BOARD OF GOVERNORS
Annual Retreat Meeting Minutes
Friday, January 31st, 2025
9:30 a.m. – 4:00 p.m.

Video Conference Call and

1240 S. Loop Road
Alameda, CA 94502

1. MEET AND GREET – LIGHT BREAKFAST

2. CALL TO ORDER

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

Board of Governors Remote: None

Board of Governors Excused: James Jackson, Natalie Williams

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 9:30 a.m.

3. ROLL CALL

Roll call was taken and a quorum was established.

4. MEDICARE FINAL DECISION DISCUSSION – VOTE

Gil Riojas provided a presentation on the Budget Update.

<u>Calendar Year 2024 Rate Update</u>

- On December 30, the Department of Health Care Services (DHCS) provided amended CY24 rates removing negative adjustments related to the Targeted Rate Increase program and population acuity.
- AAH CY24 rates increase by approximately 1.38% or $26M.
- Additional revenue was fully reflected in December's preliminary financial results, offsetting losses that occurred in the month.

Calendar Year 2025 Rate Update

- October draft rates reflected a 4.3% increase in base rates from original CY24 rates. Updated rates were received December 18. Some details are still needed but sufficient data was shared to determine potential base rate increase.
- An additional 5% increase was added to the 4.3% increase from October.
- Estimated additional revenue of $100M for the second half of FY25 (Jan-June).

Calendar Year 2024 Financial Results

FY25 Updated Results

- Estimated December Net Loss of $8.6M.
- Calendar year 2024 results recorded a $201M Net Loss for the year.
- This includes additional revenue from the recent CY24 rate increase.
- Final budget estimated a $65.2M Net Loss for FY25 (July 2024- June 2025).
- Updated forecast estimates based on November and December actual results plus updated CY24 rate increase slightly reduce FY25 Net Loss to $64.7M.

The Board discussed the DSNP scenarios that were presented by Matt Woodruff and Gil Riojas

Business as Usual – Scenario 1

- Assumes enrollment of approximately 4,000 members in 2026.
- Approved FTEs for FY25 move forward, assuming the FTE count grows for DSNP in CY26 and CY27.
- FTE assumptions were compiled as part of an exercise to determine what departments needed to stand up to the DSNP program.
- Total FTEs dedicated to DSNP are 75 costing $34.7 million for Calendar Years 2025 through 2027.
- Consulting and vendor costs are estimated to be $15.5 million for the same period.
- Total estimated cost to set up the DSNP is $216.4 million.
- Total costs include FTEs, Operating and Vendor costs plus Medical Expenses.
- Revenue begins in 2026 to offset some expenses.

Reduced Scale – Scenario 2

- Assumed enrollment builds up to 1,500 members by the end of 2026.
- Limited savings related to volume related departments (Call Center, Claims, etc.).
- Fixed cost to set up a DSNP remains.
- This allows the Alliance to enter the market on a small scale while learning from its 2026 experience.
- Total FTEs dedicated to DSNP are 60 costing $27.3 million for Calendar Years 2025 through 2027.
- Consulting and vendor costs are estimated to be $16.0 million for the same period.
- Total estimated cost to stand up DSNP is $131.7 million.
- Total estimate includes scaled back revenue stream but begins in 2026.

Question: Dr. Seevak inquired about our performance for the first half of the calendar year 2025 compared to the budget.

Response: Gil indicated that we have revised our final budget. Initially, significant losses were expected; however, due to a substantial increase in revenue, it is now anticipated that we will achieve a break-even point or slightly exceed it in the second half of our fiscal year.

Question: Chair Gebhart raised a question regarding the medical management aspect of the six-month projection. She inquired about the basis of our projections: Are we adopting a conservative approach, assuming we will make less progress over the next six months compared to what we might achieve later? How are we preparing this forecast?

Response: Gil mentioned that we are actively analyzing our existing medical trends and moving forward with them. We are leveraging our historical data on these trends to guide our efforts. Some initiatives began in December of last year, and more are expected to launch in the early part of this calendar year. However, we did not give much consideration to medical management in the initiatives reflected in our current forecast. An update will be provided in the March forecast, but for this budget update, there were not any significant changes included to the medical expenses as a result of these initiatives.

Question: Dr. Lynch asked about the risk adjustment and whether we made projections on the average risk score.

Do we have any data on the existing duals' scores?

Response: Tome explained the collaboration with Milliman on feasibility studies assessing the population's risk. They analyze CMS data from a county perspective, giving us scenarios with risk scores both below and above 1, which influences our reimbursement process. For the first year, we decided to set a standard risk score of 1 due to county coding, which will help us understand the population better. Moving forward, we will work with provider groups and community organizations to refine our coding and assess risk more accurately with Milliman's assistance. We are in the process of selecting a vendor, and once chosen, we will provide them with data to further evaluate the population's riskiness.

Question: Dr. Meade inquired about any regulatory or compliance issues regarding initially limiting access to care.

Response: Matt explained that, although we are not planning to engage in mass marketing or be as active in the community as before, members can still enroll if they call us. We cannot turn people away. Access to our services will remain unchanged, and we are required to maintain the same network with all the existing rules still in effect.

Question: Dr. Seevak asked, "What is the goal for 2027?"

Response: Matt stated that the objective is to target the remaining population.

Question: Andie asked for further clarification on the requirement to have the same network. For example, if someone calls and is part of a group that is being considered for enrollment but is not one of the first providers being onboarded, will they be enrolled at Baywell, or will they be enrolled with another provider that you have a contract with? What does it mean to have the same network if we are not starting with all the same providers?

Response: Matt explained that our approach to marketing differs from our network strategy. All access and quality requirements apply in Medicare, even with only one member. We must establish a full network and will be contracting with all providers in Alameda County.

However, we will not engage in active marketing or hire many sales reps or brokers. Instead, we will focus on a few key partnerships, ensuring smooth data flow and operations.

As we enter the Medicare space, more providers are interested in contracting with us. The board must consider this, as the Alliance requires providers to accept both commercial and Medi-Cal plans. While some are willing to take on all options, others only want dual-eligible patients, and we are currently insisting that providers accept both.

Question: Wendy inquired about individuals in a plan that is being terminated out of the county. How many are affected, and do they have an effortless way to join The Alliance?

Response: Matt explained that health plans cannot enroll new members, so no plan is eliminated; their enrollment is just paused. Currently, there are four plans in the county, and by submitting our application in two weeks, we will stop new enrollments for all but Kaiser. This limits new enrollments in the county to us and Kaiser.

Question: Andrea Schwab-Galindo highlighted the importance of considering current political implications, particularly regarding the administration's examination of Medicare. This could impact us financially and operationally in the future, and there are many uncertainties. As a board member, Andrea thinks having a clear timeline or roadmap for our initiatives would be helpful. If we choose to proceed gradually, we need to know when to accelerate or step back, as these decisions could significantly affect the plan and require substantial operational effort.

Response: Matt mentioned that we are finalizing the milestones and will share them with the board in a few months. The plan is to provide monthly updates on the D-SNP progress during board meetings, covering what is working and what is not. The board can expect this information shortly.

Question: Dr. Aboelata asked about starting small and selecting a couple of providers. What do we hope to learn from this, and how will it guide our choices? What are our goals and learnings with this gradual strategy?

Response: Matt noted that we are focusing on practices with 400 to 500 members that represent diverse races and ethnicities. Our goal is to ensure effective reporting, tracking appeals, grievances, member data, and quality data. For risk adjustment, we need to accurately capture and report this data. Our strategies will vary for different demographic groups, and we will work with smaller practices for initial testing. It is important to remember that marketing materials require approval from CMS, DHCS, and DMHC, making the process slower as all content needs regulatory review.

Question: Supervisor Tam values the discussion on minimizing competition. Lessons learned from absorbing Anthem patients and their cost impacts on the Alliance noted at 131.7 million under Scenario 2, are crucial. Given uncertainties with federal reimbursements and other plans, how can we contain costs if projections are inaccurate? We must avoid a scenario where Medi-Cal funds subsidize Medicare, leading to a deficit and the risk of conservatorship.

Supervisor Tam asked for more information on improving collaboration between the compliance, fraud, and claims departments, as there are potential savings, but past issues need to be addressed.

Response: Matt highlighted three key areas that impact Medicare members: medical management, risk adjustment, and star ratings. Starting small allows us to establish the systems and reporting needed to effectively influence future payments. One of the main focuses is getting things right before scaling up.

Gil mentioned that we are coordinating with our compliance department to investigate potential fraud and billing errors among providers. While some cases are under investigation, this does not confirm fraud. We are identifying suspicious patterns and taking action to avoid unnecessary costs, estimating around half a million dollars in open cases. Richard emphasized that any recovered funds from potential fraud should not be labeled as savings, as they simply represent money returned to the plan.

Question: Chair Gebhart raised a question regarding the selection of participants in the pilot phase. Is there a team responsible for this choice that evaluates individuals? How is this decision made?

Response: Matt mentioned we will evaluate those with a good track record in grievances and appeals, as well as reporting capabilities. We will reach out next month or the following one to see if they are interested in participating.

Motion: A motion was made by Yeon Park and seconded by Dr. Marty Lynch to approve the Executive Committee's recommendation to select Scenario 2.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Tosan Boyo, Dr. Rollington Ferguson, Andrea Ford, Byron Lopez, Dr. Marty Lynch, Andie Martinez-Patterson, Dr. Kelley Meade, Jody Moore, Yeon Park, Wendy Peterson, Andrea Schwab-Galindo, Dr. Evan Seevak, Supervisor Lena Tam, Chair Rebecca Gebhart and Vice-Chair Dr. Noha Aboelata.

No opposition or abstentions.

Medical Management Presentation presented by Dr. Carey

Medical Management Strategies

1. Inpatient strategies

    • Enhanced Care Management (expansion, TCS, prioritize MIF) – future
    • Over/Under Utilization Workgroup – current
    • Hospital partner rounds - current
    • On-site staffing (vendor partner) – future

2. Long-term care strategies

    • Implement Sitter criteria-future
    • Community Supports criteria update – current
    • Alliance staff on-site visitation in LTC facilities – current

3. Pharmacy strategies

    • Heart Failure/Sepsis pilot – current
    • Process improvements - ex-carve-out drugs - Sept 2024/Dec 2024
    • Pharmacy network update – current
    • Formulary/PA review and updates – current

4. Improving Access to clinical care (Avoidable ED visits)

    • ED navigators (partner with AHS) – future

- Member education campaign – current
  - Telehealth
  - Urgent Care
- Expand networks (PCP, Urgent care) – future

4. Reduce Avoidable Re-admissions
   - Designated analyst – current
   - Transition of Care Services
     - High/low-risk outreach – current
     - Vendor contract – future

5. WELCOME, INTRODUCTIONS, AND REVIEW OF MEETING GOALS/AGENDA

Dr. Kathleen Clanon was introduced as the new Board member who will soon fill the seat vacated by Colleen Chawla.

6. LEADERSHIP UPDATE AND BOARD DISCUSSION: QUALITY, ACCESS AND HEALTH EQUITY

a) What have we achieved, and where have we made progress?
b) Where have we struggled and what have we learned?
c) What directions and strategies are we exploring for the future?

Quality and Access to Care Presentation presented by Dr. Carey.

<u>California's "Bold Goals"</u>

- Close racial/ethnic disparities in childhood well-child visits and immunization
- Close disparity gap in maternity care for Black and Native American persons
- Improve maternal and adolescent depression screening
- Improve follow-up for mental health and substance abuse
- Improve children's preventative care measures

<u>Alliance 2024 Quality Programs</u>

State Mandated PIPs
- Improve FUM/FUA
- WCV 0-15 months AA Children

MCAS

Health Equity

Community Programs
- CFMG
- Washington Hospital
- Roots

DHCS 2024 Focus
- Health Equity
- Quality
- Access

- Accountability
- Transparency

2025 QIHE Key Priorities

- HEDIS
  - Achieve rates above MPLs and incremental improvement above HPLs

- Access to Care/Member Experience
  - Improve timely access to care survey scores (i.e., CAHPS, CG- CAHPS) and the number of corrective action plans

- Population Health & Equity
  - Implement data-driven and coordinated efforts to address health disparities in prioritized sub-populations

- Utilization
  - Identify and act on trends of over and under-utilization of services

PCP Network Access

- DHCS PCP Time Standard – 30 minutes, Distance Standard – 10 miles
  - Met for 98% of Alliance members with a PCP assignment

- DHCS Annual Network Certification requires the FTE ratio of 1 FTE PCP to every 2,000 members (1:2,000)
  - No need to request alternative access standards for primary care

- While DHCS requirements are met, the data does not account for potential delays or access issues members may experience when trying to obtain an appointment with their assigned PCP.

What are we doing to improve access?

- Local network expansion
- Transitions of Care
- Telehealth Providers
- Provider incentives/retention

Question: Yeon asked how our organization can improve our partnerships with community organizations. She inquired about what we learned from our past experiences, the challenges we faced, and how we can better coordinate our efforts to enhance services for community members.

Response: Dr. Carey highlighted challenges faced by CFMG in encouraging well-child visits. Their phone calls and emails were ineffective, so they sought funding for a texting campaign. We helped them develop a texting platform, which successfully increased visit rates and improved quality scores. Dr. Carey also emphasized that incentives are effective.

Comment: Dr. Meade shared her perspective as a pediatrician, highlighting community messaging and vaccination challenges. She noted many undecided families and emphasized that texting incentives for groups are effective. However, she mentioned difficulties with the California registry interface, which needs improvement. Any assistance in enhancing this process would be beneficial.

Question: Andrea Schwab-Galindo raised a question about improving workforce metrics, especially regarding utilization and data analysis for specific groups. She asked how we can use technology to prioritize and educate individuals, as we noted last year that the right groups are not always prioritized.

Additionally, she inquired about addressing the connection between workforce, utilization, and quality metrics. How can we leverage technology, like AI, to enhance efficiency and improve our quality metrics moving forward?

Response: Dr. Carey highlighted that for 2025, the focus is on addressing workforce challenges, particularly in health and in the MA workforce of our clinics. High turnover complicates maintaining quality programs due to constant hiring and training needs. One potential initiative is to support the MA workforce to stabilize medical assistance in primary care offices and clinics, enabling staff to make calls and assist with screenings. This is a key strategy for moving forward in workforce support.

Question: Dr. Lynch inquired about bold goals for the SPD and elderly populations.

Response: Dr. Carey emphasizes that we need to understand the reasons behind the high readmission rates among our SPD and elderly population. Our initial focus is to identify these causes so we can address them and reduce readmissions. Currently, we are exploring ways to intervene and break this cycle.

Question: Andie emphasized the importance of adding an Alliance bold goal in addition to California's goals. She inquired about the quality programs highlighted in the slide, specifically if there's data showing that the interventions achieved the desired outcomes, noting that some interventions take years to show results. She also asked if, now that CFMG has found texting effective, there are plans to implement this across all providers. Additionally, she mentioned a table in the appendix showing membership proportions: HCN 43%, Alliance 22%, and Alameda Health System 20%. She wondered if there is a forum for these entities to share successful collaborations and best practices.

Response: Dr. Carey mentioned that the QIHEC Meeting brings together representatives from various areas to share best practices on quality. Last year, we focused on improving lead screening, as we did not meet the minimum performance level. We provided funding for point of care testing and equipment in different clinics, which significantly increased our performance in that area. This support allowed providers to conduct lead screenings in-office, making it easier for members compared to going to a laboratory.

Question: Doctor Meade noted that our targeted interventions in the ED for children with asthma were effective. To build on this, it is crucial to analyze data to identify the most beneficial interventions.

Response: Dr. Carey emphasized the importance of long-term cancer screenings rather than just one-year interventions. Low screening rates can lead to higher costs later due to advanced cancer cases. It is essential to invest more in preventive care rather than readmissions, while balancing member needs and state expectations to ensure optimal health for members.

Comment: Judy Moore recommends contacting UC Santa Barbara's exceptional autism clinic, which utilizes state-of-the-art research. Their behavioral experts implement standard goals using PRT (Pivotal Response Training), offering a vast library of research beneficial for families, children, and institutions.

Question: Yeon mentioned that with the new federal administration, immigration agents are appearing at schools and clinics, causing fear in the community, and affecting attendance at check-ups. How will it affect our organization, and do we have a plan for this?

Response: Matt mentioned that during the previous Trump administration, we did not get undocumented status information from California. We are updating our materials to emphasize the importance of care and rights protection for everyone. Our legal team is creating talking points to guide community interactions and inform individuals of their rights. More updates will come as we progress.

Question: Doctor Seevak asked about the over-utilization point, wanting to confirm it aligns with the medical management work aimed at identifying frequent emergency room visitors and redirecting them for better care management.

Response: Dr. Carey noted that we need to analyze the reasons behind the overutilization of inpatient stays and emergency department visits. Understanding these factors will take time, but it will allow us to implement targeted interventions to address the issue.

Question: Dr. Ferguson discussed HEDIS in relation to the single plan model and concerns over a potential drop in scores due to removing the Kaiser subset. What was the outcome of the HEDIS score? What trends are we observing, and if there was a decline, how are we addressing it?

Response: Matt and Tiffany said our scores improved in 2023. We are missing 4 measures for 2024, but the Quality team has worked hard on outreach and data cleanup to counteract the lower rates from Kaiser and Anthem members. So far, these efforts are paying off.

Question: Tosan mentioned that in 2024, there has been an increase in the number of medical patients visiting emergency departments, especially following Anthem's departure. He asked what steps can be taken to proactively guide these patients back to their primary care physicians (PCPs). It is important to have the right care at the right time and in the right place, and building a relationship with PCPs is essential. What strategies are being considered for 2025 to address this issue?

Response: Dr. Carey mentioned that a member campaign started in December to educate members about alternatives to emergency departments, such as 24/7 telehealth services for acute issues and expanding urgent care networks. Members are encouraged to use urgent care for minor issues instead of the emergency room. They are also open to suggestions.

Question: Dr. Ferguson raised concerns about access to psychiatry for members and asked what steps are being taken to improve this. He emphasized the need for better integration of psychiatrists in member care and believes it should be a priority for the organization.

Response: Dr. Carey mentions collaborating with Alameda County Behavioral Health to link psychiatrists for mild to moderate cases, though most of their members require more severe psychiatric care. The operations team actively seeks local psychiatrists who are not already credentialed to expand their network. However, there is a shortage of psychiatrists available to take on new members, which is why they are exploring virtual psychiatry options.

Question: Dr. Aboelata believes recruitment incentives would be beneficial and suggests discussing workforce pipelines, such as CHW to LCSW or medical assisting to nursing. She emphasizes the need to connect various providers and strategically leverage available resources for effective matchmaking.

Response: Matt noted that last year, the alliance leadership worked with the board to create a two-year plan, allocating $2 million for provider recruitment this year and another $2 million next year. However, there were over $6.5 million in requests for providers. An additional $2 million will be available in June or July. The gap between requests and budget underlines the urgent need, and they may seek more funding from the board based on the financial situation.

Comment: Andrea Schwab Galindo stresses the need to prioritize retention alongside recruitment in workforce issues. She cites research highlighting the importance of keeping current providers due to their limited availability. While she values the existing recruitment plan, she recommends revisiting it for flexibility in the upcoming budget. Additionally, she emphasizes that improving processes along with technology is crucial for enhancing telehealth access and helping providers adopt new systems. Her main focus is on retaining the valuable providers already in the system.

Comment: Wendy noted that telehealth benefits older adults and individuals with disabilities, particularly those facing mobility and transportation challenges. However, low-income individuals often struggle with device accessibility and bandwidth issues for both phone and internet. Providers should find solutions, such as providing higher volume phones or addressing bandwidth limitations, to support these individuals effectively at the Alliance.

Health Equity Presentation presented by Lao Paul Vang, Chief Health Equity Officer

Achievements

1. Established 3-year HE & DEIB Roadmap (6 milestones & Goals)
2. Regulatory Compliant Issues: DHCS APL 23–025/APL 24–016 DEI Training Curriculum and DMHC APL-24-018 (SB 923) TGI Training.
3. Established intersectoral collaboration with key stakeholders (Providers, CBOs & Faith-Based Communities).

Challenges & Lessons Learned

1. Unfunded Health Equity Mandate & Structure.
2. System Approach to effectively mitigate SDOH, institutional racism & systemic inequities in healthcare practices.
3. Organizational Transformation – can be challenging, expensive, and time–consuming.
4. Overlapping and gaps in Health Equity Activities; and parallel operations.
5. Community Engagement and Intersectoral Collaboration.

2025 Strategies/Directions

1. Implement 3-Year Roadmap Strategies (2025 – 2028) - Solicit BOG feedback on milestones.
2. Advocate and integrate HE & DEIB into healthcare policies and services.
3. Establish a health equity data governance system to comprehensively assess and identify health disparities.
4. Collaborate and support HCS, PHM, QI & UM to ensure quality and access.

Question: Yeon inquired if this strategy is only based on state requirements and if we are gathering input from stakeholders, providers, or members and wants the diagram to reflect that stakeholders are involved in the process.

Response: Lao states that our initiative goes beyond state requirements, driven by a committee of staff, members, and providers providing feedback on milestone design.

Question: Dr. Meade suggested that part of the strategic plan should focus on forming search committees and vetting vendors from that diverse perspective.

Response: Lao emphasized that we currently have two diverse committees representing all divisions, contributing perspectives on how HealthEquity and DEI are implemented within the agency. Engaging staff members is crucial for creating a holistic and inclusive approach. Additionally, our vendor management department ensures we evaluate potential vendors and providers through a different lens.

Comment: Dr. Clanon noted that the County of Alameda's Public Health Department has a Community Health Improvement Planning (CHIP) process, which includes various elements. She is interested in the potential for collaboration between the two processes.

Question: Dr. Lynch asked how our equity engagement strategy relates to eliminating health disparities, such as heart failure and hypertension, and addressing mortality rates among our members. How do these elements connect?

Response: Lao mentions that he collaborates closely with Dr. Carey, who provides a technical perspective. Their work aligns well in addressing health inequities related to ethnicity and gender in the county. This effort is part of milestone number six, focusing on both tackling these specific inequities and enhancing MCAS and HEDIS measures simultaneously.

Question: Dr. Ferguson noted that DEI has gained a negative connotation. How do we plan to redefine it and ensure our work continues regardless of national developments? What steps will we take to navigate this space?

Response: Lao emphasizes that HealthEquity initiatives have always focused on marginalized communities. DEI aims to create equal opportunities across various areas, ensuring equality and engagement. Unfortunately, DEI is often seen as token gestures rather than addressing systemic inequities.

HealthEquity strategies must factor in historical data on social determinants affecting health disparities in America, aiming to serve these communities better by tackling historical marginalization.

Tosan, with experience on national committees, highlighted the importance of targeting health outcomes to address disparities. He cited Joint Commission regulations and stressed urgent issues like higher maternal mortality rates among Black women.

The strategy should close outcome gaps without getting sidetracked by political debates, which risk funding and effectiveness. Tosan believes aligning HealthEquity initiatives with broader healthcare goals will drive progress.

Comment: Wendy highlighted that ageism and ableism are significant issues often overlooked in society. For marginalized individuals who age into these categories, additional challenges arise. She stressed the importance of considering age and disabilities when engaging with CBOs and community members to ensure these factors are not overlooked.

7. WORKING LUNCH – PRESENTATION AND DISCUSSION OF POLITICAL ENVIRONMENT

Linnea Koopmans, Local Health Plans of California provided a presentation on the political environment.

State Landscape

Governor's Budget

Big picture:
- $322.3 billion proposed budget
- LAO Estimates a $2B budget deficit but a double-digit budget deficit in future years
- "No capacity for new commitments"
- Overall revenue running higher, likely near $7B from expectations
- Risks include activity at the federal level that would impact state revenue

Medi-Cal:
- $188.1 billion total funds ($42.1 billion General Fund)
- Preserves major commitments in recent years, and funding to implement new CalAIM components
    - Approximately $20 million for transitional rent ($10 million General Fund)
- Funding for counties to implement Prop 1, BHSA, and BH-CONNECT waiver
- Allocates funding for Prop 35 but no details regarding implementation
- Proposed elimination of PHE unwinding Medi-Cal eligibility flexibilities that will decrease the Medi-Cal caseload
- Largely a placeholder budget until the May Revision when more will be known about what occurs (or will likely occur) at the federal level.

Health & Medi-Cal Legislative Issues

Issues that may be the subject of policy bills:
- Maternity access, including addressing the trend of Labor & Delivery unit closures.
- Rural health care and access.
- Medi-Cal network adequacy, including alternative access standards.
    - Current Medi-Cal time and distance standards sunset and need to be renewed (or modified).
- CalAIM
    - Addressing provider pain points
    - Transitioning community support to benefits
- Other issues:
    - Health plan provider directories

    - Utilization management/prior authorization
    - Timely payment
- Other emerging issues or priorities of new members in the Legislature

Federal Landscape

Potential Congressional Agenda

- House GOP menu of spending cuts
- Extension of Trump's tax cuts relies on substantial reductions to federal spending.
- Included many proposed Medicaid cuts, totaling $2.3T.
- Provides options for proposals to include in the budget reconciliation process.
- Possible Medicaid financing proposals include:
    - Work requirements
    - Decreasing the enhanced federal match for ACA expansion populations
    - Per capita caps
    - Limiting Medicaid provider taxes
    - Lowering floor for federal Medicaid match
- Budget reconciliation may begin as early as late Spring, but it is still unknown whether there will be one or two packages.

What's at Stake for California

- Any major changes to Medicaid financing will have significant impacts on California's Budget:
    - The ACA Medi-Cal Expansion population represents approximately one-third of overall Medi-Cal enrollment (nearly 5 million beneficiaries).
    - Federal funding to California for this population is in the tens of billions of dollars annually.
    - Timeline and impact may not be immediate given reconciliation process scores savings over a decade, so effective dates may be multiple years out.
    - Some spending cuts are simpler or easier politically, whereas others are more complex. However, it is more of a question around what cuts will be made rather than whether cuts will be made.
- Waivers:
    - CalAIM waiver is up for renewal effective 2027.
    - In addition to political influence on waiver negotiations, Medicaid financing changes could pose challenges for program sustainability.
    - However, much of CalAIM is in California's 1915(b) waiver which is more procedural in nature, which could provide a degree of protection.
- Nexus of health and immigration:
    - California's investment in the state-only expansion to undocumented populations represents billions of dollars of state spending.
    - Day 1 Executive Orders targeting immigrant communities, some of which were quickly challenged by many states including California.
    - Public charge.

Protecting Medicaid

- Protecting Medicaid will require significant coalition work at the local, state, and national levels.
- Partnerships with local business leaders, hospitals, doctors, and others will be important to support messaging about the impact of potential cuts.

- Connection through state and national trade associations will be key, including working together or supporting red states that have expanded Medicaid or provider taxes similar to California and have a lot of Medicaid funding on the line.
- Messaging will need to be tailored to the interests of the Republican Congressional delegation.

Question: Rebecca asked if the new housing benefits are similarly funded, considering that community supports require significant subsidies from all implementing plans.

Response: Linnea mentioned that DHCS will finance the state differently than community supports, which are often not fully funded. While details on the reimbursement structure are pending, it will not be risk-based. Instead, it will involve an add-on payment based on the number of members placed, with a ceiling to be established. Utilization will be submitted for reimbursement. This approach will reduce risk for plans compared to community support. Implementation is set for 2026, and eligibility may be determined through local provider referrals or by the plan itself.

Question: Andrea Schwab-Galindo asked about the impact of current political implications on the alliance's financial and operational stability.

Response: Matt assured the board that they are monitoring the situation and will provide updates as needed.

Question: Andie asked Linnea about consultants' views on block grants and per capita caps. Are they expecting the current waiver and SPA structures to stay, or do they foresee tougher negotiations with reduced funding? Will states likely accept less money in exchange for more flexibility? Andie is curious about what Linnea is hearing.

Response: Linnea mentioned that she initially overlooked block grants in the Medicaid financing discussion but believes they could be easier to implement than per capita caps, which involve complex formulas based on diagnosis groups and can vary per enrollee. She noted skepticism around the feasibility of per capita caps due to their complexity. A simpler mechanism like block grants could streamline the process.

She also pointed out that the enhanced federal match introduced by the Affordable Care Act offers a straightforward change that could significantly impact funding. Lastly, while waivers might seem less financially advantageous, they could allow for more flexibility and creativity in program implementation, though negotiations would remain challenging.

Question: Andie mentioned that California's FMAP is already low, and she heard it might drop to 20%. Can California have a 20% FMAP while other states have 50%, or is there a law against setting different rates by state?

Response: Linnea mentioned that FMAP rates vary by state based on revenue and wealth. States with lower income may have a higher FMAP, while California has significant wealth disparity, with 1/3 of residents on Medicaid. She suggested that differential FMAP rates should have a logical basis rather than arbitrary percentages for states like California and Texas. Richard stated that it is currently protected by law at 50%. Any changes would require a change in law.

Question: Dr. Lynch asked if the association has begun scenario planning and discussed potential program designs for various scenarios.

Response: Linnea mentioned they have discussed needing to address it depending on what proposals are made and what unfolds in the coming months.

Comment: Dr. Meade believes we should collaborate with national organizations like the American Academy for Pediatrics to promote the importance of vaccinations. Recently, her patients avoided in-person visits due to fear and opted for telehealth instead. She urges collective action with these organizations to emphasize the necessity of in-person care, as we will not meet vaccine quality standards if children do not come in.

8. LEADERSHIP UPDATE AND BOARD DISCUSSION: FINANCIAL POSITION, PROJECTIONS AND STRATEGIC APPROACH

Gil Riojas discussed our current financial position, the 2025 forecast and the Alliance's strategic approach and framing.

Alameda Alliance Financial Strategy, Short-Term and Long-Term

Short-Term

- Medical management initiatives begin in 2025
- Provider and hospital contract management (billed charges, DRG) ongoing
- Authorization and claims alignment project goes live March 2025
- Fraud waste and abuse avoidance
- Continued advocacy with the state (DHCS, DMHC) executive leadership

Long-Term

- Provider and hospital contract process revamp
- Complete program evaluation of CalAIM and in lieu of services savings
- High-cost member engagement and management
- Preparation for policy changes related to federal administration changes

Question: Dr. Seevak inquired about which lines of business might be at risk due to federal changes, especially related to care for undocumented individuals and optional expansions, and how these might impact the bottom line. He also asked if launching new programs, like dental care, would mean initially assuming losses and how that might influence the decision to pursue them.

Response: Gil emphasized that the priority is ensuring members receive care, noting the risk of members losing coverage. He mentioned that optional expansion members have negatively impacted margins recently, but losing that membership might have a short-term positive financial effect, though it overlooks the care needs of members and staff.

Regarding program changes, Gil stressed the importance of focusing on core business. He acknowledged that new programs might pose risks to margins amid uncertainty and that these factors would influence future decisions about expanding services like dental care.

Comment: Dr. Meade hopes as we move forward in the next couple of years she hopes that if we do have to make hard financial decisions that we focus on the people and the direct service so that the values of quality, mandatory, regulatory and people stay balanced.

9. CHARTING THE FUTURE - STRATEGIC PLANNING PROCESS OVERVIEW AND EXTERNAL ENVIRONMENT/STRATEGIC ISSUES DISCUSSION

The Board and executive team reviewed strategic planning goals and discussed items to address in the strategic planning process.

Discussion Goals

- Introduce strategic planning, outline Board role and input opportunities
- Share staff leadership preliminary reflections on strategic issues, questions, and directions to address in planning
- Solicit Board perspectives on key environmental factors and strategic issues to address in planning

Strategic Planning Goals

- 5-year strategic plan that serves as a roadmap for the future
- Craft a strategic plan that is…
    - Clear, simple, focused, and flexible
    - Has a broad vision but offers achievable steps
    - Looks forward and outward, not just internally or immediate
    - Prioritizes wide buy-in and participation by the Board, executives, staff leaders, and stakeholders
    - Has clear outcomes that let us know if we have been successful

Board Discussion

- Small Group exercises to address the following questions
    - Planning Assumptions
        - What are some key assumptions about the future that the Alliance should use to inform its next strategic plan?
    - Strategic Issues and Questions
        - What strategic directions, issues or questions do you think are the most critical to address during strategic planning?
    - Preliminary Priorities
        - Preliminarily, what are one or two top strategic priorities that you would articulate right now for the Alliance in the next 5 years?

Question: Andie asked what we are currently trying to solve with the strategic plan.

Response: Matt mentioned that the old strategic plan is complete. As he discusses the next five years, we must quickly adapt to changes at the federal level and consider new state programs and benefits. He would like to begin the conversations with the board to think about taking on some of these initiatives for the community, focusing on opportunities that could be beneficial.

Comment: Dr. Meade believes that Covered California will not benefit current members, but that behavioral health and dental services would help the Alliance's population.

Comment: Andrea has observed that Medicare Advantage is frequently mentioned in memos and communications from the White House. Considering potential political implications and forthcoming changes, we might need to consider looking into this further.

Comment: Dr. Aboelata asked that we explore the fiscal impacts of dental and behavioral.

Comment: Andie highlighted that if we lose half of our Medi-Cal patient population, that impacts our mission significantly. Regarding Medicare Advantage, while it may be beneficial as it allows for growth and creativity, there is a risk in optional benefits like dental to set them up and potential costs. Additionally, integrating behavioral health is crucial since mental illness significantly drives hospital utilization. Addressing these complexities aligns with our core challenges, and having accurate data would be valuable.

Comment: Andrea Schwab-Galindo suggested revisiting our values and principles. She emphasized the need to balance our mission-driven business and identify priorities and areas for subsidization in line with our values. Revisiting this could help address some of our current questions.

Comment: Supervisor Tam supports the integration of behavioral health from the perspective of medical coverage and reimbursement. While she acknowledges that the complexities surrounding this issue can be scary, she believes it is important for us to explore it to provide the necessary care for our clients.

Group Exercise Questions and Suggestions from the Board:

- What are the values and principles that we should use to guide our decision-making around the line of business?
- What should the organizational focus be, ensuring alignment with the organization's mission and goals?

Comment: Supervisor Tam wants to avoid duplication, operating in silos is not helpful in different managed plans.

Comment: Dr. Aboelata wants to make sure we fill in gaps in the landscape, and how we invest in the resources of partners that we have so we are not duplicating the wheel, but we are actually investing in who is out there doing this work but may not be connected as well to us.

Comment: Wendy emphasized the organization's responsibility to the community, highlighting the importance of compassion and ensuring that decisions impacting people's lives involve their meaningful participation.

Comment: Dr. Clanon emphasized the importance of safeguarding the plan, as doing so involves risks both to the plan itself and to the people we care about. There will be times when protecting the plan may create tension with other priorities we wish to pursue.

Comment: Rebecca highlighted that we have struggled to manage our high-utilizing population effectively. As we plan our next steps, it is crucial to integrate strategies for this group since it consumes a significant portion of our budget. What adjustments can we make to better manage this population and improve outcomes?

Comment: Dr. Lynch stated that to improve quality work, if the state lacks a bold goal for our population, we should help establish a bold goal for the aging population that frequently utilizes the hospital.

Comment: Dr. Aboelata emphasized that when we seek grants, it is essential to clearly communicate our strengths. We need either an academic or a research partner to help distinguish us. By doing this, we can gain a competitive edge and significantly advance our efforts if we get this aspect right.

Comment: Dr. Seevak emphasizes the importance of retaining our current providers and clinicians, especially given the challenges in recruiting new ones. It is not just about physicians; this applies to nurses, nurse practitioners, administrators, and others as well. We have an opportunity to simplify their lives as a health plan by making it easier for them to navigate the system. Additionally, we can provide training and support to help combat burnout and better support our providers.

Comment: Dr. Meade wants to revisit the discussion on coalition building and identifying roles. There has been an overlap in the care management space over the last five years, so we need to clarify responsibilities and advocate for our respective positions in an organized manner.

Comment: Andrea Schwab-Galindo emphasized the importance of involving patients in discussions about how to improve their care. She pointed out the need to understand patients' wants and needs better, questioning if they have truly done their due diligence in gathering this information. For instance, the rise of telehealth highlights opportunities that could have been identified earlier. She urged the board and leadership to avoid making assumptions about patient needs and to consider what outsiders might do differently to improve their approach. This perspective can help reframe discussions and encourage innovative thinking.

Comment: Rebecca emphasized the need to shift from traditional approaches to a more engaging relationship with members, encouraging innovative strategies to enhance care.

10. ANNOUNCEMENTS

There were no announcements.

11. PUBLIC COMMENT (NON-AGENDA ITEMS)

There were no public comments.

12. BOARD REFLECTIONS AND ADJOURNMENT

Chair Gebhart adjourned the meeting at 3:32 p.m.