



BOARD OF GOVERNORS
Regular Meeting Minutes
Friday, August 14th, 2026
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: Andrea Schwab-Galindo (Chair), Dr. Noha Aboelata (Vice Chair), Aaron Basrai, James Jackson, Byron Lopez, Dr. Marty Lynch, Yeon Park, Wendy Peterson, Supervisor Lena Tam, Natalie Williams

Board of Governors Remote: Dr. Rollington Ferguson, Andrea Ford, Jody Moore, Marcus Watkins

Board of Governors Excused: Dr. Kathleen Clanon, Rebecca Gebhart, Dr. Kelley Meade, Dr. Evan Seevak

Alliance Staff Present: Matthew Woodruff, Dr. Donna Carey, Gil Riojas, Stephen Smythe, Sasi Karaiyan, Tiffany Cheang, Beau Hennemann

Chair Andrea Schwab-Galindo called the regular Board of Governors meeting to order at 12:02 p.m.

2. ROLL CALL

Roll call was taken, and a quorum was established.

3. AGENDA APPROVAL

There were no modifications to the agenda.

4. INTRODUCTIONS

There were no introductions.

5. CONSENT CALENDAR

- a) JUNE 9th, 2026, FINANCE COMMITTEE MEETING MINUTES
- b) JUNE 12th, 2026, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES
- c) JUNE 12th, 2026, BOARD OF GOVERNORS MEETING MINUTES
- d) APPROVE RESOLUTION APPOINTING QIHE-UMC MEMBERS

Motion: A motion was made by Natalie Williams and seconded by James Jackson to approve the Consent Calendar.

Vote: The motion was passed unanimously.

Ayes: Aaron Basrai, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Byron Lopez, Dr. Marty Lynch, Yeon Park, Wendy Peterson, Supervisor Lena Tam, Marcus Watkins, Natalie Williams, Vice Chair Dr. Noha Aboelata, Chair Andrea Schwab-Galindo.

No opposition or abstentions.

6. BOARD MEMBER REPORTS

a) COMPLIANCE ADVISORY COMMITTEE

The Compliance Advisory Committee discussed the DMHC deficiency related to approximately \$9.5 million in claims, reviewed the internal remediation process, and plans for future prevention in collaboration with DMHC. The committee also covered the DHCS audit, HSHAG and NAB audits, and the counter data verification audit. Updates were provided on privacy, noting a reduction in incidents and ongoing improvements in documentation and accuracy. Board of Governors training compliance was reviewed, with three members having completed all required CMS trainings and several others in progress; options for online and hybrid training were discussed. Medicare and Medi-Cal pharmacy benefit management updates were shared, highlighting smoother contract submissions to CMS compared to the previous year, with anticipated approval by the end of September. The committee previewed the upcoming enterprise risk management presentation and confirmed ongoing reminders for board training dates.

b) FINANCE COMMITTEE

Dr. Ferguson reported on the Finance Committee meeting held August 11th, covering May and June financials. Key points included a continued decline in enrollment, with a loss of 41,310 members for the fiscal year. Tangible Net Equity (TNE) increased to 301 in May but decreased to 291 in June due to compliance issues. Medical Loss Ratio (MLR) was stable at 93.7% in May and rose to 97.2% in June, reflecting higher medical expenses. Administrative expenses were over budget by approximately \$2 million in both May and June. Medical expenses increased from \$173 million in May to \$185 million in June. Despite stabilization after a rocky start to the fiscal year, enrollment remains a concern, and the plan continues to lose money across all lines of business.

7. CEO UPDATE

The CEO report highlighted that most health plan–related priorities in the recent state budget did not materialize, including requested changes around care management and efforts to keep certain members in managed care, which will result in continued membership shifts to Medi-Cal fee-for-service. A significant driver of enrollment change is the scheduled transition of approximately 62,000 members, with additional membership losses expected, although leadership noted that these impacts were already built into the approved budget and that enrollment is expected to stabilize in the coming year. The report also emphasized ongoing efforts to manage membership decline through new initiatives, including the evaluation of a platform to improve electronic outreach, track Medi-Cal redeterminations, support gaps-in-care management, and connect members to additional social services such as CalFresh. In addition,

the organization is exploring potential product expansion such as a chronic care SNP (C-SNP) alongside existing D-SNP growth strategies, with the broader goal of mitigating enrollment loss while strengthening member engagement and coordination efforts.

The Board reviewed and evaluated the written Grievance and Appeals Report and Summary Log for July 2026, for Medi-Cal, IHSS, and D-SNP. Management presented detailed written records of grievance and appeal volumes, categories, resolution outcomes, and regulatory timeliness metrics. The Board thoroughly discussed the trends, formally accepted the written record, and acknowledged receipt and review of the report and management's ongoing monitoring of grievance and appeal performance.

8. BOARD BUSINESS

a) REVIEW AND APPROVE MAY AND JUNE 2026 MONTHLY FINANCIAL STATEMENTS

MAY 2026 Financial Statement Summary

Enrollment:

Enrollment decreased by 5,467 members since April 2026. Total enrollment decreased by 36,497 members since June 2025.

Net Income:

For the month ended May 31st, 2026, the Alliance reported a Net Income of \$1.5 million (versus budgeted Net Loss of \$1.0 million). For the year-to-date, the Alliance recorded a Net Income of \$68.5 million versus a budgeted Net Income of \$20.1 million.

Premium Revenue:

For the month ended May 31st, 2026, actual Revenue was \$184.5 million vs. our budgeted amount of \$181.0 million.

Medical Expense:

Actual Medical Expenses for the month were \$173.0 million, vs. budgeted amount of \$174.9 million. For the year-to-date, actual Medical Expenses were \$1.9 billion vs. budgeted Medical Expense of \$2.0 billion.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 93.7%. The year-to-date MLR was 92.4%.

Administrative Expense:

Actual YTD Administrative Expenses for the month ending May 31st, 2026, were \$12.4 million vs. our budgeted amount of \$10.1 million. Our Administrative Loss Ratio (ALR) is 6.7% of our Revenue for the month, and 5.6% of Net Revenue for year-to-date.

Other Income / (Expense):

As of May 31st, 2026, our YTD interest income from investments show a gain of \$27.2 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending May 31st, 2026, we reported \$62.2 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of \$59.5 million. Our MCO Tax Expense was \$62.2 million vs. budgeted MCO Tax Expense of \$59.5 million.

Tangible Net Equity (TNE):

For May, the DMHC requires that we have \$78.9 million in TNE, and we reported \$237.8 million, leaving an excess of \$158.8 million. As a percentage we are at 301%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported \$635.1 million in cash; \$470.2 million is uncommitted. Our current ratio is above the minimum required at 1.22 compared to regulatory minimum of 1.0.

Capital Investments:

We have acquired \$51,000 in Capital Assets year-to-date. Our annual capital budget is \$1.4 million.

JUNE 2026 Financial Statement Summary**Enrollment:**

Enrollment decreased by 4,813 members since May 2026. Total enrollment decreased by 41,310 members since June 2025.

Net Income:

For the month ended June 30th, 2026, the Alliance reported a Net Loss of \$6.1 million (versus budgeted Net Income of \$913,000). For the year-to-date, the Alliance recorded a Net Income of \$62.4 million versus a budgeted Net Income of \$21.0 million.

Premium Revenue:

For the month ended June 30th, 2026, actual Revenue was \$190.6 million vs. our budgeted amount of \$179.0 million.

Medical Expense:

Actual Medical Expenses for the month were \$185.4 million, vs. budgeted amount of \$169.8 million. For the year-to-date, actual Medical Expenses were \$2.1 billion vs. budgeted Medical Expense of \$2.1 billion.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 97.2%. The year-to-date MLR was 92.8%.

Administrative Expense:

Actual YTD Administrative Expenses for the month ending June 30th, 2026, were \$13.6 million vs. our budgeted amount of \$11.2 million. Our Administrative Loss Ratio (ALR) is 7.1% of our Revenue for the month, and 5.7% of Net Revenue for year-to-date.

Other Income / (Expense):

As of June 30th, 2026, our YTD interest income from investments show a gain of \$29.5 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending June 30th, 2026, we reported \$62.0 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of \$58.7 million. Our MCO Tax Expense was \$62.0 million vs. budgeted MCO Tax Expense of \$58.7 million.

Tangible Net Equity (TNE):

For June, the DMHC requires that we have \$79.7 million in TNE, and we reported \$231.7 million, leaving an excess of \$152.0 million. As a percentage we are at 291%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported \$704.6 million in cash; \$142.6 million is uncommitted. Our current ratio is above the minimum required at 1.14 compared to regulatory minimum of 1.0.

Capital Investments:

We have acquired \$51,000 in Capital Assets year-to-date. Our annual capital budget is \$1.4 million.

Motion: A motion was made by Natalie Williams and seconded by James Jackson to approve the May and June 2026 Monthly Financial Statements.

Vote: The motion was passed unanimously.

Ayes: Aaron Basrai, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Byron Lopez, Dr. Marty Lynch, Jody Moore, Yeon Park, Wendy Peterson, Supervisor Lena Tam, Marcus Watkins, Natalie Williams, Vice Chair Dr. Noha Aboelata, Chair Andrea Schwab-Galindo.

No opposition or abstentions.

b) MEDICAL MANAGEMENT UPDATES & PROGRAMS

Summary:

- Dr. Carey outlined the Healthcare Services philosophy focused on improving daily member outcomes through coordinated clinical and social care and better engagement across services.
- The department structure includes key areas such as utilization management, case management, pharmacy, quality & health equity, behavioral health, and long-term support services.
- A department vision was introduced emphasizing cross-functional collaboration, trust, member-centered care, and alignment with the Alliance mission.
- Core operating values were expanded to include trust, efficiency, adaptability, member focus, wellness, operations, resilience, communication, and kindness.
- Quality strategy focuses on health equity, access, safety, performance improvement, closing care gaps, and continuous improvement across populations.
- Population health model uses analytics, risk stratification, and community/member assessments to tailor interventions from low-touch outreach to intensive case management.
- Key 2026 priorities include improving chronic disease outcomes, advancing women's health equity, strengthening behavioral health access, and increasing pediatric well-care engagement.
- Birth equity initiatives were highlighted, including doula programs, maternal mental health support, and improved prenatal/postnatal data coordination tools.
- The doula program expanded significantly, growing network capacity and supporting provider onboarding through scholarships and financial assistance.
- Community health worker programs expanded substantially and are now actively supporting chronic disease, behavioral health, pharmacy outreach, and care coordination.

- Performance data showed strong results in most quality measures, with multiple metrics exceeding high-performance thresholds and overall improvement in member experience.
- ECM programs were emphasized through member case examples showing coordinated medical, behavioral, housing, and social support improving outcomes and transitions in care.
- Transitional rent and housing supports were highlighted, with dozens of members housed and a goal of scaling to hundreds of households annually.
- Behavioral health utilization increased significantly after insourcing, alongside major growth in ABA services and improved network access.
- Pharmacy and care transition programs focused on reducing readmissions, including ADT feeds, medication reconciliation, and hospital-based nursing support, contributing to reduced readmission rates.

Question: Dr. Lynch inquired whether the Alliance tracks effectiveness of interventions in reducing high-cost utilization (e.g., hospital stays, ED visits, readmissions) and how outcomes are evaluated. Dr. Carey and Tiffany confirmed they analyze data and use PDSA cycles to evaluate interventions; example given where placing an inpatient nurse at Washington Hospital was associated with reduced readmissions. Tiffany added that analysis of specific high-cost utilizer subsets within programs should be strengthened further.

Question: Dr. Lynch asked how many members are served through ECM compared to internal case management programs. The team said approximately 9,000 members are enrolled in ECM, and about 2,500 members are served through internal complex and basic case management programs.

Question: Dr. Lynch asked what the elder wellness/community health worker initiative involves. The team responded that the program focuses on reducing social isolation among seniors through partnerships with community organizations, with plans to enroll members into a pilot program and expand to D-SNP populations; additional housing-related pilots are also being explored.

Comment: Mr. Watkins requested additional outcome data demonstrating the measurable impact of programs such as doula services, prenatal and postpartum supports, and mental health initiatives.

Comment: Dr. Lynch requested a focused briefing on Long-Term Services and Supports (LTSS), including an overview of the services provided, program data, and the Alliance's work in this area. Dr. Carey confirmed that staff would coordinate a focused LTSS presentation, potentially led by Dr. Lo, who has extensive knowledge of the program. Dr. Carey also noted that the LTSS Director position is currently vacant and recruitment is underway.

Informational Item only.

c) ENTERPRISE RISK MANAGEMENT – ONBOARDING PRESENTATION

Summary:

- ERM framework defined as a structured, common language approach to identify, assess, prioritize, and manage organizational risks to support leadership decision-making.
- Purpose is proactive risk identification before issues occur, enabling early logging, monitoring, and mitigation planning to reduce operational, financial, and member impact.
- Risk evaluation is based on likelihood (probability of occurrence) and consequence (impact severity), including member harm, regulatory exposure, and organizational risk.

- Likelihood scoring is categorized from low to critical based on probability thresholds, supporting consistent risk prioritization across the organization.
- Consequence assessment considers severity of member impact (including safety and access), as well as regulatory, financial, and reputational exposure.
- Governance model follows the Three Lines of Defense framework, separating operational ownership, oversight/compliance functions, and independent internal audit review.
- COSO framework is used as the underlying structure to strengthen internal controls, risk visibility, and monitoring of control effectiveness across the organization.
- Risks are organized into a three-level taxonomy: strategic (high-level enterprise risks), tactical (subcategories), and operational (individual issues/events).
- Future-state process includes logging risks, calibrating and prioritizing them with leadership, and escalating critical risks for SLT decision on mitigation vs. monitoring.
- Mitigation process includes root cause analysis, control enhancements, ongoing monitoring, and internal audit validation of design and operating effectiveness.
- ERM implementation is aligned with regulatory expectations (including CMS) and supports maintaining an effective compliance program and audit readiness.
- Board will receive periodic updates on risk management progress and evolving risk profiles as part of ongoing governance cadence.

Question: Dr. Ferguson inquired about how the risks are prioritized or sized within the ERM framework? Ms. Beech explained that the risks are calibrated and ranked through discussion with leadership, aligning different perspectives and standardizing evaluation across functions to ensure consistent prioritization.

Question: Dr. Ferguson asked what top organizational risks have been identified to date. Ms. Beech stated that the primary internal risks are execution and resource planning, driven by competing priorities, evolving regulatory requirements, and capacity constraints.

Question: Dr. Ferguson asked which external risks are considered high priority. Ms. Beech identified AI-related exposure as a key external risk, particularly regarding third-party and delegated entity use, governance gaps, and the potential handling of sensitive data outside the organization's control.

Informational Item only.

9. STAFF UPDATES

There were no staff updates.

10. UNFINISHED BUSINESS

None.

11. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

None.

12. PUBLIC COMMENT (NON-AGENDA ITEMS)

Public comment was provided by Zouberou Sayibou from Humane Health, who shared observations gathered from social workers and discharge planners in skilled nursing facilities across the Bay Area. He noted that older adult patients who are medically ready for discharge often experience delays in returning to the community due to challenges in determining eligibility for enhanced care management (ECM) and community supports. He also highlighted that referral processes for these services can depend on personal relationships rather than clear, standardized documentation pathways, which can contribute to inconsistencies and slower transitions from facility care to community-based settings.

13. ADJOURNMENT

Chair Schwab-Galindo adjourned the meeting at 2:02 p.m.