ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

Board of Governors

Retreat

Friday, January 26th, 2024
9:30 a.m. – 3:30 p.m.

Video Conference Call and

7986 Tesla Road, Livermore, CA 94550

AGENDA

BOARD OF GOVERNORS
Strategic Retreat Meeting
Friday, January 26th, 2024
9:30 a.m. – 3:30 p.m.

In-Person and Video Conference Call

Garré Winery
7986 Tesla Road
Livermore, CA 94550

PUBLIC COMMENTS: Public Comments can be submitted for any agendized item or for any item not listed on the agenda, by mailing your comment to: "Attn: Clerk of the Board," 1240 S. Loop Road, Alameda, CA 94502 or by emailing the Clerk of the Board at brmartinez@alamedaalliance.org. You may attend meetings in person or by computer by logging in to the following link: Click here to join the meeting. You may also listen to the meeting by calling in to the following telephone number: 1-510-210-0967 conference id 215057951#. If you use the link and participate via computer, you may use the chat function, and request an opportunity to speak on any agendized item, including general public comment. Your request to speak must be received before the item is called on the agenda. If you participate by telephone, please submit your comments to the Clerk of the Board at the email address listed above or by providing your comments during the meeting at the end of each agenda item. Oral comments to address the Board of Governors are limited to three (3) minutes per person. Whenever possible, the board would appreciate it if public comment communication was provided prior to the commencement of the meeting.

PLEASE NOTE: The Alameda Alliance for Health is making every effort to follow the spirit and intent of the Brown Act and other applicable laws regulating the conduct of public meetings.

1. **MEET AND GREET – LIGHT BREAKFAST** *(9:30 A.M.)*

2. **CALL TO ORDER**
   (A retreat meeting of the Alameda Alliance for Health Board of Governors will be called to order on January 26th, 2024, at 10:00 a.m. in Alameda County, California, by Rebecca Gebhart, Presiding Officer. This meeting is to take place in person and by video conference call)

3. **ROLL CALL**

4. **WELCOME AND INTRODUCTIONS** *(10:00 A.M. – 10:10 A.M.)*

5. **MEDICARE** *(10:10 A.M. – 11:25 A.M.)*
   a) Overview of current DSNP in California
      i. How different from the past
      ii. What to expect over the next 18 months
   b) Questions and Answers
   c) Alliance/Alameda County
      iii. What should the Board know
      - Quality
      - Stars

- Risk Adjustment
- Benefits

d) What should the Board ask/Judge Success
e) Alliance Readiness

6. FINANCE TRAINING *(11:25 A.M. – 11:55 A.M.)*

7. LUNCH *(12:00 P.M. – 12:30 P.M.)*

8. HEALTH EQUITY AND QUALITY *(12:40 A.M. – 2:10 P.M.)*

f) Quality and Sanctions APL Implications
g) Single Plan Model Effect
   i. Anthem members
   ii. CalAIM
   iii. Rates
   iv. Quality
h) Health Equity Plan/Roadmap
i) Health Equity and Quality
   i. CalAIM Effect
   ii. Underserved Populations
   iii. BH and ABA
   iv. Pediatric Services
   v. Older Adult Services

9. BREAKOUT SESSIONS - Discuss focus topics. Board to decide on the meeting, over the next five months, in a small group of experts to discuss obstacles surrounding: *(2:15 P.M. – 2:50 P.M.)*

j) BH/ABA
   i. What are the key issues, what are the key improvements that as a Board member you want the Alliance to pay attention to over the next 12 months
k) Pediatric Services
   ii. What are the key issues, what are the key improvements that as a Board member you want the Alliance to pay attention to over the next 12 months
l) Older Adult Services
   iii. What are the key issues, what are the key improvements that as a Board member you want the Alliance to pay attention to over the next 12 months

10. COMPLIANCE DISCUSSION *(2:50 P.M. – 3:25 P.M.)*

m) Compliance Process and Goals
   i. Cal Optima
   ii. Kaiser BH
   iii. Alliance Audit
   iv. Next Steps and Planning

11. ANNOUNCEMENTS *(3:25 P.M. – 3:30 P.M.)*

12. PUBLIC COMMENT (NON-AGENDA ITEMS)

13. ADJOURNMENT *(3:30 P.M.)*

14. WINE TASTING (OPTIONAL) *(3:45 P.M.)*

NOTICE TO THE PUBLIC

The foregoing does not constitute the final agenda. The final agenda will be posted no later than 24 hours prior to the meeting date.

The agenda may also be accessed through the Alameda Alliance for Health's Web page at: www.alamedaalliance.org

Board of Governors meetings are regularly held on the second Friday of each month at 12:00 p.m., unless otherwise noted. This meeting is held both in person and as a video conference call. Meeting agendas and approved minutes are kept current on the Alameda Alliance for Health's website at www.alamedaalliance.org.

Additions and Deletions to the Agenda: Additions to the agenda are limited by California Government Code Section 54954.2 and confined to items that arise after the posting of the agenda and must be acted upon prior to the next Board meeting. For special meeting agendas, only those items listed on the published agenda may be discussed. The items on the agenda are arranged in three categories. **Consent Calendar:** These items are relatively minor in nature, do not have any outstanding issues or concerns, and do not require a public hearing. All consent calendar items are considered by the Board as one item and a single vote is taken for their approval, unless an item is pulled from the consent calendar for individual discussion. There is no public discussion of consent calendar items unless requested by the Board of Governors. **Public Hearings:** This category is for matters that require, by law, a hearing open to public comment because of the particular nature of the request. Public hearings are formally conducted, and public input/testimony is requested at a specific time. This is your opportunity to speak on the item(s) that concern you. If in the future, you wish to challenge in court any of the matters on this agenda for which a public hearing is to be conducted, you may be limited to raising only those issues which you (or someone else) raised orally at the public hearing or in written correspondence received by the Board at or before the hearing. **Board Business:** Items in this category are general in nature and may require Board action. Public input will be received on each item of Board Business.

Supplemental Material Received After the Posting of the Agenda: Any supplemental materials or documents distributed to a majority of the Board regarding any item on this agenda after the posting of the agenda will be available for public review. To obtain a document, please call the Clerk of the Board at (510) 747-6160.

Submittal of Information by Members of the Public for Dissemination or Presentation at Public Meetings (Written Materials/handouts): Any member of the public who desires to submit documentation in hard copy form may do so prior to the meeting by sending it to "Attn: Clerk of the Board", 1240 S. Loop Road, Alameda, CA 94502. This information will be disseminated to the Committee at the time testimony is given.

Americans With Disabilities Act (ADA): It is the intention of the Alameda Alliance for Health to comply with the Americans with Disabilities Act (ADA) in all respects. If, as an attendee or a participant at this meeting, you will need special assistance beyond what is normally provided, the Alameda Alliance for Health will attempt to accommodate you in every reasonable manner. Please contact the Clerk of the Board, Brenda Martinez, at (510) 747-6160 at least 48 hours prior to the meeting to inform us of your needs and to determine if accommodation is feasible. Please advise us at that time if you will need accommodations to attend or participate in meetings on a regular basis.

I hereby certify that the agenda for the Board of Governors was posted on the Alameda Alliance for Health's web page at www.alamedaalliance.org by January 23rd, 2024, by 10:00 a.m.

Brenda Martinez, Clerk of the Board

ALAMEDA Alliance FOR HEALTH

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PRESENTATIONS APPENDIX

Please click on the hyperlink(s) below to direct you to corresponding material for each item.

ALAMEDA Alliance FOR HEALTH

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MEDICARE PRESENTATION

Betsy Seals is the CEO and co-founder of Rebellis Group a consulting firm established to provide advisory and hands-on services to Medicare Advantage Organizations and their subcontractors. Betsy is a nationally recognized leader in the managed care industry with over 20 years of experience.

Betsy brings to the table a solid mix of leadership and business acumen, as well as regulatory and strategic knowledge within the Managed Care landscape. Betsy's expertise is focused in the areas of mergers and acquisitions, compliance, sales and marketing, strategy, supplemental benefit landscape, innovative benefit design that address social determinants of health (SDoH) and health plan operations.

Prior to founding Rebellis Group, Betsy served as the Chief Consulting Officer for Gorman Health Group (GHG). In this role, Betsy managed the Medicare consulting practice, including implementation of strategic initiatives, development of new practice areas, and oversight of day-to-day consulting operations.

Prior to her role as Chief Consulting Officer, Betsy Served as Senior Vice President, Compliance Operations where she assisted Medicare Advantage Organizations (MAOs) and Part D Sponsors to attain and maintain compliance with the Centers for Medicare & Medicaid Services (CMS) regulations and guidance by conducting risk assessments, preparing organizations for CMS audits, performing mock CMS audits, and creating and implementing internal and delegated entity oversight programs.

Before joining GHG in 2006, Betsy worked for Medicare Advantage Organizations where she served in Customer Service and Compliance with responsibility for creation and implementation of oversight programs, CMS audit preparation, implementation of internal corrective action plans, and the day-to-day management of Compliance operations. Betsy has also worked as a CMS Sub-Contractor to conduct CMS Compliance Program Audits.

BIOGRAPHY
JEFF FOX

Jeff Fox is a seasoned executive leader currently serving as an operating partner with Chicago Pacific Founders (CPF), a private equity firm focused on thesis- and technology-driven innovation within health services and senior living. Fox also works as a growth-focused senior advisor for EvolveNXT, a broker commission and training platform and Ellipsis Health, a mental health telephony technology company. For over 35 years, Fox has become adept in developing, administrating, and improving progressive healthcare plans – as well as building market-growth initiatives delivering returns in local and national markets alike. Fox sits on the Boards of Atrio Health Plan, a Medicare Advantage (MA) health plan in Oregon and Nevada. Fox also sits on the Allymar Health Board, that offers MA back-office administration support while driving a 5-Star outcome for their customers. Jeff also sits on Duo Health's board, a chronic kidney disease (CKD), a care management platform, taking risk on CKD patients. His other skills include but are not limited to market strategy development, sales, product innovation, provider strategy, marketing, and health plan growth.

Fox brings a proven ability to conceptualize and execute large-scale health plan strategies, and he leverages these capabilities in aiding CPF's ongoing commitment to transformative healthcare models. As an operating partner, his roles include consultancy and building connections between start-ups, healthcare organizations, and CPF-affiliated companies.

Prior to his time with CPF, Jeff Fox served as the CEO of Atrio Health Plans**,** where he bolstered Atrio's efforts to deliver high-quality, community-focused health insurance. He also spent 17 years as the CEO and President of Gorman Health Group, a leading advisory and software solutions firm specializing in government health programs. During this time, Fox oversaw the development of a comprehensive Medicare Advantage Advisory Expert model.

Fox's other past roles include Senior Vice President of Government Programs at Health Net, a California-based health plan provider, and Vice President for Medicare at Intergroup of Arizona, a start-up Medicare program that provided quality health plans in the Arizona and Oregon markets and played a key role in launching the first PPO product and broker program in the health plan industry.

REBELLIS GROUP

Alameda Alliance for Health

BOARD OF DIRECTORS PRESENTATION

January 26th, 2024

REBELLIS GROUP

Company Overview

- Rebellis Group, LLC was founded in 2020.
- The principals of Rebellis served as executives at a prior Medicare consulting firm (since acquired) for over 10 years.
- The Rebellis executive team, and in fact many Rebellis expert consultants, have worked together for upwards of 20 years.
- Rebellis is a private, 100% woman-owned business.

Unmatched Experience in Medicare Advantage and Part D

80+ expert consultants

Multiple CalAim Clients

60+ active plan clients

With decades of experience in health plan operations, compliance program build and evaluation, M&A compliance due diligence support, government consulting and technology, Rebellis Group includes former CMS subcontractors and administrators, plan compliance officers and executives, and industry experts.

Our focus is to assist organizations in streamlining and optimizing systems and processes, connecting the dots between strategic and operational functions to maximize revenues, increase agility, and develop fundamental insights for effective management.

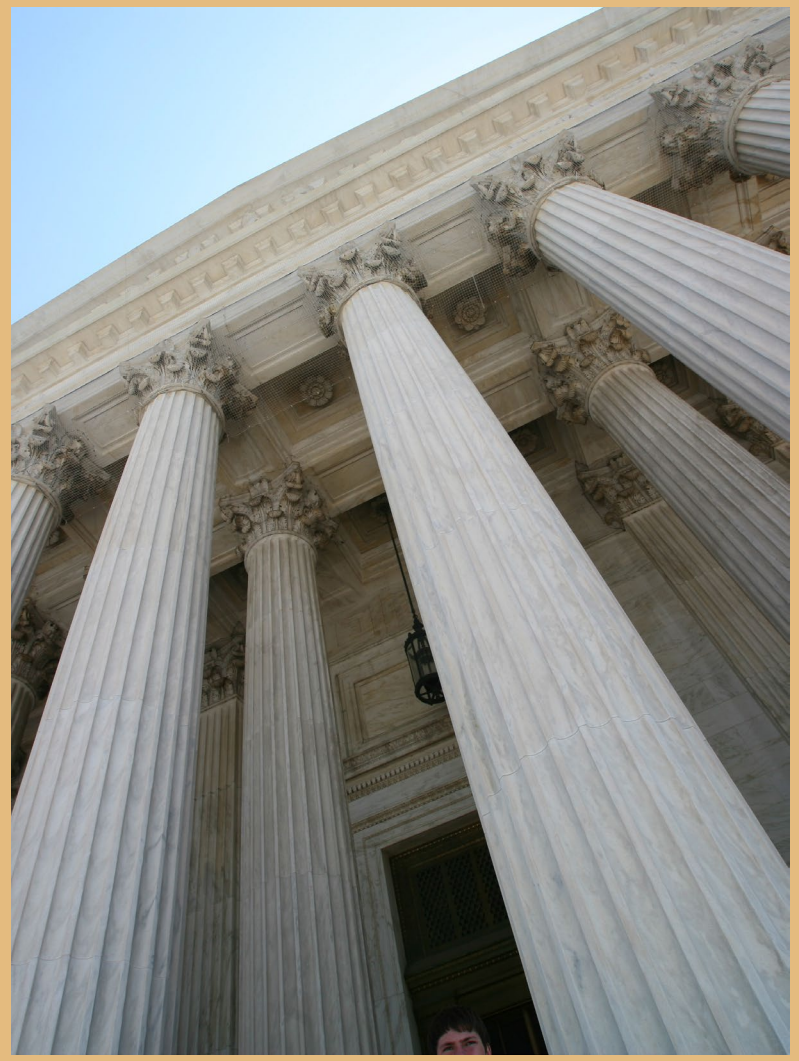
CMS regulators

Health plan executives

MA compliance expertise

Agenda

- Introductions
- CMS Industry Overview (10 minutes)
- Overview of Current D-SNP in California (20 minutes)
- Board Brilliance: What Should the Board Ask/Judge Success (30 minutes)
- Alliance Readiness (5 minutes)
- Questions and Answers (10 minutes)



CMS Industry Overview

CMS Oversight Activity

- Government oversight of MA plans has increased in key areas, such as:
  - Focus on recoupment of improper payments
    - Risk Adjustment auditing (OIG Audits)
    - Ad Hoc CMS auditing using sophisticated algorithms
    - Machine learning algorithms

CMS Oversight Activity Continued

- Focus on misleading activities coming from third party marketers

- Appeals and Grievances, Call Center
- Prior Authorization process and oversight

- CMS using it’s ability to terminate contracts for multi-year low performers

Stars Overview

D-SNP Regulatory Structure

D-SNP

Medicaid

- CA DHCS Contract
- Population Health Management (PHM)
- Comprehensive Quality Strategy (CQS)
- CalAIM
- NCQA

Medicare Regulations

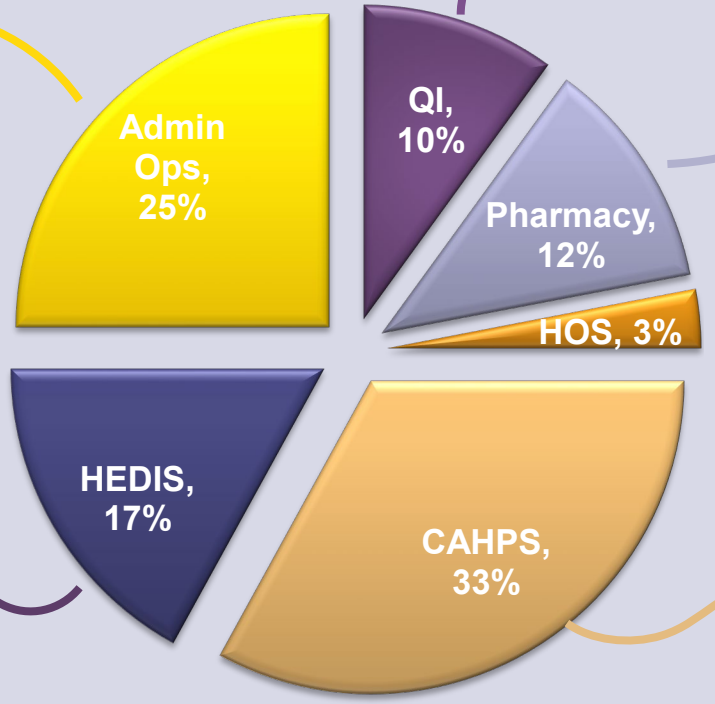
- Part C & D Reporting
- HEDIS
- Stars
- Risk Adjustment
- Model of Care

Star Ratings – Primary Purpose

- Annual Performance Evaluation of Part C & D Plans
- Determines Quality Bonus Payments (QBPs)
- Publicly reported on cms.gov website every October
- Displayed within Medicare Plan Finder (MPF) for beneficiaries at medicare.gov

How Star Ratings Work

Star Ratings Measure Sources



Quality Improvement
Health Plan & Drug Plan

Pharmacy
Adherence & Rx Benefit
Administrative Ops

HOS Survey
Member Outcomes & Health Status

CAHPS Survey
Member Experience with the Plan

Administrative Operations
HRAs, Complaints, Appeals, Disenrollment, Call Center Interpreter

HEDIS
Clinical Process and Outcome Measures

Local Market Landscape

Alameda County Market Demographics

- 28% of the 60+ population are ages 60-64
- 23% of the 60+ population are between the ages of 65 and 69 with 42% of this population between the ages of 65 and 74

Household Income	Householder Count	%
Less than $10,000	9,261	6.6%
$10,000 to $14,999	8,443	6.1%
$15,000 to $29,999	17,629	12.6%
$30,000 to $49,999	14,733	10.6%
$50,000 to $74,999	18,638	13.4%
$75,000 to $99,999	16,500	11.8%
$100,000 to $149,999	22,543	16.2%
$150,000 +	31,785	22.8%
Householder Age 65+	**139,532**	**100%**

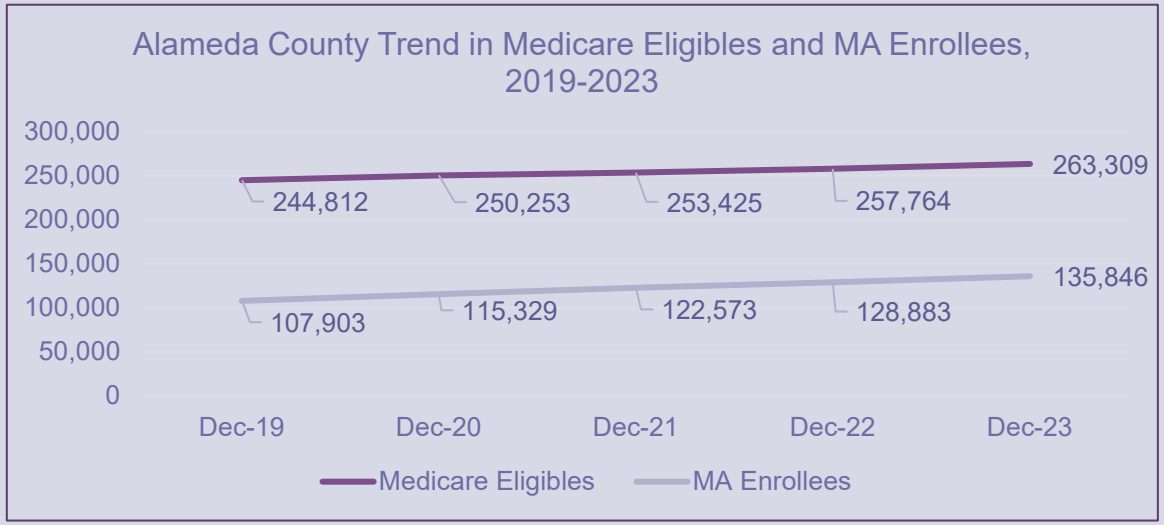
Age Segment	Population Count	%
60 to 64 years	97,055	28.5%
65 to 69 years	77,811	22.9%
70 to 74 years	65,475	19.2%
75 to 79 years	41,482	12.2%
80 to 84 years	27,596	8.1%
85 years and over	30,875	9.1%
Total	**340,294**	**100%**

Race and Ethnicity in Population 60+	
One race	92.7%
White	40.9%
Black or African American	11.4%
American Indian and Alaska Native	0.8%
Asian	32.0%
Native Hawaiian and Other Pacific Islander	0.6%
Some other race	7.1%
Two or more races	7.3%
Hispanic or Latino origin (of any race)	13.0%
White alone, not Hispanic or Latino	39.5%

MA Has a Strong Presence in Alameda

- Alameda County has an MA Penetration of nearly 52%, and 263k current Medicare eligibles.
- MA penetration indicates there is an appetite for MA but not yet saturation.
- MA enrollment growth (27.9k) has outpaced Medicare eligible growth (18.5k) since 2019, a signal that MA growth will continue.

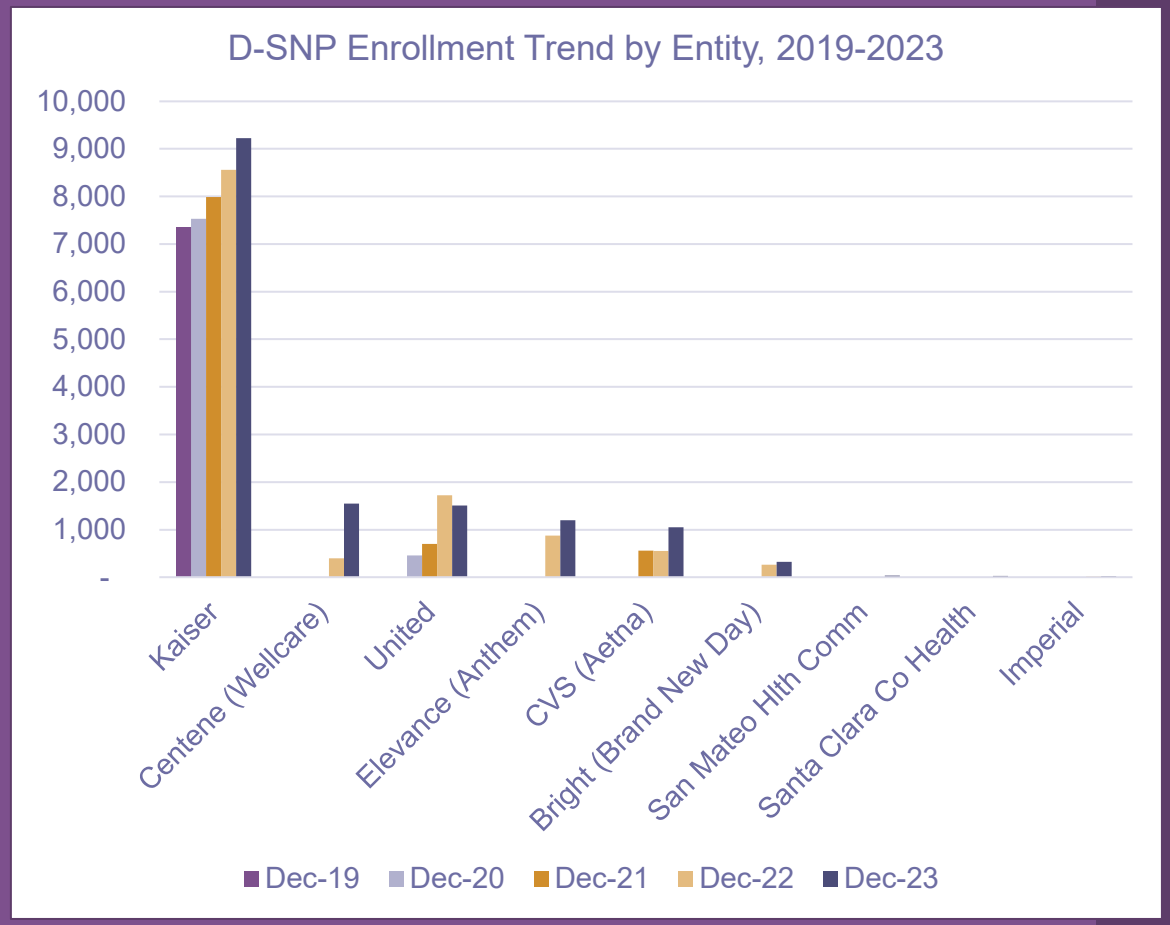
MA Penetration, December 2023			
Market	**MA Eligibles**	**MA Enrollees**	**MA Penetration**
Alameda County	**263,309**	**135,846**	**51.59%**
CA Total	6,813,097	3,425,945	50.28%
National	66,324,253	32,660,634	49.24%



Kaiser Direct Contract

- Kaiser Permanente began a **five-year term** as a Medi-Cal managed care plan **directly** contracted in specific regions of California, effective January 1, 2024.
- Kaiser will operate as a full-risk, full-scope Medi-Cal managed care plan, **relinquishing previous exceptions** or alternative standards.
- Kaiser's enrollment will expand from **22 to 32 counties**, including a 25% growth commitment for new Medi-Cal members, over five years.
- The growth will include continuity, dual eligibles, and open choice enrollment for foster youth, **diversifying** Kaiser's case mix.
- Kaiser will open to default enrollment for all Medi-Cal beneficiaries, subject to an annual cap **per county** based on projected capacity.
- The proposal aims to align Kaiser with other Medi-Cal managed care plans, **eliminating exceptions** while preserving member continuity and ensuring quality outcomes.
- Kaiser will implement CalAIM Enhanced Care Management and Community Supports, supporting FQHCs, and providing specialty care in underserved areas.
- **Network adequacy standards** will be enforced for Kaiser, denying future exemptions and assessing compliance in Knox-Keene licensed service areas.

Recent D-SNP Growth Has Been Driven by Regulatory Changes

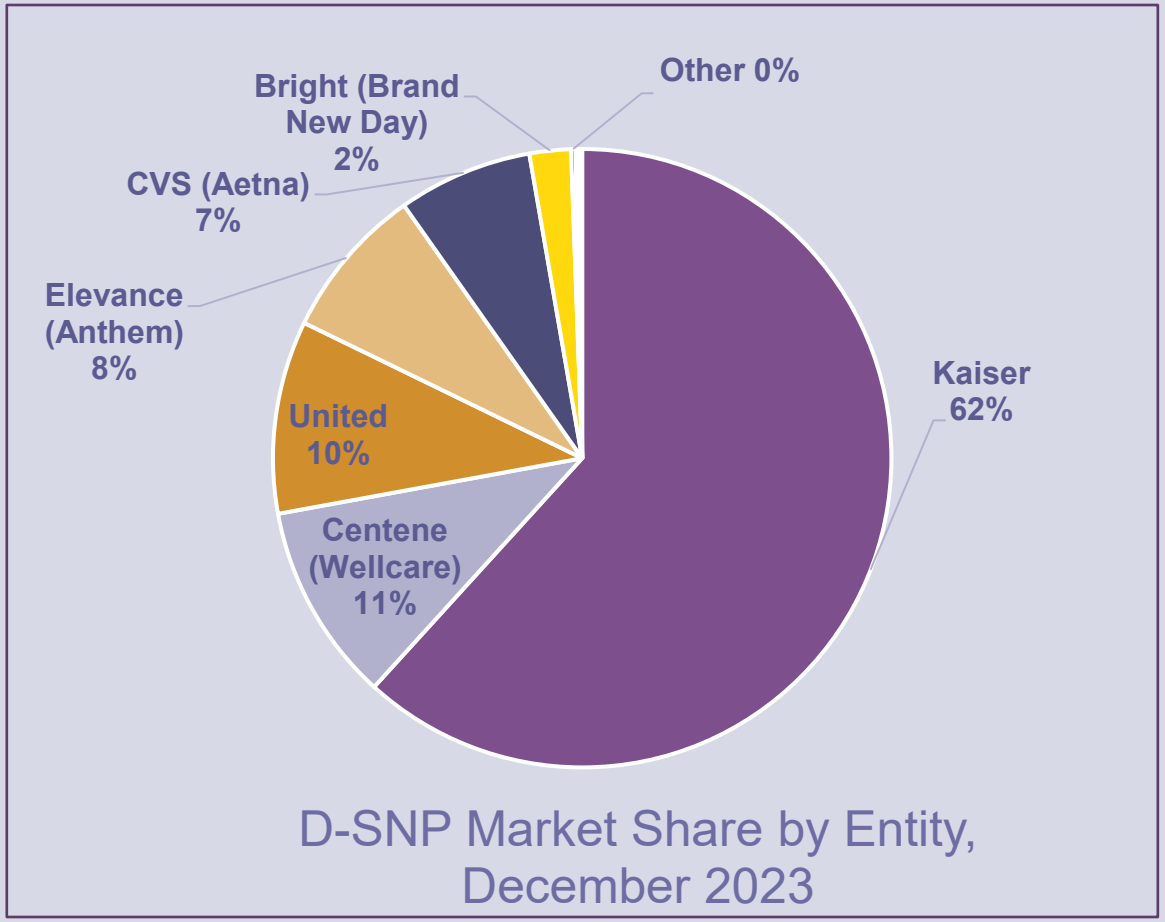


- Key regulatory changes impacted overall D-SNP growth in CA, including Alameda County:
  - Effective 2023, dual eligibles are required to be enrolled in a MediCal Managed Care Plan.
  - Effective 2023, CMS did not renew qualifying D-SNP look-alike plans in states with existing D-SNPs or MMPs.
- Overall, D-SNP products have grown by 103% since 2019, adding over 7.5K lives.
- The majority of growth has occurred during the past two years, with 3.1K and 2.5K new D-SNP lives in 2022 and 2023, respectively.
- Kaiser (62% D-SNP market share) has seen the most growth since 2019, adding 1.9K lives in D-SNP.
- Centene and United, with 10% D-SNP market share, have seen the next largest growth since 2019. However, both carriers exited the county in 2024.
  - United will still offer MA-PDs
- Centene (WellCare) saw the largest recent growth in their D-SNP, growing over 1.1K members from December 2022 to December 2023. United saw a decline of 219 members during this same time.

Alameda County: Kaiser Dominates the D-SNP Market

- Kaiser leads D-SNP enrollment with 62% share in Alameda County.
- WellCare and United both exited the county in 2024.
- January 2024 CMS data is not yet available.

D-SNP Enrollment by Entity, December 2023		
Entity	**D-SNP Enrollment**	**Total Individual Enrollment**
Kaiser	9,225	66,616
Centene (WellCare)	*1,550*	*4,298*
United	*1,507*	*8,368*
Elevance (Anthem)	1,198	2,082
CVS (Aetna)	1,051	4,648
Bright (Brand New Day)	323	2,658
San Mateo Hlth Comm	35	35
Santa Clara Co Health	31	31
Imperial	20	223
Total	**14,940**	**88,959**



WellCare and United are no longer offering D-SNP in Alameda County in 2024. D-SNP enrollment is 11% of the total Medicare Advantage market in Alameda County (December 2023).

Duals Have Rich Benefit Options in Alameda

	Anthem	Aetna
Dental	✓	✓
Eye wear	✓	✓
Hearing aids	✓	✓
Over the Counter (OTC) items	✓	✓
Flex (pre-paid card)	✓	✓
Home & bath safety	✓	✓
Fitness	✓	✓
Transportation	✓	✓
Personal emergency response system	✓	✓
Meals	✓	✓
Acupuncture	✓	✓
Annual routine physical	✓	✓

- In keeping with nationwide trends, D-SNPs in Alameda County offer rich benefit designs with the following non-negotiables:
  - Dental
  - Eyeglasses
  - Over the Counter (OTC) personal health items
  - Fitness
  - Acupuncture
- Anthem offers a single allowance towards OTC, assistive and safety devices, groceries and utilities (via a pre-paid card)
- Aetna has separate benefit allowances for OTC & healthy food (via a pre-paid card)

Alameda Aliance – Dual Conversion

- Alameda Alliance has approximately sixty thousand Dual Eligibles enrolled today. The conversion of these members into the Dual-SNP will require a multi-pronged approach, including:
  - Education beginning far in advance of Annual Enrollment
  - Direct outreach
  - Provider based marketing
  - Community focused presence/events

D-SNP Implementation Timelines & Readiness

AEP Begins 10/1/2025

Go-Live 1/1/2026

2023			2024				2025			
Q2	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Project Launch	Proforma; IT Assessmt.	Compliance; IT; Provider Workgroups Begin	Clinical and Operations Work Effort Begins Provider Contracting & Payment Strategy Decisions (by 4/15/24) **DMHC MA SAE Filing (3/1/24)** **DHCS Required Filing(s)**	HEDIS and Stars Work Effort Begins PBM RFP or Contract Discussions Continued Preparation for Next DMHC Filing (D-SNP)	Finalize and Push PBM RFP (as applicable) **DMHC MA SAE Filing Approval** Begin CMS Application Filing Work Effort (due 2/25) PBM RFP Next Steps (as applicable)	PBM RFP Next Steps (as applicable) **DMHC D-SNP Filing (10/1/24)** **Notice of Intent to Apply to CMS (11/24)**	**DMHC D-SNP Filing Approval** **MA; Part D; DSNP Applications to CMS (2/25)** **Model of Care to CMS (2/25)** **Network Adequacy to CMS (2/25)**	Vendor Implementations System and Readiness Testing Begins Member Material Development and Submissions **Bid to CMS (6/25)**	Finalize Program and Policy Documents **CMS Contract Approved and Executed** Q2 Activities Continue	Marketing; Sales; Enrollment Begins Q2 and Q3 Activities Continue

Workgroups; Decisions and Readiness

Boardroom Brilliance

GUIDING SUCCESS THROUGH STRATEGIC INSIGHT

January 26th, 2024

Going Live January 1, 2026

Never enough time...in 20 months you will be accepting enrollments

Easy to allow current fires to cloud measuring your implementation

Difficult to prioritize Boards involvement—be a data driven board

Too many variables that drive decisions/success

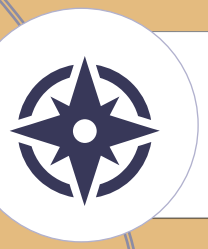
Escaping analysis paralysis with strategic clarity

Embrace the power of inquiry

Cadence to Success

Strategic Vision and Planning for Go-Live 2026	Risk Management & Compliance of Medicare Start Up	Manage Financial Health of Go-Live Project	Innovation & Technology Adoption	Drive towards operational excellence and efficiency
Develop and refine the organizations long-term strategic vision, ensuring alignment with market trends and opportunities.	Implement robust risk management strategies and ensure compliance with CMS and California regulations, protecting the Alameda from potential setbacks and legal issues.	Ongoing monitoring of financial performance leading up to go-live with monitoring of key financial metrics. (2025 budgeting will have a lot of assumptions.)	Foster a culture of innovation and monitor the adoption of new technologies to stay competitive and adaptable to the rapidly changing Medicare landscape	Streamline operations, optimize processes, and enhance overall efficiency to maximize productivity and reduce cost

Keeping Your Sanity Leading to Go-Live



Navigating the Boardroom calmly on the road to go-live will keep your sanity

- This is not a time to have scorecards…

The next 20 months will be a balancing act for this Board

Maximizing Momentum: Elevate Boardroom confidence with comprehensive go-live updates

- Don’t shortchange your value you bring to Matt’s team

Safeguard Sustainable Growth by Managing the Following

- Dive deep into execution risk for sustainable growth strategies
  - Do not assume success because you are building a plan and you have current Medicaid members that have Medicare—unless they auto assign them to your D-SNP
  - Do you currently have Dual members that get their Medicare from a Medicare Advantage plan? - I'm assuming yes
- Provider education takes center stage in Q2-3 2025
- Because your Dual members currently on your Medicaid plan are your members, you can touch them prior to AEP 2026

Not doing these three things well will drive a painful financial experience

1. Stars bonus is set for the first three years at 3.5%—January 1, 2026 data starts your scoring for 2029
2. Failure to execute your risk adjustment program will sink a D-SNP by year two! New members coming from fee-for-service will not have a big enough score for you to succeed
3. Managing the integrity of your data will drive successful care management strategies

www.rebellisgroup.com

https://www.linkedin.com/company/rebellis-group

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

FINANCE CONCEPTS PRESENTATION

Gil Riojas

Alameda Alliance for Health

Financial Concepts Presentation

January 26th, 2024

Questions to answer

What do the different components of a financial statement represent?

As a board member, what are the most important financial concepts/metrics to be aware of?

How do the financial metrics represent our performance?

What is Tangible Net Equity?

How do our financial reserves compare to other plans?

What are the components of a financial statement?

- **Balance Sheet-** Reports the Alliance's assets and liabilities during a given period. Assets include things like cash, investments, property and equipment, accounts receivable. Liabilities include things like claims payable, accounts payable, Incurred But Not Paid claims (IBNP). We should report more assets than liabilities. Answers the question, do we have enough funding to cover what is owed to others?
- **Income Statement-** Reports revenues and expenses during a given period. Revenue includes funding paid by DHCS and the County of Alameda to provide care to our members, it also includes income we earn from our investment portfolio. Expenses include amounts paid to our providers and for our administrative functions. Answers the question, did we receive more funding in the period than we paid out in the period? If so, this is reflected as net income, if not this is reflected as net loss.
- **Cash Flow Statement-** Reports inflow and outflows of cash in the period. Answers the question, where did our cash come from and where did it go to?

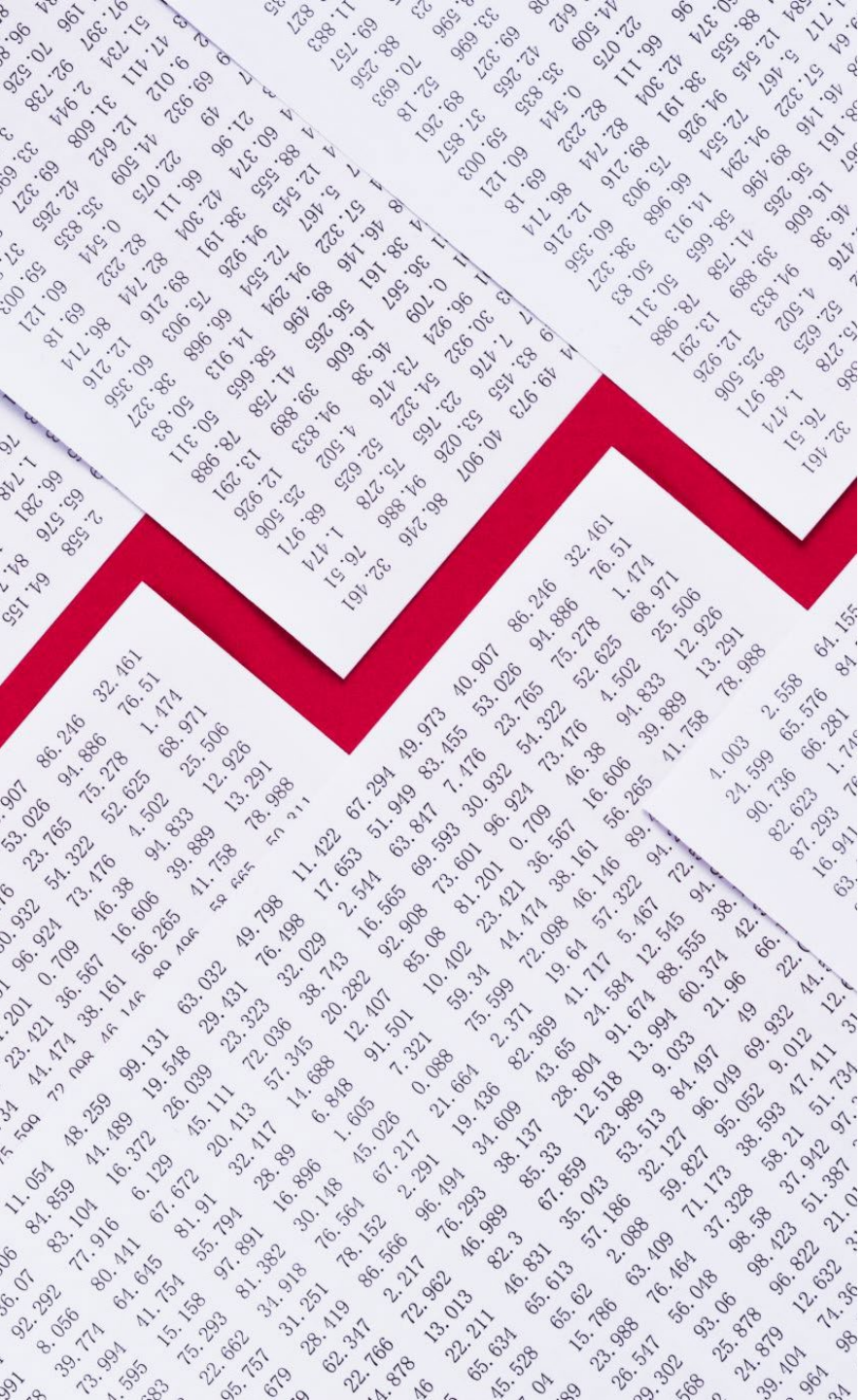
An organization's financial statements reflects its values. It shows what the organization considers important based on how it spends its money

What is our financial package showing the board?

- Is our enrollment growing or shrinking? Enrollment changes are a primary driver of changes to our revenue and expenses. Increasing enrollment means increasing revenue and expenses.
- Did we report income or loss? What is our trend of earning or losing over the last 12 months?
- How much have we spent on our core business?
- How much have we spent on our administrative support of our core business?
- How much do we have in reserves?
- Do we have enough current assets to cover liabilities that are coming due?

Quick ways to identify our financial position

- **Net Income/Loss**-Did we make money or lose money? We budgeted Net Income of $9.3M
- **Medical Loss Ratio** (MLR)-Did we spend at least 85% of our funding on medical care?
- **Administrative Loss Ratio**(ALR)-How much did we spend on administrative functions?
- **Tangible Net Equity**(TNE)-Is our reserve growing or shrinking, there are implications for both over the long-term. How does it compare to what is required by regulators?
- **Current Ratio**-Do we have sufficient short-term cash and investments to cover our short-term liabilities?
- **Trends**-We will have losses and gains from month to month but what is our long-term trend?

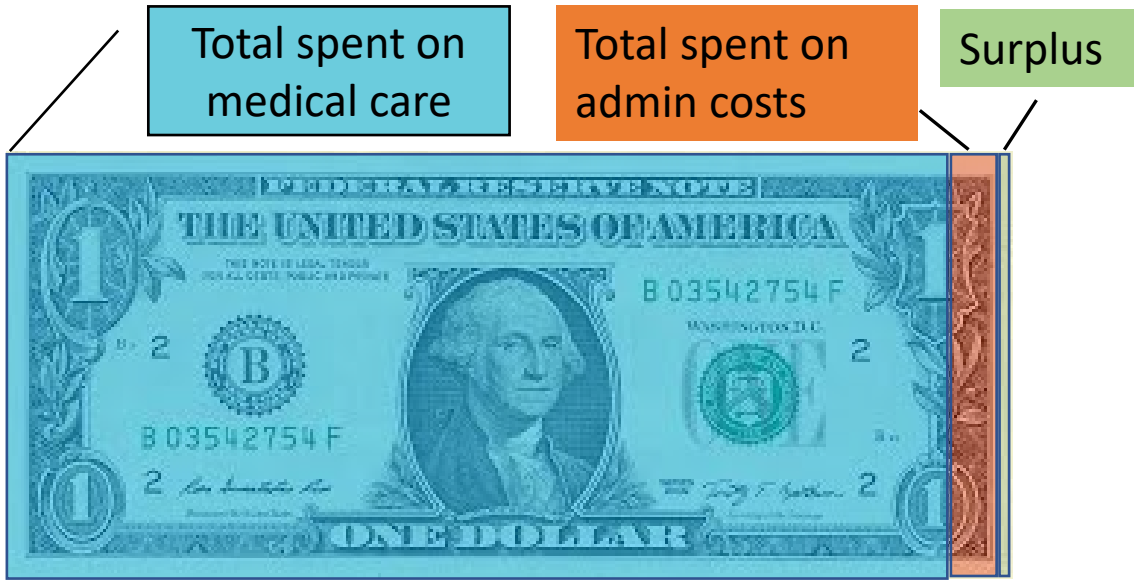


Income Statement

- Compares revenue received from DHCS and the County to expenses paid for medical and administrative expenses.
- A Net Income means
  - TNE reserves grow from the previous month.
  - MLR typically ranges between 85-93%.
- A Net Loss means
  - TNE reserves shrink from the previous month.
  - MLR is typically at or above 95%, closer to 100%.

Medical Loss Ratio (MLR)

- MLR illustrates how much of our revenue was spent on medical services.
- Calculated as Medical Expenses/Revenue.
  - An MLR reported at or below 94% typically means we reported net income in the period.
  - An MLR reported at or above 95% typically means we reported net loss in the period.
  - MLR reported above 100% means we spent more in medical expenses than receive in revenue for the period.
  - To meet the Board's directive of 1% Net Income for the year we would need to report MLR at 93% or below. This assumes ALR of 5.8%.



Administrative Loss Ratio (ALR)

- Illustrates how much of our revenue was spent on administrative services.
- Calculated as Administrative Expenses/Revenue.
  - The Administrative Loss Ratio plus Medical Loss Ratio is our expense ratio.
  - On average our ALR ranges from 5-7%. Our budgeted ALR is 5.8%.
  - The ALR ratio increases as our administrative costs increase through FTE increases, increases in consulting costs, computer support costs, licensing and insurance increases, non-clinical community reinvestment, etc.

Tangible Net Equity (TNE)

- TNE is a required amount of assets, made up of things like cash, investments, property, capital assets, the plan must have on hand to cover a certain amount of expenses on hand.
- The calculation of TNE is based on a statutorily defined formula. The amount of reported TNE and required TNE changes month by month as our Net Income goes up or down and as our Fee-for-Service expenses go up or down.
- The State monitors and considers the TNE of plans when developing future program and benefit requirements of plans. DHCS may capitalize plans to prepare for these new and upcoming services.

Tangible Net Equity Calculation

+ Net Equity (Reported TNE)

– % Fee for Service Health Care Expenses (Required TNE)

(8% of the first $150M annualized FFS health care expenses) + (4% of the annualized FFS health care expenses in excess of $150M)

= Excess Tangible Net Equity (Excess TNE)

For November, the tangible net equity requirement represents approximately 39% of total medical expenses for the period. Capitated expenses are not a component of the TNE requirement calculation.

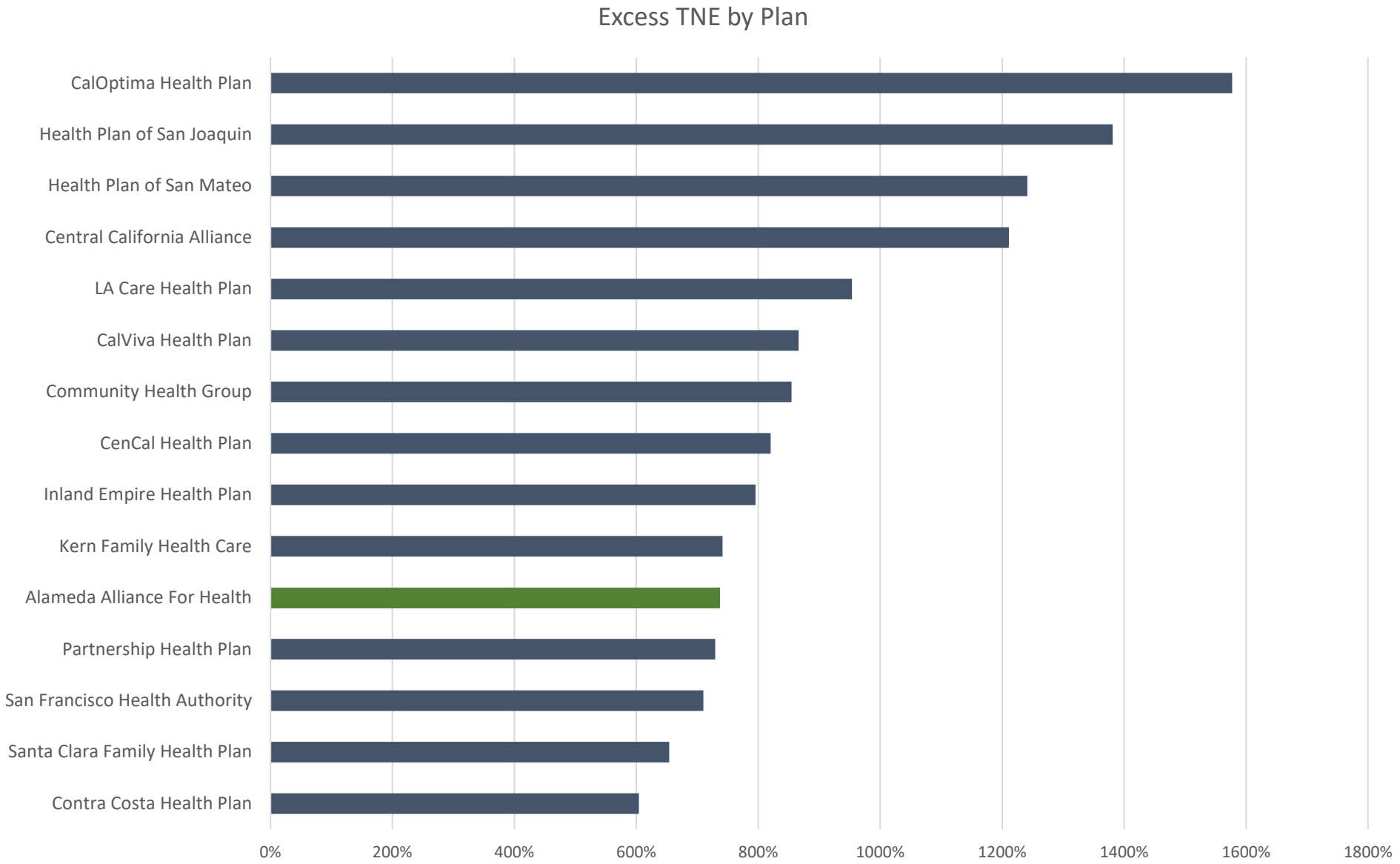
How much TNE do we have compared to expenses?

Total Expenses Reported-$136.2M

Tangible Net Equity Reported-$348.8M

Tangible Net Equity is equal to 2.5 times our expenses. This means we have enough TNE to cover our total expenses for two and a half months.

How do our reserves compare to other plans?



Questions?

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

QUALITY & EQUITY STRATEGY PRESENTATION

Quality & Equity Strategy

Board of Governors Retreat
January 26, 2024

EPSDT

Older Adults

Behavioral Health

ALAMEDA Alliance FOR HEALTH

Agenda

- Single Plan Model
- Quality Focus
- Rise of Equity Focus

EPSDT	Older Adults
• Current state • Quality & Equity approach • Underutilization • Key partnerships • Behavioral Health: Autism services	• Current state • Quality & Equity approach • Underutilization • Key partnerships • Behavioral Health: Dementia screening

Goals

- Provide key information
- Receive feedback from Board on current state and future direction

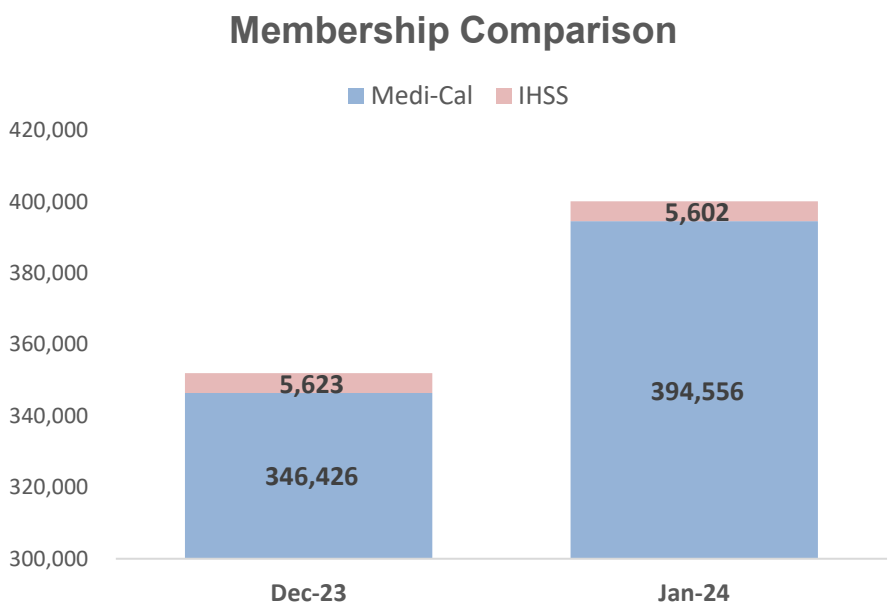
Single Plan Model Impact

ALAMEDA Alliance FOR HEALTH

Single Plan Model

- Anthem and Undocumented Transitions
  - Membership as of January 1st
    - 400,199 (preliminary)
  - Majority of Anthem members with CHCN and AHS
  - Authorizations received from Anthem
    - Loading 1100 authorizations
  - DHCS Network Certification
    - Passed at 94%
    - Specialist, working on contracts outside Alameda County
  - Community Supports
    - 500-600 members in Community Supports (compared to Alliance 1600)
    - Loading authorizations
  - Enhanced Case Management
    - 168 members (compared to Alliance 1500)

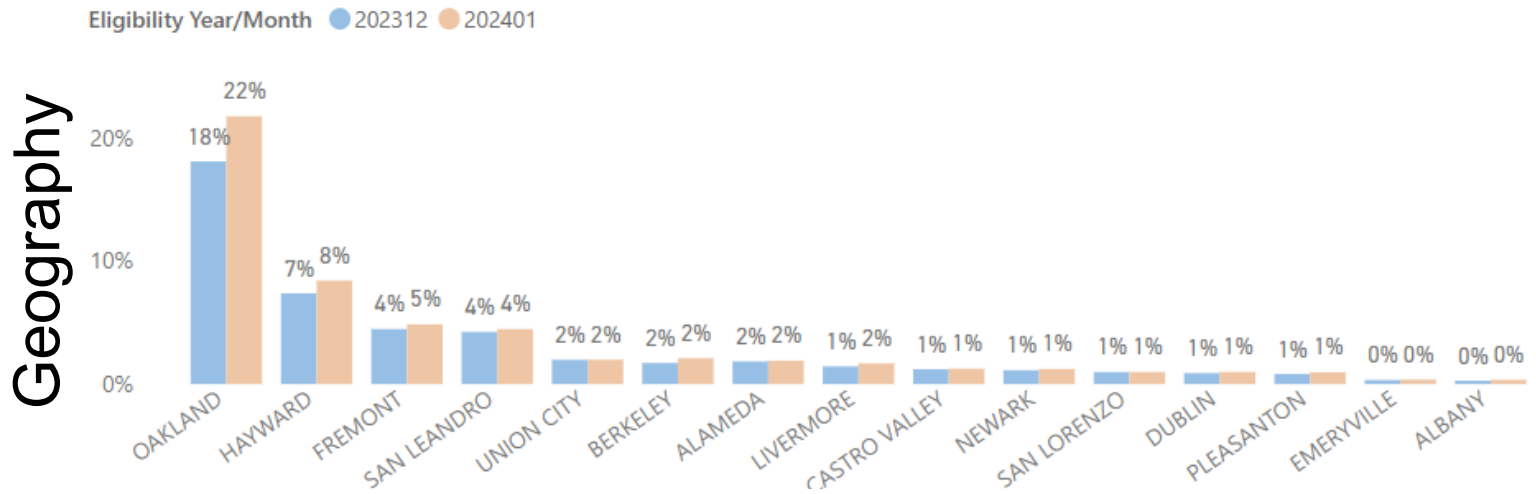
Single Plan Model: Membership



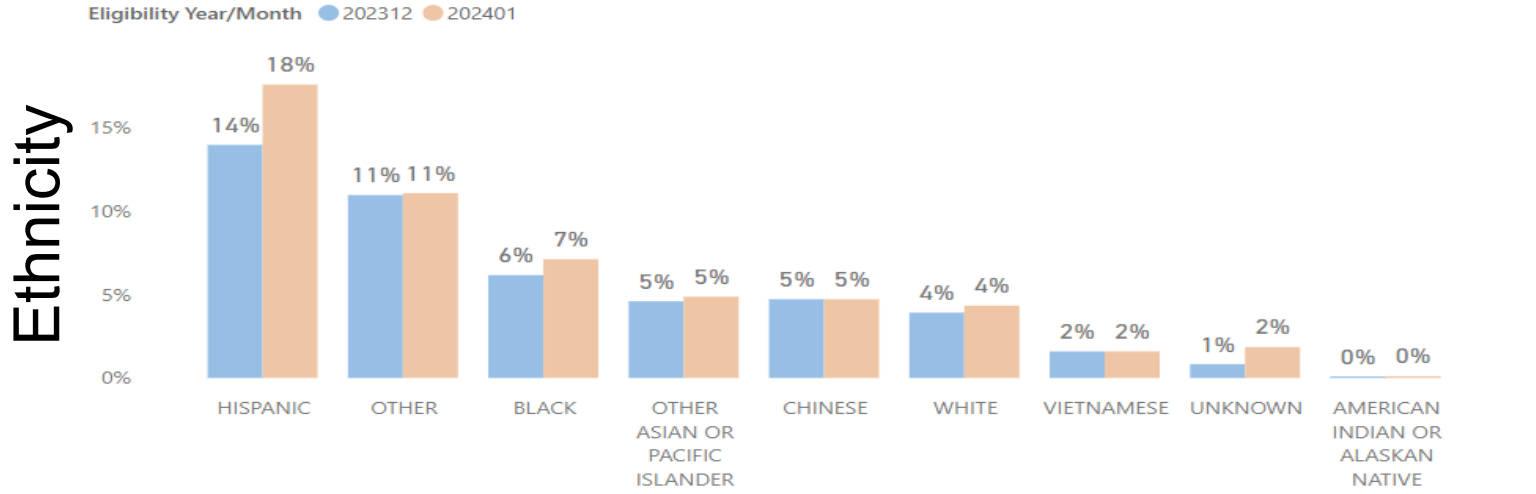
- The Medi-Cal membership grew by ~48K members in January 2024.
- The majority of the variance is attributed to:
  - ~20% increase from the Anthem transition out of the county (~78K)
  - ~5.5% increase from Adult Expansion carve in (~21K)
  - ~12% decrease from Kaiser's transition to a direct contract (~48K)
- IHSS membership remained static.

Single Plan Model: Membership

Geography



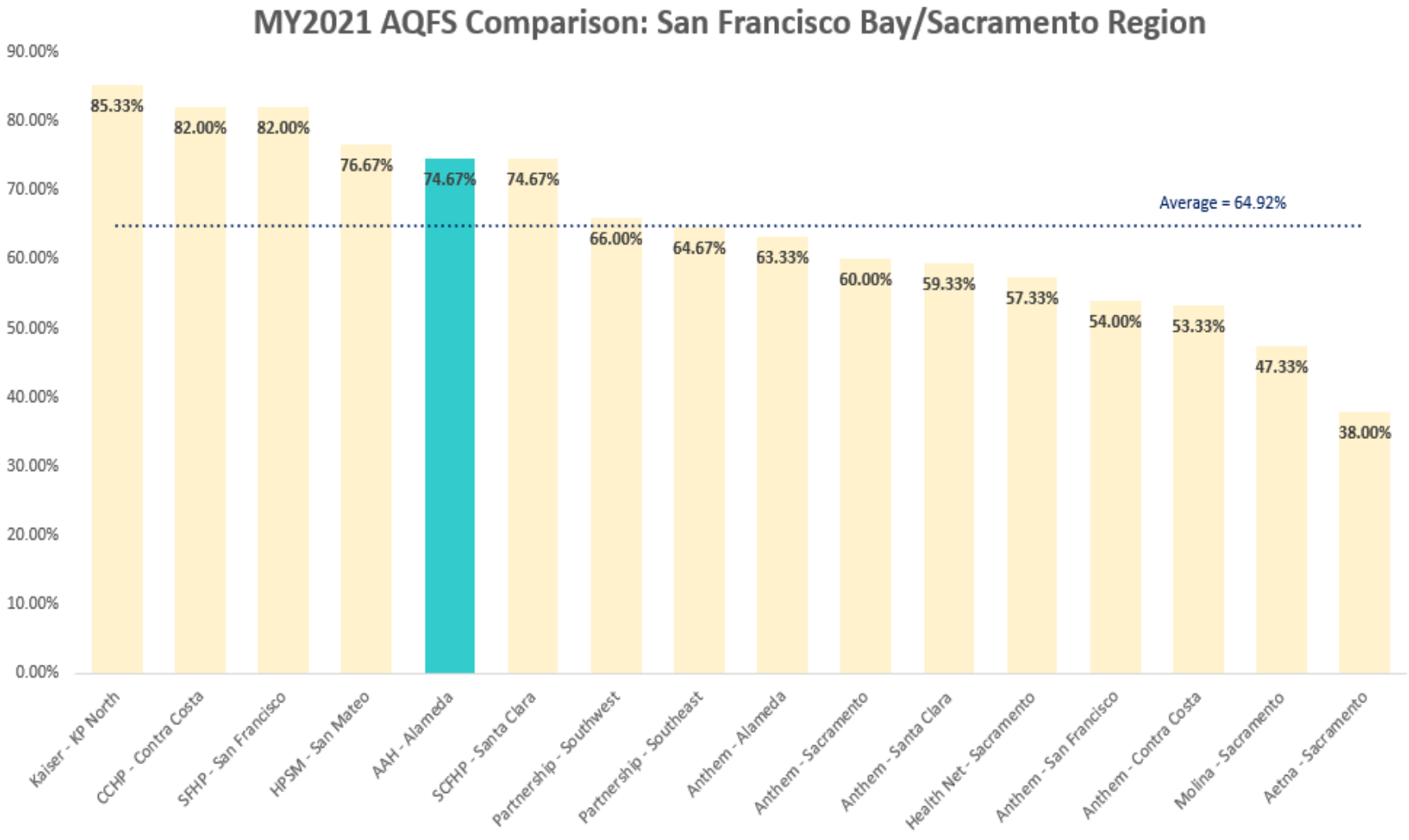
Ethnicity



Single Plan Model

- Rates
  - Final rates up approximately 2% overall 1.5% from preliminary budget (preliminary)
  - Overall rates up approximately 6.5% but the majority increase is pass through
- Tangible Net Equity (TNE)
  - Current projected TNE is 640%

Single Plan Model: Quality



Single Plan Model

- Program Discussions
  - Lyft Program
  - Kaiser
    - Default members/algorithm
    - 2025
  - Stanford
  - Sutter

Quality Focus

Quality

What's at risk?

- Sanctions: 25K → 80K
  (2022) (2023)
- Rate withholds : ~8M
- Value Based Payment
  - FQHC APM
  - PCP VBP
- Medicare STARS

Impact Factors

- Single Plan County
  - Anthem → negative impact
  - Kaiser → negative impact
- Bay Area Comparators
- Impact of Access
- Community Reinvestment & Provider recruiting

Quality Sanctions

- New December 2023
  - Final postponed to January 2024 due to inconsistencies
- New Language
  - DHCS may require or impose a CAP on an MCP and/or impose other enforcement actions for the violations set forth in W&I section 14197.7(a) and outlined below. For example, sanctions may be imposed on an MCP together with a CAP, in lieu of a CAP, or if the MCP fails to meet CAP requirements.
  - Subcontractors:
    - MCPs are further responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all Subcontractors and Network Providers. DHCS may impose Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions for non-compliance on the MCP and Subcontractors.

Quality Sanctions

- All fines double for each year or:
  - DHCS may impose sanctions of up to $25,000 per violation for the first violation of the conduct set forth at W&I 14197.7(f), up to $50,000 for the second violation, and up to $100,000 for each subsequent violation.
  - Suspension of an MCP's new enrollment activities, including default enrollment.
  - Suspension of an MCP's marketing activities.
  - Requiring an MCP to temporarily suspend specified personnel and/or a specified Subcontractor.
  - Requiring MCPs to ensure that Subcontractors cease certain activities, including referrals, assignment of Eligible Beneficiaries, and reporting, until DHCS determines that the MCP is in compliance with Contractual Obligations and applicable state and federal laws and regulations. DHCS must impose temporary management if it finds that the MCP has repeatedly failed to meet the substantive requirements or contract termination.

How is Quality measured?

- **Healthcare Effectiveness Data Information Set (HEDIS)**
  - National benchmarks to compare health plan performance
    - Updated annually for evidence-based guidelines, benchmarks, and revised quality measures
  - 6 dimensions of quality of care and service
    - Effectiveness
    - Access/Availability
    - Experience of Care
    - Utilization
    - Descriptive Information
    - Electronic systems

How is Quality measured?

- **Medi-Cal Accountability Set (MCAS)**
  - DHCS HEDIS subset
  - Domains
    - Behavioral Health
    - Children's Health
    - Chronic Disease
    - Reproductive Health
    - Cancer Prevention

https://www.dhcs.ca.gov/dataandstats/reports/Documents/Medi-Cal-Accountability-Set-Reporting-Year-2024.pdf

HEDIS MCAS Performance

Measure Description	MY2022	MY2023	50th Pctl (MPL)
Behavioral Health			
Follow-Up After Emergency Department Visit for Substance Use (30-Day)	29.82%	30.60%	36.34%
Follow-Up After Emergency Department Visit for Mental Illness (30-Day)	49.03%	30.92%	54.87%
Children's Health			
Childhood Immunization Status—Combination 10	63.26%	57.06%	30.90%
Developmental Screening in the First Three Years of Life	44.24%	54.28%	34.70%
Immunizations for Adolescents—Combination 2	50.61%	49.24%	34.31%
Lead Screening in Children	60.58%	60.67%	62.79%
Topical Fluoride for Children	12.18%	9.95%	19.30%
Well-Child Visits in the First 15 Months - Six or More Well-Child Visits	46.56%	56.39%	58.38%
Well-Child Visits for Age 15 Months to 30 Months -Two or More Well-Child Visits	69.01%	73.95%	66.76%
Child and Adolescent Well-Care Visits	49.69%	55.18%	48.07%
Chronic Disease Management			
Asthma Medication Ratio	74.71%	70.12%	65.61%
Controlling High Blood Pressure	54.74%	46.65%	61.31%
Hemoglobin A1c Control for Patients with Diabetes—HbA1c Poor Control >9%	29.20%	34.73%	37.96%
Reproductive Health			
Chlamydia Screening in Women	64.14%	66.40%	56.04%
Prenatal and Postpartum Care - Postpartum Care	87.50%	85.44%	78.10%
Prenatal and Postpartum Care - Timeliness of Prenatal Care	85.42%	85.88%	84.23%
Cancer Prevention			
Breast Cancer Screening	56.08%	59.25%	52.60%
Cervical Cancer Screening	53.83%	57.85%	57.11%

*Note: Rates as of 1/5/2024; MY 2023 rates are finalized in June 2024

Key Points:

- Increase in rates from MY 2022 to MY 2023 for children and reproductive health domain measures
- 6 preliminary* measures are below MPL for MY 2023

Member Satisfaction

Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.1H Survey

Summary Rate Scores: Medi-Cal Child				
	2023 PG BoB Region	**MY2022**	**Previous Year Comparison**	**MY 2021**
Getting Needed Care (% Always or Usually)	78.2%	79.2%	↑	78.4%
Getting Care Quickly (% Always or Usually)	78.8%	73.0%	↓	77.8%

Summary Rate Scores: Medi-Cal Adult				
	2023 PG BoB Region	**MY2022**	**Previous Year Comparison**	**MY 2021**
Getting Needed Care (% Always or Usually)	78.4%	75.2%	↓	75.9%
Getting Care Quickly (% Aways or Usually)	75.4%	72.9%	↓	75.9%

Quality Investment: Summary

1. Provider Engagement
   - **P4P Funding $2.5 Million**
   - **Health Equity Incentive $1 Million**
   - Value-Based Payment Program
   - On-going Network Development to ensure timely access
2. Member Engagement
   - **2 FTEs** telephonic outreach on care gap lists
   - Explore integrated care management platform (FY 2025)
3. Data collection & sharing **$400K**
4. Funding/Resources
   - Community Investment funds
   - QI/Performance Improvement Projects: **2 FTEs**
     - Pediatrics
     - Behavioral Health measures
     - Support for VBP, EPT, health disparity projects
   - Practice coaching consultants/ training/staff (vendor): **$300K**
5. Organizational Alignment
   - Coordinated campaigns**: multi-modal communication methods (i.e. letters, text, flyers, etc.) $150K**
   - Utilize **Alliance staff incentives** to reward HEDIS activities/performance

Rise of Equity Focus

ALAMEDA Alliance FOR HEALTH

Equity Initial Efforts

- Current efforts
  - Health Equity Incentive Pilot
  - NCQA Health Accreditation
  - PHM Strategy
    - Population Segmentation
  - DEI Consultant
  - Shift to QIHE Program
- Underutilization

Health Equity Incentive Pilot

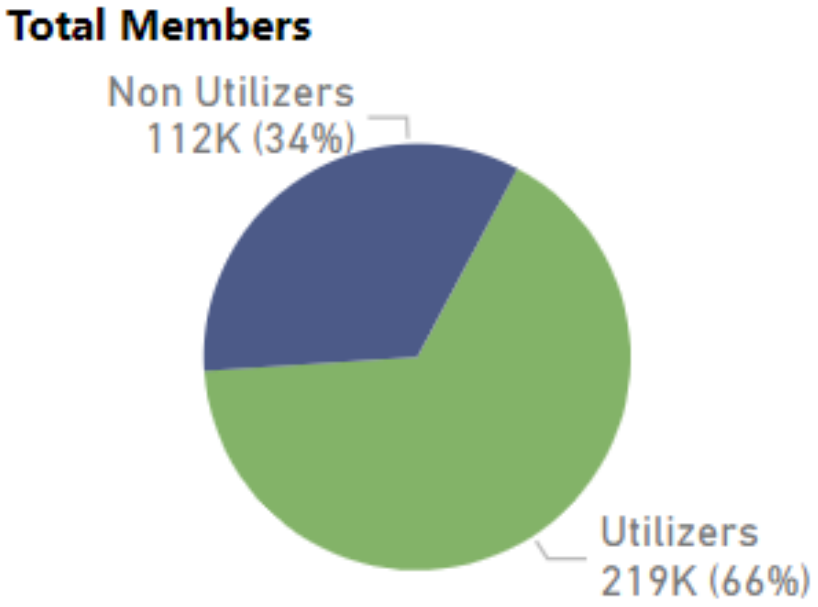
- Overview:
  - Focus on 3 measures in 3 different domains from the MCAS list that were below the MPL in 2022.
  - Focus on race/ethnicities that were 5% below the overall admin rate in 2022.
  - Add a flag to the gap-in-care reports to identify members.

Health Equity Incentive Pilot

Domain	Measure	% of Pool	$ in Pool
Children	6 or more well-child visits in the first 15 months of life (W15) for the following race/ethnicities: * Asian or Pacific Islander * Black * Filipino * Korean * White * Other * Unknown	25%	$250,000
Cancer Prevention	Cervical Cancer Screening (CCS) for the following race/ethnicities: * Amerasian * American Indian or Alaskan Native * Asian Indian * Filipino * Guamanian * Hawaiian * Korean * Samoan * White	50%	$500,000
Chronic Disease	Controlling High Blood Pressure (CBP) for the following race/ethnicities: * American Indian or Alaskan Native * Asian Indian * Asian or Pacific Islander * Filipino * Japanese * Samoan * Unknown	25%	$250,000
	Total	**100%**	**$1,000,000**

Non-Utilizers*

*** Member with no utilization identified in a 12-month period**



- ~ 1/3 of all AAH members
- 21-50 year old highest percentage (43%)
- ~50% are age <21 or 50+

Non-Utilizers Race/Ethnicity

Age group:

<21

Hispanic*

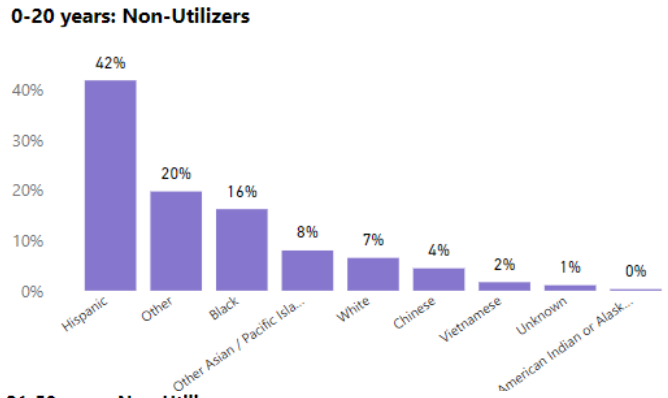
21-50

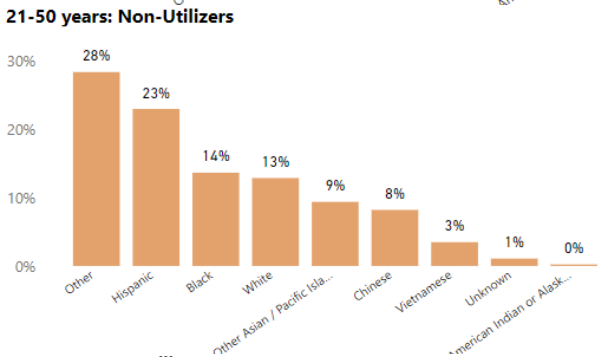
Hispanic & Other*

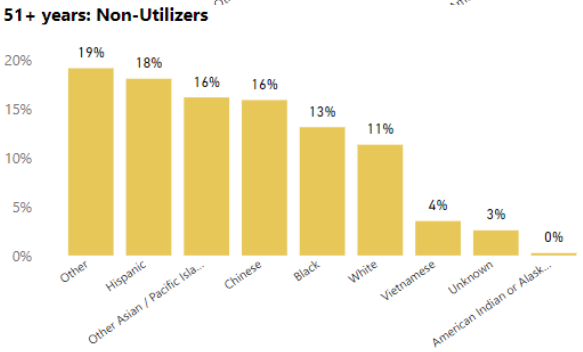
>50

Hispanic & Other*

* Most impacted







Board Feedback

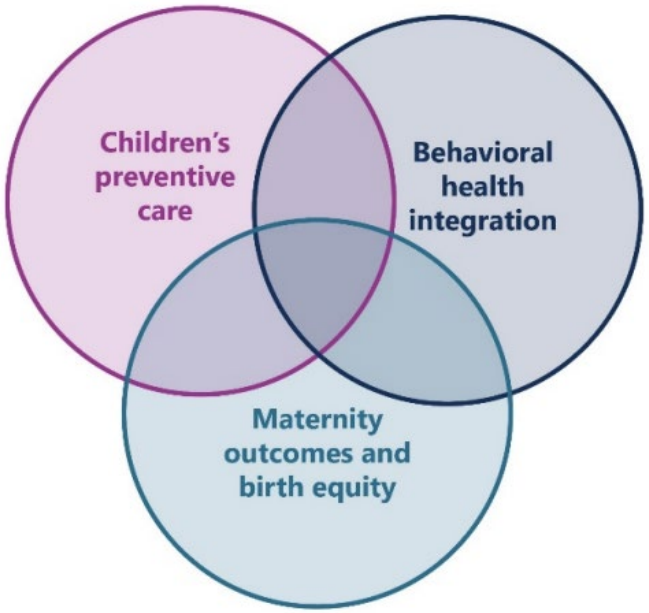
- Concerns regarding current state of Quality?
- Comfortable with initial direction of Equity initiatives?

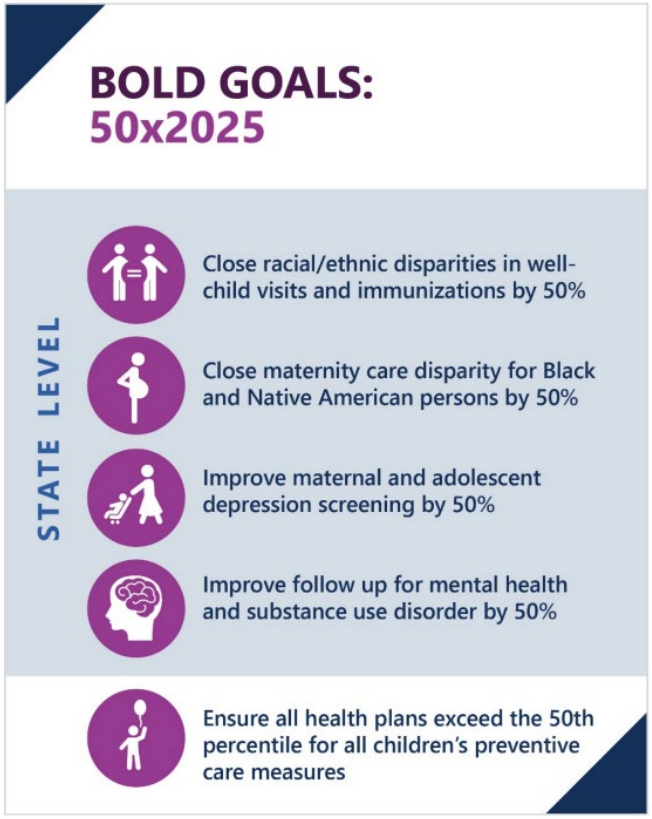
EPSDT

Medi-Cal

Cover 50% of children in CA

DHCS Quality Strategy Clinical Areas of Focus



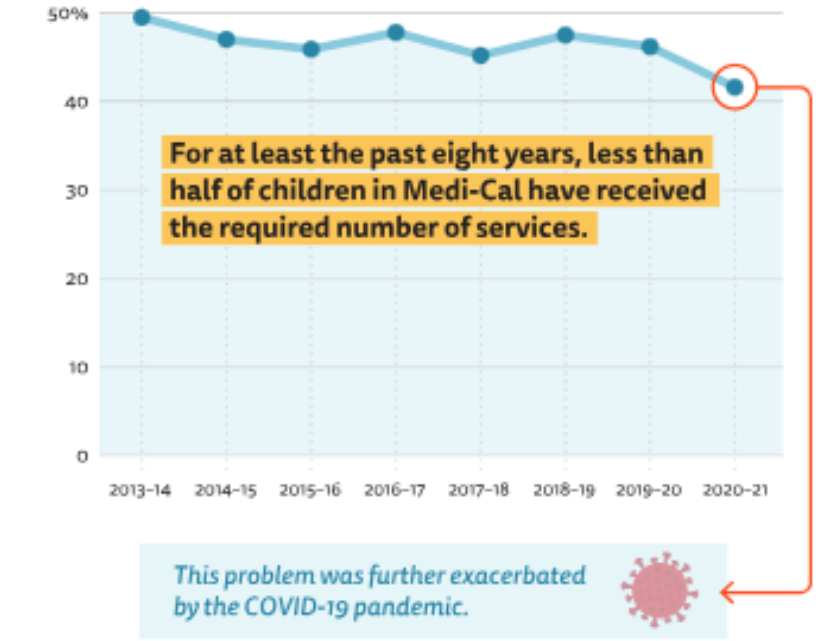


Auditor of the State of CA

Report 2018-2011

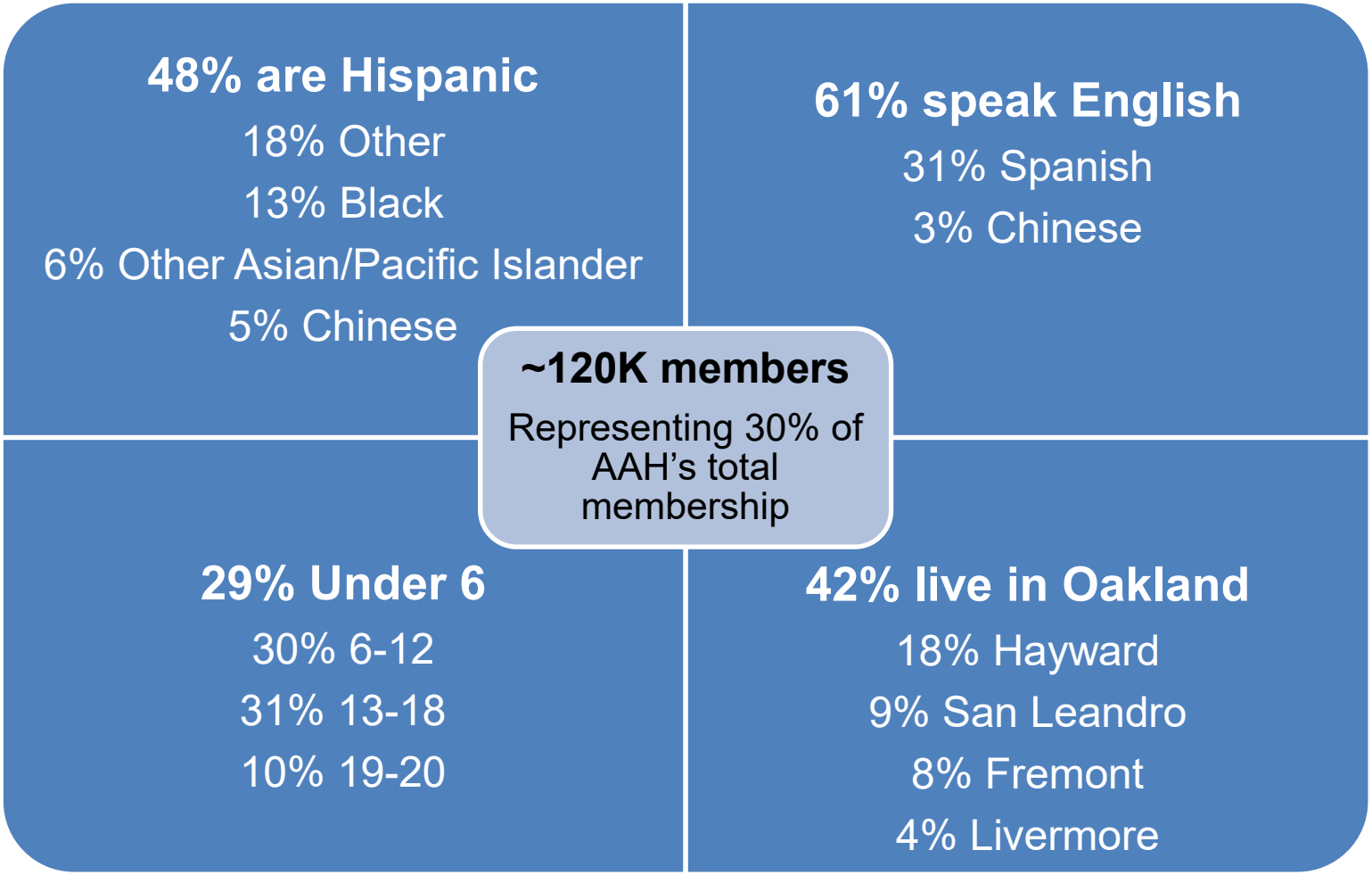
California Continues to Struggle to Ensure That Millions of Children in Medi-Cal Receive Preventive Care

Figure 2

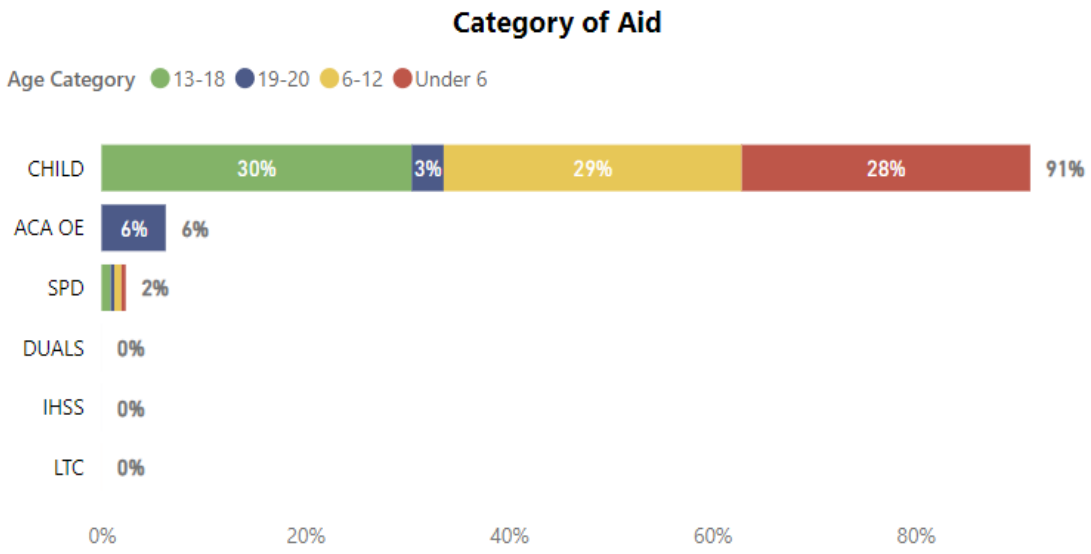


An average of 2.9 million children in Medi-Cal per year did not receive all required preventive services during fiscal years 2018–19 through 2020–21.

Current State: January 2024 Under 21 Population



Current State: January 2024 Under 21 Population



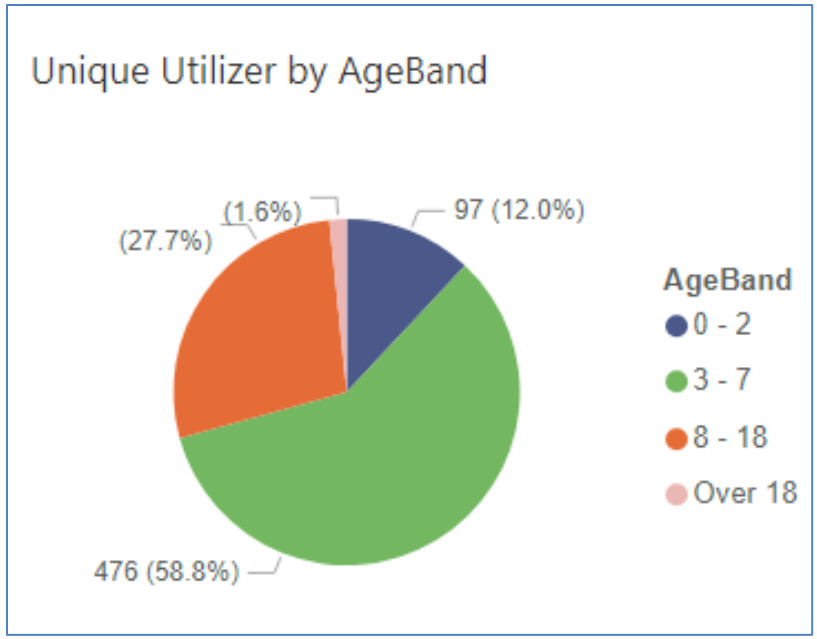
- **The Under 21 population accounts for:**
  - **100% of total Child category of aid**
  - **5% of total Duals**
  - **8% of total SPDs**
- **~4% qualify for CCS**

- Historical utilization:
  - ~26% of members without a PCP visit in the last 15 months
  - ~0.4% of members were enrolled in ECM
  - ~0.2% of members received one or more CS services

Autism Services

BHT Member Demographics

- 673 unique utilizers (Oct)
- 746 unique utilizers (Dec)
  - Age 3-7
    - 476 UU, $7,180,852 in paid claims
    - In this age group, 34% more males than females use the services.



Utilization Takeaways

- Increase in Unique Utilizers
  - 550 prior to insourcing
  - 746 since insourcing
- Positive trend and increased demand
- Network limitations

Strengths

- Member Experience
  - Up-trending utilization
  - Down-trending grievances
  - Individualized case management
- Network
  - 39 credentialed provider groups with over >600 BCBAs
- Community Relationships
  - Special Needs Committee
  - High volume providers
- Alliance
  - Dedicated teams focused on member care and experience

Opportunities

- Network
  - At capacity provider network
  - No additional regional provider groups with whom to contract
  - Instability (High Turnover) of the ABA paraprofessional providers who provide direct services.
- Member Experience
  - Network Limitations resulting in increased wait times
  - Increased wait times for afternoon / evening hours and for non-English speaking families
- Alliance
  - Ongoing evaluation and revision of go-live workflows
  - Ongoing staff hiring and training

Where do we want to go?

- Expand Network
  - "Out-of-the-box" network development strategies to increase access - especially for the Limited CDE Provider Psychologists and related specialists (e.g., Speech, OT).
- Help establish additional CDE centers of excellence.
- Reduce barriers to access and the # of members awaiting BHT/ABA services.
- Improved care coordination between BHT/ABA providers and referring pediatricians/psychologists.

Other EPSDT Mental Health

- School-Based Mental Health
  - Build upon the success Student Behavioral Health Integration Program (SBHIP) to establish and grow mental health services in and around schools.
  - Current 11 SBHIP LEAs
  - Goal to expand to all LEAs in Alameda County
- Work with ACBH to ensure mental health services for children and youth
- Support provider adoption of the dyadic care model with a focus on CHCN, AHS, and BCHO.

Network

- **Current**
  - Children First Medical Group, (CFMG) - 140 Pediatricians
  - Direct contracts - 6 Pediatricians and 53 Family Practice providers. (AAH Delegates - CHCN & AHS not included)
  - Executed agreement with Alameda County First 5 to provide Member Outreach, Care Coordination, Quality Improvement for linkage and access to Primary care
- **Future**
  - Plan outreach to various stakeholder groups within the county to assist in identifying potential new providers and network gaps in services.
    - Town Hall meetings
    - Listening Sessions
    - Annual provider training
    - FAQs

Board Feedback

- Are there specific steps we should be taking in autism services?
- Suggestions or goals for the autism network?

Case Management
Quality Efforts
Key Partnerships

Case Management (CM) & Community Supports (CS)

All EPSDT CM referrals are evaluated for all CM programs & CS

Care Coordination

Connects members to services
Mostly non-clinical staff

Complex CM

Intense coordination of resources
Mostly clinical staff (RN, MSW)

Community Supports

Caregiver respite
Personal caregiver
Home modifications
Housing bundle
Medical food

ECM

Community-based
Mostly non-clinical staff (CHWs, lived-experience) Eligibility:
Homeless, high-utilizers, SMI, substance use, CCS, Foster Kids

Quality Efforts

- **Member Facing**
  - Multiple QI Projects focused on the pediatric population
  - Direct reach out to under & non-utilizers
- **Provider Facing**
  - Multiple QI Projects
  - EPSDT training
  - Pay For Performance Program
  - Health Equity Incentive Pilot
  - First 5 gap-closure outreach
  - CHDP sunsetting planning Lead screening work

Underserved: Initiatives to Increase PCP Visits

QI Outreach Campaign connect member with PCP	No PCP Visit within the last 15 months 0-6 years old 3,334 members	Outreach = **100% (20%Goal)** **55% successful connection** Primary Care Visit Completed: **1.25% (2% Goal)**
Member Services IVR call campaign	No PCP selection within 30 days of enrollment Under 18 years ~500 members	Outreach attempts completed Jan-Dec 2023
C&O Outreach Campaign & member orientations	No PCP Visit within the last 15 months	Completed ~5,000 live outreach calls resulting in 258 completed member orientations.

Underserved Population

- **Incentive programs**:
  - Pay for Performance Program (P4P) includes 8 metrics for the Under 21 population
  - Health Equity Incentive Pilot includes the HEDIS measure for *6 or more well-child visits in the first 15 months of life (W15)* for ethnicities that fall 5% below the AAH average.
- **Quality metric monitoring:**
  - % of members with no ambulatory or preventive visit within a 12-month period
  - % of members who had at least one primary care visit within a 12-month period
  - % of members who had more ED visits than primary care visits within a 12-month period

Key Partnerships

- CCS (HCSA)
- BHT
  - Alameda County Office of Education / LEAs
  - Special Needs Committee
  - Regional Center
  - UCSF / CHO
  - Alameda Health System
    - Possible Neurodevelopment Assessment Services
- Dental Providers
- Probation Department

Board Feedback

- Any recommended additional efforts in CM, Quality, or Equity?
- Any additional community partners we should work with?

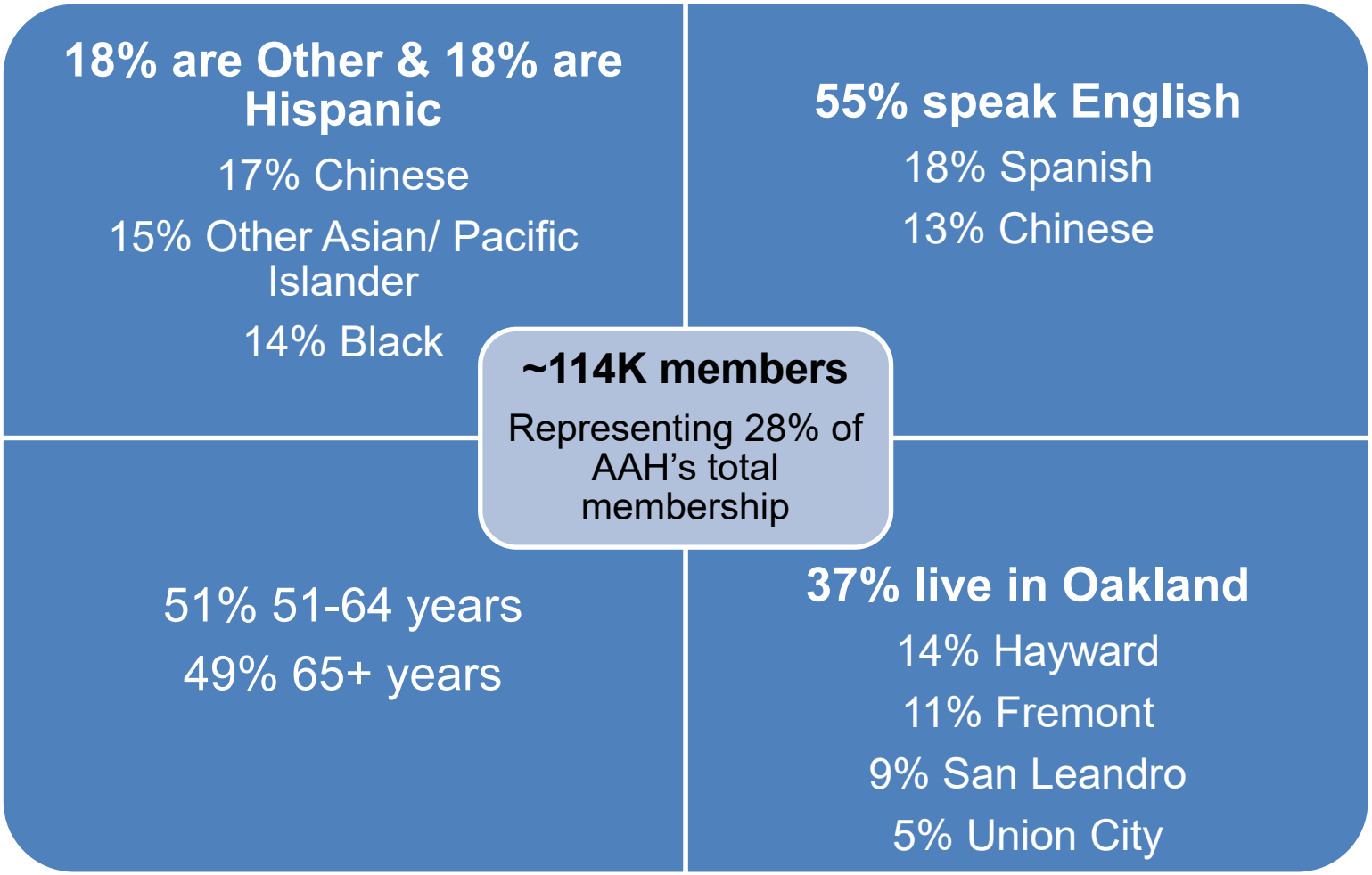
Older Adults

Medi-Cal focus on older adults*:

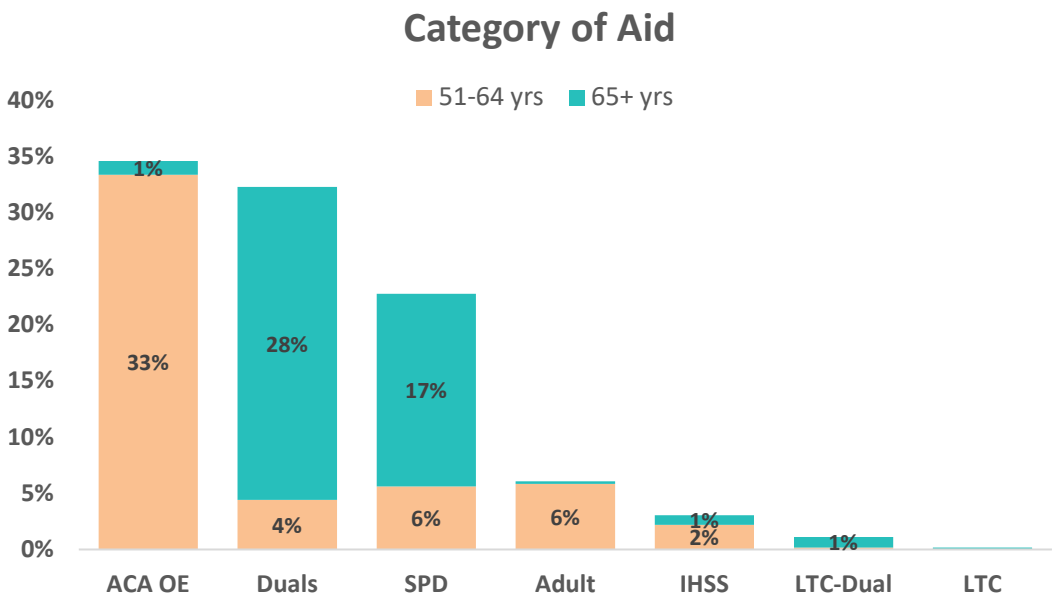
- Clinical: older adults have the highest burden of illness, utilization, and significant SDOH impacts
- Assembly Bill (AB) 133: Older Adult Full Scope Medi-Cal Expansion for individuals ≥ 50 years of age
- CalAIM:
  - 2023: Long-Term Care Benefit
  - 2025: Dual Eligible Special Needs Plan (D-SNP)

*Older adults defined as members >50 year old

Current State: January 2024 Over 50 Population



Current State: January 2024 Over 50 Population



- The Over 50 population accounts for:
  - 27% of total ACA OE's
  - 91% of total Duals
  - 73% of total SPDs

Historical utilization:

- ~23% of members without a PCP visit in the last 15 months
- ~2% of members were enrolled in ECM
- ~3% of members received one or more CS services

What programs are available for the elderly?

Case Management (CM) & Community Supports (CS)

Care Coordination

Connects members to services
Mostly non-clinical staff

Complex CM

Intense coordination of resources
Mostly clinical staff (RN, MSW)

Transitional Care

Intense coordination between care sites
Clinical staff (RN, MSW) for high risk
Non-clinical staff for low risk

Community Supports

Caregiver Respite
Personal Caregiver
Home Modifications
Housing bundle (3 separate services)
Medical food
Get Out SNF/Stay Out SNF
Medical Respite

ECM

Eligibility:
Homeless, high-utilizers, SMI, sub use, Justice Inv
Community-based
Mostly non-clinical staff (CHWs, lived-experience)

Key Partnerships

- CBAS
- Senior Services Coalition
- HCSA
  - IHSS
  - Adults and Aging Services
- SNFs/LTC Facilities
- D-SNPs
- Bay area agency on aging
- MSSP – Cities of Berkeley and Oakland

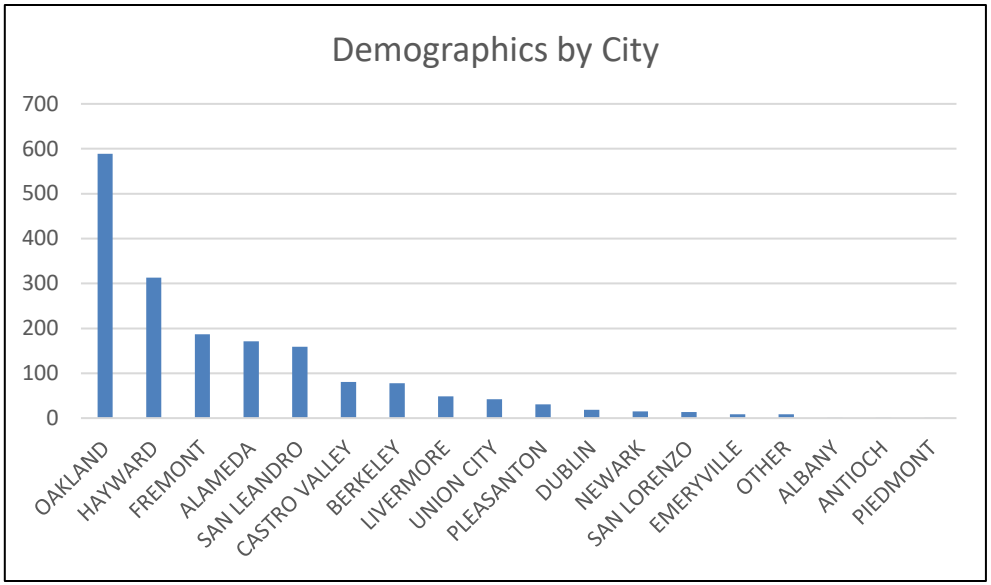
Board Feedback

- What other services for older adults exist in Alameda County?
- What programs/services should we prioritize?

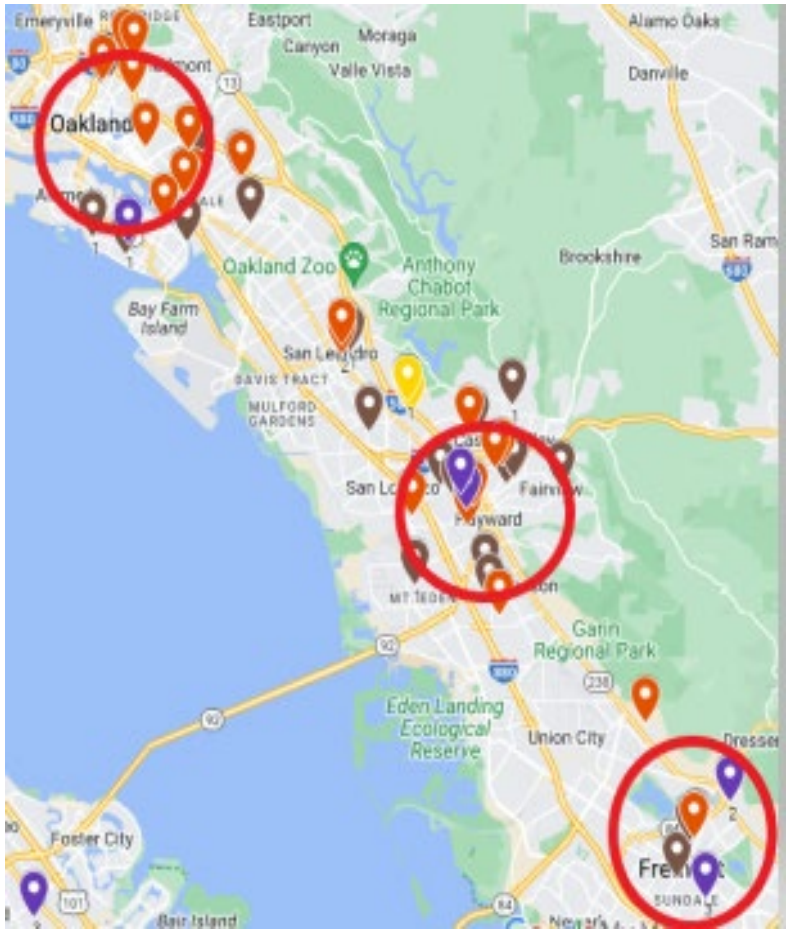
Long Term Care

- Custodial Facilities
  Non-medical care, assist with daily activities
  - 1,957 patients in 113 facilities
- Subacute Facilities
  Medically fragile requiring special services (e.g. wounds, trach care)
  - 43 patients in 9 facilities
- Intermediate Care Facilities (ICF)
  Long-term care members with developmental disabilities
  - 163 patients in 30 facilities
    - Developmentally disabled (ICF-DD)
    - DD/Habilitative (ICF-DD/H)
    - DD/Nursing (ICF-DD/N)

LTC Demographics



- LTC providers are in areas of largest Alliance member density



Long Term Care Stabilization

- Continued efforts being made to collaborate with LTC Partners to obtain real-time ADT information
  - SW on-site rounding
  - LTC Rounding Form creation and implementation
  - Updated Discharge Disposition form to align with TCS regs
  - Census clean-up

LTSS Intensive Case Management

- Members in the LTC programs have additional opt-in oversite with Social Workers and RNs with a focus on members with SDOH Barriers to discharge and/or decreasing high utilization
- Staff make referrals to:
  - CalAIM Community Supports & ECM
  - PACE Programs
  - MSSP Programs
  - Caregiver Supports/ Alzheimer's Programs
  - 1915c Waiver Programs
  - Palliative Care

LTC Quality Monitoring

- Compliance with SNF and Sub-Acute CMS Quality Assurance Performance Improvement (QAPI) Program
- HEDIS LTC Quality Measures:
  - Emergency room visits
  - Hospital Acquired Infections
  - Preventable readmissions
- Medicare Stars performance for SNFs
- Potential Quality Issues
- California Department of Public Health (CDPH) findings

Board Feedback

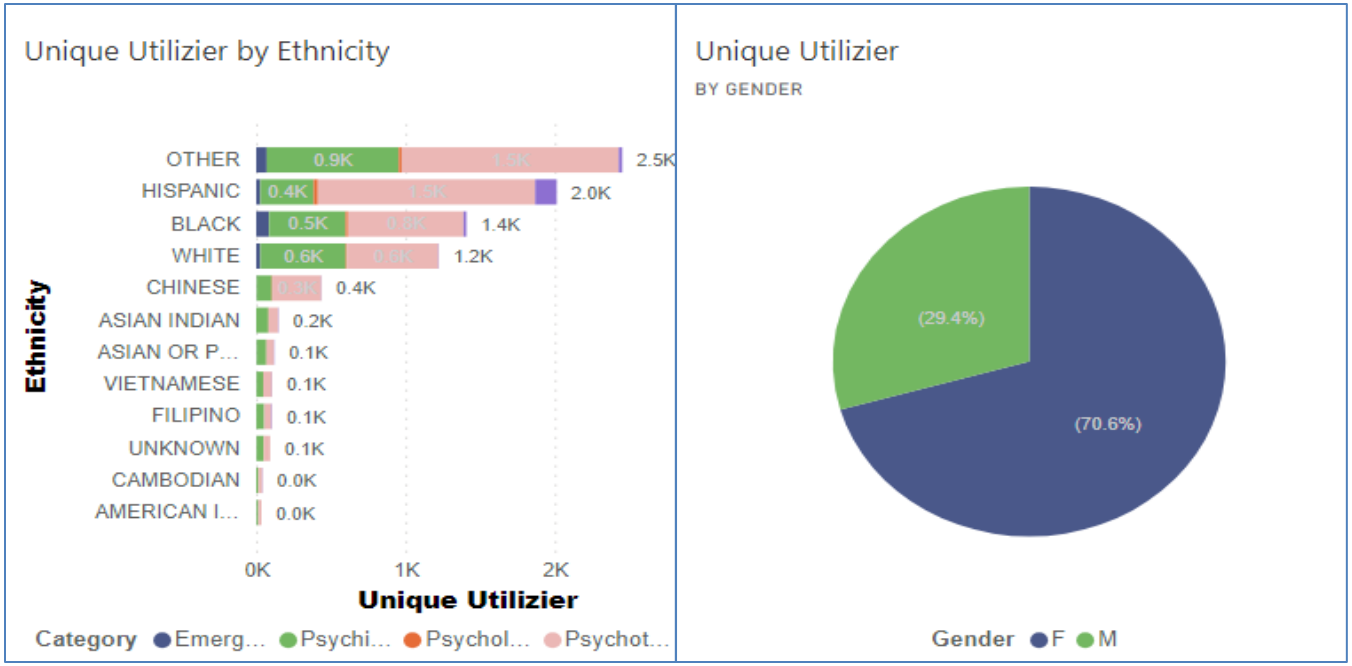
- What key areas should we focus on for members in Long Term Care?

Mental Health Resources for the Elderly

Mental Health

Demographics

- 1,773 / 388 unique utilizers age 51-65 / 66+
  - Ethnicity: Other, Hispanic, Black, Caucasian, and Chinese
  - Gender: 70.6% female



Utilization Takeaways

- Medi-Cal elderly have high rates of Mental Health needs
  - Limited data given payer of last resort
  - Increases in utilization
  - Decreases in barriers to care
  - Focus on member outreach
  - Focus on expanding the network
  - Opportunities to increase collaboration with ACBH

Network

- Current network analysis – efforts in the following areas to support the Older Adult population and network readiness for the launch of the Medicare Dual Special Needs Plan (D-SNP) in January 2026.
  - Primary Care, Internal and Geriatric Medicine
  - Geriatric Mental Health Providers
  - Cardiology, Nephrologists, Endocrinologists, Rheumatologists
  - The potential of existing PCPs or Specialists to contract in dual specialties
  - Build the Gastroenterology network
  - Consider contracting in more contiguous counties for broader access
  - Seek contracts with Specialty Networks to gain more providers under one umbrella contract
  - Additional specialties to be added, Pain Management and Chiropractic care, and others to develop a more robust specialty network.
- D-SNP Network Readiness
  - Conduct Network review of existing providers as part of 2026 DSNP Implementation
  - Develop plan and timeline for building DSNP network – work began January 2024
  - Contracting to begin Q4 2024

Quality Efforts

- HEDIS / MCAS List
  - Controlling Blood Pressure
  - Diabetes
  - Colonoscopy screening
  - Cervical Cancer Screening
- Dementia Screening
- Fall prevention
  - Senior Injury Prevention Program (SIPP) Coalition
- SNF/LTC Quality Monitoring
- Data sharing with many programs will coordinate information and make it more available to members

Underserved: Initiatives to Increase PCP Visits

QI Outreach Campaign connect member with PCP	No PCP Visit within the last 15 months 50+ years old 35,717 members	Outreach = **12% (20% Goal)** **47% successful connection** Primary Care Visit Completed: **2.25% (2% Goal)**
Member Services IVR call campaign	No PCP selection within 30 days of enrollment SPD members ~2,700 members	Outreach attempts completed Jan-Dec 2023
C&O outreach campaign and member orientations	No PCP Visit within the last 15 months	Completed ~5,000 live outreach calls resulting in 258 completed member orientations.

Underserved Population

- Incentive programs:
  - Pay for Performance Program (P4P) includes 7 metrics that include older adults
  - Health Equity Incentive Pilot includes the HEDIS measure for *Controlling High Blood Pressure (CBP) and Cervical Cancer Screening (CCS)* for ethnicities that fall 5% below the AAH average.
- Quality metric monitoring
  - % of members with no ambulatory or preventive visit within a 12-month period
  - % of members who had at least one primary care visit within a 12-month period
  - % of members who had more ED visits than primary care visits within a 12-month period

Health Equity Incentive Pilot

- Overview:
  - Focus on 3 measures in 3 different domains from the MCAS list that were below the MPL in 2022.
  - Focus on race/ethnicities that were 5% below the overall admin rate in 2022
  - Add a flag to the gap-in-care reports to identify members

Health Equity Incentive Pilot

Domain	Measure	% of Pool	$ in Pool
Cancer Prevention	Cervical Cancer Screening (CCS) for the following race/ethnicities: * Amerasian * American Indian or Alaskan Native * Asian Indian * Filipino * Guamanian * Hawaiian * Korean * Samoan * White	50%	$500,000
Chronic Disease	Controlling High Blood Pressure (CBP) for the following race/ethnicities: * American Indian or Alaskan Native * Asian Indian * Asian or Pacific Islander * Filipino * Japanese * Samoan * Unknown	25%	$250,000
	Total	**75%**	**$750,000**

Board Feedback

- Any recommended additional efforts in CM, Quality, or Equity?
- Any additional community partners we should work with?

Thank You

Questions?

Board Breakout Discussions

- **3 Breakout Groups:**
  - Behavioral Health / Applied Behavioral Analytics (Matt)
  - Pediatric Services (Dr. O'Brien)
  - Older Adult Services (Ruth)
- **Guidance**
  - Pick the group you are interested in participating in
  - 20-25 minute discussion
  - Quick report out of key themes

- **Breakout Discussion Question**
  - **As the Alliance staff and Board advance work in this area in the coming months, what are the critical issues or questions that we should be considering and addressing?**

Supplemental Slides

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Supplemental

- MCPs

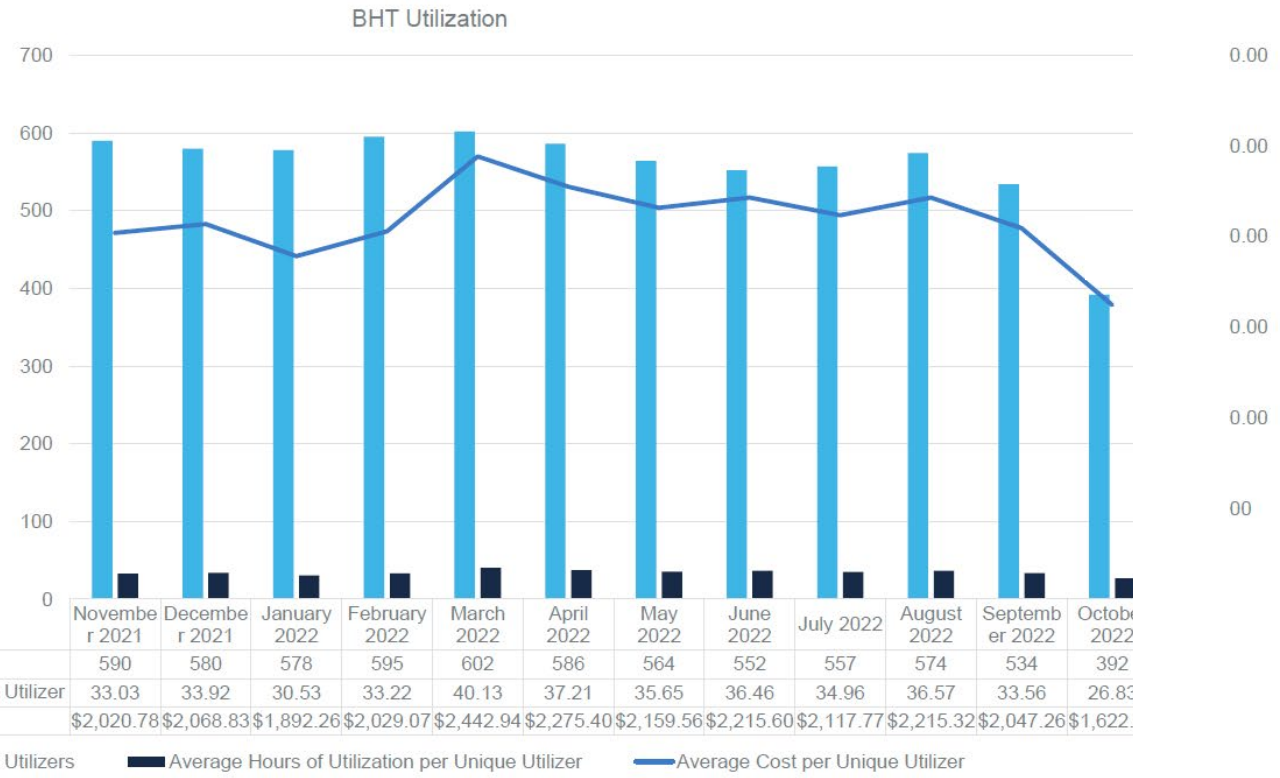
Enforcement Tier	Tier 1	Tier 2	Tier 3
Triggers (per MPL/domain)	**One (1)** measure below MPL in any **one (1)** domain	**Two (2)** or more measures below MPL in any **one (1)** domain	**Three (3)** or more measures in **two (2)** or more domains
Enforcement Action	Not subject to monetary sanctions	Subject to monetary sanctions	Subject to monetary sanctions

EPSDT

Utilization: Pre-Insourcing

Approximately 550 Unique Utilizers in 2022

BHT/ABA Utilization



	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022
Unique Utilizers	590	580	578	595	602	586	564	552	557	574	534	392
Average Hours of Utilization per Unique Utilizer	33.03	33.92	30.53	33.22	40.13	37.21	35.65	36.46	34.96	36.57	33.56	26.83
Average Cost per Unique Utilizer	$2,020.78	$2,068.83	$1,892.26	$2,029.07	$2,442.94	$2,275.40	$2,159.56	$2,215.60	$2,117.77	$2,215.32	$2,047.26	$1,622.

Unique Utilizers Average Hours of Utilization per Unique Utilizer Average Cost per Unique Utilizer

beacon

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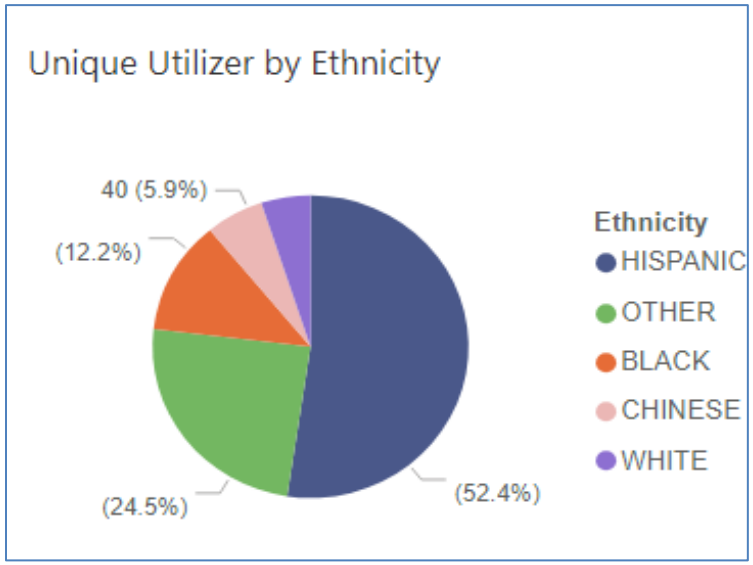
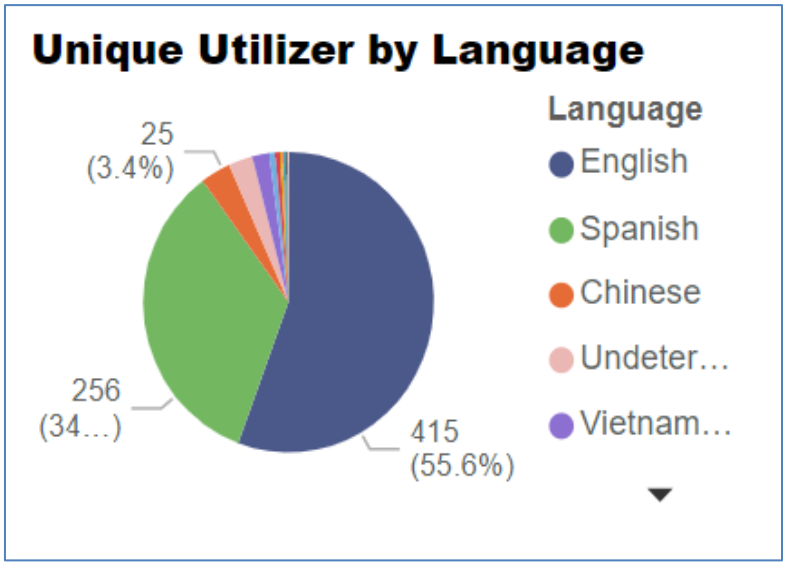
BHT Member Demographics

April 2023 and September 2023

- Limited Spanish speaking providers
  - Resulting in delays in accessing services

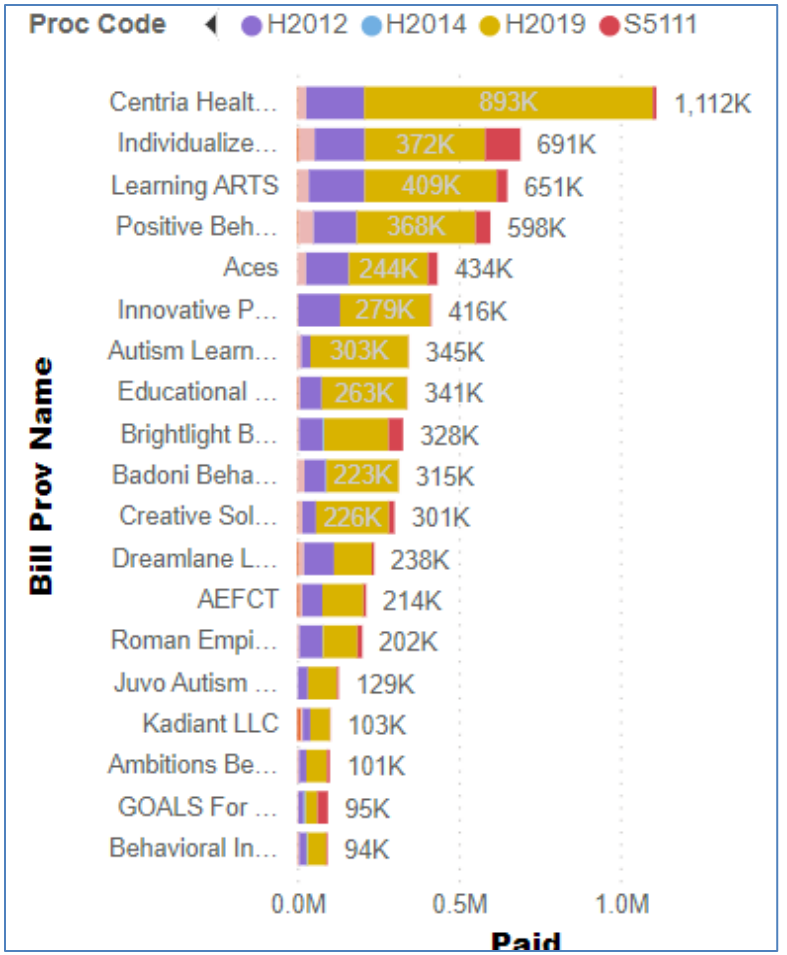




Member Utilization

Codes / Providers

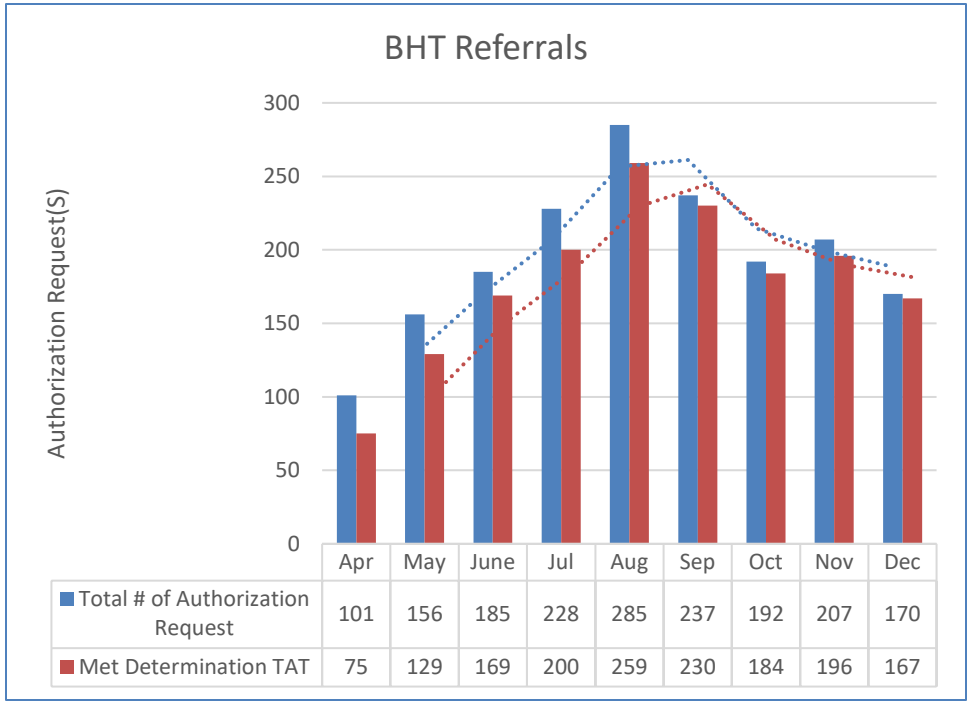
- H2019 (Therapeutic Behavioral Services, per 15 minutes)
  - Most frequently utilized code is
  - 554 Utilization Units
  - $4,714,714 in paid claims
- Leading service providers
  - Centria Healthcare
  - Individualized ABA Services for Families
  - Learning ARTS



Member Utilization

April - Oct 2023

- Increased BHT authorizations
  - 746 unique utilizers
  - 1,393 total authorizations



	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec
Total # of Authorization Request	101	156	185	228	285	237	192	207	170
Met Determination TAT	75	129	169	200	259	230	184	196	167

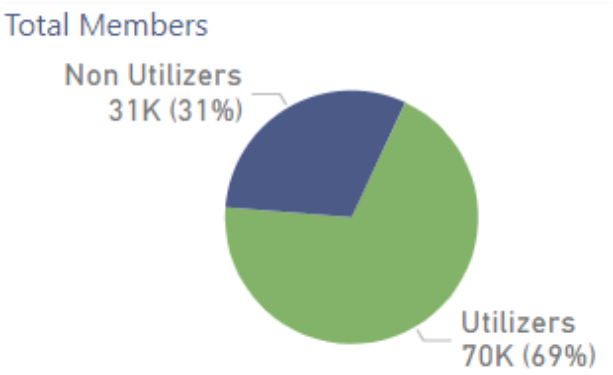
AAH BHT Authorizations

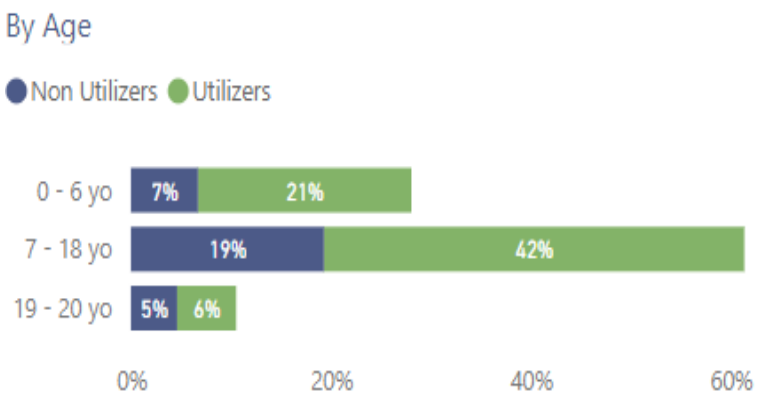
(600 authorizations pre-loaded from Beacon in March 2023)

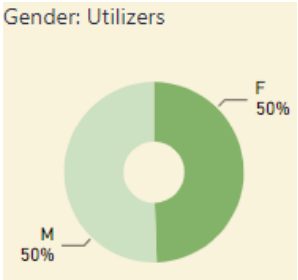
Case Management & CS

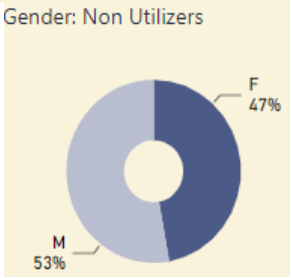
- State encouraging further CS network expansion
  - CS (and ECM) have a thorough vetting process for bringing on any new CS (or ECM) provider
    - Entity Interest Form is submitted and held until network expansion is needed (depending on the CS service or ECM Population of Focus)
    - Scorecard is used to evaluate all providers interested in providing the CS service (or ECM PoF)
    - Scorecards are evaluated and discussed within CS/ECM Leadership
    - Potential Provider List is narrowed based on scoring and the need of expansion
    - Outreach is made to potential providers for the initial meeting

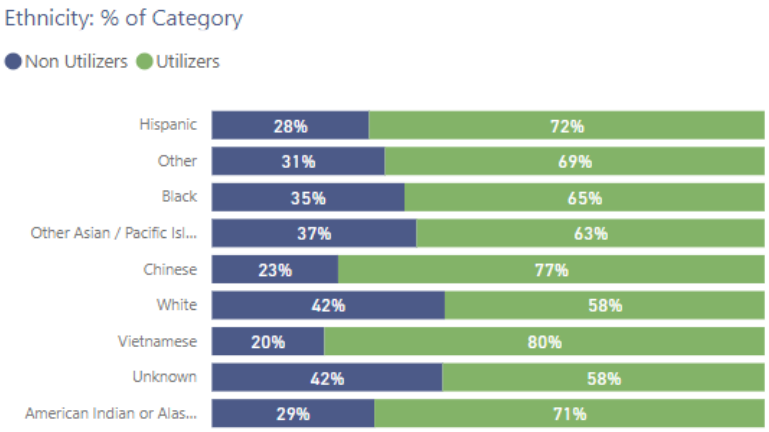
Underserved Population: Non-Utilizers

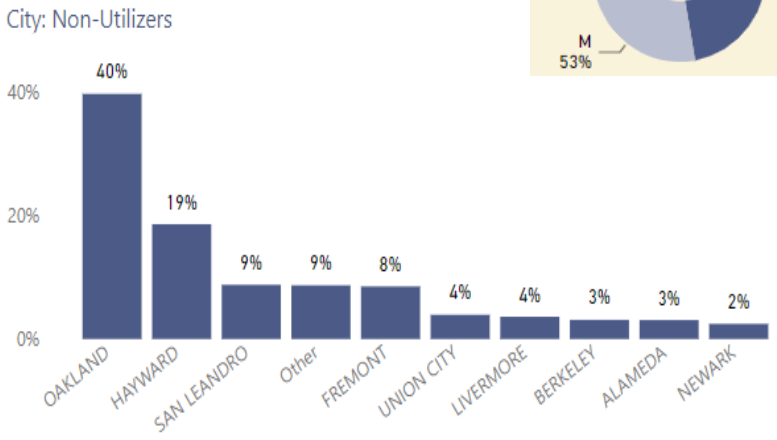












**** Non-utilizer = member with no utilization identified in a 12-month period. Based on claims/encounter data for time Period: 7/1/2022-6/30/2023. Excluding Kaiser.***

2024 P4P Measures

ALAMEDA Alliance FOR HEALTH

MY24 P4P Clinical/HEDIS Measures

Clinical Quality Measures								
#	Measures	Direct Points			Delegate Points			Goal
		Family	Internal	Pediatric	AHS	CFMG	CHCN	
1	Breast Cancer Screening (BCS)	15	20	N/A	10	N/A	10	**DIRECTS** 100% Points awarded, per measure, if the NCAQ 50th Percentile is met. If below 50th Percentile: points awarded, per measure, based on % increase from prior year (2023) rate: • .05% increase = 10% of points • 1.0% increase = 20% of points • 1.5% increase = 30% of points • 2.0% increase = 40% of points • 2.5% increase = 50% of points **DELEGATES** 75% of points awarded per measure if the NCQA 50th Percentile is met. • 75th Percentile = 100% of points If below 50th Percentile: • 3% increase from 2023 = 20% of points • 6% increase from 2023 = 40% of points
2	Cervical Cancer Screening (CCS)	15	20	N/A	10	N/A	10	
3	Child and Adolescent Well-Care Visits (WCV)	15	N/A	15	10	10	10	
4	Childhood Immunization: Combo 10 (CIS)	N/A	N/A	10	5	10	5	
5	Colorectal Cancer Screening (COL-E)	10	10	N/A	5	N/A	5	
6	Glycemic Status Assessment for Patients with Diabetes (GSD)*	15	20	N/A	5	N/A	5	
7	Immunizations for Adolescents: Combo 2 (IMA)	N/A	N/A	10	5	10	5	
8	Lead Screening in Children (LSC)	N/A	N/A	5	5	10	5	
9	Well-Child Visits in the First 15 Months of Life: Six or More Visits (W30-6+)	N/A	N/A	15	10	15	10	
10	Well-Child Visits in the First 30 Months of Life: Two or More Visits (W30-2+)	N/A	N/A	15	5	15	5	
Clinical Quality Measures Total Points		70	70	70	70	70	70	

MY24 P4P Other Measures

Other Measures								
#	Measures	Direct Points			Delegate Points			Goal
		Family	Internal	Pediatric	AHS	CFMG	CHCN	
11	Members with at least one primary care visit completed by the PCP Group within the measurement year	20	20	20	10	20	10	**DIRECTS** Full points awarded if PCP Group meets 90th Percenile from 2023. Otherwise, 1/3 points for each 0.5% increase from 2023 visits per 1,000 rate. **DELEGATES** Increase from 2023: • 1.50% = full points • 1.00% = 2/3 points • 0.50% = 1/3 points
12	**Readmission Rate** Definition: 30-day readmit; Excludes OB admits and planned readmits (eg. IP chemo, IP rehab, planned procedures)	N/A	N/A	N/A	10	N/A	10	**AHS & CHCN** Will be judged as a whole for readmission rate. **DIRECTS & CFMG** Decrease from 2023: • 1.50% = full points • 1.00% = 2/3 points • 0.50% = 1/3 points
13	**Member Satisfaction Survey:** Non-Urgent Appt Availability	5	5	5	5	5	5	Full points if 80% of responses indicate able to get a non-urgent appt w/in 10 days. • 3% improvement based on prior year gets 50% of points. • Minimum 10 responses required. Note: 10 days is based on State requirements.
14	**Member Satisfaction Survey:** Urgent Appt Availability	5	5	5	5	5	5	Full points if 70% of responses indicate able to get an urgent appt w/in 48 hours. • 3% improvement based on prior year gets 50% of points. • Minimum 10 responses required. Note: 48 hours is based on State requirements.
Other Measures Total Points		30	30	30	30	30	30	

Health Information Exchange Incentive

ALAMEDA Alliance FOR HEALTH

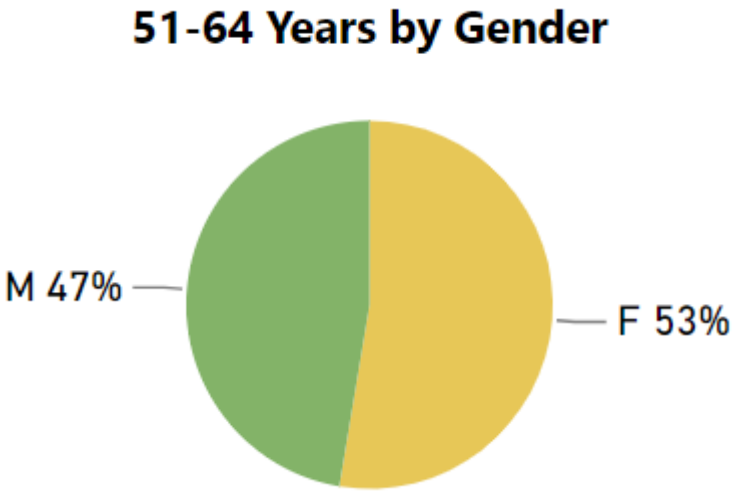
MY24 P4P HIE Participation

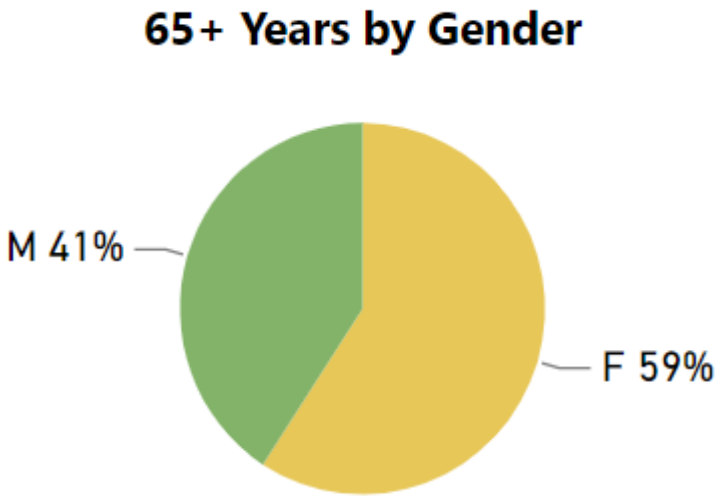
Participate in the Manifest MedEx Health Information Exchange (HIE) with continuous data submission throughout the measurement year. Payment will be based on the following payment tiers:

Members at the end of the Measurement Year	15-999	1,000 - 4,999	5,000 - 14,999	15,000+
New Participant	$2,000	$ 3,000	$ 5,000	$10,000
Ongoing Participant	$1,000	$ 1,500	$ 2,500	$ 5,000

Older Adults

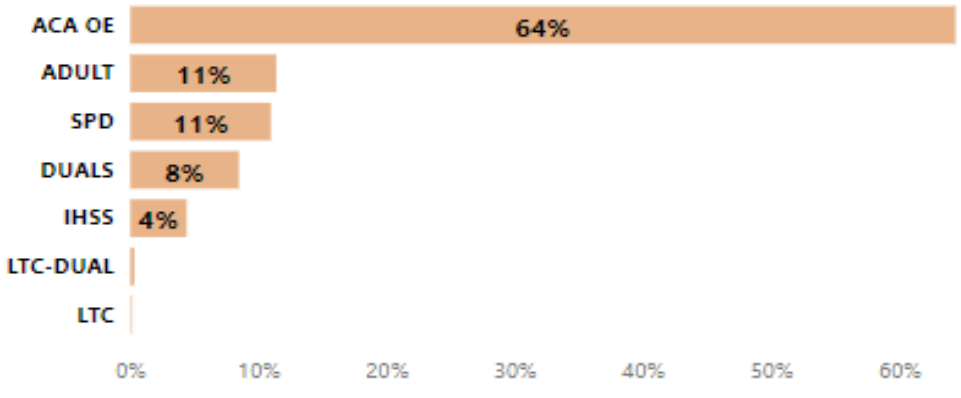
Demographics: Gender



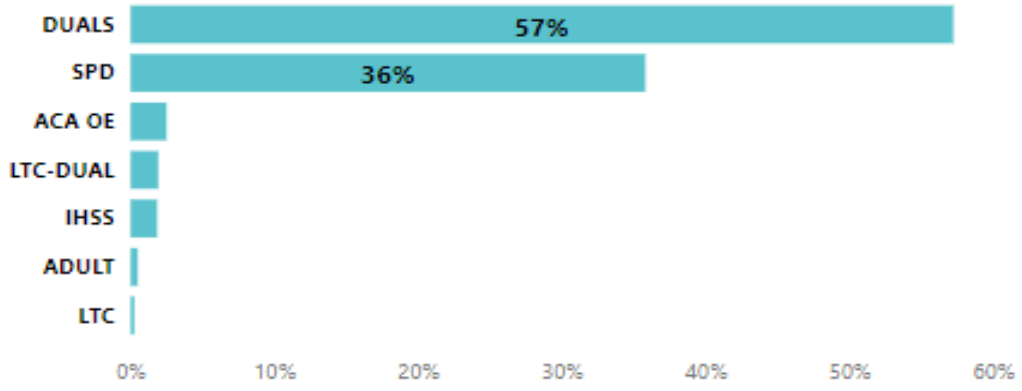


Demographics: Category of AID

Age 51-64

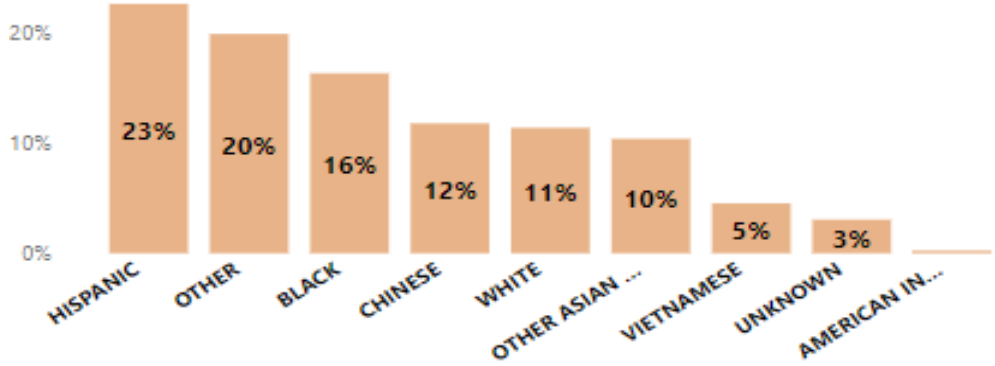


Age 65+

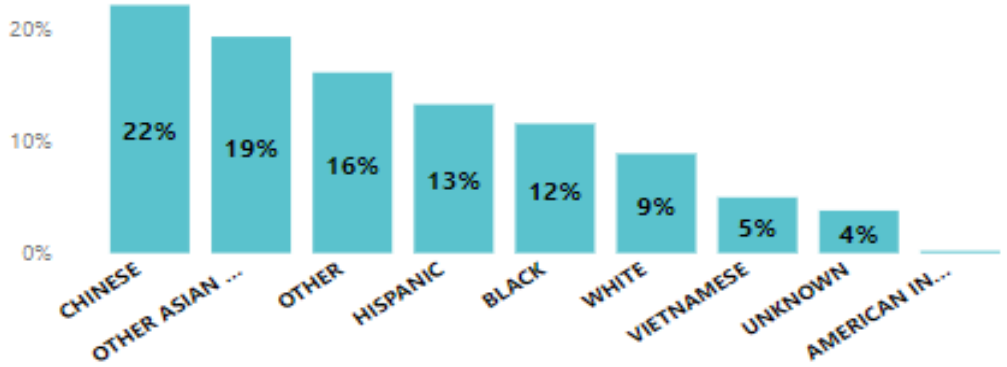


Demographics: Ethnicity

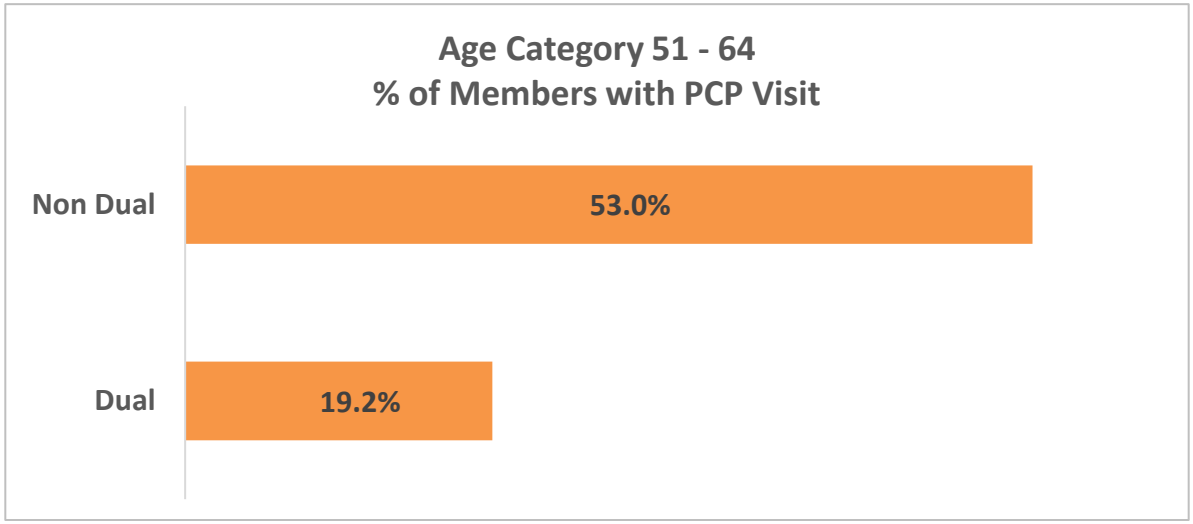
Age 51-64

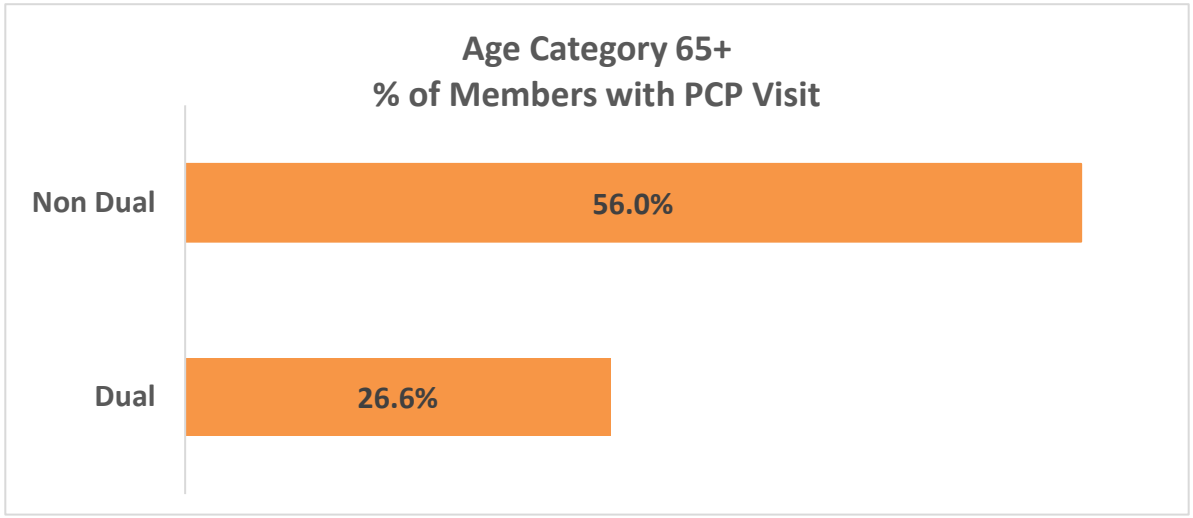


Age 65+



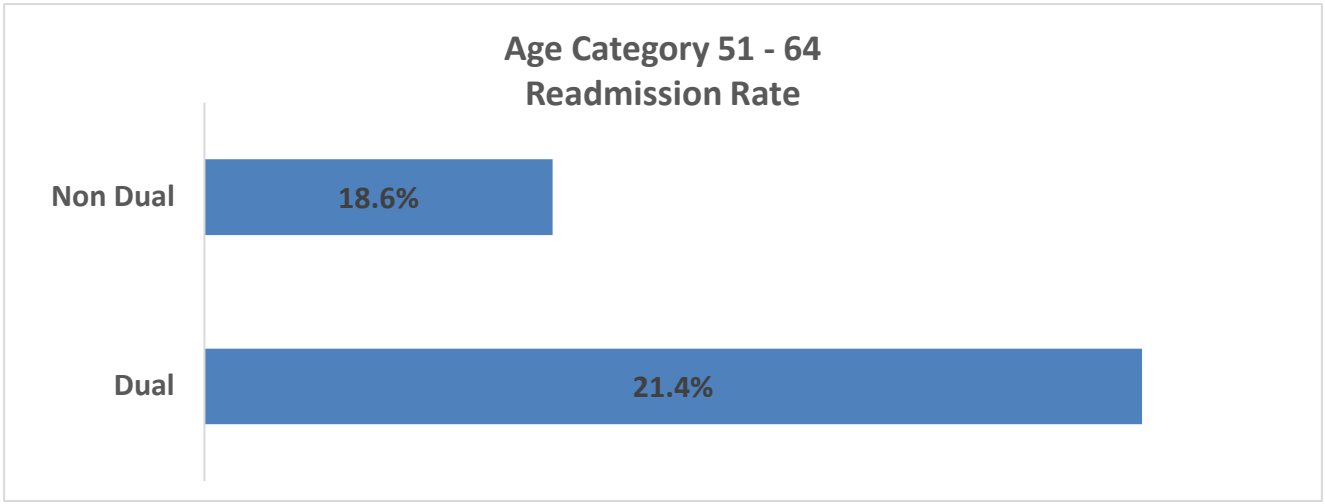
Demographics: Non-Utilizers

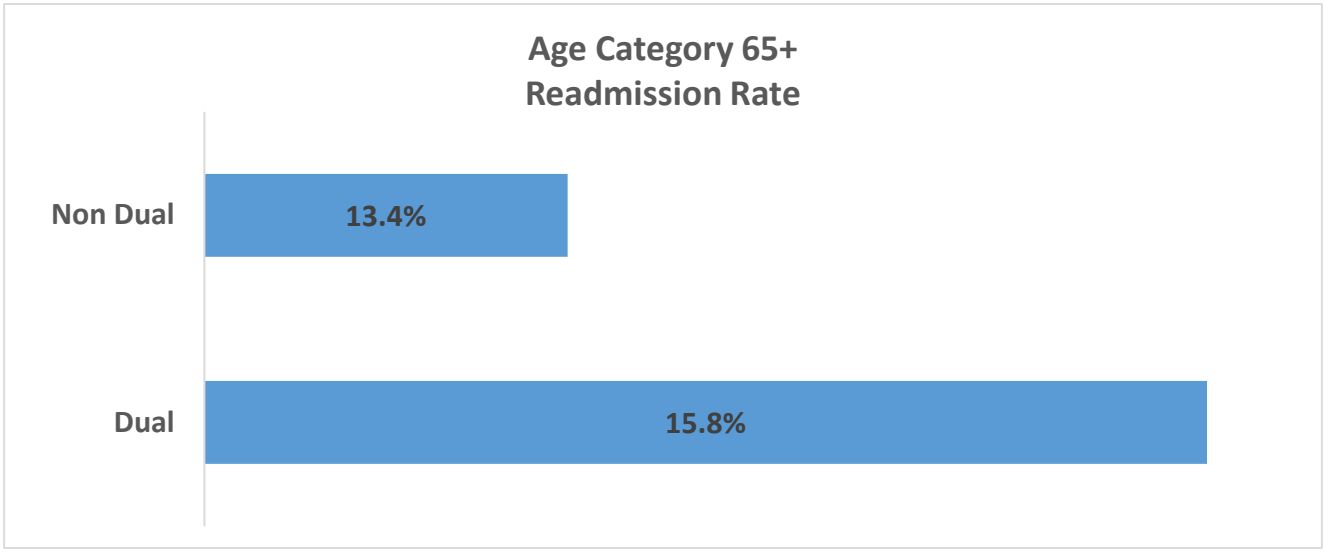




- Dual Data Challenges given Medi-Cal is payor of last resort

Demographics: Readmission Rates

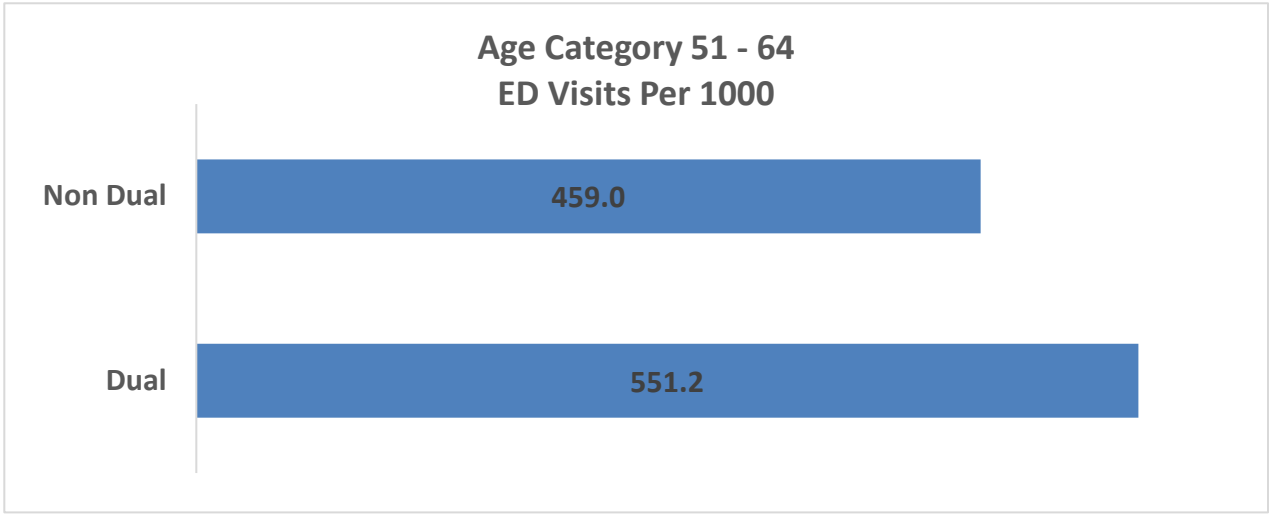


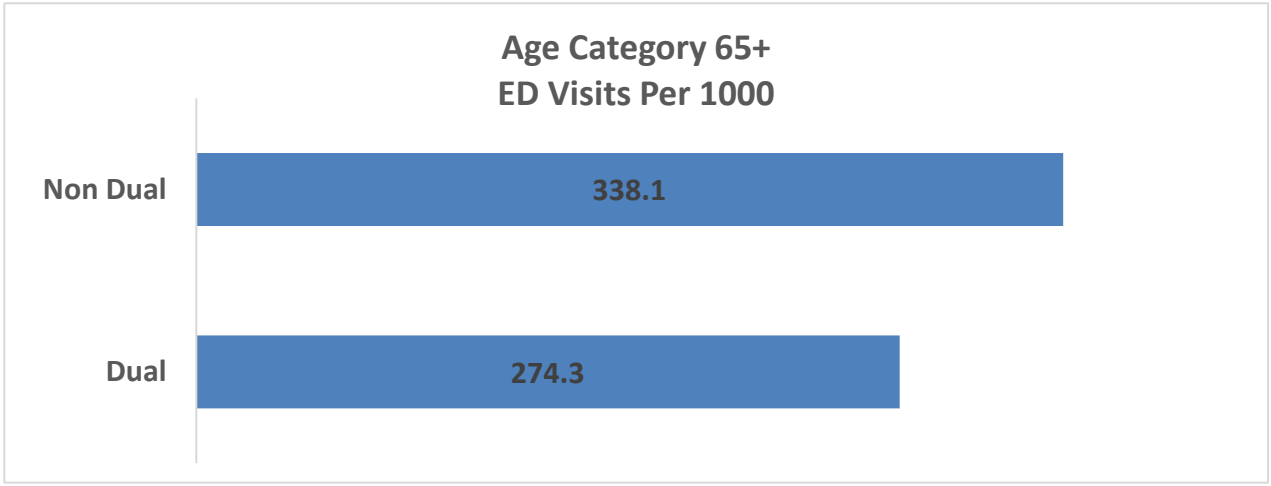


- Dual Data Challenges given Medi-Cal is payor of last resort

Elderly Demographics

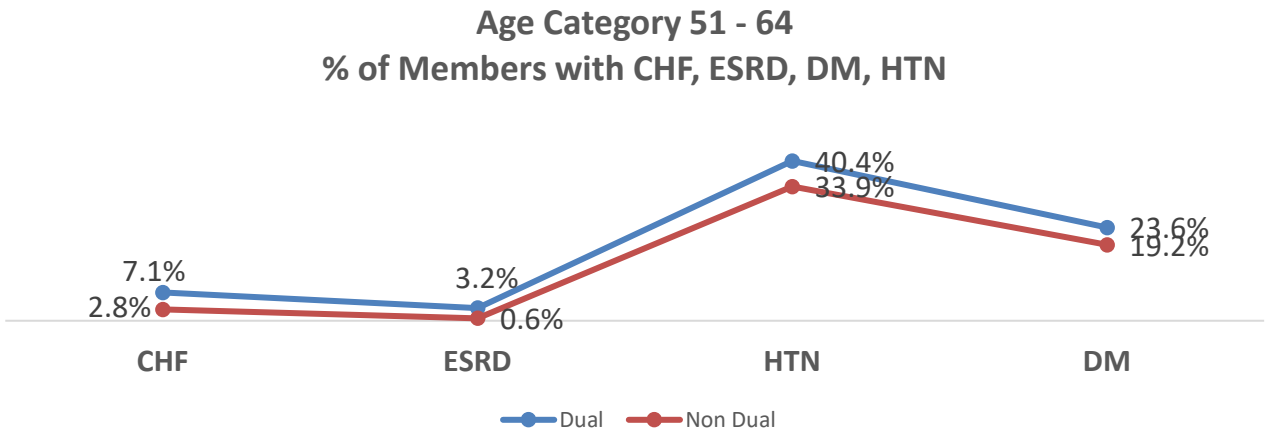
ED Visits / 1000

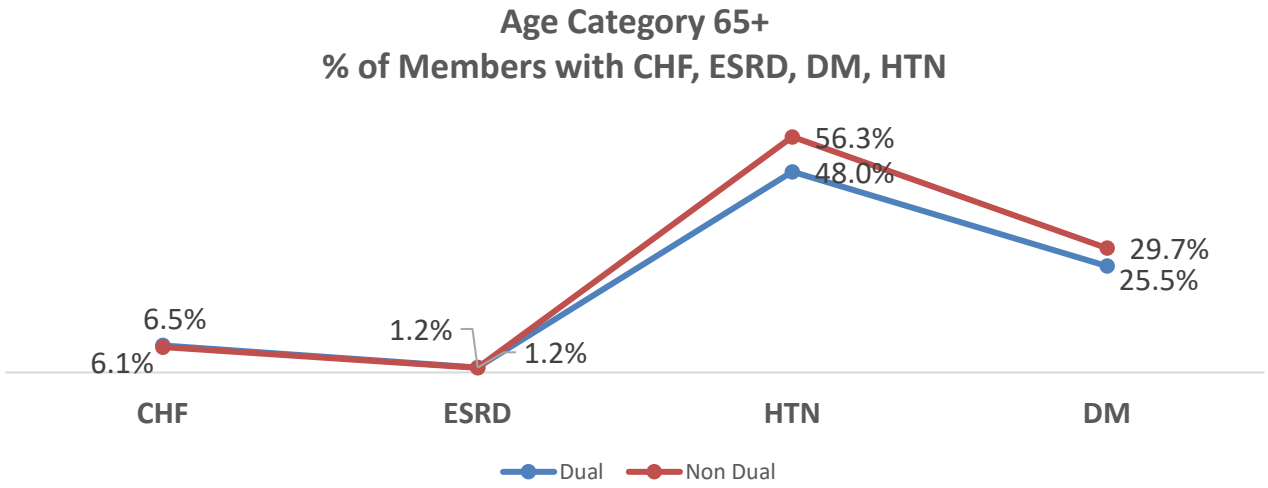




- Dual Data Challenges given Medi-Cal is payor of last resort

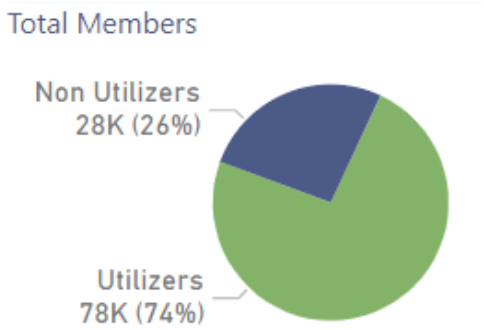
Demographics: Chronic Disease

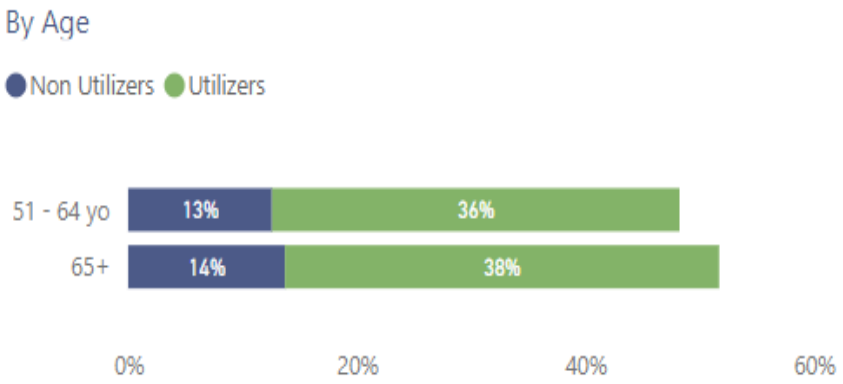


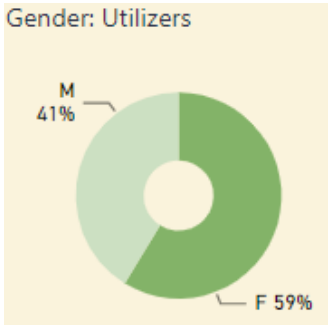


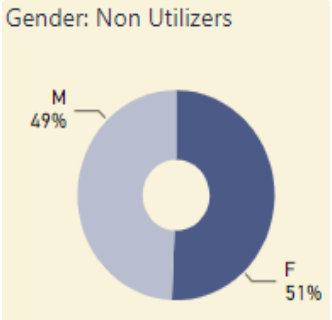
- Dual Data Challenges given Medi-Cal is payor of last resort

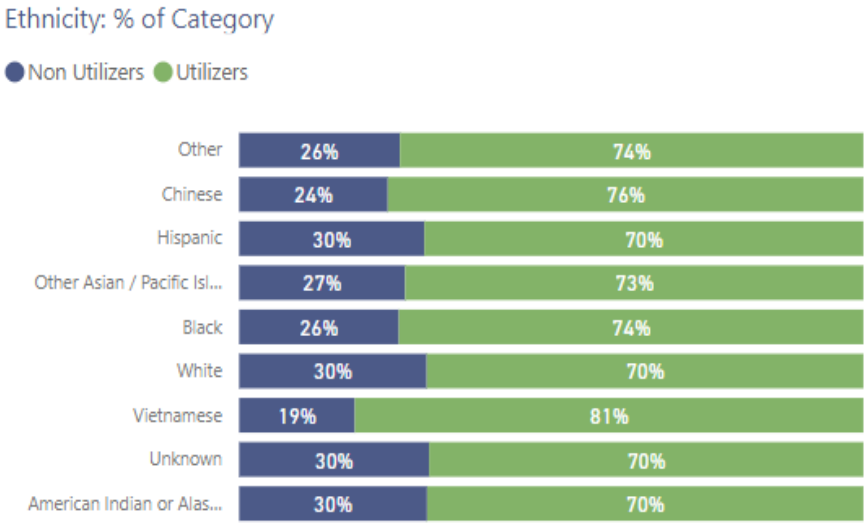
Underserved Population: Non-Utilizers

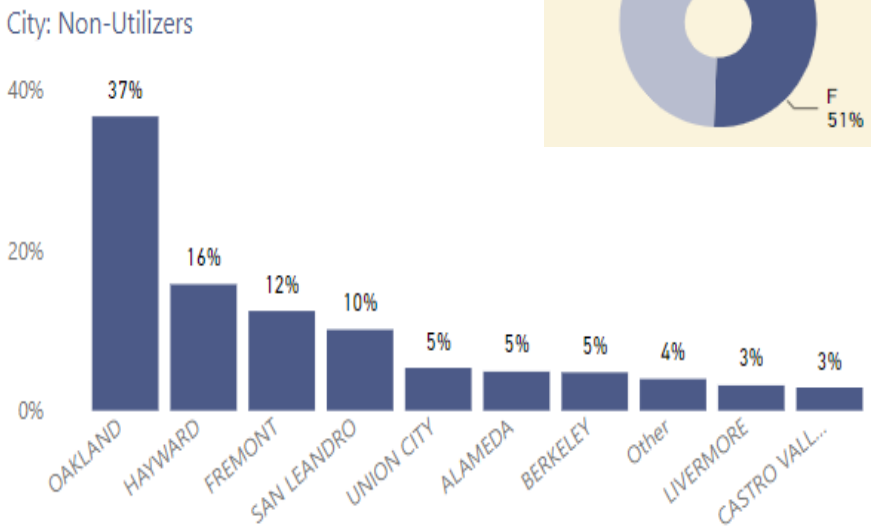






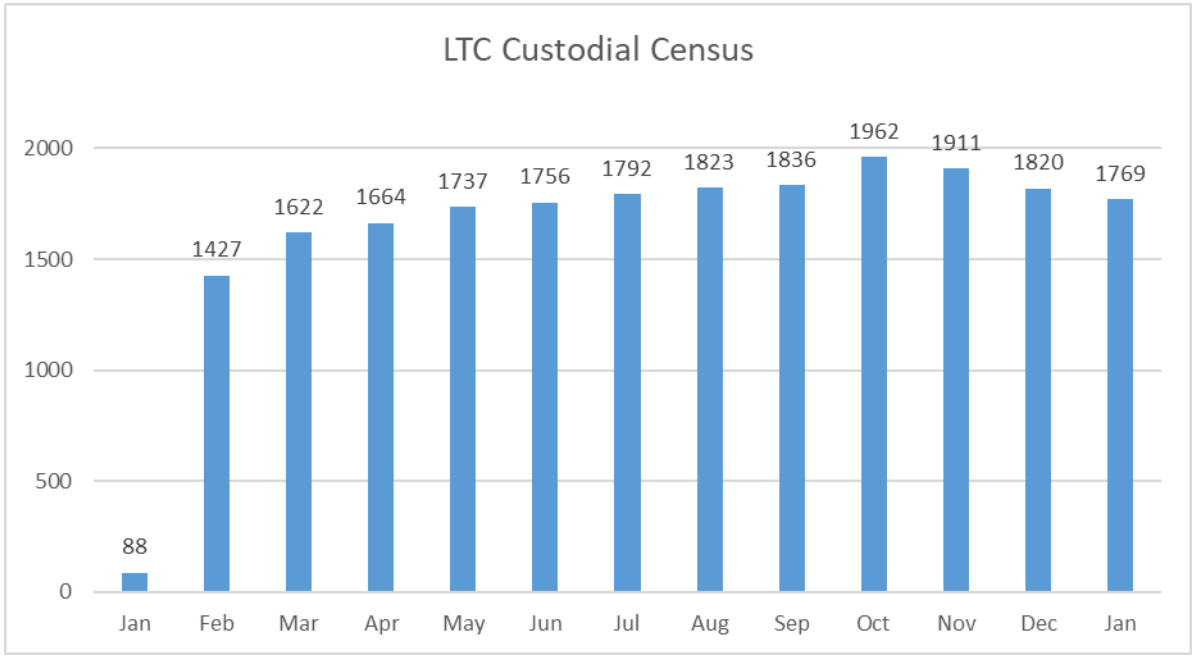






**** Non-utilizer = member with no utilization identified in a 12-month period. Based on claims/encounter data for time Period: 7/1/2022-6/30/2023. Excluding Kaiser.***

LTC Demographics



- Although the LTC Custodial Carve in occurred in Jan 2023, we did not get majority of files from DHCS until February 2023
- Census Peaked in October and has begun to drop steadily related to Member's expiring, discharging or losing eligibility due to Medi-Cal Redeterminations

2024 LTC Incoming Volumes

- ICF/DD and Subacute Carve-Ins to the Alliance
  - Expected: 163 (122 ICF/DD & 41 Subacute)
  - Auto- batch delayed until 1/18/23
- Anthem Volume:
  - Expected: 765
  - Received: 305- Majority of Anthem TARs expired prior to 1/1/24. Remaining auths will be entered Manually
- Adult Expansion Volume:
  - Expected: 3 TARs (1 ICF/DD & 2 LTC Custodial)
  - Auto-batch in process

ALAMEDA Alliance FOR HEALTH

LTSS Case Management Program

LTSS Intensive Case Management Program

Basic Population Health

Basic Care Coordination Services provided by the Facility

- Scheduling Appts
- Transportation

Complex Case Management

Complex Case Management typically interact directly with the members which may not be appropriate for this population

Enhanced Case Management

LTC Populations fall into 2 primary ECM categories:

Adults Living in the Community and At Risk for Long Term Care

(LTC) Institutionalization

- Adult Nursing Facility Residents Transitioning to the Community

Utilization: Post-Insourcing (preliminary)

- Trend toward increased utilization

6,157 members → 7,424 members

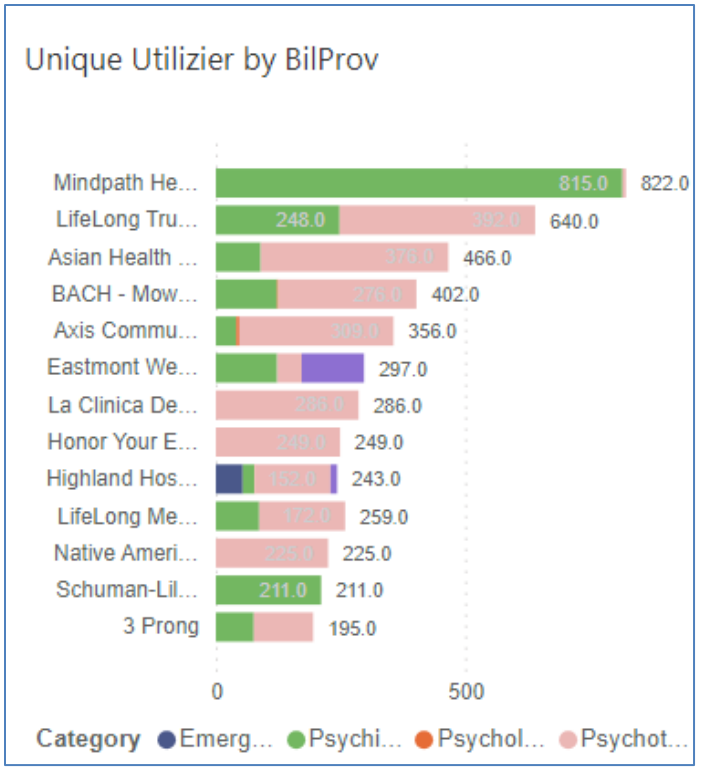
4 months before insourcing

4 months after insourcing

AgeGroup	Unique Utilizier	Unique Visit	Units	Units Per UU	Total Cost	Avg Cost Per Visit	Avg Cost Per Unit	Avg Cost Per UU
00 - 05	61	106	929.00	15.23	299,003	2,820.79	321.86	4,901.70
06 - 12	386	1,673	1,834.50	4.75	421,268	251.80	229.64	1,091.37
13 - 20	1,052	4,037	4,432.00	4.21	725,297	179.66	163.65	689.45
21 - 30	1,289	6,374	10,971.00	8.51	1,629,494	255.65	148.53	1,264.15
31 - 50	2,529	12,730	27,044.00	10.69	3,162,573	248.43	116.94	1,250.52
51 - 65	1,773	7,139	10,760.00	6.07	1,540,984	215.85	143.21	869.14
66 +	388	1,042	1,150.00	2.96	136,158	130.67	118.40	350.92
Total	**7,424**	**33,101**	**57,120.50**	**7.69**	**7,914,778**	**239.11**	**138.56**	**1,066.11**

Mental Health Services (66+)

- Leading providers
  - Mindpath Health, LifeLong Trust Health Center, and Asian Health Service



Supplemental Equity Slides

ALAMEDA Alliance FOR HEALTH

DHCS APL 23-025, DIVERSITY, EQUITY, AND INCLUSION (DEI) TRAINING PROGRAM

- We are currently collecting feedback from our internal and external stakeholders to design and develop a comprehensive DEI training curriculum in close collaboration with our HR and NCQA teams, and we plan to roll out this training in 2025.
- The goals of this program are to promote best practices and behavior change not only within our organization but with our provider partners to advance health equity for our staff and Medi-Cal members.
- The comprehensive DEI training program will include sensitivity, diversity, cultural competency, cultural humility, and health equity training programs.

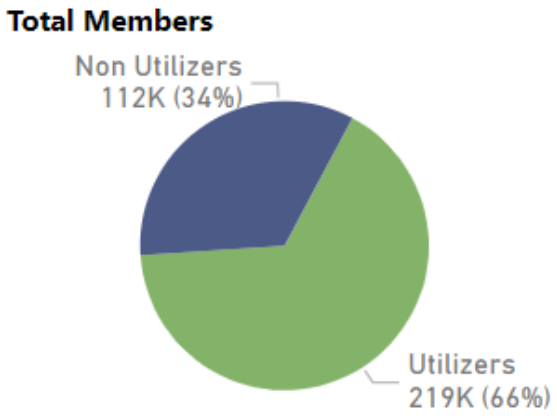
DMHC 23-029 - Health Equity and Quality Measure Set Benchmark, Accreditation, and Stratification Process

- The All-Plan Letter sets benchmark, accreditation, and stratification processes that all Plans must follow.
- Attended trainings hosted by DMHC to gain further information on the HEQMS benchmark, accreditation and stratification process, and what the Alliance needs to implement.
- The HE team will work towards getting our NCQA accreditation by gathering significant data to meet health equity and quality benchmarks.

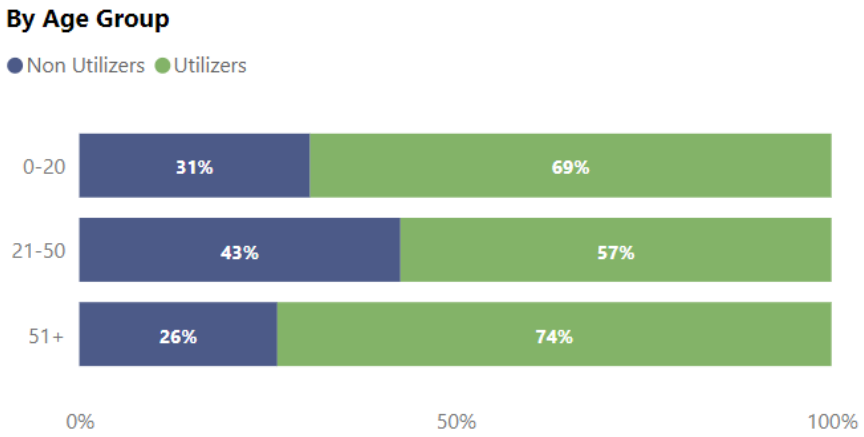
NCQA Health Equity Standards and Accreditation

- Preparing for NCQA Health Equity Accreditation by having ongoing meetings and discussions with the CHEO of DHCS.
- Our goal is to have it completed by summer 2025
- Becoming NCQA accredited will help meet our multicultural population's needs by improving the quality of services and reducing disparities to create a more inclusive and healthy community.
- The NCQA Health Equity Standards include but are not limited to organizational readiness, the collection of SOGI data, and the reduction of health care disparities.

Underserved Population: Non-Utilizers*



- ~ 1/3 of AAH's population is a non-utilizer.
- The 21-50 year-old age group has the highest percentage of non-utilizers (43%).



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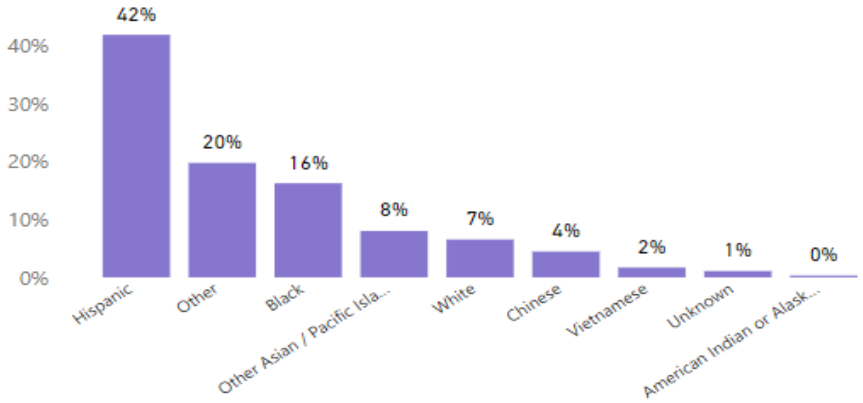
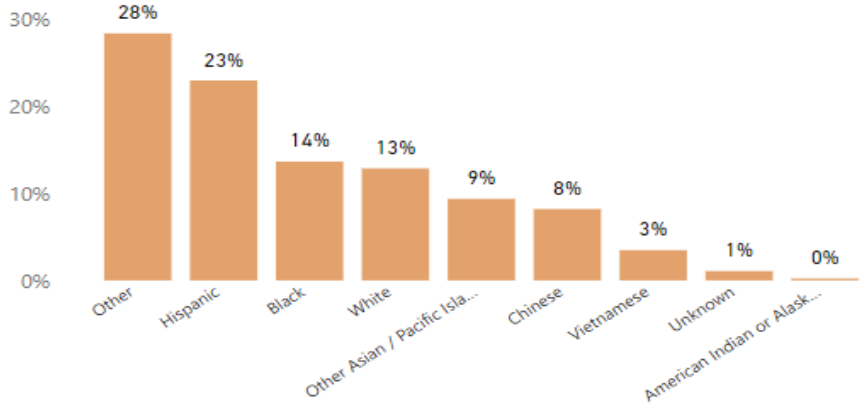
Underserved Population: Non-Utilizers*

0-20 years: Non-Utilizers

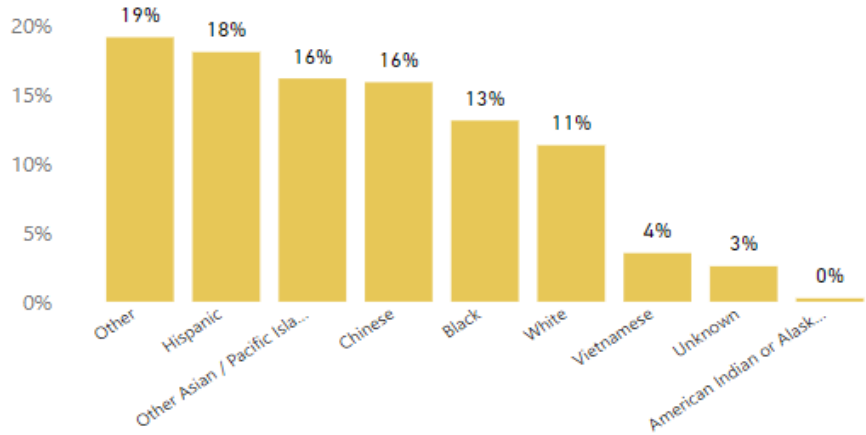


21-50 years: Non-Utilizers



- The Under 21 age group is predominantly Hispanic (42%), while the 21-50 and 51+ age groups both fall predominantly in the Other and Hispanic ethnicities/races.
- Both the Under 21 and 21-50 age groups follow their overall population ethnicity/race distribution.
- The Other and Hispanic population in the 51+ age group have the highest % of non-utilizers compared to the other populations.

51+ years: Non-Utilizers



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Equity Efforts

- **Focused Efforts on Healthcare Effectiveness and Data Information Set (HEDIS) For Minimum Performance Level (MPL).**
  - Well–child (W-15) visits in the first 15 months and 15-30 months (specifically African-American children)
  - Child Immunization Status (CIS-10) for African-American children
  - Lead Screening in Children (LSC)
- **External Health Equity & DEI Strategies:**
  - Engage with our Native American Health Centers to increase Native American mental health support: Native American youth (high school students) on suicidal prevention and counseling.
  - Engage with our LGBTQ+ community to increase support for mental health conditions. LGBTQ+ youth experience a greater risk for mental health conditions and suicidal ideation.

Equity Efforts

- **Current efforts:**
  - The Quality Improvement Team conducted outreach and education to African American women members ages 52-74 for Breast Cancer Screening (BCS) to encourage this high–risk subgroup to schedule a screening.
  - HHIP (Housing & Homelessness Incentive Program) aligns with our health equity efforts to reduce and prevent homelessness by expanding housing services, creating pathways for our underserved communities to obtain resources for housing placement, and increasing health outcomes for our members.
  - Increasing HEDIS scores for Cervical Cancer Screening (CCS) and Controlling High Blood Pressure (CBP) by collaborating with our QI and C&O team to create strategies to target our at-risk member populations.
- **Future Efforts:**
  - Building and developing our DEI Roadmap. We have identified our Strategic Roadmap Committee, and they will begin meeting in February.
  - Collaborating with PHM, QI, & UM to increase our MPL in all areas to improve the quality of care and to avoid sanctions by partnering with providers and creating a strategy to connect with our members.
- **External DEI Efforts:**
  - Developing External DEI efforts by engaging with our community partners, including but not limited to Native American Health Centers, to increase Native American healthcare education and access to healthcare, as well as engaging with our LGBTQ+ community to increase support for mental health conditions. The Alliance will seek more partners as we launch our external committee.

Breakout Sessions

Board of Governors Retreat
January 26, 2024

EPSDT

Older Adults

Behavioral Health

ALAMEDA Alliance FOR HEALTH

EPSDT

ALAMEDA Alliance FOR HEALTH

Older Adults

Behavioral Health

COMPLIANCE PRESENTATION

Richard Golfin III

Compliance Division Plan Updates

Internal Audit Activities for CY 2023 & 2024

As Presented to the Alameda Alliance Board of Directors

Presented by: Richard Golfin III
Chief Compliance & Privacy Officer

January 26th, 2024

ALAMEDA Alliance FOR HEALTH

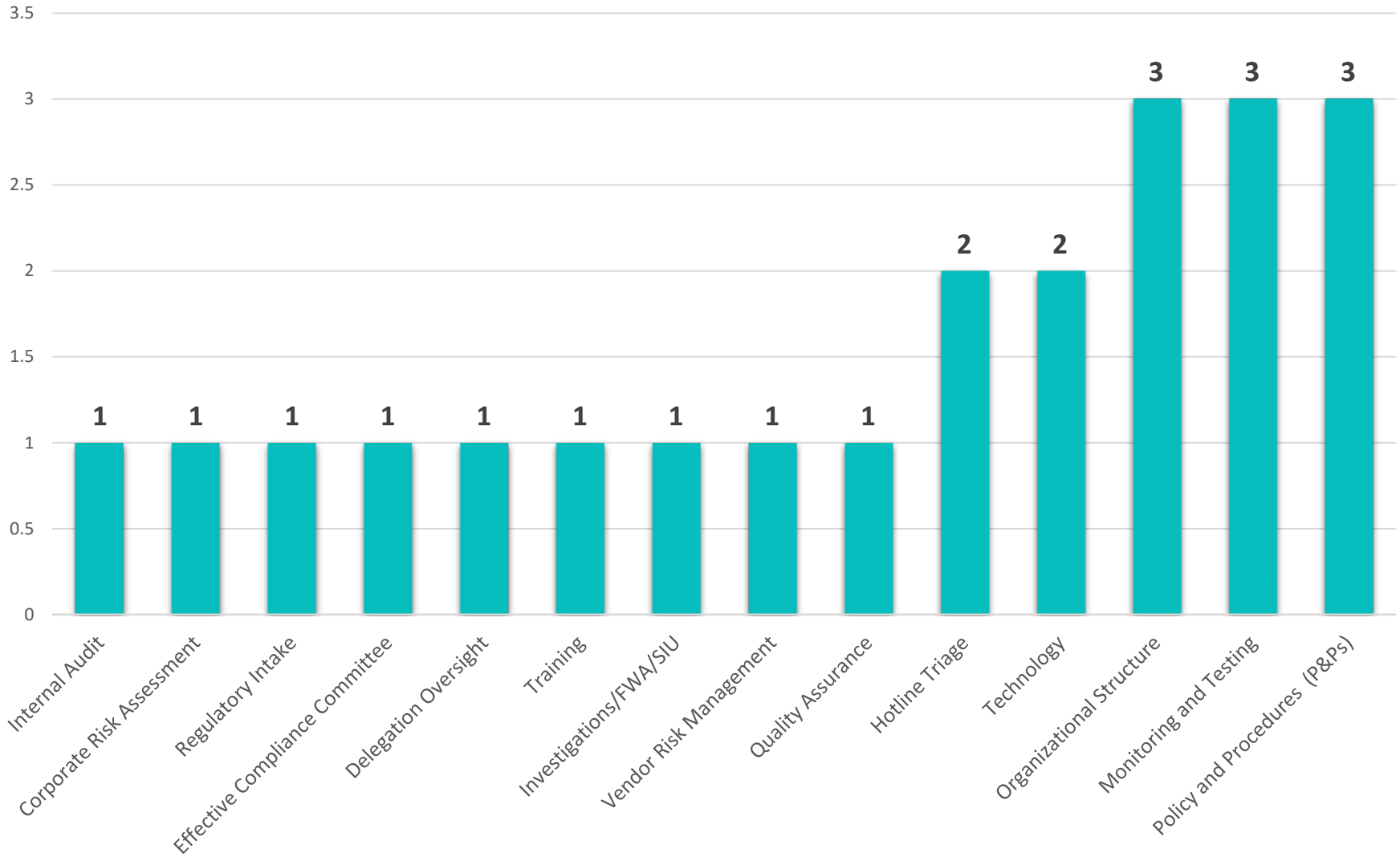
Compliance Risk Assessment

ALAMEDA Alliance FOR HEALTH

Compliance Risk Assessment (CRA) by RGP

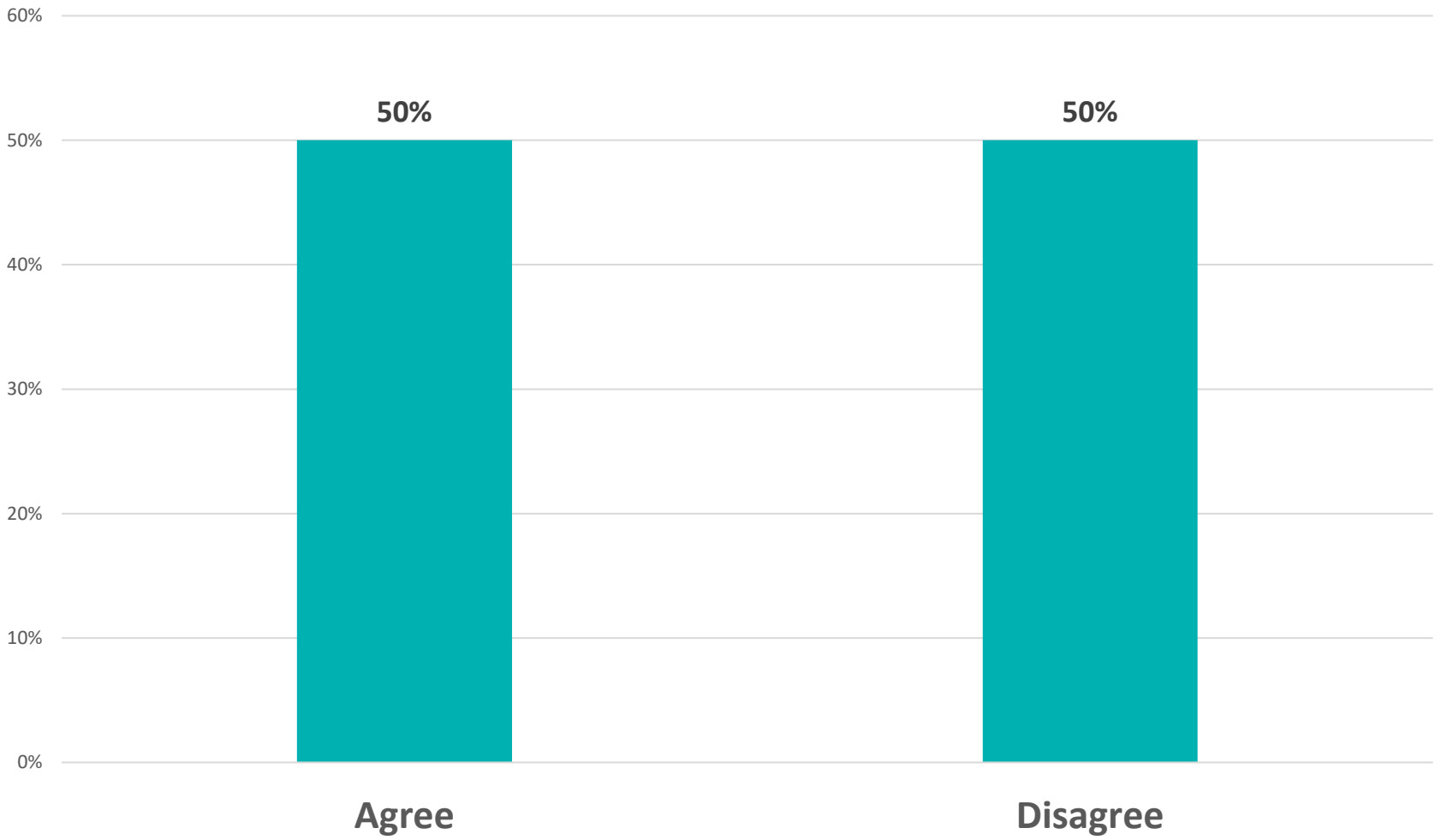
- CRA was conducted from December 2022 through May 2023 by RGP (third-party consultant) and includes 22 findings and recommendations regarding: internal audits, risk, communication/training, policies/procedures, workflows, and reporting.
- CRA did not account for programs and policies in development, so Compliance reviewed RGP's findings against current processes to ensure the most accurate and up-to-date information was used to assess the Alliance.
- After internal assessment, the Compliance Division agrees with 50% of RGP's recommendations and has developed additional actions beyond RGP's recommendations to mature the compliance program.
- All recommendations will be implemented by the end of Q4 2024.

Number of Findings by Area of Opportunity



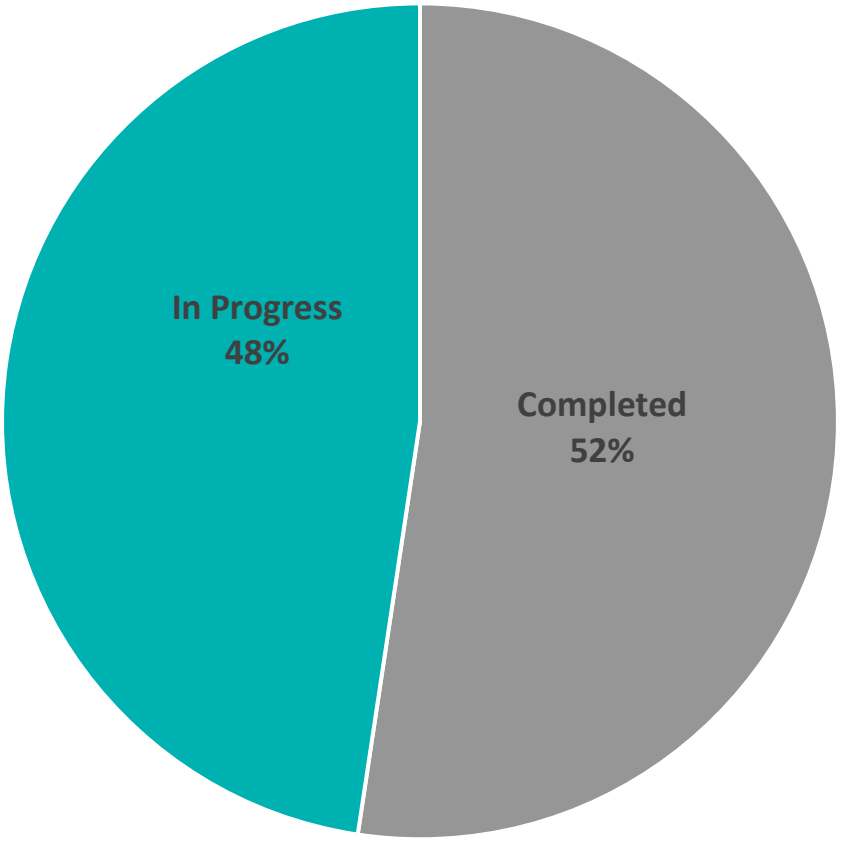
AAH Internal Audit Assessment

Agree/Disagree – 22 Findings

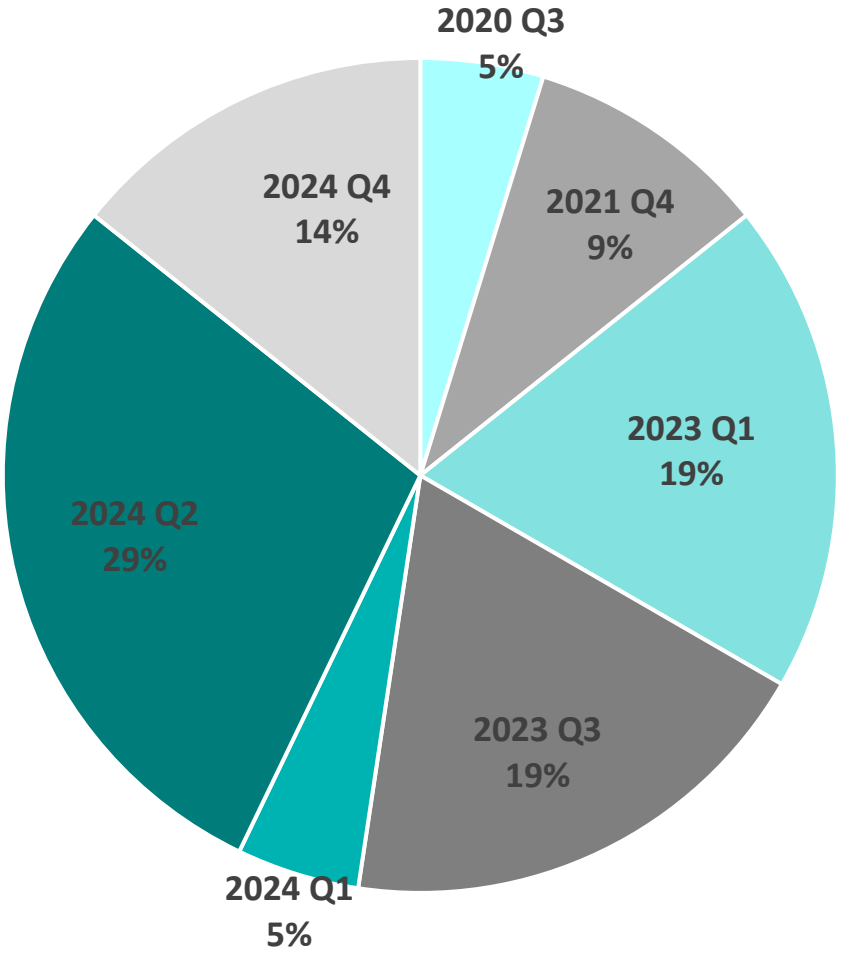


AAH Internal Audit Status

In Process vs. Completed



Estimated Completion



Recommendations Completed

Completed	Quantity	Description
2020 Q3	1	• 7.1 Compliance Committee meeting minutes already include the information recommended by RGP.
2021 Q4	2	• 9.2 Compliance implemented Policy Tech which is the Alliance's policy repository. • 12.1 Policy Tech houses both finalized policies and in development. It also tracks each policy's approval process. Also, new and revised policies plus requests to retire policies are submitted to the Compliance Committee for final approval on a quarterly basis.
2023 Q1	4	• 2.2 The Internal Audit Plan is the auditing program for the Alliance. • 2.3 The Internal Audit Plan includes a tracking process for audit findings. • 5.1 Regulatory Affairs is the regulatory intake program for the Alliance and partnered with Integrated Planning Division to develop a more robust implementation process. • 12.2 The Code of Conduct governs the manner employees conduct business and establishes ethical standards. It was last updated and approved on February 10, 2023.
2023 Q3	4	• 1.1 Legal now reports to the Chief Executive Officer. • 6.1 Compliance developed triage protocols for complaints received through the Compliance Hotline. • 8.1 The Alliance has a robust delegation oversight program which includes the Delegation Oversight Committee (DOC). DOC meets on a quarterly basis to review and discuss the compliance status for the Alliance's delegated and subcontracted networks. • 11.1 The Alliance has multiple processes in place for investigating and reporting FWA; developed workflows for referrals; tracking cases through Ethics Point; and implemented Fraud Shield.

California State Auditor's Report for CalOptima

ALAMEDA Alliance FOR HEALTH

- In May 2023, the CSA completed an audit of CalOptima's budget, services, programs, and organizational changes.
- Compliance compared the Alliance to the CSA audit report on CalOptima to meet the Alliance's goal to identify risk and improve operations.
- Compliance found the Alliance is compliant with the findings for CalOptima, but provided recommendations to improve the following areas:
  - Financial transparency
  - FWA Investigations
  - Hiring: Best Practices
  - Monitoring Effective Use of Funds
  - Surplus Funds
  - Timely Access
- The recommendations have been shared with the impacted areas on December 15th, 2023, and responses were due January 18th, 2024.

Kaiser and DMHC Behavioral Health Settlement Agreement

ALAMEDA Alliance FOR HEALTH

- DMHC entered into a settlement agreement with Kaiser regarding Kaiser's violation of timely access and clinical standards by canceling and inadequately providing behavioral health appointments.
- The Compliance Division is comparing the Alliance internal operations to outcomes based on this settlement agreement potential areas for improvement and to bolster risk mitigation.
  - This will be known as the Alameda Alliance Kaiser Behavioral Health Comparison Audit (AAH BHCA).
  - Kaiser's violations include, but are not limited to, a shortage of high-level facilities, insufficient oversight of medical groups, failure to make proper out-of-network referrals, and inadequate handling of enrollee grievances.
  - Evaluation will include Eight (8) audit areas over 66 points of interest.
- Compliance will present the results of the audit at the October 2024 Board of Governors meeting.

Compliance Division Summary

ALAMEDA Alliance FOR HEALTH

Compliance Division Summary

- Compliance Division has grown 200% in the past 10 years.
- Primary Objective: To ensure that the Alliance is operating in compliance with regulatory standards.
- Due to growth, Internal Audits has been able to leverage internal audits and develop advanced reporting internally and to government agencies.
  - Increased proactivity to risk identification and CAP mitigation.
  - Development of the Internal Audit Plan (Approved Q1 2023).
- Next Steps: Build an Enterprise Risk Management (ERM) program which is a holistic and strategic approach to identify, assess, prioritize, and manage risks across all facets of the Alliance.
  - Compliance will leverage ERM data to ensure the organization operates with resilience, compliance and the ability to deliver high-quality healthcare services.
  - ERM will provide a framework for assessing the effectiveness of existing controls and will help to systematically identify, evaluate and prioritize potential risks that could impact the achievement of an organization's objectives.

Questions?

ALAMEDA Alliance FOR HEALTH