DEPARTMENT OF Managed Health Care

Financial Solvency Standards Board Meeting
August 21, 2013
Meeting Notes

Financial Solvency Standards Board (FSSB) Members in Attendance:

Chairperson Ann Pumpian, Senior Vice President and CFO, Sharp HealthCare
Elizabeth Abbott, Director of Administrative Advocacy, Health Access
Brent Barnhart, Director, Department of Managed Health Care
Edward Cymerys, Senior Vice President and Chief Actuary, Blue Shield of CA
Larry deGhetaldi, M.D., The Palo Alto Medical Foundation
Jacob Furgatch, President, AltaMed Health Network
David Meadows, Senior Vice President of Government Programs, LIBERTY Dental Plan
Richard Shinto, M.D., President and CEO, InnovaCare Health, Inc.
Tom Williams, Executive Director, Integrated Healthcare Association
Keith Wilson, President and CEO, Molina Health Plan

DMHC Staff Presenters:
Dennis Balmer, Deputy Director, Office of Financial Review
Suzanne Goodwin-Stenberg, Chief, Division of Financial Oversight
Gil Riojas, Senior Examiner

Presenters:
William Barcellona, Senior Vice President for Government Affairs, California Association of Physician Groups (CAPG)
Brett Johnson, Associate Director, Center for Medical and Regulatory Policy, California Medical Association (CMA)
Donald S. Comstock, Comstock & Associates
Tim Madden, Randlett Nelson Madden, *Representing* American College of Emergency Physicians, California Chapter (ACEP)

1) Welcome
Brent Barnhart, Director of the Department of Managed Health Care (DMHC), called the meeting to order and welcomed the attendees.

2) Introductions of New Board Members and Chair Selection

Director Barnhart asked the board members to introduce themselves and provide brief descriptions of their backgrounds. Mr. Barnhart acknowledged and thanked Dr. Keith Wilson for his three years of service as Chairperson of the board. Mr. Barnhart nominated Ann Pumpian to serve as the new Chairperson of the board, and Dr. Keith Wilson seconded the motion. There were no further comments. The Board approved the nomination, and Mr. Barnhart turned over the meeting to Chairperson Pumpian.

3) Minutes from February 11, 2013 FSSB Meetings

Richard Shinto made a motion to approve minutes from the February 11, 2013 FSSB Meeting. Tom Williams seconded the motion. Meeting minutes were approved.

4) Minutes from May 9, 2013 FSSB Meetings

Richard Shinto made a motion to approve minutes from the May 9, 2013 FSSB Meeting. Tom Williams seconded the motion. Meeting minutes were approved.

5) Provider Solvency Updates

Gil Riojas, Senior Examiner, Department of Managed Health Care (DMHC), Mr. Riojas provided an overview of the functions of the Provider Solvency Unit, as well as updates on enrollment and financial survey information. Mr. Riojas also gave an overview of current Risk Bearing Organizations (RBO), their compliance statements, corrective action plans (CAP), and the audit schedule for the Provider Solvency Unit. As of March 31, 2013, there were 176 RBOs, 9 of which are currently on corrective action plans. Lastly, he shared the audit schedule for the Provider Solvency Unit, which includes a planned 25 audits for 2013.

Discussion:

Elizabeth Abbott asked about the availability of information regarding RBO's financial solvency and whether or not this information is available online.

Mr. Riojas replied that the DMHC website contains financial information for all RBOs on a quarterly basis, although it may not be in great detail.

Ms. Abbott pointed out that this information will be of great importance to consumers in the near future, and asked if the information online is clear enough that everyone could understand.

Dennis Balmer, Deputy Director, DMHC Office of Financial Review, explained that there is a lot of statistical data on the website including information regarding CAPs, compliance with CAPs, and annual descriptions and statistics of RBOs.

Larry deGhetaldi asked about the number of enrollees in the 9 RBOs that are currently non-compliant, in order to understand the potential impact of the insolvency risk.

Keith Wilson asked whether a group that is on a CAP is allowed to add to its enrollment.

Mr. Riojas responded that, in general, enrollment is not frozen when an RBO is placed on a CAP. An order to freeze enrollment may be issued when the Department doesn't receive a timely, approvable CAP that adequately addresses the RBO deficiencies or if the RBO is not compliant with its final CAP.

Ms. Pumpian asked if a CAP can apply to one deficit as well as multiple deficits.

Mr. Riojas confirmed that a CAP can be for multiple deficits.

Ms. Pumpian inquired whether the public information indicates if a CAP is for one or multiple deficiencies.

Mr. Balmer confirmed that information is available on a quarterly basis and addresses the specific areas of deficiency.

Richard Shinto asked why there was an increase in number of RBO audits between 2010 and 2013.

Mr. Riojas responded that increased efficiency and staffing have enabled the unit to perform a greater number of audits. He also confirmed that all RBOs are audited, not just those that are outliers.

Jacob Furgatch asked for clarification of the definitions of the phrase "monitored closely" and the term "superior."

Mr. Riojas replied that "superior" refers to those RBOs that hit a higher threshold in meeting the grading criteria, such as a higher working capital or higher tangible net equity (TNE).

Mr. Furgatch asked if there is a certain percentage or gradation used to make the distinction.

Mr. Riojas responded that it is based on a formula which he would provide to the FSSB..

Mr. Barnhart elaborated on the role of DMHC in relation to RBOs. While DMHC does not license RBOs, it is authorized to perform financial examinations. If DMHC is

unsuccessful in helping an RBO get out of trouble, the health plan would be directed to shift their enrollment population away from the RBO.

Edward Cymerys directed attention to the 25 RBOs that are being closely monitored or in corrective action. He asked if DMHC anticipates that the enrollment increases as of January 1st will aggravate the situation for these RBOs.

Mr. Riojas confirmed that this is a concern.

Jacob Furgatch asked how the DMHC can be certain that all RBOs have been identified.

Mr. Balmer responded that if a medical group wants to receive capitation from a health plan, the medical group must complete a questionnaire. The DMHC reviews the questionnaire and determines whether the medical group is an RBO or just a capitated provider and issues the appropriate five digit number. RBO numbers start with 1 as the first digit and capitated provider numbers start with a 2.

Ms. Pumpian asked to have screen shots from the website to accompany the other handouts, and a brief presentation to explain content to first-time viewers.

Bill Barcellona, CAPG, asked for clarification regarding the population numbers presented, as they do not match figures found on Grant Cattaneo's website.

Mr. Barnhart clarified that the discrepancy in numbers is due to the fact that Kaiser is excluded from the definition of an RBO, and therefore Kaiser enrollment is not included in the total.

Mr. Barcellona recommended the website of the Office of the Patient Advocate (OPA) as a strong reference tool. He suggested the inclusion of a similar financial status report device, to assist consumers as they select medical groups.

Brett Johnson, CMA, mentioned the upcoming 2014 Medi-Cal expansion, new Exchange products and the financial risks associated with Exchange products. He asked whether the Board and DMHC plan to pay additional attention or oversight to Exchange products.

Dr. Wilson noted that DMHC would have oversight only of HMO mechanisms. He would like clarification regarding oversight of PPOs.

Mr. Barnhart confirmed that both the Department of Insurance (CDI) and DMHC approve and regulate products offered in The Exchange.

Mr. Williams referred to Mr. Barcellona's comments regarding the OPA website. Although the managed Medi-Cal population enrolled in RBOs is not included, is there some work being done to correct that?

Mr. deGhetaldi emphasized the importance of transparency around quality of service. He noted that it is unfair that half of California's low-income population doesn't have this level of visibility into performance of medical group partners.

Ms. Pumpian asked if there were any further questions. There were none.

6) Health Plan Solvency Updates

Suzanne Goodwin-Stenberg, Chief of the Division of Financial Oversight (DFO), provided a brief overview of the role and function of DFO in monitoring and evaluating the financial solvency of health plans. She shared updates on: (1) the number of licensed plans, (2) the enrollment in these plans, (3) the tangible net equity (TNE) of these plans, (4) closely monitored plans, and (5) TNE-deficient plans.

Discussion:

Ms. Abbott asked how DFO determines the financial solvency of health plans that are newly operating in California, without data to show their track record.

Ms. Goodwin-Stenberg replied that when a plan applies for licensure, DFO reviews the projections and current financial position of the plan, as well as its affiliates and parent company. These new plans are placed on the closely monitored list, and DFO reviews their monthly financial statements to determine if they are in line with their initial projections.

Ms. Abbott asked if DFO visits the plans in the beginning.

Ms. Goodwin-Stenberg responded that DFO sometimes performs orientation examinations after the plan has been in operation for a year. Normally, there is no on-site visit during the first year.

Ms. Pumpian asked for clarification regarding a plan that has over 500 percent of TNE but is surrendering its license.

Ms. Goodwin-Stenberg responded that although the percentage may appear high, the dollar amount probably is not. As the plan moves toward surrendering, it is still required to keep a certain amount of money on hand.

Ms. Pumpian asked if a surrendering plan would work its way up through the chart of TNE.

Mr. Balmer responded that the plan may see a rise in effective TNE, as they will resolve liabilities as they move toward surrendering their license.

Mr. Williams asked if there is a managed Medi-Cal plan that DMHC does not oversee.

Ms. Goodwin-Stenberg replied that there is one plan that DMHC does not oversee, because it is not a Knox-Keene licensed plan. However, DMHC performs an MLR audit of this plan, under an Interagency Agreement with DHCS.

Mr. Williams asked if DMHC performs claims audits for non-KKA licensed plans.

Ms. Goodwin-Stenberg responded that DMHC does not.

Mr. Williams wondered why DMHC does not perform claims audits for non-KKA licensed plans, and recommended looking at regulations to fix this.

Mr. deGhetaldi pointed out that County Organized Health System (COHS) plans have separate rules excluding them from licensure, with the exception of Healthy Families contracted plans. He expressed his concern that Medicare Advantage is going to see some stress over the next few years, as the Affordable Care Act (ACA) drives rates down to match Medicare fee-for-service.

Mr. Cymerys asked for clarification regarding the financial backing required by plans as they apply for licensure.

Ms. Goodwin-Stenberg responded that plans are required to show financial backing before their license is approved. If the plan becomes TNE deficient, DMHC will contact the plan. In many cases, the plans will infuse more cash, from either the parent company or an affiliate.

Mr. Furgatch asked if it's possible to indicate whether or not plans surrender licenses for reasons other than TNE deficiency. He asked if there is a way to differentiate between those plans that surrendered licensure for financial or other reasons.

Mr. Balmer pointed out that some plans surrender licenses due to mergers and acquisitions.

Mr. Furgatch mentioned he would also like to see some differentiation between plan-to-plan versus full-service organizations.

Ms. Abbott expressed her concern about discount health plans and advised caution in dealing with them.

Don Comstock, Comstock & Associates, suggested that DMHC should break out the enrollment of limited license plans, so as not to double-count enrollment figures.

Ms. Pumpian asked if there were any further questions. There were none.

7.) Presentation: Pioneer Accountable Care Organization Status Update

Dennis Balmer, Deputy Director, Office of Financial Review, provided an update on the Pioneer ACOs in California. According to feedback received from the ACOs, four out of six will continue forward with the CMS pilot and two will change to the Medicare Shared Savings Program. Among those continuing with the pilot, none have elected to take population-based payments.

Discussion:

Mr. deGhetaldi asked if CMS or the ACOs provided an affirmation regarding the population-based payments.

Mr. Balmer responded that the ACOs provided affirmations and attestations.

Ms. Pumpian explained that ACOs may have some providers who take a discounted Medicare fee schedule payment from CMS. The ACO and CMS will reconcile at the end of each period, and each ACO will be required to set aside funds to protect government funds.

Ms. Pumpian asked if there were any further questions. There were none.

8) Risk Bearing Organizations – Potential Changes to Reporting Requirements

Mr. Balmer provided an overview of Risk Bearing Organizations (RBO), including the factors that define an RBO. He prompted the discussion by sharing the RBO questionnaire and asking if the current definition of RBO is appropriate and whether other providers should be subject to further RBO requirements. The second half of the presentation revolved around the reporting requirements of RBOs, specifically affiliate reporting.

A. RBO Definition and Questionnaire Discussion:

Mr. Furgatch asked whether the questionnaire is current or proposed.

Mr. Balmer confirmed that it is current and clarified that he wanted the Board to discuss whether or not it is appropriate for the emerging models.

Mr. Shinto asked when the questionnaire was first written, as it doesn't seem to pertain to the evolution of health care over the last few years.

Mr. Balmer did not know when the questionnaire was developed. The questions were based on Health and Safety Code Section 1375.4. Mr. Balmer asked the group if these questions are still applicable today.

Mr. Wilson asked how RBO regulations apply to the foundation model in the hospital sector.

Mr. Balmer responded that DMHC oversees medical foundations as defined in Health and Safety Code Section 1206 (l) and reviews their financial statements and claims payment practices.

Mr. Cymerys suggested the DMHC conduct a survey of specialty organizations that are emerging, for the Board and Department to understand the nature of these organizations.

Mr. Furgatch pointed out that the regulation's definition of a physician-owned organization may limit the department.

Mr. Balmer expressed concern with the growth of delivery models that do not qualify as RBOs, and whether there is enough oversight of these organizations.

Mr. Shinto agreed that the increase in specialty organizations increases the chance that they will slip under the radar and not be audited by DMHC. He suggests revisiting the questionnaire, because it may need a different emphasis today than when it was created.

Ms. Pumpian explained that many of these organizations contract directly with RBOs. Since they do not qualify as RBOs themselves, DMHC does not have authority to oversee them.

Mr. Wilson expressed concern that as risk is pushed downstream, contracted specialty groups accept capitated payments, but do not qualify and are not regulated as RBOs.

Mr. Cymerys stated that increased transparency would be helpful to gain a more comprehensive view of what is going on, even if it pushes toward more regulation.

Mr. deGhetaldi explained that he sees Medicare as a potential ideal in terms of transparency, and that the board should advocate for Medi-Cal adopting a similar level of transparency.

Bill Barcelona, CAPG, explained the role of SB 260 in managing risk and providing a level of transparency. He suggested that it could be reopened to apply to these emerging entities and delivery systems.

Don Comstock, Comstock & Associates, shared his concern that there will be a large number of entities that are not physician-owned, but will be taking risk through capitation.

Tim Madden, California Chapter of American College of Emergency Physicians, encouraged the board to continue looking at ways to increase transparency with regard to sub-capitation.

B. RBO Affiliate Reporting Discussion:

Mr.Balmer provided overview of the RBO reporting regulation. He explained the components of an RBO and a definition of the term affiliate. He noted DMHC's concerns when services are being provided and reported by affiliates.

Mr. Balmer asked for suggestions on how to change the reporting requirements for RBOs that are substantially dependent on affiliates.

Mr. Shinto suggested that trying to perform in-depth audits of all layers of the RBO could create a large problem. He stated that RBOs are already responsible and accountable for all of the services below them.

Mr. Williams recalled the time when SB 260 emerged, and the link between struggling Management Service Organizations (MSOs) and groups going under. He suggested looking for patterns of corrective action, and if several appear under one MSO, then DMHC should audit that particular MSO.

Mr. Balmer stated that affiliate relationships with RBOs contributed to the failure of medical groups.

Mr. Cymerys asked for clarification on the specific situations in which Mr. Balmer thinks affiliate reporting is necessary.

Mr. Balmer gave the example of paying special attention to affiliate relationships as part of an RBO's annual audit.

Mr. Cymerys suggested alternate wording containing more objective criteria than "substantially dependent."

Mr. Balmer clarified that the wording was taken from the health plan reporting requirements.

Mr. Furgatch asked if "substantially dependent" was a question of the viability of the balance sheet items.

Mr. Balmer responded that it is both what is financially reported and what is on the balance sheet as a potential receivable.

Mr. Wilson asked how DMHC can regulate the affiliated MSO in conjunction with the RBO when they are separate entities, with separate reporting and/or regulatory requirements.

Mr. Balmer replied that the DMHC cannot have a comprehensive financial picture of an RBO without also looking at the affiliates. He explained that the largest problem in the failure of RBOs is the payment of claims. The goal is to develop a clear picture of what it takes to provide services to enrollees.

Ms. Pumpian expressed the concern that one MSO could be providing services to multiple RBOs, and that its assets would be double-counted.

Mr. Williams asked whether or not this oversight would be across the board, or targeted. Since DMHC does not regulate RBOs, he wondered where the authority would come from. He suggested focusing on RBOs that are in corrective action or already on a watch list, as a way of focusing in on where the problem occurs.

Mr. deGhetaldi raised the question of whether or not DMHC could even require medical groups to provide their financials and balance sheet information.

Mr. Furgatch suggested that the focus be on reviewing balance sheet items on the affiliates and the risks associated.

Mr. Meadows asked if affiliate receivables for an RBO and for a plan are treated the same way in calculating TNE.

Mr. Balmer responded that affiliate receivables are excluded for TNE for both plans and RBOs.

Mr. Balmer stated his concern was with RBOs that have not yet faced claims payment issues. He wonders how problems could be identified earlier.

Ms. Pumpian asked what happened to the three examples provided in the presentation.

Mr. Balmer replied that they all went out of business.

Don Comstock, Comstock & Associates, suggested that health plans should be required to perform more oversight of RBOs. He pointed out that many MSOs do not perform any medical management, but are more of an administrative service organization (ASO). He suggests that there needs to be a distinction between the two.

Ms. Pumpian asked if there were any further questions. There were none.

9) Public Comment on Matters Not on the Agenda

Bill Barcellona, CAPG, thanked Director Barnhart and the DMHC for reconvening the FSSB. He provided an overview of key trends and issues, including: the impact of the impending cut to Medi-Cal Managed Care under AB 97 while the Medi-Cal population expands; the impact of the Exchange on the delegated model; the implementation of AB 1602 on standardized products in the Exchange, as well as off-Exchange products. He also discussed the movement of Medicare Advantage toward parity with fee-for-service, and the expansion of Medi-Cal Managed Care to a larger population at lower rates of pay.

Mr. Barcellona shared a solution being pursued by Health Net, L.A. Care and CAPG. This is to allow Medi-Cal Managed Care plans to pay providers a percentage of premium. This would require the deletion of a section of the Welfare and Institutions Code, Section 14452. So far, there has been no objection from the Department of Health Care Services or from stakeholders in the industry. He asked for the Board's input on moving Medi-Cal Managed Care to a payment system based upon a percentage of premium.

Mr. Williams asked what the rationale was for the exclusion that precludes percent of premium payment.

Mr. Meadows believed that it came from a federal prohibition.

Dr. Wilson suggested that instead of pursuing legislative change, perhaps CAPG could look at a bifurcation of the revenue stream, and continue to receive a percent of premium on the Medicare product, even if groups are not receiving a percent of premium on the Medi-Cal product. He stated further that the percent of premium methodology encourages providers to enhance the level of care. He is concerned that losing Medicare's risk-based payment structure would diminish the care of the patient population.

Mr. Shinto stated that groups have seen the Medicare Advantage model of payment improve the level of care and wellness prevention, compared to the flat capitation model.

Mr. deGhetaldi stated that there are three parts of Medicare Advantage payment structure that are appealing: (1) the percent of premium, which encourages the elimination of waste, (2) the Medicare STARS program, which advances payments based on quality, and (3) the risk adjustment scores that drive population risk. He suggested applying these traits to the emerging Medi-Cal capitated population.

Ms. Pumpian agreed with Mr. deGhetaldi and cautioned against taking a percentage of capitation without making a risk-based adjustment. She sees this causing the delegated groups to take on all responsibility, except for the minimal administrative roles of the health plan.

Mr. Meadows stated that the risk-type basis is a way to match a higher compensation with those with higher risk scores.

Mr. Barcellona stated that risk adjusting enrollees in a Medi-Cal population is a positive sign. It allows a lower payment for healthy people and a higher payment for sicker people. Providers and plans work together to provide people with the right care.

Ms. Pumpian asked if there were any further comments. There were none.

10) Agenda Items for Future Meetings

Mr. Cymerys stated that in response to questions raised in the February FSSB meeting, he and Tom Williams had discussed the attributes of some of the new payment methods. He suggested gathering information on these methods, assessing the level of risk in each of the arrangements, and bringing the information back to the Board's November meeting. He would like to see these other payment methods arranged on a spectrum of financial risk. This would give the board the opportunity to identify areas that may require additional attention by the Department.

Mr. Williams agreed to work on this with Mr. Cymerys.

Mr. Shinto would like to see an update of the RBO questionnaire, with the focus being not only financial, but more about the business itself.

Ms. Abbott shared that NAIC is re-examining what a market conduct survey should look like, and what works in assessing plans and insurers nationally. Dianne Longley, with Health Management Associates in Texas, is writing a paper and Ms. Abbott would like to share this information with the board when it becomes available. The report is due to be released at the December NAIC meeting. Perhaps the paper can be shared with the Board at the spring meeting.

11) Closing Remarks/Next Steps

The next FSSB meeting is scheduled for November 18, 2013 at 10:00 a.m.

The meeting was adjourned at 12:44 p.m.