Financial Solvency Standards Board Meeting
June 17, 2015
Meeting Notes

Financial Solvency Standards Board (FSSB) Members in Attendance:
Edward Cymerys, Healthcare Consultant
Dr. Larry de Ghetaldi, The Palo Alto Medical Foundation
Betsy Imholz, Consumers Union
Deborah Kelch, Alternate, Independent Consultant
Dave Meadows, Liberty Dental Plan
Ann Pumpian, Chairperson, Sharp HealthCare
Shelley Rouillard, Department of Managed Health Care
Dr. Rick Shinto, Alternate, InnovaCare Health, Inc.
Tom Williams, Alternate, Stanford Health Care Alliance
Dr. Keith Wilson, Molina Healthcare

Department of Managed Health Care (DMHC) Staff Present:
Rachel Arrezola, Deputy Director, Communications and Planning
Stephen Babich, Supervising Examiner, Office of Financial Review
Pritika Dutt, Supervisor, Office of Financial Review
Kelvin Gee, Senior Examiner, Office of Financial Review
Gabriel Ravel, General Counsel
Gil Riojas, Deputy Director, Office of Financial Review
Mary Watanabe, Deputy Director, Health Policy and Stakeholder Relations

Department of Health Care Services (DHCS) Staff Present:
Hannah Katch, Assistant Deputy Director, Healthcare Delivery Systems
Meredith Wurden, Assistant Deputy Director, Healthcare Financing

1) Welcome & Introductions- Agenda

Chairperson Ann Pumpian called the meeting to order and welcomed attendees. Director Shelley Rouillard introduced Mary Watanabe, DMHC's new Deputy Director of Health Policy and Stakeholder Relations, and Rachel Arrezola, the new Deputy Director of Planning and Communications. Ms. Rouillard also recognized Board member Deborah Kelch for her years of service to the FSSB. Ms. Kelch is taking a sabbatical through the end of the year.

2) Minutes from March 18, 2015 FSSB Meeting

Dr. Keith Wilson made a motion to approve the March 18th FSSB meeting minutes. Dr. Larry de Ghetaldi seconded the motion. Meeting minutes were approved with no opposition.

3) Director's Remarks

Ms. Rouillard announced the DMHC should be getting 40 new positions in the 2015-2016 budget, including:

- 11 positions for mental health parity.
- Seven positions for the Help Center and administrative support as a result of individual market expansion.
- One and a half positions for dental and medical loss ratio reviews related to AB 1962.
- 25 positions for the review of provider networks and plan compliance with timely access under SB 964.

DMHC will also receive about $600,000 in Federal grant spending authority for the rate review program.

Ms. Rouillard said the Department has extended the deadline for the health plans to comply with mental health parity to January 1, 2016. Plans that are not in compliance by this date will be subject to enforcement action.

The DMHC recently froze enrollment for Daughters of Charity Health System (DCHS) Medical Foundation due to extreme financial losses.

The Department has reviewed plan data on reasonable and customary methodology and found that there is no standard methodology. The Department is working on a report to present the findings.

Ms. Rouillard added, in response to the California Association of Physician Group's (CAPG) proposal on restricted licenses, the DMHC will be introducing a regulation to codify existing practice around restricted licenses. She added that there have been internal meetings to review the Knox-Keene Act as it relates to CAPG's interest in contracting with The Employee Retirement Income Security Act of 1974 (ERISA) Plans.

4) Alameda Alliance for Health Update

Mark Abernathy, appointed conservator of the Alameda Alliance for Health, provided an update on the plan, including the following summary of what brought the plan to a conservatorship and where they are now.

- Tangible Net Equity (TNE)
  - The plan had an extended and ongoing decline.

    - The plan's TNE has increased from a $6.2 million deficit on June 30, 2013 to a $24.7 million surplus on March 31, 2015.
- Cash Flow
    - Cash flow had reached critical levels and had declined from $63.7 million in June 2011 to $400,000 at the end of 2013.
    - At the end of March, cash reserves were $130 million.
- Capital Spending
    - Capital spending had continued unchecked and is now under control.
- Staffing Levels
    - The number of FTEs had increased from 1.11 per thousand members in 2010 to 1.47 at the end of 2013.
    - At the end of May, they were at approximately 0.81 per thousand members.
- Reliance on Consultants
    - Reliance on consultants has been dramatically reduced, especially in the IT department. IT and consultant staff have been cut in half.
- Financial Losses
    - The plan had sustained financial losses, which have now become profits.
- Failed IT Conversion
    - The failed IT conversion is now moving forward with an implementation date of mid-August.
- Claims Processing
    - The plan had a mounting claims backlog.
    - The plan is now processing claims within 15 days of receipt and customer service levels are much improved.
- Customer Service
    - Customer services levels were plummeting and the average wait time for calls to member services was 83 minutes and the abandonment rate was 55 percent.
    - Now, the average wait time is around one minute and the abandonment rate is around five percent.
- Decision Making
    - Poor decisions had created a perfect storm and the plan was operationally dysfunctional with departments operating in silos.
    - The plan's operations are now much improved and the implementation of the Health Suites IT system will improve the functionality of all departments.

Mr. Abernathy added that he is overly conservative about the TNE outlook for the future due to the claims backlog and IT systems not functioning properly yet. In addition, there is uncertainty about the advent of the Medi-Cal Expansion (MCE) population. The plan's experience with this population has been that medical expenses are 85 percent of premium while the experience across the state has been less than 85 percent.

Discussion:

Dr. de Ghetaldi asked if there had been a failure of governance, because there were so many issues that should have been seen.

Mr. Abernathy responded that there were a lot of signs of trouble. Management wasn't attuned to some of their own situations, and there was a lack of clear communication to the board.

Dr. Rick Shinto said he was concerned that the current picture of financial health is due to Medicaid expansion money, and wanted to know what the infrastructure will look like once that cash source diminishes. Dr. Shinto also asked if the same provider network remained intact throughout this process.

Mr. Abernathy responded that the provider community in the county has stood by the health plan. He said a mistake was made in advancing payments to out-of-state providers, which has been difficult to recoup. He added that of the $72 million advanced, they have recouped all but $400,000.

Dr. Shinto said the conservators had done a great job on the turnaround, but expressed his concern about the sustainability of the turnaround given the market, positions, and the network of doctors.

Mr. Abernathy responded that having the provider community stick with them really helped. However, member satisfaction has suffered. Adding 35,000 lives on day one, all wanting to get their primary care doctor or change doctors, overwhelmed member services and led to 83 minute wait times.

In addition, there was confusion over ID cards because the Health Suites system had a different number than the Diamond system, which added to the problems.

Dr. Wilson asked how long the plan would remain under conservatorship since it appeared they were in a good place now.

Ms. Rouillard responded the DMHC and the conservator are in the process of stepping back, and that an agreement is under review by the board as to what major milestones need to be met for the conservator to withdraw, such as being at 200 percent of TNE and a successful claims system conversion. She added that a lot of the benchmarks

are close to or are being met, so she is optimistic that the conservator will be discharged by the end of the year.

Ms. Rouillard introduced Scott Coffin, the new Chief Executive Officer (CEO) who started in May. She added that Mr. Coffin is in the process of building his management team, and the board is receiving training on their responsibilities, all of which are key milestones to be met.

Ed Cymerys asked what the biggest risks will be for the plan in the next six to 12 months.

Mr. Abernathy responded that the biggest risk is the successful implementation of the Health Suites system. The Health Suites system was originally supposed to go-live on July 1st, but that has been pushed out to August 1st. He added that while financially the plan is on track, development of the infrastructure and policies and procedures are other risks.

Ms. Pumpian asked how much of TNE growth has been a result of shifting from fee-for-service to capitation.

Mr. Abernathy replied that while he hated to speculate, he estimated that they had saved up to $2 million on an annual basis. He added that this number was just on a Durable Medical Equipment (DME) contract and he believed their contract with Care Core has saved the plan similar amounts of money. He said that he also believes medical management protocols have created behavioral change.

Betsy Imholz congratulated Mr. Abernathy on the positive direction of the plan, and asked if the silo problems with the IT systems, claims system, and provider directory system had been addressed.

Mr. Abernathy explained that the silo problem is complex because it is ingrained in the culture. They have convened weekly meetings to include middle management to encourage communication. He added the IT silo is the biggest challenge because it requires the provider directory and relationship with providers to be in the system correctly.
Ms. Imholz asked what the plan is doing to check in with members as they progress to make sure they are also feeling the positive benefits of the changes the plan has made.

Mr. Abernathy said the plan received much higher satisfaction ratings on a recent DHCS survey than anticipated. He also stated that since other departments typically recruit staff from member services and leave that department under- staffed, they have instituted a policy that other departments can't hire from member services until a person has been there at least a year. They are also doing secret shopper calls, and have plans to survey the membership for feedback.

Ms. Kelch asked how the plan is working to align the FQHCs with hospital providers in the county in terms of their availability to consumers.

Mr. Abernathy replied that FQHCs are their primary source for Primary Care Physicians (PCPs) and will continue to be. He added the alignment of a particular clinic to a hospital isn't as well-defined as one would like since practice patterns vary widely and it will require the plan to learn new ways to work with providers.

5) Medi-Cal Rate Setting

Meredith Wurden, Assistant Deputy Director, Healthcare Financing, from DHCS, said the Department has seen incredible growth in the managed care program in the last few years and currently sets rates for contracted health plans that serve 80 percent of Medi-Cal beneficiaries and represents $37 billion in reimbursement annually.

Ms. Wurden provided an overview of the rate setting process, including how the Department works with Federal partners, the data used for rate setting and the data adjustments that are made.

- Overview
    - The goal of the rate setting process is to align health plan's contracted risk with the capitated payment and to promote quality and efficiency.
    - Health plan experience is used to develop rates, when available. For newer populations or plans, data from other state's or fee-for-service is used.
    - Rates are typically county specific with some exceptions such as the rural expansion counties.
    - The Department has convened several workgroups to work closely with the plans on the rate setting methodology for new populations and programs.
    - Historically, plans have had different rating periods, but last year they all moved to the State fiscal year, which has helped to streamline the processes and procedures.
- Federal and State Rate Setting Requirements
    - Federal regulations require all health plans to be actuarially sound.
    - The Department uses a contracted actuary, Mercer, to review the plan's documentation and actuarial certification that supports the rate development, including base data, trend information and other assumptions.
    - The Centers for Medicare and Medicaid Services (CMS) also review health plan contracts during the annual rate setting process and anytime there is a rate update.
    - In June 2015, CMS issued a proposed rule that includes sweeping changes to requirements for rate setting, contract processing and network adequacy

for Medicaid Managed Plans. DHCS is currently responding to the proposed rules, comments are due on July 31.

- Data Used for Rate Development
    - Primarily use health plan specific rate development cost information submitted by the plan through the Rate Development Template (RDT).
    - Increasingly able to rely on encounter data as it becomes more robust.
    - Rely on health plan financial statements submitted to DHCS and DMHC to check for reasonableness.
    - In cases where there is no individual health plan data, fee-for service data or other program data is used. For example, for the Coordinated Care Initiative (CCI), they used a combination of health plan data and fee-for-service data from Long Term Support Services (LTSS). This included home and community based care, long-term care and other health plan experience.
    - Ms. Wurden reviewed the main Categories of Aid (COA) and Categories of Service (COS), which are aggregated and reviewed for trends and reasonableness.
- Base Data Adjustments
    - Base data is typically 2 years old when it is received from the plans, so adjustments are needed to bring it up to the rating period, including:
        - Smoothing for less credible population groups.
        - Applying program changes when the base data does not capture program changes that have occurred in the two years since the data was reported and should be assumed for the rating period. Examples include:
            - Inclusion of Community-Based Adult Services (CBAS)
            - Annual LTC rate increases
            - AB 97 Provider payment reduction
            - Blood Factor Drug Carve-Out
            - Hepatitis C Carve-Out
            - Mid-level mental health services incorporation into managed care
    - Once adjustments are made, rate cells are created for population categories of eligibility, age, region, and risk adjustments.
    - Currently, the rate development includes two efficiency adjustments for pharmacy purchasing practices, known as Maximum Allowable Cost (MAC) pricing adjustment and Potentially Preventable Hospital Admissions (PPA).
    - In addition, for the two-plan and Geographic Managed Care (GMC) health plans, risk adjustment is applied to account for different risk associated with

health plan experience. There is no risk adjustment for the County Organized Health Systems (COHS) since they are the only plan in the county.

- The amount of risk adjustment has increased since 2009-10 and in 2015-16, currently 50 percent was risk adjusted.
- Risk adjustment is done using a program called Medicaid RX, which looks at pharmacy claims to assess the varying levels of risk in acuity of the members.
- Various other risk mitigation strategies are incorporated into rate development, including the following supplemental payments:
  - Maternity.
  - Hepatitis C to account for the high cost of drugs, like Sovaldi.
  - Behavioral health treatment as it relates to autism services.
- There are two age bands for the supplemental payments, zero to six and seven to 20.
- Other risk mitigation strategies include:
  - Optional expansion risk corridors, or Medical Loss Ratio (MLR) corridors, based on medical expenditures compared to net capitation payments. Plans with a ratio of 85 percent or below would make a remittance to the Department and a plan at 95 percent or above would receive an additional payment.
  - Time limited risk corridor for the Coordinated Care Initiative (CCI) to account for the uncertainty regarding utilization of services.
  - Rate recasting methodology for full dual beneficiaries

- Rate Range Program
  - In addition to the regular rate setting program, the Department also has a "rate range" Program where the actuary sets rates and certifies them at a certain rate range. The Department will typically pay on the lower end of the range.
  - The lower and upper end of the rate range varies based on profit, administration and contingency factors.
  - To achieve reimbursement at the higher range, public entities can participate in the rate range program to provide the non-Federal share through an intergovernmental transfer (IGT) to increase the capitation rates to the upper end. For most rate range arrangements, the transferring entity is also assessed a 20 percent administrative fee.

Discussion

Mr. Cymerys thanked Ms. Wurden for the presentation and asked her to clarify whether when she used the term “capitation” she meant capitation to health plans as opposed to providers.

Ms. Wurden said she meant capitation to the health plans.

Mr. Cymerys asked if the Department was looking at encounter data to see if the capitation to the provider is adequate compared to the fee-for-service schedule. He asked whether there is oversight of the capitation payment to the providers and if it is adequate to keep the provider groups solvent and the system functioning.

Ms. Wurden responded that the federal government is increasingly requiring them to look at encounter data. However, the Department typically does not get involved in the contracts between the health plans and the providers. As they set health plan rates, they look at the underlying utilization and cost based on encounter data.

Dr. de Ghetaldi said that the Integrated Healthcare Association (IHA) has moved from using risk adjustment to diagnosis-related grouping in the commercial HMO population because it is a better indicator of variation of population risk. He believes it is probably a simpler tool in the commercial HMO population.

He also commented that there is huge variation in the TNE across plans, and that he thinks this variation is reflective of how well organized local delivery models are across the continuum between the FQHC, the independent specialists, and the hospitals. He expressed concern that using actuarial experience was penalizing the more efficient delivery models in the rate setting process.

Ms. Wurden said the Department appreciates the opportunity to have conversations about refining the rate setting methodology, but at this time they are continuing to use Medicaid Rx risk adjustment. They are always open to considering better tools, but any changes would need to be discussed with the health plans. She added that the Medi-Cal 2020 waiver could allow the more efficient plans to realize those efficiencies.

Dr. Wilson noted that his organization is operating in several states and California is the only state that uses the pharmacy risk adjustment methodology. IHA and CAPG found that in the Medi-Cal population a large number of prescriptions go unfilled, so it’s not an accurate reflection of the population’s disease burden. He added that looking at different methodologies would be beneficial.

Ms. Wurden agreed and reiterated that it is something they are continuing to look at, but would have to be discussed with their health plans before any changes were made.

Ms. Pumpian asked about plans whose population is more than 50 percent Medi-Cal enrollees and whether these plans have the resources when there is a retrospective adjustment they need to pay back. She added that TNE is calculated based on the

costs they have today and does not necessarily consider having set up adequate reserves for these kinds of adjustments.

Ms. Wurden responded that the MLR risk corridor is specific to the optional expansion population and is time limited to two phases. The initial phase is for the 18 month period of January 1, 2014 to June 30, 2015 and the second phase is the 2015-16 fiscal year from July 1, 2015 to June 30, 2016. Ms. Wurden added that there has been a downward trend in expansion rates and the recent release showed a statewide reduction of about 19 percent from prior rates.

She explained that for the initial 18 month period, rates were set in six month increments given the uncertainties and the 2015-2016 period will be an annual rate. They have been in close conversation with health plans about the impact of those revenues to their financials and their ability to pay back revenues. She believes the plans are in a good place, but they will continue to have conversations with the plans.

Mr. Cymerys asked what percentage of births in California are funded by the Medi-Cal program to understand how important the supplemental maternity payment is.

Ms. Wurden replied that a high proportion of births are in the fee-for-service program.

Ms. Imholz asked if there is anything particularly problematic or exciting in the CMS guidance that DHCS is currently commenting on.

Ms. Wurden explained that they were still reviewing the guidance but it is a comprehensive regulation with a large number of updates since 2002. The timing for some of the requirements will be particularly challenging for California. They are looking closely at the requirements for providers and program integrity.

Linda Nguy from the Western Center on Law and Poverty asked if there are plans to publicize the data for encounter utilization claim data.

Ms. Wurden responded that they already use encounter data and are working with the plans to improve and standardize the data reporting. She added that they continue to work to make the data more robust and usable for various rate development processes. The pharmacy encounter data is one of the most robust and used significantly in their risk adjustment processes.

6) Department of Health Care Services 1115 Waiver

Hannah Katch, Assistant Deputy Director, Healthcare Delivery Systems, from DHCS, provided an overview of the 1115 Waiver. She stated that her slides were from a larger slide deck available on the DHCS website along with the actual waiver application.

Ms. Katch said that the 2010 Medicaid Waiver, called the “Bridge to Reform Waiver”, was really about California fully embracing the Affordable Care Act. Over the last five

years, there has been a 50 percent reduction in the uninsured rate in the state. The entire Medi-Cal Managed Care Program is in the current 1115 Waiver, which includes about 82 percent of beneficiaries.

She explained that 1115 waivers are agreements between states and the Federal Government to allow flexibility in how the states run their Medicaid program. The Department is in the process of renewing the 1115 waiver.

Ms. Katch reviewed the chart showing the decrease in uninsured and increase in Medi-Cal enrollment. Currently, the Medi-Cal program serves approximately 12.5 million Californians, or one in three Californians. The program has experienced significant expansion since 2013, adding about 3.3 million individuals.

She said that while the 2010 Waiver was about expanding the Medi-Cal Managed Care Program to all 58 counties and sustaining the critical role of the safety net, the next waiver, known as Medi-Cal 2020, is the next phase of the ten-year effort to transform the Medi-Cal program. The goal of Medi-Cal 2020 will be to improve quality and access to care by ensuring long-term sustainability of the program.

The Department began a robust stakeholder process in fall of last year to get input on priorities, goals, and strategies to achieve those goals. She added that this process culminated in the submission of their application to CMS at the end of March. They are in conversations with CMS about the proposal, but it is unclear what will be approved in the final waiver.

Ms. Katch provided the following overview of the core goals, metrics, and the six core strategies to achieve the goals:

- Core Goals:
    - Improve health care quality and outcomes for the Medi-Cal population.
    - Strengthen primary care delivery and access.
    - Build a foundation for an integrated health care delivery system with the right incentives.
    - Address social determinants of health and improve health care equity.
    - Use the Medicaid Program to test innovative approaches to whole-person care.
- Waiver-wide Performance Metrics:
    - Reducing the volume of preventable events
    - Improving access to timely care
- Six Delivery System Transformation and Alignment Programs

1. Managed Care Systems Transformation & Improvement Program to align incentives for the health plans and to share savings between State and health plans to incentivize plans for providing more efficient care.
    - Specific metrics to measure strategies that lead to efficiencies while maintaining or improving the health quality of members.
    - Integration of behavioral health with physical health services, including mental health and substance abuse disorder services.
    - Standardize pay-for-performance strategies
2. Fee-for-Service (FFS) Transformation & Improvement Program to improve the value of the care provided and to align incentives to provide the right care at the right time. Incentives will be focused on the areas with the largest fee-for-service population, maternity care and dental care.
3. Public Safety Net System Transformation & Improvement Program builds on the success of the 2010 delivery system incentive pool and continues the quality improvement strategies in designated public hospitals and expands to include non-designated public hospitals.
4. Workforce Development Program to expand the healthcare workforce that serves Medi-Cal, including:
    - Incentives for providers who historically have not provided care to Medi-Cal beneficiaries and additional incentives to providers who serve Medi-Cal to increase their capacity.
    - Attract workforce that is culturally and linguistically competent.
5. Increased Access to Housing and Supportive Services Program aimed at improving care coordination for health system beneficiaries who are experiencing or at high risk of homelessness. These individuals are likely to be very high cost and not accessing the appropriate healthcare services. This strategy would encourage partnerships with plans, counties, housing authorities, community-based organizations and others serving these individuals.
6. Regional Integrated Whole Person Care Pilots to allow greater flexibility for counties to achieve the goals of the waiver in their own way.

In addition to the six core strategies identified above, Ms. Katch reviewed the Public Safety Net System proposal, which would unify the payment structure to Disproportionate Share Hospitals (DSH) and the Safety Net Care Pool (SNCP) to a global budget for all uninsured services with incentives for providing coordinated upstream care.

Ms. Katch stated that she provided additional information regarding the State-Federal Shared Saving and Reinvestment proposal in her presentation, which would garner significant savings for both the state and federal government.

The Medi-Cal 2020 waiver requests $2 billion per year for five years. The Department will be working with CMS on an evaluation design that incorporates lessons learned from the 2010 waiver.

Discussion:

Dr. Shinto asked how the Department will prioritize the implementation of the strategies. He also asked how the Federal Government looks at an application like this with so many different projects.

Ms. Katch replied that it is unknown how many of the strategies will end up in the final waiver and some will be implemented at the county level or by the plans and providers. They also have the authority to pilot test some of the strategies so they won't necessarily be implemented statewide.

Dr. de Ghetaldi stated he appreciated the comment on syncing up the various pay-for-performance measures across the Medi-Cal plans. He encourage DHCS to work with IHA, who has done work on this with the commercial HMO population, including adding the patient experience as part of the value report card and focusing on the components of waste that exist in the delivery model.

Ms. Katch acknowledged that they have received great feedback from IHA and look forward to continuing to work together.

7) Updated Financial Summary of Local Initiative Health Plans and County Organized Health Systems

Gil Riojas, Deputy Director of the Office of Financial Review, reviewed the changes to the Financial Summary Report of Local Initiative (LI) Health Plans and County Organized Health Systems (COHS) from the report that he presented at the March 18 FSSB meeting. The changes were made in response to a request from the Board to modify a few items. The changes included adding the combined per member per month (PMPM) medical expenses with the PMPM premium revenue and excluding the pass-through amounts that were previously included in the expenses and revenue.

Mr. Riojas stated that when the pass-through expenses were removed, the majority of the plans saw a significant decrease in both PMPM medical expenses and premium revenue.

Discussion:

Ms. Pumpian asked why some counties did not have pass-through expenses.

Mr. Riojas replied that it may be a function of how they report the numbers. Some plans may report pass-through expenses on their balance sheet instead of an income

statement or it could be timing. He added that depending on where the pass-through expenses is reported, it may not be reflected in the premium revenue amount.

8) Acquisition of Care1st Health Plan by Blue Shield of California

Ms. Rouillard provided an update on the acquisition of Care1st Health Plan by Blue Shield of California. She said in March, two events came to the public light relevant to the acquisition of Care1st Health Plan by Blue Shield of California. First, the Franchise Tax Board revoked Blue Shield's tax exempt status as of August 2014. The second was Blue Shield's proposed purchase of Care1st for approximately $1.2 billion.

Ms. Rouillard added that while DMHC had been reviewing the proposed transaction since January, the spotlight on these two issues prompted significant public interest in the Department's review of the transaction. In response, the DMHC held a public meeting on June 8th to give the public an opportunity to comment on what the Department should consider in its review of the transaction.

Ms. Rouillard summarized the DMHC's authority in reviewing such transactions and explained that while most non-profit corporations are governed under the Attorney General's Office, the DMHC has sole jurisdiction over non-profit health care service plans to determine if there are assets subject to a charitable trust obligation.

Ms. Rouillard added that Article 11 of the Knox-Keene Act describes the rules that non-profit health plans must follow when restructuring or converting their activities from non-profit to for profit. If a non-profit wishes to restructure or convert itself to for profit, the plan must obtain DMHC approval prior to the restructure or conversion. She noted that a fundamental question in this transaction is whether it is a restructuring or a conversion.

Ms. Rouillard said Article 11 applies to restructuring or conversion of a non-profit only to the extent that the plan has held or currently holds assets subject to a charitable trust obligation. Whether or not Blue Shield has assets subject to charitable trust obligation is a legal question based on facts that are currently in dispute. One purpose of the June 8th meeting was to solicit public comment for consideration in making this determination. In addition, DMHC has been consulting with the Attorney General's Office and other concerned individuals, but has not yet made a determination as to whether Blue Shield has assets subject to charitable trust obligation.

Ms. Rouillard noted she was pleased that the Chief Executive Officers of Blue Shield and Care1st came to the meeting to speak about the benefits for the community, for the plan, the State, and their members. There were quite a few speakers who gave important and comprehensive comments and additional comments were submitted through June 12.

Ms. Rouillard stated this is an extremely complex transaction, and promised that the Department would look deeply into this and the many issues that raised by the

stakeholders. She added that because of the complexity of the issue, there is not a timeline for when this transaction will be final, but acknowledged that many people at the Department are working on this complicated matter, including staff from licensing, legal services, and financial review.

Discussion:

Ms. Imholz said that while she missed the public meeting, Consumers Union was represented and thanked the Department for the opportunity to have a public conversation about it. She added that these are complicated transactions and she believed Article 11 was written to ensure a public process is in place for when these kinds of transactions occur because there wasn't a good law in place at the time of the Blue Cross conversion.

Ms. Imholz added that Consumers Union does believe Blue Shield holds a charitable trust obligation and urges the Department to take a close examination to adopt that view as well. She reiterated her appreciation for the process so far.

Tam Ma of Health Access California thanked the Department for holding a public meeting and giving the proposed transaction careful scrutiny. She agreed with Ms. Imholz's comment that Blue Shield has a charitable trust obligation.

Ms. Ma encouraged the Board to be vigilant in ensuring Blue Shield maintains sufficient reserves to meet its existing and new obligations, should the transaction be approved. She added that the Board and the Department should pay specific attention to Blue Shield's obligation to provide an adequate network and information about its networks, as there have been numerous consumer complaints about access to network physicians. She added DMHC has found significant inaccuracies in Blue Shield's provider directory in the past.

Ms. Ma stated they don't think the transaction should be approved unless Blue Shield meets its obligations to existing enrollees with regard to network adequacy. She encouraged the Department to ensure Care1st's networks are adequate given the State Auditor's recent findings about the adequate monitoring of Medi-Cal Managed Care Plans. She believes Blue Shield has more than adequate reserves to assure network adequacy for existing enrollees and any new enrollees they take on as a result of this transaction.

Mr. Cymerys commented that given the Wall Street Journal's report about all the merger activities going on, this is good practice for what the Board and DMHC will be looking at down the road.

9) California State Auditor Medi-Cal Provider Network Audit

Gabriel Ravel, General Counsel, provided a summary of the California State Auditor's Medi-Cal Provider Network audit. DMHC reviews both Medi-Cal and commercial plans'

provider networks for adequacy as part of its oversight of health plans. This includes an initial review for new licenses, when there is a change in provider network or service area, and an annual review of the network and performance under the Department's timely access standards.

In addition to this review, DMHC is required by statute to contract with DHCS to perform quarterly network adequacy reviews for Medi-Cal Managed Care Plans. Mr. Ravel said DMHC is also required to conduct on-site surveys of licensed health plans at least once every three years.

In August 2014, the Joint Legislative Audit Committee directed the California State Auditor to perform an audit of the Medi-Cal Managed Care Program to determine whether DHCS and DMHC have an appropriate framework of oversight and guidance in place to ensure that managed care plans have adequate provider directories and an adequate network of providers to serve Medi-Cal beneficiaries.

Mr. Ravel explained that the DMHC Office of Plan Licensing, Network Division, as well as the Division of Plan Surveys, worked closely with the auditors to provide the depth of information necessary to complete the audit.

The final audit report was released on June 7 and included two findings regarding DMHC. First, delays in executing an interagency agreement with DHCS prevented DMHC from performing all quarterly assessments of health plan provider networks for the Medi-Cal plans. Second, DMHC and DHCS can more efficiently fulfill their overlapping responsibilities with respect to audits of the Medi-Cal plans.

Mr. Ravel said the State Auditor had two recommendations based on these findings. First, DMHC should perform the additional quarterly reviews of provider network adequacy under that interagency agreement with DHCS, beginning with the first quarter of 2015. Second, DMHC should complete its planned assessment of the extent to which it can rely on DHCS's annual audit work in order to improve collaboration and minimize overlap in duties.

Mr. Ravel stated the DMHC agreed with these recommendations as noted in its formal response to the audit report and has been working to address these issues even before the findings were released.

Mr. Ravel stated that under the interagency agreement with DHCS, starting in 2011, the DMHC has conducted quarterly reviews of the 30 counties that participated in the enrollment of Seniors and Persons with Disabilities (SPD) into managed care. DMHC also includes an overall evaluation of the availability of providers and their impact on access for all Medi-Cal enrollees as part of its quarterly assessment.

DMHC entered into another interagency agreement with DHCS in June 2014 to perform assessments on the other 28 counties for DHCS, and performed assessments for Medi-Cal plans servicing all counties for the first quarter of 2014. However, due to staffing

issues and a delay in executing the interagency agreement, the Department was unable to resume those reviews until the first quarter of 2015.

Mr. Ravel also noted that although quarterly review of the 28 counties did not take place in quarters two, three and four of 2014, as required by the interagency agreement, DMHC did continue its full network reviews under the Knox-Keene Act and thus all Knox-Keene licensed plans, including Medical Plans, in those 28 counties were subject to complete DMHC network reviews. These counties were also reviewed in 2013 as part of the Healthy Families Program transition to Medi-Cal, and their networks are reviewed annually as required under SB 964.

In regards to the second finding, Mr. Ravel said DMHC is required to perform on-site surveys for all plans at least once every three years. DHCS is also required to perform outside audits of all its contracted Medi-Cal Managed Care plans once per year. The auditor recommended that DMHC complete an assessment not later than December 2015 to determine the extent to which DMHC can rely on DHCS's annual audit findings where there is overlap in the elements that are reviewed. Mr. Ravel acknowledged that there is overlap in areas such as access to care, utilization management, grievance and appeals and quality of care.

The two departments have been coordinating surveys for several years, including developing the scope of the audit, on-site logistics, audit activities and sharing findings. Mr. Ravel stated that DMHC is assessing DHCS's processes and reports to determine where it can rely on DHCS's audits to use resources more efficiently and avoid duplication.

Discussion:

Ms. Imholz stated this is an important audit and the findings, most of which do not relate to DMHC, are important and unsettling. She stated that a worthy goal was to ensure the deep quality of the audits, particularly given the finding about the Ombudsman Office and phone system difficulties. DHCS is trying to address the huge number of complaints that never made it through the system. She asked DMHC to work with DHCS since the HMO Help Center is a rich resource of information about consumer problems

Dr. de Ghetaldi stated he appreciated the tone of DMHC's acknowledgment that there is a gap the Department is working to close. He added that 2014 stressed capacity for all patients in California, especially Medi-Cal beneficiaries. He encouraged the Department to measure the network adequacy and accuracy for the Medi-Cal delivery system as it has done with Covered California and the commercial HMOs.

Dr. de Ghetaldi asked if the five COHS exempt from Knox-Keene licensure for the Medi-Cal line of business are exempt from DMHC oversight.

Ms. Rouillard responded that they are exempt for Medi-Cal lines of business, but not for other lines of business. Mr. Ravel added that one voluntarily obtained a license.

Ms. Kelch asked if SB 964 requires the two departments to coordinate their audits of the networks.

Mr. Ravel explained there was a provision in SB 964 that specifically removed the deeming clause, which previously stated that DMHC could rely entirely on DHCS's audits, which is no longer the case. He added there is still a provision that allows DMHC to rely on specific areas of the audit performed by other entities.

Ms. Ma stated that the audit confirms long-standing concerns that Health Access has had about access and oversight in the Medi-Cal Managed Care Program. Health Access sponsored SB 964 last year to address such issues and appreciates the DMHC's implementation of SB 964. She added that they are co-sponsoring SB 137 this year with Consumers Union and the California Pan Ethnic Health Network (CPEHN) to require health plans to have accurate and updated provider directories.

Brett Johnson from the California Medical Association (CMA) asked if DMHC has looked into ways to automate the process of assessing the accuracy of data upon which network adequacy is assessed. He added that CMA had proposed solutions that would reduce the administrative burden of secret shopper calls and other labor intensive methods.

Ms. Rouillard stated that since the bill is still pending, there hasn't been specific work around how to verify the accuracy of the directories. She added that if the bill passes, the Department will develop some new processes and will automate the process as much as possible. Ms. Rouillard said the CMA members also need to update their information.

Ms. Nguy asked if the interagency agreement to audit the additional 28 counties was specific to primary care or did it also look at specialty care.

Ms. Rouillard responded that it includes the entire network.

10) County Organized Health Systems Licensure

Ms. Rouillard stated that SB 260 (Monning) was recently amended to repeal the COHS exemption from licensure under the Knox-Keene Act. The bill was amended a few weeks ago, and while DMHC has no official position on the bill, the staff is providing technical assistance.

Discussion:

Ms. Ma stated that Health Access strongly supports SB 260 and thanked Senator Monning and the Western Center on Law and Poverty for sponsoring and carrying the

bill. She added that they want the 2 million consumers in COHS plans to have the same level of protection as those consumers in plans currently regulated by the Knox-Keene Act, including compliance with network adequacy requirements, access to Independent Medical Review (IMR), better grievance and appeal procedures, access to the HMO Help Center, protection from balanced billing for emergency care, and continuity of care protections. She believes the bill will provide greater equity for consumers across the Medi-Cal Managed Care plans and give the state better oversight.

11) Provider Solvency Quarterly Update

The Provider Solvency Quarterly Update was provided in advance. Ms. Pumpian asked the Board members and audience if there were any questions. There was none.

12) Health Plan Quarterly Update

The Health Plan Quarterly Update was also provided in advance. Ms. Pumpian asked the Board members and audience if there were any questions. There was none.

13) Draft Meeting Schedule for 2016

Ms. Rouillard asked Board members to check their calendars for the proposed FSSB meeting dates in 2016, and to let the Department know if any adjustments needed to be made.

The next meeting is scheduled for September 9, 2015, followed by December 9, 2015.

14) Public Comment on Matters not on the Agenda

Ms. Pumpian asked for public comment on items not on the agenda. There was none.

15) Agenda Items for Future Meetings

There were no suggestions for future agenda items.

16) Closing Remarks/Next Steps

The meeting was adjourned at 12:39 p.m.