ALAMEDA ALLIANCE FOR HEALTH
BOARD OF GOVERNORS
REGULAR MEETING
July 8th, 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, Dr. Marty Lynch, Byron Lopez, Dr. Rollington Ferguson, James Jackson, Dr. Noha Aboelata, Dr. Michael Marchiano, Aarondeep Basrai, Andrea Schwab-Galindo, Natalie Williams

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: Supervisor Dave Brown

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

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
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 July 8th, 2022, Consent Calendar. a) June 10th, 2022, Board of Governors Meeting Minutes b) July 5th, 2022, Finance Committee Meeting Minutes Motion to Approve July 8th, 2022, Board of Governors Consent Calendar. A roll call vote was taken, and the motion passed.	Motion to Approve July 8th, 2022, Board of Governors Consent Calendar. Motion: Dr. Rollington Ferguson Second: Dr. Kelley Meade 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 telephonically on July 8th, 2022, at 10:30 am. Rebecca Gebhart gave the following Compliance Advisory Committee updates. 2022 DMHC Behavioral Health Investigation: • Pertains to the commercial line and is now actively in the pre-audit phase. This is a Mental Health Parity and Addiction Equity Act (MHPAEA) audit. The audit is complex, and the State has undertaken now for a second year and applies only to our commercial lines and group care. • The State has requested, and we have submitted over one thousand (1,000) documents. The pre-audit phase ends today. • A question was asked about how they are going to establish the Chief of Health Equity, and the answer was that they are reviewing files from multiple parts of the system, both on the behavioral health side and on the medical side, in order to establish parity or lack-there-of. • This is an extremely comprehensive audit, which includes interviews of our local providers. The State may also be interested in gauging how the local initiatives and commercial plans differ in dealing with parity issues. This audit will be going into the regular audit phase soon, and in the next couple of months, we will get information about the audit outcomes. Question: This is a standard audit, and it isn't the result of a complaint? Answer: No, this is not the result of a complaint. This is from the State, and they are doing it systematically; we just happen to be in the second batch, and it is not due to a complaint against the Plan. Internal Delegation Oversight Committee: • The internal delegation oversight committee within the Plan oversees the performance and ensures compliance and accreditation and many other requirements of our delegates.	Informational update to the Board of Governors. Vote not required.	

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	• In their meeting, they review the status of the various audits, and anything that may have come up as a rebuild of something going on with the delegates. • There is a document, "Delegation Grid" which lists all of our delegates and specifically what they are delegated for. For example, Kaiser is a closed system, so they are not delegated – they are delegated to handle their own grievance, whereas we handle grievances for other delegates. Delegation Audit Schedule: • We looked at the delegation audit schedule, which is where we are auditing our delegates in the same way that our regulatory agencies are auditing us. • This is used as a planning tool that provides which delegates will be audited and when. The Committee reviews this at the beginning of the year; it is a helpful and comprehensive planning tool on the delegate audit side. • The delegate audit process occurs concurrently with our own regulatory audit process and general audit season, so at the same time that we have multiple audits with our delegates, we are also in audits with our regulatory agencies. Delegation Reporting and Escalation Protocols: • The document differentiates between routine issues and egregious issues. It also provides examples of routine issues, which generally are no system-wide implications, and a non-systemic infraction; for example, it could be a lack of record-keeping in particular situations. • Egregious issues require immediate escalation. Egregious issues are systemic deficiency with system-wide implications or a specific situation surrounding a death, etc., and utilization management issues impacting members. • The document also addresses escalation protocols for egregious issues, such that the compliance director must report to the CEO with five (5) calendar days, and the CEO must report to the Board within seven (7) calendar days. The agency then has twenty-one (21) calendar days to report to the regulatory agency.		

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	Informational update to the Board of Governors. Vote not required.		
6. b. BOARD MEMBER REPORT – FINANCE COMMITTEE			
Dr. R. Ferguson	The Finance Committee was held telephonically on Tuesday, July 5th, 2022. Since Dr. Ferguson was not present for the meeting, Dr. Marchiano provided the following updates: Highlights: • Our enrollment has increased by over two thousand (2,000) members since April 2022, and by over twenty-two thousand (22,000) members over the past year. Higher enrollment is partly due to the Public Health Emergency, which is expected to end in October 2022. • For the fiscal year-to-date (YTD) ending May 31st, 2022, actual revenue was $1.1B and the budgeted revenue was also $1.1B • We looked at the TNE and MLR parameters to help the organization remain favorable. Our TNE exceeds the DMHC's requirement. Informational update to the Board of Governors. Vote not required.	Informational update to the Board of Governors. Vote not required.	None
7. CEO UPDATE			
Scott Coffin	Scott Coffin, Chief Executive Officer, presented the following updates:	Informational update to the Board of Governors.	None

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	Scott began by thanking the Alliance staff for their hard work in reaching one hundred percent (100%) compliance on regulatory metrics in the month of May. Key Performance Indicators: • Regulatory Metrics: The regulatory metrics were fully met. • Non-Regulatory Metrics: We are continuing the work on non-regulatory metrics. The member services team and our call center team have been stepping up to answer the calls that come in, nearly thirteen thousand (13,000) calls per month. • Customer service is a key component of our operations, and the team has been working very hard to reduce the wait time for our members and the abandonment rate each month. Anastacia Swift, Chief Human Resource Officer, provided the following update on Staffing: • Our current recruitment rate is at eighteen percent (18%). From last month, we have added approximately twenty-four new positions (24) among which we have budgeted for the different programs. We have a timeline to start recruitment efforts for these positions. • Over the past month, we have had twenty-four (24) new hires, many of which had start dates in June, and some in July. • We are working on filling our recruiter positions internally for the Alliance. Additionally, the external recruiters we are working with are receiving our listings for them to source for candidates for the upcoming programs. These recruiters understand the timelines and start dates we are following, and we are giving them sufficient time to source within those timelines. • Furthermore, our hiring managers internally are aware of the timelines corresponding to both sourcing for candidates through external as well as internal efforts. Preliminary Budget – Fiscal Year 2023: • As previously stated last month, for FY2023, we have seventy-eight positions that have been approved.	Vote not required.	

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	• We are not hiring for all these positions in the first quarter of the fiscal year; however, we have initiated the recruiting efforts. Program Implementations: • During each Board meeting, we present on the highest priority Medi-Cal initiatives, one of which is on the insourcing of Mental Health and Autism Spectrum Services. The insourcing for the Mental Health Services is November 1st, 2022. • Quality/Quality Improvement: The Department of Health Care Services (DHCS) announced a Medi-Cal quality component that will be applied to the base Medi-Cal rates starting in the Calendar Year 2023. • For the 2023 Implementation of Quality component, the requirement will be based on a proposed set of HEDIS measures of Calendar Year 2021. We have a projected score of seventy-five percent (75%) that is yet to be validated by the State. • The quality component is being highlighted to the Board Members for purposes of discussion, as we present the final budget as we are factoring in the potential impact to the rates. We will go more into the details when the State finalizes the proposed set of ten to fifteen (10-15) HEDIS measures. Question: Your understanding is that this is a withhold for not meeting metrics, and not a bonus for doing well? Answer: Correct, however, there is a defined amount of funding that is based on our rates being paid. For example, if one Plan does better than the other in a two-plan county, the Plan that did better will gain more of those dollars as a bonus in addition to the base rate. Question: To clarify, if we do well on our metrics, we can get more funding, and if we don't, we get less? Answer: Yes, there is a comparison between the two plans. There will also be a baseline that is established for single-plan counties.		

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	Single Plan Model: • The Department of Health Care Services (DHCS) has provided a deliverable submission timeline for the next eighteen (18) months. We are currently working on the first submission, due August 12th, 2022. A series of documents are being prepared and going through our Compliance division. We will keep the Board apprised as we go through the Single Plan Model process. • Effective on January 1st, 2024: Implementation of the Single Plan Model. Question: Are the deliverables solely from the Plan, or are there any from Alameda County? Answer: There are two-hundred-forty-six (246) deliverables and based on the review of the deliverables due in Phase 1 and Phase 2, the assessment is whether the Plan has existing infrastructure to submit those deliverables. We have not completed a review of whether deliverables would be required from the County or any other entity. We will expand our review and report back to the Board. CalAIM Incentives: • Last month we distributed a table showing our incentive programs; we will update this table each time there is an action taken in terms of dollar allocations. • Item number three, which is the CalAIM Incentive Program reflects the activities between last month and this month. We have advanced through the first wave of funding, which is also an application process where we invite our community-based organizations here in Alameda County to participate. They go through an evaluation process that examines the compliance of the request to the parameters for the CalAIM Incentive Program. • We have three-point-seven million dollars ($3.7M) that is approved. We have a second wave of funding that is beginning – Tiffany Cheang and her team are coordinating across the organization. • There is required criteria defined by the State that we are following. Additionally, we have developed a process for how we are doing the evaluations, including the scoring, and awarding. The Team has done a great job on the CalAIM Incentive Program. • The Housing and Homelessness initiative also provides significant opportunity; there is a lot of work involved with this one, and we are using		

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	the same process and framework that has yielded results for these other incentive programs. • We will be reporting on these incentive programs to demonstrate full transparency – the money that we receive from the State for these programs and goes into the community is very important to the organization. Therefore, we will be keeping close optics on that. • We will be forecasting administrative costs associated with the incentive programs; we will be transparent in showing what money we received and what money was paid out. Question: Can you please clarify the difference between awarded and approved? Answer: (Tiffany Cheang) The awarded amount is what comes directly from the State. The approved amount is what we approved for distribution. Question: The way we did with the vaccine – will there be descriptions where we listed the grants our partners received? Answer: Yes, we will be making that available. Informational update to the Board of Governors. Vote not required.		
8. a. BOARD BUSINESS – REVIEW AND APPROVE MAY 2022 MONTHLY FINANCIAL STATEMENTS			
Gil Riojas	Gil Riojas gave the following May 2022 Finance updates: Enrollment: • For the month ending May 31st, 2022, the Alliance had an enrollment over 310,000 members, a net income of $5.2M, and the Tangible Net Equity (TNE) was 594% of the required amount. • Our enrollment has increased by over 2,000 members since April 2022, and on a fiscal YTD, we gained over 22,000 members since June 2021. This is primarily due to the Public Health Emergency and the extension of it. We are expecting the Public Health Emergency to end in October;	Motion to Approve May 2022 Monthly Financial Statements as presented. Motion: Dr. Rollington Ferguson Second: Dr. Michael Marchiano Vote: Yes	None

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	however, it may be extended. If it is extended, it will have implications on our membership in FY2023. • Our seniors and persons with disabilities enrollment is going up slightly, and our group care line of business has remained flat for twelve (12) months. Net Operating Results: • For the fiscal YTD ending May 31st, 2022, the actual net income was $20.3M. We have done well this past fiscal year in part due to savings on administrative expenses. Revenue: • For the month ending May 31st, 2022, the actual revenue was $99.4M vs. the budgeted revenue of $96.8M. • For the fiscal year ending May 31st, 2022, the actual revenue was $1.1B vs. the budgeted revenue of $1.1B. • For the month ending May 31st, 2022, the favorable revenue variance of $2.6M is largely due to favorable $1.5M CalAIM Incentive Revenue, favorable $470,000 Medi-Cal Base Capitation Revenue, and favorable $381,000 Student Behavioral Incentive Revenue, offset by unfavorable $378,000 Behavioral Health Supplemental Revenue. The favorable Medi-Cal Base Capitation Revenue variance of $470,000 is net of unfavorable $1.4M DHCS recoupment resulting from Date of Death Audit. Question: The first recoupment was $2.6M, and the second recoupment was $1.4M? And it was the same timeframe when they went back to 2011? Answer: Correct. They went back to 2011 and went forward to calendar year 2022. Medical Expense: • For the month ending May 31st, 2022, the actual medical expense was $89.1M, and the budgeted medical expense was $86.8M. • For the fiscal year ending May 31st, 2022, the actual medical expense was $1.0B vs. the budgeted medical expense of $992.4M.	No opposed or abstained.	

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	• We had a slight decrease in our Incurred-But-Not-Paid (IBNP) claims estimate of $750,000, that reduced our Medical Expenses slightly. • We are about thirteen million ($13.0M) over our budget in terms of medical expenses, primarily driven by increase in enrollment. • On a PMPM basis, medical expense is 0.8% favorable to the budget. Medical Loss Ratio (MLR): • For the month ending May 31st, 2022, the MLR was 89.6% and 92.7% for the fiscal year-to-date. • Ideally, we would like to maintain our MLR between 90.0% and 95.0%. Administrative Expense: • For the month ending May 31st, 2022, the actual administrative expense was $5.6M vs. the budgeted administrative expense of $6.7M. • For the fiscal YTD ending May 31st, 2022, the actual administrative expense was $59.1M vs. the budgeted administrative expense $74.5M. • For FY2023, we will be doing significant hiring – we are anticipating in our budget to hire seventy-eight (78) people. The goal is to narrow the gap between actual and budgeted, particularly for employee expense since this is a category that is of significant expense for FY2023. • Our administrative loss ratio (ALR) for the month was 5.6% of net revenue and 5.4% of net revenue year-to-date. • Our budget target for FY2022 was about seven percent (~7%) – we are below that, which is positive. Other Income / (Expense): • As of May 31st, 2022, our fiscal year-to-date net investment revenue reported an eighty-two-thousand-dollar loss ($82,000). We anticipate this number to change. • Fiscal-year-to-date claims interest expense from July 2021 to May 2022 is three-hundred-sixty-three thousand dollars ($363,000).		

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	Tangible Net Equity (TNE): • The Department of Managed Health Care (DMHC) requires TNE to be thirty-eight million dollars ($38.0M). • We reported an actual TNE of two-hundred-twenty-five-million-dollars ($225.8M), and an excess TNE of one-hundred-eighty-seven-million-dollars ($187.8M). • Of the required TNE, we have five-hundred-ninety four percent (594%). Cash Position and Assets: • For the month ending May 31st, 2022, the Alliance reported $297.9M in cash; $196.7M in uncommitted cash. Our current ratio is above the minimum required at 1.72 compared to the regulatory minimum of 1.0. Capital Investment: • Fiscal year-to-date capital assets acquired: $234,000. • Annual capital budget: $1.4M. • For FY2022, capital investments are primarily related to our generator this year that we installed in the office building. We also continue to acquire IT assets as we increase our memory and storage. Question: Do you have a sense of how June is going to be? Answer: Right now, we are going through our Moss Adams audit; I would suspect the results to be favorable, over the last several months we've seen favorability in our trends in both revenue and expenses. I anticipate this will continue. Motion to Approve May 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 AND APPROVE RESOLUTION #2022-02 NOMINATING YEON PARK FOR APPOINTMENT TO DESIGNATED AT LARGE LABOR SEAT			
Scott Coffin	Staff Report: • Due to the resignation of Nicholas Peraino, the Alameda Alliance for Health "Alliance" Board of Governors has a vacancy for the At-Large Labor Seat (Regular #4). • The Executive Committee of the Board has recommended Yeon Park, a labor union leader, from SEIU Local 1021, as the nominee for this vacant seat. Motion to Approve Resolution #2022-02 Nominating Yeon Park for Appointment to Designated At Large Labor Seat as presented. A roll call vote was taken, and the motion passed.	Motion to Approve Resolution #2022-02 Nominating Yeon Park for Appointment to Designated At Large Labor Seat as presented. Motion: Dr. Evan Seevak Second: Dr. Marty Lynch Vote: Yes No opposed or abstained.	None
8. c. LONG TERM CARE INSOURCING UPDATE, MENTAL HEALTH MILD-TO-MODERATE & AUTISM SPECTRUM DISORDER SERVICES			
Ruth Watson	Presented by the Integrated Planning, Health Care Services, and Operations Division Leadership Teams. CalAIM Long Term Care Carve in Agenda: • This is an enterprise-wide program and involves our partners from outside of the organization. • The Program Scope encompasses the Critical Path and requires us to have the following: Provider Contracting and Credentialing, Workflows and	Informational update to the Board of Governors. Vote not required.	None

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Matthew Woodruff	Process Requirements, System Development and Configuration, Staffing, Cultural Competency, and Financial Forecast. • We will also review the timeline, risks, and mitigation, as well as have a discussion. Program Scope: • Long Term Care (LTC) is currently not the responsibility of Alameda Alliance; however, the Plan will be responsible for LTC Skilled Nursing Facility (SNF) and Custodial Care, effective January 1st, 2023. • The Alliance is currently responsible for the month of admission and the month after for a sixty (60) day period. • The LTC Sub-acute, Intermediate Care Facilities (ICF) and Institutions for Mental Disease (IMD) will transition to MCPs no earlier than July 1st, 2023. • The transition with two LTC Populations of Focus that also go live on January 1st, 2023: (1) Adults Living in the Community at Risk for LTC Institutionalization and (2) Nursing Facility Residents Transitioning to the Community. Critical Path: • Provider Contracting and Credentialing: Ensuring Continuity of Care is critical for all transitioning members making contracting/credentialing an essential and expansive effort. We currently contract with sixty-four (64) SNF facilities, and contracts will be amended to include the new requirements. • We have nearly nineteen hundred members currently with LTC Aid Codes (1,891). Member-specific data is expected from DHCS in November. The data will provide information on which facility each member resides in, and the implementation team will utilize the data to address any gaps in the SNF network. Additionally, we are contracting with SNF medical providers as well as other providers serving LTC members. Question: There are six hundred long-term care facilities in the county, do you have to have amendments for all of them? Answer: The six hundred encompasses everything discussed in the previous slide. What we are focusing on right now are the sixty-four (64) SNF facilities we are contracting with. On June 27th, we received data estimates from DHCS. There is		

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Tami Lewis	a chance that the beneficiaries are not listed accurately. We will know more when we receive the specific data in the coming months. Question: When a patient is discharged from the hospital to a long-term care facility – doesn't that sometimes occur across a county line? If this happens, how does the Plan handle that request? Answer: Yes, that does happen. We have a policy and plan for dealing with such requests. How we handle the request depends on the facility – for some members with certain complexities, they must go to a specific facility, and we go through an agreement basis where we contact the facility, negotiate the rate, how long the member will be staying and other logistics. Workflow & Process Design Requirements: • The development of business processes and understanding how we are going to manage all the various processes is key in successfully executing this insourcing. • As previously stated, this is an enterprise-wide initiative and encompasses multiple departments – Utilization and Case Management, Claims, Member and Provider Services. System Development & Configurations: • We need to understand what our business requirements are to develop systems and configurations. For example, we will be developing custom codes so that providers will be able to submit claims and process the information in our system and be able to report the information to the State in industry-standard coding. Staffing & Recruitment: • There will be a new long-term care department that is being created to support this initiative once we bring this in-house. Initially, there will be five (5) dedicated positions in Heath Care Services; however, other departments will also have supporting positions.		

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Annjanette Dixon	• Finance has estimated that the total staffing cost for this new department will be one-point-five to one-point-six million dollars ($1.5M - $1.6M) annually. Development of Cultural Competency for Older Adults & Long-Term Care Patients: • We will be expanding our understanding of the unique needs of Older Adults and physically disabled long-term care residents to support them both in terms of their clinical needs as well as their emotional needs. • In order to accomplish this level of understanding, we will schedule listening sessions with targeted stakeholders and create a Long-Term Care Collaborative as part of the countywide CalAIM Stakeholder Committee provide input from the community regarding the transition of this population to managed Medi-Cal. Provider Focus: • Additionally, we want to focus on the providers, and provider education and engage on the transition and timing, authorization request process, and new coding requirements. AAH Utilization & Clinical Impact: • The long-term care population is largely unmanaged since it is handled by Fee-for-Service Medi-Cal. • However, with this transition, there will be an increase in the number of members in acute care facilities; an increase in the number and complexity of Transitions of Care; an increase in focus on quality of care, palliative care and end of life issues for some of our most ill members; and adhering to regulatory recommendations for Continuity of Care requirements and Member Rights.		
Gil Riojas	Financial Forecast 2023: • In our preliminary budget, we anticipated around fifteen hundred (1500) members in total of long-term care, three hundred (300) of which are Medi-Cal only members and twelve hundred (1200) of which are long-term care duals. We will have additional information from the State in November.		

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	• We have budgeted around eighty million in revenue ($79.3M) and around seventy-eight million in expense ($77.7M) for the first part of the calendar year, from January to June of calendar year 2023. • The forecasted Medical Loss Ratio (MLR) is 98%. We anticipate our total cost will potentially be over the revenue that we receive. • The Department of Health Care Services (DHCS) has not established a risk corridor for long-term care. This may cause potential risk because our expenses could be significantly over our revenue. We don't anticipate that happening, however, we don't have the risk corridor that we do for other initiatives, such as major organ transplant.		
Tami Lewis	Timeline & Implementation Phases – CalAIM Long Term Care Carve-In: • Long-Term Care Provider Contracting is commencing, for the duration of July 15th, 2022 – November 1st, 2022. • The Training and Testing will be ongoing for the duration of October 1st, 2022 – December 31st, 2022. • We will go live with the Long-Term Care and Population Health initiative January 1st, 2023. • Once we have gone live, we will start the work for the remaining population that is scheduled to go live no earlier than July 2023 – this would be the Sub-acute, ICF, IMD, starting with provider contracting and credentialing. These are the members that we don't know what facilities they are in; therefore, we will have to determine whether we have contracts with these facilities or not. We will repeat the training and testing cycle, and then go live with that population no earlier than July 1st, 2023.		
Ruth Watson	Risks & Mitigation Plan: • With this transition, there are inherent risks that we identify on a regular basis as we manage the project. • One area of concern is Contracting and Credentialing. As stated previously, we have sixty-four (64) facilities requiring contract amendments and Providers Credentialing. Our Mitigation Plan is we are adding Contracting Specialist Consultants to work on Contracting. • Another area of concern is that DHCS will not be providing us with identified Member data with facility location until November 2022. There		

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Dr. Peter Currie	could be potential delays in getting Members loaded into our Systems to support care. This may also cause members to be placed in non-contracted facilities. Our mitigation plan is to use historical utilization and encounter data to try to predict location and volume, as well as have strong LOA process in place for missed facilities. • Lastly, we have staffing concerns as we need to hire for five (5) positions, which involves recruiting, onboarding, and training. A recruitment firm has been hired to support Long-Term Care and other hiring efforts. • There are many competing priorities, with risks of human resource and system constraints. However, we will continue to meet on a weekly basis to monitor performance and just resource assignments. • Our goal is to ensure everything goes smoothly as this transition impacts our most vulnerable members. Question: What if the Provider does not sign the contract or letter of agreement? Answer: Most of them already have a contract with the State of California. Mental Health Mild-to-Moderate & Autism Spectrum Disorders Service Domains: • There are seven (7) service domains that we transition from Beacon – we are about halfway through the process in preparing for the launch November 1st, 2022. • Care Transitions with some improvements in order to be compliant with new APLs, No Wrong Door which requires us to coordinate closely with the county around care transitions and care coordination. • Utilization Management – we have studied their processes and will be building it into our existing systems and ensuring our systems can support UM Management for behavioral health. • Quality Improvement – we have a very robust Quality Improvement program within the Alliance; we have mapped the Policy and Procedures that Beacon has in place under delegation through us and ensure we could transition any Beacon policies to us while making sure they work in our existing Quality Improvement framework. • For Provider Network, the contracting is in progress and got underway this week; we have sent out multiple credentialing packages and contracts to the top-tier providers that are actively seeing our members. There are		

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Anastacia Swift	about three hundred (300) in that target network that we believe we see as a priority. • Credentialing is commencing – we received our first Credentialing package in Behavioral Health Provider this week and will be following the process to get them credentialed. • Customer Service also transitions to us – we are building the positions both in Member Services as well as the navigators of positions within the Behavioral Health departments. We are actively interviewing and selecting that team. We hope to have most of the team onboarded by mid-August. We are making great progress and identifying the key Behavioral Health team members to perform customer service and all the other workflows in the Behavioral Health department. • Claims Processing and Payment is being mapped and I believe we will be in good shape to take on all of these responsibilities. Contracting & Credentialing: • We have prioritized a network that Beacon has of approximately eleven hundred (1100) providers. • We have prioritized them by volume and the first wave of contracts is being sent to the Providers treating the most of our members. We hope to have the first tier of Providers receive the package of contracts by the end of next week. Workflow Design Requirements: • In progress and going well – we have met with our IT team and are on target to implement workflows. • Our design will be to bring on the new Behavioral Health team – the licensed clinicians and the new capacity that will be coming into the Alliance to begin their training in August in preparation for the November 1st effective date. Staffing Update: • We are interviewing for the positions required for this insourcing transition.		

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Tami Lewis	• As of this morning, we have made another verbal offer to a candidate and started another background check. Risks & Mitigation Plan: • An area of concern for this insourcing transition is Contracting and Credentialing. The risk is there are over two-hundred Providers requiring contract amendments. We have brought on additional consultant resources to assist with this process. • Competing priorities is also a concern; we are continuing to monitor that and ensure we have the appropriate resources and system capabilities to insource. Other Constraints: • The competing priorities include all CalAIM initiatives that are going live in January 2023 and the Incentive Programs that we continue to work on. • The Operational Readiness for the 2024 DHCS MCP Contract for the Single Plan Model will also be a heavy lift enterprise wide. • We are also in the midst of multiple audits, as well as performance evaluations. Question: As a primary care physician, access has always been an issue in the past. With this new system and bringing it in-house, access should not be a problem, especially expedited access for those who need an appointment as soon as possible – will bringing this in-house make access an issue? Answer: We understand this is one of the things we need to look at. We are prioritizing continuity of care; therefore, we are focusing on the providers that are treating our members. We will be working on improving access and watching what we can do to facilitate expedited appointments. We are building a foundation to build a much more responsive network than we are accustomed to. Informational update to the Board of Governors. Vote not required.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
9. STANDING COMMITTEE UPDATES			
Dr. Steve O'Brien	The Peer Review & Credentialing Committee (PRRC) and the Pharmacy & Therapeutics Committee (P&T) were held on June 21st, 2022 . Dr. Steve O'Brien provided the following Committee updates: • At PRRC, fifteen (15) initial providers were credentialed, and forty-three (43) providers were re-credentialed. • Twenty-nine (29) providers left the Alliance, however, twenty-three (23) of them were from CHCN. • We are anxiously awaiting our behavioral health providers, and the Committee has prepared to process those applications. • At P&T, there were five (5) therapeutic categories and drug monographs reviewed, sixty-two (62) formulary modifications, thirteen (13) prior authorization guidelines reviewed with no updates, and thirteen (13) prior authorization guidelines were reviewed with updates. The Health Care Quality Committee was held June 24th, 2022: • We welcomed Dr. Tornabene, the Chief Medical Officer at Alameda Health System to the Committee. • Also, the Committee moved to a daytime because of the virtual presence of the meeting at the request of Committee members. • Additionally, we discussed the new quality factor and rates that were discussed earlier today, and we had our routine Utilization Management (UM) policy updates, and we had a future presentation was the QI (quality improvement) work plan.	None	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
Scott Coffin	The Member Advisory Committee (MAC) was held on June 16th, 2022. CEO Scott Coffin provided the following Committee updates: • There was an update from the CEO on the operations and financial performance of the health plan. • The leadership team presented on the insourcing of Mental Health and Autism Spectrum Disorders Services, similar to what we presented today. • Additionally, there was a report delivered by a member of the Grievances and Appeals team on an activity from the first quarter of 2022 and our Community Outreach team. 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
12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS			
Dr. Evan Seevak	None	None	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
13. PUBLIC COMMENT (NON-AGENDA ITEMS)			
Dr. Evan Seevak	None	None	None
14. CLOSED SESSION			
Dr. Evan Seevak	DISCUSSION REGARDING REVIEW OF EXTERNAL PRELIMINARY AUDIT OBSERVATIONS AND FEEDBACK (CALIFORNIA CODE, GOVERNMENT CODE SECTION 8545.1); PROTECTION OF CONFIDENTIAL AUDIT INFORMATION AND POTENTIAL REMEDIAL PLAN OF THE HEALTH AUTHORITY. ESTIMATED PUBLIC DISCLOSURE WILL OCCUR IN THE MONTH OF NOVEMBER 2022.	None	None
15. ADJOURNMENT			
Dr. Evan Seevak	Dr. Evan Seevak adjourned the meeting at 1:48 pm.	None	None

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