Financial Solvency Standards Board Meeting
January 18, 2017
Meeting Notes

Financial Solvency Standards Board (FSSB) Members in Attendance:
Jeffrey Conklin, Adventist Health Plan
Dr. Larry de Ghetaldi, The Palo Alto Medical Foundation
Paul Durr, Sharp Community Medical Group
John Grgurina, Jr., San Francisco Health Plan
Betsy Imholz, Consumers Union
Dr. Jeff Rideout, Integrated Healthcare Association
Shelley Rouillard, Department of Managed Health Care
Amy Yao, Blue Shield of California

Department of Managed Health Care (DMHC) Staff Present:
Rachel Arrezola, Deputy Director, Communications and Planning
Steven Babich, Supervising Examiner, Division of Financial Oversight
Rodger Butler, Information Officer, Communications and Planning
Pritika Dutt, Deputy Director, Office of Financial Review
Marta Green, Chief Deputy Director
Dr. Kenneth Kizer, Chief Medical Officer
Sarah Ream, Deputy Director, Office of Plan Licensing
Dan Southard, Deputy Director, Office of Plan Monitoring
Mary Watanabe, Deputy Director, Health Policy and Stakeholder Relations
Michelle Yamanaka, Supervising Examiner, Office of Financial Review

1) Welcome & Introductions - Agenda

DMHC Director Shelley Rouillard called the meeting to order and welcomed attendees. Ms. Rouillard announced she would facilitate the meeting until the Board selected a new chair.

2) Minutes from September 14, 2016 FSSB Meeting

Ms. Rouillard asked if there were any changes to the September 14, 2016 FSSB meeting minutes. Meeting minutes were approved without objection.

3) Board Member Welcome and Election of Board Chair

Ms. Rouillard stated the Department had selected several new Board members since the last meeting. A solicitation was released after the September Board meeting and

over 20 responses were received. The Department looked for a mix of experience and perspectives including actuarial experience, health and medical economics, and health care administration.

Ms. Rouillard announced the reappointment of Dr. Larry de Ghetaldi and asked the following new board members to introduce themselves:

- Jeffrey Conklin, Adventist Health Plan
- Paul Durr, Sharp Community Medical Group
- John Grgurina, San Francisco Health Plan
- Amy Yao, Blue Shield of California

Ms. Rouillard announced Betsy Imholz had agreed to serve as the Board Chair. There were no objections from the Board.

4) Director's Remarks

Ms. Rouillard provided an update on DMHC's recruitment efforts. The DMHC hired five Deputy Directors in the past three months and now has a fully-staffed Executive Team. The new Deputy Directors include:

- Elizabeth Landsberg, Deputy Director, Help Center
- Drew Brereton, Deputy Director, Office of Enforcement
- Pritika Dutt, Deputy Director, Office of Financial Review
- Sarah Ream, Deputy Director, Office of Plan Licensing
- Dan Southard, Deputy Director, Office of Plan Monitoring

In addition, the DMHC appointed Dr. Ken Kizer as its Chief Medical Officer. Dr. Kizer will advise the Department on clinical matters and develop the Department's comprehensive health plan quality improvement program to drive improvement in clinical outcomes for health plan enrollees.

Ms. Rouillard reviewed the DMHC's 2015 Annual Report, which was released in October. The report highlights the key accomplishments and statistics for each office, including summary statistics for Independent Medical Reviews (IMRs) and complaints by health plan.

5) 2016-17 Governor's Budget Update

Marta Green, Chief Deputy Director, discussed the Governor's budget for the 2017-2018 fiscal year. The proposed budget includes nearly $77 million in total spending

authority for the DMHC and 451 authorized positions. This is a net increase of five positions over the prior fiscal year.

The Department has four Budget Change Proposals (BCPs) for the upcoming fiscal year, three that add funding and positions and one that reduces funding and positions. The BCPs include:

- The Help Center Case Backlog and Workload BCP adds eleven permanent and five limited-term positions. It includes a budget augmentation of $3.4 million in the 2017-18 fiscal year and ongoing funding of $2.6 million.
- The Information Technology (IT) and Resource BCP will support DMHC's IT functions related to the growth of the Department. This BCP equates to funding of $746,000 for the upcoming fiscal year and an ongoing budget of $289,000.
- The Prohibition on Surprise Balance Billing BCP is associated with the implementation of Assembly Bill (AB) 72, which prohibits surprise balance billing when an enrollee receives services at an in-network hospital and receives a surprise bill because one of the treating physicians or other personnel was not in-network. This BCP adds 16 permanent staff, which equates to $3.5 million in the 2017-18 fiscal year and ongoing funding of $2.2 million. The vast majority of the added positions will be allocated to the Help Center to run the Independent Dispute Resolution Process (IDRP) and the Office of Plan Monitoring, which will monitor the implementation of AB 72.
- The Medicaid Managed Care Final Rule BCP proposes a reduction of 18.5 permanent staff and a budget reduction of $3.4 million in the 2017-18 fiscal year and an ongoing reduction of $2.9 million. The BCP terminates four interagency agreements with the Department of Health Care Services (DHCS), who will take on monitoring functions required by the federal government in the Final Rule. This reduction will mostly pertain to the Office of Plan Monitoring and a few in the Office of Financial Review and the Help Center, but there will be no layoffs. The reductions will be absorbed through attrition and vacancies.

Discussion

Betsy Imholz stated the Help Center is one of the jewels of the DMHC and asked how the Department will handle the potential onslaught of calls during these uncertain times and the confusion that will likely follow. Ms. Green explained the Help Center has undergone a significant reorganization to increase efficiency and reduce redundancy of work. The streamlined processes, in addition to the positions associated with the BCPs, will help the DMHC remain flexible in responding to whatever comes.

Amy Yao requested clarification regarding the redundant activities associated with DHCS. Ms. Green replied the activities the Department was conducting on behalf of DHCS, such as conducting surveys or network reviews, will no longer be conducted by DMHC.

Anthony Wright, Health Access California, expressed his organization's appreciation of the investments in implementing AB 72 and added the ultimate goal is the Help Center would no longer need to resolve complaints pertaining to surprise medical billing. Mr. Wright questioned the reduction of three Help Center positions since the number of Medi-Cal enrollees that contact the Help Center is relatively small. Ms. Green clarified that there are about 140 staff in the Help Center, but the three positions in question were to administer the Coordinated Care Initiative (CCI) Ombudsman Program not to provide direct consumer assistance.

Dr. Jeff Rideout asked how restrictive the AB 72 resources are and if they could be used to assist with other consumer issues. Ms. Green said the resources are primarily intended to administer the IDRP program required by AB 72. She added the eleven positions associated with the Help Center BCP will give the Help Center the appropriate resources to handle incoming complaints.

Bill Barcellona, CAPG, stated the Department has had an on-going balance billing protection since 2007 that uses the Gould criteria for balance billing related to ER services. Mr. Barcellona asked if the DMHC has considered how it might combine the IDRP processes. He also asked if there will now be two standards for payment or if the DMHC will blend the two. Mary Watanabe, Deputy Director, Health Policy and Stakeholder Relations, answered the DMHC envisions the binding arbitration process for AB 72 will be separate from the IDRP process for emergency services. Ms. Watanabe indicated there will stakeholder engagement taking place before July 1.

6) National Trends in Individual and Small Group Premiums

Donna Novak, NovaRest Actuarial Consulting, presented an overview of how California compares to other states in several areas, including rate increases and their drivers, components of final premium rates, number of carriers per rating area, and risk adjustment.

Ms. Novak stated California had the lowest rate increases, including the lowest overall average increase in both the individual and the small group markets in 2017.

Ms. Novak explained metal level is particularly important in the individual market because the silver metal level is what determines the subsidy for lower income enrollees and if someone doesn't get a subsidy and can only afford the bronze level, the lowest cost tier is also important. She made the following observations about metal tiers in the individual market:

- California had one of the lowest average increases at the bronze level.
- At the silver tier, there was a big difference between the states with a low increase versus a high increase and California was close to the states with the lowest increase.

- California had the second lowest increase in both the gold and platinum tier.

Ms. Novak noted the following observations regarding the small group market:

- California had the lowest increase in the bronze and silver tiers.
- California tied for the lowest increase in the gold tier.
- At the platinum level, one state had a reduction in their rates, followed by California with the lowest average increase.

Ms. Novak noted that her company looks at hundreds of rate filings and what is driving rate increases. By far, the largest impact has been the trend, but there are other factors such as changes in administrative cost, non-benefit expenses and worsening morbidity. The end of the reinsurance program also increased rates slightly across the board. In addition, some carriers projected their experience to be lower than what it really was, so they were underpriced and therefore had larger rate increases.

California was in the middle when looking at trends in the individual market, which is amazing considering the rate increases were so low. California had the lowest trend in the small group market.

California had the second lowest profit margin percentage. However, when you look at profit margin on a per member per month (PMPM) basis, California had the lowest profit margin in both the individual and small group market.

Ms. Novak compared rates for a 21 year old by market and tier. The reason age 21 is used is because it is an age factor of one. This comparison is also adjusted by cost of living because it is expected that states with a high cost of living would have higher premium rates. This is particularly relevant because California has the third-highest cost of living of the fifty states. However, California had the lowest average rate in all tiers in both the individual and the small group markets.

She then compared the number of carriers offered per area on the Exchanges. California ranks second with an average of four carriers per region in the individual market and three per region in the small group market.

Finally, Ms. Novak discussed risk adjustment and the problems caused by carriers who don’t have the information to estimate their risk and the kind of risk adjustment they will have to pay. California had the second highest risk adjustment transfer with $628.6 million in the individual market and $327.5 million in the small group market.

The Federal Government may be providing more detail in the future, but the information may not be timely or mature enough to be helpful as risk adjustment changes from year to year. Population migration between plans is another problem. Plans are seeing

individuals change from carrier to carrier as the lowest cost silver plan changes, which is creating a lot of swing in some parts of the market. In addition, individuals who were allowed to keep their individual and small group plans are now transitioning into the market and it is difficult to predict their morbidity or impact on the risk adjustment.

Discussion

John Grgurina asked if the averages presented were an aggregate of all plans on-Exchange or if it was a weighted average. Ms. Novak answered it was a weighted average.

Mr. Grgurina asked if the trends only included on-Exchange plans or if she also included individual products sold off of the Exchange. Ms. Novak said she believed they focused just on-Exchange and stated most of the time off-Exchange plans would use on-Exchange rates so the trend would be the same.

Ms. Yao confirmed the industry uses the same trend data for both on-Exchange and off-Exchange, but the benefit levels and pricing can vary off-Exchange.

Dr. Larry de Ghetaldi asked if there is a better way to understand the variation in the rate increases within California's regions. Ms. Novak explained one factor that controls rates in different regions for a carrier is the geographic factor. She added that when they see a change in the geographic factor they can ask questions to ensure the geographic factors do not reflect morbidity and just reflect the cost of care in that area.

Dr. Rideout stated the analysis done in the Integrated Healthcare Association's (IHA's) Statewide Cost and Quality Atlas confirms that even when adjusted for wages, there is still a significant variation of 20 to 25 percent in the total cost of care in some regions.

Dr. de Ghetaldi stated when a physician completes an encounter with a patient, they complete the medical record and assign an International Classification of Diseases (ICD)-10 and Current Procedural Terminology (CPT) code. Physicians have been taught that the CPT code is what drives revenue, but the ICD-10 code is important, particularly in Medicare Advantage, for risk adjustment. An accurate diagnosis in the Covered California, individual and small group market may accurately identify morbidity and improve affordability and the opportunities for subsidies. If this is true, it could change the thinking of physicians.

Ms. Novak responded that accurate coding will impact the risk adjuster, which impacts the revenue because it is basically an adjustment to claims for the carrier and will have an ultimate impact on the premiums. Dr. de Ghetaldi stated this is a revelation for some that have been in the healthcare industry for a long time that accurate coding is increasingly important.

Paul Durr asked if the variation between states would be as great if utilization were to be normalized at a standard cost relative to the premiums. Ms. Novak responded it is

difficult to obtain accurate utilization and cost information because they usually get the baseline with trends. They tried to account for some of that by normalizing for cost of living.

Ms. Yao explained that California's premium rates are lower than other states because California has one of the biggest populations and it is healthier overall. In addition, California started managed care a long time ago and providers have done a better job of managing utilization compared to other fee-for-service states. In the small group market, the California legislation that discouraged small employers from moving to self-funded kept healthier employer groups in the pool which has kept rates down.

Ms. Imholz asked if the explanations carriers gave for rate increases is accurate. Ms. Novak responded it varies from carrier to carrier but they believe the carriers are doing a good job of isolating what is driving the rates increases.

Ms. Imholz was surprised that plan design changes was number four on the list of reasons for increases of 15 percent or more since Covered California has pretty standard designs. Ms. Novak clarified that this was across all states and some states have a lot more variation within each metal tier.

Ms. Imholz asked if California was one of the states to receive the highest risk adjustment transfer because it has a big market or for some other reason. Ms. Novak stated that it could be an indication that some carriers are getting healthier individuals and other carriers are getting significantly less healthy individuals. Ms. Novak added risk adjustment does not compensate for the sickest individuals, meaning a carrier that attracts very unhealthy individuals is being under-compensated by risk adjustment.

Dr. Rideout stated there was one state that had 33 different silver plans and 26 of them were from one carrier. The variation has narrowed, but it is still confusing for consumers. Dr. Rideout added that while managed care deserves a lot of credit, the proposed rate increases by carrier that were presented at the September FSSB meeting showed the carriers that had more integrated care had some of the lowest rate increases. There is variation within managed care in terms of the degree of integration.

Dr. de Ghetaldi stated he agreed that the early introduction of managed care in California had a positive downstream impact on utilization and total cost of care. He asked if being one of the states with the highest risk adjustment has a negative impact on the plan. Ms. Yao said risk adjustment is good from her perspective because it allows plans to offer broad PPO networks and to have sicker patients. Without the risk adjustment, plans might eventually exit the market.

Jeffrey Conklin asked if the variation in profitability was explained by the mix among the metal tiers or if it is truly a reflection on the plans. Ms. Novak explained the biggest driver of profitability is if a plan has solvency issues and they have to make up for that in profits. The medical loss ratio can't be lower than 80 percent so there is a limit on how

much profit they can make. If a plan has a lot of reserves and surplus, a plan can be competitive with a lower profit.

Mr. Barcellona raised three issues for the Board to consider. First, there is an instance in San Francisco County where an unexpectedly high risk adjustment transfer has resulted in a dispute by a capitated provider related to several million dollars in claw back of capitation. This is a good example of the impact of high rates of risk adjustment transfer on downstream risk-bearing providers.

Mr. Barcelona stated this was a great presentation about the individual and small group market, which represents about 1.5 to 1.8 million Exchange members. A similar presentation for the large group market would be very interesting, particularly given the huge erosion of HMO in the large group market over the last decade.

Finally, Mr. Barcelona suggested the DMHC should present this information to the members of Congress and the California Congressional delegation. The presentation shows California's Exchange has had superior results over the last four years.

Ms. Rouillard asked if it was possible to do a similar presentation for the large group market. Ms. Novak responded that many states don't gather information on the large group market and information is not readily available.

7) Legislative Update

Ms. Watanabe provided a summary of the legislation implementation activities the DMHC has been involved in during the past year, as well as some that are yet to come.

Ms. Watanabe stated the goal of Senate Bill (SB) 137 is to improve the accuracy of provider directories and to provide standardization across directories. Since the last meeting, the Department held a stakeholder meeting and released the first draft of the standards on December 30, 2016. The plans have until January 1, 2018, to implement the initial standards. There will be two opportunities to make changes to the standards before promulgating regulations by January 1, 2021.

Ms. Watanabe acknowledged Havi Jogani for working collaboratively with the California Department of Insurance on the development of the initial provider directory standards required by SB 137. It was quite an undertaking that proved to be very complex.

SB 546 requires large group plans to file large group aggregate rate information with DMHC annually beginning October 1, 2016. Plans are also required to provide information in their notices to employers about how the rate increase compares to the average rate increase for Covered California and the California Public Employees Retirement System (CalPERS). SB 546 also requires the DMHC to hold an annual meeting to discuss large group rates. The meeting is scheduled for February 1 in San Francisco.

Ms. Watanabe then reviewed AB 72, which takes effect on July 1, 2017, and prohibits surprise balance billing. The DMHC is required to establish a methodology for calculating the reimbursement rate to non-contracted providers by January 1, 2019. The rate paid to non-contracting providers will be the greater of the average contracted rate or 125 percent of the Medicare rate. AB 72 preserves the out-of-network benefit for those in a PPO but they must give written consent 24 hours in advance.
In addition, prior to July 1, 2017, plans must provide information to the DMHC about their methodology for calculating the average contracted rate and their policies and procedures. The DMHC will hold a stakeholder meeting in the spring. As discussed in the budget presentation, the DMHC will also be establishing an IDRP process for services provided by a non-contracted provider at an in-network facility.

The final bill Ms. Watanabe discussed was SB 908, which extends the time period for plans to file their premium rate changes with the DMHC. It also requires a plan to provide written notice to renewing groups, policyholders, or applicants when the Department determines a premium rate increase is unreasonable or unjustified.

Discussion

Ms. Yao stated rate review was not new for the DMHC and asked what the new requirement was under SB 908. Ms. Watanabe responded that SB 908 extends the time period for rate review from 60 days to either 100 or 120 days. Ms. Rouillard added the extended filing period in SB 908 will allow for more time to review and go back and forth with the plans. It will also allow more time for the DMHC to consider the comments submitted by consumer advocates.

Ms. Yao said while she understands the rationale, this will require the plans to develop the rates earlier than would be typical. This means they will have to use two months older experience and the longer period they have to project out, the more risk in the rates. This could create opportunities for corrections the following year.

Dr. de Ghetaldi said it appears there will be two doors for IDRP – the traditional one for emergency services and the one created by AB 72. He added he would like to hear more in a year from now about the volume and the conflicts that are seen. Ms. Watanabe committed to providing updates at future meetings.

Ms. Imholz said there was a recent Journal of the American Medical Association (JAMA) article on the specialties that tend to have the greatest likelihood of surprise bills. She added that this is an issue of deep interest for Consumers Union, which has a big national campaign to end surprise medical bills. She asked that in addition to reporting on IDRP trends it would be good to also report on consumer complaints to get a full picture.

Tim Madden, on behalf of the California chapter of the American College of Emergency Physicians (CalACEP) and California Society of Plastic Surgeons, asked what criteria will be used by the arbiters for the IDRP required by AB 72. Ms. Watanabe responded

that there is a lot to be learned from the existing IDRP process but this would be part of the discussion during the stakeholder meeting. She suggested individuals interested in updates should sign up for DMHC's listserv or contact her directly for more information about the stakeholder meetings.

Mr. Wright asked how the legislation implementation timelines intersect with the existing corrective action plans, health plan mergers, and other activities related to provider directories and rate increases. Ms. Watanabe answered the DMHC has a requirement in one of the undertakings that involves unreasonable rate increases and they are looking at the impact of SB 908. She also mentioned that through the undertakings related to the Blue Shield/Care1st merger, there is an Advisory Committee that is looking at where the financial investment is needed to ultimately create a multi-plan directory. Ms. Rouillard added the Advisory Committee is in the information gathering stage but they are working on something that will be easy to use and useful for both providers to update their information and for plans to get information to populate their directories.

Mr. Barcellona said the delegated risk-bearing groups will need guidance on how the DMHC will require the addition of the adjuster to the 2015 base rates and what CPT codes they will need to report on. He added historically when the Department has requested data from the delegated payers, it was a manual process. He encouraged the Department to consider an automated process for collecting the data through an automated portal. Ms. Watanabe responded the DMHC anticipates about 400 entities will be filing and the DMHC will be working quickly to provide the necessary guidance.

8) Website Enhancements

Rachel Arrezola, Deputy Director, Communications and Planning, and Rodger Butler, Information Officer, Communications and Planning, presented an overview of the recent enhancements to the DMHC website including the health plan dashboard and the rate review website.

Ms. Arrezola said the DMHC launched the health plan dashboard last fall. The goal was to centralize all the health plan data to make it easier for the public to find and to help the DMHC better utilize the data internally.

Mr. Butler demonstrated the health plan dashboard, which is located on the DMHC website at www.dmhc.ca.gov. The Dashboard includes data such as enrollment, consumer complaints, enforcement actions, and health plan finances. He showed how information for two like plans can be compared side by side. The Dashboard also provides an aggregate market-wide view of the entire industry regulated by the DMHC.

Ms. Arrezola then discussed the rate review enhancement project. She explained health plans are required to file proposed premium rate changes for the individual and small group markets with the DMHC. The DMHC reviews the proposed changes to ensure they are supported by data, such as medical costs and trends. There is also an

opportunity for the public to provide comments to the Department. The goal of this project was to educate the public about the rate review program and to make it easier to navigate the site.

Mr. Butler demonstrated the premium rate review webpage. The page displays the amount saved per calendar year, as well as other educational and informational pages. Mr. Butler demonstrated how to access the filing details for each plan and where to leave comments. He also pointed out a new "stay informed" feature that will send an e-mail notification when there is a new rate filing or a change in filing status.

Mr. Butler showed the educational and informational section of the website, which now includes information and videos on topics such as the rate review process, the cost of health care, how rates are developed, medical loss ratio and rebates. Mr. Butler pointed out that there is also a new enhanced key terms section and frequently asked question (FAQ) section.

Discussion

Dr. de Ghetaldi asked if the Dashboard links to the Office of the Patient Advocate (OPA) data because it would be helpful for consumers to link this with information about customer service and quality. Ms. Arrezola confirmed it does. She added the Department is looking at future enhancements that could bring in new datasets.

Ms. Yao recommended also including data from the Department of Insurance (CDI) to provide a comprehensive view of the California market. This was seconded by Ms. Imholz and Mr. Grgurina. Ms. Arrezola noted that, according to the most recent annual report from California Health Care Foundation (CHCF), DMHC regulates 95 percent of the commercial market.

The Board congratulated the Department on the improvements to the website and the ability to easily find information in one place.

Beth Abbott, Director, Office of the Patient Advocate, announced OPA's recent release of its 2015 Complaint Data Report, which includes complaint information from DMHC, CDI, DHCS, and Covered California.

8) Department of Health Care Services Update

Mari Cantwell, Chief Deputy Director, Health Care Programs and State Medicaid Director, DHCS, provided several updates about the Department, particularly related to the recent release of the Governor's budget. The DHCS budget is projected to be $105 billion in the 2017-2018 fiscal year, which includes about $20 billion in General Fund. This is an increase of $10 billion from the prior fiscal year and a contributing factor to the deficit the Governor spoke about in his budget presentation.

Ms. Cantwell stated the Coordinated Care Initiative (CCI) requires the mandatory enrollment of dual eligibles into managed care and the integration of long term services and support in seven counties. The statute contains a poison pill trigger that if the Department of Finance (DOF) finds the program is not cost effective, it will become inoperative the following January. In determining the cost effectiveness of the program, the DOF looked at the fiscal components of the program, including the increased cost of in-home supportive services (IHSS) over time and found that the program is not cost effective. Therefore, the poison pill is activated and would result in CCI ceasing in January 2018.

DHCS believes in the program and the long term benefits of integration in reducing institutional care and bringing individuals back into the community. The Governor proposed keeping the programmatic aspects of CCI but removing IHSS from the health plan responsibility and capitation rate. There will be no impact to beneficiaries because they didn't really know it was part of their health plan and the coordination with IHSS and the care team will continue. This will require a statutory change, which will be done through a trailer bill.

Ms. Cantwell also described changes for newly qualified immigrants. Currently, the state provides full-scope, State-only Medi-Cal coverage for legal immigrants who have been in the country for less than five years. They are not eligible for Federal Medicaid due to the five year bar. In 2013, the state enacted legislation that would enroll these individuals in Covered California so they could receive subsidies. Additional costs or comprehensive Medi-Cal benefits not covered by Covered California would be paid by Medi-Cal.

Originally, the plan was to transition only adults with no children, but the Governor's budget proposed moving all newly qualified immigrant adults to Covered California unless they are pregnant or have some other form of minimum essential coverage (MEC). This will help individuals that might be subject to tax penalties because state-only Medicaid is not considered MEC. The proposed change could result in up to 120,000 individuals transitioning from Medi-Cal to Covered California on January 1, 2018.

Ms. Cantwell discussed the implementation of a couple of Federal regulations that impact Medicaid Managed Care. The Medicaid Managed Care Final Rule requires plans to report MLR data to the DHCS, which DHCS is required to consider in rate setting so there is a minimum 85 percent MLR.

In addition, the Final Rule also makes several significant changes to rate setting and the rates paid with non-General Fund dollars. Currently, billions of dollars in hospital payments flow through Medicaid Managed Care Plans to hospitals. The biggest one is hospital provider fees in the amount of $3 to 4 billion. The Final Rule sets new limits and requirements around whether those can continue. DHCS is talking to the health plans and the hospitals about the best way to make this work.

Ms. Cantwell also discussed the work DHCS is doing related to the Final Rule requirements for network adequacy. By July 1, 2018, states are required to develop specific network adequacy standards that are broader than the Knox-Keene standards. In addition to having different standards for adults and children, they must include time and distance standards for other providers such as specialists, behavioral health providers, dental providers, Obstetrics/Gynecology (OB/GYN), hospitals and pharmacies. In addition, the state must certify the networks annually. DHCS anticipates releasing the draft standards by the end of January.

The Final Rule also requires DHCS to develop a quality rating system to rank the health plans against each other. The effective date is several years away, but DHCS is planning to release a draft proposal in the first quarter of the year.

Ms. Cantwell concluded by discussing the Mental Health Parity Rule that becomes effective in October. This is different from the ones the commercial plans already had to comply with. DHCS is in the process of analyzing utilization management, limitations on the number of services and network standards.

Discussion

Ms. Imholz asked if financial status would be incorporated into the quality rating system. Ms. Cantwell responded DHCS is still working on it.

Ms. Imholz also asked about the how the requirement in the Final Rule regarding provider directories interacts with the work DMHC is doing on provider directories. Ms. Cantwell answered DHCS is working with DMHC and the plans on the various requirements.

Mr. Grgurina thanked Ms. Cantwell and DHCS for their continued support of the plans that implemented the CCI program and he was pleased to hear that enhanced coordination for these individuals will continue.

Dr. de Ghetaldi expressed his concern for individuals in the counties that don't have CCI because for some solo physicians, the Medicare Access and CHIP Reauthorization Act (MACRA) requirements have gone too far and they may stop taking Medicare patients. These counties may start to see access issues.

Don Comstock, Comstock and Associates, requested that DHCS once again publish the rates paid to the health plans. The plans are forthcoming with the decreases but not the increases and it would be helpful for the groups to have this information. Ms. Cantwell explained it is the DHCS's intent to publish the rates but they have had a 50 percent vacancy rate in the Rate Development Division so there has been a delay.

10) Risk Bearing Organization Sub-delegation

Michelle Yamanaka, Supervising Examiner, Office of Financial Review, reviewed the definition and criteria of a Risk Bearing Organization (RBO) and defined sub-delegation as an RBO delegating all or part of its risk to another RBO.

Ms. Yamanaka reviewed two examples of RBO sub-delegation that came up when the reporting RBO became non-compliant with the solvency criteria and was required to do a corrective action plan (CAP). The CAP process is usually a collaborative effort between the contracting health plan, the RBO and the Department. However, in these examples, not all of the health plans were involved in the CAP process even though the majority of the enrollment came from these plans.

Discussion

Dr. de Ghetaldi asked if patients will be negatively impacted if the sub-delegated RBOs are not monitored. Ms. Yamanaka replied claims may not get paid. If claims go unpaid, it is possible the providers may stop seeing their patients or improperly balance bill enrollees.

Mr. Grgurina asked if the sub-delegated RBO is overseen by the DMHC. Ms. Yamanaka said for those RBOs that come to the Department and request an identification number, the Department reviews their financials. However, it is unknown how many of these arrangements exist and if there are entities that don't come to the Department to request an identification number.

Ms. Yamanaka further explained that typically when an RBO contracts with a health plan, the health plan is responsible for reviewing the financials, but in the example provided, there was no health plan reviewing the financial information of the sub-delegated RBO. In this case, only the DMHC was reviewing the financials. In addition, if any administrative action is needed, the DMHC would normally go through the health plan to review the books or records. However, in this example, there was no contract between the health plan and the sub-delegated RBO.

Mr. Durr said that if the Department is reviewing audited financial statements for the RBOs, they should include any downstream risk arrangements they have with other RBOs. That should give the DMHC some comfort to the financial stability of the downstream RBO.

Ms. Yao asked how often this situation occurs to get a sense of how big the problem is. Ms. Yamanaka said it is unknown how often this occurs and there are a couple other arrangements, in addition to the examples provided, where this is occurring. Ms. Yao suggested asking health plans to do a comprehensive survey or study to get a better sense of how many sub-delegated arrangements exist.

Dr. de Ghetaldi stated during the last three years of plenty in Medi-Cal, there have been a lot of RBOs with financial solvency issues. He expects this to become more

problematic over the next five years and recommended a broader scope of oversight into the sub-capitated arrangements of RBOs.

Mr. Durr asked if this included capitation sub-delegation to an orthopedic group or dental surgery group which is a much larger volume. He added that ultimately, RBO number one is responsible for meeting the financial solvency requirements. Dr. Rideout agreed and recommended requiring disclosure of any arrangements below the primary RBO as a good start.

Jennifer Jackman, representing a medical group, said when the Department implemented SB 260 years ago, one of the questions raised was whether the patient could be harmed. In all of these situations, RBO number one is the delegated entity to the health plan so they are on the hook to pay claims. Even if RBO number one delegates claims processing to RBO number two and neither RBO pays the claims, the health plan is ultimately responsible to pay the claims.

She added the delegation agreements between the health plans and the RBOs are very specific and it is unlikely they allow the RBO to give up claims processing to another entity without being subject to approval or audit. Ms. Jackman said she does not think this is very common and the health plans are aware of the delegation. It is a matter of making sure that the health plans are doing their job by monitoring the claims.

Mr. Comstock cautioned that there are hundreds of contracts with entities, such as a laboratory, where claims are paid within the company. He cautioned DMHC to clearly define what a sub-delegated entity is because it could apply to a much larger number of contracting arrangements. Ms. Rouillard responded that an entity owned and operated by physicians who pay their own claims would not meet the definition of an RBO and would not be included.

Mr. Barcellona called attention to the confusion between sub-capitation and sub-delegation. He clarified, and Ms. Rouillard agreed, the DMHC is not investigating sub-capitated relationships. Mr. Barcellona clarified that there are hundreds of sub-capitated arrangements, but not very many sub-delegated arrangements. He believed that these are outlier situations and simple remedies could be put into place to solve this problem. He suggested the DMHC could simply freeze enrollment for an irresponsible RBO until the contracting issues are resolved.

Mr. Barcellona said there have been several changes to the financial solvency requirements and reporting over the last decade. He cited the Centinela Freeman case, which establishes a cause of action for negligent delegation by a plan and incentivizes the plans to have tighter contracting relationships with their capitated entities. He added, most of the plans on the DMHC watch list are in Medi-Cal. However, there are already Medi-Cal Managed Care (MMC) rules that require plans to ultimately pay downstream claims.

Wendy Soe, California Association of Health Plans, provided support for the delegated model in California and said there is a lot of oversight already in place. She cautioned the DMHC from making any changes that could disrupt affordability and access for a problem that is not widespread.

Derek Schneider, Chief Financial Officer for MedPOINT Management, commented on the importance of properly defining sub-delegation and echoed previous remarks cautioning the broadening of SB 260. In his experience, the plans are doing a fairly comprehensive audit regularly so most of the arrangements should be known by the health plans.

11) Provider Solvency Quarterly Update

Ms. Yamanaka provided an update on the financial solvency of RBOs for the quarter ending September 30, 2016:

- 179 RBOs were required to file annual survey reports. Of those, 129 RBOs filed quarterly survey reports and 50 RBOs submitted compliance statements.
- 4 RBOs are on a corrective action plan (CAP), all of which are meeting the requirements.
- 5 RBOs are on the monitor closely list.
- The number of CAPs decreased from 13 to 11 compared to the prior quarter. Eight RBOs are improving and three are new in this quarter.

Ms. Rouillard explained the Board had previously asked for a list of RBOs on CAP so they could see which RBOs are going on and off of CAPs. This is the first time this information was presented and shows that RBOs do come on and off the list and it is not always the same ones.

Discussion

Mr. Durr suggested including if the plans were on a CAP in the prior year or two to indicate the overall stability of the organization.

Dr. Rideout asked if enrollment information is available to determine if these RBOs have Medi-Cal versus commercial enrollment. Ms. Yamanaka explained that the DMHC gets information on the enrollment mix by different products but this information is considered confidential. Ms. Rouillard said she could share aggregate level data and of the 17 plans on CAP, 10 have some Medi-Cal and 7 have more than 50 percent Medi-Cal enrollment. This indicates that it is not as Medi-Cal heavy as many have thought.

12) Health Plan Quarterly Update

Stephen Babich, Supervising Examiner, Division of Financial Oversight, presented the highlights of the health plan quarterly update for the quarter ending September 30, 2016:

- There are 74 full-service health plans.
- There are nine applications pending, six of which are full-service.
- Enrollment in full-service plans is almost at 26 million lives, with a fairly even distribution between commercial enrollment and government enrollment.
- There are now 17 full service and 7 specialized plans on the closely monitored list, compared to 22 full service and 6 specialized plans in the prior quarter.
- There was one tangible net equity (TNE) deficient plan. The deficient plan was identified as Sutter Health Plus.

Mr. Babich provided an update on the TNE disbursement of all plans and the closely monitored plans by enrollment and line of business. There are three plans below 130 percent of minimum TNE.

Discussion

Ms. Yao said she was surprised by the number of Medicare Advantage plans on the closely monitored list because the Centers for Medicare and Medicaid Services (CMS) has strict requirements for participating in Medicare. Mr. Babich explained CMS delegated financial oversight of Medicare Advantage to the states, but retained items such as networks and other licensing issues. The DMHC is responsible for administrative capacity and financial solvency, but shares information with CMS on occasion.

Ms. Rouillard asked how many of the plans on CAPs are limited licensees versus full service plans. Mr. Babich answered one of the Medi-Cal plans, five of the Medicare Advantage plans, and one of the commercial plans are restricted licensees. He added many of the restricted licensees are former RBOs who are used to significantly lower TNE requirements.

Mr. Grgurina asked what the criteria is for being on the TNE deficient list. Mr. Babich said the plans with less than 100 percent TNE end up on the list with the vast majority of the plans in the 80 percent to 90 percent range. Two-thirds of the plans come out of a TNE deficiency relatively fast. The threshold for the closely monitored list is at 130 percent.

Mr. Barcellona asked if plans are placed on the closely monitored list for the first three years after licensure. Mr. Babich explained newly licensed plans are immediately on monthly reporting for the greater of one year or until the plan breaks even.

Mr. Barcellona asked how many plans in the Medi-Cal Managed Care category are approaching 100 percent MLR such that they would start to burn into their reserves. Mr. Babich said he cannot disclose the MLRs, but generally the Medi-Cal plans have high MLRs.

Mr. Grgurina said the Medi-Cal plans are tapping into their reserves the moment they start losing money. He expects the Medi-Cal plans to start to break even or lose some money due to the Medi-Cal expansion rates and they will start tapping into their reserves. Mr. Grgurina said for his plan, they are approaching $600 million annually, or $50 million a month in premium. They have a TNE of $11 million, which equates to one week's worth of expenses. It would appear their reserves are nine times TNE, but this would only last for about two months, which is why the plans are hanging on to their reserves.

In the past, when the state budget wasn't passed and the Medi-Cal plans didn't get paid, they used their reserves to pay community providers, especially the Federally Qualified Health Centers (FQHCs). This was particularly important for the FQHCs because they were not getting paid for their fee-for-service business and would not have been able to keep going during those times.

13) 2017 Meeting Schedule

The next meeting is scheduled for April 19, 2017. The remaining meeting dates for 2017 are:

- Wednesday, April 19, 2017
- Wednesday, July 19, 2017
- Wednesday, October 18, 2017

11) Public Comment on Matters not on the Agenda

Ms. Rouillard asked for public comments on items not on the agenda. There were none.

12) Agenda Items for Future Meetings

Ms. Rouillard asked if there were any agenda items for future meetings. There were none.

13) Closing Remarks/Next Steps

The meeting was adjourned at 1:09 p.m.