	14 new statutory requirements. 6 of the 14 are not applicable to AAH. The others are still under review.	Ongoing
3	DHCS	20-002	1/31/2020	Non-Contract Ground Emergency Medical Transport Payment Obligations (GEMT)	Medi-Cal	Provides Medi-Cal managed care health plans (MCPs) with pertinent information concerning enhanced reimbursement obligations for Fee-For-Service (FFS) ground emergency medical transport (GEMT) "Rogers Rates" On September 6, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 19-0020, with an effective date of July 1, 2019. SPA 19-0020 continues the GEMT QAF program and a reimbursement add-on amount for GEMT services provided by emergency medical transport providers to MCP Members beginning on July 1, 2019. DHCS intends to renew the GEMT QAF program and the reimbursement add-on for GEMT services provided by emergency medical transport providers for future program years. Beginning on July 1, 2019, in addition to the FFS fee schedule base rate for GEMT services, emergency medical transport providers will be entitled to a fixed add-on amount of $220.80 for non-contracted GEMT services provided to MCP Members. The resulting payment amounts will be equal to the sum of the FFS fee schedule base rate and the add-on amount for each CPT Code. The resulting total payment amount for CPT codes A0429, A0427, A0433, and A0434 is $339.00 and for CPT code A0225, it is $400.72.	Closed
4	DMHC	20-002	1/21/2020	Enrollment Data Reporting	Group	New template to be used annually to report MEWA and Exchange Enrollment Report as of December 31st. Must be filed by 2/15/20 as an attachment to the 4Q19 Financial Satement via the DMHC's Financial Statements web portal. Subsequent years filing due by 2/15.	Closed
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.	Closed
6	DHCS	20-003	2/27/2020	Network Certification Requirements	Medi-Cal	MCP's must: Contract with the required number and mix of primary and specialty care providers; Provide medically necessary services needed for their anticipated membership and utilization; Confirm that the geographic location of network providers complies with time and distance standars; and Comply iwth service availability, physical accessibility, out-of-netowrk (OON) access, timely access, continuity of care, and 24/7 language assistance requirements.	Closed

7	DHCS	20-004	3/27/2020	Emergency Guidance for Medi-Cal Managed Care Health Plans in Response to COVID-19	Medi-Cal	1. Well-Child Visits: DHCS is providing guidance on pediatric well-care services via telehealth during the pandemic. The guidance suggests that well-child visits should be initiated through telehealth, however there are some services that should be done in person such as the comprehensive physical exam, office testing, immunizations, hearing, vision, and oral health screenings. These services would be a continuation of services provided via telehealth/virtual and the provider should only bill for one encounter/visit. In addition, to ensure adherence to the Bright Futures guidelines, DHCS is advising MCPs to encourage pediatric providers to discuss with members the benefits of attending well-child visits in person to receive the necessary immunizations and screenings, in addition to the provision of services via telehealth. 2. File and Use: DHCS has approved for MCPs to submit certain documents including proposed telephone outreach scripts related to COVID-19 as file and use, which means that once an MCP submits documents or scripts to DHCS, the MCP can immediately begin using those documents or scripts with its members. All information communicated to members must be information related to COVID-19 that directly came from DHCS, the California Department of Public Health, or the CDC. In addition, documents or scripts must not contain any PHI or Personal Information of a member. The following are documents and scripts approved for file and use. 3. Temporary Reinstatement of Acetaminophen and Cough/Cold Medicines: DHCS issued guidance on May 13, 2020 regarding the temporary reinstatement of non-legend acetaminophen-containing products and non-legend cough and cold products for adults as covered benefits with the Medi-Cal FFS program. MCPs are required to follow this FFS-issued guidance, including the provision of these over-the-counter drugs without prior authorization. 4. Temporary Addition of Provider Types at FQHCs and RHCs: Pursuant to SPA 20-0024, DHCS issued guidance on May 20, 2020, temporarily adding the services of Associate Clinical Social Workers (ACSWs) and Associate Marriage and Family Therapists (AMFTs) at FQHCs and RHCs as billable visits. The California Board of Behavioral Sciences (BBS) does not consider ACSWs or AMFTs to be licensed practitioners, therefore licensed behavioral health practitioners must supervise and assume the professional liability of services furnished by the unlicensed ACSW and AMFT practitioners. FQHCs or RHCs can be reimbursed in accordance with the terms of the MCPs contract with the State related to FQHCs and RHCs for a visit between an FQHC or RHC patient and an ACSW or AMFT. The visit may be conducted as a face to face encounter or meet the requirements of a visit provided via telehealth.	Ongoing
8	DMHC	20-004	2/7/2020	Federal SBC Template Filing		A new federal template must be used for the Summary of Benefits and Coverage (SBC) to enrollees. The template must be used in connection with Individual and Group contract issued, amended, or renewed for plan or policy years that begin on or after Juanuary 1, 2021. Filing is due March 2, 2020.	Closed
9	DMHC	20-005	2/7/2020	Plan Year 2021 QHP an QDP Filing Requirements	N/A	Doesn't Apply to AAH	N/A
10	DHCS	20-005		Extension of the Adult Expansion Risk Corridor for SFY 2017-2018	N/A	Doesn't Apply to AAH	N/A
11	DMHC	20-006	3/5/2020	COVID-19 Screening and Testing	Both	1.Immediately reduce cost-sharing (including, but not limited to, co-pays,deductibles, or coinsurance) to zero for all medically necessary screening andtesting for COVID-19, including hospital (including emergency department),urgent care visits, and provider office visits where the purpose of the visit is to bescreened and/or tested for COVID-19. 2.Notify, as expeditiously as possible, the plan's contracted providers that the planis waiving cost-sharing as described above. 3.Ensure the plan's advice line/customer service representatives are adequatelyinformed that the plan is waiving cost-sharing as described above and clearlycommunicate this to enrollees who contact the plan seeking medically necessaryscreening and testing for COVID-19. 4.Prominently display on the plan's public website a statement that the plan iswaiving cost-sharing for medically necessary screening and testing for COVID-19. 5. Plans should work with their contracted providers to use telehealth services to deliver care when medically appropriate, as a means to limit enrollees' exposure to others who may be infected with COVID-19, and to increase the capacity of the plans' contracted providers. 6. In the event of a shortage of any particular prescription drug, plans should waive prior authorization and/or step therapy requirements if the enrollee's prescribing provider recommends the enrollee take a different drug to treat the enrollee's condition.	Ongoing
12	DHCS	20-006	3/4/2020	Site Reviews - Facility Site Reivew and Medical Record Review	Medi-Cal	The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (MCPs) of updates to the Department of Health Care Services' (DHCS) site review process, which includes Facility Site Review (FSR) and Medical Record Review (MRR) policies. This APL includes changes made to the criteria and scoring of DHCS' FSR and MRR tools and standards.	*on hold due to Covid-19

13	DMHC	20-007	3/12/2020	"Social Distancing" Measures in Response to COVID-19	Both	1. If the health plan has pre-authorization or pre-certification requirements that contracted providers must meet before the plan will cover care delivered via telehealth, as defined in Business and Professions Code section 2290.5, the plan should either expedite the plan's review process or relax those pre-authorization/pre-certification requirements to allow the plan to more quickly approve providers to offer services via telehealth. 2. Plans should waive applicable cost-sharing for care delivered via telehealth, notwithstanding that a cost-share might apply if the provider delivered the care in-person. 3. Plans should allow enrolless to receive at least a 90-day supply of maintenance drugs, as defined in California Code of Regulations section 1300.67.24(d)(3)(D), unless the enrollee's provider has indicated a shorter supply of a drug is appropriate for the enrollee. 4. Plans should suspend prescription drug refill limitations where the enrollee's provider has indicated a refill is appropriate for the enrollee. 5. Plans should waive delivery charges for home delivery of prescription medications.	Closed
14	DHCS	20-007	3/30/2020	Policy Guidance for Community-Based Adult Services in Response to COVID-19 Public Health Emergency	Medi-Cal	1. Congregate services provided inside the center are not allowed during the period of this public health emergency. Essential services to individual members may be provided in the center so long as they meet criteria defined in this APL and with proper safety precautions. 2. CBAS centers are granted time-limited flexibility to reduce day-center activities and to provide CBAS in the home, telephonically, or via live virtual video conferencing, including but not limited to: Professional nursing care-Personal care services Social Services-Behavioral Health Services-Speech therapy-Therapeutic activities-Registered dietician-nutrition counseling 3. CBAS centers are also permitted to provide or arrange for home-delivered meals, in absence of meals provided at the CBAS center, and may continue to provide transportation services, as necessary and appropriate. 4. CBAS centers are eligible to receive their existing per diem rate for the provision of CBAS as described in this APL. MCPs must continue to authorize and reimburse CBAS centers for the delivery of services provided in the member's home, telephonically o via live virtual video conferencing. Delivery of services must be based on a CBAS member's assessed needs as documented in the current Individual Plan of Care (IPC), and/or identified by subsequent assessment by the center's multidisciplinary team. 5. Per the current 1115 Waiver special terms and conditions, for initial eligibility determinations, an initial face-to-face review is not required when an MCP determines that a member is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on the information that the MCP possesses. MCPs may extend eligibility re-determinations for the ongoing receipt of CBAS to up to 12 months for members determined by the MCP to be clinically appropriate. DHCS encourages MCPs to minimize or eliminate requirements for face-to-face interactions, whenever possible. 6. Existing CBAS health record documentation standards for services provided will continue to apply. CBAS centers are responsible for updating member IPCs when a change in assessed need is identified through regularly scheduled reassessments and reassessments conducted due to a change in participant condition. 7. MCPs may require regular reporting by the CBAS centers, at a frequency and format required by the MCP, to substantiate the provision of services provided in accordance with this APL. 8. MCPs are responsible for ensuring that their subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all subcontractors and network providers.	Closed
15	DMHC	20-008	3/18/2020	Provision of Health Care Services During Self Isolation Orders	Both	1. On March 16, 2020, seven Bay Area counties (Contra Costa, Santa Clara, San Mateo, San Francisco, Alameda, Santa Cruz and Marin) and the city of Berkeley issued an order (Orders) directing people to self-isolate to the maximum extent possible at their residences through April 7, 2020. 2. The County and City Orders are explicit that health plan personnel whose work is necessary to "avoid any impacts to the delivery of healthcare, broadly defined" are exempt from the Orders and may travel to and from work. Also exempt from the Orders are health plan personnel whose work is necessary to ensure the continued performance of core health plan functions and/or facilitate the remote work of other health plan employees. 3. The DMHC understands plans may choose to delay some services, such as elective surgeries or other non-urgent procedures, during this time. This is permissible provided the referring or treating provider, or the health professional providing triage or screening services, as applicable, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee. 4. If the plan does not have personnel available to mail hard-copy information, it is sufficient to communicate with enrollees and providers electronically and/or telephonically, so long as the plan maintains a log or record of the communications.	Closed

16	DHCS	20-008	4/7/2020	Mitigating Health Impacts of Secondary Stress Due to the COVID-19 Emergency	Medi-Cal	1. MCPs and their providers are reminded to utilize the ACEs-oriented, trauma-informed care training for providers, as well the ACEs screening services, billing codes, and minimum provider fee schedule described in APL 19-018. 2. MCPS and their providers are to stay informed as to the most current guidance and best practices relative to COVID-19. 3. MCPs and their providers should support continuity and integration of medical and behavioral services via telehealth and related adaptions in delivery during the crisis. 4. MCPs should educate their providers on disaster-responsive, trauma-informed care. 5. MCPS should ensure their providers learn the signs of and assess for stress-related morbidity, and create responsive treatment plans, including supplementing usual care with measures that help regulate the stress response system. 6. MCPs are responsible for ensuring that their subcontractors and network providers comply. Requirements must be communicated by each MCP to all subcontractor and network providers.	Closed
17	DMHC	20-009	3/18/2020	Reimbursement for Telehealth Services	Both	1. Health plans shall reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim. For example, if a health plan reimburses a mental health provider $100 for a 50-minute therapy session conducted in-person, the health plan shall reimburse the provider $100 for a 50-minute therapy session done via telehealth. 2. For services provided via telehealth, a health plan may not subject enrollees to cost-sharing greater than the same cost-sharing if the service were provided in-person. 3. Health plans shall provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the enrollee.	Closed
18	DHCS	20-009	4/15/2020	Preventing Isolation of and Supporting Older and Other At-Risk Individuals to Stay Home and Stay Healthy During COVID-19 Efforts	Medi-Cal	1. MCPs must continue to support telehealth for all services for which it is medicall\ appropriate. 2. MCPs and their contracted providers should continually assess for and provide allowable additional services and supports during this time that may be vital for an older or at-risk adult to stay home and stay healthy. 3. MCPs and their contracted providers should support continuity and coordinate the integration of medical and behavioral health services for all ages. 4. MCPs are encouraged to continue their check-in calls (see below resources) with older and other at-risk adults, to check on basic needs, health care, mental health, and safety from abuse and neglect.	Closed
19	DHCS	20-010	4/20/2020	Cost Avoidance and Post-Payment Recovery for Other Health Coverage	Medi-Cal	1. MCPs must report new OHC information not found on the Medi-Cal eligibility record or OHC information thaty is different from what is found on the Medi-Cal eligibility record to DHCS within 10 calendar days of discovery. 2. Beginning January 1, 2021, MCPs must include OHC information in their notification to the provider when a claim is denied due to the presence of OHC. 3. MCPs must ensure providers review the Medi-Cal eligibility record for the presence of OHC. 4. Prior to delivering services to members, MCPs must ensure providers review the Medi-Cal eligibility record for the presence of OHC. 5. MCPs must ensure providers do not refuse a covered Medi-Cal service to a Medi-Cal member regardless of the presence of OHC. 6. Effective February 9, 2018, prenatal care is subject to cost avoidance. 7. MCPs must not process claims for a member whose Medi-Cal eligibility record indicates OHC, other than a code of A or N, unless the provider presents proof that sources of payment have been exhausted or the provided service meets the requirements for billing Medi-Cal directly.	Ongoing
20	DMHC	20-010	3/18/2020	Special Enrollment Period; Coverage Effective Dates	N/A	Doesn't Apply to AAH	N/A

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

25	DMHC	20-013	4/7/2020	Billing for Telehealth Services; Telehealth for the Delivery of Services	Both	1. APL is a follow up to APL 20-009 to increase uniformity and efficiency with respect to provider billing during the COVID-19 State of Emergency to drecrease admnistrative burdens on providers and plans. As per APL 20-009, a) Reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim. b) For services provided via telehealth, not subject enrollees to cost-sharing greater than the same cost-sharing if the service were provided in-person. c) Provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the enrollee. 2. During the COVID-19 State of Emergency, when a provider delivers a service via telehealth that the provider would normally deliver in-person, the provider should document and bill the service(s) as follows: a) Thoroughly document the visit as if the visit had occurred in person. b) Use the CPT codes for the particular services rendered. c) Use Place of Service "02" to designate telehealth. d) Use modifier 95 for synchronous rendering of services or GQ for asynchronous. 3. During the COVID-19 State of Emergency, a health plan may not exclude coverage for certain types of services or categories of services simply because the services are rendered via telehealth, if the enrollee's provider, in his/her professional judgment, determines the services can be effectively delivered via telehealth. 4. During the COVID-19 State of Emergency a health plan may not place limits on covered services simply because the services are provided via telehealth if such limits would not apply if the services were provided in-person. 5. During the COVID-19 State of Emergency, a health plan may not require enrollees to use the plan's telehealth vendor, or a different provider from the one the enrollee typically sees, if the enrollee's provider is willing to deliver services to the enrollee via telehealth and the enrollee consents to receiving services via telehealth.	Closed
26	DHCS	20-013	5/13/2020	Proposition 56 Directed Payments for Family Planning Services	Medi-Cal	1. DHCS is requiring MCPs, either directly or through their delegated entities and Subcontractors, to pay qualified contracted and non-contracted Providers7 a uniform and fixed dollar add-on amount for the specified family planning services (listed below) provided to a Medi-Cal managed care member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D), with dates of service on or after July 1, 2019, in accordance with the CMS-approved preprint for this program, which will be made available on DHCS' Directed Payments Program website upon CMS approval. 2. MCPs are responsible for ensuring that qualifying family planning services are reported to DHCS in encounter data pursuant to APL 14-019, "Encounter Data Submission Requirements" using the procedure codes. 3. MCPs are responsible for ensuring that the encounter data reported to DHCS is appropriate for the services being provided. 4. MCPs must include oversight in their utilization management processes, as appropriate. The uniform dollar add-on amounts of the directed payments vary by procedure code. 5. The uniform dollar add-on amounts for these family planning services must be in addition to whatever other payments eligible Providers would normally receive from the MCP, or the MCP's delegated entities and Subcontractors. 6. Starting with the calendar quarter ending June 30, 2020, MCPs must report to DHCS within 45 days of the end of each calendar quarter all directed payments made pursuant to this APL, either directly by the MCP or by the MCP's delegated entities and Subcontractors. Reports must include all directed payments made for dates of service on or after July 1, 2019. MCPs must provide these reports in a format specified by DHCS, which, at a minimum, must include Health Care Plan code, procedure code, service month, payor (i.e., MCP, delegated entity, or Subcontractor), and the Provider's National Provider Identifier. All reports shall be submitted in a consumable file format (i.e., Excel or Comma Separated Values) to the MCP's Managed Care Operations Division (MCOD) Contract Manager. 7. For clean claims or accepted encounters with dates of service between July 1, 2019, and the date the MCP receives payment from DHCS, the MCP must ensure that payments required by this APL are made within 90 calendar days of the date the MCP receives payments accounting for the projected value of the directed payments from DHCS. From the date the MCP receives payment onward, the MCP must ensure the payments required by this APL are made within 90 calendar days of receiving a clean claim12 or accepted encounter for qualifying services, for which the clean claim or accepted encounter is received by the MCP no later than one year after the date of service. MCPs are not required to make the payments described in this APL for clean claims or accepted encounters for applicable family planning services received by the MCP more than one (1) year after the date of service. These timing requirements may be waived only through an agreement in writing between the MCP (or the MCP's delegated entities or Subcontractors) and the affected Provider. 8. MCPs must have a formal procedure for the acceptance, acknowledgment, and resolution of Provider grievances related to	Ongoing

27	DHCS	20-014	*5/27/2020	Prop 56 Value-Based Payment Program Directed Payments	Medi-Cal	1. Subject to obtaining the necessary federal approvals and consistent with 42 CFR section 438.6(c), MCPs, either directly or through their delegated entities and Subcontractors, must make directed payments for qualifying VBP program services (as defined below) for dates of service on or after July 1, 2019, in the specified amounts for the appropriate procedure codes, in accordance with the CMS-approved preprint. The directed payments are in addition to whatever other payments eligible Network Providers would normally receive from the MCP or MCP's delegated entities and Subcontractors. 2. MCPs must make value-based directed payments to eligible Network Providers for specific qualifying services tied to performance across four domains, as set forth in the VBP program specifications and the valuation summary. 3. For qualifying events tied to Members diagnosed with a substance use disorder, a serious mental illness, or who are homeless or have inadequate housing, MCPs must make the add-on directed payments corresponding to at-risk Members. For qualifying events tied to all other Members, MCPs must make the add-on directed payments corresponding to non-at-risk Members. 4. MCPs must make VBP directed payments for qualifying services provided by eligible Network Providers with dates of service on or after July 1, 2019, in accordance with the requirements outlined within the VBP program specifications. If applicable, for purposes of VBP directed payments, the “measurement year” for a given service is the calendar year in which that service was provided. 5. Individual rendering Network Providers qualified to provide the VBP program services are eligible to receive VBP directed payments. In addition to the requirements outlined in APL 19-001, Network Providers must meet the following criteria; posses an individual (tpye 1) NPI and be practicing within their practice scope. 6. Starting with the calendar quarter ending June 30, 2020, MCPs must report to DHCS within 45 days of the end of each calendar quarter all directed payments made pursuant to this APL, either directly by the MCP or by the MCP’s delegated entities and Subcontractors. Reports must include all directed payments made for dates of service on or after July 1, 2019	Ongoing
28	DMHC	20-014	4/7/2020	Mitigating Negative Health Outcomes due to COVID-19	Both	The purpose of this All Plan Letter (APL) is to offer reminders and resources to help health care service plans serve enrollees and mitigate negative health outcomes to members due to the COVID-19 emergency. 1. Health care service plans should educate their providers on disaster-responsive,trauma-informed care. This education or training should include the crucial roles of the following: Ensuring physical and emotional safety of patients; Building trust between providers and patients; Recognizing and responding to the signs and symptoms of stress on physicaland mental health Promoting patient-centered, evidence-based care; Ensuring provider and patient collaboration in treatment planning; Sensitivity to the racial, ethnic, cultural, and gender identity of patients; Supporting provider resilience 2. Health care service plans may wish to ensure providers learn the signs of and assessfor stress-related morbidity, and create responsive treatment plans, includingsupplementing usual care with measures that help regulate the stress responsesystem, such as: Supportive relationships; Age-appropriate, healthy nutrition; Sufficient, high-quality sleep; Mindfulness and meditation; Adequate physical activity; Mental health care. 3. Health care service plans and their providers should support continuity and integrationof medical and behavioral health services. 4. Health care service plans must continue to support telehealth for all services for whichit is medically appropriate. The DMHC recently issued guidance on telehealth.	Closed
29	DMHC	20-015	4/13/2020	COVID-19 Temporary Extension of Plan Deadlines	Both	1. In light of the COVID-19 State of Emergency, the Director has determined that select deadlines and requirements may be temporarily extended to give health plans additional time to comply. 2. Quarterly Grievance Reports: extended by 60 days; reports must not be submitted no later than 90 days after the end of each quarter. 3. Arbitration Decisions: unredacted arbitration decisions must be submitted within the date of the decision and redacted arbitration decisions must be submitted within 60 days after the close of the quarter in which they should have been submitted 4. Quarterly Claims Settlement Practices Report: due date extended to June 20, 2020 5. Standard Formulary Template Implementation: go-live date extended to July 1, 2020 6. Timely Access Compliance and Annual Network Reporting: extended to May 1, 2020	Closed

30	DMHC	20-016	4/15/2020	Prevention Isolation and Supporting 60+ and other At-Risk Individuals to Stay Home and Stay Healthy during COVID-19 efforts.	Both	1. Health plans must continue to support telehealth for all services for which it is medically appropriate. 2. Health plans and their contracted providers should continually assess for and consider the provision of allowable additional services and supports during this time, such as nutrition, that may be vital for an older or at-risk adult staying home and staying healthy. 3. Health plans and their contracted providers should support continuity and integration of medical and behavioral health services for all ages. 4. Health plans are encouraged to continue check-in calls with older and other at-risk adults, to check the basic needs, health care, mental health, and safety from abuse and neglect. RESOURCES 1. The State is partnering with 211 in all communities to be a first stop for all local food and other human service needs. 2. The State's Aging and Adults Info Line connects to local Area Agencies on Aging. Dial 1-800-510-2020 3. The Friendship Line, run by Institute on Aging, provides 24/7 connection and crisis line for older adults. Dial (888) 670-1360 4. "Feeling Good & Staying Connected" is a new activity guide and weekly planner available from CDA in English, Spanish, Traditional Chinese and Simple Chinese. 5. Additional resources on how to mitigate the stress-related health outcomes anticipated with the COVID-19 emergency can be found on www.ACEsAware.org.	Closed
31	DHCS	20-016	9/29/2020	Blood Lead Screening of Young Children	Medi-Cal	Blood Lead Anticpatory Guidance and Screening Requirements: *MCPs must ensure that their network providers who perform PHAs on child members between the ages of six months to six years comply with current federal and state laws and industry guidelines for health care providers issued by CLPPB, including any future updates or amendments to these laws and guidelines. *MCPs must ensure that their network providers provide oral and written anticipatory guidance to the parent(s) or guardians(s) of a child member that, at a minimum, includes information that children can be harmed by exposure to lead. This guidance must be provided to the parent or guardian at each PHA, starting at 6 months of age and continuing until 72 months of age. *Order or perform blood lead screenign tests on child members. *Follow CDC recommendations for Post-Arrival Lead Screening of Refugees contained in the CLPPB issued guidelines. *MCP's must ensure that the network provider documents the reason(s) for not performing blood lead screening tests in the child menber's medical record. *In order to comply with Health Insurance Portability and Accountability Act requirements, MCPs must utilize the CMS-1500/UB 04 claim forms, or their electronic equivalents (837-P/837-I), to report confidential screening/billing to DHCS. *MCPs are required to submit complete, accurate, reasonable, and timely encounter data consistent with the MCP contract and APLs 14-019 and 17-005.12 Additionally, MCPs must ensure that blood lead screening encounters are identified using the appropriate indicators, as outlined in the most recent DHCS Companion Guide for X12 Standard File Format, which can be obtained by emailing the Encounter Data mailbox at: MMCDEncounterData@dhcs.ca.gov. *Updated P&Ps are due via email 90-days after issuance of APL.	ongoing
32	DMHC	20-017	4/16/2020	Guidance Regarding DMHC General Licensure Regulation	Both	1. On June 14, 2019, the Department of Managed Health Care (DMHC) issued All Plan Letter 19-014. The All Plan Letter provided guidance regarding the Department's recently adopted General Licensure Regulation. The General Licensure Regulation requires an entity that accepts any amount of global risk, as defined in the General Licensure Regulation, to obtain either: (1) a health care service plan license; or (2) an exemption from the licensure requirements. 2. Due to the uncertainty caused by the COVID-19 pandemic, the DMHC is extending the phase-in period through December 31, 2020.	Ongoing
33	DMHC	20-018	4/29/2020	Modification of Timely Access Provider Appointment Availibility Surveys Timeframes	Both?	Currently, Health and Safety Code section 1367.03(f)(3) and page 11 of the PAAS Methodology require health plans to complete the administration of the PAAS between April 1 and December 31. For MY 2020, health plans shall begin administration of the PAAS no earlier than August 1, 2020.	Ongoing
34	DMHC	20-019	5/5/2020	Association Health Plans: Extension of "Phase-Out" Period	N/A	Doesn't Apply to AAH	N/A

35	DMHC	20-020	5/20/2020	Ensuring Continued Network Adequacy and Removing Unnecessary Burdens on Providers	Group	Each plan must submit an informational filing to the DMHC explaining the steps the plan has taken, and/or will take, to ensure continued network adequacy. If actions have been taken, provide details (no later than COB Tuesday June 2nd) regarding: * the approximate dates the plan took or will take the actions described; * the amount of investments made to support California providers; * the geographic areas in California where the plan has targeted or will target its actions; *and, whether the actions apply to provider groups, hospitals and/or other entities. The DMHC encourages health plans to communicate with their contracted providers to determine whether the providers are experiencing financial difficulties that may threaten the adequacy of the plans' networks. If providers are experiencing financial difficulties, the DMHC, in the context of plan financial stability, encourages plans to take one or more of the following steps: 1. Expedite claims review and payment to decrease the accounts receivables owed to providers. As a reminder, the DMHC will continue to monitor timely payment of claims during our financial exams. 2. Identify and remove administrative burdens that may be delaying providers' abilities to submit and be paid for claims. For example, providers report experiencing extended telephone wait-times to talk with plan personnel and limits on the number of cases a provider may discuss with a plan in one phone call. The DMHC encourages plans to remove or reduce these burdens when possible. 3. Work with the plan's contracted providers to give the providers advance payments when feasible and desired by the provider. These payments could include advances on capitation payments or no-interest loans to assist providers with remaining solvent while they begin to provide more non-urgent and non-emergent procedures that were deferred during the previous several months. 4. Amend coordination of benefit procedures in situations where the enrollee has not yet verified he/she does not have alternative coverage, such that the default is to pay the claim. The DMHC understands that in some instances plans will delay reimbursement until the enrollee confirms in writing they do not have alternate coverage. During this time when many providers are delivering services via telehealth, obtaining information from enrollees may be very difficult, resulting in delayed payment to the provider. The DMHC encourages plans to pay the claims and then follow up with the enrollee regarding the existence of alternate coverage. If the enrollee did have alternative coverage that should have paid the claim, the plan could seek recoupment, as appropriate, from the provider.	Closed
36	DMHC	20-021	6/1/2020	Health Care Service Plan §1368.7 Filings for Governor's State of Emergency in Los Angeles County Due June 2, 2020	N/A	Doesn't Apply to AAH	N/A
37	DMHC	20-025	7/1/2020	Guidance Regarding New or Innovative Benefits	N/A	Doesn't Apply to AAH	N/A
38	DMHC	20-026	7/8/2020	Preventive Health Services Coverage for HIV Preexposure Prophylaxis (PrEP)	Both	By August 7, 2020 all health plans must submit an Amendment via eFiling titled, "Preventive Health Services Coverage for HIV Preexposure Prophylaxis (PrEP)," with the following exhibits and information a) Exhibit E-1: Affirm the Plan shall update all contracts as necessary to reflect the changes (including, but not limited to PBM contracts, plan to plan agreements, etc.) and shall revise all policies and procedures as necessary to reflect the changes (including, but not limited to Utilization Management, Claims Processing, etc.). If the affirmation does not apply, explain in the Exhibit E-1 why it does not apply to the Plan, AND o State either: • The plan has updated its policies & procedures, contracts, and all other necessary documents to reflect the preventative health services coverage for HIV PrEP. OR • The plan will update its policies & procedures, contracts, and all other necessary documents to reflect the preventative health services coverage for HIV PrEP by _____.	complete
39	DMHC	20-027	7/13/2020	Guidance Regarding Assembly Bill (AB) 731 Reporting Requirements	Both	AB 731 (Kalra, 2019) amended section 1385.03 to the California Health and Safety Code. This bill requires health plans offering a large group health care service plan contract to file information regarding the methodology, factors, and assumptions used to determine rates with the Department of Managed Health Care (DMHC) at least 120 days before implementing any change in the methodology, factors, or assumptions that would affect the rates paid by a large group. In addition, health plans must include geographic rating region trends in the individual and small group rate review filings. *Health plans shall comply with the new reporting and filing requirement for all large group filings submitted after July 1, 2020. Health plans are required to file a separate filing for each rating method. *The annual filing required by Health and Safety Code section 1385.03(a)(3) shall be submitted annually to the Department via SERFF on or before September 2 or 120 days before a change, whichever is earlier.	Closed

40	DMHC	20-028	7/23/2020	Emergency Regulation Regarding COVID-19 Diagnostic Testing	Group	Supercedes DMHC 20-006 to the extent the regulation conflicts with that APL. Reinstates cost sharing for some COVID-19 testing. Health plans must continue to impose no cost-sharing for COVID-19 testing for enrollees with symptoms of or known/suspected exposure to COVID-19. For all other enrollees (i.e., enrollees without symptoms of or known/suspected exposure to COVID-19), health plans may impose ordinary cost-sharing for COVID-19 testing. For purposes of access to COVID-19 testing, enrollees are classified into one of three broad categories: (1) enrollees (including "essential workers") with symptoms of or exposure to COVID-19; Health plans must reimburse providers for COVID-19 tests administered to enrollees with symptoms of COVID-19 or known/suspected exposure to COVID-19, regardless of whether the enrollee received the test from an in-network or out-of-network provider. A health plan may not limit the number or frequency of tests an enrollee receives when the enrollee has symptoms of COVID-19 or known or suspected exposure to COVID-19. (2) asymptomatic enrollees who are "essential workers" who have not been exposed to COVID-19; health plans must offer an enrollee who is an "essential worker" a COVID-19 testing appointment that will take place within 48 hours of the enrollee's request. A health plan may not limit the number or frequency of tests an enrollee who is an essential worker receives. the appointment must be with a provider located within 30 minutes or 15 miles of the enrollee's residence or workplace. If the plan does not offer the enrollee an appointment meeting these time and distance requirements, the enrollee may access a COVID-19 test from any available provider (whether in or out of network). In-network cost-sharing applies in such instances. (3) asymptomatic enrollees who are not "essential workers" and who have not been exposed to COVID-19. A health plan may impose prior authorization requirements on such testing. If the health plan requires prior authorization and finds the testing to be medically necessary for the enrollee, the plan must offer the enrollee an appointment for a COVID-19 test to occur within 96 hours of the enrollee's request. The appointment for all other asymptomatic enrollees (who have had no exposure to COVID-19) must be with a provider located within 30 minutes or 15 miles of the enrollee's residence or workplace. If the plan does not offer the enrollee an appointment meeting these time and distance requirements, the enrollee may access a COVID-19 test from any available provider (whether in or out of network). In-network cost-sharing applies in such instances. If a health plan experiences difficulty securing COVID-19 testing appointments for its enrollees due to regional or state-wide testing shortages, the health plan should contact its assigned reviewer in the DMHC's Office of Plan Licensing.	Ongoing
41	DMHC	20-029	7/31/2020	Extension of Special Enrollment Period to August 31, 2020	N/A	DOES NOT APPLY TO AAH	Closed
42	DMHC	20-030	8/19/2020	State of Emergency due to Extreme Weather and Wildfires	Both	Within 48 hours of a proclamation of a State of Emergency by the Governor that displaces or has the immediate potential to displace enrollees, each plan operating in the county(ies) included in the proclamation must file a notice with the DMHC: Describing whether the plan has experienced or expects to experience any disruption to plan operations; • Explaining how the plan is communicating with potentially impacted enrollees; and, • Summarizing actions the plan has taken or is in process of taking to ensure the health care needs of enrollees are met. This proclamation of a State of Emergency is statewide for California. Please submit the information required by Section 1368.7 and described above as an Exhibit J-17 through the DMHC's eFiling system as an Amendment filing.	Closed
43	DMHC	20-031	8/21/2020	Association Health Plans: Extension of "Phase-Out" Period Through February 28, 2021	N/A	DOES NOT APPLY TO AAH	N/A
44	DMHC	20-032	9/4/2020	Continuation of DMHC's All Plan Letters Regarding Telehealth During the California Declared State of Emergency Due to COVID-19	Both	Provider home addresses are not to be used in the Provider Directories unless they give permission. Instead Plans can use the Practice Address as of March 3, 2020 (the day before the gov declared a state of emergency. APLs 20-009 and 20-013 remain in effect until the end of the state of emergency or until further notice, whichever comes first.	ongoing
45	DMHC	20-033	9/18/2020	Implementation of COVID-19 Testing		The APL contains 10 questions and answers from the DMHC regarding testing	ongoing

46	DMHC	20-034	9/23/2020	COVID 19 Screening and Testing (replacing APL 20-006)	Both	This APL supersedes and replaces APL 20-006 DMHC reminds plans of existing California laws that require plans to ensure their enrollees are able to access medically necessary care in a timely fashion. *Covering all medically necessary emergency care without prior authorization *Complying with the utilization review timeframes for approving requests for urgent and non-urgent services, as required by Health and Safety Code section 1367.01 *Ensuring the plan's provider networks are adequate to handle an increase in the need for health care services, including offering access to out-of-network services where appropriate and required, as more cases of COVID-19 emerge in California. *Ensuring enrollees are not liable for unlawful balance bills from providers, including balance bills releated to testing for COVID-19. *Ensuring plans have 24-hour access for to a person with the authority to authorize services and ensuring the DMHC has contact information for that person. Proactive steps: *Plans should work with their contracted providers to use telehealth services to deliver care when medically appropriate, as means to limit enrollees exposure to others who may be infected with COVID-19, and to increase the capacity of the plans contracted providers. *In the event of a shortage of any particular prescription drug, plans should waive prior authorization and/or step therapy requirements if the enrollees prescribing provider recommends the enrollee take a different drug to treat the enrollees condition.	ongoing

ALAMEDA Alliance FOR HEALTH

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

Health Care Services

Steve O'Brien, MD

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

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

Date: **October 9, 2020**

Subject: **Health Care Services Report**

Utilization Management: Outpatient

The Outpatient UM team continues to maintain Turn-Around-Times (TAT) above benchmark.

- The Trucare, the computer software used by the UM team, was upgraded to the latest version, 8.0 on September 26th. The team worked with IT and TruCare on optimizing the system, and are now using the upgraded system.
- The UM team is receiving authorizations submitted online via the Provider Portal. About 35% of referrals are being received via the Portal, and it is creating process efficiencies.
- NOA (Notice of Action) Letter monitoring is continuing, in order maintain to regulatory compliance and have consistent processes. Engagement with delegates on monitoring their NOAs has also begun.
- The UM team had started work with Stanford oncology for AAH members, which launched on 9/21/20.
- OP UM is engaged with CHCN to improve alignment processes and work collaboratively on initiatives.

Outpatient Authorization Denial Rates			
Denial Rate Type	**July 2020**	**August 2020**	**September 2020**
Overall Denial Rate	4.0%	4.0%	3.5%
Denial Rate Excluding Partial Denials	3.9%	3.8%	3.2%
Partial Denial Rate	0.1%	0.2%	0.3%

Turn Around Time Compliance			
Line of Business	**July 2020**	**August 2020**	**September 2020**
Overall	99%	99%	99%
Medi-Cal	99%	99%	99%
IHSS	98%	97%	99%
Benchmark	*95%*	*95%*	*95%*

Utilization Management: Inpatient

- The impact of the pandemic is lower on the current Inpatient hospitalization rates: The rate of hospitalization was initially 30% down from typical levels, but most recently has gone to low normal levels. There are still few elective admissions. As of 10/1/20, there have been a total of 284 number of members hospitalized with COVID-19 during the pandemic. There has been less difficulty placing members in Skilled Nursing Facilities, and we continue to work with our SNF partners on the barriers.
- Inpatient UM continues to place members with Bay Area Community Services, (BACS) respite beds at the Henry Robinson center. This provides medically appropriate homeless members a safe place to recuperate from a hospitalization instead of going directly back to the street.
- Trucare, the software used by UM and CM, successfully launched to the 8.0 version on September 26th, following training and testing.
- The clinical criteria used by UM, called MCG, will be upgraded to the latest version in October, after staff training.
- The inpatient team works with Case Management on the Transition of Care bundle for members transitioning out of Alameda Health System, and for any members discharging with a diagnosis of COVID-19. Planning for expansion to Sutter discharges is starting.
- IP UM re-engaged CHCN to further align processes and collaboratively work on initiatives such as NOAs.

Inpatient Utilization Total All Aid Categories **Actuals (excludes Maternity)**			
Metric	**June 2020**	**July 2020**	**August 2020**
Authorized LOS	5.5	5.9	4.9
Admits/1,000	52.6	52.1	58.0
Days/1,000	286.7	309.4	281.4

Pharmacy

- Pharmacy has 100% turn-around time compliance for all line of business.
- Outpatient initial approval rate is 40% and denial rates are 32%. The approval rate was increased while denial rates decreased compared to previous reporting periods. Medications for pain, influenza vaccine, diabetes, chronic obstructive pulmonary disease (COPD), acne, anxiety medications share formulary issues as

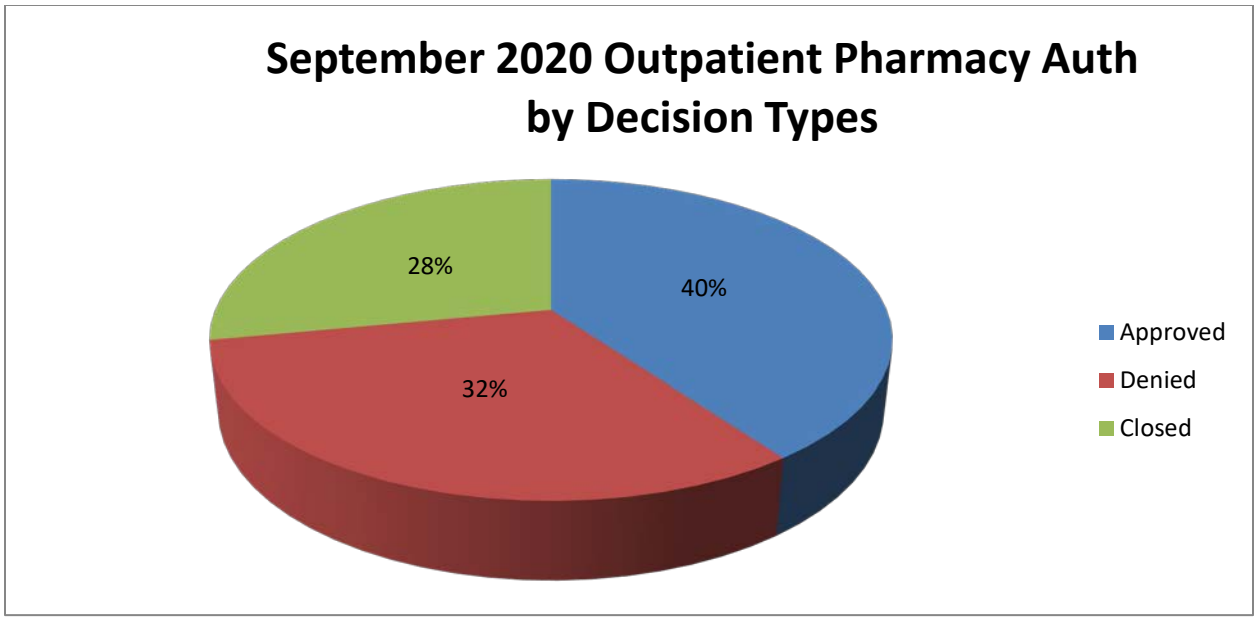
the most common reason for denials. AAH offers clinically equal and more cost effective formulary alternatives.

- Pharmacy continues to ensure that our members have access to the medications that they need during wild fires. Pharmacy placed basic disaster edits from 8/29/2020 to 9/21/2020. We have in place refill too soon and out of network overrides for our Medi-Cal and Group Care members.
- DHCS intends to proceed with pharmacy carve-out implementation effective 1/1/2021. Magellan and DHCS will send out communication to all enrolled providers. After post carve-out, the State of California will take back many pharmacy responsibilities including drug coverage, rebate, utilization management and pharmacy provider network. AAH is to maintain beneficiary care coordination, drug adherence, disease and medication management, in authorization, denial & appeals of physician administered drugs (PAD) and outpatient infusion drugs.
- Quality improvement and cost containment initiatives continue with focus on effective formulary management, coordination of benefit & joint collaboration with Quality and case management to improve drug adherence, disease medication management, and generic utilization. Senior Pharmacy Director Helen Lee is also leading initiatives on Asthma Affinity Work Group, biosimilar optimization, PAD focused partnership, biosimilar optimization, and channel management, and infusion strategy.

Outpatient Pharmacy Prior Authorization Request Summary August 2020

Summary Table

Decisions	Number of PAs Processed
Approved	743
Denied	596
Closed	501
Total	**1840**



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	FLUZONE HIGH-DOSE QUAD 2020-21	Flu Vaccine	
3	JANUVIA 100 MG TABLET	Diabetes	Criteria for approval not met
4	TRETINOIN 0.025% CREAM	Acne	Criteria for approval not met
5	BUDESONIDE-FORMOTEROL 160-4.5		
6	TRETINOIN 0.05% CREAM	Acne	Criteria for approval not met
7	ALPRAZOLAM 0.5 MG TABLET	Anxiety	Criteria for approval not met
8	CLINDAMYCIN PHOSP 1% LOTION	Acne	Criteria for approval not met
9	CLINDAMYCIN PHOSPHATE 1% GEL	Acne	Criteria for approval not met
10	TRETINOIN 0.01% GEL	Acne	Criteria for approval not met

Case and Disease Management

- The Trucare, the computer software used by the UM & CM teams, was upgraded to the latest version, 8.0 on September 26th. The team has worked with IT and TruCare on optimizing the system on the Care Plans, and are now using the new functions.
- A focus for Medical Expense Reduction is reducing Readmissions, and the CM department has launched focused work in this area, now working with both AHS and Sutter.

- One outcome expected from the Transition of Care (TOC) bundle deployed in pilot phase with Alameda Health System's three campuses is a reduction in readmission. Expansion to Sutter campuses is in planning.
- 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.
- The care bundle in Oncology has been launched, emphasizing using benefits as tools to help members more successfully engage in care. Launch of the Heme-Onc bundle was Sept 21, with a slow ramp up.
- Dr. Donna Carey has joined the Alliance as our new Medical Director of Case Management

Health Homes & Alameda County Care Connect (AC3)

Monitoring of our HHP network performance is a focus for FY19/20, both for medical CB-CMEs and those for Severe Mental Illness, (SMI.)

- A quality improvement project for services to members who are homeless is launching.
- Bay Area Community Services, (BACS) launched on October 1 as a site for people with SMI.
- A second SMI focus CB-CME is in contract discussions.
- 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 is planning our Population Health strategy, based on prioritization of our target populations.

Case Type	New Cases Opened in August 2020	Total Open Cases As of August 2020
Care Coordination	193	575
Complex Case Management	37	62
Transitions of Care	224	456

Grievances & Appeals

All cases except expedited grievances were resolved within the goal of 95% within regulatory timeframes; the three expedited grievances that were not resolved timely

were due to the Alliance having to obtain LOA for OON services which took longer than the 72 hours required.

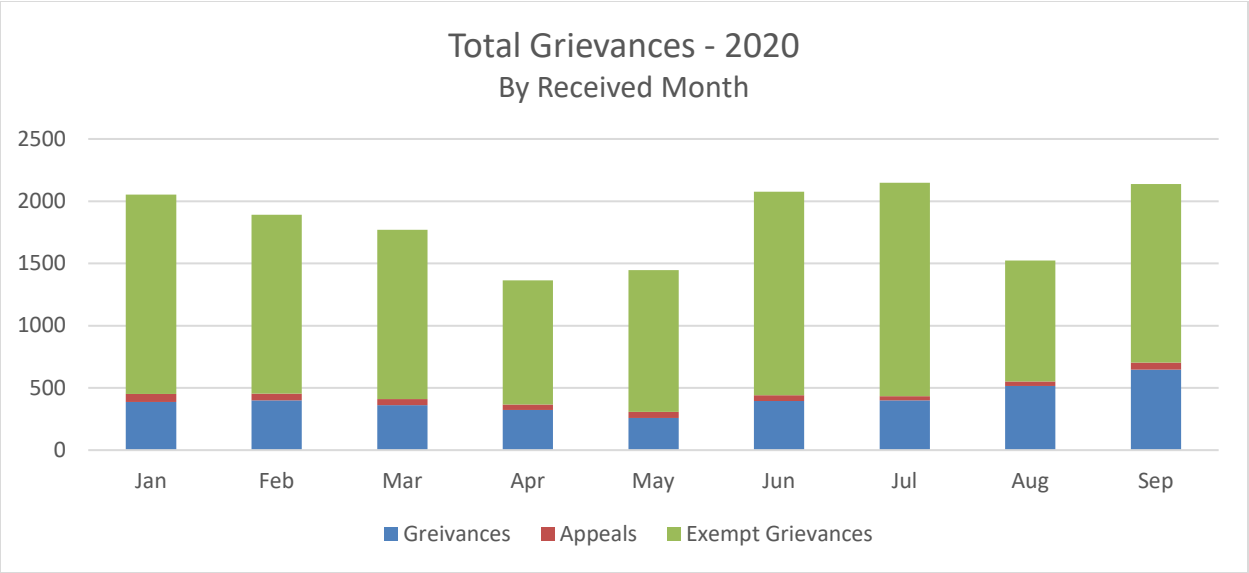
- Total grievances resolved in September went over our goal of less than 1 complaint per 1,000 members at 7.31 complaints per 1,000 members;
- The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of September 2020; we did not meet our goal at 31.1% overturn rate;

September 2020 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	531	30 Calendar Days	95% compliance within standard	517	97.4%	1.99
Expedited Grievance	7	72 Hours	95% compliance within standard	4	57.1%	0.03
Exempt Grievance	1,369	Next Business Day	95% compliance within standard	1,368	99.9%	5.13
Standard Appeal	41	30 Calendar Days	95% compliance within standard	41	100.0%	0.15
Expedited Appeal	4	72 Hours	95% compliance within standard	4	100.0%	0.01
Total Cases:	1,952		95% compliance within standard	1,934	99.1%	7.31

*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.)

- **Grievance Tracking and Trending by Quarter:** There has been an overall increase of standard grievances in the month of September due to a change in process with Member Services. Previously, the Member Services Department were resolving complaints that were categorized as coverage disputes as exempt grievances. The definition of an exempt grievance states that coverage disputes cannot be exempt from the standard grievance process and require written correspondence to the member; therefore, regardless if the Member Services Representative was able to resolve the issue within the next business day they must forward to the G&A Department to be handled as a standard grievance. The overall received grievance have not increase compared to previous months of June and July; however, because of this change you will see an increase of standard grievances as well as the decrease in exempt grievances

- Coverage disputes accounted for 53.5% of the total of standard grievances resolved in September; coverage disputes are separated into two categories, billing and benefit disputes. Under billing, cases that involve members being billed, members being balanced billed, and members requesting reimbursement for monies paid. Under benefit, cases that involve members being denied services; for example, when a member goes to a pharmacy out of county and gets denied a fill/refill because they are not within network.

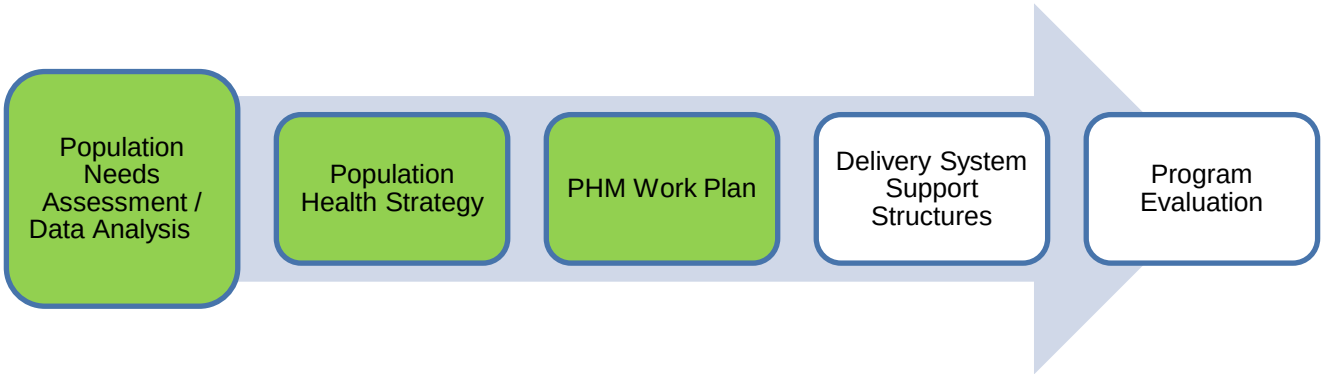


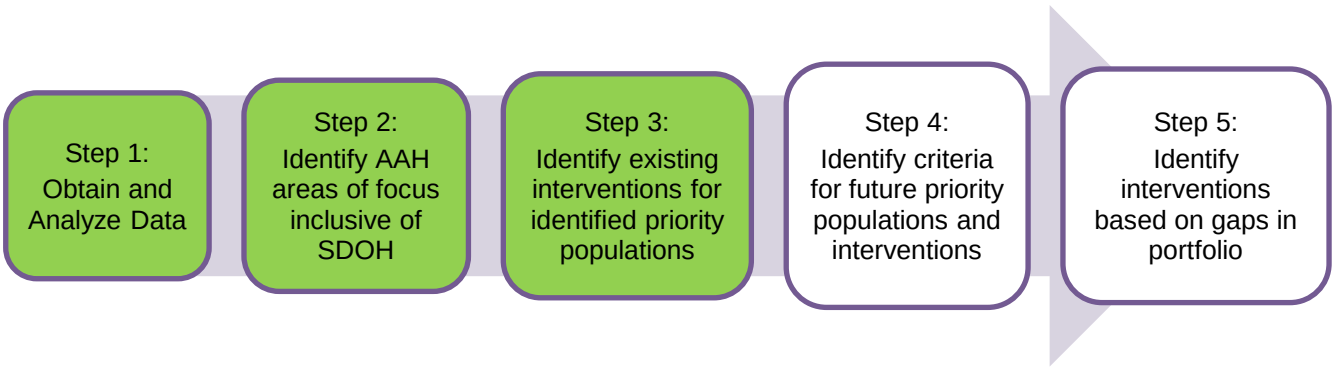
Quality Assurance

- The Alliance is currently in the process of preparing for our upcoming audits with DMHC, DHCS and NCQA. NCQA will conduct their review of UM 7B in February 2021, we are conducted routine monthly audits of NOAs both internally and with our delegates to ensure that we are meeting the requirements outlined in Element UM 7B.

Quality

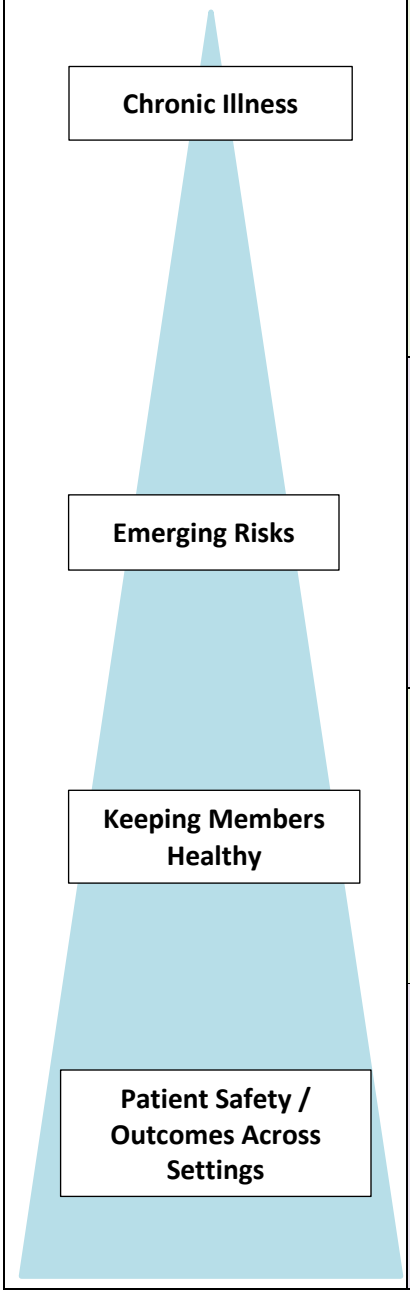
Population Health Management (PHM) and the Population Needs Assessment (PNA) informs the Alliance strategies for managing the engagement, treatment, and clinical outcomes of selected populations. AAH is strengthening our PHM/PNA focus with increased organizational structure, based on NCQA/DHCS standards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




Step 1:
Obtain and Analyze Data
Step 2:
Identify AAH areas of focus inclusive of SDOH
Step 3:
Identify existing interventions for identified priority populations
Step 4:
Identify criteria for future priority populations and interventions
Step 5:
Identify interventions based on gaps in portfolio

NCQA targeted focus goals for population health management include:

Figure 1: Example of Goals by Acuity



QI:

- Pediatric Asthmatic ED utilizers at CHO are referred to Asthma Start; HEd follows EDU for those referred to asthma Start
- Share ED Utilization and Pharmacy Data with RTs at CHO
- FindConnect Referrals

CM:

- Asthma is Health Homes Qualifying Disease, along with high utilization or homelessness
- From the Pop Health report –send to Asthma Start (for ages 6-12)
- For a member with Asthma, the typical focus is on other complications
- Obtain materials from Health Ed on self-management

QI:

- Asthma Start
- FindConnect Referrals (first point of connect)
- AMR on 2020 P4P
- Grant Pediatric Home Visits (Tri-City)

CM:

- Referral to Asthma Start or Health Ed Materials

Pharmacy:

- Working with AHS to conduct asthma workshops for adults
- AMR Project TBD

QI:

- Health handouts on Secondhand Smoke, Asthma
- Tobacco Cessation Referrals (indirect focus on asthma)
- Working with AHS to conduct asthma workshops for adults
- Participation in regional asthma management prevention program (RAMP)

CM:

- For members in CM or received info on HRA, send Health Ed materials on mitigating risk of developing Asthma

QI:

- Data Sharing (Gaps in Care Reports) (Analytics)
- Data Sharing (ED Utilization)
- Share ED Utilization Data with RTs at CHO

CM:

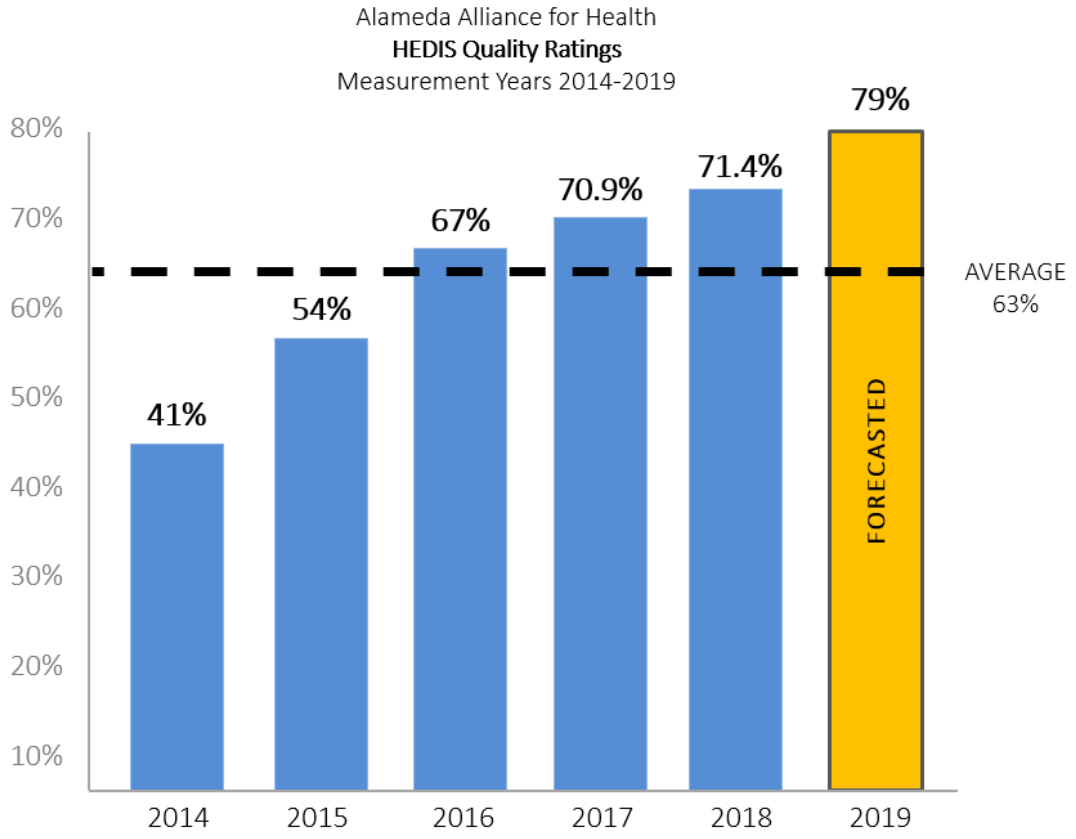
- For members in CM or received info on HRA, send Health Ed materials on mitigating risk of developing Asthma

UM:

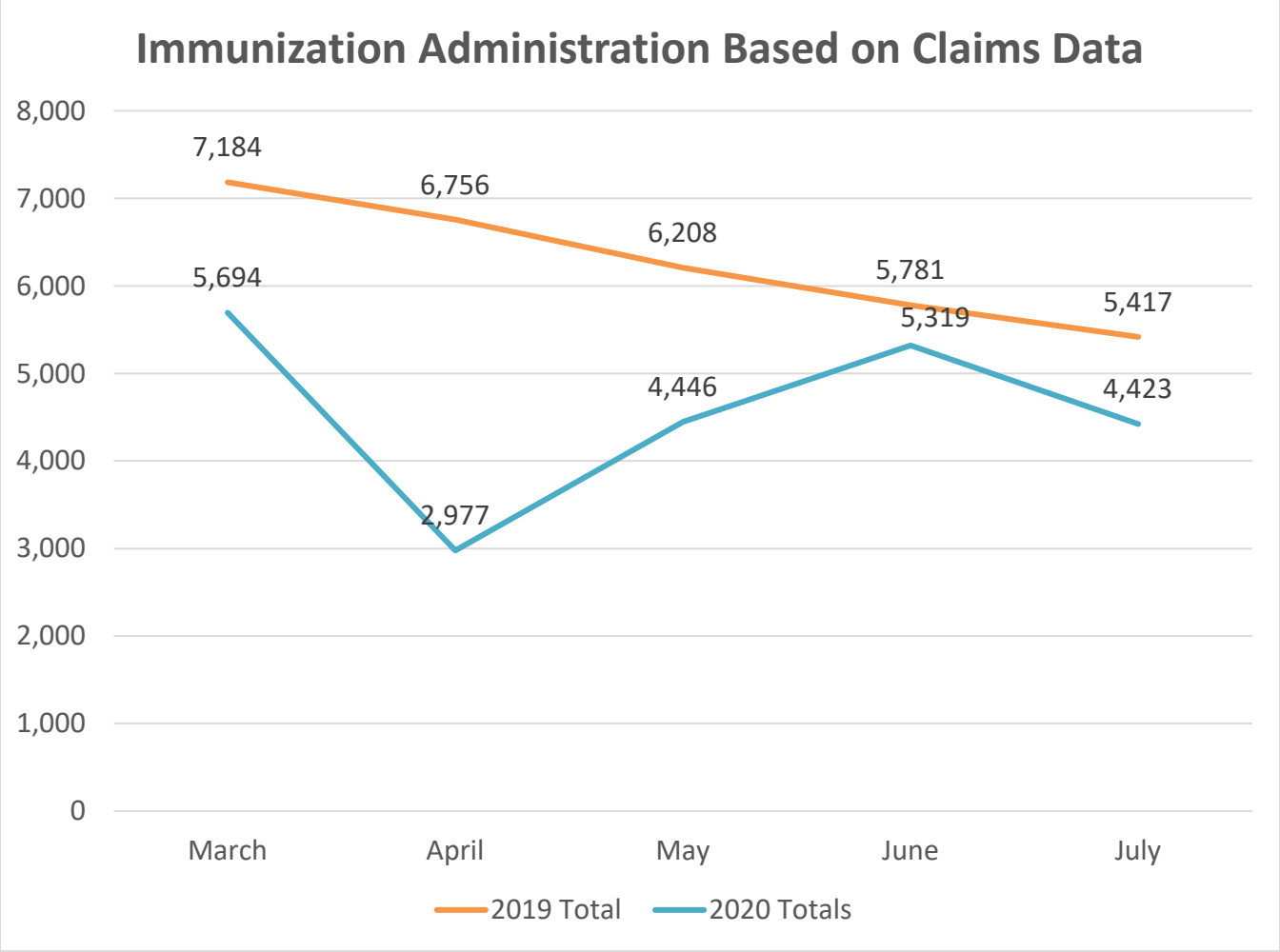
Pharmacy:

- **HEDIS** results continue to inform our Quality Improvement strategic planning for the second half of the fiscal year in areas including our Quality Improvement Plans (QIPs) with the state, as well as internal department integrated Performance Improvement Projects. HEDIS Gap in Care (GIC) reports served as an 'access to care' performance tool for our network and delegate provider office staff to engage members for scheduling clinical appointments. Preliminary HEDIS results indicate that our health plan/provider collaboration, in addition to member gift card incentives has resulted in increased GIC closure and service utilization for timely health assessments, screenings and referrals with year over year improvement in our Aggregated Quality Factor Scores (AQFS) from MY 2014 - 2019.

Figure 2: Alliance HEDIS Quality Ratings MY2014-2019



- AAH continues its commitment to **Pediatric Care Coordination (PCC),** as part of our pediatric strategy in FY21. 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 targeted 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, remains a focus of this exciting pilot for FY21. Targeted focus for campaign Well Child and Adolescent Care Visits including 1) IZ and 2) Blood Lead Screening. There has been a 27.09% decrease in the number of vaccines given 2020 compared to 2019 as well as a decrease in pediatric well-child visits.



HEDIS Measure	2019 Compliance Rate	2020 Compliance Rate	Variance
W15 - well child visits for ages 0-15mo	33.92%	33.72%	-0.20%
W34 - well child visits for up to age 6	43.44%	26.61%	-16.82%
AWC - adolescent visits for ages 12-21	25.49%	14.71%	-10.78%

- **DHCS**, effective August 2020 requested that HPs resume outbound calls as part of the Pediatric Preventive Care Outreach project, paused in March due to

COVID – 19 'shelter in place' mandates. The resumption of this outbound call campaign now targets Alliance beneficiaries ages 7 and under (est 8K kids), in 2 separate phases, who have not utilizes or under-utilized preventive care services available to them as part of their EPSDT benefit. Many HPs and HP associations raised concerned about violation of the Telephone Consumer Protection Act Law (TCPA) regarding conducting "robo call" outreach campaign and the legal risk posed for organizations. New guidance from DHCS is expected soon that offers alternative outreach methods for the plans. Alliance has received guidance from DHCS approving alternative options for member outreach. The Alliance will conduct a mailer outreach campaign in 2 phases. The first wave will begin no later than Nov. 1, 2020.

- **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 Alameda County First 5 for FY21.

- **Access to Care:** Multiple member and provider surveys are completed throughout the year to assess member Access to Care. Access standards are established by state/federal regulations and outlined within AAH internal Policy & Procedures. Policy requires the plan to issue Corrective Action Plans to providers found to be non-compliant with access standards. The Alliance understands that COVID-19 has changed the landscape of office visit care delivery with a shift to telephonic/telehealth visits as a new norm. Like many local and national HPs the Alliance has seen a decline in members accessing care, due to safety concerns on part of the members and providers, as well as, office staff shortages. DHCS has temporarily allowed MCPs extended timeframes for issuing providers CAPs due to the impact of **COVID-19** on provider offices administrative capacity. Cross functional department stakeholders are in discussions regarding next steps to support and minimize administrative burden on provider office resources while maintaining expected regulatory compliance with access standards.

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

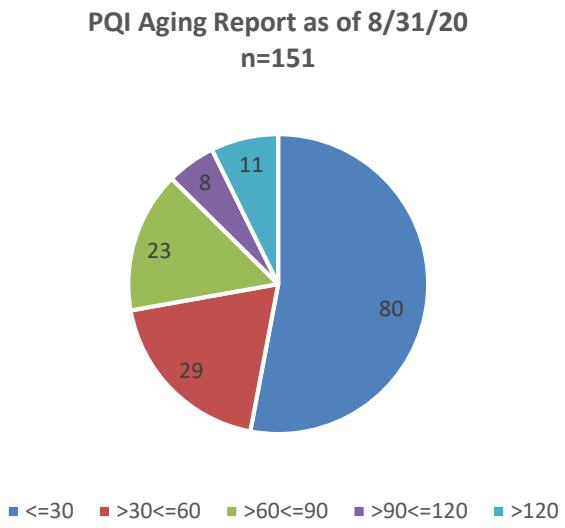
Improvement Strategies:

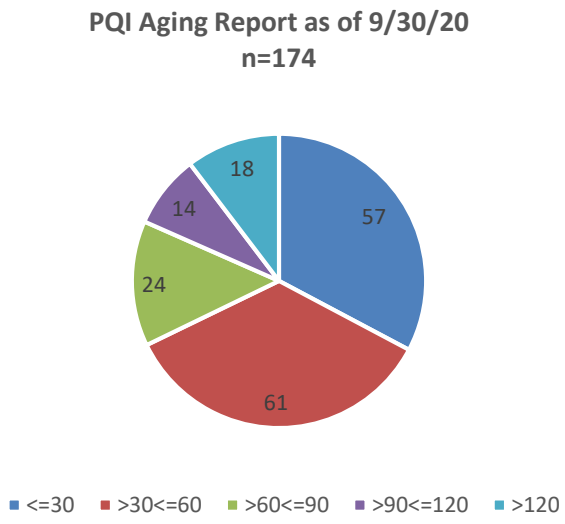
- Discussion of improvement strategies using data and the PDSA quality improvement model resulted in the development of cross functional stakeholder work groups.

- “Did you know” Provider Outreach and Education Campaign initiated in August. 8 weeks of provider engagement and education about provider focused initiatives currently in existence with the plan
- Provider office staff focus groups also being considered

Potential Quality Issues (PQI) Aging Report

- A PQI is defined as a suspected deviation from expected provider performance, clinical care or outcome of care that requires further investigation to determine whether an actual quality issue exists. Recent extension of PQI TAT from 90 days to 120 days (from receipt to resolution date) has afforded the department additional time achieve maintain compliance for 1) continued development and deployment of operation efficiencies, 2) procurement medical of records from provider offices with staffing shortages and 3) timely internal investigation and resolution in light of department staffing shortages. The Quality team has recently added another Quality Review nurse to our team. This addition will support the department in managing regulatory compliance for PQIs.





- As of Oct 1, 2020, the Alliance transition of **Telephonic Interpreter Services** via CyraCom vendor is complete. A small group of provider offices are needing assistance with video capability. Updated guides for accessing interpreter services and Interpreter Services Request form are available for providers.

- Quality Award and Recognitions – The Alliance

    - **Dr. Bert Lubin Award** – To recognize and honor a community Pediatrician who demonstrates high quality of care in their practice and dedication to inclusive community health care serve delivery, with the fervor exhibited by Dr. Lubin. We are pleased to have BOG member Dr. Kelley Meade as a physician champion providing input into criteria for this prestigious award.

ALAMEDA Alliance FOR HEALTH

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

Information Technology

Sasikumar Karaiyan

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

From: **Sasi Karaiyan, Chief Information & Security Officer**

Date: **October 9, 2020**

Subject: **Information Technology Report**

Call Center System Availability

- AAH phone systems and call center applications performed at 100% availability during the month of **September** despite supporting 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 (Calabrio Application) of the project is now in progress.

Encounter Data

- In the month of September, AAH submitted 61 encounter files to DHCS with a total of 188,772 encounters.

Enrollment

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

HealthSuite

- The HealthSuite application continued to operate normally with an uptime of 99.99%.

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

TruCare

- The TruCare system continued to operate normally with an uptime of 99.99%. A total of 8,113 authorizations were loaded and processed in the TruCare application.

- The TruCare system was successfully upgraded from version v7.0 to v8.0. This upgrade includes new features useful to end users. Although this upgrade has the latest version of HTML (Hypertext Markup Language) version 5, this is expected to be enabled during the month of December after end users get trained. HTML 5 gives the users a new look and feel of the application.

Web Portal

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

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

Information Security

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

- Email based metrics currently monitored have increased with a return to a reputation-based block for a total of 129.0k.

- Attempted information leaks detected and blocked at the firewall are slightly higher from 64 to 88 for the month of **September.**

- Network scans returned a value of 1, which is in line with previous month's data.

- Attempted User Privilege Gain is higher at 339 from a previous six month average of 23.

Data Warehouse

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

- In the month of October, the Alliance is working on adding the authorization and case management data to the Data Warehouse. The authorization data domain is expected to be complete before the end of December 2020. The provider credentials and case management deliverable will be completed in March 2021.

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

Data Governance

- As part of our Data Governance initiative, the Alliance is in the process of de-identifying PHI (Protected Health Information) data in a development environment for external vendors. Only the development environment is accessible to external vendors. This process shall reduce the risk of exposing PHI data to our external vendors and will stay in compliance with the regulatory terms. We are planning to complete this process before the end of December 2020.

Information Technology

Supporting Documents

Enrollment

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

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
September	267,101	4,564	1,922	6,012	153	152

1. MC – Medical Member

2. GC – Group Care Member

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

Auto-Assignments	Member Count
Auto-assignments MC	1,642
Auto-assignments Expansion	1,655
Auto-assignments GC	44
PCP Changes (PCP Change Tool) Total	3,165

TruCare

- See Table 2-1 “Summary of TruCare Authorizations for the month of September 2020”.
- There were 8,113 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 September 2020

Transaction Type	Inbound EDI Auths	Failed PP-Already In TC	Failed PP-MNF	Failed PP-PNF	Failed PP-Procedure Code	Failed PP-Diagnosis Code	Misc	Total EDI Failure	New Auths Entered	Total Auths Loaded In TruCare Production
EDI-CHCN	4,418	136	0	11	6	0	18	172	0	4,246
Paper to EDI	2,640	0	0	0	0	0	0	0	0	2,647
Manual Entry	0	0	0	0	0	0	0	0	1,220	1,220
Total										8,113

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 August 2020

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	3,518	2,742	108,520	328
MCAL	65,430	2,147	4,215	840
IHSS	2,569	66	128	16
AAH Staff	163	43	832	2
Total	**71,680**	**4,998**	**113,695**	**1,186**

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

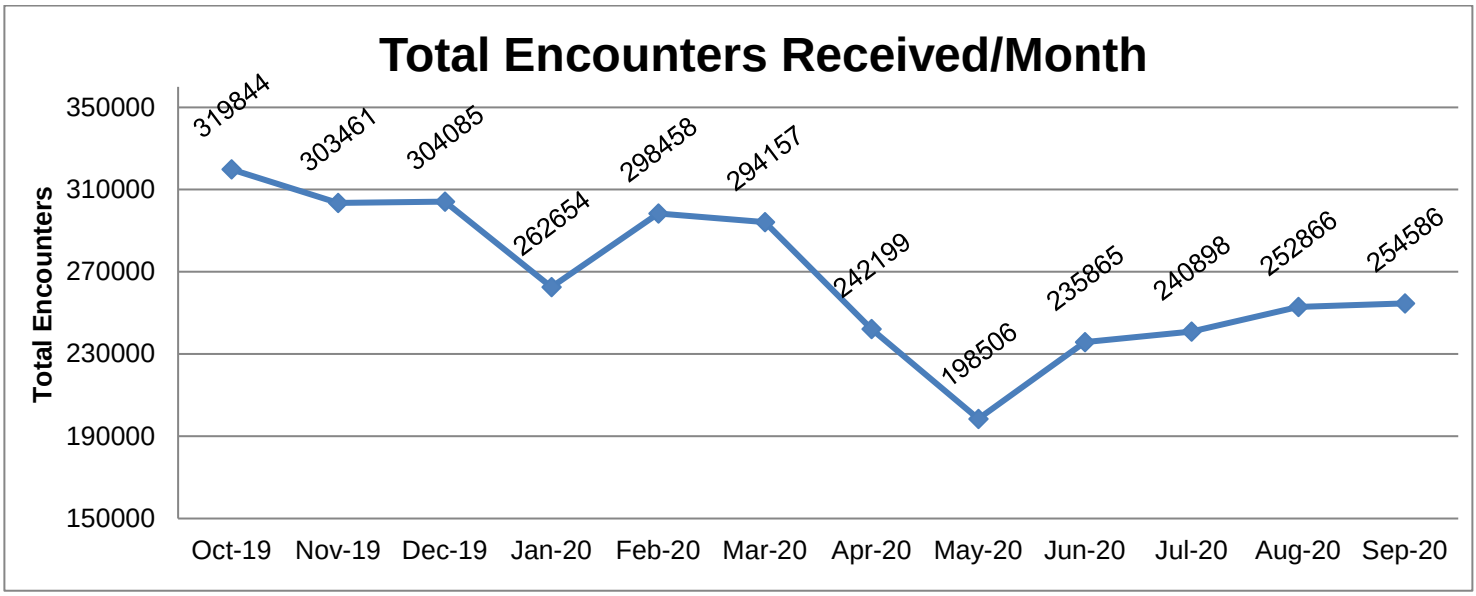
Top 25 Pages Viewed		
Category	**Page Name**	**August-20**
Provider	Member Eligibility	515,820
Provider	Claim Status	88,844
Provider	Member Roster	12,017
Member - Eligibility	Member Eligibility	6,594
Member - Claims	Claims - Services	4,664
Provider	Auth Submit	3,831
Member - Help Center	Member ID Card	2,947
Provider	Auth Search	2,082
Member - Help Center	Select/Change PCP	1,207
Member - Help Center	Find a Doctor or Facility	1,085
Member - Pharmacy	My Pharmacy Claims	624
Provider - Provider Directory	Provider Directory	479
Provider	Pharmacy	425
Provider - Home	Forms	354
Member - Help Center	Update My Contact Info	297
Provider - Provider Directory	Manual	276
Member - Pharmacy	Pharmacy - Drugs	243
Member - Help Center	Contact Us	187
Member - Help Center	Authorizations & Referrals	151
Member - Forms/Resources	Authorized Representative Form	126
Member - Health/Wellness	Personal Health Record - intro	114
Member - Pharmacy	Pharmacy	106
Provider - Provider Directory	Attestation	95
Member - Health/Wellness	Member Materials	94
Member - Help Center	File a Grievance or Appeal	85

Encounter Data From Trading Partners 2020

- AHS:
  September daily files (849 records) were received on time.
- Beacon:
  September monthly files (20,434 records) were received on time
- CHCN:
  September weekly files (54,812 records) were received on time.
- CHME:
  September monthly file (3,832 records) were received on time
- CFMG:
  September weekly files (8,787 records) were received on time.
- Docustream:
  September weekly files (640 records) were received on time.
- PerformRx:
  September monthly files (149,970 records) were received on time.
- Kaiser:
  - September monthly files (25,829 records) were received on time.
  - September monthly Kaiser Pharmacy files (18,348 records) were received on time.
- LogistiCare:
  September weekly files (14,821 records) were received on time.
- March Vision:
  September monthly file (2,270 records) were received on time.
- Quest Diagnostics:
  September weekly files (11,005 records) were received on time.
- Teladoc:
  September weekly files (52 records) were received on time.

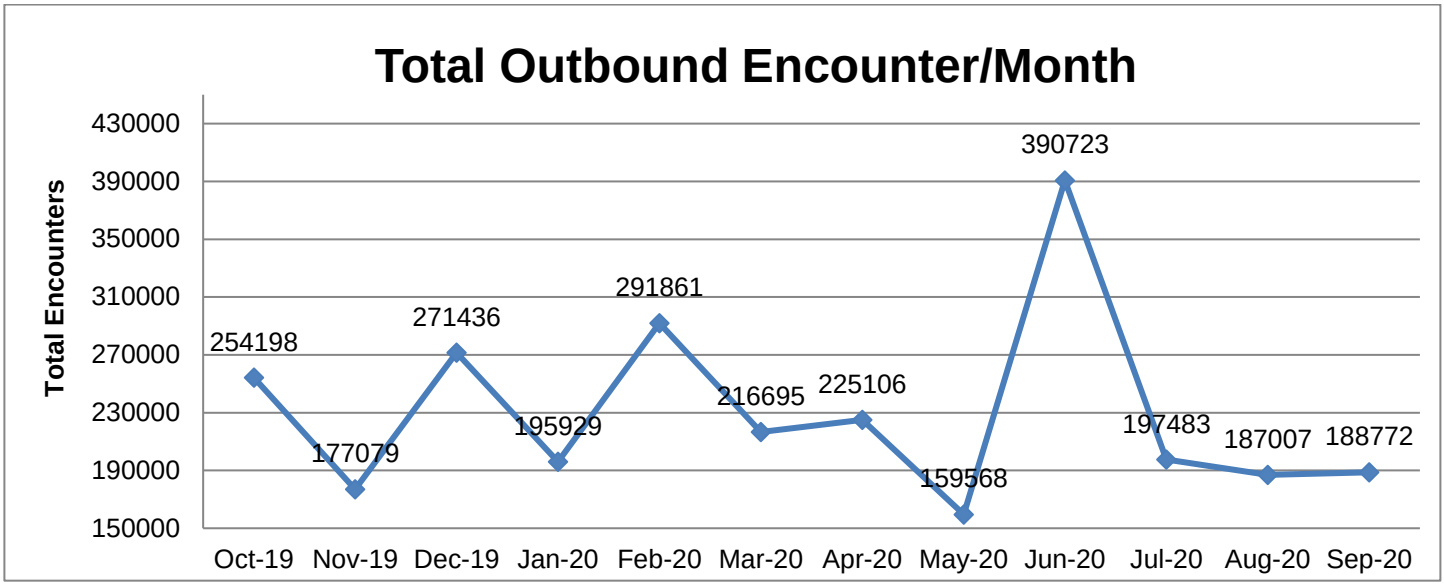
Trading Partner Encounter Inbound Submission History

Trading Partners	19-Oct	19-Nov	19-Dec	20-Jan	20-Feb	20-Mar	20-Apr	20-May	20-Jun	20-Jul	20-Aug	20-Sep
HealthSuite	125442	122333	103132	104147	118309	115716	86578	89063	95735	107093	104293	111255
Kaiser	35517	44533	38079	34890	35167	36334	33670	16030	19364	22508	26057	25829
Logisticare	18411	16867	14261	16911	19665	21375	10812	10893	10857	12865	10145	14821
March Vision	3428	3792	3183	5495	0	3127	3389	1395	1336	1839	2568	2270
AHS	3347	2531	12186	7385	4949	9907	9040	7698	7129	10154	9353	849
Beacon	12163	8328	8843	6407	14626	10010	12606	8546	9612	11413	10193	20434
CHCN	88478	72359	94805	60204	69402	76884	64623	45221	73144	53049	64935	54812
CHME	2963	3928	3090	7201	5604	3612	4346	7241	4903	4344	4987	3832
Claimsnet	15028	16604	13396	9027	16607	7317	12653	5484	6154	6545	6608	8787
Quest	14539	11593	12697	10509	13574	9334	3803	6072	6809	10135	12783	11005
Docustream	528	593	413	478	555	541	679	863	822	912	919	640
Teladoc										41	25	52
Total	319844	303461	304085	262654	298458	294157	242199	198506	235865	240898	252866	254586



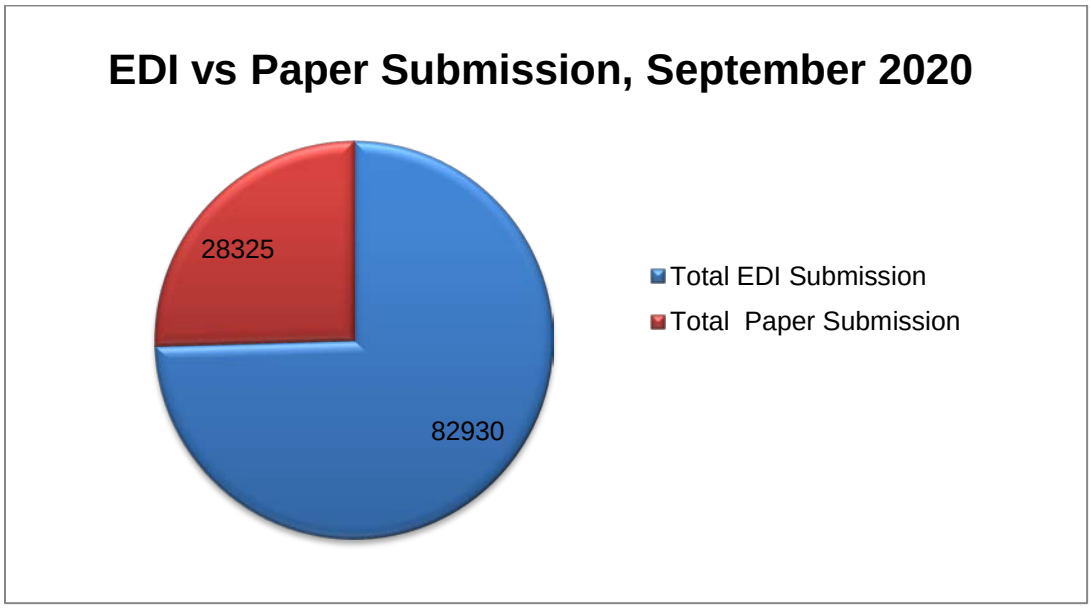
Outbound Encounter Submission

Trading Partners	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
HealthSuite	87691	24746	78764	62186	141458	81483	79506	72631	60932	76561	73815	71394
Kaiser	35352	13947	37789	34583	34561	35565	32223	15191	15545	21968	25720	25666
Logisticare	21631	8299	21692	11883	24522	22887	12988	10513	10438	14934	9924	11134
March Vision	2531	2826	2564	2150	1672	2118	2362	813	803	1121	1909	1687
AHS	5303	2328	11823	8412	4711	8545	7880	8708	6727	10662	8083	353
Beacon	9557	7204	7369	5392	11058	6	19228	8464	7377	9507	7620	17466
CHCN	62669	19042	83370	51732	49459	43356	54436	27819	270473	43686	38537	42221
CHME	2589	3493	2692	3100	4981	3166	3847	6860	4640	4081	4663	3632
Claimsnet	10566	3892	10283	6295	8835	8788	7468	3266	5643	4792	6110	4342
Quest	15100	4829	14701	9757	10087	10331	4579	4566	7425	9331	9789	10236
Docustream	1209	510	389	439	517	450	589	737	720	799	812	609
Teladoc										41	25	32
Total	254198	177079	271436	195929	291861	216695	225106	159568	390723	197483	187007	188772



HealthSuite Paper vs EDI breakdown

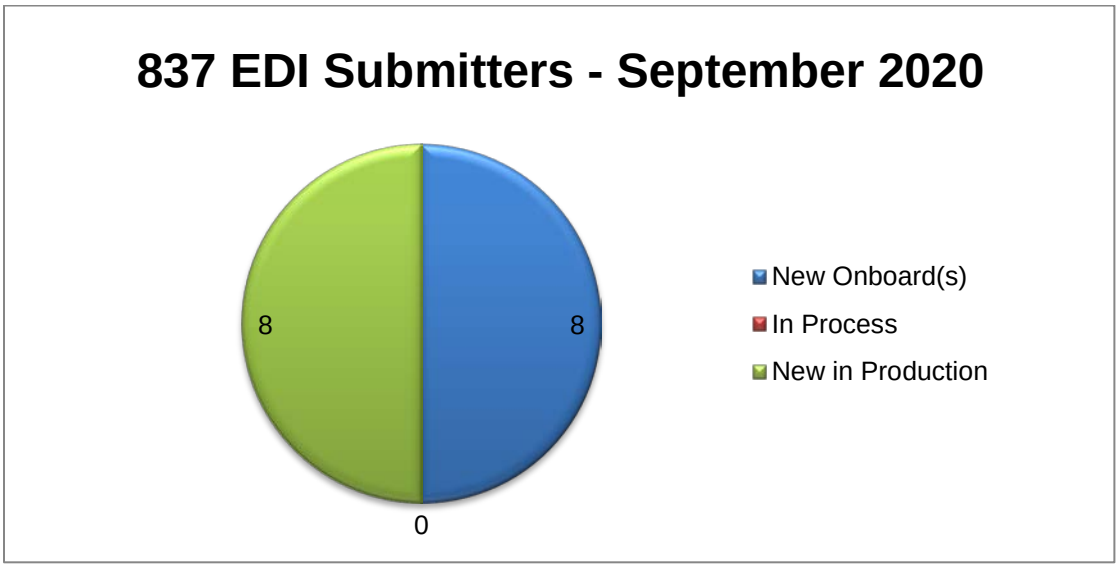
Period	Total EDI Submission	Total Paper Submission	Total Claims
20-Sep	82930	28325	111255

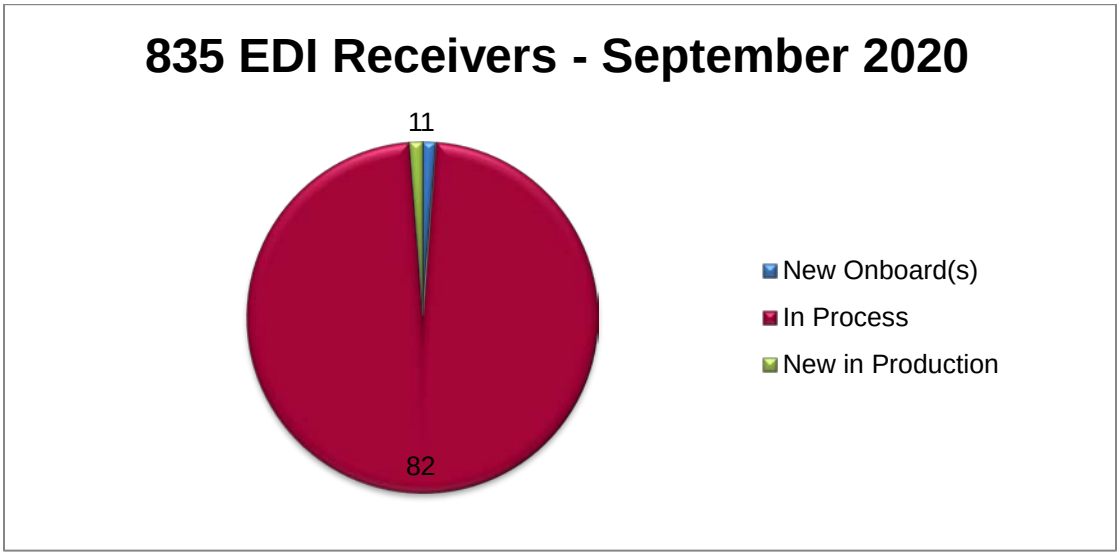


Onboarding EDI Providers - Updates

- September 2020 EDI Claims:
  - A total of 979 new EDI submitters have been added since October 2015, with 8 added in September 2020.
  - The total number of EDI submitters is 1711 providers.
- September 2020 EDI Remittances (ERA):
  - A total of 190 new ERA receivers have been added since October 2015, with 1 added in September 2020.
  - The total number of ERA receivers is 229 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
Oct-19	17	0	17	1545	6	76	5	217
Nov-19	18	0	18	1563	2	77	1	218
Dec-19	17	0	17	1580	2	77	2	220
Jan-20	11	2	9	1589	2	77	2	222
Feb-20	8	0	10	1599	1	77	1	223
Mar-20	9	0	9	1608	3	79	1	224
Apr-20	40	0	40	1648	2	80	1	225
May-20	15	0	15	1663	2	81	1	226
Jun-20	17	0	17	1680	2	82	1	227
Jul-20	11	0	11	1691	1	82	1	228
Aug-20	12	0	12	1703	0	82	0	228
Sep-20	8	0	8	1711	1	82	1	229





EDSRF/Reconciliations

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

File Type	Sep-20
837 I Files	9
837 P Files	52
NCPDP	9
Total Files	70

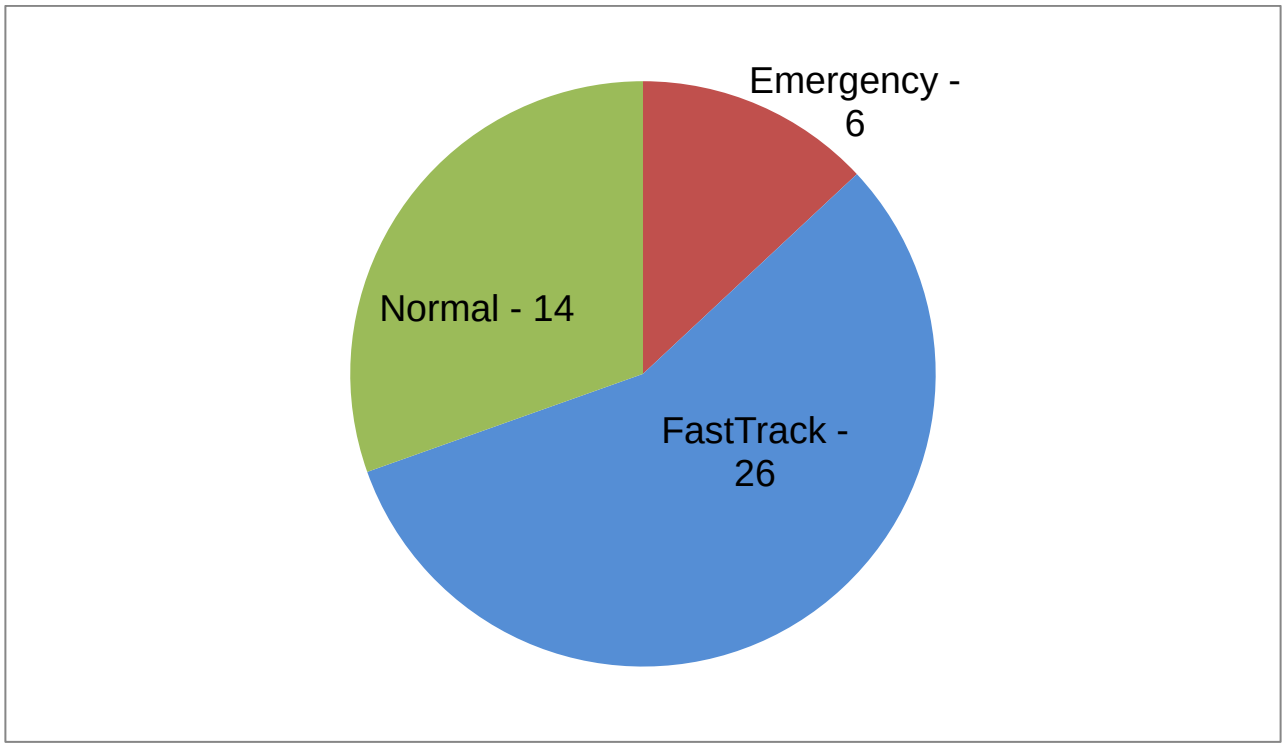
Lag-time Metrics/KPI's

AAH Encounters: Outbound 837	Sep-20	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	95%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	98%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	91%	73%
Timeliness-% Within Lag Time – Professional 0-180 days	95%	80%

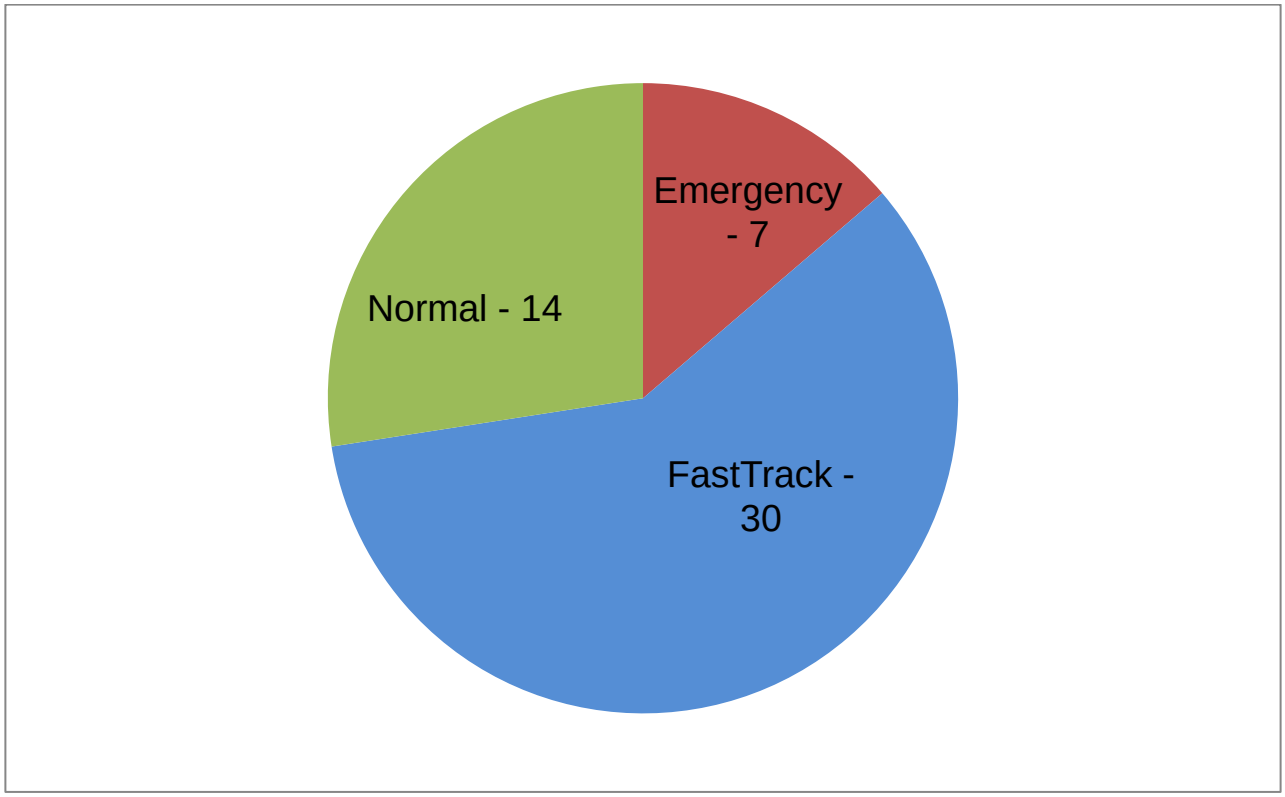
Change Management Key Performance Indicator (KPI)

- Change Request Submitted by Type in the month of September 2020 KPI – Overall Summary.
    - 1,736 Changes Submitted.
    - 1,634 Changes, Completed, and Closed.
    - 118 Active Changes.
    - 189 Changes Cancelled and Rejected.

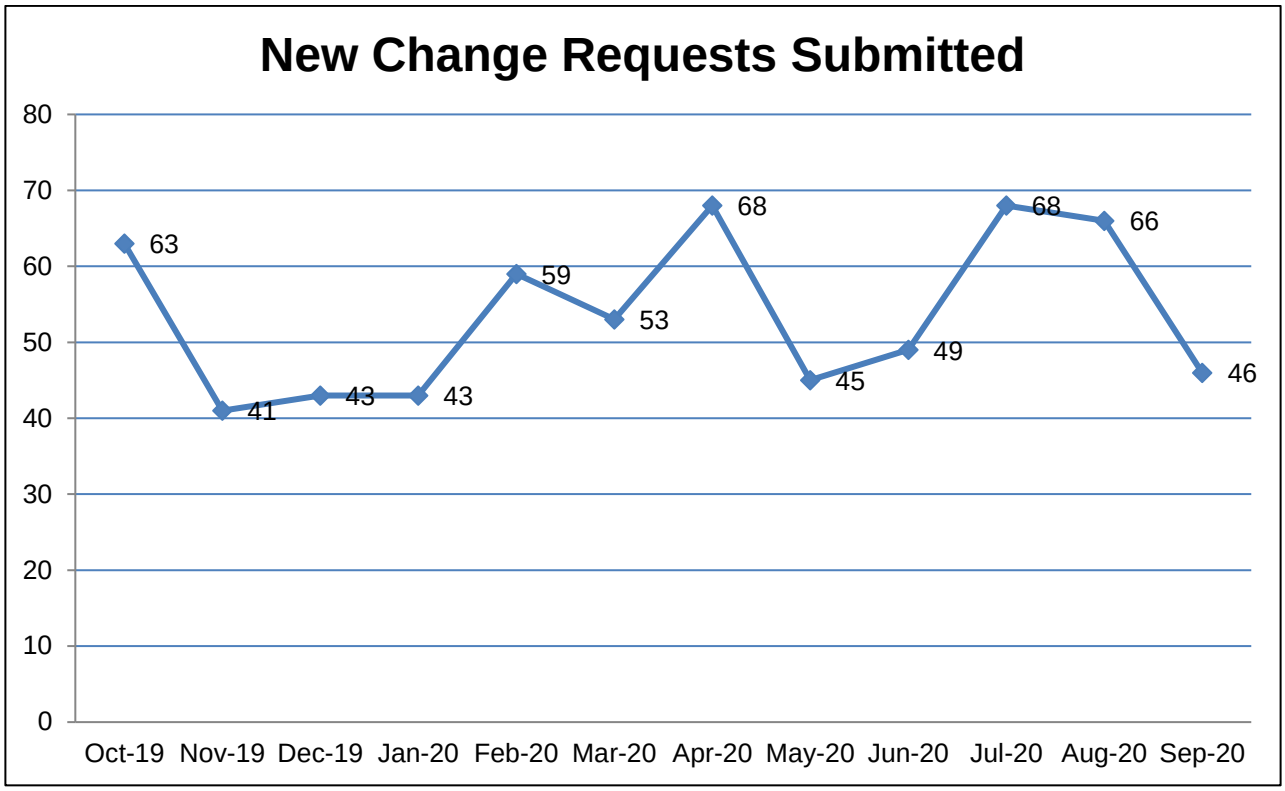
- 46 Change Requests Submitted/logged in the month of September 2020



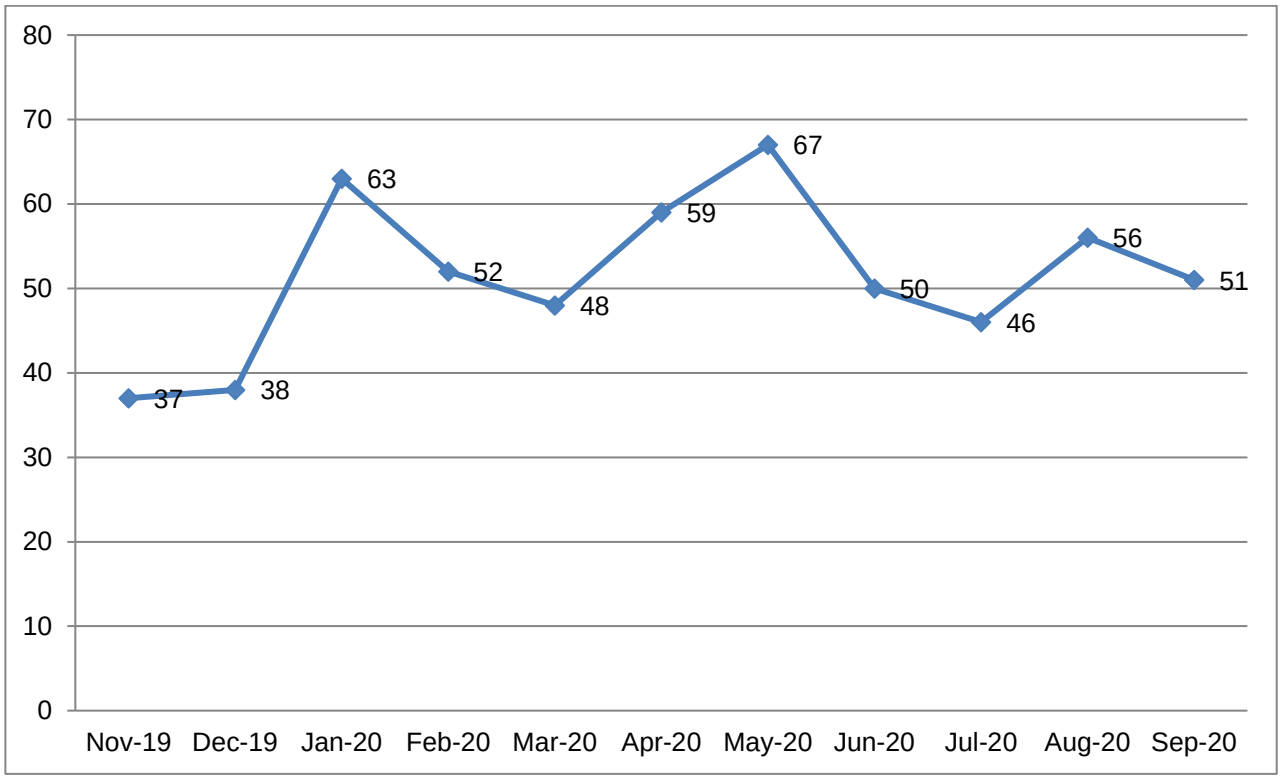
- 51 Change Requests Closed in the month of September 2020



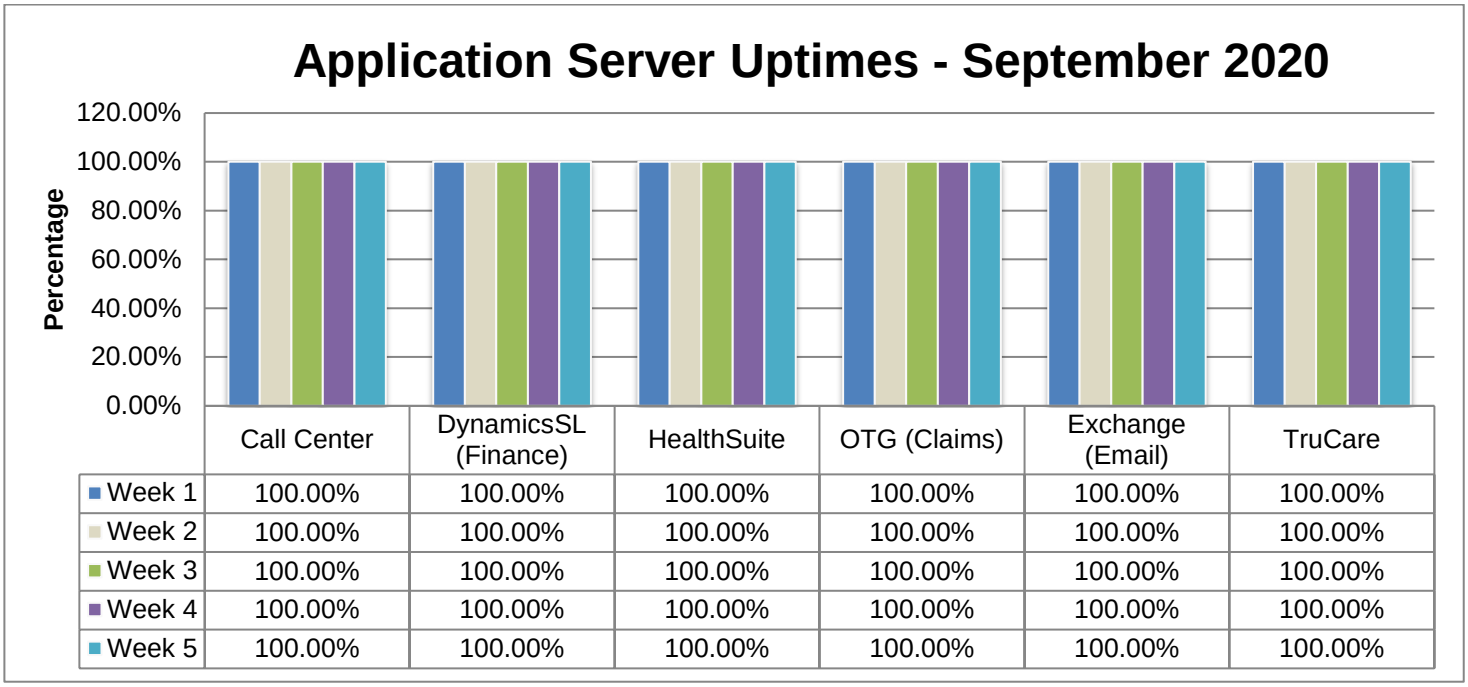
- Change Requests Submitted: Monthly Trend



- Change Requests Closed: Monthly Trend



IT Stats: Infrastructure



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

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

Call Center System Availability

- Overall, we are continuing to perform the following activities to optimize the call center eco-system (applications, backend integration, configuration, and network).

Projects:

Network Infrastructure Upgrade

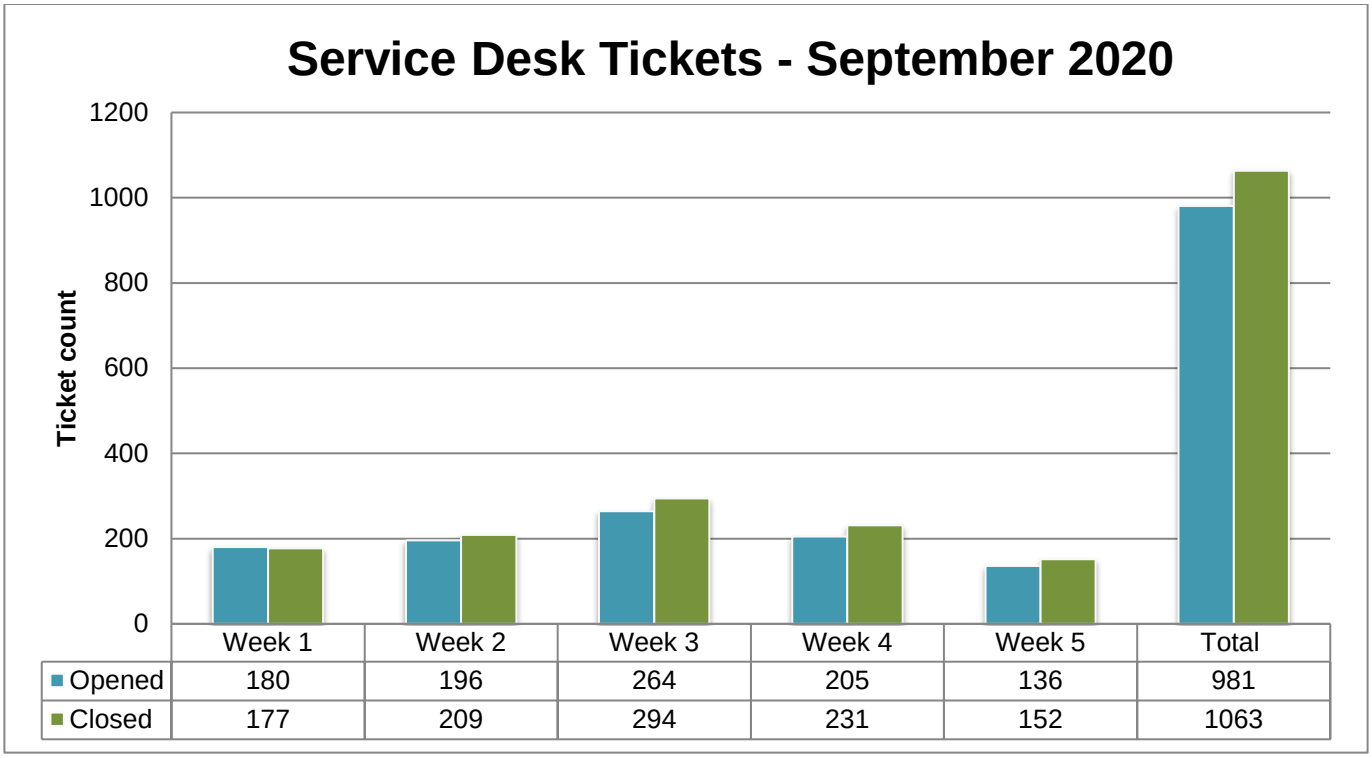
- Phase 3:
  - Activated two new 1gig Internet circuits – Completed.
  - Deployed two new Cisco enterprise routers – Completed.
  - Deployed two new Cisco enterprise firewall hardware with Intrusion Prevention and Advanced Malware Protection capabilities – Completed.

Office 365 Project

- Phase 1:
  - Migration of email services to the cloud (Migration of Microsoft Office application to the cloud model) has been completed.
- Phase 2:
  - Rehydration of archive email to Microsoft O365 has been completed.
  - Office 365 Suite Client deployment is in progress.

Call Center Application Upgrade Project

- Phase 1: Calabrio application upgrade - in progress.
- Phase 2: Cisco Application upgrades – not started.

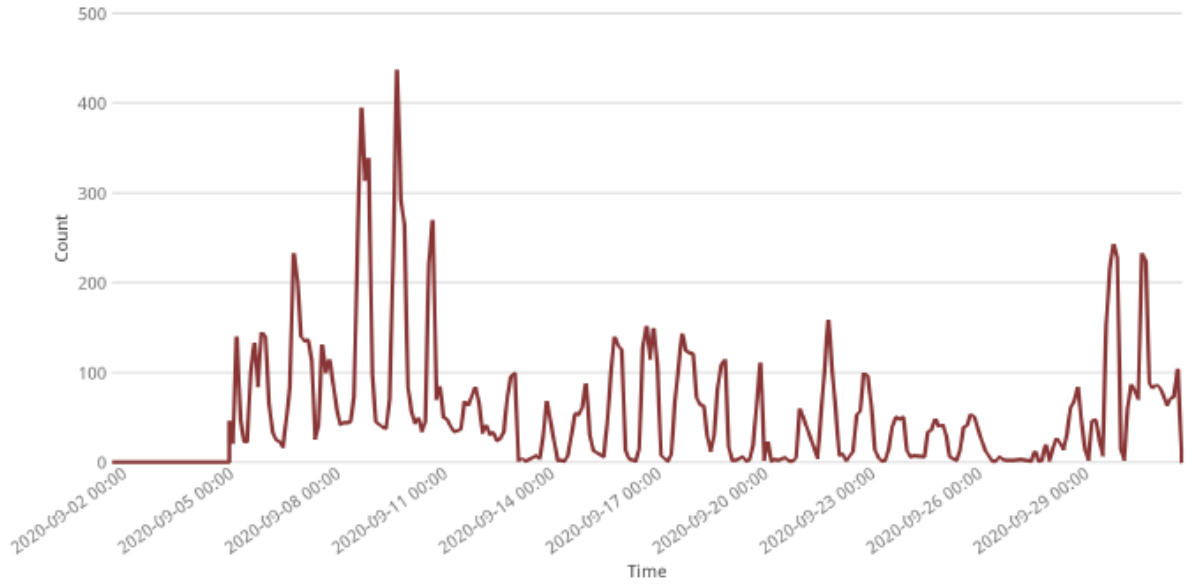


	Week 1	Week 2	Week 3	Week 4	Week 5	Total
Opened	180	196	264	205	136	981
Closed	177	209	294	231	152	1063

- 981 Service Desk tickets were opened in the month of **September**, which is 15% lower than the previous month and 1,063 Service Desk tickets were closed, which is 0.4% higher than the previous month.

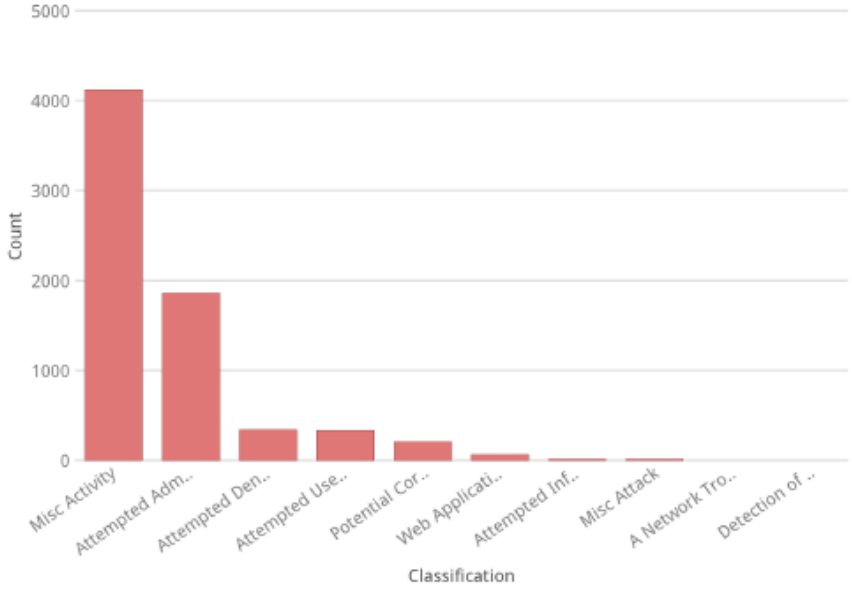
All Intrusion Events

Time Window: *2020-09-01 10:03:44 - 2020-10-01 10:03:44*

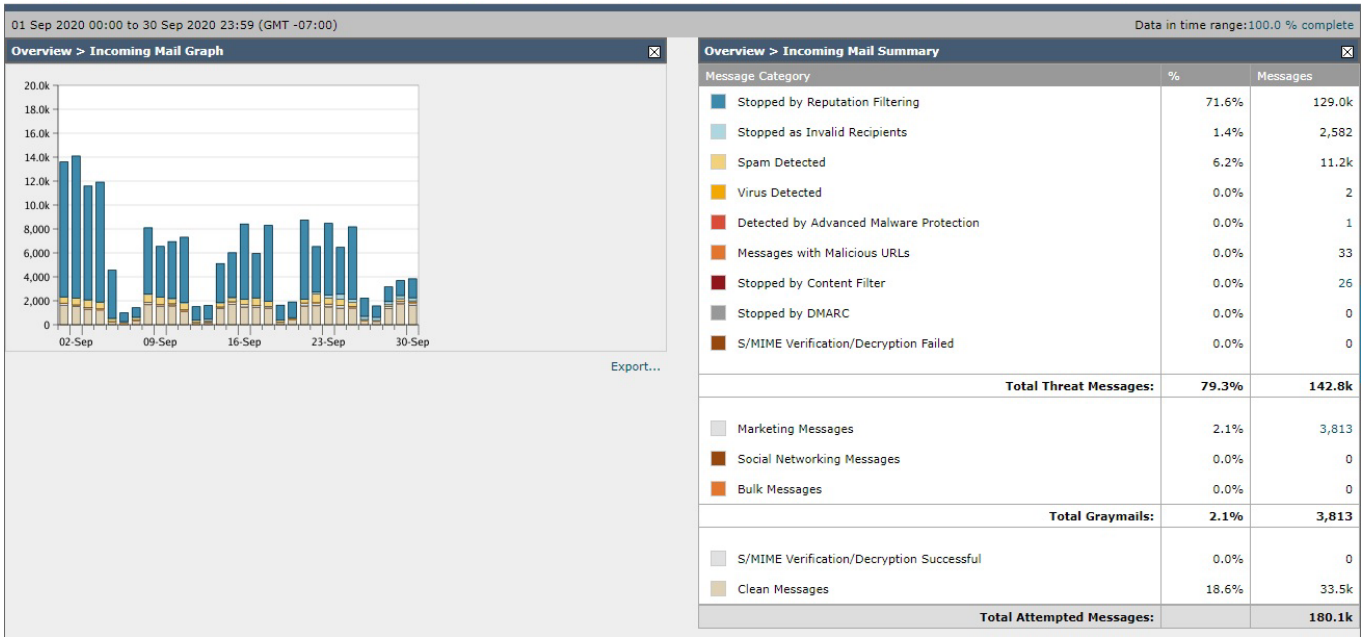


Dropped Intrusion Events

Time Window: *2020-09-01 10:03:44 - 2020-10-01 10:03:44*
Constraints: *Inline Result = dropped*



Classification	Count
Misc Activity	4,127
Attempted Administrator Privilege Gain	1,865
Attempted Denial of Service	343
Attempted User Privilege Gain	339
Potential Corporate Policy Violation	210
Web Application Attack	65
Attempted Information Leak	18
Misc Attack	14
A Network Trojan was Detected	2
Detection of a Network Scan	1



Item / Date	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Aug-20	***Sep-20***
Stopped By Reputation	10.7k	293.7k	301.0k	264.0k	275.3k	306.6k	234.0k	280.8k	249.7k	278.0k	322.6k	237.0k	***129.0k***
Invalid Recipients	0	22	51	0	4	0	4	56	39	55	50	612	***2,582***
Spam Detected	599	15.5k	17.1k	14.0k	12.0k	13.6k	12.8k	16.4k	11.4k	17.1k	15.9k	16.9k	***11.2k***
Virus Detected	0	2	3	13	0	0	0	3	4	3	1	2	***2***
Advanced Malware	1	3	4	1	1	0	4	6	0	0	1	0	***1***
Malicious URLs	21	117	140	239	81	122	91	14	36	43	47	50	***33***
Content Filter	0	14	10	17	7	4	9	48	9	23	14	10	***26***
Marketing Messages	145	1,748	4,606	4,677	3,854	4,211	3,804	4,296	3,730	3,834	4,024	3,715	***4,127***
Attempted Admin Privilege Gain	1,643	971	1,475	360	1,425	704	518	596	1,064	1,292	2,573	33	***1,865***
Attempted User Privilege Gain	116	1	8	0	12	7	27	17	18	23	94	22	***339***
Attempted Information Leak	46	30	38	46	43	31	37	59	63	48	64	88	***18***
Potential Corp Policy Violation	59	13	26	8	25	29	10	77	21	32	19	59	***210***
Network Scans Detected	6	12	18	3	4	1	4	3	15	2	2	1	***1***
Web Application Attack	111	19	40	45	35	72	45	121	47	124	42	0	***65***
Misc. Attack	29	7	18	21	1	30	21	25	18	56	18	0	***14***

- All security activity data is based on the current month's metrics as a percentage. This is compared to the previous three month's average, except as noted.
- Email based metrics currently monitored have increased with a return to a reputation-based block for a total of 129.0k.
- Attempted information leaks detected and blocked at the firewall are slightly higher from 64 to 88 for the month of **September.**
- Network scans returned a value of 1, which is in line with the previous month's data.
- Attempted User Privilege Gain is higher at 339 from a previous six month average of 23.

Projects and Programs

Ruth Watson

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

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

Date: **October 9, 2020**

Subject: **Projects & Programs Report**

Project Management Office

- Completed phase one - project portfolio ranking exercise with Senior Leadership team.
    - 39 projects currently on the Alliance enterprise-wide portfolio (includes PMO managed and department managed projects).
        - 18 projects actively in-flight.
        - 3 projects completed.
        - 18 projects not active.
            - Phase 2 – portfolio ranking scheduled for Q2.

- Key projects currently in-flight:
    - Alliance.org Phase 2 – rebuild of the Member portal; target go-live is mid-December 2020.
    - Pharmacy Carve-out – transition of the pharmacy benefit for Medi-Cal members from managed care plans to the State; go-live date is January 1, 2021.
    - Coordination of Benefits Agreement (COBA) Phase 1 – implementation of the COBA file from CMS; AAH will receive claims directly from CMS for members that have Medicare as primary so providers will no longer have to submit paper claims with the Medicare EOB attached; go live date is October 30, 2020.
    - HealthSuite Upgrade – annual core system upgrade; go live date is December 31, 2020.
    - Data Warehouse Expansion Phase 3 – expand the existing data warehouse to include all critical domain data; go live date is June 30, 2021.

- Projects completed in September:
    - Admission, Discharge, Transfer (ADT) Data Feeds Phase 3A – automate ADT feed into TruCare; project phase completed on September 17, 2020
        - Case Manager report for patients who visited hospitals in the prior 24 hours being delivered daily.
        - Analytics team generating monthly ADT Referral metrics report.
        - Case Manager report being delivered daily to CHCN, CFMG and AHS; Sutter and St. Rose reports will be delivered by end of September.

- TruCare Upgrade – annual core system upgrade; completed September 25, 2020.
- Stanford Oncology Collaboration - collaborative partnership with a tertiary and quaternary care setting to facilitate access to AAH members; implemented September 21, 2020.
  - Business Objectives:
    - Expand provider network.
    - Increase access to AAH members.
    - Increase AAH Service lines.
    - Introduce alternative payment model.

- Key projects commencing soon:
  - Interoperability Mandate – requires CMS-regulated payers, including Medicaid managed care plans, to implement and maintain a secure, standards-based Patient Access application programming interface (API) that allows patients to access their claims and encounter information, including cost, as well as a defined sub-set of their clinical information through third-party applications of their choice.
    - Enforcement date is July 1, 2021.
    - RFP underway and vendor selection expected mid-October.

Recruiting & Staffing

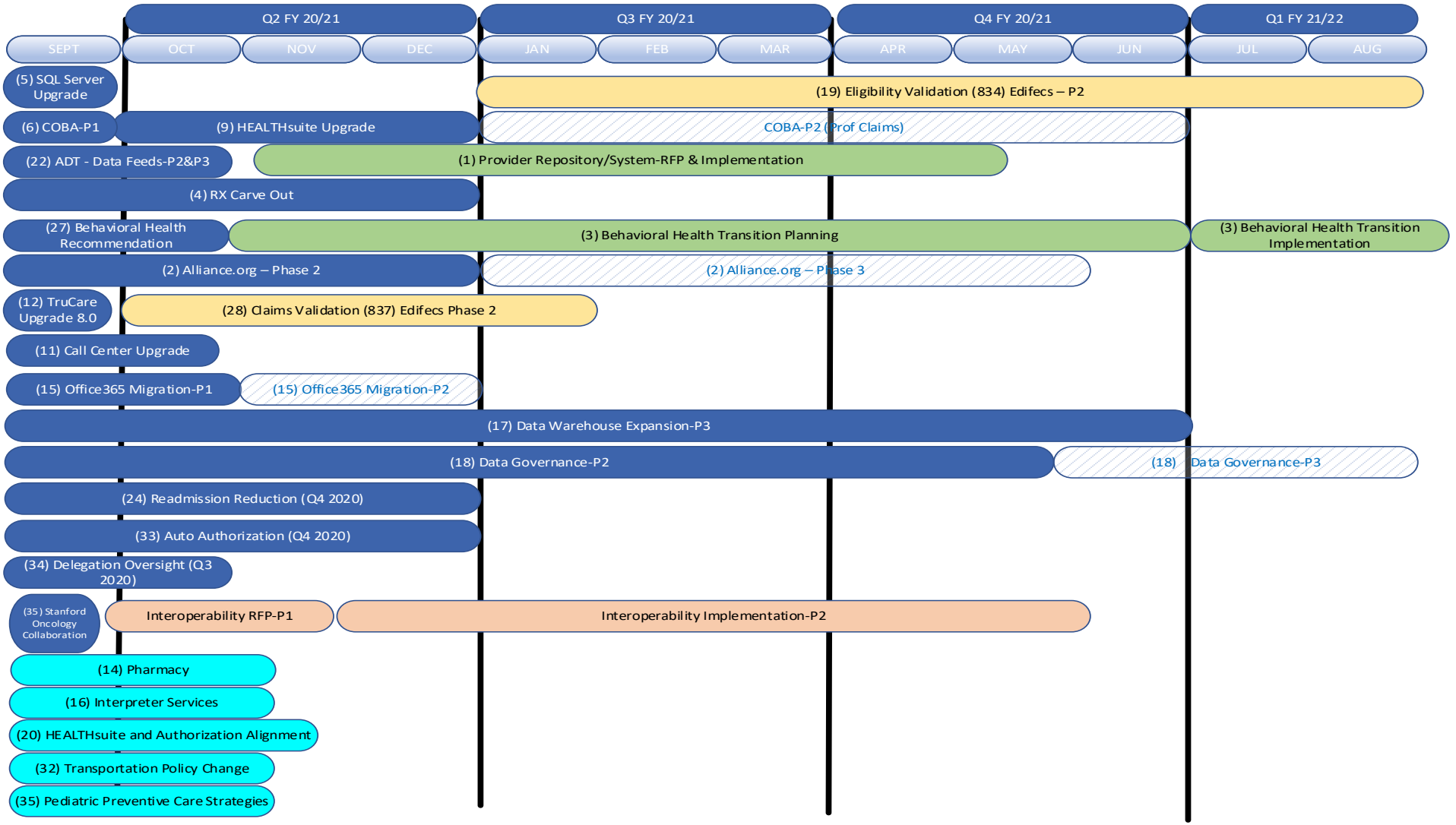
- Recruitment underway for the following position(s):
  - Director, Service Excellence and Portfolio Management.
  - Executive Assistant.

- Open position(s):
  - Senior Project Manager; recruitment will begin when Director position is filled.

Projects and Programs

Supporting Documents

AAH Project Portfolio - Active +



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: **October 9, 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: July 2019 – June 2020 dates of service
Prior reporting period: July 2018 – June 2019 dates of service
(Note: Data excludes Kaiser Membership data.)

- For the Current reporting period, the top 7.5% of members account for 82.2% of total costs.

- In comparison, the Prior reporting period was slightly higher at 7.6% of members accounting for 81.6% of total costs.

- Characteristics of the top utilizing population remained fairly consistent between the reporting periods:
    - The SPD (non duals) and ACA OE categories of aid saw no change to account for 58.8% of the members, with SPDs accounting for 29.7% and ACA OE's at 29.1%.
    - The percent of members with costs >= $30K slightly increased from 1.5% to 1.6%.
    - Of those members with costs >= $100K, the percentage of total members remained consistent at 0.4%.
        - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, increasing to 47.5%.

- 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 7.5% is more concentrated in the 45-66 year old category (41.1%) compared to the overall population (21.4%).

Analytics

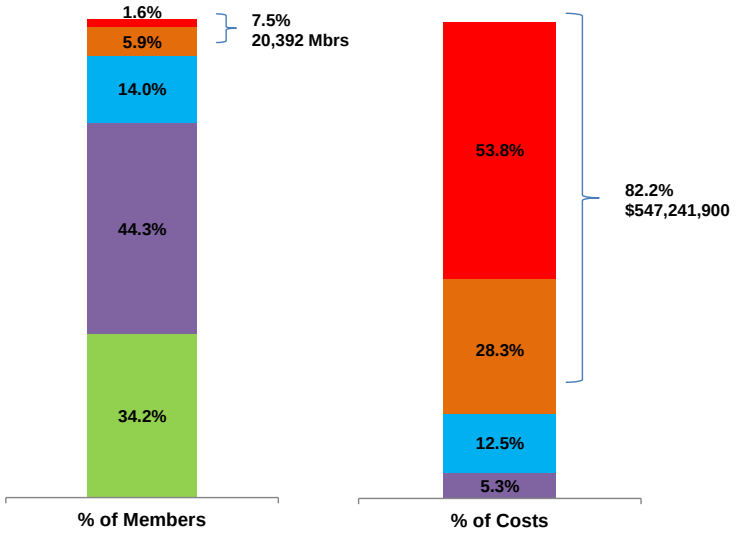
Supporting Documents

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

Note: Data incomplete due to claims lag

Run Date: 09/28/2020

Member Cost Distribution



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	4,234	1.6%	$ 358,449,814	53.8%
$5K - $30K	16,158	5.9%	$ 188,792,086	28.3%
$1K - $5K	38,000	14.0%	$ 83,365,357	12.5%
< $1K	120,463	44.3%	$ 35,435,454	5.3%
$0	92,792	34.2%	$ -	0.0%
Totals	**271,647**	**100.0%**	**$ 666,042,711**	**100.0%**

Top 7.5% of Members = 82.2% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	957	0.4%	$ 183,199,015	27.5%
$75K to $100K	520	0.2%	$ 44,708,032	6.7%
$50K to $75K	1,056	0.4%	$ 64,842,979	9.7%
$40K to $50K	686	0.3%	$ 30,692,847	4.6%
$30K to $40K	1,015	0.4%	$ 35,006,941	5.3%
SubTotal	***4,234***	***1.6%***	***$ 358,449,814***	***53.8%***
$20K to $30K	1,989	0.7%	$ 48,673,802	7.3%
$10K to $20K	5,814	2.1%	$ 80,554,528	12.1%
$5K to $10K	8,355	3.1%	$ 59,563,757	8.9%
SubTotal	***16,158***	***5.9%***	***$ 188,792,086***	***28.3%***
Total	**20,392**	***7.5%***	**$ 547,241,900**	***82.2%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Jun 2020	223,486	$ 585,579,694
Dis-Enrolled During Year	48,161	$ 80,463,018
Totals	**271,647**	**$ 666,042,711**

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

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
7.5% of Members = 82.2% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Jul 2019 - Jun 2020
Note: Data incomplete due to claims lag
Run Date: 09/28/2020

7.5% of Members = 82.2% of Costs
29.7% of members are SPDs and account for 36.2% of costs.
29.1% of members are ACA OE and account for 28.5% of costs.
8.2% of members disenrolled as of Jun 2020 and account for 13.0% of costs.

Highest Cost Members: Cost Per Member >= $100K
41.7% of members are SPDs and account for 41.1% of costs.
27.1% of members are ACA OE and account for 27.5% of costs.
18.5% of members disenrolled as of Jun 2020 and account for 19.8% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	117	558	675	3.3%
MCAL	MCAL - ADULT	403	2,958	3,361	16.5%
	MCAL - BCCTP	2	3	5	0.0%
	MCAL - CHILD	168	1,410	1,578	7.7%
	MCAL - ACA OE	1,245	4,681	5,926	29.1%
	MCAL - SPD	1,666	4,389	6,055	29.7%
	MCAL - DUALS	92	1,025	1,117	5.5%
Not Eligible	Not Eligible	541	1,134	1,675	8.2%
Total		**4,234**	**16,158**	**20,392**	**100.0%**

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	28	2.9%
MCAL	MCAL - ADULT	68	7.1%
	MCAL - BCCTP	2	0.2%
	MCAL - CHILD	5	0.5%
	MCAL - ACA OE	259	27.1%
	MCAL - SPD	399	41.7%
	MCAL - DUALS	19	2.0%
Not Eligible	Not Eligible	177	18.5%
Total		**957**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 9,801,363	$ 6,092,466	$ 15,893,829	2.9%
MCAL	MCAL - ADULT	$ 29,426,987	$ 33,129,430	$ 62,556,418	11.4%
	MCAL - BCCTP	$ 272,778	$ 29,874	$ 302,652	0.1%
	MCAL - CHILD	$ 7,769,205	$ 15,943,633	$ 23,712,838	4.3%
	MCAL - ACA OE	$ 103,046,200	$ 52,855,408	$ 155,901,608	28.5%
	MCAL - SPD	$ 144,104,027	$ 53,962,406	$ 198,066,434	36.2%
	MCAL - DUALS	$ 7,111,899	$ 12,574,172	$ 19,686,071	3.6%
Not Eligible	Not Eligible	$ 56,917,355	$ 14,204,696	$ 71,122,051	13.0%
Total		**$ 358,449,814**	**$ 188,792,086**	**$ 547,241,900**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 5,028,370	2.7%
MCAL	MCAL - ADULT	$ 11,742,128	6.4%
	MCAL - BCCTP	$ 272,778	0.1%
	MCAL - CHILD	$ 787,619	0.4%
	MCAL - ACA OE	$ 50,447,573	27.5%
	MCAL - SPD	$ 75,306,153	41.1%
	MCAL - DUALS	$ 3,398,817	1.9%
Not Eligible	Not Eligible	$ 36,215,578	19.8%
Total		**$ 183,199,015**	**100.0%**

% of Total Costs By Service Type

Breakout by Service Type/Location

Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
$100K+	6%	0%	1%	13%	55%	2%	14%	6%	2%	8%
$75K to $100K	6%	1%	3%	18%	48%	3%	8%	5%	7%	11%
$50K to $75K	4%	0%	3%	21%	39%	2%	8%	7%	10%	12%
$40K to $50K	5%	1%	3%	17%	46%	3%	8%	9%	3%	14%
$30K to $40K	5%	2%	4%	16%	43%	6%	9%	8%	2%	16%
$20K to $30K	4%	4%	6%	19%	38%	7%	10%	7%	2%	17%
$10K to $20K	1%	0%	12%	20%	36%	6%	13%	9%	3%	14%
$5K to $10K	0%	0%	12%	24%	23%	9%	13%	15%	1%	15%
Total	**4%**	**1%**	**5%**	**17%**	**43%**	**4%**	**11%**	**8%**	**4%**	**12%**

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

ALAMEDA Alliance FOR HEALTH

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

Human Resources

Anastacia Swift

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

From: **Anastacia Swift, Chief Human Resources Officer**

Date: **October 9, 2020**

Subject: **Human Resources Report**

Staffing

- As of October 1, 2020, the Alliance had 330 full time employees and 2-part time employees.
- On October 1, 2020, the Alliance had 51 open positions in which 4 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 47 positions open to date. The Alliance is actively recruiting for the remaining 47 positions and several of these positions are in the interviewing or job offer stage.
- Summary of open positions by department:

Department	Open Positions October 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	10	1	9
Operations	18	1	17
Healthcare Analytics	4	0	4
Information Technology	9	2	7
Finance	4	0	4
Compliance	2	0	2
Human Resources	2	0	2
Projects & Programs	2	0	2
Total	51	4	47

- Our current recruitment rate is 15%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in September 2020 included:
    - 5 years:
        - Dacheng Peng (IT Development)
        - Shirish Mallavolu (Healthcare Analytics)
        - Smita Kaza (IT Applications)
    - 7 years:
        - Alexandra Loza (Complaints & Resolutions)
        - Catherine Patrick (Case Management and Disease Management)
        - Hellai Momen (Quality Improvement)
    - 8 years:
        - BJ Gerona (IT Infrastructure)
    - 16 years:
        - Carol Van Oosterwijik (Finance)
    - 18 years:
        - Steve Le (Community Relations)