DEPARTMENT OF
Managed
HealthCare

Financial Solvency Standards Board Meeting
June 18, 2014
Meeting Notes

Financial Solvency Standards Board (FSSB) Members in Attendance:

Ann Pumpian, Chairperson, Sharp HealthCare
Elizabeth Abbott, Health Access California
Edward Cymerys, Blue Shield of California
Larry de Ghetaldi, The Palo Alto Medical Foundation
Jacob Furgatch, AltaMed Health Services
Dave Meadows, LIBERTY Dental Plan
Shelley Rouillard, Department of Managed Health Care
Dr. Keith Wilson, Molina Health Plan
Deborah Kelch, Alternate, Independent Consultant
Dr. Rick Shinto, Alternate, InnovaCare Health, Inc.
Tom Williams, Alternate, Integrated Healthcare Association

DMHC Staff Present:
Gary Baldwin, Deputy Director, Plan & Provider Relations
Michelle Yamanaka, Manager, Provider Solvency Unit
Gil Riojas, Senior Examiner, Office of Financial Review

1) Welcome

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

2) Minutes from November 18, 2013 FSSB Meeting

Jacob Furgatch made a motion to approve the November 18th FSSB meeting minutes. Edward Cymerys seconded the motion. Meeting minutes were approved with no opposition.

3) Director's Remarks and Introductions

Shelley Rouillard announced that she became DMHC's Director in December. She introduced DMHC's new General Counsel, Gabriel Ravel, who's coming from Covered California. Ms. Rouillard also announced DMHC is very close to announcing a new

deputy director for the Office of Financial Review. The department has also been looking for a deputy director over the Office of Technology and Innovation.

Ms. Rouillard stated DMHC is working hard to implement the federal mental health parity. There's a budget proposal that will enable DMHC to start working more closely with plans on how they're going to demonstrate compliance with the federal law.

Ms. Rouillard explained that the DMHC has embarked on a five-year strategic plan. The plan will include the Department's mission, vision, and goals. It will be DMHC's roadmap for the next five years.

Ms. Rouillard announced that DMHC has started a non-routine survey of Anthem Blue Cross and Blue Shield regarding their provider networks in the individual market. The final report should be released before open enrollment starts on the Exchange.

Ms. Rouillard also announced DMHC has an updated website. She asked everyone to take the survey when they're on the website and give the Department feedback on it.

Discussion:

Larry de Ghetaldi asked if EPO and PPO plans are included in the Covered California network adequacy assessment or just HMO plans.

Ms. Rouillard responded it's all of their product lines.

4) Alameda Alliance for Health Updates

Gil Riojas, representing the Office of Financial Review, provided an update on Alameda Alliance for Health. Due to ongoing deficiencies with their working capital and TNE, and an increasing claims backlog, in May 2014 the DMHC stepped in and appointed a conservator. The plan is to restore Alameda to a firm financial footing, decrease the claims backlog, and then turn it back to local control at the most appropriate time.

Discussion:

Dr. Keith Wilson asked since they were TNE deficient and behind in working capital, how did they get that way.

Mr. Riojas responded there are a number of reasons. They had significant costs associated with their claims processing systems; they were using three concurrent systems to process claims. That was one of the main reasons they got there.

Ms. Rouillard added there were many factors that went into the decline of their financial health. They had some high-cost cases they needed to manage. There were also management decisions made about how to spend money or how to invest it that were not wise. The plan agreed to install a monitor in November. The DMHC has not heard of any problems with access from the enrollees.

Mr. Furgatch asked how many health plan members are involved.

Mr. Riojas responded about 204,000 to 206,000 members.

Ms. Rouillard pointed out about 6,000 members are Medicare and the rest are Medi-Cal.

Mr. Riojas stated in 90 days, the conservator will give us a summary of what they've found and a proposal for going forward.

Ms. Rouillard explained it's not simply a matter of low rates the plan feels they were getting from DHCS, because other Local Initiative plans similarly situated are not having the same problems, at least not that the DMHC is aware of.

Deborah Kelch asked if there was anything suggesting that members in Alameda Alliance should be concerned and move to the other plan.

Ms. Rouillard responded no.

Mr. Riojas added that the goal with the conservator, is not to wind down the plan, but to make sure it continues by getting it back to a healthy state.

Ms. Pumpian raised a concern about getting the plan back to a healthy state and then handing it back to the board, a board that faltered on their obligation and diligence to oversee the plan. Ms. Pumpian asked what could we have done differently, what introspection should we be looking at and how should we examine all plan compliance.

Ms. Rouillard responded one of the challenges is the makeup of the Board. For Local Initiatives, the structure of the board is set in statute. Members are appointed by the county board of supervisors. In the case of Alameda, the board is heavily provider-oriented so two-thirds of the board can't vote on anything related to finances because they have a conflict.

Mr. Furgatch asked if enrollment is frozen or can people continue to enroll.

Mr. Riojas replied they can continue to enroll.

Ms. Abbott said it could carry additional risk if Alameda Alliance was allowed to continue to accept enrollment while experiencing solvency issues. If the plan fails then these consumers would have to transition to another plan.

Mr. Furgatch asked if there are any issues with continued enrollment such as cost of administrative issues or was it just their claims system. He asked if there are other administrative issues going on.

Mr. Riojas replied there are other operational factors that are challenges for them. The conservator is working hard to get those factors fixed.

Mr. Cymerys stated at the last meeting there was concern about the health of local initiatives and COHS and then this tremendous enrollment increase happened in January. Because of what's happened at Alameda, Mr. Cymerys asked if DMHC is looking at the other local initiatives and COHS to see how they're doing.
Mr. Riojas responded yes. The situation with Alameda is a red flag for the department and staff are already looking closer at all the Medi-Cal plans.

Ms. Rouillard added, with respect to COHS, DMHC oversight of them is very limited.

Ms. Abbott asked if TNE is still the right standard or does it need to be reevaluated due to this new experience.

Ms. Rouillard responded that is an evaluation the DMHC will be doing.

Dr. Wilson asked if there are any underlying actuarial factors, patient selection, or funding issues that have led to the demise. His concern is whether other plans may have been inadequately funded. He asked the DMHC if there are lessons learned here that can be used to predict other failures in the state.

Mr. Riojas replied that's something the DMHC is reviewing. For example, comparing the enrollment of Alameda with other plans whether the business type and rates are similar. Another aspect is how plans manage their enrollment compared to Alameda.

Mr. de Ghetaldi explained the two million new Medi-Cal members may not be the same as historical Medi-Cal members. He asked if actuarially the DMHC is predicting the needs of this new two million expansion population properly. That could stress the system even more. Also, Alameda is a dual demonstration county. He asked if this will affect that rollout.

Ms. Rouillard responded the DMHC will get the 90-day assessment from the conservator in early August. Part of their assessment will be the potential of participating in the duals demonstration.

Ms. Pumpian asked if there were any other comments from the audience or from the phone lines. There were none.

5) Delegated Model Update

Bill Barcelona, from CAPG, provided an update on the delegated model including current trends, revenue cuts and continued erosion of employer-sponsored HMO enrollment. He suggested, as we move into next year, that great attention is paid to groups taking on a large number of Medi-Cal Managed Care lives in this environment, given the rates.

CAPG is looking at the historic restricted license and limited license with the Department. It allows a group to subcontract to a full service plan and take both institutional and professional risk. CAPG has proposed to codify the long-standing practice at DMHC. CAPG drafted a model regulation and a statement of reasons

behind the regulation.

Ms. Abbott asked Mr. Barcelona to give a quick assessment of what dire predictions he has and what it means to physicians, health plans and consumers.
Mr. Barcelona responded it revolves around whether or not California wants a delivery system that is incented to provide a coordinated care model for patients. That can be done through a fragmented PPO network, but partial capitation is needed under a fee-for-service structure.

Mr. Cymerys stated he has seen firsthand the benefits that come from the coordinated care model in California. Plans that went ahead with a PPO model in Covered California were solely driven by the urgency and the short time frames. Mr. Cymerys thinks there will be a rapid evolution to that model under Covered California.

Mr. Barcelona agreed.

Dr. Wilson asked if the proposed structure, with financial requirements the same as full risk plans, would accelerate consolidation because only the strong plans or strong groups would be able to meet the requirements.

Mr. Barcelona responded the consolidation has been troubling in the north because there is now much less competition and rates are higher. Rates are lower in the south because there is much more competition. Consolidation has occurred for a variety of different reasons.

Tom Williams asked Mr. Barcelona if he's proposing a regulation to codify an existing practice that seems to have some value, making it simpler to put these full-risk contracts through the approval process.

Mr. Barcelona replied that for the grandfathered entities, it would be streamlining going forward, allowing them to contract more readily the way a health plan contracts for new product lines. For newly formed entities, the purpose would be to create and identify an entity that is not a full-service health plan. From the consumer perspective and from a transparency perspective, an RBO would be elevated to a level that has more consumer protection. He stated from a regulator perspective, this would push transparency equitably and across the entire spectrum of health care in California.

Dave Meadows stated as long as the entity meets all the financial criteria this is a good thing. It gives everybody more predictability, more control, it aligns incentives better, and it works to increase performance, which leads to increased quality. It doesn't bring more dollars into the pot, though. Mr. Meadows added that dollars are really tight and Medi-Cal is under-funded. There are new populations coming in. They're a higher risk, they're a higher cost, they're higher revenue dollars that brings higher PMPM, and that actually increases the reserve levels.

Mr. Barcelona agreed.

Mr. Meadows added that these entities will have to find a way to build capital.

Mr. Barcelona explained how it would change the tax model and stated that's why CAPG is proposing the codified restricted license as a solution, because it allows the entity to capitalize adequately, handle all the consumer protection, and can diversify payer sources.

Ms. Pumpian recommended that everyone, including the audience in the room and on the phone, with questions or alternative ideas should document those questions via e-mail to DMHC, attention Shelley. These questions can then be reviewed at the next meeting.

6) Provider Solvency Updates

Michelle Yamanaka, Supervising Examiner, provided an update on the Provider Solvency Unit and Medi-Cal Risk Bearing organizations that are on corrective action plans.

Ms. Yamanaka's presentation included an explanation of DMHC's Corrective Action Plan (CAP), the general time frame to complete the CAP process, an update of the RBOs that have 50 percent or more Medi-Cal enrollment and those on corrective action plans. Her presentation also included information on procedures used to oversee the delegated RBOs and some financial concerns regarding RBOs and their affiliates. She added the Provider Solvency Unit will be teaming up with DMHC's Division of Financial Oversight to conduct on-site reviews of health plans' procedures used to oversee their RBOs.

Ms. Yamanaka discussed DMHC's concerns with the reporting requirements for RBOs and the affiliates they are substantially dependent on for healthcare management or other services. The regulation states that RBOs combine their financials if the organization or affiliate is legally or financially responsible for the payment of the organization's claims.

Discussion:

Mr. Furgatch asked what the process is at the DMHC for understanding who is an RBO, how their financials are supposed to be reported and if there is a membership threshold below which they don't need to report to the Department.

Ms. Yamanaka replied if a health plan contracts with an RBO, the health plan informs the RBO it needs to come to the Department and obtain an RBO number. Also, any entity that meets the definition of an RBO is required to report to the Department. There is a threshold for what type of filing they submit. If the RBO membership is less than 10,000, the RBO submits a compliance statement, which is an attestation that they are meeting the solvency criteria. If membership is over 10,000, the RBO must submit financial statements.

Mr. Williams voiced his concern that 40 percent of those with over 50 percent Medi-Cal are in some kind of oversight. Mr. Williams asked if there is anything this group can do

to help advise or come up with ideas.

Ms. Rouillard pointed out a regulation that applies to health plans and affiliates, and requires the plans to report their affiliates' financial statements to the Department. There is no similar regulation for RBOs. If the FSSB would like to make a recommendation, that would be appropriate, as the DMHC is seeking the Board's input.

Mr. Furgatch asked if DMHC is looking for a suggestion, since there are regulations that exist for a health plan that don't exist for an RBO.

Ms. Yamanaka replied that regulation would help the DMHC see the whole picture. Right now, the regulations state RBOs and affiliates have to combine financial statements only if they're legally or financially responsible for the payment of claims.

Ms. Rouillard clarified that DMHC is not making a recommendation to the board, because the board makes recommendations to the Department.

Mr. de Ghetaldi asked if the benefits outweigh the downside to implementing this. He asked if it would protect California's Medicaid patients and if it would empower the DMHC to do the right thing on behalf of patients.

Ms. Yamanaka replied it would. DMHC would have a clearer picture of what's going on financially with the entire organization. Right now, DMHC is not able to see the entire organization. If one side is going down, it's possible the other side is going to go down. At that point, it may be too late.

Mr. Williams asked for clarification if RBOs would be required to give all the affiliate documents all the time or only when there are concerns.

Ms. Yamanaka responded based on the health plan regulation, an affiliate would be included when the RBO is substantially dependent on the affiliate; for example, medical services or administrative services.

Ms. Rouillard added any regulation would go through the whole regulatory process, public hearings, and comments, etc. Even though DMHC may propose a regulation that is identical to this regulation, in the regulatory rulemaking process it may change.

Mr. Meadows added if there was something like this for RBOs, there probably would be changes in these types of arrangements. Some of these relationships are structured in this manner because of the way the Department operates.

Ms. Yamanaka agreed.

Ms. Kelch asked if this would include the ability of the Director to waive the requirement.

Mr. Meadows recommended the Department should have the regulatory authority to require affiliate transaction information from RBOs. Mr. Meadows also recommended making it discretionary, to avoid administrative burden on both the RBOs and the

Department.

Ms. Abbott seconded.
Don Comstock, Comstock and Associates, stated when it comes to MSO agreements, he doesn't think they have to be an affiliate for the Department to be concerned. Many of the IPAs can't function and perform those functions without an MSO. An MSO doesn't have to be related. There are large MSOs that have no affiliation with a medical group. The Department should understand what those transactions are and the financial condition of those MSOs.

Derek Schneider, Chief Financial Officer for one of the largest independent MSOs in the state, asked about the definition of an affiliate. If the definition relies upon services, that's not entirely accurate. As an independent MSO, clients can go anywhere and get those same services from other MSOs. There are not financial relationships going back and forth.

Mr. Furgatch recommended waiting for a more specific recommendation regarding RBOs and modifying the existing Knox-Keene plan language.

Ms. Rouillard stated her intent to include this issue on the agenda for the next meeting.

Dr. Wilson asked for it to be sent out in advance so it can be reviewed prior to the meeting.

7) County-Organized Health Systems.

Gary Baldwin, Deputy Director for Plan and Provider Regulations for the DMHC, explained at the last FSSB meeting there was a question in regards to County Organized Health Systems, or COHS, and Knox-Keene licensure. The COHS are exempted from licensure by the DMHC under Knox-Keene. This exemption is found in Welfare and Institutions Code 14087.95. All other Medi-Cal Managed Care plans are required to get a license. The DMHC does not have a position on licensure for the COHS one way or the other.

Discussion:

Mr. Williams proposed all Medi-Cal Managed Care plans, including COHS, should be under the oversight of the DMHC.

Mr. de Ghetaldi asked if in San Mateo, which is a COHS and a dual demonstration project, they adopt a duals functionality would they then become subject to DMHC or would they remain outside our jurisdiction. What was behind Healthy Families' thinking that plans would have to be licensed by the DMHC?

Ms. Kelch replied it was a Managed Risk Medical Insurance Board decision. The Board required every plan contracting with Healthy Families to be licensed by the DMHC.

Ms. Pumpian noted Healthy Families was considered a commercial product, not a Medi-

Cal product.

Mr. de Ghetaldi asked if a duals Medicare Advantage plan or a Cal Medi-Connect plan would be considered a commercial product.
Ms. Rouillard replied they are Medicare Advantage plans with a Medi-Cal component to them.

Ms. Kelch asked if the Medicare Advantage part has to be licensed by the Department.

Ms. Rouillard replied they have to be licensed by DMHC. When it comes to the elements of a Medicare Advantage Plan, like network adequacy, claims, etc., that is CMS's responsibility, not the DMHC's.

Ms. Pumpian asked if the recommendation to DMHC is to suggest that all Medi-Cal plans come under licensure by the Department. She asked if it could be voted on now since it was on the agenda.

Trent Smith, a Legislative Representative for five county organized health systems, clarified that COHS, while not Knox-Keene licensed, have almost every element of a Knox-Keene license in their contract with the Department of Health Care Services (DHCS). They are very heavily regulated and undergo several financial audits. They would see Knox-Keene licensure as redundant and unnecessary.

Dr. Wilson asked if the amount of oversight provided by the DHCS, from a financial perspective, is available publicly.

Mr. de Ghetaldi stated the DMHC could ask for transparency from DHCS to bring the exact same reporting. DMHC may have no oversight, but could make information about COHS transparent and level the playing field at least from a reporting perspective.

Ms. Pumpian asked for a comparison of the COHS model contract and the DMHC requirements.

Mr. Comstock replied there are differences in definitions between DHCS contracts and a DMHC contract as it relates to the rights and definitions in the contracts.

Ms. Pumpian is interested in obtaining the historical legislative reasoning for the disparity and a comparison of the financial requirements.

Mr. Furgatch stated more discussion is needed on this topic. There's a lot of history and we need a lot more information before we can make any sort of recommendation.

Ms. Pumpian agreed.

8) Division of Financial Oversight/Provider Solvency Updates

Ms. Pumpian announced that the Board received the Division of Financial Oversight Update and the Provider Solvency Update via e-mail. Ms. Pumpian asked if there were

any questions on these two reports.

Discussion:

Ms. Pumpian asked if there was any 2014 update for the total medical group enrollment by business type slide.

Ms. Yamanaka replied no. This information is received annually.

9) Public Comments

Ms. Pumpian asked if there any public comments that had not been addressed. There were none.

10) Agenda Items for Future Meetings

Ms. Pumpian asked if there were any agenda items for future meetings, other than the ones already discussed.

Ms. Rouillard asked for people emailing her regarding the restricted license to please send their questions only to her and not the whole Board. Comments will be brought to the next meeting.

11) Closing Remarks/Next Steps

The next meeting is scheduled for August 20, 2014.

The meeting was adjourned at 1:02 p.m.