DEPARTMENT OF Managed Health Care

Financial Solvency Standards Board (FSSB) Meeting
May 10, 2012
Meeting Notes

FSSB Members in Attendance:
Chairperson Keith Wilson, President and CEO, Talbert Medical Group
Brent Barnhart, Director, Department of Managed Health Care
Grant Cattaneo, CEO and Founder, Cattaneo & Stroud
Edward Cymerys, Senior Vice President and Chief Actuary, Blue Shield of California
Larry deGhetaldi, M.D., Palo Alto Medical Foundation
Deborah Kelch, Independent Consultant
Dave Meadows, Senior Vice President of Government Programs, LIBERTY Dental Plan
Ann Pumpian, Senior Vice President and CFO, Sharp HealthCare
Richard Shinto, M.D., Aveta Inc.
Tom Williams, Executive Director, Integrated Healthcare Associates

DMHC Staff Presenters:
Steven Babich, Supervising Examiner, Division of Financial Oversight
Dennis Balmer, Deputy Director, Financial Solvency Standards Board
Michelle Yamanaka, Manager, Provider Solvency Unit

1) Welcome

Keith Wilson, FSSB Chairperson, called the meeting to order and welcomed attendees.

2) Opening Remarks

Brent Barnhart, Director of the Department of Managed Health Care (DMHC), commented on the importance of the topics slated for discussion, especially with the department's enhanced involvement in Medi-Cal issues.

3) Minutes from February 9, 2012 FSSB Meeting

The board approved the minutes.

4) FSSB Purpose and Priorities

Discussion Document: FSSB Purpose and Priorities

Dennis Balmer, DMHC Deputy Director of the Financial Solvency Standards Board (FSSB), discussed Health and Safety Code section 1347.15 regarding the purpose of the FSSB, which is to develop and recommend to the Director the financial solvency requirements and standards related to plan operations, plan affiliate operations and transactions, plan provider contractual relationships, and provider affiliate operations and transactions.

Mr. Wilson asked what it meant to “develop standards.”

Mr. Balmer replied that it means giving feedback and recommendations regarding legislation that could impact solvency standards. Mr. Balmer also mentioned current areas of focus for the board which include many elements of healthcare reform implementation, such as Accountable Care Organizations, Medical Loss Ratio, Health Benefit Exchange, Premium Rate Review, Expansion of State Sponsored Business, Affordability of Coverage, Risk Adjustment, and Reinsurance.

Mr. Wilson asked if there were any questions or comments from the audience. There were none.

5) Medi-Cal Managed Care Delivery Models

Presentation: Medi-Cal Managed Care Delivery Models

Dave Meadows, formerly of Health Net, presented an overview of Medi-Cal Managed Care Delivery Models. Mr. Meadows discussed how Medi-Cal Managed Care has experienced significant growth that could present solvency considerations for plans and providers. Mr. Meadows went on to provide background on Medi-Cal, discussing aid categories, managed care models, enrollment, beneficiaries and cost, delivery networks, and the financial pressures facing plans and providers.

Discussion:

Mr. Meadows then discussed the Medi-Cal Managed Care rate development process and opened up the topic for discussion. Mr. Wilson asked about the prevalence of subcontracting, specifically in Los Angeles.

Mr. Meadows said that subcontracting has been used since the beginning of the Medi-Cal Managed Care Program, but is not occurring as often in new networks and counties.

Larry deGhetaldi asked how much of the growth in Medi-Cal Managed Care has been in Federal Qualified Health Centers (FQHC), how many of the projected three million new Medi-Cal members in 2014 will be in FQHCs, and if this will put the FQHCs at risk.

Mr. Meadows said the growth in FQHCs has been significant and noted the potential for risk and financial pressures on Medi-Cal Managed Care plans. Providers, transitioning from the traditional enrollment population of “moms and kids” to an older, less healthy population, requires a different kind of medical management. He mentioned FQHC concerns about losing their cost-based reimbursement, which plans like because Medi-Cal backfills costs. He explained that there is a two-year lag between reported data reflected in reimbursement rates. For example, the Two-Plan, 2010 calendar-based data for that calendar year, 2010, is filed with the State late in 2011 and that data is used to determine the rates for the October 2012 to September 2013 period.

Mr. Wilson noted that County Organized Health Systems (COHS) rates to medical groups are higher. He stated that when looking historically at SB 260 performance and which groups have been in jeopardy of needing Corrective Action Plans (CAP), a disproportionate number lie in the Medi-Cal reimbursement arena, especially those with more than 50 percent Medi-Cal enrollment. Mr. Wilson asked whether the Department is anticipating an increase in exposure and more medical groups falling into CAPs, and insolvency as a result of the enrollment of Seniors and Persons with Disabilities (SPD) into the managed care system, and groups receiving less money than the cost of support in this population.

Mr. Meadows responded that groups with financial problems now will likely have more when the SPDs are enrolled.

Edward Cymerys commented that medical groups are being underpaid for what their risk is to serve this population.

Ann Pumpian expressed concern that with all of the major changes going on in Medi-Cal Managed Care there is a lack of providers to keep preventable admissions from occurring.

Beth Abbott with Health Access commented that the transition of the SPDs into Medi-Cal Managed Care is going very poorly. She also commented on the importance of collaboration between CDI and DMHC, and the need to work with the National Association of Insurance Commissioners on the development of white papers regarding the impacts of the Affordable Care Act on a plan's solvency.

Mr. Meadows responded that, in the long term, the transition will become a cost-effective and efficient way to provide services to the SPDs. He stated that the movement of the SPDs into managed care is a good thing and ultimately the results will be positive. He identified the speed of the transition as a potential problem, and commented it may take longer to get control over the health care costs.

Tim Madden with the California Chapter of the American College of Emergency Physicians commented that subcontractors to Medi-Cal Managed Care plans are affecting access, and resulting in the Medi-Cal Managed Care population coming to emergency departments. He added that it may be time to review solvency standards to make it easier to identify groups experiencing solvency issues earlier. He asked the FSSB to consider whether the plan to plan subcontracting model makes sense in the Medi-Cal Managed Care world. He also suggested that emergency physicians and other providers work with the FSSB on a regular basis to give DMHC a "snapshot" of the problems they are seeing.

Mr. Balmer responded that with respect to the evaluation of SB 260 standards and Tangible Net Equity (TNE) requirements for a health plan, he has asked the Department's contracted actuary to take some time to look at risk-based capital compared to TNE requirements - how well they correlate, both with large plans and smaller plans, particularly Medicare plans and COHS, to reach a better understanding of the adequacy of TNEs. He added that there is a serious question as to whether $1.00 of TNE is adequate for a provider group given the risk.

Mr. Williams then sought clarification on whether the DMHC regulates COHS.

DMHC Director Barnhart responded that the DMHC does not regulate COHS unless they engage in business other than Medi-Cal, for example Healthy Families, then they would fall under the DMHC's jurisdiction.

Deborah Kelch added that it was her understanding that if a COHS has Healthy Families business, or wants to participate in the Individual Insurance Exchange, the COHS would have to be licensed by the DMHC. She asked how the Department would review these plans.

Stephen Babich, supervisor in the DMHC Division of Financial Oversight, responded that if a COHS has solely a Medi-Cal line of business, it does not have to be licensed by the Department;

however, if the COHS goes into any other line of business, that would trigger a full service license application being filed with the Department.

Richard Shinto commented that issues with SPD patients are not limited to medical problems; there are also psycho-social issues and the social issues that are harder to address. When SPDs are under managed care, the cost will go down but it might take three years, it could be longer. He then asked who is going to take responsibility to follow-up on this issue.

Mr. Wilson responded that the board's discussion on this topic is meant to inform the Department to develop a plan of action.

Mr. Shinto then stated he hopes there will be something done on this issue, beyond the board commenting, because this has the potential to become a large problem.

DMHC Director Brent Barnhart responded that it is helpful for the DMHC to be part of these very important discussions and that the Department's concern and focus do not end here.

6) Provider Solvency Updates

Presentation: Provider Solvency Update

Michelle Yamanaka, Manager of the DMHC Provider Solvency Unit, provided an update as of December 31, 2011. She mentioned that since the last FSSB meeting, four CAPs have been completed, and those groups are currently maintaining compliance with all solvency criteria. Ms. Yamanaka also discussed the steady decrease in the length of time it takes for the DMHC to approve CAPs and the length of time it takes for Risk Bearing Organizations (RBO) to obtain compliance after a CAP is in place.

Discussion:

Grant Cattaneo asked what happened to the RBO that was subject to an enforcement action.

Ms. Yamanaka responded that the DMHC required the health plans that were contracted with the RBO to de-delegate claims payment responsibility. Therefore, the organization is no longer classified as an RBO.

Mr. Cattaneo asked if the DMHC has ever performed an "autopsy" after the de-delegation process to determine if this is the best approach, and to determine if a more affirmative action would be appropriate. He also asked if, while auditing RBOs, the Department verifies that payments made by check were actually cashed by the recipient.

Ms. Yamanaka responded that the Department does look at check cashing as part of its review. She added that the only mechanisms available to the Department are to either freeze enrollment or to de-delegate.

Mr. Balmer commented that in the last quarter there were four RBO CAPs successfully completed, demonstrating that while the process may not be perfect, it is working.

Mr. Shinto commented that freezing a group's enrollment when they are already struggling, and asking them to increase their TNE may not be the best approach for the providers and the beneficiaries. Perhaps the Department should follow-up on the CAPs to see if what was included

is accurate. He encouraged the Department not to keep propping up RBOs that are not paying claims.

Mr. deGhetaldi asked if there are RBO characteristics that could assist in identifying RBOs that are at risk of having solvency issues.

Ms. Yamanaka responded that finding out which groups will be receiving the SPDs population may be helpful.

Mr. Wilson invited public questions and comments.

Ms. Abbott asked if there was anyone present from the Department of Health Care Services.

Stuart Busby, Chief Capitation Rate Development, responded that he was in attendance.

Mr. Madden commented that the Department should look at changing TNE requirements through the legislative process, and offered his organization's assistance.

Mr. Balmer responded that could put additional stress on an already stressed system.

7) Division of Financial Oversight Updates

Presentation: Health Plan Solvency Update

Stephen Babich, supervisor in the DMHC Division of Financial Oversight, provided a brief update of the DMHC's oversight of health plans and an update on their financial health. The DMHC regulates 109 active (55 full-service) health plans with approximately 22.6 million people enrolled.

Mr. Wilson invited board and public questions and comments. There were none.

8) Public Comment on Matters Not on the Agenda

None.

9) Agenda Items for Future Meetings

Mr. Wilson invited the board to submit agenda items for future meeting via email.

10) Closing Remarks/Next Steps

DMHC Director Barnhart thanked those is attendance and reiterated that these meetings are incredibly valuable to the Department.