

Meeting Notes
Financial Solvency Standards Board (FSSB) Meeting
February 9, 2012

FSSB Members in Attendance:

Chairperson Keith Wilson, President and CEO Talbert Medical Group
Brent Barnhart, Director, Department of Managed Health Care
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
Dave Meadows, Vice President of California Health Programs, Health Net of California
Ann Pumpian, Senior Vice President and CFO, Sharp HealthCare
Tom Williams, Executive Director, Integrated Healthcare Associates

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
Suzanne Goodwin-Stenberg, Chief, Division of Financial Oversight
Shelley Rouillard, Chief Deputy Director
Mark Sumner, Legal Counsel, Office of Legal Services
Michelle Yamanaka, Manager, Provider Solvency Unit

1) Welcome

Keith Wilson, FSSB Chairperson, called the meeting to order and welcomed attendees.

2) Minutes from November 9, 2011 FSSB Meeting

Chairperson Wilson made a minor spelling correction to the November 9, 2011 board meeting minutes. The board approved the corrected minutes.

3) Opening Remarks

Board member Brent Barnhart, Director of the Department of Managed Health Care, commented on the importance of the topics slated for discussion in anticipation of full implementation of federal health care reform.

4) Medical Loss Ratio Discussion

Discussion Document: [Topic for Input](#)

Dennis Balmer, DMHC Deputy Director of the Financial Solvency Standards Board, requested board discussion regarding the Centers for Medicare and Medicaid Services' (CMS) Medical

Loss Ratio (MLR) Interim Final Rule guidance letters clarifying reimbursement for clinical services. He asked whether the proposed federal rules regarding MLR would have the same impact on fee-for-service provider arrangements as for capitated provider arrangements. The board's comments focused on the intent of the law to treat capitation payments and fee-for-service payments similarly.

Chairperson Wilson stated that the overhead costs of running an individual practice is included in the cost of providing medical care and is not billed separately. Board member Williams said the medical loss ratio was intended to target the insurance industry. Board member Cymerys described the national discussion regarding MLR preceding the passage of the ACA and stated that from an insurance company perspective, capitated payments fall entirely under the cost of health care.

Mr. Balmer stated that the CMS clarification calls for treating payments made to third party vendors differently than those to providers. Board member Cymerys said he believed the clarifications apply to specific types of providers, such as pharmacies, where plans can clearly see the distinction between the cost of drugs and overhead. He said behavioral health services could be another potential third-party vendor where the guidance could apply.

Chairperson Wilson closed the board discussion by saying that he believed that if fee-for-service and capitated providers were treated differently, an undue burden would be placed on capitated providers. Chairperson Wilson asked if there were any questions or comments from the audience.

Dietmar Grellman with the California Hospital Association stated that the intent of the legislation was not to carve out administrative payments from capitation payments and treat capitation differently from fee-for-service. He said that doctors and hospitals are not third party vendors.

Bill Barcellona with the California Association of Physician Groups explained that in drafting the regulations, federal regulators were concerned about health plans trying to game the system by delegating administrative functions so those costs would not be reported in the plan's MLR. He stated that the draft guidance attempted to address this issue and that the delegated model was caught in the crossfire. He expressed concern about creating a regulatory system that could destroy the delegated model. IPAs may be designated as third party vendors and could trigger administrative reporting requirements even though this is contrary to the goals expressed by the Affordable Care Act (ACA). Mr. Barcellona indicated that discussions are ongoing with CMS to identify a four-part test to determine whether a third-party vendor entity is a care provider who is providing covered clinical services under an at-risk agreement, or is merely acting as an administrator, such as a PBM.

Keith Pugliese with Brown & Toland Physicians agreed that administrative duties in capitated medical groups were tied to medical care.

Beth Abbott with Health Access indicated she worked on the federal MLR regulation and that consumers did not win on every point. She said that on the whole, with tradeoffs, the positions taken by the National Association of Insurance Commissioners were balanced. She said that CCIIO doesn't have a full understanding of the delegated model and how health care is delivered

in California. She advocated that in cases where health plans delegate administrative expense to IPAs that those expenses be counted towards the plan's administrative expense. Board member Pumpian asked Ms. Abbott how she would differentiate between the services that are delegated to an IPA and those to a medical group. Ms. Abbott stated that the distinction would take some discussion and parsing out. She urged the DMHC to give full consideration to the spectrum of positions expressed.

Board member Cymerys noted the evolution in oversight of risk bearing organizations and their distinctions from health plans. He said the DMHC has drawn a line between activities and responsibilities that would require state licensure as a health plan.

Chairperson Wilson stated that the California model has moved away from fee-for-service to fee-for-value for the benefit of consumers and providers. He acknowledged the challenge of distinguishing between an IPA and medical group.

Bill Barcelona commented that the federal guidance is trying to address the issue of capturing administrative services that are contracted downstream from the health plan.

Chairperson Wilson reiterated that the MLR is targeted to health plans and attempts to improve transparency. He stated that the average independent private practice has very high administrative overhead, which he estimates at 50 to 60 percent. He discussed ways in which IPAs lessen individual practice overhead through capital investments and electronic health record adoption.

5) Federal Accountable Care Organization regulation updates

Gary Baldwin, DMHC Assistant Chief Counsel in the Division of Licensing, gave a brief update on Accountable Care Organizations (ACOs). The department continues to receive inquiries regarding ACOs, but has not received a license application from a new entity wanting to become an ACO.

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

6) Provider Solvency Updates

Presentation: [Provider Solvency Update](#)

Michelle Yamanaka, Manager of the DMHC Provider Solvency Unit, provided an update as of September 30, 2011. Ms. Yamanaka highlighted the decrease in commercial health plan enrollment and the increase in Medi-Cal managed care plan enrollment since 2010. DMHC attributes the majority of the increase in Medi-Cal to the transition of individuals from fee-for-service into Medi-Cal managed care. She also highlighted the correlation between a high rate of Medi-Cal enrollment and risk for insolvency. Ms. Yamanaka discussed the steady decrease in the length of time it takes for the DMHC to approve corrective action plans and the length of time it takes for RBOs to obtain compliance after a corrective action plan is in place.

Board member deGhetaldi asked that future provider solvency presentations include the percentage of enrollees in at-risk RBOs that are in Medi-Cal managed care because he is

concerned this is growing. Board member Barnhart noted that with the transition of more individuals into Medi-Cal managed care, the percentage is likely to increase.

Ms. Yamanaka noted that the majority of RBOs on corrective action plans have less than 20,000 total enrollees.

Chairperson Wilson opened for public question and comments.

Discussion:

Tim Madden with the California Chapter of the American College of Emergency Physicians said his organization is interested in the trends related to the solvency of RBOs with high rates of Medi-Cal enrollees.

Beth Abbott with Health Access stated that there are lots of people transitioning quickly into Medi-Cal managed care. She is in support of managed care generally, but voiced the need for safeguards for consumers. She expressed concern that the Department of Health Care Services (DHCS) is unaware of solvency issues with Medi-Cal managed care plans. She urged the DMHC and DHCS to coordinate closely to prevent moving additional enrollees into Medi-Cal managed care plans at risk for insolvency. Shelley Rouillard, DMHC Chief Deputy Director said that the DMHC and DHCS are meeting monthly on these and other topics.

Bill Barcelona stated that the MLR requirement does not apply to Medi-Cal managed care and that the plans lack fiscal transparency. He said greater fiscal transparency is needed in the Medi-Cal managed care program.

Board member deGhetaldi asked who from the state is looking at the total value Medi-Cal managed care plans provide to patients, beyond just financial. He stated he'd like to see a report card that encompasses service, quality, access and financial solvency.

Don Comstock, private consultant, said that moving the seniors and persons with disabilities into Medi-Cal managed care plans isn't a financial burden if provider negotiations with health plans are appropriate. Capitated provider networks have demonstrated coordinated care and cost savings over fee-for-service networks. He expressed concern with health plans basing provider rates for the mandatory managed care enrollment population on the voluntary enrollment population as they are two different populations.

7) Division of Financial Oversight Updates

Presentation: [Health Plan Solvency Update](#)

Stephen Babich, supervisor in the DMHC Division of Financial Oversight, first addressed a concern raised by Beth Abbott regarding communications and coordination between DHCS and DMHC related to the transition of seniors and persons with disabilities into Medi-Cal managed care. He stated that DMHC is conducting MLR examinations of Medi-Cal managed care plans and he is coordinating daily with DHCS staff. He also stated that DMHC has set a lower level of materiality* for the Medi-Cal managed care to ensure that every dollar is accounted for.

[*referring to using a potentially lower dollar amount to trigger DMHC review]

Mr. Babich then provided a brief an overview of the DMHC's oversight of health plans and an update on their financial health. The DMHC regulates 109 active (55 full-service) health plans with approximately 22.5 million people enrolled.

Board member deGhetaldi asked whether the influx of newly eligible people into the Medi-Cal program in 2014 will impact the financial solvency of managed care plans. Mr. Babich said there will be more risk in 2014 because the state does not have a detailed history of the health costs of the newly eligible population.

Board member Cattaneo asked whether three health plans were still reporting out-of-state data in their enrollment and financial data. Mr. Babich said a couple of plans may be including some out-of-state enrollment but DMHC staff work with the plans to fix errors in their reporting. Mr. Cattaneo raised a concern with the difference between the federal ACA's MLR calculation and the one used by the DMHC for Medi-Cal and MRMIB. Mr. Babich stated that the MLRs for DHCS and MRMIB are more stringent than the proposed ACA calculation. Board member Pumpian said that it would be helpful to see the enrollment figures with all out-of-state enrollment excluded. She also asked whether the enrollment in PPOs regulated by the California Department of Insurance is declining, flat or increasing. Mr. Babich said the DMHC does not have those figures.

Derek Schneider (public) clarified that the decrease in commercial enrollment could be attributed to a multitude of economic factors.

Board member Pumpian said that the market is also increasingly moving to self-insured business, not regulated by the DMHC.

Mr. Babich discussed the claims payment examinations and provider dispute resolution violations and reported that the violations appear lower during the second round of claims payment exams. He also reported the status of MLR examinations for MRMIB and DHCS. Mr. Babich described the violations that may result in a referral for consideration of enforcement action.

Board member Cattaneo raised broad questions regarding trends in enforcement actions taken by the department. Board member Barnhart asked to table this discussion until a future board meeting so that DMHC Deputy Director of Enforcement could present the requested information.

Board member Meadows asked whether the closely monitored plans are mostly small enrollment Medicare plans. Mr. Babich stated that there was a flood of Medicare Advantage applications 4-5 years ago and that may contribute to more Medicare Advantage plans struggling financially. Board member Meadows asked whether the capital requirements are high enough for these plans. Mr. Babich stated that they are the same for all plans.

Board member Williams asked about the Bureau of State Audits exam and whether the Board should be concerned with the findings. Suzanne Goodwin-Stenberg, chief of the Division of Financial Oversight stated that there were two findings related to financial oversight that the DMHC is addressing. She also clarified that the financial oversight and monitoring of local initiatives is the same as for all health plans.

8) Public Comment on Matters Not on the Agenda

None.

9) Agenda Items for Future Meetings

The following topics were suggested for future meetings:

- Impact of Medi-Cal cuts on Independent Practice Associations and Medical Groups
- Impact of Health Care Reform on DMHC rules and regulations
- Grievance tracking
- More information on enforcement actions
- Presentation by Medi-Cal Managed Care Plans
- Discussion with ACO Pioneer organization
- What will the Medi-Cal world look like in three years
- Revisit the scope of topics the FSSB should be talking about
- Joint report on specific things DMHC and CDI are coordinating on

10) Closing Remarks/Next Steps

The next FSSB meeting is scheduled for May 10, 2012 in Sacramento.