ALAMEDA ALLIANCE FOR HEALTH
BOARD OF GOVERNORS
REGULAR MEETING
December 9th, 2022
12:00 pm – 2:00 pm
(Video Conference Call)
Alameda, CA

SUMMARY OF PROCEEDINGS

Board of Governors on Conference Call: Dr. Evan Seevak (Chair), Rebecca Gebhart (Vice-Chair), Dr. Kelley Meade, Nicholas Peraino, Dr. Marty Lynch, Dr. Rollington Ferguson, James Jackson, Dr. Noha Aboelata, Dr. Michael Marchiano, Aarondeep Basrai, Andrea Schwab-Galindo, Supervisor Dave Brown, Byron Lopez

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: Natalie Williams

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
1. CALL TO ORDER			
Dr. Evan Seevak	The regular board meeting was called to order by Dr. Seevak at 12:02 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			
Dr. Evan Seevak	A telephonic roll call was taken of the Board Members, and a quorum was confirmed.	None	None
3. AGENDA APPROVAL OR MODIFICATIONS			
Dr. Evan Seevak	None	None	None
4. INTRODUCTIONS			
Dr. Evan Seevak	None	None	None
5. CONSENT CALENDAR			
Dr. Evan Seevak	Dr. Seevak presented the December 9th, 2022, Consent Calendar. a) November 11th, 2022, Board of Governors Meeting Minutes b) December 6th, 2022, Finance Committee Meeting Minutes Motion to Approve December 9th, 2022, Board of Governors Consent Calendar. A roll call vote was taken, and the motion passed.	Motion to Approve December 9th, 2022, Board of Governors Consent Calendar. Motion: Supervisor Dave Brown Second: Dr. Marty Lynch Vote: Yes No opposed or abstained.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
6. a. BOARD MEMBER REPORT – COMPLIANCE ADVISORY COMMITTEE			
Rebecca Gebhart	The Compliance Advisory Committee (CAC) was held on December 9th, 2022, at 10:30 am. Rebecca Gebhart gave the following Compliance Advisory Committee updates. 2022 DMHC Full Service Financial Audit: • We have received the final findings of the 2022 DMHC Full-Service Finance Audit, about two (2) months after the exit conference. The lookback period for this was the prior audit as well as the three-year period. We discussed four (4) minor findings today. These minor findings serve to illustrate the extent of detail that the State gets into with our audits and how we are addressing them. • The first finding was timely acknowledgement that provider disputes were reviewed. A few were found to be late; there is a fifteen-day (15) turnaround required, and they were a day (1) or two (2) late. This was due to a training issue which was remediated by training, and not a system-wide issue. In all findings, our primary focus is whether there is a system issue that needs to be addressed, or whether it is an isolated situation. • The second finding concerned claims that were not reimbursed accurately. The specific situation for this finding was this was one contract where one item in a large contract was entered incorrectly into the health suite system with a number transposition. This was corrected during the audit, so there was no corrective action plan needed. • An additional finding was that we did not timely file changes in plan personnel; the Plan is required to provide notice of personnel changes related to executive staff, certain finance staff, and Board members. These filings must be made timely with organizational charts and resumes, and we were a few days late. Since then, a new process has been executed and we have been able to meet those filings in a timely manner. • The next finding is also minor and concerned our fidelity bond, which did not have thirty-day (30) notice prior to cancellation, and this is required for	Informational update to the Board of Governors. Vote not required.	

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	Knox Keene. Banks do not always provide this, however, we got our bank to provide the documentation, so this has also been fixed. Medi-Cal Program Updates – RFP Single Plan Model Transition: • We have completed the final deliverables for 2022 and we are working on the next set of deliverables for 2023. Four-hundred-seventy-one (471) deliverables will be submitted over the Operational Readiness period. The submissions have all been timely and on schedule. • For these deliverables, the State has a portal where we upload our submissions. The State keeps track of whether the deliverable is accepted at the initial submission, or whether it requires correction and resubmission. We have a ninety-five (95%) approval rate. Behavioral Health Network Transition: • For the April 1st, 2023, launch date, everything has to be finalized by the end of March. We were looking at our network with the State and noticed that the State did not see some of our providers in the categories that they wanted to see them in due to the naming conventions not being aligned. This misalignment caused them to perceive our network in a less complete manner than it needed to be. • We worked with the State and have changed our naming conventions; we have entered new names into our provider files and changed them in our contracts so that we should be in good shape and aligned with State requirements. Long-Term Care Transition: • From last month's meeting, we followed up on how we were receiving data of people in long-term care from the State and how we were working with that data to ensure that services were not interrupted. • Dr. O'Brien shared that we received an initial data set from the State; however, it had six (6) years of data, and much was expired. The Analytics team did a great job sorting this data and focusing on the most recent members and working to ensure that services are not interrupted for members. The team is aware that there may be changes that arise, so they are setting up a command center to deal with issues in real time as they arise.		

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	• In January, we will get the members who picked the Alliance and in February, we will get the members who were assigned to the Alliance. The Team conducted town halls to facilitate outreach with providers to ensure that everyone had sufficient anticipatory guidance concerning this transition. Medi-Cal RX Transition: • Dr. Lee reported in previous meetings that they had made prescriptions not require prior authorizations, and that resulted in the State having to pay a lot of money. They are now bringing authorizations back into place. We will continue to monitor that. • Dr. O'Brien also shared that in the Medi-Cal Rx Transition, certain sensitive services now have been fully shifted to Medi-Cal Rx. The Alliance hung onto certain services due to the sensitivity of the services; these were continuous glucose monitoring for type one diabetic adults, and enteral feed nutritional supplements for fragile members. • The Alliance held onto these services because it concerns some of our most fragile members. In the interim, the Alliance conducted a lot of outreach and provided guidance to members using those services to ensure a smooth transition. Population Health Management 2023 Roadmap: • With Population Health Management, there is a very big focus on transitions of care, which is critical and at times, can create higher risk. In the rollout of Population Health Management, we must implement these transitions of care with a focus on high risk, which we are ready to do. • In 2023, the State has required that we focus on transitions of care for all members, including low risk members. This will be a significant lift for the organization; I wanted to address this because more visibility for the Board is better so we can continue to track this transition and receive updates. 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, December 6th, 2022. Dr. Ferguson provided the following updates: Highlights: • Our enrollment continues to increase; for the month ending October 31st, our membership increased to over three-hundred-twenty-three-thousand (323,198). Since the pandemic, there has been a constant increase in our membership. • We were projected to have a loss of eight-point-seven million ($8.7M) by the end of October; instead, we have a twenty-one-point-six-million-dollar ($21.6M) net income. • Our Medical Loss Ratio (MLR) was eight-six-point six percent (86.6%) for the month and eighty-nine-point-weight percent ($89.8%) 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
6. c. BOARD MEMBER REPORT – CEO SEARCH COMMITTEE			
Dr. Evan Seevak	Dr. Evan Seevak provided an update on the CEO Search Committee: • We have engaged with Kiefer, and they are currently sourcing candidates for us to replace Scott when he retires in May. It seems to have been a very popular position; we have had over one-hundred (100) people identified who have shown interest in this nationwide search. • The firm is actively screening a diverse pool of candidates, and we were tracking to review profiles soon. The Search Committee is targeting the review of profiles of approximately ten (10) candidates, so we anticipate that with Kiefer, we will be presenting the ten (10) candidates that they feel have risen to the top of the pool.		

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	• We want the full Board to have the opportunity to review the final two (2) candidates and meet them in person. We currently have two (2) dates held and we are looking for a third; January 27th in the afternoon and February 10th after the Board meeting are currently being held. • I will also be stepping down as the Chair of the Board, but I will continue as Chair of the Search Committee until it is completed. • We are currently taking nominations; next month we will elect our new Board Chair. We will also likely be needing a new Board Vice Chair – if any of you are interested in either nominating yourself or nominating someone else. It is a great role, email or call Scott or me if you are interested in nominating or discussing the role. Informational update to the Board of Governors. Vote not required.		
7. CEO UPDATE			
Scott Coffin	Scott Coffin, Chief Executive Officer, presented the following updates: July 2022 Closed Session Public Disclosure: • In accordance with the Brown Act, we are required to provide a public disclosure of all closed session topics. This update is to disclose that the closed session in July 2022 Board of Governors meeting was regarding our NCQA reaccreditation status. • During my CEO update in the October 2022 Board of Governors meeting, I disclosed the outcome, which was that the Alliance has received NCQA reaccreditation for both lines of business, including Medi-Cal and Group Care. Financials: • We are presenting two (2) financial reports today – the first is the October 2022 Financial Report, and the second is the final budget for the fiscal year 2023, which ends on June 30th of next year.	Informational update to the Board of Governors. Vote not required.	None

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	• As shared in previous Board meetings, our Medi-Cal enrollment growth continues to set records each month. This is due primarily due to the Public Health Emergency and the suspension of the annual redetermination process. • In addition to the Public Health Emergency, the California Department of Health Care Services is shipping Medi-Cal beneficiaries enrolled in the fee-for-service delivery system into the Medi-Cal Managed Care delivery system. • Alameda County has approximately eighty thousand (80,000) adults and children enrolled in the Medi-Cal fee-for-system currently. Effective January 1st, 2023, approximately twenty-nine thousand (29,000) of these individuals will be transitioned into managed care and will be enrolling in Alameda Alliance. This is a forecast, and more information will be covered today during our financial reports. Final Budget – FY 2023: • The California Department of Health Care Services typically releases the Medi-Cal base rates for our following calendar year in the month of September. The DHCS has extended these in 2022; the target date from the DHCS right now is by the end of this calendar year. Therefore, the final budget being presented today excludes the final base rates for Medi-Cal. Rather, the final budget includes revenue estimates that were developed during the year. • The final rates for calendar year 2023 will be included in our third-quarter forecast, which is scheduled for presentation in February 2023. This is an unusual year and therefore, an unusual financial reporting process. However, the team has done a great job of providing all the details. Revised State Legislature Report: • There is a revised state legislative report, on pages fifty-two (52) through sixty-eight (68) of the Board packet. The State Assembly and Senate bills are organized in a new way to show the active legislation that is related to health care services. This is a product from our Public Affairs department – I encourage Board members to pause and take a look at your convenience.		

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	Key Performance Indicators: • The executive dashboard shows our performance in the month of November – one-hundred percent (100%) of the regulatory metrics were met; encounter data reporting, member and provider grievances, health services authorization, turnaround time, claims payment turnaround. • These are all examples of regulatory metrics; overall, the Alliance team did a fantastic job in the month of November again to deliver these results. Kaiser Permanente Contract & Program Implementations: • The direct contract between the State of California and Kaiser Permanente is scheduled to be effective on January 1st, 2024. The contract between Alameda Alliance for Health and Kaiser Permanente will terminate on December 31st, 2023, as this new contract takes effect. • On the dashboards you'll see that approximately forty-nine thousand (49,000) of the Alliance's Medi-Cal enrollees are enrolled in Kaiser and every one of these beneficiaries will have the option to remain with Kaiser or to be reassigned into a different part of Alameda Alliance's provider network. • Next year, a series of outreach campaigns will be conducted to inform our Medi-Cal members of their choice to remain with Alameda Alliance for Health. • Later in the Board meeting, we will be providing separate updates on CalAIM, Long-Term Care, and Population Health. We will go further into the status of these implementations – where we are, some of the issues that we are facing, and lastly, and update on the Public Health Emergency and some of the work that Alameda Alliance is doing with our safety-net partners and health care agencies. Scott paused the update to recognize Board member Dr. Noha Aboelata for her presentation in Washington, DC at the White House. White House Summit on COVID-19 equity. Dr. Aboelata provided the following comments:		

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	• Thank you, this was a couple of weeks ago, it was a great event. It was about COVID equity, but also, it was about the broader concept of Health Equity. It was a heartfelt discussion; I was on the third panel, and my panel was about COVID equity to health equity. For many of us, we were doing health equity work before COVID and centering those who are most marginalized. COVID was another example and an opportunity for us to get out into the community and do what we could to try and mitigate or prevent disparities from being as severe. • I also had the opportunity to discuss threats that concern me. For example, I think the pandemic showed where a lot of our weaknesses are on data infrastructure, especially around public health data. I am hopeful that there will be other areas of data infrastructure that will be maintained on public health – not just on the delivery system, but on that whole continuum. • Additionally, the concern of having appropriate tools; I did raise the issue of the pulse oximeter; the darker someone's skin tone, the less accurate the pulse oximeter becomes. It is about the importance of continuing to advocate; that we don't just say the word equity, but that we're looking at our disparities and we're making sure that we're investing towards ending those. It was great to be representing the Bay Area in DC, thank you for the opportunity to share. Scott concluded the CEO Update with the following: • I want to acknowledge that the financial performance that we're going to be running through today is reflective of every employee in Alameda Alliance. Then of course, the support from our Board of Governors to make this all happen. • The team are doing a fantastic job. We are at one of the best operating points in the last eight years, and I'm very proud of the accomplishments that have been derived. It is a team effort to get this done – many thanks to everyone at Alameda Alliance for Health for making this happen. Question: As more duals have to get their Medi-Cal through the Alliance, does that include Kaiser Duals and would we lose them in 2024? Answer: We are having a broader discussion on the twenty-nine thousand (29,000) Medi-Cal members that are coming in, which seventy-five percent (75%) are dual. It is about twenty-two thousand (22,000) on January 1st. For 2024, part of that		

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	depends on the direction we have with Medi-Care expansion. The State is going to keep the duals enrolled as they are, and then part of the discussion we are having with the Department of Health Care Services will help to decide on whether we will keep the duals enrolled beyond 2024. Informational update to the Board of Governors. Vote not required.		
8. a. BOARD BUSINESS – REVIEW AND APPROVE OCTOBER 2022 MONTHLY FINANCIAL STATEMENTS			
Gil Riojas	Gil Riojas gave the following October 2022 Finance updates: Enrollment: • For the month ending October 31st, 2022, the Alliance had an enrollment of over 323,000 members, a net income of $9.5M, and the Tangible Net Equity (TNE) was 681% of the required amount. • Our enrollment has increased by over 1,800 members since September 2022, and on a fiscal YTD, we gained over 10,000 members since June 2022. By category of aid, consistent with prior results, are child-adult optional expansion enrollment continues to increase. • We also see increases in our Medi-Cal SPDs and Medi-Cal Duals. The only area of slight fluctuation is related to our group care – in-home support services, which is the commercial line of business. It has been trending down but was typically within the 5800–6000-member range over the year. Question: When we see situations like this, does the State expect we pay for these with savings from other lines of business, or do they expect that they will adjust these rates on the go forward if we continue to see losses in a particular population? Answer: The rates should stand on their own, so each rate by category should stan on its own and should be actuarily sound. I think we've continued to see sustained losses in our SPD, but our other rates particularly our optional expansion and our adults and child Medi-Cal, you know that those positive variances are making up for the shortfall with the SPD. The State looks at this every year – they look at	Motion to Approve October 2022 Monthly Financial Statements as presented. Motion: Mr. James Jackson Second: Dr. Kelley Meade Vote: Yes No opposed or abstained.	None

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	medical expenses by category of aid and category of service. Historically, we have seen certain categories make up the difference for areas where there are significant net losses. Net Operating Results: • For the fiscal YTD ending October 31st, 2022, the actual net income was $9.5M, versus a budgeted net loss of $2.9M. Revenue: • Positive Revenue Changes: For the month ending October 31st, 2022, the actual revenue was $105.7M vs. the budgeted revenue of $102.9M. • For the fiscal year ending October 31st, 2022, the actual revenue was $408.4M vs. the budgeted revenue of $409.7B. • We have also had some higher than expected interest income from our investment, so that is really the reason for the variance between budget to actuals. • The revenue continues to grow as membership grows. Medical Expense: • For the month ending October 31st, 2022, the actual medical expense was $91.6M, and the budgeted medical expense was $98.6M. • For the fiscal year ending October 31st, 2022, the actual medical expense was $366.9M vs. the budgeted medical expense of $390.6M. • There is some variance in our actual versus budgeted; we also had a decrease in our incurred but not paid claims estimate; so that estimate of expenses has gone down by about $4.0M for the month, which means we have less liability than we anticipated looking at our historical claims payments. • Actual to Budget Variance on a PMPM Basis: On a year-to-date (YTD) basis, looking at our budgeted medical expenses to actual expenses, the largest variance is related to our inpatient expenses. Utilization has been favorable to our budget by about 15%, offset slightly by our unit cost, which has been more. The net effect of that has been about a 5.1% favorable variance, and that variance equates to about $6.8M.		

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	• The other area of favorability that is significant is in our ER Services. If you look at our budget to actuals, our unit cost related to fee for service ER Services has been lower than anticipated. This has resulted in about $3.0M in savings. • We also have variances in our other benefits and services, which is related to the clinical administrative expenses, the FTE expense, and our net reinsurance – looking at our premiums to the amount of money we have collected over this prior period and this period. Those are the primary drivers of the favorable variance of about $15.0M. • For the per member per month (PMPM) perspective, it is about a 4.3% variance, which equates to about $13.11 per member per month. It tracks relatively closely to the actual dollar variance 3.9% for the dollars and about a 4.3% on a PMPM level. • All these variances have been favorable for the most part, along with our increased revenue above what we had anticipated for our budget, which impact our medical loss ratio (MLR). Medical Loss Ratio (MLR): • For the month ending October 31st, 2022, the MLR was 86.6% and 89.8% for the fiscal year-to-date. • Ideally, we would like to maintain our MLR between 90.0% and 95.0%. We are in a good spot for the fiscal year to date at about 90%; overall, our medical loss ratio has been relatively stable. • We spend the bulk of our revenue as we should on medical care; about 90% of the revenue we receive goes to medical care. The remaining goes to administrative expenses and is also held as tangible net equity; as you move forward into some period of uncertainty, it will be good for us to continue to build up our TNE and we can do that by managing our medical aspect ratio.		

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	Administrative Expense: • For the month ending October 31st, 2022, the actual administrative expense was $5.3M vs. the budgeted administrative expense of $7.3M. • For the fiscal YTD ending October 31st, 2022, the actual administrative expense was $21.5M vs. the budgeted administrative expense $28.0M. • The major reasons for variance: about $3.0M 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. • Administrative Loss Ratio (ALR) represented 5.0% of net revenue for the month ending October 31st, 2022, and 5.3% of net revenue YTD. Other Income / (Expense): • Our fiscal year-to-date net investment revenue reported a gain of $1.7M; this equates to about $770K in increased interest income from our investments in prior months. We have been able to take advantage of a market where interest rates are increasing rapidly. • Fiscal-year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $104,000. Tangible Net Equity (TNE): • As our net income goes up, our reserves go up. The Department of Managed Health Care (DMHC) requires TNE to be thirty-eight million dollars ($37.0M). • We reported actual TNE of two-hundred-fifty-two-point two million-dollars ($252.2M), and excess TNE of two-hundred-fifteen-point two million dollars ($215.2M). • Of the required TNE, we have six-hundred-eighty one percent (681%). • It is good to maintain healthy reserve, particularly as we move into Long-Term Care next month. As we take on new populations of health, there will		

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	be significant changes that may impact the TNE, so we want to ensure we build it up as much as we can. Cash Position and Assets: • For the month ending October 31st, 2022, the Alliance reported nearly $321.2M in cash of which $219.7M was uncommitted cash. The remaining was pass-through liabilities at $101.5M. Our current ratio is above the minimum required at 1.77 compared to the regulatory minimum of 1.0. Capital Investment: • Fiscal year-to-date capital assets acquired: $197,000. • Annual capital budget: $1.0M. Question: What assumptions are made to create the budgeted number for medical expense? Answer: The budget comparison to actual is reflective of our preliminary budget; it's a budget that we put forth back in May and June of this year. So significant variances between now and then – one of them would be enrollment; anticipating when enrollment was going to start to decline, that was one of the variables. The other variable was utilization – looking at the potential trends of what we have seen over the past and how we reflected that in our budget. Utilization has not been as high as we anticipated for the first several months of the fiscal year. We looked at the catastrophic cases over the last several years and thankfully to date we have not had as many as expected. Those are some of the main drivers of that variance between our preliminary budget which you see here on the screen and the results that are actuals. Motion to Approve October 2022 Monthly Financial Statements as presented. A roll call vote was taken, and the motion passed.		

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8. b. BOARD BUSINESS – REVIEW & APPROVE FISCAL YEAR 2023 FINAL BUDGET			
Gil Riojas	Budget Process: • We presented our preliminary budget in June 2022 and our budget today represents both our Q1 forecast and our final budget. • It has results from July to October; we are trying to reflect as accurately as we can using the most relevant months of financials that we have. Calendar Year 2023 Rates: • One of the major challenges that we have had with both our preliminary budget and final budget is related to incomplete rates from DHCS. We anticipate an update to the major organ transplant rates. We haven't had that – the last update we got was back in November 2021. We are expecting to receive updates on our MOT rate in December. • We recently received the Enhanced Care Management rates for the next calendar year (CY 2023) and we have been able to incorporate some of that information into our budget. • The big area of variance would be related to our Medi-Cal base rates; although we received some information related to our base rates for calendar year 2023 in September, it did not constitute the complete package. Therefore, it was not enough information for us to fully finalize what the rates would be for calendar year 2023. We are expected to get those rates before the end of this month is over. • The State has also been working on separating members with satisfactory immigration status and unsatisfactory immigration status for months now; this has also delayed the rate process. CalAIM Incentive Programs: • We have also updated the October results. The CalAIM Incentive Program dollars – we are able to know how much more we are going to earn. These have also been reflected in our final budget. FY2023 First Quarter & Final Budget Highlights: • The projected net income is close to eighteen million dollars ($17.8M). The bulk of that will be for Medi-Cal with small net positive results with our Group Care line of business.	Motion to Approve FY 2023 Final Budget as presented. Motion: Dr. Marty Lynch Second: Dr. Rollington Ferguson Vote: Yes No opposed or abstained.	None

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	• Our Tangible Net Equity (TNE) is one-hundred-ninety-five point three ($195.3M), 532% of TNE required by DMHC. • Medical Loss Ratio (MLR) is 93.2%, compared to 94.7% in the Preliminary Budget. • We expect our membership to be at about three-hundred-fifty-seven (357,000) members. We have about twenty-nine thousand members (29,000) transitioning from Fee-for-Service to Managed Medi-Cal in January of this year. There will be significant Medi-Cal enrollment increases, which is going to be a driver of some of the impact to our final budget. • Medi-Cal enrollment will make up the bulk of our membership at three-hundred-fifty-one-thousand members (351,000) and Group Care enrollment will be trending at normal levels from fifty-eight hundred to six thousand (5800-6000) members per month. • Revenue on a per member per month (PMPM) basis is higher than our preliminary budget and related to getting some additional insight into Long-Term Care services and how it impacts our SPD and Duals populations as well as the Incentive dollars that we know more information about. • We believe for the fiscal year – July of this year to June of next year – awards for Incentives will add thirty million dollars ($30.3M) in revenue and expenses. • From a medical expense perspective looking at a PMPM basis, we forecast will be $2.23 unfavorable to our preliminary budget, mainly due to Long-Term Care Services and the categories of service in our SPD and Duals populations. • We anticipate our administrative expenses to be about five million ($4.7M) lower than the preliminary budget. As we see month after month, the decrease is driven by delayed hiring and the timing when positions will actually be hired and a delay in projects. • By the end of the fiscal year, we expect our full-time employees (FTEs) to be at four hundred-eighty-nine (489). This reflects an addition of seven and a half (7.5) Administrative FTEs and four (4) Clinical FTEs from the Preliminary Budget.		

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	CalAIM Incentives: • From an incentive perspective, we have more clarity on our CalAIM Incentives. We forecast maximum potential CalAIM Incentives from 2021 through 2024 total eight million dollars ($80.4M). To date, we have been awarded fifteen-point three million dollars ($15.3M) and paid out eight-point-five million dollars ($8.5M). • Most of the CalAIM funds will be passed onto our community partners. • CalAIM Incentives of thirty-point-three million ($30.3M) are assumed in the Final Budget from November through June of next year. • We have broken out the Incentive Programs – the bulk of what we are earning is through Housing and Homeless Incentive Program, which will be about twenty-four million dollars ($23.9M). • Six million dollars ($6.0M) will be through the CalAIM Incentive Payment Program, and about half a million ($0.4M) related to Student Behavioral Health Incentive Program. Areas of Uncertainty: • There are some things that are still uncertain and will potentially impact on our final budget that will be reflected in our future forecast. One is enrollment – significant changes in enrollment are estimates based on limited DHCS data. We have several Members that will be transitioning from fever service into managed care by 2024. The State has indicated 99% of beneficiaries that are currently in Fee-for-Service will be transitioned into Medi-Cal Managed Care by the end of 2024. We don't know when that will happen, but it will happen sometime in the next year or two. • The State's delay of Medi-Cal base rates for calendar year 2023 is also an area that remains uncertain, as well as performance metrics and CalAIM Incentives; how much we earn will determine if the metrics are met. There is potential risk if we pay out more than what we earn based on our performance metrics. • The State is dividing members by categories of immigration status; although DHCS is aiming for budget neutrality, there is risk that there may be some adjustments made to the rates as the State looks further into this. • The number and cost of major organ transplants have been conducted, although it is difficult to predict. To date, the number of transplants has been less than anticipated.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	• Contracted rate negotiations with our providers and hospitals, and there may be some changes to our future contracts that may potentially impact on our final budget. Membership Forecast: • Our Medi-Cal enrollment is forecasted to peak in May and ends the year at three-hundred-fifty-seven thousand (357,000) members. We have about twenty-nine thousand members (28,800) that are anticipated to transition from Medi-Cal Fee for Service. • The largest transitions include about twenty-two thousand Dual members (21,500). Some are related to Long-Term Care, and some are related to system issues DHCS had. The issues have been corrected, and they are transitioning those members into the Managed Care population. We also have some seniors and persons with disabilities that are transitioning along with additional optional expansion members. We have seen and will expect significant increases in the numbers of categories of aid, with the largest being in the duals, which will double the duals population from the current period. • We forecast group care to remain relatively flat with no significant changes. • The Public Health Emergency and the timing of when it ends will be very important; it impacts both revenue and expenses, as well as an impact on our FTE and our administrative expenses. When we think enrollment will peak and when it will start to decrease and the rate it will decrease significantly impacts our financial statements, administrative expenses, as well as medical expenses. • The transition to the Single Plan Model in 2024 will also have a net effect on our membership; there is a lot that we are considering by the end of the fiscal year, but also into the next fiscal year. • We are forecasting a significant increase starting in January and peaking in May, and then a small decline. Right now, we have about a one percent (1%) decline for the last several months. However, this is an area of uncertainty, both when the PHE will end and when disenrollment will begin again, and the rate at which our members will start to decline.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Membership Forecast by Population: • Forecasted by category of aid, our populations Optional Expansion and Child will be the largest, with our Adults third, and our Duals increasing. The other populations are relatively stable. • There will additionally be two new categories of aid related to Long-Term Care as well. Revenue: • We are anticipating ending the year at one-point-five billion dollars ($1.5B) a year. We are forecasting significant growth both in revenue and expenses from the prior year. • We have almost doubled our revenue in the last six (6) years, which is significant growth. The bulk of that is related to significant increases in membership along with some changes to programs, with DHCS shifting some of the programs they were responsible for to Managed Care. Medical Expense: • We expect to see an increase in our expenses; hospital contract changes may exceed six million dollars ($6.0M). We are looking at that and continuing to negotiate contracts with our hospital and provider partners. • Long-Term Care revenue and expense we are assuming will be neutral to our bottom line. • Medi-Cal enrollment: The increase in enrollment has an increase in our medical expenses, we assume by about fifty million dollars ($50.0M) compared to our preliminary budget. Comparison to Preliminary Budget: • There are forecasted significant changes to our revenue related to enrollment, so the number of enrollees and how long they have been enrolled has an impact on revenue. • Along with the changes in medical expenses, adding new categories of aid and Long-Term Care, potential changes to Major Organ Transplant rates have impacts on the final budget. Question: I want to know what this means, especially for those duals – our Kaiser members that I assume will join us in January 2023. Are we going to coordinate care?		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Answer: We don't have a lot of details on the profile of those members, but you are correct – I would assume some of those members already have Kaiser for Medicare, so I would expect there to be some of those members that are rolling into the Alliance. We don't have the numbers of what those will be, but that will be something we will have to work with Kaiser and coordination of care. I also would expect some members that are already enrolled in Kaiser to enroll in the Alliance as well. Dr. O'Brien provided the following comment: • Almost always, the patient comes in with Kaiser, I would assume very strongly that those patients are going to want to be a part of Kaiser. I would assume they would be delegated to Kaiser through us. If we had a member we would be fully prepared to be able to dialogue with, but we have no circumstances in which we have a patient who has Kaiser and us. Question: When we delegate to Kaiser, do we have a mechanism to track quality outcomes? Answer: Absolutely, we look at all of our delegates and look at their quality scores. Kaiser has excellent quality scores, but yes, we have ways of looking by specific populations and tracking these members. Question: I would expect their quality scores to be excellent on the medical side, but I am not sure I have seen what their quality scores would look like when it comes to Long-Term Services and supports and other non-medical measures. I don't know if it exists or not? Answer: That is a good point and they definitely have less experience in that area – it is not traditionally one of their offerings. Matthew Woodruff provided the following comment: • You are correct, Dr. O'Brien, those would be delegated back to Kaiser. Staffing Comparison to Preliminary Budget: • From our preliminary budget to our final budget, we have had an increase of eleven and a half (11.5) FTEs.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Motion to Approve FY 2023 Final Budget as presented. A roll call vote was taken, and the motion passed		
8. c. REVIEW & APPROVE RESOLUTION #2022-05 NOMINATING DR. KELLEY MEADE FOR REAPPOINTMENT TO DESIGNATED HOSPITAL SEAT (REGULAR #15).			
Scott Coffin	Recommended Action: • Resolution #2022-05 nominates Dr. Kelley Meade for reappointment to the Designated Hospital Seat, Regular #15. • Dr. Meade's current term at the Alameda Alliance for Health Board Governors Hospital Seat will expire on February 25th, 2023. Dr. Meade has chosen to serve an additional four (4) year term. Discussion: • Resolution #2022-05 provides for the approval of documents for reappointment to the Hospital Seat. If the resolution is passed and adopted by the Board of Governors today, it will be sent to the Alameda County Board of Supervisors, who will vote on Dr. Meade's reappointment. Motion to Approve Resolution #2022-05 as presented. A roll call vote was taken, and the motion passed.	Motion to Approve Resolution #2022-05 Reappointing Dr. Kelley Meade to Designated Hospital Seat (Regular #15) Motion: Dr. Evan Seevak Second: Ms. Rebecca Gebhart Vote: Yes No one opposed or abstained.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
8.d. PUBLIC HEALTH EMERGENCY UPDATE			
Matthew Woodruff	Public Health Emergency (PHE) Overview: • The Public Health Emergency legislation had two (2) main parts – there was Program Requirements and Redetermination. • Program Requirement Changes: There have been over one hundred (100) program changes – we will touch on a couple of them. • Redetermination: Eligibility for disenrollment was not done during the Public Health Emergency and members are still able to enroll. PHE Impacts on the Alliance: • Telehealth – we connected to telehealth two times during the public health emergency. • 24-hour access code authorizations and payment guideline changes; our guidelines changed for COVID. We had to pay for these ourselves. • Texting for the Public Health Emergency: the Alliance was allowed to text for the public health emergency, and we still are. • Enrollment Growth. Changes after the PHE Ends: • Redetermination will begin, and there will be disenrollment. • The Alliance is working with Alameda County Social Services Agency (SSA) and Community Partners to assist members who are due for renewal and who may have recently lost coverage. We are working with SSA in a way we haven't been allowed to previously. We will also be assisting with Covered California transitions. • SSA will definitely take the lead, but we will be working with them and coordinating with them. We also want to coordinate with our community partners • On December 31st, 2022, we have a draft outreach plan due to the Department of Health Care Services. • Currently, the date of the ending of the Public Health Emergency is not final – the federal end date is January 11th. The Centers for Medicare and Medicaid Services (CMS) will provide sixty (60) day public notice.	Informational update to the Board of Governors. Vote not required.	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	• The official end date remains uncertain; we had heard the PHE would end in the first quarter, but now we are hearing it may end in June. It is currently estimated to end March 31st, 2023. • The State estimates that up to twenty percent (20%) of our members could be disenrolled when the Public Health Emergency ends. • We have a lot of community outreach planned, both through the Social Services Agency and through partnering with Covered California for outreach. We can only outreach to our members who are enrolled or who have been disenrolled. • Outreach Costs: We do not know yet what the cost will be, but it will depend on when the Public Health Emergency will end. We are planning to begin a budget February 2023 through June 2023, and budget for the next fiscal year July 2023 through June 2024. • Marketing Campaigns: We want to explore what to do for marketing campaigns; we have started discussing how we want to have separate outreach strategies for adults and children. We have discussed utilizing local television, radio, social media, texting which we have already been doing, postcards since members generally respond to those, and print ads. • With texting, postcards, and other forms of communication, our primary goal is to have direct outreach to members working with Federally Qualified Health Centers, Community Health Centers, and Community-Based Organizations. • Our next steps include drafting the Implementation Plan for the Department of Health Care Service's approval and coordinating with SSA. Additionally, we have started commencing the DHCS Ambassador Program, so all our outreach team are already Ambassadors. Our goal in these efforts is to reduce the State's estimate of twenty percent (20%) disenrollment. Question: What is the content and message of the outreach? Answer: There's two types of messages we can do – one is telling the member that "next month is redetermination month, did you know you can command redetermination? If you need help, you know where to go." The second type of outreach will be, "you were just disenrolled, let's talk about what we can do to get you re-enrolled again."		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Question: Could you clarify what you said about peds and adults, and is there anything anticipated to change the cadence y which the children go through redetermination? Answer: We were thinking about how do we target different populations, whether we need to work more with the screening, what the different groups we need to work with are to ensure that we are giving information to the right people at the right time. Upcoming Presentations: • We will also be presenting on Monday, December 12th with SSA at the Health Committee on both our roles throughout the Public Health Emergency and what we will be doing and how we will be doing it. • There is also another presentation on Monday with Alameda Alliance, Contra Costa, and Department of Health Care Services about how we can outreach to our members and providers. Public Comment: What is the stakeholder community engagement specifically around for ending of the public health emergency? Answer: We have not started our plan yet, but we would be happy to receive any feedback. Informational update to the Board of Governors. Vote not required.		
8.e. CalAIM UPDATES			
Dr. Steve O'Brien	CalAIM-Enhanced Care Management: • For Enhanced Care Management, full credit to Dr. Amy Stevenson who is managing that program for us as well as her team in case management, along with Dr. Carey. • New Populations of Focus related to Long-Term Care will be effective January 1st, 2023. We are not launching community supports, however, we will do a pilot of those community supports that relate to those ECM Populations because the real issue is those are primarily housing related		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
Ruth Watson	community supports. We have ECM Providers lined up to see them – two of our existing providers, CHCN and EBI will be working with some members at risk for institutionalization. • We also have two new ECM providers working their way through the process of getting credentialed – MedArrive and Institute on Aging, both of which have done ECM work in other counties in the Bay Area. They have a track record and hopefully can add to our capacity to provide mor eservices to our members. CalAIM – Duals Enrollment: • Currently, over seventy percent (70%) which equates to one-point-one million (1.1M) of beneficiaries are dually eligible for Medicare and Medi-Cal Managed Care. This will be twenty-one thousand (21,000) for the Alliance. • On January 1st, 2023, the coverage for Medi-Cal for most remaining dually eligible beneficiaries will change from Fee-for-Service (FFS) Medi-Cal to Medi-Cal Managed Care. Notices were sent out to members on November 1st of this year to notify. • Medi-Cal Managed Care enrollment will not impact a beneficiary's Medi-Cal providers or Medicare Advantage Plan – for now. We are not sure if this will change in the future. • If they have a standard Medicare provider that is not in the Medi-Cal network or they are assigned in a Medicare Advantage Plan, they will not need to be in the Medi-Cal Managed Care network to continue for these providers to provide care to their Medicare beneficiaries. We probably don't know who these providers are that are in the primary care physicians on the Medicare side. On coordinating – we are happy to coordinate, but we may not have the opportunity to do so because we won't always know who these members are assigned to from a Medicare perspective. However, they can reach out to us for some wrap-around Medicare services, and that is ECM in particular and Enhanced Care Management and Community Supports. If they are delegated to Kaiser, Kaiser already participates in ECM and Community Supports; for instance, if they are not with Kaiser, then they can reach out to us and we can provide ECM. Question: Doesn't Medi-Cal pay their part D drug premiums if they are a dual? Answer: Yes, if they are a dual, Part D is included and they do pay it. That would		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	be covered under the Medi-Cal pharmacy benefit. We do not cover it now and we do not cover regular Medi-Cal drugs.		
Dr. Steve O'Brien	CalAIM – Long-Term Care Carve-In: • The final Long-Term Care APL came out at the end of October. The teams have been working hard on deliverables and processes. • We had sixteen (16) deliverables submitted which included policies and procedures as well as program descriptions. Two (2) of these deliverables have already been approved by DHCS.		
Matthew Woodruff	• We have met our contracting requirement that required us to contract with a minimum of sixty percent (60%) of total eligible SNFs in the MCP's HEDIS Reporting Unit. • We are currently at seventy percent (70%) and increasing. We have contracted seventy-three facilities for Custodial Level of Care and fifty-one (51) of the seventy-three (73) are credentialed. • We have had three (3) Long-Term Care Provider Town Halls which went very well, and we learned a lot and received wonderful feedback from the providers. We had over one hundred and fifty people at the town halls; it went very well.		
Dr. Steve O'Brien	• It was a great interaction and primarily, we shared contact information. We wanted them to know who to contact and how to make it simple to contact. • We received the DHCS Member Data; it wasn't particularly clean data – it was complete in certain areas and not in others. We have requirements for continuity of care – a year for the facility and a year for the provider, ninety days (90) for the services like transportation or CPAP services. • There are pre-existing treatment authorizations (TARs) and we are uploading as much as we can from the State file to ensure that people have active TARs and continue through that process. We know that there will be plenty of manual entry and manual processes – we are preparing for that as well in terms of contingency planning with a lot of crossover coverage from all of our departments.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	• We anticipate that hopefully a lot of the data is accurate, but we know there will be some patients who weren't on the list. We are preparing our provider partners to get a hold of us quickly to ensure we get people on coverage. Our Integrated Planning Division is putting together a command center that will go live on January 1st where we will have representatives from across the organization who will be ready to handle acute issues as they arise. Population Health Management: • The PHM APL was finalized at the end of November, which means we have ninety (90) days to update and submit any relevant policies and procedures to DHCS. We have already submitted some of our deliverables and we received some clarifying questions back from DHCS today. • One thing we want to point out from this APL is the focus on transitions of care – there are new specific requirements. It has not been a called-out case management service, but it is now. In January, it is high-risk members who we have to identify through an algorithm. In July, the State will give us their algorithm and we must ensure transitional care services for all high-risk members. However, by January 2024, we are required to ensure all transitional care services are complete for all members. Informational update to the Board of Governors. Vote not required.		
9. STANDING COMMITTEE UPDATES			
Dr. Steve O'Brien	The Peer Review & Credentialing Committee (PRRC) was held on November 15th, 2022. Dr. Steve O'Brien provided the following Committee updates: • At PRRC, there were one-hundred-sixteen (116) initial providers and one-hundred four (104) of those were behavioral health providers. • Twenty-one (21) providers were re-credentialed. The Health Care & Quality Committee (HCQC) was held on November 18th, 2022.	None	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Dr. Steve O'Brien provided the following Committee updates: • We heard the QI Program Evaluation and Workplans by two (2) of our delegates, Kaiser and Beacon. This will be the last QI Program we hear from our delegate Beacon, because we will be absorbing those responsibilities, so it will be part of our QI Program moving forward for the mental health services. • For Kaiser, we will have one (1) more year and after this coming year, they will stop being a delegate. • We also looked at our CAP results from our CAP survey, a PHM update which we just covered, some updates from Health Education Quality Initiatives, our P4P Program for this year, as well as PQI's. Question: The behavioral health providers differentiated by their degree and training? Answer: Yes, we have a new breakdown that we will bring to the next meeting. We have psychologists, psychiatrists, and more. 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

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS			
Scott Coffin	None	None	None
13. PUBLIC COMMENT (NON-AGENDA ITEMS)			
Dr. Evan Seevak	None	None	None
14. CLOSED SESSION			
Dr. Evan Seevak	PROPOSED ACTION ON MATTERS INVOLVING TRADE SECRETS (WELFARE & INSTITUTIONS CODE SECTION 14087.35). THE PROPOSED ACTIONI WILL CONCERN A NEW LINE OF BUSINESS; PROTECTION OF ECONOMIC BENEFIT TO THE HEALTH AUTHORITY. ESTIMATED PUBLIC DISCLOSURE WILL OCCUR IN THE MONTH OF JANUARY 2025.	None	None
15. ADJOURNMENT			
Dr. Evan Seevak	Dr. Evan Seevak adjourned the meeting at 1:50 pm.	None	None

Respectfully Submitted by: Danube Serri, J.D.
Legal Analyst, Legal Services.