ALAMEDA ALLIANCE FOR HEALTH
BOARD OF GOVERNORS
REGULAR MEETING
January 13th, 2023
12:00 pm – 2:00 pm
(Video Conference Call)
Alameda, CA

SUMMARY OF PROCEEDINGS

Board of Governors on Conference Call: Rebecca Gebhart (Chair), Dr. Noha Aboelata (Vice-Chair), Dr. Evan Seevak, Dr. Kelley Meade, Dr. Marty Lynch, Dr. Rollington Ferguson, James Jackson, Dr. Michael Marchiano, Byron Lopez, Andrea Schwab-Galindo, Natalie Williams, Yeon Park, Jody Moore

Alliance Staff Present on Conference Call: Scott Coffin, Dr. Steve O'Brien, Gil Riojas, Anastacia Swift, Ruth Watson, Matt Woodruff, Sasi Karaiyan, Richard Golfin III, Tiffany Cheang, Michelle Lewis

Guests Present on Conference Call:

Excused: Aarondeep Basrai

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
1. CALL TO ORDER			
Rebecca Gebhart	The regular board meeting was called to order by Rebecca Gebhart at 12:03 pm. The following public announcement was read. "The Board recognizes that there is a proclaimed state of emergency at both the State and the local Alameda County levels, and there are recommended measures to promote social distancing in place. The Board shall therefore conduct its meetings via teleconference in accordance with Assembly Bill 361 for the duration of the proclaimed State of emergency." "Audience, during each agenda item, you will be provided a reasonable amount of time to provide public comment."	None	None

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2. ROLL CALL			
Rebecca Gebhart	A telephonic roll call was taken of the Board Members, and a quorum was confirmed.	None	None
3. AGENDA APPROVAL OR MODIFICATIONS			
Rebecca Gebhart	None	None	None
4. INTRODUCTIONS			
Rebecca Gebhart	None	None	None
5. CONSENT CALENDAR			
Rebecca Gebhart	Rebecca Gebhart presented the January 13th, 2023, Consent Calendar. a) December 9th, 2022, Board of Governors Meeting Minutes b) January 10th, 2023, Finance Committee Meeting Minutes Motion to Approve January 13th, 2023, Board of Governors Consent Calendar. A roll call vote was taken, and the motion passed.	Motion to Approve January 13th, 2023, Board of Governors Consent Calendar. Motion: Dr. Evan Seevak Second: Yeon Park Vote: Yes No opposed or abstained.	None

6. a. BOARD MEMBER REPORT – COMPLIANCE ADVISORY COMMITTEE			
Dr. Kelley Meade	The Compliance Advisory Committee (CAC) was held on December 9th, 2022, at 10:30 am. Since Committee Chair Rebecca Gebhart was absent from the Compliance Advisory Committee Meeting, Committee Vice Chair Dr. Kelley Meade gave the following updates. • The Compliance Advisory Committee met this morning, and it was an informational session since we did not meet quorum. • The Compliance Audit Performance dashboard was reviewed, and there are positive trends. Compliance Dashboard: • There were one-hundred-sixty-one (161) findings, and one-hundred-thirty-eight (138) have been completed. Twenty-three (23) are in progress. 2022 DHCS Routine Medical Survey: • There were fifteen (15) findings, nine (9) of which were repeat findings. • A Memorandum of Understanding (MOU) with County Mental Health Plan was put into place last month on December 15th, 2022. 2022 DMHC Routine Financial Examination: • There were three (3) deficiencies that are still at hand, however, they have Corrective Action Plans (CAPs) in place. They relate to provider dispute resolutions, changes in Plan personnel, and notification to the State of fidelity bond change. 2021 DMHC Full Medical Survey: • The preliminary report has six (6) findings – three (3) are in the grievances and appeals category, and three (3) are in prescription drug coverage. • There are updates to the Plan formulary. We submitted a Corrective Action Plan (CAP) to the State on December 30th, 2022.	Informational update to the Board of Governors. Vote not required.	

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	2021 DHCS Routine Medical Survey: • There was a total of thirty-three (33) findings and four (4) repeat findings reviewed. • The Plan's final response to the findings was provided to us on September 23rd, and we submitted documentation on December 15th. This related to an audit tool working with CHCN. 2018-2020 Audits: • The Kindred Focused Audit is closed. There are three (3) other audits that are being closed. • There is also activity at the Plan with internal audits – a total of forty–seven (47), and there is one specific issue on the 2021 DHCS self-identified audit that we would like to discuss regarding utilization management and transportation. CEO Scott Coffin provided the following comments: • This finding relates to the requirement for us to collect a medical necessity form ahead of provision a ride for an appointment. • The challenge that we faced over the years is receiving this form in advance of the appointment, and under the State regulation, it prohibits us from fulfilling that transport until that form is received. • I have made the decision and asked my team to carry forward with transporting our members to their appointments because that I feel is more important than deferring that appointment and possibly missing the opportunity to provide that person with care. • We are taking active steps to remediate this deficiency; it will likely not be in time for the upcoming audit. However, we are taking active steps, and will continue to transport our members as needed considering the regulatory rules. • We'll do our best to collect these forms; we are putting in some technology solutions that are going to help, and we're also hiring staff to assist in the coordination and collection of these medical necessity forms, referred to as PCS forms. Informational update to the Board of Governors. Vote not required.		

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6. b. BOARD MEMBER REPORT – FINANCE COMMITTEE			
Dr. R. Ferguson	The Finance Committee was held telephonically on Tuesday, January 10th, 2023. Dr. Ferguson provided the following updates: Highlights: • Our enrollment continues to increase; for the month ending November 30th, 2022, our membership increased to over three-hundred-twenty-five thousand (325,925). • We also spent time discussing the capital assets acquired, and the amount of money we are spending on internet security. • Our Medical Loss Ratio (MLR) has increased significantly; for the month ending November 30th, 2022, the MLR was ninety-seven percent (97.1%) and ninety-one percent (91.3%) for the fiscal year-to-date. Informational update to the Board of Governors. Vote not required.	Informational update to the Board of Governors. Vote not required.	None
7. CEO UPDATE			
Scott Coffin	Scott Coffin, Chief Executive Officer, presented the following updates: Financials: • Governor Newsom released the first edition of the two-hundred-ninety-seven-billion-dollar budget ($297.0B) for fiscal year 2024, and it reports a deficit of about twenty-four billion dollars ($24.0B). The governor will be releasing a second edition, which is referred to as the May Revision in a few months in the month of May. • Currently, we have seen that healthcare spending has been reduced as other sectors have been in this budget. However, the reductions in health	Informational update to the Board of Governors. Vote not required.	None

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	services have been disproportionately less than in other areas. There is a lot of analysis taking place to better understand the underlying logistics. • The Alliance is beginning its fiscal year 2024 budget process in a couple of months; the Board will be presented with the preliminary budget in June, as we do each year. I do not anticipate a deficit anywhere close to California's budget, but it is going to be a challenging fiscal year with all the changes that we are experiencing with the Medi-Cal program. • In the month of November 2022, the Alliance reported a one-point-four million dollar ($1.4M) net loss and is posting a year-to-date net income of twenty-point-two million dollars ($20.2M). • We are expecting annual revenues to exceed one-point five billion dollars ($1.5B) by the end of this fiscal year, so our growth continues. • Total enrollment has exceeded three-hundred-thirty thousand (330,000) as of January 1st. Our group care product remains steady at about five-thousand six hundred (5,600). The Medi-Cal program continues to grow each month; right now, we are at about three-hundred-twenty-five thousand (325,000). The membership, revenue, and expense attribute ninety-eight percent (98%) to all our numbers. Key Performance Indicators: • Referring to the executive dashboard on page fifty-four, one-hundred percent (100%) of the regulatory metrics were met in the month of December. Many thanks to each staff member for going the extra mile in working together to achieve these results – it takes a lot of work; thank you to the Alliance team. • Medi-Cal enrollment is one of our leading indicators of our growth and each month, we are setting new records. We are seeing increases of twelve to fifteen hundred (~1,500) and in this last month, twenty-seven hundred (2,700). • The California Department of Health Care Services had announced in December that approximately twenty-nine thousand adults and children would be moved from the Medi-Cal Fee-for-Service Program into Managed Care, and that would occur on January 1st, 2023 – that transfer of the Alameda County residents did not occur as planned. As discussed in the Compliance Advisory Committee, a very small number of the long-term care		

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	beneficiaries moved over as well as the other beneficiaries that we will be serving soon as the State works out issues on the eligibility determinations. • We are going to see this growth likely in February and March and will be adjusting our budget accordingly. Medi-Cal Redetermination Process: • The federal Public Health Emergency (PHE) has been extended to April 11th, 2023. • The Medi-Cal Redetermination Process follows the federal timeline, so we are adjusting the member outreach campaign to begin later this year. I shared at the last Board meeting that the Alliance is partnering with Alameda County Social Services community-based organizations and other health agency partners to conduct outreach campaigns over a fourteen-to-sixteen-month (14-16) time period. • The campaign will begin somewhere around April 2023 and continue through the second quarter of 2024. Our goal is to minimize the disruption for those individuals that are redetermined and identified as ineligible. The question becomes – where do they go for their health insurance and healthcare? There are options, of course; Covered California has options. However, the situation that people will face relates to paid premiums and more out-of-pockets; we will be working together to minimize the disruption. Question: For enrollment, there are seventy-five thousand adults and children enrolled in fee-for-service and ninety-nine percent of them will be transitioning to Medi-Cal; there is a bullet that says twenty-nine thousand adults and children will be transitioned, most of them being duals. What is the difference, is everyone in the difference between those going to be enrolled with the Alliance or Anthem? Answer: The total number of individuals enrolled in Medi-Cal fee-for-service in Alameda County is seventy-five thousand (75,000). The State announced last year that they intend to move ninety-nine percent (99%) of all individuals in Medi-Cal Fee-for-Service over into Managed Care. They will conduct this in phases; this first phase was set to occur on January 1st, 2023, and had twenty-nine thousand (29,000) identified. We don't know that we are going to get all seventy-five thousand (75,000) of those individuals, but there is still over forty thousand (40,000) that will remain in Fee-for-Service. Some will also be enrolled with Anthem. We are not sure		

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	yet when they expect to get the other individuals – the Department of Health Care Services has not announced the schedule yet for subsequent phases. We expect to be hearing more by April or May on subsequent phases. CalAIM: • Long-Term Care, Enhanced Care Management, and Population Health are being presented later in the meeting. In addition, Ruth Watson will be updating on the progress with the insourcing of mental health and autism spectrum services. • CalAIM is a very important component of the Medi-Cal Program; the Department of Health Care Services is serious about listening to all participants in the Medi-Cal program and those that are serving the program. • Senior Leadership at the Department is conducting a listening tour and we received an update this morning that they will be visiting Alameda County in February. The venue for this meeting will be here at the Alliance's headquarters and will include representatives from across the county safety-net. We are looking forward to this opportunity to share some local stories and talk with the Department about opportunities to increase our partnership as we move into this calendar year 2023 with the many changes that are coming, such as Enhanced Care Management and the expansion of these populations of focus. HEDIS: • The California Department of Health Care Services (DHCS) issued a twenty-five-thousand-dollar ($25,000) sanction on the Alliance related to HEDIS scores in calendar year 2021. • This sanction is related to the three quality measures that were below the minimum level. We reviewed this at the Compliance Advisory Committee today and talked about these three measures: (1) progressive cancer screening and (2) pediatric well-care visit measures. • The HEDIS scores are a reflection of the great work our providers do every day, and I am appealing the sanction based on the timing of the financial penalty. I believe that the state regulatory agencies should not penalize the safety net system during a public health emergency, and that they need to consider other factors related to healthcare quality while in a pandemic state.		

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	• In response to the sanction, DHCS has requested a comprehensive quality strategy that defines our interventions in 2023 to improve quality, and the document will be submitted to the Department prior to the deadline on January 31st. I will keep the Board of Governors updated on the status of the appeal regarding the sanction. • I am expecting that the Alliance will receive another sanction for Calendar Year 2022 related to HEDIS scores, which will be issued at some point in December 2023. Question: Why are you anticipating additional sanctions? Answer: Yes, I am anticipating based on what we have experienced for calendar year 2021, and we are still pending to receive our final results for all the scores. In looking at the performance in calendar year 2022, it is likely we are going to receive sanctions for this time period as well. This is more informational right now to inform the Board of Governors of the potential risk. Question: Is it possible that a part of the basis of the appeal that the infractions in 2021 and possibly in 2022 had to do with COVID and the changed circumstances related to healthcare delivery? Answer: Yes, that is part of the discussion with the Department regarding the impact of the pandemic and the timing of these sanctions. Question: So Board members can expect further reports regarding the appeal with the State, and we could hear about this at the Compliance Advisory Committee and the February Board meeting? Answer: Yes, we should know more by the end of January. Informational update to the Board of Governors. Vote not required.		

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8.a. BOARD BUSINESS – BOARD CHAIR / VICE CHAIR ELECTIONS			
Scott Coffin	Prior to the commencement of the Board Elections, Rebecca Gebhart and fellow Board members thanked Dr. Seevak for his years of service as Board Chair. CEO Scott Coffin provided the following appreciation for Dr. Seevak: • Thank you, Dr. Seevak for being a friend and a partner in working though and problem solving; for all those evening phone calls that you would take, I appreciated every one of them. The Vice Chair yielded to the Secretary (CEO) to commence the Board Election for the Chair Position: • We are holding this election to fill the current vacancy for the Chair of the Board. Nominees have been received over the previous few months. However, nominees may still be accepted until the vote is concluded for the vacancy, nominees may be present during the vote itself, and a nominee is permitted to vote for themselves. A nominee may abstain from voting for themselves as well. • If a new vacancy is created through this election, additional election(s) will be held to fill those vacancies as permitted – I am referring to the Vice Chair seat. • A motion and second and vote were taken to commence the election for Board Chair. • There is one (1) nominee for Chair – Ms. Rebecca Gebhart, who occupies the Regular Seat #5, which is the at-large subject matter expert. Are there any last-minute nominations? If not, the nominations are now closed, and we will take a vote for the Chair. The vote was taken for Ms. Rebecca Gebhart as Chair. The vote passed, and Board members congratulated Ms. Rebecca Gebhart on being voted in as Chair. Vice Chair Election: • We now have a vacancy for Vice Chair. Are there any public comments? • A motion and second was facilitated to begin the election for Vice Chair.	*Motion to begin election for Board Chair* Motion: Natalie Williams Second: Dr. Kelley Meade Vote: Yes No opposed or abstained. *Vote for Ms. Rebecca Gebhart as Chair*: Yes No one opposed or abstained. *Motion to begin election for Vice Chair* Motion: Natalie Williams Second: Dr. Evan Seevak Vote: Yes No one opposed or abstained.	None

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	• The floor is now open for discussion – there are two (2) nominees for Vice Chair: Dr. Noha Aboelata, who occupies Regular Seat #3 as the Designated Position from Alameda-Contra Costa Medical Association in sync with the Miller Medical Association, and the second is Mr. James Jackson who occupies Regular Seat #10 as CEO for Alameda Health System. • Are there any last-minute nominations? Hearing none, the nominations are now closed. • If you would like to vote for Dr. Aboelata, say Dr. Aboelata; if you would like to vote for James Jackson, say James Jackson at the end of the call-out from the Clerk. Board Member & Vice Chair nominee Mr. James Jackson made the following comment: • I would like to offer my support for Dr. Aboelata. I was honored to be nominated for the Vice Chair role but learning that Dr. Aboelata had been nominated as well, I believe that she would be a fantastic Vice Chair. If this changes how the process moves forward, I apologize for not making the statement earlier. Question: Are you withdrawing your name? Answer: I don't know if that would be the appropriate next step; I would throw my support for Dr. Aboelata if the appropriate step would be to withdraw my name, I'm willing to do so. I would be honored and prepared to serve, but I think Dr. Aboelata is the right choice. Mr. Golfin, should I withdraw my name, or how should we proceed? Chief Compliance & Privacy Officer, Richard Golfin III provided the following comment: • Mr. Jackson, thank you – if you would like to remain on the ballot, certainly you can, and also place your vote for Dr. Aboelata. You can also withdraw as well. Mr. James Jackson made the following comment:		

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	• With respect, I will withdraw my name from the nomination for the Vice Chair. A vote was taken for Dr. Aboelata for the Vice Chair position. The vote passed, and Board members congratulated Dr. Aboelata on being voted in as Vice Chair Dr. Aboelata made the following statement: • I'm very honored and really look forward to working closely with Rebecca and continuing to work with all of you, thank you.	*Vote for Dr. Aboelata as Vice Chair*: Yes No one opposed or abstained.	
8. b. BOARD BUSINESS – REVIEW AND APPROVE NOVEMBER 2022 MONTHLY FINANCIAL STATEMENTS			
	Gil Riojas gave the following November 2022 Finance updates: Enrollment: • For the month ending November 30th, 2022, the Alliance had an enrollment of over 325,000 members, a net loss of $1.4M, and the Tangible Net Equity (TNE) was 661% of the required amount. • Our enrollment has increased by over 2,700 members since October 2022. Scott mentioned the Public Health Emergency ending, and that will potentially change our trend in growth. Up to now, we have experienced growth in the child category of aid, adults, optional expansion, and in our seniors and persons with disabilities, as well as our duals. Our group care has remained relatively flat. • There are big changes expected this year in 2023 and at the end of 2024. The Public Health Emergency is going to be a significant factor in our results, primarily as membership drives up our revenue and expenses. • When the Public Health Emergency ends and the disenrollment process begins again, we do anticipate seeing a bit of a decline in membership. We also know that in 2024 with moving to a Single Plan Model, we will have some growth in membership from that. Additionally, as Scott mentioned, the remaining population of those currently fee-for-service will at some point be transitioned to managed care.	Motion to Approve November 2022 Monthly Financial Statements as presented. Motion: Dr. Rollington Ferguson Second: Mr. James Jackson Vote: Yes No opposed or abstained.	None

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	Net Operating Results: • The results that I'm sharing today are reflective of our final budget that we passed last month. We had budgeted a net loss of about $1.9M, and we reported a net loss of $1.4M. • For the fiscal YTD ending November 30th, 2022, the actual net income was $20.2M, versus a budgeted net income of $19.7M. • The graphs we have for this month and for the next few months will show three (3) lines – the dashed line is reflective of our preliminary budget, so we wanted to show the results from our preliminary budget that we passed in June of last year. The red line is reflective of our final budget using actual results for the first four months of the fiscal year, and the blue line is the results that are actual as well. We will see in future months a little more deviance between these lines. Revenue: • For the month ending November 30th, 2022, the actual revenue was $102.4M vs. the budgeted revenue of $103.2M. • For the fiscal year ending November 30th, 2022, the actual revenue was $510.7M vs. the budgeted revenue of $511.6M. Medical Expense: • For the month ending November 30th, 2022, the actual medical expense was $99.4M, and the budgeted medical expense was $98.3M. • For the fiscal year ending November 30th, 2022, the actual medical expense was $466.4M vs. the budgeted medical expense of $465.2M. • We also had changes to our incurred but not paid claims estimate, which increased by about $4.3M. • The Year-to-Date medical expenses by category of service, the biggest numbers are related to our inpatient fee-for-service – on a Year-to-Date basis, about $147.0M, slightly lower than our budget. We see some		

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	favorability there, but it is offset by some of what we are seeing relating to our outpatient fee-for-service and pharmacy fee-for-service. • One thing to note which was also mentioned in the Finance Committee was that the pharmacy benefit transitioned to the State last year, so we have seen significant decreases in our pharmacy fee-for-service expense. Medical Loss Ratio (MLR): • As stated, we had a little slight net loss, which impacted on our medical loss ratio. We saw an increase from October to November 2022. • For the month ending November 30th, 2022, the MLR was 97.1% and 91.3% for the fiscal year-to-date. It is one month, so it is not a trend, but something to keep an eye on. • For the month of November, our medical expenses and our administrative expenses were more than the revenue. Question: What were the specific drivers that caused this increase in MLR for the month of November? Answer: A lot of it was related to our incurred, but not paid claims estimate; we increased our incurred-but-not paid claims estimate by about $4.3M. Looking at the completion of prior months claims, we determined that there were some additional claims that were outstanding that we had thought were complete, so we bumped up that estimate and in doing that, increased medical expenses. It primarily related to the fact that we had a bit less complete claims from prior months and when those claims came in, we adjusted our estimate for that. Question: Is this something you foresee in future months? Answer: Not necessarily. Our incurred-not-paid claims estimate is done every month, so we look at historical trends, and potential, upcoming, outstanding changes with in-patient stays. There are many factors that go into it. At the same time, we are monitoring inpatient trends. As we go into cold and flu season, we would expect there to potentially be some increases related to either ER services or inpatient hospital services. That is expected, and working with the healthcare services team, we are monitoring that.		

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	Administrative Expense: • For the month ending November 30th, 2022, the actual administrative expense was $5.5M vs. the budgeted administrative expense of $6.9M. • For the fiscal YTD ending November 30th, 2022, the actual administrative expense was $27.0M vs. the budgeted administrative expense $28.3M. • The major reason for variance is related to Purchased and Professional Services, which is the need for consultants and computer support services. We have also seen some in our employee expenses – this concerns FTEs and start dates for positions or vacancies. This impacts employee expenses, to about $341,000. • Administrative Loss Ratio (ALR) represented 5.4% of net revenue for the month ending November 30th, 2022, and 5.3% of net revenue YTD. Our administrative loss ratio has remained relatively stable in the mid 5% range, and we anticipate that to stay for the foreseeable future. Other Income / (Expense): • Our fiscal year-to-date net investment revenue reported a gain of $2.9M. We have done better than in previous years, primarily because the federal interest rates have increased. Therefore, we have been able to take advantage in short-term investments, and that is why we that in investment gain. • Fiscal-year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $132,000. Tangible Net Equity (TNE): • The Department of Managed Health Care (DMHC) requires TNE to be thirty-eight million dollars ($38.0M). • We reported actual TNE of two-hundred-fifty-point eight million-dollars ($250.8M), and excess TNE of two-hundred-twelve point nine million dollars ($212.9M).		

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	• Of the required TNE, we have six-hundred-sixty one percent (661%). • Over the last twelve (12) to eighteen (18) months, we have been building up our reserve gradually in preparation for Long-Term Care where there is potentially significant risk. • As we get established into new programs, the excess reserve will be good for us in helping withstand any potential changes, either to some of the programs that are being added or changes that may happen due to rate changes. Cash Position and Assets: • For the month ending November 30th, 2022, the Alliance reported nearly $351.4M in cash of which $236.3M was uncommitted cash. The remaining was pass-through liabilities at $115.1M. Our current ratio is above the minimum required at 1.69 compared to the regulatory minimum of 1.0. Capital Investment: • Fiscal year-to-date capital assets acquired: $208,000. • Annual capital budget: $1.0M. • We likely won't spend the total $1.0M, but we will get relatively close. We may see some pick-up in that number in the second half of the fiscal year. Motion to Approve November 2022 Monthly Financial Statements as presented. A roll call vote was taken, and the motion passed.		
8. c. BOARD BUSINESS – PROGRAM IMPLEMENTATION UPDATES			
Ruth Watson	CalAIM – Long Term Care Carve-in: • On January 1st, 2023, we carved in the Long-Term Care benefits from the State. As discussed before, the Long-Term Care program has come into all the managed-care programs. Our transition does not include Pediatric and Adult Subacute Facilities, Intermediate Care Facilities, or Institutions	None	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	for Mental Disease, which will be implemented no earlier than July 1st, 2023. • The State required Managed Care Plans (MCPs) to demonstrate Operational Readiness prior to the transition. Several initiatives were implemented – deliverables were given to the State by October 2022. Additional required deliverables were submitted to DHCS on November 28th, 2022. • Contracting and Credentialing were among the largest initiatives that we had – the State requires that we contract with a minimum of sixty percent (60%) of total eligible skilled nursing facilities and the Managed Care Plans HEDIS reporting unit – that is a list that comes from the State. We have met and exceeded that goal – we are currently at seventy-one percent (71%) and increasing. We have contracted seventy-three (73) facilities for Custodial Level of Care. Fifty-two (52) of those seventy-three (73) facilities have been credentialed. They are not considered fully executed by us until they are credentialed; this is in progress. • We also have seventy-seven (77) primary care physician providers that were identified; twenty-three (23) contracts have been signed. • We have forty-seven (47) out-of-area facilities; contracting and credentialing activities continue. The out-of-area facilities are important because we do have members that have been identified in those out-of-area facilities. If we do not have a contract with those facilities, we will proceed with a letter of agreement to ensure that there is continuity of care for these members. • Effective January 1st, 2023, we are responsible for Treatment Authorization Requests (TARs) approved by DHCS for SNF services inclusive of the SNF per diem rate for a period of twelve (12) months after enrollment with the Alliance, or for the duration of the TAR – whichever is shorter. • Effective January 1st, 2023, the Alliance is responsible for all other DHCS approved TARs for services exclusive of the SNF per diem for a period of ninety days (90) after enrollment with the Alliance, or until we are able to reassess the member and ensure provision of medically-necessary services.		

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	• We must reimburse Network Providers of SNF services for those services at exactly the Medi-Cal Fee-for-Service per-diem rates for dates of service from January 1st, 2023, through December 31st, 2025. • We have conducted three (3) town halls for Long-Term Care Providers on November 3rd, November 10th, and December 1st. Long-term care training for all long-term care providers and facilities was required, and we have accomplished that at this point. • DHCS Member Data is probably the biggest challenge we got in the beginning. We received existing authorization data from DHCS, and we continue to work on file-loading options in core systems. Contingency planning includes entering authorizations manually until automated load is complete. • The January eligibility from the State contained fewer members than expected, and Dr. O'Brien could speak to this. We expected about fourteen hundred members (1,400), and we got a lot less than that. We also had higher than expected Aid Code errors, which means these are individuals in skilled-nursing facilities, but they do not have a long Aid Code. This is important to the Plan because the reimbursement is significantly different for those people. This is a process we will continue to work on. • Our Analytics and IT departments are reviewing daily and weekly eligibility file updates from DHCS. We anticipate that the February eligibility file will contain the majority of our expected members. • The TAR file from DHCS was not received as of December 30th; the issue was escalated to the State and we are expecting an additional four (4) TAR files this month. The State has acknowledged that there has been a systemwide delay with TAR files. • From a staffing perspective, our long-term care team and health care services are fully staffed. Question: The people we haven't gotten sent to us yet – who will be paying their bills? Answer: Of the fifteen to eighteen hundred (1500-1800) people in the county that we know are in Long-Term Care, there are some assigned to us; it is less than one-hundred (100) currently that we know of. We have some people that are assigned to us in our eligibility list, but they are not under long-term care, so we do not know to flag them until we hear about them from the facility. There is also		

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	a source of truth with the State, a lot of people are still saying fee-for-service; in that case, it would be the State. This means currently, they would pay for it, but it does not mean they would not come back to us and say you need to reimburse these things. Question: As people transition to the Alliance, we are also working on ECM area to start including the elderly, people at risk and in nursing homes – are we able to evaluate people for a possible successful transition back into the community or are we just dealing with the business aspect of getting them on to our records at this point? Answer: Excellent point. We're hitting it on a variety of different aspects; one is the daily work as it comes in dealing with all that comes with the facilities. But we're also taking the opportunity to realize we have around eighty (80) facilities and they each have a certain number of Members. As we engage them, we find out who are the key people and start to run their list of people and start to get to understand each of the facilities and understand who the key members are who have the highest needs in those facilities. Lastly, we are launching with one of our current ECM partners, EBI, a pilot for Community Supports related to getting people out of skilled nursing facilities as well as having now opened not only the EBI, but some others for those populations in ECM. Question: Who are the PCPs you have contracted with? Answer: We have contracted with several SNF groups. The facilities that have told us that they have an outside-medical director, we have contracted with those. We do not necessarily need to contract or credential them because that should all be done by the facility. Long-Term Care Carve In – Continuity of Care Requirements: • One of the main things that have changed is continuity of care requirements. The final document and guidance on this did not come through until December, so it's a little bit different than what we've done with other programs with continuity of care. • Effective January 1st through June 30th, we must automatically provide twelve (12) months of continuity of care for Members residing in a SNF		

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	and transitioning from Medi-Cal Fee-for-Service to the Alliance. That was something we anticipated in the 12-month period. • The automatic continuity of care means that if the member is currently residing in a SNF, they do not have to request continuity of care to continue residing in the SNF. Members may request an additional twelve (12) months of Continuity of Care following the initial twelve (12) month period. A member residing in a SNF who enrolls after June 30th, 2023, does not receive automatic Continuity of Care, but is entitled to request it. We are seeking to ensure that there is no disruption of care for these members. • Post Transition Monitoring: This is being pushed very hard by the State – they require daily, weekly, and monthly reporting to monitor any potential access to care and technical issues. So far, we have done very well. Daily reporting is required January 2nd through January 13th; weekly reporting January 20th through January 27th; and monthly reporting begins February 28th. • We have a Command Center (went live on January 3rd) that is monitoring this implementation very closely. We use the Command Center daily to promptly identify, research, and resolve Long-Term Care issues as they arise. We also review daily faxes from facilities with members attributed to the Alliance. • We provide consistent feedback and data to DHCS regarding the implementation of the Long-Term Care Carve-In benefit. Population Health Management (PHM): • January 1st, 2023, all Medi-Cal managed care plans were required to develop and maintain a whole system, person-centered population health management strategy. • Population Health Management is a comprehensive, accountable plan of action for addressing resilience across the continuum of care. It is intended to build trust and meaningful engagement with members. We are to gather, share, and assess timely and accurate data on the members' 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.		

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	• This addresses upstream factors that link to public health and social services, so that there's a very broad aspect of this to make sure that members get all they need. The point here is to support all Members to stay healthy, provide care management members at higher risk of poor outcomes, provide transitional care services for members transferring from one setting of level of care to another – another big emphasis from the State, and we identify and mitigate the social drivers of health to reduce those disparities. • We received our All-Plan Letter (APL) late in the year which provided final guidance and requirements for the program. We submitted our readiness document in October, and our final approval was received on January 4th, 2023. • There is a strong emphasis on transitional care requirements; we must develop and execute a plan to ramp up transitional care services, which takes place when someone transfers from one type to another service. • Managed Care Plans (MCPs) must implement timely prior authorization, which is not a problem for us. We also need to know when members are admitted, discharged, and transferred. We must ensure transitional care services are complete for high-risk members. • January 2023 requirements have been completed, and we are now meeting the State’s guidance. In January 2024, we are required to ensure all transitional care services are complete for all members. • Risk Stratification Methodology: We have developed our own Risk Stratification Methodology and we will use it until DHCS rolls out a statewide methodology. Once they do, we can continue to use our own stratification methodology, but for reporting services, we will have to make sure we implement the State RSS as well. • Disease Management: We currently have two Disease Management programs – Asthma and Diabetes. Member letters have been sent to DHCS for approval. We will also be adding depression and cardiovascular programs as well in the coming year. • We are also required to do daily reporting – the Transition of Care Report was created and is in production. The High-Risk Member Engagement Report is a monthly report and has also been created and is in progress.		

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	• Post Go-Live Activities: Work continues to build out project workstreams and story writing. The system impact meetings continue to identify needs for reconfiguration of HealthSuite (claims), TruCare (care management). We have ninety days (90) to update and submit any relevant P&Ps to DHCS – the due date is February 26th, 2023. Question: The Population Health Management and Risk Stratification (RSS) issue – has the State stopped using the old pharmaceutical based risk score? And are we adding social determinants of health peace into the scoring methodology? Answer: For Social Determinants of Health (SDOH) – yes, that is a big goal with what the State is trying to do, which is include a lot of SDOH data. We have tried in our own methodology to include the data we have. As Ruth stated, once the statewide comes out, we are most likely going to switch over to it because that is what the State will hold us accountable for. The proposed date for when the State will release that was July. We are trying to incorporate more SDOH data as we get them. For the pharmacy-based score, it was RX1 and now they are moving to a CDPS RX. The RSS Methodology has a lot more in it in terms of including the SDOH factors; one for rates and one for Population Health. CalAIM – Enhanced Care Management (ECM): • Two (2) new Populations of Focus became effective January 1st. These members are eligible for Long-Term Care and At-Risk of Institutionalization. There are nine-hundred-and six (906) members identified on the first eligibility file. The Nursing-Home Residents Transitioning to Community are currently at zero; these will be referral based, which is why it must be something that comes to us. • The ECM Providers for new Population of Focus are CHCN and EBI. There are two (2) new ECM Providers, MedArrive and Institute on Aging. Contracts with all four (4) providers have been fully executed and credentialing is complete for the two new providers. Question: Where would the nursing home referrals come from, the doctor who is treating them, or how do we know? Answer: We are going to need people that are going out to the facilities – phase one is getting to know the facilities and seeing who these particular people are		

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	and then educating our team on the members who might potentially be candidates for helping them get out of the facilities. Question: Do you envision more ECM providers than these four (4), or is it too early to tell? Answer: At this point, it is too early to tell, but I would envision yes, the State's expectations is that these programs will get broader and more enhanced. There will be more providers and expanded. We are trying to make sure we do it right before we expand it to somewhere else, but yes, we will likely look for additional providers. Dr. Steve O'Brien provided the following comment: We also must have enough eligible members so that our existing providers have enough members to serve. CalAIM – Enhanced Care Management: • Testing will continue with MedArrive and Institute on Aging. The reason why we are waiting on the other two (2) is that there are certain eligibility and provider data issues that we work through with any new provider – we are still in the process of doing that. Mental Health Insourcing: • Services are currently performed by Beacon Health Options and will be brought in-house effective March 31st, 2023. We have had to do a Material Modification for the Department of Managed Health Care (DMHC) and it continues. This has been a lot of work, particularly for our Compliance team. • Block Transfer Filing of Provider Network: DMHC has requested an "Information Only" Block Transfer Filing. A narrative will be submitted to DHCS to address the specified requirements. • Contracting and Credentialing is proceeding; we have a total of three-hundred-eighty-six (386) providers. We also have a neuropsychologist who will be starting later in January. • Member notifications have gone out, and we have a sixty-day (60) member notice which will be mailed to members on February 1st, 2023. The thirty-day (30) member notice will be mailed on March 1st, 2023.		

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	• Provider notification letters have been submitted to DMHC for their review. We have developed Provider FAQs and also submitted those for review, and we are working on Provider Orientation and Trainings. We have deferred the plan to January for orientations, and training will be held in February and March. Informational update to the Board of Governors. Vote not required.		
8. d. SUPERVISOR DAVID BROWN TERM CONCLUSION ANNOUNCEMENT			
Scott Coffin	CEO Scott Coffin made the following announcement on Former Supervisor Dave Brown's Term Conclusion: • Effective January 1st, 2023, Former Supervisor Dave Brown's term ended as Supervisor of District Three (3) in Alameda County, and therefore, he has resigned from the Alameda Alliance Board of Governors. • Supervisor Lena Tam has commenced her role as the new District 3 Supervisor, but the Board of Supervisors may choose to appoint a supervisor from any district to the Alliance Board. • Supervisor Nate Miley, President of the Alameda County Board of Supervisors, is considering an appointee. Accordingly, the seat will remain empty until Supervisor Miley confirms. A meeting is being coordinated to finalize the appointment, and an update will be provided to the Board of Governors at a later date. Informational update to the Board of Governors. Vote not required.	None	None

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9. STANDING COMMITTEE UPDATES			
Dr. Steve O'Brien	The Peer Review & Credentialing Committee (PRRC) was held on December 20th, 2022. Dr. Steve O'Brien provided the following Committee updates: • At PRRC, there were one-hundred-seventy-nine (179) initial providers of which there were three (3) PCPs and one-hundred-sixty-three (163) of those were behavioral health providers. • Next week, we will have the Credentialing Committee and there will be about one hundred (100) behavioral health providers coming on. • Thirty-three (33) providers were re-credentialed. There was one (1) provider recredentialed who had fifty-eight (58) grievances in three (3) years, which is significantly higher than average. That provider was re-credentialed for one (1) year and asked to come before the Committee to explain his plan for addressing and decreasing those grievances. The Pharmacy & Therapeutics (P&T) Committee was held on December 20th, 2022. Dr. Steve O'Brien provided the following Committee updates: • We reviewed the efficacy, safety, cost, and utilization profiles of twelve (12) therapeutic categories, one-hundred-and-three (103) formulary modifications, and fourteen (14) prior authorization guidelines; ten (10) PA guidelines were also reviewed with no updates. Question: The big influx of behavioral health credentials – does this have to do with the insourcing of behavioral health? Answer: Yes, we are building the network, everyone is getting in their applications and coming in – which is great. Question: How often do people not get credentialed, if there are enough concerns or complaints? Answer: It is uncommon, however, there absolutely is a path for that. There are other steps that we can take in terms of putting a cap on their enrollment so they don't get other action plans, but ultimately, there is a path where a provider can	None	None

	be not re-enrolled. This is reportable – if we chose not to allow a provider in, that is an 805 reportable event. (*Note: An 805 Report is the mechanism in which peer review bodies are required to report specific information regarding licensees to the Medical Board*). Question: What kind of a provider or doctor is the one with fifty-eight (58) complaints? How long did it take to get these complaints? Answer: The provider is a primary care provider (PCP). It took three (3) years to get to fifty-eight (58). Dr. Ferguson provided the following comment: • The Board is not concerned with the details of the specific provider, rather, the concern is the number of grievances. Question: Are these complaints the same, or are they different? Answer: We look for patterns in grievances, and indeed, there were patterns in this grievance – many were related to office practice and perceptions of rudeness. This was service related as opposed to quality of care. Question: From the Board perspective, we want to know if this was an outlier instance? Answer: Dr. O'Brien provided a high level report of discussions which take place in the Committee and the provider files and names are architected in that Committee. There are representatives from that Committee who sit on the Board, and due to the public nature of the general Board meeting, I would recommend that discussions on provider specifics be limited to that Committee. Dr. Kelley Meade made the following comment: • As we get into issues related to grievances and providers, I would offer we defer further discussion on this until we hear the report after they meet with the individual provider and that we follow whatever existing compliance Bylaws we have around the direct reporting because clearly, we have a situation where we have interest, but we should follow the book. CEO Scott Coffin made the following comment:		

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	• The message I would like to share is we have a standardized process in place, and we must protect the interests of our providers, members, as well as the duty to share what we can publicly. We cannot go into the details here in any form, but we have that covered through the PRCC, which is the form we handle those matters. We have done it the same way for many years, and we pursue all investigations equally, by looking at the severity of the complaints. These are conducted with the goal of maintaining equity across all decisions. In order to do that, we have to maintain confidentiality. I ask the Board to trust the processes in place. Question: Generally, what expectations should the Board have about what would come to us? Answer: Typically, if it if it developed into a significant matter of risk to the organization, that certainly would be a point in time that it would come to the Board. Each situation is unique in terms of the circumstances of the complaints; in this case, for this provider, we measure each of those based on the situation. But again, if it becomes an organizational risk or a threat to the organization, that's at that point it becomes elevated to the Board of Governors. Chair of the Board, Rebecca Gebhart provided the following comment: • Thank you everyone, I appreciate all of your comments. I agree with Dr. Meade's suggestion that we wait for this process to take its course and then get a high level update since the Board is interested in this issue. After the conclusion of the process, it would be great to get a report either through the Compliance Advisory Committee or directly to the Board in whichever manner is appropriate.		
Scott Coffin	The Member Advisory Committee (MAC) was held on December 15th, 2022. CEO Scott Coffin provided the following Committee updates: • A presentation was made by the Chief Executive Officer on the operating financials and overall performance of the Alliance. Matt Woodruff, the Chief Operating Officer presented on the Public Health Emergency and the proactive steps we are taking to coordinate with the Alameda County safety net partners.		

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	• Dr. Peter Currie presented on the Mental Health and Autism Spectrum Services that are being in-sourced in the month of April. • Jorge Rosales, our Manager of Case Management presented on the status of the Alliance's case management programs. • Kisha Gerena, our Manager of Grievances and Appeals presented the outcome of member grievances for the third quarter of 2022. • Michelle Lewis, our Manager of Communications and Outreach presented the Community Outreach Report for the third quarter of 2022. The update included the annual program to assemble and distribute five thousand (5,000) care bags. These care bags are distributed to people in our street and campus across the county. This idea started years ago, and the Member Advisory Committee began handing out care bags which have hygiene products, gift cards, food items – and it is all contained in a nice waterproof bag. We started off with a very small number and now we are up to five thousand (5,000), which is incredible. This all gets distributed into the community through the hands of staff, friends, and others. • The next MAC meeting is scheduled for March 16th, 2023. Informational update to the Board of Governors. Vote not required.		
10. STAFF UPDATES			
Scott Coffin	None	None	None
11. UNFINISHED BUSINESS			
Scott Coffin	None	None	None

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12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS			
Scott Coffin	• I will continue to bring the updates on the Cal AIM initiatives as we proceed forward. Specifically, Long-Term Care and Population Health.	None	None
13. PUBLIC COMMENT (NON-AGENDA ITEMS)			
Rebecca Gebhart	None	None	None
14. ADJOURNMENT			
Rebecca Gebhart	Rebecca Gebhart adjourned the meeting at 1:55 pm.	None	None

Respectfully Submitted by: Danube Serri, JD.
Legal Analyst, Legal Services.