DEPARTMENT OF
Managed
HealthCare

Meeting Notes

Financial Solvency Standards Board (FSSB) Meeting
November 9, 2011

FSSB Board Members in Attendance:
Brent Barnhart, Director, Department of Managed Health Care
Grant Cattaneo, CEO and Founder of Cattaneo & Stroud
Edward Cymerys, Senior Vice President and Chief Actuary, Blue Shield of California Keith Wilson, President and CEO of Talbert Medical Group
Ann Pumpian, Senior Vice President and CFO, Sharp HealthCare
Dave Meadows, Vice President of California Health Programs, Health Net of California Rick Shinto, President and CEO of Aveta, Inc.
Larry deGhetaldi, M.D., Palo Alto Medical Foundation
Deborah Kelch, independent consultant

1) Welcome

Keith Wilson, FSSB Chairman, called the meeting to order and welcomed attendees. Dr. Wilson introduced DMHC's new director, Brent Barnhart. Also introduced were new Chief Deputy Director Shelley Rouillard, and Division of Finance Oversight Chief, Suzanne Goodwin-Stenberg.

2) Minutes from November 9, 2011 FSSB Meeting

The minutes from the November 9, 2011 board meeting were approved.

3) Opening Remarks

DMHC Director Brent Barnhart shared his experience over the years attending Financial Solvency Standards Board meetings during the evolution of SB260. He shared that he found the meetings valuable to discuss difficult and essential financial issues. Mr. Barnhart commented on the Federal Health Care Reform topics on the agenda and the importance of the discussion to how the Department will move forward with day-to-day business.

4) Timely access regulations

Maureen McKennan, Deputy Director, Plan and Provider Relations provided an overview of the Timely Access Regulations that became effective January 17, 2012. The first plan filings to DMHC were required January 18, 2010 and included provider network data, primary care provider to enrollee ratios, quality assurance policies and procedures,

subscriber and enrollee disclosures, and provider contract amendments. To date, only one plan requested alternative standards and the request was denied. All full service and mental health plans must file their first annual report by March 31, 2012 for the calendar year ending December 31, 2011. Ms. McKennan gave a demonstration of the web portal application for plans' timely access annual reports. The reports will be reviewed by DMHC for compliance to standards and will focus initially on patterns of non-compliance. DMHC must ensure the reported information allows consumers to compare the performance of plans and their contracting providers. DMHC expects to prepare a summary report of the information reported by the plans. All data submitted by plans will be public unless confidentiality is requested and granted by the Department. The results will be incorporated into the Office of the Patient Advocate's annual quality of care report card. The Board discussed how data is defined, how much data is being requested, how the data would be interpreted by different audiences, and who the target audience is. Ms. McKennan explained that the data is a snapshot in time and not real- time information. A concern was raised that the network snapshot could be outdated and mislead consumers.

5) Federal Accountable Care Organization regulation updates

Gary Baldwin, Assistant Chief Counsel, Division of Licensing, gave an update on Accountable Care Organizations (ACOs). CMS published new comprehensive regulations for ACOs on November 2, 2011 that are being reviewed and analyzed by the DMHC. Mr. Baldwin reiterated the broad statutory authority of the Knox-Keene Act (KKA) to regulate Health Care Service Plans. He also indicated KKA licensure contemplates the passing of risk. The department has a long-held position that taking global capitation will require KKA licensure. Mr. Baldwin stated that the current ACO Medicare Shared Savings Program, as described, is a fee-for-service arrangement and would not trigger DMHC jurisdiction. The ACO Pioneer program appears to be fee-for-service in the first two years and therefore would not initially trigger DMHC jurisdiction. However, in year three, switching to population-based payment could trigger KKA jurisdiction and a licensure requirement. An element of the CMS regulation requiring further discussion is the ability of CMS to contract directly with providers for Medicare Part B professional risk. This arrangement would also likely require KKA licensure. Mr. Baldwin indicated DMHC would schedule stakeholder workshops to discuss this and other potential capitation arrangements being contemplated, e.g., with non-KKA plans, self-funded plans, hospital-based arrangements, etc.). Beth Abbott from Health Access asked to include consumers and CMS in its workshops with industry groups.

6) SB260 Updates

Michelle Yamanaka, Provider Solvency Unit Supervisor, provided an update on SB260. DMHC has initiated 11 new Corrective Action Plans (CAPs) to date in 2011. The Department's approval time for CAPs in 2011 is 57 days, down slightly from 2010 and 30 days less than the statutory requirement. As of June 30, 2011 the DMHC had 185 Risk Bearing Organizations (RBOs) reporting SB260 information to the Department, down two from the quarter ended March 31, 2011. As of October 31, 2011 there are 11 RBOs on CAP (8 continuing and 3 new). Of the eight continuing RBOs on corrective action, seven are improving and one has worsened. Enrollment in eight of the eleven RBOs on CAP is over 50% Medi-Cal. Seven of the 11 CAPs are less than 1 year in duration. Following up on a request from the Board, Ms. Yamanaka stated that there are over 400,000 enrollees in the RBOs on corrective action. This is down from over 600,000 at year end 2009 and 2010. Ms. Yamanaka also showed the enrollee distribution on CAPs by the size of the practice. DMHC was asked to comment on the results of provider group audits conducted by the Provider Solvency Unit for the next FSSB meeting.

7) Division of Financial Oversight Updates

Stephen Babich, Division of Financial Oversight Supervisor, gave an overview of the DMHC's oversight of health plans and an update on the financial health of DMHC's licensed plans. Altogether, the DMHC oversees 109 plans. DFO has removed Quality Improvement Fund plans from the count because they are redundant and not unique operational plans. DMHC oversees 55 full service plans, down one from August. Plan enrollment (as reported by plans) as of March 1, 2011 was approximately 22.0 million (the actual is approximately 18.8M after eliminating plan-to-plan duplication, out-of -state enrollment, and other adjustments). Reported enrollment is up by about 200K versus the previous quarter report. Commercial enrollment declined across all lines and Medi-Cal enrollment drove the bulk of the increase. The DMHC is closely monitoring the financial condition of 23 full service plans on a monthly basis. They represent over 1.5M lives. Nineteen of the twenty three plans on the financial watch list are Medicare or Medi-Cal plans. Mr. Babich showed a slide contrasting the average Tangible Net Equities (TNE) maintained by the different types of plans. Three specialty plans, two vision and one dental plan were TNE deficient, representing over 56,000 lives. Mr. Babich also highlighted the number and types of exams DFO has conducted and the filings received. He provided information breaking out the eleven enforcement referrals. There were three referrals each for "Failure to Maintain TNE" and "Provider Dispute Resolution Violations" and four violations for "Unfair Claims Payment Patterns".

8) Public Comment on Matters Not on the Agenda

There were no matters presented.

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 to DMHC rules and regulations
- Grievance tracking
- Enforcement actions specific to the timely access requirements

10) Closing Remarks/Next Steps

The next FSSB meeting is scheduled for February 9th, 2012 in Sacramento.