MetroPlus Health Plan, Inc.
Board of Directors Meeting
March 30th, 2021

Minutes

The meeting of the Board of Directors of the MetroPlus Health Plan, Inc. (hereafter "MetroPlus or the Plan") was held in the 7th Floor Board Room at 50 Water Street, New York, NY 10004, on the 30th day of March 2021 at 2:00 P.M., pursuant to a notice which was sent to all the Board of Directors of the Corporation and which was provided to the public by the Secretary. The following Directors were present via video conference/ via teleconference:

Ms. Sally Hernandez- Piñero
Dr. Talya Schwartz
Mr. Matt Siegler
Dr. Eric Wei
Mr. Christopher Roker
Mr. Sherif Sakr
Ms. Vallencia Lloyd

Ms. Sally Hernandez-Piñero, Chair of the Board, called the meeting to order at 2:04 P.M.

Ms. Hernandez-Piñero chaired the meeting and Ms. Jessica Bauer, Secretary to the Board, kept the minutes, thereof.

ADOPTION OF THE MINUTES

The minutes of the meeting of the Board of Directors held **February 2nd, 2021** were presented to the Board. On a motion by Ms. Hernandez-Piñero and duly seconded, the Board adopted the minutes.

Ms. Hernandez-Piñero announced the appointment of Mr. Matt Siegler to be a member of the Customer Experience & Marketing Committee.

There being further no questions or comments, Ms. Hernandez-Piñero turned the meeting over to Mr. Sherif Sakr, Chair of the Audit & Compliance Committee, to introduce the Grant Thornton audit presentation.

INFORMATION ITEM

Mr. Sakr introduced Mr. Bryce Decker, Lead Managing Director at Grant Thornton (GT), explaining that he is in attendance on behalf of Mr. Dana Wilson, Managing Partner at GT. Mr. Sakr noted that Mr.

Wilson attended the Audit & Compliance Committee meeting where the MetroPlus 2020 Annual Audit was first presented.

Mr. Sakr explained that on March 24th, 2021 the Audit & Compliance Committee did a full detailed review of the financial statements with GT and the scope of the audit. The audit covered five primary areas including the audit scope, significant risk areas according to GT's risk assessment performance part of the audit, quality of the accounting practices, internal control aspects, and a review of the financial statement line items. The Audit & Compliance Committee approved the financial statements of the audit.

Mr. Sakr opened the floor up to the Board for any questions regarding the GT MetroPlus 2020 Annual Audit.

There being no further questions or comments, Mr. Sakr thanked the GT team for all the work that was done and for joining the Board meeting. Mr. Sakr turned the meeting back over to Ms. Hernandez-Piñero.

ACTION ITEMS

The **first** resolution was introduced by Ms. Hernandez-Piñero.

> ***Approving a resolution honoring the extraordinary leadership and service of retiring member of the MetroPlus Board of Directors, Ms. Nella Lewis.***

Ms. Hernandez-Piñero thanked Ms. Lewis for her years of service and noted that a couple of items were presented to Ms. Lewis as a token of the Board's appreciation.

There being no further questions or comments. On motion by the Chairman of the Board, the Board approved the resolution.

The **second** resolution was introduced by Dr. Eric Wei, Chair of the Quality Assurance & Performance Improvement Committee.

> ***Authorizing the Executive Director of MetroPlus Health Plan, Inc. ("MetroPlus" or the "Plan") to negotiate and execute a contract with AArete LLC ("AArete") to provide benchmarking and pricing validation services for a term of three years with two 1-year options, solely exercisable by MetroPlus.***

Dr. Sanjiv Shah, Chief Medical Officer, explained that the Plan was in need of a vendor that would perform a focused review of contracts in order to determine if pricing is appropriate and competitive when compared to historical market data. The vendor would provide services that may include contract optimization, unit cost reduction, utilization management, payment integrity, revenue enhancement, member satisfaction, and quality metrics. Historically, the Plan has not contracted with a vendor for this type of service.

Dr. Shah read through the minimum criteria that were issued in the request for proposal (RFP) and the senior level staff that were part of the evaluation committee. There were four vendors that submitted proposals for the evaluation committee to review and score, with AArete scoring the highest.

Dr. Shah noted that AArete has experience with over ninety (90) payer organizations in the United States with over 5 million lives under its management and 3.4 million managed Medicaid lives (1.7 million lives in the 5 New York City boroughs).

The various Board Members asked questions regarding whether the vendor's data would inform the contracting for new contracts as well as renewals and whether the vendor would monitor the standards that the Plan uses and how the standards are applied. Dr. Shah confirmed that the vendor's services could inform new, renewing and extended contract discussions. Dr. Shah also confirmed that the vendor could inform whether services, such as endoscopies are being provided in the most efficient setting when clinically appropriate. Board members also asked whether the vendor would have access to protected health information about specific Members.

Dr. Shah responded that the vendor's focus will be on contract optimization to ensure that the Plan is competitively priced compared to the market.

Dr. Schwartz added that the Plan is not delegating the contract negotiating to AArete. The Plan will continue to conduct the negotiation and AArete will provide the analytics and market intelligence to the Plan. Board Members asked if the Vendor could assist with moving towards value-based payment (VBP) arrangements.

Dr. Shah responded that AArete would focus on vendor and provider contract reimbursement to ensure the Plan is competitively priced in the market.

Dr. Schwartz added that there is not a lot of good benchmarking data available and as part of the Plan's negotiating process AArete will provide a market view of what is happening in the market and provide guidance on what would be considered reasonable contract terms. Dr. Shah provided a detailed, hypothetical example of how AArete's services would benefit the Plan in a contract negotiation.

In response to Board questions, Dr. Shah added that AArete is an adjunct to the Plan's work and will not suspend the Plan's intelligence and the approach to the work at hand.

There being no further questions or comments. On motion by the Chairman of the Board, the Board approved the resolution.

The **third** resolution was introduced by Dr. Wei.

> ***Authorizing the Executive Director of MetroPlus Health Plan, Inc. ("MetroPlus" or the "Plan") to negotiate and execute a contract with Change Healthcare ("Change") to provide a claims payment software solution, for a term of seven years.***

Dr. Shah explained that the Plan currently uses ClaimCheck, a claim editing software, which is purchased through Security Software & Consulting Technologies (SS&C) who processes the Plan's claims. ClaimCheck is 'manufactured' by Change Healthcare and is set to sunset in July 2022, thereafter, ClaimCheck will no longer be available, and the Plan will have to utilize a different claim editing software. The current annual cost of ClaimCheck includes licensing and hosting. Implementation of new claim editing software is estimated at 12-15 months regardless of the selected replacement.

Of the four vendors identified, two were automatically eliminated because they do not support NYS Medicaid rules. Even though the third vendor, Optum, does operate in the NYS Medicaid market it does not currently support integration with the Plan's current claims system, PowerSTEPP, which is a critical element in transitioning to a new product within the 12-15 months' timeframe. It would be too risky for the Plan to leverage Optum's services. Thus, the Plan is recommending to the Board to approve the selection of Change Health's next generation claim editing software, ClaimsXten.

Dr. Shah noted that most of Change Health's clients have already fully transitioned from ClaimCheck to ClaimsXten. ClaimsXten has substantial experience with over 80% of Health Plans with members in NYS using ClaimsXten for claim editing.

Dr. Shah noted that the Plan opted for the 7-year software licensing term instead of the 5-year term, because ClaimsXten offers a discount for the 7-year term.

Dr. Shah reported that Change Healthcare has submitted a 30% MWBE waiver and read a statement provided by Change Healthcare:

> *Change Healthcare has ongoing diversity and inclusion initiatives to support its efforts. These include Business Resource Groups, Supplier Diversity Programs (including joining the National Minority Supplier Development Council (NMSDC), and vendor relationships that help Change identify core diversity and inclusion training for rollout across the organization.*

Dr. Shah read through Change Healthcare's staff diversity and inclusion statistics and their business resource groups.

A Board member asked if this was a sole source contract and Dr. Shah confirmed, adding that Change is the only vendor in the NY market that can integrate with PowerSTEPP, provide national guidance on claim editing, and has experience with NYS Medicaid. This claim editing software is utilized pre-payment before adjudication. A step-by-step example of how a claim would be processed leveraging ClaimsXten was explained.

There being no further questions or comments. On motion by the Chairman of the Board, the Board approved the resolution.

The **fourth** resolution was introduced by Ms. Vallencia Lloyd, Chair of the Customer Experience & Marketing Committee.

Authorizing the Executive Director of MetroPlus Health Plan, Inc. ("MetroPlus" or the "Plan") to negotiate and execute a contract with Silverline to provide Salesforce system integrator services for a term of two years with two 1-year options, solely exercisable by MetroPlus, for a 4-year term.

Mr. Ganesh Ramratan, Chief Information Officer responded to the resolution. In December 2020, the Board approved the use of the Salesforce platform as the Customer Relationship Management (CRM) system which will be used across multiple business areas and will elevate employee efficiency and increase member and provider satisfaction. Salesforce will combine disparate information from multiple systems into a "single pane of glass", rather than having an employee toggle between logging into multiple applications in order to get a holistic view of a member's information. The Plan requires a System Integrator (SI) to bring together the component subsystems into one and ensure that those subsystems function together. The Contract Review Committee approved an application to issue an RFP for a SI in November 2020.

Mr. Ramratan read through the minimum criteria outlined in the RFP, participants of the evaluation committee and the various evaluation criteria categories that the vendors were being scored on. There were five proposals received and Silverline scored the highest. Salesforce also highly recommended Silverline. Silverline has successfully implemented over 200 projects and recently created a consulting practice solely focused on the payer industry. Silverline's team of certified professionals includes three certified technical architects, for which there are only 100 of these certified professionals in the United States. Silverline's success places them in a very small and elite group of consulting organizations that can bring this level of expertise to this project.

Mr. Ramratan explained the fives phases of the implementation plan. Mr. Ramratan noted that Silverline submitted at 31.86% MWBE utilization plan.

Ms. Hernandez-Piñero asked to confirm the date of implementation completion.

Mr. Ramratan stated that the implementation is scheduled to be completed in June 2022.

Ms. Hernandez-Piñero expressed how exciting and important of a step forward this is for MetroPlus.

There being no further questions or comments. On motion by the Chairman of the Board, the Board approved the resolution.

The **fifth** resolution was introduced by Ms. Lloyd.

Authorizing the Executive Director of MetroPlus Health Plan, Inc. ("MetroPlus" or the "Plan") to negotiate a lease with BNN FULTON FLUSHING OWNER LLC (the "Landlord") for the use and occupancy of 136-13 Roosevelt Avenue, Flushing, New York, for a term of ten years at a rent of $324,000.00 per year to be escalated by 2% per year for a total of $3,548,510.60.

Mr. Roger Milliner, Chief Growth Officer, read through the PowerPoint presentation.

Mr. Milliner explained that MetroPlus is implementing a strategic growth plan to increase member retention in an area with high rates of uninsured and immigrant populations in north Queens. The plan is to compete within a crowded NYC market by positioning and operationalizing new acquisition channels (e.g. community office) and integrate into current marketing mix.

Mr. Milliner stated that the Plan currently has low penetration within target zip codes, lack of professional "business" space, deep competitor market share and market nurturing. The desired future state is to implement multi-tiered media & communication strategy, establish a physical location and dedicate resources to launch and sustain growth within targeted zip codes. The benefits of this new community office include enhancing the Plan's professional image, generating a new channel of growth and demonstrating commitment to Flushing and the surrounding community.

Mr. Milliner described the target zip codes and audiences based on demographic age range, industry and key partnerships. Mr. Milliner outlined the lease agreement and other comparable office spaces that were considered. Enrollment and membership growth projections due to the use of this new office space were presented.

Board members noted MetroPlus' presence was needed in the community to successfully connect with the target audience for membership growth and agreed it is a worthwhile endeavor as long as it is properly utilized, where the staff would hold events to draw in consumers.

Dr. Schwartz added that due to its prominent location in Queens it will also serve as a marketing tool for the Plan in this area. The Plan negotiated hard to include termination rights along with subleasing in the lease so that after 2-3 years, if the Plan is not making the desired traction, then there is the option to sublease.

There being no further questions or comments. On motion by the Chairman of the Board, the Board approved the resolution.

Ms. Hernandez-Piñero turned the meeting over to Dr. Schwartz.

CHIEF EXECUTIVE OFFICER'S REPORT

Dr. Schwartz's remarks were in the Board of Directors packet and a copy is attached hereto and incorporated by reference.

Dr. Schwartz stated that Ms. Lauren Leverich-Castaldo has been appointed the position of Chief Financial Officer (CFO), noting that Ms. Leverich-Castaldo had been serving as the Interim CFO when the previous CFO retirement in 2020.

Dr. Schwartz reported that the Board meeting was taking place in the MetroPlus Board Room at 50 Water Street. It took a few weeks to move into the new location and everyone is looking forward to being in the same building with more of NYC Health + Hospitals (H+H).

Ms. Raven Ryan-Solon, Chief Regulatory & Compliance Officer, presented the regulatory updates to the Board.

Ms. Ryan-Solon reported that all NYS COVID-19 related Executive Orders were currently extended through March 2021. The extensions are given thirty (30) days at a time and it is expected that more of the rules will be extended, including cost-sharing rules expected to be extended beyond April 4, 2021. Disenrollment moratorium for Medicaid, Child Health Plus (CHP), and Essential Plan (EP) are expected to be continued through at least June 2021. Medicaid disenrollment for members with Third Party Health Insurance (TPHI) resumed February 28, 2021. MetroPlus has already started receiving the files from the State determining who is no longer eligible for Medicaid.

Ms. Ryan-Solon reported that open enrollment was extended through the end of 2021. Pharmacy carve-out was postponed one month to May 1, 2021. This is still being discussed, so the Plan is proceeding as if this is moving forward until the Plan hears otherwise. Managed Long-Term Care (MLTC) Independent Assessor Program is on hold due to pending approval from the Centers for Medicare and Medicaid Services (CMS) and Office of the State Comptroller (OSC) and promulgation of regulations. CMS and OSC stated they start as soon after April 1, 2021 as possible. One-year wait time to qualify for fertility coverage is waived for same-sex couples.

Ms. Ryan-Solon stated that additional regulations are the federal government passed the American Rescue Plan Act (ARPA). The Plan impact is that for the Qualified Health Plan (QHP) individual's eligibility for tax subsidies, which the Plan refers to as APTC for tax credits has been expanded to people making up to 400% of the federal poverty level. That means a lot more people will be eligible for QHP coverage and a lot more people are going to be able to afford QHP coverage with this expansion and the assistance of these tax credits. This is good news for the Plan and even more efforts will be put into place to ensure that more people obtain access to coverage. The State has notified all plans that, in addition to the other budget cuts, they are instituting a 2% withhold on the Health and Recovery Plan (HARP) line of business. Meaning the State withholds the Plan's funds up front and the premium and capitation payments that the Plan would otherwise be entitled to receiving. The Plan then must prove to the State that it has met a series of quality metrics in order to earn back the premium that the Plan would have received up front.

Dr. Schwartz added that there is a consensus across the board that the quality incentive will be restored, more details to come. The HARP withhold was very unexpected. With the COVID-19 adjust, across-the-board (ATB) cuts, claims withhold and now the HARP quality withhold, it potentially forces the Plan to operate in a deficit because the Plan's margins are not so significant that it can experience all of the withholds without any issues. Although the COVID-19 adjustment is temporary, the Plan does not know yet about the ATB cuts until the rates going forward are released, which determine whether or not the Plan is has no choice but to operate at a deficit.

Ms. Hernandez-Piñero asked that the Plan would be potentially operating at a deficit as of what date.

Ms. Lauren Leverich-Castaldo responded that the Plan should know within the next thirty (30) days.

There being no further questions or comments on the regulatory updates, Ms. Ryan-Solon turned the meeting over to Dr. Schwartz.

Ms. Lauren Leverich-Castaldo, Chief Financial Officer, presented the updates on membership and utilization as reflected in the included slides. Trends are largely positive with the Plan membership at 609,030 through February which is on target with the Plan's current forecast. The percent of medical spend at H+H has been affected over the last couple quarters due to increase in utilization outside of the H+H system, in addition to the rate cuts surrounding COVID-19. Behavioral Health in-sourcing continues to make steady progress.

Ms. Leverich-Castaldo noted that membership in January and February in the NYC region had a jolt of enrollment due to the TPHI sweeps that the State has started doing again. The Sales team is doing outreach to ensure that all membership identified as having TPHI does actually have TPHI, or the Plan is working with the State to rectify.

Ms. Leverich-Castaldo reported that based on COVID-19 vaccination administration claims data through provider billing, the Plan knows this is only a small percent of the population that is receiving the vaccination. This is due to people not being required to show their health insurance card to receive the vaccination. This is similar to what was seen towards the beginning of COVID-19 with the COVID-19 testing.

Dr. Schwartz explained the additional effort that the Plan is putting towards using other sources to identify more members that have received the vaccine. This way there can be more targeted efforts toward the populations that have not received the vaccination, possibly due to vaccine hesitancy.

Ms. Leverich-Castaldo presented the financial performance updates as reflected in the provided slides. A brief review was provided of the summary of the year end findings and year end regulatory reporting that had been covered in the GT presentation. A reduction of -4.5% in total medical expenditures per member per month (PMPM) in 2020 as compared to 2019. The main contributor being a decrease of outpatient services during the COVID-19 lock down period. Urgent care visit PMPM increased by $1.8 PMPM (+57.1%) in 2020 as compared to 2019. This also correlated to COVID-19 testing at urgent care sites.

There being no further questions or comments, Ms. Leverich-Castaldo turned the meeting over to Dr. Sanjiv Shah, Chief Medical Officer.

Dr. Shah presented the Utilization Management Article 44 update as reflected in the provided slides. Dr. Shah reported on how a previous Article 44 review led to a corrective action plan (CAP) being issued to the Plan. Since then, an internal audit had been conducted to show the Plan had successfully implemented over 90% of the plan of correction (POC), before submitting the POC to NYS Department of Health (NYSDOH). Utilization Management department has implemented all action items in the currently accepted POC.

Dr. Shah reported that the main areas where corrections were implemented were in staff training, workflow modifications, system updates, daily queue reviews, and monthly audits. All to ensure that all reviews were completed timely, and both the members and provider received timely notification on completed reviews. Prior authorization timeliness rate improved from 78.8% in April 2019 to 96.9% in January 2021. Concurrent review timeliness (24-hour turnaround time) improved from 50% in April of 2019 to 93% in December 2020 and 90.9% in January 2021.

Dr. Shah reviewed the ongoing performance improvement that is taking place.

There being no further questions or comments, Dr. Shah moved on to present the Behavioral Health (BH) transition update as reflected in the provided slides.

Dr. Shah reported that 63% of contracts have been returned and credentialed providers is at 32% of target. Claims configuration is 70% complete. Testing to begin in April. NYSDOH desk review documentation successfully submitted at the end of March. The Plan is required to have a separate call center for BH. Contracting with Vibrant Emotional Health on 24 hours a day/ 7 day a week/ 365 days a year telephonic crisis intervention and support services.

A Board member asked how much money the Plan has spent thus far on the BH transition. Dr. Shah advised that most of the spend has gone toward hiring the needed staff, including temporary staff hired to assist in credentialing the BH providers.

A Board member asked about highlights of the feedback that the Plan had received from the State on March 1st, 2021.

Dr. Shah responded that feedback was received from a targeted survey of the Plan's claim denials as a result of Beacon's work. The State has telephonically implied that even though this is Beacon's work, the Plan's oversight is important. As a result, since the Plan will be taking over the work from Beacon, the oversight and scrutiny by the State will continue.

There being no further questions or comments, Dr. Shah turned the floor over to Mr. Colin Laughlin, Head of Product.

Mr. Laughlin presented the report on the Open Enrollment Results stating that the Plan retained a significant proportion of QHP membership in 2020 and achieved an increased renewal rate due to focused outreach by. There was a significant increase in members switching to other lines of business primarily due to the economic impact of the pandemic and the availability of our plans with lower income thresholds. GoldCare showed stable growth of 3%, which is consistent with prior years.

Mr. Laughlin reported that the Gold line of business experienced a small enrollment decline from 2019. H+H staff comprise the largest proportion of enrollment in the Gold product.

Mr. Laughlin reported that the Medicare LOB had a 78% increase in new enrollments over last year.

Dr. Schwartz said that MetroPlus is considering introducing a broker channel for the next open enrollment. MetroPlus is the only Medicare Plan that does not use brokers and that puts the Plan at a severe disadvantage.

A Board member asked reasons for the disenrollment rate and the staff discussed various possible reasons.

A Board member asked whether various products were the subject of strategy discussions singly or combined.

There being no further questions or comments, Mr. Laughlin turned the floor over to Mr. Paul Angeli, Senior Director of Procurement and Vendor Management.

Mr. Angeli presented the report on the updated Procurement and Vendor Management process. Procurement, Vendor Management, and Purchasing have been three distinct MetroPlusHealth departments for many years. The Plan's recent reorganization created the department of Procurement and Vendor Management reporting to the Chief Operating Officer for improved continuity, coordination, and effectiveness. The process flow achievements include service procurement, contract negotiation, contract execution, and management of vendor/contracted relationships. Steps toward organizational performance improvement are being achieved through staff education, knowledge and experience synergies, and best practice implementation.

Mr. Angeli explained that a Contract Review Committee was established and will review the contracts first, before moving forward. Mr. Angeli also highlighted accomplishments with implementing a Minority and Women-owned Business Enterprise (MWBE) policy consistent with MetroPlusHealth goals and standardizing the vendor management role and responsibilities. This covers both delegated and non-delegated vendors.

There being no further questions or comments, Mr. Angeli turned the floor over to Mr. Ryan Harris, Chief Human Resource Officer.

Mr. Harris presented the report on employee engagement and. Mr. Harris explained that it cannot be ignored that there was a physiological and psychological burden that COVID-19 pandemic has had on the MetroPlusHealth staff. The Plan wanted to be intentional in connecting and engaging the staff through a series of virtual events on different topics and issues of interest. The first event of the series was Broadway from Home in December 2020. There were live virtual performances by Broadway actors and actresses singing songs from some of the most popular Broadway shows while also recognizing some of the staff that were awarded Employee of the Year.

Mr. Harris described the series of Black History Month newsletters that were issued for staff to read. To celebrate Women's History Month, the Plan created a montage of the women that had a lasting impact on MetroPlusHealth employees, highlighting mothers, woman family members, mentors, teachers, etc.

Mr. Harris highlighted the mentorship program with the first cohort that started in October 2020 and ran through March 2021. Mr. Harris explained how staff were selected to participate, how they were paired up with their mentor, the events that took place, participation expectations, and the overall goals that the program was trying to achieve. The next cohort to launch in June 2021.

Dr. Schwartz added this was the first time the Plan launched its own mentorship program, where senior and executive level staff are mentoring employees. The Plan did not know it would be received since this was planned under pre-pandemic circumstances, but the feedback has been very positive.

There being no further business, Ms. Hernandez-Piñero adjourned the meeting at 3:34 PM.