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BOARD OF GOVERNORS
Regular Meeting Minutes
Friday, December 12th, 2026
12:00 p.m. – 2:30 p.m.

Video Conference Call and
1240 S. Loop Road
Alameda, CA 94502

1. CALL TO ORDER

Board of Governors Present: Rebecca Gebhart (Chair), Aarondeep Basrai, Dr. Kathleen Clanon, Dr. Rollington Ferguson, James Jackson, Dr. Marty Lynch, Andie Martinez-Patterson, Dr. Kelley Meade, Yeon Park, Wendy Peterson, Dr. Evan Seevak, Natalie Williams

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

Board of Governors Excused: Andrea Ford, Byron Lopez, Jody Moore, Andrea Schwab-Galindo, Supervisor Lena Tam

Alliance Staff Present: Matthew Woodruff, Dr. Donna Carey, Richard Golfin III, Gil Riojas, Anastacia Swift, Sasi Karaiyan, Tiffany Cheang, Lao Paul Vang

Chair Gebhart called the regular Board of Governors meeting to order at 12:04 p.m.

2. BOG CHAIR ANNOUNCEMENT

Ms. Gephardt announced her resignation as chair, effective March 2026 with Vice Chair Dr. Noha Aboelata expected to assume the role if a new chair is not elected.

3. ROLL CALL

Roll call was taken, and a quorum was established.

4. AGENDA APPROVAL

There were no modifications to the agenda.

5. INTRODUCTIONS

There were no introductions.

6. CONSENT CALENDAR

- a) **OCTOBER 10th, 2025, BOARD OF GOVERNORS MEETING MINUTES**
- b) **OCTOBER 7th, 2025, FINANCE COMMITTEE MEETING MINUTES**

c) OCTOBER 10th, 2025, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

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: Aarondeep Basrai, Dr. Kathleen Clanon, Dr. Rollington Ferguson, James Jackson, Dr. Marty Lynch, Andie Martinez-Patterson, Dr. Kelley Meade, Wendy Peterson, Dr. Evan Seevak, Natalie Williams, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

No opposition or abstentions.

7. CLOSED SESSION

a) PUBLIC EMPLOYEE PERFORMANCE EVALUATION – CONTRACT RENEWAL: CHIEF EXECUTIVE OFFICER (GOV. CODE SECTION 54957(b)(1)).

8. READ OUT FROM CLOSED SESSION

The Board unanimously voted to move forward with negotiating and renewing the CEO's employment agreement, with the Executive Committee leading the process and the final contract to be brought back to the Board for ratification.

9. BOARD MEMBER REPORTS

a) COMPLIANCE ADVISORY COMMITTEE

The Compliance Advisory Committee reviewed progress in closing out items from recent audits and surveys, discussed preparations for the 2026 DHCS medical survey, and addressed the need to renew data access grants annually for Medicaid and Medicare programs. They learned about the "Readily" data tool to support CMS program audits and vendor remediation, noted significant improvements in compliance infrastructure under current leadership, and expressed confidence in the organization's ability to manage ongoing compliance challenges.

b) FINANCE COMMITTEE

Dr. Ferguson reported on the final budget and financials for September and October 2025, highlighting ongoing improvement in the plan's financial position. Key metrics discussed included a positive trend in TNE (from 219 in September to 229 in October), a slight decline in enrollment (from approximately 405,000 to 404,000), and medical loss ratios within target range (94.6% in September and 92.7% in October). The committee also noted improved CR ratios (1.1 and 1.14), which are closely monitored by the state, and a small positive net income. Overall, the committee concluded that the plan is showing financial improvement and is on track with budget expectations.

c) COMMUNITY ADVISORY SELECTION COMMITTEE

The Community Advisory Selection Committee selection process was described, including outreach to foster care providers and senior services, resulting in a new slate of candidates and the addition of Donna Griggs Murphy, with ongoing efforts to ensure member and caregiver representation.

10. CEO UPDATE

CEO Woodruff provided an update that focused on legislative developments affecting the organization, particularly the tension between federal and state positions on programs like DEI, gender-affirming care, and social determinants of health, with the federal government labeling some community supports as potential spending abuses while the state remains committed to continuing these initiatives; Mr. Woodruff assured the board that the organization will comply with state contracts and keep the board informed of any required changes. He also highlighted the involvement of local leaders on the Future of Medical Committee, ongoing advocacy for indigent care, and preparations for upcoming changes related to HR1, including the establishment of planning, communications, and data committees to coordinate with county partners. Mr. Woodruff noted that Alameda County is ahead of other counties in organizing responses to new work requirements and praised the collaborative efforts and facilitation supporting these initiatives.

Question: Dr. Lynch inquired whether the organization could challenge the federal government's position that community supports are fraudulent or abusive.

Response: Mr. Woodruff explained that they are advocating through associations, signing letters, and collaborating with the state to preserve those programs, emphasizing their disagreement with the federal characterization.

Question: Dr. Meade inquired whether there is a plan to increase pediatric representation on committees.

Response: Mr. Woodruff clarified that the current committees are focused on administrative and outreach work. As they transition into HEDIS and quality measures, input from pediatric experts will be included.

Question: Dr. Ferguson requested a brief update on the implementation of the DSNP and inquired about any current challenges.

Response: Mr. Woodruff summarized that implementation is going well, enrollment is strong, and the organization is taking a slow, careful approach to ensure quality and provider readiness before scaling up.

11. BOARD BUSINESS

a) HEDIS PRESENTATION

Ms. Cheang provided a HEDIS presentation that covered the organization's performance on quality measures used by agencies such as DHCS, DMHC, NCQA, and CMS, highlighting the financial impacts of meeting minimum standards. She explained the increase in measures held to the Minimum Performance Level and the discontinuation of statewide ranking via AQFS. The organization improved its MPL compliance to 83% in recent years. However, challenges persist with measures like topical fluoride and controlling high blood pressure, which have led to sanctions but were partially mitigated through appeals. The presentation detailed data challenges, the role of health information exchange

(Manifest) in supporting record retrieval, and ongoing initiatives, including member outreach, provider education, and collaborations, to boost scores, noting that most measures are trending positively, except for well-child visits and prenatal care timeliness.

Question: Chair Gebhart inquired as to what happened with the controlling high blood pressure measure, and why it was missed?

Response: Ms. Cheang explained it is a challenging hybrid measure, affected by random sampling and the requirement to use the last blood pressure reading of the year, which may not reflect overall control.

Question: Dr. Lynch inquired about strategies to improve blood pressure control, particularly given its significance for addressing disparities.

Response: Dr. Carey described ongoing provider education, encouraging rechecks in-office, and frequent follow-up for members with hypertension.

Question: Dr. Seevak inquired about how members who avoid care or lack data are counted in HEDIS measures.

Response: Ms. Cheang explained that for some measures (like blood pressure), members without relevant data are not included, but for others (like breast cancer screening), eligible members are counted even if there is no data, which can negatively affect rates.

Question: Ms. Martinez-Patterson asked how the use of Manifest affected HEDIS scores.

Response: Ms. Cheang said Manifest has helped by providing more data and clues for record retrieval, but it is too early to quantify the impact on scores.

Question: Mr. Jackson asked why the topical fluoride measure goes up to age 20, and is this standard? Is there an appeal process for challenging measures like topical fluoride?

Response: Ms. Cheang clarified that the measure is not a standard HEDIS measure but was adopted by DHCS from another agency. The HEDIS version covers ages 0–5, which the Alliance has recommended to the state. The Alliance uses the “meet and confer” process with the state to present evidence and rationale, which has resulted in reduced sanctions in some cases.

b) MEDICARE UPDATE

Competitive Landscape & Plan Exits

- The Alliance reviewed the D-SNP (Dual Eligible Special Needs Plan) environment in Alameda County, noting that Kaiser remains but can only grow by enrolling current or closely affiliated members, not through broad marketing. Several competitors, including Aetna and Blue Cross, are exiting the county, which means affected members must choose between joining the Alliance or moving to fee-for-service Medi-Cal. About a third of new Alliance D-SNP members are transitioning from Aetna.

Benefit Design & Comparison

- The Alliance’s D-SNP benefit package was crafted after analyzing competitor offerings and consulting with Milliman for actuarial and financial input. The plan prioritizes robust dental and hearing benefits, which are more generous than Kaiser’s and, in the case of hearing, more robust than Molina’s. The over the counter (OTC) benefit is slightly lower than Molina’s but competitive

overall. The plan also adapts to regulatory changes, such as the scheduled expiration of Medicare telehealth benefits at the end of January, after which only Medi-Cal telehealth will remain unless Congress acts.

Enrollment Strategy & Progress

- The Alliance is taking a cautious, phased approach to D-SNP enrollment, targeting 1,500 members in the first year, primarily through a partnership with CHCN clinics. This strategy is intended to ensure operational readiness and high-quality service before scaling up, with a review planned for mid-year to consider broader expansion. Enrollment is now allowed monthly, not just during open enrollment, which supports ongoing growth.

Member Experience & Navigation

- Recognizing the complexity of Medicare and dual eligibility, the Alliance has implemented a concierge model for member support. Sales and customer service teams spend extended time with each member (average 90-minute calls), reviewing benefits, verifying providers and prescriptions, and assisting with portal adoption and telehealth access. Each member is also assigned a care coordinator for ongoing navigation support. The Alliance is collaborating with CHCN navigators and exploring partnerships with community health workers to further assist members.

Outreach & Communication

- The Alliance has conducted extensive outreach, including community events, provider engagement, and translation of over 1,200 documents into seven languages. Persistent follow-up is conducted on leads, with efforts underway to ensure outbound calls are clearly branded as Alliance to improve response rates. Leads are closed only after multiple unsuccessful contact attempts.

Operational Readiness & Monitoring

- A command center approach is in place for the D-SNP launch, with daily and weekly meetings to address issues as they arise. The Alliance is closely monitoring enrollment, member experience, and operational metrics, and will adjust strategies as needed based on early results and feedback.

Question: Ms. Martinez-Patterson asked what happens to beneficiaries when a plan exits the county.

Response: Ms. Watson and Mr. Meyers clarified that affected members receive notice and can choose to enroll with the Alliance or move to fee-for-service Medi-Cal. About a third of new Alliance members are coming from Aetna, which is exiting.

Question: Dr. Seevak inquired about how decisions were made about which supplemental benefits to offer.

Response: Ms. Watson said the Alliance analyzed competitor offerings, consulted with Milliman, and considered member needs and financial solvency. They prioritized benefits such as dental and hearing care that are valued by their population.

Question: Ms. Peterson inquired about how the Alliance is addressing member experience and navigation for dual-eligible individuals, considering the complexities of Medicare.

Response: Mr. Meyers described a concierge approach: sales and customer service teams spend extra time with members, review benefits, help with portal adoption, and coordinate with care coordinators. They are also working with CHCN navigators and community health workers for additional support.

Motion: A motion was made by Dr. Rollington Ferguson and seconded by Dr. Marty Lynch to approve the Bakertilly Financial Audit Review.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Dr. Kathleen Clanon, Dr. Rollington Ferguson, James Jackson, Byron Lopez, Dr. Marty Lynch, Dr. Kelley Meade, Wendy Peterson, Andrea Schwab-Galindo, Supervisor Lena Tam, Natalie Williams, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

No opposition or abstentions.

c) REVIEW AND APPROVE SEPTEMBER AND OCTOBER 2025 MONTHLY FINANCIAL STATEMENTS

SEPTEMBER 2025 Financial Statement Summary

Enrollment:

Enrollment decreased by 2,024 members since August 2025. Total enrollment decreased by 5,846 members since June 2025.

Net Income:

For the month ended September 30th, 2025, the Alliance reported a Net Income of \$3.1 million (versus budgeted Net Loss of \$3.2 million). For the year-to-date, the Alliance recorded a Net Income of \$7.8 million versus a budgeted Net Income of \$9.8 million.

Premium Revenue:

For the month ended September 30th, 2025, actual Revenue was \$188.0 million vs. our budgeted amount of \$186.4 million.

Medical Expense:

Actual Medical Expenses for the month were \$177.8 million, vs. budgeted amount of \$175.0 million. For the year-to-date, actual Medical Expenses were \$538.7 million vs. budgeted Medical Expense of \$525.3 million.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 94.6%. The year-to-date MLR was 94.7%.

Administrative Expense:

Actual YTD Administrative Expenses for the month ending September 30th, 2025, were \$9.3 million vs. our budgeted amount of \$10.2 million. Our Administrative Loss Ratio (ALR) is 5.0% of our Revenue for the month, and 5.3% of Net Revenue for year-to-date.

Other Income / (Expense):

As of September 30th, 2025, our YTD interest income from investments show a gain of \$7.5 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending September 30th, 2025, we reported \$129.7 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of \$64.6 million. Our MCO Tax Expense was \$129.7 million vs. budgeted MCO Tax Expense of \$64.6 million.

Tangible Net Equity (TNE):

For September, the DMHC requires that we have \$80.7 million in TNE, and we reported \$177.1 million, leaving an excess of \$96.4 million. As a percentage we are at 219%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported \$765.6 million in cash; \$458.1 million is uncommitted. Our current ratio is above the minimum required at 1.11 compared to regulatory minimum of 1.0.

Capital Investments:

We have acquired \$0 in Capital Assets year-to-date. Our annual capital budget is \$1.4 million.

OCTOBER 2025 Financial Statement Summary**Enrollment:**

Enrollment decreased by 1,409 members since September 2025.

Net Income:

For the month ended October 31st, 2025, the Alliance reported a Net Income of \$6.5 million (versus budgeted Net Loss of \$2.7 million). For the year-to-date, the Alliance recorded a Net Income of \$14.3 million versus a budgeted Net Income of \$7.1 million.

Premium Revenue:

For the month ended October 31st, 2025, actual Revenue was \$189.4 million vs. our budgeted amount of \$186.1 million.

Medical Expense:

Actual Medical Expenses for the month were \$175.6 million, vs. budgeted amount of \$180.7 million. For the year-to-date, actual Medical Expenses were \$714.3 million vs. budgeted Medical Expense of \$706.0 million.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 92.7%. The year-to-date MLR was 94.2%.

Administrative Expense:

Actual YTD Administrative Expenses for the month ending October 31st, 2025, were \$9.7 million vs. our budgeted amount of \$10.1 million. Our Administrative Loss Ratio (ALR) is 5.1% of our Revenue for the month, and 5.2% of Net Revenue for year-to-date.

Other Income / (Expense):

As of August 31st, 2025, our YTD interest income from investments show a gain of \$10.0 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending October 31st, 2025, we reported \$64.4 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of \$64.5 million. Our MCO Tax Expense was \$64.4 million vs. budgeted MCO Tax Expense of \$64.5 million.

Tangible Net Equity (TNE):

For October, the DMHC requires that we have \$80.1 million in TNE, and we reported \$183.6 million, leaving an excess of \$103.4 million. As a percentage we are at 229%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported \$542.1 million in cash; \$382.4 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 \$0 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 Dr. Kelley Meade to approve the September and October 2025 Monthly Financial Statements.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Dr. Kathleen Clanon, Dr. Rollington Ferguson, James Jackson, Dr. Marty Lynch, Dr. Kelley Meade, Yeon Park, Wendy Peterson, Dr. Evan Seevak, Natalie Williams, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

No opposition or abstentions.

d) REVIEW AND APPROVE FISCAL YEAR 2026 FINAL BUDGET

Budget Process

- Preliminary Budget presented to Finance Committee on June 10th and to the Board of Governors on June 13th.
- CY2026 Prospective Rates were received on November 12th. The rates were favorable to the Preliminary Budget.
- Final Budget was presented to Finance Committee on December 9th and to the Board of Governors on December 12th.

Material Areas of Uncertainty

- The Department of Health Care Services (DHCS) may reduce Calendar Year 2025 (CY25) rates in 2026. Furthermore, DHCS may retroactively adjust Calendar Year 2026 (CY26) rates.
- With CY26 MCO tax liability unclear, CY25 is being used as a placeholder.
- Effective January 1, 2026, the Medi-Cal Asset Limit will be reinstated as part of determination of Medi-Cal eligibility. This will negatively impact enrollment.
- Determining the potential impact of membership decline and immigration status on utilization remains challenging.
- Contract changes for hospitals and delegated providers in projections have not been finalized.

Highlights

- 2026 Projected Net Income of \$21.0 million.
- Projected Tangible Net Equity (TNE) is 238% of required TNE.
- Year-end projected enrollment is 370,000 in June 2026, down 41K from the prior year.

- Revenue is \$2.2 billion, \$10.7 million higher than the Preliminary Budget due to favorable rates.
- Medical Expense totals \$2.06 billion in FY 2026, a decrease of \$56 million (-2.7%) from the Preliminary Budget.
- Administrative Department Expenses are \$8.6 million higher than Preliminary, representing 5.9% of revenue.
- Clinical Department Expenses are \$25.3 million higher than Preliminary and comprise 1.8% of revenue.
- AAH's Medicare D-SNP Program is projected to start in January 2026.

Staffing

- Staffing includes 661 full-time equivalent employees by June 30, 2026.
- The Alliance is continuing the soft hiring freeze to appropriately manage staffing as enrollment declines.

Enrollment

- Medi-Cal enrollment is projected to decrease over FY26. Projected enrollment loss is approximately 41,000 compared to FY25.
- Group Care enrollment will remain relatively flat with only slight increases.
- Medicare enrollment will start January 2026 with gradual ramp up. Enrollment is projected to end at 1,500 members by the end of the calendar year.

Capital Expenditures

- Final Budget is \$1.4 million for capitalized purchases.
- Final Budget is unchanged from the Preliminary Budget.

Total includes \$1.3 million for IT hardware and \$0.1 million for building improvements.

Question: Mr. Jackson asked how the \$20 million set aside for possible clawbacks was handled, whether it is earning interest, and when it will be released.

Response: Mr. Riojas said that all cash set aside is invested and earns interest; the release depends on state decisions expected by mid-calendar year, and if not needed, the funds may be used for other items or D-SNP expenses.

Question: Dr. Ferguson inquired about the financial implications of the increased costs for employee health benefits.

Response: Mr. Riojas stated that the cost of employee health benefits, including Kaiser and Blue Shield, has risen significantly, estimated to be at least \$25 to \$30 million above previous budgets.

Question: Dr. Ferguson asked whether it is possible for employees to be interested in an Alliance benefit plan instead of Blue Shield or Kaiser?

Response: Mr. Riojas stated that offering a self-insured Alliance plan would require a different model and risk assessment, which can be considered but is not currently in place.

Motion: A motion was made by Dr. Rollington Ferguson and seconded by Dr. Evan Seevak to approve the Fiscal Year 2026 Final Budget.

Vote: The motion was passed unanimously.

Ayes: Dr. Kathleen Clanon, Dr. Rollington Ferguson, James Jackson, Dr. Marty Lynch, Andie Martinez-Patterson, Dr. Kelley Meade, Yeon Park, Wendy Peterson, Dr. Evan Seevak, Natalie Williams, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

e) STRATEGIC PLAN OVERVIEW

2025 Strategic Planning Activities

- Board of Governors' Annual Retreat (January 2025)
- Individual Interviews with Board of Governors
- Two Board Strategic Planning Committee Meetings
- Two Board of Governors Meeting Progress Updates
- Six Community Stakeholder Interviews
- Community Health Center Network (CHCN) Focus Group Discussion
- 4+ Executive Leadership Team Planning Sessions
- Executive Leadership Team Enterprise Metric and 2026 Tactics Development

Organizational Strategic Plan: 2026-2028

Strategic Plan Definitions

- **Priorities.** Major areas or categories of organizational focus
- **Goals.** *What* the organization seeks to achieve by 2028. Set the direction and purpose for strategic activities and serve as 'north stars' for decision-making, resource allocation, and performance measurement.
- **Strategies.** *How* the organization will advance/achieve Goals. High level directional (not operational) approaches or methods to advance Goals. Serve as the basis for specific tactics or activities.
- **Enterprise Metrics.** Organization-wide outcomes that indicate if the organization has been successful in achieving strategic plan Goals.
- **2026 Tactics.** Proposed activities or milestones to be enacted in the first year of the strategic plan. Will be translated into departmental goals and annual operational workplans.

Informational Item Only.

12. STAFF UPDATES

There were no staff updates.

13. UNFINISHED BUSINESS

None.

14. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

None.

15. PUBLIC COMMENT (NON-AGENDA ITEMS)

There were no public comments for non-agenda items.

16. ADJOURNMENT

Chair Gebhart adjourned the meeting at 2:31 p.m.