BOARD OF GOVERNORS
Annual Retreat Meeting Minutes
Friday, January 30th, 2026
9:00 a.m. – 4:00 p.m.

Video Conference Call and

1240 S. Loop Road
Alameda, CA 94502

1. BREAKFAST

2. CALL TO ORDER

Board of Governors Present: Rebecca Gebhart (Chair), Dr. Noha Aboelata (Vice Chair), Aarondeep Basrai, Dr. Kathleen Clanon, Dr. Rollington Ferguson, Andrea Ford, Byron Lopez, Dr. Marty Lynch, Andie Martinez-Patterson, Dr. Kelley Meade, Jody Moore, Wendy Peterson, Dr. Evan Seevak, Supervisor Lena Tam, Natalie Williams

Board of Governors Remote: James Jackson

Board of Governors Excused: Yeon Park, Andrea Schwab-Galindo

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

Chair Gebhart called the regular Board of Governors meeting to order at 9:01 a.m.

3. ROLL CALL

Roll call was taken and a quorum was established.

4. WELCOME, INTRODUCTIONS, MEETING AGENDA AND GOALS

Mr. Woodruff welcomed and introduced Jennifer Kent of The Kent Group and Aneeka Chaudhry, Interim Alameda Health Director, who were in attendance at the Board Retreat.

5. DUAL SPECIAL NEEDS PLAN PRESENTATION AND BOARD DISCUSSION

Medicare Strategic Plan: 2026 - 2028

<u>Membership and Network Growth</u>

- D-SNP Launch 1/1/2026.
- Lessons learned
- Enrollment
- PY2027 Benefit Design
- 2026 D-SNP Initiatives

3 Year DRAFT D-SNP Membership Projections

	CY 26	CY27	CY28
Membership	1,500	7,000	12,000

- CMS Access & Availability Standards

Goals
- Meet and exceed membership projections
- Meet CMS Access and Availability standards

Strategies
- Develop proactive personalized member engagement
- Use data to understand member needs for better benefits
- Ensure access through strong provider relationships
- Prioritize collaborative provider partnerships
- Build strategic community partnerships to support members
- Create trust by making the system easy to understand
- Monitor and analyze market trends within Alameda County

Tactics
- Foster personalized connections with members via sales, care management, and concierge-style customer service.
- Provide resources to help members and providers navigate Medicare and Medi-Cal
- Enhance provider and community involvement through PACs, provider training, and community events.
- Introduce Alternative Payment Models (APMs) that include shared savings and downside risk to motivate providers.
- Leverage technology to optimize and streamline administrative processes between the Plan and our partners

<u>Risk Adjustment</u>

Metrics
- Timely and accurate encounter data submission to CMS
- Provider documentation quality and consistency
- In-home assessment utilization

Goals
- CMS submissions compliance and accuracy
- Improve provider documentation and coding practices through education and accountability
- Expand clinical data capture for hard-to-reach populations

Strategies
- Strengthen provider engagement and optimize provider programs
- Promote member-engagement for hard-to-reach and underutilizing populations
- Encourage member utilization of covered services
- Compliant, audit-ready Risk Adjustment program

Tactics
- Provider education, performance feedback, and reporting
- Provider and member incentive programs

- Utilize an in-home assessment vendor to capture undocumented clinical data
- Conduct targeted medical record retrieval for CMS submissions
- Performance tracking and monitoring

Medicare Stars

Metrics
- Star ratings for Part C and Part D

Goals
- Achieve Stars ratings of 3.5+

Strategies
- Establish enterprise Stars accountability and governance for Part C and Part D performance
- Strengthen provider engagement, initiatives and programs
- Develop Member-focused initiatives and education
- Maintain a flexible and sustainable Stars program amid frequent CMS updates/changes.
- Develop enterprise Stars performance monitoring

Tactics
- Stars Workgroup with assigned business and process owners accountable for each measure's performance
- Provider and member incentive program
- Targeted member outreach
- Focused provider engagement (education and listening)
- Monitoring performance (ex. Stars dashboard, Member experience indicators, Care gap closure reports by providers for Part C and D)

Population Health Management

Metrics
- Annual Wellness Visit/Initial Preventive Physical Exam completion rate
- Health Risk Assessment (HRA) completion

Goals
- 60% of members have an Annual Wellness Visit/Initial Preventive Physical Exam
- 100% of enrolled members have a HRA within 90 days of enrollment

Strategies
- Develop and implement new DSNP specific programs
    - Dementia
    - Palliative Care
    - Behavioral Health
    - Pharmacy (Part D)
- Develop and implement a case management program (CICM)

Tactics
- Assessment of all members for program identification, resource referral, and care coordination
- Innovate community partnerships focused on DSNP
- Vendor support for HRAs and home visits
- Medication management program
- Opportunities for community feedback

- Develop reporting to monitor and evaluate programs

Questions and Comments:

Dr. Seevak asked if there were particular specialties causing network gaps. Ms. Watson responded that behavioral health, gastroenterology, and neurology were challenging, and some large specialty centers were not interested in contracting at this time.

Dr. Lynch asked if the Alliance was still requiring providers to take all lines of business or if Medicare-only contracts were considered. Mr. Woodruff responded that the Alliance was still requiring all lines but may need to make concessions due to network gaps.

Ms. Moore asked why Sutter or Stanford might not want to contract for Medicare. Mr. Woodruff explained it was mainly about what they were asking for and what the Alliance could pay, not about losing money.

Dr. Lynch asked for clarification on the “one size fits all” contracting principle. Mr. Woodruff responded that the strategy was intended to avoid cherry-picking populations and that opening Medicare-only contracts to certain providers could diversify the network and impact the safety net.

Ms. Martinez Patterson asked if the conversation was for awareness, council, or policy change. Mr. Woodruff responded that it was for all those reasons, seeking feedback and awareness of potential consequences for the safety net.

Dr. Ferguson suggested forming a link between Alameda Health System and specialty networks to provide care and asked about the feasibility. Matt and James responded that it was viable but limited by hiring timelines and current capacity.

Ms. Peterson asked what would be best for current and incoming members regarding customer experience. Mr. Woodruff acknowledged the importance of member experience in decision-making.

Dr. Aboelata asked if a pilot approach leveraging outpatient provider relationships could help with the administrative burden. Ms. Watson acknowledged the idea and said it could be considered, given the crunch.

Dr. Clanon asked about how the risk adjustment vendor would capture undocumented items. Ms. Cheang explained that the vendor conducts in-home visits to assess and document member needs.

Dr. Ferguson asked if quarterly updates would be provided to anticipate 2027 star ratings and make corrections. Ms. Cheang and Mr. Woodruff replied that some measures could be reported quarterly, while others (such as CAPS) are annual, and that dashboards could be developed based on prior-year data.

Ms. Williams asked whether star rating managers were assigned to members to ensure they met the required criteria. Ms. Cheang and Dr. Carey responded that case managers are assigned to each member and monitor their progress, and this is on their to-do list.

Board Feedback and Guidance: D-SNP Strategy and Tactics

Board members participated in small group discussions focused on the D-SNP strategy, including Stars, Risk Adjustment, Population Health, and network strategy. Following the breakout sessions, groups reconvened and shared key themes from their discussions.

Incentivizing and Enhancing HRA and Eligibility Processes
One group discussed strategies to incentivize quarterly Health Risk Assessments (HRAs), embed eligibility workers onsite, and leverage enhanced care management learnings to improve member retention and redetermination processes.

Technology, Data, and Cultural Strategies for Member Engagement
One group discussed challenges related to meeting Medicare guidelines, the need to invest in provider capacity, and opportunities to use technology and mobile applications to improve member engagement. The importance of addressing cultural and language differences within the member population was also emphasized.

Workload Distribution and Provider Support in Safety Net Settings
Discussion focused on staff capacity constraints in safety net provider offices, the difficulty of meeting performance metrics, and the need for both human and technological workflow supports to assist providers.

Network Adequacy and Contracting Strategies
This group raised concerns about limited specialty network options and potential challenges with uncooperative providers. Collaborative models involving academic medical centers and safety net institutions were discussed as potential strategies to ensure specialty access and network adequacy.

Population Health, Wellness Visits, and Dementia Care Initiatives
Board members discussed implementation of annual wellness visits, the need for appropriate incentives and operational support, and the importance of caregiver education and dementia care resources, including potential partnerships with external vendors.

6. BREAK

7. STRATEGIC PLAN ADOPTION AND INTRODUCTION OF 2026 “NORTH STARS”

CEO Woodruff presented the 2026-2028 Strategic Plan and provided an overview of the strategic context. He reviewed the development process, which included interviews with Board members, senior leadership, hospitals, providers, and community representatives to inform the plan’s priorities.

The Board reviewed the four primary pillars of the Strategic Plan: financial sustainability, quality, access and equity, and community partnership. Organizational capability was identified as an area for future reporting and further development.

Board members also provided feedback regarding the format and frequency of strategic plan progress reporting. Members emphasized the value of concise updates, visual alignment with strategic priorities, and clear linkage between reporting metrics and the adopted plan.

Mr. Woodruff informed the board that the two-year, $4 million Provider Grant Program for safety net providers had concluded. He indicated that staff plans to return to the board in March to seek authorization for a potential renewal or extension, highlighting both the program's impact and anticipated financial considerations.

Mr. Woodruff asked how often board members want to be updated on the strategic plan's progress, and what reporting should look like. Dr. Lynch suggested that quarterly spotlight presentations should be short and infrequent, as monthly or quarterly reports would be repetitive and not helpful. Dr. Ferguson agreed, adding that urgent issues should be reported more frequently, possibly monthly, using a color scheme to highlight areas needing attention. Ms. Peterson agreed that less reporting is needed but emphasized connecting all reports to the strategic plan and having pivot conversations at least twice a year. Dr. Meade suggested using a visual slide into board presentations to show which part of the plan is being discussed, helping keep the board informed.

Motion: A motion was made by Dr. Marty Lynch and seconded by James Jackson to adopt the Strategic Plan.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Dr. Kathleen Clanon, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Byron Lopez, Dr. Marty Lynch, Andie Martinez-Patterson, Dr. Kelley Meade, Jody Moore, Wendy Peterson, Dr. Evan Seevak, Supervisor Lena Tam, Natalie Williams, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

8. LUNCH

a. LEGISLATIVE-POLICY PRESENTATION

State and Federal Policy Changes Impacting Medicaid

Ms. Kent provided an overview of recent and anticipated state and federal policy changes affecting Medicaid. The presentation included discussion of H.R. 1, the expiration of key financing mechanisms and provider taxes, potential work requirements, and semiannual redeterminations. Ms. Kent outlined the anticipated fiscal and operational impacts on the state, health plans, providers, and members.

The Board discussed the implications of expiring subsidies and the removal of certain funding mechanisms, including the potential loss of MCO tax revenue and Hospital quality assurance fees. It was noted that while recent CMS action allows the state to retain certain MCO tax revenue through 2026, a significant funding gap may emerge thereafter, requiring new revenue strategies for program adjustments.

Discussion also addressed the likely impact of redeterminations and work requirements on planned membership and provider stability. While actuarial rate setting may provide some short-term insulation for plans, providers may face increased financial strain as uninsured rates rise, and reimbursement pressures intensify.

Ms. Kent cautioned that in the context of budget deficits, the state may consider reducing eligibility benefits or provider rates, with optional benefits such as ECM, CSS, and adult dental potentially at risk. She emphasized the importance of prudent financial planning and preparation for continued volatility.

Questions and Comments:

Ms. Martinez Patterson asked whether, if the plan loses membership, the cost increase is one-for-one or whether there are other implications for the plan. Ms. Kent responded that plans are insulated because the state is legally required to pay them for what they are contracted to do, but if providers struggle due to fewer dollars, it can impact access and network adequacy, which may require state adjustments.

Dr. Clanon asked if the plan is affected by timeliness and access standards if providers have fewer dollars? Ms. Kent said that the state may need to adjust standards or rates if network adequacy is threatened, but plans are generally protected as long as they fulfill contract requirements.

Dr. Lynch asked what the impact would be if provider taxes were removed after 2026. Ms. Kent responded that the loss of the MCO tax would create a significant funding gap (about $8 billion/year), and the state would need to find alternative revenue sources or make program cuts.

Ms. Martinez Patterson asked whether there is an incentive for plans to reduce costs or create efficiencies if savings are recaptured in future rate-setting. Ms. Kent responded that currently, the state's policy is to reclaim savings, so there is little incentive for plans to reduce costs beyond what is required.

Mr. Golfin asked whether investing in FIDE SNP or I-SNP depends on D-SNP success, or if they are separate. Ms. Kent responded that success in D-SNP would support expansion into FIDE SNP or I-SNP, as strong performance demonstrates the capability to regulators.

9. STRATEGIC PLAN 2026 ACTIVITIES BREAKOUT SESSIONS

CEO Woodruff and the executive team presented the 2026 Strategic Plan priorities and activities. The strategic focus areas include Financial Sustainability, Quality, Access and Equity, Community Partnership, and Organizational Capability. The presentation outlined key objectives within each priority and the approach to implementation in 2026.

Stakeholder Engagement and Communication Strategies

Mr. Woodruff and the executive team led a discussion on enhancing stakeholder engagement, including communication with members and providers about legislative changes, the use of dashboards, and the effectiveness of various outreach methods, with board members providing feedback on best practices.

Population Health and Quality Initiatives

Dr. Carey and the quality team provided an overview of the population health management framework, including risk stratification, case management, provider supports, and community partnerships. Efforts to improve care transitions and reduce readmissions were discussed, including hospital-based nursing support and vendor partnerships for home visits. Pharmacy coordination at discharge was identified as a key strategy.

The team also described provider and member incentive programs designed to improve quality outcomes, while acknowledging that fiscal constraints may limit expansion of member incentives. Ongoing community partnerships were highlighted as essential to addressing social determinants of health and promoting equity.

Financial Strength – 2026 Focus and Activities

Mr. Riojas presented the Financial Strength framework supporting the Strategic plan, including performance trends, reserve positioning, rate development considerations, and operational efficiency initiatives.

Mr. Riojas reviewed FY25 and FY26 financial performance. FY25 reflected a net loss of $86 million and 100% MLR. FY26 year-to-date performance reflects $22 million in net income and a 94.1% MLR. ALR and other liquidity metrics remain stable.

Key financial metrics were reviewed, including:

- Tangible Net Equity (TNE)
- Current ratio
- Days cash on hand
- Working capital
- Medical loss ratio (MLR)
- Administrative loss ratio (ALR)

2026 Financial Priorities:

- Building reserves and maintaining sufficient cash levels
- Monitoring and stabilizing D-SNP financial performance
- Modeling potential enrollment and revenue variability
- Ensuring accurate expense capture for rate development
- Maintaining cross-functional coordination among contracting, IT, and Finance

Café Walk and Board Discussion

The Board participated in a facilitated “Café Walk” discussion designed to solicit feedback and creative input on the Alliance’s 2026 priorities, including Financial Strength, Access, Quality and Equity, and Community Partnership.

Board members rotated through discussion stations, asking questions, offering guidance, and sharing strategic ideas regarding the staff’s proposed 2026 focus and approach. The format emphasized open dialogue, board-driven insights, and surfacing themes for full-group discussion.

Following the small group sessions, the full Board reconvened to share key themes and reflections from each station.

10. ANNOUNCEMENTS

There were no announcements.

11. PUBLIC COMMENT (NON-AGENDA ITEMS)

There were no public comments.

12. BOARD REFLECTIONS AND ADJOURNMENT

The meeting was adjourned at 2:56 p.m.