ALAMEDA ALLIANCE FOR HEALTH
BOARD OF GOVERNORS
REGULAR MEETING

February 8, 2019
12:00 pm – 2:00 pm
1240 South Loop Road, Alameda, CA

SUMMARY OF PROCEEDINGS

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

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
1. CALL TO ORDER			
R. Gebhart	The regular board meeting was called to order by R. Gebhart at 12:12 PM. A board quorum was established by a simple majority for the meeting.	None	None
2. ROLL CALL			
R. Gebhart	R. Gebhart led the roll call of the board members as well as the attendees in the audience.	None	None
3. AGENDA APPROVAL OR MODIFICATIONS			
R. Gebhart	There were no modifications to the agenda.	None	None
5. CONSENT CALENDAR			
R. Gebhart	R. Gebhart requested a motion to approve the Consent Calendar: • January 11, 2019 Board of Governors Meeting Minutes A. Vliet moved to approve the Consent Calendar. The motion was seconded by A. Basrai. The motion passed unanimously.	Motion: D. Vliet Second: A. Basrai Motion passed unanimously.	None
6. a. BOARD MEMBER REPORT – COMPLIANCE ADVISORY GROUP			

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R. Gebhart	R. Gebhart provided the following updates from the Compliance Advisory Committee. The committee tracks DHCS, DMHC, and internally identified findings. • There were 38 findings from the most recent DHCS medical audit, as well as several self-identified findings: o All corrective action plans (CAPs) were submitted to DHCS at the end of January and DHCS has begun to review. o We anticipate DHCS will approve and close all findings in four to six weeks so the Alliance can be ready for the next Medical Services audit which is tentatively set for June. o The audit identified a number of issues including items related to grievances and prior authorizations. CAPs have all been implemented and validated by Alameda Alliance. • DMHC Medical Service Audit: o Accepted all CAPs but left eight open, they will validate and close these when they return in 16 – 18 months for the next audit. • The next DMHC financial audit is in October where they will review balance sheets, claims, payments, contracts, and policies and procedures. The board's major focus should be delegation oversight as this is a key area that is often a focus during the various audits. Other key areas for board member focus include: • Implementation of the Governor's proposed pharmacy plan changes and how that relates to the 340B program in regards to understanding the large system tensions • Oversight of delegates, vendors, and providers • Governor's focus on pediatric issues • Utilization Management o Deployment of medical services, how offered, appropriateness, quality, and data tracking • Encounter reporting • 340B compliance	None	None
6.b. BOARD MEMBER REPORT – FINANCE COMMITTEE			

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
R. Ferguson	R. Ferguson reported from the Finance Committee meeting on February 5th. • Trend in members has been down the last 6 months, however, two months ago there was a slight increase of about 120 members. • At the beginning of the year, the Alliance projected a loss of $38.7 million, however, to date the net income has been positive. • Tangible Net Equity (TNE) above 600%. • Discussing changes in Finance Committee Procedures: o Currently meeting monthly at 7:30 am – committee would like to change meeting time to 8:00 am. o Committee would like to still meet monthly, however would alternate monthly between meeting in person and telephonically. o Brown Act requirements must be taken into consideration: ▪ A space must be made available that is open to the public. ▪ Meeting schedule and agenda must be posted in a public place. ▪ Voting members must be in Alameda County in order to vote. o R. Ferguson will discuss details with S. Coffin.	None	Report on decision for updated Finance Committee meeting times and locations
7. BOARD BUSINESS – REVIEW AND APPROVE FINANCIAL STATEMENTS			
G. Riojas	G. Riojas provided the following financial updates for December 2018: • Net income $2.6 million for December. • TNE went up to 605% of required. • Enrollment is at 264,000 members for December: o Enrollment increased by 123 members. o Year to date below budget for year due to overall downward trend in enrollment. o Downward trend in child category. o Adults leveled off from November to December. o MCE/Optional Expansion membership is flat. o Seniors and Persons with Disabilities (SPD) remains flat.	Motion: M. Marchiano Second: N. Peraino Motion passed.	

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	o Minor increase in Dually-eligible members. o Group Care line of business – no change in enrollment. • January enrollment dropped by 2,500 members due to the state cleaning up records and annual county re-determination. • Year-to-date net income is $375,000. We had originally budgeted a year to date net loss of $17.8 million. • Revenue on target with budget both monthly and year-to-date. • We have seen a large variance in medical expenses starting in August and September: o December medical expenses were $67.8 million, December budgeted was $74.7 million. o Year to date budgeted was $445.3 million, a $16 million in variance in budged vs actual which has contributed to net income year to date. • Tables have been included in the packet to show the impact in budgeted verses actual numbers as well as to provide more details regarding the various items that go into each category that makes up the medical expenses. • Medical Loss Ratio (MLR) is at 90.2% for the month and 94.8% for the fiscal year, lower than the 98% we had budgeted: o Upward trend in the first six months of 2018 which is what we had used in our budget. Other plans budgeted similarly and now all these plans are showing similar results to us. o Each percentage point in the MLR represents $9 million expense. • Second quarter forecast and more details on trends and how they have changed will be presented at the next board meeting. • The board asked if there is a correlation between decline in membership and MLR: o Fewer members equals fewer expenses, however this also affects our revenue. • For the second month the administrative expenses have been		

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	over what we have budgeted: o Administrative expenses for December were $5.3 million, budgeted $4.5 million, which is attributed to the accrual for the Managed Care Organization (MCO) tax. ▪ When the state provided estimate of what we would pay for this tax they used enrollment numbers that were higher than what we are actually seeing. ▪ Revenue we are receiving from membership is lower than what the tax bill is. ▪ Not related to consulting or FTE actuals. ▪ Risk based approached. ▪ Final rate received in December and then we were able to book the rest of the year. ▪ The board asked why tax is considered an administrative expense. • Not related to medical care, funding stream for the state. • Would increase MLR if included in medical expenses. ▪ The board asked if it was typical when there is a negative variance to pay a bigger tax then what we got back. • Not dollar to dollar and risk based, may come out favorable or not. For us the first year was favorable however this year was not. • A new tax may come but not currently in the Governor's budget proposal, details are still being worked out regarding continuation in some form.		
8. CEO UPDATE			

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S. Coffin	S. Coffin provided the following updates: • Last year we discussed a California State audit on Medi-Cal eligibility which could affect the Alliance this fiscal year and/or next fiscal year: o The audit found deceased Medi-Cal members who were still enrolled statewide, one to three years after being deceased. o In Alameda County, $102 million in payments were made for deceased members still enrolled in the Medi-Cal system o The findings have been released but actions from the State have not yet been announced. o The audit identified approximately 16,700 enrolled deceased individuals in Alameda County. o The Alliance's Analytics department is working with Alameda County Social Services analytics to try and identify how many of these members passed and when. o The Board asked if there is a process to determine members who are deceased. ▪ S. Coffin stated that notification process regarding Medi-Cal members who pass away is the responsibility of Alameda County, and this information then gets updated to the State who then gives AAH a monthly eligibility file. o N. Aboelata remarked that the Alliance could have their own due diligence because our providers are generally the ones who sign the death certificate. We create an internal process to close the gap. S. Coffin stated we may pursue this going forward. o S. Coffin is co-presenting with Alameda County Social Services and Health Care Services Agency Directors at the March 11th Board of Supervisors Health Committee Meeting. • The Alliance is currently tracking favorably, next month the updated forecast will be released, including more detailed explanations and drivers of the budget variance. • Alliance's revenue is nearly one billion dollars, so a move of 1% is	None	

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	a significant amount of money, for example, 2% on MLR has made the Alliance 18% favorable; 1% changes in medical expenses equates $9 million per percentage point of medical costs (MLR). • Medi-Cal enrollment is fluctuating each month, long-term trend is downward, and is consistent with statewide averages. • The Governor's proposal assumes Medi-Cal reducing enrollment over the next fiscal year, some areas seeing slight increases but the Alliance is following the majority of the state. • At the Alameda County Board of Supervisors Health Committee Meeting on March 11th, enrollment trends verses state wide trends will be discussed, including eligibility services, information and data regarding why people are exiting Medi-Cal. • S. Coffin distributed a turnaround plan to the Board of Governors in November 2018, that outlined the steps to return the Alliance to profitability in the next three years - the Alliance is tracking the priorities and will be updating the plan by end of month • Budget updates – process starting for next fiscal year. o June preliminary budget will be presented to the board for approval. o Final budget will be presented in August. • The Governor's proposed budget and executive order released in January. o Executive order includes an outline for the formation of a single purchasing system for pharmaceuticals and transitioning the pharmacy benefit out of medical managed care and into fee-for-service. ▪ Transition time-line is less than 23 months from now. ▪ Governor Newsom requested a report from DHCS, due in July, to outline how this transition will occur. ▪ Will be a carved out service. ▪ The Alliance will be watching closely, pharmacy is 19% of expenses, $160 million dollars annually. ▪ S. O'Brien remarked it makes sense fiscally for the state to keep rebates but will have a negative impact on the 340B system. Additionally there are many potential models. • Plans may be involved in administration if		

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	single state formulary. • There will still be a prior authorization (PA) process either at state level or sub-out to plans to run PA using the state's formulary. • State would still be in charge of discounts and pricing. ▪ A. Basrai remarked it will be a big impact on FQHCs since this is a revenue stream for them that will disappear. o Expanded eligibility for young undocumented immigrants up to the age of 26, may have an effect on enrollment o $100 million state wide allocated to the Whole Person Care housing program. • Managed care procurement update. o On Jan 30th DCHS removed procurement timeline from their website which addressed two plan counties for commercial plans in managed Medi-Cal. Accordingly, the timeline in 2021 to retain Anthem Blue Cross or select a new plan is not going to happen and the state hasn't said when and if this would resume. • Internal Audit Results & Next Steps: Claims & Authorizations. o Project portfolios formed to prioritize work on projects where we will receive the best outcomes. o Cost containment initiatives and operations projects launched and more are being launched throughout the year. o Internal claims and authorizations audit results were received from the external consultant in January 2019 and an internal workgroup was formed to work through findings and determine the highest-priority corrective actions: ▪ Highlighted some system challenges in claims, membership, and authorization systems. ▪ How to make changes and fix problems. ▪ The Board will receive a summarized conclusions memo.		

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	• Operations Dashboard. o There is one regulatory measure out of compliance: Provider Dispute Resolutions (PDRs) and resolutions has been in the "RED" status for the last couple of months: ▪ The Alliance received a large volume of provider disputes from a single provider, causing the turnaround time to be missed. ▪ To reach compliance, the PDR must be processed within 45 days. Due to the backlog the Alliance will continue out of compliance until March. ▪ Provider disputes can come from claims processing errors, configuration errors, or provider data input error. • The current issue stems from a provider data input error. • Contract configured many years ago affected entire provider group and now needs to be corrected. • Currently researching areas of over and underpayment to determine potential costs to the Alliance, once determined the board will be advised. o Two call center outages occurred last month totaled seven hours of interruptions, and members were unable to reach a customer service agent during the outage periods: ▪ Root cause was a technology failure in our call management system, currently being addressed by service partners and internal support staff. ▪ Outages have been reported to State as a courtesy. ▪ Alliance is taking corrective actions to assess our current system architecture and understand how the systems are set up so we can ensure we have constant availability. • Managed Care Health Plan - Performance Benchmarks.		Impact of the provider data input error will be reported out to the board

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	o The Alliance is in the early stages of developing benchmarks to compare operating performance against other public health plans in California. o Currently a comparative performance index does not exist. • Encounter Data. o DHCS announced a new monitoring score card called a "stop light" report which is in addition to QMED report that measures the timeliness, accuracy, and completeness of encounter data: ▪ Currently we report out on how we are sending encounter data to the state and will be modifying this based on the state's dashboard. ▪ The report will track the last 18 months of encounter reporting, and focus on the last six months. ▪ Once the DHCS distributes the report, the Alliance will have six months to correct deficiencies. o The Alliance is deploying a new encounter reporting system in the next two to three months. o The board asked about the relationship between claims and encounters. ▪ S. Karaiyan explained that claims are fee-for-service, and the Alliance contracts with providers who submit the claims, and then we adjudicate the claims and pay. Based on the claim information, an encounter is created and sent to the State. ▪ Encounters also apply to capitated providers, as they process and pay the claims with their contracted entities (e.g. specialists) and then send the encounters to the Alliance. o The State is driving towards capturing all activity, which is		

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	viewed as the encounter. ▪ An example of encounters is 340B drugs, and the encounters must be delivered to the State in a timely and accurate manner. ▪ Dashboard will be public, posted on DHCS website. • Health Homes Self-Funded Pilot Program, and the ACA/State-Funded Pilot Program: o In December of 2016, a self-funded Health Home pilot was approved through the annual budget by the Board of Governors: ▪ Request for Proposal process started December 2016. ▪ Pilot officially launched in July 2017. ▪ Linked with Alameda County Whole Person Care initiative, "AC3". ▪ The Board of Governors approved $1.5 million to operate the program (2017-2018). o The ACA/Health Home Program is starting in Alameda County in July. ▪ Shifts funding to the state and federal level. ▪ Currently filling out application to submit to the state, due March 1st, 2019. ▪ Alameda County has been recognized for partnering the Whole Person Care initiative with the self-funded Health Home pilot. ▪ The Health Homes Program is funded through ACA through the 1115 Waiver, ending 12/31/2020. ▪ Program is a three year pilot and is not mandatory in every county. o An audience member asked how it is decided which members are enrolled in Health Homes: ▪ Alliance will receive a target engagement list from the State based on hospitalization and ER visit data. ▪ Alliance will assess the list and prioritize the highest-need members based on the information.		

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	▪ PCPs, Specialists, and CB-CMEs can refer members to the program, and members are able to self-refer into the program. • DHCS finalizing All Plan Letter (APL) regarding the timeliness and accuracy of 340B encounter reporting o Procurement initiated to find 340B exchange service provider for AAH. ▪ Currently in evaluation phase. ▪ Will help us perform validation steps needed for accurate reporting to state. ▪ Plan to finalize by July 1st. o Once state issues finalized APL there will be a six month period of time for health plans to come up with a solution. The Alliance is starting now to stay ahead of the compliance deadline. • TRACK week: o Celebrate our core values of Teamwork, Respect, Accountability, Commitment, and Knowledge. o Daily activities to remind and reinforce values.		
9. BOARD BUSINESS – RESOLUTION TO FILL BOARD VACANCY			

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R. Gebhart	Resolution to fill vacancy of Hospital Council of Northern and Central California Member seat. Hospital Council nominated two candidates to fill the seat vacated by the departure of Dr. Lubin in December 2018: • Kelley Meade, MD, Research Unit at Children's Hospital, Oakland. • Tracey Lewis Taylor, Chief Operating Officer at Stanford Health Care - Valley Care. Resumes of both candidates were provided to the Board. S. Coffin completed the initial screening of both candidates and recommended Dr. Meade to the Chairperson and Vice-chairperson of the board due to her areas of expertise and the alignment with the strategic focus of the Alliance in pediatric care programs and pediatric services. E. Seevak and R. Gebhart interviewed Dr. Meade and strongly recommend the board accept the nomination to the Alliance Board of Governors. A. Vliet moved to approve the resolution to fill the vacancy of the Hospital Council seat for Northern and Central California with Dr. Kelley Meade. The resolution was seconded by W. Chan. The resolution passed unanimously. R. Ferguson requested a summary of the process for nominating Board members, and the interview and screening process to identify eligible Board members. S. Coffin agreed to draft a response for the Board of Governors. R. Gebhart will sign the resolution and S. Coffin and W. Chan will bring the resolution to the next County Board of Supervisors meeting for final approval. Once the resolution is approved Dr. Meade will join as a board member at the table.	Motion: D. Vliet Second: W. Chan Resolution passed.	Process of nomination for a vacant seat on the board of governors.

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10.a. STANDING COMMITTEE UPDATES – OPERATIONAL EFFICIENCIES UPDATE			
M. Woodruff	M. Woodruff provided an update on operational efficiencies • Goals for the Operational Efficiency Initiatives are to continually find ways to improve work efficiency, increased regulatory compliance, and reduce wasteful spending. • Problems Targeted to Solve: o Interest expense reduction. ▪ $2 million in interest paid out in each of the last three fiscal years – target is less than $100,000 per year. ▪ FY19 year to date paid $405,000 in interest expense. ▪ Auditing increased, including provider disputes, interest, claims processors, and contracts. o Improving accuracy on manual work arounds. ▪ Upcoming HEALTHsuite upgrade, 126 patches and three major enhancements. • HEALTHsuite revenue codes which were not priced based on line item affecting dialysis claims causing overpayments. • ER claims were not being paid if other codes billed along with the ER code. • DRG validation – if DRG is incorrect or outdated the system will now deny it. o Standardizing data warehouse for single system reporting. o Consolidation of the three repository systems for grievances, appeals, potential quality issues, and provider disputes so they can be integrated with the website to allow providers to put information directly into system and allow for easier reporting out. o Go green initiatives will create $500,000 annualized savings. ▪ Paper based to electronic reports. ▪ Increase utilization of the website instead of mailers. • Claims and Authorization internal audit.	None	

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	o 400 professional facilities claims sampled from calendar year 2017, if we paid interest and why. ▪ 94% of time correctly paid. ▪ 6% incorrectly paid: • 80% were overpaid - looking at why and recouping what we can. • 80% of incorrect payments were made by HEALTHsuite - increased auditing of the system as well as contracts. ▪ Looking at contract configuration, staff training, audit methodologies, and systematic errors with HEALTHsuite and TruCare. ▪ The Board asked how we extrapolate for total universe of 2017 claims: • 400 claims we audited were based on our largest providers who submit majority of claims. ▪ The Board asked how we recoup these payments: • There are regulatory requirements, we send letters and give providers 30 days to respond, if they do not and are contracted we can recoup, however if they are not contracted another letter will be sent. ▪ The Board asked about the cost to fixing systems: • Patches are in normal upkeep of the system that are built into the budget. • Enhancements have been paid for already through the current budget. ▪ The Board requested more information regarding contract configuration and audit methodology be brought to the Alliance's Compliance Committee. • Expected outcomes: o Improve customer service internally and externally. o Increase member service and reduce member grievances. o Reducing provider disputes. o Reduce overpayments and refund checks. o Reduce interest payments.		Information regarding contract configuration and audit methodology to be reported out at the Compliance Committee

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	o Reduce regulatory deficiencies. o Growth of membership and provider network.		
10. b. STANDING COMMITTEE UPDATES – HEALTH CARE QUALITY COMMITTEE			
S. O'Brien	S. O'Brien provided a summary of the most recent Health Care Quality Committee meeting, which was held on January 17, 2019.This is the lead committee for reviewing quality outcomes, quality programs, utilization management changes, grievance and appeal trends, and pharmacy and therapeutic trends. • Review of HEDIS: o The Alliance met the minimum performance level (MPL) for all 17 external accountability set HEDIS measures picked by DHCS. o 2019 HEDIS season is launching – the Analytics Department is leading and the Quality Department is supporting. • Turnaround time is in compliance with potential quality issues (PQIs). • Phase one of two completed in the PQI application development with assistance from the IT Department. • Performance Improvement Projects to help improve outcomes, aligned with P4P: o Access to primary care for teenagers from 12 – 19, pilot with Tri-City Health Center. o Comprehensive diabetes care measuring hemoglobin a1c levels, working with Highland Hospital. o Members on persistent medications, working with Tiburcio Vasquez. o New projects: ▪ Tdap for pregnant women. ▪ Opioids. ▪ Encouraging Initial Health Assessments (HIS). • Access Improvements. o Telephone calls must be returned in one business day. o Wait times at offices maximum of one hour.	None	

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	• NCQA: o Coming Sept 11th for onsite survey. o Preparation is starting now with NCQA consultant. o Focus on Utilization Management and Population Health. o NCQA has tightened standards (e.g. 90% of NOAs must be approved). • Senior Quality Director, Stephanie Wakefield, will be joining the Alliance on February 11th, 2019. • The Board asked if we have a list of members taking the three recalled ARBs and are we sending this to providers? o Letters are being sent by the Alliance to members. o Alliance to verify if letters are being sent to providers and whether regulations allow for direct member contact.		Are we able to send letters to providers regarding the recall of ARBs
10. c. STANDING COMMITTEE UPDATES - PEER REVIEW AND CREDENTIALING Committee			
S. O'Brien	S. O'Brien provided a summary of the most recent Peer Review and Credentialing Committee Meeting, which was held on January 23, 2019. The purpose of the committee is to review and approve initial and renewal applicants for our network based on a set of standards. The committee also reviews peer review related issues which are quality, behavioral, medical, legal, or criminal: • There were 11 initial providers credentialed in January: o 4 primary care, 2 specialty care, 1 ancillary, and 4 midlevel practitioners. • There were 32 recredentialed providers in January: o 15 primary care, 9 specialty care, 3 ancillary, and 5 mid-level practitioners. • There were 215 total providers credentialed from January 2018 to January 2019: o 46 primary care, 67 specialty care, 40 ancillary, and 62 midlevel practitioners. • There were 409 total providers recredentialed from January 2018 to January 2019:	None	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	o 118 primary care, 205 specialty care, 16 ancillary, and 70 midlevel practitioners. • There were 110 providers who terminated with the Alliance from January 2018 to January 2019, mostly due to moves or changes in their employment status. • 105 net positive in growth of provider network. • APL 17-019 requires providers register with Medi-Cal ID member o 124 providers left to enroll. o Mid-level providers will also now need to be registered and are included in the 124 providers left to enroll. • Increased focused on peer review in the committee. One provider's contract was terminated.		
11. STAFF ADVISORIES FOR FUTURE MEETINGS			
S. Coffin	o None	None	None
12. PUBLIC COMMENTS (NON-AGENDA ITEMS)			
R. Gebhart	There were no public comments.	None	None
13. ADJOURNMENT			
R. Gebhart	The meeting was adjourned at 1:58 PM.	None	None

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