ALAMEDA ALLIANCE FOR HEALTH
BOARD OF GOVERNORS
REGULAR MEETING

January 11, 2019
12:00 pm – 2:00 pm
1240 South Loop Road, Alameda, CA

SUMMARY OF PROCEEDINGS

Board Members Present: Marty Lynch (Chair), Dr. Evan Seevak (Vice Chair), Scott Coffin, David Vliet, Delvecchio Finley, Feda Almaliti, Michael Marchiano, Dr. Noha Aboelata, Rebecca Gebhart, Dr. Rollington Ferguson, Travis Stein, Will Scott, Wilma Chan
Excused: Aarondeep Basrai, Nicholas Peraino
Alliance Staff Present: Scott Coffin, Gil Riojas, Matt Woodruff, Dr. Steve O'Brien, Tiffany Cheang, Anastacia Swift, Jeanette Murray

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
1. CALL TO ORDER			
M. Lynch	The regular board meeting was called to order by M. Lynch at 12:04 PM. A board quorum was established by a simple majority for the meeting.	None	None
2. INTRODUCTIONS			
M. Lynch	Introductions were made for those present.	None	None
3. AGENDA APPROVAL OR MODIFICATIONS			
M. Lynch	There were no modifications to the agenda.	None	None
4. CONSENT CALENDAR			
M. Lynch	M. Lynch requested a motion to approve the Consent Calendar: • December 14, 2018 Board of Governors Meeting Minutes F. Almaliti moved to approve the Consent Calendar. The motion was seconded by W. Scott. The motion passed unanimously.	Motion: F. Almaliti Second: W. Scott Motion passed unanimously.	None
5. a. BOARD MEMBER REPORT – COMPLIANCE ADVISORY GROUP			
R. Gebhart	R. Gebhart provided the following updates from the Compliance Advisory Committee. Board members who participated were F. Almaliti, W. Scott and T. Stein. The committee tracks DHCS, DMHC, and internally	None	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	identified findings. Currently there are five dashboards being tracked and two corrective action plans (CAPs) which have not been completed or validated. • The three dashboards from 2016 and 2017 all have CAPs that have been completed and are currently in the process of being validated • 2018 DHCS Medical Services Audit from June had 38 findings o Nine findings related to authorizations of claims: documentation of appropriate application of criteria, documentation that medical necessity employed in the decision, documentation that the correct level of clinical staff look at denials, and turnaround times ▪ One day turnaround time for pharmacy authorizations was met during the week but weekends and holidays were not covered in the Pharmacy Benefits Manager (PBM) contract and those auths were waiting to the following working day, contract amended and weekend and holiday coverage is occurring now o Three delegation oversight findings. This is a big issue for all plans and the state looks closely at how plans are monitoring delegates o Initial Health Assessment (IHA) – ▪ Plan has 120 days to ensure new members get an IHA ▪ Member services educates the members on importance and how to get it an IHA done by providers ▪ Communication to members is managed by plans ▪ Completion rate is 30%, which is an industry issue • April 2018 DMHC audit findings o Potential Quality Issues (PQIs) that hadn't been dealt with: ▪ Backlog has been fixed and now being done timely ▪ DMHC requested report on these PQIs and how they are being handled o The board asked why the findings do not reflect they have been corrected:		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	▪ DMHC needs to be onsite to validate – these items will remain open until then ▪ The CAP is still in progress for 3 findings • The board asked why, if internal audit scores are all above 90% there are still findings from DMHC and DHCS? o There are many nuances and complexities to the regulations and surveys can have different areas of focus then our internal audits have been focusing on • The board asked since IHAs are challenging to get done, do we have incentives in place to encourage completion? o This is a measure in Pay for Performance (P4P) that was removed last year but is back in this year and we will evaluate how this affects completion rates o The board asked if it was possible to incentivize members to encourage completion of IHAs and if there were any regulations regarding this o The board asked if the goal for IHA completion is reasonable. ▪ S. O'Brien explained the expectation of the state is 100% completion, however Alameda Alliance completion levels are currently in line with the majority of plans ▪ We can help notify members as well as help providers get in contact with members ▪ The board requested to see the average IHA completion rates across all plans. R. Gebhart emphasized that Care Coordination and work with High Utilizers should be the biggest area of focus for the board		Incentivizing members to complete the IHAs Average IHA completion rate across all plans.
5.b. BOARD MEMBER REPORT– FINANCE COMMITTEE			
R. Ferguson	R. Ferguson reported from the Finance Committee meeting on January 8th. This meeting was also attended by board members, N. Peraino and M. Marchiano. • Overall actual net income for the month ended November 30, 2018 was $42,000 while the budgeted net loss to date was $3.1 million for the month ended November 30, 2018 • The year-to-date actual net loss as of November 30,2018 was	None	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP

	$2.2 million, this would have been $14.5 million year-to-date if we had stayed with original budgeted net loss
	• Medical expenses and pharmacy costs are the main items that stand out and are above budget
	• Administrative expenses typically run below budget but are currently above budget for the reporting period
	• Tangible Net Equity (TNE) is 594% above requirement
	• Medical Loss Ratio (MLR) is 95.8% for the fiscal year-to-date
	  o MLR had to pay back to the state last year due to being below where it should have been
	• Potential problem regarding HealthSuite which was obtained 3-5 years ago and cost a significant amount of money to implement
	  o Currently doesn't integrate well with the care management systems, causing a lot of work arounds which is a problem since this was such a recent and major investment
	• Meeting anticipating adjustment for net loss		

6.a. BOARD BUSINESS – FINANCIAL REPORT - NOVEMBER			

G. Riojas	G. Riojas provided the following financial updates for November:
	
	• November Net Income is $42,000, and 594% of required Tangible Net Equity (TNE).
	• Enrollment decreased 942 members from October 2018
	  o Optional expansion steady over last 12 months
	  o SPD and IHSS remained flat while Medi-Cal Duals decreased
	  o The board questioned why enrollment continues to decrease and what the trends look like with other plans and at the state level
	  ▪ At the state level total enrollment is still relatively strong at 10.6
	  o Decreases at the county level could be contributed to the economy as well as changes in immigration initiatives. There were no trends found when looking at ethnicity
	  o Los Angeles and Inland Empire plans are showing growth however other counties are in decline
	• Year-to-date Net Loss is at $2.2 million compared to the
			Additional information on enrollment trends at other plans

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	budgeted Net Loss of $14.5 million • Change in Medical Expenses is what is driving the reduction in net loss: $9 million difference between budgeted and actual year-to-date o Variance in Pharmacy fee for service (FFS) expenses related to specialty drug unit cost including anti-rheumatoid and oncology drugs o Inpatient, and outpatient expenses favorable compared to budget • The board asked what specific services and costs are captured in the primary, specialty, ancillary, and outpatient expense categories. o Outpatient can include lab costs, radiology, mental health, infusion, and other services done in an outpatient setting o G. Riojas will provide more indication of what is included in each of the categories going forward o N. Aboelata also requested radiology expenses be broken out so they can be reviewed further • Medical Loss Ratio (MLR) as a percentage of our revenue was 94.5% for November and 95.8% year-to-date (YTD) which is under budgeted of 98.9% and favorable for the month and YTD • Administrative expenses are above budget o Mainly related to printing cost which are allocated over 12 months, however most costs were experienced in November due to printing of HEDIS season materials and was higher than anticipated for November • YTD interest income from investments is $2.6 million which is lower than budgeted – We had anticipated two additional months of interest income in November and December, however DMHC requested reimbursement for the MLR in October 2018 instead of December causing this to fall short of budget • YTD claims interest expense was $340,000 due to delayed payment of certain claims or recalculated interest on previously paid claims • TNE is at 594% of required, actual is $187.9 million, which is a surplus of $156.3 million • Cash and cash equivalents are $232.9 million, of that $178 million is uncommitted and will go into investment strategy		Details regarding what is included in expense categories and break out radiology expenses

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	• The board asked when the updated budget will be reviewed o Q2 forecast review with AAH departments for July to December is starting now and information will be reported out at the March Board meeting	Motion: R. Ferguson Second: E. Seevak Motion passed.	
6. b. BOARD BUSINESS – CHAIR AND VICE CHAIR NOMINATIONS			
M. Lynch	Motion for Dr. Evan Seevak to serve as Chairperson Both R. Gebhart and R. Ferguson were put forward as candidates for Vice—Chairperson. The voting was done via paper ballot and R. Gebhart was selected to serve as Vice-Chairperson via a simple majority.	Motion: R. Ferguson Second: M. Marchiano Motion passed.	None
6.d. BOARD BUSINESS			
M. Lynch	M. Lynch made the following announcements: • Currently in talks with potential candidates to fill the vacant hospital council board seat • Board members will be polled on moving the monthly Board of Governors meeting to the 4th Friday of the month.	None	None
6. c. COST CONTAINMENT AND QUALIY INITIATIVES			
S. O'Brien	S. O'Brien provided an update of the cost containment and quality initiatives that are currently being worked on: • Medical Loss Ratio (MLS) is lower than we had budgeted for but is still too high at 94% o Required to spend a minimum 85% o Goal is 85% – 90% o Lots of work still needed, each percentage is a significant amount of money • The work being done falls under the leadership of Health Care Services working in partnership with all of Alameda Alliance • Cost Containment Goals: o The top priority is each initiative must maintain or improve quality o Focus on eliminating waste and decrease expenses that do not have a value add o Maintain regulatory readiness • Excess days initiative – Length of stay and hospital throughput o Inpatient care largest medical expenditure and excess stays in the hospital are unsafe for patients as well as	None	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	financially wasteful o Decrease barriers to discharge and improve throughput o Engaging hospitals in barrier identification and decrease barriers in partnership with hospital teams o We have been meeting with leadership at Alameda Health Systems; meetings with front line will start on January 14th o Alameda Health Systems has already started working on their own initiatives and we are working with them to strengthen these as well as identifying and working on additional initiatives based on the meetings with them o Currently Alameda Alliance has two nurses stationed at Highland who will be key team members in helping launch these initiatives. In addition we will leverage our local team to work in partnership with Alameda Health Systems to accomplish our mutual goals o The goal is to decrease length of stay by ¼ day ▪ We will need to know the average in both paid and actual length of stay at each hospital in order to decrease both ▪ Average length of stay, depending on the illness, is 4 – 5 days and the industry standard is 3.5 to 4.5 days o The initiatives at Highland Hospital will launch in February o After Alameda Health Systems we will roll out similar strategies at Alta Bates, followed by Eden, St. Rose, and Washington Hospitals o The board asked how we are determining timelines for length of stay ▪ Established parameters for average length of stay based on diagnostic code ▪ Complexity is figuring out length of stay by hospital o The board asked if we have staffing to help get members out on the weekend. ▪ Currently we have on call staff over weekend for authorization to get emergency people out ▪ Weekends can also have throughput issues for hospitals, especially regarding MRIs, consults, and other critical services		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	• High utilization management initiative o 7% of members account for 81% of medical spend o Timely identification of high utilizers can facilitate connection to services resulting in improved outcomes and cost avoidance o Currently defining key issues that have occurred in high utilizers in the past and leveraging information to design initiatives to focus on and target those high utilizers o Leveraging case management network, including CBCMEs to outreach to patients o Planning to use community health record, which is scheduled to go live this year and will be a critical step to provide information o A case management glossary has been included in the Board packet and shows the complex array of case management programs that interconnect to care for Alliance members who are in need of case management ▪ Only 2-3 of these entities use traditional EMR, the rest use their own system which makes it difficult to find out what they are doing – a community health record will help with this o Many providers of high utilizers are associated with FQHCs or are directly contracted physicians ▪ Setting up CBCMEs in these programs or connecting to these programs ▪ Analytics targeting where to go o The board asked if there are enough case managers overall. ▪ As we build a more integrated network we will have a better idea of capacity and need in the community, however this will require the community health network o High utilizers are defined differently depending on programs and internal criteria. The board asked for the definition, demographics on age, and mortality data. o R. Ferguson stated if we only look at cost to define high utilizers it doesn't get to bottom of question because it also depends on their illness and other factors.		Definition of high utilizers including demographics on age and mortality data

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	▪ The goal is to prevent people from getting into the high cost category with interventions on more complex illnesses however we need to know what these most often are (e.g. dialysis) so proper outreach can occur before catastrophic events ▪ T. Cheang added that cost is just first layer of looking at data, we will be looking at how to categorize those complex illness or co-morbidities as well o The goal is to have information regarding high utilizers flow to providers via the provider portal, however in the interim Community Based Care Management Entities (CBCMEs) will feed information as close to real time as possible so the provider can take action ▪ We are developing ways to feed providers the information in the portal so they are able to digest and act, instead of requiring them to log into the portal to receive this information o The board asked if there has been discussion on being more aggressive with advanced care planning and education of members. The Alliance goal is to educate providers and make information available however we do not currently have initiatives. o D. Finley recommended for simplicity delving into the top high utilizers and getting to know who they are, who they are assigned, disease state, and other pertinent information • Out of network initiatives o Having a network of providers is a regulatory requirement, however exceptions exist for continuity of care, network constraint, and medical necessity o Strategy of bringing members back in network. Regarding continuity of care for out of network providers, we are offering Medi-Cal rates, if the provider declines we are able to bring the member back in network ▪ Initiative started at Stanford in June and has shown good results in the first 6 quarters • Down to 36 Stanford referrals per month,		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	which is a decrease of 50% • Zero is not the goal due to medical necessity o The board inquired how this works in regards to Stanford's purchasing of practices, what happens when a contract provider sells to Stanford? ▪ Some stop seeing Medi-Cal patients, but many continue to see our members ▪ The issue is they refer to Stanford so we must reeducate them, this initiative of denying the referral when there is no medical necessity to go to Stanford is part of process ▪ Provider Relations is reeducating as well. ▪ When denied the provider and member get information about denial and rights to appeal • Pharmacy o Costs up, 20% of medical spend o Strategy is to target pharmacy administration and delivery system as well as making sure formulary is evidence based for quality of care o Initiatives: ▪ PMB contract and rebate improvements ▪ Formulary management changes are all evidence based, including move to biosimilar drugs, which are injectable medications and are basically like generics for these complicated medications ▪ Improved management of expensive drugs, including a switch of vendors for hepatitis C ▪ Drugs administered in physician's office to see if they are more appropriately driven through the pharmacy in order to obtain the rebate ▪ Split fills for oncolytic drugs ▪ Vendor management: considering RFP for PBM and specialty pharmacy vendors ▪ 340B looking at regulatory data exchange for compliance requirements, as well as starting the analysis for a 340B specific reimbursement strategy ▪ Enhanced coordination of benefits which flags if you have insurance other than Medi-Cal since Medi-Cal		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	is payer of last resort • Utilization Management initiatives o Consistency of evidence based care and cost avoidance o Preferred vendor selection for skilled nursing facilities, outpatient infusion, home health, oncology, and imaging to maximize care o Training standard work development with inpatient and outpatient UM and case management teams • Translation services initiatives o We have a large number of members who utilize translation services and we are looking to improve efficiency and modalities o Tightening translation requests processes will result in more telephonic and less in person interpretation ▪ Our plan by far has most in person interpretation in the state ▪ 3 phase process starts now through 2019 o The board requested a breakdown of translation needs of members		Breakdown of translation needs of members
7. a. STANDING COMMITTEE UPDATES PEER REVIEW AND CREDENTIALING COMMITEE			
S. O'Brien	S. O'Brien provided a summary of the most recent Peer Review and Credentialing Committee Meeting, which was held on December 18, 2018 • There were seven initial providers credentialed o Two primary care and five specialty care practitioners • There were 20 recredentialed providers o Seven primary care, ten specialty care, one ancillary, and three mid-level practitioners • There were 17 providers who terminated with the Alliance, mostly due to moves or changes in their employment status	None	None
7. b. STANDING COMMITTEE UPDATES PHARMACY AND THERAPEUTICS COMMITTEE			
S. O'Brien	S. O'Brien provided a summary of the most recent Pharmacy and Therapeutics Committee meeting, which was held on December 11, 2018 o There were 544 denials and 528 approvals. We are maintaining the same level of approval and denials o Reviewed staffing levels o Updates regarding the start of phase one of the opioid program o Policy and procedure updates o IVIG and biologic and immunologic drugs review	None	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	o Medical request guidelines changes		
7. c. STANDING COMMITTEE UPDATES MEMBER ADVISORY COMMITTEE			
S. Coffin	S. Coffin provided a summary of the most recent Member Advisory Committee (MAC) meeting, which was held on December 20, 2018. o The committee meets quarterly and has 15 members and county advisory advocates. This committee provides direct feedback on how we are doing as a health plan o Prior minutes were reviewed and approved o Grievance and appeals provided an update o Reviewed member screening questions of the Health Risk Assessment o Reviewed charter and bylaws o Built 1,000 homeless care bags, an idea which originated through the MAC committee. o The bags included supplies for basic needs, gift and cash cards, food, nutrition, and cosmetic supplies. o This is the second time they have created these bags o The bags are distributed to community and faith based organizations. They are also distributed by Alliance team members and MAC members when they see someone in need o The next meeting is scheduled for March 21st	None	None
8. CEO UPDATE			
S. Coffin	S. Coffin provided the following updates: o We are performing better than planned but continuing forward to find ways to remove excess o Four main project portfolios for calendar year 2019: o Cost containment, relates to quality and excess o Operational efficiency initiatives o Core infrastructure o Regulatory mandates, which must get done o Claims and authorizations audit, internal audit initiated by Alameda Alliance o Findings received in December o Internal workgroup now looking at findings of report o Findings and recommendations for next steps for work processes, technology, and core systems (Health Suite and TruCare)	None	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	o A summary of the findings will be distributed to the board o Managed care trends o Our highest enrollment was mid-2018 and has been steadily declining over the last six months o There has been an overall decline in enrollment in the majority of counties o In Alameda County seeing movements on people who dis-enrolled but are now coming back o Potential causes of decline in enrollment include changes around immigration and refugees as well eligibility due to income changes ▪ Alameda Alliance is working with Alameda County social services to see what is driving these declines o The recently proposed California Government budget indicates will decline further o Financial forecast more positive but still operating at a $2.2 million loss between July and November o Statewide there are a number of other health plans also experiencing losses, of the 23 or 24 plans, about seven are forecasting a loss o Rates trend for ACA o Rate reduction of 40% over last several years o Steps in contracted rates with Alameda Health Systems to make an improvement and renew our commitment to ensure the safety network o Continuing to track on work we have done as well as market factors that affect our operating performance o Forecast should show continued improvement o Federal Heath Homes Program operational readiness o Initial stages in getting ready for July 1st o The Alliance self-funded pilot launched in 2017 then connected to Whole Person Care AC3 initiative lead by the county and we are now in the process of transitioning from self-funded to sustainable federally funded program that will be run through the state beginning in July o Several counties are part of initiative o M. Lynch noted some other health plans are opting out due to rate structure from state		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	▪ Partnership Health Plan and Central Alliance are two of these ▪ In addition to the rates there are concerns regarding provider networks, especially in plans that are in more rural counties o Operations Dashboard has four red items o Call center: Calls answered within 30 seconds is 1% below target at 79% and abandonment rate 1% higher than target at 6%: issues that have driven this number up ▪ December overflow call center launched – vendor also does our secret shopping • Falling below internal targets can switch to vendor • Vendor needed more staff since were not able to meet staffing levels needed, they are currently staffing up, more representatives have been added in January, should see better results o Provider disputes and resolutions at 64%, target is 95% ▪ Transitioned to internal rate organization ▪ Moved provider disputes team to claims unit ▪ Uncovered process inefficiencies o Overturn rates 12% of internal target		Rate structure and strategy for Health Homes at an upcoming meeting.
9. STAFF ADVISORIES FOR FUTURE MEETINGS			
S. Coffin	o None	None	None
10. PUBLIC COMMENTS (NON-AGENDA ITEMS)			
M. Lynch	There were no public comments.	None	None
11. ADJOURNMENT			
M. Lynch	The meeting was adjourned at 2:02PM.	None	None

Respectfully Submitted By:
Roberta Robertson, Executive Assistant to the Chief Medical Officer