



**Financial Solvency Standards Board (FSSB) Meeting
November 8, 2012
Meeting Notes**

FSSB Members in Attendance:

Chairperson Keith Wilson, President and CEO, Talbert Medical Group
Grant Cattaneo, CEO and Founder, Cattaneo & Stroud
Edward Cymerys, Senior Vice President and Chief Actuary, Blue Shield of California
Larry deGhetaldi, M.D., Palo Alto Medical Foundation
Deborah Kelch, Independent Consultant
Dave Meadows, Senior Vice President of Government Programs, LIBERTY Dental Plan
Ann Pumpian, Senior Vice President and CFO, Sharp HealthCare
Richard Shinto, M.D., Aveta Inc.

DMHC Staff Present:

Steven Babich, Supervising Examiner, Division of Financial Oversight
Gary Baldwin, Assistant Chief Counsel, Division of Licensing
Dennis Balmer, Deputy Director, Financial Solvency Standards Board
Shelley Rouillard, Chief Deputy Director
Maureen McKennan, Deputy Director, Plan and Provider Relations
Michelle Yamanaka, Manager, Provider Solvency Unit

Panel Members:

Jennifer Jackman, Monarch HealthCare
Keith Pugliese, Brown & Toland
Rick Martin, Heritage Provider Network
Karen Gee, PrimeCare
Ann Pumpian, Senior Vice President and CFO, Sharp HealthCare

1) Welcome

Keith Wilson, FSSB Chairperson, called the meeting to order and welcomed attendees. He informed attendees that Shelley Rouillard, Chief Deputy Director of Department of Managed Health Care (DMHC) would be filling in for DMHC Director Brent Barnhart for this meeting.

2) Opening Remarks

Ms. Rouillard informed the FSSB that the DMHC received a letter from an organization named Our SALUD and that Our SALUD would be at the meeting to present to the FSSB. She reminded the FSSB that since the Our SALUD wanted to discuss items not on the agenda, under the Bagley-Keene Act, the topic could not be discussed among the FSSB or with the presenters. The only context in which the topic could be discussed is whether or not to agendize it for a future FSSB meeting.

3) Minutes from August 9, 2012 FSSB Meeting

The board approved the minutes from the August 9, 2012 meeting with the correction that Ann Pumpian was not present.

4) DMHC Accountable Care Organization (ACO) Update

Gary Baldwin, Assistant Chief Counsel, Division of Licensing, provided an update on Accountable Care Organizations (ACO) and the DMHC's oversight of them as it pertains to the Medicare ACOs that are contemplated under the Affordable Care Act (ACA).

Mr. Baldwin noted that there are generally two types of Medicare ACOs: the Medicare Shared Savings Program ACOs and Pioneer ACOs.

Medicare Shared Savings Program compensates providers on a fee-for-service basis. There is no prepaid or periodic payment involved, so it does not fit the definition of a healthcare service plan. In the Pioneer ACO Program, in years one and two providers are compensated on a fee-for-service basis and there is no prepaid or periodic payment. In year three, the program includes a population-based payment, which could be a prepaid or periodic payment that could trigger licensure.

Mr. Baldwin also reiterated that the SB 260 solvency criteria for risk-bearing organizations applies to entities that contract with a health plan or provide services to health plan enrollees. The SB 260 solvency criteria would not apply to Pioneer or Medicare Shared Savings ACOs since those entities do not contract with a health plan and the enrollees are not health plan enrollees.

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

5) California Pioneer ACOs: Presentations and Panel Discussion

Presentation: [Comparison of Medicare ACO Payment Models](#)

Jennifer Jackman, of Monarch Healthcare, presented a comparison of the payment models of the Medicare Shared Savings ACOs, overseen by the Centers for Medicare and Medicaid Services (CMS), and Pioneer ACOs, overseen by the Center for Medicare and Medicaid Innovation (CMMI).

Discussion:

Edward Cymerys asked if there are different incentives for effectively managing the different populations' health.

Ms. Jackman responded that the differences are tremendous. Medicare fee-for-service beneficiaries cannot have their care restricted nor can they be subjected to utilization management where patients are assigned to a primary care physician to direct their care.

Mr. Wilson asked for clarification on the payment methodology for Pioneer ACOs.

Ms. Jackman responded Monarch has 800 primary care physicians in its group, but only 300 in the ACO. It's a small panel of providers and no hospitals. A smaller panel of primary care providers, actively engaged does a good job at managing the ACO population. The ACO would only receive the payments that doctors earned in the previous year for their ACO patients. According to Medicare, about 70 percent of the Medicare fee-for-service population might become aligned with the ACO in the primary care practice. Services for which the ACO or the doctor would be prepaid are only those services that those patients used in the doctor's office.

Larry deGhetaldi asked how the increasing risk of an aging population and changing fee schedules will be accounted for.

Ms. Jackman responded that Medicare has built in fee protections and if there are dramatic programmatic changes, such as to the Medicare fee schedule, CMS reserves the right to adjust the financial model. And with regard to an aging population, the way the ACO is protected is Medicare compares one ACOs population expenses to a reference population. If the population is aging, it's aging all across the country, so everybody's expenses will increase. Monarch has seen this in some of the modeling; each year the expenses increase. The goal is to have expenses go up at a lower rate than the country's. That's where the potential is to make this model profitable.

California Pioneer ACOs Presentations:

[PrimeCare](#) Karen Gee

[Brown & Toland Physicians](#) Keith Pugliese

[Sharp](#) Ann Pumpian

[Heritage](#) Rick Martin

[Monarch HealthCare](#) Jennifer Jackman

A representative of each of the five California Pioneer ACOs on the panel provided a brief presentation on their ACO focusing on organization overview, strengths, goals, challenges and opportunities.

Panel Discussion

Dennis Balmer, Deputy Director, FSSB, opened a panel discussion on the shared experiences of the California Pioneer ACOs by asking what is the biggest obstacle facing a Pioneer ACO.

Keith Pugliese responded that for Brown and Toland, communicating with patients who have little knowledge of their organization has been a challenge. When dealing with patients, instead of identifying as a representative from Brown & Toland, they identify as a case manager working on behalf of an enrollee's doctor. In addition, there are information technology challenges in dealing with CMS data that is much different than HMO data.

Mr. Balmer then asked the panel what advice they would give to organizations that don't have as much experience providing managed care.

Karen Gee, of PrimeCare responded it is very important to have an established provider network that's engaged.

Ann Pumpian responded that organizations should not minimize their information technology needs.

Richard Shinto asked the panel if the Pioneer ACOs have considered common data warehousing.

Ms. Jackman responded that she does not think the California ACOs have started sharing data, but CMS has a Data Analytics Action Group which shares best practices. She added that organizations need to be prepared to move forward without the kind of quality data they have on HMO patients.

Mr. Shinto commented that the Pioneer ACOs should create a data warehouse with certain templates and metrics that are common to gain consistency.

Mr. Pugliese commented that California is somewhat advantaged in having the delegated model infrastructure to build upon.

Mr. Wilson asked if the panel anticipates any other Pioneer ACOs coming to fruition within the state.

Ms. Pumpian responded that there will be no additional Pioneer ACOs as it is only a five year program.

Mr. Pugliese commented that the Shared Savings Program is open. The first applicants started on April 1, the second wave on July 1, and thereafter every January 1.

Mr. Balmer then asked the panel if they see the Pioneer ACO experience translating to commercial business.

Mr. Pugliese responded yes, because Brown & Toland has worked hard to achieve clinical integration and have started implementing that in the commercial PPO realm.

Ms. Jackman responded that Monarch had a commercial PPO ACO before they had the Pioneer ACO agreement.

Ms. Pumpian responded that Sharp participates in two commercial ACO plans.

Karen Gee responded that PrimeCare launched a commercial ACO product with Aetna.

Mr. Balmer then asked the panel what the overall enrollee response been to the ACO experience.

Rick Martin responded that Heritage has performed a lot of patient outreach, and once enrollees are educated about ACOs, they are receptive.

Ms. Pumpian responded that some of their beneficiaries are yearning for a connection. Sharp has had a hundred beneficiaries with five or more hospital admissions in one year, all of them through an emergency department. These individuals are looking for someone with whom to connect. This can drive a different outcome that is less expensive.

Mr. deGhetaldi asked the panel if they are prohibited from marketing to these enrollees.

Ms. Pumpian responded affirmatively.

Ms. Jackman commented that Monarch has found some patients in its ACO who had been in a HMO product years ago and chosen to get out of that model. This gives these patients another opportunity to have better coordination of care.

Mr. Balmer then asked the panel what they need from State and Federal regulators.

Mr. Martin responded that with regard to licensure, if an organization takes institutional risk it needs to have a license, or a limited license. He added that Pioneer ACOs are financially strong. However, regulators should be concerned about the Shared Savings ACOs.

Mr. Pugliese responded that with Pioneer ACOs there is no health plan involved. It's a government program, so there is no need for DMHC involvement or licensure.

Ms. Pumpian responded that with the Pioneer ACOs timeframe is constrained, if the Pioneer ACOs are required to get a Knox-Keene license, they have to complete the process prior to January 1, 2014.

Mr. Balmer opened up the panel to questions from the FSSB.

Mr. Cymerys asked the panel for a quick "elevator speech" on the number one advantage for an enrollee who is part of an ACO or how they would pitch an ACO to a prospective enrollee.

Mr. Pugliese said the primary selling points are access to care management programs and health educators.

Ms. Pumpian said individuals want to join the ACO and share data because they can continue to go to any of the doctors they have seen previously, but they also are going to have access to a 24-hour nurse phone line.

Ms. Gee responded ACOs know where enrollees receive care and are able to help coordinate medication. If additional assistance is needed, access to care managers, social workers, and peer educators that can make house calls is available.

Ms. Jackman responded that ACOs provide physicians with data to better coordinate care with the goal of keeping people healthy and at home.

Mr. deGhetaldi then asked Mr. Pugliese if Brown & Toland, based in San Francisco, which enjoys extraordinarily high fee-for-service utilization, can maintain financial viability in a shared savings program year after year.

Mr. Pugliese responded that with 10,000 baby boomers reaching Medicare age each day, there is the possibility that the margin could become thinner.

Mr. Meadows asked hypothetically if everything went poorly and an ACO owed CMS four and a half million dollars and was unable to pay; is CMS the only one that loses money because the doctors have already been paid.

Mr. Martin responded that it depends on how the population-based payment process works, but at Heritage there's no downside risk to the provider.

Mr. Pugliese responded that CMS is starting to develop the population-based payment program. Brown & Toland is at risk as a doctor owned company, but it doesn't want the doctors themselves to be at risk, so their goal is to mitigate risk from the doctors' point of view. However, if Brown & Toland receive shared savings, it distributes it among the participating providers so there's an upside for doctors to participate.

Ms. Gee responded that at PrimeCare there is only upside risk and the physicians are indemnified against any losses.

Ms. Jackman responded that Monarch operates the same.

Ms. Pumpian responded that the Pioneer ACO model requires that physicians receive shared saving payments first. Also, shared savings and losses will be public information. Organizations must post on their websites the amount of any savings or losses incurred as an ACO, and how much of that money was invested in infrastructure versus distributed to physicians.

6) Timely Access Status Update

Maureen McKennan, DMHC Deputy Director of Plan and Provider Relations, provided an update on the DMHC's review of the first Timely Access Reports submitted by health plans. After completing a thorough review of the reports, the DMHC will compile a high-level summary of data that will serve as a baseline report. The DMHC's intention is to identify geographic areas where there are sufficient providers and sufficient networks, and to identify geographic locations where there are challenges such as potential shortages of either primary care physicians or specialists. The report will also include recommendations for moving forward. The main challenge the DMHC faces is that the regulations allow for flexibility in terms of rate of compliance, and because plans weren't required to use one single methodology, it has been very difficult to come up with a rate of compliance that is consistent. The DMHC will recommend that plans use one tool and one methodology for future reports. The DMHC will be working with the Office of Patient Advocate

(OPA), as well as the National Committee for Quality Assurance (NCQA), to ensure that the information included in the OPA report card is accurate.

Discussion:

Mr. deGhetaldi commented that he is concerned that there may be access issues come 2014.

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

Mr. Pugliese asked if the DMHC has considered incorporating the use of physician assistants, medical assistants, nurse practitioners, and medical homes into future Timely Access reports.

Ms. McKennan responded that physician extenders were included in the data collected this year. Medical homes were not included, but could be in future reports.

7) Provider Solvency Updates

Presentation: [Provider Solvency Updates](#)

Michelle Yamanaka, Manager of the DMHC Provider Solvency Unit, provided an update as of June 30, 2012. She commented that the DMHC has eight Risk Bearing Organizations (RBO) that are reporting non-compliance with the solvency criteria, and 177 that are considered compliant with the solvency criteria.

Discussion:

Mr. Wilson invited public questions and comments.

Elba Romo of Our SALUD commented that Health Care Partners Medical Group is operating as a health plan and should obtain a Knox-Keene Act license.

8) Division of Financial Oversight Updates

Presentation: [Health Plan Solvency Updates](#)

Stephen Babich, Supervisor in the DMHC Division of Financial Oversight, provided a brief update regarding the DMHC's oversight of health plans and an update on their financial health. The DMHC regulates 106 active (53 full-service) health plans with approximately 22.5 million people enrolled.

Discussion:

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

9) Public Comment on Matters Not on the Agenda

City of Bell Councilmember Nestor Enrique Valencia commented that Health Care Partners Medical Group is operating as a health plan and should obtain a Knox-Keene Act license. He also said that there are quality of care issues at Health Care Partners Medical Group that need to be addressed. He further commented that the DMHC should remove Dr. Keith Wilson from the FSSB because he is an officer of Health Care Partners Medical Group and holds an impermissible conflict of interest and urged the FSSB to agendaize this issue for a future meeting.

Elba Romo of Our SALUD, commented that Health Care Partners Medical Group is operating as a health plan and should obtain a Knox-Keene Act license.

Mr. Wilson asked if there were any additional public comments. There were none.

10) Agenda Items for Future Meetings

Mr. Wilson stated that he is not an officer of HealthCare Partners, and then recused himself from the room while the FSSB discussed agendaizing Health Care Partners Medical Group for a future meeting.

The FSSB elected not to agendaize this matter for a future meeting.

The following topics were suggested for future meetings:

- Access issues come 2014.
- Healthy Families transition impact on RBO solvency.
- Solvency issues associated with Medi-Cal managed care expansion.
- An update from the Pioneer ACOs.
- A presentation from the Exchange.

11) Closing Remarks/Next Steps

It was suggested a future FSSB meeting be held in Southern California.