ALAMEDA Alliance FOR HEALTH

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Board of Governors

Regular Meeting

Friday, October 13th, 2023
12:00 p.m. – 2:00 p.m.

Video Conference Call and

1240 South Loop Road, Alameda, CA 94502

AGENDA

BOARD OF GOVERNORS
Regular Meeting
Friday, October 13th, 2023
12:00 p.m. – 2:00 p.m.

In-Person and Video Conference Call

1240 S. Loop Road
Alameda, CA 94502

PUBLIC COMMENTS: Public Comments can be submitted for any agendized item or for any item not listed on the agenda, by mailing your comment to: "Attn: Clerk of the Board," 1240 S. Loop Road, Alameda, CA 94502 or by emailing the Clerk of the Board at brmartinez@alamedaalliance.org. You may attend meetings in person or by computer by logging in to the following link: Click here to join the meeting. You may also listen to the meeting by calling in to the following telephone number: 1-510-210-0967 conference id 159517119#. If you use the link and participate via computer, you may use the chat function, and 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, please submit your comments to the Clerk of the Board at the email address listed above or by providing your comments during the meeting at the end of each agenda item. Oral comments to address the Board of Governors are limited to three (3) minutes per person. Whenever possible, the board would appreciate it if public comment communication was provided prior to the commencement of the meeting.

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.

1. CALL TO ORDER

(A regular meeting of the Alameda Alliance for Health Board of Governors will be called to order on October 13th, 2023, at 12:00 p.m. in Alameda County, California, by Rebecca Gebhart, Presiding Officer. This meeting is to take place in person and 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 8th, 2023, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

b) SEPTEMBER 8th, 2023, BOARD OF GOVERNORS MEETING MINUTES

c) REVIEW AND APPROVE RESOLUTION 2023-09 NOMINATING REBECCA GEBHART AS A MEMBER OF THE COMPLIANCE ADVISORY COMMITTEE

6. BOARD MEMBER REPORTS

a) COMPLIANCE ADVISORY COMMITTEE

b) FINANCE COMMITTEE

7. REVIEW AND APPROVE MOSS ADAMS FINANCIAL AUDIT REVIEW

8. CEO UPDATE

9. BOARD BUSINESS

a) REVIEW AND APPROVE AUGUST 2023 MONTHLY FINANCIAL STATEMENTS

b) ALLIANCE PROPERTY DISCUSSION

c) CYBER SECURITY UPDATE

10. STANDING COMMITTEE UPDATES

a) PEER REVIEW AND CREDENTIALING COMMITTEE

b) PHARMACY & THERAPEUTICS COMMITTEE

c) CONSUMER MEMBER ADVISORY COMMITTEE

11. STAFF UPDATES

12. UNFINISHED BUSINESS

13. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

14. PUBLIC COMMENT (NON-AGENDA ITEMS)

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

Board of Governors meetings are regularly held on the second Friday of each month at 12:00 p.m., unless otherwise noted. This meeting is held both in person and as a video conference call. Meeting agendas and approved minutes are kept current on the Alameda Alliance for Health's website at www.alamedaalliance.org.

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 items 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.

Supplemental Material Received After the Posting of the Agenda: Any supplemental materials 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 it to "Attn: 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, Brenda Martinez, at (510) 747-6160 at least 48 hours prior to the meeting to inform us of your needs and to determine if accommodation is feasible. Please advise us at that time if you will need accommodations to attend or participate in meetings on a regular basis.

I hereby certify that the agenda for the Board of Governors was posted on the Alameda Alliance for Health's web page at www.alamedaalliance.org by October 7th, 2023, by 12:00 p.m.

Brenda Martinez, Clerk of the Board

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EXECUTIVE SUMMARY APPENDIX

Please click on the hyperlink(s) below to direct you to corresponding material for each item.

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PRESENTATIONS APPENDIX

Please click on the hyperlink(s) below to direct you to corresponding material for each item.

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SUPPORTING MATERIALS APPENDIX

Please click on the hyperlink(s) below to direct you to corresponding material for each item.

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Consent Calendar

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Compliance Advisory Committee Meeting Minutes

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COMPLIANCE ADVISORY COMMITTEE
Regular Meeting Minutes
Friday, September 8th, 2023
10:30 a.m. – 11:30 p.m.

Video Conference Call and

1240 S. Loop Road
Alameda, CA 94502

Committee Members Attendance: Dr. Kelley Meade, Bryon Lopez

Committee Members Remote: Richard Golfin, III

Committee Members Excused: Jody Moore

1. CALL TO ORDER

The regular Compliance Advisory Committee meeting was called to order by Dr. Kelley Meade at 10:30 a.m.

2. ROLL CALL

A roll call was taken of the Committee Members, in-person quorum was not confirmed. Meeting will proceed as informational only.

3. AGENDA APPROVAL OR MODIFICATIONS

There were no modifications to the agenda.

4. PUBLIC COMMENT (NON-AGENDA ITEMS)

None

5. CONSENT CALENDAR

a. May 12th, 2023, Compliance Advisory Committee Minutes
b. June 9th, 2023, Compliance Advisory Committee Minutes

No in-person quorum. Motion to approve item **5(a)(b)** on the Consent Calendar will be considered in October.

6. COMPLIANCE MEMBER REPORTS

a. COMPLIANCE ACTIVITY REPORT

i. Plan Audits and State Regulatory Oversight

1. Status Updates on State Audit Findings and Plan Responses

a. Compliance Dashboard

i. 2023 DHCS Routine Medical Survey

- The findings on the dashboard for the June 2023 DHCS audit are self-identified. No updates have been received from DHCS since the exit interview on April 28th. The preliminary report from DHCS is expected to be received in the fourth quarter of this year.

ii. 2022 DHCS Routine Medical Survey

- The Routine Medical Survey for 2022 identified 15 findings, Corrective Action Plans have been internally developed and submitted to the state for review. So far, DHCS has reviewed 8 out of the 15 findings. We are currently awaiting further guidance from DHCS regarding the remaining findings, as well as any additional documentation that may be requested before closing.

    1. Validations of Completed CAPs

        - Most of these findings are currently moving through the stages of our internal CAP validation process, which is intended to mitigate the issues.
        - The process entails determining which findings to validate first based on a risk assessment, which is part of our internal audit plan.
            - Risk can include things like if the finding is a repeat finding, or what the effect of the finding might be on the plan if it were to continue to be uncorrected.

Question: Do you have a standardized way in which she pulled the validation samples?

Answer: The decision to validate is based on risk assessment, and those items that are higher risk will be validated first.

iii. 2021 DMHC Follow-Up Survey

- The 2021 DMHC Routine Medical Survey was completed in conjunction with the 2021 DHCS Routine Medical Survey back in April of 2021. There was a total of six findings on the 2021 DMHC audit. On June 26th, 2023, DMHC notified the Alliance they will be conducting a follow-up review of those outstanding 6 deficiencies. The review period will cover November 1st, 2022, through August 17th, 2023. The six deficiencies, and what we have done to correct them, are as follows:

    1. When the Plan has notice of a G&A case requiring expedited review, the Plan does not immediately inform complainants of their right to contact the Department.
        a. The CAP for this was completed in May of 2022.
        b. We updated the process to state when a call is received by the Member Services Department and it is categorized as a potential expedited case, the call is transferred to the Grievance & Appeals Department queue and the Clerk will provide the member with their DMHC rights.
    2. The Plan's online grievance submission procedure is not accessible through a hyperlink clearly identified as GRIEVANCE FORM, does not allow the member to preview and edit the form before submission, and does not include the required disclosure.
        a. The CAP for this was completed in August of 2022
        b. The Plan worked with our internal IT department to have updates made to the website to include the Grievance Form hyperlink, the edit/preview functionality, and the updated disclosure statement. Regarding the disclosure statement, the Plan identified an outdated version of the statement. The Plan has updated the disclosure statement so that it is in alignment with the verbiage from Knox-Keene
    3. The Plan does not correctly display the required disclosure in all required enrollee communications. This disclosure statement is regarding the health plan grievance process.
        a. This CAP was completed in December of 2022
        b. We identified an outdated version of the statement, and updated the disclosure statement so that it is in alignment with the verbiage from Knox-

Keene for both appeals and grievance letters, as well as UM and Pharmacy letters.

4. The Plan's prescription drug denial and modification letters to enrollees do not include accurate information about their grievance rights.
    a. This CAP was completed in December of 2022
    b. The prescription drug denial and modification letters to enrollees were updated to include accurate information about grievance rights.
5. The Plan does not inform enrollees of their right to seek an external exception request review in formulary exception request denial letters.
    a. This CAP was completed in December of 2022
    b. The external exception request review language was inserted in formulary exception request denial letters.
6. The Plan does not display its formularies in a manner consistent with the Department's standard formulary template.
    a. This CAP was completed in December of 2022
    b. The formulary template was updated to be consistent with the Department's standard formulary template.

ii. Compliance Risk Assessment

- The Compliance Division is in receipt of the Compliance Risk Assessment analysis presented by external consultants in a 2022 review. The Compliance Division will be focused on bolstering key pillars to an effective compliance program. In addition to creating a Compliance Dashboard with all the findings, timelines, and recommendations.

b. Delegation Activity and Oversight

i. MLR Reporting for Delegation Activity

- No updates received since receiving the guidance from the State in June 2023.
- Starting with CY2023, information will be reported out in CY2024 with CY2024, information will be reported in CY2025. There is the possibility of paying money back.

Question: If 85% is not met will delegates have to pay money back. If the MLR exceeds, will they have rate adjustments?

Answer: This would be an 85% MLR floor that the delegates need to meet. If they go over 100%, they will not get money back. Instead, the delegate would be on the hook for the additional expenses, which is their risk., but until get information from the state on what is included in numerators, what is included in medical expense, and what is not, difficult to determine. For the 2024 period, that they report in 2025, if they are below the 85% threshold, they will have to pay money back. This has implications for the Alliance as well, regarding how we contract with them in regard to rates.

ii. 2022 DMHC RBO Audits

2. CFMG
3. CHCN

- The Plan's oversight of these RBOs includes quarterly audits of claims settlement practices beginning with Q1 2023 dates of service. Case files for both CHCN and CFMG remain under review.

c. Medi-Cal Program Updates

i. 2022 RFP Contract Update

- On September 1st we received our go live operational readiness letter – we are working towards wind-down stage, however we still have a few more batches to submit.
- Internal target implementation date October 1st, 2023
    - Submission of thirteen deliverables in August, and final submission in September.
- Emergency preparedness and response plan will have an extended implementation date to January 1st, 2025 – Business Continuity Plan (BCP) and RFP not contingent on one another, so removing requirement for operational readiness.

1. 2023 DMHC Material Modification
    - The Alliance staff met with the Office of Plan of Licensing, the division of provider networks and Office of Financial Review subject matter experts.
    - DMHC provided guidance that plans need only submit the documents amended to comply with the Knox Keene Act requirement or new policies developed to satisfy the Knox Keene mandate.
        - Compliance is combing through the documents previously submitted to DHCS to identify the documents that meet the criteria specified by DMHC during the pre-filing meeting.

ii. Behavioral Health Transition

2. Review of Undertakings
    - DMHC's approval was subject to and conditioned upon the Alliance's full performance to the Department's satisfaction of eight undertakings.
    - Six of the eight undertakings require deliverables to DMHC. Compliance is coordinating with internal stakeholders to gather responses for timely and complete submission of the deliverables.
        - Deliverables have been filed with DMHC undertaking five and six are still pending.

7. COMPLIANCE ADVISORY COMMITTEE BUSINESS

a. Revisit Motion and Discussion for New Compliance Advisory Committee Meeting Schedule.

- Dr. Kelley Meade suggested to consider a seven-meeting schedule at the next in-person quorum.

8. STAFF UPDATES

None

9. UNFINISHED BUSINESS

None

10. STAFF ADVISORIES ON COMPLIANCE BUSINESS FOR FUTURE MEETINGS

a. Please Note: There was no meeting in July 2023

11. ADJOURNMENT

Dr. Kelley Meade adjourned the meeting at 11:20 a.m.

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Board of Governors Meeting Minutes

BOARD OF GOVERNORS
Regular Meeting Minutes
Friday, September 8th, 2023
12:00 p.m. – 2:00 p.m.

Video Conference Call and

1240 S. Loop Road
Alameda, CA 94502

1. CALL TO ORDER

Board of Governors Present: Rebecca Gebhart (Chair), Dr. Rollington Ferguson, James Jackson, Byron Lopez, Dr. Marty Lynch, Dr. Kelley Meade, Andrea Schwab-Galindo, Dr. Evan Seevak

Board of Governors Remote: Dr. Noha Aboelata (Vice-Chair)

Board of Governors Excused: Aarondeep Basrai, Dr. Michael Marchiano, Jody Moore, Yeon Park, Supervisor Lena Tam, Natalie Williams

Alliance Staff Present: Matthew Woodruff, Dr. Steve O'Brien, Gil Riojas, Anastacia Swift, Ruth Watson, Sasi Karaiyan, Tiffany Cheang, Michelle Lewis, Lao Paul Vang

Chair Gebhart called the regular Board of Governors meeting to order at 12:00 p.m.

2. ROLL CALL

Roll call was taken, and a quorum was established.

3. AGENDA APPROVAL OR MODIFICATIONS

There were no modifications to the agenda.

4. INTRODUCTIONS

There were no introductions.

5. CONSENT CALENDAR

a) JULY 14th, 2023, BOARD OF GOVERNORS MEETING MINUTES

b) RESOLUTION 2023-07 CHANGING HEALTH CARE QUALITY COMMITTEE (HCQC) TO QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE (QIHEC)

c) RESOLUTION 2023-08 ASSIGNING A NEW RESOLUTION NUMBER TO THE PREVIOUSLY ADOPTED RESOLUTION CHANGING THE FREQUENCY OF BOARD OF GOVERNORS TO CORRECT NUMBERING ERROR

Motion: A motion was made by Marty Lynch and seconded by Dr. Kelley Meade to approve the Consent Calendar Agenda Items 5a through 5c.

Vote: The motion was passed unanimously.

Ayes: Dr. Rollington Ferguson, James Jackson, Byron Lopez, Dr. Marty Lynch, Dr. Kelly Meade, Andrea Schwab-Galindo, Dr. Evan Seevak, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

No opposition or abstentions.

6. BOARD MEMBER REPORTS

a) COMPLIANCE ADVISORY COMMITTEE

During the update provided by Dr. Kelley Meade on the Compliance Advisory Committee, it was mentioned that the committee had met informally due to a lack of quorum. The committee discussed the compliance dashboard, which had 178 findings, including state audit findings and self-identified findings. However, 163 of these findings have been completed, indicating good progress. They also discussed the 2023 DHCS Routine Medical Survey, which had a positive interview in April. The preliminary report is expected to be released in Q4 of this year. The committee reviewed the DMHC 2022 claim settlement practices and the provider dispute resolution mechanism for children's first and CHCN. The oversight plan for these organizations includes quarterly audits of claims settlement practices starting from 2023. The DMHC Full Medical Survey had three findings in grievances and appeals, and three in prescription drug coverage. The plan submitted its final corrective action plan responses at the end of 2022 to the state. This summer, the plan received notification in June that the department will be conducting a follow-up review survey of these outstanding items. They will be evaluating general plan deficiencies with grievances and appeals, and with prescription drug coverage processes. The case files for these evaluations are due to the department by August 31st, 2023. Lastly, regarding the 2021 DHCS Routine Medical Survey, the plan is awaiting closure of the corrective action plans by DHCS, and the Kindred-focused audit of 2020 is officially closed.

The committee is currently seeking members for the compliance sub-committee. If you are interested, please contact Dr. Meade.

Question: Dr. Ferguson asked if there were any particular items we should focus on.

Answer: Dr. Meade said repeat findings is an express concern that we would want to pay attention to.

Question: Starting January 1st, when all Anthem members are integrated into, will the Compliance Committee have a role?

Answer: We have some necessary procedures to go through, including block file transfers. Our compliance team has met with DMHC to discuss the steps needed to file for these transfers. Thankfully, the majority of our members are already with AHS, CHCN, and CFMG and will remain with their physicians. However, we still need to file all regulatory paperwork for these new members. We strive to prevent repeat findings, but if they do arise, we conduct an analysis to determine if they are truly repeat issues. This analysis is discussed at the Compliance Advisory Committee and brought up by our Chair. We haven't provided updates on this matter due to the lengthy audit process. We will have more detailed updates on our findings in the coming months. If there is anything noteworthy that the Board should be aware of, we will escalate it and provide a comprehensive understanding of our progress in the 2023 DHCS Routine Medical Survey. We are still closing audits from 2021, which is a normal timeframe for DMHC.

Comment: Dr. Ferguson emphasized the importance of keeping track of all the information presented. As the board members cannot remember every detail, it is crucial to bring up any repeat findings during each meeting. The committee does an excellent job of presenting all the details, but sometimes it is helpful to see a broad picture. For example, if there is a repeat finding of a certain issue, it would be useful to know about it so the board can focus on addressing it.

b) FINANCE COMMITTEE

Dr. Ferguson stated that the Finance committee did not meet on Tuesday. However, we did meet with our auditors, Moss Adams, and they will present their findings in October.

c) JANUARY BOARD RETREAT MEETING PLANNING

Chair Gebhart mentioned that in the spirit of our new meeting schedule, we will be having a retreat in January. She will be collaborating with Matt and our Strategic Planning Committee to ensure that we have a meaningful and beneficial agenda that benefits both our plan and the Board. To assist her in convening the committee, she kindly requests that board members email her their thoughts on what topics we should focus on and how we should spend our time at the retreat. This will ensure that the committee has some suggestions to work with instead of starting with a blank slate. Board members are encouraged to send their suggestions to Chair Gebhart.

7. CEO UPDATE

In the CEO Update, Matt Woodruff shared that we've been successful in meeting both our regulatory and non-regulatory metrics. Despite the ongoing pandemic, we had one of our best months, missing only one non-regulatory metric in the area of member services. In June, the health plan started a race, gender, and ethnicity salary survey, with results to be presented to the Board in October. Alameda County's Cal AIM initiative received positive recognition for its focus on housing, food, and street medicine. On August 24th, DHCS and OMB officials met with the Alliance, CHCN, HICSA, and community-based providers to discuss why Alameda County is excelling in certain categories compared to other counties. Presentations were given on ECM and community support related to homelessness and housing support, as well as the coordinated entry system and CHCN's transformation into an ECM provider. Overall, the coordination between the plan, the county, and providers was highly praised.

On September 1st, the Alliance received final approval to be a single plan model as of January 1st. Although there are still four filings left to complete, we are incredibly proud of our achievement and the hard work that went into making it happen.

Question: What do you think contributed to the success of this county and its implementation of community support and services? Was it the coordination or the whole-person care approach? What do you think they discovered as the reason for their success, compared to other jurisdictions?

Answer: During their visit, the OMB from CMS had the opportunity to understand how we work together and how long the process has taken for our County to be successful, with the Cal AIM and other initiatives. They asked many questions about the services offered and the coordination between the county and us. Dr. Kathleen Clanon emphasized the importance of whole person care and how it was initially implemented as a self-funded pilot by the team. It was also noted that the success is the result of a long-term relationship built over many years and not just acutely.

Question: Chair Gebhart inquired about the number of deliverables.

Answer: Danube responded that there are approximately 246 deliverables, and we are scheduled to submit the next filing September 18th. Our final submission for 2023 is expected to be at the end of December. DHCS keeps us informed, and this week, we learned that out of the 20 unidentified deliverables, three or four have been identified. Danube further noted that the Compliance Advisory Committee and the Board of Governors will be kept informed on the progress.

Chair Gebhart thanked everyone for their hard work.

Question: Dr. Seevak had a question about the last bullet point in the CEO report regarding recruiting incentives for our network. Just to clarify, are you requesting the Board to provide their thoughts on this matter? Is that what is reflected in the notes there?

Answer: In response, Matt stated that during the June board meeting, he presented some information on the topic and invited anyone who wanted to make comments or edits to send them in. For any other board members who haven't commented yet or would like to see it, please get in touch with Matt.

8. BOARD BUSINESS

a) REVIEW AND APPROVE JUNE AND JULY 2023 MONTHLY FINANCIAL STATEMENTS

During the meeting, Chief Financial Officer Gil Riojas provided financial statements for a two-month period. He suggested that moving forward, we should review the details of these statements during the Finance Committee meeting and then present a two-page summary highlighting the most important topics during the board meeting.

June 2023 Monthly Financial Statement

Executive Summary:

- For the month ended June 30th, 2023, the Alliance increased enrollment by 1,503 members to 361,685 members. Net Income of $1.7 million was reported, bringing the end of the year pre-audit Net Income to $93.2 million. The Plan's medical expenses represented 89.5% of revenue at year end. Alliance reserves were 758% of regulatory requirements.

Revenue:

- For the month ended June 30th, 2023, the Actual Net Income was $1.7 million. For the fiscal YTD ended June 30th, 2023, the Net Income was $93.2 million.

Medical Loss Ratio (MLR):

- The Medical Loss Ratio was 94.3% for the month and 89.5% for the fiscal year-to-date. The Plan reported a total of $1.3B in Medical Expenses at year end.

Tangible Net Equity (TNE):

- The Department of Managed Health Care (DMHC) required $42.7M in reserves, we reported $328.8M. We had a slight decrease in reserves from the previous month, but our reserves continue to be well above DMHC requirements.

The Alliance continues to benefit from increased non-operating income, particularly significant positive returns ($14.8M) in the investment portfolio. Additionally, a positive variance ($10M) in administrative expenses has resulted in lower total expense numbers for the year.

Question: Dr. Ferguson noted the success of our investment portfolio in green investments over the past year and inquired about the current state of our investments. Have we noticed a decrease in their performance, and should we consider reviewing our approach?

Answer: We have a monthly meeting with our investment advisor to review our portfolio. Regarding our green investments, we decided to start small and assess the results. Therefore, the risk for us is quite low since we invested a smaller amount than our $350 million. The returns we've seen in the last 12 months are consistent with our other investments. However, there is always a risk, especially if market conditions change. Fortunately, most of our green investments are short-term, so we can quickly take advantage of increasing interest rates, which helps to mitigate some of the risks.

July 2023 Monthly Financial Statement

Executive Summary:

- For the month ended July 31st, 2023, the Alliance had enrollment of 358,306 members, a Net Income of $9.7 million and 723% of required Tangible Net Equity (TNE).

Enrollment:

- Total enrollment has decreased by 3,379 members since June 2023. This decline was expected due to the redetermination process and is predicted to continue for the rest of

the fiscal year. We anticipate a decline in membership due to the disenrollment redetermination process as we move to a single plan model.

Category of Aid:

- The most negative impacted by enrollment decreases were in the Medi-Cal Child, Medi-Cal Adult and Optional Expansion category.
- The seniors and persons with disabilities category had a relatively flat change from the previous month.
- The Duals category was relatively level as well.
- The Group Care category appears to have stabilized after a period of decline, with a slight leveling off.
- We had a decline of about 10 members in our long-term care, which is a very small number.

Net Income:

- For the month and fiscal year-to-date ended July 31st, 2023:
  - Actual Net Income was $9.7 million.
  - Budgeted Net Loss was $723,000.

Revenue:

- For the month and fiscal year-to-date ended July 31st, 2023:
  - Actual Revenue was $138.7 million.
  - Budgeted Revenue was $136.8 million.
- For the month ended July 31st, 2023, Revenue was $1.9 million favorable, driven by incentive revenue timing and base capitation revenue, slightly offset by supplemental maternity revenue.

Medical Expense:

- For the month and fiscal year-to-date ended July 31st, 2023
  - Actual Medical Expense was $126.2 million.
  - Budgeted Medical Expense was $131.0 million.
- Reported financial results include medical expenses, which contain estimates for Incurred-But-Not-Paid (IBNP) claims. The calculation of monthly IBNP is based on historical trends and claims payments. The Alliance's IBNP reserves are reviewed by our Actuarial Consultants.
- For July updates to Fee-For-Service (FFS) increased the estimate for the prior period unpaid Medical Expenses by $164,000.

Question: Could you explain why the long-term care costs are unfavorable? The State handed over the responsibility to the plans, so why are we losing money? Is this just a timing and budgeting issue?

Answer: This was looked into, and what we're seeing is by category of aid, more expenses related to long-term care, and the SPD category which our rate for that is lower than the long-term care rate. Additionally, some expenses related to our optional expansion category of aid have long-term care costs that were unanticipated. As a result, there is a variance between our budget to actuals. We had anticipated that the majority of our membership would fall under the long-term care category, with some seniors and people with disabilities. However, we have seen a higher volume of SPDs and optional expansion cases than we initially anticipated. During the setup process, we discovered that it is common for changes to take 6 to 9 months to be made if someone

is placed in the wrong category. The facility is responsible for making the change and submitting it to the county and state. Once approved by both, it will eventually be updated by the health plan.

Question: Is there a possibility that the variance that we see in the long-term care line includes items that could have been charged to different lines in the medical expenses here? In other words, while it looks intimidating to see that we lost $4.4 million or we varied from the budget by $4.4 million, is that misleading because some of the positive variances that we're seeing in other categories wouldn't be as great if the expenses were attributed correctly?

Answer: There might be some ancillary costs that were related to long-term care, and we see some favorability there, but for the most part, the long-term care category of aid and long-term care category of service should capture all those long-term care costs.

Medical Loss Ratio (MLR):

The Medical Loss Ratio (total reported medical expense divided by operating revenue) was 90.9% for the month and fiscal year-to-date.

Administrative Expense:

- For the month and fiscal year-to-date ended July 31st, 2023
  - Actual Administrative Expense: $5.7 million.
  - Budgeted Administrative Expense: $7.3 million.

The year-to-date variances include:

- Delayed timing of start dates for Consulting for new projects, Computer Support Services and Purchased Services.
- Delayed hiring of new employees and temporary help.

Question: Mr. Jackson asked Gil if he believed that the variance would even out over time and smooth over the coming months.

Answer: Gil is of the opinion that it should. In the past, we have consistently experienced a positive difference in our administrative expenses, and so we have attempted to create a budget that is as close to realistic as possible. However, there are certain factors that can cause delays, such as the hiring process or project delays, which can lead to this difference. This is something that we are discussing with our Finance Team, with the aim of minimizing this difference. We are also exploring the possibility of reallocating funds from one area to another, in order to keep our budget steady, rather than increasing our budget beyond what we have already planned for.

Other Income/Expense:

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

- Fiscal year-to-date net investments show a gain of $2.9 million.
- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $43,000.

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. The Alliance exceeds DMHC's required TNE.
    - Required TNE $46.2 million
    - Actual TNE $334.2 million
    - Excess TNE $287.9 million
    - TNE % of Required TNE 723%
- Key Metrics
    - Cash & Cash Equivalents $477.5 million
    - Pass-Through Liabilities $228.5 million
    - Uncommitted Cash $249.0 million
    - Working Capital $312.4 million
    - Current Ratio 1.66 (regulatory minimum is 1.00)

Question: Dr. Meade asked about the steep decrease in child health enrollment and what factors are causing it despite protection measures for re-enrollment.

Answer: The goal is for those children to eventually be redetermined and then entered back into Medi-Cal again. Another possibility is that some individuals may be in their 90-day grace period and can rejoin the program during that time. Additionally, it's important to consider those who have moved out of the County.

Question: What are the majority of our pass-through liabilities? Specifically, is there an entity that the majority of the pass-through goes to?

Answer: It's likely that most of our pass-through liabilities are related to intergovernmental transfers. These are payments from the state that are meant for our provider partners and hospital partners. The state sends the money to us, and we hold on to it for a while before passing it along to the providers. Hospital systems are a big driver of those intergovernmental transfers.

Motion: A motion was made by Dr. Rollington Ferguson and seconded by Dr. Evan Seevak to approve the June and July 2023 monthly financial statements.

Vote: The motion was passed unanimously.

Ayes: Dr. Rollington Ferguson, James Jackson, Byron Lopez, Dr. Marty Lynch, Dr. Kelly Meade, Andrea Schwab-Galindo, Dr. Evan Seevak, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

No opposition or abstentions.

b) REDETERMINATIONS

Gil Riojas, Michelle Lewis, and Carol VanOosterwijk presented on the topic of the public health emergency and redeterminations. Items of discussion included:

- Alameda County Social Services Agency and Alameda Alliance Collaborative efforts
    - Discuss agency community-wide and direct outreach activities, updates, and areas for additional support.

    - Data Sharing
    - Tracking and Trending
- Alameda County Medi-Cal Renewal Data
- Enrollment by Population – Impact of Redeterminations
    - Biggest net reductions in ACA OE and Child Categories of Aid
    - Minimal change for SPD, Duals, LTC and Group Care
    - For the past 3 years, Final Enrollment has been less than Preliminary Enrollment; that changed in July. Between July 5th and August 5th, July net membership grew by 419. Between August 5th and September 5th, August net membership grew by 1,416.
    - July saw 6,829 additions and 10,249 terminations.
    - August saw 6,071 additions and 10,208 terminations.
- Membership Profiles
    - Prior Utilization
        - 93% of members terminated have less than $5,000 in costs or no utilization.
    - Ethnicity
    - Age

Comment: Chair Gebhart has expressed interest in examining the 34% of individuals who are not utilizing the aid and determining their aid categories. She also wants to compare this percentage to other plans to determine if it is better or worse. Additionally, she wants to discuss our overall approach to assisting the non-utilizers in the future. She believes that the Board would find this information very valuable.

Question: Is there a bottom line on the acuity of the member?

Answer: There could be an impact from that. In the past, the state has slightly reduced our rate due to lower quality as enrollment increased. However, with the recent influx of new members who have yet to utilize care, we may see higher acuity levels among those who remain enrolled. This could potentially have a positive impact on our rates.

Informational item only.

c) ALLIANCE STATE-FUNDED INCENTIVE PAYMENT PROGRAMS

Dani Staub, Director of Incentives & Reporting and Jessica Pedden, Quality Analytics Manager provided an update on the Incentive Program. Items of discussion included:

- Housing & Homelessness Incentive Program (HHIP)
- Student Behavioral Health Incentive Program (SBHIP)
- Cal AIM Incentive Payment Program (IPP)
- Data Sharing Agreement (DSA) Signatory Grant
- Equity and Practice Transformation Payments Program

Question: Is there an investment plan for Submission #2 or will it be developed later?

Answer: Yes, that has been submitted to the State and we received 100% funding for it.

Question: Slide 5 indicated a potential earning of $44 million, but the investment plan is only for $26.5 million. What is the plan for the remaining amount?

Answer: Although we may qualify for up to $44.4 million, we cannot guarantee that we will receive that full amount. Therefore, we must estimate how much we may receive from the State based on our deliverables. It seems that with our Submission 2 report, we may receive more funds than initially expected. If this is the case, we plan to reinvest those additional dollars back into our community.

Question: Is the plan for incentive screening for housing insecurity in a robust way that we reimburse providers to do that so that they are then eligible for this pool, or do they get to this pool at a different time?

Answer: Our efforts are streamlined through the county's coordinated entry system and housing project. We collaborate closely with the county and its established programs, which have a wide reach and involve various provider partners. Our role is a crucial link in this chain, as funding passes through this process.

Question: Homeless youth are often underreported. Is there a way to address this?

Answer: Youth are now eligible in ECM and ECM is a major component of the structure that we have for our street outreach in particular so we're definitely thinking about that and talking to our providers about that. Street medicine will be a big part of that as we move forward.

Question: Is our goal to get 100% of these incentive payments and if not, why are there things we just structurally can't get?

Answer: Some of the tasks fall within the timeframe we need to accomplish. We assess our partners' capabilities to determine what can be achieved during this period.

Informational item only.

Chair Gebhart suggested postponing the Finance training and Property discussion agenda items to the next Board of Governors meeting due to time constraints.

d) FINANCE TRAINING ON HEALTH PLAN REVENUE

The agenda item for Finance Training was postponed to the next Board of Governors meeting due to time constraints.

Motion: A motion was made by Dr. Rollington Ferguson and seconded by Dr. Marty Lynch to postpone the agenda items for Finance training and the property discussion to the next board meeting.

Vote: Motion unanimously passed.

Ayes: Dr. Rollington Ferguson, Byron Lopez, Dr. Marty Lynch, Dr. Kelley Meade, Andrea Schwab-Galindo, Dr. Evan Seevak, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

e) ALLIANCE PROPERTY DISCUSSION

The agenda item for the Alliance property discussion was postponed to the next Board of Governors meeting due to time constraints.

9. STANDING COMMITTEE UPDATES

a) PEER REVIEW AND CREDENTIALING COMMITTEE

Dr. O'Brien provided an update on the Peer Review and Credentialing Committee meeting that met on July 18th. The committee approved 10 initial providers, including 55 new Behavioral Health providers and 36 recredentialed providers.

b) PHARMACY & THERAPEUTICS COMMITTEE

An update on the Pharmacy & Therapeutics committee was shared at the last board meeting. However, Dr. O'Brien provided an update on the HCQC meeting held on August 18th. Dr. O'Brien expressed gratitude towards Matt Woodruff, Chair Rebecca Gebhart, and Vice Chair Dr. Noha Aboelata for attending the meeting. The HCQC meeting was informative, featuring an excellent presentation on HEDIS best practices, data interventions, and opportunities for improvement. Additionally, updates were shared on the HEDIS program, P4P program, access survey results, and case management work plan. The committee is currently working with Matt to discuss HEDIS efforts with an emphasis on quality and finance. Their goal is to further support providers in delivering excellent quality services. More details on this topic will be shared in the future.

c) CONSUMER MEMBER ADVISORY COMMITTEE

Matt Woodruff shared an update on the Consumer Member Advisory Committee held on June 15th. There were two main presentations that day. One was on ECM as it relates to the new children's population of focus that started on July 1st and the other main presentation that day was on the updates to our cultural sensitivity training. The next Consumer Member Advisory Committee meeting will be held on September 14th.

10. STAFF UPDATES

There were no staff updates.

11. UNFINISHED BUSINESS

None.

12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

None.

13. PUBLIC COMMENT (NON-AGENDA ITEMS)

There were no public comments for non-agenda items.

14. ADJOURNMENT

Chair Gebhart adjourned the meeting at 2:02 p.m.

ALAMEDA Alliance FOR HEALTH

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Resolution 2023-09

RESOLUTION NO. 2023-09

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH APPOINTING NOMINEE TO COMPLIANCE ADVISORY COMMITTEE

WHEREAS, pursuant to Section 7.A.1. of the Alameda Alliance for Health ("Alliance") *Bylaws*, the frequency, composition, number, terms, and nominations of members of standing committees shall be as set forth by resolution; and

WHEREAS, the Alliance Board of Governors (the "Board") on June 11th, 2021, passed Resolution 2021-11 creating the Compliance Advisory Committee as a standing committee of the Board; and

WHEREAS, pursuant to Resolution 2021-11 appointments to the Compliance Advisory Committee shall be for two (2) year terms, and members may be reappointed to additional terms by Board approval; and

WHEREAS, the Alliance Board on July 14th, 2023, passed Resolution 2023-03, which requires the Compliance Advisory Committee to have in its membership no less than three (3) and no more than five (5) Board members; and

WHEREAS, due to a Board member resigning, the Compliance Advisory Committee currently has only two Board members in its membership; and

WHEREAS, Board member Rebecca Gebhart, former Chair of the Compliance Advisory Committee, would like to rejoin said committee.

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

SECTION 1. That the Alliance Board appoints Rebecca Gebhart to serve as a member of the Compliance Advisory Committee for a two-year term.

PASSED AND ADOPTED by the Board at a meeting held on the 13th day of October 2023.

_____
CHAIR, BOARD OF GOVERNORS

ATTEST:

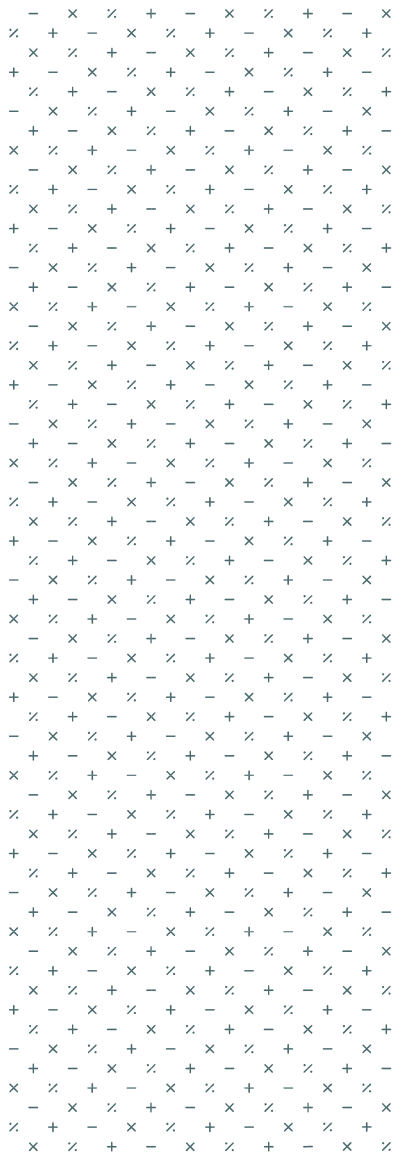
_____
Secretary

MOSSADAMS

2023 Audit Results: Alameda Alliance for Health

Rianne Suico
Health Care and Insurance Services Partner

Chris Pritchard
Health Care and Insurance Services Partner



2023 Audit Objectives

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

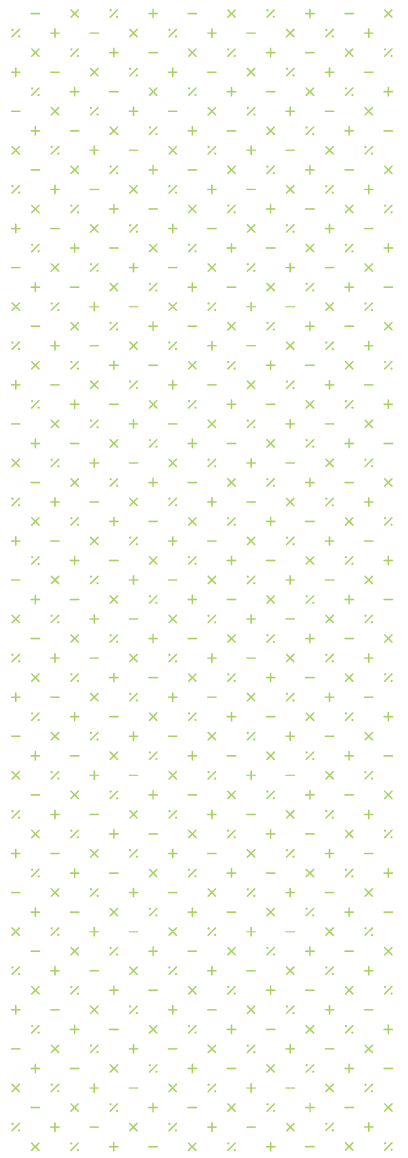
Report of Independent Auditors

Unmodified Opinion

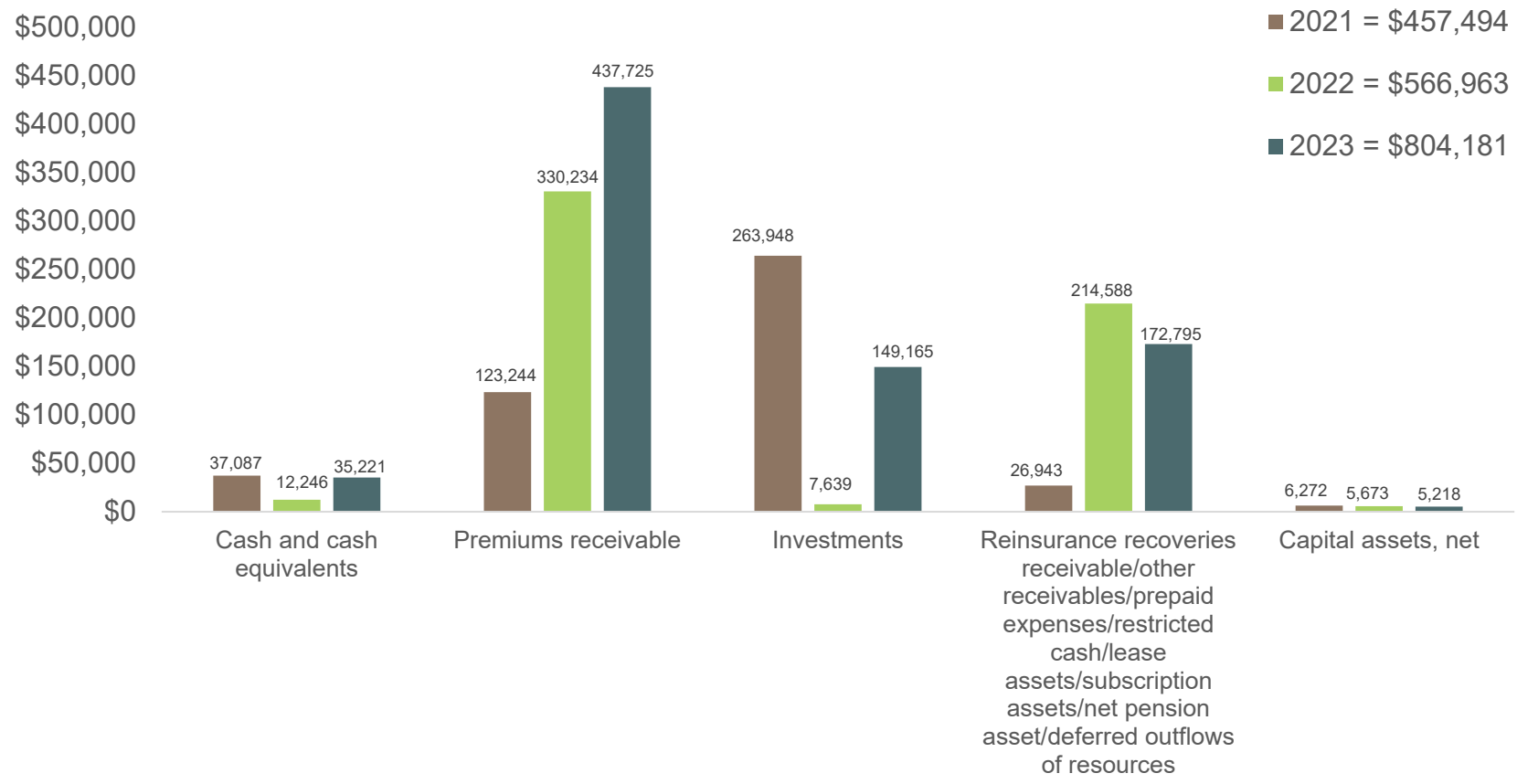
Financial statements are presented fairly and in accordance with generally accepted accounting principles.

MOSSADAMS

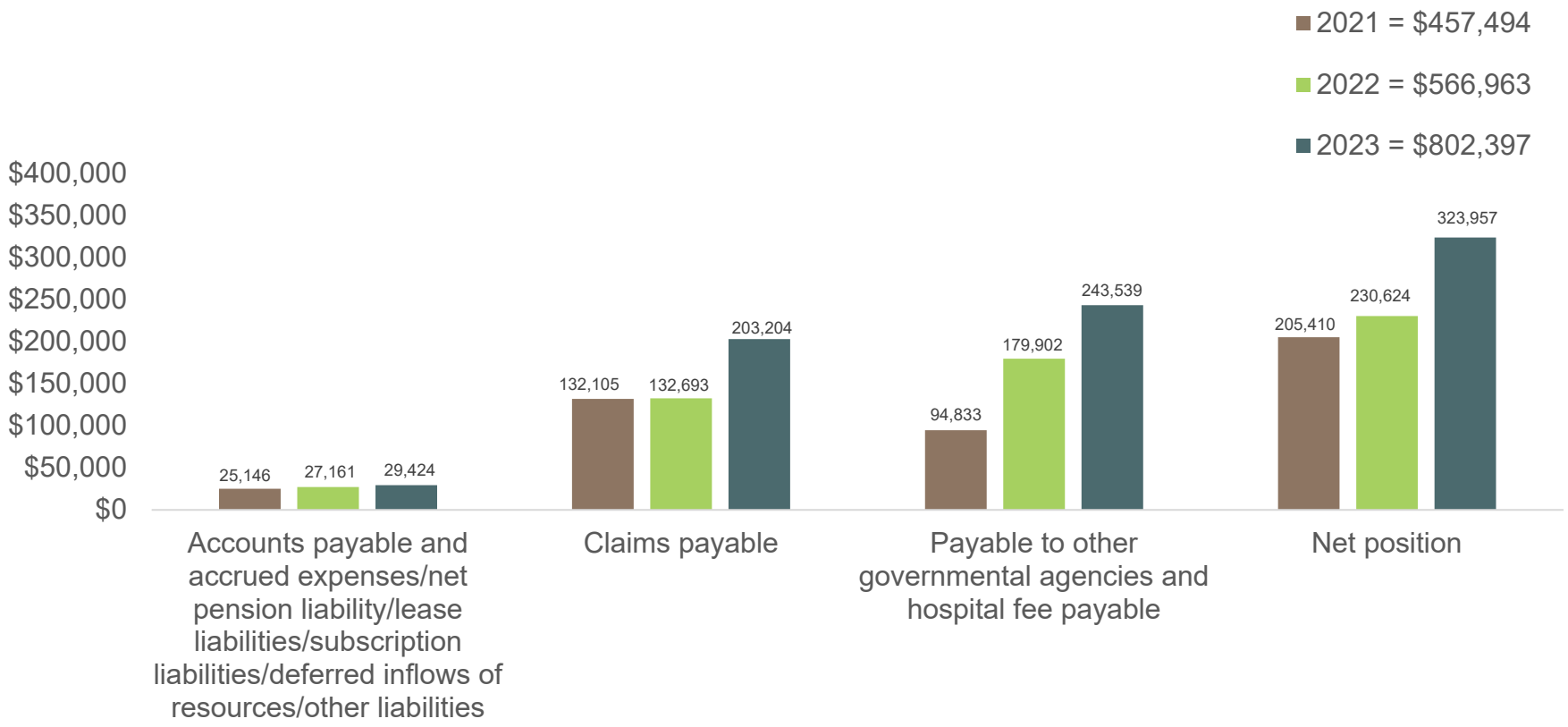
Statements of Net Positions



Assets and Deferred Outflows of Resources Composition (in thousands)

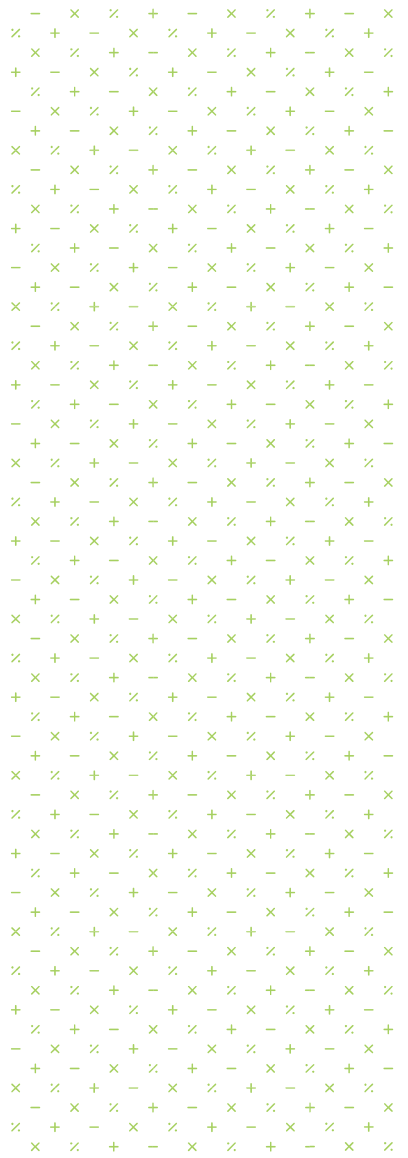


Liabilities, Deferred Inflows of Resources and Net Position Balance (in thousands)



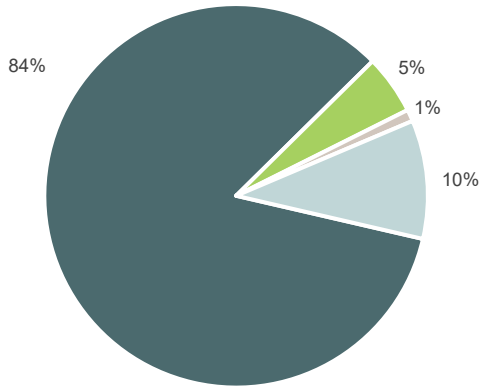
MOSSADAMS

Operations



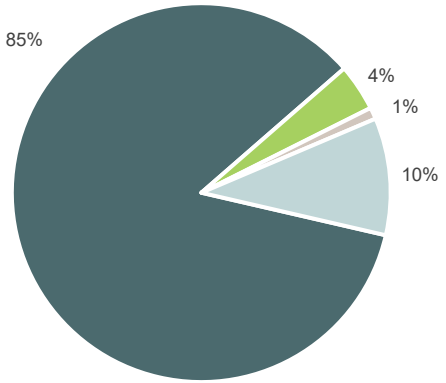
Operating Expenses (in thousands)

June 30, 2022
$1,294,271



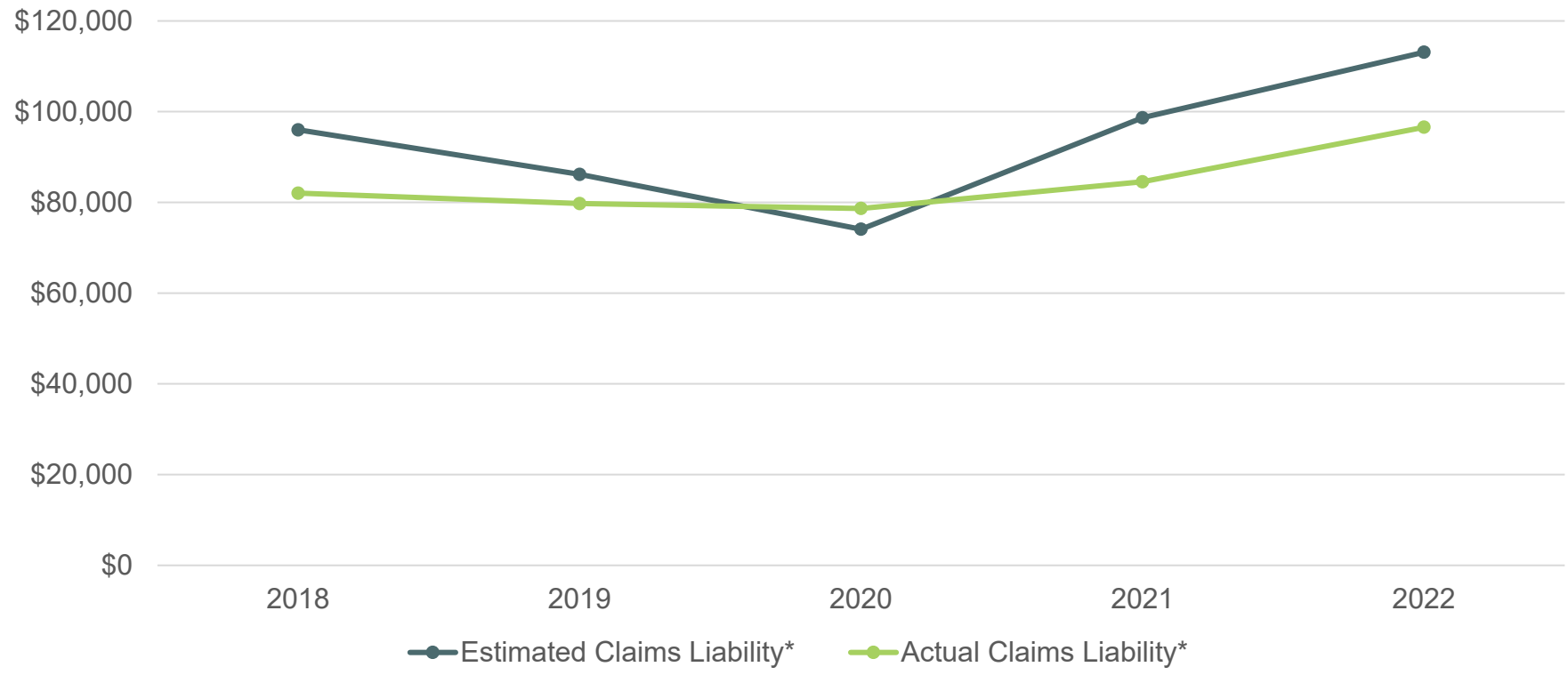
- Medical services
- Marketing, general, and administrative expenses
- Depreciation and amortization expense
- Premium tax

June 30, 2021
$1,193,599



June 30, 2023
$1,437,067

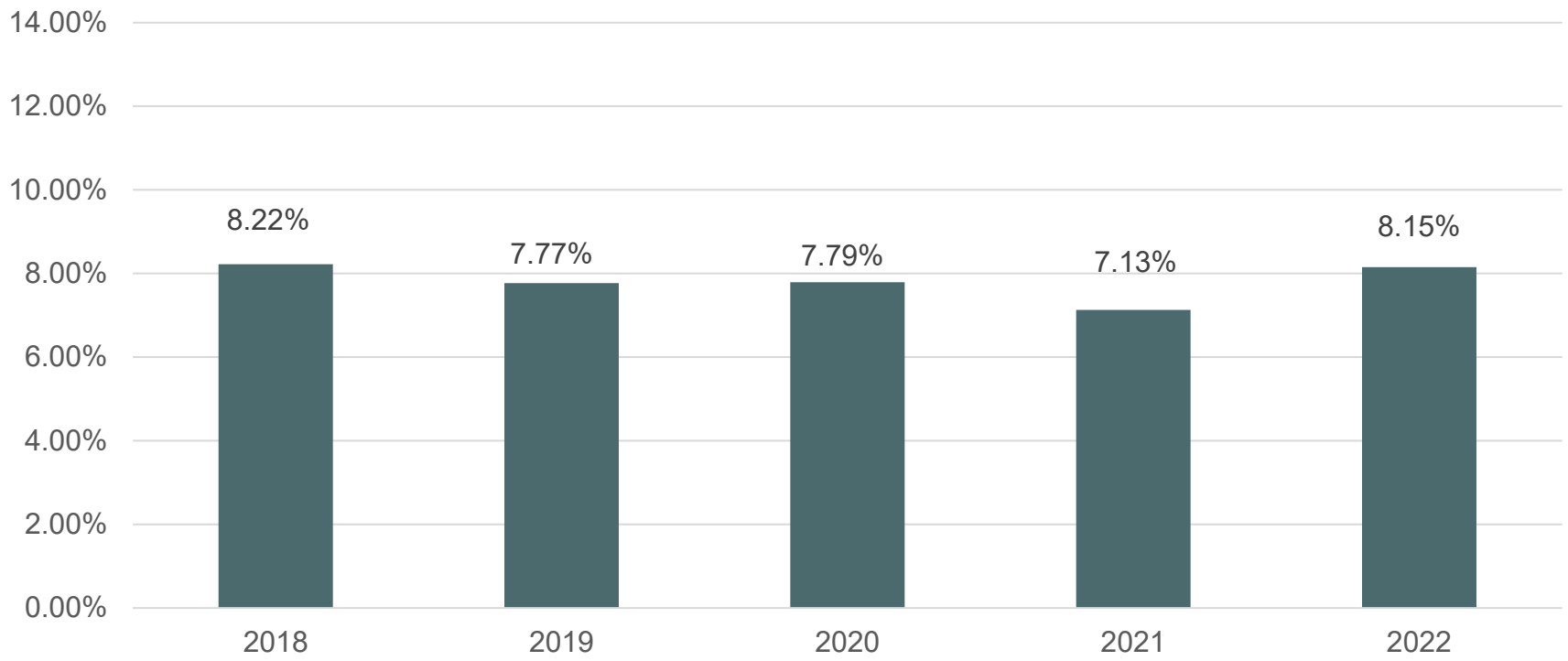
Historic Estimated Claims Liability and Historic Actual Claims Liability (in thousands)



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

Source: Alliance's internal reports

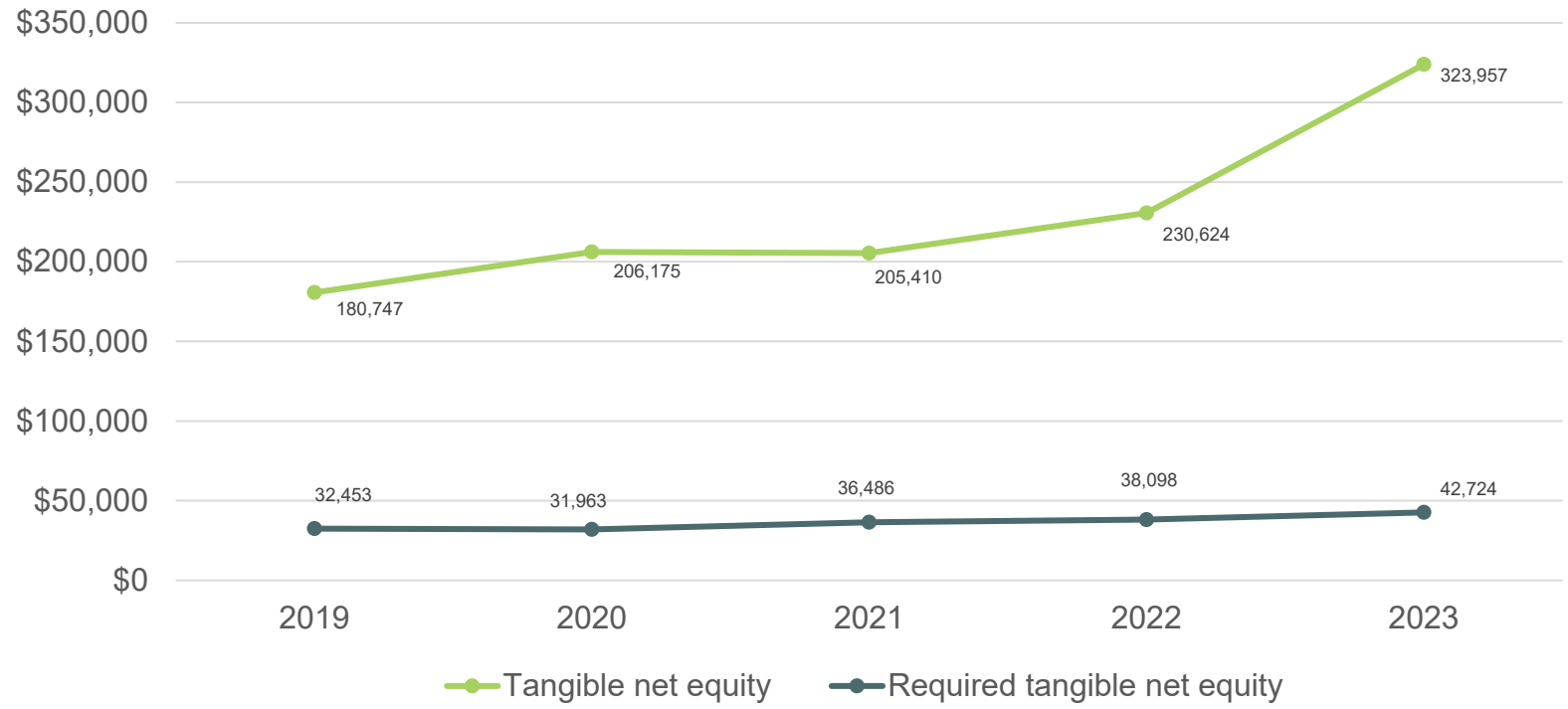
Historic Actual Claims Liability* as a % of Capitation and Premium Revenues



* Actual claims liability excludes non-hospital claims.

Source: Alliance's internal reports

Tangible Net Equity (in thousands)



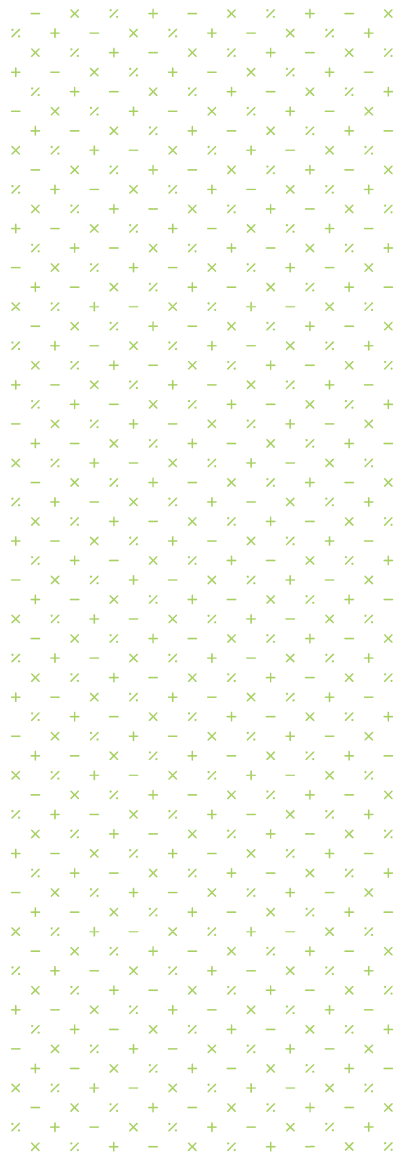
Source: Annual Department of Managed Health Care Filing

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

MOSSADAMS

Questions?



ALAMEDA Alliance FOR HEALTH

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CEO Update

Matthew Woodruff

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

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

Date: **October 13th, 2023**

Subject: **CEO Report**

- **Financials:**
  - **September 2023:** Net Operating Performance by Line of Business for the month of August 2023 and Year-To-Date (YTD):

	September	YTD
Medi-Cal	$1.9M	$11.1M
Group Care	$417K	$1.0M
Total	$2.3M	$12.1M

  - **Revenue was $138.4 million in August 2023 and $277.1 million Year-to-Date (YTD)**.
    - Medical expenses were $129.7 million in August and $255.8 million for the fiscal year-to-date; the medical loss ratio is 93.7% for the month and 92.3% for the fiscal year-to-date.
    - Administrative expenses were $8.4 million in August and $14.1 million year-to-date; the administrative loss ratio is 6.1% of net revenue for the month and 5.1% of net revenue year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 721% of the required DMHC minimum, representing $290.1 million in excess TNE.
  - **Total enrollment in August 2023 was 354,671**, a decrease of 3,635 Medi-Cal members compared to July.

- **Key Performance Indicators:**
  - **Regulatory Metrics:**
    - All regulatory metrics were met for the month of August.
  - **Non-Regulatory Metrics:**
    - The member services department did not meet one metric for the month of September. The member services team had an abandonment rate of 6% instead of the internal metric of 5%.

- **Program Implementations:**
  - **Community Supports**
    - **Review Presentation**

- **Final Budget Discussion**
  - In August, the Alliance decided to put more dollars back into the Alliance and the Community. The purpose of this is to help Alameda County with our quality and access.
    1. Hiring of staff
    2. Kaiser and Anthem transition
    3. Promote provider engagement by almost doubling the pool of dollars for the Pay for Performance Program
    4. Hiring outbound call staff who reach out to members requiring preventive care services.
    5. Building out HealthSuite / TruCare / new platform allowing AAH staff to identify a member's preventive care needs.
    6. Using a vendor to engage AAH providers on billing and coding practices.
    7. Hiring dedicated QI staff who support pediatric metrics, behavioral health metrics, and health disparity projects.
  - In June 2023 during our budget process, the Alliance projected about a $21 million net income for FY24.
    1. With these changes, the Alliance is projecting a net income of around $5-$7 million. However, we will know once we receive our draft rates later in October and complete our final budget process.

- **Pay Equity Salary Survey (Race, Gender, Ethnicity Salary Survey)**
  - In June, the Alliance began a pay equity salary survey to ensure our employees are compensated appropriately. The pay equity salary survey showed overall that we have done very well as a company.

- **Recruiting Incentives for our Network**
  - Thank you to all the Board members who sent feedback. We will review the draft program with all edits at the December meeting or at the January Board Retreat.

- **Board of Governors Grant Program**
  - The Board grant program will be out for review before the December Board meeting, or we can review at the January Board Retreat.

Community Support Services Impact Analysis

Matthew Woodruff, Chief Executive Officer

October 13th, 2023

ALAMEDA Alliance FOR HEALTH

AAH Community Support (CS) Services Offered

Community Support Offered	Implementation Date
Housing Deposits	January 1, 2022
Housing Tenancy & Sustaining Services	January 1, 2022
Housing Transition/Navigation Services	January 1, 2022
Asthma Remediation	Children: January 1, 2022 *Adults: January 1, 2024*
Medically Tailored Meals/ Medically Supportive Food	January 1, 2022 and September 1, 2022
Recuperative Care (Medical Respite)	January 1, 2022
Environmental Accessibility Adaptations (Home Modifications)	*July 1, 2023*
Respite Services for Care Givers	*July 1, 2023*
Personal Care & Homemaker Services	*July 1, 2023*
Nursing Facility Transition/Diversion to Assisted Living Facility	*January 1, 2024*
Community Transition Services/Nursing Facility Transition to Home	*January 1, 2024*
Sobering Centers	*January 1, 2024*
Short-Term Post-Hospitalization Housing	TBD
Day Habilitation Programs	TBD

Utilization Analysis
(6 Months Pre vs Post Enrollment)

Community Support Services	IP Admits/ 1000	IP Days/ 1000	ER Visits/ 1000	PCP Visits/ 1000	Rx Count/ 1000
Housing Deposits	◆	◆	●	◆	●
Housing Tenancy & Sustaining Services	◆	◆	◆	●	●
Housing Transition/Navigation Services	●	●	◆	◆	●
Asthma Remediation	●	●	●	◆	◆
Medically Tailored Meals/Supportive Food	●	●	●	◆	●
Recuperative Care (Medical Respite)	●	●	●	●	●
Total Active CS Services	●	●	●	◆	●

Utilization Analysis
(6 Months Pre vs Post Enrollment)

CS Service: Medically Tailored Meals/Supportive Food	IP Admits/ 1000	IP Days/ 1000	ER Visits/ 1000	PCP Visits/ 1000	Rx Count/ 1000
Project Open Hand	●	●	●	●	●
Recipe 4 Health	◆	◆	●	◆	●

CS Service: Recuperative Care (Medical Respite)	IP Admits/ 1000	IP Days/ 1000	ER Visits/ 1000	PCP Visits/ 1000	Rx Count/ 1000
Bay Area Community Services, Inc.	●	●	●	●	◆
Fairmont Tiny Homes Respite	●	●	●	●	●
LifeLong Medical Care	●	●	●	●	●

Cost Analysis (Pre vs Post Enrollment)
(6 Months Pre vs Post Enrollment)

Community Support Services: Active	Revenue	CS Services Expense	In Lieu Of Savings (Loss)	Net Income (Loss)
Housing Deposits	$ 420,000	$ (1,050,000)	$ (880,000)	$ (1,510,000)
Housing Tenancy & Sustaining Services	$ 420,000	$ (7,570,000)	$ (3,040,000)	$ (10,190,000)
Housing Transition/Navigation Services	$ 420,000	$ (1,370,000)	$ (4,000)	$ (954,000)
Asthma Remediation	$ 420,000	$ (140,000)	$ 140,000	$ 420,000
Medically Tailored Meals/Supportive Food	$ 420,000	$ (1,120,000)	$ 1,640,000	$ 940,000
Recuperative Care (Medical Respite)	$ 420,000	$ (1,790,000)	$ 1,690,000	$ 320,000
Total Active CS Services	***$ 2,520,000***	***$ (13,040,000)***	***$ (460,000)***	***$ (10,980,000)***

Community Support Services: Future (July 1, 2023+)	Revenue	CS Services Expense	In Lieu Of Savings (Loss)	Net Income (Loss)
Environmental Accessibility Adaptations	$ 350,000	$ (210,000)	$ -	$ 140,000
Respite Services for Care Givers	$ 350,000	$ (700,000)	$ -	$ (350,000)
Personal Care & Homemaker Services	$ 350,000	$ (3,620,000)	$ -	$ (3,270,000)
Nursing Facility Transition to Assisted Living Facility	$ 180,000	$ (90,000)	$ -	$ 90,000
Community Transition Services/NF to Home	$ 180,000	$ (50,000)	$ -	$ 130,000
Sobering Centers	$ 180,000	$ (1,420,000)	$ -	$ (1,240,000)
Total Future CS Services	***$ 1,580,000***	***$ (6,090,000)***	***$ -***	***$ (4,510,000)***

Total CS Services	***$ 4,100,000***	***$ (19,130,000)***	***$ (460,000)***	***$ (15,490,000)***

Cost Analysis (Pre vs Post Enrollment)
(6 Months Pre vs Post Enrollment)

CS Service: Medically Tailored Meals/Supportive Food	Revenue	CS Services Expense	In Lieu Of Savings (Loss)	Net Income (Loss)
Project Open Hand	$ 230,000	$ (740,000)	$ 2,160,000	$ 1,650,000
Recipe 4 Health	$ 190,000	$ (380,000)	$ (520,000)	$ (710,000)

Service: Recuperative Care	Revenue	CS Services Expense	In Lieu Of Savings (Loss)	Net Income (Loss)
Bay Area Community Services, Inc.	$ 20,000	$ (90,000)	$ 170,000	$ 100,000
Fairmont Tiny Homes Respite	$ 180,000	$ (890,000)	$ 260,000	$ (450,000)
LifeLong Medical Care	$ 220,000	$ (440,000)	$ 1,260,000	$ 1,040,000

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Executive Dashboard

OPERATIONS DASHBOARD

OCTOBER 2023

10/6/2023 7:48:15 AM

Financials

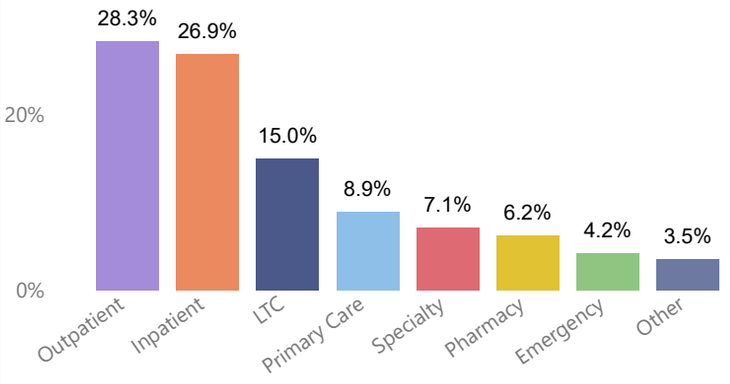
Income & Expenses

	AUGUST 2023	FISCAL YTD
REVENUE	$ 138.4 M	$ 277.1 M
MEDICAL EXPENSE	$ (129.7) M	$ (255.8) M
ADMIN EXPENSE	$ (8.4) M	$ (14.1) M
OTHER	$ 2.0 M	$ 4.9 M
NET INCOME	$ 2.3 M	$ 12.1 M

Gross Margin %

7.7%

Medical Expenses



Liquid Reserves

MLR Net %

92.3%

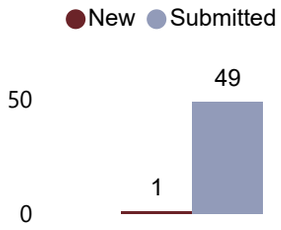
TNE %

720.6%

TNE $

$336.8M

Reinsurance Cases



Balance Sheet

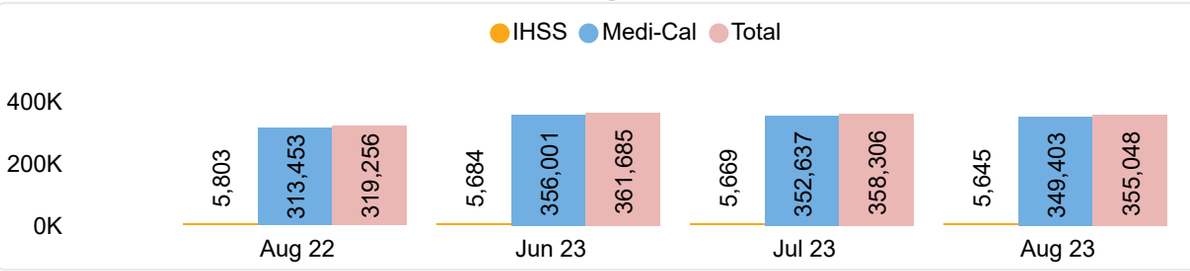
Cash Equivalents	$323.4M
Pass-Through Liabilities	$230.6M
Uncommitted Cash	$92.8M
Working Capital	$317.2M

Current Ratio

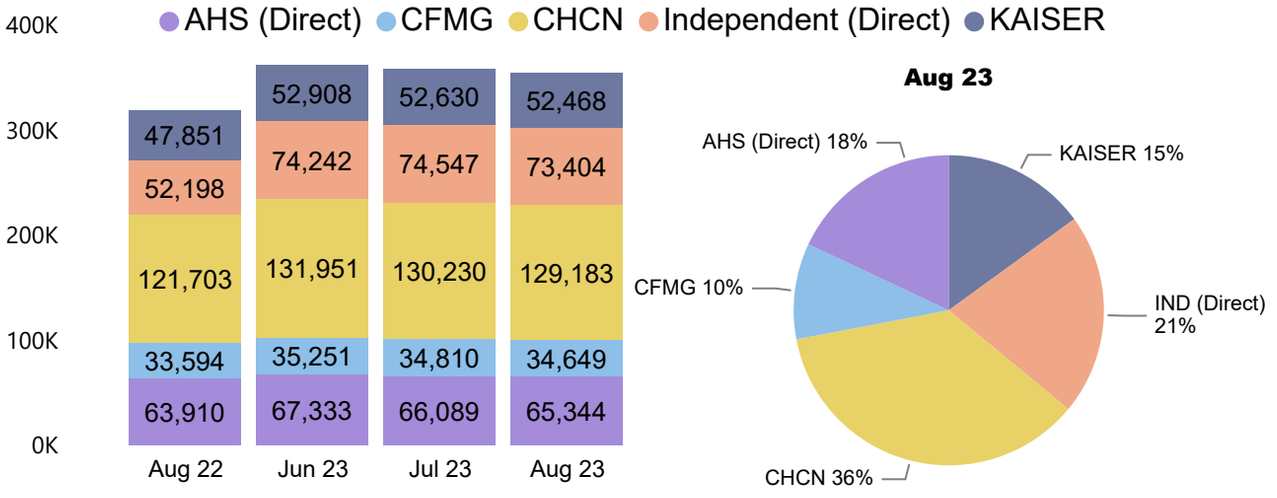
1.70

Membership

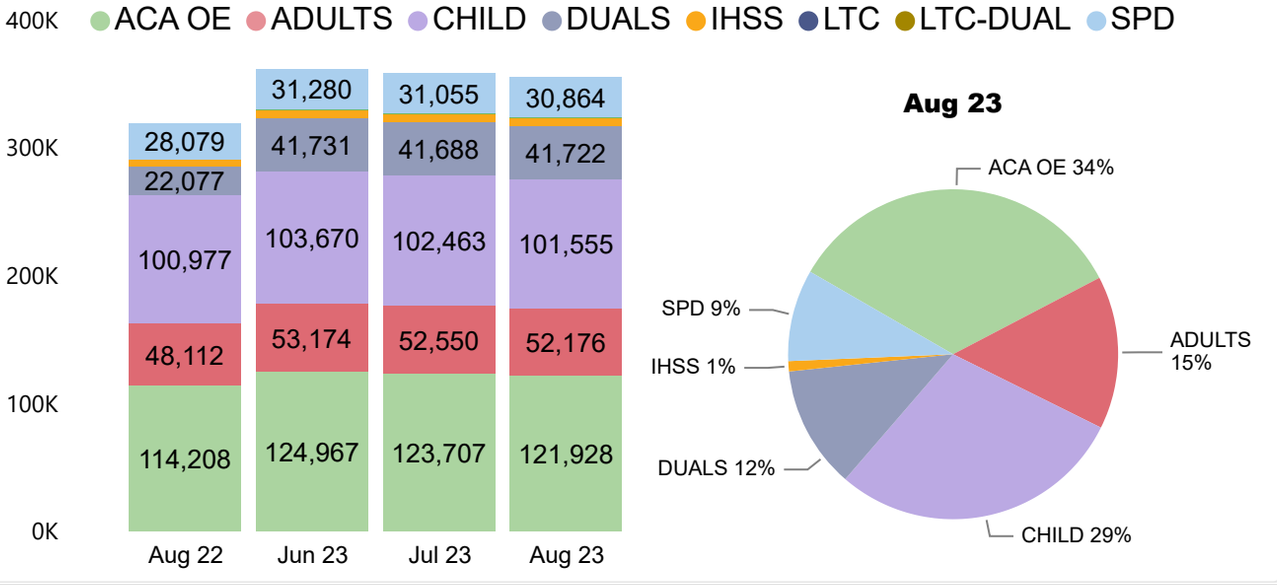
By Plan



By Network



By Category



OPERATIONS DASHBOARD

OCTOBER 2023

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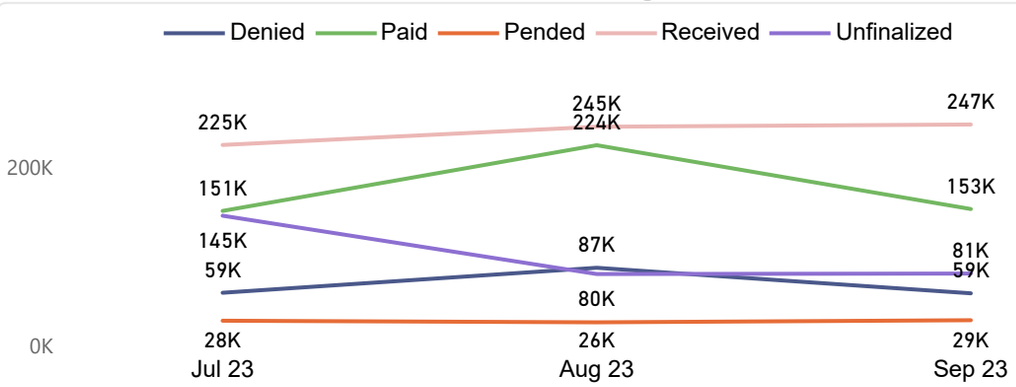
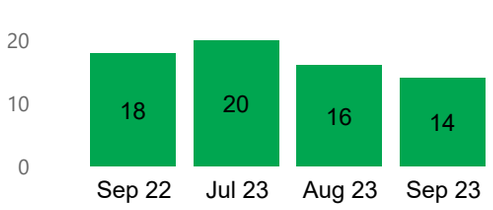
Claims

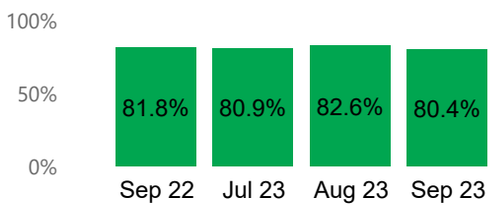
Claims Processing



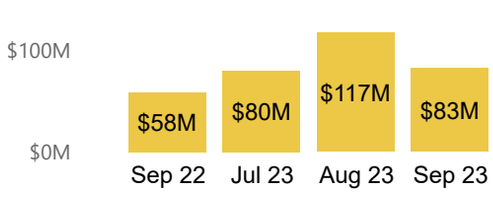
Average Payment TAT (Days)



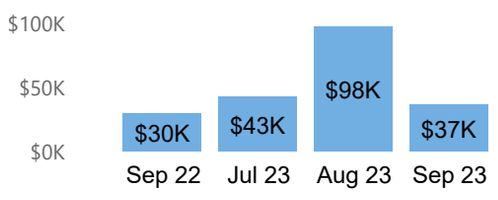
Auto Adjudication Rate (%)



Claims Paid ($)

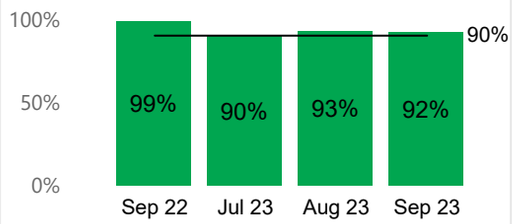


Interest Paid ($)

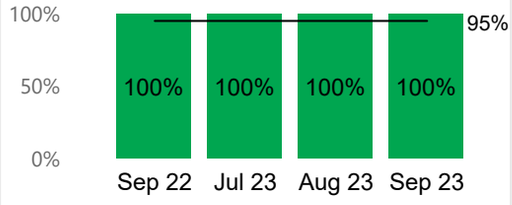


Claims Compliance

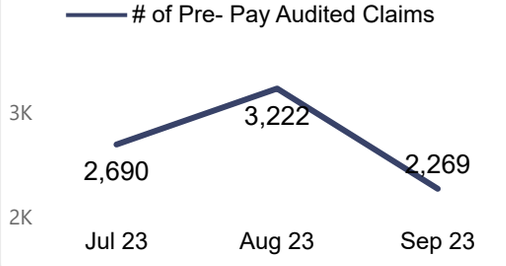
Processed 30 Cal Days (%)



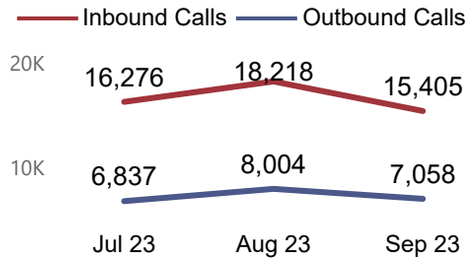
Processed 45 Work Days (%)



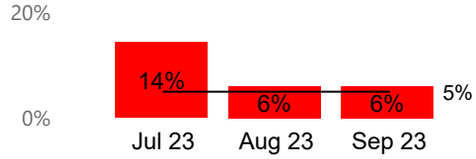
Claims Auditing



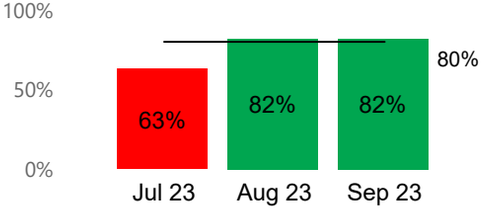
Member Services



Abandoned Call Rate (%)

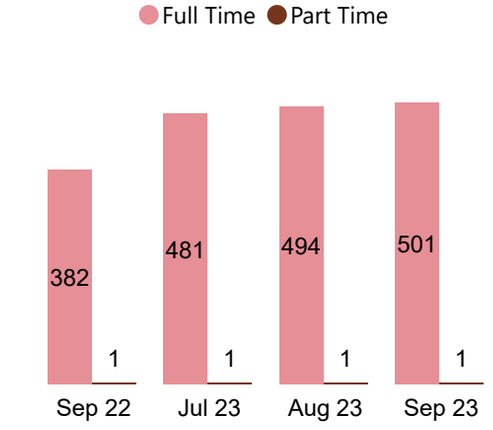


Calls Answered in 30 Seconds (%)



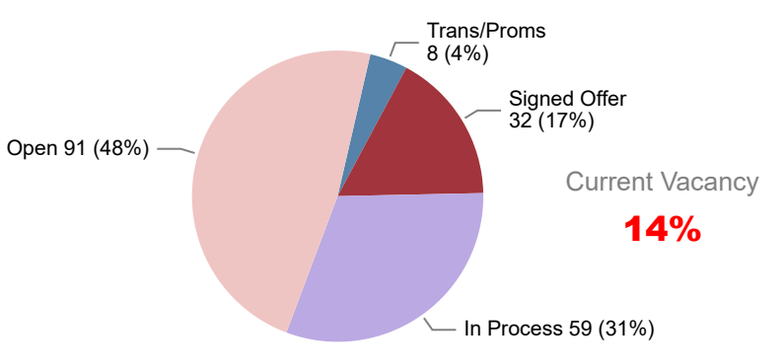
Average Call Times	Jul 23	Aug 23	Sep 23
Wait Time	01:37	00:38	00:38
Call Duration	06:35	06:29	06:36

Human Resources



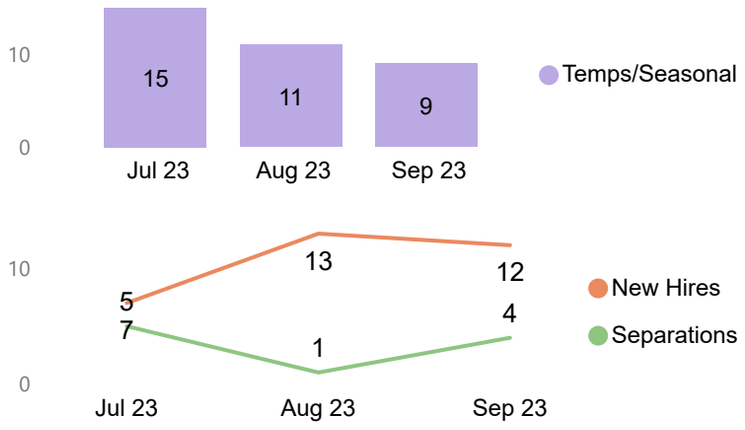
Recruiting Status

Sep 23



Current Vacancy

14%



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Provider Services

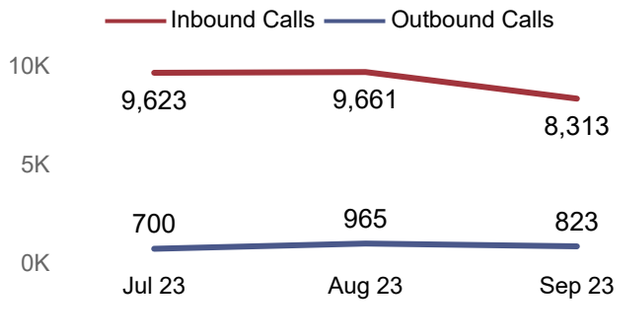
Provider Network

Hospital	17
Specialist	9,541
Primary Care Physician	764
Skilled Nursing Facility	103
Urgent Care	7
Health Centers (FQHCs and Non-FQHCs)	68
TOTAL	**10,500**

Provider Credentialing

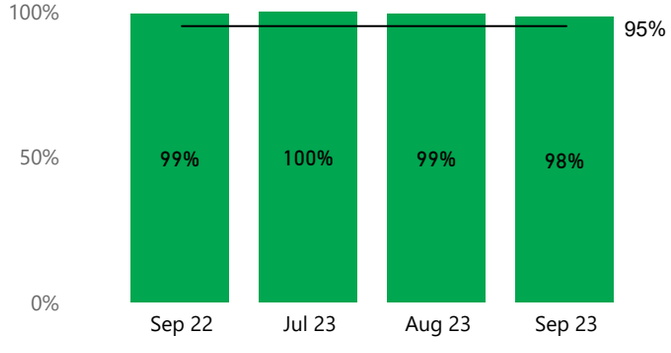
2,584

Provider Call Center



Provider Disputes & Resolutions

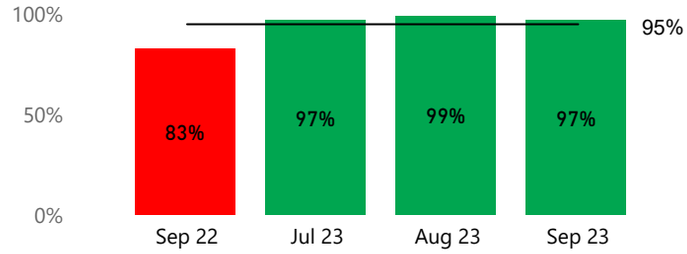
Turnaround Compliance (45 business days)



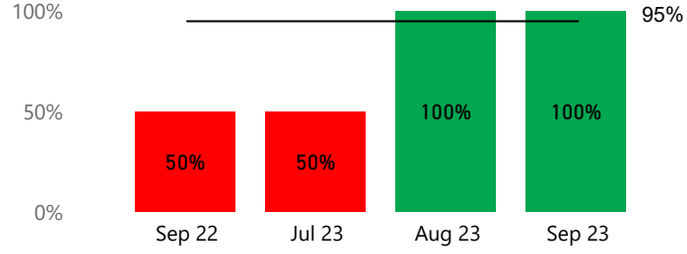
Compliance

Member Grievances

Standard (30 calendar days)

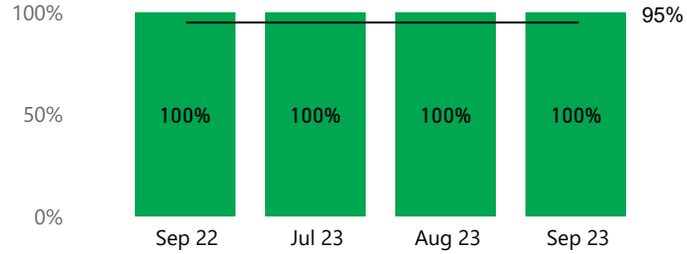


Expedited (3 calendar days)

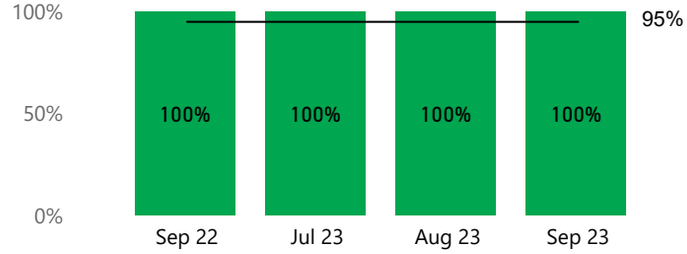


Member Appeals

Standard (30 calendar days)

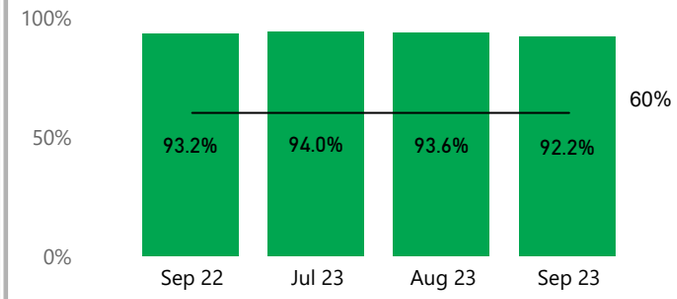


Expedited (3 calendar days)

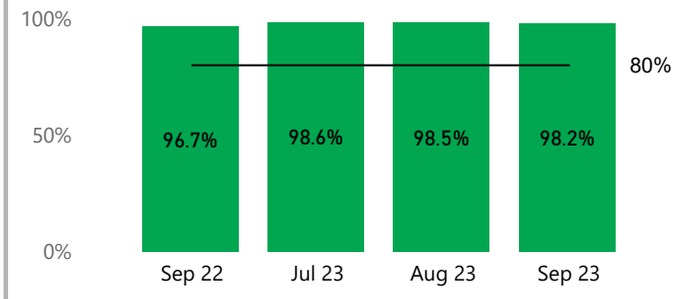


Encounter Data

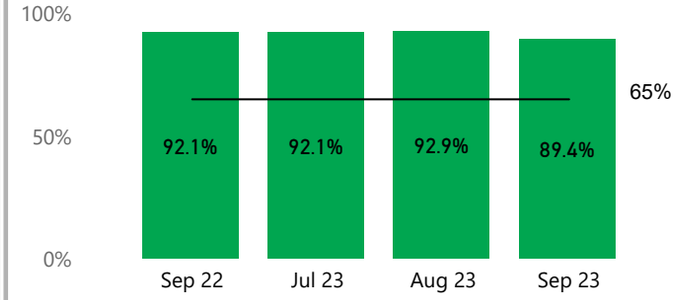
Institutional 0-90 days



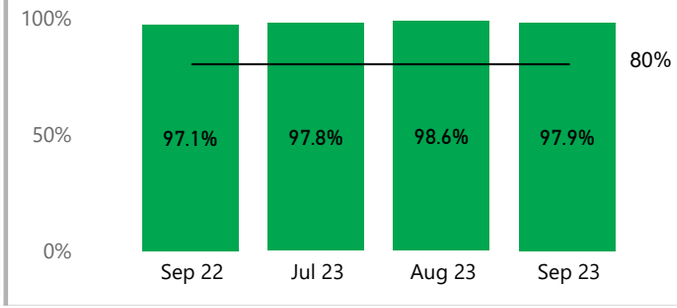
Institutional 0-180 days



Professional 0-90 days

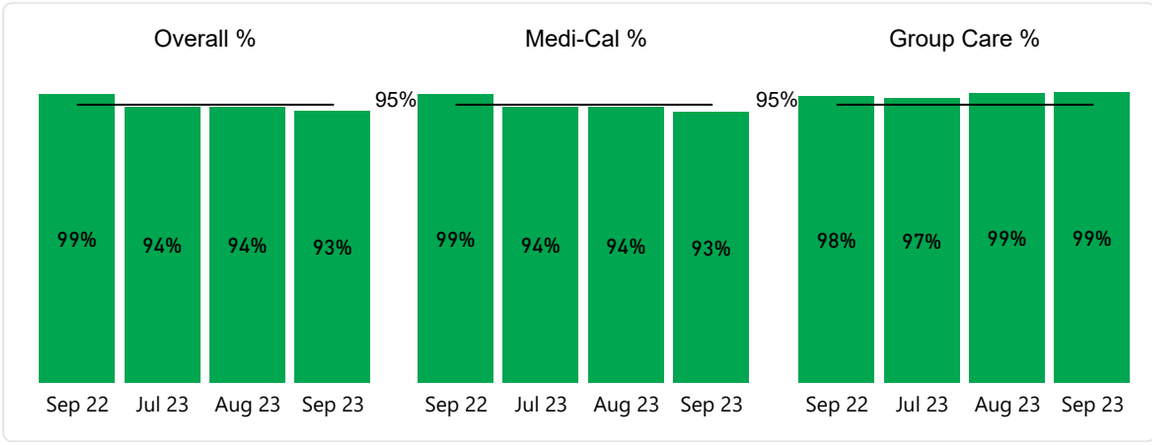


Professional 0-180 days

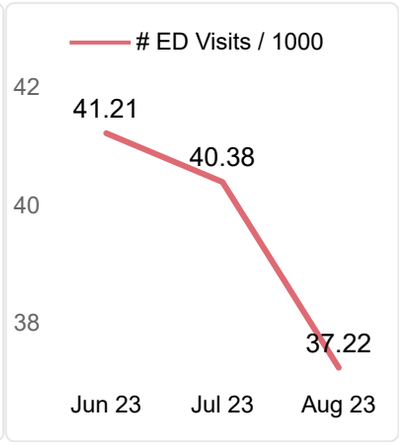


Health Care Services

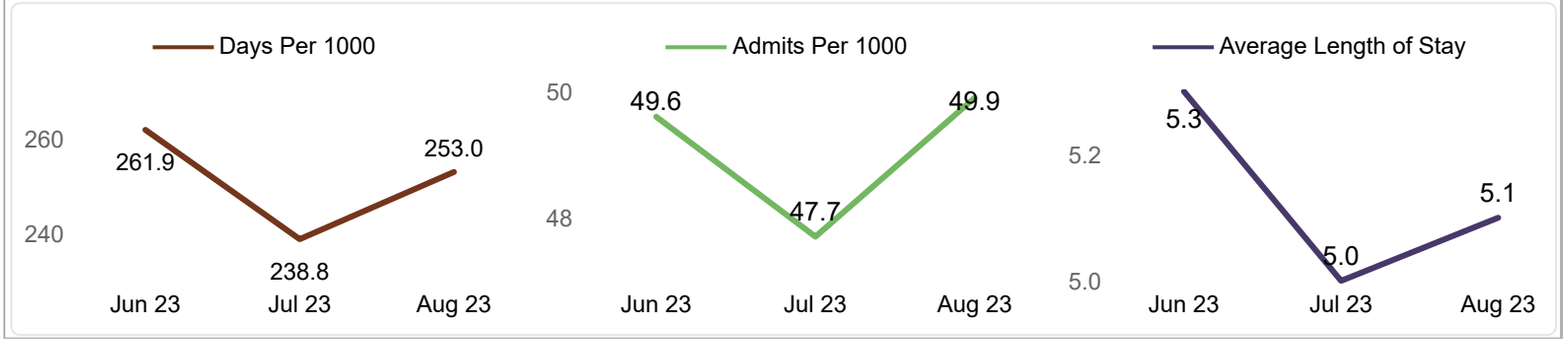
Authorization Turnaround



ED Utilization

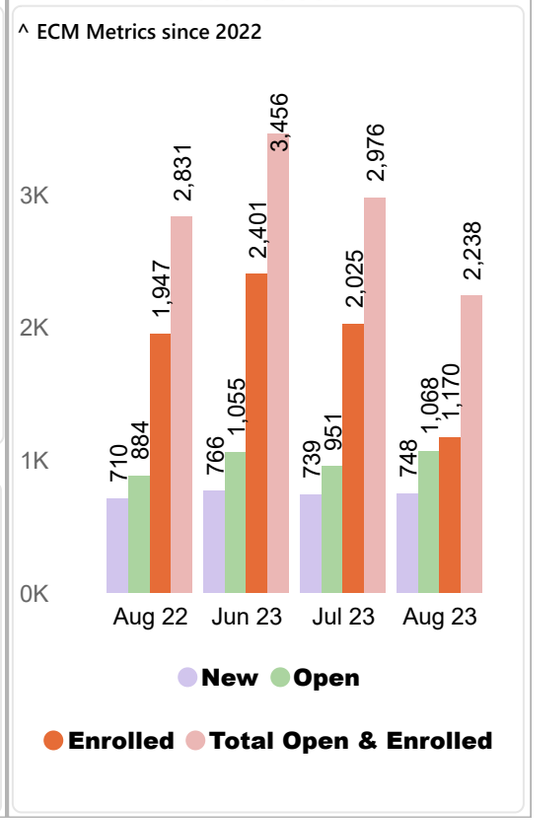


Inpatient Utilization

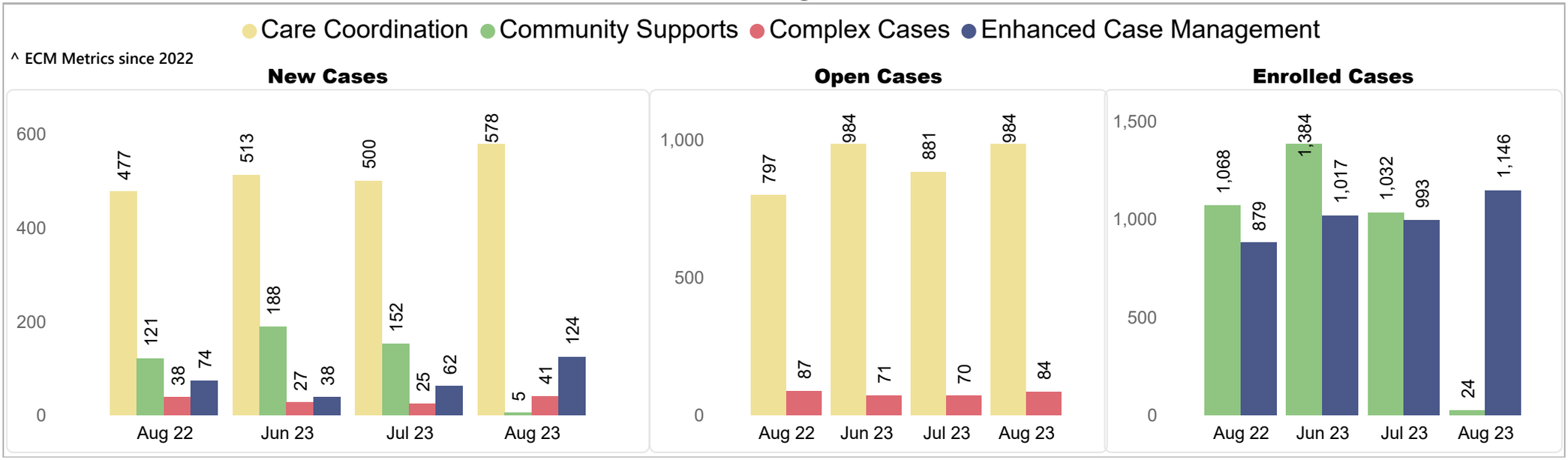


Case Management

Total Cases^



Case Management^



Technology (Business Availability)

Applications	Sep 22	Jul 23	Aug 23	Sep 23
HEALTHsuite System	100.0%	98.0%	100.0%	99.9%
Other Applications	100.0%	100.0%	100.0%	100.0%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Sep 22	Jul 23	Aug 23	Sep 23
Denial Rate Excluding Partial Denials (%)	4.3%	3.1%	3.4%	3.4%
Overall Denial Rate (%)	4.9%	3.4%	3.5%	3.6%
Partial Denial Rate (%)	0.6%	0.3%	0.2%	0.2%

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

Pharmacy Authorizations

Authorizations	Sep 22	Jul 23	Aug 23	Sep 23
Approved Prior Authorizations	35	22	38	29
Closed Prior Authorizations	110	100	103	92
Denied Prior Authorizations	29	25	26	28
Total Prior Authorizations	174	147	167	149

ALAMEDA Alliance FOR HEALTH

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Service you can trust.

Legislative Tracking

2023 Legislative Tracking List

The final day of the California State Legislative Session was September 14th, and the Governor will have until October 14th to act on those bills. The following is a list of state bills tracked by the Public Affairs and Compliance Departments that have been introduced during the current Legislative Session. These bills are of interest to and could have a direct impact on Alameda Alliance for Health and its membership. Public Affairs will provide a final legislative report in the next Board of Governors meeting packet.

AB 4 **(Arambula D) Covered California: expansion.**
Current Text: Introduced: 12/5/2022
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. on 7/13/2023)(May be acted upon Jan 2024)
Location: 7/13/2023-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Current state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Current law requires the Exchange to apply for a federal waiver to allow persons otherwise not able to obtain coverage through the Exchange because of their immigration status to obtain coverage from the Exchange. This bill would delete that requirement and would instead require the Exchange to administer a program to allow persons otherwise not able to obtain coverage by reason of immigration status to enroll in health insurance coverage in a manner as substantially similar to other Californians as feasible given existing federal law and rules.

AB 47 **(Boerner D) Pelvic floor physical therapy coverage.**
Current Text: Introduced: 12/5/2022
Status: 4/28/2023-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 12/5/2022)(May be acted upon Jan 2024)
Location: 4/28/2023-A. 2 YEAR

Desk	2 year	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2024, to provide coverage for pelvic floor physical therapy after pregnancy. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

AB 48 **(Aguiar-Curry D) Nursing Facility Resident Informed Consent Protection Act of 2023.**
Current Text: Amended: 3/16/2023
Last Amend: 3/16/2023

Status: 9/20/2023-Enrolled and presented to the Governor at 4 p.m.
Location: 7/10/2023-S. APPR. SUSPENSE FILE

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law provides for the licensure and regulation of health facilities, including skilled nursing facilities and intermediate care facilities, by the State Department of Public Health. Current law requires skilled nursing facilities and intermediate care facilities to have written policies regarding the rights of patients. This bill would add to these rights the right of every resident to receive the information that is material to an individual's informed consent decision concerning whether to accept or refuse the administration of psychotherapeutic drugs, as specified. This bill would also add the right to be free from psychotherapeutic drugs used for the purpose of resident discipline, convenience, or chemical restraint, except in an emergency that threatens to cause immediate injury to the resident or others. This bill would make the prescriber responsible for disclosing the material information relating to psychotherapeutic drugs to the resident and obtaining their informed consent, as defined.

AB 55 **(Rodriguez D) Medi-Cal: workforce adjustment for ground ambulance transports.**
Current Text: Amended: 4/27/2023
Last Amend: 4/27/2023
Status: 5/19/2023-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/10/2023)(May be acted upon Jan 2024)
Location: 5/19/2023-A. 2 YEAR

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law requires, with exceptions, that Medi-Cal reimbursement to providers of emergency medical transports be increased by application of an add-on to the associated Medi-Cal fee-for-service payment schedule. Under current law, those increased payments are funded solely from a quality assurance fee (QAF), which emergency medical transport providers are required to pay based on a specified formula, and from federal reimbursement and any other related federal funds. Current law sets forth separate provisions for increased Medi-Cal reimbursement to providers of ground emergency medical transportation services that are owned or operated by certain types of public entities. This bill would establish, for dates of service on or after July 1, 2024, a workforce adjustment, serving as an additional payment, for each ground ambulance transport performed by a provider of medical transportation services, excluding the above-described public entity providers. The bill would vary the rate of adjustment depending on the point of pickup and whether the service was for an emergency or nonemergency, with the workforce adjustment being equal to 80% of the lowest maximum allowance established by the federal Medicare Program reduced by the fee-for-service payment schedule amount, as specified.

AB 85 **(Weber D) Social determinants of health: screening and outreach.**
Current Text: Amended: 7/3/2023
Last Amend: 7/3/2023
Status: 9/21/2023-Enrolled and presented to the Governor at 3:30 p.m.
Location: 7/10/2023-S. APPR. SUSPENSE FILE

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered

1st House	2nd House	Conc.			

Summary: Would, upon specified appropriations by the Legislature, require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to include coverage for screenings for social determinants of health, as defined. The bill would require providers to use specified tools or protocols when documenting patient responses to questions asked in these screenings.

AB 137 **(Committee on Budget) Health omnibus trailer bill.**
Current Text: Amended: 8/27/2023
Last Amend: 8/27/2023
Status: 9/13/2023-Re-referred to Com. on B. & F.R.
Location: 8/31/2023-S. THIRD READING

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The California Hospice Licensure Act of 1990 requires a person, political subdivision of the state, or other governmental agency to obtain a license from the State Department of Public Health to provide hospice services to an individual who is experiencing the last phase of life due to a terminal disease, as defined, and their family, except as provided. Current law requires the department, by January 1, 2024, to adopt emergency regulations to implement the recommendations in a specified report of the California State Auditor. Current law requires the department to maintain the general moratorium on new hospice agency licenses until the department adopts the regulations, but in no event later than March 29, 2024. Current law requires the moratorium to end on the earlier of 2 years from the date that the California State Auditor publishes a report on hospice agency licensure, or the date the emergency regulations are adopted. This bill would instead require the moratorium to end on the date the emergency regulations are adopted and would extend the deadline by which the department is required to adopt those regulations to January 1, 2025.

AB 221 **(Ting D) Budget Act of 2023.**
Current Text: Introduced: 1/10/2023
Status: 1/26/2023-Referred to Com. on BUDGET.
Location: 1/26/2023-A. BUDGET

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would make appropriations for the support of state government for the 2023–24 fiscal year.

AB 236 **(Holden D) Health care coverage: provider directories.**
Current Text: Amended: 3/20/2023
Last Amend: 3/20/2023
Status: 5/19/2023-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/19/2023)(May be acted upon Jan 2024)
Location: 5/19/2023-A. 2 YEAR

Desk	Policy	2	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered

		year						Conc.			
1st House				2nd House							

Summary: Current law requires a health care service plan and a health insurer that contracts with providers for alternative rates of payment to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services enrollees or insureds, and requires a health care service plan and health insurer to regularly update its printed and online provider directory or directories, as specified. This bill would require a plan or insurer to annually audit and delete inaccurate listings from its provider directories, and would require a provider directory to be 60% accurate on January 1, 2024, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before January 1, 2027. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks and for each inaccurate listing in its directories. If a plan or insurer has not financially compensated a provider in the prior year, the bill would require the plan or insurer to delete the provider from its directory beginning July 1, 2024, unless specified criteria applies. The bill would require a plan or insurer to provide information about in-network providers to enrollees and insureds upon request, and would limit the cost-sharing amounts an enrollee or insured is required to pay for services from those providers under specified circumstances.

AB 254

(Bauer-Kahan D) Confidentiality of Medical Information Act: reproductive or sexual health application information.

Current Text: Chaptered: 9/27/2023

Last Amend: 9/1/2023

Status: 9/27/2023-Approved by the Governor. Chaptered by Secretary of State - Chapter 254, Statutes of 2023.

Location: 9/27/2023-A. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The Confidentiality of Medical Information Act (CMIA) prohibits a provider of health care, a health care service plan, a contractor, or a corporation and its subsidiaries and affiliates from intentionally sharing, selling, using for marketing, or otherwise using any medical information, as defined, for any purpose not necessary to provide health care services to a patient, except as provided. The CMIA makes a business that offers software or hardware to consumers, including a mobile application or other related device that is designed to maintain medical information in order to make the information available to an individual or a provider of health care at the request of the individual or a provider of health care, for purposes of allowing the individual to manage the individual's information or for the diagnosis, treatment, or management of a medical condition of the individual, a provider of health care subject to the requirements of the CMIA. Current law makes a violation of these provisions that results in economic loss or personal injury to a patient punishable as a misdemeanor. This bill would revise the definition of "medical information" to include reproductive or sexual health application information, which the bill would define to mean information about a consumer's reproductive or sexual health collected by a reproductive or sexual health digital service, as specified. The bill would make a business that offers a reproductive or sexual health digital service to a consumer for the purpose of allowing the individual to manage the individual's information, or for the diagnosis, treatment, or management of a medical condition of the individual, a provider of health care subject to the requirements of the CMIA.

AB 365 **(Aguiar-Curry D) Medi-Cal: diabetes management.**
Current Text: Amended: 9/8/2023
Last Amend: 9/14/2023
Status: 9/14/2023-Failed Deadline pursuant to Rule 61(a)(14). (Last location was INACTIVE FILE on 9/12/2023)(May be acted upon Jan 2024)
Location: 8/24/2023-S. THIRD READING

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would add continuous glucose monitors and related supplies required for use with those monitors as a covered benefit under the Medi-Cal program for the treatment of diabetes when medically necessary, subject to utilization controls. The bill would require the State Department of Health Care Services, by July 1, 2024, to review, and update as appropriate, coverage policies for continuous glucose monitors, as specified. The bill would authorize the department to require a manufacturer of a continuous glucose monitor to enter into a rebate agreement with the department. The bill would limit its implementation to the extent that any necessary federal approvals are obtained and federal financial participation is available.

AB 425 **(Alvarez D) Medi-Cal: pharmacogenomic testing.**
Current Text: Enrollment: 9/21/2023
Last Amend: 9/1/2023
Status: 9/21/2023-Enrolled and presented to the Governor at 3:30 p.m.
Location: 9/21/2023-A. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Would, commencing on July 1, 2024, add pharmacogenomic testing as a covered benefit under Medi-Cal, as specified. The bill would define pharmacogenomic testing as laboratory genetic testing that includes, but is not limited to, a panel test, to identify how a person's genetics may impact the efficacy, toxicity, and safety of medications.

AB 483 **(Muratsuchi D) Local educational agency: Medi-Cal billing option.**
Current Text: Enrollment: 9/21/2023
Last Amend: 9/8/2023
Status: 9/21/2023-Enrolled and presented to the Governor at 3:30 p.m.
Location: 9/21/2023-A. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Current law establishes the Administrative Claiming process under which the State Department of Health Care Services is authorized to contract with local governmental agencies and local educational consortia for the purpose of obtaining federal matching funds to assist with the performance of administrative activities relating to the Medi-Cal program that are provided by a local governmental agency or local educational agency (LEA). Current law requires the department to engage in specified activities relating to the LEA Medi-Cal Billing Option, including amending the Medicaid state plan to ensure that schools are reimbursed for all eligible services, consulting with specified entities in formulating state plan amendments, examining methodologies for increasing school participation in the LEA Medi-Cal Billing Option, and conducting an audit of a Medi-Cal Billing Option claim consistent with prescribed requirements, such as generally accepted

accounting principles. Current law requires the department to issue and regularly maintain a program guide for the LEA Medi-Cal Billing Option program. Current law requires the department to file an annual report with the Legislature that includes, among other things, a summary of department activities. This bill would require the department, when conducting an audit of a Medi-Cal Billing Option claim, to complete the audit and notify the LEA of the findings within 18 months of the date that the Cost and Reimbursement Comparison Schedule (CRCS) is submitted. The bill would require the department to provide an interim settlement or final settlement within 12 months of the March 1 due date for the CRCS. The bill would require the department to update and distribute the program guide to all participating LEAs by July 1, 2024, as specified. The bill would require the department's summary of activities in the above-described report to also include training for LEAs and a summary of the number of audits conducted of Medi-Cal Billing Option claims, as specified.

AB 488 **(Nguyen, Stephanie D) Medi-Cal: skilled nursing facilities: vision loss.**
Current Text: Introduced: 2/7/2023 html pdf
Status: 4/28/2023-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 2/17/2023)(May be acted upon Jan 2024)
Location: 4/28/2023-A. 2 YEAR

Desk	2 year	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law requires the State Department of Health Care Services, subject to any necessary federal approvals, for managed care rating periods that begin between January 1, 2023, and December 31, 2026, inclusive, to establish and implement the Workforce and Quality Incentive Program under which a network provider furnishing skilled nursing facility services to a Medi-Cal managed care enrollee may earn performance-based directed payments from the Medi-Cal managed care plan with which they contract, as specified. Current law, subject to an appropriation, requires the department to set the amounts of those directed payments under a specified formula. Current law requires the department to establish the methodology or methodologies, parameters, and eligibility criteria for the directed payments, including the milestones and metrics that network providers of skilled nursing facility services must meet in order to receive a directed payment from a Medi-Cal managed care plan, with at least 2 of these milestones and metrics tied to workforce measures. This bill would require that the measures and milestones include program access, staff training, and capital improvement measures aimed at addressing the needs of skilled nursing facility residents with vision loss.

AB 551 **(Bennett D) Medi-Cal: specialty mental health services: foster children.**
Current Text: Amended: 4/27/2023
Last Amend: 4/27/2023
Status: 7/5/2023-From committee: Do pass and re-refer to Com. on APPR with recommendation: To Consent Calendar. (Ayes 5. Noes 0.) (July 3). Re-referred to Com. on APPR.
Location: 7/5/2023-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Under current law, specialty mental health services include federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services provided to eligible Medi-Cal beneficiaries under 21 years of age. Current law requires each local mental health plan to establish a procedure to ensure access to outpatient

specialty mental health services, as required by the EPSDT program standards, for youth in foster care who have been placed outside their county of adjudication, as described. Current law requires the department to issue policy guidance on the conditions for, and exceptions to, presumptive transfer of responsibility for providing or arranging for specialty mental health services to a foster youth from the county of original jurisdiction to the county in which the foster youth resides, as prescribed. On a case-by-case basis, and when consistent with the medical rights of children in foster care, current law authorizes the waiver of presumptive transfer, with the responsibility for the provision of specialty mental health services remaining with the county of original jurisdiction if certain exceptions exist. Under current law, the county probation agency or the child welfare services agency is responsible for determining whether waiver of the presumptive transfer is appropriate, with notice provided to the person requesting the exception. Under Current law, commencing July 1, 2023, in the case of placement of foster children in short-term residential therapeutic programs, community treatment facilities, or group homes, or in the case of admission of foster children to children's crisis residential programs, the county of original jurisdiction is required to retain responsibility and presumptive transfer provisions apply only if certain circumstances exist. This bill, for purposes of foster children placed or admitted in those specific settings, would delay, until July 1, 2024, the requirement on the county of original jurisdiction to retain responsibility and the limitation on the presumptive transfer provisions.

AB 557 **(Hart D) Open meetings: local agencies: teleconferences.**
Current Text: Enrollment: 9/15/2023
Last Amend: 9/1/2023
Status: 9/15/2023-Enrolled and presented to the Governor at 4 p.m.
Location: 9/15/2023-A. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: The Ralph M. Brown Act allows for meetings to occur via teleconferencing subject to certain requirements, particularly that the legislative body notice each teleconference location of each member that will be participating in the public meeting, that each teleconference location be accessible to the public, that members of the public be allowed to address the legislative body at each teleconference location, that the legislative body post an agenda at each teleconference location, and that at least a quorum of the legislative body participate from locations within the boundaries of the local agency's jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined. Current law, until January 1, 2024, authorizes the legislative body of a local agency to use teleconferencing without complying with those specified teleconferencing requirements in specified circumstances when a declared state of emergency is in effect. Those circumstances are that (1) state or local officials have imposed or recommended measures to promote social distancing, (2) the legislative body is meeting for the purpose of determining whether, as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees, or (3) the legislative body has previously made that determination. If there is a continuing state of emergency, or if state or local officials have imposed or recommended measures to promote social distancing, existing law requires a legislative body to make specified findings not later than 30 days after the first teleconferenced meeting, and to make those findings every 30 days thereafter, in order to continue to meet under these abbreviated teleconferencing procedures. This bill would revise the authority of a legislative body to hold a teleconference meeting under those abbreviated teleconferencing procedures when a declared state of emergency is in effect.

AB 564 **(Villapudua D) Medi-Cal: claim or remittance forms: signature.**
Current Text: Amended: 4/5/2023
Last Amend: 4/5/2023
Status: 7/14/2023-Failed Deadline pursuant to Rule 61(a)(10). (Last location was HEALTH on 6/14/2023)(May be acted upon Jan 2024)
Location: 7/14/2023-S. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	2 year	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. Current law requires the Director of Health Care Services to develop and implement standards for the timely processing and payment of each claim type. Current law requires that the standards be sufficient to meet minimal federal requirements for the timely processing of claims. Current law states the intent of the Legislature that claim forms for use by physicians and hospitals be the same as claim forms in general use by other payors, as specified. This bill would require the department to allow a provider to submit an electronic signature for a claim or remittance form under the Medi-Cal program, to the extent not in conflict with federal law.

AB 576 **(Weber D) Medi-Cal: reimbursement for abortion.**
Current Text: Enrollment: 9/15/2023
Last Amend: 3/30/2023
Status: 9/15/2023-Enrolled and presented to the Governor at 4 p.m.
Location: 9/15/2023-A. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Would require the State Department of Health Care Services, by March 1, 2024, to review and update Medi-Cal coverage policies for medication abortion to align with current evidence-based clinical guidelines. After the initial review, the bill would require the department to update its Medi-Cal coverage policies for medication abortion as needed to align with evidence-based clinical guidelines. The bill would require the department to allow flexibility for providers to exercise their clinical judgment when services are performed in a manner that aligns with one or more evidence-based clinical guidelines.

AB 586 **(Calderon D) Medi-Cal: community supports: climate change or environmental remediation devices.**
Current Text: Amended: 3/30/2023
Last Amend: 3/30/2023
Status: 5/19/2023-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/3/2023)(May be acted upon Jan 2024)
Location: 5/19/2023-A. 2 YEAR

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved

by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under existing law, community supports that the State Department of Health Care Services is authorized to approve include, among other things, housing deposits, environmental accessibility adaptations or home modifications, and asthma remediation. This bill would add climate change or environmental remediation devices to the above-described list of community supports. For purposes of these provisions, the bill would define "climate change or environmental remediation devices" as coverage of devices and installation of those devices, as necessary, to address health-related complications, barriers, or other factors linked to extreme weather, poor air quality, or climate events, including air conditioners, electric heaters, air filters, or backup power sources, among other specified devices for certain purposes.

AB 608 **(Schiavo D) Medi-Cal: comprehensive perinatal services.**
Current Text: Enrollment: 9/13/2023
Last Amend: 7/12/2023
Status: 9/13/2023-Enrolled and presented to the Governor at 3 p.m.
Location: 9/13/2023-A. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Under current law, a pregnant individual or targeted low-income child who is eligible for, and is receiving, health care coverage under any of specified Medi-Cal programs is eligible for full-scope Medi-Cal benefits for the duration of the pregnancy and for a period of one year following the last day of the individual's pregnancy. This bill, during the one-year postpregnancy eligibility period, and as part of comprehensive perinatal services under Medi-Cal, would require the State Department of Health Care Services to cover additional comprehensive perinatal assessments and individualized care plans and to provide additional visits and units of services in an amount, duration, and scope that are at least proportional to those available on July 27, 2021, during pregnancy and the initial 60-day postpregnancy period in effect on that date. The bill would require the department, in coordination with the State Department of Public Health, to consider input from certain stakeholders, as specified, in determining the specific number of additional comprehensive perinatal assessments, individualized care plans, visits, and units of services to be covered.

AB 614 **(Wood D) Medi-Cal.**
Current Text: Chaptered: 9/30/2023
Last Amend: 4/19/2023
Status: 9/30/2023-Approved by the Governor. Chaptered by Secretary of State - Chapter 266, Statutes of 2023.
Location: 9/30/2023-A. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would make a change to an obsolete reference to the former Healthy Families Program, whose health services for children have been transitioned to the Medi-Cal program. The bill would make a change to an obsolete reference to the former Access for Infants and Mothers Program and would revise a related provision to instead refer to the successor Medi-Cal Access Program. The bill would delete, within certain Medi-Cal provisions, obsolete references to a repealed provision relating to nonprofit hospital service plans.

AB 620 **(Connolly D) Health care coverage for metabolic disorders.**
Current Text: Enrollment: 9/21/2023
Last Amend: 9/8/2023
Status: 9/21/2023-Enrolled and presented to the Governor at 3:30 p.m.
Location: 9/21/2023-A. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require a health care service plan contract and disability insurance policy that provides coverage for hospital, medical, or surgical expenses and is issued, amended, delivered, or renewed on and after January 1, 2024, to provide coverage for the testing and treatment of other chronic digestive diseases and inherited metabolic disorders, as specified. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 632 **(Gipson D) Health care coverage: prostate cancer screening.**
Current Text: Enrollment: 9/13/2023
Last Amend: 6/15/2023
Status: 9/13/2023-Enrolled and presented to the Governor at 3 p.m.
Location: 9/13/2023-A. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law requires an individual and group health care service plan contract or health insurance policy to provide coverage for the screening and diagnosis of prostate cancer when medically necessary and consistent with good professional practice. Under current law, the application of a deductible or copayment for those services is not prohibited. This bill would instead require that coverage when medically necessary and consistent with nationally recognized, evidence-based clinical guidelines. The bill would prohibit a health care service plan or a health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, from applying a deductible, copayment, or coinsurance to coverage for prostate cancer screening services for an enrollee or insured who is at a high risk of prostate cancer, consistent with specified guidelines and is either 55 years of age or older or 40 years of age or older and high risk, as determined by the attending or treating health care provider. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 719 **(Boerner D) Medi-Cal: nonmedical and nonemergency medical transportation.**
Current Text: Enrollment: 9/19/2023
Last Amend: 7/10/2023
Status: 9/19/2023-Enrolled and presented to the Governor at 4 p.m.
Location: 9/19/2023-A. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Would require the State Department of Health Care Services to require Medi-Cal managed care plans that are contracted to provide nonmedical transportation or nonemergency medical transportation to contract with public paratransit service operators who are enrolled Medi-Cal providers for the purpose of establishing reimbursement rates for nonmedical and nonemergency medical transportation trips provided by

a public paratransit service operator. The bill would require the rates reimbursed by the managed care plan to the public paratransit service operator to be based on the department's fee-for-service rates for nonmedical and nonemergency medical transportation service, as specified. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and the availability of federal financial participation.

AB 847 **(Rivas, Luz D) Medi-Cal: pediatric palliative care services.**
Current Text: Enrollment: 9/21/2023
Last Amend: 9/8/2023
Status: 9/19/2023-Enrolled and presented to the Governor at 3:30 p.m.
Location: 9/19/2023-A. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law requires the State Department of Health Care Services to develop a pediatric palliative care benefit as a pilot program to Medi-Cal beneficiaries under 21 years of age, to be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available. Current law requires that program to include, among other things, hospice services to individuals whose conditions may result in death, regardless of the estimated length of the individual's remaining period of life. Pursuant to the above-described provisions, the department established the Pediatric Palliative Care (PPC) Waiver in 2009, upon receiving federal approval in December 2008. After the waiver ended on December 31, 2018, the department implemented a plan in 2019 to transition some pediatric palliative care services to the Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefit, which is available to Medi-Cal beneficiaries under 21 years of age, as specified. This bill, Sophia's Act, would authorize extended eligibility for pediatric hospice services and palliative care services for those individuals who have been determined eligible for those services prior to 21 years of age to after 21 years of age, as specified. To the extent that these provisions would alter the eligibility of individuals for these services, the bill would create a state-mandated local program.

AB 907 **(Lowenthal D) Coverage for PANDAS and PANS.**
Current Text: Enrollment: 9/21/2023
Last Amend: 7/3/2023
Status: 9/21/2023-Enrolled and presented to the Governor at 3:30 p.m.
Location: 9/21/2023-A. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2024, to provide coverage for the prophylaxis, diagnosis, and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) that is prescribed or ordered by the treating physician and surgeon. The bill would prohibit coverage for PANDAS and PANS from being subject to a copayment, coinsurance, deductible, or other cost sharing that is greater than that applied to other benefits. The bill would prohibit a plan or insurer from denying or delaying coverage for PANDAS or PANS therapies because the enrollee or insured previously received treatment for PANDAS or PANS or was diagnosed with or received treatment for the condition under a different diagnostic name. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local

program.

AB 931 **(Irwin D) Prior authorization: physical therapy.**
Current Text: Enrollment: 9/15/2023
Last Amend: 9/1/2023
Status: 9/15/2023-Enrolled and presented to the Governor at 4 p.m.
Location: 9/15/2023-A. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, that provides coverage for physical therapy from imposing prior authorization for the initial 12 treatment visits for a new episode of care for physical therapy. The bill would require a physical therapy provider to verify an enrollee's or an insured's coverage and disclose their share of the cost of care, as specified. The bill would require a physical therapy provider to disclose if the provider is not in the network of the enrollee's plan or the insured's policy, and if so, to obtain the enrollee's or the insured's consent in writing to receive services from the noncontracting provider prior to initiating care. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 948 **(Berman D) Prescription drugs.**
Current Text: Enrollment: 9/14/2023
Last Amend: 8/14/2023
Status: 9/14/2023-Enrolled and presented to the Governor at 4:30 p.m.
Location: 9/14/2023-A. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law prohibits the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription from exceeding $250 for a supply of up to 30 days, except as specified. Current law requires a health care service plan contract or health insurance policy for a nongrandfathered individual or small group product that maintains a drug formulary grouped into tiers, and that includes a 4th tier, to define each tier of the drug formulary, as specified. Current law defines Tier 4 to include, among others, drugs that are biologics. Existing law repeals these provisions on January 1, 2024. This bill would delete drugs that are biologics from the definition of Tier 4. The bill would require a health care service plan or a health insurer, if there is a generic equivalent to a brand name drug, to ensure that an enrollee or insured is subject to the lowest cost sharing that would be applied, whether or not both the generic equivalent and the brand name drug are on the formulary. The bill also would delete the January 1, 2024, repeal date of the above provisions, thus making them operative indefinitely. Because extension of the bill's requirements relative to health care service plans would extend the existence of a crime, the bill would impose a state-mandated local program.

Subject
Health Plans

AB 1022 **(Mathis R) Medi-Cal: Program of All-Inclusive Care for the Elderly.**
Current Text: Introduced: 2/15/2023 html pdf

Status: 4/28/2023-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 3/2/2023)(May be acted upon Jan 2024)
Location: 4/28/2023-A. 2 YEAR

Desk	2 year	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current federal law establishes the Program of All-Inclusive Care for the Elderly (PACE), which provides specified services for older individuals at a PACE center so that they may continue living in the community. Federal law authorizes states to implement PACE as a Medicaid state option. Current state law establishes the California Program of All-Inclusive Care for the Elderly (PACE program) to provide community-based, risk-based, and capitated long-term care services as optional services under the state's Medi-Cal state plan. Current law requires the department to develop and pay capitation rates to entities contracted through the PACE program using actuarial methods and that reflect the level of care associated with the specific populations served pursuant to the contract. Current law authorizes a PACE organization approved by the department to use video telehealth to conduct initial assessments and annual reassessments for eligibility for enrollment in the PACE program. This bill, among other things relating to the PACE program, would require those capitation rates to also reflect the frailty level and risk associated with those populations. The bill would also expand an approved PACE organization's authority to use video telehealth to conduct all assessments, as specified.

AB 1085 **(Maienschein D) Medi-Cal: housing support services.**
Current Text: Enrollment: 9/21/2023
Last Amend: 9/8/2023
Status: 9/21/2023-Enrolled and presented to the Governor at 3:30 p.m.
Location: 9/21/2023-A. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under current law, community supports that the department is authorized to approve include, among other things, housing transition navigation services, housing deposits, and housing tenancy and sustaining services. Existing law, subject to an appropriation, requires the department to complete an independent analysis to determine whether network adequacy exists to obtain federal approval for a covered Medi-Cal benefit that provides housing support services. Current law requires that the analysis take into consideration specified information, including the number of providers in relation to each region's or county's number of people experiencing homelessness. Current law requires the department to report the outcomes of the analysis to the Legislature by January 1, 2024. This bill would delete the requirement for the department to complete that analysis, and instead would make housing support services for specified populations a covered Medi-Cal benefit when the department has begun a specified evaluation required under the CalAIM Waiver Special Terms and Conditions, and the Legislature has made an appropriation for purposes of the housing support services. The bill would require the department to seek federal approval for the housing support services benefit, as specified. Under the bill, subject to an appropriation by the Legislature, a Medi-Cal beneficiary would be eligible for those services if they either experience homelessness or are at risk of homelessness. Under the bill, the services would include housing transition and navigation services, housing deposits, and housing tenancy and sustaining services, as defined.

AB 1091 **(Wood D) Health Care Consolidation and Contracting Fairness Act of 2023.**
Current Text: Introduced: 2/15/2023 html pdf
Status: 4/28/2023-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 3/2/2023)(May be acted upon Jan 2024)
Location: 4/28/2023-A. 2 YEAR

Desk	2 year	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: This bill, the Health Care Consolidation and Contracting Fairness Act of 2023, would prohibit a contract issued, amended, or renewed on or after January 1, 2024, between a health care service plan or health insurer and a health care provider or health facility from containing terms that, among other things, restrict the plan or insurer from steering an enrollee or insured to another provider or facility or require the plan or insurer to contract with other affiliated providers or facilities. The bill would authorize the appropriate regulating department to refer a plan's or insurer's contract to the Attorney General, and would authorize the Attorney General or state entity charged with reviewing health care market competition to review a health care practitioner's or health facility's entrance into a contract that contains specified terms. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 1092 **(Wood D) Health care service plans: consolidation.**
Current Text: Amended: 6/28/2023
Last Amend: 6/28/2023
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/14/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-S. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law requires a health care service plan that intends to merge with, consolidate with, or enter into an agreement resulting in its purchase, acquisition, or control by, an entity, to give notice to, and secure prior approval from, the Director of the Department of Managed Health Care. Current law authorizes the director to disapprove the transaction or agreement if the director finds it would substantially lessen competition in health care service plan products or create a monopoly in this state. Current law authorizes the director to conditionally approve the transaction or agreement, contingent upon the health care service plan's agreement to fulfill one or more conditions to benefit subscribers and enrollees of the health care service plan, provide for a stable health care delivery system, and impose other conditions specific to the transaction or agreement, as specified. This bill would additionally require a health care service plan that intends to acquire or obtain control of an entity, as specified, to give notice to, and secure prior approval from, the director. Because a willful violation of this provision would be a crime, the bill would impose a state-mandated local program.

AB 1110 **(Arambula D) Public health: adverse childhood experiences.**
Current Text: Amended: 7/10/2023

Last Amend: 7/10/2023
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/14/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-S. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would, subject to an appropriation and until January 1, 2027, require the office and the State Department of Health Care Services, while administering the ACEs Aware initiative and in collaboration with subject matter experts, to review available literature on ACEs, as defined, and ancestry or ethnicity-based data disaggregation practices in ACEs screenings, develop guidance for culturally and linguistically competent ACEs screenings through improved data collection methods, post the guidance on the department's internet website and the ACEs Aware internet website, and make the guidance accessible, as specified.

AB 1122 **(Bains D) Vessels: equipment.**
Current Text: Amended: 9/13/2023
Last Amend: 9/13/2023
Status: 9/14/2023-Read second time. Ordered to third reading. Re-referred to Com. on RLS pursuant to Senate Rule 29.10(c).
Location: 9/14/2023-S. RLS.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require any equipment installed, or modification to accommodate that equipment, that could limit engine power or operational ability of specified commercial harbor craft, to be approved for use with the harbor craft's propulsion system, as specified, and not void any existing warranty. The bill would require aftermarket equipment that could limit a harbor craft's engine power or operational ability to include an automatic override or bypass feature that ensures the safe operation of the harbor craft is not affected. The bill would require the owner or operator to report a vessel's loss of power during operation, as specified.

AB 1157 **(Ortega D) Rehabilitative and habilitative services: durable medical equipment and services.**
Current Text: Amended: 7/13/2023
Last Amend: 7/13/2023
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/14/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-S. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Under existing law, essential health benefits includes, among other things, rehabilitative and habilitative services. Current law requires habilitative services and devices to be covered under the same terms and conditions applied to rehabilitative services and devices under the plan contract or policy, and defines habilitative services to mean health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. This bill would specify that coverage of rehabilitative and habilitative services and devices under a health care service plan or health insurance policy includes durable medical equipment, services, and repairs,

if the equipment, services, or repairs are prescribed or ordered by a physician, surgeon, or other health professional acting within the scope of their license. The bill would define "durable medical equipment" to mean devices, including replacement devices, that are designed for repeated use, and that are used for the treatment or monitoring of a medical condition or injury in order to help a person to partially or fully acquire, improve, keep, or learn, or minimize the loss of, skills and functioning of daily living. The bill would prohibit coverage of durable medical equipment and services from being subject to financial or treatment limitations, as specified.

AB 1202 **(Lackey R) Medi-Cal: health care services data: children and pregnant or postpartum persons.**
Current Text: Enrollment: 9/21/2023
Last Amend: 7/13/2023
Status: 9/21/2023-Enrolled and presented to the Governor at 3:30 p.m.
Location: 9/21/2023-A. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law establishes, until January 1, 2026, certain time or distance and appointment time standards for specified Medi-Cal managed care covered services, consistent with federal regulations relating to network adequacy standards, to ensure that those services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as specified. Current law sets forth various limits on the number of miles or minutes from the enrollee's place of residence, depending on the type of service or specialty and, in some cases, on the county. This bill would require the State Department of Health Care Services, no later than January 1, 2025, to prepare and submit a report to the Legislature that includes certain information, including an analysis of the adequacy of each Medi-Cal managed care plan's network for pediatric primary care, including the number and geographic distribution of providers and the plan's compliance with the above-described time or distance and appointment time standards.

AB 1288 **(Rendon D) Health care coverage: Medication-assisted treatment.**
Current Text: Enrollment: 9/14/2023
Last Amend: 7/13/2023
Status: 9/14/2023-Enrolled and presented to the Governor at 4:30 p.m.
Location: 9/14/2023-A. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would prohibit a medical service plan and a health insurer from subjecting a naloxone product, or another opioid antagonist approved by the United States Food and Drug Administration, a buprenorphine product, methadone, or long-acting injectable naltrexone for detoxification or maintenance treatment of a substance use disorder to prior authorization or step therapy. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program.

AB 1313 **(Ortega D) Older individuals: case management services.**
Current Text: Amended: 4/27/2023
Last Amend: 4/27/2023
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 7/3/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-S. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The Mello-Granlund Older Californians Act requires the California Department of Aging to designate various private nonprofit or public agencies as area agencies on aging to work within a planning and service area and provide a broad array of social and nutritional services. Under the act, the department's mission is to provide leadership to those agencies in developing systems of home- and community-based services that maintain individuals in their own homes or least restrictive homelike environments. This bill would, until January 1, 2030, and subject to an appropriation, require the department to establish a case management services pilot program. Under the bill, the purpose of the program would be to expand statewide the local capacity of supportive services programs by providing case management services to older individuals who need assistance to maintain health and economic stability. The bill would require the Counties of Alameda, Marin, and Sonoma to participate in the pilot program.

AB 1316 **(Irwin D) Emergency services: psychiatric emergency medical conditions.**
Current Text: Introduced: 2/16/2023
Status: 4/28/2023-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 3/2/2023)(May be acted upon Jan 2024)
Location: 4/28/2023-A. 2 YEAR

Desk	2 year	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would revise the definition of "psychiatric emergency medical condition" to make that definition applicable regardless of whether the patient is voluntary, or is involuntarily detained for evaluation and treatment. The bill would make conforming changes to provisions requiring facilities to provide that treatment. By expanding the definition of a crime with respect to those facilities, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 1338 **(Petrie-Norris D) Medi-Cal: community supports.**
Current Text: Amended: 4/20/2023
Last Amend: 4/20/2023
Status: 5/19/2023-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/3/2023)(May be acted upon Jan 2024)
Location: 5/19/2023-A. 2 YEAR

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under current law, community supports that the department is authorized to approve include, among other things, housing transition navigation services, recuperative care, respite, day habilitation programs, and medically supportive food and nutrition services.

AB 1437 **(Irwin D) Medi-Cal: serious mental illness.**
Current Text: Enrollment: 9/20/2023

Last Amend: 4/13/2023
Status: 9/20/2023-Enrolled and presented to the Governor at 4 p.m.
Location: 9/20/2023-A. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law sets forth a schedule of benefits under the Medi-Cal program, including specialty and nonspecialty mental health services through different delivery systems, in certain cases subject to utilization controls, such as prior authorization. Under current law, prior authorization is approval of a specified service in advance of the rendering of that service based upon a determination of medical necessity. Current law sets forth various provisions relating to processing, or appealing the decision of, treatment authorization requests, and provisions relating to certain services requiring or not requiring a treatment authorization request. After a determination of cost benefit, current law requires the Director of Health Care Services to modify or eliminate the requirement of prior authorization as a control for treatment, supplies, or equipment that costs less than $100, except for prescribed drugs, as specified. Under this bill, a prescription refill for a drug for serious mental illness would automatically be approved for a period of 365 days after the initial prescription is dispensed. The bill would condition the above-described provisions on the prescription being for a person 18 years of age or over, and on the person not being within the transition jurisdiction of the juvenile court, as specified.

AB 1451 **(Jackson D) Urgent and emergency mental health and substance use disorder treatment.**
Current Text: Enrollment: 9/15/2023
Last Amend: 7/13/2023
Status: 9/15/2023-Enrolled and presented to the Governor at 4 p.m.
Location: 9/15/2023-A. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, to provide coverage for treatment of urgent and emergency mental health and substance use disorders. The bill would require the treatment to be provided without preauthorization, and to be reimbursed in a timely manner, pursuant to specified provisions. The bill's provisions would only be implemented upon appropriation by the Legislature for administrative costs of the departments. The bill would clarify that it would not relieve a health plan or insurer of existing obligations, as specified. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 1481 **(Boerner D) Medi-Cal: presumptive eligibility.**
Current Text: Enrollment: 9/20/2023
Last Amend: 8/16/2023
Status: 9/20/2023-Enrolled and presented to the Governor at 4 p.m.
Location: 9/20/2023-A. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current federal law, as a condition of receiving federal Medicaid funds, requires states to provide health care services to specified individuals. Current federal law authorizes states to provide presumptive eligibility to pregnant women or children, and existing state law requires the department to provide presumptive eligibility to pregnant women and children, as specified. This bill would expand the presumptive

eligibility for pregnant women to all pregnant people, renaming the program "Presumptive Eligibility for Pregnant People" (PE4PP). For a pregnant person covered under PE4PP who applies for full-scope Medi-Cal benefits, if the application is submitted at any time from the date of their presumptive eligibility determination through the last day of the subsequent calendar month, the bill would require the department to ensure the pregnant person is covered under PE4PP until their full-scope Medi-Cal application is approved or denied, as specified. The bill would require the department to require providers participating in the PE4PP program to provide information to pregnant persons enrolled in PE4PP on how to contact the person's county to expedite the county's determination of a Medi-Cal application.

AB 1537 **(Wood D) Skilled nursing facilities: direct care spending requirement.**
Current Text: Introduced: 2/17/2023
Status: 9/14/2023-Failed Deadline pursuant to Rule 61(a)(14). (Last location was INACTIVE FILE on 9/7/2023)(May be acted upon Jan 2024)
Location: 9/14/2023-S. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law provides for the licensure and regulation of health facilities, including skilled nursing facilities, by the State Department of Public Health. A violation of those provisions is a crime. Existing law requires health facilities to submit specified financial reports to the Department of Health Care Access and Information. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. This bill would require, no later than July 1, 2024, the establishment of a direct patient-related services spending, reporting, and rebate requirement for skilled nursing facilities, with exceptions. Under the direct patient-related services spending requirement, the bill would require that a minimum of 85% of a facility's total non-Medicare health revenues from all payer sources in each fiscal year be expended on residents' direct patient-related services, as defined. This bill contains other related provisions and other existing laws.

AB 1644 **(Bonta D) Medi-Cal: medically supportive food and nutrition services.**
Current Text: Amended: 4/27/2023
Last Amend: 4/27/2023
Status: 5/19/2023-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/17/2023)(May be acted upon Jan 2024)
Location: 5/19/2023-A. 2 YEAR

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would make medically supportive food and nutrition interventions, as defined, a covered benefit under the Medi-Cal program, upon issuance of final guidance by the State Department of Health Care Services. The bill would require medically supportive food and nutrition interventions to be covered when determined to be medically necessary by a health care provider or health care plan, as specified. In order to qualify for coverage under the Medi-Cal program, the bill would require a patient to be offered at least 3 of 6 specified medically supportive food and nutrition interventions and for the interventions to be provided for a minimum duration of 12 weeks, as specified. The bill would only provide coverage for nutrition support interventions when paired with the provision of food through one of the 3 offered interventions. The bill would require a health care provider to match the acuity of a patient's condition to the intensity and duration of the medically supportive food and nutrition intervention and include culturally appropriate foods whenever

possible.

AB 1645 **(Zbur D) Health care coverage: cost sharing.**
Current Text: Enrollment: 9/21/2023
Last Amend: 7/13/2023
Status: 9/21/2023-Enrolled and presented to the Governor at 3:30 p.m.
Location: 9/21/2023-A. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Current law provides for the regulation of health insurers by the Department of Insurance. Current law requires a group or individual non-grandfathered health care service plan contract or health insurance policy to provide coverage for, and prohibits a contract or policy from imposing cost-sharing requirements for, specified preventive care services and screenings. This bill would prohibit a group or individual health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2024, from imposing a cost-sharing requirement for office visits for the above-described preventive care services and screenings and for items or services that are integral to their provision. The bill would prohibit large group contracts and policies issued, amended, or renewed on or after January 1, 2024, and an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, from imposing a cost-sharing requirement, utilization review, or other specified limits on a recommended sexually transmitted infections screening, and from imposing a cost-sharing requirement for any items and services integral to a sexually transmitted infections screening, as specified.

AB 1690 **(Kalra D) Universal health care coverage.**
Current Text: Introduced: 2/17/2023
Status: 5/5/2023-Failed Deadline pursuant to Rule 61(a)(3). (Last location was PRINT on 2/17/2023)(May be acted upon Jan 2024)
Location: 5/5/2023-A. 2 YEAR

2 year	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would state the intent of the Legislature to guarantee accessible, affordable, equitable, and high-quality health care for all Californians through a comprehensive universal single-payer health care program that benefits every resident of the state.

AB 1698 **(Wood D) Medi-Cal.**
Current Text: Introduced: 2/17/2023
Status: 5/5/2023-Failed Deadline pursuant to Rule 61(a)(3). (Last location was PRINT on 2/17/2023)(May be acted upon Jan 2024)
Location: 5/5/2023-A. 2 YEAR

2 year	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law establishes 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. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would make specified findings and would express the intent of the Legislature to enact future legislation relating to Medi-Cal.

SB 43 **(Eggman D) Behavioral health.**
Current Text: Amended: 7/13/2023
Last Amend: 9/8/2023
Status: 9/21/2023-Enrolled and presented to the Governor at 4 p.m.
Location: 9/21/2023-S. ENROLLED

1st House				2nd House				Conf. Conc.	Enrolled	Vetoed	Chaptered
Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor				

Summary: The Lanterman-Petris-Short Act provides for the involuntary commitment and treatment of a person who is a danger to themselves or others or who is gravely disabled. Current law, for purposes of involuntary commitment, defines "gravely disabled" as either a condition in which a person, as a result of a mental health disorder, is unable to provide for their basic personal needs for food, clothing, or shelter or has been found mentally incompetent, as specified. This bill expands the definition of "gravely disabled" to also include a condition in which a person, as a result of a severe substance use disorder, or a co-occurring mental health disorder and a severe substance use disorder, is, in addition to the basic personal needs described above, unable to provide for their personal safety or necessary medical care, as defined

SB 70 **(Wiener D) Prescription drug coverage.**
Current Text: Amended: 6/29/2023
Last Amend: 6/29/2023
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/16/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-A. 2 YEAR

1st House				2nd House				Conf. Conc.	Enrolled	Vetoed	Chaptered
Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor				

Summary: Current law generally authorizes a health care service plan or health insurer to use utilization review, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Current law prohibits a health care service plan contract that covers prescription drug benefits or a specified health insurance policy from limiting or excluding coverage for a drug on the basis that the drug is prescribed for a use that is different from the use for which it was approved by the federal Food and Drug Administration if specified conditions are met. Current law also prohibits a health care service plan that covers prescription drug benefits from limiting or excluding coverage for a drug that was previously approved for coverage if an enrollee continues to be prescribed that drug, as specified. This bill would additionally prohibit limiting or excluding coverage of a drug, dose of a drug, or dosage form of a drug that is prescribed for off-label use if the drug has been previously covered for a chronic condition or cancer, as specified, regardless of whether or not the drug, dose, or dosage form is on the plan's or insurer's formulary. The bill would prohibit a health care service plan contract or health insurance policy from requiring additional cost sharing not already imposed for a drug that was previously approved for coverage.

SB 72 **(Skinner D) Budget Act of 2023.**
Current Text: Introduced: 1/10/2023

Status: 1/11/2023-From printer.
Location: 1/10/2023-S. BUDGET & F.R.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would make appropriations for the support of state government for the 2023–24 fiscal year.

SB 238 **(Wiener D) Health care coverage: independent medical review.**
Current Text: Amended: 6/19/2023
Last Amend: 6/19/2023
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/23/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law provides for the regulation of disability insurers by the Department of Insurance. Current law establishes the Independent Medical Review System within each department, under which an enrollee or insured may seek review if a health care service has been denied, modified, or delayed by a health care service plan or disability insurer and the enrollee or insured has previously filed a grievance that remains unresolved after 30 days. This bill, commencing July 1, 2024, would require a health care service plan or a disability insurer that modifies, delays, or denies a health care service, based in whole or in part on medical necessity, to automatically submit within 24 hours a decision regarding a disputed health care service to the Independent Medical Review System, as well as the information that informed its decision, without requiring an enrollee or insured to submit a grievance, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. The bill would require a health care service plan or disability insurer, within 24 hours after submitting its decision to the Independent Medical Review System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee's or insured's provider. The bill would require the notice to include notification to the enrollee or insured that they or their representative may cancel the independent medical review at any time before a determination, as specified. The bill would apply specified existing provisions relating to mental health and substance use disorders for purposes of its provisions, and would be subject to relevant provisions relating to the Independent Medical Review System that do not otherwise conflict with the express requirements of the bill. With respect to health care service plans, the bill would specify that its provisions do not apply to Medi-Cal managed care plan contracts.

SB 282 **(Eggman D) Medi-Cal: federally qualified health centers and rural health clinics.**
Current Text: Amended: 6/19/2023
Last Amend: 6/19/2023
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/23/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including federally qualified health center (FQHC) services and rural health clinic (RHC) services. The Medi-

Cal program is, in part, governed and funded by federal Medicaid program provisions. Under current law, to the extent that federal financial participation is available, FQHC and RHC services are reimbursed on a per-visit basis, as specified. "Visit" is defined as a face-to-face encounter between a patient of an FQHC or RHC and a physician or other specified health care professionals. Under current law, "visit" also includes an encounter using video or audio-only synchronous interaction or an asynchronous store and forward modality, as specified. This bill would authorize reimbursement for a maximum of 2 visits that take place on the same day at a single site, whether through a face-to-face or telehealth-based encounter, if after the first visit the patient suffers illness or injury that requires additional diagnosis or treatment, or if the patient has a medical visit and either a mental health visit or a dental visit, as defined. The bill would require the department, by July 1, 2024, to submit a state plan amendment to the federal Centers for Medicare and Medicaid Services reflecting those provisions.

SB 299 **(Limón D) Voter registration: California New Motor Voter Program.**
Current Text: Amended: 6/13/2023
Last Amend: 6/13/2023
Status: 7/14/2023-Failed Deadline pursuant to Rule 61(a)(10). (Last location was HEALTH on 6/1/2023)(May be acted upon Jan 2024)
Location: 7/14/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	2 year	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law requires, in conformance with federal law, that the Secretary of State and the Department of Motor Vehicles establish and implement the California New Motor Voter Program for the purpose of increasing opportunities for voter registration for qualified voters. Current law requires the department to transmit to the Secretary of State specified information related to a person's eligibility to vote, which the person provides when applying for a driver's license or identification card or when the person notifies the department of an address change. Current law requires that if this information transmitted to the Secretary of State constitutes a completed affidavit of registration, the Secretary of State must register or preregister the person to vote, as applicable, unless the person affirmatively declines to register or is ineligible to vote, as specified. This bill would additionally require the Department of Motor Vehicles to transmit specified information to the Secretary of State for a person submitting a driver's license application who provides documentation demonstrating United States citizenship and that the person is of an eligible age to register or preregister to vote. The bill would deem this information to constitute a completed affidavit of registration for such persons, and require the Secretary of State to register or preregister the person to vote, unless the Secretary of State determines they are ineligible. The bill would require, if a person is registered or preregistered to vote in this manner, that the county elections official send a notice to the person advising that they may decline to register or preregister to vote and providing additional information. The bill would also require the county elections official to send a notice to a person who is already registered to vote, but for whom the Secretary of State changes their registration information after receiving updated name or address information from the department.

SB 311 **(Eggman D) Medi-Cal: Part A buy-in.**
Current Text: Enrollment: 9/20/2023
Last Amend: 9/6/2023
Status: 9/20/2023-Enrolled and presented to the Governor at 4:30 p.m.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law requires the State Department of Health Care Services, to the extent required by federal law, for Medi–Cal recipients who are qualified Medicare beneficiaries, to pay the Medicare premiums, deductibles, and coinsurance for certain elderly and disabled persons. Current federal law authorizes states to pay for Medicare benefits for specified enrollees pursuant to either a buy-in agreement to directly enroll and pay premiums or a group payer arrangement to pay premiums. This bill would require the department to submit a state plan amendment no later than January 1, 2024, to enter into a Medicare Part A buy-in agreement with the federal Centers for Medicare and Medicaid Services. To the extent that the bill would increase duties for a county, the bill would create a state-mandated local program.

SB 324 **(Limón D) Health care coverage: endometriosis.**
Current Text: Amended: 3/30/2023
Last Amend: 3/30/2023
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/23/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would prohibit a health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after January 1, 2024, from requiring prior authorization or other utilization review for any clinically indicated treatment for endometriosis, as determined by the treating physician and consistent with nationally recognized evidence-based clinical guidelines. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

SB 326 **(Eggman D) The Behavioral Health Services Act.**
Current Text: Enrollment: 9/21/2023
Last Amend: 9/8/2023
Status: 9/21/2023-Enrolled and presented to the Governor at 4 p.m.
Location: 9/21/2023-S. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: (1) Existing law, 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. Existing law authorizes the MHSA to be amended by a 2/3 vote of the Legislature if the amendments are consistent with and further the intent of the MHSA. Existing law authorizes the Legislature to add provisions to clarify procedures and terms of the MHSA by majority vote. This bill would require a county, for behavioral health services eligible for reimbursement pursuant to the federal Social Security Act, to submit the claims for reimbursement to the State Department of Health Care Services (the department) under specific circumstances. The bill would require counties to pursue reimbursement through various channels and would authorize the counties to report issues with managed care plans and insurers to the Department of Managed Health Care or the Department of Insurance. This bill contains other related provisions and other existing laws.

SB 340 **(Eggman D) Medi-Cal: eyeglasses: Prison Industry Authority.**
Current Text: Introduced: 2/7/2023
Status: 7/14/2023-Failed Deadline pursuant to Rule 61(a)(10). (Last location was HEALTH on

6/15/2023)(May be acted upon Jan 2024)
Location: 7/14/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	2 year	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would for purposes of Medi-Cal reimbursement for covered optometric services, would authorize a provider to obtain eyeglasses from a private entity, as an alternative to a purchase of eyeglasses from the Prison Industry Authority. The bill would condition implementation of this provision on the availability of federal financial participation.

SB 496 **(Limón D) Biomarker testing.**
Current Text: Enrollment: 9/21/2023
Last Amend: 9/7/2023
Status: 9/21/2023-Enrolled and presented to the Governor at 4 p.m.
Location: 9/21/2023-S. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2024, to provide coverage for medically necessary biomarker testing, as prescribed, including whole genome sequencing, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's or insured's disease or condition to guide treatment decisions, as prescribed. The bill would specify that it does not require a health care service plan or health insurer to cover biomarker testing for screening purposes unless otherwise required by law. The bill would subject restricted or denied use of biomarker testing for the purpose of diagnosis, treatment, or ongoing monitoring of a medical condition to state and federal grievance and appeal processes. This bill would apply these provisions relating to biomarker testing to the Medi-Cal program, including Medi-Cal managed care plans, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

SB 502 **(Allen D) Medi-Cal: children: mobile optometric office.**
Current Text: Enrollment: 9/20/2023
Last Amend: 6/30/2023
Status: 9/20/2023-Enrolled and presented to the Governor at 4:30 p.m.
Location: 9/20/2023-S. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Pursuant to current state law, the State Department of Health Care Services established a 3-year pilot program, from 2015 through 2017, in the County of Los Angeles that enabled school districts to allow students enrolled in Medi-Cal managed care plans to receive vision care services at the schoolsite through the use of a mobile vision service provider, limited to vision examinations and providing eyeglasses. Current law authorizes an applicant or provider that meets the requirements to qualify as a mobile optometric office to be enrolled in the Medi-Cal program as either a mobile optometric office or within any other provider category for which the applicant or provider qualifies. Current law defines "mobile optometric office" as a trailer, van, or other means of transportation in which the practice of optometry is performed and which is not affiliated with an approved optometry school in the state. Under current law, the ownership and operation of a mobile optometric office is limited to a nonprofit or charitable organization, as specified, with the owner and operator

registering with the State Board of Optometry. This bill would require the department to file all necessary state plan amendments to exercise the HSI option made available under the Children's Health Insurance Program (CHIP) provisions to cover vision services provided to low-income children statewide through a mobile optometric office, as specified.

SB 537 **(Becker D) Open meetings: multijurisdictional, cross-county agencies: teleconferences.**
Current Text: Amended: 9/5/2023
Last Amend: 9/5/2023
Status: 9/14/2023-Ordered to inactive file on request of Assembly Member Bryan.
Location: 9/14/2023-A. INACTIVE FILE

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The Ralph M. Brown Act generally requires for teleconferencing that the legislative body of a local agency that elects to use teleconferencing post agendas at all teleconference locations, identify each teleconference location in the notice and agenda of the meeting or proceeding, and have each teleconference location be accessible to the public. Current law also requires that, during the teleconference, at least a quorum of the members of the legislative body participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined. Current law, until January 1, 2024, authorizes the legislative body of a local agency to use alternate teleconferencing provisions during a proclaimed state of emergency or in other situations related to public health that exempt a legislative body from the general requirements (emergency provisions) and impose different requirements for notice, agenda, and public participation, as prescribed. The emergency provisions specify that they do not require a legislative body to provide a physical location from which the public may attend or comment. Current law, until January 1, 2026, authorizes the legislative body of a local agency to use alternative teleconferencing in certain circumstances related to the particular member if at least a quorum of its members participate from a singular physical location that is open to the public and situated within the agency's jurisdiction and other requirements are met, including restrictions on remote participation by a member of the legislative body. These circumstances include if a member shows "just cause," including for a childcare or caregiving need of a relative that requires the member to participate remotely. This bill would expand the circumstances of "just cause" to apply to the situation in which an immunocompromised child, parent, grandparent, or other specified relative requires the member to participate remotely.

SB 551 **(Portantino D) Mental health boards.**
Current Text: Amended: 6/15/2023 html pdf
Last Amend: 6/15/2023
Status: 9/14/2023-Failed Deadline pursuant to Rule 61(a)(14). (Last location was INACTIVE FILE on 9/8/2023)(May be acted upon Jan 2024)
Location: 9/14/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The Bronzan-McCorquodale Act, contains provisions governing the operation and financing of community mental health services in every county through locally administered and locally controlled community mental health programs. Current law requires each community mental health service to have a mental health board, as specified. Current law encourages counties to appoint members of the community who represent specific groups, including county offices of education and hospitals. Current law requires a

member of the board to abstain from voting on any issue in which the member has a financial interest. This bill would require one member of a mental health board's membership to be employed by a local educational agency, and at least one member to be an individual who is 25 years of age or younger in counties with a mental health board membership of 5 to 8 members. The bill would require 2 members of the board to be employed by a local educational agency and at least 2 members to be 25 years of age or younger in counties with a mental health board membership of 9 to 15 members. The bill would require at least 2 members of the board to be employed by a local educational agency and at least two members to be 25 years of age or younger in counties with a mental health board membership of 16 or more members. The bill would require counties to give a strong preference to appointing members of the board who have experience providing mental health services to students. The bill would state that the intent of the Legislature is for youth appointments to a mental health board to address or prevent health and mental health disparities or inequities through representation of vulnerable, underserved, and marginalized communities.

SB 582 **(Becker D) Health information.**
Current Text: Enrollment: 9/21/2023
Last Amend: 9/7/2023
Status: 9/21/2023-Enrolled and presented to the Governor at 4 p.m.
Location: 9/21/2023-S. ENROLLED

1st House				2nd House				Conf. Conc.	Enrolled	Vetoed	Chaptered
Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor				

Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current law requires health care service plans and health insurers to establish and maintain specified application programming interfaces (API), including patient access API, to facilitate patient and provider access to health information and for the benefit of enrollees, insureds, and contracted providers. Current law authorizes the Department of Managed Health Care and the Department of Insurance to require a plan or insurer to establish and maintain specified API, including provider access API. This bill would instead require the departments to require the plans and insurers to establish and maintain these specified API. The bill would exclude from the requirements of these provisions dental or vision benefits offered by a plan or insurer, including a specialized plan or insurer. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

SB 598 **(Skinner D) Health care coverage: prior authorization.**
Current Text: Amended: 8/14/2023
Last Amend: 8/14/2023
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/23/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-A. 2 YEAR

1st House				2nd House				Conf. Conc.	Enrolled	Vetoed	Chaptered
Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor				

Summary: Would, on or after January 1, 2026, prohibit a health care service plan or health insurer from requiring a contracted health professional to complete or obtain a prior authorization for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent completed one-year contracted period. The bill would set standards for this exemption and its denial, rescission, and appeal. The bill would authorize a plan or insurer to evaluate the continuation of an exemption not more than once every 12 months, and would authorize a plan or insurer to rescind an exemption only at the end of the 12-month period and only if specified criteria are met. The bill would require a plan or insurer to provide an electronic prior authorization

process. The bill would also require a plan or insurer to have a process for annually monitoring prior authorization approval, modification, appeal, and denial rates to identify services, items, and supplies that are regularly approved, and to discontinue prior authorization on those services, items, and supplies that are approved 95% of the time. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

SB 694 **(Eggman D) Medi-Cal: self-measured blood pressure devices and services.**
Current Text: Enrollment: 9/20/2023
Last Amend: 9/1/2023
Status: 9/20/2023-Enrolled and presented to the Governor at 4:30 p.m.
Location: 9/20/2023-S. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law sets forth a schedule of benefits under the Medi-Cal program, including pharmacy benefits (Medi-Cal Rx) and durable medical equipment. The State Department of Health Care Services announced that, effective June 1, 2022, personal home blood pressure monitoring devices, and blood pressure cuffs for use with those devices, are a covered benefit under Medi-Cal Rx as a pharmacy-billed item. This bill would make self-measured blood pressure (SMBP) devices and SMBP services, as defined, covered benefits under the Medi-Cal program subject to utilization controls. The bill would state the intent of the Legislature that those covered devices and services be no less in scope than the devices and services that are recognized under specified existing billing codes or their successors. The bill would condition implementation of that coverage on receipt of any necessary federal approvals and the availability of federal financial participation.

SB 717 **(Stern D) County mental health services.**
Current Text: Enrollment: 9/21/2023
Last Amend: 9/1/2023
Status: 9/21/2023-Enrolled and presented to the Governor at 4 p.m.
Location: 9/21/2023-S. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law prohibits a person from being tried or adjudged to punishment while that person is mentally incompetent. If a defendant who has been charged with a misdemeanor has been determined to be mentally incompetent, existing law authorizes the court to either grant diversion for a period of one year, refer the defendant to treatment, or dismiss the charge. Te Bronzan-McCorquodale Act governs the organization and financing of community mental health services for persons with mental disorders in every county through locally administered and locally controlled community mental health programs. This bill would require the court to notify an individual of their ongoing need for mental health services if the individual has been found incompetent to stand trial and is not receiving court directed services. The bill would require the court to provide the individual with specified information, including the name, address, and telephone number of the county behavioral health department..

SB 729 **(Menjivar D) Health care coverage: treatment for infertility and fertility services.**
Current Text: Amended: 8/14/2023
Last Amend: 8/14/2023
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on

8/23/2023)(May be acted upon Jan 2024)

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require large and small group health care service plan contracts and disability insurance policies issued, amended, or renewed on or after January 1, 2024, to provide coverage for the diagnosis and treatment of infertility and fertility services. With respect to large group health care service plan contracts and disability insurance policies, the bill would require coverage for a maximum of 3 completed oocyte retrievals, as specified. The bill would revise the definition of infertility, and would remove the exclusion of in vitro fertilization from coverage. The bill would also delete a requirement that a health care service plan contract and disability insurance policy provide infertility treatment under agreed-upon terms that are communicated to all group contractholders and policyholders. The bill would prohibit a health care service plan or disability insurer from placing different conditions or coverage limitations on fertility medications or services, or the diagnosis and treatment of infertility and fertility services, than would apply to other conditions, as specified. The bill would make these requirements inapplicable to a religious employer, as defined, and specified contracts and policies.

SB 779 **(Stern D) Primary Care Clinic Data Modernization Act.**
Current Text: Enrollment: 9/21/2023
Last Amend: 9/8/2023
Status: 9/21/2023-Enrolled and presented to the Governor at 4 p.m.
Location: 9/21/2023-S. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law provides for the licensure and regulation of clinics, including primary care clinics and specialty clinics, by the State Department of Public Health. A violation of these provisions is a crime. Existing law excludes certain facilities from those provisions, including a clinic that is operated by a primary care community or free clinic and that is operated on separate premises from the licensed clinic and is only open for limited services of no more than 40 hours a week, also referred to as an intermittent clinic. This bill would provide that no reimbursement is required by this act for a specified reason. This bill contains other existing laws.

SB 786 **(Portantino D) Prescription drug pricing.**
Current Text: Enrollment: 9/11/2023
Last Amend: 6/15/2023
Status: 9/11/2023-Enrolled and presented to the Governor at 3 p.m.
Location: 9/11/2023-S. ENROLLED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would prohibit a pharmacy benefit manager from discriminating against a covered entity or its pharmacy in connection with dispensing a drug subject to federal pricing requirements or preventing a covered entity from retaining the benefit of discounted pricing for those drugs.

SB 819 **(Eggman D) Medi-Cal: certification.**
Current Text: Amended: 6/26/2023

Last Amend: 6/26/2023
Status: 9/14/2023-Failed Deadline pursuant to Rule 61(a)(14). (Last location was INACTIVE FILE on 8/28/2023)(May be acted upon Jan 2024)
Location: 9/14/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law requires the State Department of Public Health to license and regulate clinics. Current aw exempts from those licensing provisions certain clinics that are directly conducted, maintained, or operated by federal, state, or local governmental entities, as specified. Current law also exempts from those licensing provisions a clinic that is operated by a primary care community or free clinic, that is operated on separate premises from the licensed clinic, and that is only open for limited services of no more than 40 hours per week. Current law sets forth various procedures, including the submission of an application package, for providers to enroll in the Medi-Cal program. Under current law, an applicant or provider that is a government-run license-exempt clinic as described above is required to comply with those Medi-Cal enrollment procedures. Under current law, an applicant or provider that is operated on separate premises and is license exempt, including an intermittent site or mobile health care unit that is operated by a licensed primary care clinic that provides all staffing, protocols, equipment, supplies, and billing services, is not required to enroll in the Medi-Cal program as a separate provider or comply with the above-described enrollment procedures, if the licensed primary care clinic has notified the department of its separate locations, premises, intermittent sites, or mobile health care units. This bill would additionally exempt from the Medi-Cal enrollment procedures an intermittent site or mobile health care unit that is operated by the above-described government-run license-exempt clinic if that clinic has notified the department of its separate locations, premises, sites, or units.

ALAMEDA Alliance FOR HEALTH

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

Board Business

To: **Alameda Alliance for Health, Finance Committee**

From: **Gil Riojas, Chief Financial Officer**

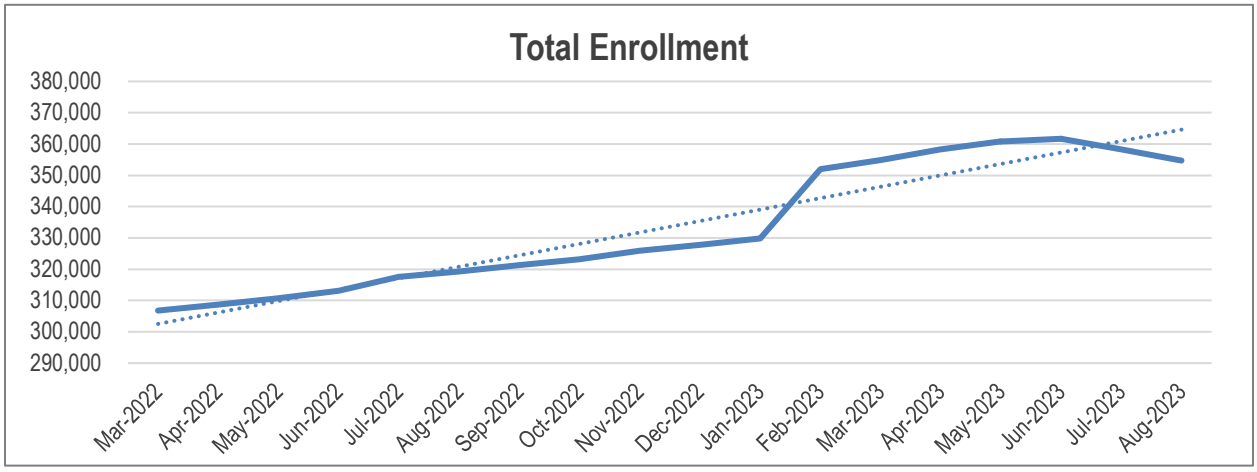
Date: **October 10th, 2023**

Subject: **Finance Report –August 2023**

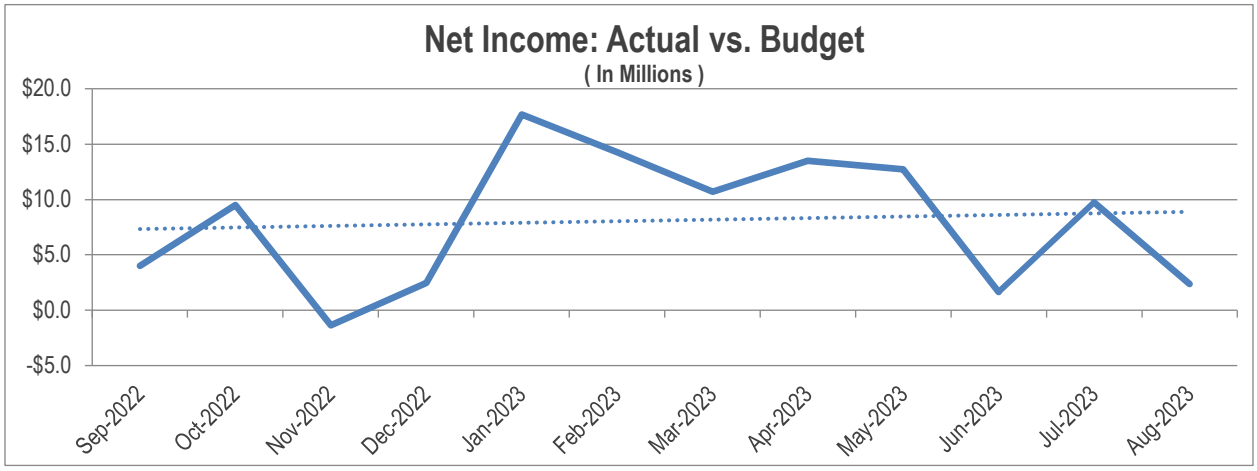
Executive Summary

For the month ended August 31st, 2023, the Alliance continued a decrease in enrollment related to redetermination efforts. Enrollment decreased by 3,635 members to 354,671 members. Net Income of $2.3 million was reported in the second month of the fiscal year. The Plan's medical expenses represented 93.7% of revenue. Alliance reserves declined by 3 percentage points to 721% of required but remain healthy and well above minimum requirements.

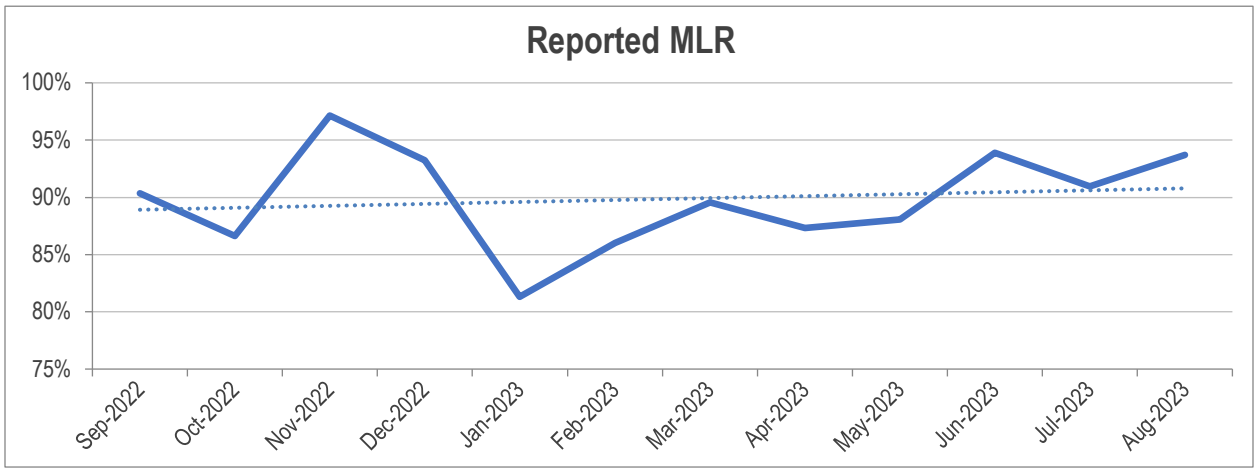
Enrollment – Enrollment continues to decline. Enrollment fell by 3,635 members due to redetermination.



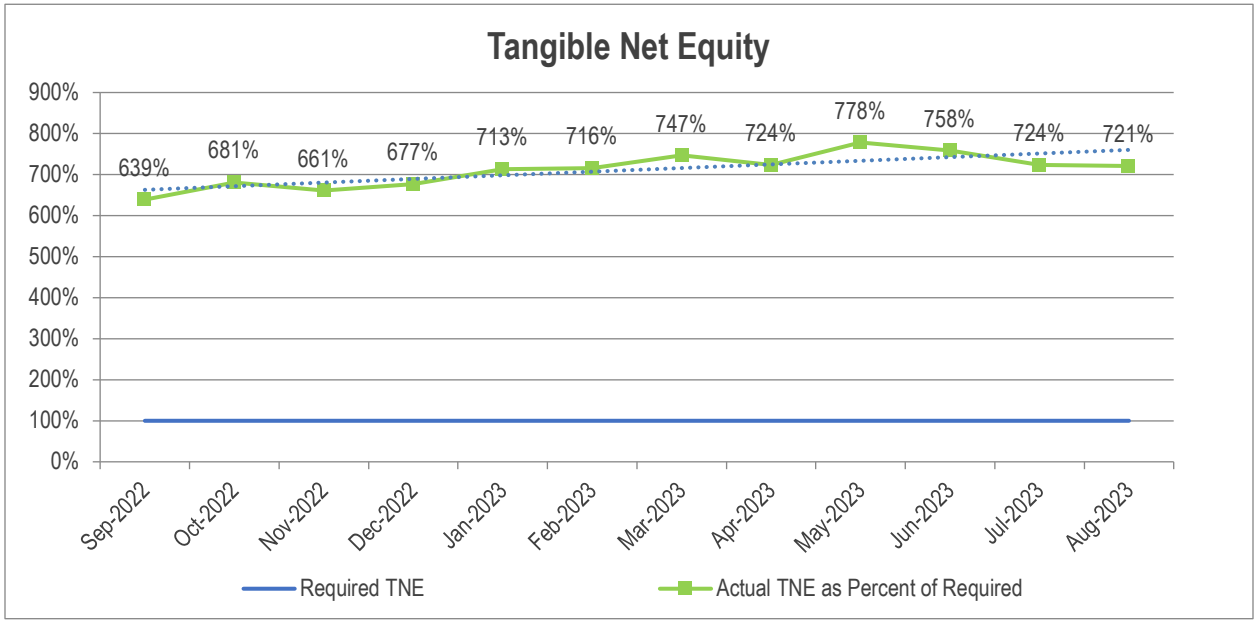
Net Income - For the month ended August 31st, 2023, actual Net Income was $2.3 million vs. budgeted Net Loss of $161,000. Fiscal year-to-date actual Net Income was $12.1 million vs. Budgeted Net Loss of $884,000.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 93.7% for the month and 92.3% for the fiscal year-to-date. MLR percentages above 95% may result in net losses for the plan.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required $46.7M in reserves, we reported $336.8M. We had a third month of slight decreases in reserves, but our reserves continue to be well above DMHC requirements.



The Alliance continues to benefit from increased non-operating income. For August we reported returns of $2.0M in the investment portfolio. Conversely, we experienced a negative variance of $1.3M in administrative expenses. This negative variance was a factor in reducing our reported Net Income for August.

Property Discussion

Ruth Watson, Chief Operating Officer

October 13th, 2023

ALAMEDA Alliance FOR HEALTH

Current State

- Suite 1320 lease expires on May 31, 2025
- 1240 building assessed value in 2019 = $19M
  - Commercial real estate market for office space continues to be an evolving landscape – vacancy rates are high and property values have declined.
  - Building value will need to be re-assessed for current value.
- Proposed Relocation Plan: Initiate in 2025 for a 2027 move

Building Requirements

- Space to accommodate 300 Employees (assume 50% of staff for meetings and functions)
  - 1 large conference room
  - 2 medium conference rooms
  - Estimated dedicated offices: 35
  - Minimum of 60,000 square feet
- Proposed Locations
  - Oakland
  - Downtown San Leandro
  - Hayward

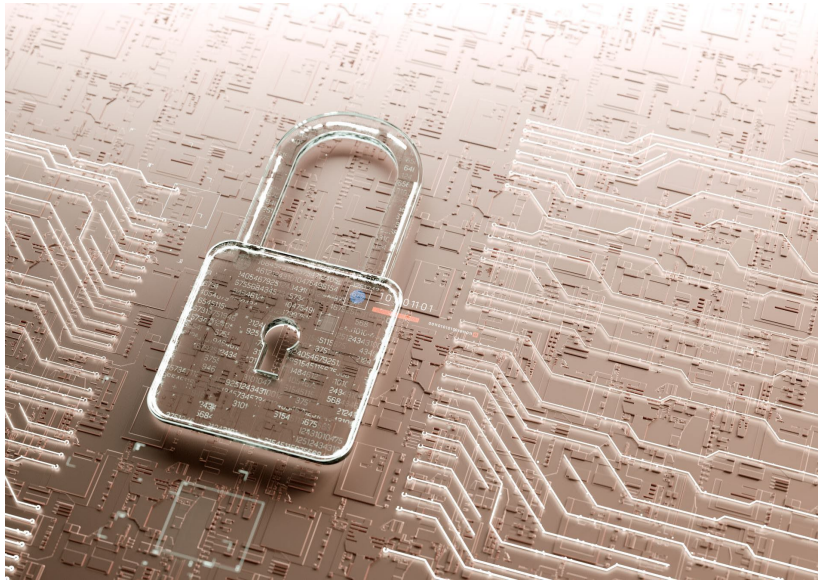
Building Requirements (Continued)

- Member Accessibility
  - Close access to Public Transportation and BART
- Secure and safe environment for Alliance employees and Members
- Sufficient parking for staff, Members and visitors

Questions?

INFORMATION SECURITY OPERATIONS

October 13th, 2023



ALAMEDA Alliance FOR HEALTH

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

Our Security Mission

"Our Mission is to strengthen the digital information assets, enterprise security postures, and promote the efficiency and stability through technology, collaboration, information sharing, and comprehensive oversight."

Goals

- ✓ Protect the confidentiality of all the Alliance information, data, and assets.
- ✓ Preserve the integrity of data.
- ✓ Promote the access and availability of information and data for authorized use ONLY.
- ✓ Proactive risk identification and its mitigation plan.

Security Strategies

- ✓ Create security foundation and framework.
- ✓ Strengthen the security team and stay ahead of the threat landscape by enabling secure and innovative solutions.
- ✓ Proactive security monitoring and risk management.
- ✓ Improved situational awareness and increased cybersecurity posture.
- ✓ Collaborate with key partners to promote resilience and reduce the incidence and severity of cyber security breaches.
- ✓ Implement robust crisis and incident response management.

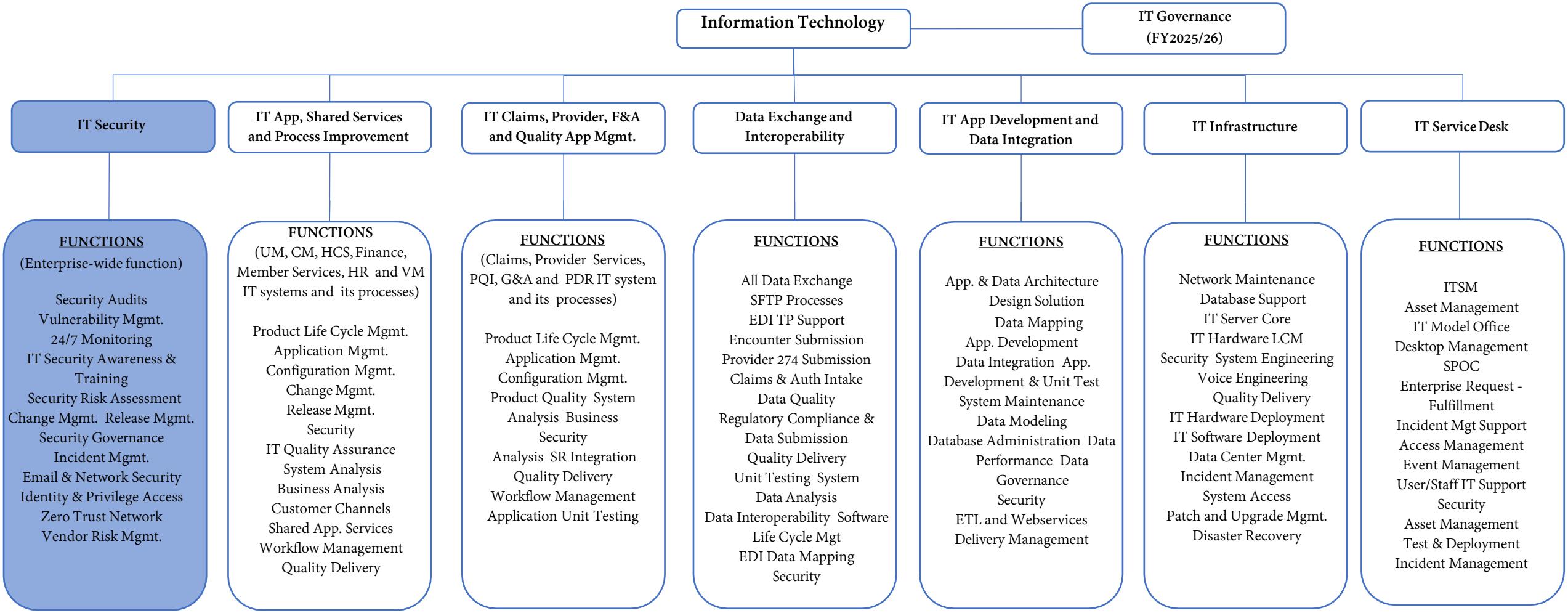
Accomplishments

- ✓ Implemented and maintained secured technology infrastructure.
- ✓ Cybersecurity risk assessment.
- ✓ 360-degree communication.
- ✓ Security awareness and train employees.
- ✓ Improved identity and access management.
- ✓ Implemented security control baselines.
- ✓ Deployed vulnerability management program and real-time detection of security Anomalies.
- ✓ Cybersecurity insurance coverage.
- ✓ State of the art in resilient networked systems .
- ✓ In-depth understanding of the IT environment.
- ✓ Developed disaster recovery runbook for tier 0 and 1 systems/applications.
- ✓ Created security incident response plan.

Inflight Initiatives

- ➢ Enterprise immutable cloud storage back-up before end of October 2023.
- ➢ Complete the business continuity plan before end of December 2023.
- ➢ Develop disaster recovery runbook for Tier 2 and 3 systems before end of June 2024.

IT Security Function



SECURITY FUNCTIONS

Security Operation Center (SOC), Information Risk Management, Security Governance & Incident Management, Identity and Keys, Cyber Security, PnP, Assets Security, Infrastructure & End Point Security, Security Training and Thread Preparation & Notification Management

Healthcare Incidents in US

Hospital & Healthcare Cyberattacks In 2023

- ✓ 390 Cyber attacks.
- ✓ The records of ~ 630 million individuals have been stolen or compromised.
- ✓ ~ 6 billion financial losses.

Top 4 major reasons for these cyber-attacks are:

a) Lack of awareness and training.

b) Email/Message/Voice phishing scam.

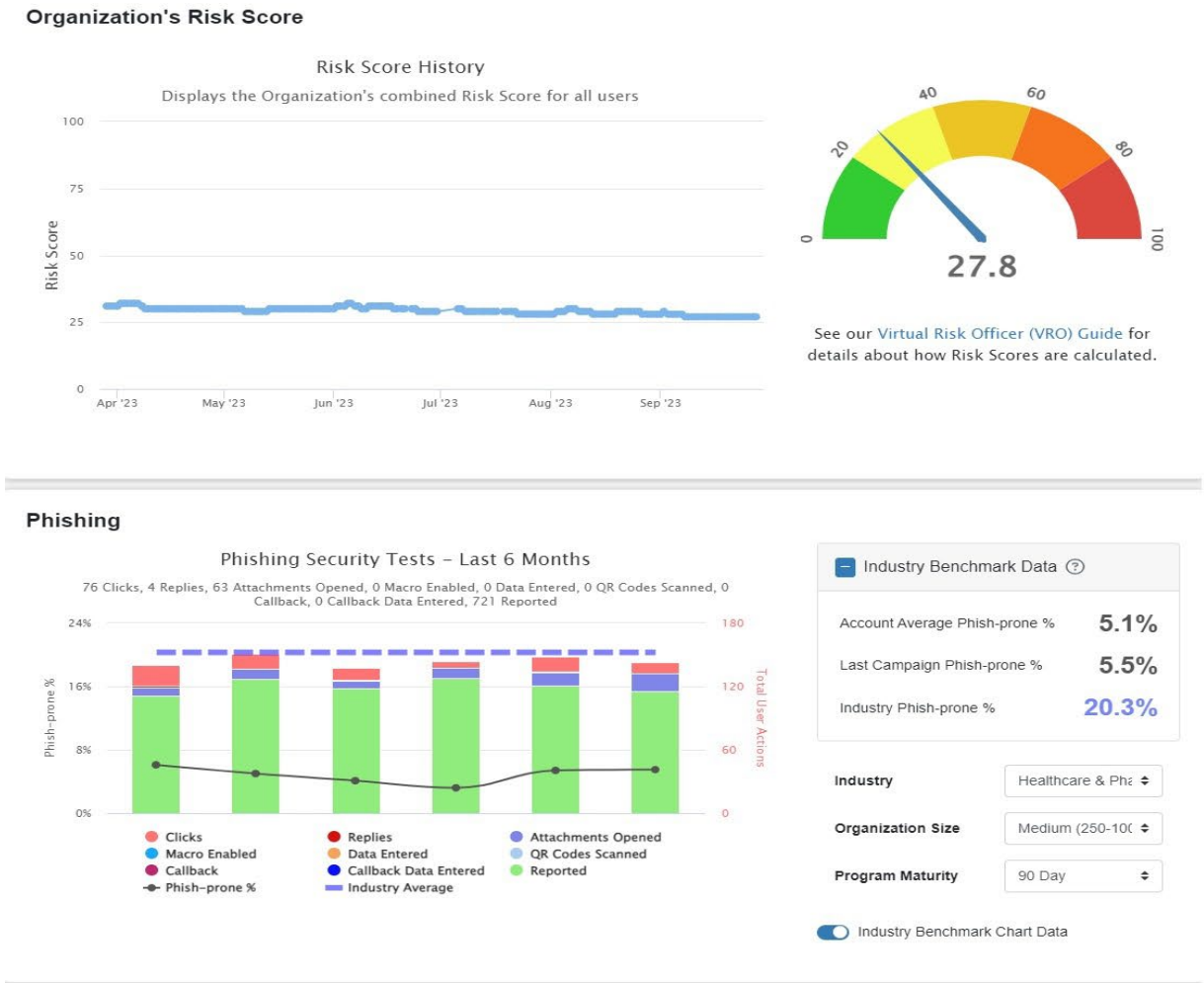
c) Limited security on system access and network infrastructure.

d) System and process vulnerabilities.

Security Training and Awareness

- ✓ Cyber Security and Phishing training mandate since May 2021.
- ✓ AAH employees, contractors, and temp resources are required training upon hire.
- ✓ Security training consist of 5 exercises and videos, and these training will be revised each year.
- ✓ New employees are automatically enrolled into the training exercises.
- ✓ 100% of staff completed security training in FY2023.
- ✓ Conducted ongoing phishing tests - These tests are authentic looking emails that are delivered to the employee's inbox monthly.
- ✓ Frequency: Monthly - simulated phishing test emails sent out every month.
- ✓ All security training awareness and simulated phishing tests are conducted using Knowbe4.

AAH's Virtual Risk Officer



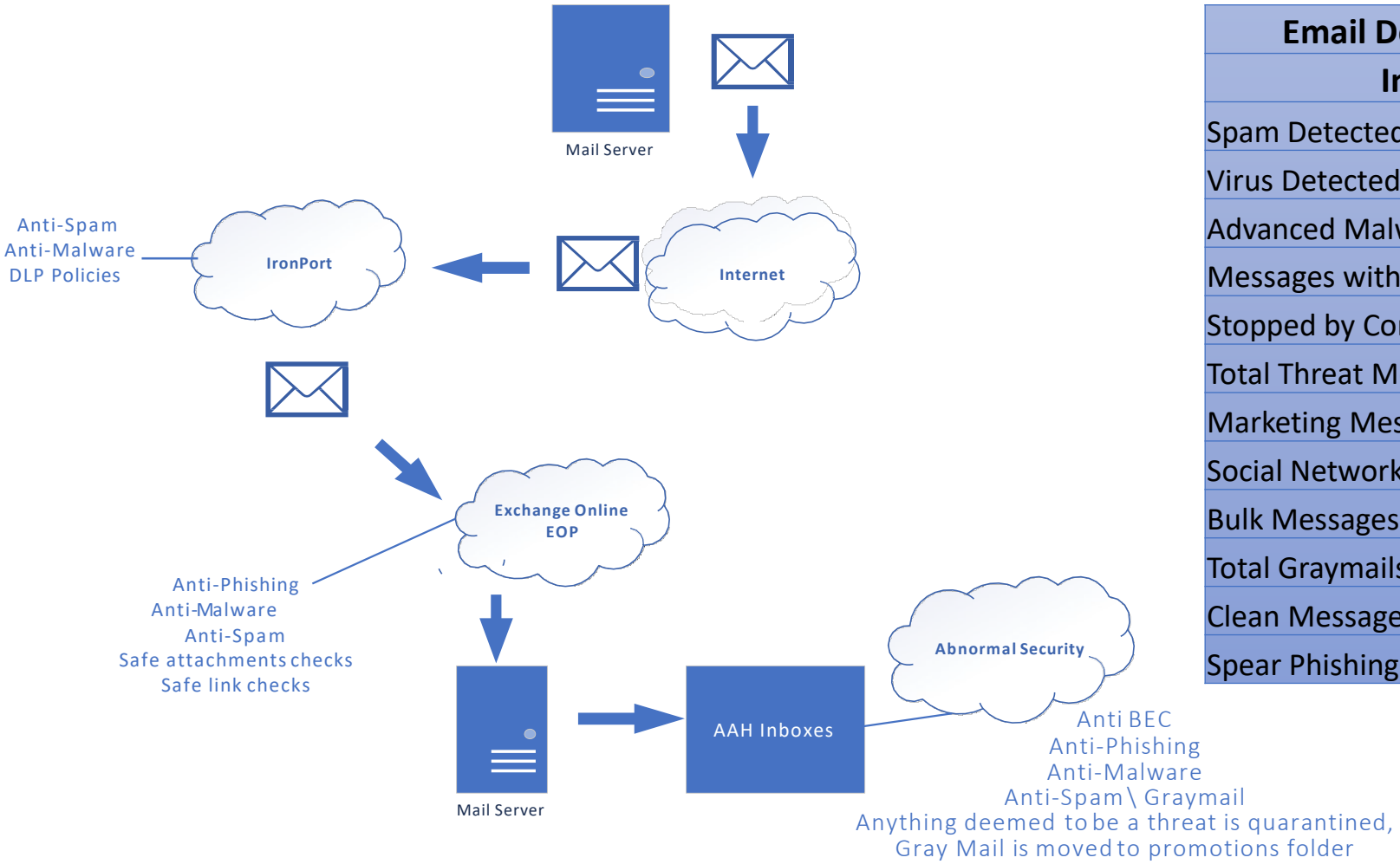
KnowBe4, our security awareness platform records the risk score for each of the users and are calculated using a deep learning neural network that combines several different factors such as:

- Results of phishing test
- Security awareness training
- Email exposure
- User job functions and activities

Alameda Alliance Average for last 6 months is 27.8%.

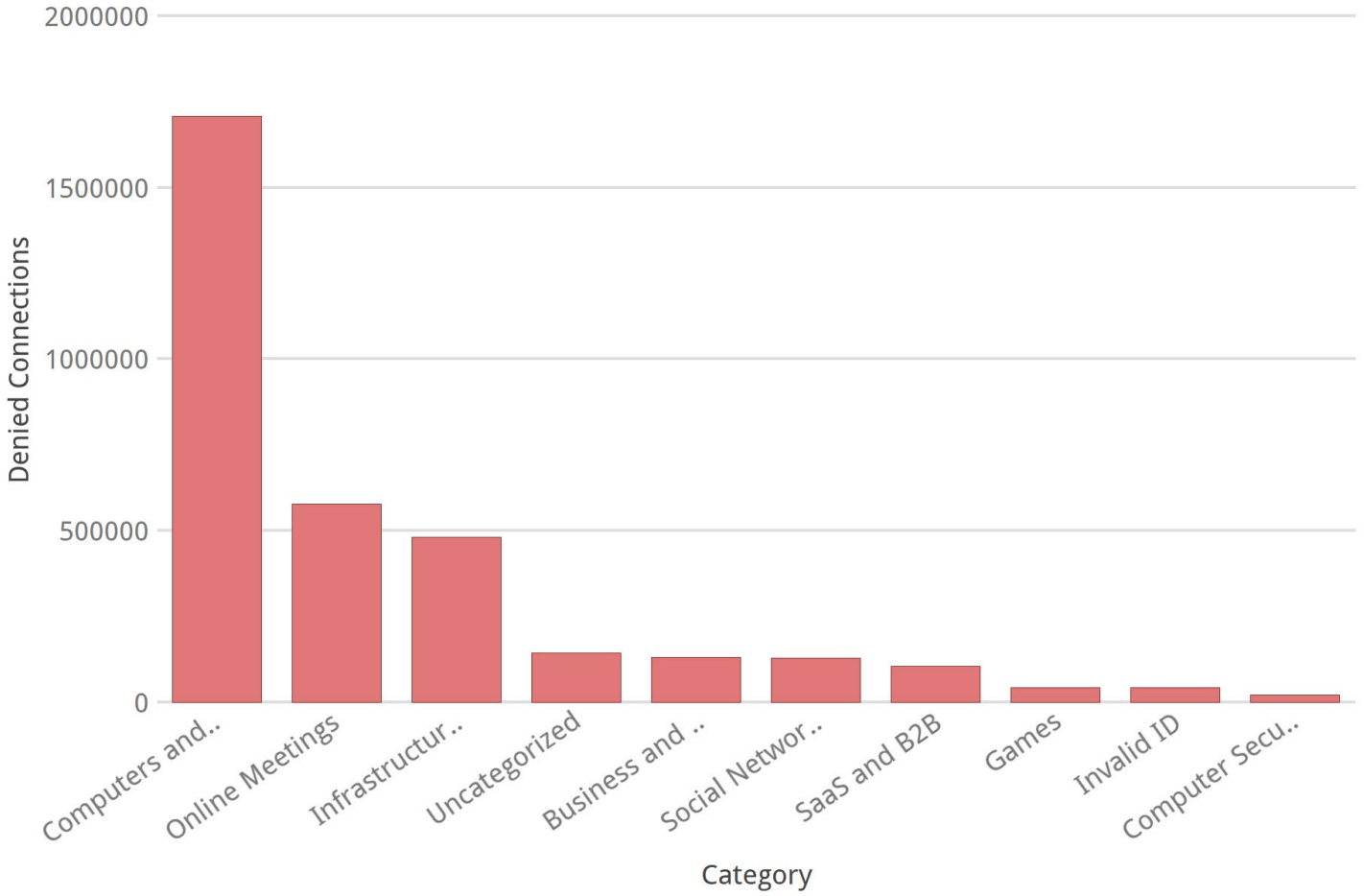
HealthCare industry average is 41%.

AAH Email Security



Email Detected Metric in last 6 months	
Incident Type	**Count**
Spam Detected	99,210
Virus Detected	17
Advanced Malware Protection	5
Messages with Malicious URLs	928
Stopped by Content Filter	540
Total Threat Messages	382,060
Marketing Messages	96,850
Social Networking Messages	4,986
Bulk Messages	128,972
Total Graymails	230,808
Clean Messages	657,195
Spear Phishing Attempts	200

AAH Network Intrusion Detection



Category Denied	Denial Connections
Computer and Internet	1.7M
Online Meeting	570K
Infrastructure and Network	480K
Uncategorized	140K
Business and Industry	130K
Social Networking	130K
Invalid ID	42K
Computer Security	21K

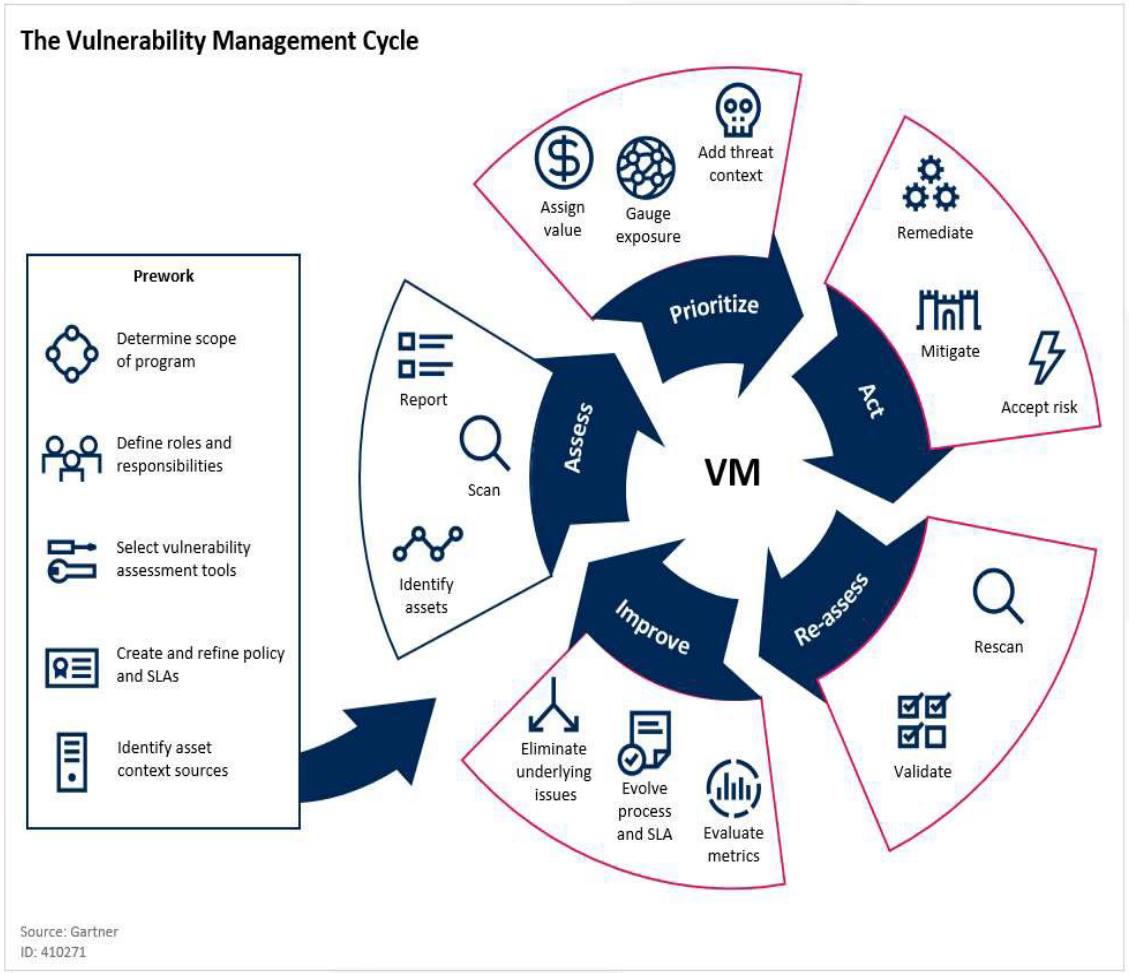
Toolsets and Processes Aligned with Security Framework

Identify	Protect	Detect	Response	Recover
Asset Management	**Identity Management**	**Anomalies and Events**	**Incident Response**	**Recovery Planning**
Ticket System	Secure End Point	Secure End Point	Secure End Point	Secure End Point
Mobile Device Mgt.	Advanced Firewall	Advanced Firewall	Advanced Firewall	Advanced Firewall
Infrastructure Device Mgt.	Virtual Private Network	Virtual Private Network	Incident Response Plan	Secondary Data Center
Single Sign On	Active Directory	Mobile Device Mgt.	Network Performance	Disaster Recovery Runbook
Advance Patch Management	Vendor Access Mgt.	Network Performance	Mobile Device Mgt.	Cyber Insurance
Risk Management	Mobile Device Mgt.	Email and Web Security	Business Continuity Plan	Business Contiunity Plan
Annual Risk Assessment	Single Sign On	Mobile Iron	Incident Command Center	**Recovery**
Knowbe4	Multi-Factor Authentication	Securelink	24/7 Monitoring	VEEAM backup
Vendor Access Mgt.	Anti-Spam/Malware	BitSight	Disaster Recovery (DR)	Zerto
Vulnerability scanning	24/7 Monitoring	**Detection**	**Impact Analysis**	VM Ware
24/7 Monitoring	**Awareness & Training**	Vulnerability scanner	24/7 Monitoring	Pure Storage
Vendor Risk Management	Knowbe4	Advance Patch Management	Track-IT	Immutable Storage
CobbleStone (Contracts)	BitSight	Track-IT	Share 911	Mobile Device Mgt.
BitSight	CISA.gov	24/7 Monitoring	Zerto	SolarWinds
SOC Audit	Quest Notifications	Knowbe4	O365 Email Exchange	Commvault
Third Party Trust	**Data Security**	Advanced Firewall	Knowbe4	O365 Email Exchange
Policies & Standards	Bit Locker	Anti-Spam	Hotline	Hotline
HIPAA Based Policies	Advance Patch Management	Anti-Malware	Email and Web Security	Commvault
Compliance 360	Data De-identification	Vulnerability Mgt Program	Vendor Management	Forensic Report
Awareness & Training	**Physical Security**		Privacy and Compliance	Awareness & Training
	Cameras			
	Key cards			
	Data Center Access			

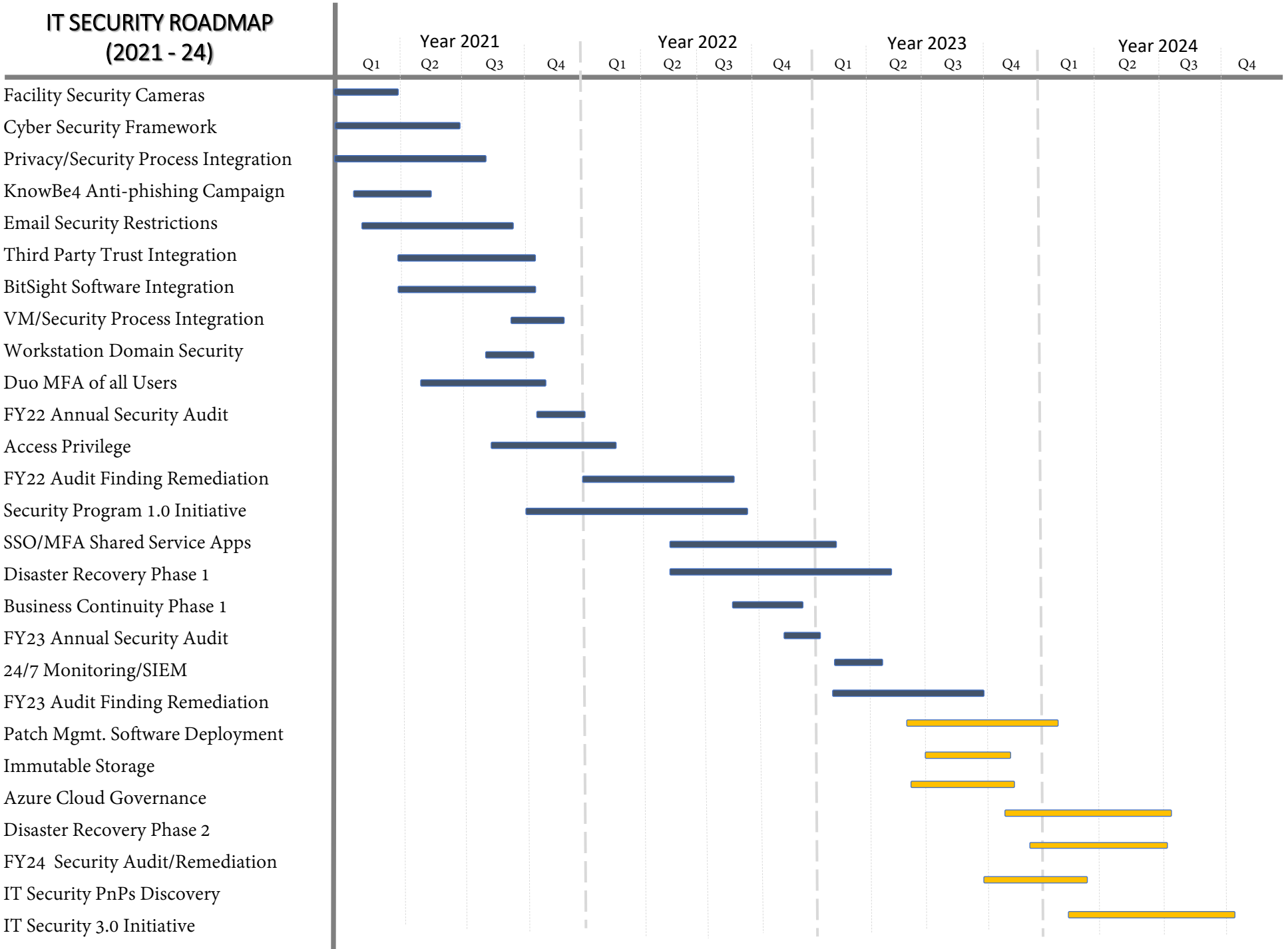
Note: The security tool names are not disclosed in the above table due to security and confidentiality reasons.

Vulnerability Management Program

Phase	Activity	Team Responsible
Assess	Identify Assets	IT Security Process/ Product Owner IT Infrastructure & Service Desk Vendor Management Privacy Office
	Scan	
	Report	
Prioritize	Assign Value	IT Security Process and Product Owner
	Gauge Exposure	
	Add Threat Context	
Act	Remediate	IT Infrastructure & Service Desk Process and Product Owner Implementation Team
	Mitigate	
	Accept risk	
Reassess	Rescan and Validate	IT Security
Improve	Eliminate Underlying Issues	IT Security Process/ Product Owner IT Infrastructure & Service Desk Vendor Management Privacy Office
	Evaluate Metrics	



IT SECURITY ROADMAP (2021 - 24)



QUESTIONS

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 13th, 2023**

Subject: **Finance Report – August 2023**

Executive Summary

- For the month ended August 31st, 2023, the Alliance had enrollment of 354,671 members, a Net Income of $2.3 million and 721% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$138,363	$277,095
Medical Expense	129,659	255,814
Admin. Expense	8,407	14,101
Other Inc. / (Exp.)	2,046	4,911
Net Income	**$2,343**	**$12,090**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal	$1,927	$11,065
Group Care	417	1,025
	$2,343	**$12,090**

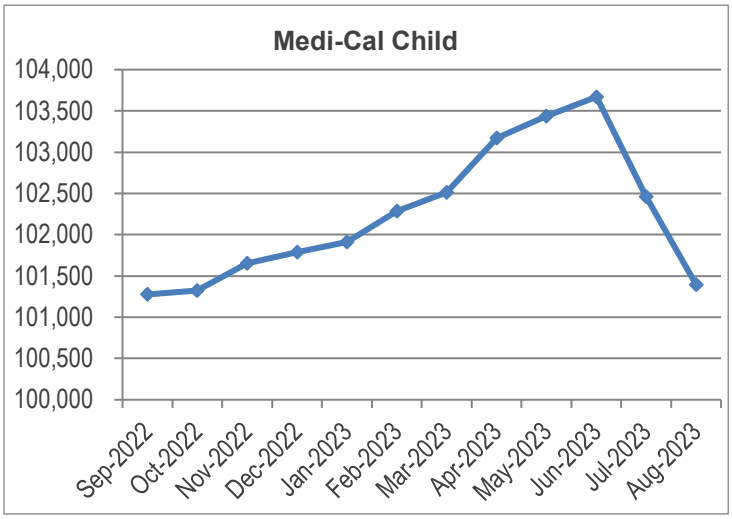
Enrollment

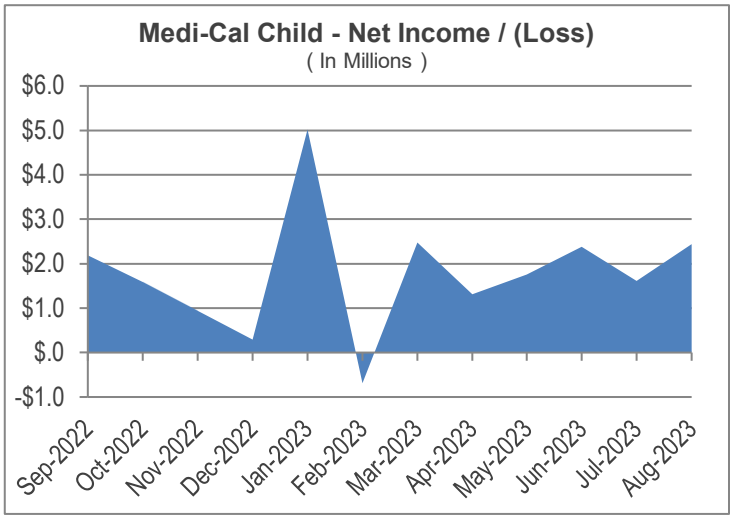
- Total enrollment decreased by 3,635 members since July 2023.
- Total enrollment decreased by 7,014 members since June 2023.

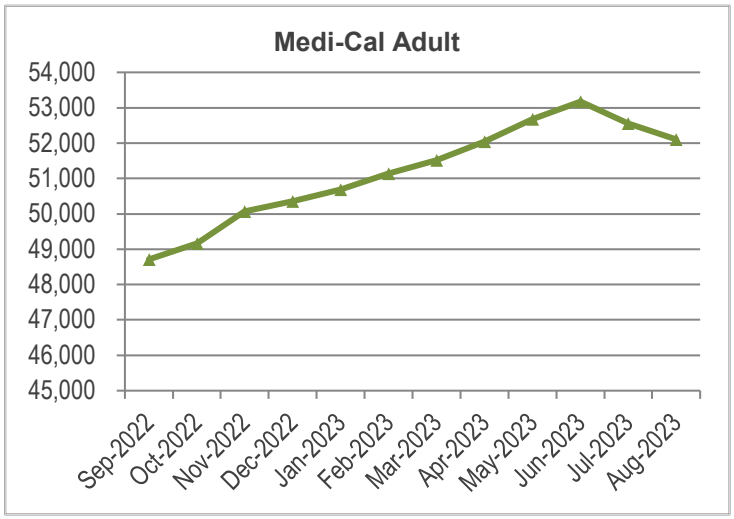
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

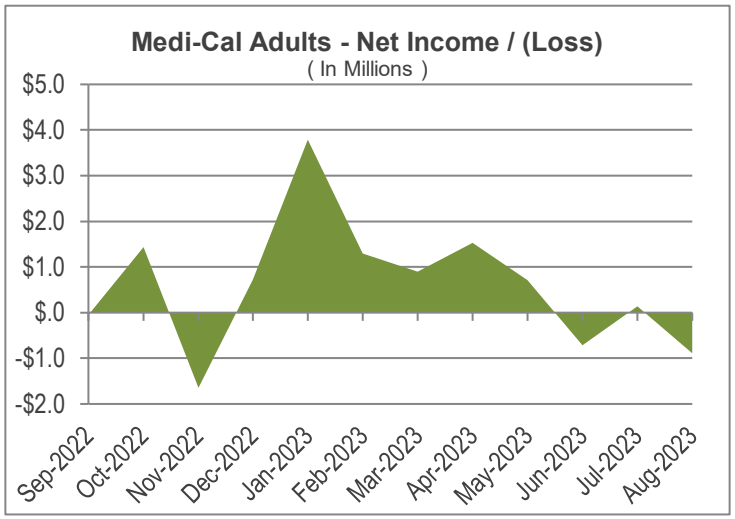
Enrollment					Member Months			
August 2023					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
52,102	50,776	1,326	2.6%	Adult	104,652	102,555	2,097	2.0%
101,393	103,088	(1,695)	-1.6%	Child	203,856	206,632	(2,776)	-1.3%
30,840	31,353	(513)	-1.6%	SPD	61,895	62,688	(793)	-1.3%
41,715	42,304	(589)	-1.4%	Duals	83,403	84,608	(1,205)	-1.4%
121,819	120,204	1,615	1.3%	ACA OE	245,526	243,352	2,174	0.9%
138	145	(7)	-4.8%	LTC	279	290	(11)	-3.8%
1,019	983	36	3.7%	LTC Duals	2,052	1,966	86	4.4%
349,026	**348,853**	**173**	**0.0%**	**Medi-Cal Total**	**701,663**	**702,091**	**(428)**	**-0.1%**
5,645	5,669	(24)	-0.4%	Group Care	11,314	11,338	(24)	-0.2%
354,671	**354,522**	**149**	**0.0%**	**Total**	**712,977**	**713,429**	**(452)**	**-0.1%**

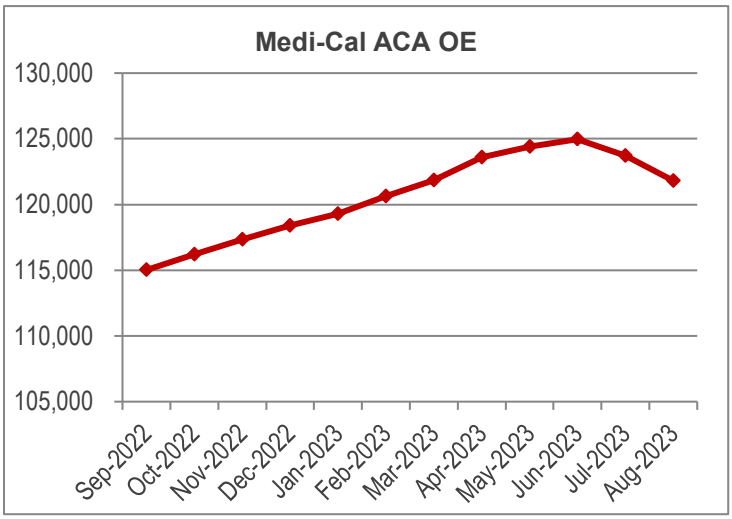
Enrollment and Profitability by Program and Category of Aid

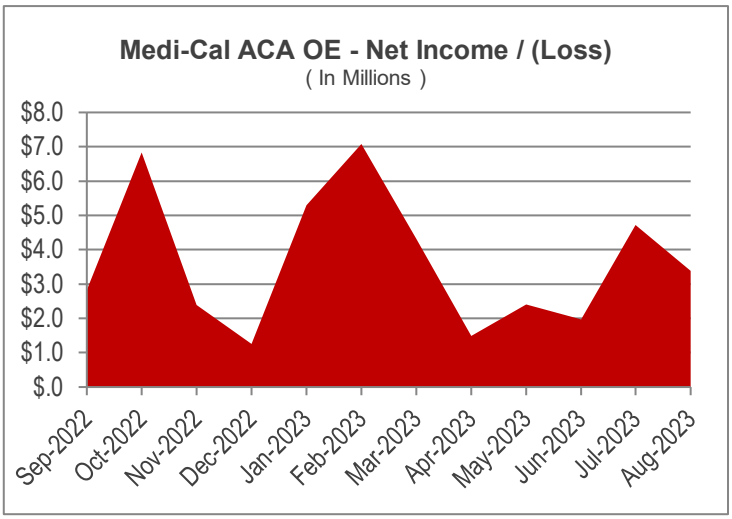




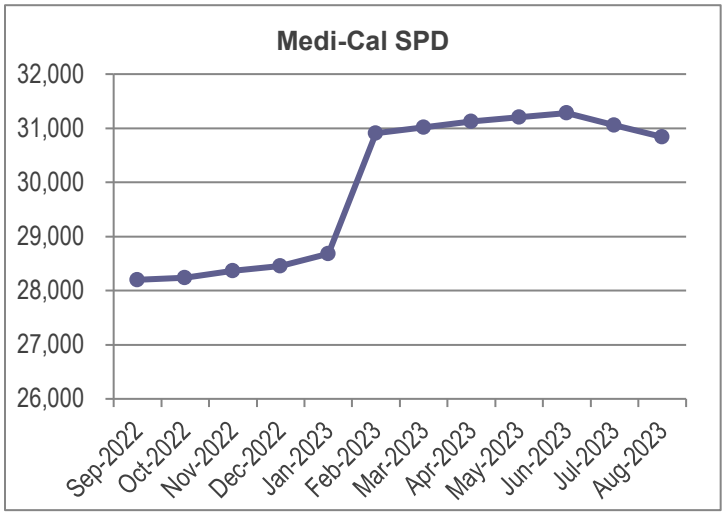


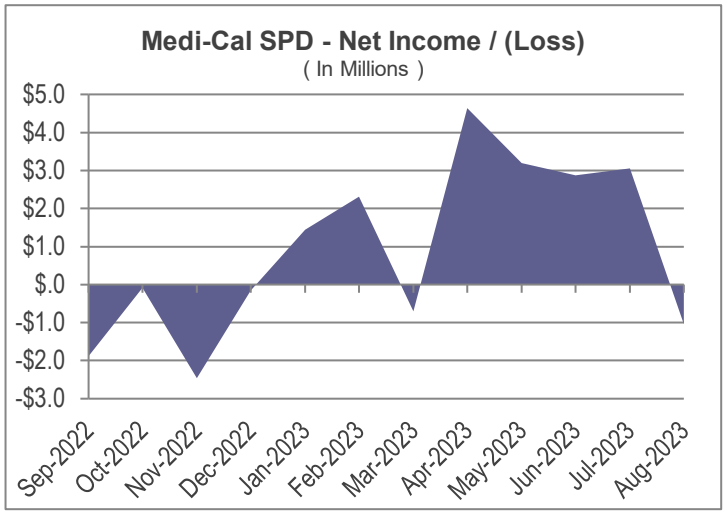


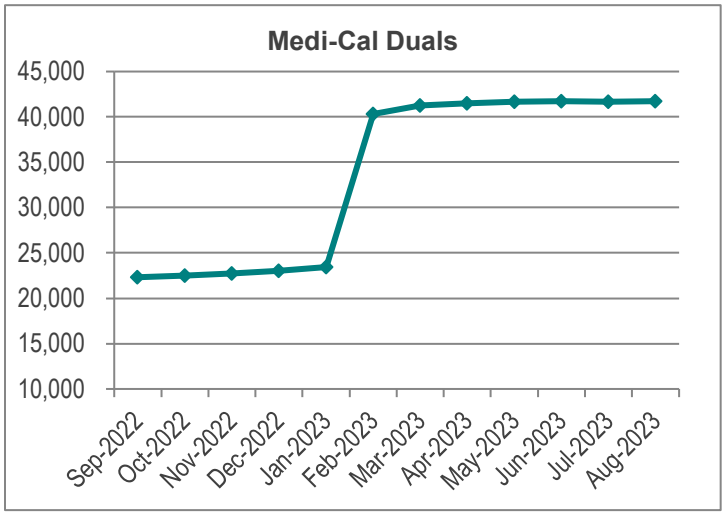


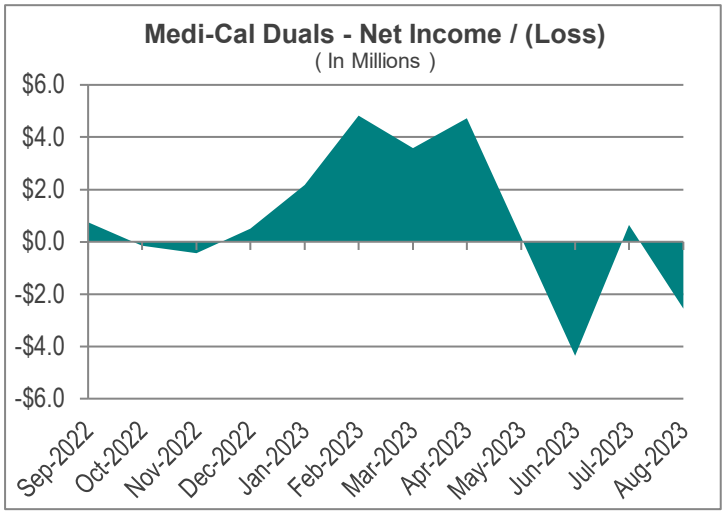


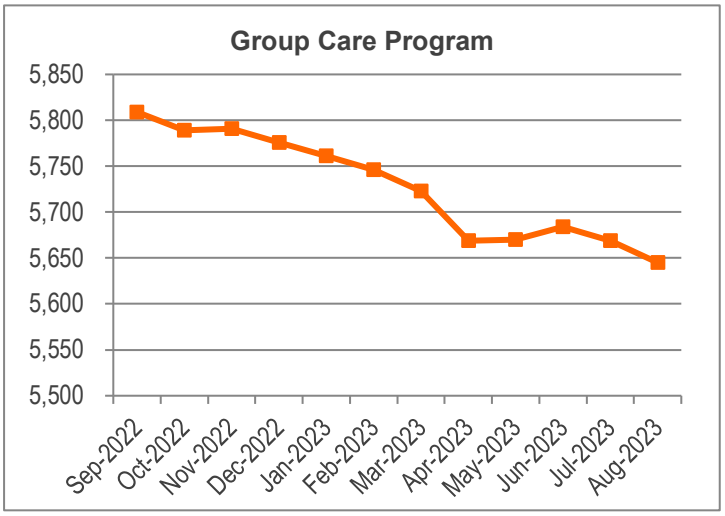
Enrollment and Profitability by Program and Category of Aid

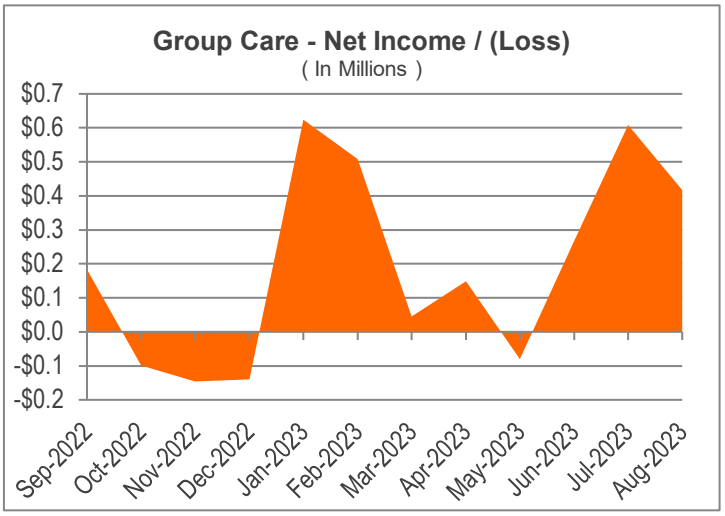




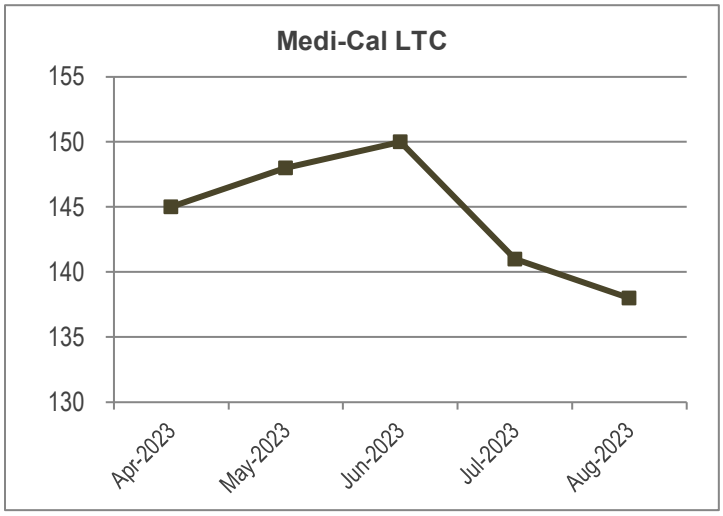


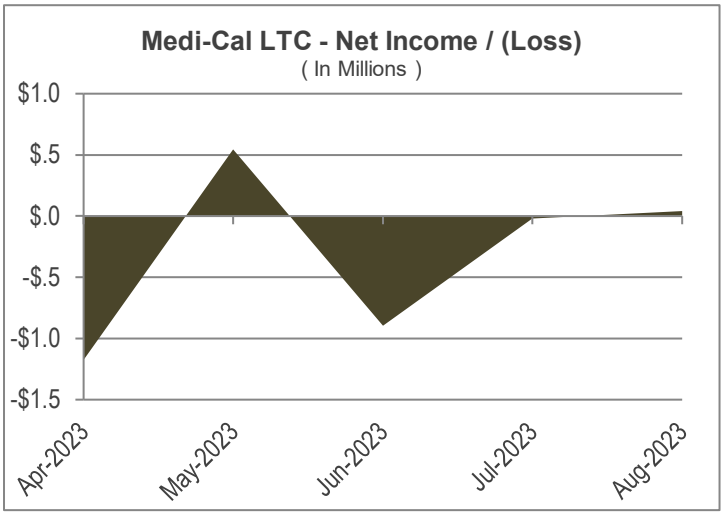


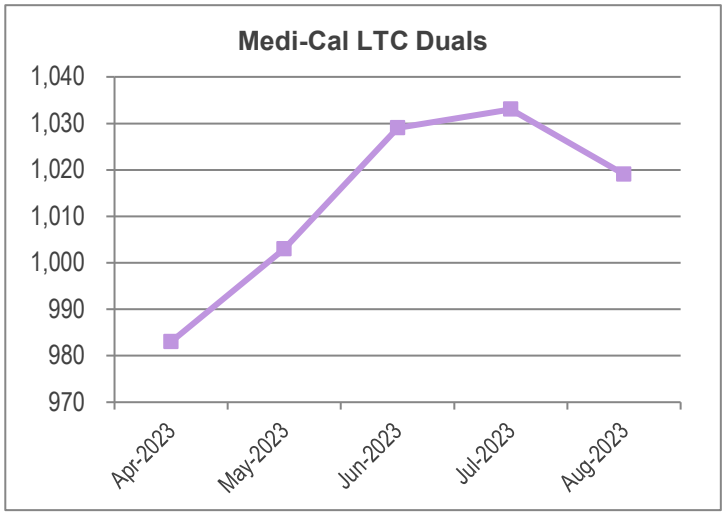


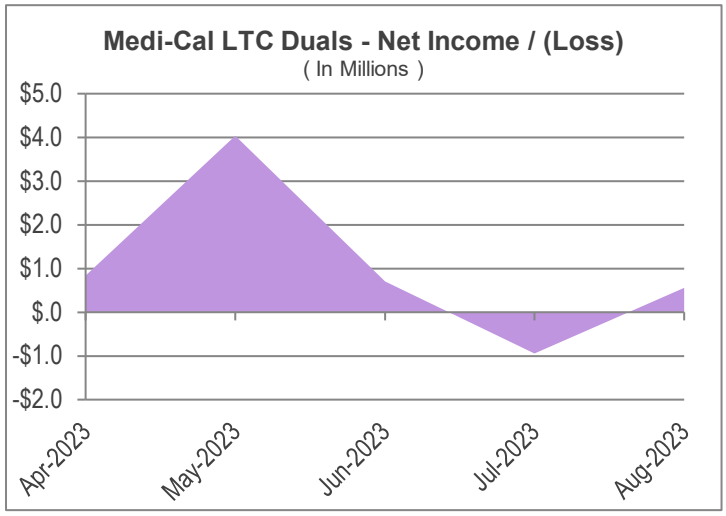


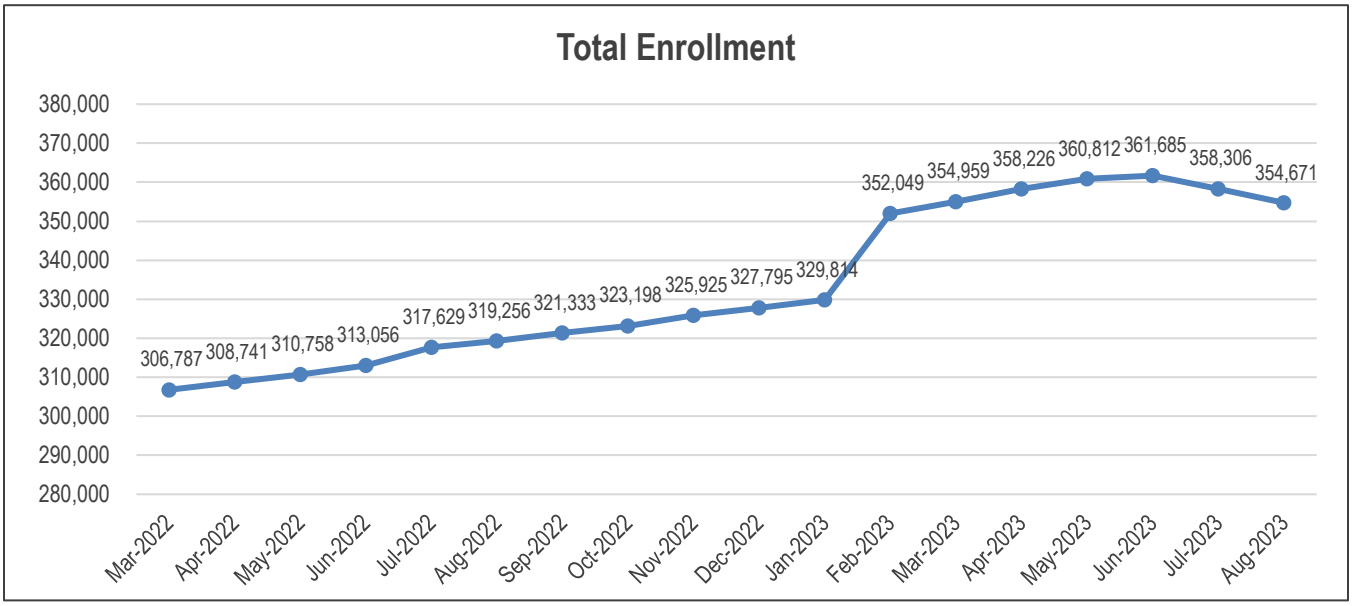
Enrollment and Profitability by Program and Category of Aid

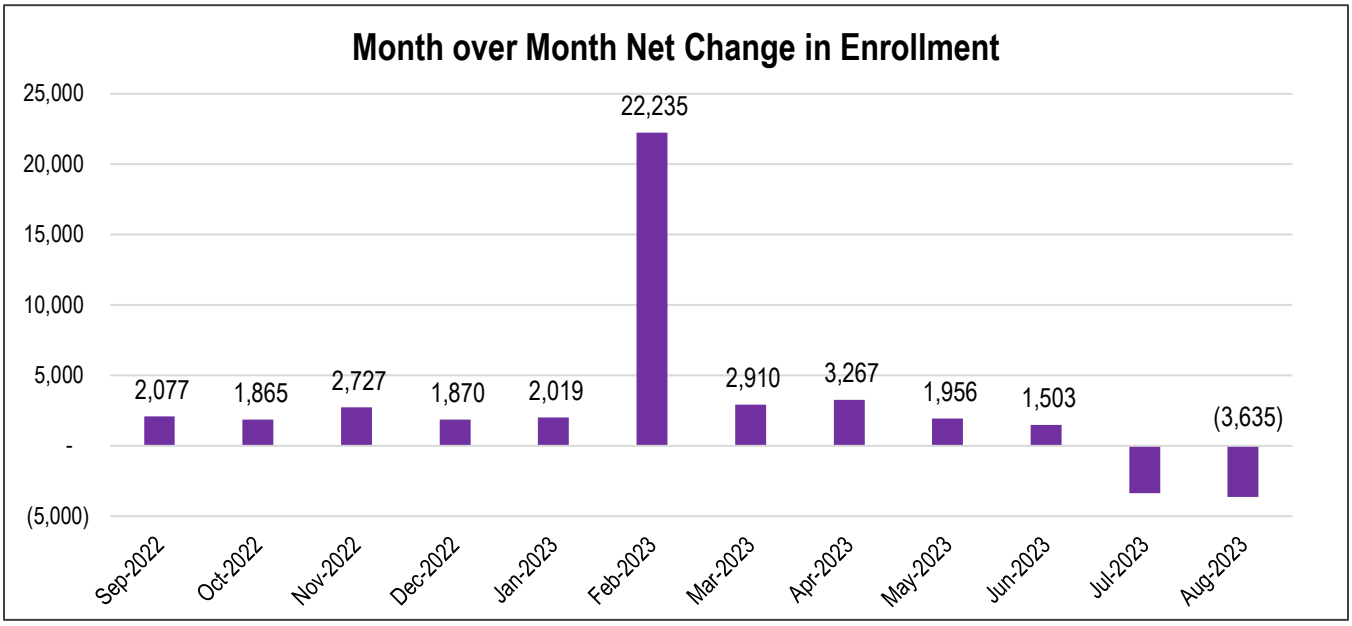










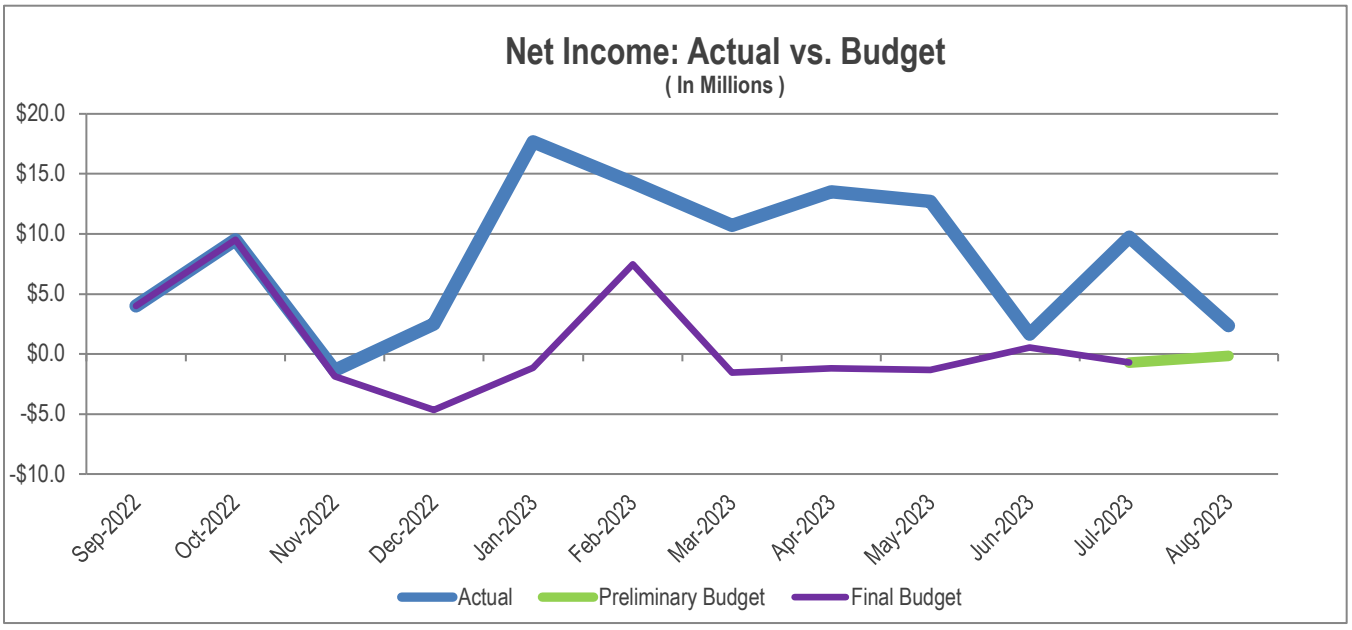


- The Public Health Emergency (PHE) ended May 2023. Disenrollments related to redetermination started in July 2023.

Net Income

- For the month ended August 31st, 2023
  - Actual Net Income $2.3 million.
  - Budgeted Net Loss $161,000.

- For the fiscal YTD ended August 31st, 2023
  - Actual Net Income $12.1 million.
  - Budgeted Net Loss $884,000.

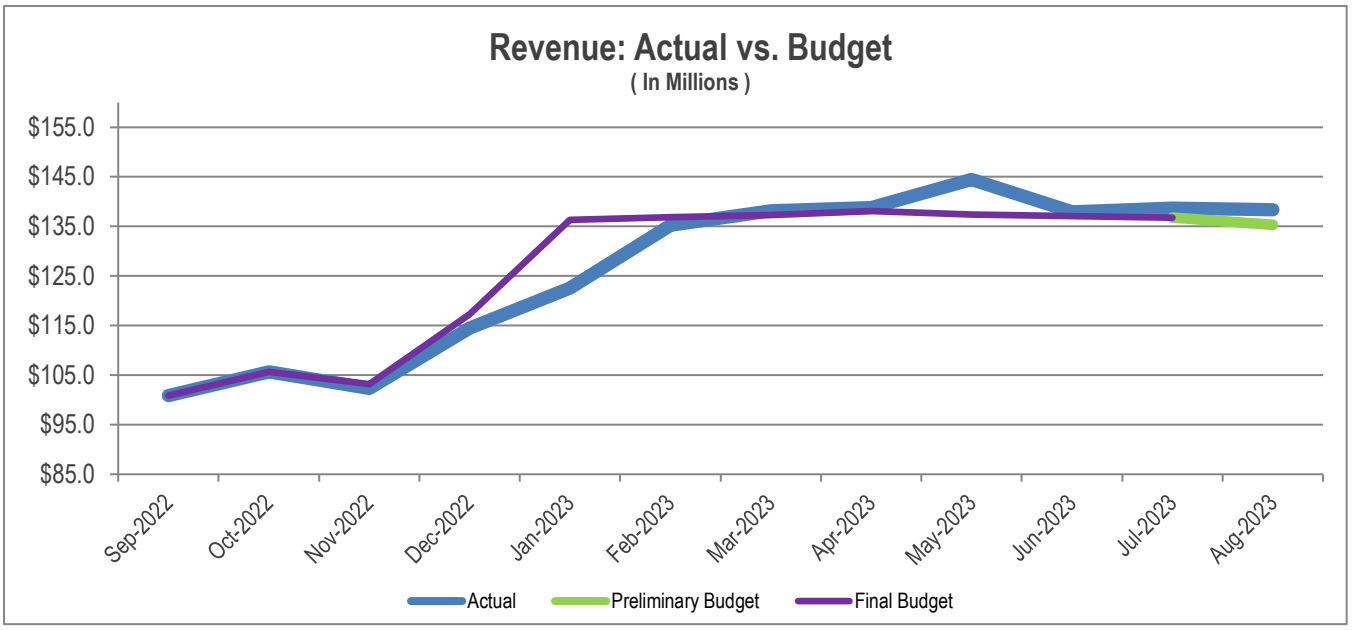


- The favorable variance of $2.5 million in the current month is primarily due to:
  - Favorable $3.0 million higher than anticipated Revenue.
  - Favorable $1.3 million higher than anticipated Net Other Income/Expense.
  - Unfavorable $1.3 million higher than anticipated Administrative Expense.
  - Unfavorable $533,000 higher than anticipated Medical Expense.

Revenue

- For the month ended August 31st, 2023
  - Actual Revenue: $138.4 million.
  - Budgeted Revenue: $135.3 million.

- For the fiscal YTD ended August 31st, 2023
  - Actual Revenue: $277.1 million.
  - Budgeted Revenue: $272.1 million.

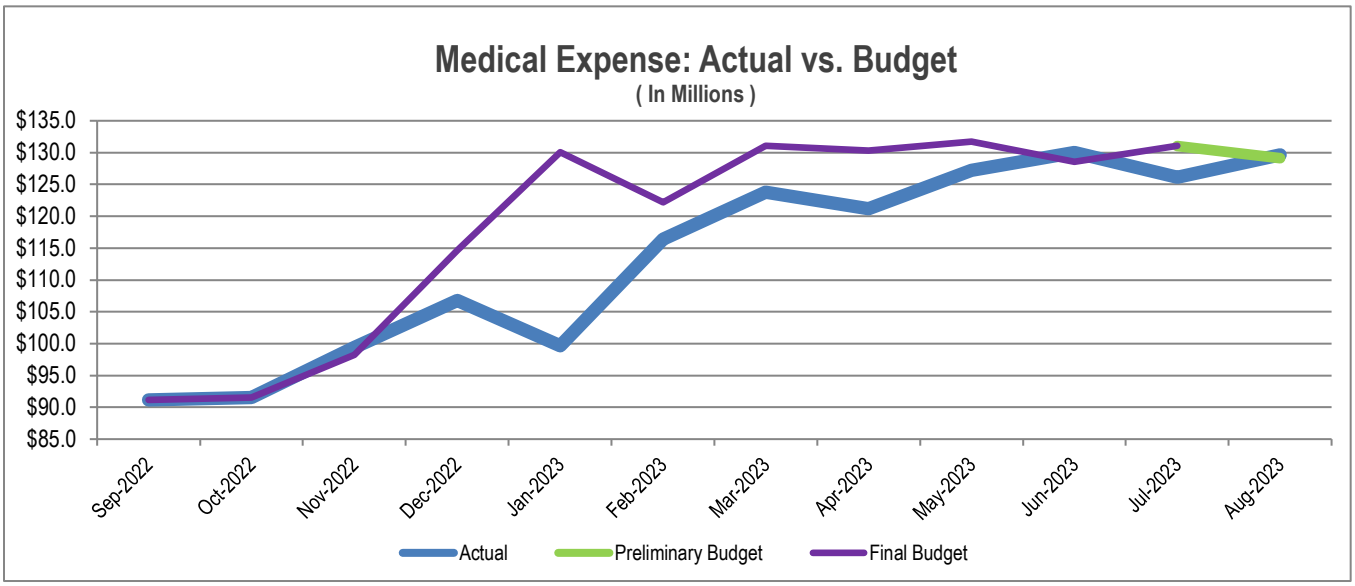


- For the month ended August 31st, 2023, the favorable revenue variance of $3.0 million is primarily due to rates being received from DHCS after the budget was finalized:
  - Favorable $2.1 million CalAIM Incentive Program revenue (IPP, HHIP, and SBHIP). The majority of this revenue has corresponding CalAIM Incentive expenses.
  - Favorable $908,000 capitation revenue due to higher proportion of members with higher rates and enrollment variance.

Medical Expense

- For the month ended August 31st, 2023
  - Actual Medical Expense: $129.7 million.
  - Budgeted Medical Expense: $129.1 million.

- For the fiscal YTD ended August 31st, 2023
  - Actual Medical Expense: $255.8 million.
  - Budgeted Medical Expense: $260.2 million.



- Reported financial results include medical expense, which contains estimates for Incurred-But-Not-Paid (IBNP) claims. Calculation of monthly IBNP is based on historical trends and claims payment. The Alliance's IBNP reserves are reviewed by our Actuarial Consultants.

- For August, updates to Fee-For-Service (FFS) increased the estimate for prior period unpaid Medical Expenses by $6.1 million. Year to date, the estimate for prior years increased by $5.7 million (per table below).

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

	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$51,674,040	$0	$51,674,040	$52,985,751	$1,311,711	2.5%
Primary Care FFS	$11,547,144	$58,704	$11,605,849	$10,487,847	($1,059,297)	-10.1%
Specialty Care FFS	$10,276,511	($438,653)	$9,837,859	$11,312,222	$1,035,710	9.2%
Outpatient FFS	$16,008,370	$594,574	$16,602,944	$17,014,201	$1,005,831	5.9%
Ancillary FFS	$21,136,131	$2,298,502	$23,434,633	$24,431,468	$3,295,337	13.5%
Pharmacy FFS	$16,576,675	($684,415)	$15,892,259	$18,100,502	$1,523,827	8.4%
ER Services FFS	$10,403,043	$255,982	$10,659,025	$12,259,427	$1,856,384	15.1%
Inpatient Hospital & SNF FFS	$64,361,399	$4,430,701	$68,792,100	$71,390,500	$7,029,101	9.8%
Long Term Care FFS	$39,102,308	($794,954)	$38,307,354	$31,156,015	($7,946,293)	-25.5%
Other Benefits & Services	$8,577,618	$0	$8,577,618	$10,480,828	$1,903,210	18.2%
Net Reinsurance	$430,690	$0	$430,690	$536,972	$106,282	19.8%
	$250,093,930	**$5,720,441**	**$255,814,371**	**$260,155,733**	**$10,061,803**	**3.9%**

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

Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

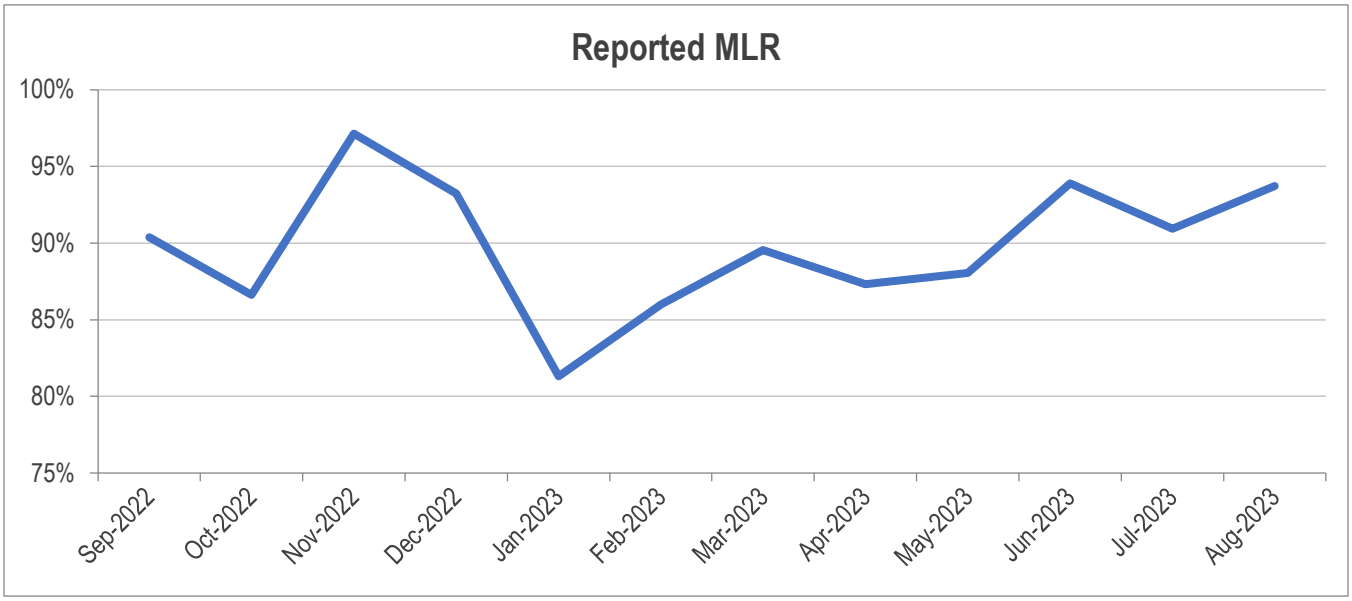
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$72.48	$0.00	$72.48	$74.27	$1.79	2.4%
Primary Care FFS	$16.20	$0.08	$16.28	$14.70	($1.50)	-10.2%
Specialty Care FFS	$14.41	($0.62)	$13.80	$15.86	$1.44	9.1%
Outpatient FFS	$22.45	$0.83	$23.29	$23.85	$1.40	5.9%
Ancillary FFS	$29.64	$3.22	$32.87	$34.25	$4.60	13.4%
Pharmacy FFS	$23.25	($0.96)	$22.29	$25.37	$2.12	8.4%
ER Services FFS	$14.59	$0.36	$14.95	$17.18	$2.59	15.1%
Inpatient Hospital & SNF FFS	$90.27	$6.21	$96.49	$100.07	$9.80	9.8%
Long Term Care FFS	$54.84	($1.11)	$53.73	$43.67	($11.17)	-25.6%
Other Benefits & Services	$12.03	$0.00	$12.03	$14.69	$2.66	18.1%
Net Reinsurance	$0.60	$0.00	$0.60	$0.75	$0.15	19.7%
	$350.77	**$8.02**	**$358.80**	**$364.66**	**$13.88**	**3.8%**

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $10.1 million favorable to budget. On a PMPM basis, medical expense is 3.8% favorable to budget. For per-member-per-month expense:
    - Capitated Expense is slightly under budget, largely driven by favorable FQHC expense, partially offset by unfavorable Global Subcontractor rates, due to delay in contract amendment to increase rates.
    - Primary Care Expense is unfavorable compared to budget across all populations driven generally by unfavorable unit cost.
    - Specialty Care expenses are below budget, favorable across all populations except for Group Care generally driven by favorable utilization.
    - Outpatient Expense is under budget generally due to favorable dialysis, facility other, lab and radiology unit cost and utilization in the Duals category of aid.
    - Ancillary Expense is under budget mostly due to favorable unit cost in the SPD, ACA OE and Dual categories of aid.
    - Pharmacy Expense is under budget mostly due to favorable Non-PBM expense driven by favorable utilization for SPDs, Adults, ACA OE and Duals.
    - Emergency Room Expense is under budget driven by favorable unit cost in the SPD, ACA OE, Child and Dual categories of aid.
    - Inpatient Expense is under budget mostly driven by favorable utilization in the SPD, LTC Duals, Child and Duals categories of aid offset by unfavorable utilization in the Adult category of aid.
    - Long Term Care expense is over budget mostly due to utilization for ACA OEs and Duals enrollees and unfavorable LTC Dual unit cost.

- Other Benefits & Services is under budget, due to favorable Cal AIM Incentive, community relations and other purchased services expense.
- Net Reinsurance year-to-date is favorable because more recoveries were received than budgeted.

Medical Loss Ratio (MLR)

The Medical Loss Ratio (total reported medical expense divided by operating revenue) was 93.7% for the month and 92.3% for the fiscal year-to-date.



Administrative Expense

- For the month ended August 31st, 2023
  - Actual Administrative Expense: $8.4 million.
  - Budgeted Administrative Expense: $7.1 million.

- For the fiscal YTD ended August 31st, 2023
  - Actual Administrative Expense: $14.1 million.
  - Budgeted Administrative Expense: $14.4 million.

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

Month					Year-to-Date			
Actual	Budget	Variance $	Variance %		Actual	Budget	Variance $	Variance %
$4,835,744	$4,258,546	($577,198)	-13.6%	Employee Expense	$8,966,061	$8,323,063	($642,998)	-7.7%
877,102	52,140	(824,962)	-1,582.2%	Medical Benefits Admin Expense	938,454	104,652	(833,802)	-796.7%
1,250,968	1,367,906	116,938	8.5%	Purchased & Professional Services	2,008,135	2,831,438	823,303	29.1%
1,443,301	1,459,217	15,916	1.1%	Other Admin Expense	2,188,837	3,141,183	952,346	30.3%
$8,407,115	$7,137,809	($1,269,305)	-17.8%	Total Administrative Expense	$14,101,487	$14,400,336	$298,849	2.1%

The year-to-date variances include:

- Delayed timing of start dates for Consulting for new projects and Computer Support Services.
- Unfavorable Employee Expense primarily driven by retroactive July 2023 merit salary increases paid in August 2023.
- Unfavorable Medical Benefits Admin Expense caused by unfavorable $818,000 unbudgeted Behavioral Health Administrative fees relating to the termination of third-party behavioral health service provider.

The Administrative Loss Ratio (ALR) is 6.1% of net revenue for the month and 5.1% of net revenue year-to-date.

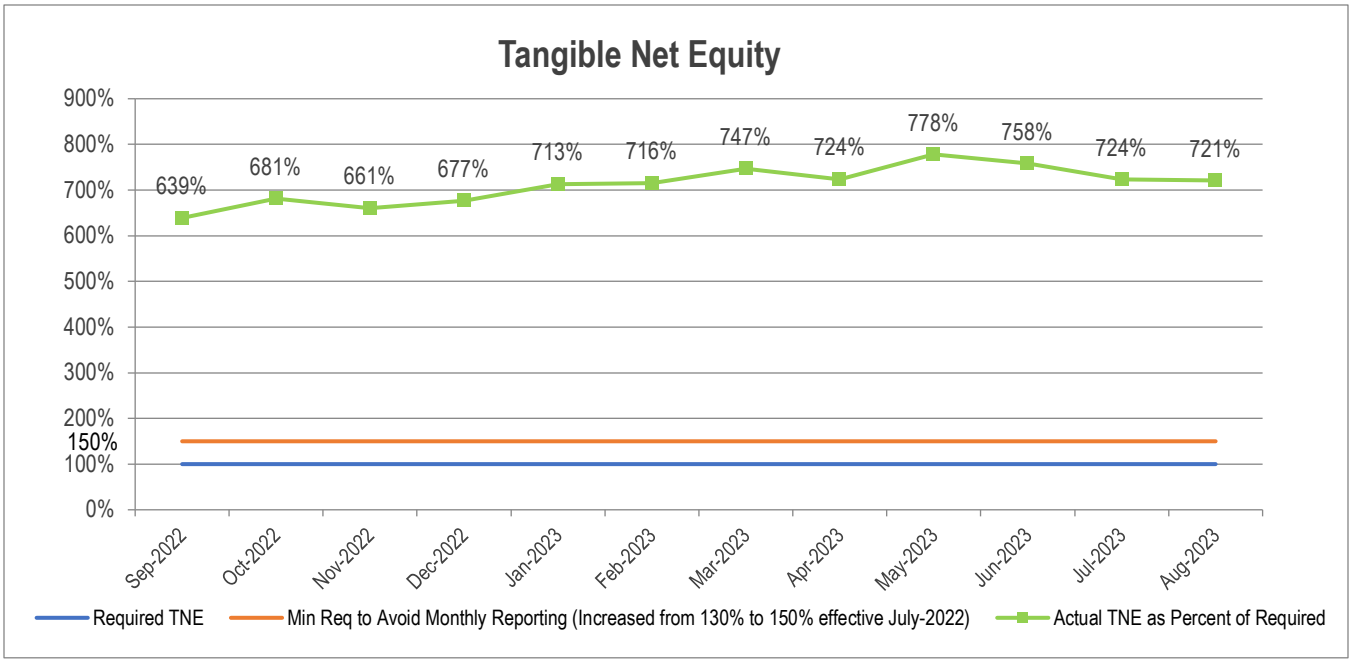
Other Income / (Expense)

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

- Fiscal year-to-date net investments show a gain of $5.1 million.
- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $141,000.

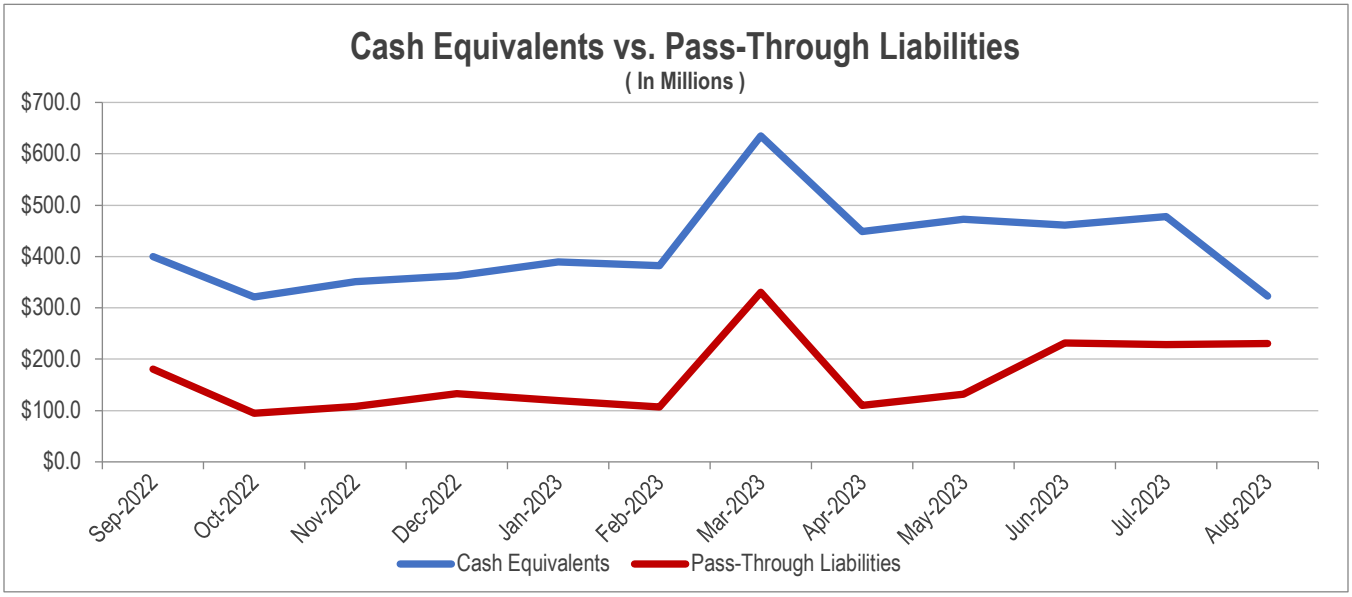
Tangible Net Equity (TNE)

- 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 $46.7 million
    - Actual TNE $336.8 million
    - Excess TNE $290.1 million
    - TNE % of Required TNE 721%



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

- Key Metrics
  - Cash & Cash Equivalents $323.4 million
  - Pass-Through Liabilities $230.6 million
  - Uncommitted Cash $92.8 million
  - Working Capital $317.2 million
  - Current Ratio 1.70 (regulatory minimum is 1.00)



Capital Investment

- Fiscal year-to-date capital assets acquired: $433,000
- Annual capital budget: $1.5 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 (MEDICAL EXPENSE BY PAYMENT TYPE)
COMBINED BASIS (RESTRICTED & UNRESTRICTED FUNDS)
FOR THE MONTH AND FISCAL YTD ENDED AUGUST 31, 2023

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				MEMBERSHIP				
349,026	348,853	173	0.0%	1 - Medi-Cal	701,663	702,091	(428)	(0.1%)
5,645	5,669	(24)	(0.4%)	2 - GroupCare	11,314	11,338	(24)	(0.2%)
354,671	**354,522**	**149**	**0.0%**	**3 - TOTAL MEMBER MONTHS**	**712,977**	**713,429**	**(452)**	**(0.1%)**
				REVENUE				
$138,362,991	**$135,332,362**	**$3,030,629**	**2.2%**	**4 - TOTAL REVENUE**	**$277,094,836**	**$272,132,304**	**$4,962,532**	**1.8%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses:				
$25,799,174	$26,318,063	$518,889	2.0%	5 - Capitated Medical Expense	$51,674,040	$52,985,751	$1,311,711	2.5%
				Fee for Service Medical Expenses:				
$34,478,181	$35,535,600	$1,057,418	3.0%	6 - Inpatient Hospital FFS Expense	$68,792,100	$71,390,500	$2,598,400	3.6%
$6,360,497	$5,210,372	($1,150,125)	(22.1%)	7 - Primary Care Physician FFS Expense	$11,605,849	$10,487,847	($1,118,001)	(10.7%)
$5,398,152	$5,633,977	$235,824	4.2%	8 - Specialty Care Physician Expense	$9,837,859	$11,312,222	$1,474,363	13.0%
$11,296,237	$12,216,404	$920,167	7.5%	9 - Ancillary Medical Expense	$23,434,633	$24,431,468	$996,835	4.1%
$8,529,377	$8,472,992	($56,386)	(0.7%)	10 - Outpatient Medical Expense	$16,602,944	$17,014,201	$411,257	2.4%
$5,532,850	$6,103,611	$570,761	9.4%	11 - Emergency Expense	$10,659,025	$12,259,427	$1,600,402	13.1%
$8,355,007	$9,017,372	$662,365	7.3%	12 - Pharmacy Expense	$15,892,259	$18,100,502	$2,208,242	12.2%
$19,765,589	$15,589,520	($4,176,068)	(26.8%)	13 - Long Term Care FFS Expense	$38,307,354	$31,156,015	($7,151,339)	(23.0%)
$99,715,891	$97,779,847	($1,936,044)	(2.0%)	14 - Total Fee for Service Expense	$195,132,023	$196,152,182	$1,020,159	0.5%
$3,926,458	$4,760,530	$834,072	17.5%	15 - Other Benefits & Services	$8,577,618	$10,480,828	$1,903,210	18.2%
$217,259	$266,926	$49,667	18.6%	16 - Reinsurance Expense	$430,690	$536,972	$106,282	19.8%
$129,658,782	**$129,125,366**	**($533,416)**	**(0.4%)**	**17 - TOTAL MEDICAL EXPENSES**	**$255,814,371**	**$260,155,733**	**$4,341,362**	**1.7%**
$8,704,209	**$6,206,996**	**$2,497,214**	**40.2%**	**18- GROSS MARGIN**	**$21,280,465**	**$11,976,571**	**$9,303,894**	**77.7%**
				ADMINISTRATIVE EXPENSES				
$4,835,744	$4,258,546	($577,198)	(13.6%)	19 - Personnel Expense	$8,966,061	$8,323,063	($642,998)	(7.7%)
$877,102	$52,140	($824,962)	(1,582.2%)	20 - Benefits Administration Expense	$938,454	$104,652	($833,802)	(796.7%)
$1,250,968	$1,367,906	$116,938	8.5%	21 - Purchased & Professional Services	$2,008,135	$2,831,438	$823,303	29.1%
$1,443,301	$1,459,217	$15,916	1.1%	22 - Other Administrative Expense	$2,188,837	$3,141,182	$952,346	30.3%
$8,407,115	**$7,137,809**	**($1,269,305)**	**(17.8%)**	**23 - TOTAL ADMINISTRATIVE EXPENSES**	**$14,101,487**	**$14,400,336**	**$298,849**	**2.1%**
$297,095	**($930,814)**	**$1,227,909**	**131.9%**	**24 - NET OPERATING INCOME / (LOSS)**	**$7,178,978**	**($2,423,765)**	**$9,602,743**	**396.2%**
				OTHER INCOME / EXPENSE				
$2,046,366	**$770,000**	**$1,276,366**	**165.8%**	**25 - TOTAL OTHER INCOME / (EXPENSES)**	**$4,911,416**	**$1,540,000**	**$3,371,416**	**218.9%**
$2,343,460	**($160,814)**	**$2,504,274**	**1,557.3%**	**26 - NET INCOME / (LOSS)**	**$12,090,394**	**($883,765)**	**$12,974,159**	**1,468.1%**
6.1%	**5.3%**	**-0.8%**	**-15.1%**	**27 - ADMIN EXP % REVENUE**	**5.1%**	**5.3%**	**0.2%**	**3.8%**

ALAMEDA ALLIANCE FOR HEALTH
BALANCE SHEETS
CURRENT MONTH VS. PRIOR MONTH
FOR THE MONTH AND FISCAL YTD ENDED August 31, 2023

	August	July	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	$4,648,471	$102,769,434	($98,120,962)	-95.48%
Short-Term Investments	318,754,308	374,685,277	(55,930,969)	-14.93%
Interest Receivable	545,674	480,923	64,751	13.46%
Other Receivables - Net	431,590,802	296,073,117	135,517,685	45.77%
Prepaid Expenses	5,211,393	4,787,550	423,843	8.85%
Prepaid Inventoried Items	88,105	19,870	68,235	343.40%
CalPERS Net Pension Asset	(5,286,448)	(5,286,448)	0	0.00%
Deferred CalPERS Outflow	14,099,056	14,099,056	0	0.00%
TOTAL CURRENT ASSETS	**$769,651,361**	**$787,628,779**	**($17,977,418)**	**-2.28%**
OTHER ASSETS:				
Long-Term Investments	9,319,265	11,580,343	(2,261,078)	-19.53%
Restricted Assets	350,000	350,000	0	0.00%
Lease Asset - Office Space (Net)	1,315,408	1,378,046	(62,638)	-4.55%
Lease Asset - Office Equipment (Net)	150,650	153,925	(3,275)	-2.13%
SBITA Asset-GASB 96 (Net)	5,822,694	6,071,830	(249,136)	-4.10%
TOTAL OTHER ASSETS	**$16,958,017**	**$19,534,144**	**($2,576,127)**	**-13.19%**
PROPERTY AND EQUIPMENT:				
Land, Building & Improvements	10,113,570	10,113,570	0	0.00%
Furniture And Equipment	12,288,567	11,855,077	433,489	3.66%
Leasehold Improvement	902,447	902,447	0	0.00%
Internally-Developed Software	14,824,002	14,824,002	0	0.00%
Fixed Assets at Cost	38,128,585	37,695,096	433,489	1.15%
Less: Accumulated Depreciation	(32,589,321)	(32,525,998)	(63,323)	0.19%
NET PROPERTY AND EQUIPMENT	**$5,539,264**	**$5,169,098**	**$370,166**	**7.16%**
TOTAL ASSETS	**$792,148,642**	**$812,332,020**	**($20,183,379)**	**-2.48%**
CURRENT LIABILITIES:				
Accounts Payable	1,123,528	1,383,068	(259,540)	-18.77%
Other Accrued Expenses	16,930,498	17,432,943	(502,445)	-2.88%
Interest Payable	101,145	84,896	16,249	19.14%
Pass-Through Liabilities	230,640,982	228,483,953	2,157,029	0.94%
Claims Payable	33,593,308	32,930,053	663,255	2.01%
IBNP Reserves	151,339,847	174,622,283	(23,282,436)	-13.33%
Payroll Liabilities	7,037,647	6,271,208	766,439	12.22%
CalPERS Deferred Inflow	5,004,985	5,004,985	0	0.00%
Risk Sharing	3,628,337	5,607,183	(1,978,846)	-35.29%
Provider Grants/ New Health Program	(11,640)	0	(11,640)	0.00%
ST Lease Liability - Office Space	830,487	824,245	6,243	0.76%
ST Lease Liability - Office Equipment	39,300	39,300	0	0.00%
SBITA ST Liability-GASB 96	2,177,736	2,202,863	(25,127)	-1.14%
TOTAL CURRENT LIABILITIES	**$452,436,160**	**$474,886,978**	**($22,450,818)**	**-4.73%**
LONG TERM LIABILITIES:				
LT Lease Liability - Office Space	670,878	743,624	(72,746)	-9.78%
LT Lease Liability - Office Equipment	111,350	114,625	(3,275)	-2.86%
SBITA LT Liability -GASB 96	2,090,597	2,090,597	0	0.00%
TOTAL LONG TERM LIABILITIES	**$2,872,825**	**$2,948,846**	**($76,021)**	**-2.58%**
TOTAL LIABILITIES	**$455,308,985**	**$477,835,824**	**($22,526,839)**	**-4.71%**
NET WORTH:				
Contributed Capital	840,233	840,233	0	0.00%
Restricted & Unrestricted Funds	323,909,030	323,909,030	0	0.00%
Year-to Date Net Income / (Loss)	12,090,394	9,746,933	2,343,460	24.04%
TOTAL NET WORTH	**$336,839,657**	**$334,496,196**	**$2,343,460**	**0.70%**
TOTAL LIABILITIES AND NET WORTH	**$792,148,642**	**$812,332,020**	**($20,183,379)**	**-2.48%**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 8/31/2023

PRELIMINARY

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$2,581,064	$7,772,771	$15,604,037	$5,173,101
Total	2,581,064	7,772,771	15,604,037	5,173,101
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	135,781,883	407,820,522	821,436,743	271,921,586
Allowance for Doubtful Accounts	0	0	0	0
Deferred Premium Revenue	0	0	0	0
Premium Receivable	(135,781,679)	(245,670,674)	(251,855,176)	(131,686,414)
Total	204	162,149,848	569,581,567	140,235,172
Investment & Other Income Cash Flows				
Other Revenue (Grants)	130,881	238,472	283,009	195,195
Investment Income	2,038,093	6,516,091	12,619,245	4,906,933
Interest Receivable	(64,751)	101,212	(125,852)	168,901
Total	2,104,223	6,855,775	12,776,402	5,271,029
Medical & Hospital Cash Flows				
Total Medical Expenses	(129,658,780)	(385,883,984)	(758,042,679)	(255,814,373)
Other Receivable	263,994	223,699	197,625	317,097
Claims Payable	663,255	(24,612,532)	(4,189,720)	(5,106,616)
IBNP Payable	(23,282,436)	(263,169)	5,921,355	(13,164,556)
Risk Share Payable	(1,978,846)	(1,991,582)	(1,963,603)	(1,978,846)
Health Program	(11,640)	(11,640)	(139,180)	(11,640)
Other Liabilities	0	0	0	(1)
Total	(154,004,453)	(412,539,208)	(758,216,202)	(275,758,935)
Administrative Cash Flows				
Total Administrative Expenses	(8,529,674)	(21,800,057)	(40,292,823)	(14,292,054)
Prepaid Expenses	(492,078)	1,640,117	830,604	(398,779)
CalPERS Pension Asset	0	0	0	0
CalPERS Deferred Outflow	0	0	0	0
Trade Accounts Payable	(761,421)	1,408,293	1,135,265	(71,398)
Other Accrued Liabilities	16,249	92,989	92,024	30,242
Payroll Liabilities	766,439	(1,899,448)	(612,623)	1,107,760
Net Lease Assets/Liabilities (Short term & Long term)	220,144	(1,567,234)	(1,567,999)	(342)
Depreciation Expense	63,323	165,167	362,274	112,197
Total	(8,717,018)	(21,960,173)	(40,053,278)	(13,512,374)
Interest Paid				
Debt Interest Expense	0	0	0	0
Total Cash Flows from Operating Activities	**(158,035,980)**	**(257,720,987)**	**(200,307,474)**	**(138,592,007)**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 8/31/2023

PRELIMINARY

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	2,261,078	9,305,244	15,932,505	2,241,271
	2,261,078	9,305,244	15,932,505	2,241,271
Restricted Cash & Other Asset Cash Flows				
Provider Pass-Thru-Liabilities	2,156,466	100,265,477	125,736,735	(1,198,417)
Restricted Cash	0	0	0	0
	2,156,466	100,265,477	125,736,735	(1,198,417)
Fixed Asset Cash Flows				
Depreciation expense	63,323	165,167	362,274	112,197
Fixed Asset Acquisitions	(433,489)	(433,489)	(547,559)	(433,489)
Change in A/D	(63,323)	(165,167)	(362,274)	(112,197)
	(433,489)	(433,489)	(547,559)	(433,489)
Total Cash Flows from Investing Activities	**3,984,055**	**109,137,232**	**141,121,681**	**609,365**
Financing Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Total Cash Flows	**(154,051,925)**	**(148,583,755)**	**(59,185,793)**	**(137,982,642)**
Rounding	(7)	1	(2)	6
Cash @ Beginning of Period	477,454,711	471,986,533	382,588,574	461,385,415
Cash @ End of Period	**$323,402,779**	**$323,402,779**	**$323,402,779**	**$323,402,779**
Difference (rounding)	0	0	0	0

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 8/31/2023

PRELIMINARY

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$2,343,460	$14,663,817	$51,607,532	$12,090,394
Add back: Depreciation	63,323	165,167	362,274	112,197
Receivables				
Premiums Receivable	(135,781,679)	(245,670,674)	(251,855,176)	(131,686,414)
First Care Receivable	0	0	0	0
Family Care Receivable	0	0	0	0
Healthy Kids Receivable	0	0	0	0
Interest Receivable	(64,751)	101,212	(125,852)	168,901
Other Receivable	263,994	223,699	197,625	317,097
FQHC Receivable	0	0	0	0
Allowance for Doubtful Accounts	0	0	0	0
Total	(135,582,436)	(245,345,763)	(251,783,403)	(131,200,416)
Prepaid Expenses	(492,078)	1,640,117	830,604	(398,779)
Trade Payables	(761,421)	1,408,293	1,135,265	(71,398)
Claims Payable, IBNR & Risk Share				
IBNP	(23,282,436)	(263,169)	5,921,355	(13,164,556)
Claims Payable	663,255	(24,612,532)	(4,189,720)	(5,106,616)
Risk Share Payable	(1,978,846)	(1,991,582)	(1,963,603)	(1,978,846)
Other Liabilities	0	0	0	(1)
Total	(24,598,027)	(26,867,283)	(231,968)	(20,250,019)
Unearned Revenue				
Total	0	0	0	0
Other Liabilities				
Accrued Expenses	16,249	92,989	92,024	30,242
Payroll Liabilities	766,439	(1,899,448)	(612,623)	1,107,760
Net Lease Assets/Liabilities (Short term & Long term)	220,144	(1,567,234)	(1,567,999)	(342)
Health Program	(11,640)	(11,640)	(139,180)	(11,640)
Accrued Sub Debt Interest	0	0	0	0
Total Change in Other Liabilities	991,192	(3,385,333)	(2,227,778)	1,126,020
Cash Flows from Operating Activities	**($158,035,987)**	**($257,720,985)**	**($200,307,474)**	**($138,592,001)**
Difference (rounding)	(7)	2	0	6

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 8/31/2023

PRELIMINARY

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received From:				
Capitation Received from State of CA	$204	$162,149,848	$569,581,567	$140,235,172
Commercial Premium Revenue	2,581,064	7,772,771	15,604,037	5,173,101
Other Income	130,881	238,472	283,009	195,195
Investment Income	1,973,342	6,617,303	12,493,393	5,075,834
Cash Paid To:				
Medical Expenses	(154,004,453)	(412,539,208)	(758,216,202)	(275,758,935)
Vendor & Employee Expenses	(8,717,018)	(21,960,173)	(40,053,278)	(13,512,374)
Interest Paid	0	0	0	0
Net Cash Provided By (Used In) Operating Activities	(158,035,980)	(257,720,987)	(200,307,474)	(138,592,007)
Cash Flows from Financing Activities:				
Purchases of Fixed Assets	(433,489)	(433,489)	(547,559)	(433,489)
Net Cash Provided By (Used In) Financing Activities	(433,489)	(433,489)	(547,559)	(433,489)
Cash Flows from Investing Activities:				
Changes in Investments	2,261,078	9,305,244	15,932,505	2,241,271
Restricted Cash	2,156,466	100,265,477	125,736,735	(1,198,417)
Net Cash Provided By (Used In) Investing Activities	4,417,544	109,570,721	141,669,240	1,042,854
Financial Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Net Change in Cash	**(154,051,925)**	**(148,583,755)**	**(59,185,793)**	**(137,982,642)**
Cash @ Beginning of Period	477,454,711	471,986,533	382,588,574	461,385,415
Subtotal	$323,402,786	$323,402,778	$323,402,781	$323,402,773
Rounding	(7)	1	(2)	6
Cash @ End of Period	**$323,402,779**	**$323,402,779**	**$323,402,779**	**$323,402,779**
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	$2,343,460	$14,663,817	$51,607,532	$12,090,394
Depreciation	63,323	165,167	362,274	112,197
Net Change in Operating Assets & Liabilities:				
Premium & Other Receivables	(135,582,436)	(245,345,763)	(251,783,403)	(131,200,416)
Prepaid Expenses	(492,078)	1,640,117	830,604	(398,779)
Trade Payables	(761,421)	1,408,293	1,135,265	(71,398)
Claims payable & IBNP	(24,598,027)	(26,867,283)	(231,968)	(20,250,019)
Deferred Revenue	0	0	0	0
Accrued Interest	0	0	0	0
Other Liabilities	991,192	(3,385,333)	(2,227,778)	1,126,020
Subtotal	(158,035,987)	(257,720,985)	(200,307,474)	(138,592,001)
Rounding	7	(2)	0	(6)
Cash Flows from Operating Activities	**($158,035,980)**	**($257,720,987)**	**($200,307,474)**	**($138,592,007)**
Rounding Difference	7	(2)	0	(6)

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF AUGUST 2023

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments	101,393	52,102	30,840	121,819	41,715	138	1,019	349,026	5,645	-	354,671
Net Revenue	$13,476,712	$17,030,749	$36,020,960	$47,378,413	$12,120,951	$1,480,248	$8,273,896	$135,781,928	$2,581,063	$0	$138,362,991
Medical Expense	$10,466,537	$17,226,976	$35,183,981	$41,981,826	$14,053,646	$1,362,445	$7,357,632	$127,633,044	$2,025,738	$0	$129,658,782
Gross Margin	$3,010,175	($196,227)	$836,979	$5,396,586	($1,932,695)	$117,802	$916,264	$8,148,884	$555,326	$0	$8,704,209
Administrative Expense	$686,875	$902,710	$2,519,816	$2,659,721	$833,582	$105,709	$502,925	$8,211,339	$175,776	$20,000	$8,407,115
Operating Income / (Expense)	$2,323,301	($1,098,937)	($1,682,838)	$2,736,865	($2,766,277)	$12,093	$413,339	($62,455)	$379,550	($20,000)	$297,095
Other Income / (Expense)	$121,826	$212,200	$645,717	$648,985	$205,153	$30,472	$144,829	$2,009,182	$37,184	$0	$2,046,366
Net Income / (Loss)	$2,445,126	($886,737)	($1,037,120)	$3,385,850	($2,561,125)	$42,565	$558,168	$1,946,727	$416,734	($20,000)	$2,343,460
PMPM Metrics:											
Revenue PMPM	$132.92	$326.87	$1,167.99	$388.92	$290.57	$10,726.43	$8,119.62	$389.03	$457.23	$0.00	$390.12
Medical Expense PMPM	$103.23	$330.64	$1,140.86	$344.62	$336.90	$9,872.79	$7,220.44	$365.68	$358.86	$0.00	$365.57
Gross Margin PMPM	$29.69	($3.77)	$27.14	$44.30	($46.33)	$853.64	$899.18	$23.35	$98.37	$0.00	$24.54
Administrative Expense PMPM	$6.77	$17.33	$81.71	$21.83	$19.98	$766.01	$493.55	$23.53	$31.14	$0.00	$23.70
Operating Income / (Expense) PMPM	$22.91	($21.09)	($54.57)	$22.47	($66.31)	$87.63	$405.63	($0.18)	$67.24	$0.00	$0.84
Other Income / (Expense) PMPM	$1.20	$4.07	$20.94	$5.33	$4.92	$220.81	$142.13	$5.76	$6.59	$0.00	$5.77
Net Income / (Loss) PMPM	$24.12	($17.02)	($33.63)	$27.79	($61.40)	$308.44	$547.76	$5.58	$73.82	$0.00	$6.61
Ratio:											
Medical Loss Ratio	77.7%	101.2%	97.7%	88.6%	115.9%	92.0%	88.9%	94.0%	78.5%	0.0%	93.7%
Gross Margin Ratio	22.3%	-1.2%	2.3%	11.4%	-15.9%	8.0%	11.1%	6.0%	21.5%	0.0%	6.3%
Administrative Expense Ratio	5.1%	5.3%	7.0%	5.6%	6.9%	7.1%	6.1%	6.0%	6.8%	0.0%	6.1%
Net Income Ratio	18.1%	-5.2%	-2.9%	7.1%	-21.1%	2.9%	6.7%	1.4%	16.1%	0.0%	1.7%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE AUGUST 2023

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	203,856	104,652	61,895	245,526	83,403	279	2,052	701,663	11,314	-	712,977
Net Revenue	$27,063,128	$33,953,732	$72,216,493	$94,801,566	$24,233,014	$2,992,818	$16,660,984	$271,921,736	$5,173,100	$0	$277,094,836
Medical Expense	$22,259,003	$33,714,464	$67,461,682	$83,811,508	$25,258,410	$2,859,599	$16,513,998	$251,878,662	$3,935,709	$0	$255,814,371
Gross Margin	$4,804,126	$239,268	$4,754,812	$10,990,058	($1,025,395)	$133,219	$146,986	$20,043,074	$1,237,391	$0	$21,280,465
Administrative Expense	$1,041,226	$1,492,468	$4,318,183	$4,430,339	$1,380,973	$183,824	$874,576	$13,721,589	$299,898	$80,000	$14,101,487
Operating Income / (Expense)	$3,762,899	($1,253,200)	$436,628	$6,559,720	($2,406,368)	($50,604)	($727,590)	$6,321,485	$937,493	($80,000)	$7,178,978
Other Income / (Expense)	$289,984	$510,080	$1,575,894	$1,554,678	$479,851	$71,841	$341,343	$4,823,671	$87,745	$0	$4,911,416
Net Income / (Loss)	$4,052,884	($743,120)	$2,012,522	$8,114,397	($1,926,517)	$21,237	($386,247)	$11,145,156	$1,025,238	($80,000)	$12,090,394
PMPM Metrics:											
Revenue PMPM	$132.76	$324.44	$1,166.76	$386.12	$290.55	$10,726.95	$8,119.39	$387.54	$457.23	$0.00	$388.64
Medical Expense PMPM	$109.19	$322.16	$1,089.94	$341.35	$302.85	$10,249.46	$8,047.76	$358.97	$347.86	$0.00	$358.80
Gross Margin PMPM	$23.57	$2.29	$76.82	$44.76	($12.29)	$477.49	$71.63	$28.57	$109.37	$0.00	$29.85
Administrative Expense PMPM	$5.11	$14.26	$69.77	$18.04	$16.56	$658.87	$426.21	$19.56	$26.51	$0.00	$19.78
Operating Income / (Expense) PMPM	$18.46	($11.97)	$7.05	$26.72	($28.85)	($181.38)	($354.58)	$9.01	$82.86	$0.00	$10.07
Other Income / (Expense) PMPM	$1.42	$4.87	$25.46	$6.33	$5.75	$257.50	$166.35	$6.87	$7.76	$0.00	$6.89
Net Income / (Loss) PMPM	$19.88	($7.10)	$32.52	$33.05	($23.10)	$76.12	($188.23)	$15.88	$90.62	$0.00	$16.96
Ratio:											
Medical Loss Ratio	82.2%	99.3%	93.4%	88.4%	104.2%	95.5%	99.1%	92.6%	76.1%	0.0%	92.3%
Gross Margin Ratio	17.8%	0.7%	6.6%	11.6%	-4.2%	4.5%	0.9%	7.4%	23.9%	0.0%	7.7%
Administrative Expense Ratio	3.8%	4.4%	6.0%	4.7%	5.7%	6.1%	5.2%	5.0%	5.8%	0.0%	5.1%
Net Income Ratio	15.0%	-2.2%	2.8%	8.6%	-7.9%	0.7%	-2.3%	4.1%	19.8%	0.0%	4.4%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED August 31, 2023

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSE SUMMARY				
$4,835,744	$4,258,546	($577,198)	(13.6%)	Personnel Expenses	$8,966,061	$8,323,063	($642,998)	(7.7%)
877,102	52,140	(824,962)	(1,582.2%)	Benefits Administration Expense	938,454	104,652	(833,802)	(796.7%)
1,250,968	1,367,906	116,938	8.5%	Purchased & Professional Services	2,008,135	2,831,438	823,303	29.1%
596,182	257,095	(339,087)	(131.9%)	Occupancy	1,058,071	502,931	(555,139)	(110.4%)
426,685	260,453	(166,233)	(63.8%)	Printing Postage & Promotion	392,914	518,480	125,566	24.2%
386,914	925,119	538,205	58.2%	Licenses Insurance & Fees	689,649	2,091,404	1,401,754	67.0%
33,519	16,551	(16,969)	(102.5%)	Supplies & Other Expenses	48,202	28,367	(19,835)	(69.9%)
$3,571,370	$2,879,263	($692,108)	(24.0%)	Total Other Administrative Expense	$5,135,426	$6,077,272	$941,847	15.5%
$8,407,115	$7,137,809	($1,269,305)	(17.8%)	Total Administrative Expenses	$14,101,487	$14,400,336	$298,849	2.1%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED August 31, 2023

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
3,229,822	2,853,640	(376,182)	(13.2%)	Salaries & Wages	5,993,790	5,487,177	(506,613)	(9.2%)
387,933	300,794	(87,139)	(29.0%)	Paid Time Off	664,965	574,860	(90,105)	(15.7%)
575	2,960	2,385	80.6%	Incentives	6,425	6,220	(205)	(3.3%)
51,586	74,778	23,192	31.0%	Payroll Taxes	95,066	187,707	92,640	49.4%
44,820	14,267	(30,553)	(214.2%)	Overtime	71,294	27,833	(43,461)	(156.1%)
291,981	240,702	(51,279)	(21.3%)	CalPERS ER Match	544,093	462,555	(81,538)	(17.6%)
697,915	544,374	(153,541)	(28.2%)	Employee Benefits	1,331,965	1,077,286	(254,679)	(23.6%)
4,277	0	(4,277)	0.0%	Personal Floating Holiday	2,779	0	(2,779)	0.0%
1,395	24,024	22,629	94.2%	Employee Relations	(566)	45,399	45,965	101.2%
15,530	19,550	4,020	20.6%	Work from Home Stipend	31,010	38,150	7,140	18.7%
127	4,721	4,594	97.3%	Transportation Reimbursement	933	9,317	8,384	90.0%
7,655	11,662	4,007	34.4%	Travel & Lodging	18,780	28,462	9,683	34.0%
103,751	130,902	27,151	20.7%	Temporary Help Services	192,400	259,427	67,027	25.8%
8,005	35,140	27,135	77.2%	Staff Development/Training	22,409	111,607	89,198	79.9%
(9,629)	1,031	10,660	1,033.7%	Staff Recruitment/Advertising	(9,282)	7,062	16,345	231.4%
$4,835,744	**$4,258,546**	**($577,198)**	**(13.6%)**	**Total Employee Expenses**	**$8,966,061**	**$8,323,063**	**($642,998)**	**(7.7%)**
				Benefit Administration Expense				
20,509	21,808	1,299	6.0%	RX Administration Expense	42,509	43,616	1,107	2.5%
817,710	0	(817,710)	0.0%	Behavioral Hlth Administration Fees	817,710	0	(817,710)	0.0%
38,883	30,332	(8,552)	(28.2%)	Telemedicine Admin Fees	78,236	61,036	(17,200)	(28.2%)
$877,102	**$52,140**	**($824,962)**	**(1,582.2%)**	**Total Benefit Administration Expenses**	**$938,454**	**$104,652**	**($833,802)**	**(796.7%)**
				Purchased & Professional Services				
264,575	469,006	204,431	43.6%	Consulting Services	539,192	1,073,537	534,344	49.8%
456,042	426,082	(29,961)	(7.0%)	Computer Support Services	683,364	908,951	225,587	24.8%
11,875	12,500	625	5.0%	Professional Fees-Accounting	23,750	25,000	1,250	5.0%
0	33	33	100.0%	Professional Fees-Medical	0	67	67	100.0%
309,887	213,832	(96,055)	(44.9%)	Other Purchased Services	419,923	342,813	(77,110)	(22.5%)
857	717	(140)	(19.6%)	Maint.& Repair-Office Equipment	2,621	1,434	(1,187)	(82.8%)
78,531	115,017	36,486	31.7%	HMS Recovery Fees	194,784	210,699	15,916	7.6%
87,194	37,667	(49,527)	(131.5%)	Hardware (Non-Capital)	112,810	75,334	(37,476)	(49.7%)
34,864	41,702	6,838	16.4%	Provider Relations-Credentialing	33,428	83,404	49,976	59.9%
7,142	51,350	44,208	86.1%	Legal Fees	(1,737)	110,200	111,937	101.6%
$1,250,968	**$1,367,906**	**$116,938**	**8.5%**	**Total Purchased & Professional Services**	**$2,008,135**	**$2,831,438**	**$823,303**	**29.1%**
				Occupancy				
63,323	53,957	(9,366)	(17.4%)	Depreciation	112,197	102,830	(9,366)	(9.1%)
62,638	74,147	11,509	15.5%	Building Lease	123,117	148,294	25,177	17.0%
6,401	5,870	(531)	(9.1%)	Leased and Rented Office Equipment	10,220	11,740	1,520	12.9%
30,907	14,700	(16,207)	(110.3%)	Utilities	67,100	17,500	(49,600)	(283.4%)
147,000	86,510	(60,490)	(69.9%)	Telephone	201,546	173,020	(28,526)	(16.5%)
36,776	21,911	(14,865)	(67.8%)	Building Maintenance	45,621	49,547	3,926	7.9%
249,136	0	(249,136)	0.0%	SBITA Amortization Expense-GASB 96	498,271	0	(498,271)	0.0%
$596,182	**$257,095**	**($339,087)**	**(131.9%)**	**Total Occupancy**	**$1,058,071**	**$502,931**	**($555,139)**	**(110.4%)**

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED August 31, 2023

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Printing Postage & Promotion				
104,242	33,703	(70,540)	(209.3%)	Postage	76,855	66,605	(10,249)	(15.4%)
(2,241)	5,700	7,941	139.3%	Design & Layout	2,062	11,000	8,938	81.3%
223,689	42,552	(181,137)	(425.7%)	Printing Services	149,309	83,838	(65,470)	(78.1%)
10,379	6,910	(3,469)	(50.2%)	Mailing Services	21,971	13,820	(8,151)	(59.0%)
11,619	6,355	(5,264)	(82.8%)	Courier/Delivery Service	20,182	12,750	(7,432)	(58.3%)
187	0	(187)	0.0%	Promotional Products	187	0	(187)	0.0%
0	150	150	100.0%	Promotional Services	1,450	300	(1,150)	(383.4%)
53,808	152,417	98,609	64.7%	Community Relations	87,092	304,833	217,741	71.4%
25,001	12,667	(12,335)	(97.4%)	Translation - Non-Clinical	33,807	25,333	(8,473)	(33.4%)
$426,685	**$260,453**	**($166,233)**	**(63.8%)**	**Total Printing Postage & Promotion**	**$392,914**	**$518,480**	**$125,566**	**24.2%**
				Licenses Insurance & Fees				
0	0	0	0.0%	Regulatory Penalties	0	250,000	250,000	100.0%
26,816	28,000	1,184	4.2%	Bank Fees	54,393	56,000	1,607	2.9%
76,771	89,100	12,329	13.8%	Insurance	150,119	178,199	28,080	15.8%
160,505	664,649	504,144	75.9%	Licenses, Permits and Fees	312,613	1,297,153	984,540	75.9%
122,822	143,370	20,548	14.3%	Subscriptions & Dues	172,525	310,051	137,526	44.4%
$386,914	**$925,119**	**$538,205**	**58.2%**	**Total Licenses Insurance & Postage**	**$689,649**	**$2,091,404**	**$1,401,754**	**67.0%**
				Supplies & Other Expenses				
5,043	3,759	(1,284)	(34.2%)	Office and Other Supplies	8,493	7,868	(625)	(7.9%)
350	0	(350)	0.0%	Furniture and Equipment	350	0	(350)	0.0%
5,510	3,700	(1,810)	(48.9%)	Ergonomic Supplies	7,224	5,400	(1,824)	(33.8%)
2,616	8,625	6,009	69.7%	Commissary-Food & Beverage	7,286	14,166	6,880	48.6%
20,000	0	(20,000)	0.0%	Miscellaneous Expense	20,000	0	(20,000)	0.0%
0	0	0	0.0%	Member Incentive Expense	4,850	0	(4,850)	0.0%
0	100	100	100.0%	Covid-19 IT Expenses	0	200	200	100.0%
0	367	367	100.0%	Covid-19 Non IT Expenses	0	733	733	100.0%
$33,519	**$16,551**	**($16,969)**	**(102.5%)**	**Total Supplies & Other Expense**	**$48,202**	**$28,367**	**($19,835)**	**(69.9%)**
$8,407,115	**$7,137,809**	**($1,269,305)**	**(17.8%)**	**TOTAL ADMINISTRATIVE EXPENSE**	**$14,101,487**	**$14,400,336**	**$298,849**	**2.1%**

ALAMEDA ALLIANCE FOR HEALTH
CAPITAL SPENDING INCLUDING CONSTRUCTION-IN-PROCESS
ACTUAL VS. BUDGET
FOR THE FISCAL YEAR-TO-DATE ENDED JUNE 30, 2024

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco Catalyst 9300 - Catalyst Switches	IT-FY24-01	$ -		**$ -**	$ 50,000	$ 50,000
	Cisco Catalyst 8500 - Routers	IT-FY24-02	$ -		**$ -**	$ 60,000	$ 60,000
	Cisco AP-9166 - Access Point	IT-FY24-03	$ -		**$ -**	$ 10,000	$ 10,000
	Cisco UCS-X M6 or M7 Blades x 6	IT-FY24-04	$ -	$ 426,371	**$ 426,371**	$ 310,000	$ (116,371)
	PURE Storage array	IT-FY24-05	$ -		**$ -**	$ 300,000	$ 300,000
	PKI management	IT-FY24-06	$ -		**$ -**	$ 20,000	$ 20,000
	IBM Power Hardware Upgrade	IT-FY24-07	$ -		**$ -**	$ 405,000	$ 405,000
	Misc Hardware	IT-FY24-08	$ -	$ 7,119	**$ 7,119**	$ 15,000	$ 7,881
	Network / AV Cabling	IT-FY24-09				$ 30,000	$ 30,000
Hardware Subtotal			**$ -**	**$ 433,489**	**$ 433,489**	**$ 1,200,000**	**$ 766,511**
2. Software:							
	Zerto renewal and Tier 2 add	AC-FY24-01	$ -		**$ -**	$ 126,000	$ 126,000
Software Subtotal			**$ -**	**$ -**	**$ -**	**$ 126,000**	**$ 126,000**
3. Building Improvement:							
	Appliances over 1k new/replacement (all buildings/suites)	FA-FY24-01	**$ -**	$ -	**$ -**	$ -	$ -
	ACME Security: Readers, HID boxes, Cameras, Doors (planned/unplanned	FA-FY24-02	$ -	$ -	**$ -**	$ 20,000	$ 20,000
	HVAC: Replace VAV boxes, duct work, replace old equipment	FA-FY24-03	$ -	$ -	**$ -**	$ 20,000	$ 20,000
	Electrical work for projects, workstations requirement	FA-FY24-04	$ -	$ -	**$ -**	$ 10,000	$ 10,000
	1240 Interior blinds replacement	FA-FY24-05	**$ -**	$ -	**$ -**	$ 25,000	$ 25,000
	EV Charging stations, if not completed in FY23 and carried over to FY24	FA-FY24-06				$ 50,000	$ 50,000
Building Improvement Subtotal			**$ -**	**$ -**	**$ -**	**$ 125,000**	**$ 125,000**
4. Furniture & Equipment:							
	Office desks, cabinets, shelvings (all building/suites: new or replacement)	FA-FY24-17	$ -		**$ -**	$ 20,000	$ 20,000
	Replace, reconfigure, re-design workstations	FA-FY24-18				20000	$ 20,000
Furniture & Equipment Subtotal			**$ -**	**$ -**	**$ -**	**$ 40,000**	**$ 40,000**
GRAND TOTAL			**$ -**	**$ 433,489**	**$ 433,489**	**$ 1,491,000**	**$ 1,057,511**

5. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 8/31/23	**$ 38,128,585**
Fixed Assets @ Cost - 6/30/23	**$ 37,695,096**
Fixed Assets Acquired YTD	**$ 433,489**

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
SUMMARY - FISCAL YEAR 2024 ***PRELIMINARY***

TANGIBLE NET EQUITY (TNE)

	Jul-23	Aug-23
Current Month Net Income / (Loss)	$9,746,933	$2,343,460
YTD Net Income / (Loss)	$9,746,933	$12,090,393
Actual TNE		
Net Assets	$334,159,921	$336,839,657
Subordinated Debt & Interest	$0	$0
Total Actual TNE	**$334,159,921**	**$336,839,657**
Increase/(Decrease) in Actual TNE	$9,746,933	$2,343,460
Required TNE[(1)]	**$46,228,233**	**$46,744,204**
Min. Req'd to Avoid Monthly Reporting (Increased from 130% to 150% of Required TNE effective July-2022)	$69,342,350	$70,116,307
TNE Excess / (Deficiency)	$287,931,688	$290,095,453
Actual TNE as a Multiple of Required	**7.23**	**7.21**

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	$334,159,921	$336,839,657
Fixed Assets at Net Book Value	(5,169,098)	(5,539,264)
Net Lease Assets/Liabilities/Interest	(1,503,651)	(1,267,259)
CD Pledged to DMHC	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$328,640,823**	**$330,950,393**
Liquid TNE as Multiple of Required	**7.11**	**7.08**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2024

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

	Actual Jul-23	Actual Aug-23	Actual Sep-23	Actual Oct-23	Actual Nov-23	Actual Dec-23	Actual Jan-24	Actual Feb-24	Actual Mar-24	Actual Apr-24	Actual May-24	Actual Jun-24	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	102,463	101,393											203,856
Adult	52,550	52,102											104,652
SPD	31,055	30,840											61,895
ACA OE	123,707	121,819											245,526
Duals	41,688	41,715											83,403
MCAL LTC	141	138											279
MCAL LTC Duals	1,033	1,019											2,052
Medi-Cal Program	352,637	349,026											701,663
Group Care Program	5,669	5,645											11,314
Total	**358,306**	**354,671**											**712,977**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(1,207)	(1,070)											(2,277)
Adult	(624)	(448)											(1,072)
SPD	(225)	(215)											(440)
ACA OE	(1,260)	(1,888)											(3,148)
Duals	(43)	27											(16)
MCAL LTC	(9)	(3)											(12)
MCAL LTC Duals	4	(14)											(10)
Medi-Cal Program	(3,364)	(3,611)											(6,975)
Group Care Program	(15)	(24)											(39)
Total	**(3,379)**	**(3,635)**											**(7,014)**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	29.1%	29.1%											29.1%
Adult % of Medi-Cal	14.9%	14.9%											14.9%
SPD % of Medi-Cal	8.8%	8.8%											8.8%
ACA OE % of Medi-Cal	35.1%	34.9%											35.0%
Duals % of Medi-Cal	11.8%	12.0%											11.9%
Medi-Cal Program % of Total	98.4%	98.4%											98.4%
Group Care Program % of Total	1.6%	1.6%											1.6%
Total	**100.0%**	**100.0%**											**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2024

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

	Actual Jul-23	Actual Aug-23	Actual Sep-23	Actual Oct-23	Actual Nov-23	Actual Dec-23	Actual Jan-24	Actual Feb-24	Actual Mar-24	Actual Apr-24	Actual May-24	Actual Jun-24	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	74,547	73,027											147,574
Alameda Health System	66,089	65,344											131,433
	140,636	138,371											279,007
Delegated:													
CFMG	34,810	34,649											69,459
CHCN	130,230	129,183											259,413
Kaiser	52,630	52,468											105,098
Delegated Subtotal	217,670	216,300											433,970
Total	**358,306**	**354,671**											**712,977**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(939)	(2,265)											(3,204)
Delegated:													
CFMG	(441)	(161)											(602)
CHCN	(1,721)	(1,047)											(2,768)
Kaiser	(278)	(162)											(440)
Delegated Subtotal	(2,440)	(1,370)											(3,810)
Total	**(3,379)**	**(3,635)**											**(7,014)**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	39.3%	39.0%											39.1%
Delegated:													
CFMG	9.7%	9.8%											9.7%
CHCN	36.3%	36.4%											36.4%
Kaiser	14.7%	14.8%											14.7%
Delegated Subtotal	60.7%	61.0%											60.9%
Total	**100.0%**	**100.0%**											**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2024	PRELIMINARY BUDGET												
	Budget Jul-23	Budget Aug-23	Budget Sep-23	Budget Oct-23	Budget Nov-23	Budget Dec-23	Budget Jan-24	Budget Feb-24	Budget Mar-24	Budget Apr-24	Budget May-24	Budget Jun-24	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program by Category of Aid:													
Child	103,544	103,088	102,632	102,175	101,718	101,260	107,566	107,077	106,587	106,097	105,607	105,116	1,252,467
Adult	51,779	50,776	49,772	48,768	47,763	46,758	49,018	47,940	46,861	45,781	44,701	43,620	573,537
SPD	31,335	31,353	31,371	31,389	31,407	31,425	35,606	35,627	35,648	35,669	35,690	35,711	402,231
ACA OE	123,148	120,204	117,258	114,310	111,361	108,410	138,802	134,913	131,022	127,129	123,234	119,336	1,469,127
Duals	42,304	42,304	42,304	42,304	42,304	42,304	44,536	44,536	44,536	44,536	44,536	44,536	521,040
MCAL LTC	145	145	145	145	145	145	175	175	175	175	175	175	1,920
MCAL LTC Duals	983	983	983	983	983	983	1,107	1,107	1,107	1,107	1,107	1,107	12,540
Medi-Cal Program	353,238	348,853	344,465	340,074	335,681	331,285	376,810	371,375	365,936	360,494	355,050	349,601	4,232,862
Group Care Program	5,669	5,669	5,669	5,669	5,669	5,669	5,669	5,669	5,669	5,669	5,669	5,669	68,028
Total	**358,907**	**354,522**	**350,134**	**345,743**	**341,350**	**336,954**	**382,479**	**377,044**	**371,605**	**366,163**	**360,719**	**355,270**	**4,300,890**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	1,335	(456)	(456)	(457)	(457)	(458)	6,306	(489)	(490)	(490)	(490)	(491)	2,907
Adult	1,459	(1,003)	(1,004)	(1,004)	(1,005)	(1,005)	2,260	(1,078)	(1,079)	(1,080)	(1,080)	(1,081)	(6,700)
SPD	(576)	18	18	18	18	18	4,181	21	21	21	21	21	3,800
ACA OE	3,641	(2,944)	(2,946)	(2,948)	(2,949)	(2,951)	30,392	(3,889)	(3,891)	(3,893)	(3,895)	(3,898)	(171)
Duals	(3,158)	0	0	0	0	0	2,232	0	0	0	0	0	(926)
MCAL LTC	(8)	0	0	0	0	0	30	0	0	0	0	0	22
MCAL LTC Duals	(201)	0	0	0	0	0	124	0	0	0	0	0	(77)
Medi-Cal Program	2,492	(4,385)	(4,388)	(4,391)	(4,393)	(4,396)	45,525	(5,435)	(5,439)	(5,442)	(5,444)	(5,449)	(1,145)
Group Care Program	(120)	0	0	0	0	0	0	0	0	0	0	0	(120)
Total	**2,372**	**(4,385)**	**(4,388)**	**(4,391)**	**(4,393)**	**(4,396)**	**45,525**	**(5,435)**	**(5,439)**	**(5,442)**	**(5,444)**	**(5,449)**	**(1,265)**
Enrollment Percentages:													
Medi-Cal Program:													
Child % (Medi-Cal)	29.3%	29.6%	29.8%	30.0%	30.3%	30.6%	28.5%	28.8%	29.1%	29.4%	29.7%	30.1%	29.6%
Adult % (Medi-Cal)	14.7%	14.6%	14.4%	14.3%	14.2%	14.1%	13.0%	12.9%	12.8%	12.7%	12.6%	12.5%	13.5%
SPD % (Medi-Cal)	8.9%	9.0%	9.1%	9.2%	9.4%	9.5%	9.4%	9.6%	9.7%	9.9%	10.1%	10.2%	9.5%
ACA OE % (Medi-Cal)	34.9%	34.5%	34.0%	33.6%	33.2%	32.7%	36.8%	36.3%	35.8%	35.3%	34.7%	34.1%	34.7%
Duals % (Medi-Cal)	12.0%	12.1%	12.3%	12.4%	12.6%	12.8%	11.8%	12.0%	12.2%	12.4%	12.5%	12.7%	12.3%
MCAL LTC % (Medi-Cal)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%
MCAL LTC Duals % (Medi-Cal)	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%
Medi-Cal Program % of Total	98.4%	98.4%	98.4%	98.4%	98.3%	98.3%	98.5%	98.5%	98.5%	98.5%	98.4%	98.4%	98.4%
Group Care Program % of Total	1.6%	1.6%	1.6%	1.6%	1.7%	1.7%	1.5%	1.5%	1.5%	1.5%	1.6%	1.6%	1.6%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2024	PRELIMINARY BUDGET												
	Budget Jul-23	Budget Aug-23	Budget Sep-23	Budget Oct-23	Budget Nov-23	Budget Dec-23	Budget Jan-24	Budget Feb-24	Budget Mar-24	Budget Apr-24	Budget May-24	Budget Jun-24	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted	141,664	139,841	138,017	136,193	134,368	132,542	175,235	172,548	169,859	167,168	164,475	161,781	1,833,691
Delegated:													
CFMG	34,754	34,568	34,382	34,196	34,010	33,824	44,249	43,997	43,745	43,493	43,241	42,989	467,448
CHCN	130,622	128,908	127,193	125,475	123,756	122,035	162,995	160,499	158,001	155,502	153,003	150,500	1,698,489
Kaiser	51,867	51,205	50,542	49,879	49,216	48,553	0	0	0	0	0	0	301,262
Delegated Subtotal	217,243	214,681	212,117	209,550	206,982	204,412	207,244	204,496	201,746	198,995	196,244	193,489	2,467,199
Total	**358,907**	**354,522**	**350,134**	**345,743**	**341,350**	**336,954**	**382,479**	**377,044**	**371,605**	**366,163**	**360,719**	**355,270**	**4,300,890**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	8,226	(1,823)	(1,824)	(1,824)	(1,825)	(1,826)	42,693	(2,687)	(2,689)	(2,691)	(2,693)	(2,694)	28,343
Delegated:													
CFMG	684	(186)	(186)	(186)	(186)	(186)	10,425	(252)	(252)	(252)	(252)	(252)	8,919
CHCN	(4,995)	(1,714)	(1,715)	(1,718)	(1,719)	(1,721)	40,960	(2,496)	(2,498)	(2,499)	(2,499)	(2,503)	14,883
Kaiser	(1,543)	(662)	(663)	(663)	(663)	(663)	0	0	0	0	0	0	(4,857)
Delegated Subtotal	(5,854)	(2,562)	(2,564)	(2,567)	(2,568)	(2,570)	51,385	(2,748)	(2,750)	(2,751)	(2,751)	(2,755)	18,945
Total	**2,372**	**(4,385)**	**(4,388)**	**(4,391)**	**(4,393)**	**(4,396)**	**94,078**	**(5,435)**	**(5,439)**	**(5,442)**	**(5,444)**	**(5,449)**	**47,288**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	39.5%	39.4%	39.4%	39.4%	39.4%	39.3%	45.8%	45.8%	45.7%	45.7%	45.6%	45.5%	42.6%
Delegated:													
CFMG	9.7%	9.8%	9.8%	9.9%	10.0%	10.0%	11.6%	11.7%	11.8%	11.9%	12.0%	12.1%	10.9%
CHCN	36.4%	36.4%	36.3%	36.3%	36.3%	36.2%	42.6%	42.6%	42.5%	42.5%	42.4%	42.4%	39.5%
Kaiser	14.5%	14.4%	14.4%	14.4%	14.4%	14.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.0%
Delegated Subtotal	60.5%	60.6%	60.6%	60.6%	60.6%	60.7%	54.2%	54.2%	54.3%	54.3%	54.4%	54.5%	57.4%
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 2024

	Variance Jul-23	Variance Aug-23	Variance Sep-23	Variance Oct-23	Variance Nov-23	Variance Dec-23	Variance Jan-24	Variance Feb-24	Variance Mar-24	Variance Apr-24	Variance May-24	Variance Jun-24	YTD Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	(1,081)	(1,695)											(2,776)
Adult	771	1,326											2,097
SPD	(280)	(513)											(793)
ACA OE	559	1,615											2,174
Duals	(616)	(589)											(1,205)
MCAL LTC	(4)	(7)											(11)
MCAL LTC Duals	50	36											86
Medi-Cal Program	(601)	173											(428)
Group Care Program	0	(24)											(24)
Total	**(601)**	**149**											**(452)**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted	(1,028)	(1,470)											(2,498)
Delegated:													
CFMG	56	81											137
CHCN	(392)	275											(117)
Kaiser	763	1,263											2,026
Delegated Subtotal	427	1,619											2,046
Total	**(601)**	**149**											**(452)**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED August 31, 2023

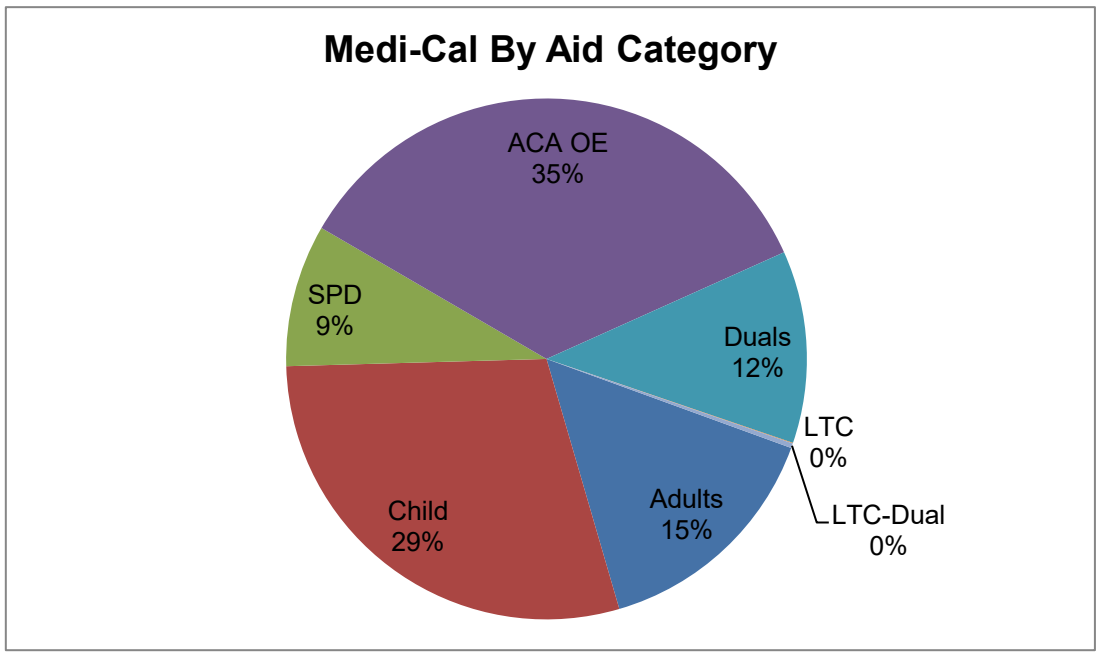
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES:				
$1,164,903	$1,162,591	($2,312)	(0.2%)	PCP-Capitation	$2,337,828	$2,331,283	($6,545)	(0.3%)
4,390,032	4,663,509	273,477	5.9%	PCP-Capitation - FQHC	8,782,047	9,389,853	607,806	6.5%
299,969	300,228	259	0.1%	Specialty-Capitation	601,439	602,076	636	0.1%
3,813,967	4,036,653	222,686	5.5%	Specialty-Capitation FQHC	7,647,941	8,135,161	487,220	6.0%
490,991	492,974	1,983	0.4%	Laboratory-Capitation	987,882	991,288	3,406	0.3%
252,355	254,973	2,619	1.0%	Vision Cap	507,871	512,859	4,988	1.0%
87,292	87,438	147	0.2%	CFMG Capitation	175,035	175,349	314	0.2%
188,960	200,734	11,774	5.9%	Anc IPA Admin Capitation FQHC	379,083	404,299	25,217	6.2%
14,144,814	13,737,866	(406,948)	(3.0%)	Kaiser Capitation	28,317,642	27,666,726	(650,915)	(2.4%)
251,575	611,636	360,060	58.9%	Maternity Supplemental Expense	503,151	1,235,588	732,437	59.3%
714,316	769,461	55,145	7.2%	DME - Cap	1,434,122	1,541,268	107,147	7.0%
$25,799,174	**$26,318,063**	**$518,889**	**2.0%**	**5 - TOTAL CAPITATED EXPENSES**	**$51,674,040**	**$52,985,751**	**$1,311,711**	**2.5%**
				FEE FOR SERVICE MEDICAL EXPENSES:				
(9,589,641)	0	9,589,641	0.0%	IBNP-Inpatient Services	(5,635,432)	0	5,635,432	0.0%
(287,689)	0	287,689	0.0%	IBNP-Settlement (IP)	(169,063)	0	169,063	0.0%
(767,171)	0	767,171	0.0%	IBNP-Claims Fluctuation (IP)	(450,834)	0	450,834	0.0%
40,204,307	35,535,600	(4,668,708)	(13.1%)	Inpatient Hospitalization-FFS	67,703,070	71,390,500	3,687,430	5.2%
2,658,903	0	(2,658,903)	0.0%	IP OB - Mom & NB	4,019,845	0	(4,019,845)	0.0%
614,161	0	(614,161)	0.0%	IP Behavioral Health	825,289	0	(825,289)	0.0%
1,645,311	0	(1,645,311)	0.0%	IP - Facility Rehab FFS	2,499,225	0	(2,499,225)	0.0%
$34,478,181	**$35,535,600**	**$1,057,418**	**3.0%**	**6 - Inpatient Hospital & SNF FFS Expense**	**$68,792,100**	**$71,390,500**	**$2,598,400**	**3.6%**
(471,802)	0	471,802	0.0%	IBNP-PCP	(494,018)	0	494,018	0.0%
(14,155)	0	14,155	0.0%	IBNP-Settlement (PCP)	(14,822)	0	14,822	0.0%
(37,743)	0	37,743	0.0%	IBNP-Claims Fluctuation (PCP)	(39,520)	0	39,520	0.0%
2,544,185	1,807,606	(736,578)	(40.7%)	Primary Care Non-Contracted FF	4,234,479	3,632,022	(602,457)	(16.6%)
1,099,697	190,786	(908,911)	(476.4%)	PCP FQHC FFS	1,399,063	383,657	(1,015,406)	(264.7%)
2,318,837	3,211,979	893,142	27.8%	Prop 56 Direct Payment Expenses	4,666,304	6,472,168	1,805,864	27.9%
14,223	0	(14,223)	0.0%	Prop 56 Hyde Direct Payment Expenses	28,604	0	(28,604)	0.0%
79,599	0	(79,599)	0.0%	Prop 56-Trauma Expense	160,340	0	(160,340)	0.0%
95,917	0	(95,917)	0.0%	Prop 56-Dev. Screening Exp.	192,808	0	(192,808)	0.0%
731,739	0	(731,739)	0.0%	Prop 56-Fam. Planning Exp.	1,472,610	0	(1,472,610)	0.0%
$6,360,497	**$5,210,372**	**($1,150,125)**	**(22.1%)**	**7 - Primary Care Physician FFS Expense**	**$11,605,849**	**$10,487,847**	**($1,118,001)**	**(10.7%)**
(1,496,883)	0	1,496,883	0.0%	IBNP-Specialist	(1,590,039)	0	1,590,039	0.0%
297,856	0	(297,856)	0.0%	Psychiatrist - FFS	410,473	0	(410,473)	0.0%
3,061,927	5,560,503	2,498,576	44.9%	Specialty Care-FFS	5,024,215	11,164,510	6,140,294	55.0%
180,361	0	(180,361)	0.0%	Anesthesiology - FFS	361,101	0	(361,101)	0.0%
1,581,113	0	(1,581,113)	0.0%	Spec Rad Therapy - FFS	2,526,593	0	(2,526,593)	0.0%
17,006	0	(17,006)	0.0%	Obstetrics-FFS	31,622	0	(31,622)	0.0%
474,490	0	(474,490)	0.0%	Spec IP Surgery - FFS	700,578	0	(700,578)	0.0%
737,627	0	(737,627)	0.0%	Spec OP Surgery - FFS	1,376,986	0	(1,376,986)	0.0%
627,662	0	(627,662)	0.0%	Spec IP Physician	1,036,231	0	(1,036,231)	0.0%
81,647	73,474	(8,173)	(11.1%)	SCP FQHC FFS	135,000	147,712	12,712	8.6%
(44,905)	0	44,905	0.0%	IBNP-Settlement (SCP)	(47,700)	0	47,700	0.0%
(119,750)	0	119,750	0.0%	IBNP-Claims Fluctuation (SCP)	(127,202)	0	127,202	0.0%
$5,398,152	**$5,633,977**	**$235,824**	**4.2%**	**8 - Specialty Care Physician Expense**	**$9,837,859**	**$11,312,222**	**$1,474,363**	**13.0%**
(1,007,017)	0	1,007,017	0.0%	IBNP-Ancillary	1,075,195	0	(1,075,195)	0.0%
(30,210)	0	30,210	0.0%	IBNP Settlement (ANC)	32,257	0	(32,257)	0.0%
(80,561)	0	80,561	0.0%	IBNP Claims Fluctuation (ANC)	86,014	0	(86,014)	0.0%
6,968	0	(6,968)	0.0%	IBNR Transportation FFS Expense	1,059	0	(1,059)	0.0%
1,808,207	0	(1,808,207)	0.0%	Behavioral Health Therapy - FFS	2,826,345	0	(2,826,345)	0.0%
1,342,589	0	(1,342,589)	0.0%	Psychologist & Other MH Prof.	2,040,972	0	(2,040,972)	0.0%
328,053	0	(328,053)	0.0%	Acupuncture/Biofeedback	629,823	0	(629,823)	0.0%
124,017	0	(124,017)	0.0%	Hearing Devices	215,840	0	(215,840)	0.0%
47,783	0	(47,783)	0.0%	Imaging/MRI/CT Global	102,375	0	(102,375)	0.0%
44,869	0	(44,869)	0.0%	Vision FFS	82,915	0	(82,915)	0.0%
0	0	0	0.0%	Family Planning	20	0	(20)	0.0%
653,836	0	(653,836)	0.0%	Laboratory-FFS	1,053,902	0	(1,053,902)	0.0%
139,375	0	(139,375)	0.0%	ANC Therapist	227,134	0	(227,134)	0.0%
1,271,144	0	(1,271,144)	0.0%	Transportation (Ambulance)-FFS	2,186,019	0	(2,186,019)	0.0%
1,443,923	0	(1,443,923)	0.0%	Transportation (Other)-FFS	2,874,892	0	(2,874,892)	0.0%
1,653,257	0	(1,653,257)	0.0%	Hospice	2,988,084	0	(2,988,084)	0.0%
1,615,008	0	(1,615,008)	0.0%	Home Health Services	2,904,982	0	(2,904,982)	0.0%
0	9,660,806	9,660,806	100.0%	Other Medical-FFS	0	19,349,250	19,349,250	100.0%
(51,984)	0	51,984	0.0%	HMS Medical Refunds	24,154	0	(24,154)	0.0%
(9,894)	0	9,894	0.0%	Refunds-Medical Payments	(8,960)	0	8,960	0.0%
16,154	0	(16,154)	0.0%	DME & Medical Supplies	24,862	0	(24,862)	0.0%
(373,988)	0	373,988	0.0%	GEMT Direct Payment Expense	(373,988)	0	373,988	0.0%
1,442,645	1,454,748	12,103	0.8%	ECM Base/Outreach FFS Anc.	2,907,436	2,923,203	15,767	0.5%
25,321	79,472	54,151	68.1%	CS - Housing Deposits FFS Ancillary	48,566	158,941	110,375	69.4%
214,426	504,999	290,573	57.5%	CS - Housing Tenancy FFS Ancillary	435,189	995,305	560,116	56.3%
44,312	92,517	48,205	52.1%	CS - Housing Navigation Services FFS Ancillary	89,475	182,538	93,063	51.0%
57,740	135,640	77,900	57.4%	CS - Medical Respite FFS Ancillary	117,372	271,276	153,904	56.7%
15,217	83,222	68,005	81.7%	CS - Medically Tailored Meals FFS Ancillary	29,690	164,017	134,327	81.9%

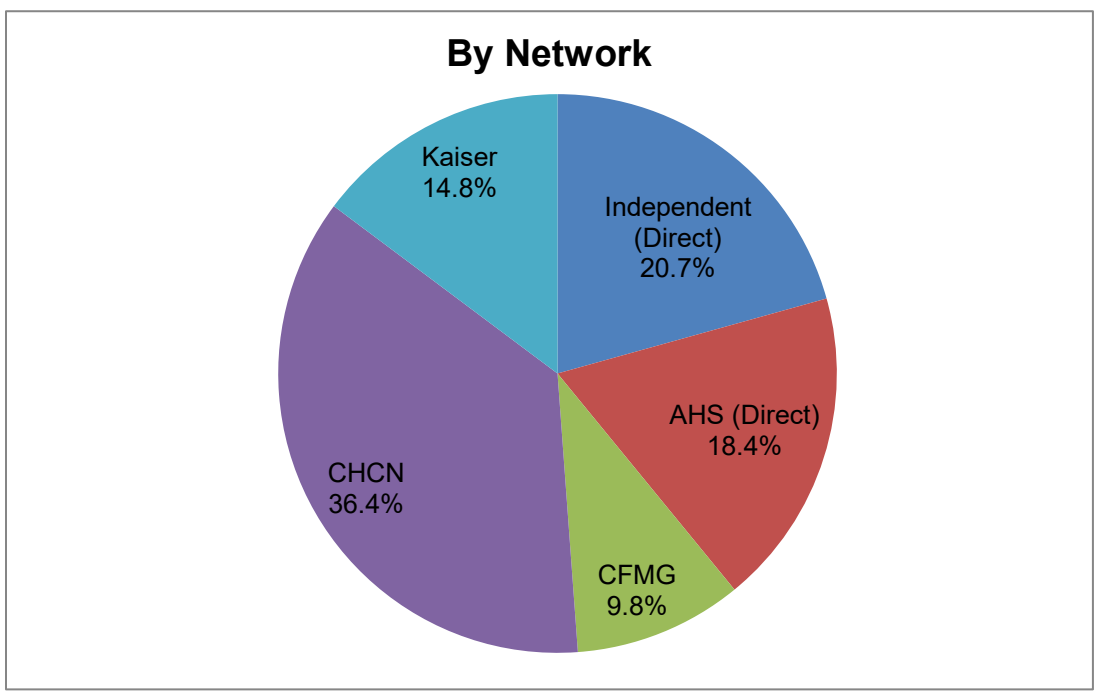
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED August 31, 2023

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
49	31,226	31,177	99.8%	CS - Asthma Remediation FFS Ancillary	90	39,391	39,301	99.8%
0	10,002	10,002	100.0%	MOT - Wrap Around (Non Medical MOT Cost)	0	20,004	20,004	100.0%
0	3,190	3,190	100.0%	CS - Home Modifications FFS Ancillary	0	6,380	6,380	100.0%
0	56,029	56,029	100.0%	CS - Personal Care & Homemaker Services FFS Ancillary	0	112,057	112,057	100.0%
0	10,861	10,861	100.0%	CS - Caregiver Respite Services FFS Ancillary	0	21,721	21,721	100.0%
611,410	0	(611,410)	0.0%	Community Based Adult Services (CBAS)	805,274	0	(805,274)	0.0%
0	7,646	7,646	100.0%	CS - Pilot LTC Diversion Expense	0	15,291	15,291	100.0%
4,587	3,823	(765)	(20.0%)	CS - Pilot LTC Transition Expense	7,646	7,646	0	0.0%
(61,000)	82,226	143,226	174.2%	Justice Involved Pilot	0	164,449	164,449	100.0%
$11,296,237	**$12,216,404**	**$920,167**	**7.5%**	**9 - Ancillary Medical Expense**	**$23,434,633**	**$24,431,468**	**$996,835**	**4.1%**
(1,134,635)	0	1,134,635	0.0%	IBNP-Outpatient	(295,083)	0	295,083	0.0%
(34,040)	0	34,040	0.0%	IBNP Settlement (OP)	(8,854)	0	8,854	0.0%
(90,771)	0	90,771	0.0%	IBNP Claims Fluctuation (OP)	(23,605)	0	23,605	0.0%
2,112,712	8,472,992	6,360,280	75.1%	Out-Patient FFS	3,509,326	17,014,201	13,504,875	79.4%
1,982,655	0	(1,982,655)	0.0%	OP Ambul Surgery - FFS	3,802,166	0	(3,802,166)	0.0%
2,105,880	0	(2,105,880)	0.0%	OP Fac Imaging Services-FFS	3,574,149	0	(3,574,149)	0.0%
(32,057)	0	32,057	0.0%	Behav Health - FFS	(52,691)	0	52,691	0.0%
666,537	0	(666,537)	0.0%	OP Facility - Lab FFS	1,050,529	0	(1,050,529)	0.0%
221,219	0	(221,219)	0.0%	OP Facility - Cardio FFS	325,094	0	(325,094)	0.0%
66,644	0	(66,644)	0.0%	OP Facility - PT/OT/ST FFS	127,792	0	(127,792)	0.0%
2,665,235	0	(2,665,235)	0.0%	OP Facility - Dialysis FFS	4,594,122	0	(4,594,122)	0.0%
$8,529,377	**$8,472,992**	**($56,386)**	**(0.7%)**	**10 - Outpatient Medical Expense Medical Expense**	**$16,602,944**	**$17,014,201**	**$411,257**	**2.4%**
(1,137,164)	0	1,137,164	0.0%	IBNP-Emergency	(870,640)	0	870,640	0.0%
(34,115)	0	34,115	0.0%	IBNP Settlement (ER)	(26,118)	0	26,118	0.0%
(90,972)	0	90,972	0.0%	IBNP Claims Fluctuation (ER)	(69,649)	0	69,649	0.0%
1,024,872	0	(1,024,872)	0.0%	Special ER Physician-FFS	1,680,034	0	(1,680,034)	0.0%
5,770,229	6,103,611	333,382	5.5%	ER-Facility	9,945,398	12,259,427	2,314,029	18.9%
$5,532,850	**$6,103,611**	**$570,761**	**9.4%**	**11 - Emergency Expense**	**$10,659,025**	**$12,259,427**	**$1,600,402**	**13.1%**
(858,710)	0	858,710	0.0%	IBNP-Pharmacy	(773,409)	0	773,409	0.0%
(25,763)	0	25,763	0.0%	IBNP Settlement (RX)	(23,205)	0	23,205	0.0%
(68,697)	0	68,697	0.0%	IBNP Claims Fluctuation (RX)	(61,873)	0	61,873	0.0%
454,418	376,385	(78,034)	(20.7%)	Pharmacy-FFS	940,805	751,362	(189,443)	(25.2%)
215,058	8,610,329	8,395,272	97.5%	Pharmacy- Non-PBM FFS-Other Anc	313,328	17,287,955	16,974,627	98.2%
5,699,856	0	(5,699,856)	0.0%	Pharmacy- Non-PBM FFS-OP FAC	10,448,854	0	(10,448,854)	0.0%
236,751	0	(236,751)	0.0%	Pharmacy- Non-PBM FFS-PCP	322,634	0	(322,634)	0.0%
2,775,796	0	(2,775,796)	0.0%	Pharmacy- Non-PBM FFS-SCP	4,785,896	0	(4,785,896)	0.0%
18,004	0	(18,004)	0.0%	Pharmacy- Non-PBM FFS-FQHC	24,231	0	(24,231)	0.0%
8,297	0	(8,297)	0.0%	Pharmacy- Non-PBM FFS-HH	15,002	0	(15,002)	0.0%
(4)	0	4	0.0%	HMS RX Refunds	(4)	0	4	0.0%
(100,000)	30,659	130,659	426.2%	Pharmacy-Rebate	(100,000)	61,184	161,184	263.4%
$8,355,007	**$9,017,372**	**$662,365**	**7.3%**	**12 - Pharmacy Expense**	**$15,892,259**	**$18,100,502**	**$2,208,242**	**12.2%**
(5,279,318)	0	5,279,318	0.0%	IBNR LTC	(3,276,538)	0	3,276,538	0.0%
(158,379)	0	158,379	0.0%	IBNR Settlement (LTC)	(98,296)	0	98,296	0.0%
(422,345)	0	422,345	0.0%	IBNR Claims Fluctuation (LTC)	(262,122)	0	262,122	0.0%
22,366,191	0	(22,366,191)	0.0%	LTC-Custodial Care	36,004,636	0	(36,004,636)	0.0%
3,259,440	15,589,520	12,330,081	79.1%	LTC SNF	5,939,675	31,156,015	25,216,340	80.9%
$19,765,589	**$15,589,520**	**($4,176,068)**	**(26.8%)**	**13 - Long Term Care FFS Expense**	**$38,307,354**	**$31,156,015**	**($7,151,339)**	**(23.0%)**
$99,715,891	**$97,779,847**	**($1,936,044)**	**(2.0%)**	**14 - TOTAL FFS MEDICAL EXPENSES**	**$195,132,023**	**$196,152,182**	**$1,020,159**	**0.5%**
0	(233,590)	(233,590)	100.0%	Clinical Vacancy	0	(257,862)	(257,862)	100.0%
119,406	88,582	(30,824)	(34.8%)	Quality Analytics	241,523	200,354	(41,169)	(20.5%)
717,745	739,750	22,006	3.0%	Health Plan Services Department Total	1,378,700	1,356,608	(22,092)	(1.6%)
533,352	521,585	(11,767)	(2.3%)	Case & Disease Management Department Total	1,025,009	960,043	(64,967)	(6.8%)
1,362,539	2,570,872	1,208,334	47.0%	Medical Services Department Total	3,563,022	6,136,011	2,572,989	41.9%
754,281	627,952	(126,330)	(20.1%)	Quality Management Department Total	1,512,458	1,215,168	(297,290)	(24.5%)
246,160	253,518	7,358	2.9%	HCS Behavioral Health Department Total	472,976	492,644	19,668	4.0%
157,502	131,102	(26,400)	(20.1%)	Pharmacy Services Department Total	275,921	258,046	(17,875)	(6.9%)
35,473	60,760	25,287	41.6%	Regulatory Readiness Total	108,009	119,818	11,809	9.9%
$3,926,458	**$4,760,530**	**$834,072**	**17.5%**	**15 - Other Benefits & Services**	**$8,577,618**	**$10,480,828**	**$1,903,210**	**18.2%**
(848,000)	(800,777)	47,223	(5.9%)	Reinsurance Recoveries	(1,709,000)	(1,610,915)	98,085	(6.1%)
1,065,259	1,067,703	2,444	0.2%	Stop-Loss Expense	2,139,690	2,147,886	8,196	0.4%
$217,259	**$266,926**	**$49,667**	**18.6%**	**16 - Reinsurance Expense**	**$430,690**	**$536,972**	**$106,282**	**19.8%**
$129,658,782	**$129,125,366**	**($533,416)**	**(0.4%)**	**17 - TOTAL MEDICAL EXPENSES**	**$255,814,371**	**$260,155,733**	**$4,341,362**	**1.7%**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend							
Category of Aid	**Aug 2023**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	52,176	15%	9,779	10,030	791	21,936	9,640
Child	101,555	29%	7,386	9,317	31,432	34,142	19,278
SPD	30,864	9%	9,987	4,481	1,114	12,969	2,313
ACA OE	121,928	35%	18,124	38,070	1,310	47,680	16,744
Duals	41,722	12%	24,790	2,570	2	9,867	4,493
LTC	138	0%	138	-	-	-	-
LTC-Dual	1,020	0%	1,020	-	-	-	-
Medi-Cal	349,403		71,224	64,468	34,649	126,594	52,468
Group Care	5,645		2,180	876	-	2,589	-
Total	**355,048**	**100%**	**73,404**	**65,344**	**34,649**	**129,183**	**52,468**
Medi-Cal %	98.4%		97.0%	98.7%	100.0%	98.0%	100.0%
Group Care %	1.6%		3.0%	1.3%	0.0%	2.0%	0.0%
	Network Distribution		*20.7%*	*18.4%*	*9.8%*	*36.4%*	*14.8%*
			% Direct:	**39%**		**% Delegated:**	**61%**

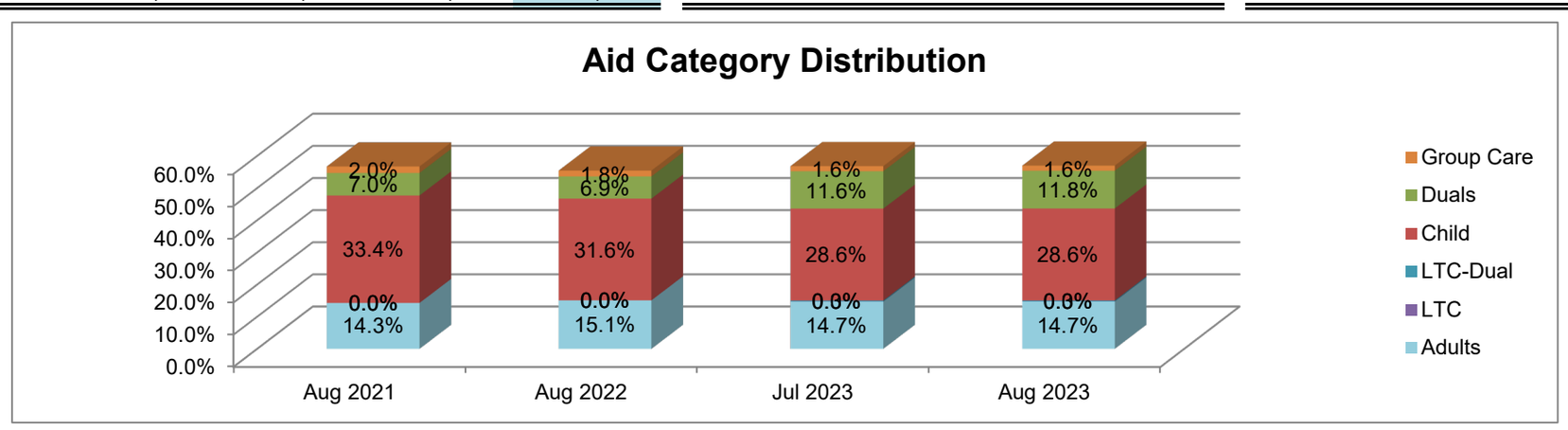




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

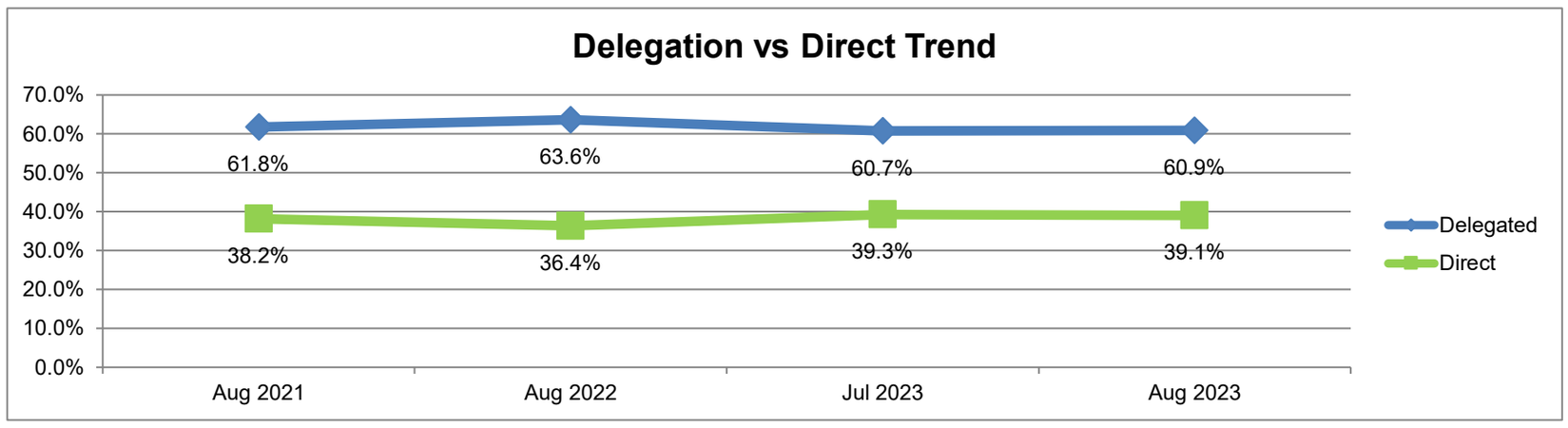
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021 to Aug 2022	Aug 2022 to Aug 2023	Jul 2023 to Aug 2023
Adults	41,519	48,112	52,550	52,176	14.3%	15.1%	14.7%	14.7%	15.9%	8.4%	-0.7%
Child	97,324	100,977	102,463	101,555	33.4%	31.6%	28.6%	28.6%	3.8%	0.6%	-0.9%
SPD	26,316	28,079	31,055	30,864	9.0%	8.8%	8.7%	8.7%	6.7%	9.9%	-0.6%
ACA OE	99,783	114,208	123,707	121,928	34.3%	35.8%	34.5%	34.3%	14.5%	6.8%	-1.4%
Duals	20,388	22,077	41,688	41,722	7.0%	6.9%	11.6%	11.8%	8.3%	89.0%	0.1%
LTC	-	-	141	138	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-2.1%
LTC-Dual	-	-	1,033	1,020	0.0%	0.0%	0.3%	0.3%	0.0%	0.0%	-1.3%
Medi-Cal Total	285,330	313,453	352,637	349,403	98.0%	98.2%	98.4%	98.4%	9.9%	11.5%	-0.9%
Group Care	5,877	5,803	5,669	5,645	2.0%	1.8%	1.6%	1.6%	-1.3%	-2.7%	-0.4%
Total	**291,207**	**319,256**	**358,306**	**355,048**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.6%**	**11.2%**	**-0.9%**



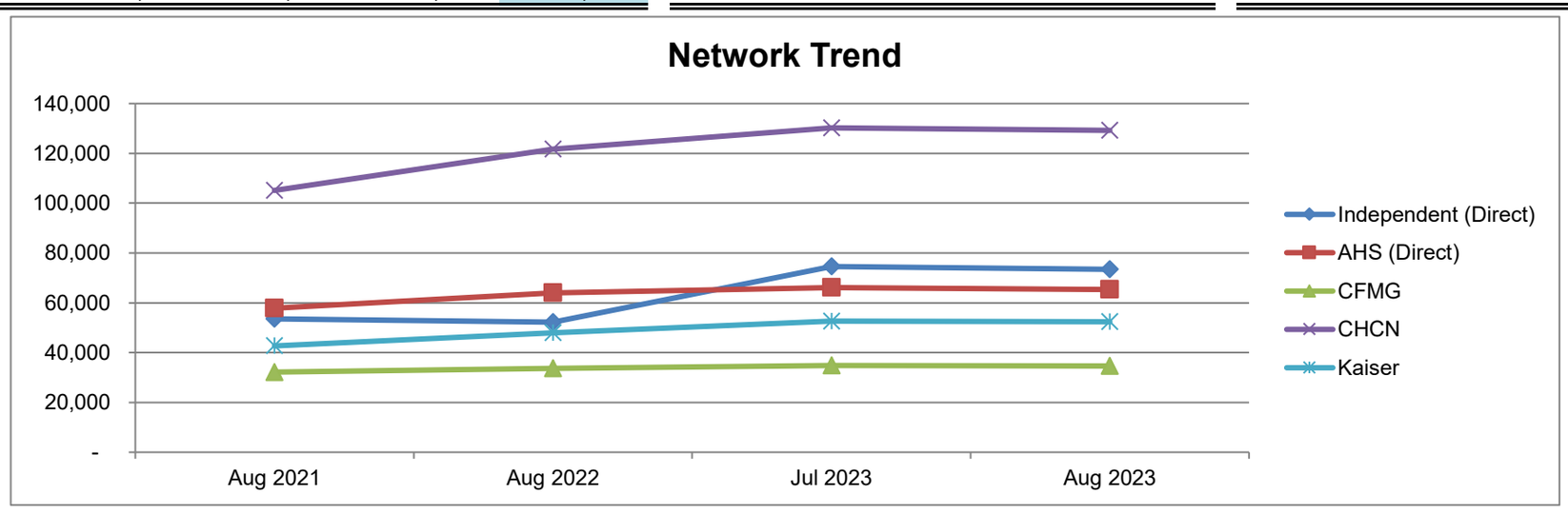
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021 to Aug 2022	Aug 2022 to Aug 2023	Jul 2023 to Aug 2023
Delegated	179,954	203,148	217,670	216,300	61.8%	63.6%	60.7%	60.9%	12.9%	6.5%	-0.6%
Direct	111,253	116,108	140,636	138,748	38.2%	36.4%	39.3%	39.1%	4.4%	19.5%	-1.3%
Total	**291,207**	**319,256**	**358,306**	**355,048**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.6%**	**11.2%**	**-0.9%**



Network Trend

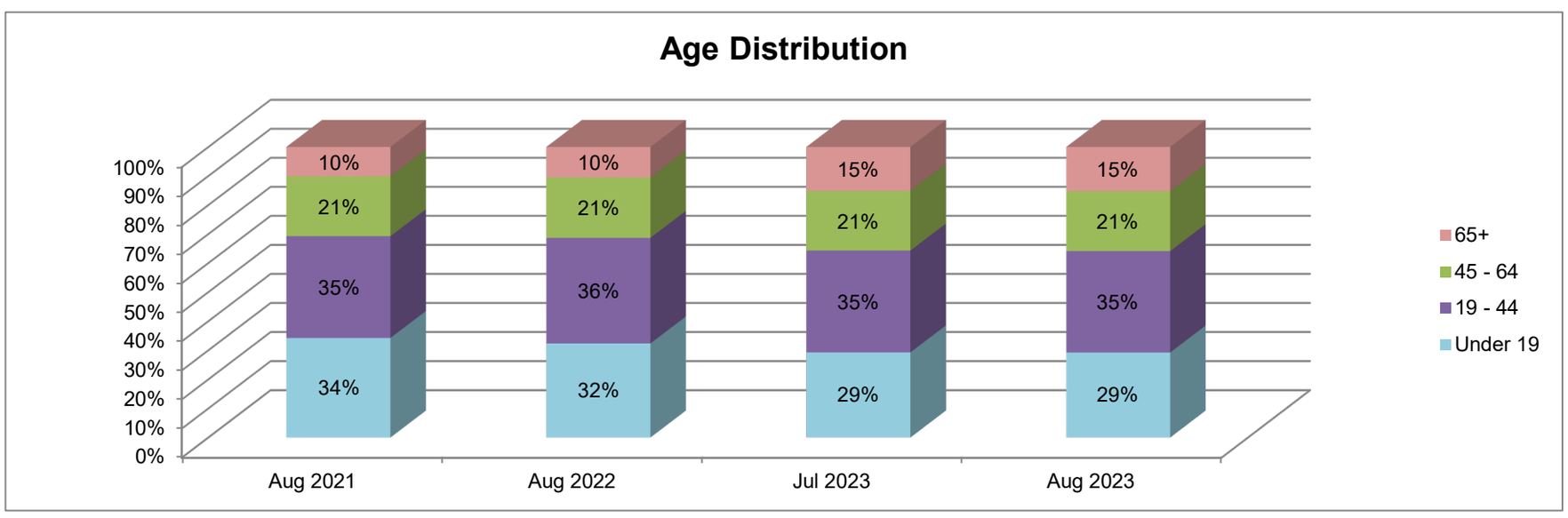
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021 to Aug 2022	Aug 2022 to Aug 2023	Jul 2023 to Aug 2023
Independent (Direct)	53,441	52,198	74,547	73,404	18.4%	16.3%	20.8%	20.7%	-2.3%	40.6%	-1.5%
AHS (Direct)	57,812	63,910	66,089	65,344	19.9%	20.0%	18.4%	18.4%	10.5%	2.2%	-1.1%
CFMG	32,167	33,594	34,810	34,649	11.0%	10.5%	9.7%	9.8%	4.4%	3.1%	-0.5%
CHCN	105,113	121,703	130,230	129,183	36.1%	38.1%	36.3%	36.4%	15.8%	6.1%	-0.8%
Kaiser	42,674	47,851	52,630	52,468	14.7%	15.0%	14.7%	14.8%	12.1%	9.6%	-0.3%
Total	**291,207**	**319,256**	**358,306**	**355,048**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.6%**	**11.2%**	**-0.9%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

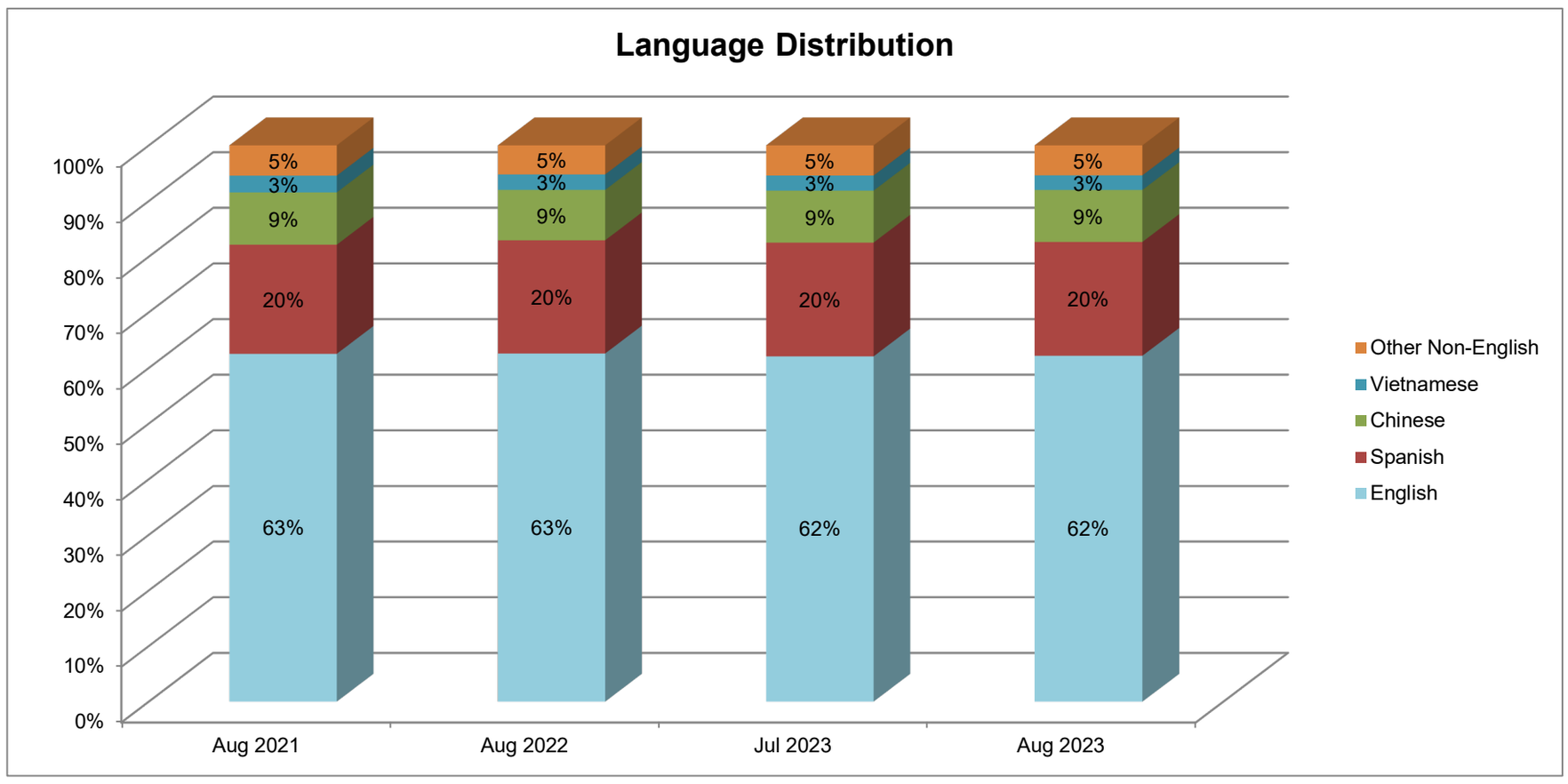
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021 to Aug 2022	Aug 2022 to Aug 2023	Jul 2023 to Aug 2023
Under 19	99,634	103,223	104,832	103,615	34%	32%	29%	29%	4%	0%	-1%
19 - 44	102,009	116,003	125,554	123,787	35%	36%	35%	35%	14%	7%	-1%
45 - 64	60,200	66,526	73,866	73,287	21%	21%	21%	21%	11%	10%	-1%
65+	29,364	33,504	54,054	54,058	10%	10%	15%	15%	14%	61%	0%
Total	**291,207**	**319,256**	**358,306**	**354,747**	**100%**	**100%**	**100%**	**100%**	**10%**	**11%**	**-1%**



Language Trend

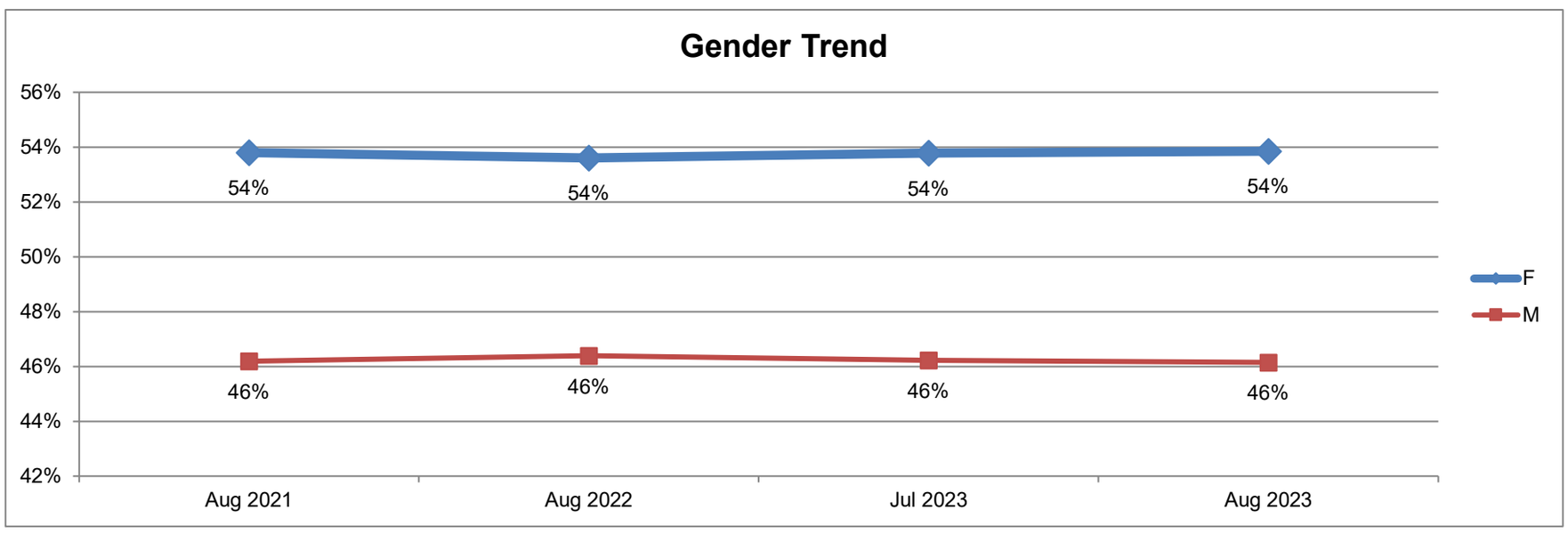
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021 to Aug 2022	Aug 2022 to Aug 2023	Jul 2023 to Aug 2023
English	182,065	199,798	222,387	220,565	63%	63%	62%	62%	10%	10%	-1%
Spanish	57,124	64,967	73,273	72,596	20%	20%	20%	20%	14%	12%	-1%
Chinese	27,385	28,938	33,455	33,152	9%	9%	9%	9%	6%	15%	-1%
Vietnamese	8,772	8,869	9,733	9,308	3%	3%	3%	3%	1%	5%	-4%
Other Non-English	15,861	16,684	19,458	19,126	5%	5%	5%	5%	5%	15%	-2%
Total	**291,207**	**319,256**	**358,306**	**354,747**	**100%**	**100%**	**100%**	**100%**	**10%**	**11%**	**-1%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

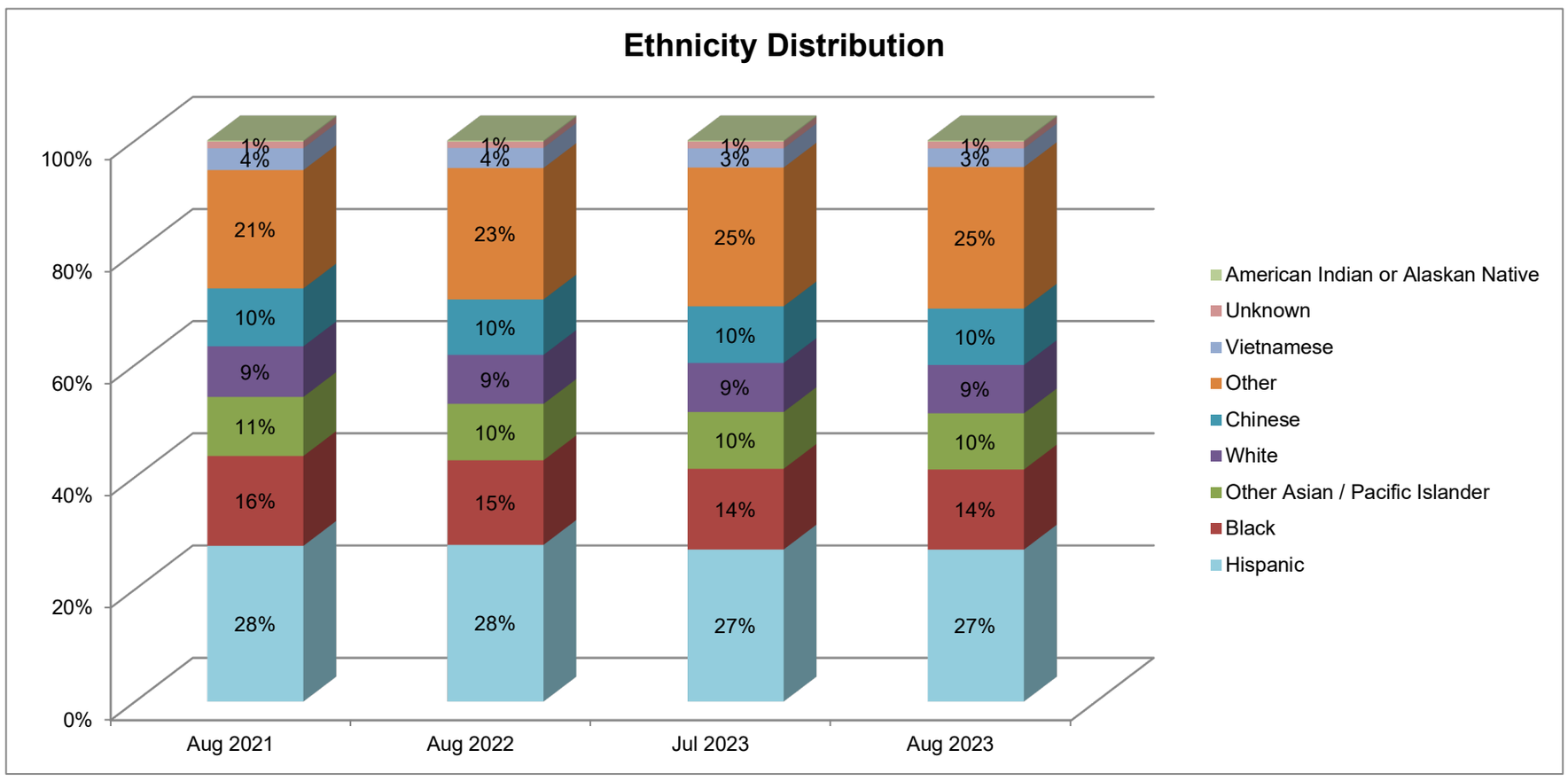
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021 to Aug 2022	Aug 2022 to Aug 2023	Jul 2023 to Aug 2023
F	156,688	171,141	192,702	191,034	54%	54%	54%	54%	9%	12%	-1%
M	134,519	148,115	165,604	163,713	46%	46%	46%	46%	10%	11%	-1%
Total	**291,207**	**319,256**	**358,306**	**354,747**	**100%**	**100%**	**100%**	**100%**	**10%**	**11%**	**-1%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021 to Aug 2022	Aug 2022 to Aug 2023	Jul 2023 to Aug 2023
Hispanic	80,668	88,998	96,921	95,902	28%	28%	27%	27%	10%	8%	-1%
Black	46,640	48,133	51,522	50,614	16%	15%	14%	14%	3%	5%	-2%
Other Asian / Pacific Islander	30,667	32,123	36,301	35,566	11%	10%	10%	10%	5%	11%	-2%
White	26,303	27,887	31,347	30,572	9%	9%	9%	9%	6%	10%	-2%
Chinese	30,056	31,586	36,209	35,715	10%	10%	10%	10%	5%	13%	-1%
Other	61,466	74,839	88,676	89,524	21%	23%	25%	25%	22%	20%	1%
Vietnamese	11,324	11,428	12,243	11,808	4%	4%	3%	3%	1%	3%	-4%
Unknown	3,468	3,579	4,360	4,327	1%	1%	1%	1%	3%	21%	-1%
American Indian or Alaskan Native	615	683	727	719	0%	0%	0%	0%	11%	5%	-1%
Total	**291,207**	**319,256**	**358,306**	**354,747**	**100%**	**100%**	**100%**	**100%**	**10%**	**11%**	**-1%**



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

Medi-Cal By City

City	Aug 2023	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	134,582	39%	19,209	30,159	14,165	56,273	14,776
Hayward	54,995	16%	10,681	11,721	5,913	17,269	9,411
Fremont	32,853	9%	12,736	4,825	1,290	8,713	5,289
San Leandro	31,523	9%	6,443	4,335	3,472	11,413	5,860
Union City	14,808	4%	5,214	2,210	638	3,969	2,777
Alameda	13,549	4%	2,915	2,043	1,717	4,645	2,229
Berkeley	13,108	4%	2,597	1,703	1,340	5,471	1,997
Livermore	10,774	3%	1,663	630	1,899	4,668	1,914
Newark	8,281	2%	2,469	2,539	311	1,511	1,451
Castro Valley	8,909	3%	1,900	1,317	1,126	2,653	1,913
San Lorenzo	7,356	2%	1,281	1,246	718	2,630	1,481
Pleasanton	6,130	2%	1,398	379	540	2,713	1,100
Dublin	6,536	2%	1,523	408	669	2,761	1,175
Emeryville	2,453	1%	522	443	316	750	422
Albany	2,078	1%	328	209	366	740	435
Piedmont	453	0%	90	126	30	94	113
Sunol	79	0%	19	10	6	27	17
Antioch	29	0%	9	3	12	4	1
Other	907	0%	227	162	121	290	107
Total	**349,403**	**100%**	**71,224**	**64,468**	**34,649**	**126,594**	**52,468**

Group Care By City

City	Aug 2023	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	1,803	32%	391	339	-	1,073	-
Hayward	629	11%	304	139	-	186	-
Fremont	616	11%	422	62	-	132	-
San Leandro	574	10%	224	86	-	264	-
Union City	295	5%	189	38	-	68	-
Alameda	280	5%	98	20	-	162	-
Berkeley	163	3%	49	12	-	102	-
Livermore	93	2%	29	3	-	61	-
Newark	132	2%	86	28	-	18	-
Castro Valley	194	3%	81	28	-	85	-
San Lorenzo	133	2%	47	17	-	69	-
Pleasanton	65	1%	23	3	-	39	-
Dublin	104	2%	33	6	-	65	-
Emeryville	36	1%	16	6	-	14	-
Albany	20	0%	7	1	-	12	-
Piedmont	13	0%	3	-	-	10	-
Sunol	-	0%	-	-	-	-	-
Antioch	25	0%	7	7	-	11	-
Other	470	8%	171	81	-	218	-
Total	**5,645**	**100%**	**2,180**	**876**	**-**	**2,589**	**-**

Total By City

City	Aug 2023	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	136,385	38%	19,600	30,498	14,165	57,346	14,776
Hayward	55,624	16%	10,985	11,860	5,913	17,455	9,411
Fremont	33,469	9%	13,158	4,887	1,290	8,845	5,289
San Leandro	32,097	9%	6,667	4,421	3,472	11,677	5,860
Union City	15,103	4%	5,403	2,248	638	4,037	2,777
Alameda	13,829	4%	3,013	2,063	1,717	4,807	2,229
Berkeley	13,271	4%	2,646	1,715	1,340	5,573	1,997
Livermore	10,867	3%	1,692	633	1,899	4,729	1,914
Newark	8,413	2%	2,555	2,567	311	1,529	1,451
Castro Valley	9,103	3%	1,981	1,345	1,126	2,738	1,913
San Lorenzo	7,489	2%	1,328	1,263	718	2,699	1,481
Pleasanton	6,195	2%	1,421	382	540	2,752	1,100
Dublin	6,640	2%	1,556	414	669	2,826	1,175
Emeryville	2,489	1%	538	449	316	764	422
Albany	2,098	1%	335	210	366	752	435
Piedmont	466	0%	93	126	30	104	113
Sunol	79	0%	19	10	6	27	17
Antioch	54	0%	16	10	12	15	1
Other	1,377	0%	398	243	121	508	107
Total	**355,048**	**100%**	**73,404**	**65,344**	**34,649**	**129,183**	**52,468**

Operations

Ruth Watson

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

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

Date: **October 13th, 2023**

Subject: **Operations Report**

Member Services

- 12-Month Trend Blended Summary:

    - The Member Services Department received a thirteen percent (13%) increase in calls in September 2023, totaling 15,405 compared to 13,434 in September 2022. Call volume pre-pandemic in September 2019 was 13,661, which is eleven percent (11%) lower than the current call volume.
    - The abandonment rate for September 2023 was six percent (6%), compared to fifteen percent (15%) in September 2022.
    - The Department's service level was eighty-two percent (82%) in September 2023, compared to forty-nine percent (49%) in September 2022. The Department continues to recruit to fill open positions. Customer Service support service vendor continues to provide overflow call center support.
    - The average talk time (ATT) was six minutes and thirty-six seconds (06:36) for September 2023 compared to seven minutes and twenty-five seconds (07:25) for September 2022.
    - One hundred percent (100%) of calls were answered within 10 minutes for September 2023 compared to eighty-four percent (84%) in September 2022.
    - The top five call reasons for September 2023 were: 1). Change of PCP, 2). Eligibility/Enrollment 3). Benefits, 4). Kaiser, 5). ID Card/Member Materials Request. The top five call reasons for September 2022 were: 1). Change of PCP, 2). Eligibility/Enrollment, 3). Kaiser, 4). Benefits, 5). Provider/Network Info.
    - September utilization for the member automated eligibility IVR system totaled twelve hundred sixteen (1216) in September 2023 compared to three hundred twenty-two (322) in September 2022.
    - The Department continues to service members via multiple communication channels (telephonic, email, online, web-based requests and in-person) while honoring the organization's policies. The Department responded to seven hundred twenty-eight (778) web-based requests in September 2023 compared to five hundred thirty-eight (538) in September 2022. The top three web reason requests for September 2023 were: 1). ID Card Requests 2). Change PCP, 3). Update Contact Information. Eighteen (18) members were assisted in-person in September 2023.

- Member Services Behavioral Health:

    - The Member Services Behavioral Health Unit received a total of eleven hundred seventy (1170) calls in September 2023.
    - The abandonment rate was seven percent (7%).
    - The service level was eighty-seven percent (87%).
    - Calls answered in 10 minutes were one hundred percent (100%).
    - The Average Talk Time (ATT) was ten minutes and eleven seconds (10:11). ATT are impacted by the DHCS requirements to complete a screening for all members initiating MH services for the first time.
    - Sixteen hundred forty-seven (1647) outreach calls were made in September 2023.
    - One hundred ninety-nine (199) screenings were completed in September 2023.
    - Thirty-eight (38) referrals were made to the County (ACCESS) in September 2023.
    - Twenty-five (25) members were referred to CenterPoint for SUD services in September 2023.

Claims

- 12-Month Trend Summary:

    - The Claims Department received 247,423 claims in September 2023 compared to 175,955 in September 2022.
    - The Auto Adjudication was 80.4% in September 2023 compared to 81.8% in September 2022.
    - Claims compliance for the 30-day turn-around time was 92% in September 2023 compared to 99.2% in September 2022. The 45-day turn-around time was 99.9% in September 2023 compared to 99.9% in September 2022.

- Monthly Analysis:

    - In the month of September, we received a total of 247,423 claims in the HEALTHsuite system. This represents an increase of 1.02% from August and is higher, by 71,468 claims, than the number of claims received in September 2022; the higher volume of received claims remains attributed to an increased membership.
    - We received 88.29% of claims via EDI and 11.71% of claims via paper.
    - During the month of September, 99.9% of our claims were processed within 45 working days.
    - The Auto Adjudication rate was 80.4% for the month of September.

Provider Services

- 12-Month Trend Summary:

    - The Provider Services department's call volume in September 2023 was 8,313 calls compared to 5,594 calls in September 2022.
    - 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 96 calls/visits during September 2023.
    - The Provider Services department answered 4,421 calls for September 2023 and made 823 outbound calls.

Credentialing

- 12-Month Trend Summary:

    - At the Peer Review and Credentialing (PRCC) meeting held on September 19, 2023, there were one hundred and four (104) initial network providers approved; five (5) primary care providers, eleven (11) specialists, two (2) ancillary providers, ten (10) midlevel providers, and seventy-six (76) behavioral health providers. Additionally, thirty-eight (38) providers were re-credentialed at this meeting; twelve (12) primary care providers, eighteen (18) specialists, and eight (8) midlevel providers.

    - Please refer to the Credentialing charts and graphs located in the Operations supporting documentation for more information.

Provider Dispute Resolution

- 12-Month Trend Summary:

    - In September 2023, the Provider Dispute Resolution (PDR) team received 2219 PDRs versus 642 in September 2022.
    - The PDR team resolved 1738 cases in September 2023 compared to 866 cases in September 2022.
    - In September 2023, the PDR team upheld 80% of cases versus 70% in September 2022.
    - The PDR team resolved 97.8% of cases within the compliance standard of 95% within 45 working days in September 2023 compared to 99.0% in September 2022.

- Monthly Analysis:

    - AAH received 2219 PDRs in September 2023.
    - In the month of September 1738 PDRs were resolved. Out of the 1738 PDRs, 1399 were upheld and 339 were overturned.
    - The overturn rate for PDRs was 20%, which met our goal of 25% or less.
    - 1699 out of 1738 cases were resolved within 45 working days resulting in a 97.8% compliance rate.
    - There were 39 cases closed in the past 45 working days. This is due to the incorrect resolution letter created. We went back and corrected the cases which caused the case to close at 50 days.
    - The average turnaround time for resolving PDRs in September was 39 days.
    - There were 3525 PDRs pending resolution as of 09/30/2023; with no cases older than 45 working days.

Community Relations and Outreach

- 12-Month Trend Summary:

    - In Q1 2023, the Alliance completed 2,699 member orientation outreach calls and 346 member orientations by phone.
    - The C&O Department reached 1,608 people, 59% identified as Alliance members, compared to 1,235 individuals who identified as Alliance members in Q1 2022.
    - The C&O Department spent a total of $555 in donations, fees, and/or sponsorships, compared to $770 in Q1 2022.
    - The C&O Department reached members in 15 cities/unincorporated areas throughout Alameda County, and Bay Area, compared to 17 locations in Q1 2022.

- Quarterly Analysis:

    - In Q1 2023, the C&O Department completed 2,699 member orientation outreach calls, 346 member orientations by phone, 5 community events, and 4 member education events.
    - Among the 1,608 people reached, 59% identified as Alliance members.
    - In Q1 2023, the C&O Department reached members in 15 locations throughout Alameda County and the Bay Area.

- Monthly Analysis:

    - In September 2023, the C&O Department completed 975 member orientation outreach calls and 346 member orientations by phone, and 147 Alliance website inquiries.

- Among the 491 people reached, 32% identified as Alliance members.
- In September 2023, the C&O Department reached members in 15 locations throughout Alameda County and the Bay Area.
- Please see attached **Addendum A**.

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	September 2023
Incoming Calls (R/V)	15,405
Abandoned Rate (R/V)	6%
Answered Calls (R/V)	14,487
Average Speed to Answer (ASA)	00:38
Calls Answered in 30 Seconds (R/V)	82%
Average Talk Time (ATT)	06:36
Calls Answered in 10 minutes	100%
Outbound Calls	7,058

Top 5 Call Reasons (Medi-Cal and Group Care) September 2023
Change of PCP
Eligibility/Enrollment
Benefits
Kaiser
ID Card/Member Materials Request

Top 3 Web-Based Request Reasons (Medi-Cal and Group Care) September 2023
ID Card Requests
Change PCP
Update Contact Info

Claims Department
August 2023 Final and September 2023 Final

METRICS

Claims Compliance	Aug-23	Sep-23
90% of clean claims processed within 30 calendar days	93.1%	92.0%
95% of all claims processed within 45 working days	99.9%	99.9%
Claims Volume (Received)	**Aug-23**	**Sep-23**
Paper claims	30,181	28,975
EDI claims	214,726	218,448
Claim Volume Total	**244,907**	**247,423**
Percentage of Claims Volume by Submission Method	**Aug-23**	**Sep-23**
% Paper	12.32%	11.71%
% EDI	87.68%	88.29%
Claims Processed	**Aug-23**	**Sep-23**
HEALTHsuite Paid (original claims)	224,267	152,869
HEALTHsuite Denied (original claims)	87,179	58,618
HEALTHsuite Original Claims Sub-Total	**311,446**	**211,487**
HEALTHsuite Adjustments	5,874	2,721
HEALTHsuite Total	**317,320**	**214,208**
Claims Expense	**Aug-23**	**Sep-23**
Medical Claims Paid	$117,070,804	$82,532,918
Interest Paid	$97,816	$36,688
Auto Adjudication	**Aug-23**	**Sep-23**
Claims Auto Adjudicated	257,311	169,933
% Auto Adjudicated	82.6%	80.4%
Average Days from Receipt to Payment	**Aug-23**	**Sep-23**
HEALTHsuite	16	14
Pended Claim Age	**Aug-23**	**Sep-23**
0-29 calendar days	23,915	26,813
HEALTHsuite		
30-59 calendar days	2,251	1,713
HEALTHsuite		
Over 60 calendar days	7	2
HEALTHsuite		
Overall Denial Rate	**Aug-23**	**Sep-23**
Claims denied in HEALTHsuite	87,179	58,618
% Denied	27.5%	27.4%

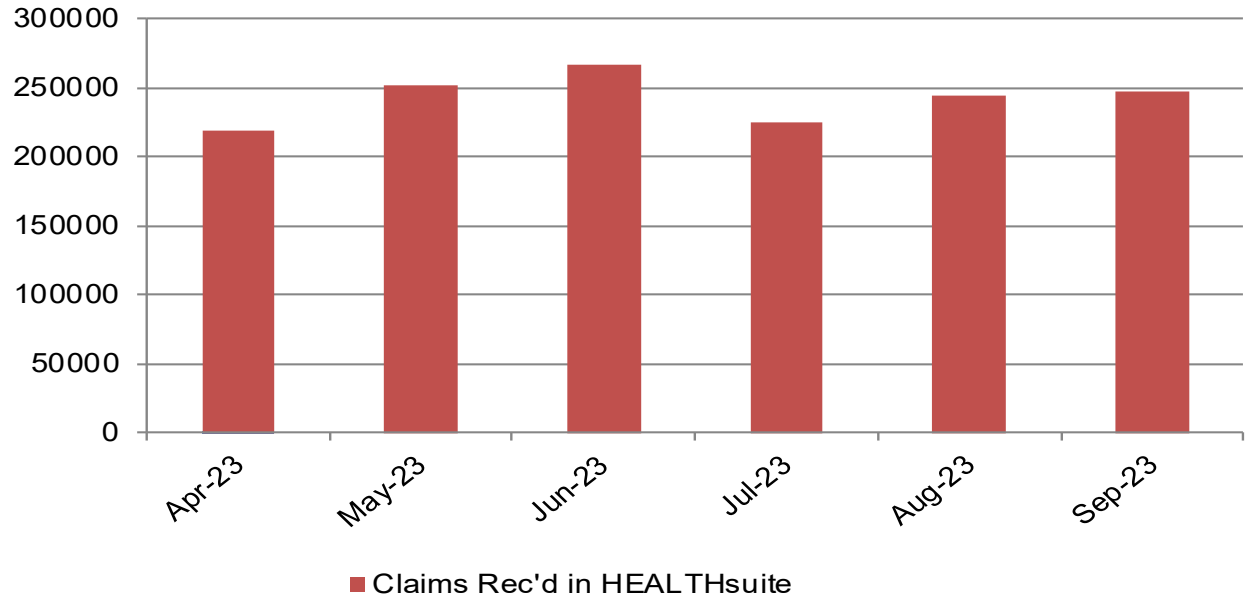
Claims Department
August 2023 Final and September 2023 Final

Sep-23

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	23%
No Benefits Found For Dates of Service	12%
Duplicate Claims	11%
Non-Covered Benefit For This Plan	10%
Must Submit Paper Claim With Copy of Primary Payor EOB	7%
% Total of all denials	**63%**

Claims Received By Month

Run Date	5/1/2023	6/1/2023	7/1/2023	8/1/2023	9/1/2023	10/1/2023
Claims Received Through	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**
Claims Rec'd in HEALTHsuite	218,296	251,858	267,437	224,540	244,907	247,423



Provider Relations Dashboard September 2023

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	5588	5936	6283	6245	8056	8013	9623	9661	8313			
Abandoned Calls	1698	1904	1557	1808	3594	3598	5981	5002	3892			
Answered Calls (PR)	3890	4032	4726	4437	4462	4415	3642	4659	4421			
Recordings/Voicemails	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Incoming Calls (R/V)	1231	953	986	849	1611	1883	3601	758	1201			
Abandoned Calls (R/V)												
Answered Calls (R/V)	1231	953	983	849	1611	1883	3601	758	1201			
Outbound Calls	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Outbound Calls	741	758	910	855	904	828	700	965	823			
N/A												
Outbound Calls	741	758	910	855	904	828	700	965	823			
Totals	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Total Incoming, R/V, Outbound Calls	7560	7647	8179	7949	10568	10724	13924	11384	10337			
Abandoned Calls	1698	1904	1557	1808	3594	3598	5981	5002	3892			
Total Answered Incoming, R/V, Outbound Calls	5862	5743	6622	6141	6974	7126	7943	6382	6445			

Provider Relations Dashboard September 2023

Call Reasons (Medi-Cal and Group Care)

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	5.3%	4.8%	5.3%	5.3%	5.9%	5.8%	4.4%	4.2%	4.1%			
Benefits	3.6%	3.4%	3.1%	3.6%	3.4%	5.1%	4.4%	4.7%	3.4%			
Claims Inquiry	46.7%	46.0%	48.8%	47.6%	49.0%	49.5%	51.9%	52.7%	54.0%			
Change of PCP	4.9%	3.8%	3.4%	3.1%	3.3%	3.1%	2.3%	2.8%	2.8%			
Complaint/Grievance (includes PDR's)	2.9%	1.7%	2.9%	3.4%	3.4%	3.6%	2.8%	4.4%	5.1%			
Contracts/Credentialing	0.9%	0.7%	0.9%	0.8%	0.7%	0.7%	1.2%	1.1%	1.2%			
Demographic Change	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			
Eligibility - Call from Provider	19.4%	20.6%	17.2%	15.7%	14.3%	13.2%	15.0%	13.1%	13.1%			
Exempt Grievance/ G&A	0.0%	0.0%	0.0%	3.5%	3.4%	0.1%	0.0%	4.5%	5.1%			
General Inquiry/Non member	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			
Health Education	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			
Intrepreter Services Request	0.7%	0.9%	0.4%	0.6%	0.4%	0.6%	0.4%	0.4%	0.6%			
Kaiser	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			
Member bill	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			
Provider Portal Assistance	2.7%	2.9%	2.5%	3.3%	4.3%	4.2%	3.8%	4.6%	3.5%			
Pharmacy	0.2%	0.1%	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%			
Prop 56	0.4%	0.5%	0.4%	0.5%	0.6%	0.6%	0.4%	0.5%	0.4%			
Provider Network Info	0.0%	0.1%	0.0%	0.1%	0.0%	0.1%	0.1%	0.1%	0.2%			
Transportation Services	0.2%	0.4%	0.1%	0.1%	0.1%	0.2%	0.1%	0.1%	0.2%			
Transferred Call	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			
All Other Calls	12.2%	14.0%	14.7%	12.4%	11.2%	13.3%	13.1%	6.4%	6.1%			
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			

Field Visit Activity Details

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Claims Issues	30	28	47	42	64	17	28	14	42			
Contracting/Credentialing	29	18	34	31	28	27	24	5	15			
Drop-ins	142	96	100	107	161	90	115	54	33			
JOM's	0	2	2	1	4	2	2	3	2			
New Provider Orientation	0	20	32	703	89	70	85	72	0			
Quarterly Visits	0	0	0	0	0	0	0	0	0			
UM Issues	13	18	0	9	3	3	0	0	4			
Total Field Visits	214	182	215	893	349	209	254	148	96	0	0	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS

Practitioners		BH/ABA 1073	AHP 468	PCP 363	SPEC 669	PCP/SPEC 11
AAH/AHS/CHCN Breakdown			AAH 1421	AHS 243	CHCN 552	COMBINATION OF GROUPS 368
Facilities	**372**					

VENDOR SUMMARY

Credentialing Verification Organization, Symplr CVO

	Number	Average Calendar Days in Process	Goal - Business Days	Goal - 98% Accuracy	Compliant
Initial Files in Process	138	15	25	Y	Y
Recred Files in Process	40	15	25	Y	Y
Expirables updated Insurance, License, DEA, Board Certifications					Y
Files currently in process	**178**				

CAQH Applications Processed in July 2023

	Invoice not received
Standard Providers and Allied Health	

July 2023 Peer Review and Credentialing Committee Approvals

Initial Credentialing	Number
PCP	5
SPEC	11
ANCILLARY	2
MIDLEVEL/AHP	10
BH/ABA	76
	104
Recredentialing	
PCP	12
SPEC	18
PCP/SPEC	0
ANCILLARY	0
MIDLEVEL/AHP	8
BH/ABA	0
	38
TOTAL	**142**

July 2023 Facility Approvals

Initial Credentialing	7
Recredentialing	12
	19
Facility Files in Process	**35**

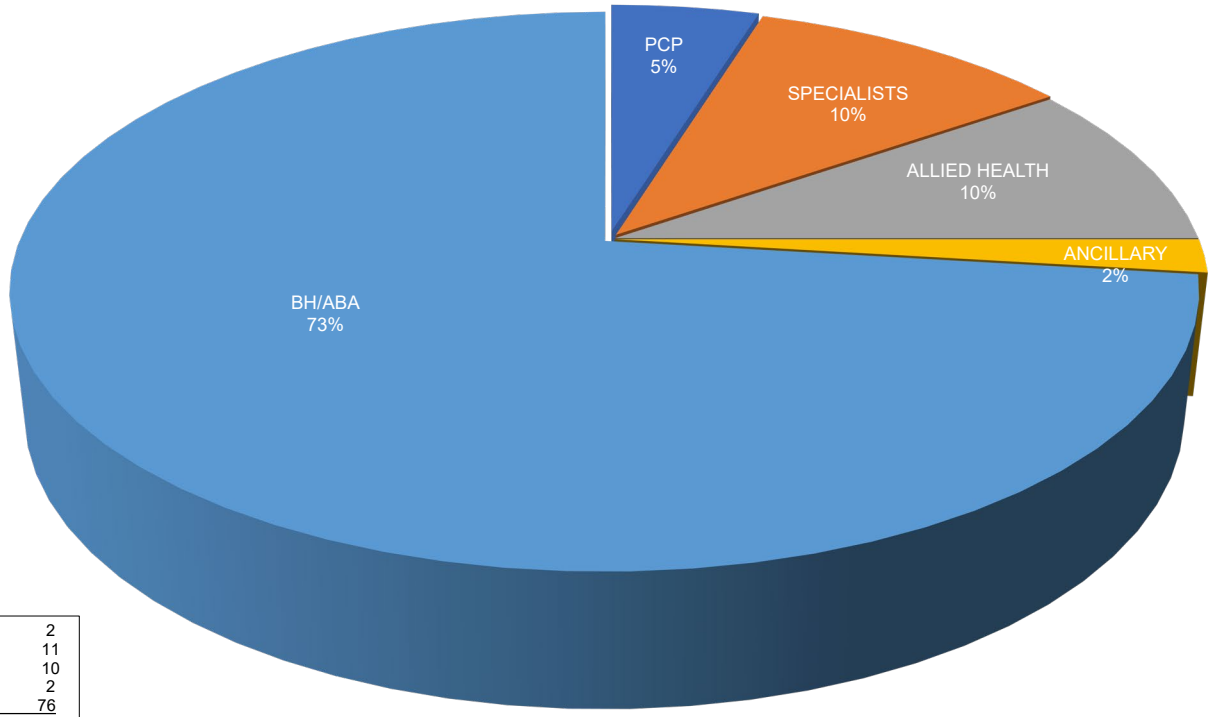
July 2023 Employee Metrics	5		
File Processing	Timely processing within 3 days of receipt		Y
Credentialing Accuracy	<3% error rate		Y
DHCS, DMHC, CMS, NCQA Compliant	98%		Y
MBC Monitoring	Timely processing within 3 days of receipt		Y

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CREDS	CRED DATE
Aglubat	Emmanuel	Allied Health	INITIAL	9/19/2023
Amos	Madison	Allied Health	INITIAL	9/19/2023
Angeley	Rachel	ABA-Telehealth	INITIAL	9/19/2023
Auclair	Angela	ABA-Telehealth	INITIAL	9/19/2023
Baekey	Diana	ABA-Telehealth	INITIAL	9/19/2023
Bailey	Ettie	BH	INITIAL	9/19/2023
Baldwin	Emily	BH	INITIAL	9/19/2023
Barrett	Carol	BH	INITIAL	9/19/2023
Bernal	Itzel	ABA-Telehealth	INITIAL	9/19/2023
Berry-Golston	DeniQuia	BH	INITIAL	9/19/2023
Bouzarif	Ghita	Primary Care Physician	INITIAL	9/19/2023
Cambra	Madison	BH-Telehealth	INITIAL	9/19/2023
Cardon	Lamont	Specialist	INITIAL	9/19/2023
Carow	Bradley	BH-Telehealth	INITIAL	9/19/2023
Chanda	Karen	ABA-Telehealth	INITIAL	9/19/2023
Chung	John	ABA	INITIAL	9/19/2023
Corey	Daniel	Specialist	INITIAL	9/19/2023
Davae	Umee	BH	INITIAL	9/19/2023
Davanzo	Pablo	BH-Telehealth	INITIAL	9/19/2023
Day Traweek	Kelsea	BH-Telehealth	INITIAL	9/19/2023
De Los Santos	Adam	ABA-Telehealth	INITIAL	9/19/2023
Dillard	Randy	BH	INITIAL	9/19/2023
Doshi	Nirmita	Primary Care Physician	INITIAL	9/19/2023
Dunham	Pattie	BH-Telehealth	INITIAL	9/19/2023
DuPraw	Stephen	BH-Telehealth	INITIAL	9/19/2023
Earle	Suzanne	BH	INITIAL	9/19/2023
Elliott-DeMars	Joy	Allied Health	INITIAL	9/19/2023
Emole	Murphy	Ancillary	INITIAL	9/19/2023
Estrada	Roberto	BH	INITIAL	9/19/2023
Finley	Andrew	BH-Telehealth	INITIAL	9/19/2023
Fischer	Craig	BH	INITIAL	9/19/2023
Galliano	Lynn	ABA	INITIAL	9/19/2023
Garcia	Taylor	BH-Telehealth	INITIAL	9/19/2023
Giang	Hien	ABA	INITIAL	9/19/2023
Gomez	Marlen	ABA	INITIAL	9/19/2023
Grewal	Harjot	Specialist	INITIAL	9/19/2023
Gwalani	Priyanka	Specialist	INITIAL	9/19/2023
Hale	Justina	BH-Telehealth	INITIAL	9/19/2023
Harlan	Stacey	BH-Telehealth	INITIAL	9/19/2023
Harris	Christelle	BH-Telehealth	INITIAL	9/19/2023
Harris	Heather	Specialist	INITIAL	9/19/2023
Henderson	Haley	BH-Telehealth	INITIAL	9/19/2023
Hong	Morgan	BH	INITIAL	9/19/2023
Iwobi	Iesha	BH-Telehealth	INITIAL	9/19/2023
Jawaid	Bushra	Primary Care Physician	INITIAL	9/19/2023
Jensen	Willem	ABA-Telehealth	INITIAL	9/19/2023
Jimenez	Crisol	ABA-Telehealth	INITIAL	9/19/2023
Johnson	Bethbirei	BH	INITIAL	9/19/2023
Johnston	Barbara	BH	INITIAL	9/19/2023
Kirsten	Kelli	ABA-Telehealth	INITIAL	9/19/2023
Kuriakose	Robin	Specialist	INITIAL	9/19/2023
Lang	Patrick	Specialist	INITIAL	9/19/2023
Lee	Aaron	Specialist	INITIAL	9/19/2023
Lee	Jennifer	BH	INITIAL	9/19/2023
Lee	May	Allied Health	INITIAL	9/19/2023
Lee	Yi-Shan	Ancillary	INITIAL	9/19/2023
Lentz	Kathryn	BH-Telehealth	INITIAL	9/19/2023
Leonard	Kristin	Allied Health	INITIAL	9/19/2023
Lewis-Smith	Arnecia	BH-Telehealth	INITIAL	9/19/2023

Lieu	Virginia	Specialist	INITIAL	9/19/2023
Lundy	Helen	ABA-Telehealth	INITIAL	9/19/2023
McKoin	Kelly	Allied Health	INITIAL	9/19/2023
Miceli	Jacob	ABA-Telehealth	INITIAL	9/19/2023
Michel	Christopher	BH	INITIAL	9/19/2023
Mims	Tishawna	BH-Telehealth	INITIAL	9/19/2023
Min	Rachel	BH-Telehealth	INITIAL	9/19/2023
Montoya	Gina	ABA-Telehealth	INITIAL	9/19/2023
Mortimer	Adam	Primary Care Physician	INITIAL	9/19/2023
Nieves	Aldrin	Allied Health	INITIAL	9/19/2023
Noon	Melissa	ABA-Telehealth	INITIAL	9/19/2023
Orquiz	Chelsea	ABA	INITIAL	9/19/2023
Pablos-Velez	Xochitl	Allied Health	INITIAL	9/19/2023
Padgitt	Denise	ABA	INITIAL	9/19/2023
Pai	Danielle	ABA	INITIAL	9/19/2023
Pardo	Tiffany	BH-Telehealth	INITIAL	9/19/2023
Parnell	April	ABA-Telehealth	INITIAL	9/19/2023
Paul	Julia	BH	INITIAL	9/19/2023
Peck	Kari	BH-Telehealth	INITIAL	9/19/2023
Pena	Michael	BH-Telehealth	INITIAL	9/19/2023
Poff	Alison	BH-Telehealth	INITIAL	9/19/2023
Pope	Madalyn	BH-Telehealth	INITIAL	9/19/2023
Ramos	Jessica	BH	INITIAL	9/19/2023
Reinertson	Tara	BH	INITIAL	9/19/2023
Reyna-Tobar	Rene	BH-Telehealth	INITIAL	9/19/2023
Ring	Catherine	Allied Health	INITIAL	9/19/2023
Robbins	Teresa	Primary Care Physician	INITIAL	9/19/2023
Rodriguez	Rachel	ABA	INITIAL	9/19/2023
Sabalza	Maritza	ABA-Telehealth	INITIAL	9/19/2023
Salazar	Jeselle	ABA-Telehealth	INITIAL	9/19/2023
Salazar	Olga	BH-Telehealth	INITIAL	9/19/2023
Sanchez	Claudine	ABA-Telehealth	INITIAL	9/19/2023
Sayadi-Grigori	Jessica	ABA-Telehealth	INITIAL	9/19/2023
Short-Fried	Rebecca	BH	INITIAL	9/19/2023
Sloan	Jeffrey	BH-Telehealth	INITIAL	9/19/2023
Smith	Pauline	BH-Telehealth	INITIAL	9/19/2023
Temple	Helen-Tracie	BH-Telehealth	INITIAL	9/19/2023
Thao	Johnny	ABA-Telehealth	INITIAL	9/19/2023
Thao	Lexus Hlee	ABA	INITIAL	9/19/2023
Valika	Aziz	Specialist	INITIAL	9/19/2023
Vargas	Alexandria	ABA-Telehealth	INITIAL	9/19/2023
Vo-Vu	Jeanette	BH-Telehealth	INITIAL	9/19/2023
Vyas	Usha	Allied Health	INITIAL	9/19/2023
Winters	Alexis	ABA-Telehealth	INITIAL	9/19/2023
Zhu	Tian	Specialist	INITIAL	9/19/2023
Adejumo	Oluwayemisi	Specialist	RE-CREDS	9/19/2023
Adey	Jennifer	Specialist	RE-CREDS	9/19/2023
Berry	Deborah	Allied Health	RE-CREDS	9/19/2023
Bhamra	Inderjeet	Specialist	RE-CREDS	9/19/2023
Bhateja	Meera	Primary Care Physician	RE-CREDS	9/19/2023
Chavez-Johnson	Christina	Primary Care Physician	RE-CREDS	9/19/2023
Chen	Cheng-I	Allied Health	RE-CREDS	9/19/2023
Cheng	Debra	Primary Care Physician	RE-CREDS	9/19/2023
Cushman	James	Specialist	RE-CREDS	9/19/2023
Davidson	Alyson	Primary Care Physician	RE-CREDS	9/19/2023
Diep	Claire	Primary Care Physician	RE-CREDS	9/19/2023
Dinh	Thanh	Allied Health	RE-CREDS	9/19/2023
Durant	Benjamin	Primary Care Physician	RE-CREDS	9/19/2023
Garcia	Cora	Allied Health	RE-CREDS	9/19/2023
Grewal	Khushdeep	Primary Care Physician	RE-CREDS	9/19/2023

Hafezi	Setareh	Specialist	RE-CREDS	9/19/2023
Heninger	Stephanie	Allied Health	RE-CREDS	9/19/2023
Hoffman	Robert	Specialist	RE-CREDS	9/19/2023
Kaur	Parveen	Primary Care Physician	RE-CREDS	9/19/2023
Lai	Jennifer	Specialist	RE-CREDS	9/19/2023
Lance	Simone	Allied Health	RE-CREDS	9/19/2023
Lee	Justin	Specialist	RE-CREDS	9/19/2023
Lee	Lan Na	Specialist	RE-CREDS	9/19/2023
Mei	Yuyang	Primary Care Physician	RE-CREDS	9/19/2023
Miller	Daphne	Primary Care Physician	RE-CREDS	9/19/2023
Murphy	John	Primary Care Physician	RE-CREDS	9/19/2023
Ponte	Sarah	Primary Care Physician	RE-CREDS	9/19/2023
Reinganum	Sara	Specialist	RE-CREDS	9/19/2023
Roark	John	Specialist	RE-CREDS	9/19/2023
Sung	Nina	Specialist	RE-CREDS	9/19/2023
Tang	Sai Ying	Allied Health	RE-CREDS	9/19/2023
Uche	An	Specialist	RE-CREDS	9/19/2023
Uhl	Valery	Specialist	RE-CREDS	9/19/2023
Van Sickle	Alexis	Allied Health	RE-CREDS	9/19/2023
Virk	Bhupinder	Specialist	RE-CREDS	9/19/2023
Weeks	Andrew	Specialist	RE-CREDS	9/19/2023
Wright	Courtney	Specialist	RE-CREDS	9/19/2023
Zaman	Warda	Specialist	RE-CREDS	9/19/2023

SEPTMEBER PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY



PCP	2
Specialists	11
Allied Health	10
Ancillary	2
BH/ABA	76
Total	104

Provider Dispute Resolution
August 2023 September 2023

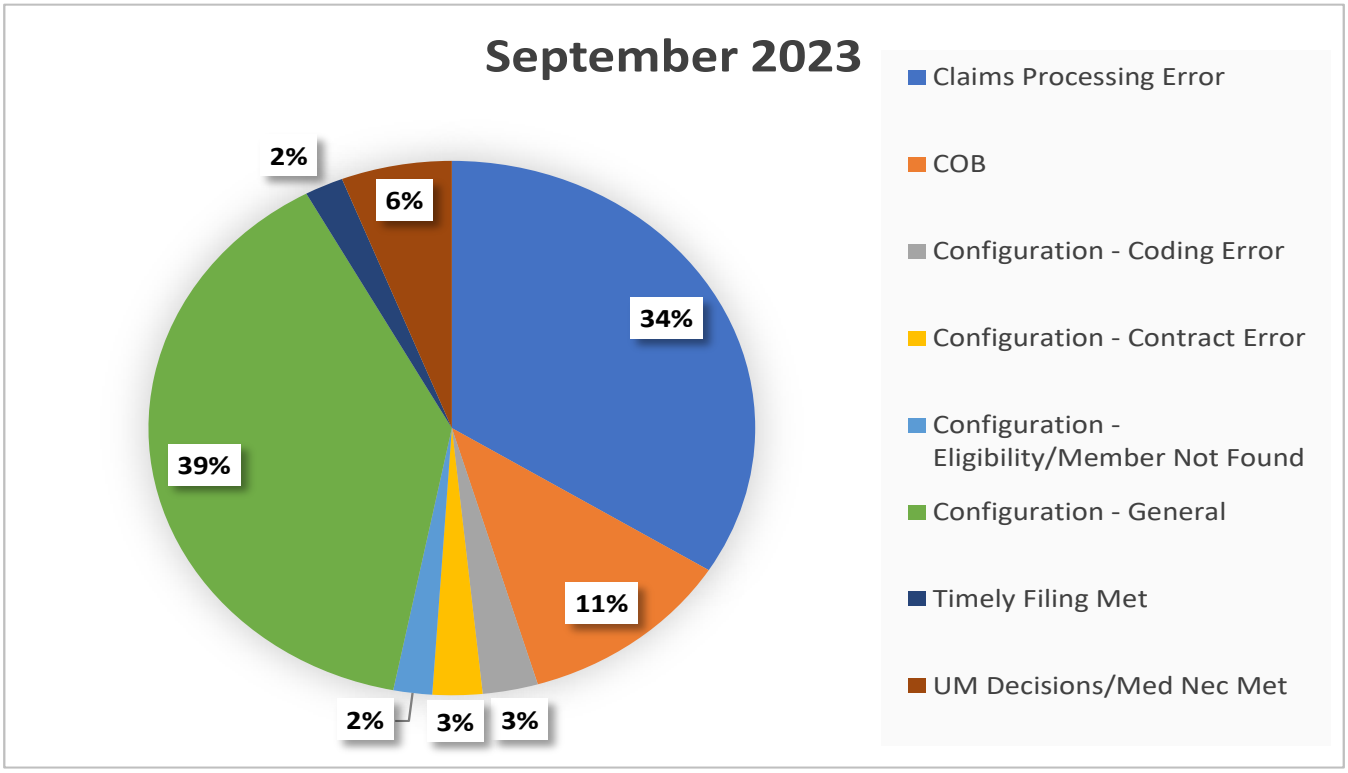
METRICS

PDR Compliance	Aug-23	Sep-23
# of PDRs Resolved	1,627	1,738
# Resolved Within 45 Working Days	1,616	1,699
% of PDRs Resolved Within 45 Working Days	99.3%	97.8%
PDRs Received	**Aug-23**	**Sep-23**
# of PDRs Received	2,092	2,219
PDR Volume Total	**2,092**	**2,219**
PDRs Resolved	**Aug-23**	**Sep-23**
# of PDRs Upheld	1,162	1,399
% of PDRs Upheld	71%	80%
# of PDRs Overturned	465	339
% of PDRs Overturned	29%	20%
Total # of PDRs Resolved	**1,627**	**1,738**
Average Turnaround Time	**Aug-23**	**Sep-23**
Average # of Days to Resolve PDRs	40	39
Oldest Unresolved PDR in Days	46	50
Unresolved PDR Age	**Aug-23**	**Sep-23**
0-45 Working Days	3,505	3,525
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**3,505**	**3,525**

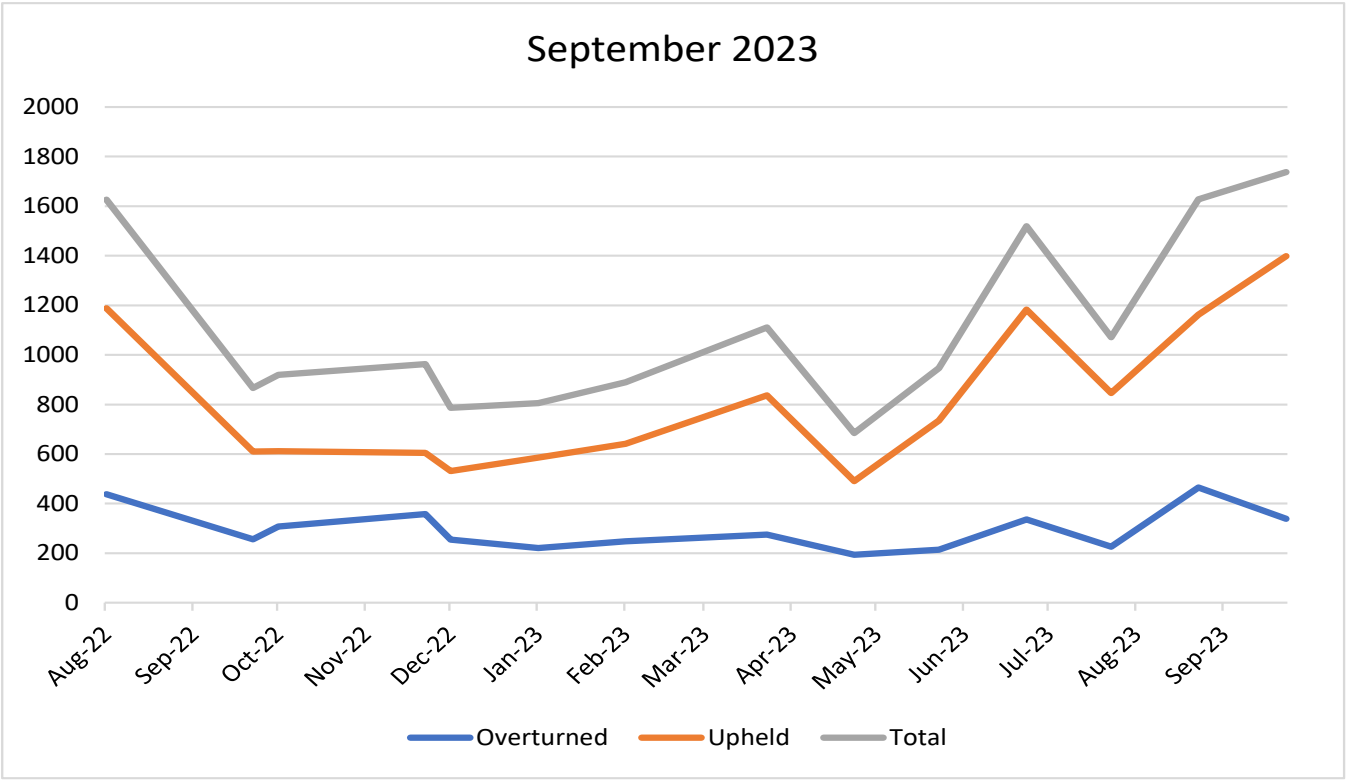
Provider Dispute Resolution
August 2023 September 2023

Sep-23

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

FY 2023 - 2024 | **1ST QUARTER (Q1) OUTREACH REPORT**

ALLIANCE IN THE COMMUNITY

FY 2023 - 2024 | 1ST QUARTER (Q1) OUTREACH REPORT

Between **July 2023** and **September 2023**, the Alliance completed **2,699** member orientation outreach calls among net new members and non-utilizers and conducted **346** member orientations (**13%** member participation rate). The Alliance Outreach team also completed **11** service requests and **147** website inquiries in Q1. The Alliance reached a total of **1,262** people and spent a total of $555 in donations, fees, and/or sponsorships at **5** community events, and **4** member education events.*

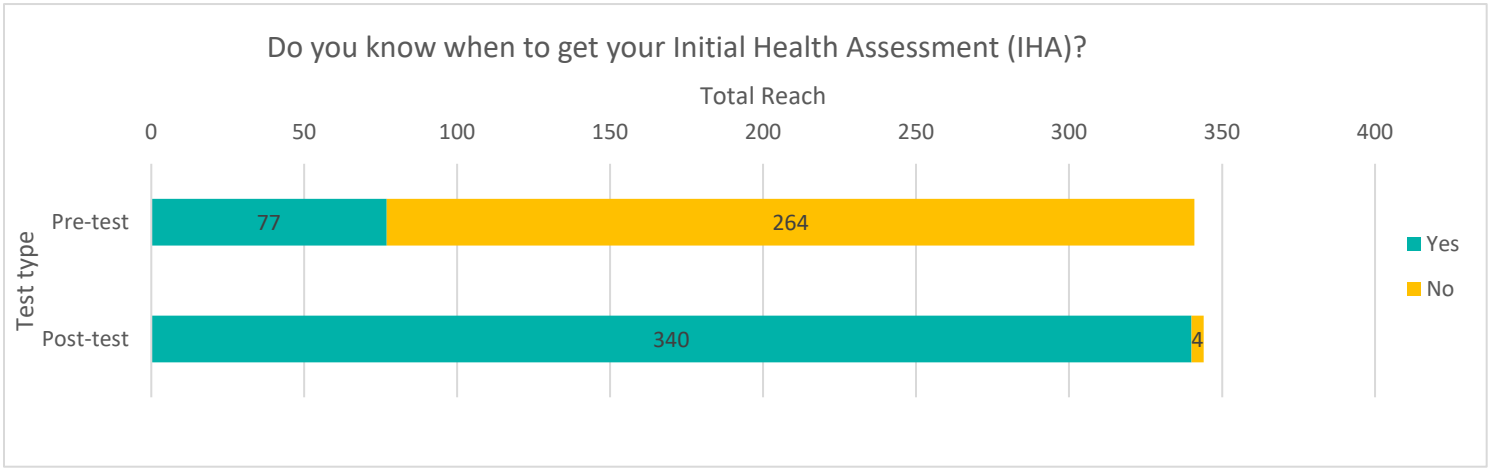
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **28,590** self-identified Alliance members have been reached during outreach activities.

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

On **Wednesday, March 18, 2020,** the Alliance began conducting member orientations by phone. As of **Saturday, September 30, 2023**, the Outreach Team completed **28,XXX** member orientation outreach calls and conducted 7,446 member orientations (2X.X%-member participation rate).

The Alliance Member Orientation (MO) program has been in place since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Assessment, by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between March 18, 2020 through September 30, 2023) – **7,446** members completed our MO program by phone.

After completing a MO **98.8%** of members who completed the post-test survey in Q1 FY 23-24 reported knowing when to get their IHA, compared to only **22.6%** of members knowing when to get their IHA in the pre-test survey.



All report details can be reviewed at: **W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Outreach Reports\FY 23-24\Q1\3. September 2023**

ALLIANCE IN THE COMMUNITY

FY 2023 - 2024 | 1ST QUARTER (Q1) OUTREACH REPORT

Q1 FY 2023-2024 TOTALS

5	COMMUNITY EVENTS	855	TOTAL REACHED AT COMMUNITY EVENTS
4	MEMBER EDUCATION EVENTS	407	TOTAL REACHED AT MEMBER EDUCATION EVENTS
346	MEMBER ORIENTATIONS	346	TOTAL REACHED AT MEMBER ORIENTATIONS
0	MEETINGS/ PRESENTATIONS	0	TOTAL REACHED AT MEETINGS/PRESENTATIONS
19	TOTAL INITIATED/INVITED EVENTS	946	TOTAL MEMBERS REACHED AT EVENTS
355	TOTAL EVENTS	1,608	TOTAL REACHED AT ALL EVENTS

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

TOTAL REACH 15 CITIES

**Cities represent the mailing addresses for members who completed a Member Orientation by phone. The italicized cities are outside of Alameda County. The following cities had <1% reach during Q1 2023:* Emeryville. *The C&O Department started including these cities in the Q3 FY21 Outreach Report.*

$555

TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

* *Includes refundable deposit.*

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 13th, 2023**

Subject: **Compliance Division Report**

Compliance Audit Updates

- 2023 DHCS Routine Medical Survey:
  - The onsite virtual interview took place from April 17th, 2023, through April 28th, 2023. There have been no updates since the exit interview held in April. An exit interview took place on September 26th, 2023. There are 15 findings and 5 identified repeat findings. Next steps will be to complete the DHCS Audit Report Response form and provide supporting documentation. The Plan is tasked to choose whether it agrees, partially agrees, or disagrees with each finding. For any disagreement the Plan must provide an explanation and supporting documentation. The response is due back to the Department on October 11th, 2023.

- 2022 DHCS Routine Medical Survey:
  - The 2022 DHCS Routine Medical Survey was held on April 4th, 2022, and completed April 13th, 2022. On September 13th, 2022, the Plan received the Final Audit Report which detailed 15 findings, 9 of which were repeat findings from the previous audit year. The DHCS has completed a review of 8 out of the 15 findings. The Plan is awaiting further guidance from DHCS.

- 2021 DMHC Follow-up Routine Survey
  - On June 26th, 2023, the Plan received notification from the DMHC that the Department will be conducting a Follow-Up Review (Survey) of the outstanding deficiencies identified in the October 23rd, 2022, Final Report of the 2021 DMHC Routine Survey of the Plan. This audit will be conducted via desktop review and telephonic interviews. The department will be evaluating the following:
    - General Plan Operations;
    - Deficiencies associated with Grievance and Appeals; and;
    - Deficiencies associated with Prescription Drug Coverage
  - The review period will cover November 1st, 2022, through May 31st, 2023. All pre-audit materials have been submitted to the Department in July 2023.

- The Department submitted their case file selections on August 17th, 2023. There are a total of 45 case files: 8 Expedited Grievance and Appeals; 3 All other Grievance and Appeals; 34 Formulary Exception Requests.

  - During the Plan's review of materials 11 of the 34 Formulary Exception Requests case files were identified as falling outside of the CAP implementation period. The Plan notified the Department and additional case files were requested. The additional 9 case files selected were submitted to the department on September 22nd, 2023. The Department will conduct the onsite virtual session on October 26th, 2023, and will cover Grievance and Appeals, and Pharmacy review. Compliance Risk Assessment:

    - The assessment provided valuable insights into the organization's current risk-landscape and helps inform risk management strategies and decision-making processes for the compliance leadership team. Sharing the compliance dashboard with the Compliance Advisory Committee in Q4 2023.

- 2022 DMHC Risk Bearing Organization (RBO) Audits:

  - In 2022, the DMHC examined the claims settlement practices and the provider dispute resolution mechanism of Children First Medical Group, Inc. (CFMG) and Community Health Center Network, Inc. (CHCN).

  - The Plan's oversight of these RBOs includes quarterly audits of claims settlement practices beginning with Q1 2023 dates of service. Case files for both CHCN and CFMG have been reviewed and the results are being finalized and reviewed by Compliance for distribution to the RBOs.

Compliance Activity Updates

- 2024 RFP Contract Update:

  - The State has noted that the Emergency Preparedness and Response Plan will have an extended implementation date of January 1st, 2025. The Plan has identified an internal target implementation date of October 27th, 2023, for all other requirements. The Plan submitted a total of 8 deliverables in September 2023. The Plan is expected to make its final Operational Readiness submissions for a total of ten (10) on December 29th, 2023. The Plan is on standby to receive additional information on the remaining undisclosed deliverables.

- DMHC Material Modification- 2024 RFP Readiness Submission:

  - The Plan has completed the exercise of combing through all the documents previously submitted to DHCS to identify only the documents that meet the criteria specified by DMHC. Additionally, Compliance has compiled the narratives from various Alliance stakeholders needed to provide DMHC with a high-level summary of the actions the Alliance has taken or is taking to prepare

for the transition to a single plan model from a two-plan model. The submission timeline is as follows:

- New and Revised Policy Submission: **10/6/2023**
- Financial Impact Submission: **11/1/2023**
- Significant Network Change Submission[1]: **12/1/2023**

- 2023 Annual Corporate Compliance Training
  - Annual Corporate Compliance Training was assigned on September 11, 2023. Staff will have ninety (90) days to complete assigned training, by December 11, 2023. Currently 22% of all staff have completed the training. The Annual Training includes:
    - Health Insurance Portability and Accountability Act (HIPAA)
    - Fraud, Waste, and Abuse
    - Cultural Competence and Sensitivity Training

- Behavioral Health Insourcing:
  - Although the Alliance has received approval from the Departments of Managed Health Care (DMHC) and Health Care Services (DHCS), as expected, DMHC's approval was subject to and conditioned upon the Alliance's full performance to the Department's satisfaction of eight Undertakings. Six of the eight Undertakings require deliverables to the DMHC. Compliance is coordinating with internal stakeholders to gather responses for timely and complete submission of the deliverables. All undertakings deliverables have been filed with DMHC. The Alliance has received substantive comments for Undertaking six and is gathering responses.

Outstanding Undertakings Chart:

Undertaking #	Deliverable	Initial Due Date	Progress
No. 2	Submit regular reports detailing the Plan's efforts to recruit and fill positions identified to support the insourcing of MH/SUD services. The initial report is due no later than 30 days following the date of the Order of Approval. Each subsequent report must be submitted within 30 days of the prior report, until all positions have been filled.	By April 28th, 2023, and every 30 days thereafter.	Final Status Report to DMHC 8/8/2023 (see closed Filing No. 20232500).

[1] After the Alliance completes the gap analysis between its existing network and that of the Exiting Plan (Anthem) the Plan will begin its contracting efforts for non-network providers. Then the Alliance will submit its entire network for the DMHC's review and approval. The DMHC's approval of the Plan's network will be separate and apart from the approval of the Material Modification.

No. 5	If applicable, submit Claims policies updated as a result of insourcing and administering mental health, substance abuse disorder, and behavioral health services.	By April 28th, 2023	Final responses sent to Status Report to DMHC 8/7/2023. DMHC Filing No. 20223134 closed on August 16th, 2023
No. 6	Submit electronically an Amendment filing to demonstrate compliance with the federal Mental Health Parity and Addiction Equity Act ("MHPAEA") (42 USC § 300 gg-26) and its regulations (45 CFR § 146.136) and Section 1374.76 of the Act. Before submitting the Amendment, the Plan shall contact the Department's MHPAEA review team by May 28th, 2023, to obtain detailed filing instructions and DMHC MHPAEA template worksheets for completion as part of the MHPAEA compliance filing.	By July 12th, 2023	Received extensive comments to which the Plan will need to respond. Compliance is currently reviewing DMHC's comments and gathering responses.

Compliance

Supporting Documents

Q2 2023 APL/PL IMPLEMENTATION TRACKING LIST						
#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
1	DMHC	23-001	01/05/23	Large Group Renewal Notice Requirements	GROUP CARE	This letter provides guidance to plans on the timing and content requirements for renewal notices to large group contractholders under HSC section 1374.21 and HSC section 1385.046. For purposes of this section, large group plans include In Home Supportive Services (IHSS) products.
2	DHCS	23-001	01/06/23	Network Certification Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) on the Annual Network certification (ANC) requirements pursuant to Title 42 of the Code of Federal Regulations (CFR) sections 438.68, 438.206, and 438.207, and Welfare and Institutions Code (WIC) section 14197. This APL also advises MCPs of the new requirements pertaining to good faith contracting requirements with certain cancer centers and referral requirements pursuant to WIC section 14197.45, as set forth by Senate Bill (SB) 987 (Portantino, Chapter 608, Statutes of 2022).
3	DMHC	23-002	01/12/23	Senate Bill 979 – Health Emergencies Guidance	MEDI-CAL & GROUP CARE	This All Plan Letter (APL) sets forth the Department's guidance regarding how plans shall demonstrate compliance with SB 979. The department expects plans to comply with SB 979 effective January 1, 2023. On September 18, 2022, Governor Gavin Newsom signed Senate Bill (SB) 979. SB 979 requires health care service plans (health plans or plans) to provide an enrollee who has been displaced or whose health may otherwise be affected by a state of emergency, as declared by the Governor, or a health emergency, as declared by the State Public Health Officer, access to medically necessary health care services. SB 979 also authorizes the Department of Managed Health Care (Department) to issue guidance to plans regarding compliance with the bill's requirements during the first three years following the declaration of emergency, or until the emergency is terminated, whichever occurs first.
4	DHCS	23-002	01/17/23	2023-2024 Medi-Cal MCP MEDS/834 Cutoff and Processing Schedule	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with the 2023-2024 Medi-Cal Eligibility Data System (MEDS)/834 cutoff and processing schedule.
5	DMHC	23-003	01/24/23	AB 1982 Telehealth Dental Care	N/A	Assembly Bill (AB) 1982 (Santiago, Ch. 525, Stats. 2022) adds Health and Safety Code section 1374.142 to the Knox-Keene Health Care Service Plan Act of 1975, effective January 1, 2023. Requires a plan offering a product covering dental services that offers a service via telehealth through a third-party corporate telehealth provider to report certain information to the Department for each product offering the service. This All Plan Letter (APL) sets forth the Department of Managed Health Care's (DMHC or Department) guidance regarding how health care service plans (plans) shall comply with AB 1982.
6	DMHC	23-004	2/7/2023	Plan Year 2024 QHP, QDP, and Off-Exchange Filing Requirements	N/A	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 23-004 to assist in the preparation of Plan Year 2024 regulatory submissions, in compliance with the Knox- Keene Act at California Health and Safety Code sections 1340 et seq. (Act) and regulations promulgated by the Department at California Code of Regulations, title 28 (Rules). The Department offers current and prospective Qualified Health and Dental Plans, Covered California for Small Business Issuers, and health plans offering non-grandfathered Individual and Small Group product(s) outside of the California Health Benefit Exchange (Covered California), guidance to assist in the preparation of Plan Year 2024 regulatory submissions, in compliance with the Knox- Keene Act at California Health and Safety Code sections 1340 et seq. (Act) and regulations promulgated by the Department at California Code of Regulations, title 28 (Rules).
7	DMHC	23-005	2/13/2023	Network Service Area Confirmation Process	MEDI-CAL	DMHC is establishing the NSACP to ensure that all network service areas on file as part of the Plan's license are consistent with network service areas submitted for Timely Access Compliance and Annual Network Reporting. DMHC will transmit NSACP Workbook to all Reporting Plans (June 2023), including a summary of all reported network service areas in the RY 2023 Annual Network Report submission. The transmittal will include a specific due date for the health plan's response.
8	DMHC	23-006	2/24/2023	Independent Medical Review (IMR) Application/Complaint Form (DMHC 20-224)	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (Department) issues this All-Plan Letter (APL) to inform all licensed health care service plans that the Department has revised the Independent Medical Review Application/Complaint Form (DMHC 20-224).
9	DHCS	23-003	3/8/2023	California Advancing and Innovating Medi-Cal Incentive Payment Program	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCP) with guidance on the Incentive Payment Program implemented by the California Advancing and Innovating Medi-Cal (CalAIM) initiative.

#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
10	DHCS	23-004	3/14/2023	Skilled Nursing Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (Supersedes APL 22-018)	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide requirements to all Medi-Cal managed care health plans (MCPs) on Skilled Nursing Facility (SNF) Long Term Care (LTC) benefit standardization provisions of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, including the mandatory transition of beneficiaries to managed care.
11	DHCS	23-005	3/16/2023	Requirements For Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (Supersedes APL 19-010)	MEDI-CAL	The purpose of this All Plan Letter (APL) is to clarify the responsibilities of Medi-Cal managed care health plans (MCPs) to provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to eligible Members under the age of 21. This policy applies to all Members under the age of 21 who are enrolled in MCPs. This guidance is intended to reinforce existing state and federal laws and regulations regarding the provisions of Medi-Cal services, including EPSDT. This guidance is also intended to outline requirements for MCPs to ensure Members have access to information on EPSDT and Network Providers receive standardized training on EPSDT utilizing the newly developed DHCS Medi-Cal for Kids and Teens Outreach and Education Toolkit.
12	DMHC	23-007	3/23/2023	Provider Directory Annual Filing Requirements (2023)	MEDI-CAL & GROUP CARE	This All Plan Letter (APL) reminds health care service plans of California Health and Safety Code section 1367.27, subdivision (m)'s requirement to annually submit provider directory policies and procedures to the Department of Managed Health Care.
13	DMHC	23-008	3/24/2023	Health Plan Requirements to Timely Pay Claims	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 23-008 to highlight and remind plans of timely payment and utilization management obligations with respect to hospitals.
14	DHCS	23-006	3/28/2023	Delegation and Subcontractor Network Certification	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance on the requirements for delegation and monitoring of Subcontractors. This APL also details the Subcontractor Network Certification (SNC) process wherein MCPs must provide assurances that each Subcontractor's and Downstream Subcontractor's Provider Network meets state and federal Network adequacy and access requirements.
15	DMHC	23-009	3/30/2023	Health Plan Coverage of Preventive Services	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 23-009 reminding California health plans of their obligation to cover preventive services as required by the Knox-Keene Health Care Service Plan Act.
16	DHCS	20-004	4/4/2023	Emergency Guidance for Medi-Cal Managed Care Health Plans in Response to COVID-19 (REVISED)	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide information to Medi-Cal managed care health plans (MCPs) on temporary changes to federal requirements as a result of the ongoing global COVID-19 pandemic. As the Department of Health Care Services (DHCS) continues to respond to concerns and changing circumstances resulting from the pandemic, DHCS will provide updated guidance to MCPs.
17	DHCS	21-011	4/4/2023	(Supplement to APL 21-011) Emergency State Fair Hearing Timeframe Changes	MEDI-CAL	The purpose of this supplement to All Plan Letter (APL) 21-011 is to provide Medi-Cal managed care health plans (MCPs) with information regarding the Centers for Medicare and Medicaid Services' (CMS) approval of portions of the Department of Health Care Services' (DHCS) Section 1135 Waiver request as related to the Novel Coronavirus Disease (COVID-19) public health emergency (PHE).
18	DHCS	23-007	4/10/2023	Telehealth Services Policy	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care health plans (MCPs) on the Department of Health Care Services' (DHCS) policy on Covered Services offered through Telehealth modalities as outlined in the Medi-Cal Provider Manual. This includes clarification on those Covered Services which can be provided via Telehealth and the expectations related to documentation for Telehealth.
19	DMHC	23-010	4/10/2023	Coverage of Misoprostol-Only Abortion Care	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 23-010 based on potential disruptions to the availability of mifepristone due to the recently issued federal district court decisions.
20	DMHC	23-011	4/10/2023	Annual Segregation Fund Report	N/A	Assembly Bill (AB) 2205 added California Health and Safety Code (HSC) section 1347.8. Effective July 1, 2023 and annually thereafter, a health plan that offers a qualified health plan through the California Health Benefit Exchange (Exchange) shall report to the director the total amount of funds maintained in a segregated account for abortion services pursuant to subdivision (a) of Section 1303 of the federal Patient protection and Affordable Care Act (Public Law 111-148). This APL provides guidance to health plans on the timing and content requirements for submitting annual segregation fund reports.
21	DMHC	23-012	4/17/2023	Health Plan Annual Assessments	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) 23-012 to provide information to health care service plans (health plans) pertaining to the DMHC's fiscal year (FY) 2023- 24 annual assessment. Health plans are required to file the Report of enrollment Plan on the DMHC eFiling web portal by May 15, 2023.

#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
22	DHCS	20-021	4/19/2023	Acute Hospital Care at Home (REVISED)	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with policy guidance regarding hospitals participating in the Centers for Medicare & Medicaid Services' (CMS) Acute Hospital Care at Home program. The APL was revised to indicate that on December 29, 2022, President Biden signed into law the Consolidated Appropriations Act of 2023. This legislation included an extension of the Acute Hospital Care at Home program waiver that was initiated during the federal public health emergency. The Acute Hospital Care at Home program has been extended to December 31, 2024.
23	DMHC	23-013	4/20/2023	Large Group Coverage of Association Health Plans: Extension of Phase Out and Guidance	GROUP CARE	On December 9, 2019, the Department of Managed Health Care (DMHC) issued All Plan Letter (APL) 19-024 reminding health plans, solicitors, brokers and others of the law codified in Senate Bill 1375 (Stats 2018 ch 700 §3). The DMHC recognizes that some health plans and MEWAs continued to renew large group coverage while the DMHC reviewed compliance submissions for SB 255 and SB 718. As such, health plans contracting with MEWAs may continue to renew large group coverage for up to one year until December 31, 2023, if the health plan submits the required information to the DMHC on or before May 19, 2023.
24	DMHC	23-014	4/24/2023	Health Care Service Plans Are Mandatory Signatories to the CalHHS Data Exchange Framework	MEDI-CAL & GROUP CARE	The purpose of this All Plan Letter (APL) is to inform all health care service plans of their requirement to sign the Health and Human Services Data Exchange Framework (DxF) Data Sharing Agreement (DSA). This DSA defines the parties that are subject to the DxF's new data exchange rules and establishes a common set of terms, conditions, and obligations to support the secure exchange of and access to health and social services information in compliance with applicable laws, regulations, and policies.
25	DHCS	23-008	4/28/2023	Proposition 56 Directed Payments for Family Planning Services	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed health care plans (MCPs) with guidance on directed payments, funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), for the provision of specified family planning services.
26	DHCS	23-009	5/3/2023	Authorization for Post-Stabilization Care Services	MEDI-CAL	The purpose of this All Plan Letter (APL) is to clarify Medi-Cal managed care health plans (MCPs) contractual obligations for authorizing post-stabilization care services. In accordance with Title 28 CCR section 1300.71.4, when a Member is stabilized, but the health care Provider believes that they require additional Medically Necessary Covered Services and may not be discharged safely, the MCP, "shall approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one half hour of the request." To clarify, the "health care provider" as referenced herein refers to both Out-of-Network Providers (i.e., non-contracting Providers) and Network Providers.
27	DHCS	23-010	5/4/2023	Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) about the provision of Medically Necessary Behavioral Health Treatment (BHT) services for Members under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, as outlined in APL 19-010 or any superseding APL, and in accordance with mental health parity requirements. This APL clarifies that the MCP has primary responsibility for ensuring that all of a Member's needs for Medically Necessary BHT services are met across environments, including on-site at school or during virtual school sessions. For example, if educational BHT services provided to a Member by school-based Providers have been discontinued during the COVID-19 Public Health Emergency (PHE), the MCP must ensure that Medically Necessary BHT services are provided. The MCP is responsible for coordinating with other entities and covering any gap in Medically Necessary BHT services for the Member.
28	DHCS	23-011	5/8/2023	Treatment of Recoveries Made by the Managed Care Health Plan of Overpayments to Providers	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) relating to an MCP's recovery of all overpayments to providers.
29	DHCS	23-012	5/12/2023	Enforcement Actions: Administrative and Monetary Sanctions	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care health plans (MCPs) of the Department of Health Care Services' (DHCS) policy regarding the imposition of administrative and monetary sanctions, which are among the enforcement actions DHCS may take to enforce compliance with MCP contractual provisions and applicable state and federal laws. This APL supersedes APL 22-015.
30	DMHCS	23-015	5/16/2023	Supplemental Provider Directory Annual Filing Requirements	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 23-015, as a supplement to APL 23-007 (OPL) – Provider Directory Annual Filing Requirements (2023), to provide additional guidance and a filing extension to health care service plans (plans) regarding the Section 1367.27 Annual Compliance (2023) filing.

#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
31	DHCS	23-013	5/18/2023	Mandatory Signatories to the CalHHS Data Exchange Framework	MEDI-CAL	The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (MCPs) of their requirement to sign the California Health and Human Services Agency (CalHHS) Data Exchange Framework (DxF) Data Sharing Agreement (DSA). This DSA defines the parties that are subject to the DxF's new data exchange rules and establishes a common set of terms, conditions, and obligations to support the secure exchange of and access to health and social services information in compliance with applicable laws, regulations, and policies.
32	DHCS	21-004	5/24/2023	Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services (REVISED)	MEDI-CAL	This All Plan Letter (APL) serves to inform all Medi-Cal managed care health plans (MCPs) of the dataset for threshold and concentration languages and clarifies the threshold and concentration standards specified in state and federal law and MCP contracts. This dataset identifies the threshold and concentration languages in which, at a minimum, MCPs must provide written translated member information.
33	DHCS	23-014	6/9/2023	Proposition 56 Value-Based Payment Program Directed Payments	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with guidance on value-based directed payments, funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), to Network Providers for qualifying services tied to performance on designated health care quality measures in the domains of prenatal and postpartum care, early childhood prevention, chronic disease management, and behavioral health care.
34	DHCS	23-015	6/9/2023	Proposition 56 Directed Payments For Private Services	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information on required directed payments, funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), for the provision of specified state-funded medical pregnancy termination services.
35	DHCS	23-016	6/9/2023	Directed Payments for Developmental Screening Services	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with guidance on directed payments, initially funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), for the provision of standardized developmental screening services for children.
36	DHCS	23-017	6/13/2023	Directed Payments for Adverse Childhood Experiences Screening Services	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with guidance on directed payments, initially funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), for the provision of standardized Adverse Childhood Experiences (ACE) screening services for adults (through 64 years of age) and children.
37	DHCS	23-018	6/23/2023	Managed Care Health Plan Transition Policy Guide	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to all Medi-Cal managed care health plans (MCPs) regarding the 2024 MCP Transition effective January 1, 2024. The 2024 Managed Care Plan Transition Policy Guide (Policy Guide) establishes and details the requirements for the implementation of the 2024 MCP Transition.
38	DMHC	23-016	6/29/2023	Implementation of SB 1338 (2022) - Community Assistance, Recovery, and Empowerment (CARE)	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 23-016 to set out the Department's guidance about how health plans shall ensure they identify enrollees who are involved in CARE implemented by SB 1338 (the CARE Act) and how health plans shall process and pay claims arising from their enrollees' CARE agreements or CARE plans.
39	DMHC	23-017	7/21/2023	Impact of the End of the Federal PHE	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 23-017, which addresses the impact of the end of the COVID-19 public health emergency (PHE) on health plan coverage of COVID-19 tests, immunizations, and therapeutics.
40	DHCS	23-019	7/25/2023	Proposition 56 Directed Payments for Physician Services	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with guidance on directed payments, funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), for the provision of specified physician services.
41	DHCS	23-020	7/26/2023	Requirements for Timely Payment of Claims	MEDI-CAL	The purpose of this All Plan Letter (APL) is to remind Medi-Cal managed care plans (MCPs) of their legal and contractual obligation to timely pay claims submitted by Providers for Covered Services to MCP Members.
42	DHCS	23-021	8/16/2023	Population Needs Assessment and Population Health Management Strategy	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance on the modified Population Needs Assessment (PNA) and new Population Health Management (PHM) Strategy requirements for Medi-Cal Managed Care Plans (MCPs). Additional operational details on the PNA and PHM Strategy are located in the PHM Policy Guide. Any future updates will also be communicated via the PHM Policy Guide.

#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
43	DHCS	23-022	8/16/2023	CoC for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal FFS, on or After January 1, 2023	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with guidance on Continuity of Care for beneficiaries who are mandatorily transitioning from Medi-Cal Fee-For-Service (FFS) to enroll as Members in Medi-Cal managed care. This APL applies to both Medi-Cal only beneficiaries and those dually eligible for Medicare and Medi-Cal, for their Medi-Cal Providers. This APL also describes other types of transitions into Medi-Cal managed care for specific Medi-Cal Member populations for which MCPs must allow Continuity of Care. This APL supersedes APL 22-032
44	DHCS	23-021	8/16/2023	Population Needs Assessment and Population Health Management Strategy	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance on the modified Population Needs Assessment (PNA) and new Population Health Management (PHM) Strategy requirements for Medi-Cal Managed Care Plans (MCPs). Additional operational details on the PNA and PHM Strategy are located in the PHM Policy Guide. Any future updates will also be communicated via the PHM Policy Guide.
45	DHCS	23-022	8/16/2023	CoC for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal FFS, on or After January 1, 2023	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with guidance on Continuity of Care for beneficiaries who are mandatorily transitioning from Medi-Cal Fee-For-Service (FFS) to enroll as Members in Medi-Cal managed care. This APL applies to both Medi-Cal only beneficiaries and those dually eligible for Medicare and Medi-Cal, for their Medi-Cal Providers. This APL also describes other types of transitions into Medi-Cal managed care for specific Medi-Cal Member populations for which MCPs must allow Continuity of Care. This APL supersedes APL 22-032.
46	DMHC	23-018	8/17/2023	RY 2024/MY 2023 Provider Appointment Availability Survey NPMH Provider Follow-Up Appointment Initial Performance Target for Corrective Action	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues All Plan Letter (APL) 23-018 (OPM) – RY 2024/MY 2023 Provider Appointment Availability Survey (PAAS) Non-Physician Mental Health Provider Follow-Up Appointment Initial Performance Target for corrective Action. If this APL does not apply to your health plan, no further action is required related to this APL.
47	DHCS	23-023	8/18/2023	Intermediate Care Facilities for Individuals With Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (and associated Model Contract Language)	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide requirements to all Medi-Cal managed care plans (MCPs) for the Long-Term Care (LTC) Intermediate Care Facility/Home for Individuals with Developmental Disabilities1,2 services provisions of the California Advancing and Innovating Medi-Cal (CalAIM) benefit standardization initiative.3,4 This APL contains requirements related to Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Homes, Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) Homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N) Homes.
50	DHCS	23-024	8/24/2023	Doula Services	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the qualifications for providing doula services, effective for dates of service on or after January 1, 2023.
51	DHCS	23-025	9/14/2023	Diversity, Equity, and Inclusion Training Program Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the Diversity, Equity, and Inclusion (DEI) training program requirements.
52	DHCS	22-016	9/18/2023	Community Health Worker Services Benefit - REVISED	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the qualifications for becoming a Community Health Worker (CHW), the definitions of eligible populations for CHW services, and descriptions of applicable conditions for the CHW benefit. Revised text is found in italics.
53	DMHC	23-019	9/21/2023	Health Plan Expansion for Medicare Medi-Cal Plans	MEDI-CAL & GROUP CARE	This All Plan Letter (APL) provides background and identifies the subsets of health care service plans (plans) regulated by the Department of Managed Health Care (Department) that are required to submit a filing for Medicare Medi-Cal Plans (MMPs), the California-specific names for Exclusively Aligned Enrollment Dual Eligible Special Needs Plans (EAE D-SNPs).
54	DHCS	23-026	9/25/2023	Federal Drug Utilization Review Requirements Designed to Reduce Opioid Related Fraud, Misuse and Abuse	MEDI-CAL	The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care plans (MCPs) of their responsibilities related to the implementation of federal Medicaid Drug Utilization Review (DUR) requirements outlined in section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (H.R. 6, the SUPPORT Act, P.L. 115-271).
55	DHCS	23-027	9/26/2023	Subacute Care Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide requirements to all Medi-Cal managed care plans (MCPs) on the Subacute Care Facility Long Term Care (LTC) benefit standardization provisions of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, including the mandatory transition of Medi-Cal members to managed care.

#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
56	DHCS	23-028	10/3/2023	Dental Services – Intravenous Sedation and General Anesthesia Coverage	MEDI-CAL	The purpose of this All Plan Letter (APL) is to describe the requirements for Medi-Cal managed care health plans (MCPs) to cover intravenous (IV) moderate sedation and deep sedation/general anesthesia services provided by a physician in conjunction with dental services for MCP Members in hospitals, ambulatory surgical settings, or dental offices. This APL supersedes APL 15-012.1 This APL identifies information that MCPs must review and consider during the prior authorization process as described and detailed in the attached guidelines for IV moderate sedation and deep sedation/general anesthesia for dental procedures (Attachment A).

ALAMEDA Alliance FOR HEALTH

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Health Care Services

Steve O'Brien, MD

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

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

Date: **October 13th, 2023**

Subject: **Health Care Services Report**

Utilization Management: Outpatient

- The Health Suite (HS) - Prior Authorization (PA) project to ensure up front PA alignment with back-end claims payment is in its final stages. The last 5 PA categories are being configured, enabling AAH to update to current billable coding by DHCS, refine PA coding requirements and align with claims for proper adjudication. This will also create a PA coding master list by PA category as a resource for our provider partners. On an annual basis, coding will be reviewed and updated with any changes from DHCS. There will be an ongoing internal assessment to identify PA categories appropriate for this process.

- Managed Care Plan Transition in 2024 Planning for Single Plan Model: Augmenting current workflows to encompass 2024 expansion elements along with specific processes to manage transition CoC requests which include:

    - Automation process for CoC authorizations for first 6-12 months
    - develop internal process to capture CoC requests from members and/or providers starting 11/1/23
    - Reporting requirements for DHCS beginning in November through 12/31/2024 as part of the DHCS monitoring and oversight process.

- OP processed 3,300 authorizations for the month of September. The top 3 categories of auth type are radiology at 24%, Op Rehab 20%, HH 7%.

Outpatient Authorization Denial Rates			
Denial Rate Type	**July 2023**	**August 2023**	**September 2023**
Overall Denial Rate	**3.4%**	**3.5%**	**3.6%**
Denial Rate Excluding Partial Denials	**3.1%**	**3.3%**	**3.4%**
Partial Denial Rate	**0.3%**	**0.1%**	**0.2%**

Turn Around Time Compliance			
Line of Business	**July 2023**	**August 2023**	**September 2023**
Overall	**99%**	**99%**	**99%**
Medi-Cal	**99%**	**99%**	**99%**
IHSS	**100%**	**99%**	**100%**
Benchmark	***95%***	***95%***	***95%***

Utilization Management: Inpatient

- The inpatient UM team processed 1,977 authorizations in the month of September, including: 1,321 acute, 371 skilled nursing and subacute, 62 short term custodial addition to discharge related services, IP UM Team maintained average TAT of 0.3 days.

- The 40% volume increase in SNF admissions related to 2023 volume increases from both the Long Term Care carve-in and the dually eligible (MediCare and Medi-Cal) population has been sustained in quarter 3. These new populations have a higher hospitalization rate, which contributed to increases in acute inpatient admissions: Admits/1000. Auth TAT compliance declined to (91%) and is being closely monitored to ensure we return to meeting or surpassing benchmark TAT of 95%.

- At the end of September, TruCare (our system of record for UM review and authorization,) was successfully tested and upgraded. This included the launch of ADT feed Authorization automation, so that authorizations are created automatically in the TruCare system from the ADT feed received by several contracted hospitals (including AHS and Sutter). IP UM is in the monitoring phase of this implementation, that will facilitate earlier notification of admission, reduce administrative burden on hospital providers, and allow the team and our providers to focus efforts on review, care coordination for our members at their most vulnerable, when they are in an acute hospital and transitioning to the next level of care.

- As part of the Transitional Care Services (TCS) requirement for Population Health Management, the IP UM team is identifying high risk members admitted to a hospital, conducts discharge assessment, provides the name of Care Manager for inclusion in the discharge summary, and refers to Case Management department for follow up. In 2024, TCS will also include simplified requirements for low risk members and the IP team will be working on operationalizing the requirements.

- In collaboration with CM, IP UM is working with hospital partners and community based TCS programs to focus on readmission reduction, aligning with their readmission reduction goals.

- IP UM department meets weekly for rounds with contracted hospital providers; Alameda Health System, Sutter, Kindred LTACH, Kentfield LTACH, and Washington, to discuss UM issues, address discharge barriers, and improve throughput and real time communication. These meetings also provide a forum for discussing new requirements, such as Community Supports including Nursing Caregiver Support at home for members transitioning home from hospitals under the care of family members as designated caregivers.

- TruCare Upgrade testing and roll out completed at the end of September. This included testing and roll out of automation of authorization creation for facilities that are sending ADT feed for hospital admissions.

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	**June 2023**	**July 2023**	**August 2023**
Authorized LOS	**5.3**	**5.0**	**5.1**
Admits/1,000	**49.6**	**47.7**	**49.9**
Days/1,000	**261.9**	**238.8**	**253.0**

Turn Around Time Compliance			
Line of Business	**June 2023**	**July 2023**	**August 2023**
Overall	**94%**	**94%**	**91%**
Medi-Cal	**94%**	**94%**	**91%**
IHSS	**94%**	**90%**	**100%**
Benchmark	***95%***	***95%***	***95%***
Inpatient Authorization Denial Rates			
Denial Rate Type	**June 2023**	**July 2023**	**August 2023**
Full Denials Rate	**2.8%**	**1.8%**	**1.7%**
Partial Denials	**0.0%**	**0.0%**	**0.0%**
All Types of Denials Rate	**2.8%**	**1.8%**	**1.7%**

Utilization Management: Long Term Care

- LTC census during September was 1990 members.

- The planning for the carving in of members in need of Intermediate Care Facilities for persons with Developmental Disabilities (ICF-DD) and Subacute in 2024 continues. The LTC team continues working closely with the Integrated Planning Department (IPD) and key stakeholders, such as ICF-DD and Subacute providers, Regional Center of the East Bay, and AAH departments such as Provider Relations, Member Services, Claims and C&O.

    - The final APL for the carving in of members in need of Intermediate Care Facilities for persons with Developmental Disabilities (ICF-DD) in 2024 was issued in August. DHCS deliverables are due 90 days from the APL date.
    - Sub-Acute carve in All Plan Letter was released by DHCS on 9/26/23, and final changes to the Sub-Acute procedures are being made to reflect the requirements.

- In August, LTC members had 37 hospital admissions, with an average LOS of 4.2 days in the hospital.

- ICF-DD and Sub acute Provider Education Town halls scheduled for November and December 2023.

Pharmacy

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

Decisions	Number of PAs Processed
Approved	29
Denied	28
Closed	92
Total	**149**

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

- Medications for nerve pain, hepatitis B, diabetes, anemia, dry eyes, colon cleanse, bacterial infection and migraines are in the top ten categories for denials.

Rank	Drug Name	Common Use	Common Denial Reason
1	LIDOCAINE EXTERNAL PATCH 5%	Nerve Pain	Criteria for approval not met
2	VEMLIDY ORAL TABLET 25 MG	Hepatitis B	Criteria for approval not met
3	OZEMPIC (0.25 or 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PREN-INJECTOR 2 MG/3ML	Diabetes	Criteria for approval not met
4	MIRCERA INJECTION SOLUTION PREFILLED SYRINGE 75 MCG/0.3ML	Anemia	Criteria for approval not met
5	CEQUA OPHTHALMIC SOLUTION 0.09%	Dry Eyes	Criteria for approval not met
6	SUPREP BOWEL PREP KIT ORAL SOLUTION 17.5-3.13-1.6 GM/177 ML	Colon Cleanse	Criteria for approval not met
7	DOXYCYCLINE HYCLATE ORAL CAPSULE 100 MG	Bacterial Infection	Criteria for approval not met
8	ZTLIDO EXTRENAL PATCH 1.8%	Nerve Pain	Criteria for approval not met
9	EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML	Migraines	Criteria for approval not met
10	NA SULFATE-K SULFATE-MG SULF ORAL SOLUTION 17.5-3.13-1.6 GM/177 ML	Colon Cleanse	Criteria for approval not met

- Pharmacy is leading initiatives on PAD (physician administered drugs) focused internal and external partnership and reviewed PAD related UM authorizations as follows:

LOB	Decisions	Number of PAs Processed
Medi-Cal	Approved	244
	Denied	9
IHSS	Approved	10
	Denied	0
Total Cases Closed		73

Line of Business	Turn Around Rate compliance (%)
Medi-Cal	99%
GroupCare	100%

- The Alliance routinely reviews benefits to ensure there is proper alignment of authorized services and proper claim payment to provider partners. This is to ensure that medical services provided to our members are medically necessary and appropriate.

- Effective 9/1/23, the Alliance has updated their Prior Authorization List for Physician Administered Drugs. This will impact outpatient drugs being submitted under the medical benefit as medical claims that are often administered at doctor office or outpatient hospital. This will not affect drugs acquired at the pharmacy level.

- These changes were communicated to our providers and delegates on 8/1/23. In addition, there have been targeted outreach to our top impacted providers to provide supplemental Q&A sessions.

- The Alameda Alliance for Health (AAH) Pharmacy Department has successfully carried out Medi-Cal RX go-live as of 1/1/2022 and continues to serve its members with the same high standards of care.

    - As of September 22, 2023, approximately 124.29 million point-of-sale pharmacy paid claims to participating pharmacies totaling approximately $12.30 billion in payments.
    - Processed 439,643 prior authorization requests.
    - Answered 419,350 calls and 100 percent of virtual hold calls and voicemails have been returned.
    - We have closed submitting Medi-Cal PAs and informing doctor offices to submit to Medi-Cal RX:

Month	Number of Total PA Closed
September 2023	57

- Pharmacy is collaborating with multiple healthcare services departments:

    - Pharmacy is collaborating with multiple departments within healthcare services as well as in-network Intermediate Care Facilities (ICF) partners to help support Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF DD) Carve-In implementation.

    - Pharmacy's TOC (Transition of Care) Program continues collaborating with the AAH Inpatient UM Department and Case Management Disease Management (CMDM) Department to help reduce the number of re-admissions after members are discharged from hospitals through education to the members as well as filling potential gaps between providers and their patients.

- At the start of 2023, DHCS is requiring all MCPs to perform medication reconciliations for their highest risk TOC members based on new criteria from the state. Referred cases from the CMDM daily feed are evaluated to determine if Pharmacy is required for each case. Pharmacy is focusing on lower volume, higher need cases where pharmacy may have the greatest impact on member outcomes.

- Pharmacy is collaborating with CDPH, QI and HealthEd for additional asthma intervention and smoking cessation strategies (e.g., data sharing, toolkit exchange and community worker training materials/programs).

- Pharmacy is collaborating with QI on an educational campaign to providers on untreated hepatitis B and C.

- Pharmacy continues to monitor members on use of opioids.

MME	IHSS	MCAL	Total
July 2023			
50-89	2	244	246
90-119	0	7	7
120-199	0	27	27
200-299	0	17	17
300-399	0	6	6
>400	0	14	14
August 2023			
50-89	7	236	240
90-119	0	14	10
120-199	0	25	31
200-299	0	9	12
300-399	0	7	8
>400	0	11	12

Case and Disease Management

- CM collaborated with IP UM, LTC and ECM to incorporate DHCS's new requirements for Transitional Care Services (TCS). Go-Live was 1/1/23. The requirements include an assigned care manager, completion of a discharge risk assessment and discharge documentation to ensure the member understands their discharge plan.
  CM is continuing to collaborate with internal partners in preparation for extending TCS to all members in January of 2024. CM collaborated with IT to update the ADT feed and automate referrals into the system of record when a member is admitted or discharged.

- CM is collaborating with AAH Pharmacy and one of our hospital partners, Sutter Health, to discuss targeting members with a Congestive Heart Failure (CHF) related hospitalization for Transitional Care Services.

- Major Organ Transplant (MOT) CM Bundle continues to be offered to members in need of evaluation and transplantation of major organs and bone marrow. The volume continues to increase, (currently 393 members). All nurses in case management support members throughout the MOT process, and coordinate services with both the AAH UM department and the Centers of Excellence staff.

- CM continues to collaborate with UM and Pharmacy regarding high-risk utilizers, and CM has improved the workflow to increase CM engagement with high utilizers. The workgroup does deep dives into high utilizer cases with UM partners to understand the drivers of high utilization and identify areas for improvement.

- CM has taken on the responsibility to acquire Physician Certification Statement (PCS) forms before Non-Emergency Medical Transportation (NEMT) trips to better align with DHCS requirements for members who need that higher level of transportation. The transportation coordinators have been able to increase PCS form acquisition from 60% to 85% since implementation in March. CM continues to educate the provider network, including hospital discharge planners, about PCS form requirements.

- CM is working closely with the Population Health Management team to move Disease Management programs forward. The collaborative is working on final touches to the Asthma and Diabetes workflows. Cardiovascular Disease and Depression discussions are beginning.

- CM Continues to collaborate with LTC team on case management needs of LTC members while in the facility or when transitioning out of the facility. CM is assisting the LTC team in outreach to LTC facilities regarding use of capitated brokers for transportation and durable medical equipment.

Case Type	Cases Opened in August 2023	Total Open Cases as of August 2023	Cases Opened in September 2023	Total Open Cases as of September 2023
Care Coordination	578	984	440	846
Complex Case Management	26	84	24	102
Transitions of Care (TCS)	258	394	339	479

CalAIM

Enhanced Case Management

- ECM is working with IPD, Analytics and Provider Services to launch Populations of Focus (Justice Involved & Birth Equity) on 01/01/24.
- California Children's Services (CCS) launched as an ECM provider on 9/1/23. Meetings continue to discuss program stabilization and troubleshoot issues if they arise.
- On going meetings for the Justice Involved (JI) Pilot with ROOTS are underway.
- MOC requirements for Birth Equity were submitted to DHCS on 10/2/23.
- DHCS has extended the MOC submission for the Justice Involved to 10/16/23. The ECM leaders continue to meet with IPD with plans to finish timely.
- Meetings continue with Anthem to discuss and plan for continuity of care the ECM/CS Anthem conversion on 01/01/24.
- Meetings underway with Kaiser on KPHP-AAH transition on 01/01/24
- Meetings with IPD and new ECM providers will begin in October to start the onboarding process.

Case Type	ECM Outreach in June 2023	Total Open Cases as of June 2023	ECM Outreach in July 2023	Total Open Cases as of July 2023	ECM Outreach in August 2023	Total Open Cases as of August2023
ECM	98*	1130	371	1143	696	1235

*06/01/23 Pandemic outreach modifications ended, so face to face outreach was re-instated. Some providers submitted wrong billing codes, so ECM is working with providers to correct.

Community Supports (CS)

- CS services are focused on reducing unnecessary hospitalizations and ED visits. The six initial CS services launched on 1/1/2022 were:
  - Housing Navigation
  - Housing Deposits
  - Tenancy Sustaining Services
  - Medical Respite
  - Medically Tailored/Supportive Meals
  - Asthma Remediation

- CS went live with 3 additional services 7/1/23:
  - (Caregiver) Respite Services
  - Personal Care & Homemaker Services
  - Environmental Accessibility Adaptations (Home Modifications)

- A Self-Funded Pilot for 2 additional Community Supports-like Services continues to support members diverting from skilled nursing or transitioning to home. East Bay Innovations (EBI) is the provider.

- AAH CS staff team continues to meet regularly with each CS provider to work through logistical issues as they arise, including referral management, claims payment and member throughput.

- To meet the regulatory requirements of a closed loop referral process, AAH continues to work with FindHelp as the support platform. AAH has started with onboarding Community Supports providers and the CS team is working closely with each CS provider to bring them onto the platform.

- The CS team will be meeting regularly in October with new CS providers to bring the following programming live 1/1/24:
  - Asthma Remediation for adults
  - Further network expansion for Nursing Facility Transition/Diversion
  - Further network expansion for Community Transition Services
  - Sobering Centers
  - Alameda County Community Food Bank for Medically Tailored Meals/Medically Supportive Food

Community Supports	Services Authorized in June 2023	Services Authorized in July 2023	Services Authorized in August 2023
Housing Navigation	454	471	479
Housing Deposits	156	147	137
Housing Tenancy	1016	1194	725
Asthma Remediation	56	61	58
Meals	1240	1197	1205
Medical Respite	72	85	83
Transition to Home	5	5	4
Nursing Facility Diversion	4	5	5
Home Modification	NA	0	0
Homemaker Services	NA	2	10
Caregiver Respite	NA	0	1

Grievances & Appeals

- All cases were resolved within the goal of 95% within regulatory timeframes.
- Total grievances resolved in September were 7.04 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 2023; we did not meet our goal at 25.9% overturn rate.

September 2023 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	1,090	30 Calendar Days	95% compliance within standard	1,061	97.3%	3.11
Expedited Grievance	1	72 Hours	95% compliance within standard	1	100.0%	0.00
Exempt Grievance	1,791	Next Business Day	95% compliance within standard	1,789	99.8%	5.12
Standard Appeal	26	30 Calendar Days	95% compliance within standard	26	100.0%	0.07
Expedited Appeal	1	72 Hours	95% compliance within standard	1	100.0%	0.00
Total Cases:	2,909		95% compliance within standard	2,878	98.9%	7.04

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

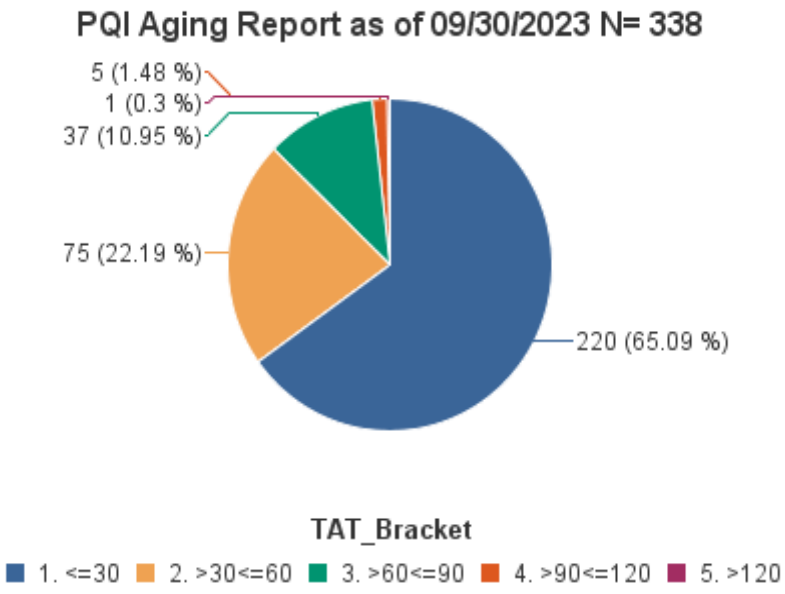
Quality

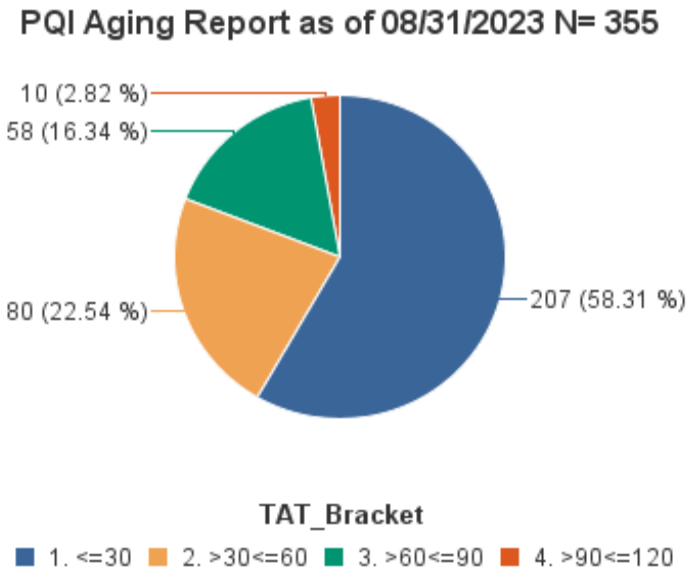
- Quality Improvement continues to track and trend PQI Turn-Around-Time (TAT) compliance. Our goal is closure of PQIs cases within 120 days from receipt to resolution via nurse investigation and procurement of medical records and/or provider responses followed by final MD review when applicable.

- As part of an effort to streamline the PQI review process, Quality of Access issues are reviewed by the Access & Availability team and Quality of Language issues by the Cultural & Linguistics team after they are triaged by the QI Clinical team. Quality of Care and Service issues continue to be reviewed by the QI Clinical staff.

- 98.52% of cases in September and 100% of cases in August were leveled and closed within the required 120-day turnaround timeframe. Therefore, turnaround times for case review and closure remain well within the benchmark of 95% per PQI P&P QI-104 for this lookback period.

- When cases are open for >120 days, it is primarily due to delay in receipt of medical records or provider responses. Measures to identify barriers and close these gaps continue to be a priority.


PQI Aging Report as of 09/30/2023 N= 338
5 (1.48 %)
1 (0.3 %)
37 (10.95 %)
75 (22.19 %)
220 (65.09 %)
TAT_Bracket
1. <=30
2. >30<=60
3. >60<=90
4. >90<=120
5. >120


PQI Aging Report as of 08/31/2023 N= 355
10 (2.82 %)
58 (16.34 %)
80 (22.54 %)
207 (58.31 %)
TAT_Bracket
1. <=30
2. >30<=60
3. >60<=90
4. >90<=120

Quality Improvement: Population Health Management (PHM)

- The Alliance Population Health Management (PHM) program follows the DHCS PHM Policy Guide and National Committee for Quality Assurance (NCQA) standards with the aim of improved health outcomes for all members through assessment of member needs and equitable access to necessary wellness and prevention services, care coordination, and care management.

- Completed first quarterly submission to DHCS for the five new PHM Key Performance Indicators (KPIs) on 8/15.

- Implementing a PHM monitoring strategy for tracking KPIs monthly, PHM strategy goals quarterly, and quality measures annually. Metrics include 1) ED versus PCP, primary care, and Complex Case Management utilization, 2) Transitional Care Services engagement, 3) Enhanced Care Management, 4) Incentive Payment Programs, and 5) HEDIS measures related to children's preventive care, maternal and birth outcomes, and behavioral health.

- Met with Alameda County Health Care Services Agency (HCSA) and City of Berkeley to begin discussions on collaboration for the modified Population Needs Assessment.

ALAMEDA Alliance FOR HEALTH

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

Health Equity

Lao Paul Vang

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

From: **Lao Paul Vang, Chief Health Equity Officer**

Date: **October 13th, 2023**

Subject: **Health Equity Report**

Staffing Plan and Selection Processes:

- **Senior Manager of Health Equity –** The selection process for this position remains on pause status at this time.

Internal Collaboration:

- **Meetings and check-ins with Division Chiefs** – Conduced ongoing 1:1 meetings with the CEO and all Chiefs of Divisions to ensure collaboration and alignment of health equity-related activities.

- **Population Health Management (PHM)** – The Health Equity team has successfully collaborated with the PHM team to develop and launch Cultural Sensitivity Training for the Alliance. Staff will complete this training by December 2023. Below, please find the link to the training.

  (file:////AAH-FILESERV2/Projects/DEPT_HealthCareServices/Health_Education/Cultural%20Sensitivity%20Training/2023/CST%20Recording)

- **Quality Improvement / Health Equity Meeting** – The Quality Improvement and Health Equity team meets bi-weekly to discuss topics of quality and equity. Items discussed at the September meetings were updates on the DEI Consultant, Data Collection Standards, and Funding for PHE projects.

- **National Committee for Quality Assurance (NCQA) Health Equity Standards and Accreditation** – The Health Equity Team is working in close collaboration with the NCQA team and consultant to integrate health equity activities with NCQA health equity standards with an aim to achieve NCQA accreditation for the Alliance by January 2026.

External Collaboration:

- **Bi-weekly meetings with Local Health Plans' Chief Health Equity Officers (CHEOs)** – Attended bi-weekly meetings with other CHEOs to discuss and exchange ideas, lessons learned, and best practices for Health Equity (HE) and Diversity, Equity, and Inclusion (DEI).

- **Monthly Meetings With DHCS' Chief Health Equity Officer (CHEO)** – Continued participation in the monthly meetings with the DHCS' CHEO to discuss and share updates on DHCS health equity priorities and foster collaboration between DHCS and the local health plans CHEOs. The September meeting agenda included APL updates and the DHCS Listening Tours for the Health Equity Roadmap.

- **Elevated Diversity (DEI Consultant) –** The Data analysis collection process started on October 2nd, with an Introduction & Foundation Setting Meeting. Elevated Diversity will meet individually with the PHM, QI, and UM teams to specifically assess and analyze their health equity-related data, including assessing and analyzing non-utilization data to identify health disparities.

    - Since launching the engagement last month, the Elevated Diversity consultants have worked closely with the Health Equity team, as well as other individuals from key functional areas, including the office of the CEO, the data analytics team, and communications personnel. Much of the work conducted to date is of a foundational nature in preparation for more in-depth next steps noted below, which are slated to take place in October and November, including:
        - Hosting 1:1 Leadership sessions, small group listening sessions, and distributing an org-wide sentiments survey.
        - Conducting an in-depth review of the data collection processes and analysis with key data analytics team members.
        - Conducting a review of the DHCS APL 23-025 on DEI Training requirements and using them as guides for developing a comprehensive DEI training curriculum for the Alliance.

Policy Development:

- **Stipend Policy** – HR, Legal, and Administration are reviewing the draft policy for the stipend payments for the Values in Action and the Diversity, Equity, Inclusion, and Belong Committees.

Diversity, Equity, Inclusion, and Belonging (DEIB) and Values in Action (VIA) Committees:

- **DEIB Committee** – The CHEO chaired the monthly meeting of the DEIB Committee. The DEIB discussed planning events for FY 2023-2024 and the discussion and planning of DEIB Employee Resource Groups (ERGs). A decision was made to have the committee attend a vendor demo on establishing ERGs for the Alliance.

- **VIA Committee** – The CHEO chaired the monthly meeting of the VIA Committee.

    - The VIA Committee discussed the upcoming event on October 20th (Staff Connection for Fall). It was brought to the committee's attention that in October, there are several other divisional activities, such as Compliance Week, IPD Week, and Customer Service Week, and it was decided to combine all functions into one event during the November 20th week. For food vendors, the group chose to find smaller, woman-owned, and minority vendors. The committee also discussed agenda items for the upcoming All Staff Meeting, the stipend policy, and other procedural issues.

Department of Health Care Services (DHCS)

- **The DHCS** issued the final All Plan Letter (APL) 23-025. This APL provides Medi-Cal managed care plans (MCPs) guidance and requirements regarding Diversity, Equity, and Inclusion (DEI) Training. The Health Equity Team is collaborating with Elevated Diversity (Consultant) to design a comprehensive DEI training based on this APL. Please see attached APL 23-025 for details.

CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

DATE: September 14, 2023

ALL PLAN LETTER 23-025
SUPERSEDES ALL PLAN LETTER 99-005

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: DIVERSITY, EQUITY, AND INCLUSION TRAINING PROGRAM REQUIREMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the Diversity, Equity, and Inclusion (DEI) training program requirements.

BACKGROUND:
As articulated in the Department of Health Care Services' (DHCS) Comprehensive Quality Strategy,[1] the following domains represent DHCS' multi-pronged vision to build analytic, workforce and programmatic capacity, at all levels, to advance health equity for Medi-Cal members:

- Data collection and stratification: Complete, accurate data on race, ethnicity, disability, language, sexual orientation, and gender identity and/or expression information for Medi-Cal members will be utilized to illuminate and address health inequities regionally and across DHCS programs.
- Workforce diversity and cultural responsiveness: Medi-Cal workforce, at all levels, should reflect the diversity of the Medi-Cal population and always provide culturally and linguistically appropriate care.
- Eliminating health disparities: Eliminate racial, ethnic, and other disparities within the Medi-Cal population and support policy efforts to eliminate disparities, driven by health-related social needs, between Medi-Cal members and commercial or other Medicare populations.

The MCP DEI training program is a core part of this effort and will support MCPs in creating a better relationship and connectivity with diverse MCP Members across populations disadvantaged by the system. Additionally, trainings can create an inclusive environment within the MCP organization and externally with Network Providers, and other community-based contractors and staff with lived experience improving MCP

[1] DHCS' Comprehensive Quality Strategy is available at: https://www.dhcs.ca.gov/services/Pages/DHCS-Comprehensive-Quality-Strategy.aspx

Members' outcomes by enhancing access to care, reduction of health disparities, and overall better quality of care. For purposes of this APL, the DEI training program includes sensitivity, diversity, cultural competency and cultural humility, and health equity training programs.

Culture is comprised of, but not limited to, belief systems, rituals, values, norms, and practices. Organizational cultural competency is the ability of health care organizations and individuals to actively apply knowledge of cultural behavior and linguistic issues when interacting with Medi-Cal members from diverse cultural and linguistic backgrounds. Cultural competency requires the recognition and integration by the health care professionals of Medi-Cal members' behaviors, values, norms, practices, attitudes, and beliefs about disease causation and prevention into health care services provided. Development and incorporation of these interpersonal and intracultural skills should effect a positive change in the manner in which health care is delivered to culturally diverse Medi-Cal members. Culturally competency enables improved communication between Providers and Medi-Cal members who may be from different ethnic and cultural backgrounds. Culturally competent care ultimately leads to improved access and health outcomes.

POLICY:
In alignment with the timeline presented in Appendix A, MCPs must develop a DEI training program that encompasses sensitivity, diversity, cultural competency and cultural humility, and health equity trainings, for all MCP staff, and Network Providers regardless of their cultural or professional training and background.[2] All trainings must be specific to MCP Member demographics including, but not limited to Members' sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, within specific regions.[3] The DEI training program must align with the National Committee for Quality Assurance (NCQA) Health Equity Accreditation Standards.[4]

Guidelines for MCP Administration Implementation:
An MCP's Chief Health Equity Officer (HEO) must oversee the DEI training program, and ensure that all MCP staff, as well as the MCP's Subcontractors, Downstream

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[2] 2024 Contract, Exhibit A, Attachment III, Subsection 5.2.11 (Cultural and Linguistic Programs and Committees). MCP boilerplate Contracts are available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.
[3] State law is searchable at: https://leginfo.legislature.ca.gov/.
[4] The NCQA Health Equity Standards and Guidelines can be purchased at: https://store.ncqa.org/.

Subcontractors, and Network Providers, receive the mandatory DEI trainings. The HEO must review all training materials issued by the MCP and ensure content is up-to-date, evidence-based, and includes best practices for serving MCP Members that are specific to the MCP's servicing counties.[5] The MCP must develop a mechanism for monitoring DEI training completion, deficiencies, and record maintenance. The developed monitoring mechanism must include disciplinary actions the MCP will enforce for individuals with a grievance concerning discrimination filed against them. Additionally, MCPs must annually inform the Quality Improvement and Health Equity Committee of the DEI training program with reports that must include at a minimum: training program materials; compliance reports; and any adjustments made to the original training program.

Guidelines for DEI Training and Education Program:
The DEI training program must be region specific and at a minimum include consideration of health-related social needs that are specific to the MCP's servicing counties, regional demographics, and disparity impacts of all of the MCP's current Members including but not limited to the Seniors and Persons with Disabilities population; those with chronic conditions; those with Specialty Mental Health Service and/or Substance Use Disorder needs; those with intellectual and developmental disabilities; and children with special health care needs. The DEI training program must also incorporate the following:

1. Explicit consideration and acknowledgement of structural and institutional racism and health inequities, and their impact on MCP Members, staff, Network Providers, Subcontractors, and Downstream Subcontractors.
2. Information about relevant health inequities and identified cultural groups in the MCP's service area, which includes but is not limited to:
    a. The groups' beliefs about illness and health;
    b. MCP Member experience, including perceived discrimination and the impacts of implicit bias;
    c. Lesbiany, gay, bisexual, transgender, queer or questioning, intersex, asexual, and more (LGBTQIA+) concerns, including asking for and respecting the name and pronouns MCP Members and family members use and avoiding assumptions about partners, spouses, and children;[6]
    d. Need for gender affirming care;

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[5] See APL 19-017, Quality and Performance Improvement Requirements, or any superseding APL. APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

[6] LGBTQIA+ is an abbreviation for lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and more. These terms are used to describe a person's sexual orientation or gender identity.

   e. Methods of interacting with Providers and the health care structure;
   f. Traditional home remedies that may impact how the Provider should treat the MCP Member; and
   g. Language and literacy needs.
3. Accommodation of different learning styles (e.g., visual, auditory, or written) and strategies to promote motivation and incentives to integrate concepts into practice and behavior change.
4. Components to the training should allow for observational assessments and evaluation strategies.
5. Community input and advisement on development of the training as well as relevant issues, barriers, and discrimination within specific MCP service locations and counties.
6. Development of a process for evaluating and determining the need for special initiatives regarding material to be included in the DEI training program.
7. Recruitment and retention of staffing that represents the community they serve, are responsive to community needs, and dedicated staff who apply the DEI training program principles.
8. Assessment of the MCP's staff, Subcontractors, Downstream Subcontractors, and Network Providers for incorporating DEI training goals into their interactions with MCP Members and staff with lived experience.
9. Designated staff for coordinating and facilitating the integration of DEI training guidelines.
10. Establishment of an array of communication tools for distributing information to MCP staff, Subcontractors, Downstream Subcontractors, and Network Providers.
11. Participation with government, community, and educational institutions in matters related to best practices encompassing the principles of DEI training so that they may be integrated into the MCP's specific DEI training program.
12. Evaluation of the effectiveness of the DEI training program strategies for improving the health status of diverse populations with applicable alterations to the DEI trainings.
13. Provision of training in multiple formats (e.g., braille, large print, audio, translations, etc.) as requested by MCP staff, Subcontractors, Downstream Subcontractors, and Network Providers.

<u>New Staff and Provider Training Requirements</u>

MCPs must provide DEI training to new MCP staff, Subcontractors, Downstream Subcontractors, and Network Providers serving MCP Members within 90 days of start date that reflects the above criteria. The objective is to teach participants an enhanced awareness of diverse imperatives and issues related to improving access and quality of care for MCP Members.

Ongoing Staff and Provider Education and Training
MCPs must implement comprehensive and ongoing DEI training for all MCP staff, Subcontractors, Downstream Subcontractors, and Network Providers serving Members during times of re-credentialing or contract renewals.

Ongoing Evaluation and Feedback for DEI Training Program
The HEO must conduct annual evaluation, or on a more frequent basis as necessary for evolving best practices, of its DEI education and training program by using the following strategies:

1. Identifying opportunities for education and training based on analysis of health outcomes impacted by cultural and linguistic issues;
2. Specifically addressing training deficiencies found in the health care delivery systems with educational solutions;
3. Instituting methods to utilize and network with community-based organizations that work with diverse communities for appraisal of educational efforts;
4. Involving community leadership and decision-makers, including those with lived experience, in the design and development of education evaluation programs; and
5. Engaging with the MCP Community Advisory Committee for continued DEI training program recommendations and feedback for consideration.

Sources from these ongoing evaluations may include encounter data analyses; feedback from MCP Members, staff, and Providers; self-assessments; and outside audits.

Sharing and Exchange of Educational Resources
MCPs located in the same county must coordinate DEI trainings that are reflective and encompassing of the criteria outlined in this APL so that if an MCP, Subcontractor, Downstream Subcontractor, or Network Provider completes the training for one MCP within the same county, then they will have met the obligation to complete the training for all other MCPs within the same county and can provide an attestation of training completion. All MCP HEOs within a similar geographical region or county must collaborate on DEI training criteria to ensure alignment and accurate training records.

Dissemination of Information
Each MCP must develop a system of communication to ensure coordination and dissemination of cultural and linguistic information and activities to MCP staff, Subcontractors, Downstream Subcontractors, and Network Providers.

Incorporating DEI Training into the Quality Improvement and Health Equity Transformation Program (QIHETP):
The HEO must incorporate the DEI training program within the QIHETP goals for quality improvement (QI) and health equity projects pertaining to cultural needs of the MCP's Members. These projects may assist the MCP in refining its delivery of health care services to achieve the optimum quality of care for its diverse membership. The purpose of QI, as it relates to culturally and linguistically diverse services, is to continuously improve service delivery and quality of care for populations disadvantaged by the system. The QI process should provide essential information to health care Providers and MCP Members about the effectiveness and appropriateness of an MCP's culturally and linguistically diverse services. The HEO must integrate components of DEI training priorities into the QIHETP allowing MCP Members to assess whether an MCP meets their culturally and linguistically diverse needs, and will in turn provide the MCP with feedback to assist it in developing and implementing strategies to further refine its operations and quality of care.

MCPs must institute, at a minimum, the following:

1. DEI training program evaluation within ongoing QI programs (see Appendix B);
2. Evaluation of staff and MCP Members' grievances and complaints regarding discrimination, cultural biases, or insensitive practices;
3. Evaluation of MCP Member's language access services to include written and oral interpretation services and ability to request auxiliary aids for both in-person office visits and telehealth visits;[7]
4. Evaluation of MCP Members' satisfaction regarding culturally competent care;
5. Monitoring of any actions taken by the United States Equal Employment Opportunity Commission regarding discriminatory practices by medical groups and other Subcontractors;
6. Methods to identify health care needs of diverse MCP Members, and conduct assessments to monitor the effectiveness of health care services; and
7. Provision of information on MCP's quality performance upon request to MCP Members in a format that is easily understood.

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's contractually required P&Ps, the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) contract manager within 90 days of the release of this APL. If an MCP determines that no

[7] For more information on language assistance services, see APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services, or any superseding APL. For any MCPs offering commercial line of businesses, changes to Language Assistance Program descriptions will need to be filed with the Department of Managed Health Care.

changes to its P&Ps are necessary, the MCP must submit an email confirmation to its MCOD Contract Manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are further 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.[8] These requirements must be communicated by each MCP to all Subcontractors and Network Providers. DHCS may impose Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. For additional information regarding administrative and monetary sanctions, see APL 23-012, and any subsequent iterations on this topic. Any failure to meet the requirements of this APL may result in a CAP and subsequent sanctions.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

[8] For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic.

Appendix A

Implementation Timeline

- Phase 1: By January 1, 2025—Training Development
  - January 1, 2024—July 1, 2024
    - New MCPs learn about their servicing populations and MCP partners within the region.
    - MCPs assess specific needs for the servicing regions, biases, and Member experiences.
  - July 1, 2024—December 31, 2024
    - MCPs begin to develop their DEI training program.
    - Cross collaboration with partnering regional MCPs.
    - MCPs submit DEI Training Programs to DHCS for review and approval.
- Phase 2: By January 1, 2026—Training Completion
  - January 1, 2025—July 1, 2025
    - MCPs begin to pilot the DEI Training Program.
    - MCPs assess the training program and address issues/concerns learned from the pilot.
  - July 1, 2025—December 31, 2025
    - Training completion required for all MCP staff, Contractors, Subcontractors, downstream Subcontractors, and Network Providers.

Appendix B

Quality Measurements must be based on timely, valid, and reliable data that, at a minimum, aligns with NCQA Health Equity Accreditation (HEA) achievement and HEA standards for collecting Race/Ethnicity, Language, Gender Identity and data. Sources of data may include, but are not limited to the following:

1. Self-assessment survey data
2. Patient satisfaction survey data
3. Provider survey data
4. Disenrollment survey data
5. Quality of care studies
6. Provider office review instruments
7. External audits
8. Administrative data
9. Population Health Management Service data
10. Grievance and Appeals data
11. Community Advisory Committee feedback and advice
12. Medi-Cal Accountability Set Performance Measures
13. Medi-Cal Rx data feeds
14. Population Health Management Program Key Performance Indicators

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 13th, 2023**

Subject: **Information Technology Report**

Call Center System Availability

- AAH phone systems and call center applications performed at 100% availability during the month of September 2023 despite supporting 97% of staff working remotely.

- As part of the call center processes of efficiency and effectiveness, IT is implementing Calabrio Analytics and Speech to Text features which will accurately and cost-effectively analyze customer interactions and agent activity along with its multichannel artificial intelligence, all-in-one solution that captures and transforms data, turning raw interactions into usable data for reporting. This Calabrio Analytics and Speech to Text feature is planned to be rolled out in the month of October 2023.

IT Security Program

- IT Security 3.0 initiative is one of the Alliance's top priorities for fiscal year 2023 and 2024. Our goal is to continue to elevate and further improve our security posture, ensure that our network perimeter is secure from threats and vulnerabilities, and to improve and strengthen our security policies and procedures.

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

    - **Key initiatives include:**

        - Remediating issues from security assessments. (e.g., Cyber, Microsoft Office 365, & Azure Cloud).

        - Continue to Create, update, and implement policies and procedures to operationalize and maintain security level after remediation.

- Immutable Backup Implementation project has kicked-off. This project has disaster recovery and IT security impacts to ensure the protection and isolation of the Alliance's data backup from ransomware attacks.

    - Immutable backup testing has been completed successfully.
    - Initial Veeam and CommVault backup sets are now in progress.
        - This process will take 4-6 weeks based on the amount of data. The seeding process is now at 90% and expected to be complete by the end of October 2023.

- The Azure Cloud Governance Framework centers to improve and strengthen our cloud security policies and procedures. It will also focus on Cost containment for cloud resources, Network and border security, Database security, Data storage security, Identity management, access control, Operational security, and Security monitoring and alerting. Additionally, it aims at Data Loss Prevention in the cloud space.
    - Best practice recommendations from the vendor have been received and is now under internal review.

Fax Services

- Our Fax application system (RightFax) has been successfully upgraded in the month of September 2023 to a new version to comply with Authorization application upgrade (TruCare).

Encounter Data

- In the month of September 2023, the Alliance submitted 197 encounter files to the Department of Health Care Services (DHCS) with a total of 320,839 encounters.

- Percentage of timely submissions was above 90% for Institutional Claims, and 89% for Professional Encounters.

Enrollment

- The Medi-Cal Enrollment file for the month of September 2023 was received and loaded to HEALTHsuite.

HealthSuite

- The Alliance received 247,423 claims in the month of September 2023.

- A total of 211,487 claims were finalized during the month out of which 169,933 claims auto adjudicated. This sets the auto-adjudication rate for this period to 80.3%

- HEALTHsuite application encountered a 15-minute outage on September 15th. This sets the uptime of 99.86% for the application.

TruCare

- A total of 16,269 authorizations were loaded and processed in the TruCare application.

- The TruCare application continues to operate with an uptime of 99.99%.

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 “Summary of Medi-Cal and Group Care member enrollment in the month of September 2023”.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of September 2023”.
- The following tables 1-1 and 1-2 are supporting documents from the enrollment summary section.

Table 1-1 Summary of Medi-Cal and Group Care Member enrollment in the month of September 2023

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
September	344,505	4,634	9,462	5,629	128	146

1. MC – Medi-Cal Member 2. GC – Group Care Member

Table 1-2 Summary of Primary Care Physician (PCP) Auto-Assignment For the Month of September 2023

Auto-Assignments	Member Count
Auto-assignments MC	1,317
Auto-assignments Expansion	1,009
Auto-assignments GC	44
PCP Changes (PCP Change Tool) Total	2,768

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of September 2023”.
- There were 16,269 authorizations processed within the TruCare application.
- TruCare Application Uptime – 99.99%.
- The following table 2-1 is a supporting document from the TruCare summary section.

Table 2-1 Summary of TruCare Authorizations for the Month of September 2023*

Transaction Type	Inbound automated Auths	Errored	Total Auths Loaded in TruCare
Paper Fax to Scan (UM, BH)	2,128	1,596	1,177
Provider Portal Requests (UM, BH)	3,744	761	3,673
EDI (CHCN historical)	4,406	561	4,391
Provider Portal to AAH Online (Long Term Care)	43	25	37
IP Auth from ADT	143	10	133
Provider Portal to AAH Online (Behavioral Health)	5	4	157 *(Manual + Automated)*
Manual Entry (all other not automated or faxed vs portal use)	N/A	N/A	2,025
Total			11,593

Key: EDI – Electronic Data Interchange

Web Portal Consumer Platform

- The following table 3-1 is a supporting document from the Web Portal summary section. (Portal reports always one month behind current month)

Table 3-1 Web Portal Usage for the Month of August 2023

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	6,509	4,672	204,619	703
MCAL	98,342	2,913	7,477	931
IHSS	3,478	81	102	17
Total	**108,329**	**7,666**	**212,198**	**1,651**

Table 3-2 Top Pages Viewed for the Month of August 2023

Category	Page Name	Page Views
Provider	Member Eligibility	833434
Provider	Claim Status	241390
Provider - Authorizations	Auth Submit	14370
Provider - Authorizations	Auth Search	7214
Member	Provider Directory	9758
Member My Care	Member Eligibility	4060
Provider - Claims	Submit professional claims	3301
Provider	Member Roster	2753
Member Help Resources	ID Card	2238
Member Help Resources	Find a Doctor or Hospital	1875
Member Help Resources	Select or Change Your PCP	1290
Member Home	MC ID Card	1174
Member My Care	My Claims Services	893
Provider - Reports	Reports	858
Provider - Provider Directory	Provider Directory	840
Member My Care	Authorization	607
Provider	Forms	572
Member Help Resources	Request Kaiser as my Provider	538
Provider - Provider Directory	Manual	352
Member My Care	My Pharmacy Medication Benefits	348
Provider - Home	Long Term Care Forms SSO	345
Member Help Resources	Forms Resources	344
Member My Care	Member Benefits Materials	329
Member Help Resources	Authorizations Referrals	250

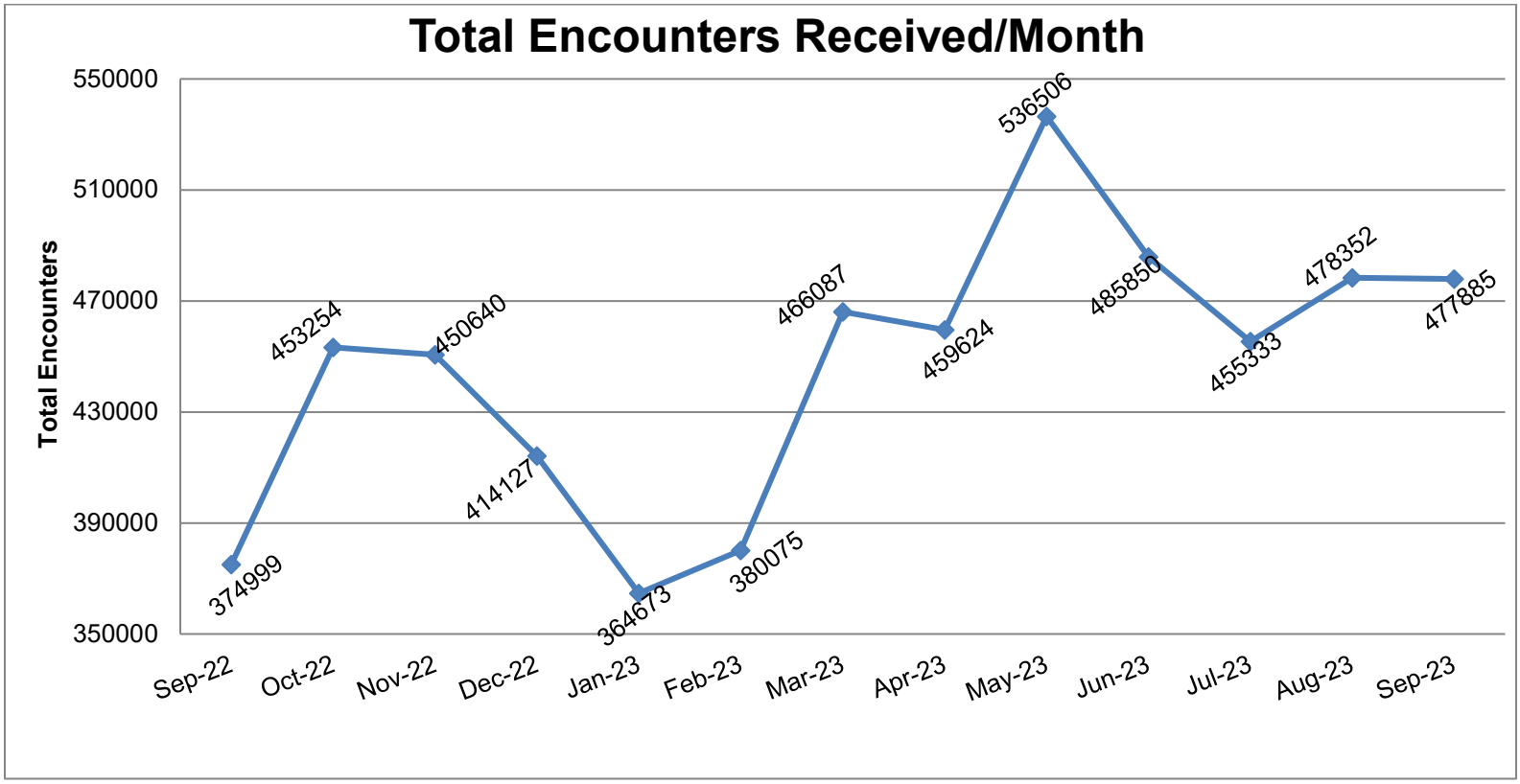
*Provider Portal (Green), Member Portal (Blue)

Encounter Data from Trading Partners 2023

- **ACBH**: September monthly files (0 records)
    - No longer receiving encounter files but through HCSA.
- **AHS**: September weekly files (5,479 records) were received on time.
- **BAC**: September monthly file (38 records) were received on time.
- **Beacon**: September weekly files (0 records)
    - No longer receiving encounter files.
- **CHCN**: September weekly files (77,060 records) were received on time.
- **CHME**: September monthly file (6,212 records) were received on time.
- **CFMG**: September weekly files (12,302 records) were received on time.
- **Docustream**: September monthly files (562 records) were received on time.
- **EBI**: September monthly files (867 records) were received on time.
- **HCSA**: September monthly files (2,490 records) were received on time.
- **IOA**: September monthly files (1,086 records) were received on time.
- **Kaiser**: September bi-weekly files (79,751 records) were received on time.
- **LogistiCare**: September weekly files (22,456 records) were received on time.
- **March Vision**: September monthly file (4,933 records) were received on time.
- **MED**: September monthly file (144 records) were received on time.
- **Quest Diagnostics**: September weekly files (17,008 records) were received on time.
- **SENECA**: September monthly file (74 records) were received on time.
- **Magellan**: September monthly files (352,811 records) were received on time.

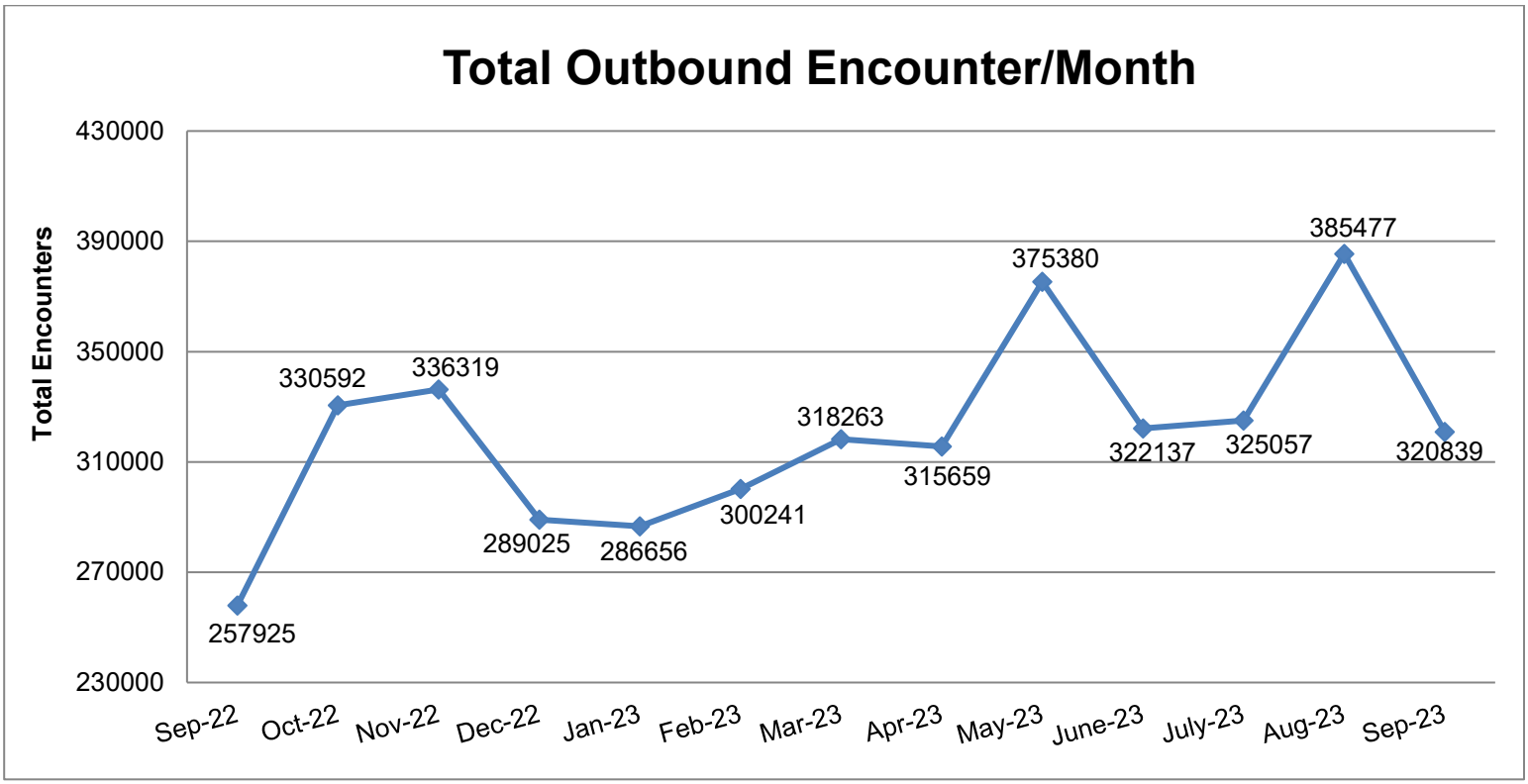
Trading Partner Medical Encounter Inbound Submission History

Trading Partners	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	July-23	Aug-23	Sep-23
Health Suite	175955	171386	174429	177828	163764	167475	238283	218296	251858	267437	224540	244907	247423
ACBH		8	51	87	86	39	95						
AHS	5609	5589	6015	6332	4568	5377	5088	6353	5380	6250	4363	4380	5479
BAC	37	39	38	35	199	34	32	38	40	37	39	38	38
Beacon	16040	13490	12883	10437	13824	11036	12159	15799	5822	4559	620		
CHCN	75234	136445	108148	83258	87182	83191	82394	84654	117764	90418	102081	85836	77060
CHME	5191	5214	5152	4822	4574	5303	4729	5277	4987	5692	5706	5704	6212
Claimsnet	6940	15668	19173	12790	9679	11694	8851	16155	12526	9986	12379	8946	12302
Docustream	1715	1294	1435	1487	1327	1794	1361	865	575	607	567	744	562
EBI								976	15	910	1664	814	867
HCSA	4440	2098	3734	1781	1825	1976	590	78	72	5573	3824	3466	2490
IOA						172	156	201	325	974	424	673	1086
Kaiser	48613	63341	76637	81333	35798	56965	73095	68883	91196	53820	56673	76278	79751
Logisticare	19257	19041	23451	16946	24456	18034	21647	20558	28628	20859	22235	27129	22456
March Vision	3824	3693	3497	4427	3598	3434	3281	4275	3647	5101	4468	4563	4933
MED											9	11	144
Quest	12144	15948	15997	12564	13793	13551	14326	17216	13671	13627	15741	14859	17008
SENECA												4	74
Total	374999	453254	450640	414127	364673	380075	466087	459624	536506	485850	455333	478352	477885



Outbound Medical Encounter Submission

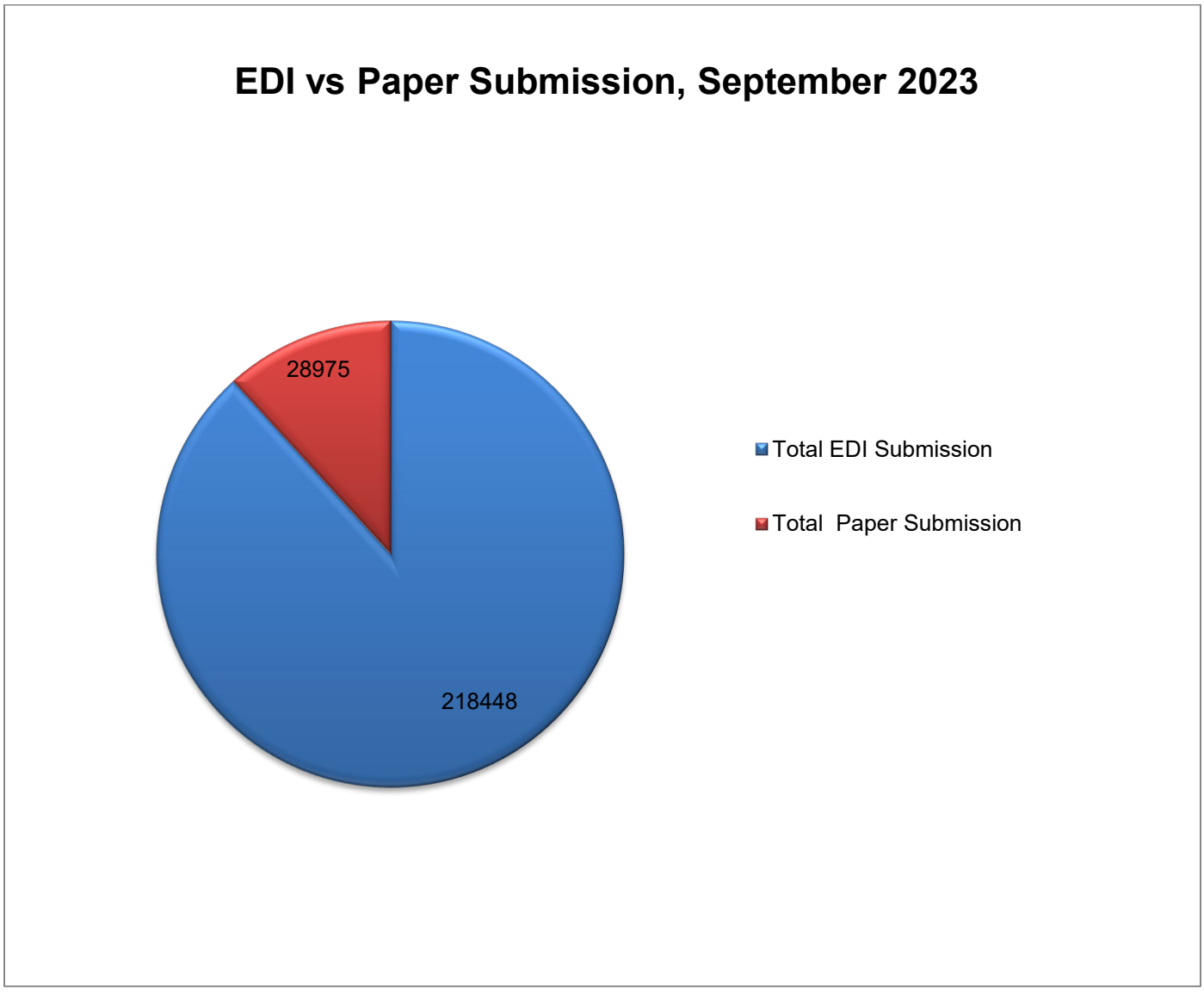
Trading Partners	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Health Suite	96495	121299	95516	97435	114224	128102	117672	117823	151866	126674	147199	170751	127465
ACBH		4	36	60	56	21	73						
AHS	4360	6626	5915	5208	5439	5260	3845	7300	5236	5070	5318	4251	4253
BAC	37	37	38	33	196	33	32	38	40	37	39	37	38
Beacon	12054	10967	10172	8001	11282	8910	9674	11927	2879	2233	318		
CHCN	50714	74449	92283	55698	58881	58279	59074	60373	79256	65595	56593	74313	55365
CHME	5069	5016	4843	4729	4470	5181	4606	5159	4864	5577	5595	5546	6063
Claimsnet	4614	10491	11118	8983	8241	8334	6361	9834	10891	7445	8849	6386	7075
Docustream	1436	1060	1134	1268	1117	1521	1232	481	411	378	347	529	441
EBI								906	15	872	1574	804	855
HCSA	2368	2013	2001	1725	1777	1304	287	52	55	1781	3778	3405	2349
IOA						168	152	45	276	751	410	654	984
Kaiser	47861	62682	75808	80464	35360	55930	72409	65652	72893	68887	55988	75591	78162
Logisticare	19001	18457	23178	16729	24291	12223	27071	20411	28455	20787	21686	26670	22142
March Vision	2631	2601	2396	2938	2454	2308	2400	3006	2366	3408	2720	2737	2992
MED											9	11	126
Quest	11285	14890	11881	5754	18868	12667	13375	12652	15877	12642	14634	13788	12456
SENECA												4	73
Total	257925	330592	336319	289025	286656	300241	318263	315659	375380	322137	325057	385477	320839



HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total Claims
23-Sep	218448	28975	247423

Key: EDI – Electronic Data Interchange

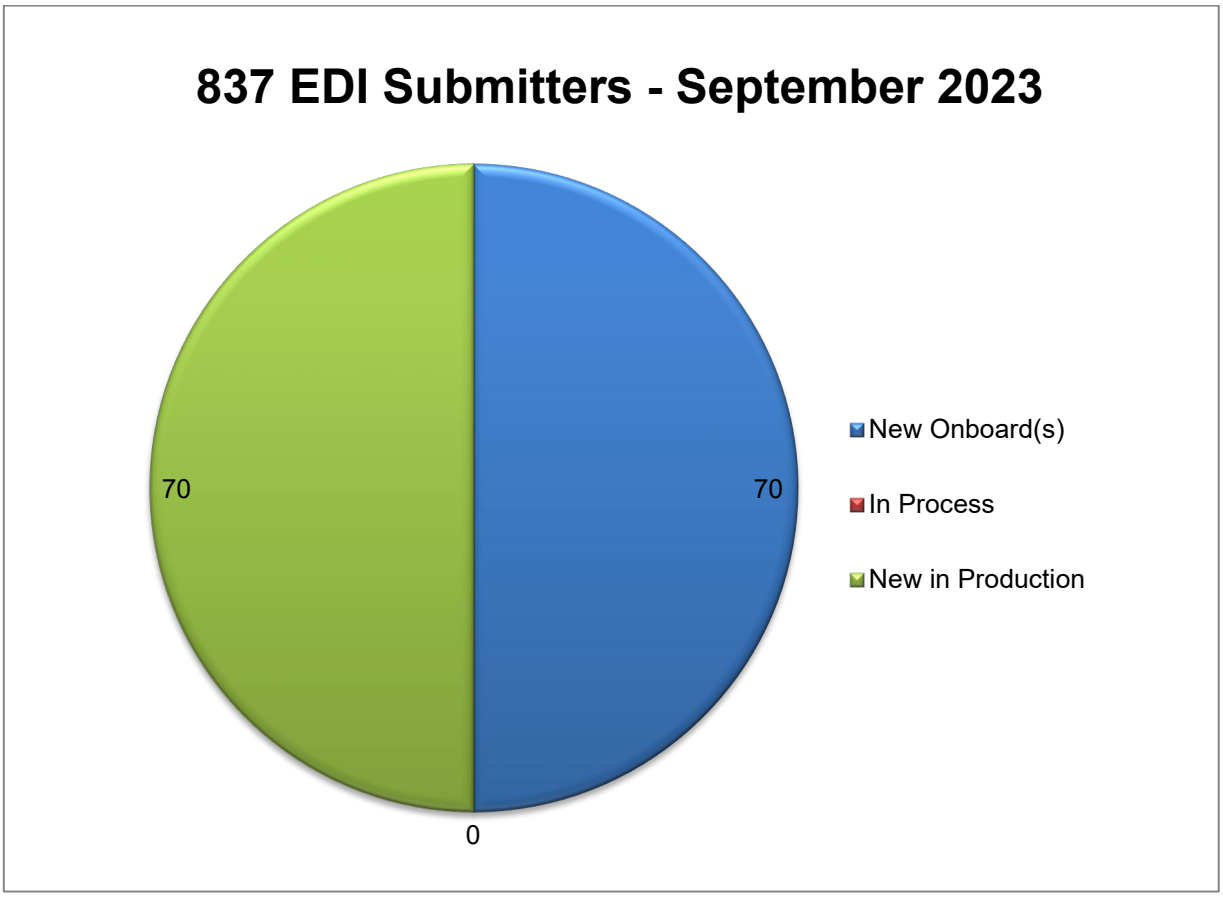


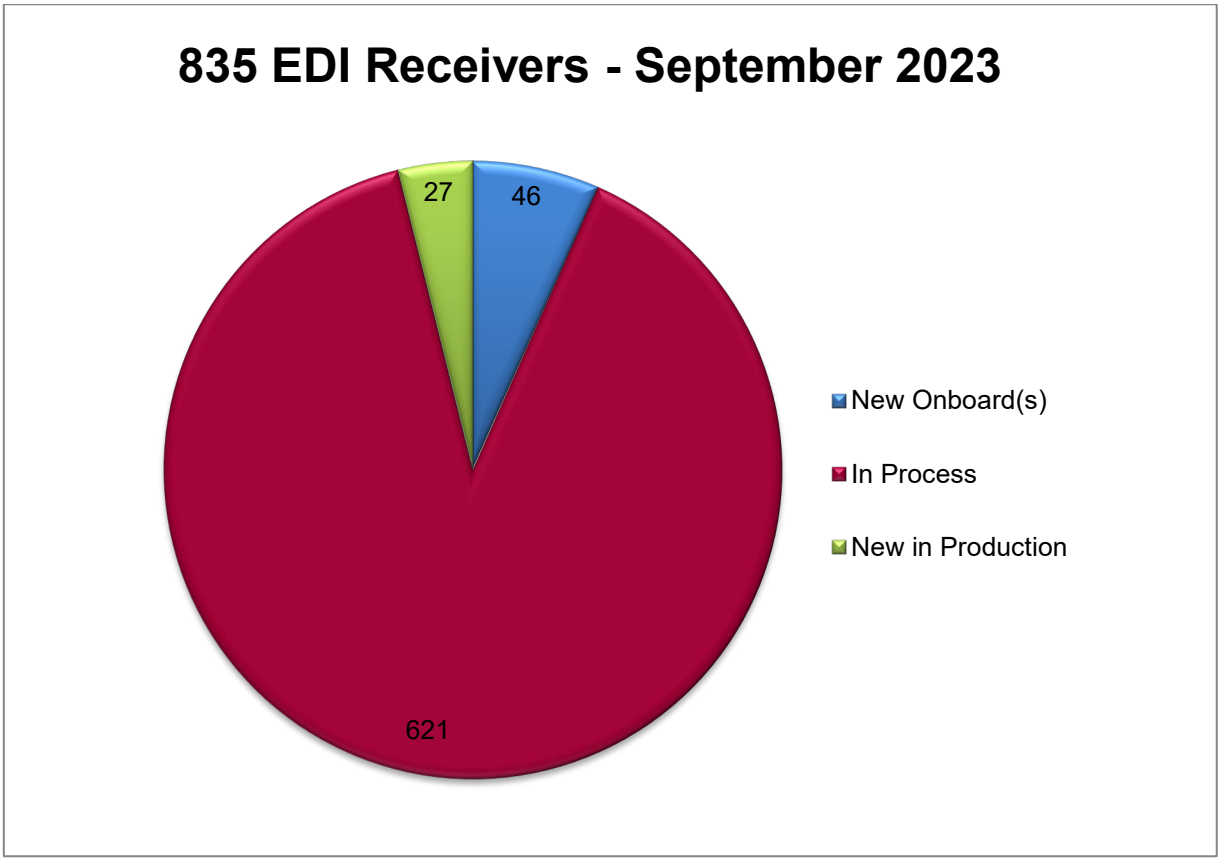
Onboarding EDI Providers - Updates

- September 2023 EDI Claims:
  - A total of 1891 new EDI submitters have been added since October 2015, with 70 added in September 2023.
  - The total number of EDI submitters is 2631 providers.

- September 2023 EDI Remittances (ERA):
  - A total of 819 new ERA receivers have been added since October 2015, with 27 added in September 2023.
  - The total number of ERA receivers is 835 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-22	17	0	17	2167	48	407	26	568
Nov-22	49	2	47	2214	50	410	47	615
Dec-22	19	0	19	2233	20	421	9	624
Jan-23	13	2	11	2244	21	423	19	643
Feb-23	24	0	24	2268	37	457	3	646
Mar-23	55	0	55	2323	78	472	63	709
Apr-23	50	3	47	2370	24	491	5	714
May-23	35	5	30	2400	44	527	8	722
Jun-23	79	7	72	2472	58	544	41	763
Jul-23	48	2	46	2518	62	583	23	786
Aug-23	44	1	43	2561	41	602	22	808
Sep-23	70	0	70	2631	46	621	27	835


837 EDI Submitters - September 2023
70
70
0
New Onboard(s)
In Process
New in Production


835 EDI Receivers - September 2023
27
46
621
New Onboard(s)
In Process
New in Production

Encounter Data Submission Reconciliation Form (EDSRF) and File Reconciliations

- EDSRF Submission: Below is the total number of encounter files that AAH submitted in the month of September 2023.

File Type	September-23
837 I Files	33
837 P Files	164
Total Files	197

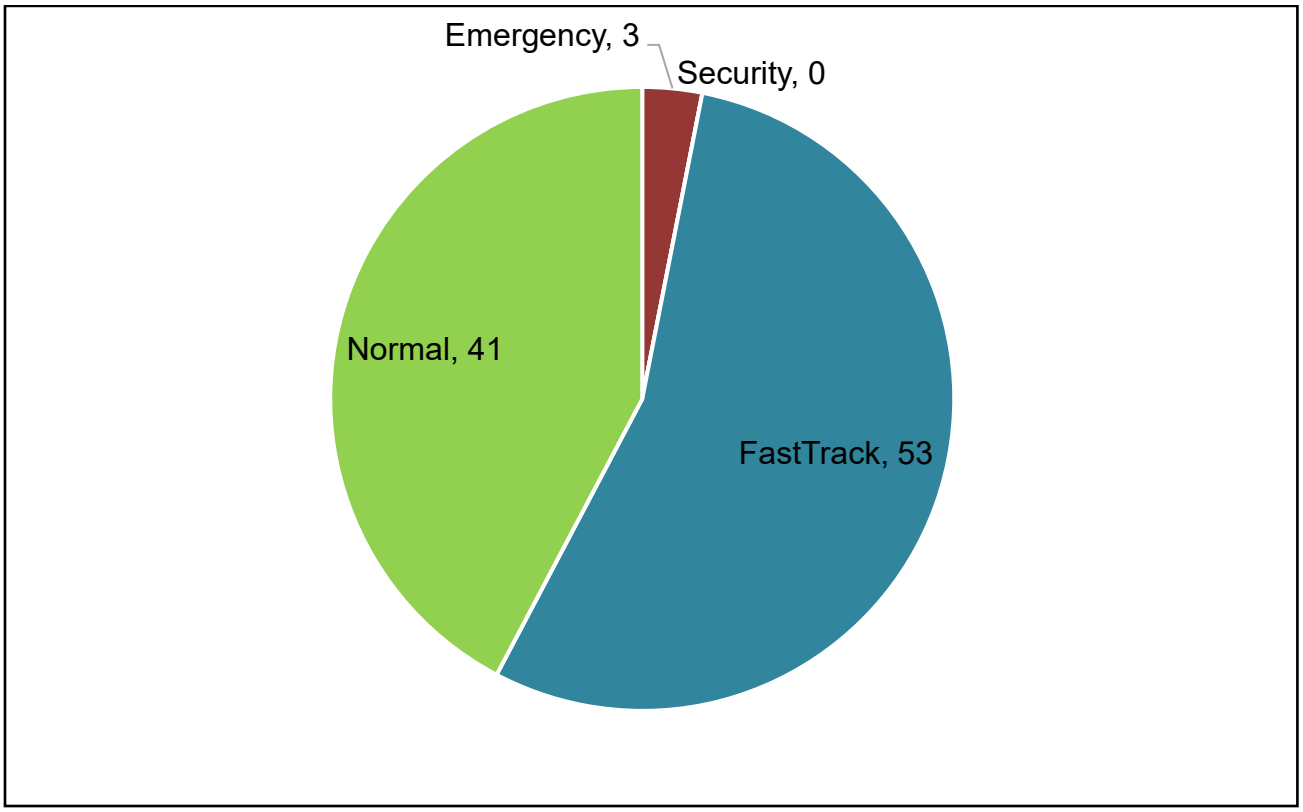
Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	September-23	Target
Timeliness-% Within Lag Time – Institutional 0-90 days	92%	60%
Timeliness-% Within Lag Time – Institutional 0-180 days	98%	80%
Timeliness-% Within Lag Time – Professional 0-90 days	89%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	98%	80%

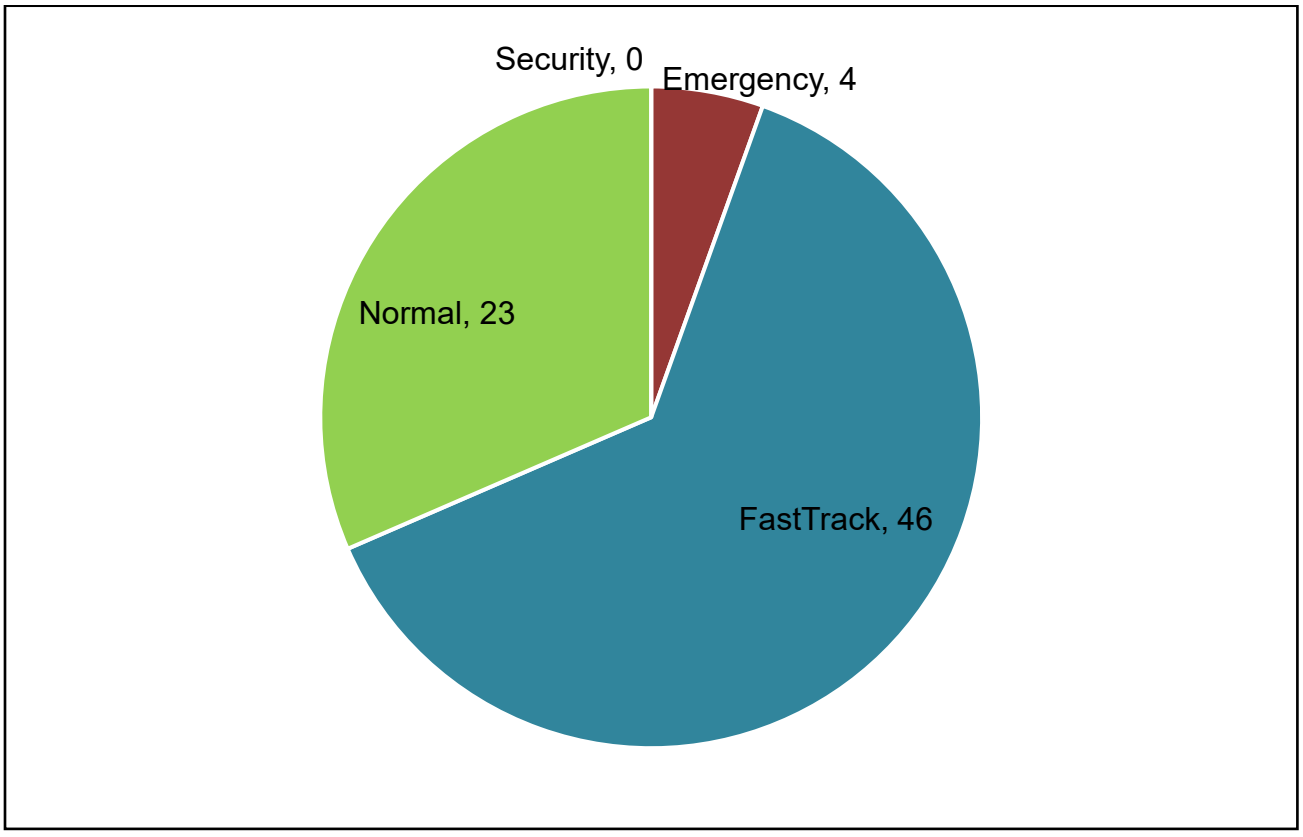
Change Management Key Performance Indicator (KPI)

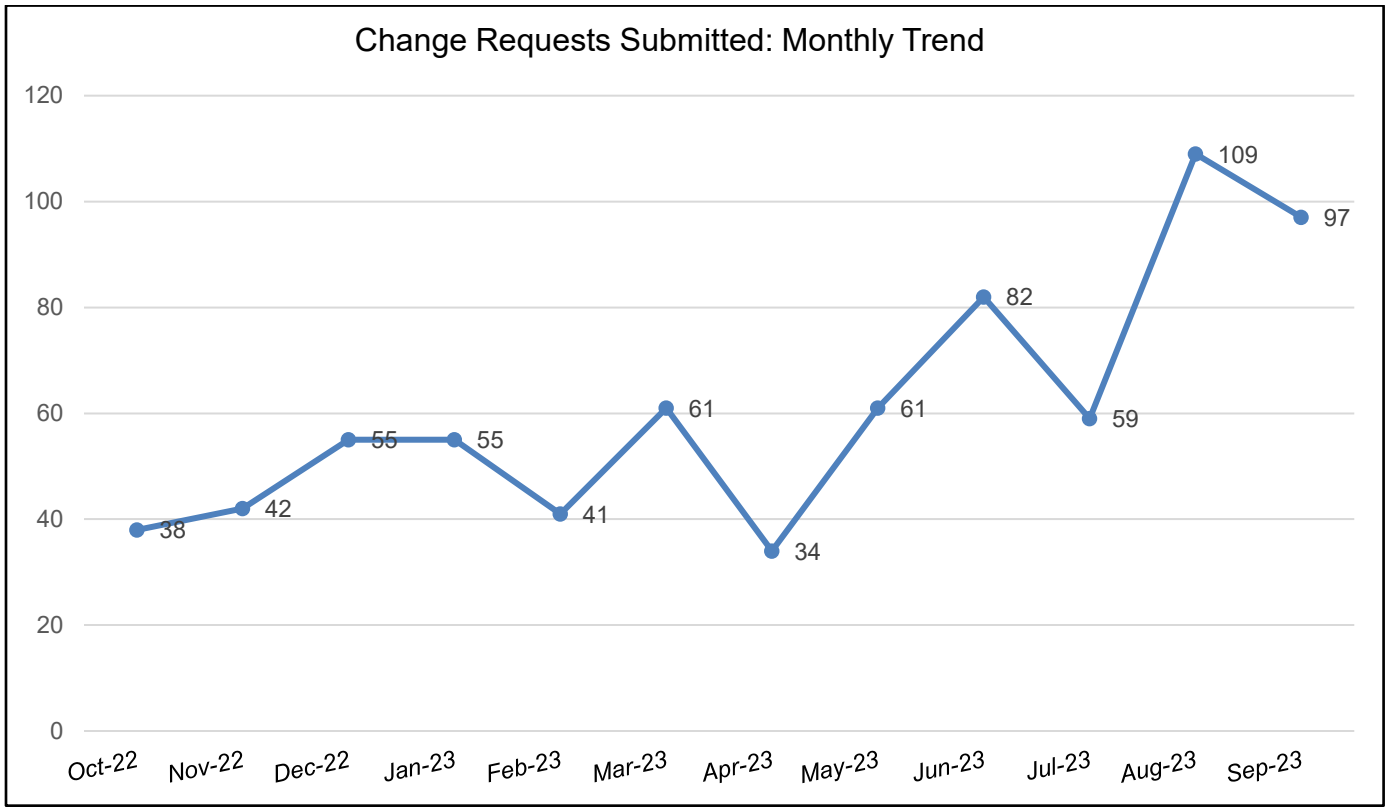
- Change Request Overall Summary in the month of September 2023 KPI:
  - 97 Changes Submitted.
  - 73 Changes Completed and Closed.
  - 213 Active Change Requests in pipeline.
  - 20 Change Requests Cancelled or Rejected.

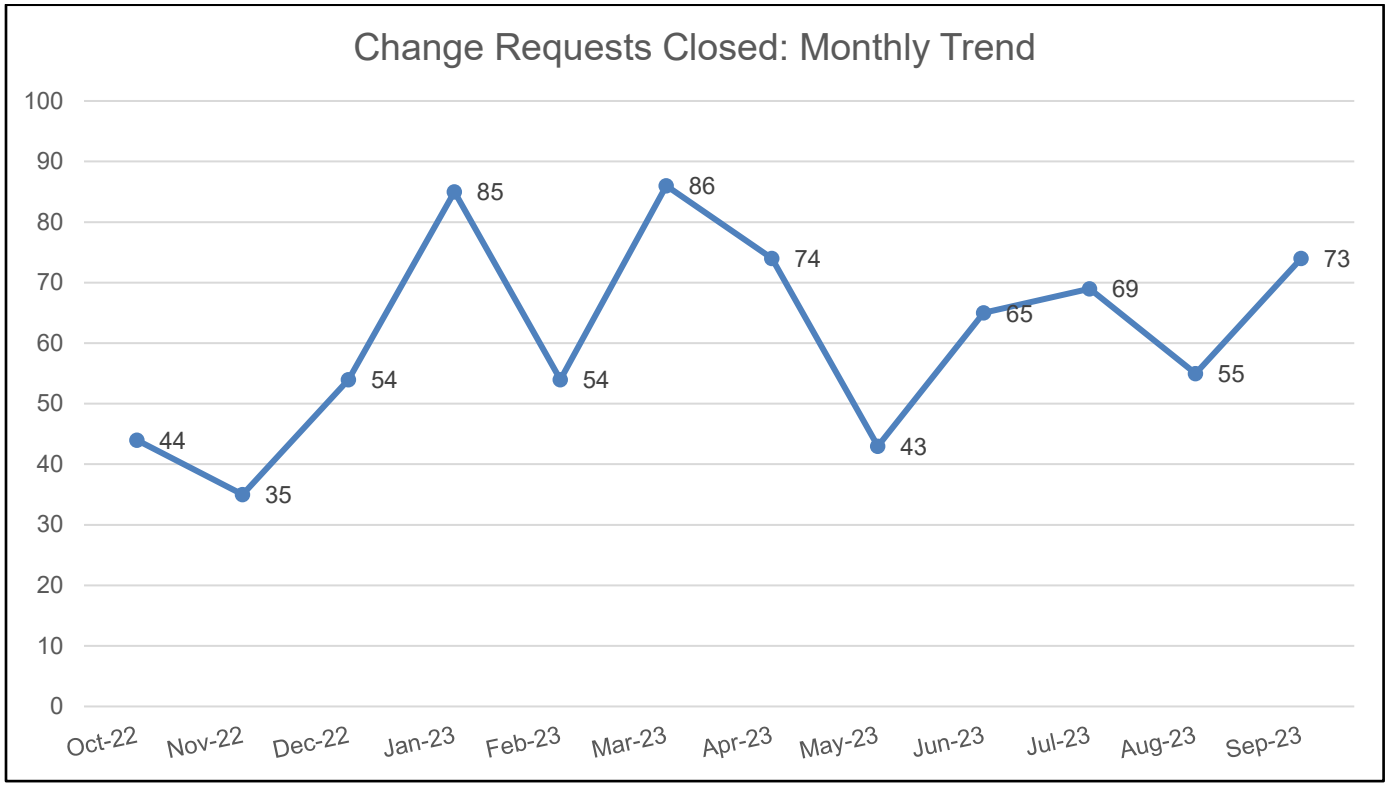
- 97 Change Requests Submitted/Logged in the month of September 2023



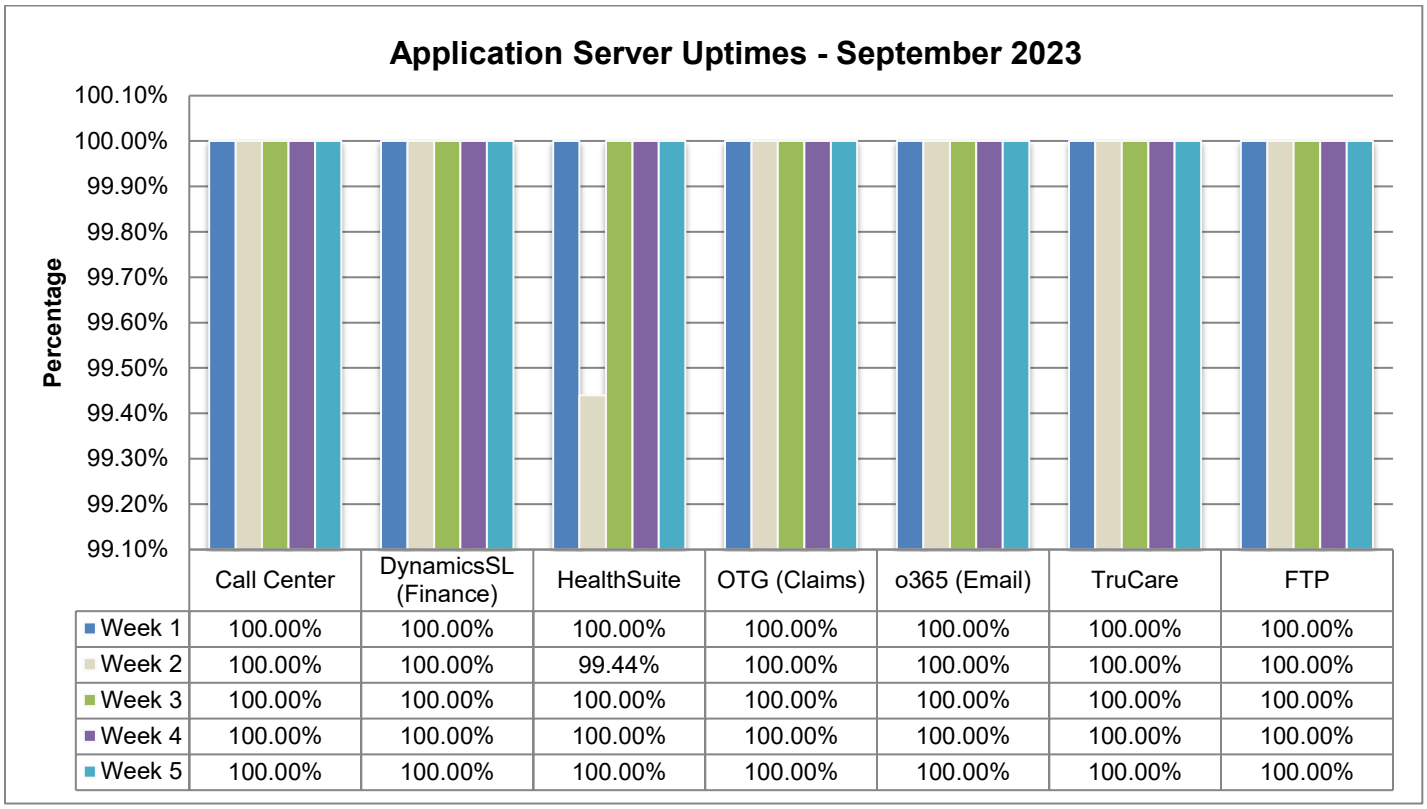
- 73 Change Requests Closed in the month of September 2023




Change Requests Submitted: Monthly Trend
120
100
80
60
40
20
0
38
42
55
55
41
61
34
61
82
59
109
97
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23

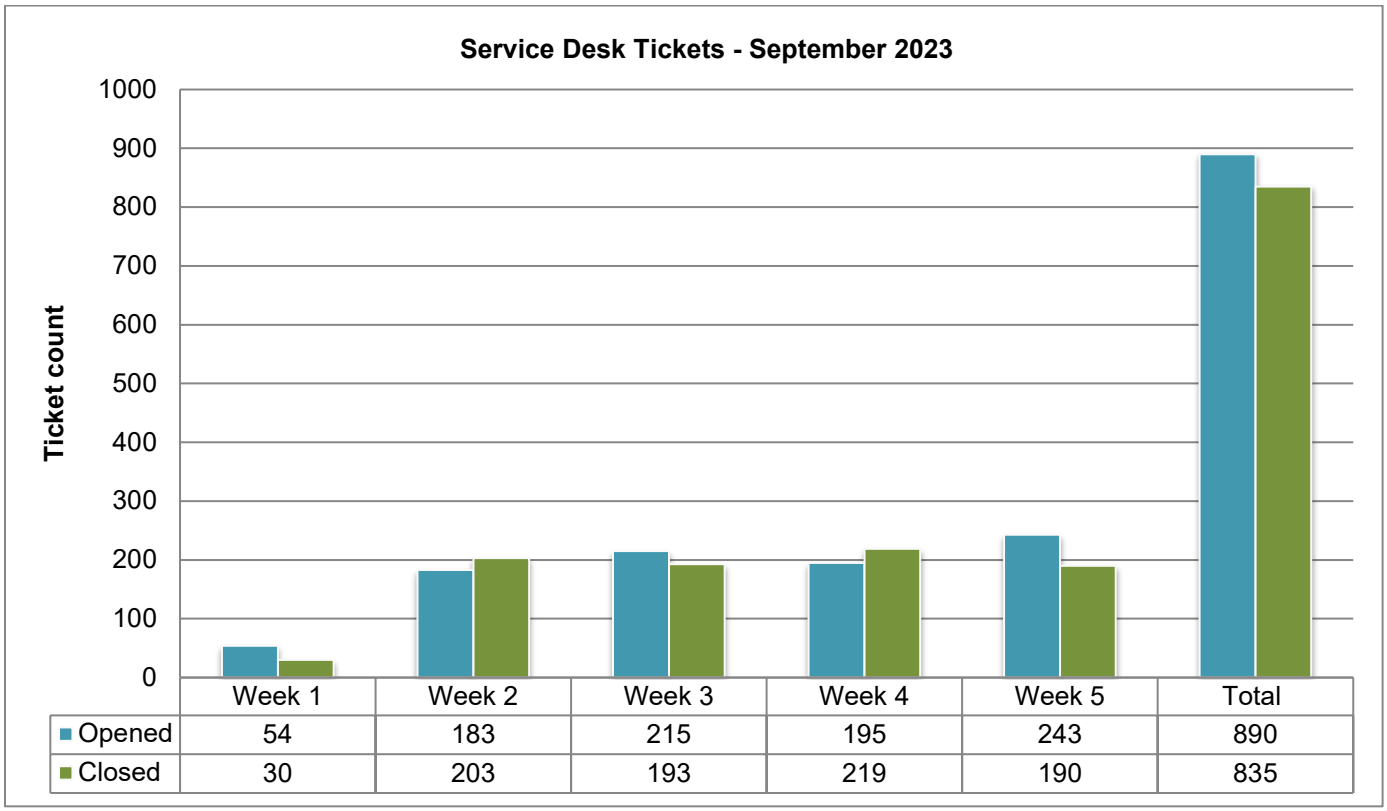

Change Requests Closed: Monthly Trend
100
90
80
70
60
50
40
30
20
10
0
44
35
54
85
54
86
74
43
65
69
55
73
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23

IT Stats: Infrastructure



	Call Center	DynamicsSL (Finance)	HealthSuite	OTG (Claims)	o365 (Email)	TruCare	FTP
Week 1	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 2	100.00%	100.00%	99.44%	100.00%	100.00%	100.00%	100.00%
Week 3	100.00%	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%	100.00%
Week 5	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

- All mission critical applications are monitored and managed thoroughly.
- HealthSuite Application experienced an outage of 15 minutes on Friday, September 15th, 2023.



	Week 1	Week 2	Week 3	Week 4	Week 5	Total
Opened	54	183	215	195	243	890
Closed	30	203	193	219	190	835

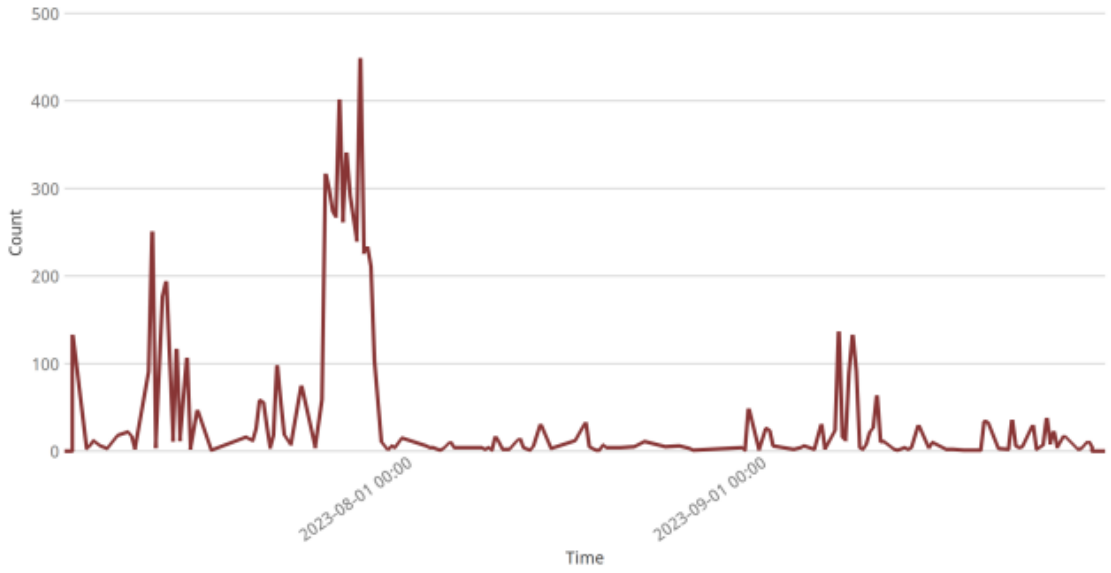
- 890 Service Desk tickets were opened in the month of September 2023, which is 3.6% lower than the previous month (923) and 1.89% lower than the previous 3-month average of 907.

- 835 Service Desk tickets were closed, which is 12.6% lower than the previous month (948) and 10.6% lower than the previous 3-month average of 928.

September 2023

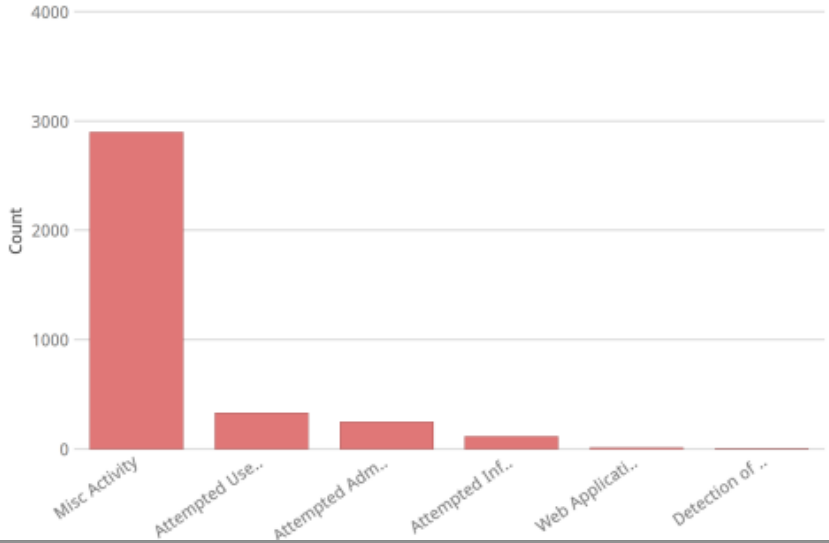
All Intrusion Events

Time Window: *2023-07-01 14:23:00 - 2023-09-30 15:23:00*



Dropped Intrusion Events

Time Window: *2023-07-01 14:24:00 - 2023-09-30 15:24:00*
Constraints: *Inline Result = !Alert,!Would **



Classification	Count
Misc Activity	2,901
Attempted User Privilege Gain	329
Attempted Administrator Privilege Gain	250
Attempted Information Leak	118
Web Application Attack	15
Detection of a Denial of Service Attack	4

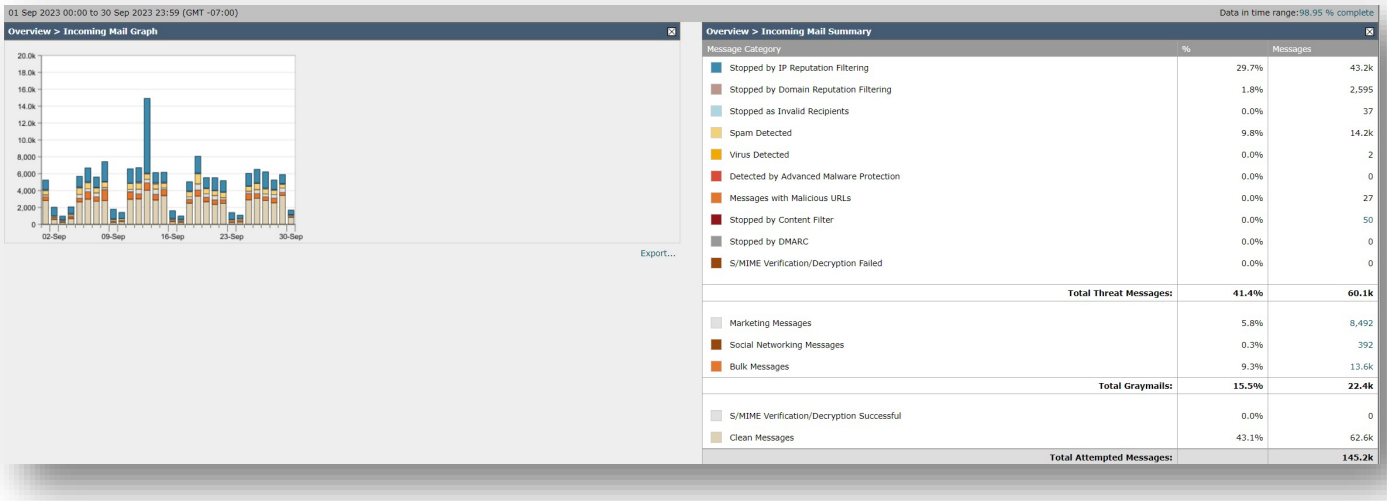
IronPort Email Security Gateways

Email Filters

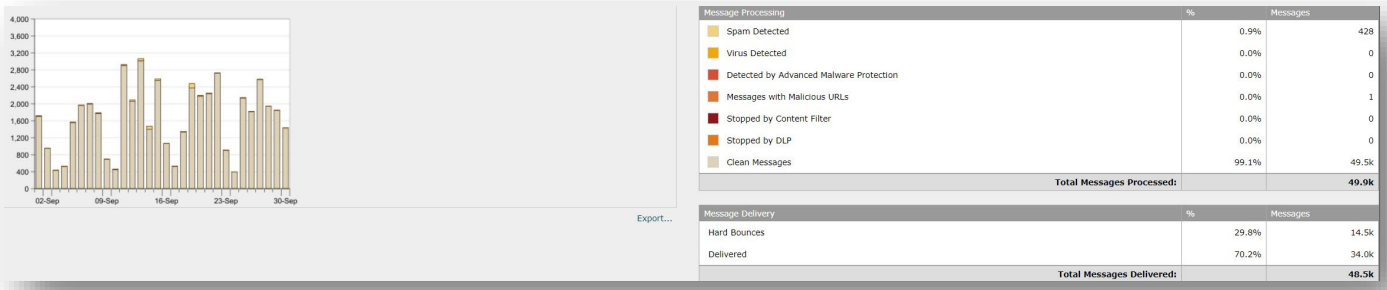
September 2023

MX4

Inbound Mail



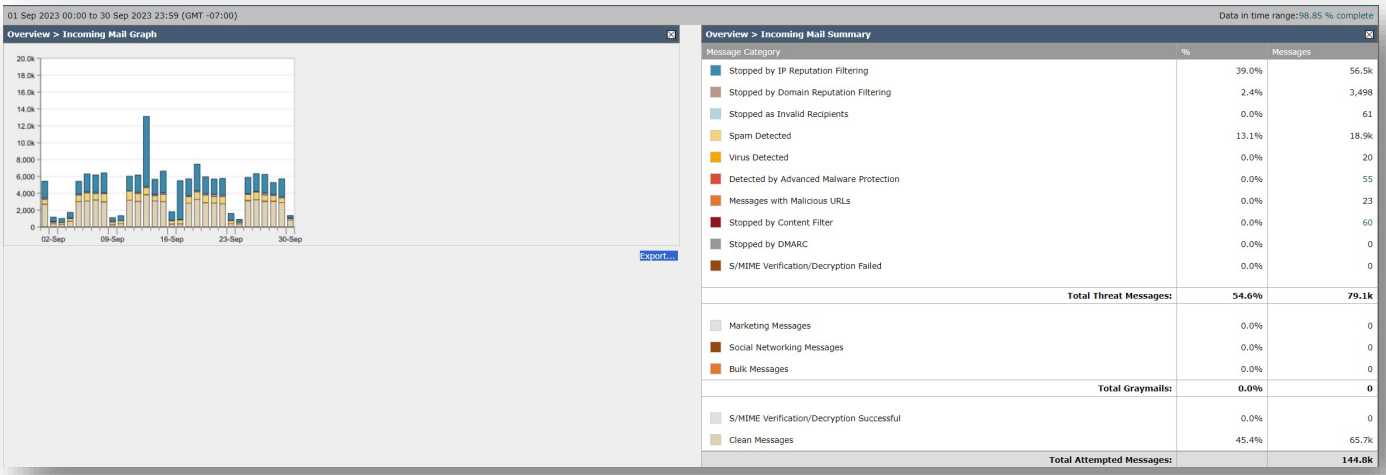
Outbound Mail



September 2023

MX9

Inbound Mail



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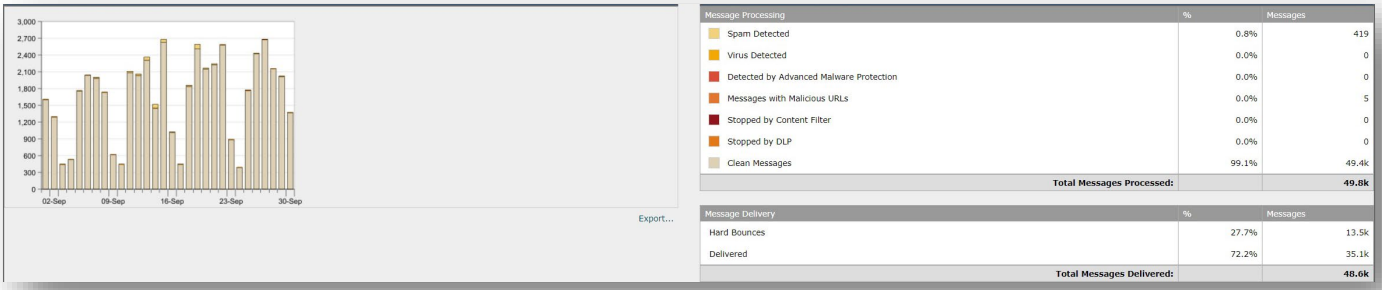


Item / Date	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	*Sep-23*
Stopped By Reputation	43.6k	20.9k	23k	53.9k	41.9k	65.3k	60.9k	31.7k	33.2k	27.1k	30.4k	59.1k	*99.7k*
Invalid Recipients	71	94	87	184	204	68	75	97	113	92	82	79	*98*
Spam Detected	14.6k	10.9k	10.9k	10.8k	10.1k	12.5k	15.4k	14.5k	13.7k	14.1k	12.5k	27.9k	*33.1*
Virus Detected	2	3	3	2	1	3	0	2	9	1	5	3	*22*
Advanced Malware	2	0	0	0	1	1	0	0	3	1	0	1	*55*
Malicious URLs	226	102	61	14	35	34	27	6	478	233	170	6	*50*
Content Filter	111	171	77	23	37	33	40	115	127	162	56	39	*110*
Marketing Messages	13.7k	13.9k	16.1k	13.4k	13.7k	13.9k	15.5k	15.5k	18.5k	16.1k	15.7k	16.2k	*8.4k*
Attempted Admin Privilege Gain	151	68	40	112	61	61	115	170	4	50	173	51	*250*
Attempted User Privilege Gain	395	180	324	797	107	307	87	428	42	66	162	47	*329*
Attempted Information Leak	10,748	12,942	12.3k	78.9k	17.8k	17.1k	12.5k	24.4k	5	1	18	53	*118*
Potential Corp Policy Violation	0	0	0	1	0	0	0	0	4	2	0	0	*0*
Network Scans Detected	0	0	0	0	0	0	0	0	0	0	0	0	*0*
Web Application Attack	0	0	0	0	19	1	2	2	7	1	8	0	*15*
Attempted Denial of Service	436	0	214	117	0	0	2.9k	109	0	0	1	0	*4*
Misc. Attack	3,295	469	87	111	240	1,288	2	521	2	3	1,862	151	*2,901*

- 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 99.7k.
- Attempted information leaks detected and blocked at the firewall is at 118 for the month of September 2023.
- Network scans returned a value of 0, which is in line with previous month's data.
- Attempted User Privilege Gain is higher at 329 from a previous six-month average of 179.

Integrated Planning

Ruth Watson

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

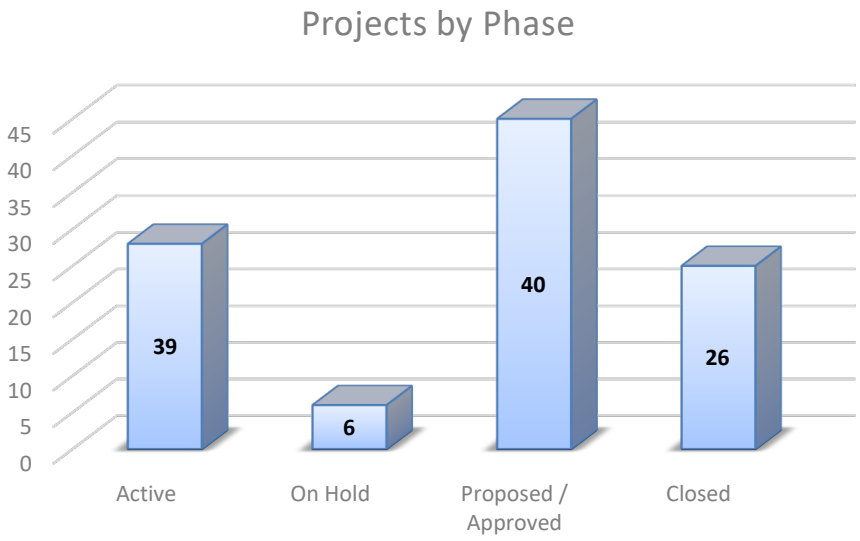
From: **Ruth Watson, Chief Operating Officer**

Date: **October 13th, 2023**

Subject: **Integrated Planning Division Report – September 2023 Activities**

Project Management Office

- 111 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
    - 39 Active projects (discovery, initiation, planning, execution, warranty)
    - 6 On Hold projects
    - 40 Proposed and Approved Projects
    - 26 Closed projects



Integrated Planning

CalAIM Initiatives

- Enhanced Care Management and Community Supports
    - Enhanced Care Management (ECM)
        - January 2024 ECM Populations of Focus (PoF)
            - Individuals Transitioning from Incarceration
                - ECM MOC Addendum III template will be due to DHCS on October 16th, 2023
            - Birth Equity – Pregnant and Postpartum Individuals At Risk for Adverse Perinatal Outcomes

            - ECM MOC Addendum template will be due to DHCS on October 2nd, 2023
        - AAH will be contracting with additional providers to support these new PoFs
    - Community Supports (CS)
        - MOC for January 2024 CS elections submitted to DHCS on July 5th, 2023, and is still awaiting approval
            - AAH is adding three (3) additional CS services effective January 1st, 2024
                - Sobering Centers
                - Nursing Facility Transition/Diversion to Assisted Living Facilities
                - Community Transition Services/Nursing Facility to a Home
            - AAH has received interest from various providers to contract for the provision of these new CS services

- Justice-Involved Initiative
    - Earliest go-live date for coordinated re-entry implementation is April 1st, 2024
        - Correctional facilities will have the ability to select their go-live date within a 24-month phase-in period (4/1/2024 – 3/31/2026)
            - As of October 1st, we are still awaiting confirmation from the county on the model for re-entry: embedded or in-reach
        - Managed Care Plans (MCPs) must be prepared to coordinate with correctional facilities as of April 1st, 2024, even if facilities in their county are not going live until a later date
    - Bi-weekly workgroup meetings with Alameda County Sheriff's Office, Probation, and AAH have started to begin collaborating on the strategy for coordination in this initiative
    - AAH has met with Wellpath, the county's provider within Santa Rita Jail, to understand their intake process flow and function
        - Similar discovery meetings with Probation and Adult Forensic Behavioral Health (AFBH) will be held in the month of October
    - Exploring potential consultant services to support building our provider network and provider training for hiring and recruiting individuals with lived experience with the justice system
        - Awaiting more detailed information on cost and scope of services from 2 consultant firms; expected to receive in early October
    - AAH pilot for post-release services began in July 2023 in preparation for the 2024 programs related to this population
        - Reporting requirements and performance metrics were determined in partnership with Roots in our September meeting
        - Monthly reporting from Roots will begin in October and Roots will also provide a lookback report for Q1 to provide data from the start of the pilot term

- Long Term Care (LTC) Carve-In – AAH became responsible for all members residing in LTC facilities as of January 1st, 2023, with the exception of Pediatric and Adult Subacute Facilities and Intermediate Care Facilities-Developmentally Disabled (ICF-DD), which will go live January 1st, 2024
    - AAH continues to refine LTC Phase 2 implementation elements
    - Final APL for LTC ICF-DD was released by DHCS on August 18th (APL 23-023)
    - Redlined Sub-acute APL was released on September 26th (APL 23-027)
        - AAH has identified approximately 150-200 members in ICF-DD homes
        - AAH received planning data from DHCS which identifies providers currently rendering service in these settings
            - Volume of members in the Sub-acute facilities is yet to be determined by the state
        - APLs 23-023 and 23-027 focus:
            - Operational definitions of the populations
            - Benefit requirements
            - Quality monitoring and oversight
            - Credentialing
            - Network readiness
            - Close management of transition of members throughout the continuum/Continuity of Care
            - Foster collaboration with Regional Centers, other health plans, and advocacy groups
            - Identification of additional support and interventions through Population Health Management
            - Claims and billing support for the ICF-DD homes
            - Inclusion/Exclusion of services

- Population Health Management (PHM) Program – effective January 1st, 2023
    - 2023 DHCS PHM Strategy deliverable
        - Preparing DHCS-required PHM Strategy documentation for submission to DHCS by October 31st, 2023
        - Held initial meetings with Alameda County Health Care Services Agency (HCSA) and City of Berkeley, Health Housing and Community Services, regarding Alliance collaboration with the Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP)
    - 2023 DHCS PHM Monitoring requirements
        - Establishing internal monitoring processes for PHM Key Performance Indicators (KPIs) and Quality metrics, including stratification by race, ethnicity, language, and age
        - Preparing 2nd quarterly report of PHM KPI data for submission to DHCS by November 15th

- Community Health Worker Benefit – Medi-Cal benefit effective July 1st, 2022, designed to promote the MCP's contractual obligations to meet DHCS broader

Population Health Management standards and as adjunctive services as part of the interventions to positively impact health outcomes.

- AAH is conducting discovery to identify if/how we can provide incentives to boost provider engagement
- AAH continues to participate in the HCSA CHW Practice Design Workgroup which includes County staff as well as representatives from organizations throughout the state who utilize CHWs
- Monitoring CHW Services (under PHM):
  - Developing data collection and quality strategy
- Working on provider communication documents
- Collaborating with PHM team regarding risk stratification strategy to identify target populations
- Meeting with potential CHW partners to provide overview of CHW services, and to learn more about their programs/services
  - Youth Alive
  - Family Resource Navigators
  - Inspiring Communities

- CalAIM Incentive Payment Program (IPP) – three-year DHCS program to provide funding for the support of ECM and CS in 1) Delivery System Infrastructure, 2) ECM Provider Capacity Building, 3) Community Supports Provider Capacity Building and Community Supports Take-Up, and 4) Quality and Emerging CalAIM Priorities:
  - For Program Year 1 (1/1/2022 - 12/31/2022):
    - AAH has earned $14.8M which is 100% of the allocated funds
    - AAH distributed funding to ten (10) providers and organizations to support the ECM and CS programs
  - For Program Year 2 (1/1/2023 - 12/31/2023):
    - AAH has been allocated $15.1M for potential earnable dollars
    - AAH completed the Submission 3 responses, for activities completed during January – June 2023, and submitted to DHCS for review on September 1st
    - AAH distributed funding to twelve (12) providers and organizations to support the ECM and CS programs
  - AAH continues to work with Anthem in preparation for the January 2024 transition to a single plan model

- Dual Eligible Special Needs Plan (D-SNP) Implementation – All Medi-Cal MCPs will be required to implement a Medicare Medi-Cal Plan (MMP) as of January 1st, 2026
  - Evaluation of AAH systems to determine clinical and operational capabilities/readiness is in process and is on track for completion of the System Evaluation by December 29th, 2023
  - Initial review of the Proforma was completed on August 30th with COO and core project team; AAH requested FY 2023 and 2024 information to be added
  - Proforma review with COO and CFO was completed on September 11th
  - Development of the project schedule and project status reporting continues

Other Initiatives

Mental Health (Mild to Moderate/Autism Spectrum Disorder) Insourcing – services previously performed by Beacon Health Options were brought in-house on April 1st, 2023

- Reports for Day 2
    - Regulatory Reports – Eighteen (18) reports identified by Compliance – Complete
    - Management Reports – Twenty-three (23) reports identified
        - Two (2) reports – No longer needed
        - Six (6) reports – Complete
        - Thirteen (13) cross-functional reports – Requirements gathering in progress
- Identification of business system process improvements and automations where necessary and feasible
    - TruCare – Automated Notification requirements gathering in progress
    - Provider Portal – Online Forms
        - Initial Evaluation Form (Priority 1) - Deployed
        - Coordination of Care Update Form (Priority 2) – Target deployment November 16th, 2023
            - Requirements gathered and approved
            - Development of online form in progress
        - ABA & MH Referral Form (Priority 3) – Pending system dependencies
            - Requirements gathering scheduled to begin week of July 10th
- Post go-live project management support continues

Student Behavioral Health Incentive Program (SBHIP) – DHCS program commenced January 1st, 2022, and continues through December 31st, 2024

- The first Bi-Quarterly Report (BQR) for the measurement period of January – June 2023, was submitted June 30th, 2023, and approved by DHCS on September 15th; payment in the amount of $1.1M is expected in October/November 2023
- Partner meetings continue with Local Education Agencies (LEAs) to further refine project plan activities for successful completion of the milestones related to the July – December 2023 measurement period
- The Alameda County SBHIP Steering Group, comprised of Alameda County Office of Education (ACOE), Alameda County Center for Healthy Schools and Communities (CHSC), Alameda Alliance, and Anthem continues to meet to provide strategic program direction
    - The Steering Group will advise in the development of an Alameda County Learning Exchange (LE) which will support targeted interventions and development of sustainability resources for LEAs
- The Alliance has hosted two SBHIP LEs; participants include LEAs and Steering Group Partners, with a focus on program updates, LEA project plan sharing, current school-based behavioral landscape
    - In conjunction with Steering Group partners, the Alliance distributed a calendar of events for the remainder of the program period inclusive of Alliance, ACOE, and planned CHSC activities to promote foundational understanding, build capacity, and develop sustainability plans

- To-date, $5.2M has been awarded to the Alliance for completed deliverables and a total of $4.4M has paid to LEA and SBHIP partners

Housing and Homelessness Incentive Program (HHIP) – DHCS program commenced January 1st, 2022, and continues through December 31st, 2023

- The Submission 1 (S1) Report for reporting period May 1st, 2022 – December 31st, 2022, was submitted to DHCS on March 10th, 2023
    - AAH earned $13.7M or 88.6% of earnable dollars for our S1 Report
    - 92% of HHIP eligible funds have been earned to-date
- Tracking and monitoring the Submission 2 (S2) Report for reporting period January – October 2023 is currently underway
- HCSA continues to complete deliverables and milestones outlined in the December 2022 MOU:
    - HCSA has submitted fifteen (15) deliverables to-date:
        - HHIP data reporting (received on February 15th, 2023)
        - Housing Financial Supports Progress Report (received on March 30th and June 30th, 2023)
        - Street Medicine Data and Program Model and Contracting Recommendations (received on January 13th, March 30th, and June 20th, 2023)
        - 2023 Q1 and Q2 Housing Community Supports Capacity Building progress report (received April 20th and July 25th, 2023)
        - Housing Community Supports Legal Services Pilot grant agreement execution with legal service provider and hiring of 1.0 FTE staff attorney
    - As of September 30th, $11.8M in total payments has been paid to HCSA for HHIP milestone completion
- Workgroup meetings continue with HCSA and Anthem Blue Cross, as well as internally, to implement Investment Plan initiatives related to street health, recuperative care coordination, medical respite, medically frail beds, data needs, and a recently approved housing community supports legal services pilot program
- DHCS released a preliminary HHIP Reinvestment Fund Option (RFO) structure that was reviewed with Managed Care Plans (MCPs) in September and that is expected to be finalized mid-fall; the RFO will offer an opportunity for MCPs to submit performance data to potentially draw down unearned funds from previous submissions

2024 Single Plan Model – activities related to the conversion from a two-plan model to a single plan model are included under one comprehensive program.

- Managed Care Contract Operational Readiness (OR)
    - Group 2 Deliverables Status
        - Total Deliverables submitted to DHCS – 225
            - Approved by DHCS – 218
            - In Review – 5
            - Additional Information Requests (AIR) – 0
            - On Hold – 2
        - Upcoming Q4 2023 Operational Readiness Deliverable Dates

        - Deliverables due 12/29/2023 – 10 total deliverables
- MCP Member Transition
    - Anthem Member Transition – members currently assigned to Anthem will transition to AAH effective January 1st, 2024
        - Planning for work related to member notification, provider contracting, data sharing, and Continuity of Care (CoC) has begun
        - No new members will be assigned to Anthem as of October 1st, 2023
    - Kaiser Direct Contract– members currently assigned to AAH but delegated to Kaiser will transition to Kaiser effective January 1st, 2024
        - Member assignment by AAH into the Kaiser subcontract will freeze on September 1st, 2023, except if member qualifies for CoC with Kaiser
        - DHCS confirmed on September 6th that AAH should only work directly with Kaiser on those members with CoC or currently in treatment; all other requests for Kaiser will be referred to DHCS' enrollment broker, Health Care Options (HCO)
    - Bi-weekly workgroups with Kaiser and Anthem have been scheduled to support the transition work and collaboration
    - DHCS continues to update the MCP Member Transition Policy Guide; the guide is being deconstructed by internal teams to identify deliverables within the updated sections
    - Final CoC Data Sharing Templates have been received and are under review with teams
    - Requests have been made to Anthem and DHCS for test files of the CoC data templates to allow for testing prior to the first required data share on 11/1/2023
    - Member Transition CoC Workflow documentation has begun for the following departments: Utilization Management, Case Management, Behavioral Health, Member Services
        - Departments will need to revise current CoC workflows to include exceptions resulting from the Member Transition
    - Internal teams have made updates to impacted policies and procedures and will be submitted to DHCS for review by 10/6/2023
- Business Continuity Plan – required as part of our 2024 Operational Readiness
    - Disaster Recovery Plan
        - Included in the overall Business Continuity Plan (BCP)
        - Development of the Disaster Recovery Plan is complete
    - Engagement with BCP Consultant – Quest
    - Quest is working with AAH business areas on the completion of the BCP Questionnaire
- Memorandums of Understanding (MOUs) with Third Parties – required as part of our 2024 Operational Readiness (OR)
    - MOUs associated with OR requirements due to DHCS on 12/29/2023
    - Received, reviewed, and provided feedback on the DHCS MOU templates
    - Final DHCS MOU templates are pending receipt

Portfolio Project Management (PPM) Tool – Team Dynamix (TDX) is the selected tool being implemented in a phased approach and started January 2023

- Implementation Phase
    - Deploy status reporting via TDX and sunset existing reports
    - Training for TDNext users
    - Closeout engagement with TDX on Implementation

Equity and Practice Transformation (EPT) Payments Program

- DHCS released program guidance, FAQs, assessment tool, and initial program application in August and September
- Identified provider practices eligible for the initial phase of the EPT program based on eligibility criteria provided by DHCS
- Sent fax blast to providers alerting them of the EPT program and added program information to AAH website on September 15th
- Preliminary meetings held with CHCN and CFMG to determine interest and address initial questions
- Engaged consultant to work with small and medium provider practices to assist in preparation of application
- Program applications are due to DHCS on October 23rd, 2023

Recruiting and Staffing

Integrated Planning Open position(s):

- Senior Project Manager – Position filled internally
- Project Manager – recruitment underway

Integrated Planning

Supporting Documents

Project Descriptions

Key projects currently in-flight:

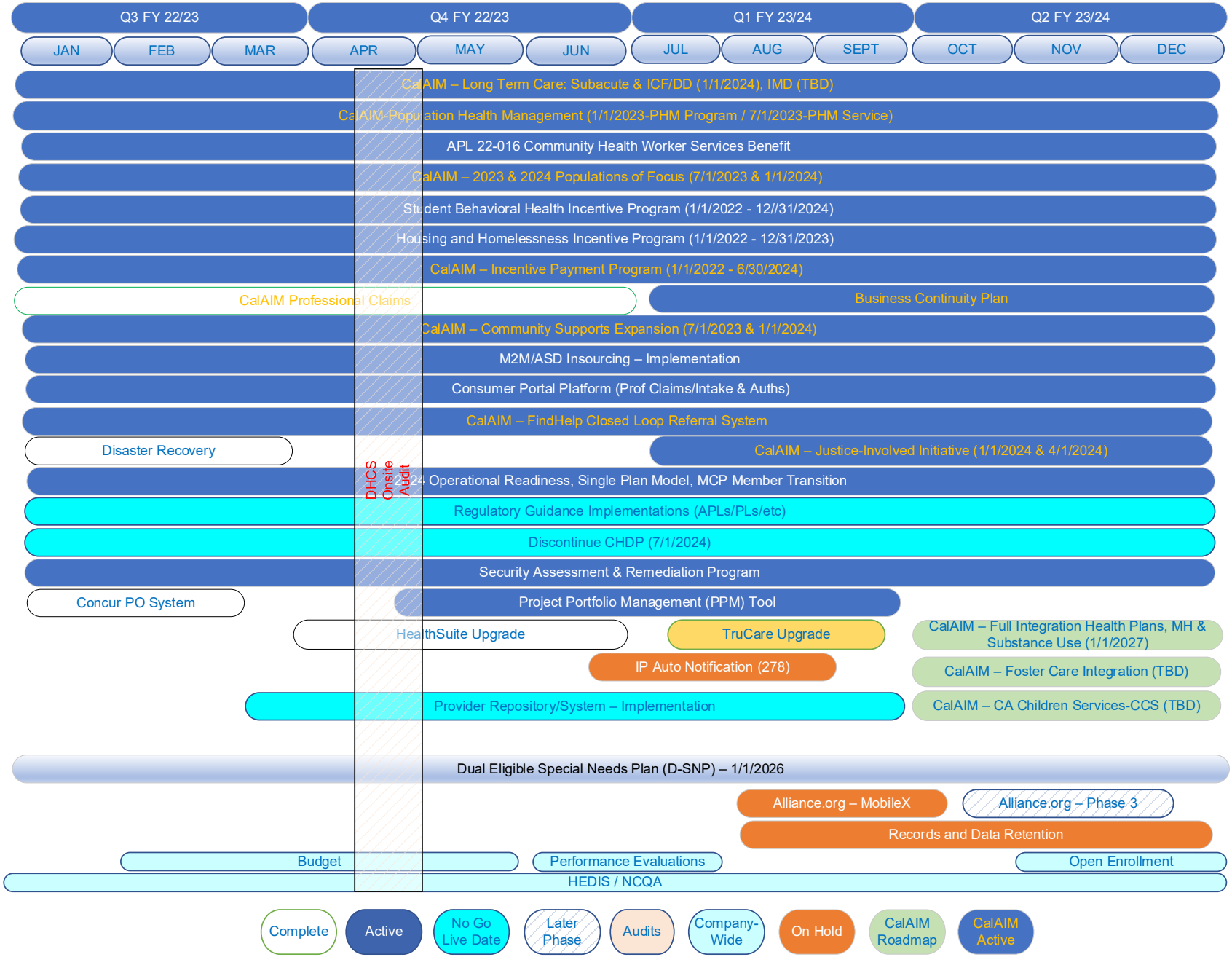
- California Advancing and Innovating Medi-Cal (CalAIM) – program to provide targeted and coordinated care for vulnerable populations with complex health needs
  - Enhanced Care Management (ECM) – ECM will target eight (8) specific populations of vulnerable and high-risk children and adults
    - Three (3) Populations of Focus (PoF) transitioned from HHP and/or WPC on January 1st, 2022
    - Two (2) additional PoF became effective on January 1st, 2023
    - One (1) PoF became effective on July 1st, 2023
    - Two (2) PoF will become effective on January 1st, 2024
  - Community Supports (CS) effective January 1st, 2022 – menu of optional services, including housing-related and flexible wraparound services, to avoid costlier alternatives to hospitalization, skilled nursing facility admission and/or discharge delays
    - As of January 1st, 2024, AAH will offer twelve (12) of the fourteen (14) DHCS-designated CS services
      - January 1st, 2022 – Six (6) Community Supports were implemented
      - July 1st, 2023 – Three (3) additional CS services went live
      - January 1st, 2024
        - Two (2) CS services that support the LTC PoFs that were effective January 2023 are being piloted in 7/1-12/31/2023 and will go live in January
        - One (1) additional CS service is also targeted for implementation
  - CalAIM Incentive Payment Program (IPP) – The CalAIM ECM and CS programs will require significant new investments in care management capabilities, ECM and CS infrastructure, information technology (IT) and data exchange, and workforce capacity across MCPs, city and county agencies, providers, and other community-based organizations. CalAIM incentive payments are intended to:
    - Build appropriate and sustainable ECM and ILOS capacity
    - Drive MCP investment in necessary delivery system infrastructure
    - Incentivize MCP take-up of ILOS
    - Bridge current silos across physical and behavioral health care service delivery
    - Reduce health disparities and promote health equity
    - Achieve improvements in quality performance
  - Long Term Care - benefit was carved into all MCPs effective January 1st, 2023, with the exception of Subacute and ICF-DD facilities which are scheduled for implementation January 1st, 2024; IMD facilities implementation date TBD
  - Justice Involved Initiative – adults and children/youth transitioning from incarceration or juvenile facilities will be enrolled into Medi-Cal upon release
    - DHCS is finalizing policy and operational requirements for MCPs to implement the CalAIM Justice-Involved Initiative
      - MCPs must be prepared to go live with ECM for the Individuals Transitioning from Incarceration as of January 1st, 2024

- MCPs must be prepared to coordinate with correctional facilities to support reentry of members as the return to the community by April 1st, 2024
- Correctional facilities will have two years from 4/1/2024-3/31/2026 to go live based on readiness

  - Population Health Management (PHM) – all Medi-Cal managed care plans were required to develop and maintain a whole system, person-centered population health management strategy effective January 1st, 2023. PHM is a comprehensive, accountable plan of action for addressing Member needs and preferences, and building on their strengths and resiliencies across the continuum of care that:
    - Builds trust and meaningfully engages with Members;
    - Gathers, shares, and assesses timely and accurate data on Member preferences and needs to identify efficient and effective opportunities for intervention through processes such as data-driven risk stratification, predictive analytics, identification of gaps in care, and standardized assessment processes;
    - Addresses upstream factors that link to public health and social services;
    - Supports all Members staying healthy;
    - Provides care management for Members at higher risk of poor outcomes;
    - Provides transitional care services for Members transferring from one setting or level of care to another; and
    - Identifies and mitigates social drivers of health to reduce disparities
  - Dual Eligible Special Needs Plan (D-SNP) Implementation – All Medi-Cal MCPs will be required to operate Medicare Medi-Cal Plans (MMPs), the California-specific program name for Exclusively Aligned Enrollment Dual Eligible Special Needs Plans (EAE D-SNPs) by January 2026 in order to provide better coordination of care and improve care integration and person-centered care. Additionally, this transition will create both program and financial alignment, simplify administration and billing for providers and plans, and provide a more seamless experience for dual eligible beneficiaries by having one plan manage both sets of benefits for the beneficiary.

- Mental Health (Mild to Moderate/Autism Spectrum Disorder) Insourcing – services currently performed by Beacon Health Options were brought in-house effective April 1st, 2023
- Community Health Worker Services Benefit – Community Health Worker (CHW) services became a billable Medi-Cal benefit effective July 1st, 2022. CHW services are covered as preventive services on the written recommendation of a physician or other licensed practitioner of the healing arts within their scope of practice under state law for individuals who need such services to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and well-being
- Student Behavioral Health Incentive Program (SBHIP) – program launched in January 2022 to support new investments in behavioral health services, infrastructure, information technology and data exchange, and workforce capacity for school-based and school-affiliated behavioral health providers. Incentive payments will be paid to Medi-Cal managed care plans (MCPs) to build infrastructure, partnerships, and capacity, statewide, for school behavioral health services
- Housing and Homelessness Incentive Program (HHIP) – program launched in January 2022 and is part of the Home and Community-Based (HCBS) Spending Plan

    - Enables MCPs to earn incentive funds for making progress in addressing homelessness and housing insecurity as social determinants of health
    - MCPs must collaborate with local homeless Continuums of Care (CoCs) and submit a Local Homelessness Plan (LHP) to be eligible for HHIP funding
- 2024 Single Plan Model
    - 2024 Managed Care Plan Contract Operational Readiness – new MCP contract developed as part of Procurement RFP; all MCPs must adhere to new contract effective January 1st, 2024
        - Business Continuity Plan required as part of Operational Readiness
        - MOUs with third parties required as part of Operational Readiness
    - MCP Member Transition
        - Anthem members will transition to AAH effective January 1st, 2024
        - Members currently delegated to Kaiser will transition to Kaiser as part of their direct contract with DHCS effective January 1st, 2024
- Project Portfolio Management (PPM) Tool - Implementation of a PPM tool to support portfolio planning, resource capacity and demand planning and project scheduling
- Equity and Practice Transformation (EPT) Payments Program – new program released by DHCS in August 2023 and is a one-time $700M primary care provider practice transformation program designed to advance health equity, reduce COVID-19-driven care disparities, and prepare practices to participate in alternative payment models
    - EPT is for primary care practices, including Family Medicine, Internal Medicine, Pediatrics, Primary Care 0B/GYN, and/or Behavioral Health in an integrated primary care setting
    - Medi-Cal Managed Care Plan (MCP) Initial Provider Planning Incentive Payments
        - $25 million over one (1) year to incentivize MCPs to identify and work with small-to medium-sized independent practices as they develop practice transformation plans and applications to the larger EPT Provider Directed Payment Program
    - EPT Provider Directed Payment Program
        - $650 million over five (5) years to support delivery system transformation, specifically targeting primary care practices that provide primary care pediatrics, family medicine, internal medicine, primary care OB/GYN services, or behavioral health services that are integrated in a primary care setting to Medi-Cal members; $200 million of the $650 million will be dedicated to preparing practices for value-based care
    - The Statewide Learning Collaborative
        - $25 million over five (5) years to support participants in the Provider Directed Payment Program in implementation of practice transformation activities, sharing and spread of best practices, practice coaching activities, and achievement of stated quality and equity goals


Q3 FY 22/23
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Q1 FY 23/24
Q2 FY 23/24
JAN
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NOV
DEC
CalAIM – Long Term Care: Subacute & ICF/DD (1/1/2024), IMD (TBD)
CalAIM-Population Health Management (1/1/2023-PHM Program / 7/1/2023-PHM Service)
APL 22-016 Community Health Worker Services Benefit
CalAIM – 2023 & 2024 Populations of Focus (7/1/2023 & 1/1/2024)
Student Behavioral Health Incentive Program (1/1/2022 - 12//31/2024)
Housing and Homelessness Incentive Program (1/1/2022 - 12/31/2023)
CalAIM – Incentive Payment Program (1/1/2022 - 6/30/2024)
CalAIM Professional Claims
Business Continuity Plan
CalAIM – Community Supports Expansion (7/1/2023 & 1/1/2024)
M2M/ASD Insourcing – Implementation
Consumer Portal Platform (Prof Claims/Intake & Auths)
CalAIM – FindHelp Closed Loop Referral System
Disaster Recovery
CalAIM – Justice-Involved Initiative (1/1/2024 & 4/1/2024)
DHCS Onsite Audit
24 Operational Readiness, Single Plan Model, MCP Member Transition
Regulatory Guidance Implementations (APLs/PLs/etc)
Discontinue CHDP (7/1/2024)
Security Assessment & Remediation Program
Concur PO System
Project Portfolio Management (PPM) Tool
HealthSuite Upgrade
TruCare Upgrade
CalAIM – Full Integration Health Plans, MH & Substance Use (1/1/2027)
IP Auto Notification (278)
CalAIM – Foster Care Integration (TBD)
Provider Repository/System – Implementation
CalAIM – CA Children Services-CCS (TBD)
Dual Eligible Special Needs Plan (D-SNP) – 1/1/2026
Alliance.org – MobileX
Alliance.org – Phase 3
Records and Data Retention
Budget
Performance Evaluations
Open Enrollment
HEDIS / NCQA
Complete
Active
No Go Live Date
Later Phase
Audits
Company-Wide
On Hold
CalAIM Roadmap
CalAIM 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 13th, 2023**

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 2022 – June 2023 dates of service
Prior reporting period: July 2021 – June 2022 dates of service
(Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 9.9% of members account for 87.0% of total costs.
- In comparison, the Prior reporting period was lower at 9.3% of members accounting for 83.6% of total costs.
- Characteristics of the top utilizing population remained fairly consistent between the reporting periods:
    - The SPD (non duals) and ACA OE categories of aid decreased to account for 58.3% of the members, with SPDs accounting for 25.0% and ACA OE's at 33.3%.
    - The percent of members with costs >= $30K increased from 1.9% to 2.6%.
    - Of those members with costs >= $100K, the percentage of total members has slightly increased to 0.6%.
        - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 44.3%.
    - Demographics for member city and gender for members with costs >= $30K follow the same distribution as the overall Alliance population.
    - However, the age distribution of the top 9.9% is more concentrated in the 45-66 year old category (39.5%) compared to the overall population (20.7%).

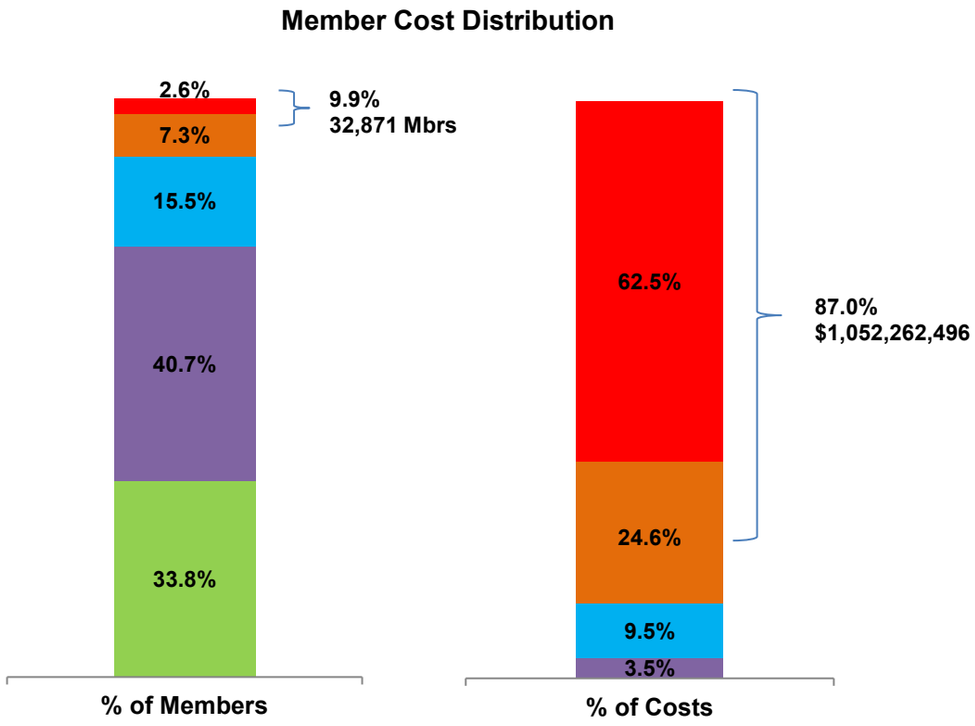
Analytics

Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Jul 2022 - Jun 2023

Note: Data incomplete due to claims lag

Run Date: 09/28/2023



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	8,576	2.6%	$ 755,051,720	62.5%
$5K - $30K	24,295	7.3%	$ 297,210,776	24.6%
$1K - $5K	51,441	15.5%	$ 114,584,863	9.5%
< $1K	134,895	40.7%	$ 42,049,137	3.5%
$0	112,034	33.8%	$ -	0.0%
Totals	**331,241**	**100.0%**	**$ 1,208,896,495**	**100.0%**

Top 9.9% of Members = 87.0% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	1,843	0.6%	$ 415,143,820	34.3%
$75K to $100K	860	0.3%	$ 74,023,648	6.1%
$50K to $75K	1,733	0.5%	$ 104,946,455	8.7%
$40K to $50K	1,741	0.5%	$ 77,672,413	6.4%
$30K to $40K	2,399	0.7%	$ 83,265,384	6.9%
SubTotal	***8,576***	***2.6%***	***$ 755,051,720***	***62.5%***
$20K to $30K	3,479	1.1%	$ 85,168,790	7.0%
$10K to $20K	9,131	2.8%	$ 128,683,320	10.6%
$5K to $10K	11,685	3.5%	$ 83,358,666	6.9%
SubTotal	***24,295***	***7.3%***	***$ 297,210,776***	***24.6%***
Total	**32,871**	***9.9%***	**$ 1,052,262,496**	***87.0%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Jun 2023	308,108	$ 1,108,178,456
Dis-Enrolled During Year	23,133	$ 100,718,039
Totals	**331,241**	**$ 1,208,896,495**

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

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
9.9% of Members = 87.0% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Jul 2022 - Jun 2023
Note: Data incomplete due to claims lag
Run Date: 09/28/2023

9.9% of Members = 87.0% of Costs
25.0% of members are SPDs and account for 30.7% of costs.
33.3% of members are ACA OE and account for 33.3% of costs.
5.4% of members disenrolled as of Jun 2023 and account for 9.0% of costs.

Highest Cost Members; Cost Per Member >= $100K
36.0% of members are SPDs and account for 35.2% of costs.
34.3% of members are ACA OE and account for 35.4% of costs.
13.3% of members disenrolled as of Jun 2023 and account for 13.8% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	153	613	766	2.3%
MCAL	MCAL - ADULT	839	4,574	5,413	16.5%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	367	2,013	2,380	7.2%
	MCAL - ACA OE	2,621	8,339	10,960	33.3%
	MCAL - SPD	2,697	5,514	8,211	25.0%
	MCAL - DUALS	469	1,904	2,373	7.2%
	MCAL - LTC	116	10	126	0.4%
	MCAL - LTC-DUAL	674	183	857	2.6%
Not Eligible	Not Eligible	640	1,145	1,785	5.4%
Total		**8,576**	**24,295**	**32,871**	**100.0%**

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	26	1.4%
MCAL	MCAL - ADULT	175	9.5%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	42	2.3%
	MCAL - ACA OE	633	34.3%
	MCAL - SPD	664	36.0%
	MCAL - DUALS	33	1.8%
	MCAL - LTC	19	1.0%
	MCAL - LTC-DUAL	5	0.3%
Not Eligible	Not Eligible	246	13.3%
Total		**1,843**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 11,329,896	$ 6,933,030	$ 18,262,926	1.7%
MCAL	MCAL - ADULT	$ 73,452,662	$ 52,914,746	$ 126,367,408	12.0%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 24,393,528	$ 23,407,634	$ 47,801,163	4.5%
	MCAL - ACA OE	$ 249,689,256	$ 100,976,474	$ 350,665,730	33.3%
	MCAL - SPD	$ 251,916,885	$ 70,907,617	$ 322,824,502	30.7%
	MCAL - DUALS	$ 27,660,372	$ 23,502,077	$ 51,162,449	4.9%
	MCAL - LTC	$ 7,368,205	$ 221,736	$ 7,589,941	0.7%
	MCAL - LTC-DUAL	$ 29,517,608	$ 3,841,937	$ 33,359,545	3.2%
Not Eligible	Not Eligible	$ 79,723,308	$ 14,505,524	$ 94,228,833	9.0%
Total		**$ 755,051,720**	**$ 297,210,776**	**$ 1,052,262,496**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 4,628,961	1.1%
MCAL	MCAL - ADULT	$ 40,723,094	9.8%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 9,422,846	2.3%
	MCAL - ACA OE	$ 146,807,515	35.4%
	MCAL - SPD	$ 146,239,235	35.2%
	MCAL - DUALS	$ 7,305,147	1.8%
	MCAL - LTC	$ 2,289,196	0.6%
	MCAL - LTC-DUAL	$ 580,552	0.1%
Not Eligible	Not Eligible	$ 57,147,273	13.8%
Total		**$ 415,143,820**	**100.0%**

% of Total Costs By Service Type

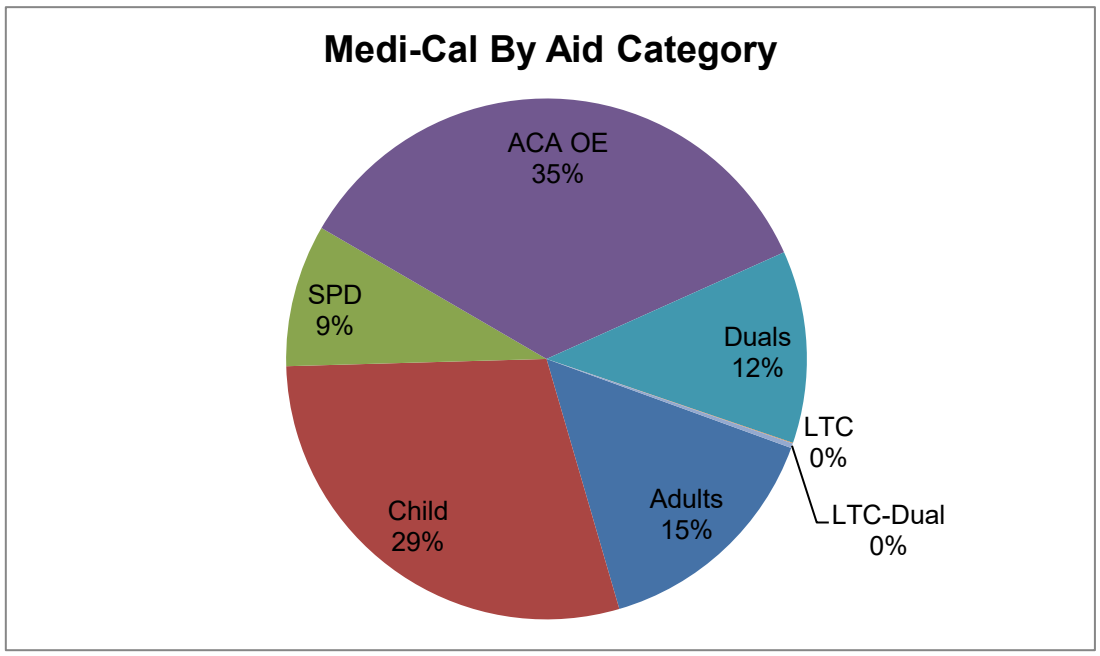
Breakout by Service Type/Location

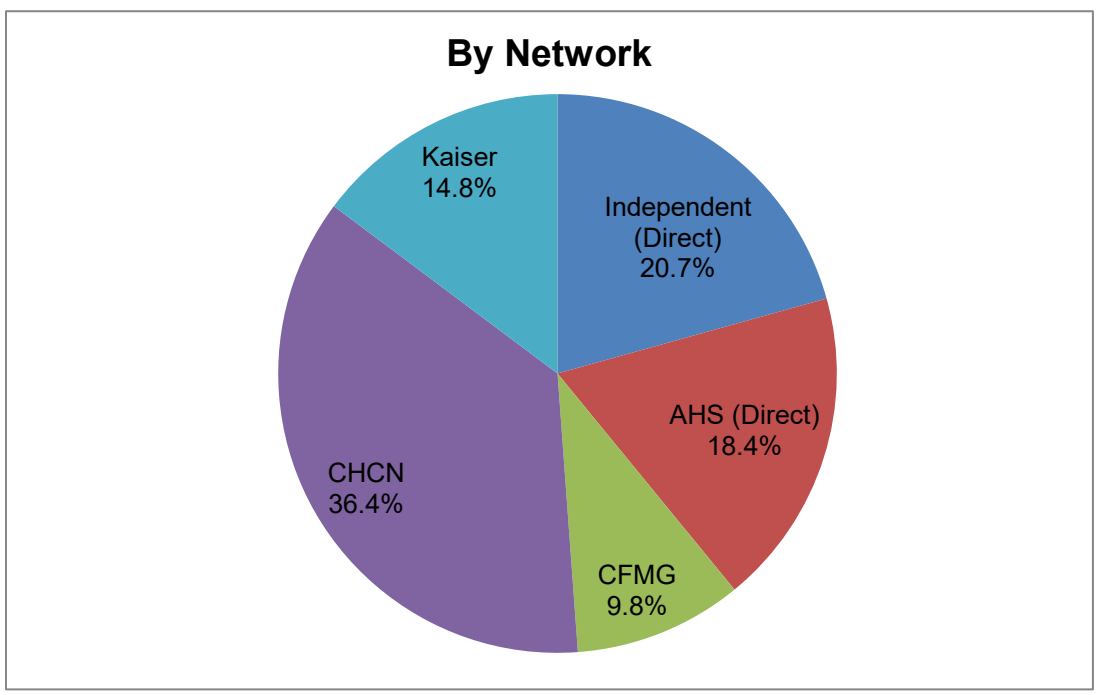
Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
$100K+	8%	0%	1%	0%	53%	1%	14%	4%	2%	8%
$75K to $100K	6%	0%	1%	0%	37%	3%	7%	5%	7%	17%
$50K to $75K	4%	0%	2%	0%	32%	3%	7%	6%	6%	24%
$40K to $50K	4%	0%	1%	1%	25%	4%	4%	4%	1%	38%
$30K to $40K	8%	0%	2%	0%	23%	9%	5%	4%	1%	29%
$20K to $30K	3%	1%	4%	0%	25%	6%	7%	7%	1%	20%
$10K to $20K	0%	0%	10%	1%	26%	5%	10%	8%	2%	15%
$5K to $10K	0%	0%	11%	1%	20%	7%	11%	12%	1%	16%
Total	**5%**	**0%**	**3%**	**0%**	**38%**	**4%**	**10%**	**6%**	**2%**	**17%**

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 - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend							
Category of Aid	**Aug 2023**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	52,176	15%	9,779	10,030	791	21,936	9,640
Child	101,555	29%	7,386	9,317	31,432	34,142	19,278
SPD	30,864	9%	9,987	4,481	1,114	12,969	2,313
ACA OE	121,928	35%	18,124	38,070	1,310	47,680	16,744
Duals	41,722	12%	24,790	2,570	2	9,867	4,493
LTC	138	0%	138	-	-	-	-
LTC-Dual	1,020	0%	1,020	-	-	-	-
Medi-Cal	349,403		71,224	64,468	34,649	126,594	52,468
Group Care	5,645		2,180	876	-	2,589	-
Total	**355,048**	**100%**	**73,404**	**65,344**	**34,649**	**129,183**	**52,468**
Medi-Cal %	98.4%		97.0%	98.7%	100.0%	98.0%	100.0%
Group Care %	1.6%		3.0%	1.3%	0.0%	2.0%	0.0%
	Network Distribution		*20.7%*	*18.4%*	*9.8%*	*36.4%*	*14.8%*
			% Direct:	**39%**		**% Delegated:**	**61%**

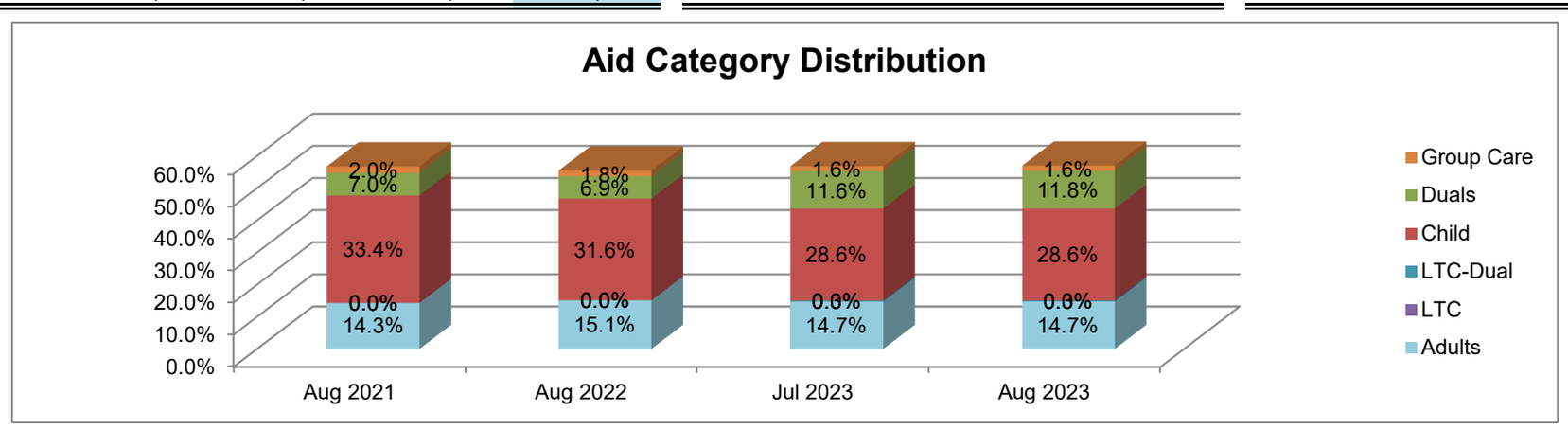




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

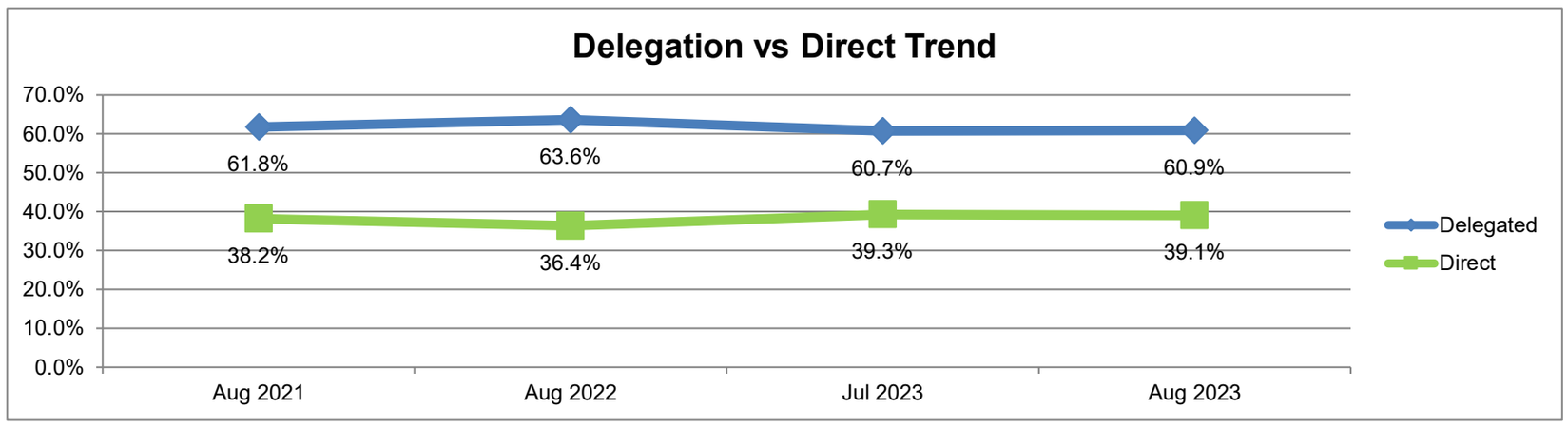
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021 to Aug 2022	Aug 2022 to Aug 2023	Jul 2023 to Aug 2023
Adults	41,519	48,112	52,550	52,176	14.3%	15.1%	14.7%	14.7%	15.9%	8.4%	-0.7%
Child	97,324	100,977	102,463	101,555	33.4%	31.6%	28.6%	28.6%	3.8%	0.6%	-0.9%
SPD	26,316	28,079	31,055	30,864	9.0%	8.8%	8.7%	8.7%	6.7%	9.9%	-0.6%
ACA OE	99,783	114,208	123,707	121,928	34.3%	35.8%	34.5%	34.3%	14.5%	6.8%	-1.4%
Duals	20,388	22,077	41,688	41,722	7.0%	6.9%	11.6%	11.8%	8.3%	89.0%	0.1%
LTC	-	-	141	138	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-2.1%
LTC-Dual	-	-	1,033	1,020	0.0%	0.0%	0.3%	0.3%	0.0%	0.0%	-1.3%
Medi-Cal Total	285,330	313,453	352,637	349,403	98.0%	98.2%	98.4%	98.4%	9.9%	11.5%	-0.9%
Group Care	5,877	5,803	5,669	5,645	2.0%	1.8%	1.6%	1.6%	-1.3%	-2.7%	-0.4%
Total	**291,207**	**319,256**	**358,306**	**355,048**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.6%**	**11.2%**	**-0.9%**



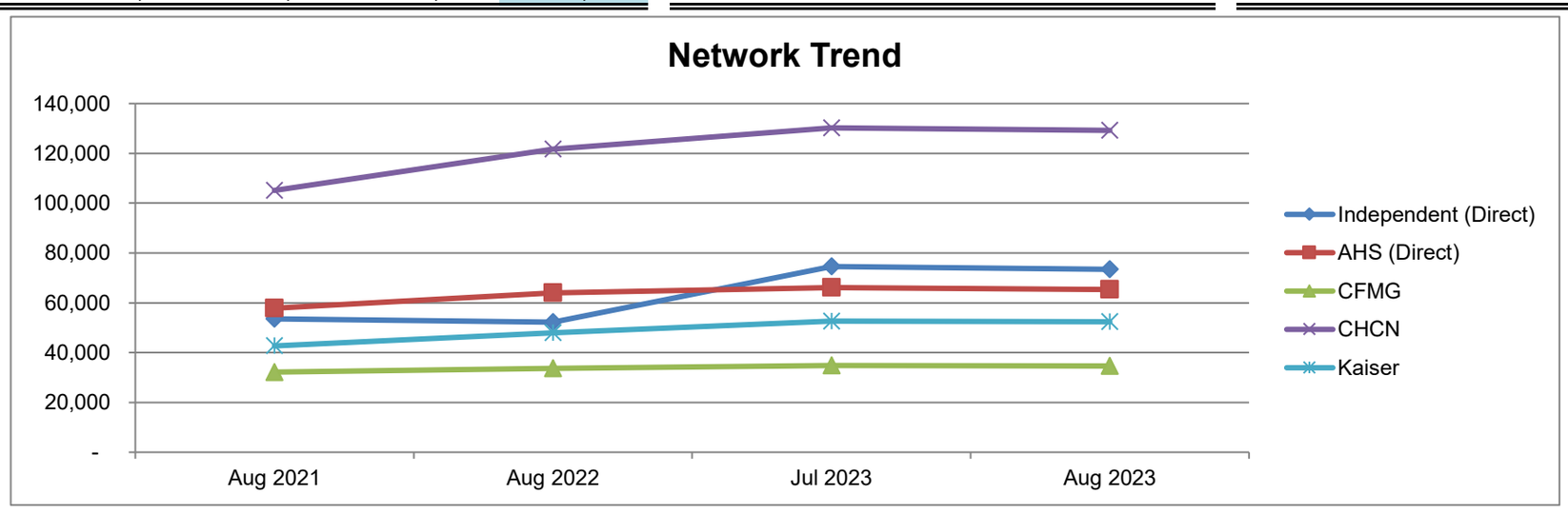
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021 to Aug 2022	Aug 2022 to Aug 2023	Jul 2023 to Aug 2023
Delegated	179,954	203,148	217,670	216,300	61.8%	63.6%	60.7%	60.9%	12.9%	6.5%	-0.6%
Direct	111,253	116,108	140,636	138,748	38.2%	36.4%	39.3%	39.1%	4.4%	19.5%	-1.3%
Total	**291,207**	**319,256**	**358,306**	**355,048**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.6%**	**11.2%**	**-0.9%**



Network Trend

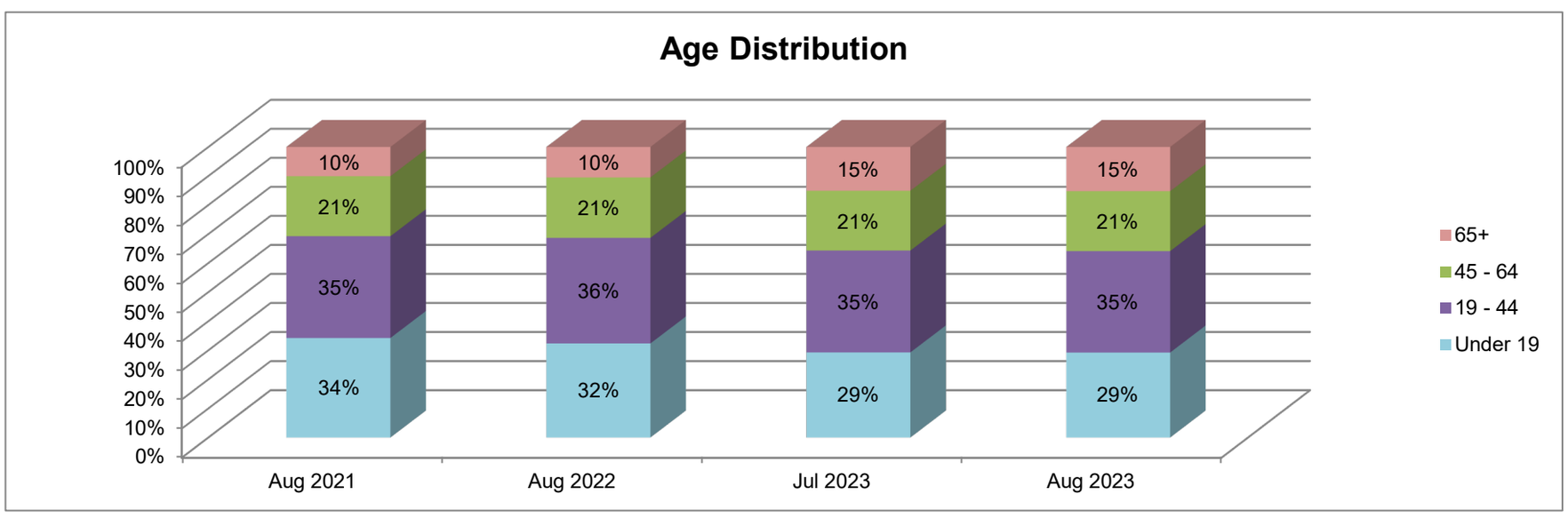
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021 to Aug 2022	Aug 2022 to Aug 2023	Jul 2023 to Aug 2023
Independent (Direct)	53,441	52,198	74,547	73,404	18.4%	16.3%	20.8%	20.7%	-2.3%	40.6%	-1.5%
AHS (Direct)	57,812	63,910	66,089	65,344	19.9%	20.0%	18.4%	18.4%	10.5%	2.2%	-1.1%
CFMG	32,167	33,594	34,810	34,649	11.0%	10.5%	9.7%	9.8%	4.4%	3.1%	-0.5%
CHCN	105,113	121,703	130,230	129,183	36.1%	38.1%	36.3%	36.4%	15.8%	6.1%	-0.8%
Kaiser	42,674	47,851	52,630	52,468	14.7%	15.0%	14.7%	14.8%	12.1%	9.6%	-0.3%
Total	**291,207**	**319,256**	**358,306**	**355,048**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.6%**	**11.2%**	**-0.9%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

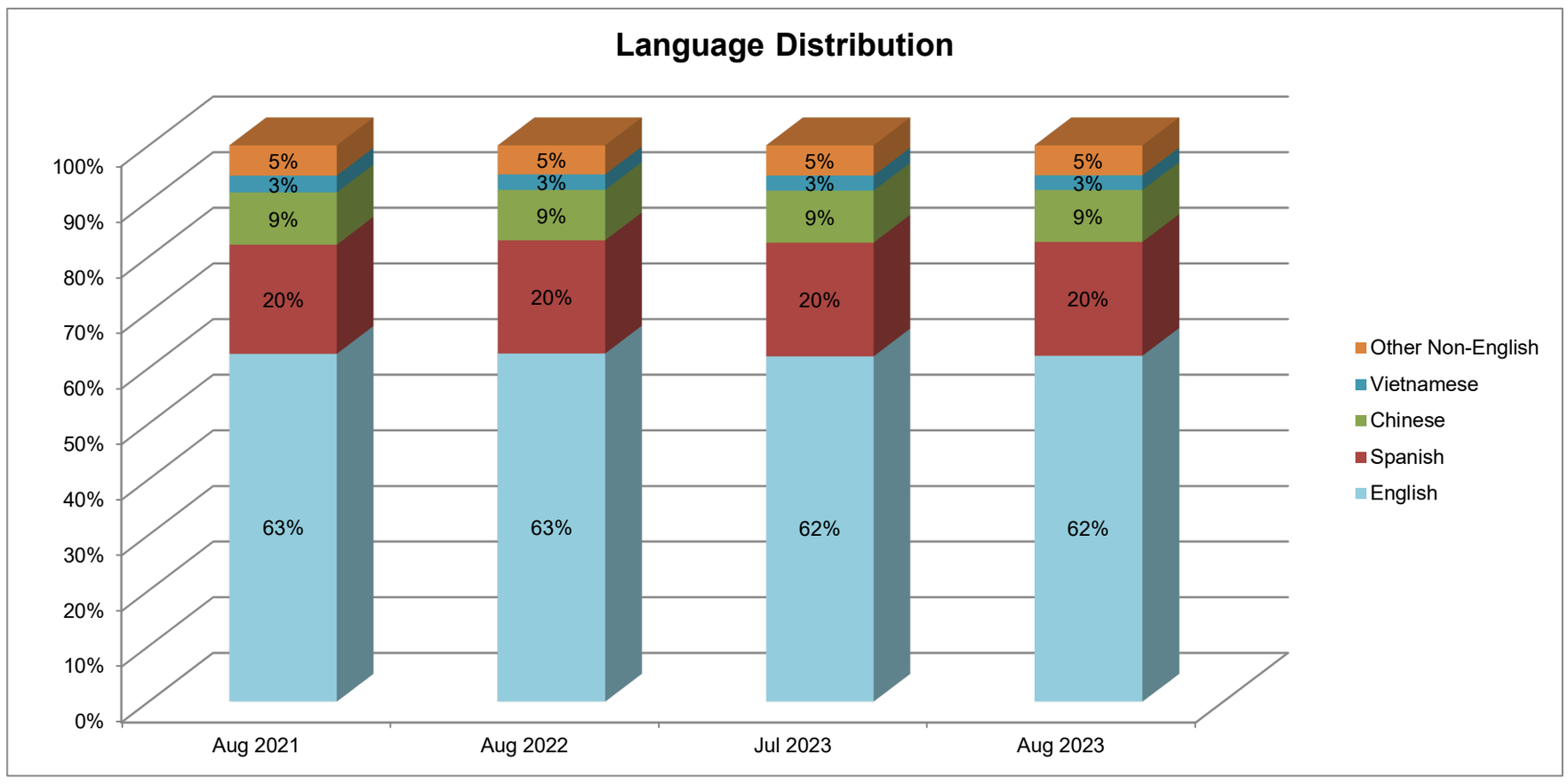
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021 to Aug 2022	Aug 2022 to Aug 2023	Jul 2023 to Aug 2023
Under 19	99,634	103,223	104,832	103,615	34%	32%	29%	29%	4%	0%	-1%
19 - 44	102,009	116,003	125,554	123,787	35%	36%	35%	35%	14%	7%	-1%
45 - 64	60,200	66,526	73,866	73,287	21%	21%	21%	21%	11%	10%	-1%
65+	29,364	33,504	54,054	54,058	10%	10%	15%	15%	14%	61%	0%
Total	**291,207**	**319,256**	**358,306**	**354,747**	**100%**	**100%**	**100%**	**100%**	**10%**	**11%**	**-1%**



Language Trend

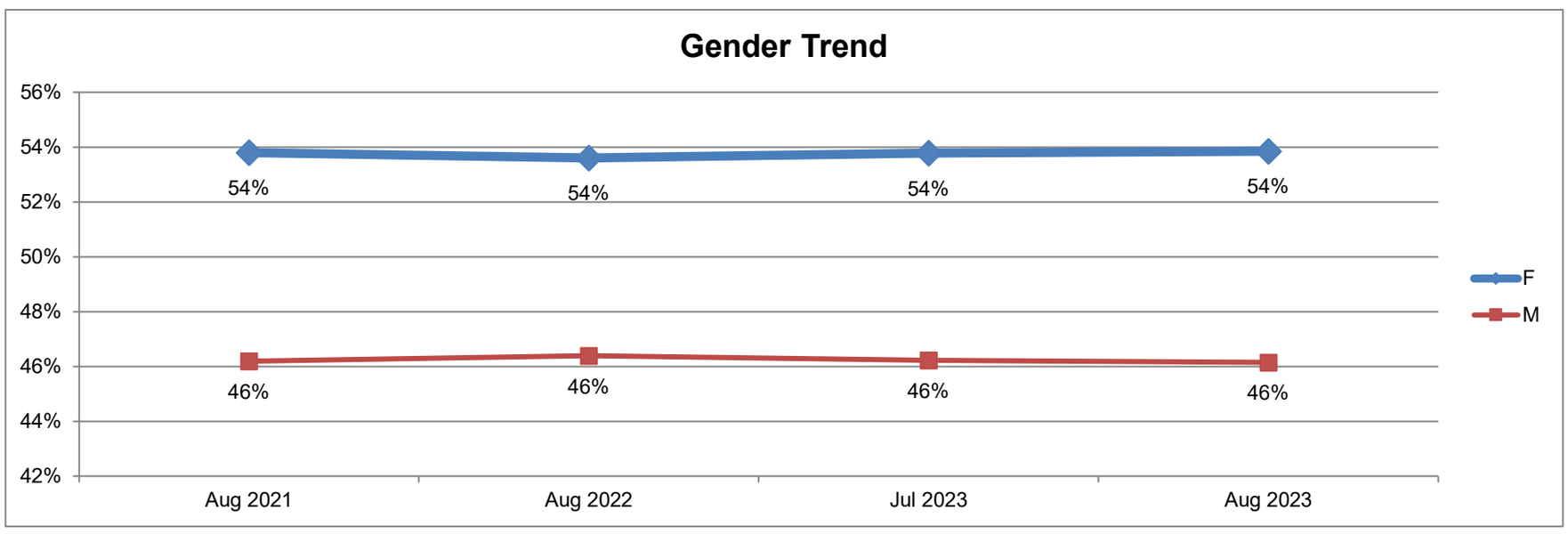
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021 to Aug 2022	Aug 2022 to Aug 2023	Jul 2023 to Aug 2023
English	182,065	199,798	222,387	220,565	63%	63%	62%	62%	10%	10%	-1%
Spanish	57,124	64,967	73,273	72,596	20%	20%	20%	20%	14%	12%	-1%
Chinese	27,385	28,938	33,455	33,152	9%	9%	9%	9%	6%	15%	-1%
Vietnamese	8,772	8,869	9,733	9,308	3%	3%	3%	3%	1%	5%	-4%
Other Non-English	15,861	16,684	19,458	19,126	5%	5%	5%	5%	5%	15%	-2%
Total	**291,207**	**319,256**	**358,306**	**354,747**	**100%**	**100%**	**100%**	**100%**	**10%**	**11%**	**-1%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

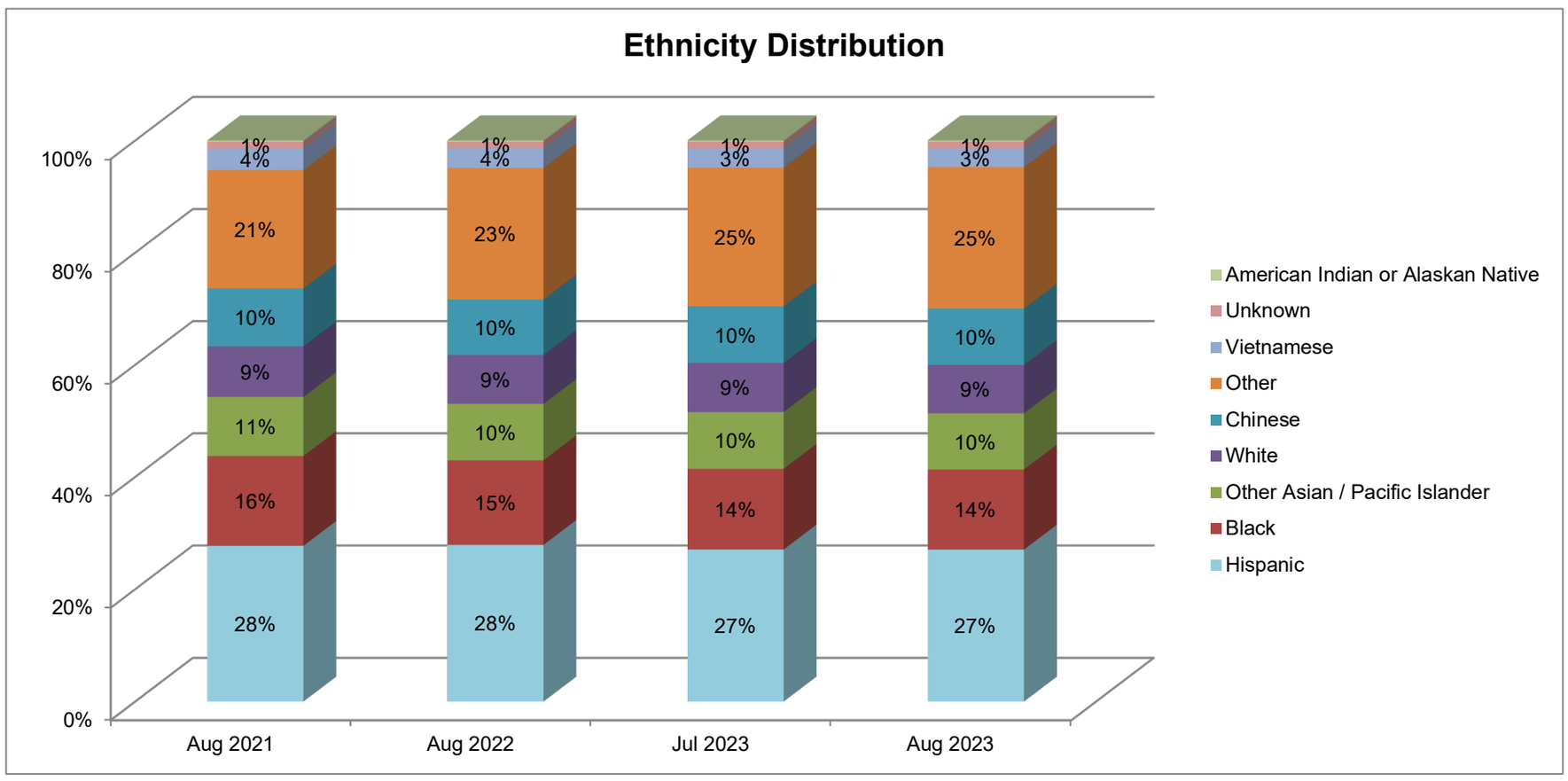
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021 to Aug 2022	Aug 2022 to Aug 2023	Jul 2023 to Aug 2023
F	156,688	171,141	192,702	191,034	54%	54%	54%	54%	9%	12%	-1%
M	134,519	148,115	165,604	163,713	46%	46%	46%	46%	10%	11%	-1%
Total	**291,207**	**319,256**	**358,306**	**354,747**	**100%**	**100%**	**100%**	**100%**	**10%**	**11%**	**-1%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021	Aug 2022	Jul 2023	Aug 2023	Aug 2021 to Aug 2022	Aug 2022 to Aug 2023	Jul 2023 to Aug 2023
Hispanic	80,668	88,998	96,921	95,902	28%	28%	27%	27%	10%	8%	-1%
Black	46,640	48,133	51,522	50,614	16%	15%	14%	14%	3%	5%	-2%
Other Asian / Pacific Islander	30,667	32,123	36,301	35,566	11%	10%	10%	10%	5%	11%	-2%
White	26,303	27,887	31,347	30,572	9%	9%	9%	9%	6%	10%	-2%
Chinese	30,056	31,586	36,209	35,715	10%	10%	10%	10%	5%	13%	-1%
Other	61,466	74,839	88,676	89,524	21%	23%	25%	25%	22%	20%	1%
Vietnamese	11,324	11,428	12,243	11,808	4%	4%	3%	3%	1%	3%	-4%
Unknown	3,468	3,579	4,360	4,327	1%	1%	1%	1%	3%	21%	-1%
American Indian or Alaskan Native	615	683	727	719	0%	0%	0%	0%	11%	5%	-1%
Total	**291,207**	**319,256**	**358,306**	**354,747**	**100%**	**100%**	**100%**	**100%**	**10%**	**11%**	**-1%**



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

Medi-Cal By City

City	Aug 2023	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	134,582	39%	19,209	30,159	14,165	56,273	14,776
Hayward	54,995	16%	10,681	11,721	5,913	17,269	9,411
Fremont	32,853	9%	12,736	4,825	1,290	8,713	5,289
San Leandro	31,523	9%	6,443	4,335	3,472	11,413	5,860
Union City	14,808	4%	5,214	2,210	638	3,969	2,777
Alameda	13,549	4%	2,915	2,043	1,717	4,645	2,229
Berkeley	13,108	4%	2,597	1,703	1,340	5,471	1,997
Livermore	10,774	3%	1,663	630	1,899	4,668	1,914
Newark	8,281	2%	2,469	2,539	311	1,511	1,451
Castro Valley	8,909	3%	1,900	1,317	1,126	2,653	1,913
San Lorenzo	7,356	2%	1,281	1,246	718	2,630	1,481
Pleasanton	6,130	2%	1,398	379	540	2,713	1,100
Dublin	6,536	2%	1,523	408	669	2,761	1,175
Emeryville	2,453	1%	522	443	316	750	422
Albany	2,078	1%	328	209	366	740	435
Piedmont	453	0%	90	126	30	94	113
Sunol	79	0%	19	10	6	27	17
Antioch	29	0%	9	3	12	4	1
Other	907	0%	227	162	121	290	107
Total	**349,403**	**100%**	**71,224**	**64,468**	**34,649**	**126,594**	**52,468**

Group Care By City

City	Aug 2023	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	1,803	32%	391	339	-	1,073	-
Hayward	629	11%	304	139	-	186	-
Fremont	616	11%	422	62	-	132	-
San Leandro	574	10%	224	86	-	264	-
Union City	295	5%	189	38	-	68	-
Alameda	280	5%	98	20	-	162	-
Berkeley	163	3%	49	12	-	102	-
Livermore	93	2%	29	3	-	61	-
Newark	132	2%	86	28	-	18	-
Castro Valley	194	3%	81	28	-	85	-
San Lorenzo	133	2%	47	17	-	69	-
Pleasanton	65	1%	23	3	-	39	-
Dublin	104	2%	33	6	-	65	-
Emeryville	36	1%	16	6	-	14	-
Albany	20	0%	7	1	-	12	-
Piedmont	13	0%	3	-	-	10	-
Sunol	-	0%	-	-	-	-	-
Antioch	25	0%	7	7	-	11	-
Other	470	8%	171	81	-	218	-
Total	**5,645**	**100%**	**2,180**	**876**	**-**	**2,589**	**-**

Total By City

City	Aug 2023	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	136,385	38%	19,600	30,498	14,165	57,346	14,776
Hayward	55,624	16%	10,985	11,860	5,913	17,455	9,411
Fremont	33,469	9%	13,158	4,887	1,290	8,845	5,289
San Leandro	32,097	9%	6,667	4,421	3,472	11,677	5,860
Union City	15,103	4%	5,403	2,248	638	4,037	2,777
Alameda	13,829	4%	3,013	2,063	1,717	4,807	2,229
Berkeley	13,271	4%	2,646	1,715	1,340	5,573	1,997
Livermore	10,867	3%	1,692	633	1,899	4,729	1,914
Newark	8,413	2%	2,555	2,567	311	1,529	1,451
Castro Valley	9,103	3%	1,981	1,345	1,126	2,738	1,913
San Lorenzo	7,489	2%	1,328	1,263	718	2,699	1,481
Pleasanton	6,195	2%	1,421	382	540	2,752	1,100
Dublin	6,640	2%	1,556	414	669	2,826	1,175
Emeryville	2,489	1%	538	449	316	764	422
Albany	2,098	1%	335	210	366	752	435
Piedmont	466	0%	93	126	30	104	113
Sunol	79	0%	19	10	6	27	17
Antioch	54	0%	16	10	12	15	1
Other	1,377	0%	398	243	121	508	107
Total	**355,048**	**100%**	**73,404**	**65,344**	**34,649**	**129,183**	**52,468**

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 13th, 2023**

Subject: **Human Resources Report**

Staffing

- As of October 1st, 2023, the Alliance had 501 full time employees and 1-part time employee.

- On October 1st, 2023, the Alliance had 91 open positions in which 32 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 59 positions open to date. The Alliance is actively recruiting for the remaining 59 positions and several of these positions are in the interviewing or job offer stage.

- Summary of open positions by department:

Department	Open Position October 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	29	9	20
Operations	38	17	21
Healthcare Analytics	4	1	3
Information Technology	6	1	5
Finance	8	1	7
Compliance & Legal	2	1	1
Human Resources	3	2	1
Health Equity	0	0	0
Executive	1	0	1
Total	91	32	59

- Our current recruitment rate is 14%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in September 2023 included:
    - 5 years:
        - Cynthia Ruiz Robledo (Claims)
        - Cynthia Catalan (Member Services)
        - Katherine Ebido (Quality Management)
    - 6 years:
        - Jennifer Leung (Facilities)
        - Benita Ochoa (Pharmacy Services)
    - 7 years:
        - Natalie McDonald (Utilization Management)
        - Sasi Karaiyan (Information Technology)
        - Ed DeOcampo (IT Infrastructure)
        - Tamara Lewis (State Directed & Special Programs)
        - Pandiyarajan Subburaman (IT Development)
        - Sankar Ganesh Rathnasamy (IT Development)
        - Anthony Taylor (Finance)
    - 8 years:
        - Smita Kaza (IT Ops & Quality Apps Management)
        - Dacheng Peng (IT Development)
    - 10 years:
        - Hellai Momen (Quality Management)
        - Alexandra Loza (Grievance & Appeals)
        - Catherine Patrick (Case/Disease Management)
    - 11 years:
        - BJ Gerona (Information Technology)
    - 19 years:
        - Carol van Oosterwijk (Finance)
    - 21 years:
        - Steve Le (Marketing & Communications)