DEPARTMENT OF
Managed
Health Care

Financial Solvency Standards Board (FSSB) Meeting
August 9, 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
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

DHCS Presenter:
Stuart Busby, Chief, Capitated Rate Division

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 financial solvency in the health care marketplace as related to the implementation of health care reform.

3) Minutes from May 10, 2012 FSSB Meeting

The board approved the minutes.

4) Medi-Cal Managed Care Rate Setting Overview

Presentation: Medi-Cal Managed Care Rate Setting Overview

Stuart Busby, Chief, Capitated Rate Division, Department of Health Care Services (DHCS) presented an overview of Federal and State requirements for Medi-Cal Managed Care rate setting.

Discussion:

Mr. Busby discussed Federal Regulations Section CFR Title 42, Chapter 4, Subchapter C, Part 438, Subpart A, section 438.6, which governs the contract requirements and the approval process by the Federal government, including an actuarial rate setting checklist. The Centers for Medicare & Medicaid Services (CMS) must approve prepaid inpatient health plan rates, prepaid ambulatory health plan rates, Managed Care Organization (MCO) contracts, entities eligible for risk contracts, (e.g., MCOs, community health centers, and certain health insuring organizations). Risk capitation contracts must have actuarially sound rates, certified by actuaries and approved by CMS, for consideration during the approval process.

Richard Shinto asked if DHCS uses outside actuarial companies to determine rates.

Mr. Busby responded that DHCS has internal actuaries and researchers, in addition to a contract with Mercer Consulting.

Tom Williams asked about the relationship between CMS, DMHC, and DHCS related to rate approval.

Mr. Busby responded that the DMHC does not have a role in rate approval, and that DHCS and its contractor develop the actuarially sound rates which are submitted to the Federal government for approval.

Mr. Wilson asked if there is there any point in this continuum in which the rates paid by health plans to medical groups are actuarially evaluated. He was particularly concerned about those risk-bearing organizations (RBOs) having financial trouble or under corrective action plans (CAPS), are predominantly those that have at least 50 percent Medicaid enrollment.

Mr. Busby responded that these are health plan-specific rates based upon the plan's data. But the question as to whether payments from health plans to RBOs are sufficient comes down to contract arrangements between the plans and the providers.

Larry deGhetaldi asked if DHCS questions whether rates are a factor in solvency issues.

Mr. Busby responded that when a plan has a solvency issue, it usually comes to DHCS seeking additional funding, and this happens on a regular basis. DHCS asks if the plan is operating efficiently and if it can find opportunities for improvement.

Mr. Busby went on to explain the capitated rate development process and capitated rate contracts, and the substantial actuarial analysis and judgment needed to develop capitated rates.

Grant Cattaneo asked for clarification on "actuarial soundness", citing an example in Los Angeles County where one plan gets more money than another plan that is serving the same population.

Mr. Busby responded that one plan may be contracting with county-run entities. A plan may subcontract a large percentage of business to another plan that competes with the commercial plan in Los Angeles. There may also be different cost structures or different risk selection between the plans. There may even be a backlog in the rate approval process.

Deborah Kelch asked if elements of rate setting would include subcontracts and plan-specific rates paid to its providers. And if there is still a connection between the fee-for-service equivalent and the capitated rates paid to the plans.

Mr. Busby responded that subcontractor issues are between the plan and the provider, and that the rate development process is predicated upon experience data submitted by health plans. He also stated there is no connection between fee-for-service and managed care anymore.

Mr. Busby then provided an overview of data elements and risk adjustment. Data specific to the Medicaid population is used to develop rates. Other types of data may be used and then adjusted to fit the Medicaid population. Data used in rate making should be adjusted to eliminate one-time events, such as outliers. Other adjustments are also made for changes in utilization, medical cost inflation, contract changes, and other items that are expected to change in the rating period.

Edward Cymerys asked if DHCS looks at what is paid by the commercial plans for a similar risk population and if that is part of the process to determine whether the rate is actuarially sound.

Mr. Busby responded that DHCS is aware of the ratios and the differentials between Medi-Cal, Medicare and the commercial market. However, in the rate setting process, DHCS is not using what is being paid on the commercial market as a gauge. DHCS uses Medicaid specific data in rate setting.

Mr. deGhetaldi asked to what extent DHCS uses the Medicare fee schedule on either the hospital or the physician side when setting rates in different geographic areas.

Mr. Busby responded that if a plan pays based on the Medicare fee schedule, DHCS considers that. If not, DHCS sets rates based on a plan's capitated rate payments. Rates could be based on an alternate fee schedule. For non-contracted hospitals, DHCS uses "Rogers rates[1]."

Mr. deGhetaldi asked if DHCS has looked at groups or areas that have had financial solvency issues and determined a correlation between higher risk populations and areas or groups that have greater financial challenges.

Mr. Busby responded that, in some cases, DHCS has looked at payment arrangements and adverse selection. He also mentioned that they don't look at just one thing, they look at multiple. There are a lot of moving parts and you have to consider everything to get it right.

Dave Meadows commented that rates are experience-based. The biggest component of a plans rate is the rates paid to contracted providers. These rates are difficult to increase because it takes a couple of years for the experienced-based rates to catch up. This leaves plans stuck not being able to increase what they spend on providers unless they fund the differential for the first couple years while rates catch up.

Mr. Busby stated that it is DHCS practice to pay the low end of the Medi-Cal actuarially sound rate range.

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[1] This refers to the Rogers Amendment. The intent of this law is to establish a basis for Medi-Cal managed care health plans to make reasonable payments to non-contacted hospitals for outpatient services, emergency inpatient services, and post-stabilization services following an emergency admission provided to Medi-Cal plan enrollees.

Mr. Shinto commented that actuaries have gotten more conservative than they were five or six years ago, leading to DHCS paying rates on the low end. Actuaries are not on the ground on the clinical side, they are just looking at the numbers.

Mr. Busby responded that there is an upward trend in rates. Rate increases overall have averaged between 1.5 percent to about 3.6 percent in an aggregate basis, and it could vary year by year.

Mr. Busby then discussed other issues that can impact rate setting, such as Intergovernmental Transfers (IGTs), Hospital Quality Assurance Fees, and MCO taxes. He offered to discuss Seniors and Persons with Disabilities (SPD) rate setting at a future meeting.

Mr. Wilson asked if there were any questions or comments from the audience.

Gary Passmore with the Congress of California Seniors commented that California eliminated a number of optional services for adults several years ago, under the State Medi-Cal plan. Dental services were eliminated, hearing, eyeglasses, podiatry for diabetics among them. He then asked how the state expects to restore and finance those services under the Affordable Care Act in January of 2014. He also stated that the state is looking at $8 billion in long-term care services under managed care. One of the foundational points of moving into managed care is care management and coordination among the providers. How is DHCS going to significantly expand this service under the rate setting scheme described?

Mr. Busby responded that the financing of optional benefits is predicated upon certain other efficiencies that would be changed as a result of coordinated care. He also stated that, regarding concerns about care coordination and the amount that may potentially be included in the rate, the appropriate venue to discuss this would be stakeholder forums that revolve around financial analysis and rate development.

Beth Capell of Health Access California asked if, during the rate development process, DHCS reviews which plans are in financial distress, and takes network adequacy into account.

Mr. Busby responded that DHCS regularly monitors the financial condition of contracting health plans and works closely with the DMHC in that respect. A solvency issue may not necessarily be reflective of a rate issue. Some plans overpay providers so it is important to look at benchmarks within the Medicaid industry. As far as the network adequacy, there are certain benchmark standards under DHCS, but ultimately DHCS looks to KKA standards.

Lucy Johns asked what kinds of incentives payments DHCS would like to see plans suggest.

Mr. Busby responded that as to defining quality measures, DHCS is not at that point yet.

Bill Barcellona of the California Association of Physician Groups (CAPG), commented that when CCIIO developed the Federal MLR regulations, they decided that care coordination activities that are paid to a capitated medical group fall on the medical side, not on the administrative side.

Mr. Busby responded that he may have misspoke on that issue and misaligned the medical administrative expense.

Don Comstock asked how rates can be actuarially sound when a plan that operates efficiently and keeps costs down has their rates reduced because DHCS uses claims experience to set rates.

Mr. Busby responded that DHCS uses an experience-based rate methodology to determine actuarial soundness, and DHCS leaves that judgment to actuaries.

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

5) 2011 Premium Rate Review Medical Loss Ratio (MLR) Summary

Presentation: 2011 Premium Rate Review Medical Loss Ratio Summary

Dennis Balmer, DMHC Deputy Director of the Financial Solvency Standards Board (FSSB), provided an update on the medical loss ratio results from the first year of SB 1163 rate review. Effective January 1, 2011 both the California Department of Insurance (CDI) and the DMHC were given authority to review commercial premium rate increases for the individual and small group market. For the individual and small group, 80 percent of plan spending had to be for medical care, and for the large group market, 85 percent. For the year 2011 the DMHC received approximately 90 individual and small group filings. California experienced plans reporting a total of $74 million in rebates. $42 million of those rebates were in DMHC licensed plans and $32 million on CDI's side. He also stated that the DMHC would be initiating MLR audits on selected plans this year.

Discussion:

Mr. Williams asked who receives the MLR rebate.

Mr. Cymerys responded that rebates can be distributed back to the employer, but there has to be an arrangement where they pass the rebate along to their employees.

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

6) Provider Solvency Updates

Presentation: Provider Solvency Updates

Michelle Yamanaka, Manager of the DMHC Provider Solvency Unit, provided an update as of March 31, 2012. She commented that she is seeing a trend in RBO enrollment, with commercial enrollment going down and an upward trend in Medi-Cal enrollment. Ms. Yamanaka also mentioned that since the last FSSB meeting, two CAPs have been completed and RBOs are reporting compliance with all solvency criteria. One RBO was de-delegated for failure to meet its final/approved CAP.

Discussion:

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

Ms. Yamanaka responded that the DMHC is focusing on trends over the past eight to ten quarters, looking at whether there are patterns. DMHC has to work with limited financial data. She further commented that the DMHC would have to gather additional information not currently possessed in order to see if that information would assist in identifying earlier warning signs for possible non-compliance with solvency criteria.

Ms. Capell commented that DHCS has risk adjustment data that might help in this analysis. She added that racial and ethnic disparities are highly correlated with higher costs and greater health care need beyond chronic conditions. Ms. Capell then suggested the DMHC work more closely with the DHCS to identify problem areas using DHCS data.

Mr. Barcellona commented that actions of the DMHC over the past decade have cut down on the number of insolvencies and disruptions in the system. He further commented that an ongoing problem with smaller RBOs in CAPG, who face unilateral capitation deductions by health plans, has had a destabilizing impact on the month-to-month financial solvency of these groups. He also mentioned problems with plans transferring Medi-Cal patients in and out of RBOs. Mr. Barcellona gave a couple of examples of problems such as a plan delegating risk for speech pathology under a cap which could result in a potentially high volume of risk. Another example he cited related to a plan transferring the cost of compliance with timely access requirements through a change in the provider manual rather than through a negotiation process.

Mr. Barcellona then suggested DMHC establish an ad hoc internal forum where groups and plans can come to the Department, and talk through these types of contracting issues.

7) Division of Financial Oversight Updates

Presentation: Health Plan Solvency Updates

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 108 active (54 full-service) health plans with approximately 22.7 million people enrolled.

Discussion:

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

The following topics were suggested for future meetings:

- Lack of uniform oversight of County Organized Health Systems, FQHCs and Medi-Cal managed care plans.
- Potential impact on solvency related to year-to-year MLR evaluations.
- How rates are going to be determined for dual eligibles.
- DMHC's areas of new responsibility, authority, or requirements for oversight related to the Affordable Care Act

10) Closing Remarks/Next Steps

Mr. Wilson suggested a future FSSB meeting be held in Southern California.