ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

January 22nd, 2025
8:00 am – 9:00 am

SUMMARY OF PROCEEDINGS

Meeting Conducted in-person and by Teleconference.

Committee Members in-person: Dr. Rollington Ferguson, Rebecca Gebhart, James Jackson, Yeon Park, Gil Riojas
Committee Members by Teleconference: None
Committee Members Excused: None
Board of Governor members in-person and on Conference Call: Andie Martinez Patterson, Andrea Schwab-Galindo, Dr. Evan Seevak, Dr. Marty Lynch, Dr. Kelley Meade, Wendy Peterson

Alliance Staff in-person and on Conference Call: Matt Woodruff, Dr. Donna Carey, Tiffany Cheang, Sasi Karaiyan, Richard Golfin III, Lao Paul Vang, Ruth Watson, Yen Ang, Shulin Lin, Linda Ly, Brenda Martinez, Felix Rodriguez, Danube Serri, Christine Corpus, Charles Walmann, Corry Keenan, Tome Meyers

CALL TO ORDER

Dr. Ferguson convened the Finance Committee meeting at 8:00 a.m.

ROLL CALL

Roll call was conducted and confirmed.

INTRODUCTIONS

There were no introductions.

CONSENT CALENDAR

Dr. Ferguson presented the Consent Calendar.

There were no modifications to the Consent Calendar, and no items to approve.

a) CEO UPDATE

Matt Woodruff provided an update on the CEO's plans regarding Medicare, discussing the finalized APL on D-SNP and the lack of a delay option. He emphasized the importance of financials and recommended starting small with Medicare and gradually expanding to keep out commercial plans and ensure financial stability and readiness.

The plan needs to report six months of income to come off the DMHC watch list, projecting this to happen from January to June, with the goal of being off the watch list by July.

We need to achieve six months of financial readings to come off the DMHC punch list, projected from January to June, with a possibility of being ready by July. Our financials will dictate our decisions, as emphasized by DMHC.

Question: Dr. Seevak requested additional information regarding being on the watchlist.

Answer: Matt explained it was a precautionary measure due to the financial trends, despite not falling below any required thresholds. Starting in November, the Plan began reporting monthly financials to DMHC. It is projected that we will be off the watch list by July if financials improve.

b) REVIEW AND APPROVE THE NOVEMBER 2024 MONTHLY FINANCIAL STATEMENTS

NOVEMBER 2024 Financial Statement Summary

Enrollment:

Enrollment increased by 725 members since October and an overall increase of 2,888 members since June 2024.

Net Income:

For the month ending November 30th, 2024, the Alliance reported a Net Loss of $27.5 million (versus budgeted Net Loss of $10.0 million). For the year-to-date, the Alliance recorded a Net Loss of $88.5 million versus a budgeted Net Loss of $71.0 million.

Premium Revenue:

For the month ending November 30th, 2024, actual Revenue was $174.2 million vs. our budgeted amount of $173.2 million.

Medical Expense:

Actual Medical Expenses for the month were $194.7 million, vs. budgeted amount of $174.9 million. For the year-to-date, actual Medical Expenses were $898.8 million vs. budgeted Medical Expense of $879.0 million.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 111.8%. The year-to-date MLR was 106.6%.

Administrative Expense:

Actual Administrative Expenses for the month ending November 30th, 2024, were $9.0 million vs. our budgeted amount of $10.2 million. Our Administrative Loss Ratio (ALR) is 5.2% of our Revenue for the month, and 5.7% of Net Revenue for year-to-date.

Other Income / (Expense):

As of November 30th, 2024, our YTD interest income from investments show a gain of $15.0 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending November 30th, 2024, we reported $63.7 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of $63.6 million. Our MCO Tax Expense was $63.7 million vs. budgeted MCO Tax Expense of $63.6 million.

Tangible Net Equity (TNE):

For November, the DMHC requires that we have $78.9 million in TNE, and we reported $166.9 million, leaving an excess of $88.0 million. As a percentage we are at 212%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported $503.4 million in cash; $386.4 million is uncommitted. Our current ratio is above the minimum required at 1.12 compared to regulatory minimum of 1.0.

Capital Investments:

We have acquired $530,000 in Capital Assets year-to-date. Our annual capital budget is $1.7 million.

Question: Mr. Jackson inquired about inpatient expenses, wondering if there will be an adjusted assessment based on the level of sickness. He asked whether this adjustment would be considered in our next budget or if we anticipate that the level of need will be reduced due to the measures we have implemented this year.

Answer: Gil stated that we will update our forecast in response to the increased trends reflected in our quarterly forecast. However, some of these expenses will be partially offset by increased revenue expected in calendar year 2025, as the state has raised our rates to reflect our higher costs. We will also incorporate these changes into our preliminary budget for 2026.

Question: Ms. Gebhart asked if the state's adjusted 2024 rates are reflected in the November financials.

Answer: Gil says it's not reflected in the November financials, but it is going to be reflected in December.

Question: Dr. Ferguson asked Gil for his assessment of specifically on where we are going and what is the overall sense in terms of our financials.

Answer: Gil mentioned that 2024 was a challenging year due to unexpected paybacks to the state and rising medical expenses. Teams are actively working to identify cost-saving measures. He expressed hope for 2025, citing anticipated rate increases that could improve the situation, although medical expense trends remain a concern. Gil reassured that they will continue to focus on managing costs effectively while looking forward to enhancing the bottom line.

Motion: A motion was made by James Jackson, and seconded by Yeon Park, to accept and approve the November 2024 Financial Statements.

Motion Passed

No opposed or abstained.

c) BUDGET UPDATES – RATES AND DECEMBER FINANCIAL RESULTS

Calendar Year 2024 Rate Update

- 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 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 approximately $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 recent CY24 rate increase.
- Final budget estimated $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.

Question: Dr. Ferguson has a question about major organ transplants. For heart patients, before the actual transplant at UCSF, there's complicated management involved. Is this considered part of the transplant process or only after the surgery?

Answer: Gil explained that while some expenses are captured in pre- and post-transplant care, the main cost comes from the transplants themselves, which were lower than expected. The state anticipated a higher number of major organ transplants, allocating funds accordingly. Since the actual utilization did not meet those expectations, they now need to repay a significant amount to the state, as the reported costs couldn’t fully offset the transplant expenses.

Question: Ms. Gebhart asked if the major organ surgical events we perform align with state expectations and if they are influenced by the external provider network, or if there are internal efforts to increase these events.

Answer: Matt stated that there haven't been many transplant cases due to extensive pre-work and follow-up. They need to assess whether patients are ready before authorizing the procedure, especially with a significant payback to the state. They prefer that members get the transplant.

Question: Ms. Park inquired whether we have data on the amount of money paid through fraud and abuse cases.

Answer: Gil noted they are refining criteria to identify potential fraud, estimating up to half a million dollars based on current analysis. While initial community support criteria were broad, they anticipate future data insights.

Question: Dr. Ferguson noted that our potential savings of 8 million annually are quickly outpaced by monthly medical expenses, indicating a need for deeper analysis. Rebecca highlighted that inpatient and long-term care costs drive many overruns and questioned whether adjusting rates alone can resolve these issues. She also referenced Dr. Carey's suggestion for increased outreach in long-term care facilities due to possible over-authorization of services.

Answer: Matt reported that the claims authorization limit project focuses on inpatient care, complying with legal guidelines. Gil mentioned that the expected rate increase will positively impact the budget. Dr. Carey noted rising medical expenses due to a sicker membership but confirmed the average length of hospital stays is appropriate. The team is targeting readmissions

for improvement, enhancing transitions of care and refining community support criteria to ensure resources are effectively used.

Question: Ms. Park asked what the criteria updates are for community supports.

Answer: Dr. Carey mentioned that we currently have eleven community supports and are revisiting guidance from DHCS to align our criteria with their policy guides. We're also collaborating with our compliance team to ensure proper coordination.

d) MEDICARE DISCUSSION

Gil and Matt presented two scenarios for the D-SNP implementation in 2026.

Business as Usual – Scenario 1

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

Delay until 2027 – Scenario 2

Scenario 2 has been removed from the discussion because last week, the state issued an APL indicating that we must start D-SNP in 2026.

Reduced Scale – Scenario 3

- 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 stand up a DSNP remain.
- This allows the Alliance to enter the market on a small scale while learning from 2026 experience.
- Total FTEs dedicated to DSNP are 60 costing $27.3 million for Calendar Years 2025 through 2027.
- Consulting and vendor costs 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: James sought clarification regarding the estimated losses. In the first scenario, the total estimated loss over three years is 52 million. In the subsequent scenarios, the total estimated losses are 39.7 million and 40.1 million. Are these also calculated over a three-year period?

Answer: Gil explained that for the same period, we had more savings in the second scenario because it started in 2027, resulting in lower medical expenses over three years. However, this option is no longer available. The remaining options are Scenario 1 and Scenario 3.

Question: Dr. Seevak asked why we chose 1,500 members instead of 2,000 or 1,000. He noted that fewer members likely mean lower medical expenses but is concerned about those not being served as the number decreases.

Answer: Matt mentioned that the projections for the 4,000 members and 1,500 members are based on a full year, with both targets set for the end of the calendar year. Starting in January and considering scenario #3, we plan to focus on one to three small community sites throughout the year rather than a large launch to effectively work with these select locations across the county.

Matt recommended Scenario 3, not only due to its financial advantages and the required work, but also because it keeps other providers out of the county. This approach strengthens our position in the marketplace.

UNFINISHED BUSINESS

There was no unfinished business.

PUBLIC COMMENTS

There were no public comments.

ADJOURNMENT

Dr. Ferguson adjourned the meeting at 9:09 a.m.