ALAMEDA ALLIANCE FOR HEALTH
BOARD OF GOVERNORS
REGULAR MEETING
May 13th, 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, Byron Lopez, Dr. Rollington Ferguson, James Jackson, Dr. Noha Aboelata, Dr. Michael Marchiano, Aarondeep Basrai, Supervisor Dave Brown, Andrea Schwab-Galindo, Natalie Williams

Alliance Staff Present on Conference Call: Scott Coffin, Dr. Steve O'Brien, Gil Riojas, Ruth Watson, Matt Woodruff, Sasi Karaiyan, Richard Golfin III, Tiffany Cheang, Michelle Lewis

Guests Present on Conference Call: Bobbie Wunsch

Excused: Anastacia Swift

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 12:03 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 May 13h, 2022, Consent Calendar. a) April 8th, 2022, Board of Governors Meeting Minutes b) May 10th, 2022, Finance Committee Meeting Minutes Motion to Approve May 13th, 2022, Board of Governors Consent Calendar. A roll call vote was taken, and the motion passed.	Motion to Approve May 13th, 2022, Board of Governors Consent Calendar. Motion: Dr. Marty Lynch Second: Andrea Schwab-Galindo Vote: Yes No opposed or abstained.	None

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6. a. BOARD MEMBER REPORT – COMPLIANCE ADVISORY COMMITTEE			
Rebecca Gebhart	The Compliance Advisory Committee (CAC) was held telephonically on May 13th, 2022, at 10:30 am. Rebecca Gebhart gave the following Compliance Advisory Committee updates. Kindred Focused Audit: • DHCS has closed the Audit and accepted the corrective action plan. • The Alliance staff will continue to monitor and make the Compliance Committee aware of anything that comes up. However, in the future, the Kindred Audit will not be reported to the Board as it is closed. 2022 DHCS Audit Observations: • Non-Emergency & Non-Medical Transport – in the observations, it was noted that non-emergency and non-medical requirements did not follow policy on collecting a PCS (Position Certification Statement), which is the paperwork that outlines the particular modality authorized by the transport. The forms were not collected in advance of the transport. • We understand all plans have trouble getting providers to fill out this form in advance of the trip or service that the member must take; the Plan's perspective is we don't want to hold up transportation for a member. Without a form, technically, it would be possible to deny transportation to the member and they would not get to where they need to go to deal with their health matter. • Our priority is to get members where they need to go for their visit, however, we do need to make improvements. Our leadership is engaged with the State because it is important to put the member first and not delay service. • HIPAA – the Plan did not report disclosures within twenty-four (24) hours of discovery. If we are unable to navigate this out of the Audit, it will be a repeat finding. The issue is we made several referrals of disclosures within twenty-four (24) hours of the Compliance Department receiving the information, but the State wants the twenty-four-hour clock to start ticking when the referral is made to the Plan. We are working on a front-office	Informational update to the Board of Governors. Vote not required.	

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	automated solution so when it is received, we do not lose time in migrating to the Compliance Department. • Similarly, with Fraud, Waste, and Abuse – if we do not report a preliminary investigation within ten (10) working days of discovery, the clock starts ticking at the time the front office or Member Services discover it. We are working to put into place an automated solution and diligently training our front office staff to be able to recognize what they are seeing relating to Privacy, HIPAA, or Fraud, Waste, and Abuse. There would be an automated alert that goes directly to Compliance so that Compliance could receive it when the front office or Member Services do. Question: Is the requirement that every time transport is ordered, a form is completed by a physician or a provider and submitted to the Alliance? Answer: There are a couple of different ways by which a provider can prescribe a particular modality for a member – in completing the form, the provider can outline a particular period of time or a one-time use. Question: For purposes of compliance and completing the form in a timely manner, would it be more effective to send out the form through DocuSign between the Plan and providers ahead of time? Answer: That is an excellent suggestion. I don't know if it is in the Plan's current workflow, but it is something we can look into. NCQA Reaccreditation: • A significant risk has been identified that may impact the NCQA reaccreditation status. • Our CEO has launched an internal Audit, and a mitigation plan will be developed to address the self-identified deficiencies. The CEO will be updating the Compliance Committee and the Board of Governors prior to the survey in June. 2022 Financial Audit: • The 2022 Financial Audit is taking place in the fall. It is a tri-annual audit, which takes place every three (3) years. The last one was in 2019. Last month, the Compliance Committee asked the CFO to refresh our memory		

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	about what is covered in the Finance Audit so that we have anticipatory guidance and are prepared for the fall. • The 2022 Financial Audit will be taking place at the same time as the Moss Adams Financial Audit for the Plan. The auditors will be looking at four (4) areas: (1) the financial statements; (2) the calculation of total net equity; (3) compliance issues and especially issues related to claims; and (4) internal controls. This audit will commence in August, and we will provide more information in the future. DMHC Behavioral Health Investigation: • The Behavioral Health Investigation is related to the commercial line (NOT Medi-Cal). The investigations started last year with various other plans, and we are one of the plans that is being reviewed in the second year. • The interview for that Behavioral Health Investigation is for the IHSS commercial line and will be taking place September 5th. More information will be available in the fall. 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, May 10th, 2022. Highlights: • Tangible Net Equity (TNE) remains above what is required at 575%. • Enrollment continues to increase – most recent numbers showed we increased by 2,335 members since February 2022. • Positive revenue adjustment – there was discussion due to the MCO tax and the expected fourteen million-plus ($14M+) that was anticipated to be paid back to the State for the FY14 through FY16. The team did an	Informational update to the Board of Governors. Vote not required.	None

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	excellent job in responding and answering the State. As a result, we have $6.7M retroactive adjustment to our revenue. Question: With the incredibly positive results we have had, does that impact your opinion on what we may want to strategically spend on? Answer: I don't think there's room for any over-spending, especially with the new State-mandates we will go through. We will likely run some major deficits, especially as related to Major Organ Transplants. We are not sure how that will turn out in the future, but it may likely be an issue. Therefore, I don't think we will have extra money for spending, we will likely be running close depending on what happens with our new programs, especially the Major Organ Transplants. Board Retreat Discussion: A discussion regarding Board Retreat Topics. The Board was informed a survey would be sent to them to find a date for the retreat. Informational update to the Board of Governors. Vote not required.		
7. CEO UPDATE			
Scott Coffin	Scott Coffin, Chief Executive Officer, presented the following updates: Executive Summary: • Public Health Emergency: Governor Newsom renewed the Public Health Emergency (PHE) for COVID-19 through the month of July. It is anticipated to be terminated by September. • The Executive Order that defers the Medi-Cal redeterminations will subsequently be terminated. • The Alameda County Social Services Agency will resume the redetermination process for Medi-Cal beneficiaries; this results in beneficiaries being disenrolled from the Medi-Cal program based on their	Informational update to the Board of Governors. Vote not required.	None

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	eligibility. The redetermination process is expected to be prospective, meaning going forward, people would be redetermined based on their redetermination date. • The forecast for enrollment is expected to reach approximately 320,000 before the redetermination date. Finances: • Update on our preliminary budget for FY2023: We have put together a forecast which supports the revenue projections as well as the expense projections. • We are on track for the preliminary budget for FY2023. In the month of June, we will be presenting to the Finance Committee and the full Board of Governors, asking for approval on the preliminary budget. Key Performance Indicators: • Regulatory metrics: We made some progress in grievances and appeals. The remediation plan was implemented in the organization to address the standard and the expedited grievances, and specifically, the regulatory turn-around time, which we need to meet. • The standard member grievances met compliance at 95%, and our expedited grievances missed by five percent (5%) this last month. There was a total of ten (10) cases in this category, and one (1) case was not met in the three-calendar days timeframe. Improvements have been made; however, we will continue to monitor and assess the work we are doing on the grievances. • Encounter data submissions for institutional claims for the month of April were seventy-seven-point-five percent (77.5%). The institutional encounters must be at eighty percent (80%) or higher, so we missed by two-point-five percent (2.5%). This was a temporary situation related to some data cleanup involving the encounters from 2021. We are expecting to be back on track next month. • The Member Services team has worked very hard on their remediation plan to improve the customer service metrics We still have some distance to go to get where we need to be, but the team has done a great job on making the right improvements.		

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	Program Implementations: • Insourcing of Beacon Health Options: The team has done a fantastic job of going through the detailed planning stages and looking at all the essential parts that we need to move as part of this transition. • We met in May to go through the status. My last report to the Board was that we are going to transition on October 1st, 2022. I have decided to move this out thirty days (30) days to November 1st, 2022 based on the information we have available to us. Kaiser Permanente: • During the week of May 2nd, 2022, legislative hearings were held in Sacramento to discuss the direct contract between the State of California and Kaiser Permanente. • There is an assembly bill that has been created, AB 2724, also known as the Arambula Bill. This bill is being modified through this public process and is expected to conclude by August 2022, prior to a vote. There will be more public forums that will be available for people to comment as they finalize the changes to the bill. We will continue to update the Board on any changes that relates to our arrangement with Kaiser Permanente. Question: The fact that Alameda County is Kaiser's home – would this have a greater impact on us? Are they going to be more focused on their work in Alameda County than other parts of California? Answer: The indicator is the location, size and the open capacity of their facilities. While the contract spans across thirty-two (32) counties in the State, they have different sized facilities and different staffed facilities in each of these counties. In our county, they have a strong presence between San Leandro and Oakland. The question will be on that mandate of growth that they have contracted with the state on for five percent (5%) growth; they don't necessarily have to do five percent (5%) in each county, it can be mixed, but it is an aggregate of five percent statewide. There may be some disproportionate growth in counties they have a stronger presence in. It is unclear on what the strategy is, Kaiser is likely still working on how to meet those growth requirements.		

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	Question: The case management numbers in the executive dashboard – does that include everyone who is getting care coordination or case management from the Alliance? Answer: It includes care coordination complex but does not include transition of care. Question: What is the difference between open and enrolled cases? Answer: The open cases are for our internal programs of care coordination and complex cases. Our open cases are different than our external cases of "enrolled." Through March of this year, we have had six-hundred eleven (611) care coordination patients, fifty-five (55) complex case management, and five-hundred sixty-five (565) transition of care patients. Medi-Cal Incentive Programs: • The funding for these programs comes from the American Rescue Plan Act, Home and Community-Based Services, State general funds, and other waivers. All of these came through and were introduced through the Governor's budget. • We are seeing more of these programs starting to break out services as part of the CalAIM program, but they all tie back into core Medi-Cal services. • Participation in the services is voluntary, but strongly encouraged by the department. We are aggressive on moving forward with these funding programs because they create a lot of opportunity to draw down funding to continue services that we started, built in partnership with Alameda County Health Care Services Agency. • There is a caveat that the incentive funding comes with performance outcomes as well as performance measures; if they are not met, there is a risk to Alameda Alliance that funding could be taken back by the State. These funds are not grants – they are performance-based funds, which come with outcomes and measures. Therefore, we must approach carefully on making sure we understand all the different aspects involved. • The funding is allocated to build capacity in local systems and intended to establish sustainable operations. After these programs end in 2024, we		

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	must demonstrate how we can continue offering these services; the initial indication is through savings. • Besides our community-based organizations, Alameda Alliance also has the opportunity to apply for incentive funds to use for building capacity – this would be for the entire Alameda community. We are pulling together all available information to build these programs effectively. • The actual structure for each program is still in process. Once we demonstrate the outcomes, the State releases funding. To simplify the process, Alameda Alliance and Anthem are partnering to develop a single plan application process, which will make it simpler for our providers and community-based organizations to apply. We are starting this off with one incentive program on the CalAIM Incentive Program. The goal is to extend this concept to the other incentive programs. We currently do not have agreement with Anthem to proceed on the other programs, but we are intending to pursue that. • In FY2023, in order to track all the reporting requirements of outcomes, which are broken down to quality, performance, and generating reports, coordinating directly with community-based organizations then to submit to the State – we are proposing to create a new department called Incentives and Reporting. This is a cross-divisional department that will be reporting to the Integrated Planning division. • The incentive program Behavioral Health Integration has been in operation for the longest. So far, we have been awarded two-hundred thousand, ($200K) and we have paid out two-hundred thousand ($200K), and we still have more funding available that will be coming. • For all incentive programs, the maximum amounts listed – for example, nearly fifteen million dollars ($14.8M) for CalAIM – we would have to earn this amount. This is a key concept, for all these programs, we have to earn these funds through our actions and outcomes. • The Student Behavioral Health initiative program – we have been awarded up to nine-point-seven million ($9.7M) and we have received three-hundred-eighty-one thousand ($381K). We are in process of doing the planning in order to draw down and pay out funds into the county. • The incentive program with the highest maximum amount is the Housing and Homelessness Program, with the amount of forty-four-point-three million dollars ($44.3M) over a two-year period. Currently, this program we know the least about because we have just received the guidance.		

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Tiffany Cheang	• Across all incentive programs, the amount that has been awarded to us so far is ten-point-one million dollars ($10.1M), and the amount we have paid out is one-point-six million dollars ($1.6M). We will be updating the Board as we go through each month, because we will be making progress on each of these incentive programs. • The total maximum amount that Alameda Alliance has been awarded across all incentive programs from the State is seventy-eight million dollars ($78M). What is more important is how we are going to earn these dollars – and then how we would spend it, and the accountability for these funds. • The COVID-19 Vaccination program was concluded at the end of February. Matt Woodruff presented to the Board of Governors our progress each month throughout the program; we started at a sixty-two-point-two percent (62.2%) and we ended at seventy-five-point-one percent (75.1%). As of today, the number continues going up because even though the program stopped, we are continuing to provide incentives for our members to get vaccinated. We had surplus on this program, which we are applying toward incentive dollars for our members. Enhanced Care Management & Community Support Programs: • In January of this year, we launched the enhanced care management and community support programs, and this incentive payment is to support those programs. The bigger goals of this is to increase capacity, improve infrastructure or build infrastructure, and increase the uptake of the community support services, all in addition to addressing disparities, equity, and improving the quality of care. • In this program, any provider or organization can submit to apply, under the condition that the provider or organization joins the Alliance's ECM and Community Supports program. The program years commenced January 1st, 2022 and goes through June 30th, 2024. • For the first year, we have allocated fourteen-point-eight million dollars ($14.8M), and so far to date, we have received fifty percent of that with seven-point-four-million dollars ($7.4M). This is considered an advanced payment for total earnings, and the State reserves the right to recoup that if they feel we have not made sufficient progress.		

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	• Payments issued to Providers: This is where we are in the process right now. All applications have been distributed to our current ECM providers and CS providers who we are contracted with or in the process contracting with. We did this in collaboration with Anthem, by working with them to create a single application form to ease the burden on the providers. We are also going to work with Anthem on reviewing the applications. • In the fall, we will have to submit to the State our status report describing how we are doing and the efforts we have made. This submission describing our outcomes will determine the full amount we get for program year 1, and if we receive the remaining fifty percent or not. Question: Is this money intended to pay for the ECM services, or to build infrastructure to provide ECM and community support services and be paid for separately? Answer: It is not to provide for the actual services, this is to support and build up the programs. Supporting and building capacity, which could be supporting staffing or technology needs. We do have requirements as an ECM or community supports provider; certain providers may not have these capabilities or require support, and that is what some of this funding is for. Also, there are programs to address inequities – we have specific outcomes and quality outcomes that we need to show improvement on. An area that we have to show improvement on is diversity metrics; based on ethnicities, and how we are improving those numbers. Question: Could that infrastructure include staffing infrastructure? How to staff up before you have enough members to pay for that staff? Answer: It is to support your hiring of staff, but not to sustain it. The ramp-up time is when you struggle – when you hire someone, and they cannot take on the full load. The idea is that once they are up to speed, the rate you are getting should pay for that individual provider's salary. This funding could help support that and fund that, as well as training. Question: Could you please say more about diversity? Would this information be coming to the Board? Answer: For all our ECM members, we have to break up the numbers by ethnicity,		

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	and report that to the State. The next time we report our numbers, we must show improvement on our lowest percentage ethnicities. This is for ECM and CSO. This is intended to address disparities and the hard-to-reach populations. We had to turn in our baseline numbers for the ethnicity metric and this will be our baseline for how the State judges us on for how well we improve when we submit our numbers in the fall. We can share that with the Board. Question: Once the funding gets up and started, how do we determine how to continue these programs? Is it intrinsic that it is put into the budget, or is there some other way to approach it? Answer: Specifically for this program, we are asking the applicants how they can sustain the program for the future. A lot of the funding can be categorized as a "start-up" cost, or development cost, helping with getting up to speed to become a provider, or helping with hiring so you can get up to speed and earn your regular payment on the services. Scott Coffin provided the following information on Incentive Programs: • We are looking and trying to understand the cost structures. The funding comes with the responsibility of doing the reporting and accounting. To do this, we need all our partners working with us and providing us the data. • The fourth program is the Student Behavioral Health Incentive Program. This incentive program introduces the managed care system to the school system, so we are working with school districts now where in the past we were not. Health services, dental services, and mental health services are being rendered in schools – this program helps to increase the capacity and we are building relationships. There will be additional funding that comes in as we finish the workplan and determine what we will focus on for the first year. • Housing and Homelessness Incentive Program is the program with the largest dollar allocation to it – we know the general structure, but we know the least about this program right now. This program addresses street medicine and some of the services that have not been directly called out in other programs. We are going to have to navigate these funds to avoid duplication and ensure when we are reporting back to the State, that we can tie back the service to the specific incentive program.		

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	• One that is not listed because it is not directly under our oversight is the PATH fund – Providing Access and Transforming Health fund. This incentive fund is coordinated between the State of California and each of the county health agencies. In Alameda County, a request for PATH funds has been submitted in three different areas: (1) Sobriety Centers; (2) Housing Navigation Tendency Sustaining Services and Housing Deposits; and (3) Street Health Outreach. • We will be coordinating with Alameda County Health Care Services Agency as well as other agencies and community-based organizations that are applying for PATH funds. We must demonstrate to the State how these funds were separated, what activity they were tied to, and what were the outcomes and performance measures were applied. • We will be providing more information and progress reports as we move forward. Question: The forty-four million dollars ($44M) for the Homeless Program Initiative – how does it compare to what we are spending now? Answer: We do not have an indication, but we will try and get initial information. Informational update to the Board of Governors. Vote not required.		
8. a. BOARD BUSINESS – REVIEW AND APPROVE MARCH 2022 MONTHLY FINANCIAL STATEMENTS			
Gil Riojas	Gil Riojas gave the following March 2022 Finance updates: Enrollment: • For the month ending March 31st, 2022, the Alliance had an enrollment over 306,787 members, a net income of $8.4M, and the tangible net equity was 575% of the required amount. • Our enrollment has increased by over 2,300 members since February 2022, and on a fiscal YTD, we gained over 18,000 members since June 2021. Net Operating Results:	Motion to Approve March 2022 Monthly Financial Statements as presented. Motion: Dr. R. Ferguson Second: Dr. Kelley Meade Vote: Yes	None

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	• For the fiscal YTD ending March 31st, 2022, the actual net income was $12.9M, and the budgeted net loss was $4.9M. Revenue: • For the month ending March 31st, 2022, the actual revenue was $109.1M vs. the budgeted revenue of $94.8M. • For the fiscal year ending March 31st, 2022, the actual revenue was $889.4M vs. the budgeted revenue of $877.2M. • For the month ending March 31st, 2022, the favorable revenue variance of $14.3M is largely due to the $6.7M retroactive MCO Tax Adjustment for FY14-FY16. Medical Expense: • For the month ending March 31st, 2022, the actual medical expense was $95.2M, and the budgeted medical expense was $85.0M. • For the fiscal year ending March 31st, 2022, the actual medical expense was $828.2M vs. the budgeted medical expense of $821.5M. • On a PMPM basis, medical expense is 1.0% favorable to the budget. Medical Loss Ratio (MLR): • For the month ending March 31st, 2022, the MLR was 87.2% and 93.1% for the fiscal year-to-date. Administrative Expense: • For the month ending March 31st, 2022, the actual administrative expense was $5.2M vs. the budgeted administrative expense of $7.6M. • For the fiscal YTD ending March 31st, 2022, the actual administrative expense was $47.7M vs. the budgeted administrative expense $60.7M. Other Income / (Expense):	No opposed or abstained.	

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	• As of March 31st, 2022, our YTD investment revenue is $157,000 and the YTD claims interest expense is $300,000. Tangible Net Equity (TNE): • Tangible net equity results continue to remain healthy, and at the end of March 31st, 2022, the TNE was reported at 575% of the required amount. Cash Position and Assets: • For the month ending March 31st, 2022, the Alliance reported $386.2M in cash; $164.1M in uncommitted cash. Our current ratio is above the minimum required at 1.47 compared to the regulatory minimum of 1.0. Capital Investment: • Fiscal year-to-date capital assets acquired: $234,000. • Annual capital budget: $1.4M. Question: Do we have a strategy for what we can to assure our members get redetermined? Answer: We've been speaking with our community partners and are having those conversations now, but we don't have a strategy solidified yet, but we are preparing those now for September. Motion to Approve March 2022 Monthly Financial Statements as presented. A roll call vote was taken, and the motion passed.		
8. b. BOARD BUSINESS – BOARD OF GOVERNORS EFFECTIVENESS ENGAGEMENT			
Bobbie Wunsch	Board Self-Assessment Report: • Board Effectiveness Survey had two major parts – the Standard Board Source survey for non-profits implemented electronically, which 100% of the Board members completed, and Individual Board Interviews. • The overall scores in the Board Source Survey were good to excellent and were slightly higher than average scores for all nationally surveyed non-profit Boards nationally.	Informational update to the Board of Governors. Vote not required.	None

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	• In the major categories of People, Culture, Work, and Impact, generally, the Alameda Alliance Board rated themselves somewhat higher than other Boards nationally. • The Board rated themselves highest in the areas of financial oversight and mission, vision and strategic direction. The lowest scores were in culture and board composition. Board Individual Interviews: • There was general agreement with the Board Effectiveness Survey results. There was interest in emergency succession planning for CEO, Executive Team, and department heads. • The Board also wants more time for discussion and questions at meetings. Many Board members believe the agendas are too packed. • Several Board members came on during the pandemic and suggested new board member orientation. • There was also a preference for mixed, hybrid board meetings going forward, some in person and some virtual. • Additionally, there was very strong support for adding the additional county seats and Community Health Center Network to the Board and adding them as soon as the Board decides how to do this. This will be a main topic covered during the Board Retreat, including Board composition options, single plan transition, Kaiser Contract and Medicare. • Every single Board member found 1:1 with CEO Scott extremely helpful. Question: Please elaborate on the hybrid meeting model? Answer: There are many Board members who would like to meet in person, especially the members who joined during the pandemic. There are others who prefer either all in person or all virtual. The preference was either or a combination. Dr. Kelley Meade, Dr. Marty Lynch, and Rebecca Gebhart provided positive feedback on the process.		

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	Dr. Seevak and Scott Coffin provided updates on changing Board packets based on Board's feedback for shorter Board packets, to be effective in the new fiscal year in July. Informational update to the Board of Governors. Vote not required.		
8. c. BOARD BUSINESS – MENTAL HEALTH MILD-TO-MODERATE AND AUTISM SPECTRUM DISORDER SERVICES			
Ruth Watson & Scott Coffin	Background: • Phase One was Internal Planning, and this was completed in December 2020. This helped us plan for the next step effectively. • Phase Two was Community Engagement, and this was completed in March 2021. We met with multiple organizations and Community Partners currently engaged in mental health and Autism Spectrum Services to listen and discuss what worked and what did not. • In April 2021, we received approval from this Board to terminate our contract with Beacon Health Options no later than December 2022, insourcing seven domains of service. Our original implementation costs were estimated between $1.2 million to $1.7 million, and our original annual administrative costs were estimated $3.0 million to $4.5 million excluding provider payments, which resulted in the hiring of 36.5 new employees. Service Domains: • The service domains that we are insourcing from Beacon that are currently outsourced to them are (1) Care Transitions; (2) Utilization Management; (3) Quality Improvement; (4) Provider Network; (5) Credentialing; (6) Customer Service; and (7) Claims Processing and Payment. Organization Priorities in 2022-2023: • The first is the Insourcing of Mental Health and Autism Spectrum Services; every division head has committed staff, resources, and whatever is needed to bring this in-house. We will go live with this on November 1st, 2022.	Informational update to the Board of Governors. Vote not required.	None

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	• There is also the CalAIM project, Incentive Programs, and various Federal and State-mandated projects and Enterprise Portfolio. We currently have twenty (20) active projects and five (5) projects in the intake phase. Matthew Woodruff presented Mental Health & Substance Use Services: • Currently, our responsibilities do not involve mental health services, some of the services on page 174 of the chart are handled by Beacon and several others by Alameda County Health Care Services. • What we are bringing in-house through Medi-Cal is Mild to Moderate Acuity. For Group Care, we are bringing the other side as well, which is the Severe Acuity. For Medi-Cal, Severe Acuity will stay with the County. • This will be confusing for a little while until we bring these services in-house. We will be providing trainings on this transition online and potentially in-person. Tami Lewis, Senior Director of Integrated Planning presented the Integrated Planning Update: • We have hired the Senior Director of Behavioral Health, Dr. Peter Currie who has insourced behavioral health at another managed care plan and is now assisting us with building a Medi-Cal Behavioral Health program. • We have re-assessed the provider network and refreshed Beacon utilization data – this is important as we continue to evaluate the services our members receive and the providers who are rendering those services. We will also be utilizing consultant services to assist with the contracting effort, as well as all the contracting we have associated with the CalAIM activities. • From a project planning and initiation perspective, we have a detailed project plan and timeline creation in progress. We have created the workstreams to identify and plan for the work that supports the "Lift and Shift" methodology. • Additionally, we have updated the cost estimates for insourcing behavioral health. • Internal Reassessment: We will continue to conduct monthly Executive Level evaluation of project deliverables, risk and timelines associated with this project. We have begun recruitment of new staff, and workstream		

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	meetings are taking place, which will allow us to identify both the business and technology requirements needed. • We are also identifying regulatory compliance requirements, so we are complying with regulator notification, member and provider notifications, as well as policy and procedure development. Corry Keenan, Director of Portfolio Management & Service Excellence presented the Insourcing Timeline: • We are currently working through critical path items, such as the member and provider notifications that require DHCS notification and approval; IT infrastructure; hiring and staffing; as well as member communications. Gil Riojas presented Cost Estimates: • We refreshed implementation and recurring cost data from April 2021 and had a slight increase in the range of implementation costs and the recurring costs. The increased implementation costs include member and provider materials, such as the increased costs for ID cards and member notifications and project consulting support. • Our recurring costs added half of an FTE, we now have 37 FTEs and that also increased our potential range from a high of four-point-five million ($4.5M) to five-point-four million ($5.4M). • Cost Comparison for Outsource vs. Insource: We estimated outsourcing would cost us an estimated thirty-three point two million ($33.2M) and insourcing will cost us more, an estimated thirty-five point four million ($35.4M), nearly a two million dollar ($2M) increase from the outsource model. • Our Staffing Model shows by division new FTEs that will help support the transition from outsourcing to insourcing mental health services. Dr. Bhatt and Dr. Currie presented the Lift & Shift Approach for Insourcing: • One of our measures of success is zero disruption in care of services on the day of insourcing – ensuring that on November 1st, our members continue to have access to their providers with ongoing approval of treatment. • Some of the pieces on Day 1 will include assurance of regulatory compliance; direct contracting to strengthen Provider relationships; continuing Tele-Psych Program which began during the pandemic and		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	allowing patients to receive virtual care, as long as the State permits; and utilizing and leveraging existing core systems and staff, such as the IT services we have; building out a team with expertise; cohesive medical and behavioral health records in our Medical Management System (MMS); and access issues and the "no wrong door" concept. • Several of the over thirty FTE's will be behavioral health clinicians by training, and hopefully with managed care experience to perform care management and utilization management processes. The intent is to integrate fully with the plan and work with the existing systems and policies to build in behavioral health competency. • "No Wrong Door" – we are participating with the Alameda County Behavioral Health Department in creating a no wrong door process for our members, so that wherever our members seek to access care, we can collaborate behind-the-scenes and help them navigate to where they can best be served. • For Day 2 and Beyond of insourcing, we will evaluate and seek improvement in areas such as warm handoffs; members who step up into care utilizing County services, or step down into care, from the County, SMI Services, back to Mild-to-Moderate Services; how to better utilize Member and Provider Portals; the referral and re-authorization process; exploring payment reform; primary care physician engagement; telehealth psych program; and assessing network gaps through considering linguistic, cultural, racial disparities and barriers to care. Ruth Watson concluded by discussing the Next Steps: • We need to notify Beacon of contract termination by June 30th, 2022 and the termination will be effective October 31st, 2022. • The insourcing implementation has been initiated and is ongoing. We have been meeting with teams regularly to review detailed planning. Additionally, we have reviewed our regulatory notification concerning important dates and what we need to provide. • We brought in individuals to help with the network development and network contracting to ensure timeliness and have started discussing with the IT Team on system updates and configuration – they unfortunately must wait until we complete our requirements.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	• Our HR department is bringing in someone to help with recruitment of the positions and we have looked at space planning. We are currently working on member notifications. It is going to take the entire Alliance to make this transition happen. We will go live November 1st, 2022. Question: Insourcing will cost more – will we be able to cover that via rates? Answer: Not necessarily; if we are intending to increase our administrative costs, typically those are not impacted in our rate, our REP. There is certainly going to be an increase in our medical expenses, but there might an increase related to administrative expenses. I don't necessarily think we will be able to incur all of that. Question: How do we see rates costing control in the future, is there any way we can predict cost increases and how we can reduce costs? Answer: The development of a network is going to be critical to ensure this insourcing transition goes smoothly. Every time there's network development, there are cost considerations. I don't know if at the beginning of this we will see any savings. Ultimately, all of that will be impacted by the network rates. Question: How do you integrate services when the providers are in different places? It is harder to understand the integration if the patient is served by different parts of our system. Answer: A part of the component that we are insourcing is care coordination, which includes coordinating information between the providers. Part of our goal and part of our education with our psychiatry providers is to be able to share information to the extent that is allowable by law. We are also working in Phase 2 on an IT component that will be a portal and will try and help share information in care plans and make it easier for providers to share information. Dr. Seevak, Rebecca Gebhart and Dr. Marty Lynch expressed appreciation to the Alliance for the insourcing project. Informational update to the Board of Governors.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Vote not required.		
9. a. STANDING COMMITTEE UPDATES – PEER REVIEW AND CREDENTIALING COMMITTEE			
Dr. Steve O'Brien	The Peer Review and Credentialing Committee (PRCC) was held telephonically on April 19th, 2022. Dr. Steve O'Brien gave the following Committee updates: • We credentialed twenty-four (24) initial applicants. Additionally, fifty-one (51) providers were re-credentialed at this meeting. • There were eleven (11) providers terminated. We had a net gain of thirteen (13). Informational update to the Board of Governors. Vote not required.	Informational update to the Board of Governors. Vote not required.	None
9. b. STANDING COMMITTEE UPDATES – HEALTH CARE QUALITY COMMITTEE			
Dr. Steve O'Brien	The Health Care Quality Committee (HCQC) was held telephonically on April 28th, 2022. Dr. Steve O'Brien gave the following Committee updates: • We introduced Dr. Tritto, the interim CMO at CHCN, our new Access to Care Manager, Loc Tran, and we said goodbye to Ms. Stephanie Wakefield, who is retiring from her role as Senior Quality Director. • We reviewed many PNP's for NCQA Reaccreditation, the 2021 QI Program Evaluation, which includes our population health strategy, annual member experience assessment including a review of a full year of complaints and grievances, and finally, our cultural and linguistic report.	Informational update to the Board of Governors. Vote not required.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Pharmacy Update: • One trend we are noticing since exchange in Medi-Cal Rx is an increase use of opioids of some of our members. This is something we are highly watching. 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			
Scott Coffin	None	None	None
13. PUBLIC COMMENT (NON-AGENDA ITEMS)			
Dr. Evan Seevak	None	None	None
14. ADJOURNMENT			
Dr. Evan Seevak	Dr. Evan Seevak adjourned the meeting at 2:19 pm.	None	None

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