FINANCE COMMITTEE
SANTA CRUZ – MONTEREY – MERCED MANAGED MEDICAL CARE COMMISSION

Teleconference Meeting

(Pursuant to Governor Newsom's Executive Order N-29-20)

(800) 700-3874
www.ccah-alliance.org

DATE: **Wednesday, May 27, 2020**

TIME: **1:30 – 2:45 p.m.**

Important notice regarding COVID-19: Based on guidance from the California Department of Public Health and the California Governor's Office, in order to minimize the spread of the COVID-19 virus, Alliance offices will be closed for this meeting. The following alternatives are available to members of the public to view this meeting and to provide comment to the Committee.

1. Members of the public wishing to join the meeting may do so as follows:
    a. Via computer, tablet or smartphone at: https://global.gotomeeting.com/join/348311589
    b. Or by telephone at:
    United States: +1 (312) 757-3121
    Access Code: 348-311-589
    c. New to GoToMeeting? Get the app now and be ready when your first meeting starts: https://global.gotomeeting.com/install/348311589

2. Members of the public wishing to provide public comment on items not listed on the agenda that are within jurisdiction of the committee or to address an item that is listed on the agenda may do so in one of the following ways.
    a. Email comments by 5:00 p.m. on Tuesday, May 26, 2020 to the Finance Administrative Specialist at tbernard@ccah-alliance.org.
        i. Indicate in the subject line "Public Comment". Include your name, organization, agenda item number, and title of the item in the body of the e-mail along with your comments.
        ii. Comments will be read during the meeting and are limited to five minutes.
    b. Public comment during the meeting, when that item is announced.
        i. State your name and organization prior to providing comment.
        ii. Comments are limited to five minutes.

3. Mute your phone during presentations to eliminate background noise.
    a. State your name prior to speaking during comment periods.
    b. Limit background noise when unmuted (i.e. paper shuffling, cell phone calls, etc.).

AGENDA

FINANCE COMMITTEE
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1. Call to Order by Chairperson Molesky. (1:30 p.m.)

A. Roll call

2. Oral Communications. (1:30 – 1:35 p.m.)

Members of the public may address the Committee on items not listed on today's agenda that are within the jurisdiction of the Committee. Presentations must not exceed five minutes in length, and any individual may speak only once during Oral Communications.
If any member of the public wishes to address the Committee on any item that is listed on today's agenda, they may do so when that item is called. Speakers are limited to five minutes per item.

3. Approve minutes of February 26, 2020 meeting of the Finance Committee. (1:35 – 1:40 p.m.)

4. Payment Assessment for Medical Cost Analysis (Discussion) – Edrington Healthcare Consulting. (1:40 – 2:00 p.m.)

5. Medical Cost Analysis and Containment Plan Recommendation (Action). (2:00-2:45 p.m.)

Members of the public interested in attending should call the Alliance at (831) 430-5523 to verify meeting dates and locations prior to the meetings.

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The complete agenda packet is available for review on the Alliance website at http://www.ccahalliance.org/boardmeeting.html and at the Alliance's offices. The Commission complies with the Americans with Disabilities Act (ADA). Individuals who need special assistance or a disability-related accommodation to participate in this meeting should contact the Clerk of the Board at least 72 hours prior to the meeting at (831) 430-5523.

FINANCE COMMITTEE
SANTA CRUZ – MONTEREY – MERCED
MANAGED MEDICAL CARE COMMISSION

Meeting Minutes

Wednesday, February 26, 2020
1:30 – 2:45 p.m.

In Santa Cruz County:
Central California Alliance for Health
1600 Green Hills Road, Suite 101, Scotts Valley, California
In Monterey County:
Central California Alliance for Health
950 East Blanco Road, Suite 101, Salinas, California
In Merced County:
Central California Alliance for Health
530 West 16th Street, Suite B, Merced, California

Commissioners Present:

Ms. Leslie Conner	Provider Representative
Ms. Mimi Hall	County Health Services Agency Director
Ms. Elsa Jimenez	County Health Director
Supervisor Lee Lor	County Board of Supervisors
Mr. Michael Molesky	Public Representative

Commissioners Absent:

Mr. Tony Weber	Provider Representative

Staff Present:

Ms. Lisa Ba	Chief Financial Officer
Ms. Stephanie Sonnenshine	Chief Executive Officer
Oksana Chabanenko	Financial Analyst I
Tina Bernard	Finance Administrative Specialist

1. Call to Order by Chairperson Michael Molesky. (1:32 – 1:33 p.m.)

Chairperson Molesky called the meeting to order at 1:32 p.m. Roll call was taken. A quorum was present.

2. Oral Communications. (1:33 – 1:34 p.m.)

Chairperson Molesky opened the floor for any members of the public to address the Committee on items not listed on the agenda.

No members of the public addressed the Committee.

[Commissioner Elsa Jimenez arrived at this time: 1:34 p.m.]

3. Approve minutes of December 4, 2019 meeting of the Finance Committee. (1:34 – 1:35 p.m.)

FINANCE COMMITTEE ACTION: Commissioner Molesky moved to approve the minutes of the December 4, 2019 meeting of the Finance Committee, seconded by Commissioner Conner. Motion carried with 4 votes affirmative, 1 absent and was so ordered.

4. Year-to-date Preliminary December Financials as of 1/31/2020. (1:35 – 1:39 p.m.)

Ms. Lisa Ba, Chief Financial Officer (CFO), updated the commissioner on the Alliance's most recent financials. As of December 2019, the net operating loss stands at $8.0M, which is an 8% net loss. The Medical Loss Ratio (MLR) is 101% compared to the budget of 94.9%. The Administrative Loss Ratio (ALR) is slightly below budget at 6.4% versus the 7.2% budgeted. The overall net operating loss for 2019 is $72M, ending at a 5.5% net loss. The MLR is 99.3% versus 97.3% budgeted. The operating loss is primarily due to the State's implementation of the Whole Child Model (WCM) for the Medi-Cal population

Ms. Ba recalled that the 2019 mid-year forecast assumed breakeven performance of the WCM. Also, revenue and operation issues to convert members with high-dollar claims to the WCM program, such as the Neonatal Intensive Care Unit – Intervention (NICU-I) and High Infant Risk Follow-up (HRIF), resulted in a revenue loss of $30M.

Commissioner Leslie Conner asked about the possibility of retroactive reimbursement. Ms. Ba responded that no reimbursement is expected based on the State's methodology. She informed the committee that dialogue with the Department of Health Care Services (DHCS) regarding WCM revenue deficiency began in December 2019. The next scheduled meeting is on March 10, 2020.

Commissioner Molesky inquired if WCM expenses are categorized to identify cost drivers. Ms. Ba reiterated inpatient hospital expenses are the root cause, specifically NICU-I and HRIF patients with high initial claims of $50-60K. The State built the revenue for WCM at All Patients Refined Diagnosis Related Groups (APR-DRG) rates, which are lower than the Plan's reimbursement rate.

Ms. Ba reminded the Commissioners that the figures presented are preliminary and open to year-end adjustments pending the completion of the annual independent financial audit. Auditors from Moss Adams will report the results to the Board in May 2020.

5. Medical Cost Analysis. (1:55 – 2:45 p.m.)

Ms. Ba presented an update on the financial impact of the payment policy change analysis with options to bring cost in line with revenue. The Alliance has experienced financial loss since mid-year 2017. The projected reserve at the end of 2020 is 81% of the Board Designated Reserve target versus the current 95%. Staff analysis concluded that provider payment is the root cause of the Plan's operating loss. Claim data from State Fiscal Year (SFY) 18/19, when the State implemented the WCM, confirmed our provider reimbursement rates exceeded industry standards. Ms. Ba emphasized the project goal is to align medical costs with the Plan's revenue and industry standards; to maintain and improve provider network and services for Alliance members, and to maintain and improve operational efficiency of Alliance staff and providers.

Ms. Stephanie Sonnenshine, Chief Executive Officer (CEO), stated this initial discussion is a result of a directive from the Board at the October 23, 2019 meeting. The Board requested a broader analysis of the provider payment structure with recommendations to align cost with revenue. She advised the Commissioners' approach a high-level policy discussion and petition information to present payment policy recommendations at the Finance Committee meeting on March 25, 2020. Proposals will be presented to the Board on April 22, 2020.

Ms. Ba continued with the project timeline. Staff performed financial and network impact analysis November 2019 through March 2020; the Finance Committee will review analysis, options and next steps today; staff performed provider outreach in February that will continue through March; staff will engage the Physician Advisory Group (PAG) in March to assess access impact; the Finance Committee will review payment policy proposal on March 25, 2020; the final proposal will be submitted to the Board on April 22, 2020 for approval. Staff plans to implement the new payment structure no earlier than October 1, 2020.

Ms. Ba moved on to a five-year review of financials from 2015-2020. The Medi-Cal Expansion revenue rates were high during 2014–2016 allowing the Alliance to accumulate reserves. The Plan earned $114M in 2015, $80M in 2016, and $30M in 2017. She reminded the committee that the provider reimbursement increase was implemented in 2016-2017 from Medi-Cal to 2015 Medicare Physician Fee Schedule. Hospital negotiated a 10% increase year-over-year for 2017-2019 resulting in $89M loss in 2018, $72M loss in 2019, and a $53M loss is budgeted in 2020.

Commissioner Conner suggested explaining the analytical approach and framework for analysis in the recommendation to the Board. For instance, admin cost might be interpreted as one of the factors. Ms. Sonnenshine agreed with the suggestion and confirmed the analysis factored admin cost. For two years the Plan reduced administrative cost to align with sister healthcare plans, with favorable variance to budget at 6.4% ending December 2019.

Ms. Ba continued with the five-year fund balance projections for 2019-2024. The forecasted budget showed a consecutive operating loss under the current provider payment structure. In 2021 the State of California will carve out the pharmacy benefit, resulting in a loss of expense and revenue associated with this benefit. The projected loss is $57M in 2021, with assumptions of 7% increase in revenue and 6% increase in medical cost. For 2022-2024, the projection assumes the expense grows 1% less than the revenue. Ms. Sonnenshine clarified the medical cost projections anticipate an increase in rate and utilization. Ms. Ba added that acuity drives the medical unit cost increase. A high-risk WCM member will have more stays in NICU versus medical/surgical day. Thus, the increase in unit cost is due to acuity, not the hospital contract rate. Calendar year (CY) 2022 is projected at a net operating loss of $44M, with break-even forecasted in 2026-2027.

The fund balance at the end of December 2019 is $452M, which is 830% of the State required Tangible Net Equity (TNE). The balance after grant exclusion is $292M, which is 95% or $14M below the Board target. Five-year projection of TNE revealed reserves in 2022 will be five times State requirements, with projections trending four times State requirements in 2023-2024. Data as of September 2019 confirmed the Alliance's current TNE reserve is at industry benchmark when compared to other sister healthcare plans. Ms. Ba emphasized that TNE below four times State requirements will necessitate submission of a monthly report to the Department of Managed Health Care (DMHC) to monitor the Plan's performance. The Alliance currently submits a quarterly report to DMHC. Ms. Sonnenshine strongly advised the Plan correct course to prevent State intervention inclusive of frequent on-site monitoring, as encountered by some local health plans.

Commissioner Conner questioned why three of the plans presented have higher TNE performance. Ms. Ba answered the plans are heavily delegated thereby shifting risk to an Independent Physician Associations (IPA), in addition to offering Medicare services. Ms. Sonnenshine added that plans in environments conducive to Medicare in a Medi-Cal fee structure with urban rates experienced higher TNE performance.

Ms. Ba revisited the top four medical cost results from the 2018 Rate Development Template (RDT). Inpatient hospital services are $314M or 30% of cost; Physician services is $210M or 20% of cost; Pharmacy is $162M or 16% of cost; Long Term Care is $130M or 13% of cost. The year-over-year analysis showed that inpatient and outpatient hospitals increased 16%, and accounted for 80% or $53M of the total increase in cost. She reviewed the rate development sequence noting the RDT for 2018 will establish rates for 2021. 2019 RDT is scheduled in the summer of 2020 to establish rates for 2022.

Commissioner Conner inquired if the analysis included Primary Care Physicians (PCP), both FQHCs and Private PCPs. Ms. Sonnenshine affirmed the analysis was inclusive of both. Ms. Ba stated that the budget assumed increased utilization in Primary Care in exchange for lower utilization in inpatient and emergency room. Commissioner Conner commented on the importance of including such information in the Board report.

Commissioner Jimenez questioned if there is any correlation between the increase of year-to-year inpatient hospital cost and the implementation of CalAIM in terms of rates with emphasis to redirect the line item cost to preventative care. Ms. Ba responded that CalAIM seeks cost effective in-lieu-of services to reduce inpatient, facility and long-term care cost. CalAIM's region definition is unknown. The State will move from year-over-year rate setting to comparing utilization across regional health plans in the future. The State rates set utilization target for each health plan, and the Alliance has not met the target. Ms. Sonnenshine added that the State will assess plans with higher cost as outliers to apply state-wide averages.

Key takeaways are inpatient and outpatient facility cost increased 16% year-over-year, while DHCS expects a 2-4% annual increase after applying the state-wide efficiency adjustment. The gap between inpatient revenue and spend is $52M. DHCS will implement regional rates effective 2021, creating a sense of urgency for the Alliance to align cost structure to other Medi-Cal Managed Care plans. The Alliance completed a survey inclusive of the Plan's pay structure by provider type for the State as part of the RDT process for 2018.

Commissioner Molesky inquired if the regional rate applies to all three service areas. Ms. Ba explained the State will issue rates in two phases. Phase I will introduce regional rates in 2021. Group rates averaging utilization across neighboring plans is scheduled for Phase II in 2023. A regional rate creates a financial disadvantage for the Alliance if compared to other plans with lower rates and higher network adequacy.

Ms. Ba presented three options recommended by staff to revise the provider payment policy. A passive approach under the current payment structure does not present an opportunity for the Plan to break-even. The moderate approach will bring cost in line with revenue rate trends and allow for the implementation of industry payment methods with break-even projected in 2025. The aggressive model brings cost in line with revenue rates and conservative utilization trends, allowing the Plan to implement industry standard payment methods with break-even projected in 2023.

Ms. Ba recommended the implementation of APR-DRG payment structure. APR-DRG is a system that classifies patients according to their reason for admission, severity of illness and risk of mortality. This method of reimbursement is adopted by the majority of Medi-Cal plans to pay inpatient claims. Under the Plan's current per diem reimbursement structure, contracted hospitals receive an agreed upon rate for each day a member is in the hospital. APR-DRG rates are fixed amounts of the member's stay, based on the member's diagnosis. This model is designed to provide hospitals with an amount of reimbursement equal to its own admission diagnosis and discharge index. Accordingly, this eliminates the need to negotiate with hospitals individually and encourages hospitals to promote a model of care.

Revisions to the payment policy present the Alliance with an opportunity to move Specialists to the current Medicare Physician Fee Schedule. The fee-schedule is a national benchmark that allows a comparison of relative prices of all providers incorporating the local market price difference. The majority of specialists are currently reimbursed at the 2015 Medicare Physician Fee Schedule with locality 99. Since each of the Plan's service areas has its own locality, there is an opportunity to bring the Specialists reimbursement to the current Medicare Fee Schedule with the appropriate

locality. Impact by provider type and an access analysis will be performed and reviewed by the Physician Advisory Group (PAG) prior to final recommendations.

Ms. Ba concluded the presentation with the financial impact of the options presented. The passive approach projects net operating reserve continues below the board target by $24.3M in 2022, $75.3M in 2023 and $109.7M in 2024. The moderate approach is forecasted to breakeven in 2025 and the net reserve is $36M below target in 2024. The aggressive method allows the Plan to break-even with a net operating positive reserve through 2023.

Ms. Sonnenshine recited the financial impact and solicited feedback from the committee about which option the Alliance should pursue.

Discussion ensued and the committee agreed to pursue a moderate to aggressive approach with staff exploring a phased approach. The committee requested an explanation of the analysis process, the impact access approach, contingency plans, utilization patterns, and opportunities to redirect members to lower cost services. The commissioners also agreed that offering incentives to hospitals and PCPs would encourage positive outcomes.

The meeting adjourned at 2:55 p.m.

Respectfully submitted,

Ms. Tina Bernard
Finance Administrative Specialist