ALAMEDA ALLIANCE FOR HEALTH
BOARD OF GOVERNORS
REGULAR MEETING AND RETREAT

September 13, 2019
9:00 am – 3:00 pm
1240 South Loop Road, Alameda, CA

SUMMARY OF PROCEEDINGS

Board Members Present: Dr. Evan Seevak (Chair), Rebecca Gebhart (Vice Chair), Dr. Noha Aboelata, Feda Almaliti, Wilma Chan, Aarondeep Basrai, Dr. Michael Marchiano, Dr. Kelly Meade, Marty Lynch, David B. Vliet, Dr. Rollington Ferguson, Delvecchio Finley, Nicholas Peraino
Excused: Will Scott
Alliance Staff Present: Scott Coffin, Dr. Steve O'Brien, Gil Riojas, Matt Woodruff, Tiffany Cheang, Anastacia Swift, Sasi Karaiyan, Jeanette Murray
Board of Governors on Conference Call: None
Guest Speakers: Bobbie Wunsch and Dr. Brad Gilbert, Pacific Health Consulting Group

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
1. CALL TO ORDER			
Dr. Seevak	The regular board meeting was called to order by Dr. Seevak at 9:03 AM.	None	None
2. ROLL CALL			
Dr. Seevak	Board Members, Alliance Staff, and Guests in the Public Seating Area were introduced.	None	None
3. AGENDA APPROVAL OR MODIFICATIONS			
Dr. Seevak	None	None	None
4. INTRODUCTIONS			
Dr. Seevak	Introductions of attendees were made during Roll Call.	None	None

5. HEALTH POLICY ENVIRONMENT AHEAD			
Dr. Brad Gilbert	Health Policy Environment ahead: Federal Landscape: 1) Multiple lawsuits challenging the Affordable Care Act: • Most recent significant one by 18 states – arguing that because Congress took away the penalty tied to the individual mandate the entire ACA is invalid. • If upheld this would end the ACA resulting in 20 million more uninsured including all Medi-Cal Expansion Members for Alameda Alliance. 2) Approval of short term and limited benefit health insurance plans – impacts Covered California. 3) Reduced funding to encourage enrollment in Exchange or Medicaid/Medi-Cal. 4) The President and the Senate want the ACA gone. If the ACA or Exchange is gone there will be about 80,000 members without insurance. Time needs to be spent on ways to discuss what are the opportunities and options for these individuals. State Landscape: 1) Enrollment trends for Medi-Cal: • Declining overall. • Minimum wage is up. • Overall improved economy. • "Gig" economy – not necessarily insured but income above 138% of Federal Poverty Level. • Area of potential growth- undocumented adults 19-25. 2) Governor Newsom Agenda: • Universal coverage – slow but sure – starting with undocumented adults 19-25. • Coverage mandate penalty for CA-encourages enrollment. • Increased subsidies for Covered California enrollees. • Focus on children – new Pediatric Preventative Services		

	quality measures and accountability. • Childhood trauma and developmental screening. 3) Executive Order carving out retail medications from Health Plans back to the state. 4) Proposition 56 payments through health plans to providers: • Rates are up. • New “Value Based Payments”. • Trauma and Developmental Screening. • Behavioral Health Integration. • Significant dollars – Plan at risk financially. 5) Department of Health Care Services: • Up oversight of access to care. • Up requirements for quality measures and minimum performance levels. • Up encounter data monitoring. • Tougher annual audits. • Federal Mega Reg impacting level of compliance. • Sanctions. 6) Rate Development: • Calendar year – implications for FY 20/21. • “Regional” rates – good or bad? • Encounter data based rates. 7) Department of Managed Health Care: • Access to care monitoring. • HMO Help Center. • Oversight of IPAs / Medical Groups. 8) Future of the Safety Net: • Emphasis on access quality and impact on rates. • Executive Order – impact on 340b funding. • Waivers 2021 – much less funding directly through waivers and potentially directed payments- funding for WPC and potentially current EPP through Plans in rates.		

	Behavioral Health Integration: 1) Coordination / Integration with Alameda County Behavioral Health: • Sharing of data on mutual members-complicated with Mental Health and Substance Use treatment. • Delineated liaison staff to county at Health Plan. • Expand programs to deliver primary care at county BH clinic(s). • Closer coordination with inpatient admissions/discharges – particularly for Plan responsible Members. 2) Integration of Behavioral Health and Physical Health in network: • FQHCs and County Hospital. • Other Primary Care clinics. • BH Staffing in primary care plus Multi-disciplinary teams. • PHQ-9, GAD-7, Social Determinants of Health assessments as part of intake and periodically. 3) Vendor versus In House Management: • Network Flexibility- Plan drives network and performs credentialing. • Better linkages to county. • Better ability to staff primary care sites with BH staff. • Contracting rates and process critical. • BH structure, leadership and staff needed at Plan. • UM/CM/Claims staffing. • Better able to integrate at provider and Plan. Long Term Services and Support: • Current benefit only month of admission and month of discharge – then dis-enrolled. • New benefit 2021 is full responsibility. • $6000 – $7000/month per member. • Relationship with LTC facilities. • Contracting / Network. • SNFs – Medi-Cal currently. • Sub-acute facilities – expensive. • Intermediate Care Facilities- complex populations.		

	• Rates Paid. • Utilization Management. • Transitions of care. • Long Term stays in facilities. • IEHP estimate is 15-20% do not need to be in facility – but complicated to transition. • Need very organized community resources, including housing. Other Benefit Additions: 1) Transplants: • High risk and high cost services – need strong UM and CM management. 2) Community Based Adult Services – Questions regarding changes. 3) Multipurpose Senior Services Program – will stay carved out from Plans. 4) In Lieu of Services – "trading" less intense service that is not a Medi-Cal benefit for a higher cost service (housing versus SNF). Medicare / Medi-Cal Dual Eligible: 1) Cal MediConnect Program authorized through 2023: • 7 counties now. • Unclear if DHCS wants to expand. • Three-way contract (CMS/DHCS/Health Plan) difficult. • Financially most plans losing money due to guaranteed savings off the top to CMS and rate processes. • Enrollment difficult – one by one. 2) Dual Eligibles Special Needs Plan (D-SNP): • Had positive results for public plans. • Enrollment difficult – one by one. • Less requirements than Cal MediConnect but still major staffing and operational impact on Plan.		

	3) Compliance: • Significantly more rules and restrictions than Medi-Cal. • Continuous oversight by CMS. • Program audit infrequent but very difficult. Strategic Readiness for Medi–Cal Procurement: 1) RFP out 2020 for implementation of new (or not) commercial plan 2023. 2) Blue Shield/Promise, Anthem/Blue Cross, Centene/Health Net, Molina will be active, less clear about United or Aetna or a public Plan? 3) Strategic Positioning: • Maintain or grow percentage of enrollment. • Maintain or improve positive relationship with providers both financially and service critical as commercial plans will attempt to “buy” providers. • Service areas include contracting, provider services, claims, Proposition 56 payments, Pay for Performance. • Particularly focus on counties and FQHCs but private providers as well. • Consider investing in safety net. • Consider Social Determinants of Health investing = housing, food, etc. Growth Strategy: 1) Undocumented children and adults age 19-25: • Strong partnerships with community entities that know/serve this population. • Strong message in community that enrollment is safe and needed. 2) Capturing “not yet enrolled” in Medi-Cal: • Consider an Enrollment Assistance Unit. • Small staff focused on “not yet enrolled”. • Assists with enrollment. • Provides positive messaging and support in community.		

	3) Focus on Medi-Cal eligible but not enrolled: • Undocumented as above. • Medi-Cal Expansion eligible but not enrolled. • Employers with part-time workers, low wage. • Students. Conclusion / Summary: 1) Will need to do more with less resources: • Contracting strategies. • Efficiency – consider LEAN efforts. • Review vendors vs. in-house economics for direct delivery of BH. 2) Integration of physical and behavioral health: • Collaboration with county mental health. • Primary Care / Behavioral Health true integration. • Integration at Plan (CM). 3) Managing transitions of care is critical to financial status: • Community to hospital. • Hospital to SNF or home. • Development of community-based care options – home health on steroids, palliative care, and hospice care. • Enhance Care Management capabilities – community and clinic based (Health Homes), integrated with BH. 4) Compliance is critical – but should not drive strategy or operations. Comments from Board Members: There are people who are not enrolled in Medi-Cal but could be; the Country relationship can help us with this and to grow. The county relationship is a key relationship. Dr. Brad Gilbert comments: • Prop 56 has a lot of money available. Rates and preventive services have been increased. • Quality payments are also more dollars for physicians and clinics.		

	• Consider Grants to spur change in the health care System. The plan should help support providers with the process of the applications. • The state has no money risk with this but the plan does.	Informational update to the Board Governors. Motion and vote not required.	
6. STRATEGIC INITIATIVES IN FY2019/2020 AND BEYOND			
S. Coffin	Strategic Initiatives FY 2019-2020 and Beyond: 1) Highest Priorities: • Membership Growth of 82% to 90% in 3 years. • Well over 300,000 people still available for Medi-Cal in Alameda County and we need to grow. We need to explore ways to grow in area as social media. • Quality & Compliance. • Organizational Change & Readiness by 2021, 2022. • Strategic positing for Medi-Cal procurement. 2) Cost Containment & Operational Efficiency Projects. 3) Provider Portal. 4) Operations Readiness: • Long-Term Care (January 2021). • Pharmacy Transition (January 2021). 5) Enterprise Data Warehouse & Governance. 6) Quality Improvement, HEDIS, NCQA. 7) Expansion of case management through community-based programs (AC3 & Health Homes). 8) Mental Health Assessment. 9) Leadership Development & Employee Retention. 10) Pilot Kickoffs: • Pediatric Carte Coordination (EPSDT). • Member Texting. • ALL IN – Food is Medicine.	Informational update to the Board Governors. Motion and vote not required.	
7. CONSENT CALENDAR			

Dr. Seevak	Review and Approve the July 2019 Board of Governors Meeting Minutes. Review and Approve 2019 Quality Improvement Program Description.	Motion: Dr. Marchiano Second: M. Lynch Motion passed. No opposed or abstained.	None
8. BOARD MEMBER REPORT – FINANCE COMMITTEE			
Dr. Ferguson	Dr. Ferguson reported that the Finance Committee Meeting was held on Tuesday, September 10, 2019.	Informational update to the Board Governors. Motion and vote not required.	
9. BOARD BUSINESS – FINANCE – a) **REVIEW AND APPROVE JUNE 2019 MONTHLY FINANCIAL STATEMENTS**			
G. Riojas	Review and approve June 2019 monthly financial statements. Net Income: • For the month ending a June 30, 2019, the Alliance ended with a Net Loss of $1.1 million (versus budgeted Net Loss of $3.9 million). • For the year-to-date, the Alliance recorded a Net Loss of $10.0 million (versus budgeted Net Loss of $37.8 million). • Factors resulting in the favorable variance are related to low than anticipated Medical Expense and Administrative Expense. Enrollment: • Enrollment increased by 604 members since the month of May, 2019. • Enrollment is at 258,385.		

	Revenue: • Revenue reported is for the month ending June 30, 2019. • Revenue at $75.9 million vs. budgeted amount of $75.8 million. Medical Expense: • Medical Expenses were $73.3 million vs. budgeted amount of $75.3 million. Administrative Expense: • Administrative Expenses were $4.6 million. • YTD the Alliance reported $51.1 million vs. budgeted $53.8 million. Other income / (Expense): • As of June 30, 2019, our YTD interest income from investments is $7.1 million. • Year-to-date claims interest expense is $568,000. Tangible Net Equity (TNE): • TNE was reported at 555% of the required amount, with a surplus of $147.7 million. Cash Position and Assets: • The Alliance reported $254.8 million in cash, $168.9 million is uncommitted. • Current ratio is above the minimum required at 1.85 compared to 1.0. Motion carried to approve the June 2019 financial report as presented to the Board of Governors.	Motion: Dr. Ferguson Second: Dr. Marchiano Motion passed. No opposed or abstained.	

b) REVIEW AND APPROVE JULY 2019 MONTHLY FINANCIAL STATEMENTS			
G. Riojas	Review and approve July 2019 Pre-Audit monthly financial statements. Net Income**:** • For the month ending July 31, 2019, and year-to-date, the Alliance ended with a Net Income of $2.3 million (versus preliminary budgeted Net Income of $195,000). • Factors creating the favorable variance were higher than anticipated revenue and lower than anticipated Administrative Expenses offset by higher than anticipated Medical Expenses. Enrollment: • Enrollment decreased by 1,740 members since the month of June and the enrollment is at 256,645. • The Alliance 12 month trend shows reductions in the Adult and Child categories of aid. Revenue**:** • For the month ending July 31, 2019, and year-to-date, revenue came in slightly higher than budgeted at $80.3 million vs. preliminary budgeted amount of $78.6 million. • The largest variances are due to maternity supplemental payments, base capitation and Hepatitis C Supplemental payments. Medical Expense**:** • Medical Expenses were $74.2 million vs. preliminary budgeted amount of $73.7 million. • The largest variances were $1.4 million IBNP adjustment related to pharmacy, which were largely offset by favorable results in capitated expenses related to contracts, Health Home, AC3 expense, and revenue timing.		

	Medical Loss Ratio**:** • The Alliance reported an MLR of 92.4% for the month and YTD vs. preliminary budgeted 94%. Administrative Expense: • Administrative Expenses were $4.2 million vs. preliminary budgeted $5.1 million for current month and YTD. • Administrative Expense represents 5.2% of net revenue for the month and YTD. Other Income / (Expense): • As of July 31, 2019, YTD interest income from investments is $608,000, and YTD claims interest expense is $34,000. Tangible Net Equity (TNE): • Tangible net equity was reported at 563% of the required amount, with a surplus of $150.5 million. Cash Position and Assets: • The Alliance reported $228.6 million in cash; $178 million is uncommitted and the current ratio is above the minimum required at 2.07 compared to 1.0. Discussion: About why are we losing children? • There is not an exact answer, other than maybe parents are obtaining jobs with commercial insurance included and the child now has commercial insurance. • Motion carried to approve the July 2019 financial report as presented to the Board of Governors.	Motion: Dr. Ferguson Second: Dr. Marchiano Motion passed. No opposed or abstained.	

c) REVIEW AND APPROVE FISCAL YEAR 2020 FINAL BUDGET			
G. Riojas	Review and Approve Fiscal Year 2019/2020 Final Budget. Budget Process - presented by Scott Coffin: • Preliminary Budget Presented to the Board of Governors on June 14th. • Final rates received from DHCS for the Med-Cal line of business are risk adjusted by the Mercer (State Actuary) in July. • Recalibrated the operational and capital expenses based on changes in assumptions, and adjusted revenue following the actuarial risk adjustment. • Final budget presented to Board of Governors on September 13th. Budget Assumptions FY2020 – presented by Gil Riojas. Health Care Services – Costs & Utilization: • Underlying utilization trend is 1.3%, unit cost trend is 0.9%. Revenue: • 97% of revenue for Medi-Cal, 3% for Group Care. Staffing: • Headcount is 346 full-time employees by June 30, 2020. • Addition of 34 staff, comprised of 18 new positions and 16 backfills. The new positions are primarily in Health Care Services (6), Human Resources (3), Information Technology (2), Analytics (2), Finance (2), Compliance (1), Legal (1), and Executive (1). 9 assumed vacancies due to turnover and open positions at year end. • Maintain vacancy under 10% through increased recruiting. Enrollment: • Alliance's market share is almost 82%, and year-end enrollment	.	

	decreases 3.9%. • Preliminary budget includes membership 3% lower than DHCS projections. • AC3 / Health Homes enrollment is over 1,300 by year-end. • Transition of self-funded Health Home pilot into the state-funded model in July. Medical Expense: • Medical loss ratio is 94.0%, an improvement of 2.2%. • Highest 5% (14,223) of members account for 75% ($523 million) of our Medical Expenses. Reimbursement Rates (DHCS to the Alliance): • Medi-Cal rates preliminarily increase by 7.9%, per member/per month basis. • This equates to an additional $60 million in revenue. Hospital & Provider Rates (Alliance to the Providers): • Hospital contract rates increase by $11.5 million in the year. • Professional capitation rates increase by $8.5 million in the year. Cost Containment & Operational Savings Initiatives: • Inpatient and Pharmacy claims recoveries yield $1.5 million in savings. • Decreased average length of hospital stays yields $3.0 million in savings. Summary of Proposed Budget to the Board of Governors: • Membership is 248,000 in Medi-Cal & Group Care, approximately 10,000 members lower (primarily Medi-Cal). • Revenue is $935.5 million, $16.4 million higher. • Medical expenses $879.1 million, $4.9 million lower. This is comprised of the impacts of lower membership, medical initiatives and reduced Hep C pricing. These reductions are partially offset by increased rates for provider contracts. • $4.5 million in medical expense savings included in the net results. • Administrative expenses 6.5% of revenue, $9.3 million higher. Led		

	by labor ($4.1 million) and purchased and professional services ($3.9 million). • Tangible net equity is 565% of required by state regulators, increasing by 7.9%. TNE projected at $180.4 million, $300 thousand lower. • Net loss is approximately $300K. Medi-Cal is $300K net income and Group Care is ($600K) net loss. Highlights of Changes from Preliminary Budget: • Final Budget has a net loss of $0.3 million, which is favorable by $8.6 million to the Preliminary Budget. Comprised of: • Revenue is $5.0 million higher reflecting inclusion for ACA OE 25% Rate Range and generally favorable Medi-Cal rates, offset by accruals of $2.4 million for FY 2019 DHCS Prop 56 recoupment and $1.5 million for DHCS recoupment for deceased members. • Medical expenses $2.6 million lower, reflecting delayed or favorable delegated provider contract increases, partially offset by an increase in non-emergent and non-medical transportation expense. • Departmental expenses are $1.0 million lower than Preliminary Budget. Largest component is reduced Pharmacy Administrative Fees, partially offset by higher purchased and professional services. • July represents Actual results. Favorable results led to a $2.2 million Net Income for July. • Year-end membership is 1,000 lower, reflecting lower than anticipated July enrollment. Capital Expenses FY2019-2020: Approximately $2.5 million in capitalized purchases for technology and facilities enhancements ($600,000 more than FY2019).		

	Information Technology: $1.5 million • Hardware: $1.1 million ▪ Voice Infrastructure, Laptops, Desktops, Monitors: $500,000. ▪ Network Cabling: $200,000. ▪ Application Servers: $200,000. ▪ Data Loss Prevention Hardware: $200,000. Software: $400,000 • Software Licensing and Upgrades: $300,000. • Data Center Upgrades: $100,000. Facilities: $1.0 million • Building Upgrades & Construction: $200,000. • Building Repairs: $400,000. • Workspace Resources: Cubicles, Workstations, Furniture: $400,000. Board Member Comment: • When a presentation on transportation is made for the Board, can you include GEMT too? • Motion carried to approve the Fiscal Year 2019/2020 Final Budget.	Motion: Dr. Marchiano Second: Dr. Ferguson Motion passed. No opposed / obtained	
10. BOARD OF GOVERNORS TRAINING			
Bobbie Wunsch	Being an Effective Board of Directors. Being Effective as a Board – Hearts and Minds: • Quality of boardroom dialog and debate. • Ability to ask tough question of management. • Diversity of thought and experience. • Meetings and materials well planned. • Board Chair manages the Board. • Members well oriented. • Commitment to participation and engagement. Comments:	Informational update to the Board Governors. Motion and vote not required	

	What are the benefits about being on the Alliance Board? • 245,000 Medi-Cal members. • Giving quality service to the members. • There is a lot to learn and as we learn it helps connect the dots. What are the challenges? • The conflict of interest. • Knowing nothing about the rate negotiations. • Rolls are less clear. • Audits. • Understanding Financials. Board of Directors Roles and Responsibilities: • Legal and Financial Oversight. • Strategic Leadership and Policy Development. • Management Oversight. • Regulatory Oversight. • Program Oversight. • Board Development. • Evaluation of Organization. Relationship with CEO and Staff: • Advises CEO. • Asks tough questions. • Hires CEO. • Evaluates CEO. • Acts collaboratively. • Active leadership on organizational strategies. • Demonstrates full commitment and engagement. By-Laws: • Attendance. • Quorum. • Committee structure.		

	• Representation of community needs and interests. • HATS OFF. The Board Packet: • Is there any feedback you could give the CEO and staff to help arrange the materials better? • What about questions? • Better use of presenting the materials. Board Orientation: • Orientation of new Board members is important for their effectiveness. • Being at the meetings is important. • Tips of best ways to have an effective Board. • The most helpful is when Scott calls in his monthly meeting and informs me. • This is a very good practice to help the Board. • All Board section have an executive summary included in their Board packet. Conflict of interest: • Most of the Board are business entitles who contract with the Alliance. • Leave the Hat that you wear at your organization and put the collective hat on for the Board. • Discussions should not be focused on one business but a whole. • How will this help the members of our community? • Not what I am getting from this but what are we getting from this. • The discussion should never be about me. • You become effective as a Board member when you put aside your organization and see the community as a whole. Board Member Comments: • Since the Board does not know anything about the contracts, and the CEO makes all the decisions, it is hard for the Board to make an informed decision.		

	• Perhaps there is more that the Board could know. Such as, a contract is up for renewal or being executed, just to be kept the Board updated. • Should the Board have any role in the contracts? • Should the Board have any roll in judging the effectiveness of the financial team or CEO in negotiating contracts? • How do we ensure we have a set of values and principles that become the framework that the CEO and Executive Team works within?		
11. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS			
Dr. Seevak	• None	None	None
12. PUBLIC COMMENTS (NON-AGENDA ITEMS)			
Dr. Seevak	• None	None	None
13. ADJOURNMENT			
Dr. Seevak	The meeting was adjourned at 3:08 PM.	None	None

Respectfully Submitted By: Jeanette Murray
Executive Assistant to the Chief Executive Officer and Clerk of the Board