DEPARTMENT OF Managed Health Care

Financial Solvency Standards Board Meeting
November 18, 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
Keith Wilson, M.D. President, Molina Medical Group
Deborah Kelch, Independent Consultant
Richard Shinto, M.D., President and CEO, InnovaCare Health, Inc.
Tom Williams, Executive Director, Integrated Healthcare Association

DMHC Staff Presenters:
Dennis Balmer, Deputy Director, Office of Financial Review
Gary Baldwin, Deputy Director, Plan and Provider Relations
Michelle Yamanaka, Supervising Examiner, Provider Solvency Unit

Presenters:
Alexander Vojta, Blue Cross of California

1) Welcome

Chairperson Ann Pumpian called the meeting to order and welcomed attendees.

2) Minutes from August 21, 2013 FSSB Meeting

Two corrections were made to the minutes from the August meeting: Jacob Furgatch pointed out that he is the President of AltaMed Health Network, and Elizabeth Abbott corrected the spelling of her name. Mr. Furgatch made a motion to approve the August 21st FSSB Meeting minutes with the noted corrections. David Meadows seconded the motion. Meeting minutes were approved with no opposition.

3) Director's Remarks and Introductions

Brent Barnhart announced that this will be his final FSSB Meeting as Director of the Department of Managed Health Care (DMHC). He thanked the Board for the experience. Mr. Barnhart also announced that Dennis Balmer, Deputy Director of the Office of Financial Review (OFR), has accepted a position with Sutter Health and thanked Mr. Balmer for the work he has done for DMHC. He announced that Kevin Donohue, Deputy Director of the Office of Legal Services, will serve as the acting Deputy Director of the Office of Financial Review.

4) Provider Solvency Updates

Michelle Yamanaka, Supervising Examiner, provided an update on the Provider Solvency Unit. Ms. Yamanaka outlined the financial survey reviews as of June 30, 2013, noting the receipt of a total of 176 filings from Risk-Bearing Organizations (RBOs) for the quarter ending June 30th. She explained the classification system used in the assessment of RBOs' financial capacity and financial trends. She also provided an overview of current Corrective Action Plans (CAPs), the closely-monitored list, and RBOs with greater than 50 percent Medi-Cal enrollment. Lastly, Ms. Yamanaka outlined the audits that the Provider Solvency Unit completed in 2013.

In response to questions raised at the August FSSB Meeting, Ms. Yamanaka explained the types of information available on the DMHC public website, including financial surveys, compliance statements, and a summary of aggregated data.

Discussion:

Elizabeth Abbott asked for clarification regarding the RBOs with non-filing status.

Ms. Yamanaka responded that these are the RBOs which are required to file statements with DMHC, but have not yet done so to date.

Larry deGhetaldi asked about the two non-compliant RBOs and the number of lives that are connected with each.

Ms. Yamanaka replied that enrollment for one is within the zero to 10,000 category and for the other it is in the 10,000 to 20,000 category. There is an additional RBO sent to enforcement that is within the 20,000 to 30,000 category.

Ms. Pumpian asked for an explanation of what it means to be sent to enforcement.

Ms. Yamanaka explained that taking enforcement action against an RBO may involve freezing its enrollment, or de-delegation, which involves directing the contracting health plans to take back claims processing thereby removing the RBO's status as a risk-bearing organization.

Ms. Pumpian noted that more and more RBOs are losing their risk-bearing organization status due to mergers. She asked what role DMHC plays when these RBOs notify the Department that they no longer meet the criteria of an RBO.

Ms. Yamanaka explained that the Department contacts the contracting health plans to ensure that they are aware that the RBO is being purchased or merged.

Richard Shinto asked what the superior category entails.

Ms. Yamanaka responded that the categories are used to prioritize the workload for reviewing financial filings. Filings from RBOs on the closely-monitored list are reviewed prior to those in the superior category.

Ms. Abbott asked who is responsible for notifying the consumers when there is a change in the status of an RBO.

Ms. Yamanaka explained that if a health plan has changes in its medical groups and the affected enrollment exceeds 2,000, the health plan is required to file a block transfer with the DMHC which will result in notices to affected enrollees.

Jacob Furgatch asked for an explanation of the process for new groups in the market.

Ms. Yamanaka explained that the RBO will submit a questionnaire for review by the DMHC. Upon completion of this review, the Department issues an RBO number and begins its usual review of financials and trends for the RBO.

Mr. deGhetaldi raised his concern about the ramifications of consumers switching between Medi-Cal and Covered California, and the impact this will have on continuity of care for the patient, as well as capacity, IBNR, and financial solvency for the groups.

Mr. Barnhart responded that while this is definitely a concern that will impact the entire marketplace, it is not yet possible to say how it will all play out.

Ms. Pumpian asked if the DMHC uses consistent methodology in determining whether or not IBNR is being calculated appropriately.

Ms. Yamanaka responded that DMHC uses lag tables as required by regulations, when calculating IBNR to determine an RBO's financial solvency.

Mr. Cymerys stressed the difficulty of trying to set reserves in an environment where populations are shifting dramatically. He shared that these large population shifts can mask what is really happening, even when an IBNR calculation appears to show that there is little risk.

Mr. Shinto suggested that there be a lock-in period, in which consumers can enter into plans, as well as an increase in data collection to assist actuaries.

Ms. Kelch asked for clarification that this issue involves those consumers who are changing their eligibility between Medi-Cal and the Exchange, and asked how a lock-in would resolve this issue.

Mr. Shinto clarified that as populations shift, the cost structures prepared by the actuary will no longer apply to the new population. A lock-in would provide a fixed time period in which to review and make readjustments based on the population.

Ms. Kelch pointed out that the lock-in would not fix the consumers' eligibility in time.

Mr. Meadows stated that it would be difficult to have a lock-in because of eligibility concerns.

Mr. Shinto clarified that his concern is with the constant movement within the market, and that the costs associated with these shifting populations might be completely different. He retracted his use of the statement "lock-in" and referred instead to a rule change.

Mr. Meadows explained that the Exchange has encouraged its plans to contract with certain safety net providers, which might allow populations to stay within the same provider or health plan.

Ms. Abbott asked if the Department has reexamined what it observes and tracks, and whether or not it has enough resources, in light of the upcoming changes in the market**.**

Mr. Balmer explained that the Provider Solvency Unit has the capability to review providers' financial statements, IBNR calculations and norms, and investigate

complaints. While they focus on certain targeted groups, they are also trying to reach all provider groups over time.

Mr. Shinto reiterated his concern that the current ratings may still allow a bad situation to be covered up. He pointed out that CMS is moving toward a star rating system, and that this encourages medical groups to police each other and compete for best practices.

Mr. deGhetaldi expressed his concern regarding continuity of care, and the ramifications of a patient moving between plans. He would like to see a broader view of the disruptions and potential harm from this movement.

Ms. Abbott shared that there is little understanding of continuity of care. Consumers do not receive information regarding their right to continuity of care, and suggested that DMHC work with other agencies to address this problem.

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

5) Health Plan Solvency Updates

Dennis Balmer provided an overview of the roles and functions of the Division of Financial Oversight (DFO), including updates on licensed plans, changes to enrollment, Exchange products, tangible net equity, closely-monitored plans and TNE-deficient plans. He explained that DFO is in the process of filling a number of positions, to help bring the office to its goal of performing financial examinations once every three years.

Discussion:

Ms. Abbott asked for clarification of the phrases “imposition of a monitor” and “conservator.”

Mr. Balmer explained that if a health plan’s financials begin to trend poorly, a monitor may be embedded within the plan. The monitor reports back to DMHC on how the plan is managing its expenses and revenue, how this compares to the plan’s peers, and what improvement opportunities exist. If a plan is unable reverse unfavorable financials trends and cannot maintain the required financial thresholds, a conservator may be installed to take control of the plan’s operations. At this level, the Department has the authority to dictate changes and potentially wind down the plan’s operations rather than just overseeing the plan’s operations and making recommendations.

Ms. Abbott asked how long this process lasts.

Mr. Balmer responded that the process can potentially take over a year, but it will depend on the findings, recommendations and course of action taken.

Ms. Abbott asked if the DMHC determines the length, duration and success of the task.

Mr. Balmer explained that DMHC defines the expectations, which is discussed with both the plan and the monitor.

Mr. Barnhart added that while conservatorship is the ultimate tool, the Department is not eager to use it, because the success or failure of the plan is entirely dependent on the efforts of DMHC.

Mr. Furgatch pointed out that with 19 out of 61 full-service plans on the closely-monitored list, almost one-third of plans are being closely monitored. He asked if this includes plans which may have had one bad quarter, and not necessarily a bad trend.

Mr. Balmer responded that the Department has significant concerns regarding those plans on the closely-monitored list.

Mr. Furgatch pointed out that there has been much focus on RBOs, but since these 19 full-service plans are at the health plan level, perhaps they do warrant more concern.

Keith Wilson asked if there are different TNE requirements for groups and plans.

Mr. Balmer confirmed that there are different TNE requirements for groups and plans. There is a formula to determine minimum TNE required, based on the size of the plan, as well as level of claim payment activity and revenue.

Ms. Pumpian asked if the Department has looked for a correlation between closely-monitored RBOs and closely-monitored health plans.

Mr. Balmer responded that there hasn't been a formal review, but that when it happens, it should be broken out between commercial versus Medi-Cal.

Mr. Shinto explained that he would like to see more of a historical view of the monitoring and intervention activities.

Mr. deGhetaldi asked who will be responsible for overseeing the county-organized health systems (COHS) who have participated in Healthy Families, now that Healthy Families is winding down.

Gary Baldwin, Deputy Director of Plan and Provider Relations**,** explained that DMHC has no statutory authority over entities operating strictly as COHS in the Medi-Cal Program.

Mr. Furgatch asked if the winding down of Healthy Families will remove DMHC's ability to look at those plans.

Mr. Baldwin confirmed that it is possible, because those plans will no longer be required to maintain a DMHC license for their Medi-Cal line of business.

Mr. Williams asked how many COHS will be affected by the transition of Healthy Families to Medi-Cal.

Mr. Baldwin responded that he didn't know the exact number, but that there are a few.

Mr. Williams stated that he does not feel that any of these entities should be outside of the oversight process, and asked how such a change can be made.

Mr. Baldwin explained that a legislative change would be required, because the exemption exists in the Welfare & Institutions Code.

Mr. Williams made the recommendation that the DMHC authority should extend to all of the Managed Medi-Cal plans.

Ms. Kelch agreed with the recommendation and stated that it would be a good alert to raise to policymakers.

Mr. Furgatch expressed that while the idea makes sense, he would like more information regarding the situation and potential ramifications.

Ms. Pumpian clarified that the recommendation is that county-organized health systems have the same consumer protection requirements as Medi-Cal Managed Health Care plans.

Mr. Barnhart stated that this topic needs to be on an agenda, and there needs to be sufficient notice prior to a vote.

Mr. Furgatch asked if staff could explore the ramifications of this recommendation, for discussion at the next meeting.

Mr. Barnhart agreed.

Ms. Abbott asked for a description of the steps that DFO or DMHC could have made to have been clearer in its communication regarding the vulnerability of a plan.

Mr. Balmer responded that there could have been earlier recognition that the plan was going to be TNE-deficient, but the Department also has to be concerned about sharing information and overstepping its authority.

Ms. Abbott asked whether or not a plan has to be deficient before DMHC sends in a monitor.

Mr. Balmer replied that a plan must be TNE-deficient before the DMHC can order the placement of a monitor.

Mr. Meadows asked if the COHS need Knox-Keene licensure in order to handle dual eligibles.

Mr. Baldwin responded that the entities involved in the duals demonstration do not have to be licensed if they operate purely as a county-operated health system.

Don Comstock, Independent Consultant, explained that monitors are independent organizations appointed by the Department. He also suggested separating out those organizations that are closely-monitored merely because they are new, in order to see a clearer trend of those being closely-monitored.

Ms. Pumpian agreed that trended data of plans would be helpful.

Brett Johnson, California Medical Association, suggested the creation of an advisory group that would keep the Board and the Department informed as to changes and potential risks in the marketplace.

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

6.) Presentation: Risk Assessment of Emerging Payment Arrangements

Ed Cymerys and Alexander Vojta, Director, Blue Shield of California**,** participated in a subcommittee with Tom Williams and Vanessa Chiu, to gather information on emerging payment arrangements and categorize them according the level of clinical risk and population risk. The goal of this effort was to provide a frame of reference with which to look

at these arrangements and to keep the Board and DMHC informed about what is happening in the marketplace.

Mr. Cymerys and Mr. Vojta provided an overview of the four main categories of payment arrangements and their associated clinical and population risks.

Discussion:

Ms. Pumpian asked whether or not this exploration took into consideration the risks associated with denials or what truly constitutes a denial of care.

Mr. Cymerys responded that his presentation outlined a very simple view of the situation, and there are many variations and adjustments that can be made.

Ms. Pumpian asked why the percentage of payment arrangements is categorized with a lower risk than the total cap.

Mr. Vojta noted that the risk is a range, rather than an absolute, so it is possible that the risk for percentage of payment arrangements could be higher.

Mr. Cymerys explained that the Exchange operates in such a way that plans receive a different risk adjustment to premium payments based on their relativity to the whole pool.

Mr. deGhetaldi shared the importance of having sophisticated and transparent risk adjusters applied to the population, in order to encourage physician groups to embrace the risk. He also suggested that having purchasers become more involved in the market and the savings, thereby encouraging providers to focus more on the total cost of care.

Ms. Pumpian stated there is much greater value in engaging the individual purchasers rather than employers, even if the employers are in fact the purchasers.

Mr. Furgatch expressed that the challenge he sees now is in gaining an understanding of population risk. Solid data is required in order to analyze, and the market does not yet have that kind of data regarding populations and their behavior.

Mr. Vojta pointed out the potential for savings by sharing the risk.

Mr. Meadows questioned whether the age/gender adjustment serves to mitigate risk or increase risk to the providers.

Mr. Cymerys shared that while the age/gender adjustment is more accurate than a flat number that is not adjusted, it is not the most accurate method for measuring a changing and dynamic population.

Ms. Kelch mentioned the Affordable Care Act (ACA) requirement of single risk pools for the market, and the impact this will have in a market that has made payment arrangements based on relationships between plans, providers, products and delivery models.

Mr. Cymerys acknowledged that with the upcoming changes to the market's population, there will be an opportunity for risk-adjustment compensation to providers.

Mr. Williams raised the point that within these risk adjustments, there will also be implications downstream at the provider level that will need to be addressed.

Ms. Pumpian suggested that the Department form an advisory group begin to evaluate the potential risks in the next few years and the steps that can be taken to mitigate those risks.

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

7) Public Comment on Matters Not on the Agenda

Ms. Pumpian asked if there were any comments from the public on matters not on the agenda. There were none.

8) Agenda Items for Future Meetings

Mr. Furgatch asked for data regarding enrollment and the cost of the upcoming enrollment changes surrounding the Medi-Cal expansion and Covered California. This information may be available for the May/June FSSB Meeting.

9) Closing Remarks/Next Steps

The meeting was adjourned at 12:46 p.m.